1976 PROCEEDINGS
THEME—TRAINING AND SERVICE FOR THE GERIATRIC CLIENT

Pragmatics of the Development of Community Resources or Why University Programs Should Provide Training in Public Relations

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INTRODUCTION

What I will be discussing are the approaches to developing community resources which will not only provide service to the hearing impaired geriatric population in the community, but will also provide practicum experience for students in a training program. It is difficult to separate these two types of program development, service and training, for they may well be developed concurrently and have overlapping goals. A training program should stress not only developing the clinical skills of a student but also stress:

1. The importance and methods of assessing community needs
2. The process of creating community resources
3. The importance of providing service to the geriatric by going to the population rather than waiting for the population to come to them.

The obvious overlap in developing these two programs is that you cannot effectively train students without providing the real thing in the real world. So, if you have a training program but lack a population, and certainly a population which is representative of geriatrics needing service, you have to find one. Statistics on hearing loss in the aged suggest

you certainly do not have to create one. Even if you have a training program with a large identified population available, client turn over through successful rehabilitation (besides all the other reasons you may loose clients) will necessitate continuous development of community resources. Even if a community has no training program, the geriatric population needs to be aware of services potentially available to them. The geriatric is frequently an individual whose needs for personal resources is very high at a time in his life when the availability of these resources and his own mobility and financial resources are very low. In all service areas for the geriatric, including aural rehabilitation, professionals need to take responsibility for facilitating the availability of services.

I would like to share with you some of the ways the University of Illinois Speech and Hearing Clinic developed community resources in Champaign-Urbana, population 70,000, and surrounding farm communities. Suggestions appropriate for our community and another large city in which I worked may not be appropriate for yours. Many of you may have done this type of activity so the ideas will not be new. The suggestions are designed to lay a foundation for idea exchange. I will also give you some of the mistakes we have made so you can avoid making the same ones and hopefully later we can share both our successes and mistakes.

Our training program has both an in-clinic and outreach or satellite component for aural rehabilitation. Both were developed over a period of time and the public relations activities used to develop them were similar.

IN-CLINIC PROGRAM CONSIDERATIONS

Planning the in-clinic program for the adult and especially the geriatric hearing impaired has to allow for flexibility and variety in scheduling times, group versus individual sessions, coordination with other audiological services and foremost provide a model for what a program in aural rehabilitation for the geriatric could be. In order to develop a broad model program, one must locate or create referral sources and then provide service for this population. The following may be usable methods for informing the public and offering aural rehabilitation services to the geriatric individual.

1. The use of letters of information regarding services. These may be sent to physicians, hearing aid dealers, senior citizens' clubs and community agencies such as mental health associations, Action on Aging and others which deal with the elderly. These letters should describe available services and options regarding scheduling, fees, etc.
2. The use of community groups. Talks can be given to Rotary Club,

Kiwanis and other service groups which are frequently looking for speakers and have contact with older people or families of older people. Our clinic has a slide show which has been developed for this purpose. It describes all services including aural rehabilitation. The use of this slide show leads me to present Mistake Number One. Feedback from one of our hearing impaired clients who watched one of our presentations at the Rotary pointed out that we should have recognized that the slide show, although professionally presented with an announcer and music background, made it difficult for the hard of hearing in the audience to understand. It was suggested that we have two audios to go with the presentation depending on the audience, one with and one without a music background.

3. The use of public media. Newspapers will print announcements of services, especially if they are written in journalistic style as a press release. It is important to stress the description of aural rehabilitation services and include information on fees and a telephone number to contact for further information. When written out for the newspaper it seems to have a better chance of being printed than if the news release is called in. Also possible is to inform the newspapers of your interest in having a feature article on hearing loss and associated services. Some communities have free weekly community newspapers in addition to regular news service which are interested in public information articles to publish.

Local radio stations provide time for public information spots which are submitted. Call in shows are other sources to utilize. A taped series can be made describing various disorders of communication and habilitation and rehabilitation approaches. The University of Illinois Public Information Service requested we provide this type of series in an interview format. The series was used locally and distributed to other stations. We help them satisfy their need to inform the taxpayers about what good things the university is doing and at the same time we inform the public about communication disorders.

Television has several sources for public information such as community calendar announcements, interview spots or night talk shows. The format for a talk show can include professionals as well as hearing impaired individuals.

Church bulletins, posters in shopping centers, laundromats, etc. can also be sources for public information announcements.

Now to share some more mistakes with you. Mistake Number Two is not understanding or taking into consideration the culture of the geriatric. For example, fear of the university by some geriatrics dictates the need for day classes for the geriatric does not want to be on campus at night. At another level fear of the university setting dictates the need for

satellite programs for the geriatric may not wish to come to a campus environment at all. Some life styles of geriatrics necessitate nighttime scheduling, however, for their daytime activities, work or reliance on transportation from working relatives means they cannot attend day classes. Fatigue factors should be considered in scheduling. For instance, late afternoon classes or lengthy classes may not be optimum times for scheduling the geriatric client. Some of our clients have requested not to be scheduled in the late afternoon because it gets dark in the winter. Geriatrics may have fear of finding a new building so bus schedules, parking information, etc. are provided.

Mistake Number Three is thinking everyone feels aural rehabilitation is important. A quality program demonstrates the importance and benefits of AR. Clients with increased communicative competence are the best public relation source, both to their geriatric peers and to professionals such as ENT's and physicians. Reliance on physicians and hearing aid dealers for initial referrals is not as satisfactory an approach as training them via their rehabilitated customers who demonstrate the worth of the product, communicative competence.

Mistake Number Four is thinking the public knows what aural rehabilitation is. It is necessary to control terminology in public relations information. Public media announcements should use public oriented terminology. For example, news releases which use "speech reading and auditory training" raise questions from callers who wonder if we also teach lip reading. With some clients the term "hearing therapy" appeared to convey more meaning. On the otherhand, in an attempt to use what I considered an easier public term, I submitted a news release using "hearing aid adjustment" rather than "hearing aid orientation." As a result further explanation was necessary to callers that I was not in the hearing aid repair business!

In all of the above activities students in training can participate for the learning experience to prepare them for similar public relations work in their future jobs. Students can also be involved in the development of outreach or satellite programs.

SATELLITE PROGRAM CONSIDERATIONS

Potential sites can be located in the following typical community centers: Independent Living Units (HEW funded, for example), religious oriented living units, nursing homes, convalescent homes, geriatric community centers and programs such as those run through park districts, mental health boards or other municipal agencies, medical centers in low income areas, or other retirement programs such as those sponsored through industry or aged activists groups.

Personal contact is an important component of public relations work and in developing potential training sites. Mistake Number Five occurs when there is an inappropriate balance between the use of upper and middle echelon people. Although upper echelon personnel need to be contacted for contracting, permission, and acceptance of service/training, the middle echelon person is the one who is most necessary for active work in program development. In several of our settings it was more effective for the initial contact to be with middle echelon staff for they better knew the politics of their own corporate structure.

In one nursing home we found the activity therapist and coordinator of volunteer services were the most helpful in establishing a program and the other professional (nursing) and administrative staff became interested later. These strong contacts with activity and volunteer services allowed for better ongoing contacts within the program for doing such things as making posters and teaching materials, contributing to the inhouse news report, or coordinating therapy with other activities. Activity therapists welcomed ideas of how their more able-bodied residents could participate in a "buddy system" using cross-ward contacts between residents who could practice with each other. They also were willing to incorporate therapy procedures into their Reality Orientation sessions. Input through personal contact from cross-ward and within-ward staff also helped avoid grouping residents who would not interact well together.

Emphasis was on personal contact with staff through verbal referrals and conferences for it reinforced staff interest, gave an opportunity for staff to interact on whatever level they chose, and gave students the opportunity to participate in these personal contacts. Inservice training sessions were also helpful for they not only provided information for the staffs but provided either an observational or experiential opportunity for the students. Although students also wrote professional reports and kept logs for the medical records, it was felt the personal contact and inservice training experiences were an important component of their training.

Nonresidential and community programs have less professional contact problems but intriguing social and scheduling problems. With these programs it was necessary to ascertain as soon as possible the population in need of and/or interested in rehabilitative services. In some instances it was better to provide an identification program first (via screening and then complete audiological testing provided through the university program and preceeded by similar public relations work.) In other instances it was more effective to provide rehabilitative services first with albeit minimal information on clients' hearing status and then incorporate the complete audiological testing later as part of the program. Very important, however, in the independent living units and community programs

is to ascertain the peer social structures, the schedule of conflicting activities within and outside the group, the attitudes towards outsiders, etc. Here again the audiologist and therefore the student in training needs to develop a sensitivity towards the geriatric culture and the characteristics of the aged. Furthermore, each independent living unit or senior citizens' club or organization has its own characteristics which need to be explored for more effective program planning.

General Mistake Number Five is overcommittment. It is important to control the amount of publicity and satellite development and thus the size of the service program in order to coordinate the service and training program. After the primary response to public relations work, activity may plateau and then be followed by a second thrust of activity, referrals and requests for service, due to clients having received satisfactory professional service. One needs to prepare for this second level so that overcommittment does not occur. Poor service or a long waiting list can lead to dissatisfaction and a breakdown in the positive relations which have been built. Overcommittment of faculty time may also lessen the quality and quantity of supervision of the students in training.

SUMMARY

Community resources can be developed in conjunction with training programs in order to provide students with "real world" experiences, not only in multi-settings with the geriatric population but in providing students with the experiences of developing these programs. Although public relations activity is occuring on the national level, professionals on the local level should be actively involved in the development of community resources, dissemination of information and delivery of services to the hearing impaired geriatric population. You can have potential for excellent service, either through a university training program or other agencies, but how good is this if the consumer does not know about the service or the service is not readily available or accessible to the target population? Are training programs accepting their responsibility for public relations work by *modeling* the development of community resources, by *reaching out* to the geriatric population, and by *offering experiences and courses* in public relations work to students in training? The University of Illinois program has offered a graduate seminar in public relations in speech and hearing and found it successful. (See Appendix for course outline) Perhaps more training programs should be considering both experiential and academic training in the area of public relations. During our discussion later we can exchange ideas as to the role various professionals should or could be playing in public relations work and the successes and mistakes they have had in attempting to do so.

APPENDIX

Course Outline for Graduate Seminar: "Public Relations and the Speech and Hearing Profession"

This course was developed and taught by Pamela Ford, Ph.D. student in the Department of Speech and Hearing Science, University of Illinois.

Definition of Public Relations:

Public Relations is the planned effort to measure and/or influence opinion and attitude through socially responsible performance based on mutually satisfactory two-way communication.

Course Objectives:

To develop an awareness of the relationship between public relations and the speech and hearing profession.

To provide a theoretical background.

To provide basic information on how to go about setting up a public relations program.

To examine what public relations can and can't do.

To examine how public relations fits in to the total delivery of services—its role in therapy.

Some Suggested Topics:

1. A definition of public relations; history of P.R. in the speech and hearing field; current trends; the role of P.R. in the rehabilitation process.
2. Attitudes as the basis for P.R. programs; methods for attitude measurement and change.
3. The function of a P.R. program; the role of the P.R. person; identifying groups within the general public.
4. Steps in setting up a P.R. program; tools of communication.
5. Problems working with specific groups, i.e., media, fund raising, etc. Special problems in different settings—schools, agencies, hospitals, etc.
6. Creativity vs. Theory and Research—an examination of current P.R. materials from ASHA, NAHSA and various state and local programs.
7. Guest speakers—people currently involved with P.R. programs including a community educator from a local rehabilitation center, the director of United Way, a professor of Radio-Television, and a local news reporter.
8. Field trips—Radio and television studios where students have an opportunity to make their own Public Service Announcements.

General Readings:

1. Cutlip and Center, *Effective Public Relations*, 4th edition, Prentice-Hall, Inc., Englewood Cliffs, N.J., 1971.
2. Goffman, Erving, *Stigma*, Prentice-Hall, Inc., Englewood Cliffs, N.J., 1963.
3. Wolfensberger, W., *Normalization: The Principle of Normalization in Human Services,* National Institute on Mental Retardation, 1972.
4. Taber, Merlin, A., et al., *Handbook for Community Professionals: An Approach for Planning and Action*, Charles C. Thomas, Publisher, Springfield, Illinois, 1972.

Other readings were on topics including attitude, theory and measurement technique, attitudes toward communication disorders, attitudes toward the profession of speech pathology and audiology and use of various media.