TRAVEL AND STUDY STABBATICAL LEAVE REPORT FOR SPRING AND FALL SEMESTERS, 1988

VISITS AND INTERVIEWS IN MENTAL HEALTH PROGRAMS AND OTHER FACILITIES FOR OLDER ADULTS SPRING AND FALL, 1988

COURSE WORK THROUGH THE DAVIS SCHOOL OF GERONTOLOGY,
UNIVERSITY OF SOUTHERN CALIFORNIA
FALL, 1988

Submitted to the Board of Trustees of
Mt. San Antonio College
by

Katherine Wendy Hanes, June 1989

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PURPOSE AND GOALS OF TRAVEL AND STUDY STABBATICAL

1. To gain new information and renew my academic background about mental health programs for the elderly in selected places in the United States and Europe.

2. To participate in a research project at the Davis School of Gerontology at the University of Southern California in the area of course offerings for senior citizens in community service type programs in California Community Colleges.

3. To collect pictures, slides, and printed material that relate to mental health and accommodations issues for seniors.

4. To develop written reports and printed material in a way that it can be used in my classes in general psychology and abnormal psychology.

5. To perform work in an internship that would allow me to understand some aspects of policy making, administration, and utilization of a local senior center.

6. To offer to share my new knowledge and experience with educators and students.

MT. SAN ANTONIO COLLEGE
Salary and Leaves Committee

APPLICATION FOR SABBATICAL LEAVE

Name of Applicant Katherine Wendy Hanes

Address 2540 Alaska Street, West Covina

Employed at Mt. San Antonio College beginning Fall, 1967

Dates of last sabbatical leave:

From September, 1979 To June, 1980

Department Psychology Division Humanities/Social Science

Length of sabbatical leave requested:

One semester ____
Fall ____ Spring ____

Two Semesters Spring, 1988
and Fall, 1988/89

Purpose of sabbatical leave:

Study ____ Project ____

Travel ____ Combination (specify) Travel/ study and research

NOTE: Sabbatical periods are limited to contractual dates of the academic year.

Effective dates for proposed sabbatical leave:

From Spring, February, 1988 To June, 1988

and (if taken over a two school year period)

From Fall, September, 1988 To January, 1989

Attach a comprehensive, written statement of the proposed sabbatical activity(ies) including a description of the nature of the activity(ies), a timeline of the activity(ies), an itinerary, if applicable, the proposed research design and method(s) of investigation, if applicable.

Attach a statement of the anticipated value and benefit of the proposed sabbatical activity(ies) to the applicant, his/her department or service area, and the College.

Any change or modification of the proposed sabbatical activity(ies) as evaluated and approved by the Salary and Leaves Committee must be submitted to the Committee for reconsideration.

Katherine Hanes
Signature of Applicant

[illegible]-1-86
Date

APPLICATION FOR SABBATICAL LEAVE

Applicant's Name Katherine Wendy Hanes

THE ACKNOWLEDGMENT SIGNATURES REFLECT AWARENESS OF THE SABBATICAL PLAN FOR THE PURPOSE OF PERSONNEL REPLACEMENT. COMMENTS REQUESTED ALLOW FOR RECOMMENDATIONS PERTAINING TO THE VALUE OF THE SABBATICAL LEAVE PLAN TO THE COLLEGE.

APPLICANTS MUST OBTAIN THE SIGNATURES OF ACKNOWLEDGMENT PRIOR TO SUBMITTING APPLICATION TO THE SALARY AND LEAVES COMMITTEE.

ACKNOWLEDGMENT BY THE DEPARTMENT/DIVISION

Signature of Department Chairperson _____ Date _____

Comments:

Signature of Division Dean C Doran Date 12/1/86

Comments: I am particularly interested in the input that the applicant will give into the proposed program of Human Services. She also might be willing to serve as a Consultant to programs for the elderly in Community Services.

ACKNOWLEDGMENT BY THE OFFICE OF INSTRUCTION

Signature of Asst. Superintendent/Vice President, Instructional & Student Services J M Majorski Date 12-22-86

Comments:

NOTE: DIVISION DEANS ARE REQUESTED TO SUBMIT A STATEMENT OF RECOMMENDATION REGARDING THE VALUE OF THE SABBATICAL PLAN TO THE COLLEGE, DIVISION/DEPARTMENT, AND INDIVIDUAL, IN CONSULTATION WITH THE APPROPRIATE DEPARTMENT CHAIRPERSON.

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FINAL ACTION BY THE SALARY AND LEAVES COMMITTEE:

_x_ Recommend approval to the Board of Trustees

_____ Not recommend approval to the Board of Trustees

Walter K. Colonis — 1/87
Signature - Chairperson, Salary and Leaves Comm. — Date

John O Rudisill — 2/11/87
Signature - Authorized Agent of the Board — Date

myw
10/22/86

Proposed Sabbatical Activities
for Katherine Wendy Hanes
from September, 1988 - January, 1989
and February, 1988 - June, 1988

Preface

During the school year of 1979-1980, I was granted a sabbatical leave for study in the Davis School of Gerontology at the University of Southern California. I completed a certificate program of twenty-four graduate units that year. Because my interest in the study of aging continued after I returned to Mount San Antonio College, I acquired a Masters degree in gerontology in 1981 with an emphasis on direct service to the elderly. My internship, study and research experiences enabled me to develop and to teach a course in adult development and aging during the 1981-82 school year. I also shared my knowledge with my colleagues in psychology, sociology and related health areas. More recently, I have taught gerontologically based units in General Psychology and Abnormal Psychology.

In 1977, the book, Creative Mental Health Services for the Elderly was published. It was an informative and concise field study of four American and six European programs published by the Joint Information Service of the American Psychiatric Association and the Mental Health Association. The volume contains case studies of a few outstanding community based programs obtained by onsite field visits. The method for identifying the specific programs is described by the authors in their introduction and can be used as validation of the credibility of the choices for many of my field visits.

Proposed Activities

While I studied at the University of Southern California, I had the opportunity to use the volume described above in a geriatric counseling course. Now, a decade later, I propose to tour eight to ten of the ten facilities described in the book and to interview some of the staff and clients. I will have a series of prepared questions, and I will tape and take notes about the changes that have taken place during the last decade.

Additionally, much critical psychosocial writing exists about retirement communities such as the Sun Cities and the Leisure Worlds. I intend to review at least two pieces of literature on the communites and to tour one thoroughly critiqued Sun City outside of Tampa, Florida and another in California. Finally, I plan to return to the University of Southern California and to Long Beach to update my knowledge of SCAN, Senior Citizens Action Network and its successors. (I was a part of a USC evaluation team in 1980.)

When I am in Europe, I propose to visit sites of importance to the history of the treatment and conception of abnormal behavior. Examples of such places include the Gheel Shrine in Belguim, the birth place of Sigmund Freud in Vienna, St. Mary's of Bethleham in London and sites related to the work of Phillipe Pinel in France.

In summary, I propose to conduct my field visits and library research locally, in other parts of the United States and in Europe during the Spring of 1988. I propose to do research and graduate study at the Davis School of Gerontology, University of Southern California, during the Fall semester of 1988. The research, internships and course work would be the equivilent of twelve semester hours of work beyond the fifty-four units of gerontology that I have now. The relatively new PhD program that exists at the Davis School of Gerontology offers many specific

opportunities for research, internships and course work. The course guide for 1988-89 will contain the specific course titles.

This sabbatical proposal will permit me to further and to renew my academic and research background in adult development and aging. It will also enhance my lectures on the history of views of abnormal behavior and mental health. Through travel, it will provide the chance to directly observe both model and controversial programs for the elderly, programs that I have known only through published materials.

Anticipated Value of the Sabbatical to the College and the Applicant

In addition to the statements made in the preface and body of this proposal, the sabbatical would have value in the following ways:

1. I would have hundreds of specific examples of social and psychological issues related to gerontology and to historical and cultural views of abnormal behavior and mental health.

2. My teaching would be enhanced by the notes, written pamphlets and at least one hundred slides edited from photographs of sites related to the above issues.

3. I would be able to relate the study and travel experiences to specific instructional modules in the brain and behavior, sensory processes, learning and intelligence, personality, mental disorders and environmental psychology.

4. After my return to Mount San Antonio College, I would present one staff development program on my study and travel experiences in gerontology and mental health. I would also present one departmental program on related material specifically related to the course contents in the psychology department.

5. My sabbatical experiences would provide additional background for my having a role in decision making about support courses for any new programs in gerontology and other human service areas.

Timeline of Sabbatical Leave Activities

Spring semester

February and part of March
Location, United States

1. Northside Neighborhood Family services Inc., Miami, Florida (tour and interview process described earlier in this proposal)

2. Douglas Gardens, Miami Jewish Home and Hospital for the Aged, Miami, Florida (tour and interview process described earlier in this proposal)

3. Sun City, vicinity of Tampa, Florida (tour and interview process described earlier in this proposal)

4. New College library, Sarasota, Florida; library at the Davis School of Gerontology, University of Southern California, Los Angeles (library research of literature related to retirement communities and mental health services)

5. Tours and interviews at Sun City, California and Leisure World, Laguna, California

6. Onsite review of changes in SCAN and other related service delivery programs for the elderly in Long Beach, California

March and part of April
Location, United States

1. Services through Council for the Jewish Elderly, Chicago, Illinois (tour and interview process described earlier in this proposal)

2. The Ebenezer Society services and facilities for the elderly, Minneapolis, Minnisota(tour and interview process described earlier in this proposal)

3. Three samples of gerontological material and programs at midwest universities selected from the following: University of Minnesota, Northwestern University, University of Michigan, University of Indiana, University of Toledo and its affiliated community college and the Toledo Hospice Program (tours, interviews and published materials about programs)

Part of April, May and part of June
Location, Europe

Tours, taped interviews and notes will be made from at least five of the following seven sites in part A., below.

1. Southhampton, England, community based program for comprehensive psychiatric service for South Hampton residents aged sixty-five and over originated under psychogeriatrician, Dr. Colin Godber

2. West Cornwall, England, towns of Truro, Reduth and Bodmin in the extreme southwestern area of England, programs related to Barncoose Hospital and St. Lawrence Hospital

3. Gloucester, England, day hospitals in towns of Stroud, Cheltenham and Lydney, a remote and rural part of Gloucester known as Forest of Dean

4. Goodmayes Hospital, London, and/or Chadwell Heath Hospital, London, England, community and home assessment systems founded by Drs. Tom Dunn and Tom Arie

5. Stockholm, Sweden, programs selected from Beckomberga Hospital, nursing home at Blackebergs Somatic Hospital, Langbro Hospital, a pensioners' hotel and family foster care

6. Peder Lykke Center operated by Ensomme Gamles Vaern in Copenhagen, Denmark (translation--"lonely old peoples' aid")

7. Contrasting care and services for the elderly in urban and rural parts of southern Germany using examples from the city of Stuttgart, villages of Möckmuhl and Grossvier

Tours, taped interviews and/or notes regarding sites of importance to the history of views of abnormal behavior and mental health will be completed from at least two of the four samples below.

1. The Gheel Shrine, Belgium in the city of Gheel

2. Vienna, birthplace of Sigmund Freud

3. St. Mary of Bethlehem, "Bedlam", London, England

4. Paris, France, site of Phillipe Pinel's work at La Bicêtre and Salpetriere hospitals in 1792 (He removed the chains and encouraged humanitarian reform in mental hospitals in France during the period following the French revolution

Fall semester

Advanced graduate work and internships at the Davis School of Gerontology within the University of Southern California as described earlier in the proposal.

Addendum to the Sabbatical Application of Katherine Wendy Hanes

3. Log of site visits, sample format

Date: February 12

Location: Miami, Florida

Specific name of site: Northside Neighborhood Family Services

Objectives of visit: to list and describe the range of services for the elderly who have mental health problems

to record the changes, trends and problems that the staff and clients recount for the visitor

Summary of the highlights of the tour or interview:

1. Full day programs enable many to remain outside of institutions.
2. Visual assessment and group counseling is available on a sliding fee basis.
3. Outreach is done by professional case managers and by information and referral counselors who are senior citizen volunteers
4. Funding sources have contracted 10% resulting in the loss of one full-time staff social worker.

Other reactions to experience: The visitor recorded many comments that indicated great empathy and high morale among staff and client population.

MT. SAN ANTONIO COLLEGE
Memorandum

TO: Walter W. Collins, Chairperson
Salary and Leaves Committee

FROM: Carter Doran
Dean, Humanities and Social Sciences

DATE: December 5, 1986

RE: Sabbatical Leave Application
Katherine Wendy Hanes

The Social Sciences Division is in the process of exploring the development of a Human Services program in conjunction with the Health Sciences Division. This, however, takes lots of research.

Wendy Hanes is proposing to study some areas where Human Services workers would be employed. I expect her to be able to give the Division recommendations on feasibility and curriculum for such a program.

I also want her to serve as a consultant to Ed Hernandez concerning the programs for the elderly in Adult Education.

For these reasons, I recommend the acceptance of Ms. Hanes' sabbatical proposal.

sv
cc: E. Hernandez

Creative Mental Health Services for the Elderly, which was published in 1977, presented a thorough summation of field studies of four American and six European programs. The volume was a joint effort of the information service for the American Psychiatric Association and the Mental Health Association. Onsite field visits yielded case studies of the ten community-based programs. During the Spring and Fall of 1988, I visited three of the American programs and four of the English programs. Those visits with supporting material are described in later sections of this report. They provided current examples of the program.

In addition, I toured facilities or interviewed administrators and inhabitants of Sun City and Leisure World retirement communities. I also learned about the unique way that New College in Sarasota, Florida advertises its program to senior citizens and other population groups. The college places full page program information in the local telephone book. A copy of the information style appears later in this report.

While I was in Toledo, Ohio, at the end of March, I made an in-depth study of the Northwestern Ohio Hospice Association which services Toledo. I interviewed its director of volunteers and talked more briefly with other staff members. Then, I viewed an orientation videotape of the entire program and collected many pieces of literature. One interview and several samples of literature are included in additional sections of this presentation. I also collected material and/or briefly toured the campuses of Purdue University, Indiana University, and Loyola, Chicago.

During the Fall of 1988, I took graduate research units (Gerontology 590) and internship units (Gerontology 591) at the Davis School of Gerontology within the University of Southern California. My research project included background interviews and reading that led to the development of two questionnaires about credit and non-credit courses for senior citizens, the distribution of one questionnaire, the tabulation of results, and a written report describing the project and evaluating the results.

I also participated in an internship at the Cortez Senior Center in West Covina. During the months I spent there, I became acquainted with the seniors, participated in their lunch program, interviewed staff, and developed a descriptive outline of a service plan for future programs for seniors in the City of West Covina. In November, I completed the British travel portion of the sabbatical and reported experiences to the senior center director and to the USC seminar class that was a part of the internship. In May of 1989, I was a visiting lecturer for one session of a class on long-term care of the elderly at California State University, Dominguez Hills. I reported on long-term care of psychiatric cases in England.

A part of the following materials contains examples of the graduate work I completed, as well as some additional library research at the University of Southern California.

Any faculty member at Mt. San Antonio College may review and use the many pictures, slides, and written literature that I have developed

or collected during the sabbatical year. Most of the material relates to mental health and accommodation issues for the elderly.

SUMMARY AND CONCLUSIONS ABOUT TRAVEL EXPERIENCES IN THE UNITED STATES AND IN ENGLAND

As indicated in the descriptive overview earlier in this report, I visited seven programs in England and the United States that had been documented as excellent comprehensive service programs for the elderly in a 1977 report. I was interested in doing follow-up tours and interviews to determine whether the programs had failed, survived, or progressed. In certain parts of the United States, I also looked at other programs serving seniors that were not in the original book. Sun City, Laguna Hills, and the Northwestern Ohio Hospice Association are examples of that type of tour and/or interviewing process.

Some samples from those experiences appear in Appendices A through D. I have a great deal of additional collected material from the facility tours and interviews that I keep in my files. Most of the material in Appendices A through D is my original writing with a few noted exceptions.

Copies of the interview questions that follow were given to selected people in the institutions I toured. In all cases, the interviewees selected a few questions for comment or suggested topics of their own. That same flexibility of commentary was also permitted by the authors of CREATIVE MENTAL HEALTH SERVICE FOR THE ELDERLY.

INTERVIEW QUESTIONS

The sample interview questions are drawn from the features highlighted by the authors of Creative Mental Health Services for the Elderly, on pages 39 to 42 of their book. Those topics formed the core material for their visits and for my observations.

SAMPLE QUESTIONS

A. Describe the processes of casefinding and outreach in your program.

B. Is home assessment part of your program for newly referred clients or patients? If it is, what are the key steps in the progressive process?

C. To what extent has the British concept of Psychogeriatric Assessment Units been continued or established in your program?

D. Is the concept of respite admissions used in your program?

E. What are the major treatment policies and modes in your program?

F. Do you have day programs for your clients? Describe the policies and the activities.

G. What provisions have been made to reduce the transportation problems of the clients in your program?

H. How are applicants for your levels of service reviewed and placed?

I. What specific rehabilitation services are available in your program? e.g., physiotherapy, speech therapy, and assessment of capacity to function.

J. Are religious services or activities provided in some way?

K. "Senility" is often related to sensory deficits, unmet psychosocial needs, and other health problems? In your program, how do you recognize and treat such correlations?

L. Are nursing home accommodations a part of your program? If they are, is the placement based on single or twin occupancy?

M. Is there a problem of inadequate capacity for services and placement? How long are the waiting lists? Can a person be moved from a list for one kind of service to a list for another kind of service without losing his priority for placement?

N. What are the processes for transfer from one component of care to another level of care of more or less intensity?

O. What services or facilities have been hurt or helped by changes in funding?

From my tours and interviews, I have concluded that several service areas for seniors need major expansion in Southern California. Home assessment of the frail elderly as done in the public system in England would be a great advance in sensitive and accurate evaluation of the physical and mental health of seniors. The Douglas Garden Program in Florida (Appendix A) and the Chicago Program of the Council for the Jewish Elderly (Appendix B) did include home assessment under certain circumstances, but in England, home assessment is standard practice and a part of initial case finding and evaluation.

Once a patient has been medically evaluated, day treatment in hospitals and/or day care for the elderly with chronic physical or mental problems can be very important. Again, Douglas Gardens in Florida and the Jewish Council Program in Chicago had many varied day programs. They compared favorably with the public approaches in England. However, most U.S. communities are without such supporting day programs, a condition that would be considered gross neglect in England.

A related service area can be addressed by respite care in day hospitals, gerontological wards of mental hospitals, general hospitals and temporary beds in nursing homes. Further, community based support groups for care-givers can be part of the same comprehension concern for the families of the elderly. Again, model programs of respite and support do exist in the United States, but in England that process is routine. Most U.S. communities do not have even the concept of such programming - a situation often decried in gerontological literature and the lay press. In my opinion, funding constraints, as well as political and medical philosophies with an emphasis on the individualism and the private sector, contribute to such service gaps.

Finally, I want to highlight the funding problems of programs in both the United States and in England. Financial resources were scarce everywhere I travelled. As a result, facilities and programs were compromised. For example, many buildings in England were antiquated even though programs were innovative. Some pictures in Appendix D show 50 to 100 year old structures. In other English programs, the nurses were on strike while we visited because their pay scales were being shifted to a new schedule that was regarded as unfair by the labor organizations. Some dedicated professionals in the English service network indicated that their weekly pay was barely enough to pay for day-to-day necessities. Interestingly, some newer facilities (See Appendix D) were having trouble maintaining or expanding programs because the structures had recently received funding priority.

In the U.S., Douglas Gardens in Florida presented another sort of funding problem. Many of the living arrangements were related to the ability to pay. Therefore, part of the Douglas Gardens program had an elegant, upper middle class ambiance. In the part of the program supported by donations and joint government ventures, there were serious budget problems; still, I must say that the model programs I saw were all wonderful by comparison to what exists in most Southern California communities. It is remarkable that every program that I visited from CREATIVE MENTAL HEALTH SERVICES FOR THE ELDERLY had successfully expanded their services against all odds.

SUMMARY AND CONCLUSIONS RELATED TO COURSE WORK AT THE UNIVERSITY OF SOUTHERN CALIFORNIA

GERONTOLOGY 590, DIRECTED RESEARCH

The focus of my work in Gerontology 590 was on the development of a questionnaire for all California Community Colleges to seek knowledge about noncredit courses for senior citizens. Many state studies have reported gaps in data about California community college courses for older adults, and several gerontologists at the University of Southern California are interested in filling some of that informational void. Dr. David A. Peterson, Director of the Davis School of Gerontology in the Andrus Gerontology Center was my mentor and supervising professor from the University of Southern California.

Following the distribution of the questionnaire regarding noncredit programming for seniors, the high response rate of over 50 percent from California Community Colleges was a sign of high interest in the issues of noncredit offerings for seniors. Appendix E contains the entire research report that I produced as the final paper for Gerontology 590. The results and discussion of the raw data highlighted several related areas of policy that have both educational and political significance.

Most respondents from the community colleges believed that the State Legislature should permit new adult or noncredit programs in community college districts that are not presently served by any providers. Because of the general rural nature of districts without programs, competition between

geographically close urban community colleges is not likely to be a political problem at the state level.

Another policy issue raised by the results of the questionnaire concerns the content categories most frequently represented in programs for seniors. Courses with a recreational or leisure orientation were mentioned at such a high frequency that one wonders if the desires of the active elderly with no social service needs will continue to dominate the curriculum. Money intake in fee-based classes can be seductive determiners of programs for seniors. The discussion section of my research paper points to the challenge of funding more small group classes to meet care-giver's needs and the typical emotional needs of seniors facing frailness in themselves or their family.

Further, the results of the survey indicate a favorable climate for off-campus locations for seniors, a concern about the lack of formal training requirements for instructors of seniors, and strong support for continued state funding of noncredit courses for seniors.

In addition to my primary project, I did preliminary interviews and reading that led to the rough draft of a second questionnaire about credit classes for older adults in California Community Colleges. That work was also reviewed by Dr. Peterson and is presented in Appendix E-3.

GERONTOLOGY 591, FIELD WORK

My field work experience took place at the Cortez Senior Center in the City of West Covina, under the direction of Mrs. Pat Bommarito, Director, and Mr. Gus Salazar, head of the City Human Resources Department. I spoke with seniors throughout the center, ate lunch with them, reviewed city documents, and under supervision, developed an outline for a sample service plan for seniors. I also prepared a description of a citizen review session that could accompany professional service planning by the city staff. Appendix F contains the documents I wrote, as well as the internship plan I developed and the course outline of the Field Practicum Seminars at USC that accompanied the internship.

As a result of my experience, I am convinced that a service plan for seniors should include their situation in the context of the large community. The outline of the service plan in Appendix F, shows my concern about neighborhood support for seniors, respite for family care-givers of the frail elderly, and intergenerational and intercultural activities at the senior center. Further, the service plan stresses direct support for the frail elderly in the form of such services as day care centers, possibly funded by joint ventures of appropriate services groups. In addition, planning for senior education needs to go beyond recreation and leisure to focus on quality of life and survival content. Part of my service plan elaborates on those educational issues.

The final document in Appendix F-4 contains my recommendation and outline for a citizen review session of any service plan for seniors. As a result of my internship and two graduate level public policy courses in gerontology, I have formed the opinion that the interplay between professional city staff work and citizen review must occur early in the planning process. Late review by committee in city governments can be merely cosmetic because the timeline allows no real opportunity for change.

VALUE OF SABBATICAL TO MT. SAN ANTONIO COLLEGE

In addition to the personal renewal from my travel and study, I believe that my sabbatical leave will be of benefit to the college, my department, and my students in the following ways:

1. The travel and formal study gave me new information and first-hand experience about mental health and policy issues related to older adults. That information will be useful in my class presentations and discussions with colleagues.

2. My updated background can enable me to function as a consultant to community service committees that relate to Mt. San Antonio College programs for the elderly.

3. Carter Doran, the former dean of the Humanities and Social Science Division, suggested that I would be able to participate in a helpful way in the discussions of proposals for further development of a program in Human Services at the lower division transfer level.

4. I have collected photographs, slides, and printed materials that relate to mental health and accommodation issues for older adults. These materials will be available for my students and colleagues.

5. Exposure to the institutional styles and culture of Great Britain as well as to the service programs in the Eastern United States has broadened the perspectives I can share with students and faculty.

CONCLUSION:

This sabbatical leave provided me with a variety of enriching experiences related to gerontology, one of my subfield interests within psychology. I am very appreciative of all those who made my opportunity possible. My husband, my colleagues, my administrative supervisors, the Salary and Leaves Committee, and the Mt. San Antonio College Board of Trustees were very supportive, both before and during my sabbatical. I thank them all for their helpful encouragement. I hope to be able to return some of what I have received.

APPENDICES A - G

SAMPLES OF SPECIFIC ACTIVITIES

AND RESEARCH

APPENDIX A

Samples of descriptions from tours, interviews, and program summaries from Florida.

A-1 Sun City, Florida

A-2 Northside Neighborhood Family Service, Miami, Florida

A-3 Legion Park, Douglas Garden's Programs, Miami, Florida

A-4 Copy of 1988 Program of Douglas Gardens, Miami, Florida

MT. SAN ANTONIO COLLEGE

INTRODUCTION TO MATERIALS FROM SUN CITY, FLORIDA

The Chamber of Commerce

On Friday, February 19, Mary Green, the office manager of the Sun City Chamber of Commerce gave her views on some aspects of the social and economic climate of Sun City, Florida. She emphasized the fact that the people were generally financially "comfortable" but she was not willing to elaborate about what that meant. With even more enthusiasm, Ms. Green stressed the high activity level of the residents.

When I tried to focus on Mental Health Services, she countered by saying, "Oh-h-h my, there are no mental health centers in Sun City - only in Ruskin five miles away or in Tampa. These people here just never stop. They are very very active." She continued by saying that she did not think there was even one full time psychiatrist in Sun City, a point confirmed by another Sun City Administrator.

Finally, Ms. Green recommended that I interview Mr. William Niehoff, the executive director of Sun City Center, Lake Towers. The Towers, now run by a "for profit" limited partnership, embraces the concept of life care. The center contains a 120 bed nursing home, an assisted care program of 20 beds, and the independent living apartments. Mrs. Green felt that Mr. Niehoff had a "good feel" for the larger community as well as his own facility.

Interview with Mr. William Niehoff, Executive Director of Lake Towers, the life care concept in retirement living. (2-23-88)

After giving a description of the services, the physical facility and the history of Lake Towers, Mr. Niehoff reviewed some of the twenty-two most commonly asked questions, items that are reproduced at the end of this summary. In between that introduction and the tour of the facility, Mr. Niehoff spoke off the record about some unique social and economic issues related to Sun City Center and the Lake Towers. Some highlights of this discussion are described below in the paragraphs that follow.

Mr. Niehoff pointed out that the original group of residents in Sun City, Florda were people retiring from positions of vocational and social leadership in their original communities. "They were used to being chiefs not Indians". As a result, the group has been too proud to seek help unless absolutely necessary. Therefore, such service needs as day care, assisted living and respite care are defensively denied. Alzheimer's disease is typically kept quiet as long as possible. Mr. Niehoff said the psychiatrist who was available for a time left because there was not enough use of her services.

Now the original residents are becoming older and, therefore, more frail physically and mentally. The new group of retired residents are much younger than the aging original group. That creates a situation of competing needs. Economically the community has changed as well. The group at Kings point in the condominiums is considered to be of lower educational and financial standing adding to some conflicts and inappropriate social discrimination. Ninety-five percent of the Lake Tower life care residents are people who were originally in the condominiums and individual homes. Even the volunteer ambulance service is having trouble finding volunteers who are strong enough to work with the system and willing enough to give up their recreation in the pursuit of community service.

A more hopeful situation has developed recently. A volunteer service organization began a very popular charity ball that provides money for a wide group of new services. The helping hand division does everything from getting groceries to driving people to doctor's appointments. There is also a fledging sitting service to relieve the primary caretaker. According to Mr. Niehoff, the volunteer group represents a major step forward in community spirit and cooperation.

MT. SAN ANTONIO COLLEGE

Interviews Related to Northside Neighborhood Family Services, Miami, Florida

Number 1: Interview on February 24, 1988 with James Sussex M.D. in the psychiatry department of the University of Miami Medical School.

Introduction: On February 24, 1988, the first in my series of Miami interviews took place with Dr. James Sussex, formerly head of the department of psychiatry at the University of Miami School of Medicine and director of the mental health services at Jackson Memorial Hospital. He is currently in the child psychiatry area of the University of Miami School of Medicine which is where I interviewed him in his office at 9 a.m.

From my visit with Dr. Sussex, I was able to form a historical impression of his involvement in the Health Ecology Project and of the initial development of the neighborhood family concept under Hilda Ross. His orientation helped me build a perspective for considering some current issues and problems in mental health, outreach services for the elderly in the Miami area. Much of what Dr. Sussex said brought to life and gave personal meaning to the information in the August, 1975 issue of Psychiatric Annals and to the Northside Neighborhood Family Services chapter in Creative Mental Health Services for the Elderly.

In addition, Dr. Sussex gave me enough background about Dr. Evelina Bestman's work as direction of the New Horizons Program that I was easily able to establish contact with that center. His warm and encouraging response to my project was a wonderful beginning for the visits of mental health service programs for the elderly in the Miami area.

Information and Historical Background of Northside Neighborhood Family Services

Originally Northside Neighborhood Family Services Inc. served a problem-ridden area of Miami that was about ten square blocks of decaying trailer camps. There were modest private homes on same streets and a large but declining shopping center. About 300 people, sixty or more years-of-age lived in one of the 1,100 housing units. A bit more than half of the housing units were trailers. In all 2,500 people lived in the target area.

The program at Northside was conceived by Hilda Ross, whose background included a graduate degree in human relations and community studies. At the time, she was serving as the head of the gerontological unit of the mental health center, one of a group of community based programs conceived by Jackson Memorial Hospital's Community Mental Health Services. Ross was determined to create a "surrogate family" model for a group of poor elderly people who could be considered a high-risk group for emotional disorder.

The neighborhood concept as Hilda Ross perceived it required every member's participation in defining their individual and collective needs. Then to help develop and maintain dynamic programs, a high level of client involvement was continually fostered. The neighborhood was viewed as a family unit.

Information and Historical Background of Northside Neighborhood Family Services
(continued)

It soon became apparent that the family concept needed a building that could serve as the core for the services and programs. The management of the fore-mentioned shopping center, though beleagured by the very high crime rate in the area, took some interest in what Hilda Ross intended to do and offered a run-down, unused warehouse free of charge. The operation of the few basic utilities that were present was also included at no charge. Initially there was no running water or air-conditioning.

With that inauspicious beginning, Hilda Ross and the few intial clients developed a basic but pleasant environment to serve as the heart for their programs. By the end of the first year, 260 different clients had been contacted by 643 units of service. Before the end of the second year, Northside Neighborhood Services were visited by the team that included it as a model program book, Creative Mental Health Services for the Elderly.

It is important to note that the unique self help program of Northside Neighborhood Family Services did not develop in a social service vaccuum. Although it was developed on the culturally significant variable of age, the services were also an integral part of the community mental health programs of Jackson Memorial Hospital. Early in 1974, the mental health center which reached out to Miami's problem ridden mental health catchment area number 4, began receiving federal support. There was a general infusion of interest in that Northside area extending beyond the median of the 79th street area.

Even before federal funding was in place, the department of psychiatry at the University of Miami school of Medicine and the Jackson Memorial Community Mental Health Services were focused on delineating and meeting the needs of its service area in the troubled inner city with its changing demographic situation. In response to the changes, the department of psychiatry had already begun what it called a Health Ecology Poject.

The project was directed toward discovering what the five major ethnic groups in the inner city of Miami thought about health related issues. Both beliefs and behaviors were studied with the intent to develop "culturally specific" spots of service that would radiate to the areas of highest concentration of Bahamians, Cubans, Haitians, native-born Americans and Puerto Ricans.

In fact, by August 1975, the whole issue of Psychiatric Annals was devoted to the work of Jackson Memorial Community Mental Health Service with a time perspective both before and after the inoption of federal funding. Dr. James Sussex was a major contributor to the August issue and a key figure in the research and program development described in the journal. As head of the department of psychiatry of the University of Miami School of Medicine and as director of the mental health services at Jackson Memorial, Dr. Sussex was very involved in the Health Ecology Project and in later developments of servicing, staffing and monitoring funding transitions for programs in the inner city.

APPENDIX A-3

Tour and Interview, Legion Park, 2/25/88, (Part of the Jewish Home and Hospital for the Aged, Douglas Garden Program, Florida)

In 1975, a day center was started at Legion Park for lonely old people who otherwise might have been at increased risk of being placed in an institution. The facility and the adjacent park was owned by the City of Miami. The building was made available by the city without charge, and the program was financed entirely by revenue-sharing funds also made available by the City of Miami.

Legion Park was still operating in 1988 with an activities and program schedule somewhat similar to the original one. The large windows still provided a pleasant view of Biscayne Bay. The American Legion building remained on the south; but on the north side, there was an increase of high rise construction. Inside, the rooms for activities were being used for the Thursday schedule. The activity schedule for the day was posted in several places as part of the plan for the entire week. The schedule included dancercise, 9:30-11:00 AM, Ceramics, 11-5 PM, Art Class, 1-5 PM, Dance 1:30-4:30 PM.

During our visit, ceramic crafts were underway in one room, and a discussion circle was in progress in the corner of a large open room. Four people on the edges of the room were engaged in quiet conversation, and two other people stared out into the center of the room. During the observer's stay in that room, a woman with a disabled right arm and a man in a walker traversed the floor. They represented the continued practice of encouraging the participation of individuals with definite, but manageable disability.

Three of the residents agreed to brief interviews and to having their pictures taken. The men, wearing badges from the center, identified themselves as Roscoe, 78, originally from Georgia, where he said he had a daughter, and Ralph, 76, who came from New York in the 1950's and who found employment in Florida. Dan, who is almost 90, said he came from Chicago four years ago. He spoke of a daughter still in that city. Ralph said he had no family, but that the center was like his family. The man had varied housing. One lived in a nursing home, one in a private apartment, and another in a housing project apartment. All expressed happiness about being able to be a regular part of the Legion Park Program. One man said he came every day, Monday through Friday, for ceramics, friends, and a meal.

APPENDIX A - 4

MT. SAN ANTONIO COLLEGE

SUMMARY OF 1988 PROGRAM OF DOUGLAS GARDENS, MIAMI, FLORIDA

LONG-TERM CARE FACILITY AT DOUGLAS GARDENS
151 NE 52 St., Miami
751-8626

Services and Evaluation
454 licensed nursing home bed of which 40 beds are certified by Medicare for skilled rehabilitation in the Toppel Center. In addition, a 32-bed geriatric specialty hospital is located on the second floor of the Chernin Building. Besides providing acute care, the Olson Hospital serves as an evaluation unit for new long-term care admissions. Licensed by Medicare and Medicaid, both the nursing home and hospital have received three year accreditation from the Joint Commission on Hospital Accreditation.

Demographics
All residents are age 65 or older. 70% Female; 30% Male

Over 65% of the population is medically indigent receiving medicaid. Average age is 87; average length of stay is 3.25 years.

Eligibility Criteria
Residents must be 65 years or older and a resident of Dade or South Broward Counties for 18 of the last 24 months.

Cost/Charges
Nursing home: Private rate is $109.47 per day and semi-private room rate is $88.76 per day. Rates include all services except medications. Medicare provides reimbursement for rehabilitative nursing. For the medically indigent, Medicaid is the sole source of payment for all services.

Toppel Center: $120 per day plus charges incurred for medication, therapies and other anciliary services.

Hospital: Covered through the Medicare Prospective Payment System (DRG) wherein there is a pre-established payment for a particular medical diagnosis. Accepted as payment in full.

Funding Source
Total annual budget is $18,925,790. Sources of funding include Medicare, Medicaid and private-pay. The Greater Miami Jewish Federation and United Way provide funds which offset some of the deficit not covered in operative revenue. The MJHHA Thrift Shops and South Broward Federation also assist in providing operating funds.

Highlights
MJHHA offers a superior quality of life through activities, rehabilitation and restorative nursing.

Because of increase population of Alzheimer's sufferers need expanded programs for this specialized segment, including respite, day treatment and ambulatory assessment.

SHORT-TERM EMERGENCY MANAGEMENT SYSTEMS (STEMS)
4500 Biscayne Boulevard, Miami
576-9020

Services and Evaluation
Crisis intervention (other than a life-threatening medical emergency). Case manager quickly assesses an individual's needs and works through other provider agencies to get immediate help to the individual or family.

Emergency assistance will be provided for as long as three weeks and can include: homemaker services, meals, medical intervention, minor physical adaptation, personal care, respite and transportaiton.

900 clients will be served during the period of the grant.

National evaluation of project to be conducted by Northwestern University will commence February 1988.

Demographics
29.4% age 65-74; 45.0% age 75-84; 25.4% age 85 +

37.2% Male; 62.7% Female

43.1% Live w/others; 56.8% Live alone

4.5% Hispanic; 13.0% Black; 82.3% White/Other

Eligibility Criteria
65 years of age and older in the North Dade/North Hialeah area who are experiencing a crisis such as:
Hospital, emergency room discharge with little or no formal/informal support services.

Illness, accident or death of a primary caregiver.

Incident of neglect, abuse or exploitation.

Cost/Charges
Case manager can expend $325 over three weeks to stabilize client's need. Clients are financially screened to participate in defraying cost of care. No one denied services due to inability to pay.

Funding Source
Project funded through September 1989 by a $350,000 grant from the Arthur Vining Davis Foundations.

Highlights
A key ingredient to the success of the STEMS Project is the collaborationmanifested through the in-kind contribution of forty case managers from our seven affiliate agencies: Catholic Community Services, Channeling Project/MJHHA, Hospice, Jewish Family Services, North Miami Foundation, North West Dade Community Mental Health Center and United Community Care. This relationship has relieved STEMS of the high cost of hiring skilled case managers.

A stress on the system is that many of the agencies that STEMS refers to service the long-term needs of such a client population have been racked by budgetary cutbacks.

IRVING CYPEN TOWER
5100 NE 2nd Avenue, Miami
756-8583

Services and Evaluation
Licensed Adult Congregate Living Facility. Eight story, 102-unit apartment complex: 48 studios and 54 one-bedrooms.

Safety and medical features. Activities, entertainment and educational events.

Fully electric kitchen in each apartment.

Kosher dinner furnished 7 days a week.

Housekeeping weekly.

Scheduled transporation.

Convenience store.

Demographics
111 Tenants currently living in Irving Cypen Tower. Average age 85.5.

75% Female; 25% Male

Eligibility Criteria
Applicant must be 65 or older and a resident of Dade or South Broward for the past three years. Able to function independently. A preadmission physical examination by Douglas Gardens Ambulatory Health Center is required.

Cost/Charges
Range per month:

Studio: $787 - $812
One bedroom: $924-$948.

(Extra person in apartment: +$229.)

Includes complete service package. Utilities are extra.

Funding Source
Annual budget of $1,127,140 with revenue derived from rent paid by tenants.

Highlights
Develop supportive peer relations and encourage independence in all activities of daily living.

GORDON AMBULATORY HEALTH CENTER AT DOUGLAS GARDENS
151 NE 52 St., Miami
751-8628

Services and Evaluation
Provides an array of medical clinics, lab, EKG, x-ray testing, annual physical exams and telephone contact. Services are delivered by physicians and nurse practitioners. Open 9 am to 5 pm., Monday through Friday. Service is provided by appointment only.

Demographics
Serves residents of long-term care facility, participants on Douglas Gardens community programs, tenants of Irving Cypen Tower and outpatients from other sources in the community. All patients are 65 or older. The majority are female, low-to-middle income who live alone in hotel-type settings.

Eligibility Criteria
65 years of age or older, residents of Dade or South Broward counties. If transportation is required, patients must live within Douglas Gardens transportation catchment area. Patients must have Medicare Part A and B.

Cost/Charges
Medicare and if applicable, co-insurance are accepted as payment in full.

Funding Source
Total annual budget is $287,480. Sources of funding are Medicare and other health insurances. The Greater Miami Jewish Federation and United Way provide funds which offset the deficit, as does the Douglas Gardens Thrift Shops.

Highlights
Clinic is geared exclusively to geriatric population.

Need to develop Social HMO concept of managed care.

CHANNELING
4500 Biscayne Boulevard, Miami
576-9010

Services and Evaluation
Comprehensive initial assessment by CARES (nursing home preadmission screening).

Six month assessments by Channeling staff.

Ongoing case management.

Direct services include: homemarker/personal care; skilled nursing; physical, speech and occupational therapies; nutritional and drug assessment, consumable medical supplies, adaptive equipment, meals, mental health services, respite, caregiver training and support; coordination of other care including physician, Medicare, etc.

Demographics
70% Hispanic; 27% White; 13% Black American

80% are aged 75 or over. 50% live alone or with impaired spouse.

28% Male; 72% Female

Eligibility Criteria
Aged 65 and over.

Resident of Dade County.

Must meet Florida's nursing home eligibility (level of care).

Financial eligibility includes monthly individual income below $881 and total assets less than $3,300.

Unmet need for two or more services.

Cost/Charges
No cost for Supplemental Security Income (SSI) recipients.

Client responsibility payment may be required (will be determined by Dept. of Health and Rehabilitative Services).

Funding Source
2176 Medicaid waivers for home and community-based services through Medicaid office, Fla. Dept. of Health and Rehabilitative Services.

Daily capitated rate received for each client.

1986-87 budget: $3.5 million.

Highlights
Currently maintains active caseload of 550 frail elderly at home rather than in institutional setting.

Financial savings to state and enhanced quality of life for clients.

Emotional and service support provided to informal caregivers.

DOUGLAS GARDENS COMMUNITY MENTAL HEALTH CENTER
1007 Lincoln Road, Miami Beach
531-5341

Services and Evaluation
Provides a range of mental health services to consumers, including: psychiatric and psychological testing and evaluations; psychiatric medication management; screening; individual and group therapy; case management; day treatment.

Demographics
2,300 clients served.

56% White/nonhispanic; 35% Hispanic; 7% Black; 2% Other

40% Male; 60% Female

80% Below poverty level

38% Over age 55

Eligibility Criteria
For individuals under 55, must be residents of Greater Miami Beach. For individuals over 55, country-wide.

Requires a mental health service.

Cost/Charges
Operates on a sliding fee schedule with a minimum contract fee of $5.00. Accepts Medicaid, Medicare and other third party insurance.

Funding Source
Overall budget of $1.8 million with the majority of support (65%) from the State of Florida via a service contract. The remainder of the budget is supported by a combination of patient fees (14%), local support (6%) and in-kind contributions (15%).

Highlights
Currently looking for larger physical space.

Development of a broader funding bases is needed.

Program needs are: a 24-hour-a-day, 7 days a week, face to face receiving capacity; children's mental health services: residential care for adult clients.

DOUGLAS GARDENS/CITY OF MIAMI SENIOR ADULT DAY HEALTH CENTER AT LEGION PARK
6447 NE 7 Ave., Miami
754-1777

Services and Evaluation
Licensed as an Adult Day Health Center, Legion Park provides: speech and hearing thearpy; health assessment and monitoring; arts and crafts; music and movement therapy; current events; hot meal and 2 snacks; transportation.

Other services are available through referral agreements.

Demographics
63 participants registered at the Legion Park program with an average daily census of 40. The participants are primarily low income, 60% white non-hispanic, 25% black, and 15% hispanic. The Center is primarily female (70%) with an average of 77 years.

Eligibility Criteria
Must be 60 years of age and have a medical certificate showing a need for adult day health services. If outside the City of Miami, must be either medicaid eligible or pay the full cost of services.

Cost/Charges
Sliding fee schedule for residents of the City of Miami; $20 for non-residents. Medicaid is accepted.

Funding Source
Budget of $248,000. Funded by the City of Miami (13%), with Medicaid fees through the State of Florida (40%) and direct payment from participants (20%).

Highlights
A broader funding base is needed.

ALZHEIMER'S CARE LINE
576-5533

Services and Evaluation
Information and referral.

Telephone counseling.

Linkage to MJHHA programs and other community service programs specializing in Alzheimer's Disease.

Demographics
Not applicable.

Eligibility Criteria
Individuals interested in information on Alzheimer's Disease.

Cost/Charges
No charge.

Funding Source
Self-funded through MJHHA information and referral network.

Highlights
Reassurance to caregivers that assistance may be available to them.

Dispersion of factual information about Alzheimer's Disease and related disorders.

LEO GELVAN AND FAMILY COMMUNITY CARE ADULT DAY HEALTH CENTER
AT DOUGLAS GARDENS
151 NE 52 St., Miami
754-1996

Services and Evaluation
A licensed Adult Day Health Center, the Center provides: speech and hearing therapy; health assessment and monitoring; arts and crafts; music and movement therapy; current events; hot meals and 2 snacks; transportation.

Other services are available through referral agreements.

Demographics
171 clients served, 50% of whom are 75 or older.

Eligibility Criteria
Must be 60 years of age or older, certified medically in need, and a resident of the Miami Beach area. All clients admitted as Community Care for the Elderly clients (basically fee-free clients) need to be certified as appropriate by the CCE lead agency.

Cost/Charges
For all CCE clients the lead agency performs a financial assessment and assigns and collects a fee. Clients are asked to make a voluntary contribution to cover some non-grant costs. For non-CCE clients, there is a $25 fee.

Funding Source
Annual budget for the 1987-88 fiscal year of $269,765. The budget is primarily supported by a Community Care for the Elderly grant, a State of Florida Program administered by United Community Care, which represents 83% of the budget. Fees for service represent 7% with the remaining 10% being an in-kind contribution.

Highlights
Enlarged space and more appropriate physical plant will be realized with relocation to Schaefer Hall in the summer of 1988.

Additional revenue sources for expansion of program are needed.

HOME-ADVANTAGE
4300 Alton Road, Miami Beach
674-2111

Services and Evaluation
Multicorporate home care entity jointly owned by Mount Sinai Medical Center and MJHHA.

Services include: nursing care, home health aides, therapies (speech, occupations, physical); medical social work; homemakers; companions; Alzheimer's respite care; infant and child care; medical supplies; ostomy care; diabetic teaching, referral assistance; durable medical equipment; infusion therapies (antibiotics, parenternal/enteral nutrition, pain management, hydration therapy, chemotherapy).

Demographics
More than 1,200 clients served in first year.

Most clients live on Miami Beach, City of Miami or North Dade County.

97% of all clients are over age 65; average age is 84.

50% of total caseload is Medicare.

35% Male; 65% Female

6% Black; 30% Hispanic, 68% White/Other

Eligibility Criteria
No age limit.

Medicare/Medicaid services in Dade County only.

Private Pay and insurance coverage provided in Dade and South Broward.

Channeling clients are eligible.

Cost/Charges
Variable depending on service(s) provided.

No current provision for sliding fee scale.

Funding Source
Medicare; Medicaid; Private pay insurance

Annual budget: $1.6 million.

Highlights
Has already established reputation as provider of high quality services.

Large pool of trained, certified nursing assistants.

Unable to provide indigent care until agency becomes profitable.

Nursing shortage in South Florida impacts ability to find and retain qualified R.N. staff.

SOPHIA AND NATHAN GUMENICK ALZHEIMER'S RESPITE CENTER
1733 NE 162 Street, No. Miami Beach
940-3510

Services and Evaluation
Provides day respite services 5 days a week, 7 hours a day. Includes: activities, music, art, relaxation, recreation, hot lunch and 2 snacks.

Transportation is available within a limited geographic area.

Demographics
Currently serves 20 clients a day with a total of 30 participants registered in the program.

Participants are predominently white non-hispanic older adults evenly split between males and females.

Eligibility Criteria
A diagnosis of Alzheimer's Disease (or related disorder).

Can benefit from and participate in a respite program.

Has a caregiver at home.

Cost/Charges
$25 a day ($20 a day without transportation).

Funding Source
Supported by a grant from the State of Florida (20%), fees for Service (36%), Greater Miami Jewish Federation/United Way (18%) and gifts and donations (26%). Total budget for the program is $282,000 for the current fiscal year.

Highlights
Need to increase the licensed capacity of the program from 20 to 25 participants a day.

Need to develop additional respite centers.

GERIATRIC RESIDENTIAL TREATMENT SYSTEM (GRIS)
1700 NE 21 Ave., No. Miami Beach
945-5340

Miami Beach Residence - 7100 Rue Granville - 864-7748

North Miami Residence - 13390 NE 6th Ave. - 940-3510

Skills Learning Center - 1733 NE 162 St., North Miami Beach - 940-4510

Case Management Services - 1733 NE 162 St., North Miami Beach - 940-3510

Services and Evaluation
Organized as a continum of residential services supported by case management and day treatment. The residential services are as follows:

Miami Beach Residence - RTF I - 14 beds.

North Miami Beach Residence - RTF II - 40 beds.

North Miami Residence RTF V - 18 beds.

Demographics
40 clients currently enrolled in program, all over the age of 55 with an average age of 67.

60% Female; 40% Male

Eligibility Criteria
Must be over the age of 55 with a history of chronic debilitating mental illness and at high risk for long-term inpatient care.

Participation in the program is voluntary and clients are expected to move toward independent living.

Cost/Charges
Sliding fee schedule with a minimum cost per resident equal to the state support "Optional State Supplement" for indigent clients (currently $550 a month).

Funding Source
Total budget of $1,855,717 for the current fiscal year. The budget is primarily supported by a contract with the State of Florida (86% of total cost) with the balance coming from patient fees.

Highlights
Broaden the funding bases of the program.

Develop additional housing capacity for organically impaired residents and an apartment/ACLF capacity for clients completing the program but unable to live independently.

SGI TRAINING AND EDUCATION
4500 Biscayne Blvd., Miami
576-9021

Services and Evaluation
Inservice - Inservice workshops presented for the growth and enrichment of all staff, thereby enhancing the quality of care and delivery of service.

Professional Workshops - Principle provider of educational programs throughout the State of Florida. From 25 to 40 workshops offered per year, averaging 38 participants per workshop.

International Conference: Alliance for Care - Held every two years to promote exchange of ideas and new models of care among different professions and cultures.

Demographics
Inservice - 850 employees of MJHHA.

Professional Workshops - Approximately 1,000 professionals in geriatrics and health care each year.

International Conference: Alliance for Care - Cross-section of local, national and international providers of geriatric care, researchers and educators.

Eligibility Critieria
Inservice - Voluntary and open to all employees.

Professional Workshops - Open to all interested professionals in the health care field.

International Conference: Alliance for Care - Open

Cost/Charges
Inservice - No cost

Professional Workshops - Varies per workshop.

International Conference: Alliance for Care - Varies per conference.

Funding Source
Inservice - Pro-rated salary of MJHHA staff.

Professional Workshops - Self-supporting, meets all direct, indirect and overhead expenses.

International Conference: Alliance for Care - Self-supporting, meets all direct, indirect and overhead expenses.

Highlights
Inservice - Develops internal capacity to implement new programs and to document them for wider dissedmination.

Professional Workshops - Enhances MJHHA's reputation as a leader in education.

International Conference: Alliance for Care - Leads to new business opportunities and working relationships with institutions and organizations throughout the world.

SGI RESEARCH
4500 Biscayne Blvd., Miami
576-9021

Task Based Assessment for Functional Ability in the Aged

Services and Evaluation
This study is designed to develop and test a measurement system for everyday living tasks. These measurements will include those physical movements made while performing everyday tasks. Examples would be lifting and carrying weights similar to pots, pans or laundry; unlocking locks; opening doors of various weights, etc. The measurments or movements to be incorporated in this system will be chosen from videotape data collected in previous "human factors" studies.

Demographics
A total of 200 individuals over the age of 60 will participate in this research. Of this group, 50 will be independent in the community and 150 persons will be solicited from the following groups: persons living in the community receiving supportive services; samples of congregate housing residents; ambulatory nursing home settings.

Eligibility Criteria
Subjects will be required to be over 60 years of age and have no major physical or mental health problems. Participation is voluntary and signed informed consent forms will be obtained from each participant.

Cost/Charges
The total direct cost of the three-year period requested on this continuation grant proposal are $539,159.

Funding Source
The continuation proporsal is under review at the National Institute of Aging of the National Institute of Health. This institute was the funding source for the first two grants in human factors research. This study is part of the ongoing human factors research conducted by SGI for the past 6 years.

Highlights
The overall goal of the study is to: identify the demands the environment makes on older persons in the process of completing daily activities; develop a valid reliable and realistic way of measuring whether or not any given individual can meet these demands and thus continue to live independently in the home.

SGI RESEARCH
4500 Biscayne Blvd., Miami
576-9021

Technology Center for Independent Living

Services and Evaluation
A full-scale exhibit of a typical living environment equipped with a broad range of assistive products will serve as a resource and education center on technology for the elderly.

An occupational therapist will work in a team arrangement with a social worker. The therapist will evaluate the functional ability of the individual, recommend appropriate assistive products and devices as well as assist in training individuals in the use of these products.

Demographics
Service component of this program under development. Prospective clients will be older persons in Dade and Broward Counties served by MJHHA.

Eligibility Criteria
Intial clients will be eligible for Channeling services.

Services will be available to any other person with limitations in the physical, sensory or cognitive areas which might make independent functioning difficult.

Cost/Charges
A flat fee schedule will be charged to business clients providing services to the elderly. Direct service to older persons will be provided on a sliding scale based on ability to pay.

Funding Source
Consultation fees, research and education grants, philanthropic gifts.

Highlights
Nationally identified need for a program of this nature. First of its kind.

SGI RESEARCH
4500 Biscayne Blvd., Miami
576-9021

Computer Aided Communication of the Elderly

Services and Evaluation
Participants will take part in two phases of research. In Phase I participants will come to the research lab and use computers to perform several tasks. Information regarding their perceptions of using the computers and suggestions for changes will be solicited. This information will be used to design the computer system used in Phase II. In Phase II, particpants will be asked to name two or three other persons who would be willing to communicate with them electronically. All participants will have computers placed in their homes and will be trained to use the system. They will be asked to use a message system to communicate with one another for a period of several months. Peformance recorded and analyzed.

Demographics
An initial group of 12 people over the age of 50 residing in the community will participate in Phase I of the study. These persons along with two or three of their friends will participate in Phase II.

Eligibility Criteria
Participants in this research will be women over the age of 50 who live in the community and are unfamiliar with the operation of computers. Participation is voluntary. Signed informed consent form from each person is required.

Cost/Charges
The total amount funded for this grant is $305,185.

Funding Source
This study is funded by the Markle Foundation and was awarded to the Stein Gerontological Institute in cooperation with Bell Communication Research (Bellcore).

Highlights
This grant has just recently been awarded and research has not yet begun. The overall aim of the research is to identify problems older people have with current computing systems and to develop design alternatives which mitigate these problems. Results will provide information regarding optimal design of computers and computer-based communication services for older adults.

APPENDIX B

Samples of descriptions and pictures from tours and interviews from the Midwest.

B-1 Weinfeld Residence, Evanston, IL

B-2 Northwest Ohio Hospice Association

APPENDIX B - 1

Interview with Rhoen Hoffman-Hammquist
Facility Coordinator of Weinfeld Residence
135 Callan, Evanston, Phone #570-7000

Group living at the Charles Weinfeld residence is a residence program sponsored by the Council for the Jewish Elderly in Chicago, Illinois. The facility houses twelve older adults in a family-like setting. Each person has a private bedroom but shares a bath with one other resident. The common areas include sitting rooms, the dining room, a crafts and activities area and laundry facilities.

Mrs. Hoffman-Hammquist gave us a tour of the entire facility. She allowed us to see a typical bedroom and encouraged us to talk with several residents. She indicated that the common support system is a major strength of the residence and emphasized that each resident had major tasks related to personal and group maintenance. The residents said that they liked the family feeling and enjoyed contributing some effort to keeping the system going. For example, even though Kosher food is prepared by a cook, the residents aid in some of the tasks related to dining.

Interview with Barbara Eikost, Volunteer Coordinator for Northwest Ohio Hospice Association
March 28, 1989

In August 1987, Mrs. Barbara Eikost told a reporter from the TOLEDO BLADE, "I am not interested as much with the quality of the volunteer's experience as I am [with the quality of experience for] the patient." Those thoughts permeated much of the interview and tone of the Toledo-based hospice headquarters with Mrs. Eikost.

The Northwest Ohio Hospice Association is the area's first comprehensive hospice program and continues to be the only Medicare-certified hospice in the area. It has served the people in the Toledo area since 1981.

The philosophy of hospice, embraced by Mrs. Eikost and stated in the literature of NOHA, sees hospice as an option in the medical care system that exists not to postpone death, but rather, to help the patient and family live as fully as possible. The approach of death is not denied, but there is an affirmation of life and a living of life until death comes. Special skills and therapies emphasize comfort, pain control, and the support of the patient and family in the home environment.

Mrs. Eikost emphasized that NOHA screens people interested in volunteering for hospice. They are interviewed both before and after attending 20 to 24 hours of classroom training. The training includes communication skills, information about illness and death, and careful work with the potential volunteer's perceptions of illness and death.

Mrs. Eikost's fifty volunteers range in age from the mid-20's to 80, and their life experiences are quite varied. Volunteers choose either bereavement work or direct care work, or both after they have finished their own training period.

Bereavement work consists of a series of phone calls to the immediate survivor or caretaker. The calls are made at predetermined intervals during the first 13 months after the death of a hospice patient.

There may also be a personal visit. During those conversations, the client sometimes gives an emotional account of the events leading to the loved one's death. Further talk usually consists of the positive memories as well. When a volunteer believes there is more than uncomplicated bereavement, he or she can refer the client to a social worker on the hospice staff. For former hospice clients who want additional support while they slowly withdraw from the hospice experience, NOHA offers a monthly discussion group during the noon hour.

The hospice team is made up of nurses, physicians, psychologists, clergy, social workers, dietitians, pharmacists, physical and occupational therapists, as well as the unpaid volunteers. The group tries to address the individual needs of a patient and his or her caretakers and

loved ones. The hospice team helps the family cope with daily frustrations, a range of emotions, and the hello's and good-bye's that must be said. Aiding that "coming to terms with death," are hospice nurses who are on call 24 hours per day. Part of their role includes teaching skills to encourage independence at home. For example, they teach caregivers and patients how to give medication to relieve pain.

Direct care volunteers may provide emotional and physical comfort. They may also do other tasks that the nurses identify with the family. Those tasks might include picking up groceries or prescriptions, baby-sitting with young children, and short-hour patient respite care. The volunteer's role is to help but not directly grieve with the family. Nevertheless, volunteers are profoundly affected by their work.

"Burn-out" is kept to a minimum by several factors that mitigate stress. Being appreciated, fully utilized, and significantly contributing counters "Burn-out." Sharing feelings with other team members on a regular basis also relieves stress. All effort is directed to keep hospice team members on the track of focusing first and foremost on the patient and the patient's family. Integral involvement and/or fleeting glimpses between tasks may meet the needs. In one way or another, Mrs. Eikost lets one know that the hospice team members are sharing their strength.

APPENDIX C

C-1 Description of the Wellington Congregate Care Facility, Laguna Hills, California

C-2 Pictures of banking, travel, and transportation services for the Wellington, Laguna Hills, California

C-3 Pictures of the Wellness Center and Message Center for the Wellington, Laguna Hills, California

THE WELLINGTON, LAGUNA HILLS

The Wellington, a Laguna Hills congregate care retirement community, is an example of one type of facility that is available to ambulatory seniors, over 55 years old. Situated across the street from one of the Leisure World entries, it offers an additional choice of accommodation for people who want to be in an area that emphasizes an active upper-middle class life style for older adults.

The complex has five different floor plans that range in size from an alcove/studio to a two bedroom unit with a den. Each unit has a full service kitchen with built in appliances, a washer and dryer, and a small veranda. The rents, which range from $1,600 to $2,800 per month, include two meals per day, scheduled transportation, weekly housekeeping services, and an activity program. Within the development are such unique amenities as a small banking office, a travel bureau, and a hair styling center.

One of the most unique features at the Wellington is a Wellness Program, a health program founded on the concept of prevention. The director of the program is Judy Higbee, a registered nurse, who oversees free quarterly health assessment, as well as resident education. Cardiac status, respiratory functions, and skeletal structure are assessed four times a year and one-to-one help is available for organizing nutrition, use of medication, and exercise programs.

At the cost of over $30 million, the Wellington was developed as a joint venture partnership between Aetna Life and Casualty Insurance Company and Birtcher, a major developer.

Menu

The Wellington

	Monday	Tuesday	Wednesday
LUNCH			
SALAD	Herring in Cream Sauce	Spanish Rice Salad	Sweet & Sour Shrimp Salad
SOUP	Split Pea	Italian Vegetable	Cream of Celery
ENTREES	Brie Cheese Plate Chicken Fajita Pita Liver and Onions	Italian Salad Egg Salad Sandwich Beef Ravioli	Taco Salad Submarine Chicken Drummies
STARCH	Rice Florentine Colbert Potatoes Cottage Fries	Rice Pilaf Risotto Twice Baked Potato Chips	Steamed Rice Oven Roasted Potatoes French Fries
VEGETABLE	Peas Francaise Steamed Corn	Squash Provencal Steamed Cauliflower	Capri Mix Harvard Beets
DESSERT	Boston Cream Pie Sugar Cookies	Coffee Cake Pistachio Pudding	Angelfood Cake with Pineapple Top Chocolate Eclair
DINNER			
SALAD	Herring in Cream Sauce	Spanich Rice Salad	Sweet & Sour Shrimp Salad
SOUP	Split Pea	Italian Vegetable	Cream of Celery
ENTREES	Fried Shrimp Filet Mignon Medallions of Pork	Roast Beef Au Jus Shrimp Scampi Curry Chicken	Broiled Lamb Lasagne Polynesian Mahi Mahi
STARCH	Rice Florentine Colbert Potatoes Baked Potato	Rice Pilaf Risotto Twice Baked Potato Baked Potato	Steamed Rice Oven Roasted Potatoes Baked Potato
VEGETABLE	Sauteed Mushrooms Broiled Tomato Crown	Coin Carrots Romano Green Beans	Baked Eggplant Steamed Broccoli
DESSERT	Orange Cake Vanilla Cream Horn	Chocolate Wipe Out Cake Peach Pie	Chocolate Raspberry Cheesecake Apple Cobbler

APPENDIX C - 2

Interior views of the Wellington Congregate Care facility, Laguna Hills, California.

APPENDIX D

Samples of descriptions and pictures from tours, interviews, and program summaries from England.

D-1 - Goodmayes Hospital, London

D-2 - Stroud, Gloucestershire, England

D-3 - West Cornwall, England

D-4 - Southampton, England

Goodmayes Hospital, London

Goodmayes Hospital, an antiquated red-brick psychiatric hospital is situated in Ilford in outer East London, an area about 12 miles from the center of London. The hospital serves two of the Greater London boroughs. The hospital is famous for the pioneering work of Dr. Tom Arie, the psychiatrist who came to Goodmayes in 1969 with the mission of creating an active treatment service for older people.

His "series of assumptions" are still the principles underlying care at Goodmayes and are outlined below:

- AVAILABILITY - The service must be readily available to patients, their families, doctors, and social workers.

- FLEXIBILITY - "I was prepared to try any solution, however unorthodox, which seemed sensible and with which my resources could cope."

- HOME ASSESSMENT - All work must be based on assessment, whenever possible at home, before any plan of action is undertaken. "Patients were never simply to arrive in hospital."

- Open and effective COMMUNICATION AND COLLABORATION. "Situations should not collapse for want of the right hand knowing what the left hand is doing."

- RESPONSIBILITY - "We should take responsibility for every solution which we formulated, and always be ready to think again."

In 1971, Dr. Aries published a provocative statement from one of his seminars that outlines the unfortunate reasons why work with older adults is often viewed as outside "the mainstream of medical careers." The perceptions below are still challenges for geriatric medicine and gerontology today.

- Human being like quick rewards. Doctors are therefore attracted to the administration of antibiotics, the lancing of an abscess, the sewing up of a burst ulcer. Within this century, medicine has been redirected toward "curing," at a loss of interest in "caring."

- Diagnosis is an end. Psychiatrists, he asserts, often prefer to make diagnosis to end rather than accepting an obligation for continuing care, giving as their rationale that the time and resources are scarce.

- Seduction by technology. A mystifying technology seems to contribute powerfully to a specialty's status, but geriatric psychiatry "has not yet established the need for expensive apparatus."

- The elderly largely stand outside our acquisitive society "because by and large they have lost the ability to acquire." They are poor in a society in which poverty is the ultimate sin.

- The work is unglamorous. The "high status fantasy figures in our society" are pop stars and advertising men, whereas the old by contrast are considered "ugly and sexless."

- Much of the work goes on in slums. "The style of the premises in which we are obliged to work and care for our patients (is such) that it is not surprising that we must often be contaminated with the stigma of slum dwellers."

- Geriatric psychiatry shares the double stigma of contact both with the elderly and with the mentally ill, "adding up to more than merely the sum of the two parts."

- The self-fulfilling prophecy, "whereby work is unattractive because it is considered unattractive."

- Vicious circles. Staff want to work in well-staffed settings, hence understaffing breeds still greater understaffing.

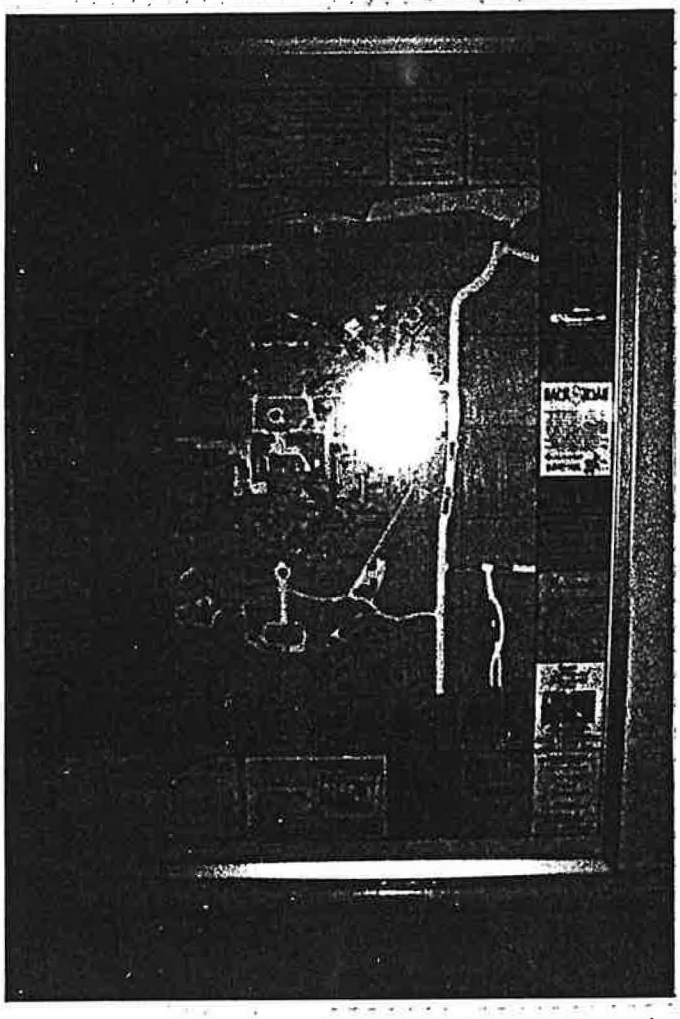
- Complaints, inquiries, "scandals," in which "I am not sure that the right balance is always struck between protection of the users of services and of the providers."

Glasscote, J., Gudeman J. E., Miles, D., 1977

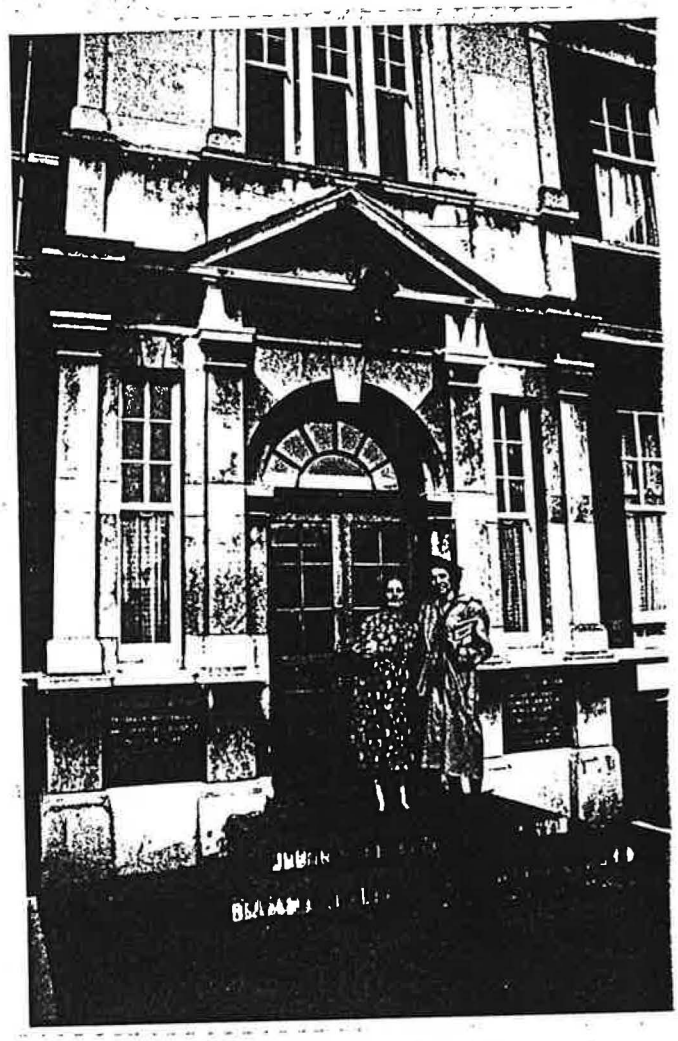
Interviews with Mr. Theo Sackey-Adoo, Assistant Director of Nurses (Sisters), Friday, October 28, 1988, Goodmayes Hospital, London

A nursing supervisor, Theo Sackey-Adoo, and a woman patient agreed to tell their present perspectives of the program. In addition, a brief visit to the day care room was possible. We had a chance to observe the check out process while "taking tea."

Goodmayes Hospital - Suburban London Psychiatric complex serving two Greater London Boroughs



Mrs. Hanes with patient, Goodmayes Hospital



Oak Dove Nursing Home private facility, 1/2 mile from Goodmayes Hospital

London Ambulance Service, a general transportation system that brings day patients and outpatients to Goodmayes

View of solarium of one of older buildings, Goodmayes Hospital, suburban London.

APPENDIX D - 2

Stroud, Gloucestershire, England, October 31 to November 2

Interviews with Dr. Ann Bailey, Chief Psychiatric Director; David Balsham, Director of the day center, Stroud; Cheryl Latham, sister, day center, Jo Smith, Director of Social Services, day center.

Gloucestershire, a county in the western central part of England, has a psychogeriatric service for a geographic area about fifty miles square. About half of the county's population is located in the central cities of Gloucester and Cheltenham which are about ten miles apart and in the town of Stroud, which is about ten miles to the south. The other half of the population can be found in many small villages and some towns of a few thousand people.

Because Dr. Ann Bailey was in her office in Stroud at the time of our interview and tour, I chose the nearby Tyndale Day Care Center as the focus of my tour. There I was able to talk with an occupational therapist and a member of the nursing staff. In addition to an hour long interview with Dr. Bailey, I had the unique pleasure of being a dinner guest in Dr. Bailey's rural home. It appeared beside a typical narrow hedged lane, complete with a sheep paddock in the yard. The conversation about the British medical system was especially interesting because Dr. Bailey's husband is in general family practice with primarily private sector patients, whereas Dr. Ann Bailey is a chief psychiatric administrator of a large local public system.

Dr. Ann Bailey emphasized many of the following aims of day hospitals fostered by the original psychogeriatric administrator, Dr. Baker:

- To maintain the patient's community role. This is "often preferable to admission to hospital and it maintains contact with home and normal life, thus causing less disturbance to the patient."

- To create an appetite among old people for companionship and purposeful living.

- To allow earlier discharge of inpatients and to provide them with continued care.

- To support and provide relief for the family, thus avoiding any intra-family tension that might result in unnecessary inpatient admission.

- To promote an effective liaison between hospital and community services by means of home nurses and occupational therapists, social workers, and volunteers.

- To provide a full assessment service which can be much more reliable than that in the ordinary outpatient clinic.

Glasscote, J., Gudeman, J. E., Miles, D., 1977

- Warden-supervised complexes accommodating 106 persons, to which admission of psychogeriatric cases very rarely occurs.

- Twenty-two privately owned "rest homes" or "nursing homes" into which an occasional psychogeriatric patient can be placed.

- A total of 336 long-stay geriatric beds in Redruth and in five other towns in various parts of Cornwall, mostly in small hospitals and former workhouses.

Glasscote, R., Gudeman, J., and Miles, D., 1977

The program emphasis has used the following criteria for placement:

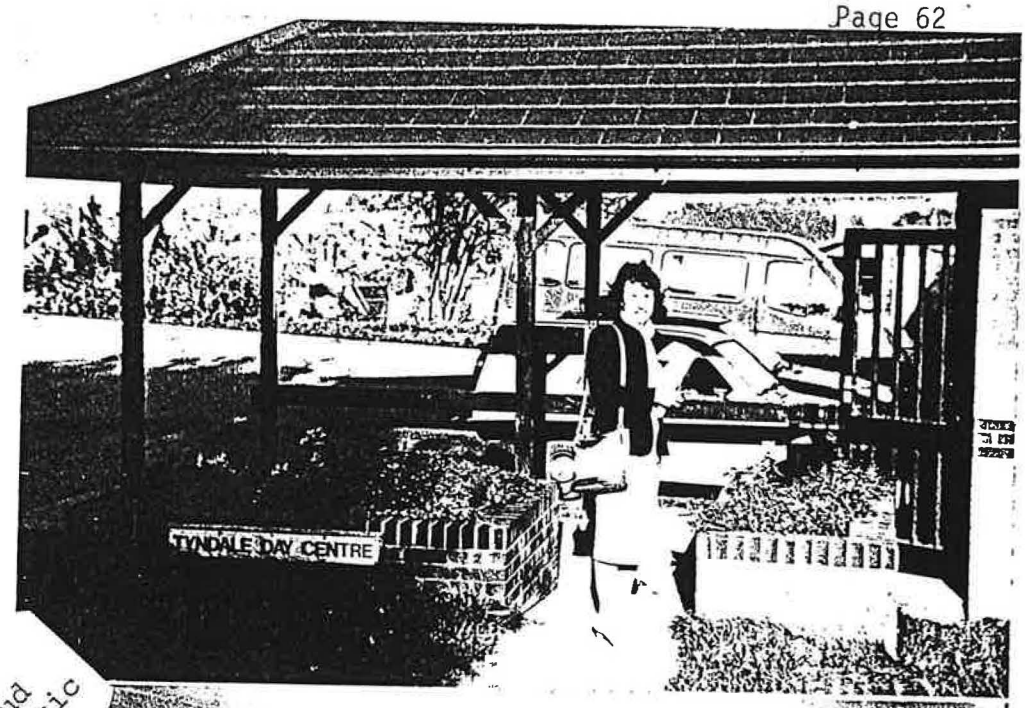
- Patients with early dementia and no disturbing behavior and still capable of appreciating their environment will return to the community either to their own homes with the necessary supports added, or if these are not available, into ordinary residential old people's homes.

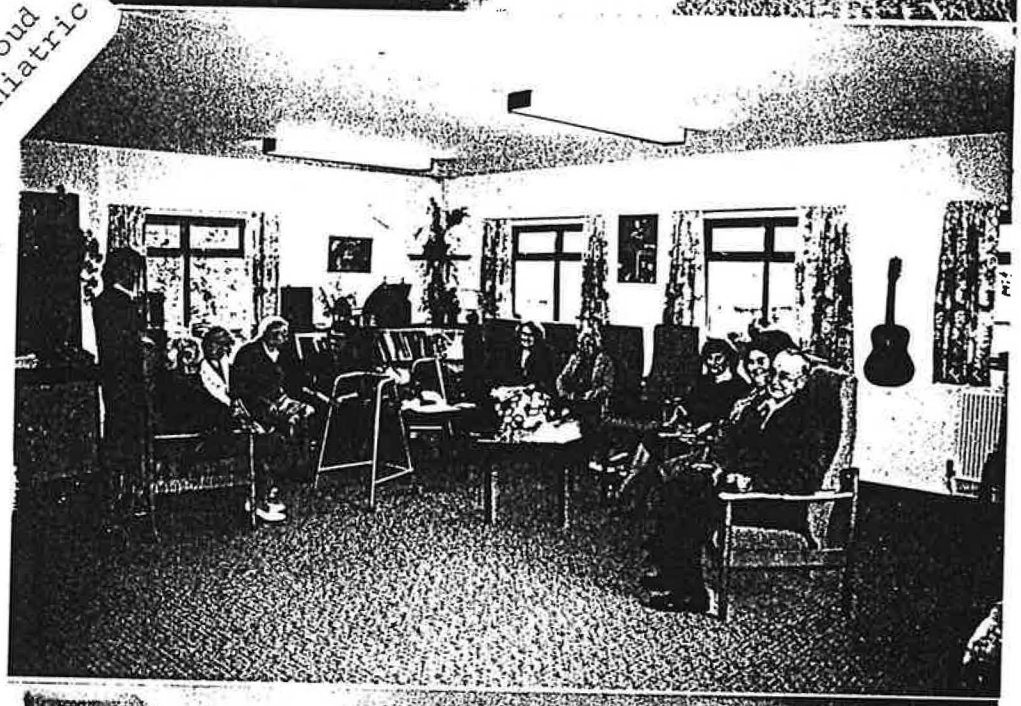
- Patients with a more advanced degree of dementia who are unable to converse rationally, but who are ambulant (and may or may not suffer from incontinence), are discharged into the Social Service's special (EMI) homes.

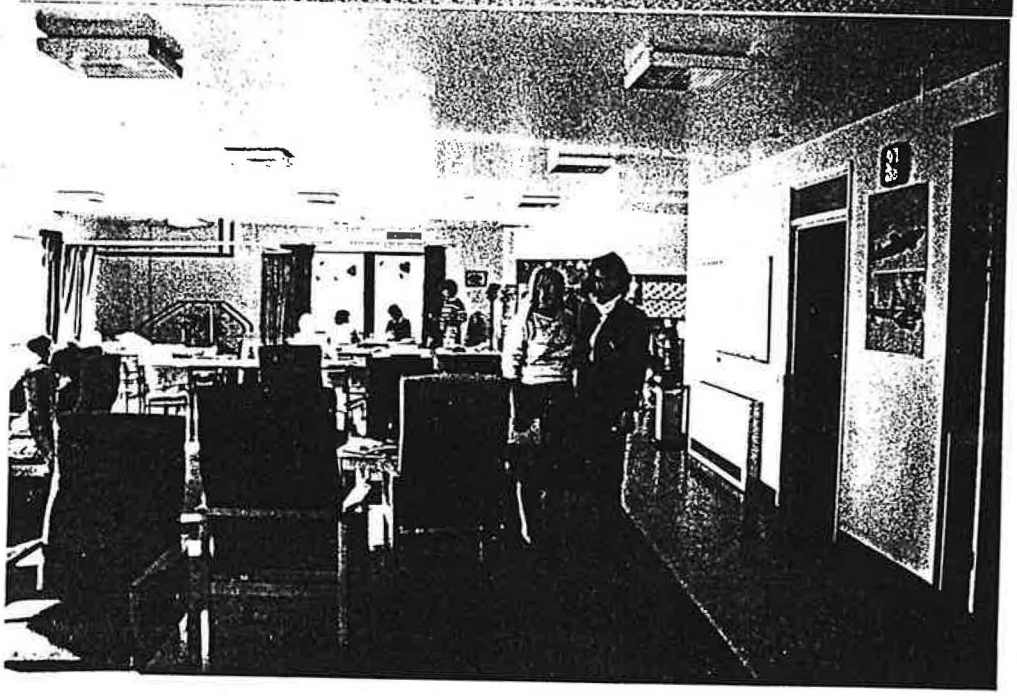
- Patients suffering from dementia with such behavior problems as wandering, hoarding of articles belonging to other persons, restlessness, and aggression, with or without concurrent physical illness, are transferred for continuing psychogeriatric care at St. Larence Hospital. "The care of these patients requires the specialized approach of mentally trained nursing personnel," Dr. Williams told us.

- Patients who have dementia without behavior problems but who suffer from severe physical disability, for example, immobility following a stroke or due to severe osteoarthritis, or with double incontinence, and who would normally qualify for general nursing care, are transferred into geriatric continuing care wards and annexes.

- Similarly, misplacement is to be avoided for the functionally mentally ill old person, for instance the paraphrenic or depressed patient, who may have been admitted to the psychogeriatric assessment unit because at first his clinical condition was indistinguishable from senile dementia. When a decision on future care is made for these patients, the overriding consideration is that they must be protected from having to share a long-stay facility with persons who are organically deteriorated to the point that they have literally no memory and who may be constantly talking nonsensically to themselves.







Interior and exterior views of Tyndale Day Center serving Stroud area of Gloucestershire psychiatric service district.

Bovine Spongiform Encephalopathy (BSE) in Great Britain

During the visit to the geriatric mental health network in New Stroud, England, from March 3 to April 2, we stayed in a bed and breakfast inn that was next to a working dairy farm. It was there that we first heard about BSE, a disease that has implications for the human population, as well as for the dairy herds of the world. The article that accompanies this explanation is one that I have used with my students as a way of talking briefly about rare degenerative diseases of the brain.

by Sam Hall

The rapid spread of the fatal cattle disease bovine spongiform encephalopathy (BSE) in Great Britain may serve as a warning for North American farmers feeding ruminant-derived protein concentrates to their beef or dairy herds.

British agricultural and medical experts, not to mention a general public already worried by a salmonella epidemic in eggs and poultry, are gravely concerned because BSE may already have been transmitted to the human food chain.

The disease attacks the central nervous system of cattle and reduces the brain to a sponge, causing anxiety and aggression followed by frenzy and death. Despite urgent controls to curb the epidemic, British Ministry of Agriculture officials say the number of cases has increased from 296 in February 1988 to 1,603 in November. Nearly 1,278 English farms are affected.

Closely linked with sheep scrapie, another widespread brain disorder, BSE is thought to have developed because dairymen, bent on increasing milk yields, have been feeding dairy cows a high proportion of protein concentrates.

British Ministry of Agriculture officials are concerned that slaughterhouse waste, including offal and sheep brains rendered into high-protein bonemeal, may have infected cows. A series of changes in the rendering processes during the 1970s and 1980s, including a higher proportion of sheep heads included and a possible reduction in temperature or processing time, may have contributed to the spread of the disease.

"Having passed from sheep to cattle, there is now a possibility that it will jump to the human food chain," says James Hope of Edinburgh University, who is leading a team of scientists investigating the epidemic for the Ministry of Agriculture and the Department of Health. Hope believes symptoms may not become apparent for five years or more after infection. "It is entirely possible that meat from those infected animals still not showing clinical signs of the disease may already have reached the human food chain," he maintains.

Doctors believe that BSE, or bovine scrapie as it is now known, may also be linked to kuru, which was a common form of death in New Guinea until cannibalism was eradicated. In terms of the recorded distribution of the duration of the illness, BSE is also comparable to Creutzfeldt-Jakob disease in humans, which also causes degeneration of the brain.

In Great Britain, butchers are not permitted to include brain in raw meat products such as sausages, but they are allowed to sell it directly to the public and to use it in cooked meat products such as meat pies. Offal from cattle is also ground down into meat meal for pets. Some major pet food manufacturers now say they are no longer buying their meat meal in Great Britain.

Worried by the rate at which the disease has spread, the British Ministry of Agriculture declared BSE a notifiable disease, ordered the carcasses of all infected animals to be destroyed, and offered farmers compensation amounting to 50 percent of the market price. But Timothy Lang of the London Food Commission says this may not be enough. "A scurrilous farmer could still get more money by sending his cow to market," he says.

The U.K. government has also suspended the feeding of animal protein to ruminants until the end of the year, despite protests by some feed manufacturers and renderers.

Some experts believe British consumers could still be at risk. Writing in the *British Medical Journal*, T. Holt and J. Phillips of St. James Hospital point out that many infected cattle in which the symptoms were not yet visible must have been used to make meat products. "The reported numbers only represent those animals with well-established, clinically manifest disease," they write. "Should not the use of brains in British foods be either abolished outright or be more clearly defined?"

With such uncertainties, Australia and Israel have imposed a ban on all imports of live cattle from Great Britain, and the British are prepared for the possibility that other nations may soon follow suit. ■

Subtle Symptoms

While no cases of bovine scrapie have been confirmed in the United States, USDA is concerned enough that its board of agriculture met in January to discuss ways of preventing the disease's spread here.

Among the options discussed, according to Paul Brown, medical director of the National Institutes of Health Laboratory of Central Nervous System Studies, were extending the quarantine for cattle imported from Great Britain from the current two or three months to as much as a year, and a complete ban on British cattle. No decision has yet been made.

What can you do? Brown suggests becoming familiar with the symptoms of bovine scrapie, and reporting them immediately to your vet or county ag commissioner. He adds that there are no "classic" symptoms that say, 'This is scrapie,' however, medical reports from Great Britain indicate subtle signs to watch for: nervous behavior, including a reluctance to enter the milking parlor; separation from the rest of the herd at pasture; apprehension and hyperesthesias (unusual sensitivity of the skin or of a particular sense); uncharacteristically vigorous kicking during milking; and subtle changes in pelvic limb gait.

Brown likens the spread of bovine scrapie in Great Britain to that of AIDS: After a stable period of two to three cases per month, incidences in Great Britain increased exponentially to 60–70 per month last year. And the disease is devastatingly quick once it sets in: 95 percent of infected English cattle have died within six months of showing initial symptoms. ■

Interviews and Tours in West Cornwall, England

The extreme southwestern portion of England is called Cornwall, a long and relatively narrow geographic area about 98 miles in length. The western portion of Cornwall has a number of small towns, and thus, that 66-mile region is considered "urban." The eastern part is rural. Because it has a relatively mild climate under coastal influence, Cornwall is a very popular vacation retreat for Britains. As a result, the summertime population triples. Many people who take their holidays in Cornwall retire there as well. Because job opportunities are scarce, many young people leave the county of Cornwall. That imbalance of age distribution contributes to a senior population that is at least 5% to 10% higher than in the rest of Britain.

In the town of Bodmin a general psychiatric facility called St. Lawrence Hospital served all of Cornwall until about 1962. St. Lawrence Hospital had been built in 1825 and expanded gradually until 1985. When Dr. J. F. Donovan became director of St. Lawrence, its 1,250 beds were always full, frequently with a waiting list besides. Dr. Donovan worked with a Dr. T. S. Wilson from Barncoose Hospital in nearby Redruth to form the beginnings of a national psychogeriatric assessment and treatment program for the Cornwall area. In spite of funding constraints imposed by the Ministry of Health and the local authority, by 1975 the potential service program for the elderly with psychiatric problems included:

- The psychogeriatric assessment unit, in a building adjoining the original structure of the Barncoose Hospital.

- In the same building, a day hospital with thirty places used mainly for geriatric but also for psychogeriatric patients.

- Attached to the day hospital, a complex of rehabilitative services, including occupational, physical, and speech therapy, serving day hospital patients and also patients from the wards of Barncoose and occasional patients from the psychogeriatric assessment unit.

- Within Barncoose Hospital itself, acute treatment geriatric wards, long-stay geriatric wards, and about 65 beds designated for psychogeriatric patients.

- The two purpose-built specialized Part III homes, exclusively for psychogeriatric residents (and thus known as "EMI" facilities, standing for "elderly mental infirm").

- For the elderly with brain syndromes and significantly disturbing behavior, and those with mainly functional psychiatric disorder such as depression or schizophrenia, a restricted number of beds at St. Lawrence psychiatric hospital.

- Ten "regular" Part III homes, whose turnover is very small and where only occasional psychogeriatric patients can be placed.

What this rather involved process of differentiation results in is a preference for placing patients by function and behavior in a manner that is only secondarily related to the diagnosis itself.

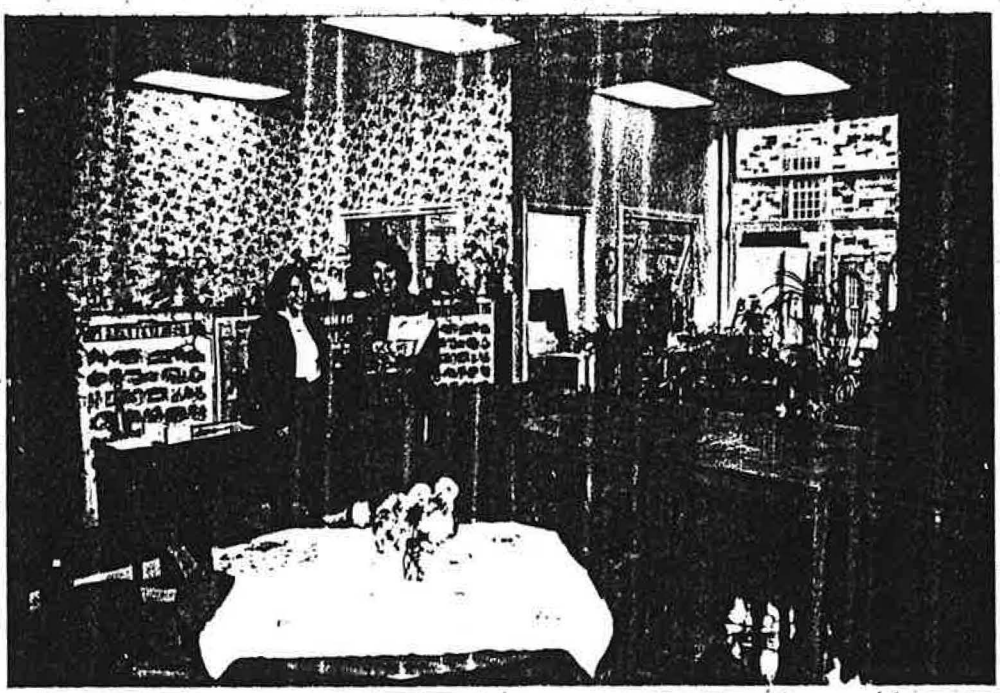
Glasscote, R., Gudeman, J.E., and Miles, D., 1977.)

Covering the entire program would have been difficult during a three-day visit. As a result, I focussed on interviews with Dr. T. Wolhurtor, the Chief of Psychiatric Services at St. Lawrence, Allison Armstrong, Head Social Worker at the psychiatric day care center at St. Lawrence Hospital, and Denise Allen, Assistant Director of a Newquay Day Care Center for non-hospital based elderly. The interviews took place on November 3 and 4, 1988, with additional self-guided tours of senior facilities on November 3 and 4. A number of pictures from Cornwall programs follow this introduction. They show excellent interior support facilities and a contrast between old and new structures. The expanded day care program is one of the most important changes between 1975 and 1988, and I have the Bude Day Care Operational Policy with supporting materials in my files.

Warleggan Geriatric Unit, St. Laurence Hospital, Bodmin, County of Cornwall, England.

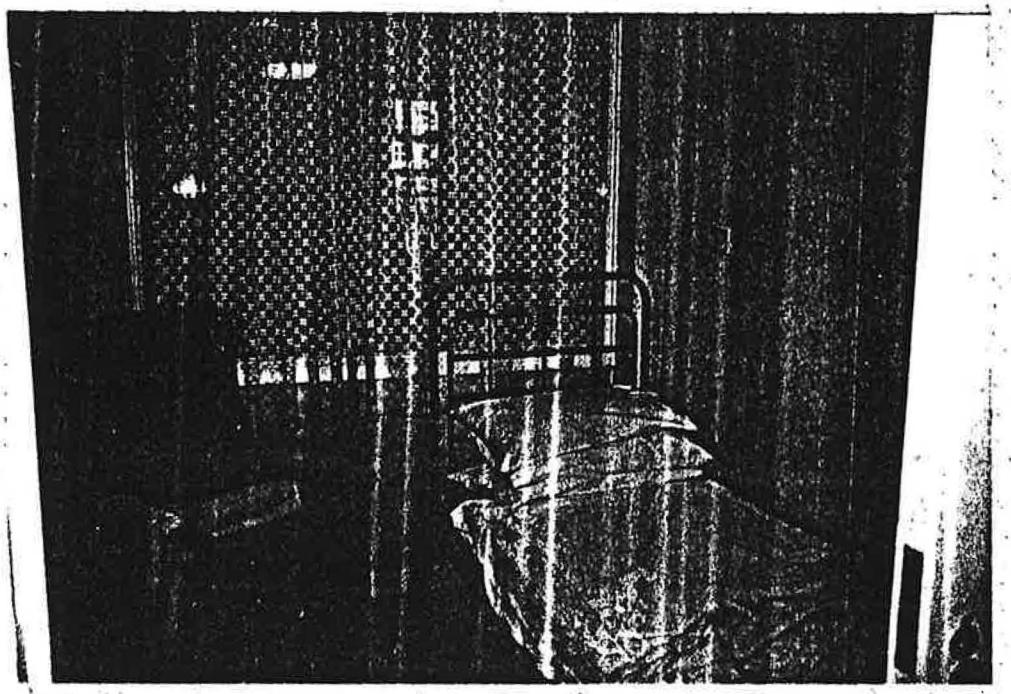
Dr. Wohlater, Chief of Psychiatry, St. Laurence Hospital, Bodmin, Cornwall.

Exterior of typical building in St. Lawrence Hospital, Bodmin.

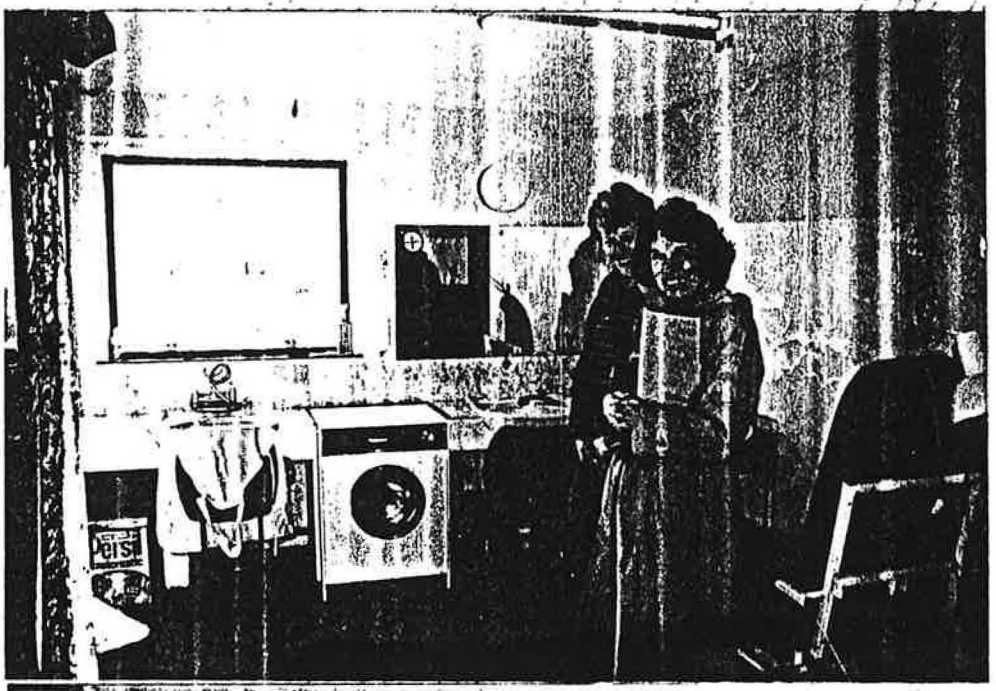


Tour with Allison Armstrong, of Occupational Therapy areas at St. Laurence Hospital, Bodmin, showing kitchen and horticulture activities.

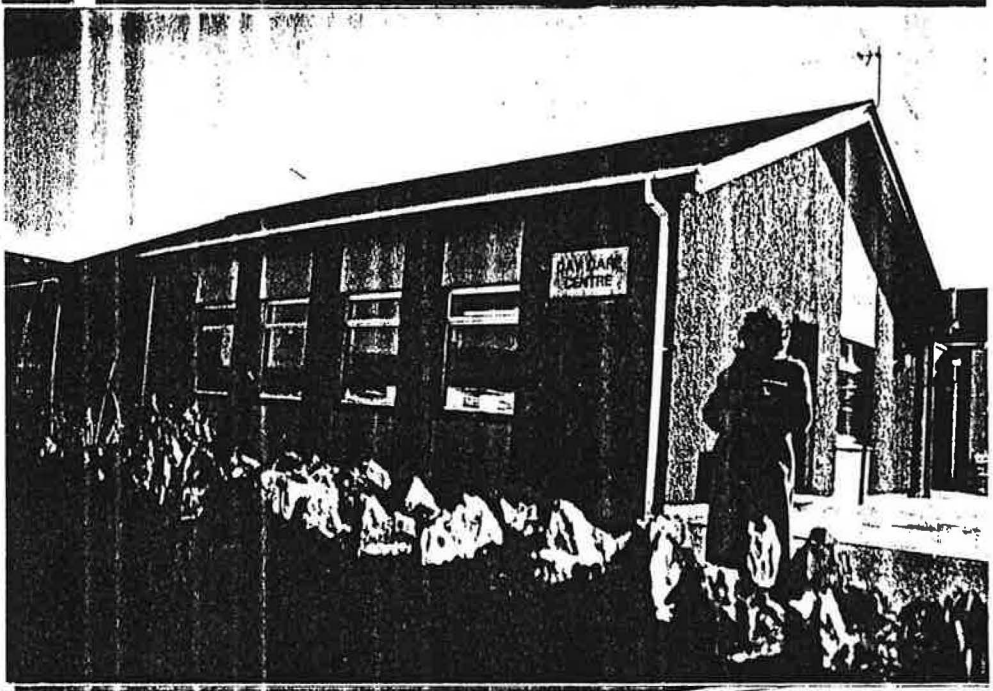
Temporary respite care sleeping quarters (to be upgraded by 12/88) St. Laurence, Bodmin, County of Cornwall.



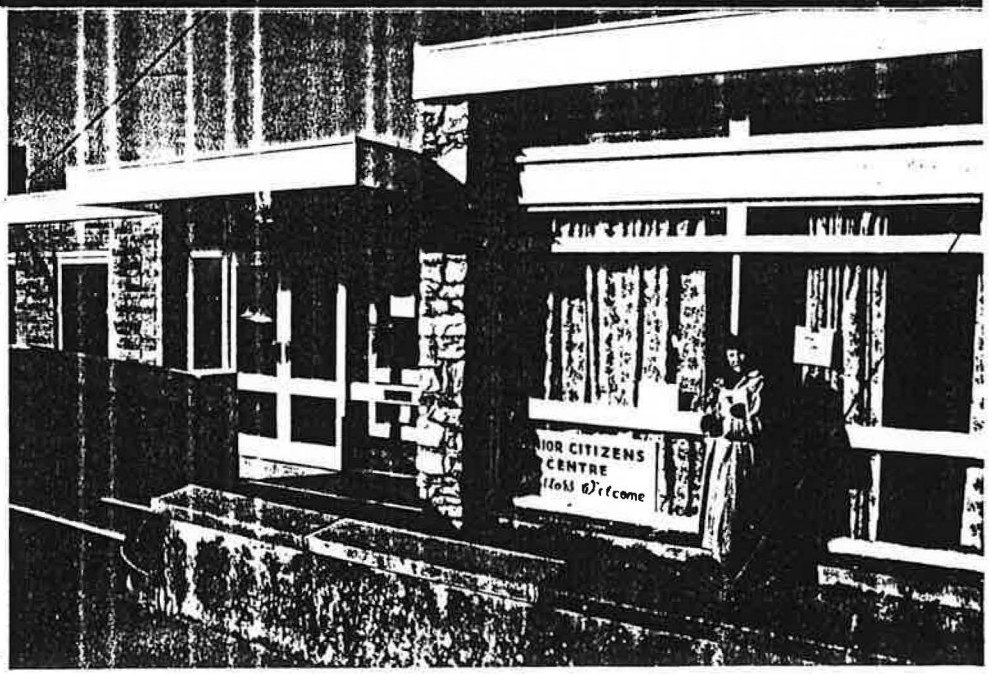
Bathing facilities for day patients with disabilities, St. Laurence Hospital, Bodmin, County of Cornwall.



Laundry and shampoo facilities with Denise Allen, assistant director, at New Quay Day Care Center.



Exterior of New Quay Day Care center.



Senior Citizens Center, Newquay, County of Cornwall, England.

Background Information for the Visit to Moorgreen Hospital, Southampton, England (adapted from Glasscote R., Gudeman, J. E., and Miles, D, 1977)

About a hundred and fifty years ago, a complex of buildings was constructed on the outskirts of the city of Southampton in order to have a work house. After many decades passed, it was converted into a medical facility that was known as Moorgreen Hospital.

Over a century later, at the end of 1973, a young psychiatrist, named Colin Godber, was hired in a newly created position for a psychiatrist with an interest in the elderly. He began building toward his goal of a fully comprehensive program to help older adults with mental illness. From the ancient base of Moorgreen Hospital, Dr. Godber began improving service for older psychiatric patients, and he developed more positive approaches for the management of functional illness in older adults.

Dr. Godber is still with the Southampton program that is central to the health district that encompasses the city of over 220,000 and a large rural area. He has always felt that he is in charge of a psychogeriatric service, not just a psychogeriatric hospital. In that way, he has been able to successfully maintain many more psychogeriatric cases in the community than could ever be treated in the few beds at Moorgreen. Community nurses, home help, general practitioners, meals on wheels, and occupational therapists have their special place in the program.

Among the typical indications for admission to Moorgreen are severe depression, acute brain syndrome (sometimes on top of a chronic one), and respite care in cases of advanced dementia. Because home or community-based assessment permits a patient's treatment needs to be determined without committing the health service to hospitalize, many cases can remain in the community. For example, medication, an antidepressant, a tranquilizer, or a sedative can be managed at home. When physical illness is found it can be treated at home, or sometimes, in the general medical ward of a hospital.

Evaluating the family's approach to the patient and the patient's problem provides an indication of how well the family or other caretakers can cope with the patient and his or her condition. Histories can be taken from the patient, if possible, and from community-based third parties who have intimate knowledge of the patient. A physical and mental status examination is also given.

The points below are basic principles that Dr. Godber and his team emphasize in their treatment approach:

- Depression occurs much more frequently in old people than in young ones; its manifestations often mimic those of organic brain disease; consequently, many old people who are elsewhere rather casually labeled as having brain syndromes are in fact functionally ill and can be treated. (For "functionally ill," in

Dr. Godber's context, one may usually read "depressed;" he believes that genuine anxiety states do not occur in old people and that behavior resembling anxiety is in reality a mask for depression.

- Acute - and thus reversible - brain syndromes are often casually labeled chronic - and thus irreversible - brain syndromes.

- Persons actually afflicted with chronic brain syndrome may subsequently develop either depression or intercurrent acute brain syndrome, and may through treatment be restored to a former status enabling them to be returned satisfactorily to whatever community setting they were previously in.

(Glasscote R., Gudeman, J. E., and Miles, D., 1977.)

Interview with Kathy Conroy, Occupational Therapist, Moorgreen Hospital, Suburban South Hampton, United Kingdom, November 8, 1988

During an interview over lunch in the institutional-looking employee cafeteria, Ms. Conroy reviewed some of the support services of the geropsychiatric program for the Moorgreen catchment area. The whole program has continued to focus on home assessment, day hospital care, and community based services for the South Hampton area. All in-hospital services are directly linked to the out-reach and assessment of the community nurses.

The work of the occupational therapist, Kathy Conroy, illustrates some of the in-hospital activities. The concern for funding programs, rather than new facilities, showed in the friendly day room for the patients. It contained big clocks, calendars, and pictures that revealed an emphasis on time and place orientation. For patients in the early stages of organic brain syndromes, such activities are helpful. In the corner of one day room, a group of elderly patients were having a group discussion session in plain but comfortable chairs. Other patients were playing table games. Outside on the grounds, a patient had just left a small greenhouse that provided opportunities for working with plants.

An ambitious program was going on in a climate of limited resources. The funding constraints of the British Health Service were more apparent in the old bleak brick buildings, outdated, and in need of paint and repair. Staffing shortages are often a problem too, and over-worked employees can have "burn out." A cooperative team approach in many service areas was a counter point that helped morale. Ms. Conroy felt that support, even though there was unrest about the national policy of new classification of nursing personnel, at the time of the November interview.

APPENDIX E

Samples of original research report and related materials from Gerontology 590, directed research related to classes for senior citizens in California Community Colleges.

E-1 - Plan for Gerongology 590,
Directed research, written by K. W. Hanes and approved by Dr. David Peterson.

E-2 - Research Paper based on questionnaire regarding noncredit programming for seniors in California Community Colleges. (The survey and paper were written by K. W. Hanes.)

E-3 - Questionnaire related to credit classes for older adults in California Community Colleges.

APPENDIX E - 1

PLAN FOR GERONTOLOGY 590 - DIRECTED RESEARCH

1. Katherine Hanes will be doing a Gero 590 research project with Dr. David Peterson during Fall term, 1988. The credit period of the project will begin September 6 and end the third week in December. Some further data analysis and writing may continue after credit is received on the student's own time schedule in Winter and Spring, 1989.

2. During the regular Fall term, Mrs. Hanes will meet with Dr. Peterson an average of two or three times monthly, except during November when both Mrs. Hanes and Dr. Peterson will be away on other educational business. Mrs. Hanes will be in Europe from October 24 to November 17 completing activities related to her community college sabbatical, her U.S.C. internship and her general research interests in gerontology. Other meetings will be scheduled by mutual agreement to enhance the overalll educational experience and to provide guidance for the research project.

3. The primary activities of the directed research will be the development of a questionnaire that assesses what California community colleges are doing and considering in community services and adult education non-credit courses for seniors, 50 years and older. That questionnaire will be sent to the community service/adult education officer or the instructional service officer in all of the California community colleges.

   At least a beginning draft of a second questionnaire will be developed. It will assess what California community colleges are offering in credit courses in gerontology. Further use and refinement of the second questionaire may be done after the U.S.C. Fall term closes by Mrs. Hanes or other interested people.

4. The goals for the directed research will have the following outcomes:

   a. Mrs. Hanes will discuss her project with at least three people in such roles as senior center director, senior users of a local multipurpose senior center and community college administrators in community services.

   b. Mrs. Hanes will review and summarize at least four documents that provide models or address issues related to non-credit courses for seniors.

   c. Mrs. Hanes will construct and mail one questionnaire and design drafts of a second questionnaire on community college education for seniors.

   d. Mrs. Hanes will do some data analysis of the non-credit questionnaire as time permits in December.

APPENDIX E - 2

CATEGORIES, LOCATIONS, AND EXPANSION OF COMMUNITY SERVICES AND ADULT EDUCATION FOR SENIORS IN COMMUNITY COLLEGES

The increase in life expectancy, along with the aging of the "baby-boom generation," has produced an increasing adult population; and a growing proportion of that adult population is aged or will become aged soon. As a result of increased medical sophistication, many disabled adults continue to live in old age.

The changing demographics in California can be expected to increase a need for adult education. More than 10% of the California population is now over age 65, amounting to a total of over 2,800,000. After the turn of the century, more than 15% of the population will be over age 65. Immigration from Asia and Latin America to California has greatly increased the rate of population growth in the state. California will be the first state to maintain a "minority majority." In the next century, some of that changed and enlarged group of citizens will grow old.

The need to educate the elderly will increase. Some will need to improve their independent living skills. Some will want to know how to be care-givers for the frail elderly. Others will wish to learn to maintain economic productivity and financial security. Still others will hope to avoid depression and have an enriched quality of life. They will use leisure time for healthful recreation and intellectual stimulation. Even sustaining or improving English language skills can still be a task for some immigrants as they age in their adopted society.

In order to plan for the challenge of community education of the elderly population, more information is needed about what is currently being thought and done in adult education for seniors. Community college programming is an important part of California's educational link to its older adults.

Numerous studies related to the work of the California Post Secondary Education Commission have documented the lack of available data on adult and non-credit education. Historically, little information about courses, categories, or students was required by the State Department of Education or the Chancellor's Office of the Community Colleges. Moreover, it is confusing to analyze adult and non-credit education in a collective manner because available data between providers is frequently not comparable.

Data about age, sex, ethnicity, and economic status is not typically sent to a central agency. Instead, it is only collected when required for some specific , federally-funded programs. Even though many adult education programs are designed for special populations, such as older adults or substantially handicapped, it is very difficult to construct a demographic profile of the consumers of such education.

Final confounding factors for beginning research in adult education are the variety of definitions and diverse criteria for designating courses as part of the State's 10 mandated categories. Follow up program review and inadequate impirical evaluation of course benefits are also a problem.

The results presented from this questionnaire will not magically solve all of the problems listed above. However, the survey takes a few small steps in the direction of finding out what is going on now in programming of non-credit courses for seniors in California Community Colleges. The instrument asks about categories and locations of classes. It looks for information about the training of teachers for older adults. The questionnaire also tries to tap the opinion of administrators about the future growth of programs and the training of teachers of courses for older adults. Finally the results may be of use to policy makers and people who lobby policy makers.

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METHODS AND PROCEDURE

A 23 item questionnaire was designed to gain information about courses for seniors within non-credit community service or adult education programs in California Community Colleges. One hundred eight surveys were mailed to all of the California Community Colleges. Usable surveys were received from 56 campuses. A tally was made from the total responses to each item. A numerical summary was also made from some of the demographic information.

RESPONDENTS

The 108 questionnaires were sent to administrators in community services or instructional services (when no community service officer was listed) of all public California community colleges. From the original group, there were 56 completed surveys and three letters without appropriate completed materials.

Administrators in the instructional area or in general campus administration returned a total of 20 of the questionnaires. Administrators in areas such as community services, adult education, senior programs, and continuing education accounted for 25 of the respondents. Four questionnaires were returned from supervisors of general extended day or evening programs. Three other responses cam from individuals who indicated areas such as department professor, adaptive P.E., or coordinator of special education.

Dividing the state into northern and southern districts allowed for some determination of the geographic implications of the responding group. Fifty-four schools north of San Luis Obispo and Bakersfield received the survey. The other 54 campuses were south of that general line. Responses were received from 27 campuses designated as northern in location and 29 campuses referred to as southern in location.

Another facet of the description of the responding group involves consideration of the sizes of the general adult education program in the community college districts. Table 1 shows the enrollment data of the 13 community college districts with the largest average daily attendance (ADA) and non-credit adult education. State-wide, about 9% of ADA from community college adult education is categorized as "older adult." Nine campuses from eight of the largest 13 programs responded to the survey. It is interesting to observe that only two of the thirteen largest programs are in the north. Six of the eight responding districts with very large programs are in the south.

Because 52 of the 56 respondents indicated that their districts were served by some form of adult education, the survey did not glean a good sample of those with no programs. Eighteen school districts that had no adult education programs in 1978 and that have failed in gaining legislative permission to do so are not represented well by the sample group of this survey.

TABLE 1

Thirteen Community Colleges with the Largest Average Daily Attendance (ADA) in Noncredit Adult Education. (The secondary source for the data was the report, "Meeting California's Adult Education Needs," by the California Post-Secondary Education Commission," September 19, 1988, draft.)

Community College Districts	1984-1985 Actual ADA	1984-1985 Headcount	1985-1986 Actual ADA	1985-1986 Headcount	1986-1987 Actual ADA	1986-1987 Headcount	Percent of Change in ADA 1984 to 1987
San Francisco	15,892	31,872	16,264	33,083	16,155	30,087	+01.7
San Diego	12,290	22,314	12,615	25,811	12,710	26,222	+03.4
Rancho Santiago	4,382	8,018	4,717	9,509	5,094	9,955	+16.2
Marin	1,406	7986	1,430	6878	1,373 7	7795	-02.3
North Orange	5,205	36,565	5,706	25,916	5,875	29,370	+13.0
Mount San Antonio	1,607	5,703	2,443	7,052	2,809	8,480	+75.0
Santa Barbara	1,825	9,238	1,874	10,387	1,966	12,767	+08.0
Glendale	1,562	7,245	1,651	6,599	1,755	4,734	+12.4
Saddleback	473	1,337	840	1,354	1,342	3,748	+184.0
Chaffey	801	1,122	864	1,372	942	1,113	+18.0
Long Beach	1,532	1,944	1,530	2,276	1,550	1,734	+01.2
Pasadena	1,668	3,801	1,760	4,093	1,745	3,786	+05.0
Santa Rosa	996	1,832	1,165	2,058	1,533	2,450	-54.0
TOTAL	49,639	131,044	52,859	129,571	54,849	134,946	+10.5
Total State ADA	61,086		66,357		69,698		+14.1

Note: Community College headcount enrollment includes only students enrolled exclusively in fall term non-credit courses.

Sources: Adult Schools: Adult Education Unit, California State Department of Education.
Adult School Enrollment: CBEDS Data Collection.
Community College Districts and Enrollments: Chancellor's Office, California Community Colleges.

RESULTS

From the 108 questionnaires that were sent to the community colleges in the State of California, 56 completed surveys were assessed. The tally of the raw data permitted some initial description of non-credit programming for seniors in California community colleges. The results also revealed some related opinion.

Two items at the beginning of the survey addressed the general issue of legislative limitations on adult education and community services. Some communities cannot offer adult education courses because they did not have programs in place before Proposition 13. The first question asked, "Is the population of your community college district served by any adult or non-credit education provider?" Fifty-two respondents answered "Yes to the item. Next, the college administrators were asked whether or not their college has "delineation of function" agreements with local school districts that permit the development of community college, noncredit programming for seniors. Thirty-six colleges indicated that such permissive "delineation of function" agreements did exist. Another item, raising the question of State authorization of new adult or noncredit programs in community college districts that are not presently served by any provider resulted in 46 affirmative responses.

Shifting to a focus on courses targeted for seniors, the survey contained several items about the locations of course offerings. Noncredit, on-campus courses targeted toward seniors are regularly offered at 28 of the 56 responding campuses. Only three other campuses indicated plans for such programming within the next two years. Noncredit, off-campus courses, targeted for seniors not confined in institutions are regularly offered at 36 of the responding campuses. Again, 3 other schools have plans for such courses within the next two years. For seniors confined in institutions, 21 off-campus noncredit programs are regularly available. Tables 2 and 3 show the variety and incidence of facilities housing courses.

The questionnaire also sought to determine the variety and number of course offerings in noncredit programs for seniors. Table 4 contains the number of campuses having programs on-campus in a variety of course categories. Sports and exercise, arts and crafts, and physical health issues were the topics cited most frequently as on-campus course offerings.

Table 5 displays the same type of data for off-campus, noncredit courses. Again, sports and exercise, arts and crafts, and physical health issues were the course categories mentioned most frequently. The various subjects classified as humanities appeared as fourth place with singing and/or performing instrumental music a close fifth in frequency.

Categories of off-campus, noncredit courses for seniors confined in institutions are listed in Table 6 with the corresponding number of campuses having programs on the topics. Sports and exercise was the most commonly cited category. All of the 21 campuses providing courses to seniors in institutions mentioned nursing homes as the most common of institutional facilities. Other institutional categories included hospitals with programs from 5 colleges, an inpatient psychiatric facility named by one respondent and "Other," designated by 8 schools.

Training in gerontology or aging issues is a topic that was explored in several items. Formal training in gerontology or aging issues is not required in the program for seniors at 32 out of 41 campuses reporting on that question. Training to meet the State requirements of adult education credentialing was cited as required by 33 administrators. Prior experience working with older adults was required by 27 of the responding units. Thirteen campuses reported requiring seminars, workshops, or in-service training meetings on aging issues. However, 38 administrators believed that seminars, workshops, or in-service training meetings on aging issues should be required. Formal course work and a certificate or a degree in gerontology were cited less frequently as a requirement for teachers of seniors.

Most of the final questions of the survey pointed to general policy issues that the administrators felt should be addressed in the next five years for community services and adult education for seniors. Respondents were asked if courses related to survival skills; i.e., nutrition, losses and grieving, and financial planning should be expanded, decreased, or remain the same. Expansion was the preference of 43 of the 54 people who answered the question. None felt that the area of survival skills should be contracted, but 11 elected "Remain the same."

A related item focused on the issue of increasing or decreasing the number of courses with a recreational and leisure orientation. Increases were favored by 32 administrators. Decreases were selected by 3, and 17 chose the option, "Remain the same."

The location of future course work was also addressed. More courses on campus are desired by 22 respondents. More off-campus facilities for non-institutionalized seniors are seen as important by 37 administrators.

The final item asked for a response to the following statement: "Community college, non-credit courses targeted for seniors should continue to have funding support from the State Legislature." Strongly agree was the choice of 41 of the 53 who answered the question. Seven more selected "Somewhat agree."

Some typographical errors on the questionnaire invalidated responses on particular items. Those response tallies are therefore eliminated from both the results and discussion portion of this report. Because the questions on total enrollment figures elicited such diverse bases for the data and more non-responses than responses, those figures were not counted as results. The lack of clarity related to the data language of noncredit programming and funding is worthy of mention in the discussion section.

Table 2

Question 10

Types of Facilities Housing Courses

Types of Facilities		Number of Sites
A.	Senior center	31
B.	School	23
C.	Other government recreation centers	31
D.	Church building	17
E.	Mobile home park	11
F.	Retirement apartment complex	19
G.	Other	3
G1.	Police department	(1)
G2.	Shopping mall	(1)
G3.	Library	(1)

NOTE: Total number of returned questionnaires = 56

Table 3

Question 10

Total of Facility Variety per Reporting Programs

No. of Site Categories		Number of Programs
A.	One	3
B.	Two	2
C.	Three	4
D.	Four	7
E.	Five	3
F.	Six	2
G.	Seven	1

NOTE: Total number of returned questionnaires = 56

Table 4

Question 7

Number of On-campus Course Categories Targeted Toward Seniors

Course Category		Number of Campuses Having Programs
A.	Sports and exercise	22
B.	Games; i.e., Bridge	5
C.	Arts and Crafts	20
D.	Physical health issues; i.e., nutrition classes, CPR	20
E.	Foreign languages	8
F.	Travel	13
G.	English as a second language	10
H.	Science other than health issues; i.e., nature walks, astronomy	7
I.	History or current events	12
J.	Humanities; i.e., philosophy, religion, literature, art, music	16
K.	Mental health and adjustment issues; i.e., losses and grief	11
L.	Singing and/or performing instrumental music	13
M.	Non-health related coping skills; i.e., finance, housing, home and car maintenance	15
N.	Journal writing or other creative writing	8
O.	Cultural and/or ethnic awareness	6
P.	Gerontology (50% or more of the content is related to aging)	4
Q.	Other	7
	Q1. Safe driving and/or traffic school	(3)
	Q2. Ballroom dancing	(1)
	Q3. Re-entry work skill development	(1)
	Q4. Computer literacy	(1)
	Q5. Sewing	(1)
	Q6. Health food workers certificate	(1)

NOTE: Total number of returned questionnaires = 56
Some courses fee and charge rather than state funded

Table 5

Question 11

Number of Off-Campus, Noncredit Course Categories Targeted Toward Seniors

Course Category		Number of Programs
A.	Sports and exercise	33
B.	Games; i.e., Bridge	4
C.	Arts and crafts	26
D.	Physical health issues; i.e., nutrition classes, CPR	24
E.	Foreign languages	9
F.	Travel	10
G.	English as a second language	9
H.	Science, other than health issues; i.e., nature walks, astronomy	6
I.	History or current events	18
J.	Humanities; i.e., literature, art, music, philosophy, religion	22
K.	Mental health and adjustment issues; i.e., losses and grief	15
L.	Singing and/or performing instrumental music	21
M.	Non-health related coping skills; i.e., finance, housing, home, and maintenance	15
N.	Journal writing and other creative writing	11
O.	Cultural and/or ethnic awareness	8
P.	Gerontology (50% or more of the content is related to aging)	6
Q.	Other	5
	Q1. Literacy	(1)
	Q2. Tutor training	(1)
	Q3. Lip reading	(1)
	Q4. Mature driving program	(2)

NOTE: Total number of returned questionnaires = 56
Some courses fee and charge rather than State funded

Table 6

Question 14

Number of Off-Campus Noncredit Course Categories Targeted Toward Seniors Confined in Institutions

Course Category		Number of Campus Having Programs
A.	Sports and exercise	16
B.	Games	2
C.	Arts and crafts	13
D.	Physical health issues; i.e., nutrition	12
E.	Current events	11
F.	Singing and other musical activities	14
G.	Mental health issues; i.e., social awareness, grief and losses, time and place orientation	11
H.	Nature and plant talks/demonstrations	3
I.	Gerontology (50% or more of the content is related to aging)	2
J.	Other	3
J1.	Planter box gardening	(1)
J2.	Personal growth from present needs	(1)
J3.	Writing or literature	(1)

NOTE: Total number of returned questionnaires = 56
Some courses fee and charge rather than state funded

DISCUSSION

A discussion of the raw data will focus on several related areas of educational policy that are suggested by the results of the survey. The first point addresses the prohibition of State authorization of programs for community college adult education and community service. Another set of results raises questions about the locations and the course contents of noncredit classes for seniors. A third issue involves the specialized training of instructors of noncredit courses for seniors. A final area looks at some opinion of community college administrators as they project community service and adult education five years into the future.

A large number of respondents believed that the State Legislature of California should permit new adult or noncredit programs in community college districts that are not presently served by any provider. Those 45 educators were in agreement with Recommendation 4 of the report, "Meeting California's Adult Education Needs," (California Postsecondary Commission, September 19, 1988, draft). That recommendation to remove legislative prohibition followed several failed legislative efforts to solve the problem.

The attempts to remove Proposition 13 restrictions waned, even though 18 school districts that did not have adult education programs appealed to the legislature for permission. Most of the districts denied adult education programs have few other educational providers. They are also mainly small districts and rural in character. The September draft of the committee stated that the prohibitions against new programs "has no rational basis and should be abandoned without delay.

Competition between geographically close urban community college districts is probably not a political issue because of the rural character of the districts without programs. The 45 administrators in the present survey who supported new programs in unserved districts indicated in earlier questions that their districts already had some adult or noncredit provider in their district and/or that they were permitted by "delineation of function" agreements to offer such programming. That cooperative climate seems positive for concerted effort to reverse the restrictive legislation that prevents new programs in unserved districts. Additional recommendations to the legislature would have to deal with the competition between area community colleges and other district adult schools. The September draft report also addressed that issue.

By turning to the raw data shown in the tables of the Result sections, the content categories most frequently found in programs for seniors can be discussed. Some categories with a largely recreational or leisure orientation were most represented. For example, sports and exercise, and arts and crafts were in the top three categories in on-campus, general off-campus, and off-campus institutional programs. Classes in physical health issues; i.e., nutrition classes and CPR were also in the top three to five of most frequently offered programming in all types of locations. Expansion of courses related to survival skills was recommended by 43 respondents. Administrators on 32 campuses also favored expanding recreation and leisure programming. As the older adult population increases and, within that group, increasing numbers of the frail elderly, some very impor-

tant decisions about state funding and course planning need to be made.

If need assessment in course planning is done by having seniors "vote with their feet," then courses for the active "young-old" will tend to dominate curriculum. When funding for educational enrichment in nursing home settings got generous financial support from the State, then many colleges suddenly began programs to meet the need and get the funds. Many creative programming opportunities are lost and joint ventures with community-based social service agencies missed if large numbers of senior "sign-ups" and massive funding of politically popular projects are the style. For example, perhaps the fee and charge class concept needs to be fine-tuned in a way that frees State funds for more small group classes to meet the care-givers' needs and general emotional needs of seniors dealing with the frailness in themselves or the family.

Tables 2 and 3 of the result section can be used to generate discussion of expanding programs into innovative off-campus locations. Colleges can get ideas from one another's program locations. Despite some confusion over a typographical error in the item, clearly administrators favored expanding off-campus facilities for courses for seniors.

Although most programs for seniors did not require their instructors to have formal training in gerontology or aging issues, administrators clearly favored both experience with older adults and seminars, workshop or in-service training meetings on aging issues. That is a positive climate for lobbying the State to mandate such training in a required and somewhat formalized continuing education program for instructors of seniors.

Finally is a testimonial to the perceived importance of courses for seniors, 41 respondents strongly agreed and 7 respondents somewhat agreed that community college, non-credit courses for seniors should continue to have funding from the State legislature. The questionnaire, though flawed, raises some important policy issues that should be on the discussion agenda in the near future.

APPENDIX E - 3

LEONARD DAVIS SCHOOL OF GERONTOLOGY
ETHEL PERCY ANDRUS GERONTOLOGY CENTER
(213) 743-5156

October 21, 1988

Dear Community College Educator:

Many state studies have reported gaps in data about California adult and non-credit education. This questionnaire is designed to fill a few voids in the category of Community College Non-Credit Courses for Seniors.

The short survey will take less than 10 minutes to complete. However, the results will establish important information and provide ideas for further study of community college programs for seniors.

As members of the academic community, we can empathize with your time management problems. We are hopeful that you will understand the importance of a high return rate for the validity of survey research. With the enormous projected growth of the adult population over age 50, it is crucial that we begin our future planning by getting more information about what is currently being thought and done in community college programming for seniors.

Sincerely yours,

David A. Peterson

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KWH stp
Enclosures

COMMUNITY SERVICES AND ADULT EDUCATION IN COMMUNITY COLLEGES

1. Some communities cannot offer adult education courses because they did not have programs in place before Proposition 13. Is the population of your community college district served by any adult or non-credit education provider?

   A. Yes ___ B. No ___ C. Unknown ___

2. Does your college have "delineation of function" agreements with local school districts that permit the development of community college, non-credit programming for seniors?

   A. Yes ___ B. No ___ C. Unknown ___

3. If your answer is NO in questions 1 and/or 2, above, do you feel the State Legislature should authorize programs for community college adult education in your district?

   A. Yes ___ B. No ___ C. Other _____
   _____.

4. If your answer is YES to questions 1 and/or 2, above, respond to this question. Do you feel that the State Legislature should permit new adult or non-credit programs in community college districts that are not presently served by any provider?

   A. Yes ___ B. No ___ C. Other _____
   _____.

5. Does your college's community service or adult education program regularly offer non-credit, on-campus courses targeted toward seniors (persons 50 years or older)?

   A. Yes ___ B. No ___ C. No, but plan to within 2 yrs. ___

6. If YES, what was the total enrollment for the 1987-88 fiscal year in non-credit, on-campus courses targeted for seniors?

   A. Total # ___ B. Total not available ___

7. Check the categories of your college's non-credit on-campus courses targeted toward seniors during the current year:

	YES	NO
A. Sports and exercise	___	___
B. Games; i.e., Bridge	___	___
C. Arts and crafts	___	___
D. Physical health issues; i.e., nutrition classes, CPR	___	___
E. Foreign languages	___	___

7. Continued

	YES	NO
F. Travel	___	___
G. English as a second language	___	___
H. Science other than health issues; i.e., nature walks, astronomy	___	___
I. History or current events	___	___
J. Humanities; i.e., philosophy, religion, literature, art, music	___	___
K. Mental health and adjustment issues; i.e., losses and grief	___	___
L. Singing and/or performing instrumental music	___	___
M. Non-health related coping skills; i.e., finance, housing, home and car maintenance	___	___
N. Journal writing or other creative writing	___	___
O. Cultural and/or ethnic awareness	___	___
P. Gerontology (50% or more of the content is related to aging)	___	___

P. Other, please list _____

_____

_____.

8. Does your community college's service or adult education program regularly offer non-credit, off-campus courses, targeted for seniors who are not confined in institutions?

A. Yes ___ B. No ___ C. No, but plan to within 2 yrs. ___

9. If YES, what was the total enrollment for the 1987-88 fiscal year in the off-campus, non-credit courses targeted for seniors not confined in institutions?

A. Total # ___ B. Not available ___

10. Check the types of facilities in which courses are offered:

A. Senior Center	___	B. School	___
C. Other Government Recreation Center	___	D. Church Building	___
		E. Mobile Home Park	___
F. Retirement Apartment Complex	___	G. Other (Pls. name)	_____
		_____	

11. Check the categories of off-campus, non-credit courses targeted for seniors not confined in institutions.

	YES	NO
A. Sports and exercise	___	___
B. Games; i.e., Bridge	___	___
C. Arts and crafts	___	___
D. Physical health issues; i.e., nutrition classes, CPR	___	___
E. Foreign languages	___	___
F. Travel	___	___

11. Continued

	YES	NO
G. English as a second language	___	___
H. Science, other than health issues; i.e., nature walks, astronomy	___	___
I. History or current events	___	___
J. Humanities; i.e., literature, art, music, philosophy, religion	___	___
K. Mental health and adjustment issues; i.e., losses and grief	___	___
L. Singing and/or performing instrumental music	___	___
M. Non-health related coping skills; i.e., finance, housing, home, and maintenance	___	___
N. Journal writing and other creative writing	___	___
O. Cultural and/or ethnic awareness	___	___
P. Gerontology (50% or more of the content is related to aging)	___	___

Q. Other (Please list) _____

_____.

12. Does your community service or adult education program regularly offer non-credit, off-campus courses, targeted toward seniors who are confined in institutions?

A. Yes ___ B. No ___ C. No, but plan to within 2 years ___

13. If YES, what is the total enrollment for the 1987-88 fiscal year in the off-campus, non-credit courses, targeted for seniors who are confined in institutions?

A. Total # ___ B. Total not available ___

14. Check the categories of off-campus, non-credit courses, targeted for seniors, confined in institutions.

	YES	NO
A. Sports and exercise	___	___
B. Games	___	___
C. Arts and crafts	___	___
D. Physical health issues; i.e., nutrition	___	___
E. Current events	___	___
F. Singing and other musical activities	___	___
G. Mental health issues; i.e., social awareness, grief and losses, time and place orientation	___	___
H. Nature and plant talks/demonstrations	___	___
I. Gerontology (50% or more of the content is related to aging)	___	___

I. Other (Please specify) _____

_____.

15. Check the types of facilities in which off-campus, non-credit courses for seniors confined in institutions are currently offered for seniors confined in institutions.

A. Nursing homes ___
B. Hospitals ___
C. Inpatient psychiatric facility ___
D. Other ___

16. Is formal training in gerontology or aging issues required of instructors of courses in your program for seniors?

A. Yes ___ B. No ___ C. Other _____.

17. Check the types of training or experience required of instructors of non-credit courses for seniors.

A. Prior experience working with older adults ___
B. Seminars, workshops, or in-service training meetings on aging issues ___
C. College course work ___
D. Certificate in gerontology ___
E. Degree in gerontology ___
F. General training to meet the State requirements of adult education credentialing ___

The last few questions deal with general issues that you feel should be addressed in the next five years for community services and adult education for seniors.

18. Courses on topics related to survival skills; i.e., nutrition, losses and grieving, financial planning should be:

A. Expanded ___ B. Decreased ___ C. Remain the same ___

19. Courses with a recreational and leisure orientation should be:

A. Expanded ___ B. Decreased ___ C. Remain the same ___

20. More courses should be offered in the following sites:

A. On campus ___
B. Off-campus facilities for non-institutionalized seniors ___
C. Off-campus facilities for institutionalized seniors ___
D. The site distribution should stay the same ___
E. None of the above ___

21. Fewer courses should be offered in the following sites:

A. On campus ___
B. Off campus facilities for non-institutionalized seniors ___
C. Off campus facilities for institutionalized seniors ___
D. Distribution should stay the same ___
E. None of the above ___

22. Check the types of training or experience that you feel should be required of instructors of non-credit courses for seniors:

A. Prior experience working with older adults ___
B. Seminars, workshops, or in-service training meetings on aging issues ___
C. College course work in gerontology ___
D. Certificate in gerontology ___
E. Degree in gerontology ___
F. Other ___

23. Select the response to the following statement that best fits your view:

Community college, non-credit courses targeted for seniors should continue to have funding support from the State Legislature.

A. Strongly agree ___
B. Somewhat agree ___
C. Feel ambivalent about the statement ___
D. Somewhat disagree ___
E. Strongly disagree ___

Please state your name, your title, and your phone number, knowing that your individual responses will be grouped with other data and not be identified personally.

Your Name _____

Your Title _____

Your Phone Number (at work) _____

Name of College _____

Name of Campus _____

Thank you very much for your help with this study. Please return the questionnaire by November 7, 1988 to:

Mrs. Katherine Wendy Hanes OR
Dr. David A. Peterson
Andrus Gerontology Center
University of Southern California
University Park, MC 0191
Los Angeles, California 90089

APPENDIX E - 3

DESCRIPTION OF CREDIT COURSES IN GERONTOLOGY

COMMUNITY COLLEGE EDITION

Institution Name _____

Campus Name _____

Campus Address _____

City, State, Zip _____

Which one response best describes your institution?

____ Single campus

____ Main campus, with branches

____ One of a multi-campus system

We would like to know about the courses and the organizational structure of Gerontology and Geriatrics Instruction on your campus. (A course must have at least 50% of its content related to aging to be considered a Gerontology or Geriatric course.)

1. Do you have regularly offered credit courses that have at least 50% of their content related to aging? (Regularly offered means at least once per year.)

   A. Yes ____ B. No ____ C. No, but plan to within 2 years ____

2. If yes, how many regularly offered credit courses do you have in Gerontology or Geriatrics?

   _____ Number of courses

   Please fill in the chart below for each regularly offered credit course with 50% aging content.

		EXAMPLE	COURSE 1	COURSE 2	COURSE 3
3.	Course Title	Physiology of Aging			
4.	No. Sem. Units				
5.	No. Qtr. Units	3			
6.	X, if elective	X			
7.	X, if required				
8.	Name(s) of special program(s) requiring course	A. B. C.			
9.	Name(s) of special program(s) accepting course as elective	A. RN, Nursing B. Human Serv. C. Biol. Major			
10.	Name of program offering course	Biology Dept.			
11.	Name the title of the mgmt. supervisor of the academic program offering course.	Division Dean, Physical & Biological Sciences			

12. Do you have any non-credit/adult ed. courses that have at least 50% of their content related to aging? (Note: Content, not target population.)

Yes ____ No ____

13. If yes, please list the non credit/adult ed. courses that have at least 50% of their content related to aging:

A. _____

B. _____

C. _____

D. _____

E. _____

APPENDIX F

Samples of original writing and related materials from Gerontology 591 - West Covina. Internship and campus practicum.

Internship and Campus Practticum

F-1 - Plan for Gerontology 591,
An internship at the senior center in the City of West Covina, written by K. W. Hanes.

F-2 - Course Outline of field practicum seminar that accompanied the seminar.

F-3 - Service plan outline for Cortez Senior Center, developed by K. W. Hanes during the internship.

F-4 - Recommendation and outline for citizen review session written by K. W. Hanes during the internship.

APPENDIX F - 1

1. Wendy Hanes is on sabbatical from her position as a tenured psychology instructor at Mt. San Antonio Community College. Her career interests are focused on general psychology, development of a human services program for para-professionals, direct service to the elderly and public policy and administration for seniors at the local community level.

   Mrs. Hanes's preparation for the internship includes completion of the following graduate degrees: Master of Education, 1959, University of Toledo, guidance and counseling; Master of Arts, 1969, Psychology, Claremont Graduate School; M.S.G., 1981, U.S.C., direct service option. She has also just completed thirteen years as a West Covina City Commissioner in human relations and human resources during a period when a senior citizen's center was planned and constructed. Mrs. Hanes is a licensed M.F.C.C. who has completed a direct service internship with the elderly.

2. a. Mrs. Hanes expects to learn to develop a service plan for the Senior Citizen's Center in the City of West Covina under the supervision and with the cooperation of Gus Salazar, Human Services Director and Pat Bommarito, Cortez Senior Center Director.

   b. She also expects to visit three or four programs for mental health care for seniors in Europe in late October and November, 1988. Some of the information gained will be helpful in developing an innovative plan for West Covina's Senior Center and its programs.

3. The supervisors expect Mrs. Hanes to have a major role in developing and writing the strategic plan for the West Covina Senior Center. The plan will outline the "best future" options for implementation of services. It will be a guide for programs and future physical changes of the Senior Center. They also expect her to share the findings from her sabbatical travel experiences.

Addresses:	Mr. Gus Salazar, Human Resources Department 1444 West Garvey, West Covina, 91793 Phone: (818) 814-8430 Mrs. Pat Bommarito 2501 East Cortez, West Covina, 91791

4. The primary goal for the internship is to write major portions of the process for developing a service plan for the Cortez Senior Center in the City of West Covina. A second goal for the internship is to gather and share written handouts and oral information about some model programs of social services for the elderly.

5. The goals will be met by accomplishing the following objectives:

   a. Mrs. Hanes will observe and participate in some of the activities of the Cortez Senior Center an average of four hours per week.

   b. Mrs. Hanes will read at least two strategic planning documents to use as models for the West Covina plan.

c. Mrs. Hanes will read at least three city documents or outlines that pertain to programs and projects for seniors.

d. 1.) Mrs. Hanes will write a general service plan that includes the categories of service to seniors, the service needs of older adults, a general review of existing programs, and a statement of service gaps with examples.

2.) The service plan will also contain a sampling of present and potential resources.

3.) It will conclude with recommendations for addressing some of the un-met needs of older adults who participate in the Cortez Senior Center.

e. Mrs. Hanes will write a brief outline for one committee meeting that will review and discuss the service plan.

f. Mrs. Hanes will visit at least three sites in Europe that were designated as model service programs for the elderly.

g. Mrs. Hanes will give some written materials about service programs for seniors that were gathered during a Spring and Fall sabbatical in 1988. She will also talk about some of her experiences at meetings with her supervisors.

6. Mrs. Hanes will write at least four progress reports at two to three week intervals. Mrs. Hanes will also meet with Mrs. Pat Bommarito at least once a week during the time that she is not traveling in Europe.

7. Some of the structure of the internship has been stated in the foregoing objectives. A time line is diagrammed below:

Beginning September 6	A. 1) Writing the internship contract 2) Observing at the Senior Center 3) Meeting with Pat Bommarito and Gus Salazar 4) Reading city documents and planning models 5) Writing drafts of parts of the service plan B. Writing summaries and distributing information learned in earlier sabbatical travel C. Making arrangements for European Travel
October 24	Visiting at least three mental health service programs listed in the book Creative Mental Health Services for the Elderly
November 15	(See A., 2-5 and B - above)
December 14	Ending of fall semester classes and work agreement with West Covina Senior Center

APPENDIX F - 2

Fall, 1988
Grace Ford Salvatori
Room 216, 10 am -12 pm

Facilitator: Fran Kobata

Offices:231 and 233
Office Phone: 743-4768
Office Hours: 9/9, 9/23 10/21, 11/4, 11/11 from 9-10 am and 1-3 pm or by appointment

GERO 591

FIELD PRACTICUM SEMINAR

Introduction: This seminar is designed to provide interns with a forum to discuss, debate, and resolve issues arising out of their internship experiences. Practice issues and skills building will be emphasized.

Seminar Objectives:

1. To debrief and resolve workplace issues using consultation and case conference methods.

2. To develop practice skills in areas such as decision-making, problem-solving, supervision, negotiation, and interviewing.

3. To learn first hand from conversations with effective successful practitioners and administrators about keys to success.

4. To prepare for job search and job readiness.

Readings: Selected articles pertinent to issues covered.

Grading Criteria: It is mandatory that students attend at least 6 seminars during the tenure of their internship experience. Students will not receive credit for GERO 591 until they have participated in at least 6 seminars. Six classes will be offered in both the fall and spring semesters so that the intern may choose the classes that are of the most personal interest and that fit into his/her time schedule. However, the intern is strongly encouraged to participate in all twelve of the classes. The intern will accrue credit for two hours of internship experience for each class that she/he attends. For example, if the intern chose to attend all twelve of the scheduled classes then she/he would accrue twenty four internship hours.

Assignments: There will be no written assignments for those interns who attend the seminars. However, students are asked to come prepared to discuss internship issues.

COURSE OUTLINE

Overview of Seminar Structure: Typically, the class will be divided into two sections. The first half of each class will cover a specific topic (career development, analyzing your organization, ethical issues, etc.). The second half of each class will be more devoted to the day-to-day issues that will arise during the student's internship experience.

SEMINAR SCHEDULE

September 9
Session 1

Introduction: Review rationale, goals, objectives, and expectations for the practicum seminar.

Major Focus: Analyzing Your Organization

Key Questions: Do you know the structure of your organization? Where does your supervisor fit into the organizational hierarchy? What are the norms? What are the expectatations for the interns? Are there any booby traps an intern could fall into?
How do you communicate in writing?

September 23
Session 2

Major Focus: Career Development/Developing the Learning Contract

Key Questions: What are your short-term and long-term career goals? How do you work with your supervisor to develop a practical, useful, and goal-directed learning contract? How might the internship be used to help you achieve your goals?

October 7
Session 3

Major Focus: How to Use One's Personal Style Effectively
Guest Speaker

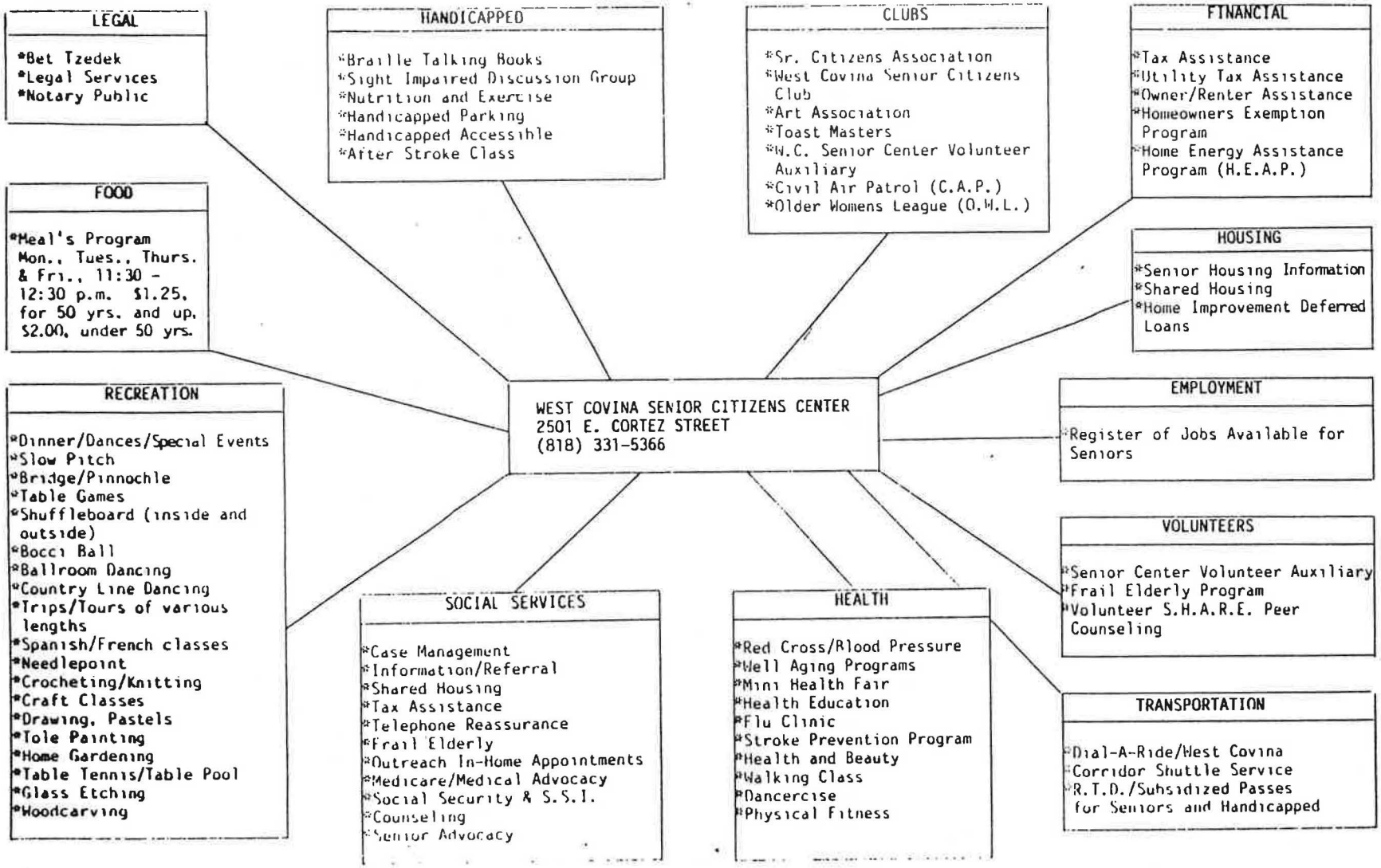
Key Questions: What is your personal style in working with people? Are you a team player? Are you a supervisor? Do you prefer to work alone?

October 21 Session 4	**Major Focus:**	Ethical Issues in the Workplace **Guest Speaker**
	Key Questions:	Do you know how to recognize ethical issues that arise in the workplace? What kinds of ethical issues might an intern encounter? What do you do when you are placed in an ethical dilemma?
November 4 Session 5	**Major Focus:**	Women's Issues in the Workplace **Guest Speaker**
	Key Questions:	What kinds of issues do women encounter in the workplace? How do women juggle work, family, and personal time?
November 11 Session 6	**Major Focus:**	Communication/Leadership **Guest Speaker**
	Key Questions:	How is communication style related to leadership? What makes an effective leader? Must a leader be assertive? What is the difference between assertiveness and aggressiveness?

CURRENT PROGRAMS AND FUTURE POSSIBILITIES FOR SENIOR CITIZENS IN WEST COVINA

I. What Are We Doing Now? A Summary of the Present Activities of the West Covina Senior Citizens' Center.

Citizens of West Covina can point with pride to the Senior Citizen's Center, its personnel and its servies. A chart of the center's current programs is included below. The diagram tells us how active we are right now and helps us focus on future concerns with civic confidence.



II. Where Are We Headed? A Vision of the Future for the Senior Citizens of West Covina.

FOCUS AREAS FOR CONCERN: a need for expanded discussion and action.

A. CONCERN ABOUT THE EXPECTED INCREASE OF FRAIL ELDERLY IN THE 21ST CENTURY

Possible Action	Examples
1. Fostering joint ventures among community groups and institutions to provide support services for the frail elderly and their caregivers.	1. Begin a day care center for older adults near the West Covina Senior Center of other local facility as a joint venture with local hospitals, churches and community groups.
2. Galvanizing West Covina neighborhoods as a source of support for the frail elderly.	2. Initiate model "Elder Watch" programs in two or three neighborhoods expanding on the concept of the police department "Neighborhood Watch".
3. Encouraging assistance and respite for the caregivers of the frail elderly.	3a. Maintain a support group for primary caregivers of the frail elderly at the W.C. Senior Citizens Center.
	3b. Participate in joint ventures for training and utilizing volunteers to help caregivers, using the training model for volunteers in hospice programs.

Sample Community Awareness Slogans

1. Help the Frail Elderly, Return Care to Those Who Cared for Us.
2. Join Elder Watch, If You're Lucky You'll Grow Old in this Neighborhood too.
3. Elder Watch, an Intergenerational Neighborhood Service Program.
4. Elder Watch, on the Alert for Neighborhood Seniors in Need.
5. Saving Primary Family Caregivers from "Burnout".

CONCERN ABOUT THE NEED FOR ADULT EDUCATION WITH INCREASED FOCUS ON QUALITY OF LIFE AND SURVIVAL CONTENT

Possible Action	Examples
1. Maintaining joint-ventures with Mt. San Antonio College providing more classes at the Senior Center that focus on how to cope with the economic, family and health issues of aging.	1. Find additional funding from donations or creative capitalism to permit small discussion classes to run on such topics as "Enhancing Intergenerational Communication", "Managing Life without a Partner", and "Loss and Grief".
2. Networking with service groups and providers to create one day of workshops covering a range of quality-of-life topics.	2. Use the workshop format for direct education of seniors and for community organizations to plan joint service ventures.
3. Using city conference space to have regular informational meetings for potential providers to integrate future community-based service to older adults.	3. Appoint several articulate West Covina seniors to serve as a volunteer informational officers assigned to let community seniors know about the local services available to them.

Sample Community Awareness Slogans

1. A Little Knowledge about Aging is Not Dangerous!
2. A Little Knowledge about Aging is Better than None!
3. Adult Education Is More Than Fun and Games!
4. They're Not Alone! Build Joint Ventures to Service the Elderly in Need.
5. The Service You Give at 65 May Be Returned to You at 85.

B. CONCERN ABOUT CONSTRUCTIVE COMMUNITY RESPONSES TO INTERGENERATIONAL, INTERCULTURAL AND ETHNIC VARIETY

Possible Action	Examples
1. Promoting intergenerational and intercultural awareness activities in the form of fairs, newsletters and service awards for person to person or neighborhood projects.	1a. Plan intergenerational and intercultural food booths, exhibits and musical programs at city festivals and fairs.
	1b. Sponsor intergenerational and intercultural Saturday breakfasts at West Covina Senior Center.
	1c. Include intergenerational and intercultural activities as categories in the human services awards programs.
	1d. Publish a newsletter that emphasizes the benefits of community diversity.
2. Encouraging joint ventures in cultural awareness with schools, civic groups, churches, neighborhoods and the local press.	2a. Co-sponsor a youth poster exhibit in the shopping malls with help from the schools and youth groups. (Prizes could be travel and scholarship awards drawn by lottery from accepted entrants.)
	2b. Send press releases to school papers, church bulletins and the local papers that emphasize information with intergenerational and intercultural themes.
	2c. Organize leaders in neighborhoods to begin get acquainted coffees with neighborhood emergency response as a theme (common projects work better than parties to bring people together).

Sample Community Awareness Slogans

1. West Covina Neighborhoods, Headquarters for Harmony and Caring.
2. Live and Help Live, Enjoy West Covina Diversity.
3. Knowing Your Neighbor May Save Your Life.

Appendix A

FUNDING RESOURCES

A. FUNDING CONCEPTS

1. Form joint ventures to spread costs.

2. Start a non-profit foundation for projects and services for the elderly.

3. Use U.S.C. interns in gerontology to write grant proposals for funds from existing foundations.

4. Begin "creative capitalism" by charging for some goods, programs and services that could provide money for other service needs.

B. EXAMPLE OF PUBLICATIONS OF FUNDING RESOURCES FOR THE ELDERLY

1. Title: National Guide to Funding in Aging

   Author: Compiled and Edited by David M. Weiss & Diane E. Mahlmann
   (Long Island Univ., Nassau County Dept. of Sr. Citizen Affairs,
   The Foundation Ctr.)

   ISBN No.: 0-87954-191-1

   Price: $35.00 / Publication Date: January 1987
   The Foundation Center, 79 Fifth Avenue, New York, N.Y. 10003

   Published by: Adelphi Univ. Press under the title: Funding in Aging: Public, Private, Voluntary

2. (20.513) Capital Assistance Program For Elderly and Handicapped Persons
   Address: Urban Mass Transp. admin. & Ofc. Grants Mgt., Ofc. Capital & Formula Assistance, 400 7th St. S.W., WA D.C. 20590
   Telephone: (202) 366-2053
   Purpose: To provide financial assistance in meeting transp. needs of elderly and handicapped persons where public svcs. are unavailable, insufficient, unappropriate.

   Support: Purchase of specialized vehicles for transportation of elderly and handicapped.

3. Fund Raiser's Guide to Human Service Funding

   1rst Edition
   The Taft Group, 1988
   5130 MacArthur Blvd.
   Washington D.C. 20016

   (800) 424-3761
   (202) 966-7086
   533 pp.

4. Guide to California Foundations

   Researched by: Morgan Gould, PhD
   Published by: Northern California Grantmakers (6th Edition - 1985)
   334 Kearny St.
   San Francisco, CA 94108

B. GOOD PLACES FOR GATHERING FUNDING INFORMATION

1. California Community Foundation (Wilshire Blvd., near Western)
2. Grantsmanship Center (650 S. Spring St., L.A.)

Appendix B

FACTS ON AGING*

1. Individuals age 65 and over represent 12% of the population.
2. It is expected that the 65 and over population will represent 21.2% by the year 2030.
3. At least 80% of individuals over age 65 have one or more chronic diseases.
4. About 20% of persons 70 years of age needs some assistance on a daily basis; by the age of 80, this figure doubles.
5. Living arrangements indicate that 38% of women over 65 live with a spouse, 18% of men over 65 live alone while 75% live with a spouse and 7% live with other relatives.
6. Social Security is the single largest source of income for the elderly.

* References: AARP, A Profile of Older Americans, 1986

Federal Register/Vol 52, No. 194/October 7, 1987.

The Rancho Owls

Rancho Los Amigos
Medical Center
Downey, CA 11988

SERVICE PLANNING FOR THE CORTEZ SENIOR CENTER - A RECOMMENDATION FOR A CITIZEN REVIEW SESSION

INTRODUCTION

The West Covina Senior Center has provided a growing list of services to older adults and to other community residents. In order to stimulate interest and involvement in additional long-range planning for the center's services, city staff members are developing a service plan for the West Covina Senior Center.

The general goals of such strategic planning is to develop a proactive, rather than a reactive approach to the problems and issues relating to seniors. The services must fit older adults heading toward the Twenty-First Century in the East San Gabriel Valley. Initially, to be proactive means to look ahead to the needs and wants of seniors in the West Covina area. Additionally, to be proactive means to move steadily from plans on paper to services in action. The hurried responses to crises and the destructive aspects of conflicting needs can be avoided.

The primary objective of this recommendation is to establish a review and discussion of staff's efforts in developing a service plan for seniors.

Group members are participating because they meet one or more of the criteria listed below:

1. The participant is a senior and has had a leadership role in a group that focuses on the needs or activities of seniors.

2. The participant is a senior and is designated as a representative of a group that focuses on the needs or activities of seniors.

3. The participant has knowledge and experience in fields, such as gerontology, public administration, social work, or health care. Financial management, architectural design and human relations are other examples of useful specialties in planning senior projects and programs.

4. The participant is a senior with special needs. A senior whose vision is seriously impaired or an older adult who is permanently confined to a wheelchair would have special service needs. A widow with a low income or the caregiver to a person with Alzheimer's disease would fit this criteria.

5. The participant is an advocate for seniors who cannot represent themselves. The confined elderly in private homes and institutions might be represented by an advocate.

In order to develop a balanced service plan, differing experiences and viewpoints are essential. Such diversity can help each participant remember that no single service category should dominate in a comprehensive program. Programs for seniors need to reflect the fact that people actually grow increasingly unalike as they age.

During the course of the meetings, information will be distributed that relates to the discussion topics. An outline of the topics for the session will follow the introductory material.

OUTLINE

What is a service plan for seniors?

A. Introduction of participants, their interests, and expectations.

B. Review of the objectives for service planning.

C. Definition of terms used by planners (getting to know a little of the jargon.

D. Report on the service plan for seniors that was developed in preliminary meetings (city staff).

E. Participant's discussion of the report.