# Social Service in Homes for the Aged

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IN RECENT YEARS many homes for the aged have developed into nursing homes for physically or mentally disabled persons of far-advanced age. This change in function was prompted by the marked increase both of infirm old people seeking admission and of residents beyond 80 years who were physically or mentally declining during their long stay in the home.

Acceptance of new responsibilities has been accompanied by adjustments in the organization of personal health services. Numerous homes have built up regular professional staffs of persons with various special skills; acquired diagnostic and therapeutic equipment of various types or arranged to use such equipment in nearby hospitals; established, or expanded, special units for the sick; and made informal arrangements with general hospitals for inpatient and outpatient care of those residents who could not be treated at the home. Going beyond this pattern, some homes have entered into definite cooperative agreements with general hospitals through which physicians on the hospital staffs provide service at the homes.

Addition of social workers to the staffs is part of the new policy. How far has this development progressed in a group of nonprofit institutions under identical auspices? What specific functions are performed by the social workers? Answers to these questions were obtained through inquiries made in connection with a series of studies on coordination of health services for patients with long-term illness. These studies were sponsored by the Council of Jewish Federations and Welfare Funds and supported by a grant from the Division of Hospital and Medical Facilities, Public Health Service.

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## Employment of Social Workers

Data on employment of social workers in 1957 were collected as part of a detailed study of the organization of personal health services in 70 Jewish homes for the aged in the United States and Canada, which accommodated approximately 11,000 people at the time of the inquiry.

Qualified social workers were on the staffs of 44 of the 70 homes. Full-time workers were employed in 33 homes containing 74 percent of all available beds and they were assisted by part-time staff members in a few of the homes. At 11 homes, with 8.3 percent of all beds, only part-time social workers were employed.

A breakdown of these figures by size of home showed that full-time social service was practically the rule in institutions with more than 200 beds but infrequent in smaller homes. Full-time social workers were found in one home with 34 beds, in 15 of the 36 homes in the 50- to 199-bed category, in all but 1 of the 14 homes with 200 to 399 beds, and in all four homes with 400 or more beds. Part-time social workers as the only representatives of the profession were employed in five homes with bed capacities between 23 and 47, in one 52-bed home, in one 77-bed home, in three homes in the 100- to 199-bed category, and in one 205-bed home.

There were no social workers on the staffs of 26 homes containing 13.7 percent of all beds. All these homes had fewer than 200 beds, and most of them fewer than 100 beds. However, 11 of them, with about 4 percent of all beds, regularly used the services of caseworkers of social agencies in the community, such as family service agencies.

It can be concluded that more than 85 percent of the 11,000 residents of the 70 homes had access to a social worker.

The number of social workers in relation to the number of residents or the number of beds is, of course, very important to the evaluation of the situation. For this analysis, 100 beds were used as the unit of measurement since the number of beds represented fairly accurately the number of residents. In 1957, the median occupancy rate of the 44 homes was 93.6 percent. The number of all social workers per 100 beds equaled one or more in 15 homes and less than one in the remaining 29. Since no standards of quantitative adequacy have been developed, the significance of this finding cannot be assessed.

### Functions of Social Workers

During certain periods of 1958, 530 residents of five Jewish homes were studied by teams of physicians, nurses, social workers, and administrators on the staffs of the homes. The institutions were located in Chicago, Miami, Philadelphia, St. Louis, and Toronto. All the homes had more than 50 but fewer than 400 beds, the category containing seven-tenths of all the beds in the 70 Jewish homes from which data on social service staffs had been obtained.

As part of these case studies information was gathered on the extent of social service and the specific functions performed by the social workers. To give the findings proper perspective, the setting in which the social workers were acting must be described briefly.

At the time of the study more than one-half of the people living in the five homes were 80 years or older, 3 out of 4 were widowed, and more than 8 out of 10 were dependent for their support on social security benefits, public assistance, or both sources. One-half the residents had been living in the home at least 3 years, the majority of these 5 years or more.

Almost all of the residents were in ill health, suffering from multiple chronic ailments, and many were severely disabled. Mental impairment with symptoms of temporary or continuous confusion was the most common affliction; it was found in more than 4 out of 10 persons studied. Marked emotional disorders were widespread among the others. Nearly one-half of all the residents were so seriously incapacitated that they required care in a special unit, such as an infirmary or a hospital division of the home. Details have been described elsewhere (*1*).

All five homes had at their disposal both special facilities and professional and auxiliary staffs. Four homes possessed clinical laboratories, X-ray laboratories, electrocardiograph machines, operating rooms suitable for minor surgery, dental divisions, and equipment for physiotherapy and occupational therapy. The fifth home, located in the same building as a well-equipped chronic disease hospital, had ready access to such facilities. Special units for the sick were operated by all the homes. The beds in these units represented 24, 24, 44, 48, and 60 percent, respectively, of the total bed capacities of the five institutions. The regular staffs of all five homes comprised physicians, including representatives of all major specialties, dentists, professional and practical nurses and nurse aides, laboratory technicians, physiotherapists, social workers, and specialists in recreational work. In addition, podiatrists, optometrists, or occupational therapists were on the staffs of some of the homes, and a psychologist was in regular attendance at one home.

The time spent by physicians on service at the home during a typical week equaled 12 hours per 100 beds in one home and exceeded 25 hours in the other homes, the maximum being 39 hours. The rate of all types of nursing personnel ranged from about 11 to about 32 per 100 beds and the rate of professional nurses ranged from 1.4 to 4.7 per 100 beds. At the time of the study nursing service was received by 9 out of 10 persons in the residential units of the homes and by all those in the infirmaries or similar divisions.

The social service staffs numbered one full-time worker each in three homes and one full-time and two part-time workers in one home.

For the home in the building with the chronic disease hospital, three full-time workers served both the home and the hospital. Excluding this home, the number of social workers per 100 beds equaled 0.4 in one home, 0.7 in two homes, and 1.2 in one home.

Two-thirds of the 530 residents were receiving social service at the time of the study. However, this average conceals exceedingly wide variations among the homes. At one home every fifth resident was assisted by social workers and at another every resident. In the other three homes, two-fifths, three-fifths, and four-fifths of the respective residents were currently attended by social workers.

Specific activities carried out by social workers averaged three per resident served. The rate of activities was highest in the two homes where all or most of the residents were assisted by social workers; it was lowest at the one home where a small proportion of all residents were receiving such help. Thus, there was a striking correlation between frequency of assistance by social workers and average number of specific activities per person receiving social service.

Of specific activities, counseling with the residents was most frequent. Next came, in this order, collaboration with nurses, collaboration with physicians, and counseling with members of the residents' families. Together these activities accounted for more than four-fifths of the total. The remaining activities consisted mainly of arrangements for sheltered employment and for recreation outside the institution. At one home, the social worker's duties included requests to the families to help pay for drugs and appliances.

Counseling with the residents ranked first in demands on the time of social workers as well as in frequency. Counseling with relatives of the residents, collaboration with staff physicians, and collaboration with nurses were, in this order, the other most time-consuming functions.

Problems to be tackled by social workers on the staffs of homes for the aged are peculiar both in nature and in scope because of the influence of four, often interdependent, factors: congregate living, long stay, high frequency of substantial physical or mental impairment, and prevalence of emotional disorders. To deal with these situations, social service must be provided at the time of admission of a resident, if not at the time of the application, and it must be continued for many weeks or months, and often for years, at least intermittently. Such a policy was the rule at all five homes studied.

The following two examples show the emphasis placed on participation of social workers in the evaluation of applicants and in service to new residents. At one home all admission procedures are under the supervision of the social service department. The physicians and social workers on the staff decide jointly whether an application should be accepted and if so, whether it should be given priority. Residents receive casework service immediately after admission. At another home, each new resident goes through an "orientation process" of 6 weeks during which every effort is made to establish all facts on physical and mental condition, social adjustment, and requirements for special services, such as occupational therapy.

Many persons entering a home for the aged feel lost in the new environment. Some cannot cope with the abrupt transition from loneliness to togetherness. Some harbor bitter feelings against relatives who have "abandoned" or "rejected" them. Some are distressed by the necessity of sharing a room with a person differing in background or interests, and some cannot reconcile themselves to the fact that they are no longer self-sufficient and capable of self-care. Newcomers are often easily annoyed by other residents and quick to complain or to start an argument. Sometimes they become hostile or depressed.

Adjustment of the resident to the environment, especially to group living, is one of the aims of casework service. Typical examples from the case studies are an 85-year-old man who is "nongregarious" and "always ready to question all procedures"; an 81-year-old man who "feels superior to other residents," influences some in adverse manner, and needs "a better outlet for his energies"; and an 81-year-old woman who needs "considerable reassurance" concerning an inactive tuberculosis as well as "assistance in adjustment to institution and partner."

Some of the residents who originally found

it very hard to accept life in an institution gradually become accustomed to it and seek the social workers for supportive help only once in a while. Others continue to require counseling service time and again, as a 75-year-old man who throughout his 4 years of residence had been a "trouble-maker" because he tended to "become easily argumentative with other residents." Not infrequently, emotional problems, mainly anxiety, develop with deterioration of the resident's physical condition or occurrence of an intermittent disease. Illustrations are a 77-year-old woman with chronic glaucoma who was haunted by the fear of complete blindness; an 81-year-old woman with carcinoma of the rectum who was "unable to face reality" and exceedingly demanding ("all is not enough"); a 74-year-old man with progressive osteoarthritis of the spine and obliterative arteriosclerosis of the legs who could not resign himself to being bed bound and restricted in functions of daily living; an 82-year-old woman who was "a well-adjusted happy person" until she had a severe case of herpes zoster causing despondency; and an 80-year-old woman who after 14 years in the home had several severe falls and was frightened by the very thought of walking.

Although continued, and at times intensive, counseling service to mentally clear residents with emotional disorders was a major activity of the social workers, some service was given to almost as many mentally confused as mentally clear residents. It ranged from "minimal counseling" for persons with severe disturbances to frequent "friendly conversations" with mildly confused residents. Occasionally, a social worker visited such residents daily in an effort to improve their relationships with other residents, nurses, and relatives. As a rule, the counseling was part of the total treatment plan, carried out in close collaboration with the attending physician, often a psychiatrist, the floor nurse, and the occupational therapist. Significantly, two-thirds of the residents with emotional or mental disorders could be helped mainly by counseling from social workers as well as by constant reassurance from the nursing personnel; they needed only occasional psychiatric service. The remaining one-third required more or less regular psychiatric treatment complemented by some social service (*2*).

Counseling with the families of residents, the second most time-consuming activity of the social workers, aimed at two principal objectives: to obtain cooperation in the care of the resident and to assist the relatives themselves. In some instances the family did not understand the behavior of a seriously ill resident, the purposes of the services provided, or the willingness of the home to help the resident. In other instances, the family's active cooperation was necessary to influence the behavior of the resident. In still other instances, relatives required assistance to withstand the stress of witnessing a resident's long suffering. Accordingly, the social worker's activities ranged from interpretation to treatment.

The social workers on the staffs of the five homes were keenly aware of the limitations of their work. Although casework service was given to two-thirds of all residents at the time of the study, its intensity was not always sufficient. This fact was freely admitted by the social workers. For instance, a 75-year-old mentally clear man, in the home more than 3 years, needed "more counseling time than can be allotted to him," and a 79-year-old mentally confused woman, in the home more than 6 years, required "more consistent individualized attention." In view of the caseloads carried by the social workers these remarks may well apply to many cases.

## Discussion

It is heartening to find that some 80 percent of the 11,000 residents of 70 Jewish homes for the aged in 1957 had the opportunity to receive service from social workers on the regular staffs of the homes and that an additional small proportion could be assisted by caseworkers affiliated with social agencies in the community. This, however, is not the full story. The question, "Is there a social worker in the house?" could be answered in the affirmative by only 44 of the 70 homes. Whether the 26 homes without social workers on their staffs can serve their residents properly seems doubtful.

Employment of full-time social workers was more frequent with increasing size of the institution; it was found at all but one of the homes with more than 200 beds. It is significant that

the homes with full-time social workers provided 74 percent of all beds although they made up only 47 percent of all homes.

How many residents can a full-time social worker effectively handle under certain clearly defined circumstances? This question is begging to be answered. Development of standards by an authoritative body would be of help to those homes that want to extend and improve their social services.

The analysis of the functions of the social workers at the five homes underlines the importance of a good social service department. The predominance of counseling with the residents could be expected in view of their particular needs. It is especially interesting that the social workers gave so much of their time to counseling with families of the residents. By establishing and maintaining liaison between the home and the family the social workers contribute not only to better care of the resident but also to better understanding of the role of the home.

Another highly important activity of the social workers was interprofessional cooperation. Collaboration with the nursing personnel was even more frequent than collaboration with physicians. One may well conclude that the principle of coordinating services for the residents can be applied easily if there are social workers on the regular staffs of the homes.

Inevitably, the findings reported here raise an important question: Are the Jewish homes for the aged typical with respect to provision of social services? At present, no answer is possible because there are no detailed studies of social service at other groups of homes for the aged. This gap in our knowledge should be filled soon. Once this is accomplished it will be easier to plan for the best possible development of social service in homes for the aged, that essential component of total care of residents.

#### REFERENCES


(*1*) Goldmann, F.: Residents of homes for the aged. Geriatrics 15: 329–337, May 1960.

(*2*) Goldmann, F.: Medical care of the mentally impaired in homes for the aged. Am. J. Pub. Health 50: 1687–1694, November 1960.


## Hospital and Medical Economics in Michigan

The University of Michigan has just completed the largest independent analysis yet made of medical and hospital economics in a State.

The 3-year study revealed that patients who stay in the hospital even a day or two longer than necessary can add as much as $15 million to the State's hospital bills in a year. On the other hand, patients who leave the hospital too early may need additional services amounting to as much as $5 million if minimum standards for medical care are to be met.

The study also found that the health insurance of most families in Michigan is insufficient to take care of major hospital and medical expenses. The report recommends improvement of health insurance coverage for aged and low-income families, continued protection for unemployed and retired workers, and broadening of benefits under existing insurance and prepayment plans.

The researchers concluded that hospital management, prepayment and insurance plans, and physicians will be under increasing pressure to provide adequate health services on a nationwide basis.

Under the title "Hospital and Medical Economics" the complete 2-volume, 1,600-page report of the study is scheduled for fall publication by the Hospital Research and Educational Trust, c/o American Hospital Association, Chicago, Ill.