ALTERNATIVE MODES OF CONDUCTING OUTREACH TO LOW INCOME ELDERLY: AN EXPERIMENTAL EXAMINATION

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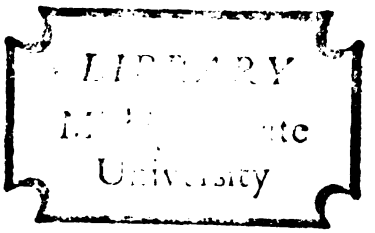

ABSTRACT

ALTERNATIVE MODES OF CONDUCTING OUTREACH
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By

Martin Gregory Kushler

The purpose of this study was to experimentally evaluate different methods of conducting outreach to low income elderly, in an attempt to inform them of services available to meet their needs. Four modes of contact (informational mail, personal mail, telephone and in-person) were analyzed for their effectiveness in reaching and influencing a target population of lower income elderly in a three county area in southwestern Michigan.

A sample of 325 low income elderly (age 65 and over), having no prior contact with the regional information and referral network, were selected as a target sample and randomly assigned to groups receiving one of the four abovementioned modes of contact or to a no-treatment control group. The goals of the outreach contact were designed to correspond to three of the outcome measures commonly used by that existing regional information and referral network. Specifically, the outcome criteria included: whether or not the person registered with the local center, whether or not the person requested to sign up to receive the center's "newsletter," and whether or not the person actually received a service from the center.

The results revealed that the in-person mode of contact was the most effective in terms of all three outcome criteria used in this study and

was clearly the preferable mode to utilize if a maximum impact was desired. In addition, however, the results indicated that the lower cost modes of mail and telephone contact would achieve some degree of success with this target population, particularly for non-complex or non-threatening outreach tasks such as providing basic information, creating name awareness and fostering a positive attitude toward an agency. Hence, it appears that the choice of a particular mode of outreach should depend on such situational variables as the purpose for which the contact was intended and the amount and nature of resources available to the organization. It is felt that the results of this study and the discussion of their implications for policy would prove interesting to anyone involved with the provision of services to the elderly.

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By

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TABLE OF CONTENTS

Chapter Page

LIST OF TABLES

TABLES PAGE

LIST OF APPENDICES

CHAPTER I

INTRODUCTION

The topic area of social services and the elderly is indeed an extensive one. Recognizing this, and in an effort to provide some broad conceptual background, this paper will begin with a fairly lengthy literature review. For those not desiring such information, the latter part of this chapter provides the specific background for the actual experimental project conducted. For those who would prefer some general background, this review will include a discussion of the problems and needs of the elderly, the services available to meet those needs and, most particularly, the role that information and referral/outreach can play in linking needy elderly with services available.

Background: The Elderly as a Problem Population

There can be little doubt that the elderly, as a subpopulation of American citizenry, face a long list of critical problems. The problems many of the elderly face are not new. Income, housing, crime, health care and transportation, to name a few, have long been concerns especially crucial to the elderly. However, a series of social, economic and demographic developments have served to heighten the impact of these problems. First, such social developments as the decline of the extended family and the relegation of the rural society to a backstage role have left many of today's elderly lacking in the traditional means of support and frequently isolated from the mainstream of modern life. In addition, they have the added handicap of being old in a society that

places a premium on youth, attractiveness and vitality. Hence, there frequently results a very real physical and social isolation. Second, the economic developments of the past few years have severely compounded the already difficult problems of income and expenditures. Inflation has hit the elderly, most of whom are on fixed or relatively fixed incomes such as pensions, social security, etc., particularly hard. They find themselves with little or no increase in income, facing raging inflation, expecially in such areas of crucial importance to the elderly as food and medical care. Clearly, many are caught in a desperate squeeze. Finally, the increase in the number of elderly, both in absolute and in percentage terms, has led to a proportional increase in the sheer volume of such problems in America. The 1970 census showed slightly over 20 million "aged" (i.e. over age 65) Americans, accounting for almost 10% of the U.S. population. This is in comparison to only 4% of the population in 1900. Projections are that the percentage of elderly will continue to climb as birth rates decline or remain level and as increased medical effectiveness, nutrition, etc., prolong life (Council of State Governments, 1973; Bild and Havighurst, 1976). As more and more Americans have the opportunity for an extended life span, the question then becomes what is to be the quality of that life? The manner in which social services for the elderly are designed and delivered will have a substantial impact on the answer to that question.

Special Characteristics of the Elderly

Any approach to the problem area of social services for the elderly must necessarily take into account the special biological, psychological and situational characteristics which frequent that population (Tibbetts, 1960; E. Palmore, et al., 1975; etc.). This is particularly important

both in identifying needs of the elderly and in designing programs to meet those needs. The following summaries, though far from comprehensive, help to illustrate some of the problems the elderly face in these areas and some of the strategies that can help to ameliorate them.

Biological Aspects of Aging

It is well established that many biological changes occur as one ages (Shock, 1962; Blumenthal, 1962; etc.). There are numerous theories attempting to explain the aging process, such as "Exhaustion Theory," "theory of accumulation of deleterious materials," etc. (Busse & Pfeiffer, 1969). However, from the standpoint of social services, it seems most appropriate to be concerned with the practical limitations that biological aging puts on the elderly person's functioning and with the practial needs that such aging creates.

Adriaan Verwoerdt (in Boyd and Oakes, 1973) does an excellent job of detailing in layman's terms some of the biological changes that occur in the elderly and some of the practical implications of those changes. For example, age-related changes in the skin and connective tissues, such as loss of elasticity and altered pigmentation, result in changes in external appearance of the elderly. This, of course, can have implications for the self image of the elderly person, resulting in tendencies to avoid social contact, etc. In addition, the elderly person is particularly prone to chronic skin sores from falling or other accidents or from prolonged immobility. Accident prevention and maintenance of the ability to walk are thus important. Changes in the muscular and skeletal system, such as stiffened joints, weakened or altered bone structure and loss of muscle strength may result in changes in posture and reduction of mobility. These developments can be painful as

well as impair the ability to perform many vital functions. Many of these undesirable changes can be eliminated or minimized through appropriate exercise (especially walking). Various health and recreation programs could be of value in these areas, and where mobility is too severely restricted, such programs as friendly visitors and home services could assist in various household chores. Changes in the cardiovascular system include degeneration of tissues, simple "wear and tear," and narrowing of the blood vessels (arteriosclerosis) resulting in increased blood pressure. It is important to remember that the aging heart is less capable of responding to the demands involved with the stress of heavy work. Thus, home services should again be available. Also, proper diet, exercise, and adequate medical supervision are necessary for optimal preventive practices. If blood pressure problems exist, drug therapy should be considered. Numerous age-related changes in the gastrointestinal system also occur. They range from a decrease in sense of smell and taste and problems with loss of teeth, to reduced motility of stomach and intestines and a decrease in production of digestive juices. (It should be kept in mind that many social-psychological factors, such as loneliness, also interrelate with these problems and influence diet.) Practical problems which manifest themselves in the gastrointestinal system include under or overeating, various nutritional deficiencies, increased intake of sweets, decreased fluid intake, constipation and/or bowel incontinence and hemorrhoids. The major objective in this area would be to assure a proper diet. This could be accomplished through a variety of means, including providing appropriate nutritional information, assuring adequate resources for food (i.e. food stamps, etc.), or through more direct means, such as

"meals on wheels" or "friendly visitor" programs. Where appropriate, of course, medical care must also be available.

The above material is by no means an exhaustive list of the biological changes which affect the elderly person. It does, however, present some indication of the problems to be faced. The most appropriate role for social services to take would seem to be to provide to those who require them, some means to prevent or minimize the aversive impact of age-related biological changes.

Psychological Aspects of Aging

In a general sense, the findings in the area of the psychology of aging appear to be important to those inolved with social services to the elderly in two major respects. First, it is important to be aware of what psychological characteristics frequent the elderly population and what practical needs thus exist; and second, it is crucial to realize that many of the dysfunctional psychological patterns observed in the elderly are not, as is often popularly assumed, a necessary characteristic of old age and can, in fact, be modified or eliminated with appropriate situational intervention.

Some of the more obvious psychological changes occur in the area of sensation and perception. Vision suffers a decline with age in several respects, including general visual acuity, adaptation to darkness, and accommodation to different distances (Riley and Foner, 1968). Age also brings about a loss in hearing, both in auditory threshold (Corso, 1959) and in ability to discriminate speech (Melrose, et al., 1963). Kinesthetic perception declines with age (Carp, 1973, in Boyd & Oakes) as does reaction time (Welford, 1959). Such changes can have a marked impact on the well-being and social functioning of elderly

individuals. The relationship between sensory losses and resultant behavior is not direct. Many people devise ways of compensating. However, such losses often tend to make the individual hesitant and unsure of him/herself, particularly among other people and may result in varying degrees of social withdrawal (Carp, 1973) or other dysfunctional symptoms such as personality changes or deteriorating interpersonal relationships (Harris, 1975). These sensory changes are examples of psychological changes which cannot, of course, be eliminated, but proper diagnosis and intervention can help to minimize their effect on the lives of the elderly.

The more serious psychiatric disorders that affect the elderly fall into two major groups: those appearing in the absence of brain damage (psychogenic) and those appearing in the presence of brain damage (organic). Although clearly disabling mental disorders appear to afflict slightly less than 10% of the 65 and over population, approximately one-third of which are under institutional care (Riley and Foner, 1968), these disorders are important to those in social services because they are the most severe that must be dealt with. The role of social services in these situations is primarily one of ensuring detection and appropriate treatment. However, with the increasing evidence of social and environmental factors playing a role in all mental disorders of the elderly (particularly with respect to social deprivation), social services may often perform a preventive function as well. This, in fact, is one rationale behind such services as the "friendly visitor" programs. In addition, some feel the actual treatment of age-related brain disease can be facilitated by the treatment of various exogenous factors (Kobrynski, 1973).

The above developments suggest an expanded role for multifaceted social services in both the prevention and treatment of mental disorders in the elderly. This seems particularly true for the less severe and more common psychological ailments afflicting the aged. There is mounting evidence that depression in the elderly should be generally understood as a reaction to real losses and stresses in the biological, psychological, and social aspects of life (Gordon, 1973; Levin, 1963; Amster and Krauss, 1974). Hence, services that minimize these stresses can be seen as minimizing the likelihood of depression. Other age-related psychological factors that are closely tied to the individual's past and present educational and social experiences include learning ability, motivation, morale, and anxiety (Carp, 1973). These areas, too, may be open for positive intervention by those in social services.

It is important to grasp the implications of this situational impact on the psychological functioning of the elderly. Many behaviors and mental states observed in older persons are simply assumed to occur because of age when, in fact, they may occur for many other reasons, including social-environmental changes that may be associated with aging (Amster and Krauss, 1974). Misconceptions about aging, even among mental health professionals, often lead to a fatalistic attitude toward the elderly (Kobrynski, 1973), which must be overcome if positive intervention is to occur. Busse and Pfeiffer discuss the question of situational impact in terms of adaptation, concluding that successful psychological adaptation by elderly persons does indeed depend to a great extent on functional or dysfunctional patterns of adaptation developed earlier in life and on various biological, social and economic factors in the individual's present environment (Busse & Pfeiffer, 1969).

Situational Aspects of Aging

As alluded to in the previous section, there are several areas in which the circumstances of the aging individual changes rather dramatically as s/he enters his/her elder years. A few of these situations will be referred to here.

The elderly typically experience a substantial drop in income over their younger years (Butler, 1975). Inadequate income is considered by many to be the greatest problem facing the elderly (U.S. Office of Economic Opportunity, 1972). The problem is particularly severe for those elderly that comprise 20% of the nation's poor (Butler, 1975) but, in fact, exists for far greater numbers of elderly than those who are below the strict poverty level. For the nation as a whole, the median income of the retired elderly couple is roughly one-half that of those still in the labor force. In more revealing terms, in early 1975, the median income of an American elderly individual was only $52 per week (Butler, 1975). Also, a shortage of income has direct ramifications on other situational problems of particular concern, such as lack of nutrition, lack of health care, inadequate housing, etc., and should be considered in these terms as well. A number of combinations of income and "in kind" assistance could conceivably provide for these needs (for example, the presently existing income programs of social security and S.S.I., and the in kind programs of food stamps, Medicare and Medicaid), if appropriately funded and administered.

Retirement is a situational transition faced by almost all elderly and involves several interrelated problems in addition to the above-mentioned drop in income. Included are such components as changes in social role and status, which are closely related to one's occupation

in this country. Tangential to this shift, there often occurs demoralization, a decline in social participation and a loss of feeling of productivity and self-worth (Blau, 1973). Finally, there is the problem of excess free time that must be put to some constructive use (Buhler & Kleemeier, 1961). The cumulative impact of these factors may have an adverse effect on the mental health of the elderly individual (Lowenthal, 1968). (Although there is a lack of literature on the subject, one might assume that "retirement" from the occupation of "housewife" might include all of the above-mentioned problems.)

Other significant situational changes for many elderly take place in the related areas of family structure and living arrangements. The process for many can be briefly described as separation and isolation. More than 25% of the nation's elderly live alone or with nonrelatives (Council of State Governments, 1973). Reflected in that figure is the additional problem of death of many loved ones, including frequently the spouse. Nationwide, almost 55% of aged women are widows, and approximately 40% of aged men are widowers (Council of State Governments, 1973). Separation and isolation can have many negative consequences for the elderly, including role loss (Blau, 1973) and poor social adjustment and cognitive functioning (Bennett, 1973). However, the effects of isolation may be reversible through various resocialization programs, such as friendly visitors (Bennett, 1973).

Finally, and not to be overlooked, is simply the fact of finding oneself to be old in a society which quite clearly is designed for and emphasizes youth. This realization requires a redefinition of one's identity and social role and obviously provides a situation where problems of adjustment can arise.

In summary, one can see that the typical elderly individual experiences a series of fairly dramatic situational changes, each of which can have significant implications for the behavior and well-being of the individual. The need for and demands of adjustment are great. To those working with the elderly, these situational changes are some of the problems toward which social service programs must address themselves.

Rationale for Social Services

After surveying some of the biological, psychological, and situational aspects of aging and the resultant problems of adjustment, it becomes apparent that the elderly as a group face numerous challenges that, without access to appropriate resources, can mean substantial hardship. Indeed, this has been the findings of numerous investigations into the subject ("Project FIND," U.S. Office of Economic Opportunity, 1972). Specifically, in 1969 it was estimated that approximately half of the nation's elderly, or about 10 million individuals, were living below the poverty level (O.E.O., 1972). By 1972, it was still found that 25% of the households below the poverty line were headed by persons 65 and over, and another 11 million persons were being kept just over the "extremely strict low standards of the official measure of poverty" by their social security benefits (Robert M. Ball, Commissioner of Social Security, 1972). In terms of health, it has been estimated that 81% of the over-65 group suffer some chronic illness, and slightly under half of the elderly are at least somewhat disabled due to a chronic illness (S. Brody, 1973, from the National Center for Health Statistics, 1969). Similarly, studies have shown that the elderly for a variety of reasons often do not receive adequate nutrition (Jordon, 1954; LeBovit, 1965; Swanson, 1964; O.E.O., 1972).

Clearly, in terms of both the expected processes of aging and the observed conditions of the aged, there exists substantial need within the elderly population. The question thus becomes, who is going to meet those needs?

Most people would agree that the preferred situation would be for the individual him/herself, or the individual's family, to be able to care for the elderly person. Some people would insist on this situation. However, it should be obvious from the preceding material that for both physical and financial reasons the elderly individual is often unable to completely care for him/herself. Even the best laid plans may fall prey to physical infirmity, health problems, the effect of inflation on fixed incomes, or even the startling fact that approximately 40% of private retirement programs fold and never meet their obligations (Butler, 1973). As for family care, the most convincing argument against this source being solely relied upon is that for many elderly it is simply unavailable. Less than 25% of elderly live with their children (Shanas, et al., 1968). Even more revealingly, less than 3% of elderly live with children and grandchildren (U.S. Bureau of Census, 1970). Hence the extended family appears quite inadequate as a widespread source of care. Finally, there is no evidence that having the elderly live with one's children is the preferred pattern for either the elderly or their children (Kaplan, 1975).

Although it has been fairly widely publicized that 75% of elderly live within a 30 minute travel distance of a child (Shanas, et al., 1968), this should not be interpreted as implying that an equal number of elderly should be able to rely on their offspring to meet their needs.

It is safe to assume that of that 75%, many of the children lack the financial resources to meet all the economic needs of the elderly person, particularly if one accepts the logical correlation between mobility and increasing resources in this country (i.e. intergenerational mobility being positively correlated with income, those offspring with less financial resources would tend to live in closer proximity to their parents). Further, even among those who are able to meet the economic needs of their parents, many may not be able to fill other important needs. For a variety of reasons, such as lack of time, lack of interest, or personal incongruence, the children may very likely be unable to provide all the social and supporting services required. Thus, it seems unrealisitc to assume (or require, as some have proposed) that the individual and his/her family should be the sole source of support for all or even most of the elderly in this country. Hence, there appears to be a legitimate role for public social services.

At this point it seems to be appropriate to respond to two often raised criticisms of social services for the elderly. First, and perhaps with the most merit, is the objection to the "sick" stereotype of the elderly that is often fostered. Hopefully without stereotyping, it is important to realize that the elderly, as a group, do indeed have substantial needs. In the words of Elaine and Stanley Brody (1974): "The widespread view of old people as sick, isolated, feeble and senile is inaccurate. Most persons age successfully and do not fit such stereotypes. Nevertheless...the elderly easily qualify as a vulnerable group... (they are) poorer economically, have more health problems both physically and mentally, experience more interpersonal losses, and lose status and social roles more than any other population group."

One way to conceptualize this situation is that numerous age-related environmental demands, magnified even further by declining physical and psychological resources, can place a tremendous burden of stresses on the elderly individual. However, various mediating factors can enter the relationship to modify the effect of these environmental stresses on the actual well-being of the aged person (Doherwend & Doherwend, 1974). The resources possessed by the individual and his/her family, as referred to previously, can function as mediators in this relationship and are preferred if adequate. When needed, however, social services are another set of mediating factors that can reduce the aversive impact of situational stresses, particularly when the elderly individual is lacking in other appropriate resources.

A second objection to the use of social services, is the hypothesized negative impact on the independence of the recipient; perhaps this is a remnant of the philosophy of rugged individualism. In order to answer this criticism, it is necessary to consider the capacity for independence in the elderly person. Aging, almost by definition, is a process where adaptive resources (physical, mental, perceptual, etc.) are being lost (Goldfarb, 1959). Hence aging typically becomes, to one degree or another, a time of increasing dependence on others (Turner, 1965). This is not to imply that all elderly are unable to meet their own needs. Certainly some fortunate elderly can maintain true "independence." However, most elderly fall somewhere on the continuum of need between the absolutes of no need and total dependence (Berg, Atlas & Zeiger, 1974). Social services must recognize this variability and provide flexible services that can be tailored to the true needs of the individual.

Rather than view this situation as a chronically passive dependence, however, it may be much more useful to consider a "search for aid" as an appropriate adaptive response on the part of an elderly individual whose own capacities are declining (Goldfarb, 1964). If care is taken to avoid the fostering of passive dependence, a variety of social services can enter this framework to increase the repertoire of resources to which the elderly individual can turn when needs arise. Services of income maintenance and health care are probably the most commonly accepted for this purpose. However, even such potentially independence-threatening services as homemaking programs (Berg, Atlas & Zeiger, 1974); mental health services (Burr, 1971) can have positive effects on the overall self-sufficiency of the elderly.

Assumptions Underlying Government's Role in Social Services

Before detailing the major legislation and structures serving the elderly, it seems appropriate to briefly mention some of the assumptions underlying the involvement of the U.S. government in the provision of services for the elderly.

Consistent with the concerns discussed in the previous section, official government policy traditionally reflected the expectation that the individual and family were responsible for support, with private charities to be relied upon as a last resort. With the occurrence of the New Deal era and the passage of the Social Security Act of 1935, the federal government at last acknowledged that the traditional means of support were ofttimes inadequate. Although this legislation placed a heavy emphasis on equity (i.e. one pays in to an insurance type program so one can draw out later), it also allowed for the concept of social

adequacy (whereby payments can be made on the basis of need). In the late 1960s, medical care was added to the role of government, once again in the dual form of insurance (Medicare) and assistance (Medicaid). This division of philosophies often creates problems for recipients both in confusion about services available and in meeting conflicting eligibility guidelines (Ozawa, 1973). The main function such a division seems to serve is to at least partially preserve, through its equity emphasis, the concept of individual responsibility.

A second discernable policy orientation is in the choice of program content. Income and health programs have been the dominant concern, often to the exclusion or neglect of related social services (S. Brody, 1973). Further, even the health care programs are in reality income rather than service programs, where the government provides for payment of certain costs incurred rather than actually ensuring the provision of any services. This approach has hindered the access to health care of many individuals, particularly in rural or other areas where transportation or health services themselves may be lacking (Harris, 1975). This avoidance of direct service provision gives some indication of what the "proper" role of government has been conceived to be. It should be noted, however, that some movements toward the provision of a wider variety of services (such as transportation, home care, etc.) have begun with the passage of the Older Americans Act of 1965 and its amendments (although funded to a much lesser degree than the income and health payment programs, and still provided and administered at the local level).

A final policy orientation deserving of note is the national emphasis on alternatives to institutionalization, particularly visible

in the last decade or so (Kaplan, 1973). As stated in the 1973 amendments to the Older Americans Act, one of the goals of the legislation is to provide for "maximum independence and dignity in home environment for older persons capable of self-care with appropriate supportive services" (Section 301). Hence, it appears that the valued concept of "independence" has been redefined somewhat, as Goldfarb and others might applaud, to include the appropriate use of some social services by the elderly person. Such a slight philosophical shift might help explain how government policymakers could in good conscience expand the role of the federal government (at least as a funding source) to include the provision of a much wider variety of services than income and health care payments (as the Older Americans Act and amendments have done).

The question of motivation for these policies, particularly the increasing involvement of government over time, is open to varying interpretation. The most favorable interpretation would be simply that an increasing elderly population made the problems of the elderly more visible and thus brought about government intervention in response to need. Many other more Machiavellian interpretations are available, including that government increases social services to quiet unrest (Piven & Cloward, 1971) and, more specifically, that many policies reflect attempts to woo the currently estimated 20 million elderly voters (Butler, 1974). Louis Lowy (1974) was probably closest to the truth when he observed that basic expediency, rather than any real desire to integrate the aged into the mainstream of American life, has characterized the responses of government to the problems of aging.

Having considered some of the assumptions underlying the government's

role in social services, one can now take a fairly descriptive look at legislation and agencies serving the elderly.

Legislation, Structures and Agencies

The two primary pieces of federal legislation providing for the elderly are the Social Security Act of 1935 and the Older Americans Act of 1965. The Social Security Act of 1935 brought the federal government into the position of providing for the elderly for the first time on a large scale by creating the programs of "Old Age Assistance" or direct financial assistance to needy elderly, and "Old Age Survivors Insurance" or the program of payroll and paycheck tax financed social security payments to eligible elderly or survivors (OASDI). These programs were intended to provide some base minimum income for elderly persons but were never intended to provide the sole supporting income. In fact, however, for many needy elderly, social security is the sole source of income. For that purpose, however, it is marginal at best and usually inadequate.

The Social Security Administration has recognized the fact that social security benefits are often "just too low to meet needs" (Ball, 1972) and has attempted to remedy that situation somewhat through the formation of the Supplemental Security Income program (SSI) in 1973 (see below). Meanwhile, the social security program has also come under fire from the political right for spending too much money, being a non-voluntary program, etc. Despite criticisms and funding problems, however, social security is a widely used program and indispensable to millions of Americans. For example, a recent survey conducted in the state of Michigan revealed that 84% of the elderly contacted were receiving some kind of social security payments (Office of Services to

the Aging, 1975). Further, the Social Security Administration estimated that by 1973, 93% of all people becoming 65 in America would be eligible for a social security benefit (Ball, 1972). In terms of sheer numbers, the Social Security Act is the price of federal legislation which has had the most profound impact on elderly Americans.

In addition to the income programs of OASDI and SSI, two amendments to the Social Security Act have produced medical programs affecting the elderly. In 1965, Title 18 created the Medicare program which provides for payment for medical services in the categories of outpatient and diagnostic tests, hospitalization, and post-hospital care. Unfortunately, the list of things Medicare does not provide for is almost as impressive, including drugs, dentistry, podiatry, medical appliances, mental health care, and home health services (Harris, 1975). Title 19 created the Medicaid program, which, in contrast to Medicare, is an "assistance" program to the needy. Medicaid can at times fill some of the gaps left by Medicare coverage; however, it is a state administered program and coverage varies widely from state to state (HEW, 1973). Finally, it should be reiterated that neither of these programs actually provides medical services, but rather provides a means for payment for certain medical services.

In 1973, amendments combined the programs of Old Age Assistance, Aid to the Blind, and Aid to the Disabled into one program entitled Supplemental Security Income (SSI). The major reason for this shift, as referred to above, was to "take a giant step toward adequacy" in the provision of income for the elderly (Ball, 1972). This was to be accomplished through such means as slightly loosened eligibility standards and slightly higher payments. It was also intended, through procedural

changes (such as moving the whole program from the Departments of Social Services in the states to the Social Security Administration (SSA) itself), to increase convenience and decrease the "welfare" stigma (Ball, 1972). However, many now contend that this procedural change has also had some adverse impact on receipt of services by the elderly, including maintaining the conflicting ideology and eligibility procedures involved with the simultaneous administration of an insurance type program (social security) and an assistance type program (SSI) (Ozawa, 1974). There is some evidence that the new SSI policies have lead to increased hardships and frustrations for the elderly client (Moses & Zander, 1975). Also, moving Old Age Assistance from the Department of Social Services (DSS) to the income oriented SSA has often served to isolate many needy elderly from contact with the more service oriented DSS (Region IV Area Agency on Aging, 1975). Hence, it remains for further evaluation to determine whether the SSI legislation, with its commendable attempt to move toward social adequacy, is in fact proving to be the best alternative for income maintenance for the elderly.

The "Older Americans Act" of 1965, in response to the increasingly visible problems of the elderly, created at the federal level the Administration on Aging (AOA) within the U.S. Department of Health, Education and Welfare (HEW). The AOA was given the primary role for administering the Older Americans Act and, thus, for planning, funding, and advocacy for the nation's elderly. Reflecting the emerging policy of promoting independence by avoiding institutionalization, the legislation provided means for funding a much wider variety of services than the basic income and health programs provided by SSA. The Act itself listed under "Title I" ten broad "national objectives" for older

Americans (including the areas of income, health, housing, etc.) and emphasized their adoption by all levels of government, thus giving impetus for organization at the state level as well. The five other Titles under this Act, briefly described, provided for the following: Title II created the Federal Administration on Aging (AOA); Title III provided for grants for community planning, services, and training (and has been, in practice, one of the most consistent sources of funding from programs for the elderly), and also furthered the intent discussed in Title I by requiring states to designate a single state agency to administer the Older Americans Act programs and assume responsibility for state planning; Title IV authorized research and development grants; Title V authorized training grants; and Title VI established an advisory committee to the HEW, consisting of a chairman and 15 members appointed by the secretary of HEW.

In 1973, amendments added increased strength to the Older Americans Act. First, the AOA was elevated in status with HEW by transferring it out from under the Social and Rehabilitation Service directly to the office of the secretary. Second, the "Federal Council on Aging" was created, consisting of 15 members appointed by the President and confirmed by the Senate. This body was given the responsibility to: assist and advise the President on the needs of elderly Americans, make recommendations to federal agencies and officials, and increase public awareness of problems of the aged (presumably through publications, etc.). Third, a new Title was added to the Act. This was "Title VII," which provided funding for a federal nutrition program for the elderly (and has resulted in such programs as "meals on wheels" as well as centrally provided nutrition programs). Fourth, the amendments created the concept of

"Area Agencies on Aging," by requiring the states to develop substate planning units, thus emphasizing the need for local planning and coordination for services to the elderly.

The Older Americans Act and amendments have been fairly successful in fostering a wide variety of service programs for the elderly. A publication by the AOA entitled Let's End Isolation (1971) describes numerous programs, both federal and non-federal, existing nationwide (such as nutrition programs, friendly visiting, transportation programs, etc.). In addition, the legislation has succeeded in causing states to create state and local agencies concerned with aging, which have been particularly useful in coordinating services, providing information and referral, and gathering data about the elderly population. (Information concerning federal legislation and agencies was obtained primarily from a publication of the "Council of State Governments" entitled On Growing Old (1973) and from copies of the legislation itself obtained from United States Statutes at Large (1939 and 1965).

At the state level, the Michigan Comprehensive Plan on Aging (1975) gives a history of structures and agencies serving the aged in Michigan and details the present structure of the state Office of Services to the Aging and the 13 associated Area Agencies on Aging. Michigan has had some form of agency involved with the aged since 1955. From 1955 to 1960, it was called the "Legislative Advisory Council on Problems on Aging." From 1960 to 1973, it was called the "Commission on Aging" and was organized under the governor's office. Thus, when the Older Americans Act of 1965 was passed emphasizing the creation of state agencies on aging under each state's executive branch, Michigan was already in substantial compliance. Then, when the 1973 amendments to the Older

Americans Act broadened state functions by requiring the development of substate planning agencies, Michigan passed Public Act 106, creating a state "Office of Services to the Aging" (OSA). The OSA then designated 13 area regions as distinct planning and service areas for services to the elderly. In 1974, the governor further strengthened the OSA in two significant ways. First, he transferred responsibility for administering the Older Americans Act from the DSS to the OSA. Second, he created a state "Interagency Council on Aging," consisting of representatives of all principle state agencies serving the elderly. The membership of this group provides a quick rundown of most of the other state agencies involved in any significant respect in services to the aging and includes the Departments of Social Services, Public Health, Mental Health, Education, etc. As a final note, the OSA was created as a "terminocracy" with an expected life span of two years. However, Public Act 146, passed in July 1975, has extended the life of the OSA for an additional two years; presumably the OSA will one day be given permanent status.

The functions of the OSA are essentially the statewide planning, coordination and evaluation of services to older citizens. As specifically stated in the State Plan, they include:

> --to prepare, in cooperation with other state agencies, a comprehensive plan for services to older citizens;
> --to approve services for older citizens funded by state funds or state administered funds;
> --to coordinate education and public information programs concerning the elderly;
> --to evaluate the effectiveness and efficiency of current state statutes on the life-styles of the elderly;
> --to coordinate the development of performance standards for the licensing of residential and medical facilities for the elderly;
> --to supervise the establishment of demonstration programs;
> --to make recommendations to the governor and the legislature on budget and grant requests for services to older citizens (p. 4).

At the local level, there are 13 distinct Area Agencies on Aging (AAA), with the expressed mandate of providing for the planning and coordinating of services and the provision of information and referral services at the local (area) level. Aside from information and referral, these Area Agencies are not direct service providers. (They can, however, under certain circumstances, purchase direct services by contract or grant.) The AAA duties, as outlined in the State Plan, are:

1. Develop an annual plan detailing priorities and objectives for services within the region;
2. Coordinate existing services to ensure their accessibility by older citizens;
3. Identify and pool untapped resources in the region;
4. Provide access to information and referral to assist elderly in obtaining knowledge of and services from service providers in the area;
5. Establish linkages with other service providers in the region.

Structurally, the Region IV Area Agency on Aging is centered around the Executive Director, who supervises the general network of the Agency. He receives technical assistance from the state OSA and is advised by an Advisory Council, composed of local residents (83% of whom currently are over age 60, thus providing a source of input for local elderly). Under the director, the Area Agency's major components are the Information and Referral, Services and Housing, and Senior Aides Programs, with a separate coordinator heading each of those areas. The Information and Referral (I & R) component is of major importance to this report and includes a Senior Information and Referral System (SIRS), consisting of eight local I and R centers distributed throughout the three county area. These local centers perform outreach, information and referral, and data gathering functions.

Other service providers operating at the local level include the county DSS offices, the local SSA office, any other local government

agencies that may exist, volunteer groups, church groups, and various non-profit organizations that may be involved in providing services.

In summary, the approach that seems to be emerging emphasizes the assessing of needs, planning, coordinating, and setting of objectives at the local level, all within a guiding framework of federal legislation. This would seem to allow for appropriate flexibility within a national policy of concern for the problems of the elderly.

Demographics and Needs of the Elderly

At the federal level, information about the demographics of the elderly is primarily available through various summaries of U.S. census material. This can be obtained through U.S. government publications or in most general texts on the elderly (e.g. Tibbitts, 1960; Riley & Foner, 1968; Woodruff & Birren, 1975; etc.). In terms of needs of the elderly, The Golden Years: A Tarnished Myth (U.S. Office of Economic Opportunity, 1972) is an excellent source. This publication represents the findings of "Project FIND," a study of 50,000 elderly individuals in a total of twelve communities nationwide. It includes excellent demographic and needs data, particularly in terms of poverty and the elderly. (Specific data at the national level will not be included in this paper for reasons of brevity. However, the situation at the national level can be inferred fairly accurately by considering the state and local situation.)

At the state level, two excellent sources of information were obtained to provide data on Michigan's elderly. These sources were The Michigan Comprehensive Plan on Aging, developed by the Offices of Services to the Aging (OSA), and Michigan Aging Citizens, a comprehensive survey of Michigan elderly, developed by that same office. The data obtained from these sources was in most cases accurate through January 1975.

Paralleling the national situation, the elderly population is the fastest growing segment of the population within Michigan. By 1970, there were 1.1 million citizens over the age of 60, accounting for 12% of the state's total population. The OSA estimates that the elderly segment will continue to grow, accounting for at least 15% of the total population by 1990. Hence, problems connected with the elderly will likely increase, at least in proportion to the population increase.

Of this elderly population, data on several demographic variables are available. For example, the proportion of elderly who are women increases dramatically with age. Of the under 65 population, 51% are male and 49% are female; for the 65-74 age bracket, 55% are female; for 75-84, 59% are female; and for 85 and over, 63% are female. In terms of geographic location, 61% of the "over-60" population live in urban areas of 50,000 or more, as compared to 64% of the total population. However, within those cities, the central city vs. suburbs distribution for the elderly is 56% vs. 44%, respectively, while for the total population the percentages are exactly reversed. Thus, one arrives at a situation where a disproportionate number of elderly today live in either a poor urban or poor rural setting. Racial data are available in only two categories, with the over-60 population being 92% white and 8% black as compared to 88% and 12% in the total population.

More specifically addressing the concept of "needs" was a survey conducted by the OSA in the spring of 1974 of 3000 non-institutionalized aged. This survey examined the major categories of: neighborhood, housing, transportation, nutrition, health, social support, employment/retirement, earnings and expenditures, government services, consumer protection, general problems and demographic characteristics. For the

entire sample, the following major problem areas were identified. They are presented in rank order, with the percentages representing percentage of those surveyed who considered that problem to be a "problem for older Americans." Thus, the question was presented in "surrogate" form. (This surrogate technique is intended to be less threatening than a direct question and is intended to help avoid the problems of denial or concealment of need as well as intentional overstatement of need. However, it also leaves one without any direct indication of personal need by the individual. Although the use of this technique may have distorted the relative percentages somewhat, the major problem listed in the highest five ranks parallel closely those identified in other studies such as in Illinois (Shore & Schilsky, 1975) and in twelve major communities nationwide (National Council on Aging, 1972).

Income	38%
Crime	31%
Health Care	24%
Transportation	21%
Nutrition and Food	15%
Consumer Protection	12%
Spare Time Activities	11-12%
Housing	11%
Employment Opportunities	8%
Age Discrimination	8%
Getting More Education	5%

The top five spots contained the same five problem areas with minor variations in rank, across all demographic subgroups. Income was consistently ranked as the major concern with the exception of two subgroups: those living in Detroit, and those with an income of over $6,000, each of whom ranked crime first and income second.

Two other topics merit mention at this time. First, the "living arrangement" of the respondent had a definite interaction with problems perceived. As might be expected, those living alone reported the highest

frequency of problems facing older Americans, while those living with spouses reported the lowest. Second, as age increased, apparent discontent tended to decrease with one major exception, that being transportation. Transportation problems increased with age, becoming particularly apparent after age 79.

This paper has outlined some of the demographic characteristics and perceived needs of the Michigan elderly population. For more detailed information, particularly in regard to the "SON" survey, please refer to the Michigan Comprehensive Plan on Aging (December, 1974).

At the local level, the Region IV Area Agency on Aging Area Plan 1975-76 was utilized. (Region IV encompasses the tri-county area of Berrien, Van Buren, and Cass counties in Michigan.) Here the elderly population and problems of the elderly generally reflect the data presented in the Michigan Comprehensive Plan. Two of the counties (Cass and Van Buren) are predominantly rural, while Berrien County includes the urban centers of Benton Harbor and St. Joseph. Within these areas, the elderly population includes a wide spectrum of demographic variables including income, age, living arrangement, race, community size, etc.

The total population of this three county area, as of the 1970 census, was approximately 263,000. Of these, approximately 36,000 or 14% were over the age of 60. To further break down those figures: of the elderly, approximately 29% were aged 60 to 64; 42%, aged 65 to 74; and 29%, aged 75 and over. In racial composition, just under 10% of the elderly were black and 89% white, with the remainder composed of American Indian, Spanish American and Oriental, with not more than 1% of

each. Perhaps the most revealing statistic of all, however, is that, of the 36,000 plus elderly in this region, over 10,000 or approximately 28% had incomes classified as below the poverty line. Further, as can logically be expected, problems of poverty often signal problems in many related areas. The data compiled in Region IV seems to bear that out, as a similar percentage to those found wanting in income also had "identified need" for health, housing, transportation, and "social and reassurance" services and about half that number had "identified need" for nutrition, employment and legal services. (For actual percentage breakdowns, refer to the Region Four Area Plan, 1975-76.)

The Problem of Linkage

Clearly, there exists a substantial population of identified needy elderly in this three county region. In addition, other studies suggest that it can safely be assumed that an equal or perhaps greater number of elderly live in a near-poverty or a low-income situation (National Council on Aging, 1975). Unfortunately, it is also true that for one reason or another, many of the most needy elderly are simply not getting the services they require, even when those services are currently available.

This problem is most strikingly evident from the results of the nationwide "Project FIND" study. Of the 50,000 elderly individuals surveyed, 28,079 cases of need were discovered where referrals could be made to existing services (as well as 24,124 cases of need for unavailable services). Thus, one can observe that there is a problem not only in providing services for the elderly but also in linking needy elderly with services provided.

A second linkage problem has occurred as a result of the shift of Old Age Assistance from the Department of Social Services to the Social Security Administration (Region IV Area Agency on Aging, 1975). As referred to previously, this move from the more service-oriented DSS to the income-oriented SSA (which is basically not involved in comprehensive service provision--Ball, 1972) has tended to isolate many elderly from other supporting services.

A third linkage problem, also involving SSI, is the apparent difficulty in linking needy elderly with the SSI program itself. At the inception of the SSI program in 1973, federal officials of the Social Security Administration insisted that over 200,000 elderly would be eligible for SSI in Michigan. Yet three years later, less than 120,000 elderly are enrolled in the program (OSA, 1975).

At the local level, each of the above-mentioned problems are concerns of the Area Agency on Aging (Region IV Area Agency on Aging, 1975). For example, most of the 10,000 plus elderly in that region with incomes below the poverty level are likely eligible for Old Age Assistance (under the new SSI payments). Yet a recently compiled list of SSI recipients for that region shows only slightly more than 2300 people are actually receiving SSI payments. Part of this discrepancy may be due to difficulties in implementation of the relatively new SSI system, but most of the lack of participation is presently unaccounted for (OSA, 1975).

In addition, as discussed previously, there exists substantial need for services among elderly of the tri-county region. As the Region IV Area Plan (1975) indicates, the location and linkage of those needy elderly with available services is one of the two essential functions of

the Area Agency on Aging (the other being the gathering of information about the needs of elderly in the area, which this study will also attempt to perform).

The previous examples illustrate some of the problems requiring the linkage of needy elderly with available services. In so doing, they help emphasize the need for some means to facilitate that linkage.

Information and Referral

To help solve the problem of linkage, the concept of an "information and referral" service has been utilized. However, as Brumfield, Fox and Goldman (1968) point out, the problem with information and referral is that the client must initiate the request for services. Hence, most of the factors that prevent the client from contacting the service providers directly also prevent him/her from contacting the information and referral (I & R) service. These factors are hypothesized to include: client unaware of service; general fear of or avoidance of unnecessary outside contact; denial of any problem (Gaitz, 1974); client apathetic toward service; general misinformation of many kinds (such as "I'm not eligible," etc.); and the desire to avoid "welfare" (Alexander & Podair, 1969).

To help overcome these obstacles, the concept of "outreach" has been added to information and referral. When the information service reaches out and contacts the client directly, it is hoped that most or all of the above-mentioned obstacles can be remedied. This is the approach that the Area Agencies on Aging have developed in their "Information and Referral/ Outreach" Service. However, they still face the problem of a limited amount of resources and a large eligible client population. The challenge thus becomes one of getting the maximum amount and quality of information

and referral from the existing I & R/Outreach and related structures.

Outreach Strategies

Very little literature exists specifically addressing the problem of how best to provide information and referral/outreach services to the elderly. This may reflect the fact that area agencies on aging are a very recent phenomenon, appearing in force only after the 1973 amendments to the Older Americans Act. However, the studies that do exist, combined with findings from related subject areas, can at least help delineate some important variables to consider. For example, from the area of business and marketing, an article by Klippel and Sweeny (1974) discusses their findings concerning the use of information sources by the elderly. Two conclusions appear particularly relevant. First, it appears that elderly consumers rely heavily on informal information sources in decision-making. This would seem to indicate the usefulness of utilizing peers or other forms of information contact to facilitate outreach. Second, their findings showed that the technique of product sampling was an important one to use in influencing the elderly consumer. If the analogy can be drawn to the "consumption" of I & R/Outreach services, it might be wise, where feasible, to ensure that needy elderly experience some favorable contact with the I & R center and/or personnel.

In terms of the design of any persuasive messages used, two findings from the area of social psychology seem particularly applicable. Information provided in a persuasive communication should be very specific (Katz & Lazarsfeld, 1955), and the act of comparing oneself to others can often be an impetus toward change (Lippitt, 1958). Each of these techniques might well be considered in designing a persuasive outreach contact.

Modes of Outreach Contact

One mode of communication that naturally comes to mind is that of the mass media. However, for a variety of reasons the use of the mass media for outreach may not be particularly desirable in this situation.

Unlike mail, telephone, and in-person contacts, the mass media are not personal media. They do not allow the selection of a specialized audience nor do they allow the delivery of a personalized message (Havelock, 1971). This would seem to hamper the effectiveness of the mass media in presenting meaningful persuasive messages to a target group of needy elderly.

The question of mass media use by the elderly is examined in a paper by Rush and Kent (1974). Their findings indicate that, although mass media usage by the elderly as a whole resembles the population at large, a certain subgroup of the elderly have more highly developed communication use skills. As might be expected, those most able to utilize mass media communications are typically not the ones I & R/Outreach services would be directed toward. Their findings reveal they are "more highly educated, have higher income levels, are frequent meeting attenders, get out frequently to talk to friends, and in this study are more often white than black."

Bergner and Yerby (1968) arrived at similar conclusions with respect to low income groups, indicating that such groups are often unable to utilize the mass media effectively to obtain health service information.

Hence, it would appear that mass media use may not be a particularly effective strategy for reaching and influencing the target group of needy elderly. (In addition, in this particular region, mass media campaigns concerning I & R services have already been conducted during the past

few years. There is little reason to believe that those elderly who have not so far responded to these campaigns would be any more likely to do so in a subsequent effort. For these reasons, as well as a lack of proper controls, no mass media component was directly manipulated in this experiment. However, by inference, the results of the "control" condition may reveal something about the relative efficacy of the mass media in this situation.)

In more practical terms, three of the most basic modes of outreach available to the typical I & R center are: direct mail, telephone and in-person contact.

Mail. Direct mail can be an effective, persuasive medium. In addition to its low cost, it has a fairly high contact rate and can allow personalized content (Barton, 1964). Also, in contrast to the mass media, one can be highly selective about who receives one's message. Thus, it is not surprising that results have shown that a direct mail campaign is most efficient when it contains a specific message and is aimed at a specialized target population (Barton, 1964; Havelock, 1971).

For example, in the political arena Eldersveld and Dodge (1954) used direct mail contact as one persuasive technique and found it to be more effective than a "mass media only" technique both in terms of influencing people to vote and in influencing "undecided" voters to vote for a particular proposal.

There is some reason to believe that a direct mail campaign may increase its effectiveness with the elderly if a more "personal" approach is taken. The Klippel and Sweeny article (previously cited) seems to support this contention through its recommendation of an informal communication strategy. Somewhat similar to Klippel and Sweeny's findings

are the results of several studies in the area of agricultural innovation acceptance, which indicate that the individual frequently uses other people similar to him/herself as referents when considering the adoption of innovations (Lionberger, 1960). Thus, there may be some usefulness in providing (in case such are not already available) individual referents or a referent group with positive attitudes toward the use of I & R services. This could be accomplished in a letter situation by including a personalized message from several senior citizens who do use the Center and its services.

The use of such a technique is also supported by Bergner and Yerby (1968) who suggested involving those who are already using a service in persuasive attempts aimed at non-users.

One problem that must be taken into consideration in using a mail contact with an elderly population is the effect that poor vision may have on the reading of mail. Goodrow (1975) cited poor vision as one of the three most prevalent factors (along with home responsibilities and lack of transportation) limiting participation of the elderly in educational programs. He recommended such policy decisions as minimal dependence on printed material, flexible scheduling of contacts, and some kind of transportation arrangement.

However, in spite of possible visual decline, numerous studies have shown that the elderly population as a whole does maintain an active interest in reading, particularly for local news and serious, as opposed to entertaining, content (Riley & Foner, 1968). Hence, it appears that a written persuasive message cannot be ruled out as an effective communicator for reaching the elderly, particularly if such conventions as large print and simple wording are followed.

Telephone. The telephone is a major vehicle of personal communication for all age groups, including the elderly and should be utilized to help facilitate the acquisition and retention of information (Rue, 1973). Similar to direct mail, it has a low cost and can allow personalized content. In addition, due to the "two-way" nature of the medium, one can be certain that contact has been established and can receive immediate feedback (Havelock, 1971).

Although very little has been written about the use of the telephone in outreach work, there is some indication from the field of advertising that it can be useful as a persuasive communication medium, particularly in a supporting role to other media efforts (Roens, 1961; Barton, 1964). Devoe (1954) devotes an entire book to the use of the telephone in sales and promotion and states that effective telephone use can cut time and costs up to 25-30% over face-to-face contacts.

In an area important to the elderly, that of public health, Brumfield, Fox and Goldman (1968) recommend the use of the telephone in outreach efforts, especially when a shortage of resources makes home visits difficult. Despite a lack of evaluation of the effectiveness of this medium, it seems that it also cannot be ruled out as a potentially effective means of reaching the elderly population.

In-Person Contact. Like mail and telephone contacts, an in-person contact is a personal medium and can allow specific selection of clients and a personalized message. In addition, this mode of outreach has the advantage of offering actual face-to-face contact, thus enabling a maximum amount of feedback and interaction.

Eldersveld and Dodge (1954), in their study of political persuasion, found that a personal persuasive visit was more effective than sending

literature through the mail or than a mass media only strategy.

In the area of health services, Bergner and Yerby (1968) advocate outreach in the form of personal visits for maximum effectiveness in reaching low income groups.

Goodrow (1975), in his study of factors limiting participation of elderly in educational programs, recommended interpersonal contact as the best means of communicating with the elderly.

The implications of the above comments with respect to in-person communication are strongly supported by the results of "Project FIND." Those involved in that project concluded that "a vigorous outreach program involving home visiting..." was the most effective in reaching the isolated, needy elderly (National Council on Aging, 1972).

The Project

The project described in this paper was designed to address the problem of linkage by actually experimentally evaluating different methods of conducting outreach operations. Alternative modes of mail, telephone and in-person contact were conducted throughout a three county area to examine them for effectiveness in reaching potential clients.

The above studies would seem to suggest that an in-person mode of contact would be the most effective in reaching and producing a positive response among the elderly. The present study examined that premise through the major manipulation of the three communication modes.

The readings would also seem to suggest that the content of a persuasive communication should be specific and serious (as opposed to entertaining) in nature, and that the format or delivery should be personal and informal, and perhaps include a chance for the person to compare him/herself with others. These premises of specific content were

followed with respect to the informational content of the outreach contacts made, and the use of dual letter conditions allowed the testing of a "personal" vs. an "impersonal" communication in the same medium. Also, the chance for "comparison with others" (belonging to a service-using "referent group" created for the individual) was provided to some extent by the use of the "names" strategy in the personal letter condition. (See Chapter II.)

Finally, the mentioned concern of transportation appears to be an important one. To avoid non-response due to this inhibiting factor, each communication mode emphasized that transportation was available for meeting with I & R center personnel and also that suitable alternatives could be arranged (such as an outreach worker visiting the home).

Rationale

Although the above studies suggest the superior effectiveness of the in-person outreach mode, the importance of an actual experimental evaluation should not be underestimated. Despite the apparent drawbacks of the other two modes of contact, they each would in most cases be substantially less expensive to conduct than personal contacts. Hence, an experimental evaluation of the relative effectiveness of these techniques could be combined with appropriate cost data to reveal the most efficient mode of outreach given various budgetary constraints. Further, by considering specific client data, alternative modes of outreach for different client types might be discovered.

Finally, this study also attempted to gather information about the central question of why many needy elderly apparently don't request, and subsequently aren't receiving, available supporting services. This problem will be approached by examining the data from a follow-up survey

questionnaire soliciting opinions, attitudes toward social services, comments about peer networks, etc.

CHAPTER II

METHOD

Subjects

A population of approximately 2000 needy elderly (aged 65 and over) in the Berrien, Cass, and Van Buren County area was identified by means of two lists provided by the Michigan Department of Social Services. (This number represents 8% of the total elderly population and approximately 20% of the estimated 10,000 elderly living at or below the poverty level in this region--Area Agency on Aging, 1975.) The first list contained the names of all those elderly receiving income under the "aged" category of the Federal Supplementary Security Income (SSI) program. The second list, mutually exclusive, identified those elderly receiving assistance under the state medical program called the "Old Age Related Medical" (a state assistance program). With the exception of income (low income is an eligibility requirement of these programs--see Appendix I), these lists provided a wide demographic variety of elderly, representative of the diverse population of this three county area. The only additional restriction that was placed on the selection of subjects for this study was that they be non-institutionalized at the time of contact.

The lists obtained for the three county area were broken down into regions roughly conforming to the seven service areas covered by the seven Senior Information and Referral Centers of the Region IV Area Agency on Aging. These resulting sublists were then given to the center directors for them to remove from the lists the names of all those elderly with whom their centers had had previous contact. (This was made possible by the comprehensive record-keeping system that was maintained by all of

the centers in the Region IV area.) The remaining "revised lists" of previously uncontacted elderly thus became the final target population (N=approximately 1000).

After receiving the revised lists of needy elderly who had had no recorded contact with the Senior Information and Referral System, the experimenter then randomly selected 25 names from each list (SSI and state medical) for each corresponding I & R Center. From this pool of 50 names for each center, 10 names (5 SSI and 5 state medical) were randomly assigned to each of the four experimental groups and to the control group. Hence, this study incorporated random selection from the target population and random assignment to treatment conditions.

Finally, the results of a follow-up survey revealed that the final sample selected had a mean age of 75 years, was 75% female, 78% white and 22% black, and had an average of an eighth grade education. (See Appendix A for more complete demographic information.)

Design

The experimental design was essentially a 2x5 analysis of variance design. (See Table 1.) There were two levels of population (SSI and state medical) and 5 levels of treatment condition (control, informational mail, "personal" mail, telephone, and in-person contact). Equal *ns* were randomly assigned to each of the 5 treatment conditions. The two subject categories had almost identical *ns*, with slight differences as described below.

To use the terminology of Campbell (1957), the experiment was a post-test only design. There were three dependent variables.

Table 1

Experimental Design

Population	Mode of Outreach: Control	Informational Mail	Personal Mail	Telephone	In-Person	Total
SSI	n=35	n=35	n=35	n=35	n=35	175
State Medical	n=30	n=30	n=30	n=30	n=30	150
	Total N = 325*					

*Note. The original plan called for 50 subjects (25 SSI and 25 state medical) to be selected from each of the 7 I & R centers, thus giving a total N of 350 persons. However, due to a limited population of eligible subjects in two areas, one center received only 10 subjects assigned to the state medical category, and another center received only 15 in that category. Thus, the n per cell was adjusted as shown above, and the total N became 325.

Procedure

Experimental and Control Conditions

The experimental and control conditions in this study consisted of the following:

Control Group. The individuals in this group served as a control by which to measure the relative effectiveness of each of the treatment categories. Hence, the individuals in this category received no contact directly resulting from I & R/Outreach services. They, of course, were not prevented from exposure to any incidental information concerning available services (i.e. by word of mouth, from other groups, by self-inquiry, from the media, etc.) that they would otherwise have been able to receive. In this manner, the only difference between those in the control category and those in the other experimental conditions, in terms of

information about I & R services, should be the outreach contact specified in each of the experimental treatment categories.

Informational Mail Contact Group. Individuals in this group received a direct mail letter from I & R/Outreach, identifying some basic services available through the I & R center and inviting the individual to contact the center either by phone, letter or in person if s/he would like any further information or would like to request services. It also noted that an outreach worker could be sent to the individual's home if desired. The overall tone of the letter was courteous, but primarily informational in nature, and emphasized a "services to meet needs" approach. The final statement of the letter was a request for the individual to call or write the I & R center if s/he would like to sign up to receive the I & R center's "newsletter." The letter was standardized for all centers with the exception of information pertinent only to a particular center such as names, phone numbers, etc. (See Appendix B for a sample letter.) The mailing of the letters was performed by Area Agency personnel through simultaneous batch mailings for all centers, according to a pre-determined schedule established by the experimenter (see p. 44).

"Personal" Mail Contact Group. Individuals in this group received a direct mail contact with the same informational content as the letter described for the informational mail group. However, the style of the letter was made more personalized through the consistent use of "you," "your neighbors," "we," etc. when presenting the material and particularly by the listing of four or five names of elderly persons who do use the I & R center. The names were listed in a personalized request to contact the helpful people at the I & R center (who were referred to

by their first and last names, i.e. Barb Jones, etc.). In contrast to the needs/services tones of the "informational" letter, this letter presented a friendly, informal approach. Once again, the letter followed a standard format for each center. (See Appendix B for sample "personal" letter.) The mailing procedure was identical to that described for the "informational" letters.

Telephone Contact Group. The individuals in this group received a telephone call from an I & R/Outreach worker, actually establishing verbal contact and presenting essentially the same information as presented in the letter conditions. To as much an extent as possible, the phone contacts followed a standardized format, beginning with an introduction and explanation of the I & R center services and winding up, as in the letter conditions, with a separate request to call or write the I & R center if they would like to sign up for the newsletter. (See Appendix B for sample phone format.) In addition, this mode of contact allowed for immediate feedback to any client-initiated questions, requests, etc. In the instances where this occurred, outreach workers then handled the individual as they would during any "normal" outreach contact.

In-Person Contact Group. The individuals in this group received a personal visit by an I & R/Outreach worker. The worker established actual face-to-face contact with the individual and provided essentially the same information as provided in the mail and phone contact. The format was similar to the phone format and was standardized to as much an extent as possible (recognizing that such an interpersonal situation requires a degree of flexibility). Once again, this contact allowed for immediate feedback to any client-initiated questions, requests, etc. When such occurred, the outreach worker handled them as in any "normal"

outreach contact. As in all other conditions, the contact included at the end a request that the individual call or write the I & R center to sign up for the newsletter.

Training and Supervision of the I & R Personnel

As soon as the final target subjects were identified and random assignment to conditions had taken place, a training session was held to explain to outreach personnel the protocols to be followed in conducting the telephone contacts and personal visits. Also, the procedures for data collection were reviewed and appropriate checklists were distributed. (See Appendix C for example of checklist.)

Upon completion of this training, the assigned client lists were distributed and center personnel were instructed to begin outreach operations. To avoid possible biasing effects of time, weather, etc., contacts were proportionately staggered (for example: 5 of each type of letter contact, 5 phone calls and 5 personal visits per center, per week) throughout the outreach phase. Administrative personnel from the Region IV Area Agency on Aging supervised daily project operations. (See Appendix D for memorandum of agreement.) In addition, the project researcher was available for telephone consultation whenever needed, as well as personally monitoring operations on a weekly basis.

Measurement of the Dependent Variables

The experimental manipulation used in this study was intended to test various modes of conducting outreach. Unfortunately, the dependent variable of "response to outreach" is something that might be defined in a variety of ways. Recognizing this fact, this study utilized three dependent measures, each of which is presumed to reflect one operational definition of "response to outreach."

The "Client Card." Whenever I & R/Outreach contacts someone for the first time and a "successful" outreach contact is made, appropriate demographic and needs information is recorded on a standardized form called a "client card." (See Appendix C for example card.) The rationale behind using this measure as an indicator of a successful outreach contact is that, if the outreach worker has established enough rapport and interaction with the elderly person to get him/her to provide the information required on that form, then the worker has presumably been able to observe and assess the major needs of that person. Following such an assessment, any necessary referrals or service provision can be arranged. This locating and serving of needy elderly encompasses the major function of I & R outreach. In fact, the number of client cards completed is one of the indices by which outreach operations are evaluated by the Area Agency on Aging. Thus, in addition to making use of the existing record-keeping system (all seven I & R centers use the standardized client card system), this particular definition of the dependent variable corresponds to the definition of the "success" of the I & R centers currently used by the Area Agency on Aging.

For this dependent variable then, a "positive" response to contact was operationally defined as any outreach contact (mail, phone, or in person) that resulted in a client showing a willingness to participate with the I & R center by providing the information necessary for a client card to be filed in his/her name (i.e. if there was a client card recorded for that person by the end of the experimental phase, it was considered a "positive" response).

The other category of this dependent variable was, of course, "non-positive" response. This included any response short of a client card

being filed in the client's name.

These two categories of response, as defined above, were used in the experimental analysis.

It should be pointed out that the personal contact mode, and to a lesser extent the telephone mode, had the advantage of allowing a "positive" response and recording to take place during the initial contact. This is a legitimate advantage of these modes and, in fact, occurs in "normal" outreach operations. Since the purpose of this experiment was to test the effectiveness of actual methods of outreach in reaching potential clients, such immediate responses, when they occurred, were fully allowable as "positive" responses in terms of the dependent variable.

The above operational definition of "response to outreach" is conceptualized in terms of the perceived function of I & R/Outreach. However, as mentioned previously, other possible indicators of response could also be obtained. For this purpose, a second dependent variable was utilized, conceptualizing "response to outreach" more in terms of response to various modes of persuasive communication.

"Newsletter Sign-Up." Each mode of outreach concluded the initial contact with a request for the elderly person to call a certain phone number or write the I & R center to be placed on the mailing list for the I & R "newsletter." (Each center publishes a monthly newsletter with bits of information and local news of interest to the elderly.) In contrast to the client card dependent variable, this measure removed the "immediate response" possibility from the phone and personal contact modes. This measure required the same specific, time-delayed response in each outreach category. Although this type of response is less reflective of the actual purpose of an outreach contact, it is nonetheless a relevant

indicator of effective persuasive communication with the elderly. In particular, signing up for a newsletter may represent a less "threatening" intermediate response for those elderly who may not be ready to acknowledge a need or may not have a need at the present time, but who might still wish to establish some connection with the I & R center. As such, it provides a chance to measure another dimension of the elderly person's response to outreach contact.

Although no specific form, such as a client card, exists to measure this dependent variable, recording positive responses was a fairly simple procedure. Each center was provided with a checklist containing the names of all those elderly to be contacted in the study. Then, as calls or letters came in requesting the newsletter, the appropriate date, mode of contact, etc. were indicated on the checklist. For this dependent variable, a positive response was operationally defined as any outreach contact that resulted in a client calling or writing to sign up to receive the I & R newsletter. The other category, i.e. non-positive response, was, of course, defined to be when the client did not call or write to sign up.

"Number of People Receiving Services." Since the linkage of needy elderly with available services is one of the main functions of I & R/ Outreach, a third dependent variable ("number of people who received services as a result of I & R contacts") was also utilized. This provided a measure of whether type of initial contact had any effect on the number of people who would receive services out of a given sample of elderly. The number of new services received through I & R center efforts was easily obtainable due to the standard practice of the I & R centers to record services provided directly and to "follow-up" all

referrals made to other agencies. Examples of the services received include the following: food and nutrition (e.g. "meals on wheels"), transportation, blood pressure checks, legal aid, social and companionship services, home repair and various miscellaneous services (i.e. getting a pair of glasses repaired, etc.).

Originally, it was planned to utilize the variable of "number of referrals" as a fourth dependent variable and to examine, first, the differences between those groups contacted by each method in terms of number of referrals received and, second, the differences between groups in terms of those not showing up for referred appointments. This plan was abandoned when the results revealed that a very small total number of referrals were made to outside agencies and, further, that all persons referred did show up for their appointments. (See Appendix E for data on number of referrals.) Hence, it was decided to focus on the number of people receiving services as a result of I & R contact, directly and by referral, as the third dependent variable.

The Follow-Up Survey

Approximately one month after initial contact, all subjects in each of the four experimental conditions, as well as the control condition, were visited by an outreach worker from the local I & R center for a follow-up interview. The standard procedure followed was fairly simple. The outreach workers identified themselves as being from the I & R center and, when applicable, referred to the earlier contact the person should have received from the center. They also identified themselves as being authorized by the Michigan Office of Services to the Aging to survey opinions of Michigan senior citizens (in order to gather information to

be used in state planning). They, thus, presented themselves as performing a dual role of (1) seeking to assist the elderly person in any area where s/he might require service and (2) seeking to gather some information about the person and his/her attitudes, etc. If the person agreed, a survey questionnaire was administered to the respondent. (The survey questionnaire included a wide variety of demographic, attitudinal and self-report items. See Appendix F for a copy of the instrument.) Overall, the approach used proved quite successful, as only 18 of the 210 people contacted (approximately 9%) refused to complete the interview.[1]

The major function of the follow-up phase was to provide necessary background data on the elderly persons involved in the project. The data gathered in the follow-up survey were used essentially in post-experimental interpretation of the "response to outreach" findings and in the examination of any relationships between demographic, attitudinal, self-report and outcome variables. The data were analyzed primarily by correlational techniques, particularly for any relationship between the survey-generated variables and the dichotomous dependent variables.

Construction of Scales

In an effort to simplify the interpretation of the follow-up data and to increase the reliability of the variables identified from that data, several scales were created from the items in the questionnaire. These scales were formed by a combination of logical and empirical processes.

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[1]It might also be interesting to note that chi square analyses revealed that there were no significant differences between the five types of initial contact ($p=.40$) or between the seven I & R centers ($p=.34$) in terms of percentage of persons who refused to complete the follow-up interview.

When the questionnaire was originally constructed, numerous items were included to reflect some basic content areas of interest in this study (social contact, knowledge of social services, "life satisfaction," etc.). After the data were collected, the item intercorrelations were examined to check on the feasibility of constructing scales. Whenever it was found that a set of items seemed to group together both logically and empirically, a tentative scale was formed and subjected to further testing. The following criteria were used: (1) each item must logically fit with the content of the scale; (2) each item must correlate with its scale total significantly ($p < .001$); (3) the correlation of each item with the total score of its scale must be higher than with the other scales; (4) the scale reliability (in terms of Cronbach's Alpha) must be sufficiently high (.50 was selected as the minimum acceptable level); and (5) the scale reliability must not be increased or decreased dramatically by the removal of an item.

After several repetitions of this selection process, four fairly distinct scales were created. These four scales are briefly outlined below. (The obtained scale reliability, in terms of Cronbach's Alpha, is shown in parentheses for each scale. For more complete information about the internal consistency of the scales, see Appendix G.)

"Family Contact" Scale (alpha=.74). This scale is composed of items #18, 20, 30, 31 and 32 from the follow-up questionnaire. (See Appendix F.) Items 18 and 20 are self-report items about frequency and amount of contact with the person's family and relatives, while items 30, 31 and 32 involve specifically the number of and amount of contact with the person's children. This scale is intended as an indicator of the individual's contact with family and relatives outside of the

immediate household. (Item 17, it should be noted, is used to gauge social contact within the household.)

"Other Social Contact" Scale (alpha=.56). This scale is composed of items #19, 21, 22, 23 and 23a from the questionnaire. It is intended to measure non-family social contact outside of the immediate household. (The questions include self-report items about frequency of social contact with friends, neighbors, clubs and through church attendance.

"Knowledge of Social Services" Scale (alpha=.68). This scale is composed of items #38, 39 (i.e. the number of social services the person knows about and the number the person has actually tried) and the four parts of item 41 (i.e. whether or not a person can identify a social service for each of the four problem areas mentioned). This scale is intended to measure the person's level of awareness of social services available.

"Life Satisfaction" Scale (alpha=.57). This scale is composed of items #28, 36, 52, 53, and 56 from the questionnaire. It is intended to measure an overall concept of current satisfaction with one's life by measuring satisfaction in each of three presumably key areas affecting an elderly person's life (loneliness, income adequacy, and health) along with two more generally worded items about satisfaction with life. (See items 36 and 56.)

Further Analysis of the Survey Items

To determine whether or not further data reduction might be possible, a factor analysis was performed on the survey items. In addition to the four previously discussed scales, one other empirically related cluster of items appeared which seemed to represent a logical content area. To determine whether or not it formed a usable scale, the same tests were

performed as were outlined for the prior scales. In this manner, the following rational scale thus emerged.

"Problems" Scale (alpha=.66). This scale is composed of six items which assess the client's self-rating of level of need in a variety of areas. The items are taken from question #51 of the follow-up survey and cover the following problem areas: housing, health care, income, crime, nutrition and food, and transportation.

In all, five logical scales were created from the follow-up survey data. As expected, there was some degree of relationship between the scales. (Nevertheless, further attempts at data reduction, including factor analysis, provided no rational or empirically sound combinations of these variables.) The following Pearson correlation matrix illustrates the relationships among the five scales. (Note: for the purposes of this matrix, all the scales are coded such that a "low" score is a "desirable" score, i.e. high family contact; high social contact; fewer problems; higher knowledge of social services; and greater life satisfaction.)

Table 2

Correlations Among the Scales

	1	2	3	4	5
1. Family Contact					
2. Other Social Contact	.12				
3. Problems	.13	.02			
4. Social Service Knowledge	.04	.13	-.21		
5. Life Satisfaction	.10	.25	.31	.04	

As one can see, several of the scales are empirically related. (Correlations of approximately .25 or greater are "significant" at $p < .01$ due to the large sample size.) However, it should be noted that the correlations are between rational scales which would logically be expected to be related. For example, one would expect that both social contact and lack of problems would be positively related to life satisfaction. Similarly, it is not surprising that those with fewer problems tend to have less knowledge of social services.

In view of these rational relationships in content, the obtained empirical correlations were not judged to be prohibitively high. Further, it was felt that the usefulness of these scales in post-experimental data analysis was not diminished (particularly since these five scales were all found to be internally consistent). In fact, somewhat intercorrelated rational scales are here regarded as much more useful than orthogonal, but uninterpretable, empirical "factors." Hence, for the purpose of subsequent data analysis, it was decided that these five scales would be used as summary variables representing key content areas from the follow-up survey.

Other Areas of Interest

Finally, in addition to the five logical scales outlined above and the basic demographic information (i.e. age, sex, race, marital status, number of persons in household, education, etc.), the follow-up survey also sought to shed some light on the central question of why some needy elderly respond to services available and seek assistance while other needy elderly do not. Toward this end, certain questions on the follow-up survey were intended to solicit client opinions about social services, client reactions to being contacted by I & R personnel, client responses

about his/her peer network and his/her peers' opinions about welfare, etc. These items were also analyzed primarily for their relationship to the three dependent variables.

Concluding Operations

Following the experimental and follow-up phases of the project, the entire original lists of elderly were provided to the centers for their use in normal outreach operations. In this way, none of the elderly were denied the opportunity to learn of services available through the I & R centers. In addition, a copy of a report of findings was provided to the Area Agency on Aging for distribution to all centers that participated in the study. This was followed by personal consultation to insure complete explanation of the findings.

Table 3

Project Outline

Initial lists.	Randomized	Begin outreach	Take responses	Follow-up	Data analysis	Conclude Operations
Initial lists of elderly broken down by area. Previously contacted names removed.	Random assignment of names to treatment.	Outreach operations begin. (Last approximately 2 weeks.)	Centers record all responses. (Allowing 30 days from date of contact.)	Follow-up contacts begin. (30 days after original contact.)	Begin data analysis. 1. response to outreach 2. newsletter 3. services 4. demographics 5. survey data	Complete lists returned to the centers. Experimental results and feedback provided.
	Informational Mail N= 35 SSI 30 Medical	C_1 ----------	----------	---------- C_2		
	Personal Mail N= 35 SSI 30 Medical	C_1 ----------	----------	---------- C_2		
	Telephone N= 35 SSI 30 Medical	C_1 ----------	----------	---------- C_2		
	Personal Visit N= 35 SSI 30 Medical	C_1 ----------	----------	---------- C_2		
	Control N= 35 SSI 30 Medical		----------	---------- C_2		

CHAPTER III

RESULTS

The Sample

Subject Mortality

Due to the inevitable procedural problems associated with such a field experiment, the final sample size deviated somewhat from that described in the projected plan. (See Table 3.) All randomization procedures for the selection and assignment of names were kept intact, however, so that the integrity of the experimental design was not violated. The final number of subjects assigned to each mode of contact, as well as the subject mortality within each mode, are presented in the table below.

Table 4

Final Sample Composition: Subject Mortality by Contact Mode[a]

	Type of Contact					
	Control	Informational Mail	Personal Mail	Telephone	In-Person	
Final Confirmed Sample	41	45	38	43	43	210
Removed from Sample[b]	19	10	19	17	17	82
Total Initial Assignment[c]	60	55	57	60	60	N=292

[a] $X^2=4.07$ df=4 ($p < .30$)

[b] Reasons for removal included: person could not be located, person was deceased, person was in nursing home, etc. This "subject mortality" occurred prior to treatment. The "final confirmed sample" (N=210) represents the actual "treated" sample.

[c] The discrepancy between these values and those projected in the original plan is due primarily to the fact that one center lost approximately half of its assignment lists. This table, then, is based on the corrected total of N=292 persons initially assigned.

The top row of the table represents the confirmed number of subjects in the final sample (i.e. confirmed to be living at the registered location and physically capable of making the responses measured as the dependent variables). As one can see, these totals represent a fairly sizeable reduction from the initially assigned sample. This was quite as expected, however, and the important finding is that there was no relationship between "subject mortality" and experimental condition ($p < .30$). Further, the sample size was still quite large and well distributed across conditions. Hence, it appears that in the above ways, the final sample composition was quite satisfactory.[2] Although these findings were very encouraging, one more characteristic of the sample was still considered prior to examining the experimental results.

Effectiveness of Randomization

In order to examine for effects of treatment in this experiment, it was important to try to determine whether or not the five contact groups were indeed "equivalent" on all salient variables other than type of contact. One would suspect that this would be the case with this large of a sample, due to the laws of probability when a randomization procedure is utilized. Nonetheless, it is preferable to check for equivalency whenever possible, particularly in this case since, as expected, a sizeable portion of the initial list of targets had to be removed from the sample.

In order to check for equivalency, a total of 21 demographic and descriptive variables were examined for differences between the five

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[2]In addition, it should be noted that chi square analyses on the final sample of 210 subjects showed no significant difference in distribution of types of contact by I & R center ($p=.91$). Also, they revealed no significant difference in distribution of SSI vs. state medical recipients by type of contact ($p=.65$), nor by I & R center ($p=.28$).

groups. The results reveal that the randomization procedure apparently was quite effective, as only one of the 21 variables was found to vary between the groups at less than the .05 level of significance. In addition, further analysis revealed that the one discrepant variable had no strong relationship to any of the dependent variables. (See Appendix H for a list of the variables tested and a discussion of the procedures used.) Hence, it appears that the randomization procedure did indeed produce functionally equivalent groups for the purposes of this experiment. With this in mind, the experimental results can now be examined.

Treatment Effects

Primary Outcome Measures

A chi square analysis was performed to test for significant effects between the independent variable, type of contact, and each of the three dependent variables: (1) client card registrations; (2) receiving a service; and (3) newsletter sign-ups. The results are shown below in Tables 5, 6, and 7.

Table 5

Client Card Registrations by Type of Contact[a]

	Control	Informational Mail	Personal Mail	Telephone	In-Person	
Client Card	0	1	4	12	34	51
No Client Card	41	44	34	31	9	159
Total	41	45	38	43	43	N=210

[a] $X^2=99.47$ df=4 ($p < .001$)

Table 6

Receiving a Service by Type of Contact[a]

	Control	Informational Mail	Personal Mail	Telephone	In-Person	
Received Service	0	2	4	8	10	24
Did Not Receive Service	41	43	34	35	33	186
Total	41	45	38	43	43	N=210

[a]X^2=15.94 df=4 (p=.003)

Table 7

Newsletter Sign-Ups by Type of Contact[a]

	Control	Informational Mail	Personal Mail	Telephone	In-Person	
Signed Up	0	0	3	1	5	9
Did Not Sign Up	41	45	35	42	38	201
Total	41	45	38	43	43	N=210

[a]X^2=11.19 df=4 (p=.024)

As one can see, all three dependent variables show a significant relationship to type of contact, with the client card dependent variable showing the most pronounced effects. In all three cases, the in-person mode of contact achieved the highest rate of effectiveness. A more detailed interpretation of these results will be presented in the "Discussion" section.

Analysis of Variance to Test for Population Differences and Interaction Effects

To examine the difference between the two client "populations" tested (SSI recipients and state medical recipients) in terms of the dependent variables and also to test for any interaction between population and type of contact, a two-way analysis of variance was performed for each of the dependent variables. The results reveal that the main effects of "type of contact" were again significant for each dependent variable (client card registration, p=.001; receipt of service, p=.006; newsletter, p=.003). As for population differences, however, none of the main effects were significant and none of the interaction effects of population with type of contact were significant. (See Tables 8, 9 and 10.)

Table 8

Analysis of Variance for Client Card Registrations by Type of Contact and Assistance Group[a]

Source	DF	Mean Square	F	Significance of F
Type of Contact	4	4.93	45.9	.001
Assistance Group	1	.01	.06	.807
2-Way Interaction	4	.01	.09	.967
Residual		.10		

[a]SSI or state medical

Table 9

Analysis of Variance for Receipt of Service by Type of Contact and Assistance Group

Source	DF	Mean Square	F	Significance of F
Type of Contact	4	.390	3.72	.006
Assistance Group	1	.203	1.93	.166
2-Way Interaction	4	.035	.33	.855
Residual		.105		

Table 10

Analysis of Variance for Newsletter Sign-Ups
by Type of Contact and Assistance Group

Source	DF	Mean Square	F	Significance of F
Type of Contact	4	3.37	4.08	.003
Assistance Group	1	.04	.05	.833
2-Way Interaction	4	.59	.71	.587
Residual		.83		

The absence of any main effects or interaction effects due to "population" (SSI or state medical) raised the question of whether or not these two sample groups of low income elderly really represent distinct populations. To be on the safe side, they were originally classified as such because they originated from two distinct lists of aid recipients. However, after examining (1) the lack of difference between these two groups in terms of outcome measures, (2) the convincing lack of difference between the two groups in terms of the follow-up survey variables, and (3) the similarity of eligibility requirements for the two programs as outlined by Michigan Department of Social Services manuals, it was decided that, for the purposes of this study, the two groups in fact represent a single population. (See Appendix I for a rationale for this decision and for a description of the data examined.) Hence, in all pertinent data analyses, the data from the groups were treated as that from a single sample, randomly selected from a target population of low-income elderly with no prior contact with the I & R network.

Secondary Outcome Measures

It was felt that the responses to certain of the follow-up survey variables could conceptually have been influenced by the experimental treatment (i.e. by having received an outreach contact of one type or

another). In particular, the scales, measuring knowledge of social services, problems the person had and life satisfaction, were thought of as potentially related to type of contact. To examine this possibility, these scales were analyzed as secondary outcome measures. A one-way analysis of variance, using type of contact as the independent variable, was performed on each of the scales. (Scale scores were calculated by summing the scores of the scale items.) The results of these analyses revealed that there were no significant differences on any of these three variables between the five experimental groups. (See Appendix J.) Thus, it appears that the I & R/Outreach contact, regardless of mode, was not a substantial enough event in the lives of the elderly persons to have produced a significant change in these more global life dimensions. (The scales of "family contact" and "other social contact" were also examined for any differences between the five groups. Again, no significant differences were found.)

The Effects of Receiving a Service

One additional area of interest that might be regarded as a possible outcome of this study was the question of what effect, if any, receiving a service might have had on an elderly individual. Although this question was not directly addressed in this study, several variables were examined to see if any possible effects could be noted. To accomplish this, T-tests were conducted between service recipients and non-service recipients on a number of variables.

Once again it appears that, for the most part, the intervention did not produce a significant effect in terms of the more global life dimensions measured by the rational scales. For example, service recipients were still the highest scorers on the "problems" scale ($p=.015$). This

is as would be expected in that their high level of need is one of the factors that determined they receive a service. (Presumably receiving a service did not increase their problems in the areas measured by that scale.) Whether or not receiving a service may have improved the "problems" situation from a previously even greater discrepancy is unknown. Unfortunately, due to the lack of a pre-test, the question of change brought about by receiving a service is unanswerable.

As for the scales measuring family contact and "other social contact," no significant differences were observed ($p=.464$ and $p=.708$, respectively). For the scale of life satisfaction, the service recipients did score higher, although not significantly ($p=.284$). The fact that the service recipients scored higher is somewhat surprising given the problems situation discussed previously and may relate in some way to the recipients' involvement with the I & R center. Again, however, such a statement can only be speculation in this case.

One scale that did show a significant difference favoring the service recipients was the social service knowledge scale ($p=.017$). Here the logical connection between receiving a service and the score on this scale is somewhat stronger. This could plausibly be an indicator of outcome to some extent. Finally, as might be expected, those who received a service more often indicated that they would call the I & R center in the future if a problem occurred ($p=.001$). (In fact, every person who received a service indicated that they would contact the center in the future if a need arose.) This may indicate that recipients were satisfied with the service received from the I & R center.

Correlational Analyses

A substantial portion of the correlational analysis of the survey data, that of the empirical analysis of items and the creation of logical scales, was described previously in Chapter II. What remains, primarily, is to see how the major survey variables relate to the dependent variables used in this experiment.

Relationships of the Survey Variables to the Three Dependent Variables

Of principal importance in this study is the attempt to identify those factors that may help explain why certain needy elderly respond to a notification of available services and other needy elderly do not. To pursue this question, a wide variety of demographic, attitudinal, and need-related variables were examined for their relationship to the three dependent variables.

To begin, eleven demographic variables (age, sex, race, education, marital status, number of persons in the household, with whom the person resides, health as rated by the outreach worker, memory/ability to pay attention as rated by the outreach worker, number of living children, and number of children living within a one hour drive) were examined for their relationship with the three dependent variables. Simply stated, chi square analyses and T-tests revealed that only two of the demographic variables significantly ($p < .05$) differentiated positive and non-positive responders on any of the dependent variables. (See Appendix K for a table of the variables and their respective significance levels.) The only significant findings out of 33 relationships tested were between positive and non-positive responders on the newsletter dependent variables, as differentiated by the demographic variables of the client's memory/attention and health ratings. (Positive

responders were ashown to have both higher memory and higher health ratings, $p < .01$.)

To further examine for any relationships, simple Pearson correlation coefficients were calculated for those variables allowing such a level of analysis. (See Table 11.) Here, only the variables of age, education, and memory achieved any significant correlations. (For age: $r=.13$, $p=.042$ with the client card dependent variables; for education: $r=.15$, $p=.021$ with the newsletter variable; for memory, $r=.14$, $p=.031$ with the newsletter variable.)

In summary, the results show that very few demographic variables were significantly correlated with response or non-response on the dependent measures. Further, the actual magnitude of even the significant relationships was quite small. Hence, it appears as though the demographic variables reveal very little in terms of answering the question of why some needy elderly respond positively to outreach contact while others do not.

Table 11

Pearson Correlations of Demographic Variables With the Three Dependent Variables

Demographic Variables	Dependent Variables		
	Client Card	Service	Newsletter
Age	-.13[a]	-.08	-.06
Sex	-.11	-.05	.01
Race	.06	-.07	.05
Education	.01	.00	.15[a]
Number of persons in household	-.11	-.06	.00
Health	.02	.08	.11
Memory	-.09	.04	.14[a]
Number of living children	-.10	-.12	.07
Number of living children within 1 hour drive	-.09	-.01	.03

[a]Correlation is significant at $p < .05$.

The next step in the process was to examine five categorical variables measuring various facets of the person's interactions with, and attitudes toward, social service. (See Questions #25, 37, 48, 50, and 54.) Once again, chi square analyses revealed that none of these items were significantly ($p < .05$) related to any of the dependent variables. (See Appendix K for a list of variables and their significance levels.) Pearson correlation coefficients were then calculated between the five variables and the three dependent variables to further examine for any relationships. Again, none were found to be significant. (See Table 12.)

The third step in the process was to examine another major category of variables from the follow-up survey, that of the five rational scales (family contact, other social contact, knowledge of social services, problems perceived, and life satisfaction). Pearson correlation coefficients were calculated between the five scales and each of the dependent variables. For the dependent variable of client card registrations, only the "problems" scale was significantly correlated ($r=.17$, $p=.015$). For the dependent variables of receiving a service, the problems scale was again the only one significantly related, with a slightly larger correlation ($r=.18$, $p=.01$). For the newsletter dependent variable, none of the scales showed a significant correlation. (See Table 12.)

The fourth step in the process was to examine the other major category of items in the follow-up survey, which was a set of questions asked specifically about how the person perceived the outreach contact s/he received. Questions #5 through 8 from the survey (see Appendix F) were examined by Pearson correlation for any relationship to the dependent variables. For the dependent variable of client card registration, none of the four items were significantly related. Two of the items came

close: question #5 (i.e. how clear was the meaning and content of the contact) and question #8 (i.e. how much need the person had for their services), with correlations of .16 (p=.05) and .11 (p=.13), respectively.

For the dependent variables of signing up for the newsletter, the situation was similar. Question #5 again was slightly related (r=.15, p=.08) and so was question #7 (extent to which the center seemed like it would be a friendly place) with a correlation of .13 (p=.10).

For the dependent variables of whether or not the person received a service, however, the relationships were much stronger. Question #7 was almost significantly related (r=.15, p=.08); question #6 (i.e. did the person think that the I & R center would be a helpful place) was significantly related (r=.20, p=.02); and question #8 (i.e. need for their services) was quite strongly related (r=.36, p=.001) to this dependent variable. (See Table 13.)

Table 12

Pearson Correlations of Survey Variables With the Three Dependent Variables

Social Service Related Variables	Dependent Variables: Client Card	Service	Newsletter
Question #25 (would friends accept foodstamps)	.14	.08	.04
Question #37 (would person accept foodstamps)	-.01	.03	-.09
Question #48 (positive, neutral or negative comment about social services in general)	-.01	.06	.05
Question #50 (how long client has been associated with Department of Social Services)	.05	.08	.12
Question #54 (does client perceive any welfare stigma)	-.05	.04	-.14

Table 12 (cont'd.)

The Rational Scales	Client Card	Service	Newsletter
Family Contact	.04	.06	.08
Other Social Contact	.05	.03	-.05
"Problems"	.16[a]	.18[a]	-.02
Social Service Knowledge	.10	.13	.08
Life Satisfaction	.02	.08	.08

[a]Correlation is significant at $p < .05$.

Table 13

Pearson Correlations of Client Ratings of the Outreach Contact with the Three Dependent Variables

	Dependent Variables		
Client Rating Items	Client Card	Service	Newsletter
Question #5 (how clear)	.16	.04	.15
Question #6 (center helpful)	.06	.20[a]	.09
Question #7 (center friendly)	.06	.15	.13
Question #8 (need for services)	.11	.36[b]	.04

[a]Correlation significant at $p < .05$.

[b]Correlation significant at $p < .01$.

Summary of the Predictability of the Three Dependent Variables Using the Survey Variables as Predictors

The four major categories of variables from the follow-up survey (the demographics, the social services related items, the five rational scales, and the four items measuring reactions to the outreach contact) were examined for their relationship to the three dependent variables. Those that were found to be somewhat significantly related to any of the dependent variables ($p < .10$) were selected for use in the final overall regression analyses. This was done in an effort to examine the usefulness of these variables as predictors of response or non-response in a group of elderly receiving an outreach contact.

For the client card dependent variable, the following variables were

entered into a "stepwise" regression analysis: age, sex, question #5 (i.e. how clear the meaning of the outreach contact was to the person), number of persons in the household, number of living children the person has, and the person's score on the problems scale. Together, these six variables accounted for only 9% of the variance in the dependent variable (p=.390). The single most important variable, the problems scale, accounted for only just less than 3% of the variance (p=.160). As one can see, the survey variables do little to explain differences between positive and non-positive responders in terms of this dependent variable.

For the dependent variable of signing up for the newsletter, the results are quite similar. For this dependent variable, the following survey variables were used in the regression analysis: health, memory, question #5, question #7 (i.e. to what extent the I & R center seemed like it would be a friendly place), education, question #50 (i.e. when the person first had contact with the Department of Social Services), and question #54 (i.e. whether or not the person feels people think poorly of those who receive government assistance). Here the results reveal that these seven variables account for only 6-1/2% of the variance in the dependent variable (p=.670) and that the most important variable, education, accounts for only 2% of the variance (p=.190).

For the dependent variable of receiving a service, the results are somewhat more encouraging. For this dependent measure the following survey variables were used: the problems scale, question #6 (i.e. to what extent did the I & R center seem like it would be a helpful place), question #7, and question #8 (i.e. to what extent did the person feel s/he had a need for the I & R center services). The results show that these variables account for nearly 14% of the variance in this dependent

measure (p=.016). However, most of the variance explained (13%) is accounted for by question #8 alone (p=.002). (See Table 14.)

Table 14

Multiple Regressions: the Three Dependent Variables with the Significant ($p < .10$) Survey Variables

	Mult. R	R Square	Simple R	Overall F	Signif.
For the Client Card Variable: Variables in the Equation					
"Problems" scale	.165	.027	-.165	2.02	.160
Question #5 (how clear)	.218	.048	-.160	1.77	.178
Sex	.245	.060	-.107	1.49	.224
Number of living children	.272	.074	-.101	1.35	.251
Age	.293	.086	.131	1.27	.283
Number of persons in household	.295	.087	.106	1.07	.390
For the Newsletter Variable: Variables in the Equation					
Education	.149	.022	.149	1.63	.190
Memory	.190	.036	.137	1.33	.270
Question #50	.220	.049	-.128	1.19	.320
Question #7 (how friendly)	.230	.053	.131	.96	.433
Health	.247	.061	.105	.89	.493
Question #54	.252	.064	.142	.76	.604
Question #5 (how clear)	.254	.065	.146	.65	.670
For the Service Variable: Variables in the Equation[a]					
Question #8 (how much need)	.360	.130	.361	10.77	.002
Question #7 (how friendly)	.368	.135	.145	5.56	.006
Question #6 (center helpful)	.368	.136	.204	3.67	.016

[a]Variables mentioned in the text which are absent from the multiple regression tables were excluded because their additional impact on the R-square value was negligible.

Predictability Including Type of Contact

Since the major independent variable of type of contact demonstrated obvious significant treatment effects, it was decided to examine what the

inclusion of this variable does to the overall level of predictability. To accomplish this task, the categorical variable of type of contact was transformed into a dummy variable and forced into the regression equations prior to the respective survey variables just discussed.

For the client card registration variable, it was discovered that the type of contact accounted for an extremely high 49% of the variance ($p < .001$). Once this portion had been explained, the remaining survey variables accounted for an additional 5%, giving an overall level of 54% of variance explained ($p < .001$).

The results were quite different for the newsletter dependent variable. Here the type of contact accounted for only 3% of the variance ($p=.715$). Once type of contact had been entered, the remaining survey variables still accounted for approximately 7% of the variance, with education still the most important variable of the group. Together, type of contact and the survey variables accounted for just over 10% of the variance ($p=.699$).

For the dependent variable of receiving a service, the type of contact demonstrated a somewhat stronger relationship, though still not quite significant. Type of contact alone accounted for slightly over 8% of the variance ($p=.196$). Once type of contact had been entered, the remaining variables picked up an additional 14% of variance, giving a total of 22-1/2% explained ($p=.008$). Once again, question #8 accounted for most of that additional 14%. (See Table 15.)

Table 15

Multiple Regressions: the Three Dependent Variables with Type of Contact and the Significant ($p < .10$) Survey Variables

	Mult. R	R Square	Simple R	Overall F	Signif.
For the Client Card Variable: Variables in the Equation[a]					
Type of contact	.688	.480	----	15.49	.000
"Problems" scale	.718	.516	.165	14.48	.000
Number of living children	.727	.529	-.10	12.55	.000
Sex	.734	.539	.160	11.03	.000
Question #5	.737	.543	-.107	9.67	.000
For the Newsletter Variable: Variables in the Equation[a]					
Type of contact	.167	.028	----	.493	.715
Education	.237	.056	.149	.810	.547
Memory	.273	.074	.137	.896	.503
Question #50	.299	.089	.127	.922	.495
Health	.307	.094	.105	.844	.568
Question #7	.314	.098	.131	.779	.636
Question #54	.321	.103	.142	.724	.699
For the Service Variable: Variables in the Equation[a]					
Type of contact	.288	.083	----	1.55	.196
Question #8 (how much need)	.470	.221	.361	3.86	.004
Question #7 (center friendly)	.474	.224	.145	3.23	.008

[a]Variables mentioned in the text which are absent from the mutliple regression tables were excluded because their additional impact on the R-square value was negligible.

Predictability Within Type of Contact

As a final means of examining the usefulness of the survey variables in predicting response or non-response, it was decided to examine the appropriate relationships within each type of contact. In other words, for example, it might be that age has a differential effect on response depending on the type of contact used. To check this possibility, the same

four categories of survey variables (demographics, social service related variables, the five scales, and the four items measuring reactions to the outreach contact) were examined for their relationship to the dependent variables within the groups receiving each type of contact.[3] Once again, those variables found to be somewhat significantly related ($p < .10$) to any of the three outcome measures were selected for use in regression analyses.

In-Person Contact Recipients. For the client card registration dependent variable, the survey variables of number of persons in the household and education were entered into the regression equation. Together they accounted for 13% of the variance in the dependent variable (p=.210), with education accounting for 9% alone (p=.135).

For the newsletter dependent variable, the survey variables of age, education and question #37 (i.e. whether or not the person would accept help from the government, such as foodstamps) were entered in the regression equation. Together these three variables accounted for 19% of the variance (p=.213), with question #37 alone accounting for 14% (p=.067).

For the dependent variable of whether or not the client received a service, the survey variables of memory, question #6, question #7, question #8, and education were entered into the equation. Together these five variables accounted for 21-1/2% of the variance (p=.421), with question #7 accounting for 10-1/2% alone (p=.116). (See Table 16.)

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[3]Because of the small number of positive responders in the informational mail and personal mail categories, these two groups were combined into an overall "mail contact" category for the purpose of the "within contact mode" regression analyses. Hence, the three types of contact discussed here will be simply: mail, telephone, and personal visit. In some cases, as noted, the number of positive responses may still be so low as to make the regression outcomes somewhat tentative in nature.

Table 16

Multiple Regressions: the Three Dependent Variables with the Significant ($p < .10$) Survey Variables (For Those Receiving an In-Person Contact)

	Mult. R	R Square	Simple R	Overall F	Signif.
For the Client Card Variable: Variables in the Equation					
Education	.307	.094	.307	2.39	.135
Number of persons in household	.364	.132	-.247	1.68	.210
For the Newsletter Variable: Variables in the Equation					
Question #37 (accept foodstamps)	.372	.138	-.372	3.68	.067
Education	.409	.167	.248	2.21	.133
Age	.435	.189	-.148	1.63	.213
For the Service Variable: Variables in the Equation					
Question #7 (how friendly)	.323	.104	.323	2.67	.116
Education	.376	.141	.284	1.81	.188
Question #6 (center helpful)	.443	.196	.233	1.71	.196
Question #8 (how much need)	.456	.207	.248	1.31	.300
Memory	.464	.216	.200	1.04	.421

Telephone Contact Recipients. For the client card dependent variable, the survey variables of question #5, question #8, number of persons in the household, education, question #48 (i.e. whether the person had any complaints or compliments toward social service agencies in general, rated on a three point scale), the social service knowledge scale, and the problems scale, were entered into the regression equation. Together these seven variables accounted for 67% of the variance in the dependent variable ($p=.020$). The problems scale alone accounted for 24% of the variance ($p=.023$). The first four variables (problems, social service knowledge, education, and number of persons in the household) accounted

for 61% of the variance (p=.003).

For the dependent variable of receiving a service, the survey variables of question #6, question #8, education, question #37, question #54 (i.e. whether or not the person feels that people tend to think poorly about those who accept help from the government), and the problems scale were read into the regression equation. Together these six variables accounted for 52% of the variance in the dependent variable (p=.074). Question #8 alone accounted for 37% of the variance (p=.003). The first three variables (question #8, education, and question #37) accounted for 49% of the variance (p=.008).

Table 17

Multiple Regressions: the Three Dependent Variables with the Significant ($p < .10$) Survey Variables (For Those Receiving a Telephone Contact)

	Mult. R	R Square	Simple R	Overall F	Signif.
For the Client Card Variable: Variables in the Equation					
"Problems" scale	.494	.244	.494	6.14	.023
Number of persons in household	.589	.347	-.231	4.79	.022
Social service knowledge scale	.699	.489	.371	5.43	.008
Education	.781	.611	-.308	6.27	.003
Question #8 (how much need)	.803	.644	.257	5.43	.005
Question #48 (attitude toward social services)	.815	.664	.220	4.61	.009
Question #5 (how clear)	.816	.666	.305	3.71	.020
For the Newsletter Variable: Variables in the Equation					
(No regression was performed due to an insufficient number of positive responders.)					

Table 17 (cont'd.)

	Mult. R	R Square	Simple R	Overall F	Signif.
For the Service Variable: Variables in the Equation					
Question #8 (how much need)	.611	.373	.611	11.29	.003
Education	.679	.461	-.389	7.70	.004
Question #37 (accept food-stamps)	.701	.491	.284	5.46	.008
Question #6 (center helpful)	.708	.501	.492	4.01	.019
"Problems" scale	.714	.510	.349	3.12	.040
Question #54 (welfare stigma)	.719	.517	.277	2.49	.074

As can be noted in the above table, there were not enough positive responders (n=1) to permit any analyses for the dependent variable of signing up for the newsletter.

Mail Recipients (Informational and Personal Letter Groups Combined). For the client card dependent variable, the survey variables of question #8 and the problems scale were read into the regression equation. Question #8 accounted for 12% of the variance in the dependent variable (p=.069). Since the problems scale is highly correlated with question #8 (r=.47), the additional variance picked up by the problems scale in this equation was negligible.

For the newsletter dependent variable, the survey variables of age, health, memory, and question #48 were read into the equation. Together these four variables accounted for only 6% of the variance (p=.821), with the variable of health alone accounting for 3% of the variance (p=.345).

For the dependent variable of receiving a service, the survey variables of race, question #8, question #50 (i.e. when the person first had contact with the Department of Social Services), and the problems scale were read into the regression equation. Together these four variables

accounted for 20% of the variance (p=.251), with question #8 accounting for 12% of the variance (p=.069). (See Table 18.)

Table 18

Multiple Regressions: the Three Dependent Variables with the Significant ($p < .10$) Survey Variables (For Those Receiving a Letter Contact)

	Mult. R	R Square	Simple R	Overall F	Signif.
For the Client Card Variable: Variables in the Equation					
Question #8 (how much need)	.348	.121	.348	3.58	.069
"Problems" scale	.349	.122	.215	1.73	.198
For the Newsletter Variable: Variables in the Equation					
Health	.185	.034	.185	.92	.345
Age	.225	.051	.143	.67	.522
Question #38 (attitude toward social services)	.244	.059	.273	.51	.682
Memory	.249	.062	.086	.39	.821
For the Service Variable: Variables in the Equation					
Question #8	.348	.121	.348	3.58	.069
Question #50 (how long a DSS service recipient)	.433	.187	.215	2.88	.075
Race	.447	.200	-.219	1.99	.142
"Problems" scale	.448	.201	.192	1.46	.251

In summary, performing the regression analyses within each group of contact recipients had some effect on which variables were related to the outcome measures and, as expected, resulted in accounting for a higher percentage of variance. However, with the exception of the telephone contact recipients, the results of the regression analyses still failed to achieve statistical significance. More about the interpretation of these findings will be presented in the "Discussion" section.

Reasons Given by Interviewees for Response or Non-Response to the Outreach Contact

A final area of the questionnaire, intended to provide information about why some needy elderly respond to an outreach contact while others do not, was a set of questions asking positive responders why they did respond and non-responders why they did not. (See items #9-12 of the questionnaire.) For those categorical items, the following frequencies of response were obtained.

Of those who had a positive response in terms of the client card registration variable, 66% said they did so because of the services available, 3% because of the social activities, 6% out of curiosity about the center (i.e. wanted to become involved and find out more about the center), 22% because the center "seemed friendly," and 3% for other, nonspecified reasons.

Of those who did not respond positively in terms of the client card registration variable, 41% did not because they had no need for the I & R center or its services, 16% because they weren't sure what the contact was talking about, 4% felt the center was too far away, and 39% just never got around to it.

For those who signed up for the newsletter, 56% did so because it sounded interesting, 22% because they wanted to know more about the I & R center, and 22% because they wanted to know more about the services available.

For those who failed to sign up, 16% flatly said it was because they didn't want it, 18% said they didn't know they could sign up, 2% lost the phone number to call, and 64% again simply never got around to it.

To see if these reasons for response or non-response varied depending

on the type of contact, a chi square analysis was done on each of the four items. The results of those analyses revealed that there were no significant differences between types of contact in terms of reasons for response or non-response ($p=.927$ for question #9; $p=.360$ for question #10; $p=.370$ for question #11; $p=.365$ for question #12). Additional comments concerning these items, as well as other survey variables, will be presented in the "Discussion" section.

CHAPTER IV

DISCUSSION

The primary purpose of this study was to experimentally examine the relative effectiveness of four alternative modes of conducting outreach contacts (i.e. informational letter, personal letter, telephone call, and home visit) with low income elderly persons. "Effectiveness" of the contacts was operationally defined in terms of three fairly distinct criteria: whether or not the person registered with the I & R center (by having a client card filled out); whether or not the person received a service (directly from the center or by referral); and whether or not the person called, wrote, or visited the center to sign up for the newsletter. The relative effectiveness of the four modes of contact was tested by means of a longitudinal field experiment conducted in a three county area in southwestern Michigan (as described in Chapter II).

Experimental Outcomes

As can be seen from the data presented in the preceding chapter, these four modes of contact do demonstrate significant differences in effectiveness in terms of each of the three dependent variables selected.

The Client Card Registration Variable

As the data indicate, there was an extremely strong relationship between type of contact and response or non-response in terms of this variable. The home visit mode of contact demonstrated a very high (79%) rate of positive response, followed by telephone contacts (28% positive); personal letter contacts (11% positive); informational letter contacts

(2% positive); and control group (0% positive). Since the similarity of these five groups on all available variables other than type of contact has been previously established, one can have a fairly high degree of confidence in these findings. Hence, efforts at interpretation of these results should focus on the nature of the contact modes themselves.

One plausible interpretation that draws support from the literature (Havelock, 1971; Klippel & Sweeny, 1974; etc.) is that the level of interaction between source and target allowed by the contact mode is related to the type of response obtained; that is, that those modes allowing direct contact, immediate feedback, 2-way communication, etc. are the ones that demonstrated the greatest success (i.e. the in-person and telephone modes). This interpretation draws additional support from the fact that another key variable identified in the literature, that of informational content (Katz & Lazarsfeld, 1955; Barton, 1964; Havelock, 1971), was standardized to as much an extent as possible across the modes of contact and, thus, should not have greatly influenced the outcomes observed. Finally, the in-person mode of contact (presumably the mode allowing the highest level of the above-mentioned attributes of immediate feedback, direct contact, etc.) was clearly the most effective. In this respect, the findings for this dependent variable appear to be quite as would be expected from the literature reviewed in Chapter I (Eldersweld & Dodge, 1954; Bergner & Yerby, 1968; Havelock, 1971; National Council on Aging, 1972; etc.). The only surprise, perhaps, might be at the magnitude of the relationship observed.

The Variable of Receiving a Service

Once again, the data demonstrate a strong relationship between type of contact and response or non-response in terms of this variable.

Further, the order of effectiveness of the modes of contact is identical to that for the client card variable. However, the magnitude of difference between the types of contact is greatly reduced (i.e. home visit resulted in 23% positive response; telephone in 19% positive; personal mail in 11%; informational mail in 4%; and control group in 0%). The interpretation that seems most plausible in this case is that, although the "high interaction level" communication modes are still more effective, the relative advantage attributable to those modes has diminished.

One possible explanation for the change in relative level of success may involve the nature of the responses required by each of the dependent variables. For example, the client card registration variable involves a response that is not particularly threatening but, on the other hand, is not of high saliency in terms of benefits (i.e. it involves a general assessment of one's situation, including one's needs, and functions as sort of an initial step toward "membership" with the I & R center). In these respects, it is a decision that requires a relatively low amount of personal investment. Hence, one might expect that the nature of the mode of contact itself might have a proportionately greater degree of impact on the type of response obtained (perhaps more of an impact than does the particular situation of the individual). In fact, this appears to be what has occurred. Those modes of contact allowing the greatest level of persuasive interaction, and also being most facilitative to a "passive" positive response (i.e. in-person and telephone modes), demonstrated the highest level of positive response. (As will be discussed shortly, the particular characteristics of the individual contacted did not appear to have much impact in terms of response or non-response to this variable.)

In contrast, a positive response in terms of requesting and receiving

a service tends to be both a threatening situation (as discussed in Chapter I; Alexander & Podair, 1969; Gatz, 1974; etc.) and of more direct benefit in terms of client needs, than is a positive response to the client card registration variable. For these reasons, a decision to request and/or accept a service very likely requires a higher degree of personal investment than does the client card response. Thus, one would expect that the particular mode of contact might have a relatively smaller impact, and the person's particular situation (needs, problems, etc.), a relatively larger impact than was true for the client card dependent variable.

Once again, the results reveal a pattern that makes this explanation plausible. The margin of superiority between contact modes is indeed much smaller than for the client card variable. (As will also be discussed shortly, the particular characteristics of the individual seem to play a much larger role in terms of response and non-response for the service dependent variable.)

Finally, in contrast to the client card variable (for which, by definition, no one had previously registered so everyone was "eligible"), one cannot assume that everyone in the sample had an existing need/eligibility for a service that the I & R center could provide. Thus, there may have been a "ceiling effect" which could have held down the absolute number of positive responses available to each mode of contact. Hence, this factor may also have contributed to the smaller margin of superiority demonstrated by the in-person and telephone modes for this variable. Nevertheless, assuming equally distributed need (and the findings of the follow-up survey give no reason to doubt that assumption), one can see that the results show an obvious and statistically significant

order of effectiveness among the modes of contact in terms of this dependent variable.

The Newsletter Dependent Variable

For this dependent variable, the effects of type of contact were even less pronounced, although still statistically significant. The home visit mode of contact resulted in a 12% positive response, followed by personal mail contact (8% positive), telephone contact (2% positive), informational mail contact (0% positive), and the control group (0% positive). Perhaps the most striking feature of these results, as contrasted with the other two dependent variables, is the overall low level of positive response. In addition, it is worthy of note that the personal letter mode surpassed the telephone mode in effectiveness.

Each of these findings may be explained to some extent by the nature of this dependent variable and the response it required. The newsletter dependent variable was included in this experiment primarily for two reasons. First, by requiring all responses to this variable to be time-delayed (i.e. all persons were required to recontact the center on their own in order to sign up for the newsletter), it was intended that the "immediacy" advantage of the in-person and telephone contact modes would be removed. Second, it was felt that this variable might represent a less-threatening alternative to asking for a service or registering with the I & R center.

The results seem to indicate that this strategy succeeded in one instance but may not have in the other. The newsletter variable does appear to have removed some of the advantage of the in-person mode of contact and much of that of the telephone mode. Although the in-person mode was still the most successful, its margin of superiority was greatly

reduced. The telephone contact effectiveness was so low it was actually surpassed by the personal mail mode. Hence, in this respect the newsletter variable performed as expected and resulted in a lower level of response for those modes previously enjoying an immediate response advantage. However, in terms of the intention of producing a less threatening response alternative and thus encouraging more responses from all groups, particularly the two letter groups, the results seem to be negative.

Indeed, the overall response level for all groups was extremely low. To what extent this was due to a failure to reduce the level of perceived threat is not known (although the reasons given for non-response seem to make this unlikely, i.e. 64% of non-responders indicated that they just "never got around to it"). What does seem to be a plausible explanation is that, in general, the perceived level of benefit was not enough to provide the motivation necessary to produce the active response required for this dependent variable. (More about the question of "active" response will be presented later.) At any rate, the in-person mode of contact remained superior in terms of this dependent variable. This would seem to demonstrate that some advantages of the face-to-face contact persisted in spite of the delayed response requirement.

As for the improved relative effectiveness of the personal letter contact, it should be kept in mind that this particular mode of contact emphasized a friendly, informal style and content. In this sense, the outreach contact itself was quite similar to the "product" it was attempting to promote (i.e. the newsletter). Therefore, it is not surprising that those to whom the outreach letter itself appealed might tend to be attracted to the possibility of receiving the newsletter.

The Informational Mail vs. Personal Mail Contacts

For most of the remainder of this discussion, the primary distinctions referred to in terms of types of contact will be between the major conceptual divisions of in-person, telephone, and mail contacts. However, it should be emphasized that in spite of the overall low level of response to mail contacts in general, the results reveal that the "personal" mail contact format consistently produced a higher level of positive response. Although the numbers of positive responders were too small to allow significance tests, the personal mail mode clearly had a higher level of response than the informational level mode on all three dependent variables.

In addition, in terms of the client ratings of the outreach modes they received, personal letter recipients rated the center as likely to be more friendly (though not quite significantly, $p=.190$) and rated the outreach contact as being much clearer ($p=.004$) than did the informational mail recipients. Further, these differences in performance and in client ratings occurred in spite of the fact that there was virtually no difference between the groups in terms of their perception of the extent to which the center would be a helpful place or their rating of the extent of their own need for I & R services. (In fact, the informational letter group rated the contact slightly, though non-significantly, higher on each of those two variables.)

It is uncertain whether the superior performance of the personal letter contact is due to the more friendly, informal tone of the letter (as Klippel & Sweeny, 1974, might suggest); the presence of the personalized invitation and the names of others provided as a "referent group" (as Lionberger, 1960, or Bergner & Yerby, 1968, might suggest); or to some

other variable. What is clear, however, is that the use of the combination of strategies composing the "personal" letter contact mode did produce observable differences on several important criteria.

Results of Attempts at Identifying Predictors of Positive Response

The experimental results in terms of the relative effectiveness of the various modes of contact are clearly demonstrated by the data. Having observed these results, one can now turn to the central question of what led certain needy elderly to respond to an outreach contact while others did not. To examine that question, possible predictors that have been identified will be discussed for each of the three dependent variables used in this experiment.

The Client Card Registration Variable: Who Responds?

The results outlined in Chapter III reveal that from the total pool of persons contacted, by far the most important variable in determining who will positively respond is the type of contact the person received. This may be due in part to the more "passive" nature of the response to this variable, as discussed previously, or perhaps to other qualities of the contact such as its immediacy of feedback. At any rate, in-person contact recipients are much more likely to be positive responders, followed by telephone contact recipients, personal mail recipients, and informational mail recipients, in an almost geometrically descending rate. (Those in the control group had no positive responses at all.) Other than type of contact, several variables demonstrated slight, but non-significant relationships as possible predictors. To summarize these: positive responders tended to have more problems as measured by the problems scale; tended to more clearly understand the outreach contact

(regardless of mode); tended to be female and slightly younger than the overall average; tended to have fewer living children; and, finally, tended to have fewer persons living in the immediate household. Once again, however, these variables had nowhere near the impact that type of contact did in terms of their relationship to response or non-response.

Within each type of contact, the relationships tend to become somewhat more selective. For those receiving a home visit, only two variables appear to have any relationship to response or non-response. Furthermore, regression analysis reveals they are not significant. This lack of identifiable predictors may likely be due to the fact that the home visit mode of contact is dominant enough to overcome most individual variables that might otherwise determine response or non-response. At any rate, as for tendencies, positive client card responders in this contact category tend to be somewhat better educated and tend to have fewer persons residing in the immediate household. (One could speculate that this might indicate such features as companionship, recreation and/or cultural activities, etc. might be acting as motivators for positive response for this group.)

For those receiving a mail contact (informational and personal letter groups were combined to provide a larger number of positive responders), there were again only two related variables that emerged. However, these variables indicate that a much different process was occurring within this contact group. The two variables were question #8 (i.e. how much need they had for the I & R center services) and the score on the problems scale, each of which was positively related to the dependent variable (i.e. higher need and more problems result in greater likelihood of positive response). In contrast to the home visit group, one might

speculate in this case that the salient motivator for positive response for mail recipients might have been the services available through the I & R center.

For those receiving a telephone contact, several variables appeared which were significantly related to type of response. Positive responders scored higher on the problems scale and also on the social services knowledge scale. Positive responders were also lesser educated and had fewer persons residing in the household. Finally, positive responders tended to perceive more need for the I & R center services, tended not to feel that persons thought poorly of those that receive help from the government, and tended to more clearly understand what the outreach contact was about (i.e. question #5). Here the interpretation is somewhat more complicated than for the other contact types. It seems clear that the positive responders perceive themselves as having problems/needs, and this may be acting as a motivator. In this respect, the positive responders to the telephone contact resemble their counterparts in the mail contact group. Also, there appears to be a familiarity with and/or knowledge of social services and lack of concern over any stigma resulting from service use.

On the other hand, the variable of fewer persons in the household once again appears in a relationship similar to that in the home visit group. This opens the possibility of companionship related variables as motivators for positive response. In view of these multiple relationships, it seems as though the telephone contact mode may lie somewhere on a continuum between home visits and mail contacts and that variables active predominantly in one or the other of those two modes are combined to some extent in helping to determine the response to telephone contact (although

such an interpretation is necessarily speculative at this point). Finally, the variable of education, for some unexplained reason, demonstrates a negative relationship to positive response (almost exactly the reverse of its relationship in the home visit group).

In summary, it appears evident that positive response, in terms of the client card registration variable, is a phenomenon that is dependent in large part upon which type of contact is being employed. In addition, the particular individual variables that relate to positive response vary depending on the type of contact.

The Variable of Receiving a Service or Not: Who Receives?

In contrast to the client card registration variable, "positive response" in terms of this outcome measure is much less dependent on the type of contact the person received (although a fairly strong significant relationship between those two variables still exists). Instead, features of the individual's situation and the individual's perception of the outreach contact seem to play a slightly larger role in predicting response or non-response for this variable. Not surprisingly, the person's "problems score" and perceived need for the I & R center services are the dominant variables that emerge as significantly related to positive response. Following these and of lesser importance than the type of contact itself are the variables of: extent to which the I & R center seemed like it would be helpful; and, extent to which the center seemed like it would be a friendly place (i.e. questions #6 and #7 rating the original outreach contact). To summarize, from the total sample, the major identifying characteristics of positive responders were: the presence of a high level of problems as rated by the problems scale; a high level of self-rated need for I & R services; a perception of the

I & R center as a place that would be helpful; and a perception of the I & R center as a place that would be friendly.

Within each type of contact, the same core of significant predictors remained, but in each case a couple other variables also joined in the relationship. For the in-person contact recipients, positive responders once again perceived the center as a friendly place and as someplace that would be helpful. Also, they had a higher self-rating of need for I & R center services. (In these respects, positive responders to this dependent variable present a notably different picture than in-person positive responders to the client card variable.) Finally, positive responders tended to be better educated and have a better memory rating. Overall, however, the regression analysis for this dependent variable within the in-person contact group revealed that these relationships did not achieve statistical significance. (This seems to suggest that, even for this dependent variable, the in-person mode of contact itself may have had more to do with determining response or non-response than the situational and individual characteristics of the persons contacted.)

For telephone contact recipients, in contrast, the regression analysis did indeed produce significant results. This was due primarily to the relationship between question #8 (i.e. self-rating of the extent of need for I & R services) and the dependent variable. In addition to having a high level of need for I & R services, positive responders tended to perceive that the center would be a helpful place, tended to be lesser educated and to have a high amount of problems and, finally, tended to have no objection to accepting help from the government, feeling that people did not think poorly of those who did. It seems clear that, for the telephone contact, personal characteristics

(particularly level of perceived need) did play an important role in distinguishing positive responders from non-responders in terms of this dependent variable.

For mail contact recipients, the client's self-rating of need for the I & R center services was once again by far the most dominant variable (though not quite significant as a predictor). In addition to a high level of perceived need, the positive responders also tended to be black, to be more recently acquainted with the Department of Social Services, and to have a higher score on the problems scale. Overall, however, the results of the regression analyses were not statistically significant.

In summary, it appears as though positive response in terms of the "receipt of service" variable is still somewhat dependent on the type of contact received. However, to a much greater extent than with the client card variable, response or non-response does seem to relate to the situational and individual characteristics of the persons contacted. (This is particularly true in terms of the level of need for the I & R center services that the person perceives.)

The Newsletter Dependent Variable: Who Signs Up?

Of the three dependent variables utilized in this experiment, the newsletter variable has the least amount of relationship between type of contact and type of response. As discussed previously, this was somewhat as expected due to the nature of the response required. (However, it should be noted that a statistically significant relationship between type of contact and response or non-response still exists for this dependent variable.) In addition, the newsletter variable also demonstrates the least amount of relationship between individual and situational

variables and response or non-response. Hence, in terms of percent of variance accounted for, the results appear to reveal little about who responds to this dependent variable and why. (This may in part be due to the difficulty of examining such relationships when there were so few positive responders.) Nevertheless, those non-significant relationships that are revealed are quite interesting. Positive responders tended to be better educated, to have better memory ratings, and to have better understood the outreach contact (i.e. question #5). They also tended to have perceived the I & R center as a friendly place, to have better health ratings, and to be more recently acquainted with the Department of Social Services. Finally, in contrast to positive responders to the service variable, they tended to feel that people do think poorly of those who accept help from the government. In terms of the total sample, these results seem to suggest that there may be some fundamental differences between newsletter variable responders and service variable responders, particularly in regard to their need situation and their perception of social services.

Within type of contact, some further interesting differences appear. For those who received an in-person contact, positive responders tended to be better educated (similar to in-person responders in terms of the client card variable) and slightly younger than non-responders. But somewhat surprisingly, the dominant relationship (almost significant in the regression) was that positive responders to the newsletter stated that they would not accept help from the government, e.g. foodstamps (i.e. questions #37). Again, in this respect the newsletter respondents seem to demonstrate some fundamental differences from the service variable responders.

For the mail contact recipients,[4] the relationships are much different. Here positive responders tended to have good things to say about social services (i.e. question #48), tended to be older and in better health, and tended to have a somewhat better memory rating than non-responders. Although they appear to be somewhat different than service variable responders (particularly in that needs and problems are not emphasized), there does not seem to be as dramatic a difference as was evident for the in-person contact recipients.

In summary, although the results are not conclusive enough to make any definitive statements, it seems as though some curious interactions occurred between type of contact, purpose of contact (i.e. dependent variable examined) and type of respondent.

In general, the in-person mode of contact demonstrated the highest level of effectiveness for each purpose of contact (i.e. for each of the three dependent variables). However, although type of contact had a very large impact on response in terms of the client card variable, it had a smaller impact on the response in terms of the service variable, and even less for the newsletter variable. Further, the results reveal that, for each of the dependent variables, the characteristics of those who respond positively tend to differ. In general, those who respond positively to the service variable are distinguished by having a higher "problems" level and by having more self-expressed need for the I & R center services. In contrast, those who respond positively to the newsletter, and to a lesser extent the client card variable, tend to be distinguished by being younger, in better health, better educated, etc. Finally, however,

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[4]The telephone mode of contact could not be examined in terms of this dependent variable due to an insufficient number of positive responders.

even those generalizations of respondent characteristics within purpose of contact tend to vary according to the type of contact utilized.

In conclusion, it appears as though some interesting relationships have been identified which may be of considerable use in understanding the larger question of why some needy elderly respond to an outreach contact while others do not (as well as in understanding the more complex question of who responds to what type of contact for what purpose). However, it must be kept in mind that many of the results of the prediction attempts did not achieve statistical significance, and hence, should be interpreted with care. Similarly, the direct experimental results, although of solid statistical significance, should properly be regarded as tentative until further replications increase confidence in those findings.

Implications for Policy

In spite of the necessarily tentative nature of the inferences drawn from this study, it is felt that the results obtained from such a large-scale, fairly well-controlled experiment can indeed be of use to policy-makers, administrators and others involved in fields related to service provision for the elderly. In particular, the most obvious usefulness of the results of the study would be in deciding what mode(s) of contact to employ in planning an outreach strategy. Toward this end, the actual results in terms of absolute and relative effectiveness of the various modes of contact have been presented and discussed previously. An additional input of information that one might want to consider, however, is an estimate of relative costs incurred through the use of each method.

Relative Costs

In addition to effectiveness information, it may also be useful to know the relative costs of the three alternative modes of contact. The costs per unit of contact of each type incurred during this project, as well as the relative costs per unit of successful response, are estimated in Appendix L.

As one might reasonably expect, a letter is shown to be the least expensive method per unit, followed by a telephone call and then by a home visit. However, to achieve an estimate of relative costs if each method were to be actually used, the hypothetical costs of completing one contact must be multiplied by the effectiveness rate (i.e. 79% effectiveness means one successful registration every 1.3 contacts, etc.). This means of estimating relative costs was used for each of the three outcome measures, with some rather interesting results.

The Client Card Registration Variable. The estimated cost per successful registration was found to be almost identical for all three modes. (The informational letter mode was not included due to its very low success rate.) The lower cost of the telephone and personal letter modes was just enough to make up for their lesser effectiveness.

The Variable of Receiving a Service. The personal letter mode actually demonstrated the lowest cost per person serviced. The telephone mode was close behind, costing approximately 30% more per person served. Finally, the mode of home visiting was the most expensive, costing almost three times as much as the personal letter mode per person served and more than twice as much as the telephone mode.

The Variable of Signing Up for the Newsletter. The personal letter mode was again the least expensive, followed by the home visit mode, which

was five times as expensive. Finally, the telephone mode was nine times as expensive as the letter mode per positive response.[5]

In using such cost information to make policy decisions, however, one fundamental question must be considered, i.e. which is more important, the absolute number of positive responses or the unit cost per positive response? The variable of whether or not the client receives a service provides probably the best example of this dilemma. Although the letter and telephone modes are less expensive per unit of service, they also result in fewer services provided for a given sample of elderly. Depending on the particular situation involved (i.e. how crucial is the service, what are the budgetary constraints of the I & R center, etc.), each administrator would presumably have to make this decision for him/herself.

Use of the Lower Cost Modes of Contact

After examining the cost data, one conclusion does appear to be warranted, i.e. that in certain circumstances (as Eldersveld & Dodge, 1954; Barton, 1964; Havelock, 1971; etc. seem to suggest) a personal letter mode of contact can indeed be competitive with other more expensive modes of contact (particularly if one's outreach budget is limited). The areas where this would seem to be most true would be in non-crucial service areas, such as in promoting newsletter sign-ups or in providing simple information (such as the name, location, phone number and brief description of the local senior citizen center). Indeed, the results show

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[5]Looking at the cost results for this dependent variable, one realizes they are unimportant in a literal sense since it would have been much less costly to simply mail out the newsletter every month to everyone on the list. However, this dependent variable is intended to be regarded as illustrative of the relative costs of seeking to persuade elderly persons to make some active response similar to calling and signing up for the newsletter. In that sense, these results are informative.

that, in spite of the low rate of actual response, 57% of those sent a personal letter remembered the letter and associated it with the senior center at the time of the follow-up survey (at least one month subsequent to the mailing).

Similarly, the telephone mode of contact may also be competitive with the in-person mode for some purposes. The survey also revealed that 78% of telephone contact recipients remembered the phone call and associated it with the center at the time of follow-up. Hence, it does appear that the more limited contact, low-cost methods of outreach are successful at least in terms of the transmission of fairly simple information.

In addition, the results obtained in terms of client rating of the outreach contacts reveal that personal mail and telephone contact recipients were not significantly lower than home visit recipients in their rating of the anticipated usefulness or friendliness of the I & R center or in the clarity of the contact itself. (In fact, personal letter recipients rated these variables somewhat higher than home visit recipients. See Appendix M.) Thus, in addition to successfully conveying information, it appears that these lower cost modes of contact can also instill in their recipients an impression of the I & R center that is as positive as that fostered by the in-person contact.

Finally, however, certain limitations of these lower cost modes of contact must be pointed out. For example, in order for the methods of telephone contact or personal letter to be used, addresses and/or phone numbers must be available. In many circumstances this limitation might severely restrict the applicability of these modes of contact. Other

important factors to consider include the ability of the potential client to read a letter or hear a telephone call. Although no data were specifically gathered on the ability to hear, only one incident (out of approximately 40 contacts) was reported to the experimenter where an inability to hear on the part of the recipient resulted in the contact attempt failing. Thus, it would appear that hearing problems would not present a major obstacle to the use of phone contacts. As for the ability to read, the follow-up survey did specifically gather this information from the entire sample. The results showed that, according to verbal reports, approximately 20% of the sample could not read a simple letter due to lack of education or poor vision. However, this figure is moderated by the fact that, of that 20%, two-thirds did have someone to regularly read their mail to them. Hence, in terms of the inability to read, a letter contact would be definitely inappropriate for only about 7% of the total sample.

The No-Contact Control Group

In discussing the policy implications of this study, some mention also needs to be made of the results for the no-contact control group. The lack of any positive responses on any of the three dependent variables for this group provides a stark contrast to the four groups receiving the various types of contact. Indeed, this lack of "success" for the control group should be underscored by stating that none of the centers received any recorded contact whatsoever from any of the control group members during the monitoring phase of the project. Yet, as the follow-up survey revealed, this group of persons did not differ from the other groups in terms of any of the observed personal or situational characteristics.

Hence, one is left with the inescapable conclusion that it was the outreach contacts that were responsible for the differences in performance in terms of the dependent variables.

The Mass Media. Implicit in the results portrayed by the control group is the failure of the mass media to produce positive responses in these domains. Although it must be emphasized that the media were not experimentally analyzed in this study, there were periodic media campaigns (newspaper, radio and television), occurring throughout this three county area (and had been for months, and in some cases years, previously). Yet none of the control group responded to these campaigns and contacted the center. Further, the overall impact of the media in terms of awareness of the centers was small. Only about 20% of the control group said they had heard of the I & R center through the media. (Incidentally, this was the same percentage cited by the total sample, thus indicating, as one would expect from having used a randomization procedure, that there was no differential impact in terms of this variable.)

In defense of the mass media, one should recall (as discussed in Chapter II) that this particular target population was a very resistent one. Indeed, various center personnel stated that media campaigns have at times resulted in many new persons contacting the center. Nevertheless, the results with this target population seem to demonstrate, as Rush and Kent (1974) suggested, that the mass media may not be a particularly effective strategy for reaching and influencing into action a target group of low-income, relatively needy elderly.[6]

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[6]The possibility of there being an interaction effect brought about by having heard of the center through the media and then receiving an

Other Miscellaneous Sources of Information. Finally, it should also be noted that various other miscellaneous sources of information were active within this three county area (i.e. church announcements, bake sales, raffles, informal word-of-mouth contacts, etc.). By inference, these various activities also produced no positive responses among the control group members (even though one can assume they must have produced positive responses from the population at large in the past). Once again, a plausible explanation for the lack of response seems to be the resistent nature of the target population of this experiment.

The Use of the In-Person (Home Visit) Mode

Having discussed the use of the lower cost modes of contact (i.e. telephone and letter) as well as the option of no direct outreach contact at all, this topic will conclude with a discussion of and, in a sense a recommendation for, the in-person mode of contact.

It is true that the lower cost modes of contact seem well-suited for many purposes, as discussed previously. However, for the more crucial functions of an I & R type agency (such as the assessment of needs, the advocacy of services, etc.), it seems that the higher absolute number of persons reached and served would be more important than the per unit cost of those persons served. Whenever this is the case, the in-person mode of contact would be recommended.

The "Passive" Recipient. The distinction between types of contact seems to be an important one for those in this target population, given

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outreach contact was also examined. This was done by comparing the responses of those who had heard of the I & R center through the media with those who had not. The results showed no significant differences between the two groups ($p=.520$ for the client card variable; $p=.992$ for the receipt of service variable; and $p=.245$ for the newsletter variable).

their apparent tendency to avoid making positive, active requests for service, information, assistance, etc. A couple of examples should serve to illustrate this apparent reluctance. First, an interesting situation emerged with the newsletter dependent variable. As originally structured (i.e. with the delayed response requirement), only 6% of the total sample made the required effort and signed up for the newsletter. Yet in the follow-up survey, only 16% of the non-responders indicated that they did not sign up because they did not want the newsletter. Non-responders were given the chance to sign up at that point, and a full 76% of those not previously signed up did so right then. Of course, the newsletter could be regarded as a low priority item and, as mentioned previously, the perceived rewards may not have been strong enough to encourage the active response required during the project. Still, the discrepancy is rather startling between the number of persons who positively responded on their own initiative vs. the number who positively responded in a situation allowing immediate response with a minimum of effort and threat.

A second example involves a more serious service situation, as opposed to the possibly entertaining or less important newsletter. The survey revealed that 87% of those in the sample were Medicaid recipients. When asked how they came to be signed up for Medicaid, only 12% of the respondents indicated that they had signed up through their own initiative. The remainder were signed up at the initiative of relatives, friends, a doctor, or some social service agency (42%). Once again, the image that emerges is one of a fairly passive recipient rather than someone actively seeking the services/benefits to which s/he is eligible and entitled.

The reasons for this lack of self-advocacy may be numerous, possibly including some of those discussed in Chapter I, i.e. general fear of or avoidance of unnecessary outside contact, or the denial of any problem (Gaitz, 1974); general apathy toward the service; continued misinformation of many kinds (such as "I'm not eligible," etc.); and the desire to avoid "welfare" or the stigma of welfare use (Alexander & Podair, 1969). Not much information was gathered in this study relating to these points, with the exception of the latter concern about "welfare." In response to the survey, only 14% of the sample flatly stated they would not accept help from the government (such as foodstamps). On the other hand, only one-third of the total sample could agree with the statement that people in general do not think poorly of those who accept help from the government. Hence, although the adamant refusal to accept help is fairly uncommon, a more widespread underlying stigma of welfare use does seem to exist and may be acting to minimize self-advocacy in terms of the use of services or assistance. At any rate, whatever the underlying reasons, it does seem fairly clear that this target population as a whole demonstrates a passive/receptive tendency rather than an active/self-advocate approach to the use of social services. If this is indeed the case, it is not surprising that the method of home visiting produced the highest levels of response.

In conclusion, the in-person mode of contact has been demonstrated to be superior in terms of all three of the dependent variables used in this experiment. Although the lower cost modes of contact appear to be quite useful in some situations, whenever somewhat threatening or complex tasks (such as registering with the senior center, signing up for a service, etc.) are required, then a home visit seems to be the recommended

mode of contact for the reasons discussed above. This may be due to a number of factors, including possibly the ability of the outreach worker to allay fears and provide immediate reassurance, the increased persuasiveness of a face-to-face contact, or the ability of the outreach worker to immediately assist in the completion of necessary tasks. Whatever the causal factors, the results of this study seem to support the conclusions of the National Council on Aging (1972) in that the mode of home visiting was indeed found to be the most effective method of conducting outreach to this target group of low income relatively needy elderly.

Conclusion

After examining and discussing the results of this experiment, it appears as though some general statements can be made regarding several aspects of the study. To begin, in terms of the primary focus of this experiment (i.e. the relative effectiveness of the five alternative outreach strategies), several tentative conclusions seem appropriate. First, and simply stated, the in-person mode of contact appears to be the most effective means of conducting outreach. Although, as previously discussed, the relative advantage of the in-person mode seems to vary somewhat depending on the purpose of the contact, it has demonstrated a superiority across all three dependent variables used in this experiment.

Second, although their overall effectiveness was lower than the in-person mode, the lower cost modes of telephone and personal letter appear to have potential usefulness in certain circumstances (i.e. where outreach budgets are limited and/or where the goals of outreach are non-threatening and non-complex, e.g. the transmission of fairly simple information, the generation of name awareness, etc.).

Third, when a letter strategy is selected as a mode to be utilized, it appears that a more "personal," "friendly" format, including possibly the names of other service users in a personalized "invitation," will be more effective than a more straightforward, information-oriented format (at least when the actual informational content is the same).

Finally, it is interesting to note that the expressed opinions of the elderly persons in the control group (as to what type of contact they would have preferred to receive had they received one) paralleled the effectiveness outcome results. The majority (56%) of the persons preferred the in-person mode of contact, followed by 28% who chose a telephone contact, and 16% who picked a letter contact.

In terms of the other major area of interest in this experiment (i.e. the question of why certain low-income elderly respond positively to an outreach contact while others do not), it appears that once again some general statements can be put forward. First, it appears that the type of contact a person receives may often have an impact over and above the personal and situational characteristics of the person receiving a contact. Indeed, the effects of type of contact were strongly demonstrated and remained fairly constant in terms of order, across all three dependent variables used in this study. (However, it must be acknowledged that the effect of type of contact in determining response or non-response does seem to vary a great deal depending on the purpose of contact one considers as well as the personal and situational characteristics of the individual.)

Second, the purpose for which the outreach contact is intended also appears to have an impact on response or non-response. For example, the results suggest that a purpose requiring an active time-delayed,

self-initiated response (i.e. the newsletter variable in this case) will produce a low level of positive response among a given target population of low-income elderly. In contrast, a similar purpose requiring only a somewhat passive and immediate response will generate a much higher level of positive response (as was demonstrated by the greatly increased response to the newsletter in the follow-up survey).

Third, the particular personal and situational characteristics of the contact recipient also seem to be related to response or non-response. Without going into full detail, it appears that the extent of self-perceived need and self-perceived problems in various areas of life are generally the most important determinants of response or non-response. Also, the person's reactions to the outreach contact (in terms of understanding it, perceiving the center as helpful, and perceiving the center as friendly) seem to be important factors.

Finally, within certain types of contact, and for certain purposes, such variables as age, memory rating, education, and attitudes toward social services also appear to relate to client response.

In summary, the results of this experiment suggest that the type of contact, the purpose of the contact and the personal/situational characteristics of the target, all play a role in determining response or non-response to outreach. Although these variables interact to some extent, the most successful mode of outreach appears to be the home visit. The "typical" positive responder (to the extent that such a generalization is possible) tends to be someone who has self-perceived need, who understands the meaning of the outreach contact, and who perceives the I & R center as potentially friendly and helpful.

APPENDICES

APPENDIX A

DEMOGRAPHIC CHARACTERISTICS OF THE PROJECT SAMPLE

Demographic Characteristics of the Project Sample

Table A-1

Mean age	75.4 years (range: 65 to 91 years)	
Sexual distribution	75% female; 25% male	
Racial distribution	78% white; 22% black	
Average number of living children	2.9	
Marital status	Presently married	27%
	Single (never married)	5%
	Widowed	64%
	Divorced/separated	4%
Residential status	Lives with spouse	25%
	Lives with child	19%
	Lives alone	42%
	Other	14%
Average number of persons living in household	1.9	
Education	Less than 8th grade	34%
	Completed 8th grade	26%
	Some high school	22%
	Completed high school	14%
	Some college	4%

APPENDIX B

EXAMPLE CONTACT FORMATS

Example Contact Formats
(Informational Letter)

Dear

The Central County Center for Senior Citizens is a multi-purpose center serving the needs of individuals aged 60+ (and their spouse) that live in Royalton, Sodus, Pipestone, Baroda, Oronoko and Berrien Townships.

We began with 23 people attending a community event sponsored by the Berrien Springs Jaycees in October of 1973. In July of 1974 we opened our doors as a federally funded drop-in center for senior citizens sponsored by the Berrien County Council on Aging. In July of 1975 we decided to go on our own and became a private, non-profit incorporation with a board of directors comprised of senior citizens and their spouses. We now provide services to over 1000 people, with about 400 being active members in our organization.

Services we provide include:

SIRS - (Senior Information and Referral Service) a county-wide program offering information to senior citizens about services available, employment, job training, volunteer positions, health care, etc. When information alone is not enough, we can arrange a direct contact with an agency through a referral.

Nutrition - we serve 40 meals each weekday, providing good nutrition to senior citizens who may not be eating properly because of loneliness, or physical or financial inabilities.

Transportation - we provide transportation to senior citizens from 9:30 to 4:30 each weekday. Please call at least 24 hours in advance.

Social/Educational - programs provided throughout the year, including BINGO, cards, crafts, trips, movies, plays and various informational programs. All activities are planned in advance and notification is given through our newsletter.

If you have questions about the services provided by our center or our activities, please call the center at 471-2017 from 9:00 to 5:00 weekdays. We can also send our outreach worker out to visit you if you would like. We will do our best to serve your needs.

Sincerely,

Barbara J. Williams
Director

P.S. Also, whether or not you have any needs at this time, please call our center at 471-2017 or write us at 608 South Mechanic St., Berrien Springs if you would like to receive the monthly newsletter, which describes upcoming activities and includes bits of news for senior citizens.

Example Contact Formats
(Personal Letter)

Dear

Hello!

All of us at the Central County Center for Senior Citizens would like to invite you to join us...

The Central County Center is a multi-purpose center used by your friends who are 60 or older and live in the townships of Royalton, Sodus, Pipestone, Baroda, Oronoko and Berrien.

What is a multi-purpose center? It's a place where older people can go to either give or receive services such as:

SIRS - (Senior Information and Referral Service) we will try to help you with problems such as taxes, part-time employment, health care, etc., and when we can't, we will put you in touch with someone who can.

Nutrition - we serve 40 great meals every weekday. These meals provide good nutrition to people who may not be eating properly because of physical or financial inability--or just because it's no fun to eat alone.

Transportation - is provided between the hours of 9:30 and 4:30 weekdays by a group of volunteer drivers using the center vehicle. We take doctor appointments as a first priority and require at least 24 hours notice to plan rides. We will consider any transportation need you have, however.

Social/Education Programs - are the fun part of the center. There are cards, crafts, trips, movies, plays, etc. which are planned in advance and listed in our newsletter each month. Cost is kept small, and many of our programs are free.

If you have any questions about our activities or our services, please feel free to call us at 471-2017. We can also send our outreach worker out to talk to you about our center if you would like.

We began with 23 people attending an ice-cream social sponsored by the Berrien Springs Jaycees in October of 1973. In July of 1974 we opened our doors as a federally funded drop-in center for senior citizens sponsored by the Berrien County Council on Aging. In July of 1975 we decided to go on our own and became a private, non-profit incorporation with a board of directors comprised of senior citizens and their spouses. We now provide services to over 1000 people, with about 400 being active members in our organization.

Here are some of your neighbors in the Central County Senior Center area who would like to invite you to come join us. We believe "there are

no strangers here, only friends we haven't met."

Grace Robinson

Ivan French

Art Robinson

Pearl Fryman

We hope to hear from you soon.

Sincerely,

Barb Williams
Director

P.S. Also, whether or not you wish to join in on center activities at this time, please call 471-2017 or write us at 608 South Mechanic St., Berrien Springs, if you would like to receive our monthly newsletter which describes the activities planned for the coming month and includes bits of news for senior citizens.

Example Contact Formats
(Phone Call Format)

Check as step is completed: Client name _____

--after identifying party--

___ "Hello, M_____. My name is _____ and I am from the _____ Senior Citizens Center."

___ "I'm calling some of our neighbors in the _____ area, and I would like to tell you about our center."

___ "We at the _____ Center provide information and services to senior citizens. We also provide social activities and recreation. Would you like to hear about some of our services and activities, M_____?"

___ Step 1: a) If yes, briefly describe the same services as in the letters. (SIRS, Nutrition, Transportation, Social) Follow-up with: "Would you be interested in any of these?" Then go to Step 2.

b) If no, go to Step 2.

___ Step 2: "Would you like to have one of our outreach workers come talk to you about our center?"

a) If yes, confirm address and set up time. Then go to Step 3.

b) If no, encourage person to contact the center if s/he ever has need for a service. Then go to Step 3.

___ Step 3: "I'd like to give you our phone number and address if you would like to write them down." Provide phone number and address to person, having him/her write them down and encourage him/her to call or write to sign up for the newsletter.

If s/he asks to sign up now say: "I'm sorry but I don't have our record book mailing list right now. If you will call the main desk at the number I gave you after we hang up or any time it's convenient for you, the center will sign you up, or you could write the center at the address I gave you, whichever is most convenient for you."

___ Step 4: Remind the person to contact the center if s/he ever has a need. Thank him/her for talking to you.

--or, if a home visit was arranged--

___ Step 5: Confirm home visit and thank him/her for talking to you.

Note: If at any point the person wants to discontinue the conversation, try to get him/her to write down the center phone number and address in case the person should ever want to talk in the future, and ask him/her to call or write to sign up for the newsletter.

Example Contact Formats
(Format for Outreach Visits)

Client name _____

1. Introduce self and explain purpose of contact.

   a) If possible, proceed as in any successful outreach contact (i.e. fill out client card with person, assess needs, discuss services, etc.). At conclusion of interview, go to Step 2.

   b) If client does not wish to talk to you, go immediately to Step 2.

2. Ask the person to write down the name, phone number and address of the center on a slip of paper. Then ask the person to call or write the center if s/he would like to receive the monthly newsletter.

   Note Do not sign the person up for the newsletter at that time! If they ask to do so, tell them you don't have the necessary list with you and ask them to call or write the center at their convenience.

3. Thank the person for his/her time and remind him/her to call the center if s/he ever has a need.

We know that each one of you has your own special ways of talking to the elderly people you contact on outreach, so we are not asking that any special approach be used. However, we would like the above steps to be followed at a minimum so that we know that all of the elderly contacted got at least that same information. In addition, we would like for you to go through the following list of items immediately after an outreach contact (for example, as soon as you return to your car) and check off all those things that did occur in that particular interview. If the interview was cut short for any reason, indicate at what point the contact stopped.

Check if occurred:

___ 1. Spoke to the correct person. (If this is "no," explain briefly.)

___ 2. Introduced self.

___ 3. Explained purpose of contact. (Mentioned the center.)

___ 4. Described some services and/or activities.

___ 5. Gave person address and phone number of center.

___ 6. Filled out client card with the person.

___ 7. Reminded person to call or write to sign up for the newsletter.

APPENDIX C

RESPONSE RECORDING DEVICES

Response Recording Devices

Instructions for Client Response

1. Enter date and the way the client contacts the center (letter, phone, drop in) each time s/he does so.
2. Put a red "C" and the date by the name when a client card is filled out.

Instructions for I & R Center Response

Enter the date each time the service is given. (Do this for each of the citizens listed to the left.)

	Client Response		I & R Center Response					
Senior Citizen's Name	Client Contacted Center	Client Requested Newsletter	Information-Giving	Referral	Transportation	Social/ Education	Health	(Other)
	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
________	3.	3.	3.	3.	3.	3.	3.	3.
________	4.	4.	4.	4.	4.	4.	4.	4.
	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
________	3.	3.	3.	3.	3.	3.	3.	3.
________	4.	4.	4.	4.	4.	4.	4.	4.
	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
________	3.	3.	3.	3.	3.	3.	3.	3.
________	4.	4.	4.	4.	4.	4.	4.	4.
	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
________	3.	3.	3.	3.	3.	3.	3.	3.
________	4.	4.	4.	4.	4.	4.	4.	4.
	1.	1.	1.	1.	1.	1.	1.	1.
	2.	2.	2.	2.	2.	2.	2.	2.
________	3.	3.	3.	3.	3.	3.	3.	3.
________	4.	4.	4.	4.	4.	4.	4.	4.

	YEAR OF BIRTH	CLIENT IDENTIFICATION NUMBER

CLIENT CARD

Area I&R # _____

Client # _____ Date _____

A. Name _____ (LAST) _____ (FIRST) _____ (INITIAL)

Address _____ Phone _____

_____ Soc. Sec. # ___ – ___ – ____

B. VITAL STATISTICS

Birth: Date ____ /____ /____ Place _____ U.S. Citizen? _____

Race: ( ) Caucasian ( ) Negro ( ) Span. Lang. ( ) Am. Indian ( ) Oriental ( ) Other: _____

Language restriction? _____

Indicate one: Male/Female Farm/Non-farm Rural/Urban Resident/Migrant

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced/Separated

C. EMPLOYMENT

Employed? ( ) No ( ) Yes _____ Phone: _____

Retired? ( ) No ( ) Yes Veteran? ( ) No ( ) Yes

D. FINANCIAL RESOURCES

Source of Income: ( ) Pension ( ) Insurance ( ) Salary ( ) Social Security ( ) Private Income ( ) Support from relatives ( ) Other: _____

Supplementary: ( ) SSI ( ) DSS ( ) Food Stamps ( ) Medicare ( ) Medicaid ( ) Other: _____

Approx. Income: $ _____ ( ) Below Poverty Level ( ) Near Poverty Level

E. HOUSING

Independent: ( ) Owns Home ( ) Rents ( ) Apartment ( ) Room ( ) Room/Board ( ) Retirement Home ( ) Public Low-Rent ( ) Mobile Home

Dependent: ( ) Hospital ( ) Nursing Home ( ) Foster Care Home ( ) Home of Relative or Friend ( ) Other: _____

Lives with: ( ) Spouse ( ) Alone ( ) Friend ( ) Relative

F. MOBILITY

Mobile: ( ) Drives ( ) Walks ( ) Public Transp. ( ) Private Transp.

Impaired: ( ) Walker ( ) Crutches ( ) Wheelchair ( ) Bedridden ( ) Housebound ( ) Other: _____

G. HEALTH: (Indicate (G) good, (F) fair, (P) poor) ( ) Sight ( ) Speech ( ) Hearing ( ) Walking ( ) General

Note any chronic health problems: _____

H. DEPENDENCY	**PROBLEM**	**NO PROBLEM**
Transportation	( )	( )
Meals	( )	( )
Laundry	( )	( )
Housekeeping	( )	( )
Home maintenance	( )	( )
Shopping	( )	( )
Personal Hygiene	( )	( )
Mental Outlook	( )	( )
Personal Safety	( )	( )

I. LIVING CONDITIONS	**ADEQUATE**	**INADEQUATE**
Lodging	( )	( )
Heating	( )	( )
Ventilation	( )	( )
Lighting	( )	( )
Accessibility to out-of-doors	( )	( )
Privacy	( )	( )
Plumbing	( )	( )
Hot Water	( )	( )

J. SERVICES NEEDED: _____

APPENDIX D

MEMORANDUM OF AGREEMENT

Memorandum of Agreement

On the part of Robert L. Dolsen, Executive Director, and Patricia J. Hohnstein, Projects Manager, of the Region Four Area Agency on Aging:

Agree to allow access to data necessary for evaluation of the project.

Agree to supervise and require cooperation of I & R personnel in outreach operations and data collection required by the project.

Agree to insure the provision of postage, telephone, and travel costs as required by the project.

Agree to allow I & R personnel sufficient time to conduct outreach operations and data collection as described by the researchers.

With the assurance of confidentiality,

Agree to permit use of project data for educational requirements and publication by the researchers.

On the part of Martin Kushler and John Jeppesen, Project Researchers:

Agree to protect confidentiality of all data obtained in the project.

Agree to design and supervise the implementation and operation of the project.

Agree to insure that the project promotes the goals of the I & R network and the best interests of the client population.

Agree to provide, for the sole use of the respective I & R centers, all lists of potential clients as soon as project operations are concluded.

Agree to take responsibility for analysis and interpretation of the data, after insuring appropriate consultation with Area Agency personnel.

Agree to act as liaison between the Office of Services to the Aging and the Region Four Area Agency on Aging for purposes of this project.

Agree to provide a written report summarizing the results and findings of the study to the Region Four Area Agency on Aging, for their use in planning, funding requests, etc.

Robert L. Dolsen, Exec. Dir.	Martin Kushler
Patricia J. Hohnstein, Proj. Mgr.	John Jeppesen

APPENDIX E

NUMBER OF REFERRALS BY TYPE OF CONTACT

Number of Referrals by Type of Contact[a]

Table E-1

	Type of Contact					
	Control	Informational Mail	Personal Mail	Telephone Call	Personal Visit	
Received Referral	0	1	2	3	5	11
Did Not Receive Referral	41	44	36	40	38	199
Total	41	45	38	43	43	N=210

[a] $X^2=6.85$ df=4 (p=.144)

APPENDIX F

THE FOLLOW-UP SURVEY QUESTIONNAIRE

The Follow-Up Survey Questionnaire

1. Have you ever heard of the _____ Senior Center?

   1. yes 2. no 8. other

If yes:

2. How did you hear about the Center?

   1. television
   2. radio
   3. newspaper
   4. friends
   5. relatives
   6. I & R/Outreach contact (letter, phone or visit)
   7. don't remember
   8. other

3. Were you contacted by a (letter, phone call, outreach worker) from the _____ Center?

   1. yes 2. no 3. can't remember 8. other

If yes:

4. What did you think about the (insert whichever way person was contacted, i.e. "the letter from the Center," "the phone call from the Center," etc.)? Open-ended--record all responses.

(Read to respondent)
I would like to ask you some questions about the (letter, phone call, visit):

	not at all	a little	some-what	quite a lot	very much
5. Was it clear what the _____ was talking about?	1	2	3	4	5
6. Did you think the Center could be helpful to you?	1	2	3	4	5
7. Did the Center seem like it would be a friendly place (from the contact)?	1	2	3	4	5
8. How much need did you have for their services?	1	2	3	4	5

If positive responder:

9. What influenced you to cooperate with the _____ Center?

(or "What interested you about the Center?")

1. the services available
2. the social activities
3. curiosity, I wanted to know more about the Center
4. they seemed friendly
8. other _____

If not a responder:

10. What influenced you to not contact the _____ Center?

1. had no need
2. don't believe in help like that
3. seemed unfriendly
4. not sure what they were talking about
5. too far away
6. never got around to it
7. other _____

What influenced you to (or not to) call or write to sign up to receive the newsletter?

11. Did sign up

1. sounded interesting
2. wanted to know about the Center
3. wanted to know about services
4. wanted to know about activities
8. other _____

12. Did not sign up

1. didn't want it
2. didn't know I could
3. I lost the number
4. never got around to it
8. other _____

If hasn't signed up for newsletter:

13. Would you like me to sign you up now?

1. yes 2. no

14. What are the most important things that the _____ Center might be able to help you with? (list below)

15. In the future, would you consider calling the _____ Center if problems arise?

1. yes 2. no 8. other

(Form B--Controls Only)

1. Have you ever heard of the _____ Senior Center?

   1. yes 2. no 8. other _____

If yes:

2. How did you hear about the Center?

   1. television
   2. radio
   3. newspaper
   4. friend
   5. relative
   6. I & R/Outreach worker contact
   7. don't remember
   8. other _____

4a. If you were to be contacted by someone to tell you about our _____ _____ Center and you had never heard about it, which type of contact (letter, phone call, or visit by someone in person) would you prefer?

   1. letter 2. phone call 3. personal visit 8. other _____

13. Would you like me to sign you up for our newsletter?

   1. yes 2. no 3. already receives 8. other _____

14. What are the most important things that the _____ Center might be able to help you with? (list below)

15. In the future, would you consider calling the _____ Center if problems arise?

   1. yes 2. no 8. other _____

16. Are you:

1. married
2. single (never married)
3. widowed
4. divorced
8. other _____

17. How many people live in your immediate household? (enter exact number) _____

18. How often did you visit in-person with a member of your family, friends or neighbors last week? (either at your house or theirs)

Family

1. every day
2. a few times
3. once
4. not at all

19. Friends or Neighbors

1. every day
2. a few times
3. once
4. not at all

20. How many close friends or relatives do you have in this neighborhood?

Relatives

1. 4 or more
2. three
3. two
4. one
5. none

21. Friends

1. 4 or more
2. three
3. two
4. one
5. none

22. About how often last week did you talk to friends, relatives or others on the telephone?

1. every day
2. several times last week
3. once last week
4. not at all

23. About how often do you go to meetings or activities of clubs, other organizations, or information meetings of groups?

1. a few times a week
2. once a week
3. 2 or 3 times a month
4. once a month
5. less than once a month or never

23a. How often do you attend a church?

1. every week
2. almost every week
3. about once a month
4. a few times a year - holidays, etc.
5. never (haven't gone in a year or more)

24. When you need help around the house, such as moving a heavy object, who do you contact for help? (check only one)

1. someone in household takes care of it
2. neighbor
3. relative
4. friend
5. hire someone
6. do it myself
7. don't know of anyone
8. other _____

25. Do you think most of your friends, if they came on hard times, would accept help from the government, such as foodstamps?

1. yes 2. no 3. don't know 8. other _____

26. Do you feel the same way as your friends about things like that?

1. yes 2. no 3. don't know 8. other _____

27. Do you think you see your friends, relatives and neighbors as much as you would like?

1. see them too much (would like more privacy, etc.)
2. see them enough (satisfied)
3. would like to see them more

28. How often do you find yourself feeling lonely? (Read items)

1. never
2. hardly ever
3. sometimes but not too often
4. fairly often
5. very often or always

29. How do you see yourself now as compared to before you were 65 in terms of involvement with friends, neighbors, relatives, in groups, etc.? (Read items)

1. much more active now
2. somewhat more active now
3. about the same
4. somewhat less active now
5. much less active now

30. How many living children do you have? (including adopted or step-children) (record exact number) _____

31. Do you have any children living in this part of the state? (within a one hour drive) (record exact number) _____

32. How often do any of your children call or visit you or do you call or visit them?

Call (phone)
1. once a week or more
2. 2 or 3 times a month
3. once a month
4. less
5. never

Visit
1. once a week or more
2. 2 or 3 times a month
3. once a month
4. less (but at least once per year)
5. less than once a year or never

33. Where do you get most of your information about what goes on in the community? (check only one)

1. television
2. radio
3. newspapers
4. friends
5. relatives
6. neighbors
7. don't know
8. other _____

34. What was the last grade of schooling you completed?

1. no schooling at all
2. some elementary (1-8)
3. completed 8th grade
4. some high school
5. completed high school
6. some college
7. completed college
8. other _____

35. What was your occupation (or the occupation of your spouse) before retirement? (If not retired, enter present job and note "not retired.")

36. Compared to other elderly people, do you think your life today is: (read items)

1. much better than others
2. somewhat better
3. about the same
4. somewhat worse
5. much worse

37. If you needed it, would you accept help from the government, such as foodstamps?

1. yes 2. no 8. other _____

Now let's talk about social services.

38. Please tell me all of the community services or social services for older people that you have heard about. (have person list as many as can and write them below.)

39. Now, please tell me all the community or social services you have tried at one time or another. (list below)

(If the above responses indicate that the person knows of services s/he has not tried, ask #40. Repeat for each service heard of but not tried.)

40. What are the reasons you have not tried those services of _____ _____? (first service heard of but not tried)

1. don't need them	4. don't know how to apply
2. not eligible	5. don't believe in welfare
3. haven't gotten around to it	6. other _____

For 2nd service not tried? _____ (enter one of above answers)
For 3rd service not tried? _____ (enter one of above answers)

41. If you found that you had a need for each of the following, who or where would you call for help?

	(First time through) Where Would Call	(Re-check)* Social Service
Food		
Income (money)		
Medical help		
Transportation		

(If client doesn't know where to call, write "don't know.")

*(Interviewer: for each "need" for which the person did not identify a social service the first time through, go back and ask them if they know a service or agency for that purpose and record that in the right hand column.)

42. Do you have a Medicare card?

1. yes 2. no 8. other _____

42a. Do you have a Medicaid card?

1. yes 2. no 8. other _____

43. Where did you first hear about Medicaid?

1. newspaper	5. relative
2. radio	6. social worker
3. television	7. doctor
4. friend	8. other _____
	9. don't remember

44. How did you come to be signed up for Medicaid?

1. applied for it myself	5. Department of Social Services signed me up
2. friend/relative helped me	6. Social Security signed me up
3. social worker contacted me	7. don't know
4. doctor helped me	8. other _____

45. If something went wrong with receiving your check, for example, is there someone who you could call at the Social Security Department? (a person s/he usually talks to, for example)

1. yes 2. no 8. other _____

46. Was (or is) there someone who you can call at the Department of Social Services? (including specific "operator number")

1. yes 2. no 8. other _____

47. Which agency, the Department of Social Services or Social Security, gives you the best personal attention?

1. Department of Social Services
2. Social Security
3. no difference between the two
4. don't know (but uses both)
8. other _____

(Interviewer: If the person doesn't know the difference between the DSS and the Social Security Agency, please write that down here.)

48. Do you have any complaints or suggestions in general about the way senior citizens are treated by social service agencies? (note all responses)

49. Do you think the people at the Department of Social Services have changed much since the first time you ever contacted them?

1. yes 2. no 3. don't know 8. other _____

50. As near as you can remember, when was the first time the Department of Social Services ever provided you with a service?

1. 1950-1960
2. 1960-1965
3. 1965-1970
4. since 1970
5. never has
6. other _____

exact year if known _____

51. Now, I am going to read you a list of areas which people feel are problems for older Americans. For each area, please tell me if it is no problem for you, somewhat of an important problem, or a very important problem. (Read list; rotate order.)

	No Problem	Somewhat	Very Important
Housing	1	2	3
Employment	1	2	3
Health Care	1	2	3
Income	1	2	3
Crime	1	2	3
Getting More Education	1	2	3
Nutrition and Food	1	2	3
Transportation	1	2	3
Loneliness	1	2	3

52. How well do you think your income and assets (including those of spouse and dependents which you can use) satisfy your needs? (Read)

1. very well
2. well
3. adequately
4. barely
5. poorly

53. Compared to other people your age, would you say your health is: (Read items)

1. much better than others
2. somewhat better
3. about the same
4. somewhat worse
5. much worse

54. Do you think a lot of people tend to think poorly about people who receive help from the government, such as foodstamps or Medicaid?

1. yes 2. no 3. don't know 8. other _____

55. How do you usually do your shopping?

1. walk
2. drive myself
3. ride with friend/neighbor
4. ride with relative
5. public transportation (bus, dial-a-ride, etc.)
6. don't go shopping (explain)
7. don't know
8. other _____

56. In general, how do you feel about your life now?

1. feel very satisfied about my life now
2. feel fairly satisfied
3. neither satisfied nor dissatisfied
4. feel fairly dissatisfied
5. feel very dissatisfied

57. Do you know anyone in the area who might be interested in our Center or some of the services we can provide?

Interviewer's Page

Date of Interview _____ Interviewer _____

Approximate Length of Interview _____(minutes)

Age _____ Sex _____ Race _____ Name _____

Client Card _____ (yes or no and number, if applicable)

Was anyone else present at the interview?_____

Did they assist in answering questions?_____

The client's health appeared to be:

1. very good
2. fairly good
3. satisfactory
4. somewhat poor
5. very poor

The client's memory and ability to pay attention appeared to be:

1. very good
2. fairly good
3. satisfactory
4. somewhat poor
5. very poor

Could the client read? (his/her mail, for example)

1. yes, well
2. yes, somewhat
3. no, poor vision
4. no, lack of education
5. don't know

(If "no," does someone read his/her mail to him/her? 1. yes 2. no)

Did the client have a phone? 1. yes 2. no

Did the client have a television and radio?

Television	Radio
1. yes	1. yes
2. no	2. no

Please write any additional notes of importance on the back of this page.

APPENDIX G

INTERNAL CONSISTENCY OF THE FIVE RATIONAL SCALES

Internal Consistency of the Five Rational Scales

Table G-1

Scale	Items	Item-Total Correlation	Alpha if Item Deleted	Overall Alpha
Family contact				.74
	Question #18	.48	.70	
	Question #20	.55	.69	
	Question #30	.58	.69	
	Question #31	.59	.66	
	Question #32	.42	.73	
Other social contact				.56
	Question #19	.51	.40	
	Question #21	.26	.55	
	Question #22	.36	.49	
	Question #23	.23	.55	
	Church attendance	.31	.52	
"Problems"				.66
	Housing	.21	.67	
	Health care	.53	.57	
	Income	.39	.62	
	Crime	.28	.67	
	Nutrition/food	.50	.59	
	Transportation	.47	.59	
Knowledge of social services				.68
	Question #38	.63	.56	
	Question #39	.55	.60	
	Question #41 (food)	.41	.66	
	Question #41 (income)	.43	.65	
	Question #41 (medical)	.42	.65	
	Question #41 (transportation)	.21	.69	
Life Satisfaction				.57
	Question #28	.18	.63	
	Question #36	.55	.39	
	Income OK	.28	.55	
	Self-rated health	.29	.54	
	Question #56	.48	.46	

APPENDIX H

EFFECTIVENESS OF THE RANDOMIZATION PROCEDURE

Effectiveness of the Randomization Procedure

In order to check for the effectiveness of the randomization procedure, a total of 21 demographic and descriptive variables were examined for differences between the 5 experimental groups. Only one of the 21 variables was found to vary between the groups with a significance level less than($p=.05$). This was the variable of age ($p=.049$).

Although finding only one barely significant difference out of such a wide range of variables lends quite strong support to the notion that the five groups were functionally equivalent, the variable of age was further examined to see where the differences occurred and how this variable related to the outcome measures. In this manner, it could be determined if the differences observed might have added bias to the analysis of the effects of type of contact.

A Duncan's multiple range test was administered as a post hoc analysis of the difference between groups. It was found that the significant difference was attributable to the fact that those in the telephone and in-person groups (mean age 73.3 and 74.0, respectively) were younger ($p < .05$) than those in the personal mail group (mean age 78.3). Those in the control group and informational mail group (mean age 74.9 and 76.2, respectively) form a homogeneous subset with either the telephone and in-person group or with the personal mail group.

The available evidence indicates that the impact of these differences upon the outcome measures was probably small. A quick glance at the ordering of the groups in terms of "success" in each of the outcome measures (see "Treatment Effects") reveals that they are not at all the same as the ordering of the groups in terms of age. Indeed a

correlational analysis shows that age has a low correlation with each of the three dependent variables. Younger age is slightly positively correlated with client card registration (r=.13, p=.04) and virtually non-correlated with signing up for the newsletter (r=.06, p=.20) and with receiving a service (r=.08, p=.13). Although the first correlation achieves significance at below the .05 level, this is primarily due to the large sample size. As can be seen, the actual magnitude of each relationship is small. Indeed, the r^2 value reveals that age accounts for only 1.6%, .4% and .7% of the variance of the three respective dependent variables. Finally, T-tests show that positive responders taken as a group did not differ from non-positive responders in terms of age. In summary, it appears that the observed differences in mean age between the groups should not add any substantial bias to the interpretation of the outcome results.

In conclusion, having examined a wide range of available data, the weight of the evidence seems clearly to demonstrate that the randomization procedure did indeed produce functionally equivalent groups for the purposes of this experiment.

Effectiveness of the Randomization Procedure

Table H-1

Results of Analyses on 21 Variables by Type of Contact

Analyses of Variance

Variable	F-Value	Signif.
Age	2.88	.025
Number of persons in household	1.45	.221
Number of living children	.56	.690
Number of living children within a 1 hour drive	.70	.594
Health as rated by outreach worker	.37	.776
Memory as rated by outreach worker	2.27	.066
Family contact scale	.74	.570
"Other social contact" scale	1.50	.223
"Problems" scale	.10	.960
Social service knowledge scale	.99	.416
Life satisfaction scale	1.73	.145

Chi-Squares Analyses

Variable	x^2 Value	Signif.
Sex	4.92	.295
Race	3.57	.467
Marital status	7.81	.090
With whom person resides	21.38	.164
Education	9.36	.313
Response to follow-up survey	4.06	.398
Source of community information (Question #33)	8.69	.369
Does person know someone who might be interested in I & R services	1.97	.741
SSI or State Medical distribution	1.29	.862
Which I & R center contacted person	15.34	.910

APPENDIX I

COMPARISON OF THE TWO ASSISTANCE GROUPS

Comparison of the Two Assistance Groups

When it became evident that the three dependent variables demonstrated no main effects or interaction effects attributable to the SSI vs. State Medical group distinction, the question arose as to whether or not these two sample groups did, in fact, represent two distinct populations. In order to pursue this question, the Michigan Department of Social Services' Medical Assistance Eligibility Manual (1976) and SSI Handbook (1976) were obtained. These sources reveal that the eligibility requirements for the two programs are quite similar. The major eligibility guidelines for the two programs are compared below.

Table I-1

Program Eligibility Requirements

	SSI ("aged" category)	State Medical ("aged" category)
Age	Over 65	Over 65
Income	$2004/yr. For 1 person $3012/yr. For 2 persons	$2688/yr. For 1 person $3540/yr. For 2 persons
Non-exempt* Property	$1500 For 1 person $2250 For 2 persons	$1500 For 1 person $2250 For 2 persons

*The two programs each consider one house, one automobile, and most household goods and personal effects as exempt from property value computations.

As one can see, in terms of the criteria of income and available assets, these two groups are, by definition, quite similar (and also quite poor).

As the third, and most important, criterion, the two groups were compared in terms of the actual data distributions gathered in the follow-up survey. The two groups were examined for any differences on a total of 19 variables, including the five logical scales discussed in the

"Methods" section. A complete listing of the variables and their significance levels are presented in Table I-2.

As one can see, the results revealed that there were only two significant ($p < .05$) differences between the SSI recipients and the state medical recipients among these 19 variables. These were with respect to the variables of age and race. The presence of only two significant differences between these population sub-groups on such a wide range of variables would seem to indicate that, for most practical purposes, the two groups were, in fact, equivalent. In order to strengthen this conclusion, however, the two variables which distinguished the two groups were examined for their relationships to the dependent variables.

Regarding the variable of race, it appeared that a similar conclusion was merited. The variable of race was not significantly related to any of the three dependent variables ($p > .50$ for each of the three variables). Hence, it appeared that this difference also should not have biased the relationship between these two groups and the dependent variable.

Finally, as a further test of the similarity of the two population sub-groups, the variances of response were compared on numerous variables from the follow-up survey, including the five rational scales. None of the variables examined showed a significant difference in variance ($p < .05$) between the two groups.

In summary, it appeared as though there were only two minor differences between the two assistance recipient groups selected for use in this study. Those differences consisted of the fact that the state medical group had a higher percentage of black persons (32% as compared to 14%) and was slightly younger ($\bar{x}$=74.1 years as compared to 76.6 years) than the SSI group. Other than that, however, comparisons on a wide range

of descriptive, demographic and attitudinal variables demonstrated that the two groups of low-income elderly were quite similar. This was also true in terms of the three dependent variables used as outcome measures in this experiment. With the weight of this evidence in mind, the two groups were collapsed into one large sample for the purpose of all pertinent data analyses.

Comparison of the Two Assistance Groups

Table I-2

Results of Analyses on 19 Variables
by "Assistance Group" (SSI or State Medical)

Analyses of Variance

Variable	F-Value	Signif.
Age	2.23	.026
Number of persons in household	1.956	.165
Number of living children	.060	.953
Number of living children within 1 hour drive	.530	.600
Health as rated by outreach worker	.776	.311
Memory as rated by outreach worker	.697	.405
Family contact scale	1.58	.117
"Other social contact" scale	.150	.882
"Problems" scale	.520	.606
Social service knowledge scale	1.09	.277
Life satisfaction scale	1.84	.068

Chi-Squares Analyses

Variable	x^2 Value	Signif.
Sex	2.81	.094
Race	9.13	.003
Marital status	3.21	.360
With whom person resides	3.71	.446
Education	1.21	.546
Response to follow-up survey	1.76	.184
Source of community information (Question #33)	.71	.698
Does person know someone who might be interested in I & R services	1.22	.270

APPENDIX J

THREE RATIONAL SCALES AS SECONDARY OUTCOME MEASURES

Table J-1

Analysis of Variance: Knowledge of Social Services Scale by Type of Contact

Source	DF	Mean Square	F	Significance of F
Main Effects	4	4.35	.536	.710
Type of Contact	4	4.35	.536	.710
Residual	133	8.11		

Table J-2

Analysis of Variance: Problems Scale by Type of Contact

Source	DF	Mean Square	F	Significance of F
Main Effects	4	.206	.996	.411
Type of Contact	4	.206	.996	.411
Residual	170	.207		

Table J-3

Analysis of Variance: Life Satisfaction Scale by Type of Contact

Source	DF	Mean Square	F	Significance of F
Main Effects	4	.654	1.59	.178
Type of Contact	4	.654	1.59	.178
Residual	186	.411		

APPENDIX K

RELATIONSHIP OF THE DEMOGRAPHIC AND SOCIAL SERVICE RELATED VARIABLES TO THE THREE DEPENDENT VARIABLES

Relationship of the Demographic and Social Service Related Variables to the Three Dependent Variables

Table K-1

Results of Analyses for the Client Card Registration Variable (Responders vs. Non-Responders)

Variable	F-Value	Signif.
Age	1.91	.058
Number of persons in household	1.21	.229
Health Rating	.18	.859
Memory rating	1.85	.068
Number of living children	1.40	.164
Number of children within 1 hour drive	1.53	.128

Chi-Squares Analyses

Variable	x^2 Value	Signif.
Sex	.82	.364
Race	.49	.486
Marital status	3.52	.318
With whom person resides	.86	.931
Education	.09	.954
Question #25 (friends accept foodstamps)	4.80	.091
Question #37 (self accept foodstamps)	.04	.846
Question #48 (comments about social services)	1.83	.608
Question #50 (when first used DSS)	2.05	.563
Question #54 (perceives welfare stigma)	.11	.741

APPENDIX L

OUTREACH COST ESTIMATES

Outreach Cost Estimates

Table L-1

Estimated Costs of Completing One Outreach Contact[a]

Mode	Outreach Worker Labor[b]	+	Related Costs	=	Cost Per Contact
Home Visit	$2.55		.45 (mileage[c])		$3.00
Telephone Call	$.85		.17 (telephone costs)		$1.02
Personal Letter	$.22		.22 (postage and materials)		$.44

[a]Note: the cost estimates provided in this table are taken from the records of the Region IV Area Agency on Aging in southwestern Michigan, from the period of October 1, 1975, through June 30, 1976. Estimates based on other regions and for other time periods may require adjustments according to local cost considerations.

[b]Outreach worker labor costs are estimated at an average of $2.55 per hour and are based on a single outreach worker making the contact. If outreach workers travel in pairs, labor costs must be increased proportionately.

[c]A rate of 15¢ per mile was used to estimate mileage costs. Actual mileage costs vary from region to region and can be expected to be higher in rural areas. To the extent that mileage required increases, the relative desirability of home visits may decrease.

Outreach Cost Estimates

Table L-2

Estimated Costs Based on Effectiveness Data

For the Client Card Dependent Variable

	Cost of 1 Contact	x	Effectiveness Factor	=	Estimated Cost Per Successful Registration
Home Visit	$3.00		1.3		$3.90 + overhead
Telephone	$1.02		3.6		$3.67 + overhead
Personal Letter	$.44		9.0		$3.96 + overhead

For the Dependent Variable of Receiving a Service

	Cost of 1 Contact	x	Effectiveness Factor	=	Estimated Cost Per Successful Registration
Home Visit	$3.00		4.0		$12.00 + overhead
Telephone	$1.02		5.0		$5.10 + overhead
Personal Letter	$.44		9.0		$3.96 + overhead

For the Newsletter Dependent Variable

	Cost of 1 Contact	x	Effectiveness Factor	=	Estimated Cost Per Successful Registration
Home Visit	$3.00		8.3		$24.90 + overhead
Telephone	$1.02		50.0		$51.00 + overhead
Personal Letter	$.44		12.5		$5.50 + overhead

APPENDIX M

CLIENT RATINGS OF OUTREACH CONTACTS

Client Ratings of Outreach Contacts

Table M-1[a]

	Mean	F	Significance
Question #5 (how clear)		2.96	.036
informational mail	2.95		
personal mail	4.11		
telephone call	3.89		
home visit	3.78		
Question #6 (center helpful)		.46	.711
informational mail	2.90		
personal mail	2.84		
telephone call	2.48		
home visit	2.70		
Question #7 (center friendly)		.68	.566
informational mail	3.79		
personal mail	4.26		
telephone call	4.00		
home visit	4.09		
Question #8 (need for services)		.34	.798
informational mail	2.26		
personal mail	2.21		
telephone call	2.35		
home visit	2.03		

[a]These questions were rated on a five point scale, from lowest to highest. (see Questions #5 through #8 in Appendix F.)

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