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ABSTRACT

A training program for prospective foster home operators and volunteer workers with creative arts was held in the fall of 1968 and again in the spring of 1969 under the joint sponsorship of the Program in Gerontology of the University of Rhode Island, the Cooperative Extension Service, and the Rhode Island Medical Center. The foster homes under consideration were those for adults, primarily for elderly persons who are ambulatory and relatively self-sufficient but who require some supervision. Topics covered included the health and mental problems of the elderly, standards for public assistance and medicare, nursing techniques, feeding the elderly, creative arts as therapy, and various special needs and problems. (mf)

COMMUNITY SERVICE PROGRAM

in

FOSTER HOME MANAGEMENT

and

CREATIVE ARTS

University of Rhode Island
Kingston, Rhode Island
1968-1969

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Sponsored by the
Program in Gerontology of the University of Rhode Island
jointly with the
Cooperative Extension Service
and
Rhode Island Medical Center

Supported in part by
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PLANNING COMMITTEE
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FOREWORD

One of the major problems of the modern mental hospital is finding a place where patients, particularly older ones, can go who are ready to be discharged but are not yet ready to make the complete transition of returning home, or no longer have a home of their own.

In Rhode Island about forty multi-patient foster homes for adults have been established to meet this problem. Public Assistance pays its share for patients with a previous diagnosis of psychiatric illness or residual effects of it. Follow-up care is provided by the Mental Hospital.

The program described herewith was undertaken to fill the following needs:

1. The need for more foster homes to absorb the number of patients referred by physicians for transfer from the Medical Center.
2. The need for instruction of current and potential operators of foster homes in the physical and emotional care of patients.
3. The lack of sufficient planned creative activities to fill the leisure time of the patients in the foster homes.

By conducting a training program for prospective foster home operators and volunteer workers, it was hoped that these people would be prepared to carry out their respective responsibilities in establishing and maintaining an atmosphere conducive to the physical and emotional well-being of the foster home patients.

The Planning Committee found this experience most rewarding. The foster home operators feel that they are now doing a better job, and can be more effective with their patients. The volunteers in creative arts have found new interest in life and talents which they did not know they possessed.

Their enthusiasm is unbounded. At their request, the series of five training sessions in creative arts in the Fall was extended to six sessions and in the Spring, to eight sessions. It was anticipated that only women would participate in this, but two men joined the group and they feel that more men might participate in the future.

The climax of the Program was the award ceremony on May 16, 1969, when fourteen ladies and one gentleman received certificates from the University of Rhode Island for participating in the training program and for contributing twenty-five hours or more in the field of creative arts as a volunteer in a health care facility.

The project was funded in part by Title I, Higher Education Act of 1965.

Orientation to General Purpose and Foster Home Programs

EVELYN ARTHUR

RHODE ISLAND is fortunate in the quality of the adult foster homes which are available to R. I. Medical Center patients who no longer need hospitalization, and who are unable to return to their own homes. Tender Loving Care (TLC) and pleasant surroundings make our patients comfortable during convalescent leave from the hospital. Ever increasing numbers of acutely ill admissions to the Medical Center mean that more vacancies in the community are urgently needed to provide high quality nursing care to ambulatory and relatively self-sufficient patients who require some supervision. We hope our two-day foster home management sessions will bring together Rhode Island Medical Center and operators in a closer relationship.

However, R. I. is not as fortunate when we consider the lack of a planned program which will bring the community closer to these Foster Homes. I regard it as an obligation to encourage the former hospital patients to resume their place in society through friendly relationships and creative arts.

We are here today to attempt to meet the problems faced by elderly R. I. Medical Center patients who have undergone a process of social breakdown known as "institutionalization." The institutionalized patient is defined as one who is apathetic, dependent on the hospital with little response to stimulation, and heading toward a meaningless existence as a "vegetable" rather than a unique human being.

There has been no organized state planning prior to this project despite the concern of the Department of Social Welfare, hospital administrators, doctors, nurses, social workers, and patients' families. This pilot community service project attempts to meet these very real problems by drawing together university, lay, and professional services to train thirty, warm-hearted yet objective volunteers to go into Foster Homes as leaders and stimulators in the area of creative arts. These volunteers can best work within a program structured for them as a group. They will attempt to capitalize on the potential each patient has for revitalization or revival of creative energies and lagging interests. These responsible volunteers should receive community credit and recognition.

This demonstration project is encouraged and partly supported by the Federal Government. Various agencies are involved with us in teamwork to help the patient regain his or her place in the community mainstream.

We are working with R. I. Rehabilitation Services, the Medical Center's Occupational Therapy Units and Social Services, Vocational Rehabilitation, Services for the Aging in the Department of Community Affairs, and an advisory committee. We are working through Church Women United, and have ecumenical support. Some churches have offered help on a one-time basis putting on a specific program. I have recruited all the volunteers in various personal contacts and talks to groups.

There are twenty-five multi-patient homes ranging from seven to fifty patient capacity, and twenty plus one-patient homes which provide lay care. We have registered fifteen new volunteers for an eight-session creative arts training course to be held at the Rehabilitation Center, R. I. Medical Center, this spring. Last fall fifteen volunteers trained through a similar course also developed and supervised by Evelyn Mason at the University of Rhode Island Cooperative Extension offices in Providence. These volunteer "occupational therapists" under my supervision have formed teams in six Foster Homes (and six hospital wards as well). We expect to service another six to ten homes.

This program is a beginning; hopefully the State will eventually take over the function of enriching the patients' lives in the Foster Homes as we demonstrate success through our activities. Perhaps it will be necessary to apply for another federal grant first. In any event team-work is crucial in providing a stimulus for re-creation.

Creative Arts

EVELYN MASON

I look forward to working with all of you on a program in which I am sure we all have much interest and hope. I would like to tell you how I see the task before us.

You are already acquainted with some of the physical and economic and social pressures influencing the program. Now I feel we all need to become acquainted with each other and our individual and collective responsibilities. The very fact we are all here demonstrates our mutual interest. This one time, when we are all here, is the opportunity to get to know our fellow workers,—how we can help them and how they can help us.

The materialistic and individual world we live in fosters selfish interests. Yet we all know, to a great degree, we still believe we are our brothers' keepers. We cannot morally live in a world of plenty, be it plenty of money, plenty of material goods, plentiful good health and happiness, plentiful spiritual richness and content without being willing to share our wealth with others. The kind of wealth we all have to share is love, peace, companionship, knowledge. This, combined with the specialized wealth of good medical and nursing care, counseling services, personalized interest and teaching, will help us reach our multiple goals of creating environmental and physical conditions that make for happy foster home patients and operators, fulfilled members of the medical, nursing and counseling professions, fulfilled instructors, and hopefully satisfied state and University officials that we have performed our assignments well.

Since the main person in our present drama is the patient, we need to be aware of his or her attitude toward the change from an institutional to a home atmosphere. Is the change going to please him, frighten him, or disturb him?

The foster home operator will no doubt be much concerned about the sex, age, personality and special needs of the patient. He will need advice on making the home attractive to the patient; the availability of medical and nursing care, food planning, counseling services, etc.

The creative arts leaders will be concerned with working most beneficially with the patient through the home operator and recognizing situations that require advice and help from other team members.

And of course, the doctors, nurses, and social workers must expect maximum cooperation from home operators and creative arts leaders who will spend more time with the patient and be able to recognize signs of progress and signals of distress.

To do our work well and succeed in our objective, we must establish good liaison between the State Hospital Staff, the homeowner and patient, the social worker, the creative arts leader and the community.

A brief example would be the creative arts leader feeling frustrated at not reaching and motivating a patient. She should feel free to discuss this with the home operator who may feel it is a problem for the social worker. The social worker may feel long inactivity at the institution or the change in environment may have caused or exaggerated the patient's emotional problem. Then the hospital psychiatrist may have to be called into the picture. Of course, this same situation may be completely reversed.

Maintaining the Health of Foster Home Patients

JOHANNES VIRKS, M. D.

It is common knowledge that the number of elderly people 65 years of age and over is increasing from year to year. The national average increase in the 65-plus age group between 1960 and 1967 was 13.5% while the total population of the United States rose 10.3% in the seven-year period. The national average of the over-65 population at the present time is estimated as 9.5% of the total population.

The increase of the 65-plus age group in Rhode Island during the past seven years was 7.8% while the total population of Rhode Island rose 4.8% in the same seven-year period.

As of last year 10.8% of Rhode Island residents were in the 65-plus age bracket. At the same time the total population of Rhode Island was 900,000. This gives a figure of 97,000 of

the over-65 population. It may be of interest to you that 96% of these 97,000 are living in home settings, either independently or with their families. Thus, only 4% or about 4,000 of the over 65 population are residing in institutions like Nursing, Convalescent, Rest, Foster Homes or chronic disease hospitals.

The General Hospital of the Rhode Island Medical Center has close to 1400 patients 65 years of age and older. The number of new admissions of 65 years and older patients has increased during the past three years from about 400 per year to about 600 per year. At the same time the total number of hospital population has not increased. This has been possible through more complete evaluation of newly admitted geriatric patients which has resulted in a greater number of discharges to home and placements to Nursing, Convalescent, Rest and Foster Homes.

Seven years ago, we at the Rhode Island Medical Center established a special geriatric admission unit. All newly admitted elderly patients, unless they are suffering from psychosis, are admitted to this unit. Within the first ten to fourteen days a complete physical, mental and social evaluation is carried out and the patient is seen and discussed in a team conference participated by the attending physician, supervising physician, nurse and social worker. On the basis of information and findings obtained concerning the patient, a decision is made as to whether the patient needs further hospitalization, or should be discharged home or transferred to a Nursing, Convalescent, Rest or Foster Home. As a result of this type of team approach, about one-third of all newly admitted patients are referred to Social Service for placement. On referral is indicated the type of facility most suitable for the patient's placement. A significant number of patients are referred for Foster Home placement.

Our Social Service, under the leadership of Mrs. Evelyn Arthur, has done a commendable job in finding and establishing Foster Homes for our patients. The program we are all participating in today is an attempt to increase the number of Foster Homes in Rhode Island.

The Foster Home care for the elderly and psychiatric patients has been practiced for many years. Perhaps the oldest and best known example of "Boarding Home" or Foster Home care is in the town of Gheel in Belgium. In Gheel great emphasis is placed in matching patient to family. It is of interest that the total population in Gheel is about 20,000 out of which 2700 are boarded-out patients. Similar boarding out and foster home systems are practiced in several other countries in Europe.

In the United States similar programs have been initiated and established since 1935. During the last two decades, on this continent Canada has been leading in the development of Foster Homes for geriatric and mental patients.

It goes without saying that for suitable patients Foster Home care is preferred to care in crowded wards of state hospitals.

My main topic is to discuss how to maintain the health of Foster Home patients.

When the decision is made to place the patient in a Foster Home, information is provided the Foster Home operator concerning the mental and physical condition of the patient, and recommendations for medications and diet are made. In addition to this preliminary information provided on the interagency referral form we send a copy of patient's discharge summary with rather complete clinical information to the doctor who will be attending the patient during his stay in Foster Home. In our opinion it is preferable that the follow-up medical care is provided by the medical practitioner in the community where the Foster Home is located. We feel that this type of arrangement makes the patient begin to feel part of the community. However, at the same time we in the General Hospital are willing and prepared to accept the patient back at any time when the need arises. The need for return may arise when patient does not adjust in a new situation and begins to show a significant degree of mental symptomatology or when the community is not able to provide necessary medical or psychiatric care for the patient. I hope that in the future under the Comprehensive Health Services Act a certain number of Community Health Centers are established. It is feasible that these Centers would be able to provide comprehensive health services—medical, psychiatric — for elderly people including those in Foster Homes.

My recommendation to the Foster Home operators is that upon arrival of the patient you contact the local medical doctor in your community and have him see the patient in order to get acquainted with the patient and with his medical history, diagnosis and treatment. After his first visit the local medical doctor should be asked to see the patient on a periodic, pre-determined interval, for instance every two or three months or whatever the frequency the doctor deems advisable. This type of follow-up care would guarantee that medications are regulated properly and would certainly decrease the likelihood of any acute or subacute flare-up of patient's physical or mental illness.

If in addition to this type of medical care attention is paid to psychological and social needs of the patient, I feel you as Foster Home

operators have done everything you could to make the patient begin to feel part of your family and community. As far as the psychological and social needs of the elderly people are concerned they are not a race apart of the rest of mankind but have the same basic desires and needs of the people of any other age level. There are certain psychological needs applicable to every age. The universal psychological needs are:

1) The wish or desire to *response*. We get response in a variety of ways: from friends, family, animals, even from inanimate objects on the wall, familiar furniture.

2) The need for *recognition*. People often get their recognition through their occupation because we are living in a work-oriented society where we get status from what we do. The elderly people in retirement are lacking this type of recognition. However, they could be recognized by allowing them to participate in meaningful activities, helping in household chores, knitting, baby sitting.

3) The need for *security*. Everyone, including elderly people, wish to know that they have a certain income to provide for their board and maintenance and for health services. The Social Security and Medicare Acts are steps in the right direction to provide security for the elderly.

4) Need for new *experience* or *adventure*. This need may be satisfied through travel, going to the theatre, learning new skills.

5) The need to *help* others or to be of some *service* to others. This need can be satisfied by allowing the elderly to participate in household activities like housework, gardening.

The Nursing, Convalescent, Rest or Foster Home does not need to be and should not be a dead-end road for the patient. Well-oriented and trained personnel should try to establish for the patient an environment in which his physical health is cared for and the psychological and social needs are satisfied as well. This type of total therapeutic approach would add not only years to life but also life to the years.

Mental Problems of Geriatric Patients

MARIO A. NICOTRA, M. D.

"SENECTUS ipsa morbus est" (aging in itself is a disease) is an old aphorism to which no gerontologist would subscribe today.

Aging and mental deterioration are not synonymous. Genetic, socioeconomic and physiologic influences can account for significant individual variations in the effects of aging process upon the mind.

Because of the advances made by medical science, the life span has been greatly extended. But the blessings of extending life are not unmixed for they bring with them the attendant problems of caring for an elderly population. It has been estimated that by 1980, 50% of the population of the United States will be over the age of 55. The problem of caring for elderly people has already exceeded the problem of treating mental patients in institutions, such as a state hospital. Geropsychiatry has become a subspecialty as important as child psychiatry.

Although the belief is widespead that aging and physical decline are synonymous, there is no proof that aging, per se, involves inevitable deterioration of intellectual functioning and social adjustment. Intellectual performance need not decline with age. Range of information and working knowledge may actually broaden in later adult period. Actually, it has been demonstrated that the capacity to learn is not reduced if the criteria of measurement are correctness rather than speed, and learning ability rather than learning rate.

The age of 65 is considered the marking point of old age. However, it is better to define aging not in chronological term but in functional terms; aging being a process in capacity to adapt, a functional decline that significantly affects the total functioning.

It is agreed that in the process of pathological aging, we are dealing with a set of interweaving factors. These can be physical, psychological, socio-economical in nature. In the past, the effect of chronic brain damage was overestimated. However, the conditions most commonly encountered in geropsychiatry are organic in nature, that is due to visible brain lesions (senile or arteriosclerotic brain disease) or functional (that is purely psychological without demonstrable brain lesions), such as the depressions or the paranoid state. Ordinarily one finds a mixture of both. The organic conditions affect primarily the areas of memory and memorizing, of orientation and intelligence.

The problem of increased admissions of geriatric population to state institutions is not only due to the relative and absolute increase in the

number of old age group, but also to social factors, such as loosening of family ties, rejection of aged people versus worship for youth, the use of smaller housing, the increased use of women in jobs other than housekeeping, the economic independence of old people.

Cultural factors also influence the problem of old age people. The Eskimos dispose of an old, useless person by letting him drift on an ice pack; the old person belonging to a tribe of hunters asks to be killed when he is not able to hunt. In the agrarian society, the old person is set aside from the rest of the family by providing him with a separate small hut. In the industrial societies, old people are put in institutions run by religious or governmental organizations (Department of Social Welfare).

The causes of organic conditions are not known. In the functional disorders, we are dealing with losses related to physical health or with losses in the socio-economic status.

Depression is frequently caused by a loss and, for this reason, depression is the most frequent of all psychiatric conditions encountered in geropsychiatry. Frequently we see a snowball effect where one loss leads to another. For instance, loss of physical strength produces loss of skill which, in turn, produces loss of job which produces loss of friends and family support.

Depressions in old age group are similar to the depressions in young people. A frequent symptom of old age depression is loneliness and boredom; ordinarily they are effect and not the cause of it. A physical ailment very often triggers a depression in old people. The rate of suicide in elderly persons affected by depression is very high.

The treatment of a depression in geropsychiatry is similar to the treatment designed for younger people; however, more caution is required in the use of organic treatment (electroshock therapy and drug therapy).

In using different forms of supportive psychotherapy, if the organic component of a psychiatric condition is not too marked, one will keep in mind that the older individual must cope, both physically and psychologically, with diminished physical powers. Psychologically, it is difficult to adapt to shifts in body image and body concept associated with growing old.

The physician who has been familiar with the patient and who knows his functioning base line is usually in the best position to consult on any change in status. Early signs may be overlooked; however, when the doctor has had long-standing ties to the patient and does not want to "accept" the incipient signs of mental decline, nevertheless, physicians should treat aging on a psychobiologic process, not just as a biologic phenomenon. The patient should not be shoved into either a "psychological corner" or a "physiological corner." Rather, the doctor must acquaint himself with the patient's social history, his present role in the family unit, and the family's attitude towards him. The appeal of functioning in reality must be increased for the patient and therapeutic efforts designed to maintain and perpetuate his social and personal attributes.

The Role of the Volunteer

MISS DOROTHEA BENSON

If you were to meet a friend some morning and she asked, "What are you doing these days?", you would probably say, "I'm teaching creative arts to patients in foster homes." That is probably all you would have time to say while your carts are on a collision course in the supermarket. But if we analyze the situation, I think you will find that you are doing something more important than teaching creative arts.

Let's look at the patient from several points of view: First, from the hospital's standpoint: Here is a patient who is no longer in need of intensive nursing care; he is able to take care of most of his own needs. He is entitled to as much contentment and enjoyment as possible, and should benefit from a more normal, homelike environment. Furthermore, the Medical Center needs his bed for a sicker patient. So *our* patient is transferred to a foster home.

From the patient's point of view, he has been placed in unfamiliar surroundings, and he feels uneasy and insecure. It is hard for a person of his age to adjust to change. He misses the other patients and the attendants he knew on the ward. He may have some hearing loss, and these unfamiliar voices are hard to understand. He was used to the voices of the hospital attendants, and the daily routine also helped him to know what they were saying. Now the routine is all different. He misses the social activities of the hospital, too—the volunteer visitors, ward birthday parties, weekly movies, etc. Life is dull; he just sits by the window and watches the cars go

by. None of them stop at this house, and he doesn't feel much like eating.

Looking at the situation from the foster home operator's point of view, here is an elderly patient sent here by the hospital. She does not have much information about his background, and he is not responsive when she tries to talk to him. She tries to fix appetizing meals, but he doesn't take much interest in food. She wants him to enjoy life as much as possible, but with three or four other patients to look out for, she just doesn't have time to plan for extra activities to make life pleasanter for them.

At this point the volunteer enters, fresh from the Medical Center's volunteer training program in creative arts. You are now on stage.

Looking at the volunteer from the Medical Center's point of view, here is what we hope you can do: Through your personal attention to his interests, we hope you will give the patient a sense of his value as a human being; through the crafts you teach him, he can gain a sense of achievement; and through this achievement, no matter how simple the project, we hope he will regain a sense of his individuality —a feeling that he is Henry Jones, and not just one of the patients at 57 Main Street. So he will feel better, eat better, move about more, and, hopefully, reach a higher level of physical and mental health.

Looking at the volunteer from the patient's point of view: here is someone who cares about him — a new friend who takes the trouble to come and visit; who remembers that his favorite color is orange, that he likes to play rummy, that he has a twin brother in Pawtucket; in short, you are someone who remembers he is Henry Jones, and who comes to see him because she wants to and not because she has to. Be sure the patients know that you are a volunteer, and not just another social worker who is paid to do this.

I would suggest that you go the first time just as a visitor. Say nothing about creative arts. Talk to the patients individually and establish a friendly relationship. Perhaps you can find a common interest. Guard against asking the patient too many questions. Many elderly people are suspicious, and he may think you are prying. Begin by telling him about yourself — your name, where you live, and that you were told the patients here might like to have visitors. Say you come from Coventry, or wherever you do come from. Is he familiar with that part of the state? Talk about your family, your husband's occupation, your hobbies, and seize upon any response of his that might turn the conversation to *him, his* interests, *his* former occupation, etc. Sometimes you may be rebuffed or ignored. Never mind. Just say "I'll see you later", and go on to another patient. When you are ready to go home, be sure to go back and say goodbye to the patient who rebuffed you. Tell him you'll be back next week.

I think the second visit is time enough to introduce crafts. Show the completed article — something very simple that they might like to have for their own use. Say you have just learned how to make this—whatever-it-is—and thought they might like to make one, too, so you brought along some materials just in case. Offer them a choice of colors, or some other means of making their article different from the others. Perhaps only one patient will rise to the bait, perhaps nobody will, in which case you can just offer to show one of them how you made *your* whatever-it-is, and try to sit where the others can watch. Perhaps someone will help you tie a knot, or will hand you the scissors, or help in some other way, and gradually you can get them interested. Never, *never,* breeze in with an armload of materials and say, "Come on, everybody, today we're going to make dish gardens!" Don't put the pressure on. Remember they are used to just sitting all day, and most of them won't be eager to make any effort. You are just there as a friend, and not to make them do something they'd rather not. Lead, don't push.

The first crafts project should be finished in one session. Later on, you can introduce a project which can be continued until your next visit, such as weaving, embroidery, a scrapbook.

Encourage the independence of the patient; let him make choices, create his own design. Let *him* show *you* how to do something. He may have a skill he'd forgotten. Perhaps you can get materials and he can show you, or perhaps he may want you to just listen while he tells about it. Listening is important. Not many people have time to listen to him any more.

And that brings me to the point that crafts are not the only kind of therapy. Bring in the outside world, so patients can feel they are still a part of it. Plan a varied program. Many people would be glad to show colored slides or home movies. Pictures of family life are most appealing to patients, especially if they are pictures of *your* family, because they consider you a friend. A family picnic, a wedding, a child's birthday party, are all occasions they can remember in their own lives, whereas your trip to Europe or to the Far West seems pretty remote and impersonal — something that never happened to them and never will. Volunteers who worked with a ward of elderly men at the Medical Center showed rented films of sports events such as the America's Cup Races, a Red Sox game, the Winter Olympics, and these were

much enjoyed. Keep movies short. Remember that the attention span of elderly people is short, they often don't hear well, and they just can't follow a film with a plot and a lot of conversation. If you are working with alert middle-aged patients, the situation may be different.

Music is always enjoyed. At the hospital we brought in a folk-singing group from a high school — two or three young people with guitars — and the patients liked this. Explain the songs a little first, and they will be able to follow the words more easily. If you can get someone to lead them in singing familiar songs, they'll get a lift out of this, too.

Games are an excellent activity because they encourage patients to do things together. Start a game of canasta, poker, parchesi, and then ask a fourth patient to take your place while you play checkers with someone else. Horseshoe pitching and croquet will get patients outdoors and moving around in good weather. You might plan a backyard picnic, if the home operator approves. Let the patients in on the planning. Patients who can't go out could be provided with small plants to care for, or the windowsill boxes of seeds. There are many possibilities.

There are limitations, too, and these should be recognized. You will want to consider the convenience of the foster home operator. Be sure to consult her in planning activities, so that your program will not interfere with her schedule of meals and patient care, and so that you will not cause extra work for her and her staff. Again, some patients will not be able to participate. They can only watch, but even this will bring them some enjoyment. A few may refuse to participate. Just bide your time on these.

Finally, it is important to limit your own emotional involvement. Be a casual, cheerful friend. Do what you can in your one visit each week, and leave the matter there. Don't take the patients' troubles home with you. And don't be completely taken in by tales of woe. Some may be imaginary. Check them out with the home operator, if you wish. Be sympathetic, but change the subject as soon as you can. Don't promise to contact relatives or deliver messages.

Be dependable. Patients will be watching for you on your day. If you cannot make your weekly visit, let them know ahead of time, and give a good reason. This course teaches you basic skills. Use them as an entering wedge. Your total achievement in the enrichment of the patients' lives depends on your ingenuity, your sensitiveness to their needs, and how much you really care.

Characteristics of the Aging

Muriel B. Wilbur, Ph.D.

DEFINING the aging depends upon one's point of view. A person of 50 may regard those of 60 as aging. When he reaches 60, he feels that 70 must be the beginning of aging. For the lucky ones, at 70 they feel that aging must start at 80. The point when an individual is aged varies tremendously. But society must take a definite age for all people. The Social Security Act is probably responsible for 65 being accepted as this age.

Thus some twenty million people are in the aging group in the United States. These people vary in age from 65 to well over 100. They represent an age span of over 35 years. They include the men and women who reached 65 yesterday, the centenarians, and everyone in between. Some of these people are physically and mentally as young as some of our 40-year old's. Others are senile. Some, a small proportion, are chronically ill. Most are in good health. Many are vibrant and happy. They are giving a great deal to life and are enjoying it. They are taking advantage of the extra time that retirement gives them to do the things they have always wanted to do but never had the time.

The number of people in this age group is increasing every year. The number of them in proportion to the rest of the population is also increasing. In fact the population of the United States has doubled since 1900, but the number of people over 65 has quadrupled. This large increase is not caused by older people living longer, but by more people reaching this age. In other words, fewer people are dying during the early years of life. Through public health and medical advances we have learned how to prevent infant mortality and deaths from childhood diseases and to improve nutrition. In 1900 a newborn baby had a life expectancy of 47 years. Today life expectancy at birth is about 70 years.

In general these are people whose pace has slowed. However they compensate for their loss of speed by planning their movements more carefully. By effective use of their time they often accomplish as much as a younger person who moves faster. In addition they have the

wisdom of experience and the good judgment acquired through years of life.

The aging as a group are not as well educated as today's youth. Those entering the aging group now have had an average of almost ten years of school, — two years of high school. Those in their seventies and older have had less education.

Since the group covers such a wide age span, it is not surprising that their major characteristic is their individual differences. They include people of all walks of life, — farmers, housewives, business executives, laborers, and professionals. They differ also in their family roles, financial status, housing, health, activities, and interests. Many of these people do not feel old, and resent being called part of the aging group.

For most of them their family roles have gone through various changes. They have been children, then parents and often grandparents. Some have dependent parents. For most their children have left home to establish homes of their own. With increased mobility, there is less likelihood that their children will be living in the same community. The three-generational family living together is increasingly rare today.

Since men and women are marrying earlier, they are younger when they have their children. Consequently the older couple have more years alone together. The happily married couple may welcome the opportunity to do things together. When retirement comes for the husband, however, some real adjustment to each other is often needed. Neither has realized how much the home has been the wife's domain during his working hours. Now they have to share it and adjust to each other's habits.

Because the life expectancy of women is about five years more than of men, and men tend to marry women younger than they, there are many more widows than widowers. Perhaps this is good, since we are told that women adjust to widowhood better than men. More heads of families are women than men, although most families headed by a woman consist only of the one woman.

Although 65 is often considered the age of retirement, over 20% of the aging are employed. Some of these have not retired. Others have retired, but have found a second career or another position in the same kind of work. Many of those not employed are serving as volunteers in various kinds of organizations or institutions or contributing to society in some real way.

Financially some of the aging are well off. From 5 to 9% have an annual income of $10,000 or more. Four out of five are financially independent, although they may be living on a reduced income. Nearly a fourth of the couples have an annual income of less than $2000, and another fourth are above the poverty level but not up to the minimum standard of $4300 estimated for a couple to live comfortably. Many find that inflation and the decreased buying power of the dollar make careful financial planning necessary.

Their housing ranges from mansions to small apartments and single rooms. Only four percent live in institutions such as hospitals, homes for the aging, and various types of health facilities including nursing homes and foster homes.

Contrary to popular opinion, the majority do not live in California, Florida, or Arizona, although these states do have more of the aging than most states. In fact five of the New England states also have more than the average number of elderly among their population. Most live in urban communities, particularly in large metropolitan cities. A third live in towns with a population under 5000. Many of these are living on farms. Few live in the suburbs.

Many of the aging live alone. Studies have shown that even in our mobile society, older persons tend to live near to at least one of their children, and that they see that child often. Most are found to live near some relative with whom they talk and visit frequently.

Most of the elderly are relatively healthy and feel well. Many have a chronic disease with which they have learned to live, and which does not make them ill. Three million are housebound because of illness or a disability. Health maintenance is a problem for many. All too few have an adequate physical examination each year. Many do not eat the proper foods to keep themselves as well as possible. When the elderly are ill or have an accident, it is more serious and takes them longer to recuperate than a younger person.

Many of these people are happy and busy pursuing various activities. But for too many time hangs heavily on their hands. They need purposeful activities. We live in a work-oriented and youth-oriented society. It takes real effort for those no longer employed or raising children to feel that they are needed. The most common characteristic of the aging is the need to be wanted and a feeling of loneliness. We all like to feel that we have accomplished something at the end of a day. But how hard it must be for some of these people to feel that they have done something worthwhile with their time when the day ends! Some of these people are the people whom you will be helping in the foster homes. For others our society has organized various activities and programs. Among these are our senior citizen centers, Golden Age clubs, church groups, American Association of Retired Persons, preretirement programs, and educational activities. Through these we are trying to reach

as many people as we can. By all of us working together, we will help the aging to keep their minds active, to feel that they are needed, that they can make a contribution to society, and that others want to have them near them.

Each member of the aging group is an individual. As you work with them, you will see how they vary. You will find that they have a desire to live, but that they want the living to be worthwhile. They are anxious to be needed, and will respond if at all able. They need your stimulation to keep them motivated.

Special Needs and Problems of the Patients

EVELYN ARTHUR

WHAT can the volunters do in the Foster Home which will best help the patient? How can the volunteers work with the busy operators? To answer these questions let us consider the ground work of placement and some of the patients' needs.

The Medical Center social workers know the patient and the community resources. Once the doctors have referred and cleared the patient in a medical sense for placement, a careful matching process takes place where the patients' needs and interests are considered in relation to a particular home. Material needs such as shelter, nourishing food, proper clothing and medical care perhaps were not met for many patients before hospitalization. Security needs of being wanted and cared for are very great in the elderly. At placement the social workers have done the ground work to provide for these needs, and the foster home operators now make the patient feel secure and wanted. We have provided the Foster Home management sessions to aid the operators in their efforts. Rhode Island Medical Center social workers will follow the patients and be of assistance to both volunteers and operators.

At this point the patient is ready for friendly volunteers offering creative and energizing activities, and for forming an identification with the community. The details will be worked out with the operator as to time and place of meeting as well as respective roles. I will assign volunteers to homes and accompany them to initial meetings and will continue to supervise and counsel them in the homes.

Three more needs of the elderly are paramount in the Foster Home: social, creative and spiritual or growth needs. The patient needs recognition, needs to belong to a group and needs to relate to others meaningfully, even helpfully. He or she needs self-expression, renewal, and release of tensions through creative activity. His spiritual needs include opportunity for growth through music and singing. He needs the feeling of venturing into new pastimes, and he vitally needs to communicate with others.

Able to meet all these latter needs, our trained volunteer starts the program with a tea or get-together which involves all the patients initially, and then moves on to meetings which may draw many or few patients at a time. The program goes from the simple to the complex based on the patients' interests and needs as perceived by the volunteer.

Problems include the limitations of the weather and the "flu," the possible poor eyesight and hearing, arthritic stiffness or shakiness, and general lack of motivation of the patient. There is a very real financial limitation in what can be accomplished. Donations of materials help greatly. The Services for the Aging in the Department of Community Affairs has allocated $500. Church groups have contributed sums of money. Medical Center Occupational Therapy contributes their "know-how." All patients in a home are offered the opportunity to participate, whether Medical Center patients or not, and whether private or welfare patients. The Foster Home operators have been most cordial and cooperative.

Art projects include simple weaving and textile stencilling, ceramic tile work, self-hardening clay modelling, sewing, braiding, drawing, and seasonal decorating. Travelogues, movies, birthday parties, Bingoes and music sessions are offered. The patients may be able to help others eventually by giving dolls and stuffed animals to the Children's Center and Lakeside Home; but first their own needs must be met.

Let us remember that the elderly have not lost their ability to learn. An art program is a tool to bring patients out of themselves, and back to community life. As a communication medium, creative art can be a non-verbal relationship or a verbal chatty approach. With the stimulus provided by the volunteer, problems fade into the background for a time. With the stimulus of a larger group experience, the patient may even be able to return to the community on a limited basis. Let us all resolve to attempt to reverse the process of institutionalization or social breakdown evident in our lonely, elderly patients.

Standards for Public Assistance and Medicare

WALTER J. BREEN

PUBLIC Assistance includes a number of categories of assistance but those which involve placements in group care homes would be patients found eligible for Old Age Assistance or Aid to the Permanently and Totally Disabled.

This group of public assistance recipients are those considered in need of maintenance payments as opposed to those considered as medically needy only. Those found eligible for the Medical Assistance program are the group considered medically needy.

Although Foster Homes are affected as far as payment for care is concerned by either Medicare or Medical Assistance (Medicaid), the patients themselves are concerned with the benefits of these programs.

Federal Medicare

Part A provides payment towards hospital care, extended care facility services and home health care.

1. *Home health care,* so called, provides for visiting nurses' services and physiotherapy. In order to be eligible for these services, however, the beneficiary:
   a. must have been hospitalized for at least three consecutive days
   b. must have the plan approved by his/her attending physician
   c. is limited to 100 visits by an R. N. and/or physiotherapist in the period of one calendar year following hospitalization or extended facility care.
2. *Extended Care Facilities* are either approved nursing homes or separate parts of general hospitals. Up to 100 days of care may be provided in one of these facilties provided that the patient has been hospitalized for three consecutive days. In addition, such care can be paid for only:
   a. when approved by the attending physician
   b. when nursing, as opposed to custodial, care is required
   c. when the patient enters a nursing home certified by the Social Security Administration
   d. for as long as such care is deemed to be essential by the facility U. R. committee and/or by the attending physician

The Medicare program provides full payment for semi-private care for the first 20 days in an Extended Care Facility. For each additional day of care, up to 80, the program pays all but $5.50 a day, which is called coinsurance. The patient is expected to pay this co-insurance, BUT if the patient also has Medicaid this may be paid for the patient by the State. If the patient is on Public Assistance, the co-insurance *will* be paid for by the State.

3. *Hospital care* is provided for a period of 60 days, after a deductible of $44.00 is paid by the patient (or by Blue Cross if enrolled in the "Over 65" program or by the State if eligible for MA or OAA). If the patient requires care beyond that point an additional 30 days of care may be provided at a (co-insurance) cost of $11.00 per day to the patient (or, again, to either the "Over 65" Blue Cross program or to the State if the beneficiary is eligible under a State program)

   There is also a "lifetime reserve" of an additional 60 days hospital care which a beneficiary may use if his/her continued hospitalization is necessary. The reserve period also requires a co-insurance of $22.00 per day.

One can enroll in Part A at any time after age 65; there is no enrollment period as such. Also, there is *no cost* to the enrollee for Part A.

A candidate must be a citizen of the U. S. or an alien who has lived in the U. S. for at least 5 years.

Part B

Part B, Supplementary Medical Insurance, includes:

a. all services of physicians — either at home, office, hospital, physician's office or a clinic.
b. home health care services — 100 visits, in addition to the 100 visits allowed under Plan A (prior hospitalization is not required)
c. Services and supplies:
   (1) diagnostic tests (including out-patient department)
   (2) X-rays, laboratory services, radium treatments
   (3) surgical dressings, splints, casts
   (4) certain ambulance services

(5) braces, prosthetic appliances
(6) rental of medical equipment (e.g. iron lung)
(7) other

Before coverage for any of these services is provided under Medicare there is a $50.00 deductible unless the patient is eligible for Medical Assistance or "Over 65" Blue Shield. The program provides for only 80% of the costs of these goods and services. The patient, if not eligible for State Medical Assistance or "Over 65" Blue Shield, must meet the balance of 20% of the cost of the item or services.

Anyone, whether he has Part A coverage or not, may be eligible for Part B if he is 65 years of age and is not excluded from the basic requirement for eligibility stated heretofore. However, for Part B one must enroll during the period three months before the month of his 65th birthday, or within three months after the month of his birthday, or during the general enrollment period which occurs between January 1 and March 31 of each year. If he does not enroll within three years after his 65th birthday, he becomes permanently ineligible for Part B.

Medical Assistance

Again, this program is State-operated but Federally supported, in part, and is formally referred to as Title XIX. As background, you should know that the Kerr-Mills Act of 1960 provided for Medical Assistance for the Aged. This enactment of Title XIX legislation, then, merely broadened the base of eligibility to include those considered to be "medically needy".

Eligibility Requirements for Medical Assistance

There is no residency requirement in any State participating in the program. Unlike Medicare, in addition, no one is excluded because of lack of U. S. residence. Eligibility is established, instead, on the basis of the financial status of the applicant as follows:

a. when the *income* is limited to $2,500 per annum for one person, $3,500 for two persons and $400 for each dependent within the family.
b. when the net value of real property *not used* by the applicant as his home, together with cash, current value of stocks and bonds which do not exceed $4,000 for one person, $6,000 for two, plus $100 for each additional person in the family unit.
c. when the face value of life insurance policies does not exceed $4,000 for each adult person and $1,000 for each dependent under 21 in the family unit.
d. when tangible personal property (e.g. auto, boat, trailer) does not exceed $5,000 for the household.

Medical Assistance Coverage

Medical Assistance coverage includes payment for the deductibles and co-insurance expenditures which are not met for Medicare beneficiaries, and also provides for full payment for medical expenditures for those Medical Assistance recipients who are not covered by Medicare.

The services provided under Medical Assistance include hospital care, nursing home care (limited to 90 days), drugs, dental care, laboratory and diagnostic services, therapeutic X-rays, major surgical and prosthetic appliances, visiting nurses' services and physicians' services. (Excluded for Medical Assistance recipients at this time are optometric, podiatry and ambulance services. These are included, however, for Public Assistance recipients).

Your Challenge to Home Nursing Care of the Older Person

MRS. LUCILE S. VOTTA, R.N.

MY congratulations to you for accepting one of the most needed challenges of today—to provide understanding care for older persons in your foster homes. Whether you have two or fifty residents, their importance is not diminished by their age nor their state of infirmity. Your challenge is great in recognizing them as your "adopted family members" and in meeting their needs and potential for abundant living in their latter years when circumstances have forced them to be apart from their own families.

What factors determine how completely healthy an individual can be? What can we change to achieve greater success? The first major component, which we cannot alter is heredity. This was determined by our ancestors. If we consider longevity as an aim, we might say that your geriatric patients chose their ancestors very wisely!

Environmental factors are the second big determinant of health.

The third big factor depends on that individual himself. How did he and how is he reacting to his environment? Each of you has tried to get one of your patients to do something obviously good for him, but to no avail. Their reactions now depend upon habits and health practices established through the years, and experiences and knowledge. It is especially difficult to change longstanding patterns of the elderly. We probably should attempt to modify only those really detrimental to total health.

I consider home nursing much more than giving the necessary pills and physical attention to someone who is ill. I believe that there is a circular path towards health. As I name the parts of this circle, think of ways you could help individuals in your home through. . . .

Promotion of Health

Prevention of Illness

Rehabilitation

HEALTH
Complete Physical,
Mental, & Social
Well-Being

Recognition of Illness

Care and Treatment when Ill

Prevention of Illness

Consider this as care of the body. How do you prevent falls and other accidents? Are there grips and rubber mats for those who use a tub for bathing and is someone always with them? Are there hand rails? Do you avoid clutter of furniture? Do you watch hot water bags and rule out electric blankets? Do you remember that nerve endings are not as sensitive as previously and there may be no warnings of burns? Do you help the families to select warm, lightweight clothing to lessen loss of body heat? Your guests are fortunate to be under continuing medical care and seen routinely at least every six months. Your doctor is a big aid in prevention of illness. One fact about stopping illness before it occurs is that you can never know how much suffering, expense, illness, or even death you may have prevented.

Recognition of Illness

Recognition of illness depends on developing your powers of observation. Don't just think of physical symptoms, but observe emotional and social behavior as well. What are your guests like when they are well? By knowing this you can recognize changes in appetite, bowel function, mood, skin condition, breathing patterns. I hope that someone in each home will have had a current course in home nursing and first aid. These are offered by the American Red Cross free of charge. They are excellent. Learn to make simple notations of what you observe. You cannot write voluminous notes, but you can keep valuable brief records for yourself or to inform the physician if necessary. These observations will be helpful in preparing the progress notes which must be written on each patient at least once each month.

Care and Treatment when Ill

Objectives of care and treatment when ill are to speed recovery, to make the patient as comfortable as possible and to enable the patient to gain something from this experience, as we should gain from every occasion in life. The same basic needs indicated earlier must still be met. They will have to be modified to fit the current situation. If the patient now must be in bed, how can you stimulate him to physical activity? Some suggestions might include: make his bed, planning for movement, encourage turning, have him push against a footboard or box. Let him take as much of his bath as possible. Encourage deep breathing. Perhaps he could play a harmonica (there are little booklets to follow easily.) Give him good back rubs and footcare. Have a hand rope to pull up on. Plan diversions which require exercise. Allow him to feed himself. Sometimes you may need specific directions to carry out some treatment the doctor has ordered. Then you should turn to your local public health nurse for help. She will show you exactly what to do. Other community or state agencies also will provide various personnel or advice at the request of your doctor or yourself. The visiting nurse can guide you to many resources.

Rehabilitation

As soon as illness or accident occurs, concern for rehabilitation is important. Again this rehabilitation must not be thought of as purely physical, but should include emotional and social rehabilitation as well. The physical therapist may have planned special exercises for Mrs. J. who is recovering use of a paralyzed hand. Could you in addition provide good utensils, adequate napkins and perhaps privacy if desired so that Mrs. J. can feed herself? Could she attempt to play Chinese checkers with another resident? Could you let her peel potatoes or vegetables? Could she be provided with colorful handwork which she could do? You can readily see that these suggestions would do more for Mrs. Jones than merely help her hands to move. They would provide her with worthwhile projects to develop her independence, feelings of achievement, and social relationships. They would lead her on the road to rehabilitation in all three areas, physical, mental, and social.

Probably the very best word, I could give you to live by with your guests is EMPATHY. Feel with them. From my observations in nursing homes recognition of worth and new horizons are often given the least attention. I think the elderly especially must be given help to get outside themselves into serving others. Let them

help you in routine and other tasks all they can. Six months ago an incident impressed me. I was in a nursing home where I encouraged an ambulatory patient to make her own bed. It was a somewhat sloppy job, but she had done it herself and sat down satisfied. When the aide came in, she commented on how poorly the bed looked and then completely remade it. You can imagine the patient's discouragement. Though physically capable this patient who is senile has not tried again since. The aide did not understand that the individual's feelings of worth could be more important than the outward appearance of the home. There are other ways patients can be encouraged to help in the home operation, both indoors and in the yard. Allowing residents to help will often take more time on the part of home personnel than actually doing the work themselves, but the rewards to residents' feelings can make it worthwhile.

Techniques to consider—thinking both of the needs of the home operator and patients or guests

DEMONSTRATION — DISCUSSION

1. Preparing an unoccupied bed.
   How can greater rest and comfort be achieved through such a seemingly simple procedure? Sleep and rest are especially important, yet sometimes difficult for the aged.
2. The patient's room
   Value of equipment such as rocking chair, hassock, bedside table.
3. Planning a happy day's routine, when well and when ill
   a) Ideas to meet physical needs
   b) Ideas to meet emotional needs
   c) Ideas to meet social needs
4. Personal Care
   a) Toileting
   b) Bathing, tub or sponge
   c) Changing bed linen
   d) Back care and other ways to improve circulation
   e) Hand, nail, and foot care—precautions to take because of real danger of infection; Diabetic foot care
   f) Grooming and care of the hair
   g) Choosing clothing
5. Making a patient comfortable through environment, position.
6. Nutrition in illness.
7. Giving medications and treatment — The need for standing orders and routine orders for first aid. Remember the five rights—right medication, right dosage, right patient, right time, right way. Be sure the patient actually takes it.
8. Keeping a record
   a) Routinely
   b) How modify when ill
9. Diversions—a key to growth and interest in others.
10. Resources available to help you and your guests. You are not alone, but part of a team.
    a) Physician
    b) Visiting nurse
    c) Consultants and professional personnel from various agencies
    d) Community groups which can be involved voluntarily
    e) Patient, his family, other patients
    f) Some general current, inexpensive literature:

Home Nursing Textbook, 7th Edition, 1963 Doubleday and Co., Inc. New York about $1.75—American Red Cross

First Aid — American Red Cross — same price as above

More Life for Your Years—a free fact sheet for older persons from American Medical Association—Published monthly
American Medical Association
535 N. Dearborn St.
Chicago, Illinois, 60610

Chronic Illness Newsletter — Free — Published bi-monthly. Order from A.M.A. see address above

Feeding the Elderly

SYBIL D. KAPLAN

BASICALLY, the nutritional requirements for the "guests" in your home are the same as they would be for younger adults. Foods should be selected from the four food groups:

Milk — 2 or more cups (including that used in cooking)

Meat — 2 or more servings

Fruits and Vegetables — 4 or more servings

Breads and Cereals — 4 or more servings

Other foods as needed to complete meals and to provide additional food energy.

Menu service for the elderly, however, is not quite as easy as it sounds. There are several reasons why I make this statement. First, food habits of older people are the result of years of eating in a certain way. These may be determined by religious, regional and economic factors. If these habits are good (or broad), your job is easier. However, if these habits are poor, it is a real challenge which will demand patience and hardwork. The general attitudes of your "guests" may influence the way in which they accept or reject food.

As important as the nutritional value of the food served is the way in which it is offered and the size of portion. While a sprig of parsley does not constitute a serving of vegetable, it does make the food attractive. Do keep in mind that food portions which are too large are often objectionable to the patient with a small appetite. They are also objectionable to the physician from the standpoint of curbing obesity — a problem common to many elderly (because of reduced metabolism coupled with reduced activity).

Encourage the social aspects of group dining at a table if possible. If tray service is indicated, make it attractive and comfortable.

The spacing of meals is another factor which deserves consideration. The length of time between meals influences appetite, particularly when the individual's activity is limited. Meals should be served at regular times with not more than a 14-hour span between an adequate evening meal of one day and breakfast of the following day. There should not be less than 10 hours between breakfast and the evening meal of the same day. Perhaps you will decide to serve breakfast at 7:45 a.m., noon meal at 12:45 p.m. and evening meal at 5:45 p.m. or fifteen minutes earlier or later — just be consistent. Contrary to popular belief, it is not necessary to serve the main meal at noon. In fact, many people prefer to eat the main meal in the evening. This is particularly true of those people who did when they were in their own homes. It seems reasonable since most of your "guests" do eat a good breakfast, and prefer a lighter lunch since it seems to follow so soon after breakfast if one is relatively inactive. By lighter lunch or meal, I do not mean skimpy or inadequate. There should be a high quality protein at each meal.

The condition of the individual's teeth will, of course, affect what is eaten. It is preferable to change the method of preparation rather than eliminate a food. On the other hand, do not strain if chopping or mashing will do.

Advance menu planning will permit you to check menus for nutritional adequacy, buy wisely and schedule your cook's time.

To help you with the day to day activities of meal planning and service, I would suggest you secure a copy of "A Guide to Nutrition and Food Service for Nursing Homes and Homes for the Aged."[1]

In order to be valuable, your meal service should supply the necessary nutrients, but, of equal importance, make mealtime a pleasurable activity for your guests. If at any time you have questions pertaining to your food service, do feel free to call upon your Extension Nutritionist.

[1] (Public Health Service Publication No. 1309 for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, Price $1.25)

Practical Experiences of Creative Arts as Therapy for the Elderly

REV. WALTER SCHOEPFER

With the development of modern medicine and greater understanding of good health procedures, there has been a rapid lengthening of the span of life for large numbers of people, so that our Senior citizens today constitute a large and ever-increasing percentage of our population. Along with this increase in longevity, there has also come a remarkable technological advance with its concomitant social problems. New patterns of living have emerged which often need interpreting to the aged, for many members of the aging group do not realize how much the pattern of living has changed in the past three decades; such as smaller homes, often both parents working, no living quarters available for the elders, higher taxes, sky-rocketing cost of medicine, food, clothing, the need of a family car for transportation and its costly care and maintenance, and most of all the transfers of nearly ¼ of our population from one section of the country to another every two years! These new patterns of living have made it necessary for older citizens to be placed either in homes of their own or into supervised homes where they might have security and tender, loving care!

In these decades, I, myself, have witnessed the rapid growth in the number of homes where the elderly have either been placed or have voluntarily entered themselves. During that period, both the State and the operators of the homes have become increasingly concerned for the welfare of this large segment of our population who are 60-65 years of age and over. Many categories of their needs have been developed. At least when anyone reaches that age, he has four great areas of concern:

1. Economic security
2. Preservation of health
3. Security in housing
4. Productive living

Federal and State governments, community agencies and private organizations have all been attacking the problems of economic security, preservation of health, and adequate housing. These, of course, have also been the concern of real religion for they are real and specific, and among the most urgent needs of human beings. But it is in the fourth category that the interests of real religion find the greatest challenge of the aging process. Here we had a unique roll to play because it was in this area that the fuller life of those who spent their declining days in homes for the aged were being neglected.

I well recall in years past visting some of my own parishioners in such homes. One of the most frequent complaints I encountered on such visits was the recurring question, "Why doesn't God take me — I'm of no use to anyone!"

Though all other needs had been taken care of, the greatest need was felt in the area of meaning and significance for life. When one has no creative work to do, life becomes dull, drab and meaningless. In those days I tried to help some of these older folks to use their time to some advantage. I would bring them magazines or books to read, only to find that poor eyesight negated this effort. I then suggested knitting or other handwork only to discover that eyesight and poor control of their hands made this effort useless. Often I found that they were sated with watching the TV and would rather sit in their rooms and wait for the evening to come when they would go to merciful sleep.

Now this was not the fault of the operators of these homes. They were already taxed enough to provide the best physical care and healthy surroundings for their guests. Nor were the operators equipped to help their guests adjust to new patterns of living or to develop the capacity to continue growing as persons and developing new interests. Problems of how an aged person might develop a healthy attitude towards his or her retirement years or how to adjust from one who has always lived a self-centered life to one requiring him to live in a social environment where unselflessness is a prime requisite for peaceful living together, are problems requiring understanding, patience and know-how, which often home operators have little time to undertake. This has provided a unique opportunity for the religious to fill in a much-needed role.

With this background of the vital interest the religious have had in the development of a feeling in those who are in their later years of life that life can become full and satisfying at their age, and perhaps even more so than at any other period of life, I want to say how thrilling it is to note the growing concern of all those groups associated with serving the elderly for the satisfaction of their total needs. In this growing concern you are assured of the support and assistance of the religious and their backing in it. I have gone into this background

at some length because I wanted those of you who operate homes for the elderly to feel free to call upon the religious in your own communities to assist you in this team project — even to provide programs for your guests which will help them achieve a productive life and no longer question the value of their own lives, so characteristic of this age.

"Worship" may be defined as "Worthship," which is the ultimate aim of any worship experience — to experience within ourselves the feeling of worth in the eyes of God and of ourselves. This, of course, should always be the prime result of any carefully planned and sincerely executed worship service. You will always find sincere clergymen ready to supply such services if asked to, either Roman Catholic, Protestant or Jewish. It would be wise, when your guests are plural in their religious affiliations, to work through either a local Council of Churches or an Association of Clergy so that all viewpoints may be presented in such a series of services.

But the recognition of worth-ship and well-being must be reinforced in practical ways as well as by the experience of worship, for it is in the practical results of the ideal in our lives and living that we really appropriate and finalize the pattern in our lives. Our attitudes toward new experiences, towards others, and toward ourselves as exemplified in all the activities of living and growing and creating are the only possible reinforcement of the feeling of worth and worthiness in us, be we young or old. So in our church we began a step at a time to work out a program of activity and new experiences for a home we had selected at the center of our activities. First, we selected and appointed a woman of near-retirement age who was in excellent health and mental ability, who had a concern for these people in her heart, to head up our operations with the guidance and advice of the minister. She began at once to plan for a continuing year-round program of activities for the guests of that home. She began by calling the attention of our women's Society to this important work and enlisted their financial backing as well as cooperation in the plan. Together they worked out plans for teas, parties, and expressional activities in the home. The women provided favors and gifts for seasonal parties such as Christmas, Valentine's Day, St. Patrick's Day and Easter. When the weather permitted, they organized car pools who took the elderly of the home who were able to get out on drives around the countryside. This was particularly satisfying during the Fall when the foliage was at its height. For those who were unable to go, there were always those of our members who took colored slides of the foliage and exhibited them at the home to the delight of the bed-ridden and nonambulatory patients.

Some of our men also got into the spirit of the effort by providing an orchestra which went to the home and played both for the enjoyment of the guests and also, on occasion, for community singing.

Our Young People's group also gave of themselves by singing for the folks on special occasions and whenever any particular dramatic programs were suitable, they would go to the home and make their presentation before as appreciative an audience as you will find anywhere. Our Church school children who took dancing lessons or other expressional activities were enlisted, and always the elderly enjoyed them and their talents very much.

Our present program in the community of Charlestown is moving along very well with more than six women of our church actively engaged in providing expressional activities for the residents of our Sunshine Home. These activities are supported by our Women's Missionary Society who willingly provide the financial backing needed and who are looking ahead to a continuing program of support for this work. So far, both men and women have worked on the projects undertaken in the Creative Arts. They have participated in weaving pot-holders in varied colors of their own choosing, placemats, bowls, lacing personal pictures into cardboard frames. We have some samples of the work done by these folks for you to see at this time.

In addition to expressional activities, one tea has been served. A colored slide travelog covering 3,000 miles through Canada was shown which evoked the comment, "Very educational!" One session very nearly became an impromptu full session of singing old-time songs and brought one fine old gentleman who had remained in his room due to disinterest in the craft program, hurrying down to participate. Needless to say, this was an excellent welding experience for the entire group.

When at first we discussed our plans with the matron of the Home for her suggestion and approval, Wednesday was accepted as the day for these sessions. But it was a difficult day for her because that was the day the guests always took their baths and usually they were so slow about them that they lasted well into the afternoon. However, since we began these programs, the baths have always been completed in the morning because they were all anxious not to miss anything of the programs! We began our programs the first Wednesday in February of this year and have held them every week since.

In order to get this program started, it was necessary for my wife and me to take this course in Creative Arts. Now we have two more of our women signed up for the second course, and we are hopeful that more will sign up at another time. This will give us a group of women capable of taking leadership of these programs and with ability to train others and the understandings gained from these sessions in dealing with the problems of the elderly will be of continuing influence for good in the lives of not only the elderly in the homes, but in the lives of the women themselves and all whom they will be able to influence.

Physical Therapy -- Consultation in Foster Homes

MARY DuVALLY

PHYSICAL therapy is a profession concerned with restoring function and preventing disability following disease, injury, or loss of a bodily part. To accomplish this, physical properties of heat, cold, light, sound, water, electricity, massage, and therapeutic exercise may be used. Physical therapists graduate from schools approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association. These schools are either four-year baccalaureate programs for the high school graduate or one-year certificate programs for students who already have B.S. degrees in physical education, biological sciences or nursing. Physical therapists only treat patients with a written prescription or referral from a physician.

As the physical therapy consultant in the Division of Chronic Diseases in the State Health Department, I work with many groups which include public health nurses, nursing home and hospital personnel, people like yourselves, voluntary agency people and other physical and occupational therapists in Rhode Island. In my participation in educational programs for some of these people, one contribution is in the area of posture and body mechanics, not just in the proper positioning of patients but in protecting those working with patients from back injuries or back pain.

In a former position in a teaching hospital we saw many patients with back injuries. Our orthopedic physicians never ordered the heat and massage for comfort that you hear about. They always ordered a series of exercise sessions in the physical therapy department. They had two goals for their patients: one, to learn specific exercises needed for muscle stretching and strengthening, and second, to learn how to change poor postural habits so that they would not continue to aggravate their back problems. One of these physicians during his patient's office checkup visit would drop the tape measure and wait to see how the patient bent to pick it up. He would also watch to see how the patient sat down on a chair or got upon the examining table. If the patient did not show signs of changing habits, he would send him back for more treatments.

I would like to share some of the body mechanics information with you. Most of us today bend or squat down to the floor correctly to pick something up but when going halfway down to pick a sweater or bag up from a chair we do not bend our hips and knees correctly. We do not always sit on and get up from a chair properly from the edge of the chair. We do not roll over, bend knees, and come up sideways from the bed nor do we reverse the procedure when getting into bed. All of these small incorrect habits act on back muscles like water wearing away a stone and our muscles are conditioned for back injuries. One important point to remember is that all activities involving lifting or bending should be carried out with our hips and knees bent. It is then almost impossible to sustain a severe back injury no matter what the weight dealt with.

In my job I am not teaching others to be physicial therapists. I am working to improve the supportive and maintenance care of individuals. When the disease process itself is involved and is to be affected by treatment, physical therapy should be given by a qualified physical therapist. When maintenance and supportive care is involved, any properly oriented individual may be involved in treatment procedures. The individuals referred to your homes will no doubt be in this phase of care. In this brief period of time I would like to discuss a few specific areas.

Did you notice Mrs. Votta's good posture when making that sick bed? If you have guests who make their own beds, you will prevent some pain by showing them the correct way to do this. If you have someone with difficulty in ambulation, you should find out from your source of referral or medical social worker what is safe for this person and any limitations. For

instance, do they need someone with them going up and down stairs. Have they understood directions about not leaning on the tops of crutches? If someone has an artificial leg, does he know how to use it safely? If chairs are too low, you can sometimes make someone independent by giving him a higher chair or by making a wooden platform to raise the chair.

In today's world of smokers, many people have emphysema or chronic respiratory disease. You should encourage people to use the Kleenex suggested by Mrs. Votta. Don't be repelled by spitting and coughing. They are clearing breathing passages properly.

All people, including ourselves, should sit properly with feet flat on the floor. If feet don't reach the floor, supply a telephone book or a cushion. If a person likes or needs to sit with feet up, make sure there is support under the knees. Knees get painful when one sits this way without support for any length of time.

We all are working together to help people live to the maximum possible within their capabilities.

Program, General Session

SEPTEMBER 20, 1968, AND MARCH 21, 1969

9:15 Registration

9:30 Presiding: Muriel B. Wilbur, Ph.D., Director, Program in Gerontology, U.R.I.

Welcome: Jerome Pollack, Ph.D., Vice President for Academic Affairs, U.R.I.[1]

Title I of the Higher Education Act of 1965

John C. O'Neill, Director

Orientation to General Purpose and Foster Home Programs

Mrs. Evelyn C. Arthur, Chief of Social Services, General Hospital, R. I. Medical Center

Mrs. Evelyn V. Mason, Extension Specialist, Textiles and Clothing, U.R.I.

Maintaining the Health of Foster Home Patients

Johannes Virks, M.D., Chief of Medical Services, Rhode Island Medical Center

Dealing with the Psychiatric Patients

Mario Nicotra, M.D., Chief of Psychiatric Services, Rhode Island Medical Center

11:45 Lunch Speaker: Reverend Walter Schoepfer, Quonochontaug and Cross Mills Baptist Churches[2]

1:15 Presiding: Professor Violet B. Higbee, Extension Professor of Home Economics, U.R.I.

Characteristics of the Aging

Muriel B. Wilbur, Ph.D.

Meeting Special Needs and Solving Special Problems of the Patients

Mrs. Evelyn C. Arthur

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[1]Spring Session, William Croasdale, Ed. D., Assistant to the President, U.R.I.

[2]Spring Session, Miss Dorothea Benson, former Chief of Psychiatric Services, Rhode Island Medical Center

Program, Orientation Session for Foster Home Operators[3]

SEPTEMBER 27, 1968 AND MARCH 28, 1969

9:15 Presiding: Mrs. Evelyn C. Arthur

Welcome: James W. Cobble, Ph.D., Dean, College of Agriculture, U.R.I.

Standards for Public Assistance and Medicare

Walter S. Breen, Senior Medical Care Specialist, Division of Public Assistance, Department of Social Welfare, R. I.[4]

Food Needs of the Elderly

Sybil D. Kaplan, Assistant Extension Professor of Food and Nutrition, U.R.I.

Nursing Techniques

Mrs. Lucile Votta, Assistant Professor of Child Development and Family Relations, U.R.I.

11:45 Lunch Speaker: Mr. Conant Faxon, Superintendent of General Hospital, Rhode Island Medical Center[5]

1:15 Presiding: Mrs. Evelyn V. Mason

Occupational Therapy

Mrs. Shirley Carr, Occupational Therapist, Massachusetts Department of Health[6]

Physical Therapy

Miss Mary DuVally, Physical Therapist, Rhode Island Department of Health

2:30 Adjournment

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[3]Creative Arts Volunteers also attended this session in the spring.

[4]Spring Session, Joseph Murray

[5]Spring Session, Reverend Walter Schoepfer

[6]Spring Session only

Training Sessions for Creative Arts Leaders

FEDERAL BUILDING ANNEX, PROVIDENCE, R. I.

October 2 *Color and Simple Hand Weaving*
Mrs. Evelyn V. Mason

October 9 *Furniture Refinishing*
Philip H. Wilson

October 16 *Rug Braiding*
Mrs. Isabel Nelson

October 23 *Ceramics*
Mrs. Arlene Kingsley

October 30 *Leather Work and Crewel Embroidery*
Mrs. Evelyn Mason and Mrs. Gussie Lawton

Training Sessions for Creative Arts Leaders

MANUEL MATHIAS BUILDING, GENERAL HOSPITAL, MEDICAL CENTER

April 2 Welcome: Mr. Conant Faxon, Superintendent of General Hospital
Leather Work
Mrs. Evelyn Mason
Mr. John Lowe

April 9 *Color and Simple Hand Weaving*
Mrs. Evelyn V. Mason

April 16 *Ceramics and Clay Modeling*
Mrs. Arlene Kingsley

April 23 *Mobiles and Textile Stenciling*
Mrs. Evelyn Mason and Mrs. Evelyn Arthur

April 30 *Rug Braiding*
Mrs. Isabel Nelson

May 7 *Creative Ideas*
Mr. John Lowe

May 14 *Creative Ideas*
Mrs. Marguerite Burns

May 16 *Ceramics*
Mrs. Arlene Kingsley

Creative Arts Program

THE Creative Arts Volunteers trained at the Fall 1968 session indicated general satisfaction with the subjects taught. However, many soon sought additional help and materials from Mr. Lowe, Occupational Therapist at the Medical Center. Many remarked they felt the skills taught at the workshops were beyond the abilities of the patients they worked with.

It was indicated to the volunteers that they would be expected to adopt simpler techniques when needed and to gear their teaching and subject matter to the patient's individual needs and capabilities. Since most volunteers did not follow this course, it was decided that the Spring, 1969 session would be modified by showing simpler techniques for some subjects and replacing some with others thought to be more within the patients' willingness to attempt.

An "idea" day was added to the Fall, 1968 session. At that time volunteers brought objects, with directions for making them, and ideas to exchange.

Two days were added to the Spring, 1969 sessions. The volunteers met at the Medical Center. One of the days was spent with Mrs. Burns who conducts recreational and occupational activities for the hospital and the other day the volunteers were instructed by Mr. Lowe, occupational therapist at the Center. Mr. Lowe also prepared a kit for each volunteer. The kits were used as introductory projects when the volunteers started working at Foster Homes.

Volunteers from the Fall, 1968, session were invited to attend the Spring, 1969 session to get instruction in the modified or substitute skills that were different from the skills they had learned. They were also invited to attend the two additional workshops at the Medical Center.

On May 16, 1969, Dr. Muriel Wilbur presented certificates of recognition to the 15 Volunteers who had participated in the program and completed their 25 hours of service to Foster Homes. The ceremony was held during a coffee hour at the No. Foster Baptist Church. The group then proceeded to Mrs. Kingsley's Ceramic Studio where they completed work started at their ceramics and modeling workshop.

Volunteers Awarded Certificates

The following volunteers received certificates on May 16, 1969, for completing the course and for giving 25 or more hours of volunteer service in a health care facility:

BETTY ANDERSON
ESTHER BICKFORD
CORA BROSNAN
IVY CRANSHAW
JEANETTE DEL PADRE
CHARLOTTE FELD
MARY MORAN
ELISABETH PINKHAM
FLORENCE SCHMIDT
MRS. WALTER SCHOEPFER
REV. WALTER SCHOEPFER
ELIZABETH SPAZIANO
VIRGINIA STANTON
ISABEL WICKS
GLADYS YAKES

ADVISORY COMMITTEE

FOR

CONTINUING VOLUNTEER PROGRAM

IN CREATIVE ARTS

FOR

THE ELDERLY IN FOSTER HOMES

Chairman, Mrs. Evelyn C. Arthur

Miss Dorothea Benson
Mrs. George W. Cherry
Mrs. H. William Koster
Miss Matilda Litwin
Mrs. Evelyn Mason
Mary C. Mulvey, Ph.D.
Mr. & Mrs. Clifford Shaw
Gilbert Siiro
Mrs. Robert Edgar Smith