Nicholas Long
Project Director
Institute for Interdisciplinary Studies
American Rehabilitation Foundation
Minneapolis, Minnesota

INFORMATION AND REFERRAL SERVICES: A SHORT HISTORY AND SOME RECOMMENDATIONS

During the past fifteen years a new kind of social service has blossomed on the American scene. This service has come to be known by a variety of names, the most popular of which is "information and referral (I&R)." Information and referral services are symptomatic of the complexity of the present mode for delivering human services, and reflect a relatively conventional response to the problems created by such complexity. It is suggested that I&R services represent a conventional response because they grew out of the tangle of human services and have evolved essentially as partners and perpetuators of the present complexity of human services.

The suggestion that I&R services perpetuate the system which forced them into existence is not necessarily a condemnation of I&R services. The fact remains that human services remain largely inaccessible to a great number of people who need them. The barriers, such as poverty, ignorance, and prejudice, which prevent the utilization of services, are not easily overcome. The means for removing such barriers fall primarily in the human services area, so that the problem becomes circular: to obtain help in changing one's condition one must have an adequate income, education, and a means for combating discrimination. But if one does not have these resources, then the probability that help can be obtained to reach such resources is greatly diminished. What appears to be needed is a revolution in the delivery of human services, or the development of an entirely new approach to their delivery that lies completely outside the present structure.

Given the magnitude of the task of revolutionizing the delivery of human services, one can scarcely fault I&R services for their conventional status vis-à-vis other services. The purpose of this article is to clarify the concept of information and referral services, and to suggest the potential and limitations of these services in the context of other human services now delivered.

TOWARD A DEFINITION OF INFORMATION AND REFERRAL SERVICES

It is important to distinguish between the activities carried out under the name of information and referral, and the setting or manner in which such activities are discharged. Because of a general lack of definition about the functions of an I&R center, the setting and functions are often confused. Thus, one finds discussion of whether I&R should be part of a multi-service center or a free-standing center; whether it should be centrally located or delivered through neighborhood centers. Such discussion is generally based on knowledge about *where* I&R services are currently delivered, rather than on knowledge about the service itself. Therefore, we shall look first at the activities that have taken place in I&R centers, and then at the kinds of settings or auspices for such activities.

ACTIVITIES ENGAGED IN UNDER THE NAME I&R

Agencies that refer to themselves as I&R centers have been known to do the following:

develop and update files about community resources in the human services area,
provide information about resources over the telephone,
provide formal referrals to service agencies,
followup with clients and agencies to determine if the service was obtained,
provide case advocacy if the service was not obtained and the client still wanted it,
provide counseling or casework services,
provide escort services,
provide outreach or case-finding services,
participate in community education,
prepare statistical reports on service requests for other agencies,
undertake research on community needs to help planners,
engage in advocacy for the development of new service programs, and
operate holiday or Christmas clearinghouses.[1]

Although this listing is probably incomplete, it does give an overview of the activities that are undertaken in at least some I&R centers. It is obvious that some of these activities are also undertaken by other agencies. A problem then arises of trying to identify what is uniquely an I&R activity. An examination of agencies which provide I&R services and their auspices may help to clarify this problem.

HISTORICAL OVERVIEW OF THE ORIGINS OF I&R CENTERS

PRIVATE SECTOR

The oldest antecedent of present-day I&R centers is the Social Service Exchange, which originated in the charity organization movement of the 1870s. For a variety of reasons, the Social Service Exchange has virtually disappeared from the social service scene. Although its more recent purpose (in theory) was to facilitate communication among agencies to enhance service coordination, the earliest purpose was to prevent duplication of service. Thus, this earliest source for I&R was organized to prevent rather than facilitate access to human services.[2]

The United Way of America (formerly the United Community Funds and Councils of America, Inc.) lists some sixty I&R centers presently in operation in the United States and Canada that are under its auspices. The history of many of these centers can be traced directly to the Social Service Exchange. Initially, these centers restricted the contents of their resource files to social welfare resources, but with the development of the Public Health Service Chronic Disease Program in the early 1960s, many of these centers began to expand their resource information to include the fields of health and aging as well.[3]

In 1966, the National Easter Seal Society adopted the delivery of information, referral and followup services as its basic program for all Easter Seal Society affiliates.[1] Since that time, approximately 10 percent of the affiliates have taken steps toward implementing this program.

In addition to these programs which are identifiable with some kind of central coordinating organization, there are numerous private I&R centers sponsored at the local level by special interest groups such as labor unions, churches, and societies for mental retardation, mental illness, and alcoholism. There are also numerous "action line" programs sponsored by newspapers, and radio and television stations. One of the best organized of these is "Call for Action," sponsored by the Urban Coalition.[4]

PUBLIC SECTOR

The first organized effort to provide some kind of information and referral service through the public sector was the Community Advisory Center, established after World War II through the Retraining and Rehabilitation Administration of the U. S. Department of Labor. These centers were popularly known as Veterans Information Centers, and were modeled after the British Citizens' Advice Bureaus. There were over 3,000 Community Advisory Centers in operation immediately after the war, but most had been shut down by 1949.[5]

The next push from the public sector came from the Public Health

Service, particularly the Community Health Services and Facilities Act of 1961, which provided "for grants to State agencies and to other public or non-profit agencies or organizations for studies, experiments, and demonstrations looking toward the development of new or improved methods of providing health services outside the hospital, particularly for chronically ill and aged persons."[6] Twenty-eight grants were given under the broad area of activity called I&R during 1962-1967.

The Social Security Administration has maintained an interest in the provision of I&R services through its offices, and has occasionally conducted studies to determine the extent and quality of such services in selected offices.[7] However, the Social Security Administration has not been an advocate of the extensive provision of I&R services in its offices because of the heavy workloads that already exist due to the administration of the various benefit programs for which it is responsible.

The Administration on Aging (AOA) of the Social and Rehabilitation Service Administration (Department of HEW) is the most recent entry from the public sector in regard to I&R. Several projects with an I&R component have been funded by AOA under Title III of the Older Americans Act of 1965. Other I&R projects, with a greater emphasis on research, have been funded under Title IV of that act. The AOA has stimulated careful investigation and definition of I&R services under its Title IV projects to better define the scope and limitations of such services as they may apply to older Americans.

In addition to the public auspices mentioned above, a number of other federal agencies currently have an interest in I&R services. These include the Community Services Administration, the Office of Economic Opportunity, the General Accounting Office, and the Department of Housing and Urban Development.

Given the multiplicity of activities engaged in by agencies which identify themselves as I&R centers, the overlap of these activities with those conducted by other agencies which do not designate themselves as I&R centers, and with the checkerboard auspices of agencies engaging in I&R services, it is not difficult to understand why there may be confusion about what I&R services and centers are.

The primary thread that seems to run through the activities of I&R centers has to do with access to the service system, as Kahn defines it.[8] From the perspective of settings or auspices, I&R seems to be associated primarily with the disabled, the chronically ill, and the aged, and the facilities that serve these people.

There presently seems to be a recognition that it is not only these categories of people who need help in gaining access to human service. There is also the understanding that "access" is not such a simple service to provide. Because service access or facilitation is the one unique service provided by all I&R centers, the concept of I&R

services is gaining increasing visibility with regard to simplifying the complexity of human services delivery. In the remainder of this article a model for I&R services is described, and the strengths and limitations of that model examined in its role vis-à-vis other human services.

A MODEL FOR A COORDINATED I&R NETWORK[9]

The model described in this section represents an effort to define the activities that might be appropriately undertaken by an I&R center which has two major objectives: improving client access to human services, and obtaining data for planning purposes about service availability and client needs. The model consists of two parts: a recommended program for delivery of I&R services in a single center, and a method for coordinating single centers into a network. The model for the program in a single center is based on a functional analysis of what I&R centers are actually presently doing. The model is discussed in terms of separate, but related, components or modules. By perceiving I&R center activities as modules, it is possible to identify administrative decision points where increases in staff and budget must be considered to achieve the objectives of specific sets of activities.

SUMMARY DESCRIPTION OF THE INSTITUTE FOR INTERDISCIPLINARY STUDIES (IIS) MODEL FOR A SINGLE I&R CENTER

Resource File Development and Telephone I&R—The first step in developing an I&R center requires a careful assessment of the relevant community resources. From this assessment a written record or file is developed on the services, programs, and agencies available in the area to be served.[10] This file must be updated and continually modified. The initial development of such a file requires between three and six months, depending on the resources and personnel available. Failure to allow sufficient time for resource file development has been a common error in demonstration projects which have attempted to start I&R centers.[11]

Once the resource file has been developed, the center is ready to open its doors to the public. In the United States there has been an almost universal finding that approximately 90 percent of all contacts with I&R centers are made by telephone, regardless of location.[12] An I&R service could, therefore, function with very modest office space, a good resource file, and sufficient staff and telephone lines to handle the incoming calls. The average number of calls received by an I&R center is 290 per year per 100,000 population. However, the range of calls per year is as few as 60 to over 1,600 per 100,000.[13] Thus, the

number of staff necessary to operate a telephone I&R service may be as few as two (an I&R specialist and a secretary). The average number of I&R specialists in existing centers, including the center manager, is about three.[13]

This small, telephone-oriented I&R service may be viewed as the "basic I&R program." It is the core around which other program activities may be added. The key criteria for a basic I&R program are a carefully developed and maintained resource file, and one or more paid staff assigned to handle information and referral.[14] Unless these criteria are met, the center could not be considered adequate.

Followup—The second module of I&R activities recommended in this model requires *systematic* followup of all appropriate contacts that come to the center.[15] It is likely that some followup will be done in a basic I&R service, but careful, systematic followup will require additional staff time and recordkeeping. Systematic followup may require as little additional staff as a half-time volunteer. It may require more if the volume of "appropriate calls" is large. Appropriate calls are those which go beyond information only. For example, all formal referrals would be followed up, and information calls where the caller left his or her name and address or phone number could also be included for followup, if the I&R specialist feels it is warranted.

Escort—Lack of transportation is often a barrier to obtaining services. In addition, for the person inexperienced with the bureaucracy of larger service agencies, a temporary "friend" to go along and be supportive at the agency may be critical in a person's decision to investigate a service program.

An escort service may also require a minimal investment of additional staff time, and may be developed by a volunteer. However, if the escort program does not receive support from volunteers, it may be necessary to lease vehicles and pay staff to operate them. This obviously will lead to greater cost for this module of an I&R service.

Both followup and an escort program represent a more active role by the I&R center in trying to improve the access of services to people. If both these modules were implemented, some additional staff time would be required beyond that necessary for the basic I&R service. Thus, these modules are seen as a way to develop a more active I&R center program; to expand slightly, but with a minimum of additional cost.

Outreach—Implementation of this module represents a major investment in new resources by the I&R center. The cost of outreach will require the I&R center to double its budget from the cost of the basic service alone. Several new staff will be required. In addition,

implementation of the outreach module requires an aggressive role by the I&R center in the area of case-finding.[16] There have been only a few experiments with outreach through I&R centers (see Additional References). Nevertheless, the findings from these experimental programs suggest that outreach is a very valuable and potent activity for facilitating access to services.

Because of the demonstrated utility of outreach programs in increasing access to services, it is included in this model for the delivery of I&R services. This module is not dependent on the follow-up and escort service modules in order to be implemented. That is, it can be added directly after the basic service is established, if the local situation suggests that this is the desired direction for the I&R center to develop.

In addition to its value as a direct service, the outreach module also serves as a *mechanism* to implement survey research for purposes of planning. Many I&R centers indicate that they see identification of service gaps and areas of unmet need as one of their functions.[17] However, a careful analysis of this function suggests that it is poorly conceived and carried out by most I&R centers. The data collected are from biased samples, and rarely representative of the needs of the community at large. Their utility for the purposes of planning can thus be strongly questioned.

If the potential of I&R centers for contributing to the planning process is to be realized there must be a component for careful research built into the center program.[18] But this creates a dilemma by draining direct service resources to undertake research. This dilemma is characteristic of many direct service programs when they are confronted with requests for better data through careful research. The development of an outreach service as part of the program of an I&R center may provide a resolution to this dilemma.

Many of the activities necessary to implement an outreach program are also key components of survey research methodology (e.g., the use of census tract data to determine areas to be canvassed, door-to-door listing procedures, and the use of interview skills in talking with people in their homes). An I&R outreach service could accomplish both objectives of direct service and survey research without compromising either. The key for accomplishing both objectives is to lodge the administrative and data processing activities for research outside of the I&R center itself. That is, the research component should be directed by a network office which has the responsibility for coordinating local I&R programs under its jurisdiction. The local I&R center would simply forward the data it gathers to the network office for processing and analysis. Aside from filling out different forms in the interview, the outreach specialist should notice no difference in his or her day-to-day activities. The same should hold true for the I&R specialists in the center.

SUMMARY DESCRIPTION OF THE NETWORK STRUCTURE

There are at least two primary considerations for developing a network of I&R centers. The first concerns the idea of universal provision of these services in the United States. If this were seen as a national objective in the near future, a network structure may be economically sound from an administrative point of view.

The second consideration concerns the potential of I&R centers to contribute to the planning process in human services. I&R centers represent a true switchboard between consumers and services. Their perspective is unique. If all I&R centers engaged in uniform data collection procedures, the possibility of comprehensive planning at all levels of government might be feasible.

Organization at the State Level—It is recommended that each state assume responsibility for development of a network of I&R centers to serve its citizens. This would require establishing an I&R staff in an appropriate state office. For a specific network, such as one to serve the aging, the logical choice would be the designated unit on aging in each state. If the program were to be general, then a human resources commission or state welfare department would seem to be a reasonable choice. However, one difficulty of lodging the program with welfare is the stigma associated with welfare. At the local level, the I&R program should be housed separately from the welfare office and the sponsorship of the program by welfare should be invisible. This is not meant as an indictment of welfare, but the plain fact is that I&R services depend very much on their image in terms of whether they will be utilized. Since these services are intended for use by all, any association with welfare is likely to restrict severely and unnecessarily the range of people who may use the I&R center.

At the state level, there should be a director with overall responsibility for the I&R program. Under the director should be a field staff, comprised of professionals who are able to provide expert training, consultation, and technical assistance on the day-to-day operation of an I&R center. It is expected this staff will spend considerable time in the field, visiting local centers regularly. The field staff should be available at all times for emergency consultation by telephone.

The reason for placing this heavy responsibility on the field staff is because another recommendation is that the local I&R centers be staffed by nonprofessionals. This is one of the more controversial aspects of this model. Many I&R centers are now staffed by competent, but not professionally trained staff. These individuals have been able to carry out successfully all components of the program of I&R activities which are included in this model. Because of manpower shortages among professionals, as well as certain qualities of

professionalism which may actually thwart the goals of an I&R service, it is recommended the centers be staffed by competent, experienced, nonprofessionals.

It is also recommended that the local I&R center staff make every effort, whenever possible, to retain professional consultants. However, since this may not always be possible, it is strongly recommended that the final responsibility for professional consultation lie with the state field staff.

In addition to the field staff under the director, there should also be an office of research and planning staffed by a qualified social planner. The qualifications for this position must include sophistication with social science research techniques, including an understanding of electronic data processing equipment. This individual will be supported by additional research assistants when necessary. The research director will process, coordinate, and analyze all data that are routinely received from the local I&R centers. He or she will also have responsibility for working as a consultant with those centers, and may suggest possible studies to local center directors for their consideration.

The research directors in each state will also coordinate activities with their counterparts in other states so that the research experience for social planning will be cumulative. For example, successful research methods developed in one locality should be replicated by researchers in other localities so that the findings of comparable studies can be validly compared.

Organization at the National Level—Appropriate staffing must be provided at the national level to support the development of state I&R programs. The national staff must have capabilities in both direct I&R service delivery and research. Their interests should lie in developing and improving the national I&R network, once it has taken shape. However, it is premature to go into detail about this aspect of the structure. Such detail should be developed after the feasibility of this network model has been demonstrated in at least one state. Plans for such a demonstration are now being developed in Wisconsin by the Division on Aging, Department of Health and Social Services.

CRITIQUE OF THE PROPOSED MODEL

STRENGTHS

This model for I&R services circumscribes a set of activities that are related to each other and that all lead toward the common goal of facilitating access to human services. Until further research and evaluation are undertaken, however, one cannot assert the service utility of this particular model.

The model does provide mechanisms for coordination of the activities of facilities offering such services, and distributes the workload for coordination so that no undue burden is put on any one participating facility. The I&R service components can be established without implementation of the coordinating mechanism (the state superstructure); and the model is designed to facilitate acceptance and participation by I&R centers already in operation. That is, the model does not require the introduction of a completely new structure, but is designed to build on what already exists and gradually to coordinate these similar but independent I&R programs.

Finally, the model is designed to work within the existing structure of human services. It poses no threat to the way such services are presently delivered, and should meet little resistance when introduced into the human services. However, it is also designed to be flexible and readily amenable to change. Change mechanisms are built into the model in the form of ongoing research and evaluation components that reside at the intermediate level of state organization. Those operating the intermediate level of the system have responsibility to maintain flexibility and prevent it from drifting into a comfortable bureaucracy. This is a tall order, and whether it is possible in practice can only be determined through application and evaluation.

LIMITATIONS

The first limitation is that this model formalizes information and referral services as another specialized human service, and thus contributes to fragmentation of the service system. In part, this is what was meant earlier when it was suggested that I&R is a conventional response to the complexity of the present mode for delivering human services. The most obvious illustration is in medicine where specialization has been the major mode of responding to health problems, so that general practice is now given the new name of family practice and added to the list of other specialities. Given the complexity of tasks involved in facilitating access to other human services, it is difficult to see I&R not developing as a highly specialized human service.

The model for I&R described here is not intended to bring about any direct change in the delivery of human services, since that is unrealistic. Although some envision the I&R center as the ideal place to undertake advocacy for changing the system, such a role is very difficult for an I&R center to pursue and still maintain the good referral relationships so necessary with other service agencies.[19] The "action line" approach of the media has done much to create the image of the I&R center as advocate; but action lines are not I&R centers in terms of the model described here, or for most I&R centers throughout the country.

It is, of course, possible (even desirable) to test an aggressive advocacy program as another module to the I&R model. However, the effect of this component on other activities should be carefully evaluated before it is recommended as part of an I&R center program. It is likely the advocacy role can be carried out more effectively if it is lodged in an entirely separate structure and simply relates to the I&R center as one information source among many.

This model for I&R services is not likely to improve coordination among other human service agencies in a direct and obvious way. Again, it is unrealistic to suppose that an I&R center could do this. This is not to say that the need for coordination is not present. However, the real problem in developing an integrated human services system is not in conceptualizing an ideal model, but in implementing the model, given the constraints of an existing nonsystem, which is comprised of autonomous, and frequently very powerful, subunits (service agencies), which would be highly threatened by and fight vigorously against any reorganization that would limit their autonomy and power.

In order to implement an integrated human services system, it would be necessary either to capture the power base of existing agencies (in terms of both financial support and regulation of service standards, i.e., accountability), or attempt to form a coalition of all involved agencies and to work out issues related to power, autonomy, and regulation before a trial implementation. It may be necessary to do both, but it is likely to be extremely difficult to do either.

If one were to assume that a workable model for an integrated human services delivery system had been developed, the role of the I&R center might emerge as a general diagnostic, intake and screening, referral, and followup service. It would function as a control point for entry to, diffusion through, and exit from the service system. If such a role for any agency were feasible, it might be viewed as the primary focus for coordinating the entire service system. However, such a center is quite different from the role and function of I&R centers today.

The difficulties in implementing such a role for an I&R center are fairly obvious: professionals in most services would be quite unwilling to proceed with treatment for an individual without performing their own evaluation. Legal issues concerning malpractice could be very difficult to resolve in such a system. Further complications might arise from the followup function, which might require an evaluation of the quality of service delivered by specific agencies. Beyond that, the application of sanctions, if the quality of service falls below the regulatory standards, could create problems in the relationship of the I&R center to the involved agency.

A final limitation of this model is to be found in the role I&R center data may play in the planning of human services. Although a

fairly elaborate system is described for the purposes of data collection and research, such data and the reports generated from them play a limited role in the overall planning activity. Determination of priorities and allocation of limited resources are influenced heavily by the quality and quantity of lobbying for specific programs or population subgroups.

While the data obtained through a coordinated network of I&R centers may be used to strengthen the lobbyist's position, the direct effect of the I&R data on decisionmakers will be necessarily limited. The intent of building a fairly sophisticated mechanism for data collection and analysis into the I&R model is to maximize the potential of this component of the planning process and to make it responsive to the needs of service consumers. Evaluation of I&R data vis-à-vis the planning process is needed to determine the extent and limitations of this function in an I&R network. Based on such an evaluation, a more rational decision can be made on whether the cost of the function is justified.

It is obvious that steps must be taken to improve access of all people to human services. It is obvious that major revisions of the ways in which human services are delivered are also necessary. Information and referral services may be able to bridge the gap between these two needs. An underlying assumption of I&R services is that human service agencies are able to help people with their problems once they begin to receive services. Although this is so in many instances, there remains a significant number of people who cannot be reached by the services that are currently offered. These are those who move from agency to agency or finally drop out of the social system that supports such services.

For revising the ways in which human services are delivered, I&R services may be able to play a more central and coordinating role among the direct service agencies, provided the power structure, both public and private, has the desire to bring about such coordination. The current dilemma of I&R centers is that, although they may have data which could be used for aggressive advocacy to stimulate the desire for coordination, they cannot use these data without endangering their primary function of aiding access to services.

If a superordinate body were to be established to bring about change in the delivery of human services, it is certain the functions of an I&R center would be of critical importance in facilitating such change. However, the functions would be greatly expanded, and perhaps for the sake of clarity a new name other than I&R would be given to this set of activities. From an historical point of view, I&R centers may be only a transitional step toward a centralized assessment and referral service for all human services.

REFERENCES

1. For further discussion see: Long, Nicholas, *et al.* Institute for Interdisciplinary Studies. *Information and Referral Centers: A Functional Analysis.* Minneapolis, American Rehabilitation Foundation, 1971.

2. Williams, Kenneth I. "Social Service Exchange." In *Encyclopedia of Social Work,* No. 15. New York, National Association of Social Workers, 1965, pp. 731-34.

3. Lester, Eileen E. Personal communication, Nov. 8, 1969.

4. Daniel, James. "Call for Action!—New Voice for the People," *Reader's Digest,* 95:207-12, Oct. 1969.

5. Kahn, Alfred J., *et al. Neighborhood Information Centers. A Study and Some Proposals.* New York, Columbia University School of Social Work, 1966; U.S. Department of Labor. Retraining and Reemployment Administration. *To Organize—To Operate Your Community Advisory Center for Veterans and Others.* Washington, D.C., U.S.G.P.O., 1944; and U.S. Department of Labor. Retraining and Reemployment Admnistration. *Community Advisory Centers Face the Future.* Washington, D.C., U.S.G.P.O., 1946.

6. U.S. Department of Health, Education, and Welfare. Public Health Service. *Classification of Approved Community Health Projects by Broad Areas of Activity.* Washington, D.C., Bureau of Disease Prevention and Environmental Control, Public Health Service, 1967.

7. Townsend, Roberta E. *Report of a Study of Referral Services by Old-Age and Survivors Insurance District Offices.* Washington, D.C., U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Old-Age and Survivors Insurance, 1957; Larson, Neota. "Collaboration Between OASDI and Central Information and Referral Services." Paper presented at the National Conference on Social Welfare, May 1961; and Haber, Lawrence D., *et al. Information and Referral Services in SSA District Offices: A Pilot Study.* Washington, D.C., U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, 1971.

8. Kahn, Alfred J. *Theory and Practice of Social Planning.* New York, Russell Sage Foundation, 1969.

9. The model described in this paper was developed at the Institute for Interdisciplinary Studies (IIS) of the American Rehabilitation Foundation under a grant from the Administration on Aging (Grant No. 93-P-75051/5-02).

10. Institute for Interdisciplinary Studies. *Information and Referral Services: The Resource File* (Working Draft). Washington, D.C., U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Administration on Aging, 1971.

11. Sigler, J. *The Trial Run: A First Quarter Report.* Kansas City, Missouri, Regional Health & Welfare Council, 1964; Hampton Roads Health Information-Referral Planning Center. *Annual Report (March 1, 1967–June 30, 1968).* Norfolk, Virginia, United Communities Health-Welfare-Recreation Planning Council, 1968; and Health and Welfare Council of Metropolitan St. Louis. *The Organizational Period: Quarterly Report Number I (February 1, 1967-March 31, 1967) Information and Referral for Older Persons.* St. Louis, Missouri, Health and Welfare Council, 1967.

12. United Community Funds and Councils of America, Inc. *Summary of Service Statistics of Community Information and Referral Centers, 1962.* New York, United Community Funds and Councils of America, Inc., Nov. 1963;

and Bloksberg, Leonard M., and Caso, Elizabeth K. *Survey of Information and Referral Services Existing Within the United States: Final Report.* Waltham, Mass., Brandeis University, Florence Heller Graduate School for Advanced Studies in Social Welfare, Public Health Service, 1967.

13. United Community Funds and Councils of America, Inc., *op. cit.*

14. U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Administration on Aging. Institute for Interdisciplinary Studies. *Information and Referral Services: Notes for Managers* (Working Draft). Washington, D.C., U.S.G.P.O., 1971; _____. *Information and Referral Services: Interviewing & Information Giving* (Working Draft). Washington, D.C., U.S.G.P.O., 1971; and _____. *Information and Referral Services: Referral Procedures* (Working Draft). Washington, D.C., U.S.G.P.O., 1971.

15. _____. *Information and Referral Services: Follow-Up* (Working Draft). Washington, D.C., U.S.G.P.O., 1971.

16. _____. *Information and Referral Services: Reaching Out* (Working Draft). Washington, D.C., U.S.G.P.O., 1971.

17. Bloksberg and Caso, *op. cit.*

18. Retaining and Reemployment Administration, *op. cit.*; and Bellamy, D. F. *A Study of Information and Referral Services for Metropolitan Toronto.* Toronto, Ontario, Social Planning Council, 1968.

19. Helling, Rudolph A. "Some Definite Opinions on Information and Advocacy," *Canadian Welfare,* July-Aug. 1971, p. 57.

ADDITIONAL REFERENCES

National Council on the Aging. *The Golden Years, A Tarnished Myth: The Project FIND Report.* New York, 1970.

Orris, M. S. *Factors Which Contribute to the Social and Economic Independence of People over 60.* Saskatoon, Saskatchewan, The Social Planning Council of Saskatoon, 1970.

Putter, H., and Malzberg, A. *Helping to Serve the Aging in Their Own Homes: The Effectiveness of Information and Referral Services for Meeting Home Health and Housing Needs of Aging Persons.* New York, Community Council for Greater New York, 1969.

REAL Service. *Information, Counseling and Referral: An Action, Research and Demonstration Program—Final Report.* South Bend, Indiana, United Community Services of St. Joseph County, Inc., 1969.