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EFFECTS OF RELOCATION ON THE INSTITUTIONALIZED

ELDERLY: A FOLLOW UP STUDY

by

Barry William Wise

A Thesis
submitted to the Faculty of Graduate Studies
through the School of Social Work
in partial fulfillment of the requirements
for the Degree of Master of Social Work

Windsor, Ontario, Canada

1978

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Research Committee

Professor P. K. Chatterjee	Chairman
Professor P. Taylor	Member
Professor Evelyn C. Aquino	Member

ABSTRACT

The purpose of this study was three-fold: first, to study the role of stress in the relocation of the aged person in particular; second, to study the cause(s) of the variance in the mortality rate associated with relocation of the institutionalized aged person; and third, to focus on the effects of pre-relocation preparation programmes in helping older institutionalized persons to relocate, hence, minimizing the risk of relocation. The purpose was achieved by means of a follow-up study of those elderly persons in Essex county, relocated from Hospital A to the chronic unit of Hospital B during a two week period in April-May 1976.

The researcher chose to present a survey of literature reflecting three major areas: namely, the role of stress and its effects on an aging population; the impact of relocation upon mortality rates of institutionalized aged persons; and the effects of pre-relocation preparation programmes in helping older persons to move.

A 30 item structured questionnaire was devised by the researcher to gather data on family viewpoints on the effects of relocation on their relatives. Herein lies the major strength of the study.

It was found that there are no sure guidelines to distinguish between those who are least and most vulnerable

to relocation. That there is a higher mortality rate in the first three months following relocation of elderly people was not substantiated. Families generally felt the responsibility for relocation laid within the realm of facility staff where their relative was being relocated. Further findings in this regard suggest the low visibility of hospital staff identifiable by families whose relative was being relocated. Half of the subjects relocated showed no physical or mental changes in status. Finally, a clear majority of family contact persons had no plans in the event of a long term illness affecting them.

The researcher concluded that families are in need of supportive and empathetic relationships during the relocation process. There were clear indications that families needed further opportunities to explore with hospital staff their roles in preparing relatives for relocation, and to share their experiences and feelings with other families in similar situations. And finally, there is little information about how older people should be prepared for a move, and what the effects of preparation are in facilitating adjustment to a new environment.

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TABLE OF CONTENTS

ABSTRACT	iii
ACKNOWLEDGEMENTS	v
LIST OF TABLES	vii
LIST OF APPENDICES	viii
CHAPTER	
I INTRODUCTION	1
II REVIEW OF THE LITERATURE	4
Relocation as Stress	
Relocation and the Mortality Rate	
The Effects of Pre-relocation	
Preparation Programmes	
Summary	
III RESEARCH DESIGN AND METHODOLOGY	17
Classification of Study	
Hypotheses	
Operational Definitions	
Sample	
Data Collection	
Limitation of Study	
Summary	
IV ANALYSIS OF DATA	26
Demographic Data	
Family Viewpoints on the Effects of	
Relocation of Their Relative	
Testing of Second Hypothesis	
Summary	
V CONCLUSION AND RECOMMENDATIONS	41
APPENDICES	46
Demographic Fact Sheet (N=50)	
Interview Schedule for Family Contact	
Person	
Letters of Recommendation	
LIST OF REFERENCES	53
VITA	57

LIST OF TABLES

	PAGE
I Frequency Distribution: Age and marital status of patient Characteristics	27
II Frequency Distribution: Country of birth of patient characteristics	28
III Frequency Distribution: Religious affiliation of patient characteristics	28
IV Frequency Distribution: Sex and health status of patient characteristics	30
V Percentage Distribution: Age and mental status	31

LIST OF APPENDICES

	PAGE
1. Demographic Data Sheet	46
2. Interview Schedule for Family Contact Person	47
3. Letters of Recommendation	50

CHAPTER I

INTRODUCTION

Interest in a study on the effects of relocation on the institutionalized elderly originated from discussions with social work faculty, the University of Windsor; professionals in the Windsor community; and a fellow student in the Master of Social Work programme. In general, this group questioned the possible negative aspects of relocation.

Due to this community concern and personal interest in the aged person, the researcher decided to undertake this research project. This study refuted previous data focusing on the effects of relocation on the institutionalized elderly.

A review of the literature on this problem indicates there are many gaps in our knowledge. While many researchers (Aldrich & Mendkoff, 1963; Killian, 1968; Markus, Blenkner, Bloom & Downs, 1962) have found that relocation has negative effects on the aged, others have failed to find debilitating effects attributable to relocation (Carp, 1968; Gutman and Herbert, 1976; Marlow, 1974). To examine this controversy, the researcher decided to go beyond the descriptive explanations typically offered for such findings and attempted to understand the effects of relocation on the institutionalized elderly by utilizing the scientific method.

In the course of the researcher's discussions, one colleague suggested that Hospital A which meets the needs of the chronic population in Essex County would afford an excellent opportunity for a research project in this area. The Medical Director of Hospital A was interested in this topic. She agreed to facilitate this project by authorizing the availability of historical data and clerical assistance where necessary. The sample that was chosen was relocated from Hospital A to the chronic unit of Hospital B, also in the Essex County area, during a two week period in April-May 1976. As the researcher was placed at Hospital A for field practicum, he was thereby able to consult with key persons involved in the area of interest for this study.

The researcher had at this time been involved directly with the elderly clientele of the community for four years. This involvement prodded him to question the available data reflecting on the psycho-social, economic, and political pressures that plague the institutionalized elderly. The following statements will direct the reader to the further rationale of this study.

Relocation is an event which represents a major change in the lives of most individuals. In general, the notion that significant life changes are stressful has been advanced and substantially supported (Dohrenwend and Dohrenwend, 1974). With increasing age, the elderly person's resistance to stress declines (Kral, 1957), with an increased likelihood of accumulating chronic diseases.

This soon results in relocation, as the elderly person cannot be supported in the community.

Secondly, we cannot minimize the amount of risk in moving the elderly from place to place, given the empirical evidence that now exists on relocation of the elderly and on the nature of institutional life. Clearly, the maintenance of the elderly in supportive community environments which minimize relocation is the best strategy, but often this is not feasible and relocation becomes a practical necessity.

And, finally, the researcher examined the mortality rate associated with relocation, in an attempt to explain the variance in mortality rates reported by researchers (e.g., Aldrich & Mendkoff, 1963; Gutman and Herbert, 1976).

The purpose of this study, combined with gaps in the literature on effects of relocation on the institutionalized elderly, makes this study both timely and necessary.

CHAPTER II

REVIEW OF THE LITERATURE

A first step in specifying the problem for research was accomplished by the researcher inspecting the literature on the subject of relocation of the institutionalized elderly. This review proved to be very beneficial, as it indicated the many gaps in knowledge in this area. The reasoning behind the researcher's examination of the evidence which bears on this issue was fourfold. The first reason had to do with the magnitude of the problem. It has been estimated that "between 1949 and 1963, two hundred and twenty thousand households were relocated, one-fifth of which included heads of households 60 years and older." (Riley and Foner, 1968). The second reason for examining the evidence stemmed from the lack of empirical support that the effects of relocation are negative. Thirdly, it was thought that a systematic review of the current information should be assessed for dealing with the magnitude of this problem. Finally, the lack of clear, conclusive evidence about the effects of relocation on the institutionalized elderly led the researcher to challenge existing theories on this subject.

The researcher conducted the review of the literature in three stages. In stage one, he examined relocation as stress; in stage two, the impact of relocation upon the

mortality rate of institutionalized aged persons; and in stage three, the effects of pre-relocation preparation programmes.

Relocation as Stress

The notion that significant life changes are stressful and consequently exact a price both psychologically and physically from the individual who experiences them has been advanced and supported by Dohrenwend and Dohrenwend, (1974). Scientific interest in stress is relatively new. Hans Selye began his pioneer laboratory studies of measurable physiological and behavioural changes associated with the General Adaptation Syndrome (stress reaction) in 1935. His first book on the subject in 1950 reported observations and measurements of laboratory rats and guinea pigs subjected to a variety of stresses such as lowered temperature, injury, and overcrowding. Human subjects have also been monitored for their reactions to experimental and life stress. Even as life stress is an integral element in human maintenance and growth, there is a finite capacity for adapting to stresses such as relocation (Selye, 1956; Levi, 1973; Toffler, 1970). We are beginning to recognize the major role of stress on physical conditions, and it has been possible to rank change events in the order of their impact on the stress-adaptation system (Rahe, R.H., 1969). These stresses seem to transcend cultural variation, as do many other life events, with their significance further

determined by individual perception. The measure of these stress factors is in the individual's ability to rally or bounce back from the insults or injuries he encounters (Audy, 1971). J. C. Brocklehurst (1975) reviews effects of this stress on our aging population, containing an increasing number of physically and mentally disabled elderly people, where relocation becomes a necessity.

In terms of physical vulnerability and old age, elderly people suffer from multiple problem pathology. "It is estimated that over 1,590 of the persons over age 65 are chronically disabled as compared to 3% of the general population." (Canada, Health Services for the Elderly, p.6.) It is well known that physiological aging in the absence of disease is compatible with good physical and mental health to an advanced age; and, in our experience, the severity of disability in the elderly is commensurate with the totality of diseases suffered (Wilson, Lawson, Brass, 1962). A study by Wilson et al (1962) showed that the mean number of diseases per geriatric patient was just under 6 (males: 6.4, females: 5.4). Not only does the presence of multiple pathology make an accurate clinical diagnosis more difficult than in younger people, but many disease processes have abnormal presentation in the elderly. Hence, elderly people have a high utilization of acute hospital beds. "They spend about 8 days per person per year in general acute hospitals, as compared with about 2 days per person per year for all ages ... For persons age 75 plus, the per person average

7

was about 12 days." (Canada, Health Services for the Elderly, pp. 6-6B) "Heart disease accounts for 17.3% of all patient days spent in general hospitals by the elderly, with cerebrovascular disease as the most major cause of hospital morbidity." (Canada, Hospitals and the Elderly, p.6) Williamson and his colleagues (1964), in their paper on the incidence of unreported disease in the elderly, build a case for preventive examination in the elderly.

It is self-evident that a great deal of physical illness is incapacitating and some of it potentially fatal. It is not easy to measure the effect of physical disorder in the production of stress.

Shanus (1968) compared the effect of disability among three urban populations in Denmark, Britain, and the United States of America.

In all these countries, the severely incapacitated were seen as more likely to be older and to include a disproportionate share of women and of unmarried persons. The more personal effects of the stress of physical disability affecting the relatives who looked after elderly people were described by Sheldon (1948) in one of the earliest reviews of old people in the community. He pointed out that the management of incontinence often requires an elderly person to relocate, thereby reducing the strain of heavy nursing. Perhaps the most vivid accounts of stress experienced by children in looking after their aged parents are recounted in "Survival of the Unfittest" by Issacs and

co-workers (1972). This study analyzed the problems in relation both to those who appear to have sufficient basic care and yet in whom undue strain is apparent, and those for whom basic care is insufficient. He found that, in less than 1 percent of the cases studied, the family was not prepared to do anything to help.

The extent of the stress of mental disease in old age is considerable. "In 1971, 32.2% of all patient days for persons aged 60 and over were attributable to mental disorders. This became the major category of the hospitalization of the elderly." (Canada, Hospitals and the Elderly, p.6) The question of whether the lowered stress resistance of the aged plays a primary role in the aetiology of acute and subacute confusional states in the elderly has been answered positively by Kral (1962). Confusional states develop in the elderly under the impact of various infectious, toxic, or traumatic stresses, the common denominator of which is the acute stress they exert on the aging organism.

The chronic brain syndrome, of which dementia is the chief cause, provides one of the great causes of morbidity and of social and emotional stress among the elderly and their families. "Ten percent of those over 65 years of age are demented, and in half of these the condition is at least moderately severe." (Pitt, 1974) Admission to an institutional setting is rarely sought for the older person simply because of the severity of the disorder, but usually because there is also social crisis involving the key supporter.

9

Dementia can be a devastating disease, eroding personality as well as intellect and damaging relationships irreparably. As for the rest of the mental disorders, a great deal can be done both by way of drug treatment and through a combined social and health service which all too often does not exist at the moment. This emphasized the premium put on coordination and collaboration of services for the elderly.

As suggested earlier, stress is a factor which is only now beginning to be appreciated by researchers. That aging organisms are less resistant to stress than young ones is generally accepted. We need to develop the technology to measure the effect of physical and mental disorder in the production of stress in the elderly. Such prescriptive use of stress is appropriate in problem-solving with the aged, whose response to stress has greatly declined.

Relocation and the Mortality Rate

In this section, literature referring to the impact of relocation upon the mortality rate of institutionalized aged persons is examined.

"The Canadian crude death rate is one of the lowest in the world (y.4 per 1000 population in 1973)... By 1971, Canadian life expectancy at birth had reached an all time high of 69.3 years for males and nearly 76.4 years for females." (Canada Year Book, 1975, pp.154-156)

Today the use of mortality rate has largely become an indicator of the cause of death at old age rather than a

measure of health conditions. The leading causes of death among the elderly are diseases of the heart, cancer and strokes. "Together, they account for about 75 percent of all deaths in this age group." (Canada, Health Field Indicators, p.7)

In recent years, a number of studies have indicated that elderly persons die at an excessively high rate during the first year, and particularly during the first three months following relocation (Aldrich and Mendkoff, 1963; Killian, 1968; Bourestom and Tars, 1974). These studies also suggest that particularly high mortality rates will be found among men, the very old, mentally impaired and those in poor physical health.

The closing of the Chicago Home for the Incurable provided Aldrich and Mendkoff with an opportunity to report a follow-up study of 182 aged residents who were relocated from one institution to another. They observed

"that the death rate of residents over 70 years of age during the first year following relocation was significantly higher than anticipated (3,890 actual compared to 2,390 anticipated); that the increase of mortality was concentrated in the first three months after relocation (26 deaths in the first three months compared to 20 deaths distributed over the succeeding nine months); and that among aged people psychological patterns of adaption and specific types of emotional response to stress are significant determinants of survival, particularly during a crucial period of three months following relocation." (Aldrich and Mendkoff, 1963)

Still unanswered at the conclusion of their study was the question of the effects of physical condition on survival.

Killian (1968) matched two groups of elderly patients

for age, sex, race, organic and functional diagnosis, length of hospitalization, and ambulatory facility. A group of patients transferred from Stockton State Hospital in California to other institutions had a higher death rate than a control group of patients allowed to remain at Stockton. Assuming there were no substantial differences in physical setting between the two institutions, we may conclude that the negative relocation effects were attributable primarily to the involuntary nature of the move.

Bourestom and Tars (1974) studied the effects of different degrees of environmental changes in 98 patients where two relocated groups were matched for age, sex, length of hospitalization and primary diagnosis with a like number in the control facility. They found a higher mortality rate for the radical-change relocatees than for the moderate-change ones, which suggests that a weighty source of the variance in relocation effects is the degree of environmental change involved. Of interest also is the fact that death rates were highest in the three months preceding and three months following relocation, which is consistent with the findings of Aldrich and Mendkoff (1963), and with Rahe's studies (1969) of the relationship between extent of life crises and subsequent changes in health. y

Outcomes for one of the most extensive involuntary institution to institution relocation projects are reported by Marlow(1974). Of the 429 patients aged 65 or older followed up a year after relocation, mortality rates were

significantly higher for this group compared to base rates four years prior to hospital closure and the non-relocated control group. Another major finding of this study consistent with that of Schulz (1976) was the importance of environmental control in patient outcomes. It is important to note here that it is not the physical characteristics of the environment which determined patient outcomes but rather the psychological milieu, the importance of which was further demonstrated in a relocation study of elderly mental patients carried out by Lieberman et al (1971).

It is also important that we take note of those relocation situations where there is not a marked increase in death rates, in order that we do not exaggerate relocation effects (Gutman and Herbert, 1976; Markson and Cumming, 1971; Miller and Lieberman, 1965; Lawton and Yaffe, 1970).

In Gutman's and Herbert's study, 81 male extended-care patients relocated due to planned demolition of the building in which their ward was located were followed for 21 months from the date of transfer. No increase in mortality rate was detected during the first three months post-relocation, an interval usually associated with high mortality in elderly persons involuntarily relocated. During the first year after relocation, the death rate was 33.33%, compared to an average annual death rate of 41.2% during the five years preceding the move. At 21 months, half the relocated population were alive. This study also concurred with Bourestom's and Tars' (1974) study suggesting that the

degree of environmental change involved may be a key factor in explaining variance in relocation effects.

The forced relocation of a group of long-term elderly chronic patients in response to budget cuts was the subject of a study done by Markson and Cumming (1971). Consistent with the findings of Gutman and Herbert (1976), there was no evidence that such forced relocation had significant impact on the patients' mortality experience. Other studies showing no increase in mortality rates following relocation (e.g., Lieberman, Tobin, and Slover, 1971; Lawton and Yaffe, 1970; and Markson and Cumming, 1971) are not strictly comparable, as their subjects were in better health than those in a hospital or nursing home population, and partly due to the selection bias operating in their studies.

In addition to this ambiguity concerning the effect of relocation on the mortality rate, little attention has been paid to the survivors of relocation experiences among the elderly. The researcher feels it is imperative to increase our knowledge concerning relocation effects, so that preventive efforts can be delivered to those most in need.

The Effects of Pre-Relocation Preparation Programmes

In this section, a review is made of the literature examining the effects of pre-relocation preparation programmes, in helping older institutionalized persons to move. The

paucity of research in the whole area of planning for relocation suggests that older people in all these situations would benefit from attempts to ease their transition into a new environment (Jasnau, 1967; Zweig and Csank, 1975; Pastalan, 1976; and Locker and Rublin, 1974).

Jasnau (1967) found in a study between a group of patients who were mass-moved and a group given individualized preparatory treatment, that mass moves with little or no preparation were followed by a 35 percent increase in death rate as compared with the rate in the year before relocation. Presumably, the use of individualized preparatory treatment served to increase the predictability and perceived controllability of the new environment.

To assess the effectiveness of their programme, Zweig and Csank compared mortality rates of patients in the same ward three years prior to relocation and one year after. "From the year before relocation to one year after, the principle finding was a 6.82% decrease in mortality, of which similar results were also observed in the Novick Study (1971)." (Zweig and Csank, 1975)

Pasalan (1976) implemented a very extensive prelocation preparation programme to over 400 aged relocatees in the State of Pennsylvania. Preliminary data showed that site visits, group discussions, and personal counselling effectively reduced mortality among relocatees, although significant differences were found for certain sub-groups of the population studies.

Finally, Locker and Rublin (1974) detailed the clinical approaches utilized to facilitate the relocation of 48 elderly people from one area to another within the same institution and on the same day. Their approach included small group meetings, individual casework, individual family counselling sessions, and implementation of a "move" day, whereby they observed that residents experienced minimal trauma on relocation.

Although the above-mentioned studies appear to support the general contention that increased pre-relocation planning reduces relocation mortality, this data should be viewed with caution. Essentially, the findings are preliminary, and no appropriate control condition was met. The paucity of research in relocation planning attracted this researcher to ascertain the extent of the family representatives' concern and plans for chronic illness in the future. Such accumulation of new knowledge will aid in the development of strategies for minimizing the relocation risk for the less adaptive aged individual.

Summary

The review of the literature revealed many gaps in our knowledge of relocation of the institutionalized elderly. The researcher conducted the review of the literature in three stages. In stage one, he examined relocation as stress, in stage two, the impact of relocation upon the mortality rate of institutionalized aged person, and in stage three,

the effects of pre-relocation preparation programmes.

As suggested earlier, stress is a factor which is now only beginning to be appreciated by researchers on aging. There is considerable ambiguity concerning the effects of relocation on the mortality rate. The paucity of research in relocation planning directed the researcher to focus on family systems and their plans for chronic illness in the future.

Having comprehensively reviewed the data encompassing this subject, the researcher moves on to the next stage of the research process, namely, the selection of the research methodology.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

In this Chapter, the researcher intends to examine the nature of the design and methodology which has guided this research. Inherent in such an examination are a number of factors which will be dealt with in the following order: classification of research, hypotheses, operational definitions, sampling, and data collection procedures. Following the description of the research design, specific limitations of this design will be discussed.

Classification of the Study

There are three major classifications used in research studies: exploratory, descriptive and experimental designs. However, there can be and there often are mixed types of designs, particularly those in the "exploratory-descriptive" category. Of the three major types of research, this research can be classified as a combined exploratory-descriptive study, sub-typed, survey of the population.

"Such studies seek to thoroughly describe a particular phenomenon and to develop ideas and theoretical generalizations. Descriptions are in both quantitative and qualitative form, and the accumulation of detailed information may be found. Sampling procedures are flexible, and little concern is usually given to systematic representativeness." (Tripodi et al, 1969)

By describing certain characteristics of the sample,

the researcher hopes to construct more sophisticated experimental research designs of the topic at a later date. This in contrast to the exploratory nature of the study, descriptive design is more specific in that it pays direct attention to particular aspects of the research target, namely institutionalized aged persons who have been relocated from Hospital A to Hospital B. Descriptive studies can reveal potential relationships between variables, thus setting the stage for future investigations. In this research study, no potential relationships between variables was established. It should be noted also, that surveys like the present study comprise a major type of descriptive research in the human services.

Hypotheses

As previously mentioned in the review of the literature, theoretical studies on relocation suggest that, while the stress of moving elderly people should not be underestimated, neither should the resilience of the elderly and the value of helping services be minimized. It was the responsibility of the researcher to sufficiently review and know the relevant literature on his topic, so that he could place his own study within the scope of current understanding and, in this way, advance understanding through his research. The potential areas of investigation of the effects of relocation on elderly persons were numerous. However, the focus of this research was threefold; first, relocation as

stress, and the role of this stress in the care of the aged person in particular; second, the impact of relocation upon mortality rates of the institutionalized aged persons; and finally, the effects of pre-relocation preparation programmes, in helping older institutionalized persons to relocate.

In view of the aforementioned focus, the researcher has formulated the following hypotheses:

- 1) That involuntary relocation is a period of stress for elderly people.
- 2) That there is a significant relationship between the mortality rate in the first three months following relocation of the elderly person than studies revealed using longer periods following relocation.
- 3) That proper planning with client and family decreases the stress of relocation.

Regardless of the source of the above stated hypotheses, they serve as a guide to the kind of data that the researcher collected, and the way in which this data could be organized most efficiently in the data-analysis. Indeed, hypothesis is the necessary link between theory and the investigation which leads to the discovery of additions to knowledge.

Operational Definitions

The following working or operational definitions are provided for the purpose of clearly conceptualizing what meaning the researcher intended by the use of terms in this study.

The term "relocation" denotes an event which represents for most individuals major changes in their lives. It also denotes a complex sequence of experiences and emotional responses, culminating in various levels of psycho-social well-being.

"Institutional," for the purpose of this study, is defined as pertaining to or partaking of the nature of an institution in structure, function or other identifiable characteristics. For example, the term may be applied to a person or persons, or to a cultural trait.

"Elderly" denotes any person who adheres to a chronological definition of age, socially defined as being sixty years and over.

"Process," for the purpose of this study, is defined as any change in which an observer can see a consistent quality or direction to which a name is given, for example, relocation and institutionalization.

"Mortality rate" denotes the number of deaths in a given area or population per unit of time and population. The word mortality is interchangeable with the word "death" in all types of rates.

"Subject," for the purpose of the study, is defined as that individual who was relocated from one institution to another.

"Family representative" refers to the subject's closest relative or the subject's legal guardian at the time of relocation.

"Stress," for the purpose of this study, is used to denote three different sets of phenomena: 1) it is equated with the noxious stimulating conditions, the stressful event or interaction; 2) it is used to refer to the state of the individual who responds to the stressful event; and 3) more often, stress refers to the relation of the stressful stimulus, the individual's reaction to it, and the events to which it leads (Rapport, 1970, p. 272).

It would be useful for the reader to return to the published literature in which the above terms were used in order to discover the various usages of these terms. Very frequently, however, one finds that the term in question has not been clearly defined at any time, but one can see how it was applied in any study. In other words, the purpose is to isolate and recombine those elements which will be most fruitful in research.

Sample

With the hypotheses in mind, the researcher constructed 30 questions characterized by the structured method. Since the researcher was developing an exploratory-descriptive project, he utilized a non-probability-purposive sample plan. The sample was 50 specifically selected individuals who were relocated to another hospital one year ago. Geographically, this sample was isolated in Windsor-Essex county. The format that was utilized by the researcher

was the survey approach. This appeared to be the most appropriate and fact-finding method for describing this sample. It also has the distinction of attempting to provide a casual explanation for the attitudes and behaviours reported.

There were no pre or post discussions with the respondents. The total interaction between respondent and researcher encompassed the survey interview procedure. The setting of this interaction took place in one of the executive offices in Hospital B, to allow for the least amount of distraction during the interview process. The researcher took total responsibility for completing the structured interview schedule to the respondents.

Major Strengths and Limitations of Survey Research

The major strengths of survey research involve a representative cross-section of the population, the sample tends to be larger than is typically the case of other research studies, all questions are asked exactly the same way and in the same order for all respondents, and the data is collected at one point in time. However, survey research does not allow for clarification of questions, minimal rapport is developed with the respondent, there is limited time for developing accurate responses, and the presence of the interviewer may bias the answers given by respondents.

Another major limitation of this particular study

was that the researcher was not employed with the agency at the time of relocation. Hence, interpersonal contacts with subjects during this period of relocation cannot be recaptured on paper.

Data Collection

"Data collection in survey research aims for a systematic and comprehensive collection of information about the attitudes, beliefs, and behaviour of people." (Williamson et al, 1977.) There are a variety of techniques for gathering data in the social sciences, but all of these are variations of three methods: observation, questioning, and measurement. The researcher has utilized techniques which lie within the questioning method. Such a method can be distinguished by three kinds of questions: the superficial, as in demographic data; the underlying, as in the public opinion poll; and the depth questions, as referring to events in one's life history. The researcher utilized both superficial and underlying questions in his study.

Two specific instruments were used in the data collection procedure; demographic fact sheet and family interview schedule. The first phase of data collection was an information sheet covering ten variables. These variables were obtained from the subject's medical record. (See Appendix I)

The second phase of data collection utilized a structured 30 item interview schedule that was developed

specifically for the study of family reactions to relocation of their relative. This interview schedule (See Appendix II) covered three types of data; 1) demographic information; 2) family reactions to the effects of relocation; and 3) the family's plans in the event of long-term illness. The interview schedule was administered by the researcher and was carried out during the time of family visiting or by pre-arranged appointments. In addition the researcher, where possible, contacted the family representative of deceased relatives.

A pre-test was conducted on five subjects of the study to assure the clarity and validity of the interview items which required closed-ended responses. Closed-ended questions were chosen so as to make data analysis manageable. Respondents completed this structured interview schedule in twenty minutes.

Summary

The study has been classified as combined exploratory-descriptive. The focus in the study was threefold; first, on relocation as stress, and on the role of stress in the case of the aged person in particular; second, on the impact of relocation upon mortality rates of the institutionalized aged person; and third, on the effects of pre-relocation preparation programmes in helping elderly institutionalized persons to relocate.

Three hypotheses were formulated in relation to the

above area of focus. Data was collected in two phases through the use of a demographic fact sheet and a 30 itemed interview schedule. From this data collection method, the researcher hoped to test out the hypotheses and to develop hypotheses for future study. Secondly, he wished to develop guidelines for families considering relocation for their elderly parent. And finally, the researcher studied the mortality rate after transfer, and explored any outstanding reasons for such rates.

The presentation of the data obtained from these research procedures will be included in the following chapter.

CHAPTER IV

ANALYSIS OF DATA

The first part of this chapter will be devoted to an examination of the subjects in the selected sample. Since the researcher was developing an exploratory-descriptive project, he utilized a non-probability-purposive sampling plan. The sample consisted of fifty specifically selected subjects who were relocated from one hospital to another one year prior to the project. Geographically, this sample was isolated in Windsor-Essex County. There were no pre or post discussions with the subjects, as the total interaction between respondent and researcher encompassed the survey interview procedure.

Demographic Data

The sample was examined in relation to several characteristics: age, sex, marital status, mental status, religion, elimination, country of birth, and health status.

Table I indicates the relationship between age and marital status of the sample. Most of the subjects in the sample, (44%) were widowed women over 75 years of age. Ten percent of the male subjects were similarly widowed and over 75 years of age. Twenty-two percent of the sample (10% male and 12% female) were married and between the ages of 65 and 84. Eight percent of the sample were single, of whom six

percent were male and two percent female. Four percent were divorced and female, from 65 to 74 years of age. A 61 year old male subject was separated, accounting for 2% of the sample.

The analysis of the data indicates that the sex breakdown of the sample was characteristic of the general female to male ratio in elderly people. Fifteen (30%) of the sample were males, contrasted to thirty-five (70%) females.

TABLE I

FREQUENCY DISTRIBUTIONAGE AND MARITAL STATUS OF PATIENT CHARACTERISTICS

AGE	WIDOW	WIDOWER	SINGLE	DIVORCED	SEP.	MARRIED
OVER 85 YEARS.	26%	6%				
75 - 84 YEARS	18%	4%	4%			12%
65 - 74 YEARS	6%	2%	4%	2%		10%
UNDER 65 YEARS	2%			2%	2%	

Table II refers to the country of birth of patient characteristics. Of those in the sample, a fairly even pattern is shown. The largest proportion of the sample, twenty (40%) were Canadian born. The second largest group, fifteen (30%) were born in European countries. The third largest group, fourteen (28%) came from the British Isles.

TABLE II
FREQUENCY DISTRIBUTION
COUNTRY OF BIRTH OF PATIENT CHARACTERISTICS

N=50		
COUNTRY	FREQUENCY	PERCENTAGE
CANADA	20	40.0%
EUROPEAN	15	30.0%
BRITISH ISLES	14	28.0%
UNITED STATES	1	2.0%

Table III reports the religious affiliation of patient characteristics. The highest concentration of subjects, twenty-nine (58%) were Protestant. Nineteen (38%) were Roman Catholic. The religious affiliation of two subjects (4%) was unknown to the hospital.

TABLE III
FREQUENCY DISTRIBUTION
RELIGIOUS AFFILIATION OF PATIENT CHARACTERISTICS

N=50		
RELIGION	FREQUENCY	PERCENTAGE
PROTESTANT	20	58%
ROMAN CATHOLIC	19	38%
UNKNOWN	2	4%

Table IV indicates the health status of the selected subjects. The diagnostic groupings are based on the Eighth

Revision International Classification of Diseases, adapted for use in the United States in 1965. If we refer to Table IV, we will see that the highest percentage of disease in the subjects was general and cerebral arteriosclerosis (64%). This affected twenty-three (46%) of the women, and nine (18%) of the men. The second highest percentage of disease was cerebrovascular accident (32%). This affected nine (18%) women and seven (14%) men. Fractures of all sites, one (2%) male, and thirteen (26%) women represented the third highest category. Arterial sclerotic heart disease (18%) was as prevalent as mental disorders (18%) in the sample. Diabetes mellitus was diagnosed in 14% of the sample, two men (4%) and five (10%) women. Aphasia represented 12% of the diagnoses, four (8%) men and two (4%) women. Five (10%) women had Parkinson's Disease. Surprisingly, cancer was reported in one (2%) male subject, and two (4%) female subjects. Blindness, deafness, and ulcers of all sites each had a prevalence rate of 4%, mostly in females.

Not only does the presence of multiple pathology make an accurate clinical diagnosis more difficult than in younger people but many disease processes have abnormal presentation in the elderly (Brocklehurst, 1975, p.252). The leading causes of death in the sample were cerebrovascular accident, general and cerebral arteriosclerosis, and bronchopneumonia.

Two other patient characteristics that have interested researchers in terms of their relationship to mortality are elimination and mental status. Forty-five subjects (90%) of the sample were incontinent, while only five (10%) of the

subjects were continent. On the other hand, mental status findings revealed that forty-four subjects (88%) of the sample were also confused, compared to six subjects (12%) who were alert.

TABLE IV
FREQUENCY DISTRIBUTION
SEX AND HEALTH STATUS OF PATIENT CHARACTERISTICS

DISEASES	MALE	FEMALE	PERCENTAGE
GENERAL AND CEREBRAL ARTERIOSCLEROSIS	9	23	64%
CEREBROVASCULAR ACCIDENT	7	9	32%
FRACTURES: ALL SITES	1	13	28%
ARTERIOSCLEROTIC HEART DISEASE	5	4	18%
MENTAL DISORDERS	4	5	18%
DIABETES MELLITUS	2	5	14%
APHASIA	4	2	12%
PARKINSON'S DISEASE	0	5	10%
CANCER	1	2	6%
ULCERS: ALL SITES	0	2	4%
DEAFNESS	0	2	4%
BLINDNESS	1	1	4%

Table V indicates the relationship between age and mental status of the selected subjects. Most of the subjects in the sample (66%) were confused, and were 75 years of age and over. An additional 22% of the subjects were confused

and from 65 to 74 years of age. Of the alert subjects (12%), two (4%) were under 65 years of age, with an identical number over 85 years of age. The latter finding supports the view of Alex Comfort (1976, p. 88) that mental status does not necessarily decline with age.

TABLE V
PERCENTAGE DISTRIBUTION
AGE AND MENTAL STATUS

AGE	MENTAL STATUS	
	ALERT	CONFUSED
OVER 85 YEARS	4%	28%
75 - 84 YEARS	2%	38%
65 - 74 YEARS	2%	22%
UNDER 65 YEARS	4%	0%

The final patient characteristic which was studied was subject outcome. A clear majority, thirty-five (70%) of the relocated subjects were still in hospital at the conclusion of this research. Two (4%) of the relocated subjects improved and were discharged to nursing home care. Twelve (24%) of the relocated subjects did not survive relocation. Thus, the relocation programme death rate was 24%.*

* Formula for Calculation

$$\frac{\text{Total deaths in relocation programme}}{\text{Total number of persons moved}} \times 100 = \% \text{ mortality}$$

Family Viewpoints on the Effects of
Relocation on Their Relative

Attitudes of families toward patient relocation have been the subject of few studies in the past. The family focus gives a major strength to this research project. The following data was elicited from twenty-seven families of relocated relatives. Unfortunately, data from the remaining families, numbering twenty-three, was unobtainable due to there being no relatives, large geographical distance and to the death of relocated relatives.

Consistent with past studies, 59% of the responsibility for aged parents rested with their daughters. Twenty-six percent listed a son as the significant other, while only seven percent listed the spouse.

In terms of the age of the supporting family members, the data revealed that seventeen (63%) of family members were under 60 years of age. This finding has important implications for the future aged, as more and more of their support is coming from younger members of their families. Such family help patterns in old age are influenced by family size, family living arrangements, and social class (Shanus, 1968). Seven (26%) of the family members were between the ages of 65 and 69. Two (7.4%) were between the ages of 60 and 64, and one (3.7%) family member was 75 years or over. Physical proximity of the families studied was not a factor, as 96.3% lived in Windsor-Essex County.

The data revealed that families of the relocated

first heard of their relative's transfer to Hospital B through two major sources, namely the newspaper (44.4%) and hospital staff (40.7%). Another 14.8% heard from a friend, radio, or as a rumour. First reactions to the news that their relatives would be relocated showed a clear majority of families had mixed feelings. All of the families interviewed in this research felt their relatives had excellent care at Hospital A, but felt the physical environment in Hospital B was much brighter and more stimulating. Five (18.5%) of the families felt shocked, and the same percentage felt saddened by the news of relocation. It is significant that only one family expressed anger over the hospital's decision to relocate their relative. Family reactions towards relative relocation lasted between seven and fourteen days in 59.3% of the families interviewed. On the other hand, eight families (29.6%) reported reactions lasting over two months. It was further found that feelings of stress experienced by family members over the prospect of relocating their relatives changed with time (70.4%). Additional information given to family members accounted for another 18.5% of changed feelings. Only three families (11.1%) said that family counselling helped them to cope with their initial feelings towards patient relocation. This finding may have implications for the need for health professionals to make a greater effort at family counselling prior to and immediately after relocation of the aged person. The goal of such counselling would be to encourage families to give

their aged relative emotional support and reassurance, and also provide an opportunity for families to express their anger, fears, and problems. It is the researcher's opinion that more education of families is required to initiate a need for family counselling. For the time being, time is man's greatest healer.

Notification of patient relocation was done by telephone contacts to nineteen families (70.4%). Another five (18.5%) said they received a letter from the social services department. Again, only three families (11.1%) had a personal interview with the social services department. It is now a known fact that older people are living longer, and hence, the need for ongoing planning as the need for relocation arises in this "new generation." Almost three quarters of the families (74.1%) felt the reason why their relatives were selected for transfer was adequately explained to them. Seven families (25.9%) did not feel that an adequate explanation was given to them by hospital staff. However, only three of these families communicated their dissatisfaction to the administrator at the hospital.

Twenty-one families (77.8%) said their relatives felt indifferent about the prospect of relocating to Hospital B. Three families (11.1%) felt their relatives felt rejected, while a similar number reported that their relatives felt supported during this traumatic event. Consistent with this finding was the fact that eighteen families (66.7%) indicated to the researcher that their relatives were not aware of what

was happening to them. In contrast, nine families (33.3%) said their relatives were indeed alert to their new surroundings, and communicated their first impressions to their family.

Families' degree of involvement during the relocation process may be an important factor in families perceiving the need for family counselling. Seventeen families (62.9%) felt a minimal degree of involvement during relocation of their relative. Four (14.8%) of the families reported a moderate degree of involvement, while six families (22.2%) spoke of a significant degree of involvement on their parts. Significantly, it should be noted that families did not feel they had any real part to play in preparing their relatives for relocation to Hospital B. A clear majority of families (fifteen or 55.6%) felt the involvement of facility staff where their relatives were being relocated would be helpful in preparing them at the time of relocation. Six families (22.2%) felt there should be a greater effort to involve the patient in planning for his move. Four (14.8%) of the families felt they should be involved in assisting with their relative's relocation. Two families (7.4%) felt first priority should be given to the actual transfer date in relative relocation. The mode of transfer for all relatives relocated, was by ambulance. This approach to patient relocation perpetuates responsibility by the institution, instead of encouraging family involvement and responsibility.

Family knowledge of the function of individual team members at the hospital seemed to play a significant role in

planning the move with the patient and his family. Fifty percent of the families felt the nurse should be involved, contrasted to 23.9% of families who said the doctor should be involved. Only 15.2% of families felt the social worker should be involved in preparing the patient and his family. Almost 11% of family responses were classified as other. Their findings suggest the low visibility of team members other than doctors or nurses. Public education as to the role of para-professional staff is sorely needed in this medical setting.

The visitation pattern of families was not affected to a significant degree by the relocation process. Thirteen (48.1%) of the families said they visited their relatives about the same number of times since relocation took place. Five families (18.5%) said they visited their relatives more. Therefore, the family visitation pattern remained 66.6% intact. Only nine (33.4%) of the families reported that they visited their relatives less frequently since relocation took place. The nursing staff at Hospital B reported that family visitation followed a predictable pattern in this age group. Families visit their aged relative regularly, never, or only on holidays and birthdays.

Approximately half (51.9%) of the families reported no physical or mental changes in their relatives after relocation. Thirteen families (48.1%) did report physical and mental changes in their relative. Over half (55.6%) of the families interviewed believed death could not be a consequence of relocation.

Contrasted to this, twelve (44.4%) felt the opposite when asked this question. A clear majority of families (77.8%) felt that personal factors make people more vulnerable to death as compared to external stress factors. Two families (7.4%) said that personal and external stress combined made people more vulnerable to death.

The fact that families of relocated relatives did not associate with one another was true in eighteen or 66.4% of the cases. Nine families (33.3%) did talk to each other about the quality of patient care at Hospital B. Just over half (55.6%) of the families were interested in joining a group for families of relocated relatives if one had existed. Another twelve families (44.4%) had no intention of joining such a group.

The researcher, in a follow up to the study done by Heyman and Jeffers (1965) entitled "Observations on the Extent of Concern and Planning by the Aged for Possible Chronic Illness," obtained the following results. Consistent with their study, 85.2% of the elderly subjects had no specific plans in the event of long term illness affecting them. Of the plans made (14.8%), two were detailed and two were strictly financial. In the event of long term illness, twelve (44.4%) said their spouses would take over the management of the home, while ten (37.0%) said they would have to hire help to come into the home. Another five (18.5%) said they would need to move, or could depend on relatives to assist in the home. Sixteen (59.3%) showed concern about a long term illness they might have at present, in contrast to eleven (40.7%) who showed

no such concern. Seventeen (63%) reported their health as good to excellent, compared to ten (37.0%) who reported their health from fair to poor.

Testing of Second Hypothesis

The second hypothesis stated that "there is a significant relationship between the mortality rate in the first three months following relocation of the elderly person than studies revealed using longer periods following relocation." The mortality rate for the patient relocation programme was 24%. A majority of these deaths occurred between the sixth and seventh month. Therefore, in view of the agreement of the present findings with those of earlier studies, the second hypothesis, quoted above, was refuted.

Summary

In summary, the findings in this section indicate that there are no sure guidelines to distinguish between those who are least and most vulnerable to relocation. This lack of knowledge unwittingly places many elderly persons in high risk situations and creates a dilemma for those responsible for their welfare.

In addition, the hypothesis that there is a higher mortality rate in the first three months following relocation of elderly people was not substantiated. Of those 24% who did not survive relocation, most died between six or seven months post relocation. As has been hypothesized already by

Pastalan (1976), advanced age, poor prognosis, and confused mental status are strong predictors of mortality following relocation. Only one person under age 70 dies, and the average age of those deceased was 81. Two subjects in the study were discharged from chronic hospital care to nursing home care after four months post-relocation.

Of 27 family members interviewed, 17 or 63% were under sixty years of age. Families' first feelings to the news that their relative would be relocated were mixed. These findings changed over time rather than with personal counselling. In addition, 62% felt a minimal degree of involvement during the relocation process. Families generally felt the responsibility for relocation laid within the realm of facility staff where their relative was being relocated. Further findings in this regard suggested the low visibility of hospital staff other than the doctors and nurses. The preferred mode of transport was by ambulance in all families interviewed. The visitation pattern of families after relocation was found to be undisturbed (66.6%). It was also found that families visited these relatives on the basis of "regularly," "never," or "on holidays and birthdays." Half of the subjects relocated showed no physical or mental change in status. A clear majority, 21 or 77.8% of those families interviewed, felt that personal factors rather than external stress make people more vulnerable to death. In addition, this study showed that, during relocation, families do not communicate with each other. Just over half felt they would have joined a group if one had been organized for families

of relocated relatives.

The study was consistent with that of Heyman and Jeffers on "Observations on the Extent of Concern and Planning by the Aged for Possible Chronic Illness." Clearly 85.2% had no plans in the event of a long term illness affecting them. Although they were aware of the possibility of their incurring such an illness, only 33.3% stated that they were very much concerned about it, and 40.7% expressed no concern at all. Any planning undertaken for future illness was chiefly in the area of adequate financial provision (7.4%).

CHAPTER V

CONCLUSION AND RECOMMENDATIONS

The researcher's involvement with the elderly clientele of the community prodded the researcher to question the available data reflecting on the psycho-social, economic, and political pressures that plague the institutionalized elderly. How can we minimize the amount of risk in moving the institutionalized elderly from place to place, given the empirical evidence that now exists? How does one explain the variance in the mortality rate associated with relocation of elderly institutionalized persons? Is relocation of the institutionalized elderly person a stressful event? These are but a few of the complex questions facing the practitioner working with this target population. There is an obvious gap between the perceived knowledge of the practitioner and the actual problems faced by the elderly in relocation. This fact alone makes this study both timely and necessary.

Since the researcher was developing an exploratory-descriptive project, he utilized a non-probability-purposive sampling plan. The survey approach appeared to be the most appropriate and fact-finding method for describing the sample. It also had the distinction of attempting to provide a causal explanation for the attitudes and behaviours reported.

Data collection in the survey research approach

aimed for a systematic and comprehensive collection of information about the attitudes, beliefs, and behaviour of people. The researcher has utilized data gathering techniques which fall within the questioning method. The first phase of data collection was an information sheet covering ten demographic variables. The second phase of data collection utilized a structured 30 item interview schedule that was developed specifically for the study of family reactions to relocation of their relative.

The focal points in the study were three-fold: first, relocation, as stress, and the role of stress in the care of the aged person in particular; second, the impact of relocation upon mortality rates of the institutionalized aged person; and third, the effects of pre-relocation preparation programmes in helping older institutionalized persons to relocate.

Inevitably, there were aspects of the effects of relocation on institutionalized elderly persons which the researcher could not cover, and which we conclude have not been previously demonstrated to be true. These then form the limitations of the research. Limitations of survey research included minimal rapport with the respondents, the short time period for developing accurate responses, and the fact that the presence of the interviewer may bias the answers given by the respondents. Another major limitation of this particular study was that the researcher was not employed with the agency at the time of relocation. Hence,

interpersonal contacts with the subjects during this period were not re-captured.

In spite of the above limitations of the study, certain implications for social work practice clearly emerged. The results obtained, especially concerning personal responses from the families of those institutionalized elderly relocated, support the principle that families are in need of supportive and empathetic relationships during the relocation process. Of special significance were the feelings of helplessness and non-involvement families felt in the early phases of relocation. In their own way, each of these families responded uniquely to the stress of relative relocation. There were clear indications that families needed further opportunities to explore with hospital staff their roles in preparing relatives for relocation. Professionally directed opportunities for families to share their experiences and feelings with other families in similar circumstances seemed clearly needed. It was the researcher's impression that families were relieved to have their elderly relative placed in some facility in the community.

The following recommendations for social work clinical intervention and research emerge from this study:

- 1) There appears to be a need for planned services to provide a means for continued family involvement during the elderly persons transition into a new environment. A general meeting of family members with staff would afford families an opportunity to

express their feelings, problems and fears. At this time families should be given written rationale for this relocation and the necessary data that would facilitate this transition period. Staff could also counsel families with the emotional support that the families need in the pre and post relocation stages.

- 2) Involvement of all levels of staff is strongly recommended in helping to prepare the elderly for relocation. This builds staff cohesiveness and allows for greater familiarity with relocation procedures. Further provisions should be made for the former staff to remain in touch with the patient for at least a few days after relocation.
- 3) There is a definite need for a control group since there is little information about how the elderly should be prepared for relocation. Without a control, judgements of the effectiveness of any particular preparation programme is mainly guesswork.
- 4) Public education as to the role of para-professional staff is needed in hospital settings. This was revealed in this study by the low visibility of team members other than doctors or nurses.
- 5) In this study the responsibility for transfer of all the elderly relocated was assumed by the hospital. The arrangements for transfer should be the responsibility of the families where possible. This alternative would allow for greater savings of money, and

time for hospitals to utilize their resources in more critical areas of patient care.

Furthermore, the conclusion of this study represents a discussion of trends within the area of relocation, rather than a discussion of exact statistical data. Social work intervention in this area has two goals; first, to use existing knowledge to manipulate environments and assist the elderly; and second, to promote accumulation of new knowledge to fill the many gaps in our understanding of the effects of relocation on the institutionalized elderly person. To this end, the researcher hopes that suggestions presented in this study may be of some use to practitioners aiding in the relocation of the elderly.

APPENDIX I *

Demographic Fact Sheet (N=50)

Patient Name: _____

Age: _____

Sex: _____

Marital Status: _____

Country of Birth: _____

Mental Status: _____

Religion: _____

Continent/Incontinent: _____

Length of Stay: _____

Patient Outcome: _____

Family: _____

Diagnosis: _____

APPENDIX II

Interview Schedule for Family Contact PersonEffects of Relocation on the Institutionalized Elderly

Instructions: There is no writing involved. Just check . . . on the dotted line beside the questions listed below. Please answer all questions.

- 1) Relationship to your relative relocated daughter
 son
 brother
 sister
 spouse
 friend
 other, please specify
- 2) Your age is: under 60 years old
 60 - 64 years old
 65 - 69 years old
 70 - 74 years old
 75 years and over
- 3) Do you reside in Windsor - Essex County - yes . . . if no, specify . . .
- 4) How did you first hear of the transfer of patients at the hospital?
 friend
 newspaper
 radio
 rumor
 hospital staff
 other
- 5) What were your first reactions to the news that your relative was to be relocated:
 shock
 anger
 sad
 happy
 mixed feelings
 other
- 6) How long did these reactions last? 7 - 14 days
 30 days
 60 - 90 days
- 7) Did these reactions change with time
 information
 counselling
- 8) How were you officially notified? letter
 phone call
 personal interview
 other - please specify

APPENDIX II
Continued . . .

- 9) Do you feel that the reason why your relative was selected for transfer was adequately explained to you?
 yes
 no
- 10) If no, did you communicate this to the hospital staff?
 yes
 no
- 11) If yes, do you feel that your relative felt
 rejected
 supported
 indifferent
- 12) Was your relative aware of what was happening?
 yes
 no
- 13) How much time did you have to prepare your relative?
 7 - 14 days
 30 days
 60 - 90 days
- 14) How much time did you have to prepare the family?
 7 - 14 days
 30 days
 60 - 90 days
- 15) The actual transfer took within
 7 - 14 days
 30 days
 60 - 90 days
- 16) If the effects of relocation were adverse, they could be preventable with careful and adequate support services.
 yes
 no
- 17) Your relative was transferred from hospital A to hospital B by:
 taxi
 private automobile
 ambulance
 other-please specify
- 18) To what degree were you involved in the relocation process?
 significantly
 moderately
 minimally
 no response
- 19) Do you visit your relative more, about the same, or less than, since relocation took place?
 more
 about the same
 less than

APPENDIX II

Continued

- 20) Did your relative show any physical or mental change after relocation?
 yes
 no
- 21) If yes, were these change
 physical
 mental
 both
- 22) Do you believe that it is possible for an individual's environment
 (in this case, a chronic hospital) to assume so much importance that on
 relocation it results in death?
 yes
 no
- 23) Do you believe that the external stress or personal factors such as health,
 life-style, or anticipation of the move make people more vulnerable to
 death?
 external stress
 personal factors
- 24) Did you talk to other families who had relatives relocated?
 yes
 no
 If yes, specify content of talks
- 25) If a group, for families of relocated relatives, was formed, would you
 join such a group.
 yes
 no
- 26) How would you manage at home in the event of a long illness?
 spouse would take over.
 other relative would take
 over in subject's home
 hire help to come in
 would need to move
- 27) In the event of a long-term illness, have you made plans of any kind?
 financial plans only
 specific plans (i.e., housing,
 nursing care)
 other plans
 no specific plans
- 28) How concerned or worried do you feel about a long illness which you
 might have?
 very concerned
 moderately concerned
 no concern
- 29) How would you rate your health at the present time?
 excellent or excellent for my age.
 good or good for my age.
 fair or fair for my age.
 poor
 very poor

November 18

76

Mrs. M. Driscoll, Director of Professional Services

Dr. M. Wilson

Research Project by Mr. Barry Wise, B.A., B.S.W., Social Work Intern

Mr. Barry Wise, Social Work Intern has been authorized to conduct a research study on the Effect of Relocation on the Institutionalized Elderly as a requirement for his Masters degree. A copy of his proposal is attached. Chronic Care patients transferred from Riverview to the Casgrain Unit will be the subjects of his research.

It would be appreciated if you would help with this project by arranging for access to medical records and other information as necessary. Mr. C. Purcell, Director of Social Services will be bringing Mr. Wise over to the ICDE Unit probably next week to introduce him to yourself and other key personnel.

Muriel Wilson, M.B., Ch.B.
Medical Director
Chronic Care Division

MW:jt
cc: Mr. C. Purcell
Director Social Services
WJHC - Riverview Unit
Attachment

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VITA

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