Evaluation of the To Hear Again Project

Évaluation du projet Entendre de nouveau

by • par

Arlene J. Carson, MSc

University of British Columbia
Vancouver, British Columbia

ABSTRACT

The present paper describes the findings of an external evaluation of the To Hear Again project. This project trained seniors with acquired hearing loss to act as 'hearing helpers' to hard-of-hearing residents in long-term care facilities (see Dahl, 1997 for a full description of this project). A qualitative approach to evaluation was used to explore anticipated and unanticipated outcomes (process and product) and impacts of the project. Findings are described in the areas of volunteer characteristics, recruitment and training, site selection and visits, and effects the program had on residents, caregiving staff, and the volunteers themselves. A major benefit of this program was the positive effect that role modeling by the hard-of-hearing volunteers had on both the residents and staff. The point is made that meaningful evaluation is intimately tied to setting precise, realistic, and measurable objectives in program planning. Recommendations for improvement of this unique project and for the planning and implementation of future projects are provided.

ABRÉGÉ

L'article décrit les conclusions d'une évaluation externe du projet « Entendre de nouveau » dans le cadre duquel des personnes âgées atteintes d'une déficience auditive acquise ont été formées pour servir d'« auxiliaire auditif » aux bénéficiaires malentendants des établissements de soins prolongés (voir l'article complémentaire de Dahl, dans le même numéro, pour une description détaillée du projet). Une approche qualitative de l'évaluation sert à explorer les résultats prévisibles et imprévisibles (procédé et produit), ainsi que les répercussions du projet. Les constatations exposées concernent les caractéristiques des bénévoles, leur recrutement et leur formation, le choix des endroits et les visites, ainsi que les effets du programme sur les bénéficiaires, les intervenants et les bénévoles eux-mêmes. L'un des principaux bienfaits du programme est l'effet positif que le rôle joué par les bénévoles malentendants a eu sur les bénéficiaires aussi bien que sur le personnel. L'auteur démontre qu'une évaluation est concluante dans la mesure où elle est intimement liée à des objectifs précis, réalistes et mesurables, établis au moment de la planification du programme. Il présente des recommandations visant à perfectionner ce projet unique et à faciliter la planification et la mise sur pied des futurs projets.

KEY WORDS

evaluation • hearing • audiological rehabilitation • long-term care • seniors

The term 'external evaluation' refers to evaluation of a project or program by someone not associated with its design or implementation. In March 1993, I was contracted by the Canadian Hard of Hearing Association (CHHA) to undertake an external evaluation of the To Hear Again project, to fulfill terms outlined by this project's funding agency, Health Canada, Seniors Independence Program. The present paper is a summary of my external evaluation. A companion article in this issue (Dahl, 1997) describes details of the To Hear Again project.

The project planners set the following goals for external evaluation: (a) to assess whether, and to what degree, the project objectives were met; (b) to identify other outcomes and impacts, intended or unintended, of the project activities; and, (c) to provide recommendations to improve the operation of this and similar future projects.

My interest in, and belief in the importance of, the processes as well as the products of this program led to my involvement in areas beyond the end of project evaluation. This included, for example, the provision of ongoing feedback to the project coordinator on aspects of volunteer training and follow-up, based on feedback solicited from volunteers on their perceptions of the training program, materials, and work settings. Here I describe the outcomes of this particular program and provide suggestions which I hope may be useful to other program planners who choose to adopt elements of the To Hear Again program. I also wish to address, in a general way and within the context of the To Hear Again project, a few of the complex issues that surround the whole notion of evaluation.

The Evaluation Process and Challenges

Part of my mandate as external evaluator was to assess project objectives. Here, then, are the objectives of the To Hear Again project, in the wording of the program's Advisory Committee[1]:

1. To train and prepare hard-of-hearing seniors to go into homes, nursing homes and other long-term care facilities: (a) to

provide empathetic support to residents who have hearing loss; (b) to show them how to use amplification and care for their hearing aids and other devices; (c) to teach them other methods of communication, e.g., speechreading skills and coping strategies; (d) to give advice to nursing staff, other care staff, and relatives and friends on how best to communicate (with hard-of-hearing residents); (e) to instruct nursing staff, other care staff, and relatives and friends in the care, maintenance and troubleshooting of hearing aids and assistive listening devices; (f) to serve as role models for those whom they are helping.

2. To produce an information kit for use by volunteers.
3. To produce a training manual, to train volunteer visitors.

There existed, from the outset, a challenge in evaluating these objectives because they lack precision and it is difficult to define and agree on the terms that are used. How, for example, does one define and measure 'empathetic support' (objective 1a)? By what (or whose) standards is a 'role model' defined (objective 1f)? The Who, What, How Much and By When criteria that serve to turn goals into measurable objects (the word from which objectives is derived) are missing from the To Hear Again project's list of objectives. It is difficult to discern whether an objective is met and impossible to ascertain to what degree it is met when objectives are not measurable. Setting clear objectives at the planning phase of any project facilitates program implementation as well as evaluation (Green & Kreuter, 1991; McKenna, 1987).

To add to the challenge, there were no pre-program measures to serve as a yardstick by which to compare post-program results. Thus, the impact of the program in terms of the stated objectives was difficult to quantify. Even for those objectives that lend themselves to measurement, such as knowledge-based activities (e.g., show them how to use amplification and care for their hearing aids), there was only anecdotal evidence (e.g., from caregivers) of the degree to which residents were capable of such tasks prior to this project.

These shortcomings in goal-setting precluded the pursuit of a more 'traditional' goals-based, quantitative, outcome-oriented type of evaluation. Instead, a combination of goals-based and goal-free[2] evaluation was undertaken. A qualitative approach to evaluation prevailed, one that relied heavily on description and direct experience with the program through participant observation, fieldnotes, and interviews (for a thorough overview of qualitative methodology and issues, see Denzin & Lincoln, 1994). Inasmuch as renewed funding for a program depends on how results are reported as well as on *what* is reported to administrators and funding agencies, easy to scan, number-based quantitative measures are still favored over qualitative measures, irrespective of the success of a program. However, I believe the strength of qualitative methods is that they enable the evaluator to be more open to the unexpected impacts of a program and to document the rich details of the experiences of program participants that are missed with a strictly goals-based approach to evaluation (see Patton, 1990 for a discussion of evaluation models, and Gubrium & Sankar, 1993 for an overview of qualitative methods as applied to research in aging).

Evaluation Tools and Strategies

The evaluation of the To Hear Again project was carried out in two stages between March 1993 and May 1994. In the first stage, I observed the pilot training session for volunteers in British Columbia (B.C.), and offered suggestions which were incorporated by the project coordinator into the three subsequent training sessions (held in Saskatchewan, Ontario, and New Brunswick). I talked informally with each of the eight B.C. volunteers, and used a brief questionnaire form to solicit written feedback from every volunteer across Canada. These forms were returned anonymously by mail. The form asked volunteers for their opinion regarding the quantity and quality of information provided in the training sessions, how well their expectations had been met, and how well prepared they felt for their site visits upon completion of training. Six months after the initial training, I attended the follow-up session for B.C. volunteers to provide feedback and to obtain feedback from the volunteers and project coordinator that would assist me in designing the evaluation.

The major part of the evaluation (stage two), was an overall assessment of the program at its completion. I developed two comprehensive evaluation forms (one for volunteers and one for staff) which I filled out in interviews with individual volunteers and staff in all four provinces. The evaluation questions were open-ended in order to solicit comments more freely than is possible with multiple-choice or scale-rated formats. In total, I conducted face-to-face or telephone interviews with 68% of the volunteers (17 of 25 volunteers who made visits) and with the contact staff person (usually the director or assistant director of care or volunteer coordinator) for nine facilities (over 30% of the total number of facilities). I made on-site visits with five volunteers (20%) in three provinces, which allowed me to observe the interaction between the volunteer and the residents and caregivers at these facilities. As well, I interviewed the project coordinator, and facilitated a focus group meeting with York district (Ontario) volunteers and coordinators. Volunteer interviews took 45 to 60 minutes to complete, with questions about all aspects of the volunteer project experience: recruitment, training, site selection and visits, materials and resources used, and overall impressions and suggestions. Interviews with site staff were constrained by staff workload to an average of 20 minutes and covered aspects of the facility's and staff's involvement with and perceptions of the program. While I did not conduct formal interviews with the residents of the facilities, many of whom were cognitively and physically frail, I did talk with

residents informally and observed their reactions to volunteers and their activities.

Evaluation Findings and Observations: Synopsis

Volunteer Characteristics

Many volunteers stated specifically that they became involved with the To Hear Again project because of a factor related to their own hearing loss. For example, many remembered receiving inadequate information when they were first fitted with a hearing aid, or reported feeling isolated due to their hearing loss. These experiences led to a desire to help others overcome these same problems. Volunteers also said that their interest in learning more about hearing loss, hearing aids, and new assistive listening devices (ALDs) prompted them to join the project. There was almost unanimous agreement that volunteers who are hard of hearing are the most appropriate volunteers for this kind of project, because of the personal experience they bring to their visits. Several staff who were interviewed observed what a positive role model the hard-of-hearing volunteer was, for hard-of-hearing residents as well as staff. As one staff member noted, "You get a different perspective, hearing [about hearing loss] from a volunteer who is, herself, hearing impaired!"

Volunteer Training

Nineteen volunteers (over 60% of the 31 who were trained) returned the course evaluation form. The course was uniformly well rated in terms of content and how material was presented. Some volunteers expressed the need for more information and hands-on training with models of hearing aids and ALDs with which they were not familiar. Several volunteers stated that they felt ill at ease handling hearing aids that belonged to others; this point was mentioned again by some at the final interview. There was a desire expressed for more information about new hearing aid and ALD technology. There was also a wish for simulated experience in training; for example, where volunteers could role play resident-volunteer 'visits' and obtain feedback from colleagues. Follow-up sessions were deemed very worthwhile. Volunteers suggested that ongoing get-togethers (which were not built into the project) would have been welcome as a way to exchange ideas and experiences from their visits with seniors.

Site Selection and Visits

There is a crucial need to carefully match volunteers with their settings. Those volunteers who had chosen the site they visited, often on the basis of prior familiarity, appeared to have the greatest success in their visits. At least two factors may account for this outcome: rapport with staff and some patients had already been established to a degree in prior visits to the facility, and the volunteer had a better idea of what to expect in visiting if she/he had already had contact with the facility.

Roughly a fifth of the volunteers had some difficulty setting up their visits in their setting, sometimes due to administrative problems of the facility and sometimes due to the size of the facility. Smaller facilities, it would seem, had less bureaucratic red tape. In one reported case there was an extensive delay by administration in approving visits, leading to a loss of valuable volunteer time and momentum. Two thirds of volunteers reported they found their contact person to be very helpful and supportive of the project. In many cases this attitude extended to most or all of the staff the volunteers met. Other volunteers had little or no contact with the front-line caregivers (often care aides). One third of volunteers described the response of staff as 'indifferent'. It is unclear whether this perception represented a lack of interest by some staff in the program or reflected, instead, the limited time and resources of caregivers in the 1990s. Site staff who were interviewed were unanimous in their stated support for the goals of the project, which as one director noted "fills a real gap in service needs". Some volunteers felt that the caregivers seemed relieved that someone was there to provide services that staff did not have the time or were unskilled to provide. Residents whom nursing staff felt would benefit from volunteer visits were referred to the volunteer. The main criterion for referral often seemed to be whether the resident had a hearing aid. As a result, almost all the residents visited by volunteers at least owned a hearing aid. Some volunteers spent quite a bit of time chatting with the seniors, not specifically addressing hearing-related concerns, but fulfilling a more social need for communication and contact.

By the time of the final evaluation in March and April, 1994, many volunteers, especially in Eastern and Central Canada, were no longer making weekly visits to their facilities. A variety of reasons were cited for stopping their visits: health reasons, declining interest, or a feeling of having done all that one could do for the residents. Some decided at this point they would return only if staff requested a visit.

Impact on Residents

One question volunteers were asked was: "What has been the greatest impact of your visits on the residents?" A majority of volunteers (all but four who were interviewed) responded with comments that seemed to fit a theme I labeled 'positive effects on residents'. Several volunteers and staff stated that residents were happy to know they could speak with the same person, at a set time every week, about their hearing loss or problems with their hearing aid. This was an ongoing service not previously available to them. Other volunteers remarked that they felt their greatest impact was that residents, regardless of their physical or cognitive abilities, appreciated the individual attention,

time and interest shown them by the volunteer. "Visiting them lets them know someone cares about them", noted one volunteer. A volunteer who visits (i.e., one who is not paid to care for the resident) may enhance the resident's self-esteem. It was apparent during on-site observations that volunteers' empathy extended beyond caring for the residents' hearing-related needs to encompass their wish to reduce their sense of loneliness by establishing social contact, trust, and friendship. Not only was the residents' quality of life thus enhanced, but a positive association may have been established in residents' minds between better hearing (e.g., improved hearing aid functioning) and a better quality of life.

It is interesting to note that volunteer visits apparently did not result in a significant increase in residents' use of their hearing aids. It is apparent that, especially in cases of decreased physical or cognitive function, volunteers were unable to promote initiative and independence in hearing aid use. Many of the frail elderly residents will likely remain dependent on others to help them with their hearing aid(s) regardless of the amount of instruction they receive.

Impact on Staff and Other Caregivers

Volunteers and staff alike rated their perception of staff knowledge of hearing loss and hearing aids at the start of the program as 'poor' to 'fair'. Staff remarked that school-based training curricula for nurses and care aides typically provide little or no information about hearing loss. Some staff and volunteers perceived there to be improvement in staff knowledge as a result of visits, especially where an information session had been presented by the volunteer; others noted little or no change in knowledge as a result of volunteer visits. A strong effect of the project on staff was an increased awareness of hearing loss and its effects on residents, as well as an increased interest in learning more about hearing loss, hearing aids, and ALDs. Most volunteers had minimal or no contact with family members of residents. The five volunteers who did have contact reported this interaction to be positive, after the family members realized the volunteer was not a salesperson.

Information Sessions

About half the volunteers presented an information session to staff, where basic information about acquired hearing loss and hearing aids was provided. These sessions were unanimously applauded in interviews with staff. Attendance was sometimes disappointing, but staff who did attend had many questions for the volunteers. One staff person apparently tried a hearing aid herself after attending a volunteer's information session. An assistant director of care at one facility stated, "I didn't know about the T-switch on hearing aids before the [volunteer's] talk."

Impact on Volunteers

An unanticipated benefit of the To Hear Again project was its positive effects upon the hard-of-hearing volunteers themselves. Almost all volunteers reported that their experience with the project was very positive in terms of the knowledge they gained, the nature of their contacts with residents and staff, and the self-confidence they gained. Eleven of the seventeen volunteers interviewed also stated that, given their experience, they would still choose the same facility if starting over. Most volunteers seemed to find their niche over the course of their visits. Some stated that they were most comfortable visiting one-on-one with residents, others enjoyed working within a group setting, and still others discovered that they may be better suited to broader community-based public relations roles (e.g., promoting such a project to seniors in the community) rather than visiting one facility on a regular basis. Some volunteers relished aspects of the project related to hearing aids and minimized their socializing with residents, while others attached great importance to the time they spent chatting with residents or helping them with activities of daily living. The rewards for most volunteers in the To Hear Again project were similar to their reasons for getting involved in the first place: a satisfaction in helping others, greater knowledge about hearing loss, and a sense of reconnection with their community.

Overall, no marked differences emerged from the data to distinguish the CHHA volunteers from York Municipality volunteers in any of the above categories.

Recommendations Arising from the External Evaluation

Areas of Success

It is concluded from the findings of this evaluation that the To Hear Again project had variable success in meeting its stated goals. In terms of intended objectives, the project's areas of greatest success were observed to be the ability of volunteers to provide empathetic support to hard-of-hearing residents, and to act as role models not only for residents, but also caregivers who seek to better understand the hard-of-hearing person. Volunteers were generally perceived by site staff to be professional in their interaction with residents. They filled a gap in needed service in the area of hearing aid care, which is overwhelmingly overlooked or deemed to be of low priority by busy caregivers who are insufficiently trained in hearing loss and hearing aid care. As such, observations and comments made by volunteers and staff matched those voiced by researchers who have surveyed nursing knowledge and attitudes toward hearing loss (e.g., Johnson, Stein, Lyons, & Lass, 1995).

The greater success of To Hear Again lay in its unanticipated effects. Unforeseen benefits of the program included the positive

effects on the hard-of-hearing volunteers themselves, and the successful partnership established between CHHA and the York Municipality Public Health Unit in coordinating this project and forging a model upon which this and future projects may expand.

Several factors were perceived to contribute to the success of this project. There was a base of volunteers most of whom possessed skills and a sense of commitment well suited to their role as hearing helpers. A good training program was designed, complimented by appropriate training materials. There were supportive staff at many facilities eager to participate in the program.

Limits to Success

There were also factors that limited the success of the project in meeting its goals. Minimal interaction between volunteers and front-line caregivers and/or family members at some facilities, for example, limited success in instructing caregivers on the care, maintenance, and troubleshooting of hearing aids, and in teaching communication strategies. Administrative changes and/or budget cutbacks which led to greater staff workload were seen to limit the interest of staff in presentations on hearing loss and/or the acquisition of ALDs for their facility. The physical and cognitive deterioration of many residents precluded showing them how to care for their own hearing aids and teaching them supplementary communication strategies, e.g., speechreading skills (one of the stated project goals) and coping strategies.

Several of these limiting factors were outside the control of the project, such as the effects of budget or administrative cutbacks. Other limitations in program success reflect limitations of program design, in particular and as mentioned previously, inattention to setting precise and measurable objectives in the planning phase of the project which could have been monitored over the course of the program. For example, the far-flung objective (1b) "show them (i.e., the residents) how to use amplification and care for their hearing aids and other devices" is not as measurable as: "Within four visits by the volunteer, Mrs. Smith will demonstrate that she is able to insert her hearing aid battery correctly without assistance". This example points out two other important points in setting objectives. First, as much as possible, objectives should be individualised to the particular setting and people with whom the volunteer is involved. What this means, in terms of the To Hear Again project, is that volunteers must have training and guidance in setting objectives to be able to customize broad-based program goals to their particular setting and to individual residents. Second, objectives must be realistic. If Mrs. Smith has severe arthritis and a hearing aid that uses small #10 batteries, not only may the above goal be unrealistic, but persisting in hopes of achieving it may do more harm than good. Another example lies in the very broad, diffuse goal of "teaching residents other methods of communication, e.g., speechreading skills and coping strategies". Aside from the separate but related questions of whether speech perception can be taught (Gagné, 1994) and whether volunteers are adequately trained to teach "speechreading skills", volunteers reported that this task was not feasible in facilities where many residents' cognitive and visual abilities were poor. (For more information on setting objectives in the context of hearing accessibility programs, see Carson & Pichora-Fuller, 1997; Gagné, Hétu, Getty, & McDuff, 1995.)

Recommendations

The many recommendations arising from the external evaluation of the To Hear Again project were directed to program planners, policy makers, funding agencies, research institutions, CHHA, and hearing health professionals. Many of the recommendations covered practical aspects of program delivery which would be relatively easy to incorporate. Some of the more important of these recommendations follow:

1. Volunteers. The program should continue to recruit hard-of-hearing senior volunteers. A good source of new recruits are organizations and agencies that work with hard-of-hearing people, as well as word of mouth via current volunteers.

2. Training. The idea of simulating resident-volunteer visits through role playing emerged from the pilot training session and is an excellent way for volunteers to practise skills and apply knowledge learned in the program. An ongoing volunteer network via a newsletter and/or electronic mail could also be routinely incorporated into such projects.

3. Site selection and visits. It is important that volunteers have the autonomy to choose the site they wish to visit, and be provided with opportunities during training to visit facilities that provide different levels of care, so they may discover where they feel most comfortable. Some volunteers in this project, for example, were not at ease working with cognitively-impaired residents even after many visits. Moreover, volunteers should not be encouraged to expect to feel they are equipped to deal with hard-of- hearing residents who have multiple disabilities.

4. Information sessions. The hard-of-hearing volunteer, through training and personal experience, has a wealth of information to impart regarding communication strategies. Greater emphasis needs to be placed on providing information to staff and family members on effective strategies to improve communication with the hard-of-hearing resident. This is particularly important in extended care facilities where many residents are too frail to absorb and apply such teaching.

The following recommendations address issues of program development and organizational structure that may have far-reaching effects on future program delivery:

1. Volunteer Coordinator. A volunteer management consultant is an essential component of a multidisciplinary team that should be assembled to oversee all aspects of a project such as To Hear Again. Depending on the size of the project, this consultant may recruit regional volunteer coordinators. One important role of a coordinator would be to screen potential volunteers prior to training (following criteria established by program planners) as to their suitability for the project. Volunteer attrition, observed in this project, may be minimized if greater attention were given to issues concerning volunteers, from recruitment to the system of rewards.

2. Professionals. The resource base of audiologists/hearing aid dispensers within each community who acted as consultants to this program should be continued and strengthened. This evaluation, for example, identified that nursing staff need information about how to better identify and refer residents with communication difficulties related to hearing loss, regardless of whether or not they have a hearing aid.

3. Nursing training. University and college nursing and care aide training programs must include in their curricula information about hearing loss, its effects, strategies to help the hard-of-hearing patient/resident, and practical information on hearing aids and assistive listening devices. Potential pitfalls of a project such as To Hear Again include the trap of having volunteers provide services that are outside their scope of expertise and that should be provided by nursing staff with regular support from hearing professionals. The danger of this happening has never been greater than in today's climate of cutbacks where untrained personnel may be called upon to provide care far beyond their scope of expertise. The prevalence of hearing loss among seniors, especially institutionalized seniors, ranks third among chronic disabilities experienced by the aged, exceeded only by heart disease and arthritis (Binnie, 1994). It behooves hearing health care advocates, therefore, to push for nursing training in the area of hearing loss and for greater use of audiologic services in long-term care facilities.

4. Outcome Measures. Funding is needed for research into valid qualitative and quantitative outcome measures which may be used in the design and evaluation of projects like To Hear Again. In this era of diminishing health care dollars, there is a greater need than ever for ways to document how much return on investment a program delivers (Gagné et al., 1995). This is an area of weakness not restricted to speech-language pathology and audiology, but noted in the entire realm of health care (e.g., Coyte, 1992.)

5. Follow-up. Evaluation of the To Hear Again project (one to two years after the initial project time frame) was recommended to assess the longer term participation by volunteers, as well as the longer term impact of the project on residents, caregivers, and volunteers. To my knowledge, such evaluation has not occurred. Planning for 'down the road' evaluation involves vision and commitment by both program planners and funding agencies. It is an unfortunate fact that the longer term beneficial and often unanticipated effects of a program frequently go undocumented either because funding is not applied for or, more likely, is unavailable for 'down the road' evaluation. With a project such as To Hear Again, the fourteen months my evaluation spanned is an inadequate time frame in which to document lasting change and benefit. Learning new skills takes time (especially for elderly students), and skills fade if not regularly practised. Instilling individuals and institutions with new attitudes and beliefs about hearing loss no doubt requires time measured in years, not months.

Conclusion

It is unfortunate that the mere mention of the word 'evaluation' inspires a sense of dread and confrontation in many who equate the term with 'examination' and all of its negative connotations. In fact, evaluation is a form of applied research. Appropriately carried out, evaluation informs action and decisions to make programs more effective and meaningful. I believe the external evaluation described in these pages enhanced the To Hear Again project because it focused on the journey of this project, not just its destination, and because the spirit of collaboration and discovery fueled the drive along the way. The lessons learned, for example, in the area of objective setting, are important not only for volunteers, but are a useful reminder to seasoned clinicians and researchers as well.

Several hearing outreach projects have been designed and implemented recently to bring much needed services to communities of seniors whose access to public or private audiologic service is restricted (Hoek, Paccioretti, Pichora-Fuller, McDonald, & Shyng, 1997; Jennings & Head, 1994; Lewsen & Cashman, 1997). These programs have been initiated or coordinated by members of the professional community who have long recognized the need for such services. What is unique about the To Hear Again project is that it represents, to my knowledge, the first time such a program was initiated and implemented by hard-of-hearing persons themselves, with services provided by hard-of-hearing volunteers. As outlined above, there are many strengths inherent in this approach, for example, the role modeling that hard-of-hearing volunteers provide. This project also forged new links between consumers and clinicians (in the consultant role, audiologists and hearing aid dispensers provided products and expertise), and between consumers and public health programs (in the liaison between CHHA and the York Municipality).

From the viewpoint of one who enthusiastically supports the active participation of hard-of-hearing persons in decisions around issues that affect them most intimately, I welcome the initiative that CHHA has taken with this project. The greater success of a project such as To Hear Again, especially in terms of cost effectiveness, is realized if momentum gathers by the continued involvement of the initial core group of volunteers, the training of new volunteers, and an expansion of these services to a variety of facilities.

The time is now ripe for hard-of-hearing persons and professionals who serve members of the hard-of-hearing community to join forces to develop and implement programs that draw on the strengths and expertise each group has to offer. The strongest recommendation I can make in terms of achieving far-reaching and long-term effects from a program such as To Hear Again is for hard-of-hearing persons to link up with professionals who serve them and together adopt a participatory research approach to hearing accessibility. A participatory research approach (Green et al., 1995) entails the collaboration of each group within a target community that has a stake in the issue at hand, or which can offer a resource toward achieving the set goal(s). In terms of the goal of achieving hearing accessibility, for example, such collaboration may include personnel from diverse disciplines, e.g., acoustic engineer or architect. Moreover, collaboration among stakeholders must exist at each stage of the project, from program planning through implementation, evaluation, and distribution of results. A well-coordinated participatory research approach applied to both the continuation of the To Hear Again program and future projects, based on the volunteer model of this project, has the potential to make a strong, practical impact towards achieving the goal of improved hearing accessibility for the growing senior segment of Canada's population.

Please address all correspondence to: Arlene J. Carson, MSc, Doctoral Candidate, University of British Columbia, School of Audiology and Speech Sciences, 5804 Fairview Avenue, Vancouver, BC V6T 1Z3, e-mail: arlene@audiospeech.ubc.ca.

Endnotes

1. Note that Dahl (1997) frames these objectives differently to reflect her role and duties as project coordinator.

2. Patton (1990, p.116) describes goal-free evaluation as "gathering data on a broad array of *actual* effects and evaluating the importance of these effects in meeting demonstrated needs".

Acknowledgements

The author expresses thanks to the Canadian Hard of Hearing Association and to the volunteers and staff of the facilities involved with the To Hear Again project who provided valuable input into this evaluation, in particular Dr. M. Dahl, project coordinator. Authorship of this paper was funded by a Studentship from the British Columbia Health Research Foundation, whose support is gratefully acknowledged.

References

Binnie, C. A. (1994). The future of audiological rehabilitation: Overview and forecast. *Journal of the Academy of Rehabilitative Audiology Monograph, 27*, 13-24.

Carson, A. J., & Pichora-Fuller, M. K. (1997). Health promotion and audiology: The community-clinic link. *Journal of the Academy of Rehabilitative Audiology, 30*, 1-23.

Coyte, P. C. (1992). Outcome measurement in speech-language pathology and audiology. *Journal of Speech-Language Pathology and Audiology, 6*, 275-285.

Dahl, M. (1997). To Hear Again: A volunteer program in hearing health care for hard-of-hearing seniors. *Journal of Speech-Language Pathology and Audiology, 21*, 153-159.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research*. Newbury Park, CA: Sage.

Gagné, J-P., Hétu, R., Getty, L., & McDuff, S. (1995). Towards the development of paradigms to conduct functional evaluative research in audiological rehabilitation. *Journal of the Academy of Rehabilitative Audiology, 28*, 7-25.

Green, L. W., George, M. A., Daniel, M., Frankish, C. J., Herbert, C. J., Bowie, W. R., & O'Neill, M. (1995). *Study of participatory research in health promotion: Review and recommendations for the development of participatory research in health promotion in Canada*. Royal Society of Canada.

Green, L. W., & Kreuter, M. W. (1991). *Health promotion planning: An educational and environmental approach*. Mountain View, CA: Mayfield.

Gubrium, J. F., & Sankar, A. (Eds.). (1993). *Qualitative methods in aging research*. Newbury Park, CA: Sage.

Hoek, D., Paccioretti, D., Pichora-Fuller, M. K., McDonald, M., & Shyng, G. (1997). Outreach to hard-of-hearing seniors. *Journal of Speech-Language Pathology and Audiology, 21*, 199-208.

Jennings, M. B., & Head, B. G. (1994). Development of an ecological audiologic rehabilitation program in a home-for-the-aged. *Journal of the Academy of Rehabilitative Audiology, 27*, 73-88.

Johnson, C. E., Stein, R. L., Lyons, R., & Lass, N. J. (1995). Study surveys views of nurses on hearing aids, hearing aid wearers. *Hearing Journal, 48*, 29-31.

Lewsen, B., & Cashman, M. (1997). Hearing aids and assistive listening devices in long-term care. *Journal of Speech-Language Pathology and Audiology, 21*, 149-152.

McKenna, L. (1987). Goal planning in audiological rehabilitation. *British Journal of Audiology, 21*, 5-11.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.