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Social service utilization assessment: An informal and formal network analysis

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SOCIAL SERVICE UTILIZATION ASSESSMENT:

AN INFORMAL AND FORMAL NETWORK ANALYSIS

by

Gloria P. James

A dissertation submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Individual and Family Studies

Fall 1994

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AN INFORMAL AND FORMAL NETWORK ANALYSIS

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DEDICATION

In memory of Janette W. Burrows, a true inspiration.

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ABSTRACT

Research has indicated that African American elders are at a somewhat disadvantaged position relative to white elders in terms of life expectancy (Atchley, 1988) and poverty rates (Markides and Mindel, 1987; Minkler and Stone, 1985). At the later stages of the life span blacks have experienced greater rates of early retirement, disability, physical disability, morbidity and higher death rates. Given these factors, it seems reasonable to assume that poverty within racial and ethnic subgroups of the elderly population contributes to racial and ethnic differences in the awareness and utilization of community-based health and social service programs.

The decision to conduct this study, in part, was based on the scarcity of investigations on social service utilization among African American elderly that incorporate community-action research utilizing the Andersen/Newman (1973) behavioral model. Consequently, various sociodemographic characteristics of black elderly were examined to determine specific factors that significantly contribute to social service utilization. Information was also gathered on the type and range of informal and formal support networks available and whether those

networks impacted African American elders' utilization of such community-based services.

Respondents for the survey came from three sources. First, a modified random sample was taken from the total population of all persons aged 60 or older who were members of Ezion Mt. Carmel United Methodist Church, Scott African Methodist Episcopal Church, Bethel African Methodist Episcopal Church or St. Matthews Episcopal Church or participants at Kingswood Community Center or People's Settlement Senior Center in inner-city Wilmington. Second, participants for the survey came from interviewee referrals. Third, community elders who sent back response cards (from a postcard distribution) indicating their willingness to participate in the research were included in the project.

Two hundred persons were interviewed face-to-face or by telephone. The survey included questions that provided data on predisposing, enabling and need factors that related to social service utilization behavior among African American elderly. The type and range of social support networks available to the respondents and how their use of such networks influenced social service use was also examined.

The findings show various significant associations between selected predisposing, enabling and need factors and social service awareness and utilization. First, service awareness was relatively high among the respondents. However, actual service utilization was somewhat low, particularly when service type was examined. Second, service awareness was significantly affected by the

educational and income level of the respondent, the type of social support network used, living arrangement and need. Third, social services ever received was significantly associated with age, source of income, the type of social network support used and need. Fourth, social services currently receiving was significantly influenced by age, marital status, source of income, type of insurance, type of social support network used and whether kin lived nearby. Fifth, informal and social support use was significantly affected by age, gender, church attendance and kin living nearby for familial support and marital status and church attendance for friend support. None of the predisposing, enabling or need factors significantly influenced formal support utilization. Sixth, need for assistance with instrumental/activities of daily living was significantly associated with age, living arrangement and church attendance. However, no predisposing or enabling factors predicted the need to have someone organize or coordinate the kinds of help that respondents needed or to help them make arrangements to receive such assistance. Need for assistance with instrumental/activities of daily living and social support use were significantly associated with church attendance and kin living nearby. Finally, the need to have someone organize or coordinate the kinds of social service help that respondents needed or help them to make arrangements to receive such services was significantly affected by formal support use.

Findings from this study provide empirically-based information about African American elderly relative to social service utilization behavior and social

support network use. Specifically, this comprehensive examination of predisposing, enabling and need factors significantly influencing social service awareness and utilization and social support usage patterns provides useful information for gerontological practitioners in the field. Results of this investigation will be used to impact the design of social welfare policy as it relates to providing social service delivery to African American elderly residing in Delaware.

Chapter I

INTRODUCTION

Overview of Chapters

The dissertation is presented in six chapters. The focus of each of the chapters is briefly summarized below.

In Chapter I, the problem statement, the study, purpose of the research, limitations and significance of the study are presented.

In Chapter II, a comprehensive review of health and social service utilization literature is given. The review covers six different perspectives of service utilization among the general elderly population in addition to the overview of formal and informal utilization behavior of the elderly.

Chapter III presents the conceptual framework upon which the research is based. Research questions of the study are also highlighted.

The methodology will be presented in Chapter IV. The location of the study, research design, sampling procedures, instrumentation, collection of data and method of data analysis are included in the presentation. Finally, the operationalization of the variables will be addressed.

In Chapter V, an overview of the findings are discussed, paying particular attention to descriptive and analytical observances.

Finally, in Chapter VI, conclusions from the study are addressed. A summary of the findings in relationship to the initial research questions will be detailed. Next, implications of the investigation will be given. Lastly, recommendations in conjunction to the implications of the research will be presented.

Problem Statement

Older persons in general and black elders in particular have not been the subject of extensive empirical investigations and discussion concerning social service utilization behavior (Spence and Atherton, 1991). In fact, Jackson (1982) notes that prior to 1981 83% of the works on the black aged were published between 1970 and 1980. More than a decade later research in this area is still limited. For example, while black elderly have been included in studies regarding the general elderly population, proportions of the sample have typically been insufficient for any meaningful statistical analysis and interpretation (Spence, 1988). Moreover, the failure to control for variables such as income, education and gender in comparative research of African American elderly and other minority groups has led to questionable findings (Jackson, 1972).

In considering the research status of black elderly from a somewhat different perspective, some gerontologists (Jackson, 1972, 1980, 1988; Hill, 1972)

maintain that the paucity of research regarding this area dictates that efforts should be targeted at separate and in-depth investigations. In addition, it is argued that research investigations employing this approach will aid in the identification of inner-group similarities and differences among black elderly which can then serve as a basis for comparisons with other groups. Jackson (1988) asserts that failure to conduct such research hinders the understanding of the heterogeneity existing among these elderly minority cohorts. Consequently, when African American elderly are the exclusive group to be investigated, the impact of factors such as income, education, gender and family structure on the lives of African American elders can be more completely explored.

In late 1990 came an identified need from Geriatric Services of Delaware and subsequent request to empirically investigate a problem found in inner-city Wilmington, Delaware, particularly among elderly African Americans. Thus, an opportunity was provided to examine various sociodemographic characteristics of minority elderly that possibly contribute to their utilization of social services. Information was gathered on the type and range of informal social support networks available and whether such networks impact the elders' utilization of community-based services. Therefore, the goals of the study were as follows:

1. To examine the extent to which black elders are familiar with community-based social services.

2. To explore factors that influence the utilization of informal and formal support.

3. To examine the extent to which black elders have access to both informal and formal support.

4. To examine the relationship between informal support and social service utilization.

Furthermore, the primary objectives of the investigation are:

1. To identify specific, formal social support services which black seniors are familiar.

2. To examine sociodemographic factors that impact African American elders' informal and formal support systems.

3. To determine whether there is a relationship between informal social support and formal social service utilization.

4. To use findings from the research to impact the design of social welfare policy as it relates to providing formal service delivery to minority elderly residing in Delaware.

The Study

The decision to conduct this study is, in part, based on the scarcity of research in this area. Additionally, in conducting this investigation, a sociodemographic approach is integrated into a community-action research model utilizing a three-stage sequence (Hoffer, 1958). This three-stage process represents a broad range of tasks to be completed at each stage. First, the "initiation of action" stage involves the recognition and illumination of a need. Second, "legitimizing the action" consists of gaining the support of individuals and/or groups in the community. It is during this phase that steps are taken to bolster interest in the project. Third, "executing the action" involves either hiring an

agency or organization to perform the task; assigning the work to an organization already existing in the community or creating a new organization specifically to perform the task. This stage includes action necessary for a steering group to carry out or at least orchestrate a project in the community.

Utilizing the Hoffer three-stage model, the Minority Outreach Survey Project was developed. In community-action research, the identification of the problem can either be initiated by the researcher, an agency/organization, or by an individual or group within the community. In this case, the initial problem was identified by an agency. In 1988, through a grant provided by the United Way, Geriatric Services of Delaware, Incorporated, a nonprofit home care agency, provided education and counseling on elder community-based support services to 183 senior citizens attending Ezion Mt. Carmel United Methodist's Senior Program which drew from participants who lived in the nearby senior-citizen high rises and the surrounding downtown (Wilmington, Delaware) areas. At the end of this year-long project, three informal conclusions were made based upon the information gathered from the 183 participants. The three informal conclusions were that: 1) minority elderly were less likely to use available community-based social service resources than their white counterparts; 2) the majority of the 183 participants were unaware of many of the formal support services available or could not identify agencies that provided support; and 3) most of the seniors resorted to informal systems for assistance. Sometimes, such reliance on informal support

resulted in numerous instances of exploitation. For example, persons calling themselves members of the clergy, charged seniors $25 each to cash their Social Security checks (at a local bank). In addition, community elders were charged $8 to $10 per round trip to be transported to the grocery store at a nearby shopping center (less than a three-mile drive). Consequently, from these findings came a need to provide a mechanism:

- To identify what support services inner-city, black elders were familiar with.
- To determine to what extent black elders were relying on informal support.
- To determine whether seniors had access to formal services.

The city council of Wilmington, Delaware and the Rotary Club provided additional funding for Geriatric Services to establish a 10-member Elderly Task Force which would be responsible for identifying specific support needs and provide follow-up for 315 identified elderly living on the east side of the city. The 10-member task force came from an already established Health Care Task Force that was part of the Ezion Mt. Carmel Senior Program. The County Director of Geriatric Services recommended to the task force that the problem be studied empirically so that results coming from such a study would warrant more support and subsequent follow-up. The task force agreed. The recommendation was then presented to the Director of Geriatric Services for approval. However, the director felt that the project had not been originally funded for research purposes.

Consequently, a grant application was submitted to the Gannett Foundation to carry out a pilot outreach program for minority elderly. Under the pilot outreach program and in collaboration with Ezion Mt. Carmel United Methodist Church, Geriatric Services would train church members through an established Elderly Task Force to: 1) access the needs of aging members of its congregation; and 2) provide advocacy and follow-up to help the elderly access needed services. However, the proposal was not funded. Therefore, the County Director of Geriatric Services solicited assistance from the Delaware Chapter of the National Black Caucus and Center for Black Aged, Incorporated (NCBA) of which she was a member.

In late 1990, the concept of undertaking a research project was presented to NCBA, an organization dedicated to improving the quality of life for older blacks through housing, career development, legislative advocacy, public policy and employment. Geriatric Services would supply the Black Caucus with initial seed money, limited clerical staff and any pertinent information from previous programs. The Black Caucus, in turn, would give input and seek additional funding and determine whether to contract the research project out or to have its members become involved in the investigation. Around the same time, the County Director of Geriatric Services met with the Assistant Director of the Census and Data Systems, College of Urban Affairs and Public Policy at the

University of Delaware and other representatives from the college to design the survey instrument.

The investigator of this study became involved with this particular phase of the project when she and other members of the Black Caucus were asked for their comments on the first draft of the survey. Criticism of the survey instrument was quite extensive, resulting in the complete redesign of the tool. In order to include various culturally-based questions on the survey instrument, suggestions were received from the task force at Ezion Mt. Carmel Church as well as People's Settlement, a community-action agency whose services provide for specific social, cultural and economic needs of preschoolers through senior citizens.

Several drafts and much input later, it was decided that the Black Caucus would work with Geriatric Services on the project. Both organizations initially agreed upon the following phases:

PHASE 1 - To develop a survey instrument in order to access the awareness and utilization of support services and service delivery among inner-city minority elderly.

Identify and train volunteers who would serve as interviewers and complete the survey process.

Finally, code and analyze the data.

PHASE 2 - To develop an analytical report documenting the extent of social service utilization among those surveyed, examine gaps in the services provided and recommend a long-range cost-effective planning approach that would address improvement, if needed, in the social service delivery system.

To send a report to the governor and the chair of the Health and Social Services/Aging and Administrative Services Committees in the Delaware General Assembly.

Finally, in cooperation with the aging network, the Caucus would lobby for proposed changes in social service/social informal support systems as they impact minority elderly within the state.

Later, the Black Caucus was given full responsibility of monitoring both phases of the project. After an aborted attempt to hire someone to coordinate the project and train the volunteers (some of whom were Black Caucus members) the coordination of the project was given to the investigator of this study.

Purpose

Much of the current literature on knowledge utilization suggests that the significant factors in getting research findings implemented are by stimulating interest and involving the client in part or all of the stages of the research process (Alkin, 1985; Glaser and Taylor, 1973; Leviton and Hughes, 1981). Consequently, the purpose of the Minority Outreach Survey Project was twofold:

1. To develop and use a culturally-based survey in order to generate greater insights on formal/informal support utilization among minority elderly living in inner-city Wilmington, Delaware.

2. To use the findings from the research to advocate for change in the social welfare policy within the state as it impacts the social service delivery system and minority elderly.

Significance of the Study

Research has indicated that African American elders are in a somewhat disadvantaged position relative to white elders in terms of poverty rates (Markides and Mindel, 1987; Minkler and Stone, 1985), work and retirement (Jackson and Gibson, 1985), institutional placement (Markides and Mindel, 1987) and life expectancy (Atchley, 1988).

Although the percentage of impoverished elderly people generally has declined dramatically since 1959, the poverty rate in 1983 among African-American elders was still 35%, compared with 12% for elderly white Americans (Markides and Mindel, 1987). Given these statistics, it seems reasonable to assume that the differential exposure to poverty by racial and ethnic subgroups in the aged population contributes to racial and ethnic differences in the utilization of public income-maintenance programs by older blacks and whites. African Americans are almost three times as likely as whites to rely mainly or solely on social security benefits in old age (Sherman, 1979) while whites are more likely to rely on income from assets (Grad and Foster, 1979).

In addition to disproportionate rates of poverty among African American elders, at the later stages of the life span blacks have experienced greater rates of morbidity, disability, early retirement and higher death rates. It is only after the age of 75 to 80 that blacks tend to show increased longevity in comparison to whites (Manton, 1982; Jackson and Gibson, 1985; Markides, 1983).

In addition, research by Gibson and Jackson (1986) on a national sample of black elderly suggests that the emergent black oldest-old group is quite heterogenous. They also reported that rather than increasing with age, physical limitations are more concentrated in the younger-old groups, those 65-74 years. Furthermore, the data indicated that the oldest-old blacks may be both physically and psychologically better off than younger-old blacks and that they have more effective and helpful informal networks to depend on.

Since the 1970s there has been an effort to include minority elderly in empirical analyses. In addition, recent concerns have focused on: the dearth of systematic research pertaining specifically to black elders (Jackson, 1982; Crawley, 1988), the under-representation of these individuals in the formal social support delivery system (Richardson, 1992; Spence and Atherton, 1991; Taylor and Chatters, 1986; Crawley, 1988; Mutchler and Burr, 1991), and the lack of adequate social welfare policy to meet the needs of this most vulnerable population (Taylor and Chatters, 1986; Gratton and Wilson, 1988; Wolinksy, Alguirie, Fann, Keith, Arnold, Niederhauer and Dietrich, 1989; and Richardson, 1992).

This study provides noteworthy information for several reasons. First, this study is important because it provides empirical information regarding a segment of the black elderly population in this country. Findings resulting from this research undertaking increase the limited knowledge base, and therefore,

contribute to the understanding of these individuals as members of a particular population as well as members of a subgroup of the general elderly population.

A second factor contributing to the study's significance is the integrative framework of identifying sociodemographic factors that influence the utilization of social services by black elderly within a community-action research model. By using this approach, the research has more practical application since the single most significant factor in getting research findings used is to enlist the involvement of the client in part or all of the stages of the research process (Alkin, 1985; Glaser and Taylor, 1973; Leviton and Hughes, 1981).

A third aspect of the study that contributes to its importance is studying black elderly as a separate entity. Exploring service utilization in this manner allows in-depth analyses in relationship to the heterogeneity among black elders. Thus, similarities and differences influencing service utilization and/or informal support can be investigated in terms of inter-group characteristics.

Chapter II

LITERATURE REVIEW

Overview of Formal and Informal Utilization Behavior and the Elderly

While the vast majority of the elderly live independently and require little assistance, one-fourth of those 65 years and older living in community settings within the United States are estimated to need help on at least one Activity of Daily Living (Katz, Downs, Cash and Grotz, 1970) and/or one Instrumental Activity of Daily Living (Lawton and Brody, 1969). Activities of Daily Living (ADL) include very basic physical activities like bathing, toileting and walking while Instrumental Activities of Daily Living (IADL) involve more secondary functions such as preparing meals, shopping, taking medications, handling money and doing housework. In addition, 54% of persons 85 years of age and older need help from another person in meeting their activities of daily living needs (Bould, Sanborn and Reif, 1989). Furthermore, the elderly are major consumers of health care in the United States, accounting for 20% of physicians visits, 41% of hospital days and 33% of total health care costs in the 1980s (U. S. Senate Special Committee on Aging 1987 - 1988).

The absence of ongoing familial caregiving for chronically ill persons has been cited as one of the main reasons why some frail, elderly individuals are admitted into nursing homes (Kane and Kane, 1987; Shanas, 1979; Brody, 1985; Sauer and Coward, 1985). In fact, the minority of persons who reside in long-term care facilities--about 5% of those 65 years and older (Lawton, 1979)--are outnumbered 2 to 1 in the United States by equally disabled elderly living in the community and being cared for by their families (Brody, 1978; Stone, Cafferata and Sangl, 1987). Consequently, compared to noninstitutionalized older persons, individuals residing in long-term care facilities have significantly fewer family supports (Branch and Jette, 1982; McAuley and Prohaska, 1982). Therefore, the above researchers contend that family members play a vital role in providing informal support to their elderly relatives and assist in keeping them maintained in the community. When family members do not actually provide services themselves they play a major role in the mobilization, coordination and monitoring of services from other sources and respond when the arranged care program breaks down or when intermittent services are needed (Sussman, 1976). Therefore, among the proportion of the elderly who receive care from combined sources, the use of formal and informal services should not be treated separately because the sources are interdependent; a service received from one source may obviate the need for that service from another source (McAuley and Arling, 1984). Furthermore, in years to come, the aging of the population will have a major effect on our social

system's ability to provide, coordinate and integrate a continuum of both health and social services on formal and informal levels as the elderly are provided assistance (Sussman, 1991).

Gerontological studies combining formal and informal utilization behavior as a primary research endeavor are seldom undertaken. As a result, the use of health and social welfare services by the elderly has had relatively limited scientific research exploration. For example, Coulton and Frost (1982) attempted to explain formal service use without taking into account informal sources, while Branch and Jette (1983) and Stoller and Earl (1983) examined informal service without controlling for formal sources of care. Nevertheless, the utilization of health and social services by the elderly has been found, in part, to be influenced by a wide range of sociodemographic factors (McKinlay, 1972; Neugarten, 1974; McCaslin and Calvert, 1975; Downing, 1978; Harris, 1975; Mutchler and Burr, 1991; Richardson, 1992; Wolinsky, Mosely and Coe, 1986; Mindel and Wright, 1982). Some studies indicate that economic, community, organizational and environmental characteristics are directly related to use (Palmore, 1972; Hammerman, 1974; Andersen, McGreely, Kravits and Anderson, 1972; Cutler, 1975; Cantor, 1975; Ward, 1977; Bastida, 1989; Meller and Mudrich, 1987; Chapman and Pancoast, 1985). Other studies have found that social and psychological factors influence use (Fabrega and Roberts, 1972; Andersen and Newman, 1973; Butler and Lewis, 1973; Lowy, 1979; Greenley and Mullen,

1990). Finally, some studies suggest that the perception and awareness of need, the availability of formal and informal support systems, and previous contact with the service delivery system are critical in determining utilization (German, 1975; Davis and Reynolds, 1975; Cantor and Mayer, 1978; Krout, 1984; Carrigan, 1977; McKinlay, 1972; Hess and Markson, 1980, Smyer, 1980; Mutchler and Burr, 1991; Stoller and Pugliesi, 1988; Mindel and Wright, 1982; Harlow and McDonald, 1991; and Jewett, Hubbard and Weeks, 1991).

The focus on the elderly in relation to the use of community-based formal social services reflects concern regarding their previously noted levels of functional ability as well as the attention directed toward two other considerations: the possible delay of premature institutionalization of those elderly, who if provided appropriate support services, can function somewhat independently in the community, and the various contradictory research findings relative to service utilization among the elderly (Spence, 1987). The term community-based formal social services, as used here, refers to the wide range of preventive, supportive and restorative services offered by social service providers in non-institutional settings (Brody, 1971). Many of the findings put forth by proponents of the prevention or delay of premature institutionalization among the elderly suggest that the elderly's conditions often do not warrant confinement to an institutional setting; that the elderly, like members of other age groups, tend to function better in familiar settings; and that the care in institutions is oftentimes inadequate and indeed too

costly (Bradshaw, Brandenberg, Basham and Ferguson, 1980). Research supporting such ideology include Roy, Ford and Folmer (1990), Wolinsky (1988), Cohen (1973), Hall (1989), Jette and Branch (1983), Tobin and Kulys (1981), Lang (1980) and Lindsey and Hughes (1981). However, Moore (1989) has contradicted such findings asserting that marginal or no significance can be found between social informal support and delayed institutionalization. Nevertheless, Pegels (1980) found that home care with elders remaining in the community was more cost-effective than institutionalization.

The second focus on the elderly in relation to the use of community-based formal services is that the various research findings are contradictory at best. For example, some studies report relatively substantial use of social services by the elderly (Holmes, Holmes, Steinbach, Hauser and Rocheleau, 1979; Cantor, 1978; Downing and Copeland, 1980; Ralston, 1982) while others indicate little or no use of services (Harris, 1975; Calsyn, 1989; Richardson, 1992; Sowers and Siddharthan, 1992). Contradictory results may be attributed to the way in which social service utilization is measured. Nevertheless, McCaslin (1989) observed three significant factors in predicting utilization of services among the elderly. First, women used more services more often than men. Second, older persons used health and social services more often than younger ones and third, it was found that the more highly educated, affluent elders used services more often than less educated, poorer counterparts.

Patterns of informal support use among the elderly vary. Litwak (1985) suggests that different primary groups best provide aid that is consonant with the nature of their structures. For example, neighbors can best handle immediate emergencies because of their geographical proximity; kin are best prepared to deal with issues involving long-term commitment because of their permanency; and friends, given the affective nature of such ties, can most effectively respond to matters involving continuous fluctuations in caregiving (Dono, Falbe, Kail, Litwak, Sherman and Siegel, 1979; Ezell and Gibson, 1989).

Cantor (1979), on the other hand, postulates an order of preference in the choice of support groups. Consequently, she asserts that regardless of the particular type of assistance needed, the elderly's choice is kin followed by friends and neighbors and last by formal organizations (Peters, Hoyt, Babchuk, Kaiser and Ijima, 1987; Mancini and Simon, 1984; Buckholz, 1978; Lebowitz, 1978; Stoller, 1985). In their absence, other groups are approached for help, but as a substitute for preferred kin support. In contrast, the task-specific model centers around which support network most effectively handles a specific task with no regards to individual or group preference (Dono et al., 1979). However, both the above hierarchial compensatory and the task-specific models were challenged by Sullivan (1986) in her research on residents of a retirement community. She found that the respondents relied on few, if any, primary support groups for assistance with their

long-term care needs. This may have been because of the additional on-site health and social resources available to the residents.

Cultural differences were also found to affect the type of informal support received. For example, while Cantor (1979) found that low socioeconomic status (SES) families of all races were more likely to give assistance to their elders than higher SES families, Mitchell and Register (1984) found that black elderly received more support even when SES was controlled, although the differences were relatively small. In addition, Mitchell and Register (1984) observed that while white elders saw their children and grandchildren more often, black elders received more help from their offspring. Furthermore, other comparative studies show higher levels of social support from black family members (Mutran, 1985; Colerick and George, 1986; Taylor, Chatters and Mays, 1988). In one of the few multivariate analyses on racial differences in service use, Mindel and Wright (1982) observed different patterns between the races. However, the data for this investigation is more than twenty years old and service delivery has since changed. Consequently, McCaslin (1989) observed minimal differences in service utilization and concluded that race was a poor predictor of service use. Instead, she found that knowledge of services and need were more significant predictors for service utilization. Using the Andersen/Newman (1973) behavioral model to health and social service utilization among African American elderly, Cantor and Little (1985) found that such service utilization behavior was due to certain demographic

factors, the availability of informal supports and knowledge of older-adult services. Black elders were more likely to use medical services and the least likely to use information and referral. Surprisingly, church assistance was the second most used social service. In fact, black elders were more likely to seek help from the church than from other formal agencies. Furthermore, Hatch (1991) found that attendance at religious social events was more important in predicting the informal support patterns of African American males and females than white females. Taylor and Chatters (1986) also found that church members provided a significant amount of informal social support to black elderly along with family, friends and extended kin. Extended kin were also shown to play a larger role in informal support for black than white elders (Smerglia, Deimling and Barresi, 1988). Elder blacks were also more often viewed to have more interactions with and support from friends, fellow church members and other associations (Colerick and George, 1986; Ortega, Crutchfield and Rushing, 1983).

A number of researchers attribute the importance of black churches to their being the only institution that has been and continues to be owned, financed and controlled by black people (Frazier, 1974; Poole, 1990; Walker, MacBride and Vachon, 1977). The structure and function of black churches enhance their ability to provide a range of formal and informal services as well as to confirm one's identity and promote unity in black communities (Carter, 1982; Walls and Zarit, 1991; Wilson and Netting, 1987). Oftentimes in the past, black churches have

provided social service programs, including food, clothing and educational and employment programs when other formalized, social service programs were not available within the community (Carter, 1982; Taylor, Thorton and Chatters, 1987; Wimberly, 1979). Since black elderly often do not have any emotional attachment to persons within formal agencies outside of their neighborhoods but are somewhat emotionally connected to their churches, those spiritual institutions may operate as a major tool in getting minority elders to participate more fully in the formal delivery of services (Taylor and Chatters, 1986). In addition, black female elders were found more likely to use their church membership as a source of social integration (Johnson and Barer, 1990).

Service Utilization and the Elderly

A critical review of the literature on service utilization generally covers two broad areas: health services and social services. In both areas, utilization is usually defined as the measure of reported frequency of seeking and/or accepting services over a particular period of time (Lind, 1977). Furthermore, the literature indicates that the research and related discussions regarding both areas are aimed at improving the utilization of these services.

Contributing to an understanding of health and social service utilization behavior, a number of research approaches have been presented (Wright, Berg and Creecy, 1980; Carter, 1978; Andersen and Newman, 1973; Wolinsky and Arnold, 1988; Spence and Atherton, 1991; Krain and Trevino-Richard, 1987; Mindel and

Wright, 1982). In a comprehensive examination of service utilization in the above two areas, McKinlay (1972) identifies six analytic approaches: socio-demographic, economic, geographic, social-cultural, social-psychological and organizational. It is within these six analytic approaches that relevant literature is presented.

The Sociodemographic Approach

The sociodemographic approach examines the relationship between service utilization behavior and various characteristics of the individuals under investigation. As noted by McKinlay (1972) and Krout (1983), some of the most commonly employed variables in using this perspective are: gender, age, education, living arrangement and religion.

Research findings on health and social service utilization with regard to the above variables are often limited and contradictory. Therefore, caution will be exercised in generalizing such findings to actual utilization behavior among African American elderly.

Gender and Service Utilization. Gender is one of the major sociodemographic variables most frequently investigated in terms of service utilization research. Typically, higher rates of health utilization are found with elderly females when compared to their male counterparts (Wan and Soifer, 1974; Monterio, 1973; Torres-Gil and Becerra, 1977; Haug and Ory, 1987; Meininger, 1986; Verbrugge, 1983, 1985; Harris, 1975). For example, Verbrugge (1983)

found, using data from the National Center for Health Statistics, that older women visit physicians more often than older men and that the interval between physician visits is shorter for females. She also found that although hospital stays were higher for elderly men, women stayed longer per episode. Women saw dentists more than men, albeit, significant declines of dentist usage is evidenced as persons grow older. In terms of long-term care, Verbrugge found that females represent more of the institutionalized. However, for chronic disease and mental health, men had higher residency/patient rates than women. Conversely, women used more ambulatory health services for both medical and dental care. Wan and Soifer (1974) also found gender to be directly related to the use of physician services. In their study, which included a random sample of 2,996 households in New York and Pennsylvania, using eighteen individual and organizational variables, they found that the percentage of females in each household was a direct "causal" variable for determining the frequency of physician visits. Although this sample was not exclusively an elder population, patterns of physician utilization based on gender, were extended into old age. Similar findings of the high percentage of female utilization of physician services were reported elsewhere (Davis and Reynolds, 1975; Monterio, 1973; McKinlay, 1972). Exploring the impact of Medicare on the use of health services among the elderly, Davis and Reynolds sampled 10,573 persons age 65 and over. Once again, their results suggested higher physician utilization by females than males. However, there was no

significance in gender variation in terms of hospitalization when Medicare benefits were factored in. Likewise, other studies investigating hospitalization patterns among the elderly found no significant gender differences in usage (Evashwick, Rowe, Diehr and Branch, 1984; McCall and Wai, 1983; Wan, 1982; Wan and Arling, 1983; Wolinsky, 1978).

More recent research have dealt with gender and mental health care utilization. When a second wave of data (3,921) was reexamined to find gender differences based on the specific type of mental health service, women were found to consult with doctors in the general medical sector about mental health-related problems more than their male counterparts (Leaf and Bruce, 1987). However, no gender differences were found in mental health-seeking behaviors in regards to specialty areas. Furthermore, in the presence of psychiatric disorder, women who had positive attitudes towards such services were more likely to utilize them. Using just under 2,500 cases in the Michigan public mental health system, Mowbray, Herman and Hazel (1992) found that more women received emergency and out-patient mental health services while men were more prevalent in residential programs. When Medicaid was factored in, using 61,000 plus persons in Monroe County, New York, Temkin-Greener and Clark (1988) found that Medicaid-eligible males were more likely to use mental health services than white females. Both white males and females were more likely to use psychiatric ambulatory services while non-whites were more likely to use ambulatory alcohol services. However,

in terms of alcohol and psychiatric illness, patient utilization among minorities (regardless of their gender) was not significant.

Finally, gender differences in patient-provider interactions were found to influence utilization in the study done by Haug and Ory (1987). They reported that physicians aged 65 years and older constituted 30% of general practitioners and 17% of internists with 20% and 35% of their patients representing similar ages (Robert Wood Johnson Foundation, 1981). Moreover, according to Haug and Ory (1987) most physicians were taught that practitioners within their profession represented the dominant factor while the patient represented the submissive factor in the physician/patient relationship. Oftentimes, these same physicians had not been trained in geriatrics, thus impacting the patients' perceptions of such medical providers which may have influenced utilization. Finally, few of these doctors were female, while most of their elder patients were women which also impacted physician/patient relationships which, in turn, affected utilization (Verbrugge, 1983).

A number of research findings concerning gender in social service utilization were consistent with the above. Most research on gender differentiation and social service utilization has focused on participant involvement in senior center programs (Harris, 1975, 1977; Cohen and Adler, 1984; Krout, 1983, 1989; Ralston, 1987; Harel, Wyatt and Lueck, 1984). In a comprehensive research study, Harris (1975) using a national survey found that blacks and women with less

education and income were more likely to attend senior centers. Cohen and Adler (1984) also demonstrated that being female and married were associated with both knowledge and use of age-related services which included attending senior centers. Krout (1989) assessed that the greater level of participation at senior centers came from white, females between the ages of 65 and 84 who were widowed, living alone with lower incomes. Similar findings came from research provided by Harel et al. (1984). Finally, Ralston (1987) found length of attendance to be greater for older, less educated female participants--characteristics seen as indicators of higher levels of social need.

While most research findings indicate substantial evidence in support of greater usage of social services by females, other findings indicate greater use by males or no sex differences. In reporting on sex differences and other factors in relation to health care center utilization, Sue (1977), found that among Native Americans, African Americans, Mexican Americans, Asian Americans and Anglo-Americans, African- and Mexican-American males had higher rates of participation. Finally, Demko (1979) and Ralston (1982) found no sex differences in the utilization of senior centers which may indicate different rates of usage between males and females in relationship to health-related versus socially-related programs.

However, contradictions to the above findings have been apparent. In regards to frequency of attendance, several studies have not found that socio-

demographic variables consistently differentiate between low- and high-frequency users (Krout, 1991). For example, some studies report that variables such as sex, marital status, income, education, living arrangements and race did not distinguish between members versus nonmembers, users versus nonusers, or low use versus high use at senior centers (Hanssen, 1978; Ralston, 1991; Krout, 1991). Furthermore, two multivariate analyses using multiple senior centers to examine various socio-demographic factors in relationship to ongoing center participation variables, found no significant factors that predicted participation duration (Krout, 1991; Ralston, 1991). Instead, factors like proximity, access, social contact and center impact were found to be significant predictors for ongoing utilization and participation in senior center activities.

In addition to senior center utilization, various studies have been undertaken in regards to gender and other social service use. For example, in study of 2,048 randomly selected, elderly Pennsylvanians, Iutcovich and Iutcovich (1988) found that persons more likely to use public transportation were those who did not own a car, lived alone in the city, were in poor health, non-white and female. Contrell (1975) also found that greater use was made of a publicly-supported transportation system by elderly females in rural Ohio who were over seventy years old and living alone. In half of the congregate-meal-program sites in a five-county area within northeast Ohio, Harel (1985) found congregate meal consumers were more apt to be minority females living alone while Burkhardt,

Lago and Blattenberger (1983) did not find gender to be a factor for participating in congregate meal programs. In fact the authors found gender, minority status, living arrangements and income to be poor predictors for usage while site characteristics and perceived costs were significant predictors in congregate meal consumption. In terms of using paid homemaker services in relationship to gender, Hanley and Wiener (1991), using the National Long-Term Care Survey of noninstitutionalized seniors sixty-five years and older found that older, white women living in urban settings were more likely to purchase such services. Likewise, Coughlin, McBride and Lui (1990), analyzing 3,940 persons, aged sixty-five and older from the 1982-84 National Long-Term Care Demonstration Project found females with higher incomes were more likely to pay for home maker services with similar findings from Stone and Kemper (1989). However, McAuley and Arling (1984) found gender not to be a significant predictor for paid in-home services. Instead, when examining 524 non-institutionalized persons aged 75 and older, they found higher education, urban residency and having better social resources as significantly predictors for purchasing in-home services. Therefore, gender differences in service utilization vary with the type of social service examined.

Age and Service Utilization. Analysis of service utilization research in relation to age indicated that a number of inconsistent findings were reported in both health and social services areas. Generally, those 65 years of age and older have been shown to disproportionately consume national health care expenditures and most types of health care services (Vladeck and Firman, 1983; Fisher, 1980). Wolinsky and Arnold (1988) found that the older the age group, the higher the average health services utilization, with two exceptions. They found that the oldest-old break the pattern, with their physician contact rates dropping off by about 2% and their dental visits substantially lessening. Eve (1984) also observed, using data from the 1975 Health Interview Survey of over 140,000 persons, that the use of physicians and hospitals were highest among the older adults aged 65 and older and lowest among younger adults while the opposite was true for dentist utilization. Then, too, McIntosh (1984) found that women, during the ten-year period of the study, used more physician services as they aged. Other studies supporting increased use of health services by octo- and nona-generians are consistent with the above (Soldo and Manton, 1985; Wolinsky, Mosely and Coe, 1986). Aggregate data, however, oftentimes obscured the concentrated service demand of the most disabled in any elder cohort group. Data from the National Care Expenditures Study showed that among those 65 years of age and older, those with limitations in ADL's were considerably more likely than those not limited in such areas to have experienced at least one hospital admission during the preceding

year (National Center for Health Services Research, 1984). It was also found that these persons were more likely to use ancillary services (i.e., contact with non-physician providers, prescription medications and purchased or rented medical equipment). However, the authors noted that the differential in service contacts between the limited and the nonlimited narrowed in the group aged 65 and older in contrast to differences among the nonelderly - differences the authors suggest - are due to the elderly's access to third-party reimbursement through Medicare, Medicaid and/or private insurance. Concentrated service use among a small segment of the elderly has been consistent with other research (Lubitz and Prihoda, 1984; Zook, Savickis and Moore, 1980; Gruenberg, 1977; Roos, Shapiro and Roos, 1984; Berki and Associates, 1986; Milazzo, 1986).

Various studies have investigated a number of demographic characteristics in determining the use of home care utilizing Andersen and Newman's (1973) predisposing set of variables. With some consistency, age, was found to be directly associated with home care use. Whether considering home care services, in general (Shapiro, 1986; Stone, 1986; Wan and Arling, 1983), or specific home health services (Berk and Bernstein, 1985; Branch and Wette, 1988; Stone, 1986) various research indicated that, with increasing age, the instances of home service provisions grew. Older women were also more likely to use home care services (Stone, 1986; Wan and Arling, 1983). However, it was widely held

that age alone did not compel service use but was associated with health and social risks that increased the likelihood of such utilization.

In contrast to the above findings Davis and Reynolds (1975) found age (employed as an indicator of morbidity) to have had a negative effect on physician service utilization. They attributed this finding to other measures of morbidity as having controlled sufficiently for health status to permit the age variable to act mainly as a measure of physical accessibility to the physician. However, in the same study, the authors reported age to be positively associated with hospitalization utilization. Similarly, Wolinsky, Mosely and Coe (1986) using a longitudinal approach to track six, four-year age cohorts observed that significant age and period effects on physician and hospital utilization were apparent. There was an inverse relationship between physician visits and increased age once persons reached eighty years of age and older (Aday, Fleming and Anderson, 1984; Haug, 1982). This may suggest that persons who reach the age of 80 or older are generally more healthy than the younger old who have frequent doctor office visits.

An inverse relationship has also been found between mental health services (Carter, 1974; Butler and Lewis, 1973) and dental services (Eve and Friedsam, 1980; Torres-Gil and Becerra, 1977; Eve, 1984) and age. As noted by Krout (1983) and Lowy (1980), one indication of the infrequent use of mental health services by members of this age group was the fact that treatment rates for them in outpatient clinics did not increase in service use for all other age groups.

In 1978, the President's Commission on Mental Health indicated that while approximately 25% of the elderly suffered from severe mental health problems that only 4% were actually served at outpatient facilities. It was also estimated that 80% of the elderly suffering from mental health problems were not receiving services from mental health providers.

Investigators targeting age and social service utilization also yield contradictory findings. Contrell (1975), for example, reported greater use of a rural elderly transportation system by individuals over age seventy. Similarly, Mindel and Wright (1982) found that age was indirectly related to use through its negative relationship with income and access to public transportation, both of which predicted poor health, one of the major determinants of service utilization. In relationship of age to population size, these authors observed that African-American elderly tended to live in smaller-sized cities and towns which put them at a disadvantage to social service systems due to limited availability.

Age has been a significant factor in several studies investigating factors that contribute to senior center utilization. Ferraro and Cobb (1987) concluded that persons who were older, lived with someone, had higher incomes, had higher levels of self-assessed health and had higher levels of life satisfaction were more likely to attend senior centers longer. Krout (1988) also found a relationship between age, income, assessed health and living arrangement and attendance at the center. Furthermore, age, sex, education, marital status, and living arrangement

have been associated with awareness and use of services, suggesting that those in most need know about and use such services (Cantor and Mayer, 1978; Krout, 1985; Snider, 1981; Ward, 1977). Based on these studies, there is some consensus that those who were older, female, unmarried, living alone with poorer health and less income, who more frequently used senior centers. Duration of attendance was also significantly related to being older and female, having higher educational levels, more positive attitudes towards the center's physical appearance and death of a close friend (Ralston, 1991). Ralston notes that under multivariate analysis, duration of attendance was influenced only by age with those who were long-term attenders. However, the other aforementioned variables were not significant in predicting stability in senior center attendance. Krout (1989) observed similar findings with health, income, living arrangement and life satisfaction not significant in either bivariate or multivariate analyses while being older was.

Finally, other studies on social service utilization indicate that there are no differences in terms of age. For example, Demko's (1979) study on senior center participation reports no differences among age groups in relationship to high and low use. A similar finding was reported by Krout (1984) in his comprehensive study of health and social services among the elderly. Lastly, Ishii-Kuntz (1990) using a national sample of women 65 years of age and older, did not find age, educational attainment or race to differentiate participants from non-participants in senior center activities. Consequently, contradictory findings occur when social

service utilization is measured as a dichotomous rather than a continuous variable in relationship to age.

Education/Income and Service Utilization. A number of investigations have indicated a positive relationship between education and the use of health services by the elderly. For example, Roberts and Lee (1980) studied African Americans, Mexican Americans and whites of various ages. They found that lower rates for general medical examinations, eye care and dental examinations by African Americans and Mexican Americans were significantly related to their lower levels of education and income. Age and health status were viewed as secondary predictors of lower utilization rates among these two groups. Davis and Reynolds (1975) also found that the elderly with more than eight years of formal education received significantly more ambulatory physician services than those with less education. The authors noted that while education was a major determinant in explaining the use of physician services, it did not eliminate the significance of income as a major determinant of service utilization. Examining the use of a wide range of health and social services, Fowler (1970) concluded that greater usage of health services was made by elderly persons who had higher levels of education, suffered chronic conditions and had higher incomes while Eve and Friedsam (1980) found education and income were more significant predictors of dental service use than was ethnicity. Similarly, Cadigan (1985) observed that those with higher educational levels who were unmarried and belonged to a synagogue had higher

rates of physician utilization than the elderly who were less educated, married and did not belong to a synagogue. Finally, using the National Center for Health Statistics for rural elderly aged 65 and older in 1983, Palmore (1984) found that although rural elderly experience greater instances of illness than their urban counterparts, they were hospitalized less often, received fewer surgical procedures, visited physicians less and received less dental treatment than their urban elderly counterparts. These differences, Palmore observed, were due to less education and knowledge about illness states in general among rural elderly. Consequently, when rural elderly become ill, they often ignore or deny symptoms surrounding their diseases.

In contrast to the above findings other studies have indicated a negative or no relationship between education and health service utilization. Sue (1977) found education to be negatively related to the use of mental health centers by various ethnic minority groups in the Seattle, Washington area. This may have been because of the stigma attached to utilizing mental health services. Eve (1984) also found, using a national survey covering three age strata that education was not a factor in predicting physician and hospitalization among those 65 years of age and older. However, it did serve as a significant predictor for dental services among those same cohorts.

Results from studies investigating the relationship between service utilization and education have been mixed. Fowler (1970) reports a positive

relationship between various types of social service utilization and elderly with more formal education. Similar findings are provided by Lopata (1975). McAuley and Arling (1984) using a Virginia sample of persons age 75 years and older found that one of the four factors affecting home care use was number of years that the elderly completed in school. Living in an urban area, having more ADL problems while having fewer IADL problems were the other three significant predictors for home care use. With regard to activity participation at 15 senior centers in a midwestern state, Ralston (1991), found that those who had higher educational levels and positive attitudes toward the physical appearance of the center, participated in more activities. Likewise, the duration of attendance was positively affected by being older, female and having a higher level of education at the bivariate level. However, when a multivariate analysis was employed, educational level and attitudes towards the physical appearance of the center were not significant in predicting duration of attendance, while educational level became the sole predictor of activity participation.

Several investigations provided findings supporting no relationship between education and social service utilization among the elderly. Demko (1979) found no significant educational differences between high-frequency and low-frequency users of a senior center in southwest Detroit. In their study, Mindel and Wright (1982) observing social service utilization between black and white elderly, found that the level of education had neither a direct nor indirect relationship with

the use of service. Krout (1988) observed no relationship between duration of attendance at senior centers and educational attainment. Finally, Ishii-Kuntz (1990) found no significance in educational attainment in differentiating participants from nonparticipants in senior activities, although in terms of nonsignificant effects, educational attainment had a negative effect on elderly women with less education, slightly more likely to participate in senior center activities. Therefore, inconsistent findings arise from bivariate versus multivariate analyses, in relationship to education and service utilization.

Living Arrangements and Service Utilization. Living arrangements is the last variable under the sociodemographic approach which has affected health and social service utilization among the elderly. Findings pertaining to this area, like those related to other sociodemographic variables were somewhat contradictory. For example, Salloway and Dillon (1973) concluded that elders who lived alone visited physicians more often. Studies based on regional and national surveys (Evashwick et al., 1984; Morgan, 1980; Verbrugge, 1979) have shown that the use of health services was higher among divorced, separated, widowed, and never-married persons than among those who were married in terms of health services utilization. Using the National Medicare Expenditure Survey, Cafferata (1987) found that older persons who lived with others, regardless of marital status, tended to visit physicians less often than those who lived alone. Wolinsky and Coe (1984) concluded that the effect of living alone on physician use was twice as

important as the effect of being married or widowed. Moreover, Coe et al. (1985) observed that noninstitutionalized elderly without family used hospital emergency rooms 7-30 times more often than those with family while Wolinsky et al. (1983) found that widowers had higher levels of emergency room use than those who were not widowed.

Elderly persons who lived with others, such as spouses or adult children, might have used fewer formal health services than persons living alone because they may have substituted family members to provide health care intervention instead of utilizing physicians (Vicente, Wiley and Carrington, 1980-81). Greene (1983) also found similar substitutions of familial home health care informal providers instead of regularly scheduled appointments with medical health care providers. among both older married persons and nonmarried elders living with others. In fact, the National Center for Health Care Statistics (1972) has reported 90% of home health care for older persons is provided by families. Furthermore, elderly persons who were married and/or lived with or near adult relatives - particularly their adult children - were less likely to be consumers of formal health services than those who lived alone (Branch and Jette, 1982). Clark, Pelham and Clark (1988) also found that among the poor elderly, receiving Medicaid in California, that the unmarried and those living alone had higher average expenditures on health care in general than those married, although married elderly had higher daily costs of hospital care. And Soldo and Manton

(1985) found that at any level of need, the probability of formal service was lowest for those elderly who lived with either spouses or other relatives (Tennstedt, Sullivan, McKinlay and D'Agostino, 1990). However, Krout (1984) in a relatively comprehensive study on use of health and social services among 250 white elderly persons living in a small urban community, found that living arrangements did not reach significance in predicting utilization.

Various studies pertaining to living arrangements and social service utilization supported higher usage of services when the elderly lived alone. For example, Demko (1979) concluded that elderly persons living alone were high frequency senior center users. Contrell's (1975) study on an elderly transportation system indicated a significant relationship between living arrangement and the use of the service system, with a greater use among those persons living alone. With regard to duration of senior center attendance, elders living with someone attended centers longer (Ferraro and Cobb, 1987). Ishii-Kuntz (1990) found that elderly women who lived alone participated in senior center activities more often than those living with others. In general, Spence and Atherton (1991) observed that black elderly living alone were more likely to use community-based social service programs than those living with others. Similarly, Clark et al. (1988) found that black, elderly, low-income women utilized the most social services while Asian American low-income, elderly women used the least. Unlike the general elderly population, however, those Medicaid respondents in the California study used more

homemaker services (49%) while only 20% utilized senior centers. In comparison, the general elderly population attended senior centers at a rate of 15% while only 1.4% of them utilized homemaker services.

Although a number of social service utilization studies indicated directional relationship in terms of living arrangement, others provided no association between living arrangement and service use. For example, Hanssen (1978) found no distinction between high and low users of senior centers in relationship to living arrangement. Burkhardt et al. (1983) also found that living alone was a poor predictor for nutrition site usage. Consequently, for more consistent findings on social service use and living arrangement, factors like social support network use, accessibility to services, age, education and income should be included in the multivariate analyses.

While some of the above findings regarding sociodemographic influences in utilization behavior in health and social services, have been fairly consistent and offered strong support for final outcomes, a number of researchers cautioned against their acceptability as having provided adequate explanations for utilization (McKinlay, 1972; Krout, 1983). These authors agreed that no in-depth reasons were given for service utilization differences, although distinctions were made about utilization behavior based on certain individual and group characteristics. Furthermore, McKinlay asserted that most sociodemographic studies explained utilization about as well as studies explained under-utilization.

Consequently, it is necessary to be cautious in interpreting the impact of sociodemographic factors on utilization behavior.

The Economic Approach

In examining the literature in terms of the economic perspective as it relates to health and social service utilization, major determinants of service usage were examined by service costs and types of insurance coverage. "Financial barriers" was the term often used in regards to this approach (McKinlay, 1972; Harris, 1975; Bradshaw, Brandenburg and Ferguson, 1980). Theodore (cited McKinlay, 1972) gave a comprehensive examination of the economic approach. Theodore suggested that a number of stages were involved relative to the demand for medical services. Such stages included: 1) the existence of physiological/psychological conditions; 2) the perception of the existence of such conditions; 3) the willingness to control or manage the conditions through service use; and 4) the ability to transform need into demand services. It was the final stage, Theodore asserted, where economic factors played a major role in determining use in that consumers were influenced by such factors as income, health insurance coverage, availability of free health care services and the cost of medical services.

In general, most of the research on health and social service utilization as it applied to the economic perspective was fairly consistent with findings that indicated that personal resources and government-provided assistance were major

influential factors in determining use (Andersen and Newman, 1973; Roberts and Lee, 1980; Ward, 1977; Eve and Friedsam, 1980). Andersen and Newman (1973) in testing Andersen's behavioral model which included income as an enabling variable found that the ability to pay and the perception of symptoms were more important in determining physician service use than a number of cultural and social-psychological factors. Roberts and Lee (1980) found that lower rates of use among Mexican Americans and blacks were primarily due to their low socioeconomic status (i.e., income). In addition, Berkanovic and Reeder (1973) observed a complex cultural pattern reflecting both ethnicity and socioeconomic status in determining health utilization with persons having higher incomes somewhat more likely to use private physicians. When Pettibone and Solis (1973) studied Chicano dental behavior in New Mexico they found that both lower socioeconomic Chicanos and Anglos perceived dental costs as financial barriers to obtaining dental services. Consequently, the two factors that determined dental care were family income and perceived financial barriers. Dutton (1978) found that public assistance had a greater positive effect on the poor and health utilization than did private insurance on the non-poor. Lastly, in relationship to system barriers to health care utilization by the poor, several factors were apparent. For example, access itself was often difficult with physician availability more scarce in poverty areas (Bullough, 1972; May, 1975) and travel difficulties were compounded by inadequate transportation (Weiss and Greelick, 1970). Access

problems frequently continued in the form of long waits in the provider's office or clinic (Aday, 1975). Finally, there was a dual system of medical care in which the poor elderly used "public" sources - hospital outpatient departments, emergency rooms and public clinics - while middle-income elders utilized many more private sources - physicians in solo or group practice (National Center for Health Statistics, 1972). In such public settings, the services provided were generally disease-oriented instead of preventive with organizational problems of service delivery common place. Therefore, oftentimes, low utilization was viewed as the natural response to multiple negative experiences with these systems (Riessman, 1974).

In an examination of the importance of insurance coverage and a number of other variables to health service utilization, Kronenfeld (1978) found that the number of affiliations with health care providers and need significantly influenced the use of physician ambulatory care. Noting the importance of government-provided assistance for health care services, Kronenfeld reported that persons with Medicare and Medicaid made more visits than did those persons with other forms of insurance or no insurance. Other researchers (Monterio, 1973; Aday, 1975) also found an increase in health service utilization by persons of low socioeconomic status when third-party payments were used.

Public assistance, in the form of Medicaid, was found (Dutton, 1978) to have a greater positive effect on the poor than did private insurance on the non-poor. In addition, Davis and Reynolds (1975) reported that publicly-assisted health programs have a positive impact on service use. They concluded that individuals who received government health entitlements, through Medicaid state plans, received 30 to 40% more health services than did other low-income persons who did not receive such entitlements. Similarly, other research supported a positive relationship between government insurance coverage on health utilization (Eve and Friedsam, 1980; Kent and Hirsch, 1972; Auerback, Gordan, Ullmann and Weisel, 1977; Hanley and Wiener, 1991). Furthermore, as Medicare has been subjected to legislative and regulatory changes resulting in decreased benefits, older persons on fixed incomes have had decreased access to health care (Moon, 1987). Lastly, the elderly experience increased home health and skilled nursing facilities utilization when the Medicare Prospective Payment system, based on Diagnosis-Related Groups, was initiated in 1983 (Manton, Vertrees and Wrigley, 1990).

There were several probable reasons for the stronger impact of Medicaid and Medicaid waiver assistance rather than private insurance on increased health care service utilization. First, unlike many private insurance policies, Medicaid covered most physician services (U. S. House of Representative, 1976). Second, with the exception of prepaid health plans, even

when private insurance did cover physician services, it generally appeared to have minimal impact on the initiation of care (Phelps, 1975). On the other hand, Medicaid coverage appeared to have been associated with higher rates of use (Aday, 1975).

Caution should be taken in statistical analyses that compared physician visits by income level of the elderly. One reason for this concern was that the underlying distribution of medical need was usually not factored into the above approach. For example, there was evidence that the poor experience more disability and lower levels of health than the non-poor (National Center for Health Statistics, 1974). Davis and Reynolds (1976) and Aday (1975) also reported that the poor still received less care for their illnesses than the more affluent even when the level of disability was factored in and when using similar office visit rates. Another reason for caution was that national data on number of physician visits may have confounded visits of different types (merging preventive and/or elective care). However, these two categories of care, when examined separately, often revealed opposite income trends. Measures of use which involved patient discretion - like preventive care - usually have been shown to display a strong positive relationship to income (National Center for Health Statistics, 1974). On the other hand, procedures identified as clinically mandatory and otherwise therapeutic care have been found to have a negative relationship with income (Andersen, 1975). Furthermore, Andersen suggested that when elective and

therapeutic services were combined, these two opposite income trends were confounded.

When gender and race were factored into the economic approach to health care service utilization, women appeared to be more at risk for nonutilization of services. Although economic conditions for the general elderly population have improved, within the last twenty years, older women were still more likely to be impoverished. For example, Keith (1987), in a longitudinal study, found that widowed and never married women who failed to obtain care or postponed having it, did so because of finances. This persisted over the ten-year duration of the study. Some of the factors contributing to their high risk status included inadequate retirement benefits, Social Security policies that adversely affected widows and the catastrophic costs of medical and long-term care for their spouses (Schulz, 1988). Poverty among older women was worse for those who were widowed and who lived alone (Dressel, 1988). While accounting for 63 percent of all elders, it was found that women comprised over 73 percent of those living in poverty (Dressel, 1988). Among elders of color, the poverty rates paralleled and sometimes exceeded those of older white women (Cook, 1989; Kramer, Polisar and Hyde, 1990; Agree, 1988).

These income disparities along gender and race lines have suggested that very high proportions of older women and minority elderly were at a disadvantage when faced with the need to purchase long-term care services beyond

those provided by Medicare, Medicaid, or other public programs. Nearly three-quarters of all noninstitutionalized paid care has been found to be privately financed by elders and their families (U. S. Bureau of the Census, 1983; Lui, Manton and Lui, 1985). Using the 1982 National Long-Term Care Survey data Coughlin and Colleagues (1990) found that older persons with incomes 300 percent above the poverty level were nearly two and one half times more likely to use community services than were those at or below the poverty line.

While the above findings indicated the importance of personal resources and third-party payment in meeting the demand for health care services, others refuted such findings. Kronenfeld (1978), reported that a strong negative relationship was found between the use of various types of ambulatory health care services and increased income. In his random sample of residents in Rhode Island, he observed that as income increased the number of health visits decreased substantially. Wright et al. (1980) also observed that the use of physicians' services increased as the income of the elderly respondents decreased. Finally, Sharp et al. (1983) reported that income had no effect on attitudes towards the medical system or on use of physicians by those persons needing such services.

Since the Omnibus Budget Reconciliation Act of 1981 (OBRA), Medicare has been subjected to a number of cost-saving legislative changes. And, in subsequent years, further changes have been made, cutting Medicare spending by approximately 15% as compared to the spending level that would have occurred

in the absence of the legislation (Committee on Ways and Means, 1986; Ruggles and Moon, 1985). Consequently, the proportion of Medicare expenses that the elder consumer is responsible for has increased. Furthermore, the combined impact of these changes has led to a reduction in Medicare benefits of about 4% while an increase of 11% in enrollee liability for Medicare covered services was experienced (Health Care Financing Administration, 1985). Moreover, savings from changes directed at providers under the prospective payment system (a system for reimbursing hospitals for care) have been about three times the level of changes that have fallen directly on beneficiaries (Ruggles and Moon, 1985). Therefore, although many of the reimbursement changes enacted to reduce Medicare's costs have been billed as affecting providers and not beneficiaries, such changes have also affected access to and costs of care (Committee on Ways and Means, 1986) with an example being increased outpatient services that had previously been inpatient offerings and earlier discharges from the hospital (Beebe, Callahan and Mariano, 1986). Skilled nursing care leads the list of Medicare services dominated by older beneficiaries. Consequently, persons aged 85 and above were more substantially affected by decreased benefits in Part A of Medicare than those persons aged 65 to 84. On the other hand, decreased benefits regarding physician and outpatient services, covered under Part B of Medicare, were more likely to have negative impacts on persons under 85 years of age. Consequently, although changes in Medicare were more likely to impact the oldest beneficiaries, such

changes would have more devastating consequences with modifications in Part A of services under Medicare. Thus, any change in cost-sharing or reimbursement policy that affected beneficiaries in one part of the program and not another has differential effects by age.

Research findings in other studies on health utilization have indicated that personal resources and publicly-assisted health programs did not significantly affect use of services. Wan and Soifer (1974) found that coverage by neither Medicare nor Medicaid had a direct or indirect effect on the use of physician services among low-income persons. Similarly, Long and Settle (1984) reported no significant differences across income groups in the use of hospital and physician services by the elderly. Kasper (1986) investigating health status and utilization of Medicaid beneficiaries compared with others, found that Medicaid beneficiaries in poor health used health services at the same rate as those of similar health status who were not poor. In fact, some have argued (although this argument was challenged within the first ten years of the programs' existences), both beneficiaries of Medicare and Medicaid have received similar access to health care (Aday, Andersen and Fleming, 1980).

Other studies focusing on the elderly have indicated little importance of socioeconomic status as a predictor of health service utilization (Berkanovic and Reeder, 1974; Krout, 1984). In relationship to the general population, Berkanovic and Reeder (1974) made a strong argument for cultural variables as the principal

explanatory factors in health service utilization rather than the person's ability to pay. Among these factors, they emphasized the importance of the culture of the service delivery system which can either be supportive, neutral or antagonistic to the cultural population it presumes to serve (Krout, 1984).

In contrast to the above findings, there have been several studies that conclude significant relationships between social service utilization and income. In Fowler's (1970) study on the use of a wide range of services (including counseling, vocational rehabilitation and homemaker services), he observed that greater use was found among the elderly with higher incomes, chronic health conditions and more formal education. Mindel and Wright (1982) found an indirect relationship between such services as counseling, home-delivered meals and day-care participation in relationship to income. This relationship was the result of income having a direct effect on health status which affected the number of services needed, one of the major predictors of service utilization. Specifically, those persons from the low-income group reported poor health and also indicated greater use of services. Harris (1975) observed similar findings relative to the influence of income on senior center participation. His findings indicated that persons with less income were more likely to have attended a senior center within the year covered by the study.

In examination of the impact of federal legislation and social service utilization in regard to senior center usage several observations were made. The

1970s were marked as the decade for the greatest expansion of senior centers throughout the country. Such growth was, in part, directly influenced by legislation coming directly and/or indirectly from the 1971 White House Conference on Aging, amendments to the Older Americans Act (mainly 1973 and 1978), the National Council on Aging and increased support at the local level.

The National Council on Aging was instrumental in providing a national forum for senior center interests providing information about senior centers and advocating for the importance of senior centers for the elderly (Leanse, 1978). Such advocacy resulted in increased numbers and influence which marked a shift in the senior center movement from recreational to multiservice, multipurpose activities as expressed at the 1971 White House Conference on Aging (Woolf, 1982). Consequently, funds were requested from the federal government to provide basic social services including supportive, preventive and protective services. The 1973 and 1978 amendments to the OAA had greatest impact on the growth of senior centers.

The purpose of Title V (emerged from 1973 amendments to the OAA) was to provide a focal point in communities for the development and delivery of social services and nutrition services designed primarily for older persons (Lowy, 1985). This was to be done by allocating funds for the acquisition, alteration or renovation of senior centers (up to 75 percent of cost), but not for their construction or operation (Gelfand, 1984). Operational funds came under Title III

instead of V. In addition, the 1973 amendment required that multipurpose senior centers make special efforts to serve low-income and minority elderly (Huttman, 1985). Also of considerable significance was the creation of Area Agencies on Aging (AAAs) - community-based organizations chartered by State Units on Aging to develop comprehensive and coordinated service systems for older persons at the local level. The Older Americans Act was amended again in 1978 with further changes in services offered by senior centers.

As suggested by the mixed review of research on health and social service utilization, the economic approach was inadequate in fully explaining the use of services. While a number of studies were fairly consistent with regard to the importance of personal resources in determining service utilization, others indicated, once financial barriers were removed, variations among various income and ethnic groups leveled out. Thus, while the approach provided some basis for making distinctions between users and non-users or high users and low users, the economic approach did not provide an independent explanatory approach to service use.

The Geographic Approach

Research employing the geographic approach focuses on investigating the geographic proximity between the individual and services and the influence of the proximity on service utilization. Data coming from studies using this approach

provided conflicting results, and thus, prevent any definitive explanation regarding the full impact of the approach.

A number of health service utilization studies indicated that the location of service facilities was a strong predictor of service use (Holmes, Holmes, Steinbach, Hauser and Rocheleau, 1979; President's Commission on Mental Health, 1978). For example, Holmes and his colleagues (1979) found that black elderly who lived in sparsely populated areas and where they represented a small portion of the population were most likely to be overlooked by service providers. They also found that the strongest predictors of the percentage of older minority persons served by an agency were the staffing patterns and the location of program offices in the minority neighborhoods. Similarly, Carp and Kataoka (1976) and Kalish and Morewacki (1973) found that the elderly conducted their lives almost entirely within Chinatown. Consequently, the success of the On-Lok daycare program in San Francisco which served minorities was attributed, in part, to its location near Chinatown, in an area where Chinese, Filipinos, and Italians lived (Kalish and Morewacki, 1973). In an examination of health among Spanish-speaking elderly, Torres-Gil (1982) also found the importance of developing comprehensive health care close to the barrio. Davis (1975) observed that transportation obstacles and the availability of medical services in the geographic area were significant determinants of Medicare benefit utilization, while it was found that persons were more likely to use mental health services if those services

were located in their neighborhoods (President's Commission on Mental Health, 1978). Aday and Andersen (1981) also concluded that not only health insurance but the number of doctors in a community had a direct effect on the number of physician visits. Thus, supplying more physicians in underserviced areas, improved equity to access in those communities. Bell, Kasschau and Zellman (1976) and Dorsett-Robinson (1974) have also discussed the development of community-based services as a major determinant of service use by older minority persons.

In more recent investigations, similar findings were reported in regard to proximity and service utilization, particularly among minority elderly. Uriarte and Merced (1985) found decreases of service utilization among Latino elderly in Boston when their community-based social service agencies were faced with funding decreases. Lew (1991) reported the importance of health care providers to establish a culturally appropriate community outreach program which included linguistic translations, cultural interpretation services and appropriate health screening and education to increase health service utilization among Cambodians within Long Beach, California. In a comprehensive analysis, using data from the National Cancer Institute/SEER program, Satariano, Belle and Swanson (1986) found, that between 1975 and 1984, while the incidence of invasive cervical cancer declined in both black and white women, black women continued to have 2 to 3 times the mortality rates due to the disease. The major differentials in rates were

inequalities in the distribution of health resources, not in genetic or biological factors. Finally, Hyde and Torres-Gil (1991) emphasized the following for state and local governments to practice in overcoming barriers to minority participation in those programs funded by OAA: hire ethnic minority staff with bilingual capabilities, develop culturally and linguistically appropriate services in ethnic communities including ethnic minority elders in advisory councils and advocacy roles and conducting ethnically-targeted outreach activities. However, German (1975) observed that perceived accessibility was neither related to health service utilization nor the rating of care received by the elderly in his sample. Perceived accessibility was defined in terms of ease of communication and constraints placed on time.

There were a handful of studies which investigate proximity and senior center utilization. Rosen, Vanderberg and Rosen (1981) in a comparison of senior center users who dropped out for health versus nonhealth related reasons, found that the former saw their health as poorer, were less optimistic about the future and were more dependent on others for transporting them to the center. Ralston (1987; 1991) observed a positive relationship between attendance frequency and proximity of residence to a center. Similarly, Krout (1988) found that frequent attenders of senior centers were persons who lived closer to them and who had more frequent contact with friends. Havir (1988) also found that older persons who lived in rural areas tended to use senior centers less often because of proximity issues in

relationship to the center. However, Krout (1989) questions whether access to the senior center was as important as previously thought. Hanssen, Meima, Buckspan, Hinderson, Helbig and Zarit (1978) also concluded that the availability of transportation to and from the center did not differentiate users from nonusers in participation rates (Leanse and Wagner, 1975).

Knowledge of Illness and Service Utilization

Knowledge of illness as an explanatory variable in the study of service utilization remains unclear, although considerable variations with regard to this variable have been observed (Tagliacozzo and Ima, 1970). They concluded that persons with low knowledge scores of various illnesses tended to terminate care earlier than did those who scored higher on the knowledge test. However, Tagliacozzo and Ima observed that while knowledge of the illness predicted behavior for individuals with limited experience with illness (hypertension, arthritis, diabetes and cancer) it did not predict behavior for those who had a considerable amount of experience with the illness. Palmore (1984) also found that rural elderly, although they experienced greater illness than their urban counterparts, utilized hospitals and engaged in surgical procedures less often. Such behavior was due to lack of knowledge of the disease state. Using data from the National Cancer Institute/SEER program, Satariano, Belle and Swanson (1986) found that older black women were at elevated risks of being diagnosed with the most advanced form of breast cancer when compared to older white women which

was due to decreased instances of early detection. Similarly, the American Cancer Society (1980) observed blacks to be only half as likely as whites to identify five or more of the seven warning signs (25% of blacks versus 54% of whites) of cancer. Even for a recognized symptom such as "a persistent cough or continuing hoarseness" only 40% of the black sample identified it as an early warning sign of cancer as well as its curability. Less frequent knowledge and use of early detection practices (i.e., mammography, Pap test) may also have accounted for survival differences between blacks and whites (Frutchter, Remy and Burnett, 1986). In comparison with the American Cancer Society investigation, although Frutchter, Remy and Burnett (1986) found (in northern California) that blacks were more knowledgeable about the seven cancer warning signs and knew that such warning signs required immediate medical attention, the beliefs in the efficacy of treatment were lower. For example, 65% of the black women believed that cancer was a death sentence for most people; 75.4% believed that surgery could expose cancer to the air and cause it to spread and 69.8% believed that getting treated for cancer was often worse than the actual disease. However, Bloom, Hayes, Saunders and Flatt (1987) found that blacks aged 40-70 had lower cancer survival rates than their white counterparts because of their lack of prevention was due to inadequate knowledge about the importance of the symptoms and the need for follow up than the actual fear of cancer. Moreover, Hispanics in general were observed to have less knowledge about cancer when compared to whites and this in

turn, affected their survival rates (Gonzalez, Atwood, Garcia and Meyskens, 1989).

Various studies explored knowledge of chronic illnesses by gender and how having such knowledge affected the person's ability to act on getting help with the illness. Mechanic and Cleary (1980) concluded that women were found to be more positive than men on light standard preventive health measures, with positive health behavior associated with better health status (although an earlier study by Mechanic, 1978 showed that differences in health behavior favoring women were seen as diminishing as health problems became more incapacitating in later life). Women were also found to have greater knowledge and more of a positive disposition toward taking actions on behalf of their health (Rakowski, Julius, Hickey and Holter, 1987).

Knowledge of Services and Utilization

Knowledge of health and social services/programs, like knowledge of illness and health, varies considerably among investigations. Lack of awareness of public services for the elderly has been cited in the gerontological literature as one of the main reasons for under or nonutilization of such programs (Fowler, 1970; Andersen and Newman, 1973). In addition, research findings on the elderly's awareness of services vary from study to study. Lopata (1975) reported only 10 percent of a Chicago sample were aware of an information center for senior citizens although 87 percent thought that it was a "good idea."

In a similar analysis regarding the underutilization of health and social services by the elderly residing in Boston, Fowler (1970) found that the lack of knowledge was the single most important factor explaining the underuse of services. He concluded that groups for whom such services were designed were oftentimes the least likely to know of their existence. In addition, he found that support group membership was not associated with increased family knowledge of community resources. Instead, increased family awareness and use of services were based on having been exposed to one or two specific services like counseling or legal services for families who cared for Alzheimer's victims (Gonzea and Silverstein, 1991).

Researchers have found variations between elderly minorities. For example, Gordan (1979) found that less than half of the 54 black respondents in his study were aware of one of the major agencies designated to serve the elderly in Douglas County, Kansas. The author noted that after a simple explanation of the availability of such services that 93% of the respondents expressed an interest to use them.

In studying Native Americans, Murdock and Schwartz (1978), found that of the 15 to 21 service agencies on the reservation, 40% of those surveyed were unaware of those services. The highest levels of awareness were reported for health-related service agencies, while the lowest were reported for employment and nutrition-related service agencies. Inadequate visibility has been attributed to

unawareness of services among black elderly (Carter, 1974; Dancy, 1977; Downing and Copeland, 1980; Richardson, 1992). Specifically, these authors argue that service facilities were not often located in the black community and that service information was not usually disseminated in the most appropriate and effective manner. For example, advertising of services often was observed as taking the "traditional" course rather than being advertised on black radio stations, minority programs, and in black churches (Spence and Atherton, 1991). In addition, Starrett et al. (1983) found that the most important predictors of social service utilization among Hispanic elderly were knowledge of the services, need, income and health status with a positive correlation between knowledge of services and utilization.

In terms of awareness of senior centers and older persons, a number of investigations have presented mixed results. Ralston (1982) reported that senior center participation among elderly blacks came from those individuals who had greater awareness of the activities as opposed to those who were unaware and did not attend. In addition, she found that a higher level of awareness existed among the elderly residing in the community with a senior center than those living in the community without a center (which may have contributed more to their awareness of such programs). Furthermore, Ralston (1987) studying the users of fifteen senior centers in Iowa, found that knowledge of the number of center activities was greater for females, more frequent attenders and for those with a positive attitude

toward the physical environment of the center. While senior center participation was by far the strongest predictor of awareness of senior center activities, Krout (1984) observed that the only variables associated with the number of senior center activities that nonparticipants could identify was length of residence in the community and whether or not an individual belonged to a senior club. However, Krout (1983) in a study comparing senior center and community service awareness, knowledge and utilization patterns for a random sample of 125 elderly senior center participants versus 125 nonparticipants, observed that while all of the respondents said they were aware of the local senior center, their sense of awareness changed considerably when they were asked to identify specific activities and services available at or through the center. Nevertheless, senior center participants were much more likely to be aware of activities and services than nonparticipants.

Gerontologists have found that informal networks play an important role in determining what the elderly know about services in general, as well as the likelihood of whether such services will be used (Waring and Kosberg, 1984). It has been argued that informal ties like friends and neighbors provide links to other networks, such as services, while "strong kin" ties may hinder the spread of service knowledge to the elderly (Granovet, 1973). Silverstein (1984) also found that older persons who received information from both the media and informal sources had greater overall knowledge of services.

Finally, Krout's (1984) study of white elderly of a New York non-metropolitan area reveals that about two-thirds were aware of four services (senior clubs and centers, mini-buses, Medicaid and luncheon clubs), whereas approximately one-third were aware of two services (homemaker and information and referral). The finding pertaining to information and referral was important in that one of the purposes of this service was to assist persons in obtaining information about needed services.

While a number of writers have investigated awareness of health and social services among the elderly, few provide information regarding characteristics of persons who have this awareness. Krout (1984) suggested that elderly persons who were female, married and had more formal education were more aware of these services. In contrast, Snider (1981) observed that service awareness was not strongly related to sex, but rather was associated more with education, prior health service use, and monthly income. Silverstein (1984) found that the primary source of knowledge to be the most important predictor of overall knowledge of services, thus, contradicting the above findings. Lastly, Taietz (1975) concluded that the structural complexity of the community, according to its geographic location, was a major determinant of awareness.

An examination of service utilization research on the relationship between knowledge of services and use generally has indicated a positive association. Lind (1977), for example, observed that knowledge of social services

was consistently significant in all service categories; in a sample of 400 physically impaired older persons had more knowledge and greater utilization of services than those less impaired. He suggested that need was a major factor explaining this finding. Finally, Krout (1984) reported that awareness was positively related to use of health and social services among his nonmetropolitan sample of elderly whites.

Observed findings regarding a negative association between awareness and service use were also provided in a number of studies (Lopata, 1975). Silverstein (1984) reported that although a greater degree of overall awareness existed among the elderly who learned of services through the media and informal sources than those who learned through formal channels, the former were less likely to use such services. Krout (1984) revealed that while a positive relationship between service awareness and service use was observed for his total sample, a negative association was found when an analysis was done on only those aware of services. For the latter group, those programs that were relatively unknown had higher usage. In explaining this finding, Krout proposed that awareness of such services was perhaps more likely to be limited to those who actively needed and used them.

The Socio-Cultural Approach

The socio-cultural approach to service use focuses on ethnic and cultural group characteristics and related factors associated with service utilization

patterns and rates. The importance of family, other social networks, values, social class, ethnicity, subculture and symbolic definitions of service providers and consumers are all concepts examined from this perspective. Discussion employing family and social networks, subcultures and ethnicity are presented below.

Social Networks and General Service Utilization. A person's social network, as used in this presentation, is considered as a series of linkages (Hooyman, 1983), social ties (Ell, 1984) or a pattern of continuous or intermittent interchanges (Cantor, 1982). Social support includes any or all of the following: emotional support, advice, guidance and appraisal, material aid, services, information, or gratification of psycho-social needs (Ell, 1984; Hooyman, 1983; Gallo, 1982).

Prior research has indicated that many of the needs of the elderly have been met by informal, social support networks (Branch and Jette, 1983; Brody, 1981; Cantor, 1980; Horowitz, 1978). Oftentimes, these networks have buffered the various stresses of aging (Hooyman, 1983), have positively affected the health of the elderly (Gallo, 1982; Riportella-Muller, 1985) and decreased the risk of illness (Ell, 1984).

Generally, in times of need, older adults first have turned to their family and friends for support (Gottlieb, 1985; Kaye, 1985). This seemed to be the case for both emotional support as well as more concrete or instrumental forms of day-to-day help like physical requirements of daily living (Stoller and Earl,

1983; Weeks and Cuellar, 1981). In addition, Uhlenberg and Cooney (1990) reported that elderly women with more children were more likely to receive assistance from their offspring, thus, providing a potential support in times of need. However, when family support was insufficient or unavailable, older persons relied on other informal supports (Clark et al., 1988). Cicirelli (1981) compared the use of services by elderly who had no or one child to those with two or more children. He found that although both groups expressed a desire for services, those with no or one child actually received more services (homemaker, transportation, etc.) than those with two or more children. However, such help came from friends, neighbors, volunteer organizations and hired providers, not governmental agencies.

While much is known about the short-term consequences of caregiving, very little has been investigated in regards to long-term consequences of caregiving, particularly, the quality of care given over time (Tobin and Kulys, 1981), or the ability to sustain high levels of intensive support over time. However, over time, it has been found, particularly with persons 85 years and older, that informal support has either diminished (Bould et al., 1989), reached a level of insufficiency due to physical, financial, informational and resource constraints or become exhausted (Blau, 1973). Consequently, when families or other informal supports were unavailable, insufficient or exhausted, they were forced to turn to formal service supports. Formal supports for this study was

defined as "government mandated or sponsored professional services whether state administered or provided through chartered intermediaries such as private nonprofit organizations" (Froland, Pancoast, Chapman and Kimboko, 1981). However, available research on formal support utilization was sparse and inconclusive. For example, although Lebowitz et al. (1973) indicated that formal organizations were rarely reported as the preferred caregiver and Dono et al. (1979) suggested that both formal and informal support systems were necessary for an effective social support system because of their different structures and because they best responded to different types of problems. For example, Krout (1984) asserted that elderly who had contact with their children were not as dependent on formal services as those who had no children or those who had no contact with them. In addition, he noted that previous work, in general, had not explicitly considered whether the frequency of interaction between an older person and informal supports such as children, friends and neighbors were related to service use. Conversely, Horowitz and Dobrof (1982) cautioned against assuming that the presence of family members would have eliminated the need for formal resources and services. Still others suggested an indirect relationship between formal and informal support systems. Ell (1984) reported that informal networks influenced help-seeking behavior by conveying social norms, providing information and making referrals. Consequently, informal networks were found to be positively, although indirectly, linked to the formal service system. In addition, Starrett,

Mindel and Wright (1983) found that the elderly who had contact with family, friends or neighbors or participated in church groups had greater awareness of services and therefore, had greater utilization (using an Hispanic sample).

Racial Differences in Support Networks of the Elderly. Research findings on racial differences in support exchanges among older adults have been contradictory. For example, Shanas (1980) found that a higher proportion of white older persons reported that they gave help to their children and grandchildren, while elderly blacks were more likely than whites to receive help from their children. However, although Cantor (1979), failed to find racial differences in the amount of support that the elderly received from their children, both black and Hispanic elderly provided greater amounts of help to their children than did elderly whites. Mindel, Wright and Starrett (1986), controlling for income, found that elderly blacks received more formal support than elderly whites, whereas the amount of informal support received was similar. Utilizing the Myth and Reality of Aging data, Mitchell and Register (1984) reported, controlling for socioeconomic status, that elderly blacks received more assistance than elderly whites, but no racial differences in giving aid were evident. In an examination of the type of social support exchanged between the elderly and their children and grandchildren, Jackson (1980), observed only one racial difference - higher income blacks were more likely than higher income whites to give financial help to their children and grandchildren and provide child care assistance for their

grandchildren. Using a multivariate analysis, Mutran (1985), overall, found black families were involved in exchanges of help across generations. In comparison to elderly whites, elderly blacks gave more help to their children and grandchildren. Elderly black parents were also more likely to receive help from adult children. However, this effect was somewhat reduced when socioeconomic status was controlled. Furthermore, disaggregating racial and socioeconomic effects, elderly blacks still tended to receive more help from their children due to their lower income and educational levels.

The literature on the black elderly and informal supports has been controversial. On the one hand, elderly blacks were considered psychological survivors, able to draw from a large pool of family, friends and neighbors (Martin and Martin, 1978; Stack, 1974; Taylor, 1985) who constituted an extensive social support system. On the other hand, the black elderly have been seen as responding to changes in family structure and to a middle class orientation characterized by losses in interaction between current African American generations (Rathbone-McCuan and Hashimi, 1982; Martin and Martin, 1985). In this view, black elders were less likely to receive social support, as they were less likely to have a spouse, children or kin available. Moreover, when children were available, these elders were more likely to give than receive support.

In regard to older blacks as recipients of support, earlier studies (Cantor, 1979; Hays and Mindel, 1973; Jackson, 1971), as well as more recent

studies (Chatters, Taylor and Jackson, 1986; Mitchell and Register, 1984; Taylor, 1986a), have indicated that elderly blacks received a great deal of support and caregiving from their children. Mindel et al. (1986) found that the black family support system provided the following in order of frequency: transportation, checking services, homemaker services and administrative/legal services. In a study conducted by Dilworth-Anderson and McAdoo (1988) involving black elderly parent-adult children dyads, the majority of elderly parents reported that their adult children assisted them when they were sick, helped during financial crisis and emergencies and advised them on matters that impacted their lives.

In addition to receiving direct assistance from their offspring, black elderly with adult children were more likely to have larger extended kin networks to provide support than those older blacks without children (Chatters, Taylor and Jackson, 1986). However, there was a gender difference in the receipt of support from adult children. Older women have a greater probability of receiving support from their children than do older men (Chatters et al., 1986; Woolf, Breslau, Ford, Ziegler and Ward, 1983).

Contrary to consistent positive findings concerning the tendency of black families to provide significant support and care to the elderly, various researchers have challenged the generalizability of these patterns to the black population. Jackson (1980) found that not all black elderly were in extended families nor did all adult children want or were able to provide support to their

parents. Other researchers reported that high levels of family assistance in black populations often were eliminated once socioeconomic status was controlled (Sokolovsky, 1985; Cantor and Little, 1985; Mindel et al., 1986). Mutran (1985) and Parnes, Crowley, Haurin, Less, Morgan, Mott and Nestel (1985) also found that blacks were no more likely than their white counterparts to have received assistance from young persons but were much more likely to provide it. Furthermore, what did seem to hold true across many studies, controlling for gender and social class, was that Hispanic elderly consistently had higher levels of interaction and support from their children than either black or white elderly had (Cantor, 1979; Valle and Martinez, 1981). However, this has been challenged by Greene and Monahan (1984). They argued that the effectiveness of the Hispanic extended family, particularly the Mexican-American family has been in secular decline under the influences of industrialization, urbanization and upward mobility and can no longer provide the level of services and resources to their elder members. And although little has been written about Asian American family support systems, recent research suggests that Chinese American elderly compared to Hispanics and blacks were the most likely to have been married and not have been living alone but least likely to visit or be visited by friends. This assertion has also been challenged (Lui, 1986).

Ethnicity and Health Care Utilization. According to Reed (1990), not only did race affect whether, when, how often and where utilization of medical care occurred, but it also profoundly influenced what services were received. And, while crude overall utilization statistics revealed few racial disparities, marked differences have been reported in the location, source and quality of care for minority health care seekers (Link, Long and Settle, 1982). For example, recent data indicated an average annual rate of office visits to physicians for coronary heart disease by non-whites to have been about half the rate as for whites (Aday and Andersen, 1984). In fact, black patients in particular, were less likely to see a specialist when compared to their white counterparts (U. S. Department of Health and Human Services, 1985). However, blacks were overly represented in utilizing hospital clinic and emergency room physicians.

When characteristics and attendant attributes of the individual were more important, as in physician utilization, as the above indicates, the use of health services by minority elderly was far more sensitive to need than it was for white elderly (Wolinsky et al., 1989). In contrast, when the decision to use health services was most likely to be up to the judgment of the physician, as in hospital utilization, the use of health services was somewhat comparable across the ethnic subpopulation (Reed, 1990). This general pattern appeared to be consistent with the longstanding assumption suggesting that minority elderly may have been more likely 1) to delay seeking a physician's care until their health conditions

necessitated it; or 2) not to have sought a physician's care for less-serious maladies compared to their majority counterparts (Riessman, 1974; Stahl and Gardner, 1976). Hessler, Nolan, Ogbru and New (1975) also found that Chinese American patients sought both western medical services and traditional Chinese medical services (mainly herbal medicine). However, this group never used one type to the exclusion of the other. Instead, Chinese medicine was used for the treatment of minor disorders and chronic conditions while western medicine was used for acute and more serious medical problems. Since this study was conducted in Boston and Chinatown is close to major medical facilities within the city, the refusal of Chinatown's residents to use exclusive western, health care might have suggested the role of culture in health behavior. Similarly, Korean immigrants were said to have approached the dual system of medicine in a similar fashion (Weaver, 1976) as an indication that Asian Americans, except Filipinos, tend to use ethnic health therapists rather than to use physicians outside of their ethnic communities. The mainstream medical system was usually sought when other methods have failed and when observable symptoms began to indicate signs of malfunctioning (Kleinman, Eisenberg and Good, 1978). In terms of Mexican Americans and health care utilization, Roberts and Lee (1980) found that with one exception, Chicanos in Alameda County, California used medical services less than whites or blacks. Consequently, Mexican Americans had the lowest rates for physician visits as well as for general medical examinations like for physicians and eye examinations.

Similarly, Galvin and Fan (1975) reported that Spanish-surname respondents had the lowest physician utilization rate in comparison to blacks and whites. Moreover, in a study which separated out various ethnic groups within the Hispanic grouping, Wolinsky and his colleagues (1989) reported that Cuban Americans' contact with hospitals as well as their hospital stays were less likely based on need like Puerto Ricans, Mexican Americans and African Americans. In fact, Cuban Americans' contact with hospitals and hospital stays were associated with need even less than the white elderly. However, with physician contact and doctor visits, Cuban Americans resembled African American and Mexican American patterns which was slightly less than Puerto Rican Americans but considerably less than Anglo-Americans.

Subculture and Health Utilization. Various authors have argued that health care utilization among ethnic groups was based on the degree to which such subpopulations were able to participate in such health services in their community (Herrick, 1979). Such an approach was based on Blau's (1977) work describing how the social structure of communities influences the interaction among and between members of its various subpopulations (Blau, Beeker and Fitzpatrick, 1984; Rytina, Blau, Blum and Schwartz, 1988). Blau and his colleagues reported that relative frequency of all types of intergroup relationships depended on the opportunities for contact which existed between and among the groups. Consequently, the use of health services by members of a particular group was

sensitive to the number of its members who work in the health care delivery system and the nature of their employment therein (Aguirre, Wolinsky, Niderhauer, Keith and Fann, 1989). Thus, the proportional representation of ethnic groups among physicians and the degree of ethnic concentration in any particular health care occupation(s), such as ancillary workers, was found to be more central to ferreting out ethnic differentials in the demand for health services than was general access measures (Hansen and Resick, 1990). In addition, Ell, Mantell and Hamovitch (1988) reported that ethnocultural factors played a significant role in the association between stressors and the onset of the illness as well as in the use of health services. Consequently, such authors asserted that not only differing cultural characteristics of Native Americans but the traditions of recent immigrants needed to be considered in how such groups accessed the health care system. Herrick (1979) also found that minority health care consumers used their own cultural belief system with respect to health and the health care system. For example, Mexican Americans were not responsive to traditional educational attempts to advertise how to involve them in the health care process. Instead, primary referral sources came from their families, relatives and friends. Lastly, others have supported a culture of poverty approach where differences were found between the poor and others with respect to the use of medical services (Aguirre et al., 1989). Aguirre and his colleagues asserted that the poor were culturally unable to make use of many health services because they lacked the experience and

information required to make use of most health care systems, suggesting that these differences act as deterrents to utilization of health care facilities.

Studies of the use of the emergency room (Gibson, 1970; Torrens, 1970) suggested that the poor represent a subculture with respect to utilization of health services. These studies showed that lower class, largely black sectors of the population were more likely to use the emergency room as a source of primary care even when other outpatient services were available to them in the same facility. Similarly, Roth (1971) in comparing the composition of services sought and the social characteristics of persons seeking such services for emergency rooms in a central city versus a white, middle-class suburb, concluded that the demands made on these facilities were very different and that these differences were linked to racial and social class subcultures. However, none of these studies differentiated the effects of the culture of poverty from cultural differences which may have been specific to the ethnic group investigated. Lastly, Wolinsky et al. (1989), refuted Blau's (1977) assertion that ethnic health utilization patterns were based on the concentration rates of that individual's ethnic group in the various health care occupations. They found that proportional representation of physicians failed to register a significant effect for any ethnic subpopulation on any measure of health utilization. Moreover, the occupational concentration index yielded a significant effect among Puerto Rican, Cuban and Anglo-Americans, but only on the number of nights spent in the hospital.

Regardless of familial, social network, racial or subcultural investigations concerning such variables on the impact of health care utilization, all conceivable explanations involved the recognition that minority elderly were disadvantaged relative to their Anglo counterparts at all ages but especially among the elderly (this factor must be kept in mind since some of the above investigations have reflected general public health utilization patterns). The recognition of the relative disadvantage of minority elderly held regardless of whether the explanation of the differential was assumed to lie in health beliefs and behavior (Stahl and Gardner, 1976; Wolinsky, 1982), methodological artifacts in health status assessment (Andersen, Mullner and Cornelius, 1987; Angel and Gronfein, 1988; Manton et al., 1987), or economic and cultural access barriers (Davis, Lillie-Blanton, Lyons, Mullan, Powe and Rowland, 1987; Long, 1987). However, there was no easy solution to reduce such differentials, inasmuch as they could not have been dealt with in isolation from the discontinuities and inequities that permeated the ethnically stratified society (Miller, 1987).

Social Networks and Social Service Utilization. Little has been written about the roles of the family, kin and non-kin support networks in determining the use of social services by the elderly. Various investigations including Laurie (1978), Litwak (1978) and Sussman (1977) have stressed the family's role as a buffer or link between the older adult and the service provider. However, this research did not address social networks and the actual social service utilization

patterns among the elderly. Other studies suggested that the perception of awareness of need, the availability of formal and informal support systems and previous contact with the delivery system were critical in determining social service utilization (Davis and Reynolds, 1974; Cantor and Mayer, 1975; Hess and Markson, 1980; Smyer, 1980; Kao, 1988). Mindel and Wright (1982) found a major difference between whites and blacks with respect to the role of informal family support. In over 2,000 cases examined, he observed that family support in white families as it was related to social service utilization was less than family support from black families. It was found that the black elderly who tended to receive aid from family members were those most in need, thus, used the greatest number of social services. In a study using a national Hispanic sample, Starrett, Decker, Araujo and Walters (1989) reported that the awareness and subsequent use of social services by Cuban elderly were affected by contact with their children and/or contact with their relatives. Similarly, using the same national sample, Starrett, Decker, Araujo and Walters (1987) found that contact with family, friends or neighbors significantly impacted predicting a positive relationship with regards to social service utilization by Puerto Rican American elders. Using the California Senior Survey conducted in 1982 and 1983, Lubben and Becerra (1987) found that whites and Chinese Americans were slightly more likely to receive help in activities of daily living from a spouse than Mexican American or black elderly.

Mexican Americans tended to get help from an adult child, whereas, blacks received more formal support (using home health aides, visiting nurses).

The feelings of older persons toward family and other social networks members have affected how and if the individual requested, accepted and/or utilized assistance from these people, should long-term care needs have arisen. This behavior, in turn, affected that person's utilization of services from social agencies (Tolsdorf, 1976; Snow and Gordan, 1980). In addition, ethnic, cultural, generational and residential characteristics of families have been associated with varying attitudes and values about who carried responsibility for the provision of long-term care services to older persons (Fandetti and Gelfand, 1976; Brody, 1981). These varying attitudes may have directed behavioral implications for the involvement of family members in the provision of such services. There were also indications that the social class position of family and other social network members may have had significant influence upon the caring roles such persons took in providing for the needs of the functionally impaired older persons, thus, having affected social service utilization (Leiberman, 1978; Lee, 1979).

Findings by Lopata (1975) and Silverstein (1984) showed that lack of knowledge about existing formal service programs or about how to obtain information on formally provided services, was positively correlated with underutilization of such services by older persons. These findings suggested that

such lack of knowledge among the older person's family and friends may also have had an impact on formal service utilization.

Aside from the major role the family played in care for the elderly, a less commonly explored social support network consisted of religious organizations. Such support systems were particularly critical for black elders as they often lived in neighborhoods where few formal services were located and where transportation was limited (Warren, 1975; Taylor and Chatters, 1986). For elderly without transportation, the resources that were utilized were often limited to a shopping and service area in a six to eight block radius of their home (Morrison, 1991). In addressing this problem, the church was one of the major resources in this service area, with church attendance and shopping the most common community-based activities used (Biegel and Sherman, 1979).

Although churches in general have provided help by utilizing supportive services from various social services offices, the church was more strongly identified with the black community and was more likely to be important in the lives of ethnic elderly than others (Morewacki and Kobata, 1983; Gelfand, 1983). In reviewing national survey data related to black elderly and the church, Taylor (1986b) found 77.6% of older blacks reported official church membership with 82% reporting that they had attended church at least three times per month. While these figures were higher than the population in general, older people reported higher rates of church attendance. Ellor, Anderson and Tobin (1983) found that

45% of older people identified with the church as a place to turn for help and suggested that there were a range of church programs that can be provided to enhance the role of the church as a service center. Furthermore, formal services were more likely utilized by an older person if the service was recommended by a physician or member of the clergy (Biegel and Sherman, 1979). In terms of informal support, regular visitation by the clergy or laypersons, modest help with chores, small cash gifts, transportation to medical services and provision of recorded sermons were typical types of assistance available for infirmed black elderly within the church (Morrison, 1991). Such support helped maintain contact, continuity and a bond with the church.

The participation of older blacks in the church is important because of its positive association with the receipt of informal support from its members. The church has promoted participation of older blacks in services and activities by explicitly encouraging involvement and improving access to other social agencies (Taylor, 1986b). The church may have also fulfilled an important information and referral service for its elderly members with regard to community services and organizations that were designed for senior citizens. The use of church networks has improved access to certain groups of hard-to-reach elderly blacks who were traditionally underutilizers of social services (Taylor and Chatters, 1986).

With regard to service delivery to elderly blacks, it was important to recognize the pivotal role played by ministers. Ministers were recognized opinion

leaders in black communities and have provided important sources of information regarding the members of their congregations. Furthermore, ministers often have served as linkages between their congregants and larger social service bureaucracies (Morrison, 1991). As such, they interpreted and represented the efforts of social service agencies and could facilitate or impede service delivery (Chatters et al., 1986).

Ethnicity and Social Service Utilization. Analyses of race and ethnicity in relation to social service utilization provide mixed outcomes. McCaslin and Calvert's (1975) research indicated that ethnicity had a differential effect on the use of information and referral services by the elderly, with whites utilizing services less frequently than blacks. The authors interpreted lower utilization rated by whites as having been attributed to their inexperience with public services and their reluctance to ask for services. Moreover, they note that greater use of services by blacks was perhaps indicative of their greater need. These findings contradicted previous research which indicated an underutilization of social services by ethnic minority elderly (Mindel and Wright, 1982; Downing, 1977; Vickery, 1972; Holmes et al., 1979; Harris, 1975).

Data on the use of community-based long-term care services by older African Americans have been limited. Multivariate analyses from the mid-1970s were contradictory with older blacks more likely than older whites to have received home care services in one local study (Evashwick et al., 1984) but no differences

were found in a different city and study by Mindel et al. in 1986. National data from 1984 found that black elderly were slightly less likely to use formal in-home services than were elder whites, although those data were not adjusted for the higher disability levels of African Americans, their lower incomes or other possible confounding factors (Hing and Bloom, 1990). Data from a Missouri study (Wallace, Snyder, Walker and Ingman, 1992) which included family and caregiver characteristics in analyzing the use of long-term care services, found that older African Americans were more likely than older whites to use adult day care and to use it more frequently. When Medicaid and family characteristics were controlled for in this study, race was not significant in predicting attendance. This suggested that the immediate cause of racial differences in the use among older adult day care users was primarily a function of economics and family status. African-American adult day care participants relied primarily on nonspousal family, whereas, whites relied equally on spouses and nonspousal family. Older black participants were also more likely than whites to have caregivers who were working nonspouse family members. Because nonspousal caregivers of both races work at the same rates, the importance of adult day care in helping African-American families was the result of the higher levels of black co-residence rather than of different rates of employment.

In addition to the racial differences in informal-support characteristics, the authors observed large differences in the source of payment for adult day care

that mirrored the threefold difference in the poverty rates between blacks and whites. This analysis showed that the disproportionate receipt of Medicaid by African Americans was likely to have enabled their use of adult day care services rather than act as a barrier.

Empirical evidence was suggested that Hispanic elderly utilize disproportionately small amounts of formal long-term care services. Lacayo (1982) found that Hispanic elderly underutilized community-based social services, although the absence of non-Hispanic comparison groups in this study, made his conclusions less than certain. Findings by Guttman and Cuellar (1982) also indicated substantial underutilization. Using a sample of Anglo- and Hispanic-elderly in the Community Services System (CSS) in Arizona, Greene and Monahan (1984) observed that the Hispanic enrollees received somewhat more assistance in transfer and with finances but markedly less assistance in the areas of housework/chore services and laundry. However, receiving lower levels of assistance in housework/chore and laundry services was surprising since 80% of direct service expenditures (excluding social casework) for the Community Services System goes to support such services. Consequently, Hispanic elderly consumed a share of CSS resources even smaller than their incidence of service utilization would suggest. Thus, the data supported previous studies that concluded that Hispanic elderly tend to use fewer social service resources than do white elderly. And in this case, even when they were enrolled in a program designed to provide

access to a wide variety of services, they still underutilized such services. Furthermore, this lower utilization could not be attributed to lower levels of functional impairment but rather was in the presence of higher levels of impairment.

The literature on senior center use has presented divergent findings on minority/nonminority utilization. Greene and Monahan (1984) indicated an underrepresentation of minorities attending senior centers. Other studies indicated that some minority elderly, mainly black and Asian Americans were more likely to be senior center participants than their white counterparts (Krout, 1989). In addition, when sufficiency of financial resources and education were controlled, higher sufficient and higher educated blacks attended senior centers when compared to their white counterparts (Krain and Trevino-Richard, 1987) while no differences of utilization were found in low education and sufficiency categories. Persons of both races with a limited degree of dependence were the most likely to attend senior centers. Those with the greatest dependence were least likely to attend which was most striking among whites (controlling for education and sufficiency). Among the highest degree of dependency and in the low-sufficiency category was the lowest senior center use of all.

In an examination of senior center utilization by black elderly, Ralston (1982) found that sociodemographic variables like sex, age and marital status, the participant's health, or means of transportation to the center did not have a

significant effect. However, factors that were found to be important in determining attendance were commitment to becoming involved in the senior center, perception of the senior center and contact with family and friends. Similarly, in a multivariate analysis of a sample of eight senior centers in western New York, Krout (1991) observed that participation duration was not based on race or age but related to closeness of residence to the center, contact with friends and the impact participants saw center attendance as having an influence on their lives. Finally, Harris (1975) reported that three in five blacks 55 years of age or older did not attend senior centers, but indicated that they were interested in doing so.

Slightly different findings have been concluded on nutrition site utilization. Burkhardt, Lago and Blattenberger (1983) found that ethnicity and the number of elderly living alone were not significant factors in predicting use. Instead, the most important variables affecting attendance at nutrition sites were the type of food preparation, the type of building where the site was located, the amount of the suggested contribution and the competition from other nutrition sites and programs (such as meals on wheels). Similarly, Lubben and Becerra (1987), observed few Mexican and Chinese Americans participating in any type of nutrition site programs.

Harel (1985) observed that significant factors differentiate utilization of nutrition sites between black and white elders. The differences were economic

security and quality of living arrangement. Consequently, blacks utilizing such services were more economically impoverished and had slightly less access to the services. Black service consumers were also found to have fewer social resources than older white consumers. This particular finding was contradictory to previous research which indicates that blacks have a more extensive network of social resources than whites (Jackson and Harel, 1983). This may have indicated that black aged who utilized the Older Americans Act-funded services were the more socially isolated among black aged and therefore in more need of these services.

While the above research provides indications of differential use of health and social services among racial and ethnic groups, another body of research showed no major differences in this regard (Demko, 1979; Sokolovsky, 1985; Jackson, 1978; Mindel et al., 1986). In Demko's study on utilization and attrition rates of senior centers in southwest Detroit, he found life space (i.e., frequency of contact with friends and relatives), duration of center membership and living arrangements rather than race and other sociodemographic variables to be significantly related to use. For example, low users tended to have a high life space (more contact with informal group members), while higher users tended to have a low life space (less contact with informal group members). Additionally, low frequency users were more likely to have been members of the center longer than were high frequency users. Jackson (1978), Sokolovsky (1985) and Mindel et al. (1986) found that high levels of family assistance in black populations often

disappear when controls for socioeconomic status were imposed. Thus, family assistance may have been forced responses to greater levels of need. Some studies have found that older blacks were no more likely than whites to have received assistance from their adult children, but were more likely to provide it (Mutran, 1985; Parnes et al., 1985). McCaslin (1989) found that race was a poor predictor of use of services. Therefore, she found minimal differences between African-American and white elderly people in the use of services. Finally, Mindel et al. (1986) in analyzing specific types of assistance (i.e., personal care, transportation, etc.) observed no racial differences in the informal system in terms of utilization.

Social-Psychological/Organizational Factors and Service Utilization

The last two categories under analytic approaches to service utilization are the social-psychological and organizational factors. The social-psychological approach affects the symbolic perceptions of the consumer in relationship to how these perceptions impact service utilization. Included in this category are morale of individuals and attitudes toward service use and service providers (Ralston, 1982; Jackson, 1972; Waring and Kosberg, 1984; Carter, 1974). A discussion of the attitudes toward the service provider and how this affects service utilization is addressed followed by the implications of organizational factors on such service utilization.

Carter's extensive case studies led him to conclude that the black elderly's negative attitudes toward service providers and service use were

legitimate in light of the lack of sensitivity oftentimes displayed by providers. Torres-Gil (1982) asserted that a pervasive sense of alienation from the norms and from medical and social systems compounded with reciprocal indifference and insensitivity towards the patient/participant may have been the major reasons for Hispanic elderly underutilization of such services. The lack of bilingual, bicultural, health personnel has been cited as barriers to access and utilization of health care among Chinese American as well as Hispanic elderly (Hussar, 1975; Lui, 1986; Gutmann and Cuellar, 1982; Greene and Monahan, 1984).

Organizational factors have contributed to the psychological perceptions that the consumers have had toward the service providers, staffing patterns, location and office hours of service facilities, providers' attitudes, and staff-client relations were included in the organization variables which influenced service utilization (Thornton and Carter, 1975; Holmes, Holmes, Steinbach, Hauser and Rocheleau, 1979). In Holmes et al.'s study of service use among black and other ethnic elderly, the location of service facilities in the respective ethnic elderly's communities, the facilities' staffing patterns which reflected the ethnic populations and the positive attitudes of agency administrators toward the importance of ethnic staff to organizational functioning were positively related to service use. Thornton and Carter (1975) attribute the success of their intervention to the positive attitudes displayed by agency staff and flexible hours of the service facility. Similarly, Blau (1977) suggested that the use of health services by members of a particular ethnic

group depended on the number of its members who were employed in the health care delivery system. Finally, Ward (1978) noted that the "culture" of the health care delivery system may have served as a barrier in itself to the use of services. However, the above findings, once again, have been challenged (Wolinsky et al., 1989; Aday and Andersen, 1984).

A Cautionary Note on Utilization

It is evident from the above research findings that race and ethnicity seemingly have some impact on service utilization. However, attempting to explain utilization behavior solely in terms of these variables may have excluded others that may have been significantly more influential.

Another point to have considered was that although many investigations have been cited in attempting to explain the complexity of causation as it impacted utilization behavior among the elderly in terms of health and social services, the consensus conclusion of the above research was that usage rates for this population were extremely low. For example, Soldo (1980) cited a government study which estimated that only 3% of the eligible elderly benefit from community-based services, 1% from meals-on-wheels, and less than 50% from Supplemental Security Income (the major income maintenance program for the very poor). Lee and Estes (1980) reported that only one of six eligible, low-income elderly persons participated in the federal Food Stamp program and Atchley (1980) noted that the elderly represent only 2% of the psychiatric clinic patients and 4% of community

mental health center patients. Usage rates of social programs were not much more encouraging; a recent review of the literature found that senior centers were restricted to between 10 and 20% of the elderly (Krout, 1985).

A major explanation for such low utilization of formal services was that the elderly knew little about such programs. Research findings on the degree of knowledge of medical and social services have varied considerably from study to study and from service to service. Whereas between one-half and two-thirds of the elderly have heard of services such as senior centers, nutrition sites and transportation, much lower rates (less than 30%) of awareness were found for programs such as information and referral, home health and help services (Krout, 1985).

Whatever the true amount of service awareness among the elderly, it has been clear that a large proportion of the elderly who knew about such services did not use them. In addition, Beattie (1976), Lowy (1980) and Soldo (1980) have all argued that a primary impediment to effective service provision was the lack of any real organization, coordination or integration within and between agencies in the business of bringing health and social services to older persons. It is precisely these three areas that this research will further investigate.

Chapter III

CONCEPTUAL FRAMEWORK AND RESEARCH QUESTIONS

In the previous chapter a discussion was presented regarding the existing literature on health and social service utilization among the elderly in particular, with selected reference to the general population. This chapter presents the conceptual framework and pertinent research questions upon which this investigation is based.

The conceptual framework for the study takes into account the importance of including a number of descriptor variables in studying the area of service utilization. It is based on an analytic model originally developed by Andersen and subsequently revised with his colleague (Andersen and Newman, 1973). In this behavioral model, health service utilization was conceptualized as the outcome of three major factors: predisposing, enabling and need.

The predisposing component reflects the fact that some individuals have a greater propensity to use health services than others. The predisposing component is further subdivided into three dimensions, including demographics, social structure and health beliefs. The demographics dimension is measured by age, sex, marital status and living arrangement. The social structural dimension is

measured by age, gender, employment, education and ethnicity. The health beliefs dimension is measured by a series of questions about attitudes toward medical care, physician and disease. When taken together, the three dimensions of the predisposing component represent the sociocultural element of this behavioral model.

Although the individual may be predisposed to use health services, s/he must nonetheless have some means for obtaining such services. It is the enabling component which includes these factors. The enabling component is divided into four dimensions. The first is familial resources. Family resources are measured by income, the presence of health insurance, and having a regular source of care. The second dimension is community resources. Accessibility to services is the next measure. This dimension is examined by one's ability to physically access such services. Service awareness is the last enabling factor. Service awareness, in turn, is measured by the number of agencies/services that one has heard of. When these four dimensions are collectively examined, they provide the economic dimension of the behavioral model.

According to Andersen and Newman (1973), the greatest use of health services comes from the perceived need of such services. Need is further subdivided into two dimensions. The first represents the amount of illness that the individual perceives to exist. It is typically measured by a self-assessed, global measure of health status. The second dimension represents professionally

evaluated need. Physician and/or other medical practitioner assessment consists of measuring limitations in performing activities of daily living due to failed health. When taken together, these indicators represent a potential or actual health problem.

The final dimension of the Andersen/Newman (1973) behavioral model is actual health service utilization based on various predisposing, enabling and need factors. Two types of utilization behavior in which individuals engage - discretionary and nondiscretionary behavior (Andersen and Newman, 1973) are identified. Discretionary behavior refers to the use of health services by individual choice while nondiscretionary behavior represents health service utilization based on health care provider determination.

Ward (1978) has argued that the above behavioral model is particularly relevant for studying the health and social service utilization of the elderly subpopulation. His reasoning is twofold: 1) the model identifies mutable factors that facilitate the discussion and formation of public policy; 2) there are significant correlations between the sociodemographic factors and the use of health services among the elderly. Consequently, Ward argues that gerontological health services research could significantly benefit from the adoption of the behavioral model (Ward, 1978).

As a point of concern, however, Ward (1978), identifies two shortcomings in applying the behavioral model to the special case of the elderly.

The first is the failure to consider how organizational factors associated with the bureaucratic nature of service delivery settings can serve as a barrier to utilization. Specifically, Ward asserts that it may be more difficult for older persons to penetrate the bureaucracies associated with the American health care delivery system. The second concern is that social networks are not given much of a role in the behavioral model. Because research on the elderly suggests that these networks might contribute significantly to the decision to use such services, I altered the model to include social network support under the enabling component.

Eve and Friedsam (1980) found the Andersen and Newman behavioral model for health service utilization as it applies to the elderly as a poor indicator of physician, hospital and dentist utilization. Coulton and Frost (1982) suggest that the model is better at predicting ancillary services like health maintenance and/or preventive care. Similarly, Wolinsky, Coe, Miller, Prendergast, Creel and Chavez (1983) also raise several issues about application of the behavioral model to the special case of the elderly. They suggest that predominantly demographic models may not be as appropriate as more psychosocial models for the older population. In addition, Wolinsky et al. (1983) speculated that the behavioral model's economic component may no longer be as salient because of government entitlements, namely Medicare and Medicaid, which may serve as a "leveling" construct in one's ability to purchase services. Nevertheless, the Andersen/Newman (1973) behavioral model has become the dominant paradigm for

studying health and social service utilization behavior of the elderly. The model seems appropriate for studying such utilization behavior in relation to other areas of human services because of its integrative approach of including numerous factors in investigating the phenomenon.

A modified version of the Andersen-Newman model which serves as the basis for this study is presented in Figure 1. While the study, in general, is based on the framework as presented, the primary focus of the investigation is based on the socio-demographic factors pertaining to the individual determinants of social service utilization among black elderly.

Implications of the Model

Predisposing Component

Some individuals have a propensity to use services more than other individuals. It is assumed within the model that this propensity can be predicted by individual characteristics which exist prior to the onset of receiving formal social services. Such characteristics include demographic, social structural and attitudinal belief variables.

The demographic variables considered for this investigation are: gender, age, marital status and education.

1. Gender - Gender, as delineated by male/female categories, is pertinent in determining whether it influences social service utilization by African American elderly. Moreover, this variable is important in light of a number of

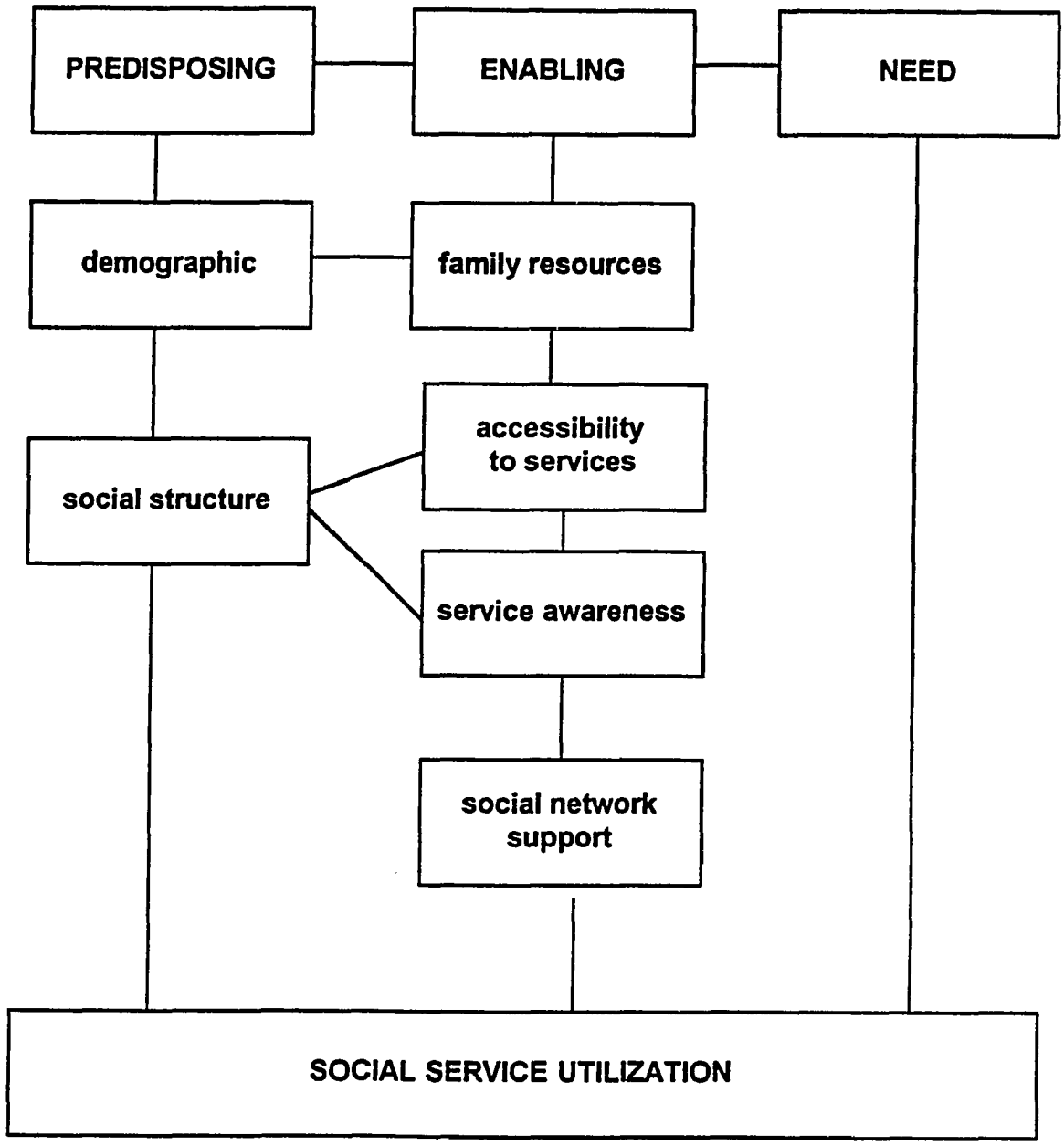

Figure 1. The Behavorial Model for Social Services
(Based on the Anderson Newman Model, 1973)

findings among the general elderly population which indicate that women use more formal services than males (Harris, 1975; Contrell, 1975; Mindel and Wright, 1982).

2. Age - Age is considered an important variable for determining if there are significant differences in the social service utilization between black elderly according to chronological age distribution.

3. Marital status - This variable is included in the study to determine if there is an association between social service utilization by the black elderly and whether they are married, separated, divorced, or widowed.

4. Education - Education refers to the degree of attainment of formal training or schooling. The inclusion of this variable in this study permits an analysis of social service utilization by black elderly in relation to their levels of formal education. Some researchers have expressed concern that ethnic minorities may have difficulty negotiating social service delivery system or understanding literature pertaining to how to access such services (Adams, 1980). Consequently, the educational component addresses such concerns.

5. Living arrangement - Living arrangement refers to the household composition or living situation in which the African American elderly reside. The analysis of service utilization in relation to this variable provides insightful information regarding how the extent to which living alone, with a spouse or other family/nonfamily members impacts service utilization.

Enabling Component

Even though individuals may be predisposed to use specific social services, some means must be available for them to do so. Enabling factors are those conditions which permit an individual to act on a value or satisfy a felt need regarding social service use (Andersen and Newman, 1973). Enabling variables in this study include: family resources, service awareness and social network support. Social network support is not a part of the original Andersen/Newman Model (1973) but is added here because of the potential importance that the black elderly's informal support system may play in increased utilization of services.

1. Family resources - Variables included under this dimension are income (refers to the amount of monthly earned income or cash benefits received), source of income (type of monetary benefit), level of health insurance coverage or other source of third party payment, and the existence, nature and accessibility of a regular source of social service assistance.

2. Service awareness - This variable measures the extent to which the black elderly are familiar with 29 services provided by social service organizations in the area under study. Its inclusion permits an analysis to determine whether it impacts service utilization.

3. Social network support - Social network support measures the extent to which members of the black elderly's support system provide services. Members of the informal social support network may include family, friends and neighbors.

Formal network support includes persons family members have hired to provide services, church members or persons from agencies.

Need Component

Given the presence of predisposing and enabling conditions, the individual or his/her family must perceive a need for or the probability of a future need for the use of social services. Need, then, is the catalyst or most direct reason for service usage. Although evaluated need is usually a part of the model, in this study, perceived need will only be included.

Research Questions

The research questions developed to achieve the objectives of the study are as follows:

1. What formal social services are most black elders familiar with?
2. What are the associations between the extent of social service utilization by black elderly and the following predisposing variables?
   a. gender
   b. age
   c. marital status
   d. education
   e. living arrangement
3. What is the association between service awareness and the following predisposing variables?

a. gender

b. age

c. marital status

d. education

e. living arrangement

4. What is the association between the extent of social service utilization by black elderly and their need for such services?

5. What are the associations between the extent of social service utilization by the black elderly and the following enabling variables?

a. income

b. source of income

c. type of insurance

d. accessibility to services

e. service awareness

f. social support network

6. What is the association between social network support and the following predisposing variables?

a. gender

b. age

c. marital status

d. education

e. living arrangement

7. What is the association between need for assistance and use of social support networks?

8. What is the association between need for assistance and the following predisposing variables?

   a. gender

   b. age

   c. marital status

   d. living arrangement

Chapter IV

METHODOLOGY

Much of the literature on knowledge utilization suggests that the most significant factors in yielding research findings that will be effectively used are to interest and involve clients or community in part or all of the stages of the research process (Alkin, 1985; Glaser and Taylor, 1973; Leviton and Hughes, 1981). Others have noted the need to involve stakeholders, a term referring to individuals or groups with a vested interest, or stake, in the research process and findings (Weiss, 1983; Greene, 1988; Ayers, 1987). The practice of including a stakeholder is a more inclusive concept in community-action research in that it includes not only clients and direct beneficiaries but also other persons or groups who may be affected by the research process and/or ultimate decision outcomes. Therefore, involving the stakeholder in the development, design and implementation of the survey instrument, will increase the likelihood that the research findings will be used because of the following (Glaser, Alderson and Garrison, 1983; Schensul, 1987):

- Participation "demystifies" the research process. Clients and other users gain understanding of the methods and the opportunity to influence data collection.

- Participation increases the stake that users have in the success of the project. Their increased understanding, trust in the data, and investment of time increases their sense of "ownership" of the project.

- The feedback that occurs because of client participation improves the researcher's understanding of the client's situation which, in turn, improves appropriateness of the data collected and quality of the recommendations.

- Participation leads to clearer identification of the ways that the research can be used.

- Understanding the research process also equips users to be advocates for change.

The community action research will equip users to advocate for effective, local, social welfare policy that reflects the needs of the targeted group, thus, improving service delivery. Therefore, the above reasons provided the impetus for engaging in a community-action research project that provided a vehicle for the Black Caucus on Aging to identify and assess formal social service utilization in conjunction with informal social supports within inner-city Wilmington, Delaware among black elderly respondents. Advocacy for change in the formal social service delivery system is based on results coming from this investigation.

In addition to conducting a community-action investigation, the research focuses on the black elderly as a separate entity. Consequently, exploring social service utilization within this subgroup, allows in-depth analyses in relationship to the heterogeneity among black elders. Thus, similarities and differences influencing service utilization and/or informal social support can be researched in

terms of group characteristics, not racial differences. Therefore, insightful information is provided for future analysis when comparing these characteristics to the general elderly population.

Sampling Procedures

The sample for this study comes from three sources. First, senior center participants or church members from inner-city sites in Wilmington, sixty years of age or older, including: Ezion Mt. Carmel United Methodist Church, Kingswood Community Senior Center, Scott African Methodist Episcopal Church, Peoples Settlement Senior Center, St. Matthews Episcopal Church, Bethel African Methodist Episcopal Church and the Salvation Army's Senior Center (this center later dropped out of the project) were used. A modified random sample (random sample within a selected group) with a random start was taken from the total population of all participants aged 60 or older who were either church members or participants of the above identified sites. Second, participants for the survey came from referrals of persons who participated in the interview process (Appendix A). Third, community elders who sent back response cards (from a postcard distribution) indicating their willingness to participate in the research were included in the project. From the total population of 763 persons (assumed to be 60 years and older), 500 were randomly chosen to be interviewed face-to-face (or by telephone if the respondent requested it).

Instrumentation

Construction of the survey instrument fit the community-action model (Patton, 1986) in that the researcher, community members, agency representatives and academics were all consulted for input into its development. A group decision was made as to: what information would appear on the instrument, the usefulness of each question, the wording, clarity and order of each question, the physical layout of the survey and determination of where to place the more sensitive questions, bias question concerns, whether the respondents would have the information necessary to answer the questions, the length of the instrument and whether the answered questions would provide data to address project goals.

All of the above considerations were examined in the Minority Outreach Survey (developed for this project). After conferring with the experts and community workers the following amendments to the survey instrument (Appendix B) were made:

1. To include a question on whether the respondent spoke another language other than English as a first language.

2. To include instructions on how Medicaid, Medicare and General Assistance (GA) Health cards looked so that the respondents could accurately respond to the possible type of health insurance that they were covered under even if they were not certain of the name of the insurance.

3. To add transportation as a component to access to services. For example, to add, "who usually provided transportation when the respondent went shopping, to the doctor's office or to pick up medicine" and whether the respondent felt that adequate transportation, both private and/or public was available in addressing his/her needs.

4. To include whether informal assistance in meeting ADL's was given without monetary cost or whether the respondent had to pay for it.

5. To include reasons why respondents attended or did not attend senior centers and/or church.

6. To include whether senior center involvement by the respondent was centered around other participants or performed alone.

7. To include a response of "money order" as a choice in how one paid bills (it was pointed out that many minority did not have checking accounts).

8. To include questions that addressed whether children, siblings or other relatives lived within one hour's driving time from the respondent.

9. To include the question, "Do you have a job that you are not working at currently (due to earlier disability issues and minority elderly)?"

10. To word the question regarding employment outside of the house, "what kind of paid work have you done or did you do most of your life?"

As a way of increasing community input on the survey design, after numerous telephone and/or in-person conversations with site leaders (senior center directors and ministers), a letter (Appendix C) was sent explaining the mission of the Black Caucus and how conducting research tied into that mission. Along with the letters the draft Minority Outreach Survey and Guide to Services for Older Delawareans were also mailed. Site leaders were asked to review the draft and make comments and suggestions on how to improve the instrument. The 1993 Guide to Services for Older Delawareans was sent to inform the site leaders of the information piece that would be left at the respondent's home after the interview

was completed, giving the respondent a description of social services for the elderly available within the state.

Site leaders were invited to attend a breakfast meeting, held at the Holiday Inn, on October 3, 1992. These community leaders (or their representatives if they could not attend) came with suggestions to improve the survey instrument, made recommendations as to the length of the interviews and provided the names and telephone numbers of the volunteers who expressed an interest from their organizations to serve as interviewers. However, at this initial meeting, they did not bring their church senior member rolls or senior center rosters. In fact, most of the discussion at the meeting centered around confidentiality issues. Consequently, it was decided by the group to have the researcher come to each site, individually, to collect the names and addresses at a later date. There was also some hesitation by one of the site leaders to use his name on future correspondence that would go out under the co-signatures of the president of the Black Caucus and each site leader explaining the research process to the potential respondents and soliciting their participation (Appendix D).

Before the final design of the survey instrument was completed, it was pilot-tested. Shortly, after receiving recommendations from site leaders, various faculty members at the University of Delaware and from the survey design committee of the Black Caucus, social workers at Geriatric Services were given a number of the surveys to interview their clients using the survey instrument.

Following these interviews, the social workers made recommendations on simplifying some of the wording on the survey as well as on amending some of the script leading into the questions. The Black Caucus also suggested that the survey include questions that would provide information: for education and follow-up training addressing the needs of the respondent group; to point out community-based social service needs of inner-city black elderly; and to provide a vehicle for information sharing with the Division of Aging and other human service agencies who serve the needs of the elderly. In addition, each volunteer interviewer pre-tested three surveys and added their suggestions to improve the survey. By employing such extensive measures to develop and pilot test the survey instrument, maximum opportunities were given to community members to impact the content and clarity of questions within its design.

Funding

Early in the planning, besides the cost for the photocopying of the surveys, a budget was drafted that included projected expenditures on: training, identification badges, consultation fees, secretarial support, printing, mailings, mailbox rental, additional xeroxing, a recognition banquet for interviewers, data processing and computer time. A considerable amount of the cost of the project was donated by the Division of Aging, Peninsula United Methodist Homes, Incorporated, Geriatric Services, Delmarva Power and Light, New Castle County Police Department, RSVP, Ezion Mt. Carmel Church and the Black Caucus on

Aging (Appendix E). Interviewers also volunteered their time and did not charge for travel expenses. However, additional costs for the project, like computer time and clerical assistance, came from: the Board of Church and Society for the Peninsula Delaware Conference of the United Methodist Church, Wilmington City Council, the Mayor's Office and the Methodist Action Program of the Peninsula Delaware Conference (Appendix F).

Recruitment of Volunteers for Data Collection

In implementing community-based research, it was important in the early stages to build trust by promoting a dynamic relationship based on mutual respect (Patton, 1986). A special effort was made to promote good relationships and understanding between the Black Caucus and the involved community members.

Recruitment of minority community members necessitated gaining entry into the community (O'Connell, 1976). Furthermore, it was crucial to recognize leaders of the black community as opposed to contacting those persons who were acknowledged as black leaders by whites, since sometimes, those perceptions of such leadership were not the same (Preston, 1983). Since the Black Caucus president was been a recognized leader within the African American community, gaining entry was easily accomplished. In addition, she is a diaconal minister which gave the Black Caucus direct entry into the community clergy. The

Director of Geriatric Services, also a member of the Black Caucus, served as an invaluable resource in locating interviewers.

Both the president of the Black Caucus and the Director of Geriatric Services talked to either center directors or senior pastors explaining the purpose of the intended research and how the results would be used before they asked them to consider participating in the project. The site leaders were also told that they would receive a letter (Appendix C) that further explained the purpose/description of the project along with the Guide to Services for Older Delawareans.

Recruitment of potential participants, both interviewees and interviewers, mainly came from the community leaders who served as site leaders for the research project. Other volunteers to serve as interviewers came from the Black Caucus. Letters were sent out to potential respondents (Appendix D) after site leaders talked about the concept of research at their sites and after mentioning that a Black Caucus representative would be sending out letters to persons 60 years of age and older who were members or participants of their sites soliciting their participation in the research. Respondent participation also included interviewee referrals and volunteer community respondents. In addition, volunteer interviewers (Appendix G) were sent letters explaining the purpose of the research and what the role of the interviewer was along with dates that they could participate in training.

Training

Volunteers received four hours of training and either attended sessions held on October 26 and November 2 or October 28 and November 2, 1992. Training was provided by a faculty member of the University of Delaware, Department of Individual and Family Studies (Appendix H). Volunteers were given a script to follow (contained within the survey instrument) when recruiting respondents and when conducting interviews. They were also given three questionnaires to practice their interviewing skills. Training also consisted of:

- an overview of the research process
- how to gain entry and rapport
- how to prepare for the interview
- how to conduct the interview
- role playing

Post Training Activities

On November 4, a follow-up letter was sent to all volunteer interviewers (Appendix I) thanking them for their willingness to participate in the research project, summarizing what happened during the training sessions and reiterating their responsibilities. Interviewers were also invited to attend a meeting on December 2, 1992, to receive revised copies of the Minority Outreach Survey and be given the Division of Aging's Guide to Services for Older Delawareans. In addition, the liaison interviewers (Black Caucus members who were also

responsible for monitoring the progress of designated interviewers, collecting the completed surveys, providing assistance out in the field and reporting bi-weekly to the project coordinator/research leader) were sent additional letters (Appendix J) detailing their additional responsibilities.

Gaining Entry

On November 16, 1992, letters were sent out to all persons either on church senior membership rolls or senior center rosters. Each letter was signed by the site director/minister (with the one exception, a representative of the church signed) and the president of the Black Caucus to personalize the research experience (Appendix D). Besides explaining who the Black Caucus was, the purpose of the research and recruitment of participants, confidentiality was stressed in the letters. As mentioned before, persons were also told that someone from the Black Caucus might be calling them to ask their permission to serve as an interviewee and to schedule an interview date.

On December 3, 1992, 500 names were divided among 22 interviewers. Additional correspondence materials were given to interviewers if the potential respondents did not have telephones. Guides to Services for Older Delawareans were also distributed at this meeting. A February follow-up meeting was held to discuss progress, submit completed questionnaires and to vote on a request. At this time, it was pointed out that the liaison reporting system was not

working. As a result, some of the interviewers directly reported their progress to the project coordinator instead of to the liaisons. In addition, the group voted on including specific results from the research in the Division of Aging's four-year plan (Appendix K).

Some of the interviewers reported becoming discouraged since securing potential participants and actually obtaining the interview were sometimes two entirely different realities. For example, some of the potential participants decided not to participate after talking to an adult child. Others questioned the legitimacy of the project and felt that callers (interviewers) represented a scam, especially those calls that were made sometime after the initial respondent mailing. Since many of the respondents were women living alone, some were concerned about victimization. Some of our interviewers also did not make reminder calls to the seniors before their scheduled appointments only to be denied entrance into their homes when they arrived for the interview. Some of the interviews had to be terminated either because the respondent was not coherent enough to understand and respond to the questions or the respondent physically was not able to endure 45 minutes of questioning or became suspicious about all the questioning and wanted the interview terminated.

Two subsequent meetings were held to negotiate an acceptable closing number of completed interviews. At first, the Black Caucus on Aging members

voted on cutting the number of completed surveys to 300. Finally, the agreed number was set at 200.

Method of Data Analysis

Characteristics of the sample are presented by descriptive statistics. Numeric and graphic techniques are employed to determine specific percentages and frequency distributions within the collected data in order to make inferences about the characteristics of the population, including what formal services black elders are familiar with.

In an effort to provide answers to the research questions regarding the associations between social service utilization and the wide range of variables, frequencies of various predisposing, enabling, and need variables were run. Second, by counting across services, indices representing the extent of awareness and total service use were constructed. Third, a scale was made of the indicators of need for assistance. Fourth, the internal consistency reliability of this preliminary scale was determined by running a Cronbach alpha. The level of acceptable internal reliability was set at .5. Fifth, if a normal distribution of values was obtained from the awareness utilization and need factors, then ordinary least squares (OLS) regression were performed to determine the extent of social service awareness, utilization and need for such services among black elders, based on the predisposing, enabling and need factors. Variables in the predisposing component included sociodemographic factors like age, gender, marital status,

education, and living arrangement as they impact social service awareness and utilization. Enabling variables used to examine social service awareness and social service utilization are family resources, service awareness and social support. The need component included variables associated with perception of social need and need for assistance with activities of daily living. If the distributions were not found to be normally distributed but were rather skewed toward either a high or low awareness, high or low usage or high or low need, logistic regressions were run. This approach was more appropriate because the dependent variable would then be constructed as a dichotomous measure (e. g., no use, some use, etc.) Sixth, the Chi-square test was used to discover any systematic relationships between the independent and dependent variables. The level of statistical significance was set at .05.

Operationalization of Study Variables

Independent Variables

Gender. Gender was delineated by categories of female and male.

Age. Subjects were asked to indicate their actual age at their last birthday or given a range to choose from that came closest to their age (if they refused to give their specific age).

Marital Status. Subjects were asked to respond "yes" or "no" in providing information regarding their marital status. Response categories included the following: never married, married, separated, widowed and divorced.

Education. Subjects were asked to indicate their level of formal schooling. Response categories included the following: the highest grade completed (0-19) and receipt of certificates/degrees beyond and/or including high school.

Income. Subjects were asked to indicate their monthly income in terms of 14 specific categories, from $0-$249 to $3,250 or more.

Source of Income. Subjects were asked to indicate the particular source or sources from which they received income from the following categories: Social Security, Supplemental Social Security, pension, railroad retirement, unemployment benefits, general assistance, VA pension, disability income, interest from stocks and other (income from employment was not reflected in under a specific source of income category but included under other).

Service Awareness. Service awareness was derived from a score based on the total number of "yes" responses to having knowledge about the existence of 29 community-based services.

Living Arrangement. Subjects were asked to respond "yes" or "no" to whether they lived alone or with others.

Accessibility to Services. Respondents were asked to respond "yes" or "no" to whether they felt that they needed transportation for shopping, going to the doctor's office, and to purchase/pick up medicine more often than was available to them.

Need for Assistance. Respondents were asked whether they needed or did not need assistance in performing 14 activities and/or instrumental activities of daily living or whether they needed or did not need to have anyone organize or coordinate the kinds of social service assistance or make arrangements for them to receive the services.

Social Support Network. Social support network included both informal and formal measures. Therefore, informal support was indicated by the total number of "yes" responses in using either family or friends for assistance in 8 areas. Formal support was measured by the number of "yes" responses in using paid assistance from an agency or church in 13 areas.

Chapter V

FINDINGS AND DISCUSSION

This chapter presents the findings of the study and provides related discussion. Before presenting the findings, a brief overview is given below.

Overview of Findings

Examination of the study's findings reveals insightful information regarding black elderly included in the sample and their social service awareness and utilization behaviors. Descriptively, the findings indicate the background characteristics of the respondents, their awareness and use of the selected 29 social services. With regard to background characteristics of the respondents, most of the individuals are female (70.5%), widowed (50.5%), live with others (59.5%) and are high school graduates (55.5%). In terms of occupation, most of the respondents have either worked as domestics/janitors (25%) or educators (19%) most of their lives. In addition, the majority of the sample earn monthly incomes below $1,000 (51.5%) and many receive a combination Social Security and pension benefits (36%). In terms of age categories, most of the respondents fall

between the ages of 65 to 74 years (52%). Only 4% of the sample represent the oldest old (85 years and older).

Based on service type (similar individual services grouped into 7 categories), service awareness was not as high as individual program awareness. However, respondents were aware of many individual programs and services by type. Service utilization, on the one hand, was relatively low for services ever received and extremely low for services currently receiving.

The results of the analysis regarding the associations between social service utilization (services ever received and/or services currently receiving) and a wide range of predisposing, enabling and need-for-assistance factors show that a number of significant relationships were found. With respect to predisposing factors (gender, age, marital status, education and living arrangements), age was the only variable found to be significantly associated with services ever received while age and marital status, along with kin living nearby, were found to be significantly associated with services currently receiving. Persons who were older both received and were currently receiving more services. In addition, persons who had other relatives living nearby were currently receiving more services. However, persons who were married were currently receiving significantly fewer services.

The results regarding the enabling factors (service awareness, income, source of income, type of insurance, accessibility to services and social support)

reveal that source of income and social support were found to be significantly associated with services ever received, while source of income, type of insurance and social support, along with kin living nearby, were found to be significantly associated with services currently receiving. Persons who used more formal support also used more services, while persons who received more retirement income from pensions used less services. Older respondents who had health insurance (hospitalization only) other than Medicare or Medicaid and had been assisted by more friends in their social support network, were currently using more services. However, persons who were married, received retirement income from Social Security, and had extended health insurance (hospitalization and doctor visits) other than Medicare or Medicaid were currently using less services.

The results regarding the need factors (assistance with instrumental/activities of daily living or need to have someone organize or coordinate the kinds of social service assistance or make arrangements for them to receive such help reveal that only instrumental activities of daily living (need for assistance with I/ADL's) was found to be significantly associated with services ever received. Persons who needed assistance with instrumental/activities of daily living used more services. However, none of the need factors were significantly associated with services currently receiving.

The result of the analysis regarding the associations among total service utilization (both services ever received and services currently receiving) and the

predisposing, enabling and need factors, showed that there were significant relationships. Marital status, living arrangements and type of insurance were factors found to be significantly associated with total service utilization. Persons who lived with others used more services, while married respondents who had extended health insurance (hospitalization and doctor visits) other than Medicare or Medicaid, used fewer services.

The foregoing discussion has provided a brief overview of the major findings of the study as it relates to social service utilization. In the next section, these findings are presented and discussed in detail.

Respondent versus State and County Background Characteristics

When available, background characteristics of the sample are compared to state and county figures for African Americans aged 60 years and older. Based on the social and economic characteristics of the 1990 Census Population, black elders make up approximately 11% (12,207) of the state's 110,638 senior population as well as 11% (4,472) of New Castle County's 40,151 elders (Department of Commerce, 1992). Furthermore, in New Castle County, approximately 60% of black elders are female, while 40% are male. However, the ratio of black females to black males is slightly higher for the sample with females representing 70.5% and males representing 29.5% respectively. Similarly, 13% of New Castle County elder residents living alone are African American in comparison to 40.5% of the sample living alone. In terms of educational

attainment, 8% of black elderly within the State have obtained their high school diploma. Ten percent of African American elders in New Castle County are high school graduates. In comparison, 55.5% of the respondents have at least a high school education. When receipt of a bachelor's degree or higher is examined, statewide, black elders represent 4% and county-wide, they represent 3% of those persons who have received an undergraduate degree or higher. In contrast, the respondents were somewhat more educated with 17.5% having a bachelor's degree or higher. No comparison on income levels can be made due to the manner in which census information was categorized. However, at least 28.5% of the respondents had incomes below the poverty level (Federal Register, 1993).

Selected Background Characteristics of Respondents

A percentage distribution with respect to selected background characteristics of 200 black elders interviewed is provide in Table 1. Background characteristics included gender, age, marital status, education, monthly income, source of income and living arrangements.

Gender. As illustrated in Table 1, females represent two-thirds of the respondents interviewed. The higher percentage of females is consistent with their greater representation, not only in the county and state, but in the general elderly black population as well. Nationally, black women constitute 59% of elderly blacks in the 60 years and older category (U.S. Department of Commerce, 1992).

Table 1. Selected Background Characteristics of Respondents

Background Characteristic	N	%
Gender		100
Male	59	29.5
Female	141	70.5
Age		100
60-64	24	13.0
65-69	46	23.5
70-74	57	28.5
75-79	38	18.5
80-84	25	12.5
85+	8	4.0
Marital Status		
a. Currently married		100.0
1) yes	72	36.0
2) no	128	64.0
b. Ever Been Married		
1) widowed	101	50.5
2) divorced	16	8.0
3) separated	6	3.0
4) never been married	5	2.5
Monthly Income		100.0
$ 0-749	57	28.5
$ 750-1,499	76	38.0
$ 1,500-2,249	22	11.0
$ 2,250-2,999	16	8.0
$ 3,000+	29	14.5

Background Characteristic	N	%
Education		98.5
None	2	1.0
Some school	84	42.0
High School Graduate only	43	21.5
2-Year Business/Trade School	18	9.0
Some College	16	8.0
College Graduate	9	4.5
Graduate Degree	25	12.5
Sources of Retirement Income		*
Social Security	180	90.0
Supplemental Security Income	10	5.0
Pension	109	54.5
Railroad Retirement	6	3.0
Disability Income	12	6.0
Interest from Stocks/Bonds	23	11.5
General Assistance	2	1.0
VA Pension	3	1.5
Other	10	5.0
Living Arrangement		*
Alone	81	40.5
With spouse	68	34.0
One or more children live with you	38	19.0
One or more grandchildren live with you	15	7.5
With other relatives	18	9.0
With a non-related person	3	1.5

* Total exceeds 100%. Respondents could choose more than one answer.

Age. The ages of the respondents range from 60 to 95 years. Over half of the respondents (52%) are 65 to 74 years old. Thirty-five percent of the respondents are 75 years to 95 years old and 4% represent the oldest old.

Marital Status. The frequency distribution shows that most of the respondents are either widowed or married. A percentage breakdown indicates that 50.5% are widowed, 36% are married, 8% are divorced, 3% are separated and 2.5% have never married. Out of the sample, 55.9% of the males and 27.7% of the females represent those persons who are married, while 61% of the females and 25.4% of the males are widowed. Though the percent of currently married female respondents is somewhat lower than the national and state levels, the marital rates are more consistent with state and national levels for the male respondents. According to the national census data, 57% of black elderly men and 43%of black elderly women are married (U.S. Department of Commerce, 1992), with the state distribution of 57% for men and 43% for women respectively. However, the trends slightly vary when widowhood is examined with males representing 20% and women representing 80% of African American elderly widowed in the United States, while 21% of the men and 79% of the women are widowed within the state (U.S. Department of Commerce, 1992). In comparison to national and state rates of widowhood, the sample has slightly less women (61%) and slightly more men (25.4%) who are widowed.

Education. The level of formal education attained by the respondents is quite diversified. The distribution shows persons range from no formal education to persons having doctoral and medical degrees. It should be noted that although 40.5% of the respondents do not have a high school diploma, 12.5% of them have received graduate degrees. This figure, as previously mentioned, is somewhat higher than the state and county levels. The data also indicate that 21.5% of the respondents list high school and 4.5% report a bachelor's degree as the highest level of formal education that they completed. A further aggregation of the categories indicates that 56% of the respondents have a high school diploma or higher. Therefore, in comparison to state levels, the sample represents a highly-educated group.

Income. The distribution of monthly incomes indicates incomes that are not commensurate with the higher education. Although 56% of the respondents have at least a high school education, approximately 41.5% have household monthly incomes that are below the poverty level guidelines (Federal Register, 1993). In fact, if household income were the sole criteria for eligibility to qualify for the Medicaid Waiver program using national figures (Catalog of Federal Domestic Assistance, 1993), 72.5% of the respondents would qualify. In addition, although 14.5% of the respondents receive income of $3,000 or more per month, general income of this sample is relatively low when compared to that of the rest of the state's (Department of Commerce, 1992) elderly population.

Source of Income. The main source of income for the respondents is Social Security (90%). Since quite a number of the respondents retired from jobs that offered pensions, 54.5% of the respondents also rely on pensions as a source of retirement income. In fact, it should be noted that although 22% of the respondents report that they were employed as domestics, one-third of them also report that their companies had provided them with pension plans when they retired (Table 2).

As mentioned previously, the respondents in this sample are well-educated. This factor may contribute to the finding that 11.5% of them receive income from stocks and bonds. Fewer respondents receive Supplemental Social Security (5%), when compared to investments (11.5%). In fact, slightly more persons receive disability income (6%) than Supplemental Social Security.

Data pertaining to various combined sources of income show that the most frequent retirement income source is a combination of Social Security and pension (36%). This is followed by Social Security, with 29.5% of the respondents depending solely on Social Security for retirement income. Lastly, 8% of the respondents receive Social Security, a pension and interest from stocks and bonds as their combined source of retirement income. However, although many of the respondents receive retirement income beyond Social Security, combined source of income are low.

Table 2. Employment Type Performed Most of Respondent's Life

Value Label	Value	Frequency	Percent	Cum Percent
Homemaker	0	4	2.0	2.0
Agriculture	1	1	0.5	2.5
Armed Services	2	1	0.5	3.0
Assembly Line	3	2	1.0	4.0
Child Care	6	1	0.5	4.5
Classroom Aide	7	4	2.0	6.5
Clerical	8	6	3.0	9.5
Construction	9	4	2.0	11.5
Dock Worker	11	1	0.5	12.0
Doctor	12	1	0.5	12.5
Domestic Worker	13	44	22.0	34.5
Food Service	14	14	7.0	41.5
Hair Dresser	15	3	1.5	43.0
Iron Worker	16	1	0.5	43.5
Janitor	17	6	3.0	46.5
Laborer	18	10	5.0	51.5
Laundry Worker	19	1	0.5	52.0
Material Handler	21	2	1.0	53.0
Government	22	2	1.0	54.0
Nurse	24	3	1.5	55.5
Porter	25	1	0.5	56.0
Postal Service	26	4	2.0	58.0
Railroad	27	5	2.5	60.5
Seamstress/Tailor	28	1	0.5	61.0
Social Worker	30	3	1.5	62.5
Truck Driver	31	4	2.0	64.5
Plumber	33	1	0.5	65.0
Education	34	34	17.0	82.0
Mason	35	1	0.5	82.5
Stenographer	37	1	0.5	83.0
Hospital Aide	38	3	1.5	84.5
Other	39	20	10.0	94.5
Missing	99	11	5.5	100.0
	Total	200	100	

Living Arrangements. The distribution in relationship to living arrangements shows that the majority of respondents live with others. Of the total sample, 59.5% live with others, whereas 40.5% live alone. Of the households where more than one person resided, others living in the household consisted of spouses, children, relatives and grandchildren. Only 1.5% of the respondents live with non-family members.

Service Awareness

As indicated in Table 3, service awareness was relatively high, ranging from 22.5% of the respondents familiar with Kimberly Quality Care to 92.5% of them having heard of the Visiting Nurses Association. Both of these services fall under homemaker home health agencies. However, the sample was not only familiar with homemaker home health services, but they were familiar with a wide cross-section of other services as well. For example, 89.5% of the respondents were familiar with the meals-on-wheels programs. Part of the increased awareness about the meals-on-wheels program may have been because one-third of the sample attended senior centers where nutrition programs are available. In addition, 87.5% of the respondents were familiar with Nemours Health Clinic, 87% knew about the American Association of Retired Persons (AARP) and 86.5% were familiar with the Veterans Administration. Respondents were also reasonably familiar with the Delaware Administration for Specialized Transportation (84.5%), Senior Citizen Affordable Taxi (74.5%), Catholic Charities Home Weatherization and Heating

Table 3. Frequency Distribution of Services Heard Of

Name	Percent (n=200)
1. Visiting Nurses Association	92.5
2. The United Way of Delaware	90.0
3. Meals on Wheels	89.5
4. Nemours Health Clinic	87.5
5. American Association of Retired Persons	43.0
6. Veteran's Administration	86.5
7. Delaware Administration for Specialized Transportation	84.5
8. Senior Citizen Affordable Taxi	74.5
9. Catholic Charities Home Weatherization or Heating Bill Assistance Programs	74.0
10. Division of Aging	71.0
11. Geriatric Services of Delaware	66.0
12. The Salvation Army Heating Bill Assistance Program	65.0
13. Delaware Hospice	63.5
14. The Retired Senior Volunteer Program	63.5
15. Congregate Meal Programs	62.0
16. Community Legal Aid's Senior Citizen Legal Assistance Program	61.5
17. Red Cross Emergency Medical Transportation Program	60.5
18. Mental Health/Alcoholism Services	59.0
19. Lion's Club Eyeglass Assistance Program	56.0
20. Delaware Elwyn Speech & Hearing Clinic	53.5
21. Deaf & Hearing Impaired Information Services	46.5
22. Delaware Energy Assistance Program	43.0
23. The United Way of Delaware's Helpline	43.0
24. Telephone Reassurance	42.5
25. Rent Assisted Housing	42.0
26. Senior Companion Program	36.5
27. Evergreen Center for Alzheimer's Day Treatment	29.0
28. Academy of Lifelong Learning	27.0
29. Kimberly Quality Care	22.5

Bill Assistance Program (74%) and the Division of Aging (71%). The level of awareness for the respondents, as it relates to the Division of Aging, is important in that throughout the state, the Division serves as a first point of entry for many seniors who want and need access to a wide variety of services within the aging network. One of the services that received a low awareness score (less than one-half of the sample were aware of the service) was the United Way of Delaware's Helpline (43%). However, many of the intake and referral questions received by the United Way could easily be handled at the Division of Aging. Two other services that received low awareness scores were Telephone Reassurance (42.5%) and the Senior Companion Program (36.5%). However, 58% of the respondents receive telephone calls on a regular basis from their family or friends to make certain that they are alright. Forty-four percent also have either a family member and/or a friend who visits on a regular basis to see if the respondent is alright. Only 42% of the respondents had heard of any type of rent-assisted housing. One explanation for this low score could have been because 74% of the sample own their home with only 21.5% of the respondents reporting themselves as renters. Approximately half of those that rent (based on their addresses) were already living in government subsidized homes. However, the three services that received the lowest awareness scores were the Evergreen Alzheimer's Day Treatment Center (29%), the Academy of Lifelong Learning (27%) and Kimberly Quality Care (22.5%).

Awareness by Type of Service

Services were grouped into the following categories: Homemaker Home Health (Delaware Hospice, Geriatric Services of Delaware, Kimberly Quality Care and Visiting Nurses Association); Nutrition (congregate meals and meals-on-wheels); Senior Assistance Programs (Catholic Charities Home Weatherization or heating bill assistance, the Salvation Army's heating bill assistance program, Delaware Energy Assistance, subsidized housing and Community Legal Senior Citizen's Legal Assistance Program); Senior Health Care (deaf and hearing impaired information services, Delaware Elwyn Speech and Hearing Clinic, Evergreen Center for Alzheimer's Day Treatment, Mental Health/Alcoholism Services, Nemours Health Clinic and the Veteran's Administration); Social Support (senior companion program and telephone reassurance); Transportation (Delaware Administration for Specialized Transportation, Senior Citizens Affordable Taxi and Red Cross Emergency Medical Transportation Program), and Senior Associations (American Association of Retired Persons, the Academy of Lifelong Learning and Retired Senior Volunteer Program). The Division of Aging, United Way of Delaware, and the United Way of Delaware's Helpline and the Lion's Club Eyeglass Assistance Program were not included in the above categories. Once categories were established, service awareness and utilization were examined.

Based on mean scores, more respondents were aware of nutrition services (mean = .757) than any other social service by type. Transportation was the second highest service based on respondent awareness by type (mean = .732). It should be noted that although the Visiting Nurses Association ranked highest in terms of individual program awareness, it ranked fourth in terms of awareness by service type (Table 4). Therefore, when service awareness was examined based on type instead of individual agency awareness, respondents were less familiar with them.

Social Service Utilization: Services Ever Received

Table 5 shows the percentage distributions for services ever received. Unlike service awareness, the data indicate low usage among the respondents. For example, although 87% of the respondents had heard of AARP, 51.5% actually ever belonged to the organization which is the highest ranked service in the group. Similarly, more respondents were familiar with the Visiting Nurses Association (92.5%), yet only 26% had ever used their services. Then, too, although 87.5% of the respondents had heard of the Nemours Health Clinic, just 23% had actually received the services. Surprisingly, only 8.5% of the respondents ever received home-delivered meals even though 89.5% of them were aware of such services. Of greater concern was that only 4.5% of the respondents ever utilized the Division of Aging's services in spite of the fact that 71% of this sample were familiar with the agency. Not using the Division of Aging as a point of entry into

Table 4. Services Heard Of by Type

Type of Service (n=200)	Total Number of Services Within Type	Percent Not Aware of Any Service Within Type	Percent Aware of One Service Within Type	Percent Aware of All Services Within Type
Nutrition	2	4.5	39.5	56.0
Transportation	3	7.0	14.0	47.5
Senior Health Care	6	.5	6.5	13.5
Homemaker/Home Health	4	3.5	18.5	14.0
Association	3	10.0	25.0	22.5
Senior Assistance	5	12.0	12.0	18.5
Social Support	2	44.5	32.0	23.5

Table 5. Frequency Distribution of Service Utilization: Ever Received

Name	Percent (n=200)
1. American Association of Retired Persons	51.5
2. Visiting Nurses Association	26.0
3. Nemours Health Clinic	23.0
4. Congregate Meal Programs	19.5
5. Veteran's Administration	14.0
6. Catholic Charities Home Weatherization or Heating Bill Assistance Programs	13.5
7. Senior Citizen Affordable Taxi	11.0
8. Meals on Wheels	8.5
9. Delaware Administration for Specialized Transportation	7.5
10. The United Way of Delaware	7.5
11. The Retired Senior Volunteer Program	6.5
12. Academy of Lifelong Learning	6.0
13. Geriatric Services of Delaware	5.5
14. Division of Aging	4.5
15. Delaware Hospice	4.5
16. Rent Assisted Housing	4.0
17. Community Legal Aid's Senior Citizen Legal Assistance Program	4.0
18. Red Cross Emergency Medical Transportation Program	3.5
19. The Salvation Army Heating Bill Assistance Program	3.0
20. Deaf & Hearing Impaired Information Services	3.0
21. Delaware Energy Assistance Program	2.5
22. Telephone Reassurance	2.5
23. Kimberly Quality Care	2.0
19. Lion's Club Eyeglass Assistance Program	2.0
25. Senior Companion Program	1.5
26. Mental Health/Alcoholism Services	1.0
27. The United Way of Delaware's Helpline	1.0
28. Delaware Elwyn Speech & Hearing Clinic	0.5
29. Evergreen Center for Alzheimer's Day Treatment	0.0

services used within the aging network could possibly impact accessing such services, particularly when only 1% of the respondents have ever used the United Way of Delaware's helpline. Of even greater concern is that only one person has used Delaware Elwyn Speech and Hearing Clinic despite the fact that 53.5% of the respondents were aware of the clinic.

Social Service Utilization: Services Ever Received by Type

Based on the mean scores, the respondents received more services from the category of associations (mean = .213). However, of those responding, 46% have never received any services of this type (Table 6). Nutrition services (mean = .140) followed as the second highest service ever received. Although Nemours Health Clinic was relatively well known (87.5%) by the respondents, when it was examined by service type, respondent awareness dropped considerably (mean = .069). The least ever used service, by type, was social support (mean = .020).

Social Service Utilization: Services Currently Receiving

Table 7 shows a percentage distribution of service utilization based on services currently receiving. Just as the number of services that respondents had ever received was somewhat low, the number of services that respondents were currently receiving was even lower. For example, only 20% of the respondents were currently receiving services from Nemours Health Clinic. It is interesting to

Table 6. Services Ever Received by Type

Type of Service (n=200)	Total Number of Services	Percent With No Receipt of Any Service Within Type	Percent With Receipt of One Service Within Type	Percent With Receipt of All Services Within Type
Association	3	46.0	44.5	.5
Nutrition	2	76.0	20.0	4.0
Homemaker/Home Health	4	67.5	27.5	.5
Transportation	3	81.0	16.0	0
Senior Health Care	4	64.0	30.5	1.0
Senior Assistance	5	78.5	17.5	1.5
Social Support	2	96.0	4.0	0

Table 7. Frequency Distribution of Service Utilization: Currently Receiving

Name	Percent (n=200)
1. American Association of Retired Persons	33.0
2. Nemours Health Clinic	20.0
3. Congregate Meal Programs	11.0
4. Veteran's Administration	7.5
5. Visiting Nurses Association	4.5
6. Meals on Wheels	4.5
7. Catholic Charities Home Weatherization or Heating Bill Assistance Programs	4.5
8. Senior Citizen Affordable Taxi	4.5
9. The Retired Senior Volunteer Program	4.0
10. Rent Assisted Housing	3.5
11. Telephone Reassurance	2.5
12. Kimberly Quality Care	1.5
13. Senior Companion Program	1.5
14. Division of Aging	1.0
15. Delaware Hospice	1.0
16. Delaware Energy Assistance Program	1.0
17. Community Legal Aid's Senior Citizen Legal Assistance Program	1.0
18. Deaf & Hearing Impaired Information Services	1.0
19. Delaware Administration for Specialized Transportation	1.0
20. The United Way of Delaware	1.0
21. Geriatric Services of Delaware	0.5
22. Academy of Lifelong Learning	0.5
23. The United Way of Delaware's Helpline	0.5
24. The Salvation Army Heating Bill Assistance Program	-
25. Delaware Elwyn Speech & Hearing Clinic	-
26. Evergreen Center for Alzheimer's Day Treatment	-
27. Mental Health/Alcoholism Services	-
28. Red Cross Emergency Medical Transportation Program	-
29. Lion's Club Eyeglass Assistance Program	-

note that although one-third of the sample attended a senior center only 1% participate in the congregate meal program. Another point of concern is that the Division of Aging, Community Legal Aid's Senior Assistance Program, Deaf and Hearing Impaired Services, and the Delaware Administration for Specialized Transportation were among those programs where only 1% of the respondents were currently receiving services. No one was receiving services from Alzheimer's Day Care Treatment Center or any of the Mental Health and Alcoholism Services Programs.

Social Service Utilization: Services Currently Receiving by Type

When service type was examined to determine the number of services respondents were currently receiving, associations once again ranked first (Table 8). A little over 34% of the respondents were currently members of at least one organization. Nutrition services ranked second, with 14.5% of the respondents receiving at least one of the nutrition programs. It should be noted that only one person in the sample was currently receiving both the congregate and meals-on-wheels programs. This may suggest that not all of the respondents who attend senior centers (30%) are involved with the congregate meal programs. Surprisingly, only 3% of the respondents were currently receiving one of the services within the Homemaker Home Health category. In fact, based on service type, homemaker home health was the least currently received service among the respondents.

Table 8. Services Currently Receiving by Type

Type of Service (n=200)	Total Number of Services	Percent Not Currently Receiving Any Service Within Type	Percent Currently Receiving One Service Within Type	Percent Currently Receiving All Services Within Type
Association	3	64.0	34.5	0
Transportation	3	94.5	5.5	0
Nutrition	2	85.0	14.5	.5
Senior Health Care	4	75.0	22.0	0
Senior Assistance	5	91.5	7.0	0
Senior Support	2	96.0	4.0	0
Homemaker/Home Health	2	97.0	3.0	0

Extent of Social Service Utilization

The descriptive percentage distribution for the extent of service utilization is presented in Table 9. As the table indicates, there is a considerable difference between service awareness and service use as previous research has indicated (Soldo, 1980; Krout, 1985; Atchley, 1980; Lee and Estes, 1980). For example, the Visiting Nurses Association was ranked first in service awareness among the respondents (92.5%). However, a little over one quarter of the sample (26%) had ever received services from VNA and even fewer (4.5%) were currently receiving services. The Community Legal Aid Senior Assistance Program was known by over one-half of the respondents (61.5%), yet 4% had ever received assistance from Legal Aid and only 1% were currently receiving such services. The extent of mental health/alcoholism service utilization was consistent with previous research (Leaf and Bruce, 1987; Mowbray et al., 1992; Temkin-Greener and Clark, 1988) in that of the 59% of the respondents who knew about such services, only 1% had ever used the service and none of the sample were currently using such services.

Extent of Social Support Network Utilization

In order to examine social support network utilization, social network support use was divided into two categories: informal and formal. Support services provided by family and/or friends were considered informal social network support. Support services provided by an agency and/or by persons who the

Table 9. Extent of Service Utilization

Name (n=200)	Heard of	Ever Received	Currently Receiving
1. Visiting Nurses Association	92.5%	26.0%	4.5%
2. The United Way of Delaware	90.0%	7.5%	1.0%
3. Meals on Wheels	89.5%	8.5%	4.5%
4. Nemours Health Clinic	87.5%	23.0%	20.0%
5. American Association of Retired Persons	87.0%	51.5%	33.0%
6. Veterans Administration	86.5%	14.0%	7.5%
7. Delaware Administration for Specialized Transportation	84.5%	7.5%	1.0%
8. Senior Citizen Affordable Taxi	74.5%	11.0%	4.5%
9. Catholic Charities Home Weatherization/ Heating Bill Assistance Programs	74.0%	13.5%	4.5%
10. Division of Aging	71.0%	4.5%	1.0%
11. Geriatric Services of Delaware	66.0%	5.5%	0.5%
12. The Salvation Army Heating Bill Assistance Program	65.0%	3.0%	—
13. Delaware Hospice	63.5%	4.5%	1.0%
14. The Retired Senior Volunteer Program	63.5%	6.5%	4.0%
15. Congregate Meal Programs	62.0%	19.5%	11.0%
16. Community Legal Aid's Senior Citizen Legal Assistance Program	61.5%	4.0%	1.0%
17. Red Cross Emergency Medical Transportation Program	60.5%	3.5%	—
18. Mental Health/Alcoholism Services	59.0%	1.0%	—
19. Lion's Club Eyeglass Assistance Program	56.0%	2.0%	—
20. Delaware Elwyn Speech & Hearing Clinic	53.5%	0.5%	—
21. Deaf & Hearing Impaired Information Services	46.5%	3.0%	1.0%
22. Delaware Energy Assistance Program	43.0%	2.5%	1.0%
23. United Way of Delaware's Helpline	43.0%	1.0%	0.5%
24. Telephone Reassurance	42.5%	2.5%	2.5%
25. Rent Assisted Housing	42.0%	4.0%	3.5%
26. Senior Companion Program	35.6%	1.5%	1.5%
27. Evergreen Center for Alzheimer's Day Treatment	29.0%	—	—
28. Academy of Lifelong Learning	27.0%	6.0%	0.5%
29. Kimberly Quality Care	22.5%	2.0%	1.5%

family had hired were considered formal social network support. Based on the utilization distribution of social support in Table 10, most services were provided by family first, friends second and agencies third. Consequently, respondents relied on informal social support networks far more than they did the formal social support networks. For example, 28% of shopping assistance was provided by the respondent's family, 7% by the respondent's friends and only .5% by agencies. Slightly more than 26% of the respondents relied on family members to take them to the doctor's office, while 9% relied on friends and .5% have a hired agent to pick them up for doctor's appointments. Though not often, when legal assistance was given by a family member, the respondents did not pay for such information, but when it was given by a friend they paid. Personal care had been provided twice as much by family members (8%) as it had been by agencies (4%). It is interesting to note that no personal care was provided by friends during the last six months before the interview.

Extent of Need

Need for services was determined by two criteria. If respondents said that they needed someone to organize or coordinate the kinds of assistance that they needed or make arrangements for them to receive such assistance, this was considered as need for services. The other need component was established if respondents required assistance in 14 selected activities of daily living and/or instrumental activities of daily living. Respondents scoring 2 on any given activity

Table10. Social Support Network Utilization

(n=200)

Informal Social Support Network Use	Percent Utilization	Percent Paid
Family Support		
Telephone/check	49.0	—
Visit/check	37.0	—
Take shopping	28.0	3.0
Take to the Doctor's	26.5	2.5
Take to pick up medicine	26.5	1.0
Provide personal care in last six months	8.0	—
Provide legal assistance	7.0	—
Friend Support		
Telephone/check	17.5	—
Visit/check	11.5	—
Take to Doctor's	9.0	2.5
Take to pick up medicine	7.0	2.0
Take shopping	7.0	3.0
Provide legal assistance	0.5	0.5
Provide personal care in last six months	—	—

Formal Social Support Network Use	Percent
Family Hired	
Provide legal assistance	2.0
Telephone/check	1.5
Visit/check	1.5
Take to the Doctor's	0.5
Take to pick up medicine	0.5
Take shopping	—
Provide personal care in last six months	—
Agency /Church	
Provided personal care in last six months	4.0
Take shopping	2.5
Take to the Doctor's	0.5
Take to pick up medicine	0.5
Telephone/check	—
Visit/check	—
Provide legal assistance	—

meant that they needed assistance in that area in order to complete the task. Respondents scoring 3 on any given activity meant that they were completely dependent on others for task completion in that area. Overall, respondents (77%) were relatively independent in performing instrumental/activities of daily living (Table 11), and only 3.5% of the respondents needed to have someone organize or make arrangements for them to receive assistance. However, a number of respondents needed assistance in performing instrumental/activities of daily living and/or were completely dependent on others to perform such tasks (Table 12). For example, 13.5% of the respondents needed assistance with housework, while 4% were completely unable to do household tasks. Another area where respondents needed assistance was with shopping with 10.5% of them needing such assistance and 4% of the respondents completely depending on others to shop for them. Lastly, dressing and undressing, grooming, telephoning, getting in and out of bed and toileting were areas where respondents needed little assistance in terms of completing the tasks and where they were not totally dependent on another person to complete such activities.

Relationships Between Variables

In order to examine social service utilization by black elderly, a conceptual framework consisting of the following three factors was established: 1) predisposing (gender, age, marital status, education and living arrangements); 2) enabling (income, source of income, insurance, accessibility to services, service

Table 11. Need No Help With Instrumental/Activities of Daily Living

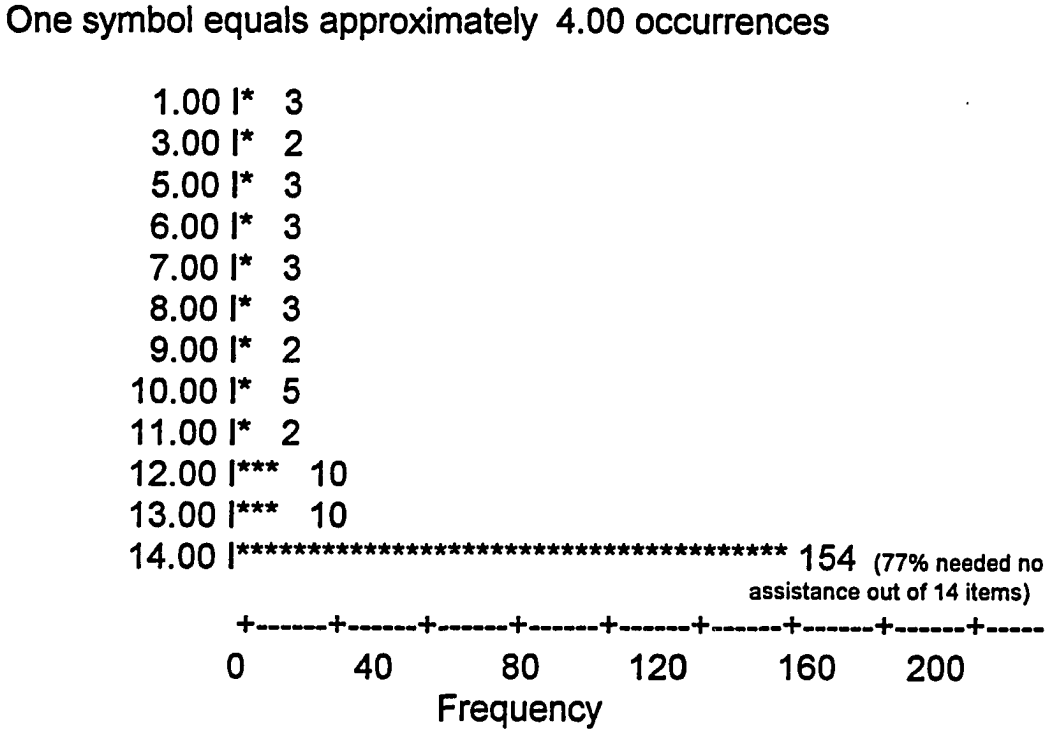

Table 12. Need for Assistance in Instrumental/Activities of Daily Living

Task	Percent Assistance Needed	Percent Completely Dependent
Housework	13.5	4.0
Get to places out of walking distance	13.0	3.0
Shopping	10.5	4.0
Prepare meals	7.5	4.0
Bathe/shower	7.0	0.5
Walk	6.5	0.5
Handle finances	6.0	0.5
Dress/undresss	5.5	—
Groom	5.0	—
Telephone	3.5	—
Take medicine	3.5	0.5
Get in/out of bed	3.5	—
Use toilet	2.0	—
Eat	1.5	0.5

awareness and social support network), and 3) need (need for assistance with instrumental/activities of daily living or need to have someone organize or coordinate the kinds of help or make arrangements for the respondent to receive such help.

Three indices were constructed by counting the number of services that respondents had heard of, ever received or were currently receiving from a list of 29 services. Another index was established to measure the level of independence on 14 instrumental/activities of daily living. In addition, a scale was constructed to determine need for assistance with the same 14 instrumental/activities of daily living. To test the reliability of the need for assistance scale (no help), a Cronbach alpha was run with the level of reliability set at .5. The scale was reliable at the .9 level.

A number of t-tests or anovas were run at the $p \leq .05$ level to determine whether various enabling and/or predisposing variables had different means in relationship to services heard of, service received and services currently receiving. First, there were no significant gender differences in services heard of, ever received or currently receiving. Second, there were no significant differences in the means between those who lived alone and those who lived with others in terms of services heard of, ever received or currently receiving. There were also no differences between age categories and services heard of, services ever received or services currently receiving. However, there were significant differences between

income categories and services heard of (F=4.5, p=.002), services ever received (F=5.45, p=.004) and services currently receiving (F=12.8, p=.000). Persons who received $3,000 or more per month in retirement income were more aware of services. Furthermore, persons earning between $750-$2,999 per month in retirement income received more services, while those earning between $750-$2,249 per month were currently receiving more services.

T-tests were also run to determine mean differences between living arrangements (living alone, living with others), gender and services heard of, services ever received and services currently receiving by service type currently receiving by service type. As a result, there were no significant differences between living arrangements and services heard of, services ever received and services currently receiving. However, significant differences were found between gender and senior support services with males never receiving such services, while females have received and are currently receiving senior support services (t=2.9, p=.004). There was also a significant gender difference for senior assistance programs (t=2.3, p=.023) with slightly more females currently receiving slightly more senior assistance than males.

There were a number of significant differences in means when anovas were run on income and age categories in relationship to services heard of, services ever received and services currently receiving by type. First, persons receiving $1,500 or more per month were more aware of homemaker home health

services (F=2.8, p=.02). Second, those persons who earned $2,250 or more monthly retirement income were more aware of social support services (F=3.4, p=.01), and persons who made $3,000 or more per month were more familiar with senior organizations (F=3.7, p=.006). Third, persons who earned between $750-$1,499 and $2,250-$2,999 per month in retirement income received more homemaker home health services (F=3.5, p=.00), while those who made $750-$1,499 per month received more nutrition services (F=3.8, p=.005). Both the senior assistance services and direct senior health-related services were used more by persons who made between $750-$2,249 per month (F=6.6, p=.001). Similarly, both homemaker home health services and nutrition services were currently used more by persons earning between $750-$1,499 per month (F=2.5, p=.04). Persons who made between $750-$2,999 per month were currently receiving more senior assistance services (F=5.9, p=.002). Lastly, more senior health services were currently used by persons who made between $750-$2,249 (F=6.9, p=.000).

There were fewer significant differences between the means when age category was examined in relationship to services heard of, services ever received and services currently receiving by type. Persons aged 60-64 (13%) years and persons 75 (35%) years of age and older received more homemaker home health services (F=2.7, p=.02) than the other age categories. In addition, persons who were aged 65-74 (52%) and those 85 years of age and older received more senior

health services (F=3.4, p=.006). Lastly, persons aged 85 years and older (4%) received, and were currently receiving, more social support services (F=2.5, p=.03).

Parametric and non-parametric correlations were run to determine significant relationships between services heard of, ever received, currently receiving and need for assistance with instrumental/activities of daily living and various predisposing and enabling variables. When Pearson correlations were examined at the $p \leq .05$ level, significant negative relationships were found between services heard of and informal familial social support (r=-.30) and between services heard of (r=-.22) and age. In addition, a negative significant relationship was found between services heard of (Table 13) and no need (r=-.25) for assistance with instrumental/activities of daily living. However, there were significant positive relationships between ever receiving services (r=.03) and currently receiving services (r=.24) and informal friend social support and between services ever received and age (r=.26). In contrast, there was a negative relationship (r=-.18) between services ever received and need for instrumental/activities of daily living. Positive relationships were found between services currently receiving and informal friend social support, formal social support and age. Therefore, persons who were currently receiving services had more informal friend and formal social support and were older. Those persons who needed little assistance with instrumental/activities of daily living had less of

Table 13. Correlation Coefficients, Social Support Network, Income, Age, Need for Assistance, Social Service Awareness and Utilization

	Familial Support	Friend Support	Formal Support	Income	Age
Familial Support	1.0000	.0883	.0441	- .0858	.1275
Friend Support	.0883	1.0000	.0766	- .0366	.0810
Formal Support	.0441	.0766	1.0000	- .0140	.1410*
Income	- .0858	- .0366	- .0140	1.0000	- .1249
Age	.1275	.0810	.1410*	- .1249	1.0000
No Assistance	- .3632**	- .0812	- .2556**	.0414	- .1948**
Service Heard Of	- .2951**	- .0280	- .0378	- .0224	- .2244**
Service Ever Received	.1084	.0268**	.1318	- .0579	.2299**
Service Currently Receiving	.1210	.2371**	.2106**	- .0919	.2550**

	No Assistance	Service Ever Heard	Service Ever Received	Service Currently Receiving
Familial Support	- .3632**	- .2951**	.1084	.1210
Friend Support	.0812	- .0280	.0268**	.2371**
Formal Support	- .2556**	- .0378	.1318	.2106**
Income	. 0414	- .0224	- .0579	- .0919
Age	- .1948**	- .2244**	.2299**	.2550**
No Assistance	1.0000	.2475**	- .1783*	- .1148
Service Ever Heard	- .2475**	1.0000	- .0083	- .0871
Service Ever Received	- .1783*	-.0083	1.0000	.6977**
Service Currently Receiving	- .1148	-.0871	.6977**	1.0000

* - Signif. LE .05 ** - Signif. LE .01 (2-tailed)
" . " is printed if a coefficient cannot be computed

an informal familial social support network. Those respondents were also younger than those persons needing more assistance. Finally, older persons were more likely to use formal social support networks.

Mann Whitney (two categories), Kruskal, Wallis, and Spearman correlations (more than two categories) were run at the $p \leq .05$ level as non-parametric analysis to determine significant relationships between services heard of, services ever received and services currently receiving and living arrangements (living alone, living with others), sample (church, senior center and collapsed category of community and a referral), income and age categories. First, there was no relationship between living arrangements and services heard of, ever received and services currently receiving. Second, there was no significant relationship between gender and services heard of, ever received and currently receiving. There was also no relationship between age categories and services awareness and utilization. However, a significant difference was found between service utilization and the sample subgroups with persons attending senior centers having received ($\chi^2=6.7$, $p=.04$) and were currently receiving more services ($\chi^2=14.05$, $p=.009$). There were also positive relationships found between income categories and services heard of ($\chi^2=14.8$, $p=.005$), services ever received ($\chi^2=16.06$, $p=.003$) and services currently receiving ($\chi^2=27.9$, $p=.000$). Finally, significant relationships were found between income and age categories and no

Table 14. Spearman Correlation Coefficients, Service Awareness and Utilization by Income and Age Categories

	Spearman Correlation Coefficients			
	No Asssistance	Services Heard Of	Services Ever Received	Services Currently Receiving
Income Categories	.1772 N(200) SIG .012	.2651 N(200) SIG .000	-.2796 N(200) SIG .000	-.3514 N(200) SIG .000
Age Cateories	-.3517 N(200) SIG .000	-.2186 N(200) SIG .002	.2557 N(200) SIG .000	.2045 N(200) SIG .004

Therefore, as income increases, need for assistance decreases. However, as persons age their need for assistance significantly increases.

Regression and logistic regression analyses were employed as assessment tools for answering the research questions that pertained to associations between social service awareness and utilization and selected predisposing, enabling and need variables. Ordinary least squares regression analysis was used with continuous dependent variables while logistic regression was employed for dichotomous dependent variables. Stepwise in multiple regression and forward step in logistic regressions were used to determine the strength of significance among the independent factors remaining in the model as they predict the dependent factors. The level of significance for each model was set at .05. Only those tables showing statistical significance of the model at .05 and the independent variable significance at .06 are presented and described in detail.

Associations between Social Service Awareness and Utilization and Selected Variables

Research Question 1. What formal social services are most black elders familiar with?

As Table 3 indicates, black elders, in the sample, are most familiar with the Visiting Nurses Association (92.5%) as an agency and with nutrition programs (mean=.757) as a service type.

Research Question 2. What are the associations between the extent of social service utilization by black elderly and the following predisposing variables: gender, age, marital status, education and living arrangements?

Social service utilization is measured in two variables: services ever received and services currently receiving. Neither variable is normally distributed (Table 15 and Table 16). Consequently, logistic regressions are used to determine associations between various predisposing, enabling and need variables and social service utilization. In each case the dependent variables, services ever received and services currently receiving, are dichotomized representations of no use (0) and some use (1) of services. For analysis purposes, education is represented by the variable school which is measured in terms of how many years of formal education the respondent completed. Marital status is measured by whether persons are currently married (1) or not (0), while living arrangement is an indication of whether persons live alone (1) or with others (0). Associations between social service utilization and predisposing variables are examined, both excluding income and including income to determine whether education and income had independent effects on service utilization.

The results of the analysis regarding research question number two are presented in Table 17 and Table 18. As illustrated by the data, only one of the five predisposing variables is significantly associated with social services ever received (Table 17). As age increases, the likelihood of whether persons have

Table 15. Number of Services Ever Received Help From (of 29)

Count	Value	One symbol equals approximately 1.00 occurrence
28	.00	**********
49	1.00	**********
39	2.00	**********
34	3.00	**********
25	4.00	**********
10	5.00	**********
7	6.00	*******
7	7.00	*******
0	8.00	
1	9.00	*

+----------+----------+----------+----------+----------+-------

0 10 20 30 40 50

Histogram frequency

Mean	2.395	Std err	.132	Std dev	1.862
Valid cases	200	Missing cases	0		

Table 16. Number of Services Currently Receiving Help From (of 29)

Count	Value	One symbol equals approximately 2.00 occurrences
79	.00	**********
65	1.00	**********
26	2.00	**********
18	3.00	*********
10	4.00	*****
1	5.00	*
1	6.00	*

+---------+---------+---------+---------+---------+

0 20 40 60 80 100

Histogram frequency

Mean 1.110 Std err .088 Std dev 1.239

Valid cases 200 Missing cases 0

Table 17. Services Ever Received Based on Predisposing Variables: Gender, Age, Marital Status, Education and Living Arrangement along with Income

Variables (In)	**B**	**Exp. (B)**	**df**	**p**
Age	.0248	1.0252	1	.0001
Chi-Square = 13.52	n=200		1	.0002

Variables (Out)	**Score**	**df**	**p**
Gender	.3006	1	.5835
Marital Status	.0344	1	.8529
Education	.0051	1	.9432
Income Category	1.7097	4	.7890
income (1)	.2141	1	.6436
income (2)	.0017	1	.9667
income (3)	.4365	1	.5088
income (4)	.0020	1	.9643
Living Arrangement	1.6498	1	.1990

Table 18. Services Currently Receiving Based on Predisposing Variables: Gender, Age, Marital Status, Education and Living Arrangement along with Income

Variables (In)	B	Exp. (B)	df	p
Age	.0187	1.0189	1	.0018
Marital Status	- .9612	.3825	1	.0021
Chi-Square = 20.13	n=200		2	.0000

Variables (Out)	Score	df	p
Gender	.4181	1	.5179
Education	.1734	1	.6771
Income Category	3.0162	1	.5551
income (1)	1.2544	1	.2627
income (2)	1.6959	1	.1928
income (3)	1.8012	1	.1796
income (4)	.2544	1	.6140
Living Arrangement	2.1672	1	.1410

ever received services increases also. This finding is consistent with results from other research (Shapiro, 1986; Stone, 1986; Wan and Arling, 1983; Contrell, 1975; and Mindel and Wright, 1982), but contradicts findings of Krout (1984); Demko, (1979); and Ishii-Kuntz (1990), who report that there is no association between age and social service use.

The results of the analysis regarding services currently receiving is presented in Table 18. In addition to age, marital status is significantly associated with social services currently receiving. However, if the respondents are married, their chances of currently receiving services decrease. This supports previous research (Cantor and Mayer, 1978; Krout, 1985; Snider, 1981; Ward, 1977; Ralston, 1991; Morgan, 1980; Branch and Jette, 1982; Verbrugge, 1979; Spence and Atherton, 1991). In contrast, Krout (1984) found that living arrangement did not reach significance in predicting utilization among 250 white elderly urban residents. Similarly, Hanssen (1978) found no distinction between high and low users of senior centers in relationship to living arrangement. Such contradictions surrounding living arrangement and social service utilization may have come from Hanssen (1978) and Krout (1984) measuring social service utilization in terms of one type of social service, whereas, this investigation measured utilization across service types.

Research Question 3. What is the association between service awareness and the following predisposing variables: gender, age, marital status,

education and living arrangement? As previously mentioned, due to the frequency distribution for service awareness, Ordinary Least Squares (OLS) multiple regression is used to determine the association between service awareness and the above predisposing variables along with income. Income, in this case, was measured as a continuous variable rather than in terms of income categories.

The results of the analysis regarding research question three are presented in Table 19. Only one of the five predisposing variables is significantly associated with service awareness. However, income also improves the model for predicting service awareness. Respondents with more formal education are aware of additional social services. Furthermore, increased levels of income significantly predicted greater awareness of services which supports previous research where additional education and income were associated with social service awareness (Starrett, 1983; Snider, 1981; Krout, 1984; Krout, 1989).

Research Question 4. What is the association between the extent of social service utilization by black elderly and their need for such services?

Need was measured in two different ways. The first need variable was measured as the need for assistance with instrumental activities of daily living. The second measurement, organizational need, was determined by positive responses to the question, "During the past six months, did you need to have anyone organize or coordinate the kinds of help you needed or make arrangements for you to receive help?"

Table 19. Service Awareness Based on Predisposing Variables: Gender, Age, Marital Status, Education and Living Arrangement along with Income

Variables (In)	**B**	**Beta**	**df**	**p**
Education	.331184	.204766	1	.0101
Income	.371830	.180240	1	.0234
Adjusted R^2 = .10	n=200	F=12.58	2	.0000

Variables (Out)	**Score**	**p**
Gender	-5.997E-04	.9930
Age	- .003018	.9953
Marital Status	7.272E-04	.9922
Living Arrangement	.068971	.3344

Table 20 indicates that those persons needing assistance with at least one instrumental activity of daily living are more likely to have ever received assistance from social services (McCaslin, 1989; Cantor and Mayer, 1978; Ward, 1977; Snider, 1981). This result contradicts other research that states that use of social services is not determined by need (Starrett, 1983; Stoller and Pugliesi, 1988; Mindel and Wright, 1982; Harlow and McDonald, 1991). The need to have someone organize or coordinate social service assistance for the respondent is not significant in predicting social services ever received. There is also no relationship between both types of need stated above and social services currently receiving. However, contradictions in findings on social service utilization, based on need, may result from different methods in measuring need for services.

Research Question 5. What are the associations between the extent of social service utilization by the black elderly and the following enabling variables: income, source of income, type of insurance, accessibility to services, service awareness and social support network?

Source of income was measured by whether respondents received retirement income from Social Security, Supplemental Social Security, pension, railroad retirement, unemployment benefits, general assistance, veteran's pensions, disability income, interest from stocks and bonds and other income. Types of insurance included: Medicaid, Medicare (hospitalization only), Medicare (hospitalization and doctor visits), General Assistance First, other insurance which

Table 20. Services Ever Received Based on Need

Variables (In)	B	Exp. (B)	df	p
Need I/ADL Assistance	1.4480	4.2548	1	.0549
Chi-Square = 5.27	n=198		1	.0217

Variables (Out)	Score	df	p
Need to Organize Assistance	.4019	1	.5261

covered hospitalization only, and other insurance that covered both hospitalization and doctor visits. Accessibility to services measured whether respondents had adequate transportation to go shopping, to the doctor's office and/or to pick up prescription medications. Social support network included both informal and formal measures. Informal social support was divided into familial and friend, while formal included receiving assistance from an agency or the church. In order to determine whether the model was affected by relatives living close by (one hour's driving time or less) or if service utilization was affected by church attendance or number of children, siblings and/or relatives living within close proximity of the respondents and church attendance were added as independent variables.

Table 21 indicates that persons who receive retirement income from a pension are less likely to have ever received services. This disputes previous research that states the more income that elders earn, the more services they receive (Eve and Friedsam, 1980; Lee, 1980; Ward, 1977). Having a relative live close by increases the likelihood of ever having received services as well. In addition, those who use formal social support are more likely to have ever received services which supports previous research (McAuley and Arling, 1984; Coulton and Frost, 1982; Cicirelli, 1981; Krout, 1984).

Table 22 indicates that although church attendance and service awareness and accessibility do not predict services currently receiving, source of

Table 21. Services Ever Received Based on Enabling Variables: Income, Source of Income, Type of Insurance, Accessibility to Services, Social Support Network, Service Awareness along with Church Attendance and Nearby Kin

Variables (In)	B	Exp. (B)	df	p
Receives Pension	-1.3033	.2716	1	.0184
Lives Close to Relative	.9826	2.6715	1	.0380
Use Formal Support	1.2379	3.4483	1	.0291
Chi-Square = 19.42	n=182		3	.0002

Variables (Out)	Score	df	p
Income Category	3.3576	4	.4999
income (1)	.5241	1	.4691
income (2)	.0101	1	.9199
income (3)	.9623	1	.3266
income (4)	.5304	1	.4664
Receives Social Security	2.3757	1	.1232
Receives Supplemental Social Security	.7074	1	.4003
Receives Railroad Retirement	.6959	1	.4042
Receives General Assistance	.0936	1	.7579
Receives Veteran's Pension	.1470	1	.7014
Receives Disability Income	1.0792	1	.2989
Receives Interest from Stocks/Bonds	1.4231	1	.2329
Receives Other Income	.0444	1	.8332
Medicaid	.6155	1	.4327
Medicare Part A	.8071	1	.3690
Medicare Part A/B	.0124	1	.9113
General Assistance Health First	.0243	1	.8762
Other Insurance Hospitalization Only	3.5790	1	.0585
Other Insurance Hospitalization and Doctor Visits	1.8912	1	.1691
Need Transport to Pick Up Medicine	1.2363	1	.2662
Need Transport to Doctor	2.0983	1	.1475
Need Transport to Go Shopping	.2289	1	.6323
Service Awareness	.0020	1	.9640
Familial Support	.1010	1	.7506
Child Lives Nearby	.0086	1	.9261
Sibling Lives Nearby	.0027	1	.9586
Friend Support	.0113	1	.9155
Attends Church	.0448	1	.8324

Table 22. Services Currently Receiving Based on Enabling Variables: Income, Type of Insurance, Accessibility to Services, Social Support Network, Service Awareness along with Church Attendance and Nearby Kin

Variables (In)	B	Exp. (B)	df	p
Receives Social Security	-1.6999	.1827	1	.0018
Other Insurance Hospitalization Only	.6448	.3825	1	.0021
Other Insurance Hospitalization and Doctor Visits	- .7665	.4646	1	.0471
Relative Lives Nearby	.8525	2.3456	1	.0122
Friend Support	.6202	1.8594	1	.0083
Chi-Square = 27.66	n=182		5	.0000

Variables (Out)	Score	df	p
Income Category	6.7945	4	.1472
income (1)	3.7383	1	.0532
income (2)	5.0104	1	.0252
income (3)	4.2393	1	.0395
income (4)	1.3345	1	.2480
Receives Supplemental Social Security	1.1302	1	.2877
Receives Pension	1.5904	1	.2073
Receives Railroad Retirement	.0341	1	.8536
Receives General Assistance	.0003	1	.9862
Receives Veteran's Pension	.7628	1	.3824
Receives Disability Income	.0214	1	.8836
Receives Interest from Stocks/Bonds	.7606	1	.3831
Receives Other Income	.7629	1	.3824
Medicaid	.0179	1	.8936
Medicare Part A	.1636	1	.6858
Medicare Part A/B	.5688	1	.4507
General Assistance Health First	.0727	1	.7874
Need Transport to Pick Up Medicine	.0171	1	.8961
Need Transport to Doctor	.1006	1	.7511
Need Transport to Go Shopping	1.1764	1	.2781
Service Awareness	.2019	1	.6532
Familial Support	3.0021	1	.0832
Child Lives Nearby	.0110	1	.9166
Sibling Lives Nearby	.4630	1	.4962
Formal Support	.2902	1	.5901
Attends Church	.0292	1	.8644

income, type of insurance, having a relative living nearby and use of informal social support significantly affect services currently receiving. Persons receiving Social Security are more likely to currently receive services. In terms of type of insurance, respondents covered under a plan other than Medicare or Medicaid (hospitalization only), are more likely to currently receive services. However, if persons are covered by an extended health plan (hospitalization and doctor visits) other than Medicare or Medicaid, they are less likely to currently receive services. Having a relative live nearby increases the chances that the respondents are currently receiving services. Furthermore, using friends for informal social support increases the likelihood of respondents currently receiving services. Although the type of informal social support and service utilization has not been heavily investigated, the results from the analysis are indirectly related to Starrett's et al. (1983) findings that the elderly who have contact with family, friends or neighbors, or participate in church groups, have greater utilization of social services.

Research Question 6. What is the association between social support network and the following predisposing variables: gender, age, marital status, education and living arrangement?

As previously mentioned, social network support was divided into two areas: informal and formal. In addition, whether respondents lived close to

children, siblings or relatives, and whether respondents attended church were added to determine if those factors affected social support network.

The results of the analysis regarding research question number six are presented in Tables 23 and 24. As illustrated by the data in Table 23, two of the five predisposing variables significantly impact use of familial social support. As persons age, they utilize additional familial social support. This finding supports previous research (Clark et al., 1988; Cicirelli, 1981; Cantor and Myer, 1978; McCaslin, 1989). Women also use familial support more than men (Verbrugge, 1983; Chatters et al., 1986). In addition, respondents who have children living close to them are more likely to use familial informal support (Wolinsky and Coe, 1984; Vicente et al., 1979; Greene, 1983; Branch and Jette, 1982). Finally, persons who attend church use less familial support which may suggest that the church serves as a source of support for black elderly (Biegel and Sherman, 1979; Morrison, 1991; Taylor, 1986; Ellor et al., 1983; Taylor and Chatters, 1986; Gelfand, 1983).

Table 24 indicates that church attendance and marital status significantly influence informal (friend) support use with less use if persons attend church and/or if they are married. This may occur because the church could provide informal support which, otherwise, might be provided by friends and/or family (Taylor and Chatters, 1986; Morrison, 1991). Widows also have greater intimacy with friends than their married counterparts (Powers and Bultena,

Table 23. Informal (Familial) Social Support Use and Predisposing Variables: Gender, Age, Marital Status, Education, Living Arrangement along with Church Attendance and Nearby Kin

Variables (In)	**B**	**Beta**	**df**	**p**
Attends Church	- 1.1143	-.2383	1	.0004
Child Lives Nearby	.8835	.2567	1	.0001
Age	.0496	.1989	1	.0029
Gender	- .4864	-.1329	1	.0444
Adjusted R^2 = .16	n=197	F=10.48	4	.0000

Variables (Out)	**Beta In**	**p**
Marital Status	-.0178	.7931
Education	-.0959	.1560
Living Arrangement	.1168	.0781
Sibling Lives Nearby	.0860	.2045
Relative Lives Nearby	.0203	.7560

Table 24. Informal (Friend) Social Support Use and Predisposing Variables: Gender, Age, Marital Status, Education, Living Arrangement along with Church Attendance and Nearby Kin

Variables (In)	**B**	**Beta**	**df**	**p**
Attends Church	- .5463	-.1861	1	.0074
Marital Status	- .3985	-.1824	1	.0086
Adjusted R^2 = .06	n=197	F=7.35	2	.0008

Variables (Out)	**Beta In**	**p**
Gender	-.0104	.8852
Age	.0282	.6858
School	-.0758	.2811
Living Arrangement	.0350	.6924
Child Lives Nearby	-.0622	.3695
Sibling Lives Nearby	.0623	.3665
Relative Lives Nearby	.0883	.2026

1976) and they have the highest frequency of neighbor interactions (Jayakody, 1993). Finally, in terms of formal support network use, none of the predisposing variables, church attendance or having kin live nearby, significantly predicted such use.

Research Question 7. What is the association between need for assistance and use of the social support network?

In order to determine whether need was affected by kin living close to respondents, children, siblings and other relatives living close to respondents were added to the model. Church attendance was also included.

Table 25 indicates that having a sibling live close by and formal support use significantly impact the need to have someone organize or coordinate the kinds of help that respondents need or help them make arrangements to receive assistance. Respondents living close to other siblings are less likely to need assistance which supports previous research (Clark et al., 1988; Vicente et al., 1979) and persons who need assistance with organizing or coordinating services use more formal social support.

Table 26 indicates that informal social support, kin living nearby and church attendance significantly affect need for assistance with instrumental activities of daily living. Respondents who use familial social support are more likely to need assistance with I/ADL's (Horowitz, 1978; Cantor, 1980; Branch and

Table 25. Need (Organization of) and Social Support Network Use, Nearby Kin, and Church Attendance

Variables (In)	B	Exp. (B)	df	p
Sibling Lives Nearby	-1.9321	.1448	1	.0619
Use Formal Support Network	1.3026	3.6790	1	.0106
Chi-Square = 10.33	n=195		2	.0057

Variables (Out)	Score	df	p
Receives Familial Support	1.7565	1	.1851
Receives Friend Support	1.9388	1	.1638
Child Lives Nearby	.3867	1	.5340
Relative Lives Nearby	.0640	1	.8002
Attends Church	.0472	1	.8280

Table 26. Need for Assistance (I/ADL's) and Social Support Use, Nearby Kin, and Church Attendance

Variables (In)	**B**	**Exp. (B)**	**df**	**p**
Use Familial Support	. 5591	1.7491	1	.0000
Child Lives Nearby	-1.1639	.3123	1	.0059
Attends Church	-1.1990	.3015	1	.0098
Chi-Square = 40.84	n=197		3	.0000

Variables (Out)	**Score**	**df**	**p**
Use Friend Support	.0071	1	.9327
Sibling Lives Nearby	.0009	1	.9766
Relative Lives Nearby	1.6239	1	.2025
Use Formal Support	1.7421	1	.1869

Jette, 1983; Cicirelli, 1983; Spitze and Logan, 1989). However, respondents who have a child living close to them are less likely to need assistance in this area which indirectly supports previous research that as older persons' levels of function or mental impairments increase so do the amounts of assistance provided by caregivers, who are mainly family members (Branch and Jette, 1983; Cicirelli, 1981; Stoller and Earl, 1983), and that the family support network primarily provides assistance with personal and home health care (Cicirelli, 1981; Horowitz and Sindelman, 1983; Johnson and Catalano, 1981). In addition, respondents who attend church are less likely to need assistance with I/ADL's.

Research Question 8. What is the association between need for assistance and the following predisposing variables: gender, age, marital status, and living arrangement?

Table 27 indicates that age, living arrangements and church attendance significantly affect need for assistance with I/ADL's. An increase in need for assistance with I/ADL's is expected with increased age. This supports previous research (Kane and Kane, 1990; Brody et al., 1983; Dawson, 1987; Fisher, 1980). Respondents living with others are also more likely to need assistance with I/ADL's. This may indirectly relate to caregivers providing more extensive amounts of help when the caregiver and care receivers share the same household (Horowitz, 1982; Lang, 1987; Reece, Walz and Hageboeck, 1983). Interestingly,

Table 27. Need for Assistance with I/ADL's and Predisposing Variables: Age, Gender, Marital Status, Living Arrangement along with Church Attendance and Nearby Kin

Variables (In)	B	Exp. (B)	df	p
Age	.0224	1.0226	1	.0642
Living Arrangement	.8346	2.3039	1	.0333
Church Attendance	-1.5537	.2115	1	.0004
Chi-Square = 25.02	n=197		3	.0000

Variables (Out)	Score	df	p
Gender	2.7114	1	.0996
Marital Status	2.2870	1	.1305
Education	.9250	1	.3362
Income Category	5.0673	4	.2805
Income (1)	.3458	1	.5565
Income (2)	2.4288	1	.1191
Income (3)	.4309	1	.5116
Income (4)	.0004	1	.9842
Child Lives Nearby	2.6498	1	.1015
Sibling Lives Nearby	.0116	1	.9142
Relative Lives Nearby	1.9308	1	.1647

persons who attend church are less likely to need assistance with I/ADL's. Consequently, more I/ADL limitations may restrict church attendance. There is also no association between gender, income, marital status, education, kin living nearby and the need for assistance with instrumental/activities of daily living.

In an effort to investigate social service utilization in a broader context, social services awareness, social services ever received and currently receiving were examined based on combined predisposing, enabling and need factors. These factors were also observed in the context of whether extended/family members (children, siblings and/or other relatives) lived nearby and whether persons attended church.

The results of the analysis regarding social services awareness based on the above combined factors is presented in Table 28. Two of the five predisposing, one of the two need and none of the enabling factors are significantly associated with service awareness. As Table 28 indicates, persons who have more formal education are more aware of services (Fowler, 1970, 1980; Roberts and Lee, 1980; Davis and Reynolds, 1975; Palmore, 1984). However, persons who use informal familial support networks are less aware of services. This finding disputes previous investigations that suggest family members serve as a link to social services utilization (Litwak, 1978; Sussman, 1977; Hess and Markson, 1980; Kao, 1989). However, this sample was highly educated which may have lessened their dependence on other family members to link them to community resources.

Table 28. Service Awareness Based on Predisposing, Enabling, and Need Variables along with Church Attendance and Nearby Kin

Variables (In)	B	Beta	df	p
Education	.3758	. 2324	1	.0005
Use Familial Support	-.7085	-.1922	1	.0057
Need for Assistance	-3.0403	-.2079	1	.0031
Living Arrangements	1.9049	.1522	1	.0193
Adjusted R^2=.19	n=197	F=12.49	4	.0000

Variables (Out)	Beta In	p
Gender	-.04	.4767
Age	.1010	.1457
Marital Status	-.0719	.3882
Child Lives Nearby	-.0450	.5054
Sibling Lives Nearby	-.0639	.3217
Relative Lives Nearby	.0332	.6075
Attends Church	.0407	.5541
Income	.0548	.5128
Receives Social Security	.0307	.6424
Receives Supplement Social Security	-.0418	.5287
Receives Pension	-.0030	.9657
Receives Railroad Retirement	.0039	.9527
Receives General Assistance	.1083	.0920
Receives Veteran's Pension	.0041	.9496
Receives Disability Income	-.0820	.2028
Receives Interest from Stocks/Bonds	.0350	.6154
Receives Other Income	-.0478	.4741
Medicaid	-.0330	.6131
Medicare Part A	-.0044	.9459
Medicare Part A/B	.1064	.0970
General Assistance Health First	.0991	.1246
Other Insurance Hospitalization Only	-1171	.0704
Other Insurance Hospitalization and Doctors Visits	.0654	.3287
Need Transport to Pick Up Medicine	-.0397	.5381
Need Transport to Doctor	-.0469	.4647
Need Transport to Go Shopping	.0084	.8964
Friend Support	.0486	.4552
Formal Support	-.0074	.9085
Need to Organize Assistance	-.0337	.6116

In terms of social service awareness, persons who need assistance with I/ADL's are less likely to know about such services (Fowler, 1970; Lee and Estes, 1980; Atchley, 1980). Finally, persons who live with others are more aware of services than persons who live alone. This supports previous research (Litwak, 1978; Sussman, 1977; and Kao, 1989).

Table 29 indicates that one predisposing, one enabling and one need factor are significantly associated with services ever received. As one ages, there is an increased likelihood that services will be received which supports previous research (Andersen and Newman, 1973; Shapiro, 1986; Stone, 1986; Contrell, 1975) and disputes other research (Krout, 1984; Demko, 1979; Ishii-Kuntz, 1990). Persons who use more formal social support are also more likely to ever have received services which also supports previous research (McAuley and Arling, 1984; Coulton and Frost, 1982; Cicirelli, 1981; Krout, 1984). Finally, persons who need assistance with I/ADL's are more likely to have ever received services (Aday and Andersen, 1974; Andersen and Newman, 1973; Ward, 1978).

Table 30 indicates that age, marital status, source of income, type of insurance and informal social support are significantly associated with services currently receiving. Just as there is a positive relationship between age and services ever received, there is one between age and services currently receiving. However, persons who are married are less likely to currently use social services. This supports previous research (Verbrugge, 1979; Morgan, 1980; Stoller, 1982;

Table 29. Services Ever Received Based on Predisposing, Enabling, and Need Variables along with Church Attendance and Nearby Kin

Variables (In)	B	Exp. (B)	df	p
Age	.0256	1.0259	1	.0007
Formal Support	1.3437	3.8332	1	.0046
Need for Assistance	1.9187	6.8122	1	.0659
Chi-Square = 27.56	n=180		3	.0000

Variables (Out)	Score	df	p
Gender	.0543	1	.8157
Marital Status	.2820	1	.5954
Education	.7494	1	.3867
Living Arrangements	.0577	1	.8101
Child Lives Nearby	.0150	1	.9026
Sibling Lives Nearby	.0126	1	.9106
Relative Lives Nearby	.9884	1	.3201
Attends Church	.0577	1	.8102
Income Category	7.5561	4	.1093
income (1)	1.6212	1	.2029
income (2)	.0395	1	.8424
income (3)	2.8993	1	.0886
income (4)	1.0632	1	.3025
Receives Social Security	2.8901	1	.0891
Receives Supplement Social Security	.3397	1	.5600
Receives Railroad Retirement	.2331	1	.6292
Receives General Assistance	.0392	1	.8431
Receives Veteran's Pension	.1944	1	.6593
Receives Disability Income	2.8158	1	.0933
Receives Interest from Stocks/Bonds	.0002	1	.9883
Receives Other Income	.2070	1	.6491
Medicaid	.0012	1	.9726
Medicare Part A	1.0199	1	.3125
Medicare Part A/B	.0009	1	.9766
General Assistance Health First	.0033	1	.9544
Other Insurance Hospitalization Only	2.7698	1	.0961
Other Insurance Hospitalization and Doctors Visits	1.5330	1	.2157
Need Transport to Pick Up Medicine	1.9083	1	.1671
Need Transport to Doctor	1.8407	1	.1792
Need Transport to Go Shopping	.5933	1	.4412
Familial Support	.3160	1	.5740
Friend Support	.1982	1	.6562
Need to Organize Assistance	.2120	1	.6452
Sevice Awareness	1.5222	1	.2173

Table 30. Services Currently Receiving Based on Predisposing, Enabling, and Need Variables along with Church Attendance and Nearby Kin

Variables (In)	B	Exp. (B)	df	p
Age	.0208	1.0210	1	.0048
Marital Status	-1.0550	.3482	1	.0033
Receives Social Security	-1.6509	.1919	1	.0199
Other Insurance Hospitalization Only	.8613	2.3662	1	.0224
Friend Support	.5361	1.7094	1	.0265
Chi-Square = 35.67	n=180		5	.0000

Variables (Out)	Score	df	p
Gender	.0013	1	.9711
Education	1.4891	1	.2224
Living Arrangement	1.3070	1	.2529
Child Lives Nearby	.0057	1	.9397
Sibling Lives Nearby	.0702	1	.7910
Relative Lives Nearby	3.2743	1	.0704
Attends Church	.1811	1	.6704
Income Category	3.5899	4	.4643
income (1)	.8726	1	.3502
income (2)	1.2406	1	.2654
income (3)	1.6948	1	.1930
income (4)	.0470	1	.8283
Receives Supplement Social Security	.6227	1	.4301
Receives Railroad Retirement	.1982	1	.6562
Receives General Assistance	.0033	1	.9539
Receives Veteran's Pension	1.7971	1	.1801
Receives Disability Income	.0004	1	.9842
Receives Interest from Stocks/Bonds	.3340	1	.5633
Receives Other Income	.9245	1	.3363
Medicaid	.1283	1	.7202
Medicare Part A	.0701	1	.7912
Medicare Part A/B	1.2262	1	.2681
General Assistance Health First	.0421	1	.8375
Other Insurance Hospitalization and Doctors Visits	.8073	1	.3689
Need Transport to Pick Up Medicine	.0443	1	.8334
Need Transport to Doctor	.0014	1	.9701
Need Transport to Go Shopping	1.2101	1	.2713
Familial Support	1.9573	1	.1618
Formal Support	.2281	1	.6329
Need for Assistance with I/ADL'S	.1366	1	.7116
Need to Organize Assistance	.0504	1	.8223
Sevice Awareness	.0881	1	.7666

Wolinsky and Coe, 1984), while the findings contradict Krout (1984), who found no significance between social service use and living arrangements. If respondents receive Social Security, they are less likely to currently receive services, however. Furthermore, persons who are covered by health insurance (other than Medicare and Medicaid), hospitalization only, are more likely to currently receive services which disputes Kronenfeld (1978), who found that those who receive Medicare or Medicaid are more likely to receive services as opposed to those who have other forms of insurance. However, Kronenfield's (1978) investigation is dated. Health insurance and its provisions for the elderly have considerably changed with decreased Medicare and Medicaid benefits. Decreased coverage may, in turn, have affected social service utilization. Finally, persons who use informal (friend) social support are more likely to currently receive services which indirectly supports Starrett et al. (1983) who found that the elderly who have contact with family, friends or neighbors or participate in church groups have greater utilization of services.

A final analysis was conducted to examine total social service utilization based on predisposing, enabling and need factors along with proximity to kin and church attendance. Total social service utilization was the combined counts of services ever received and services currently receiving.

Table 31 indicates that none of the need, one of the enabling and two of the predisposing variables are significantly associated with total social service

Table 31. Total Service Utilization Based on Predisposing, Enabling, and Need Variables along with Church Attendance and Nearby Kin

Variables (In)	B	Exp. (B)	df	p
Marital Status	-1.3500	.2592	1	.0018
Living Arrangement	.9733	2.6466	1	.0178
Other Insurance Hospitalization and Doctor Visits	-1.1265	.3242	1	.0060
Chi-Square 20.98	n=180		3	.0001

Variables (Out)	Score	df	p
Gender	.0400	1	.8414
Age	3.0262	1	.0819
Education	.4141	1	.5199
Child Lives Nearby	1.0530	1	.3048
Sibling Lives Nearby	1.0595	1	.3033
Relative Lives Nearby	.1835	1	.6684
Attends Church	2.1897	1	.1389
Income Category	6.2412	4	.1818
income (1)	3.9968	1	.0456
income (2)	4.4174	1	.0356
income (3)	2.9062	1	.0882
income (4)	1.0796	1	.2988
Receives Social Security	.8174	1	.3659
Receives Supplemental Social Security	1.2794	1	.2580
Receives Pension	2.0044	1	.1568
Receives Railroad Retirement	.2693	1	.6038
Receives General Assistance	3.1181	1	.0774
Receives Veteran's Pension	2.1615	1	.1415
Receives Disability Income	.0172	1	.8957
Receives Interest from Stocks/Bonds	1.5421	1	.2143
Receives Other Income	.2538	1	.6144
Medicaid	.6708	1	.4128
Medicare Part A	.0481	1	.8265
Medicare Part A/B	.1116	1	.7384
General Assistance Health First	.4886	1	.4846
Other Insurance Hospitalization Only	.8273	1	.3631
Need Transport to Pick Up Medicine	.0698	1	.7916
Need Transport to Doctor	.9949	1	.3185
Need Transport to Go Shopping	1.2574	1	.2621
Familial Support	.2179	1	.6407
Friends Support	3.1545	1	.0757
Formal Support	1.5739	1	.2096
Need for Assistance with I/ADL'S	.0476	1	.8272
Need to Organize Assistance	.1921	1	.6612
Sevice Awareness	.0178	1	.8938

utilization. Specifically, marital status, type of insurance and living arrangement influences such utilization. Persons who are married are less likely to use social services (Cantor and Moyer, 1978; Krout, 1985; Snider, 1981; Ward, 1977; Branch and Jette, 1982), while respondents who live with other people are more likely to utilize them. This disputes findings by Salloway and Dillon (1973), Evashwick et al. (1984), Morgan (1980) and Verbrugge (1979), but supports investigations by Ferraro and Cobb (1987) and Burkhardt et al. (1983). Hanssen (1978) found no distinction between living arrangements and social service utilization. However, contradictory findings may have resulted from the way in which living arrangement was measured. For example, living arrangement could have been measured as a dichotomous variable representing those who lived alone versus those who lived with others. Living arrangement could also have been measured as a categorical variable representing a wide range of living arrangement options. Therefore, different ways of measuring living arrangement could have affected social service utilization results. Lastly, persons who have health insurance other than Medicare or Medicaid (extended coverage - hospital and doctor visits) are less likely to receive services which contradicts Monterio (1973) and Aday (1975) who found that third-party payments increase utilization.

Summary of Findings

The findings of this study provided insightful information on social service utilization by African-American elderly residing in New Castle County. These findings are summarized below.

Although service awareness was relatively high among the respondents, service utilization was somewhat low. In addition, use was extremely lower than awareness in relation to all seven selected services types: nutrition, homemaker home health, senior health care, senior assistance, social support, transportation and associations. Based on mean scores, nutrition services (mean =.757) topped the list for service awareness, associations (mean = .213) for services ever received and associations (mean = .125) once again for services currently receiving. In contrast, social support (mean = .395) was the least recognized, and the service (mean = .020) least ever received, while homemaker home health (mean = .007) was the least currently received service. It should be noted that mean scores for service awareness, services ever received and services currently receiving were all less than one, which substantiates relative low awareness and utilization of services by type.

The major factors operating independently, which differentiated respondents in service awareness were education, income, social support network, living arrangement and need. Greater awareness was found among respondents who received more formal education, lived with others and had greater incomes.

However, persons who used more informal familial support and needed more assistance with instrumental/activities of daily living were less aware of services.

The major factors, operating independently, which differentiated respondents in the utilization of social services were age, source of income, need and social support network for services ever received (Figure 2). Age, marital status, source of income, type of insurance, social support and whether kin lived nearby significantly impacted persons currently receiving services (Figure 3). Older persons who needed more assistance with instrumental/activities of daily living and used more formal social support received more services. However, persons who received more retirement income from pensions, had received less services. Persons who were older, had health insurance other than Medicare or Medicaid with (hospitalization coverage only), had other relatives living nearby and who used more friends for their social support were currently receiving more services. However, respondents who were married and received greater levels of Social Security income were less likely to have been currently receiving services.

The major factors, operating independently, which differentiated respondents in the total use of services were marital status, living arrangements and type of insurance. Persons who were married and who have extended health insurance other than Medicare or Medicaid (hospitalization and doctor visits) were less likely to use services while those living with others were more likely to use services.

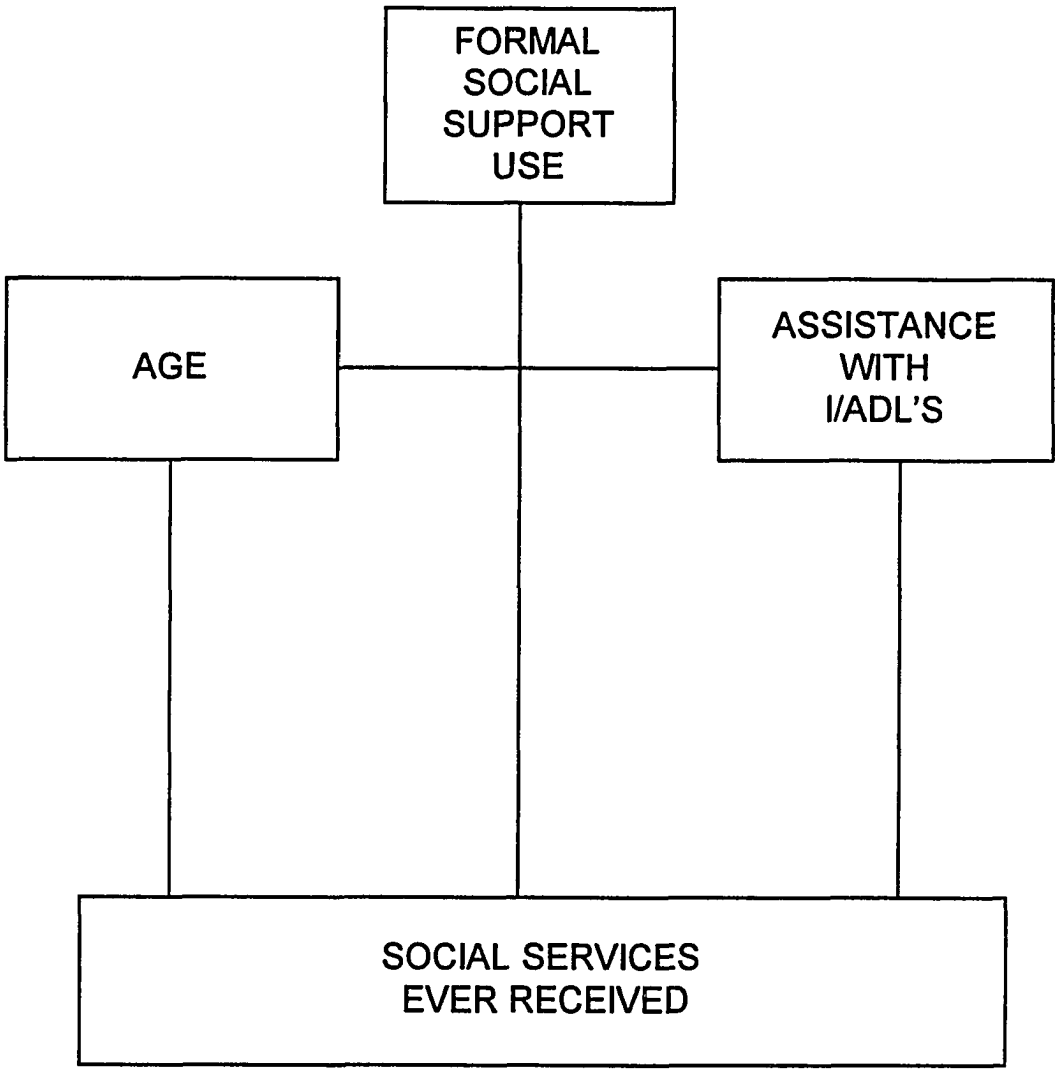

Figure 2. The Behavorial Model for Social Services Ever Received

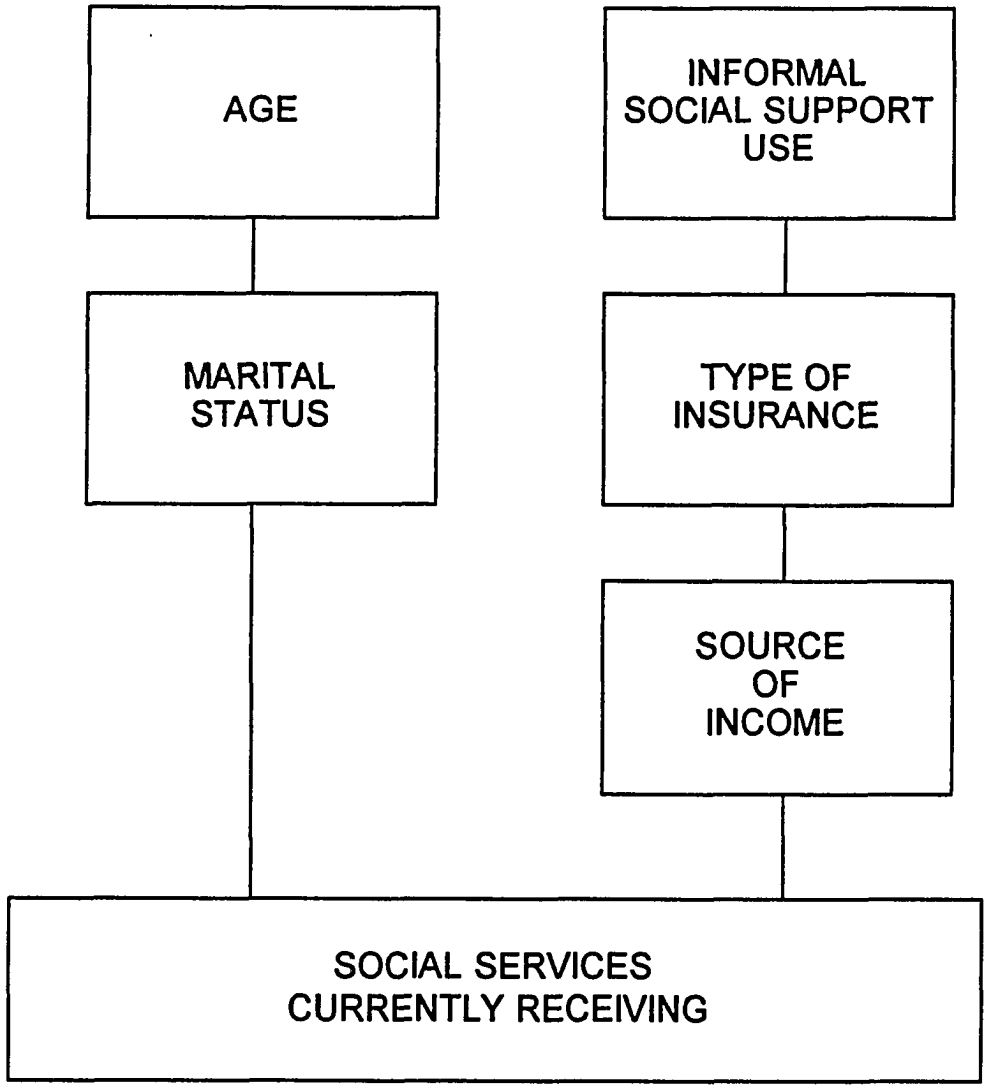

Figure 3. The Behavorial Model for Social Services Currently Received

The major factors, operating independently, which differentiated respondents in social support use were age, gender, church attendance and kin living nearby for familial support. Marital status and church attendance influenced friend support. Respondents who were older, female, and had children living nearby used more familial social support. However, persons who attended church used less familial support. Respondents who were married and attended church used less friend support. None of the predisposing, enabling or need factors differentiated respondents in formal support network utilization.

The major factors, operating independently, which differentiated respondents in need for assistance were age, living arrangements and church attendance. Persons who were older and lived with others needed more assistance with instrumental/activities of daily living. Persons who attended church, on the other hand, needed less assistance in this area. However, there were no major factors that contributed to the need to have someone organize or coordinate the kinds of help that respondents needed or help them make arrangements to receive such assistance.

The major factors, operating independently, which differentiated respondents in need for assistance and social network use were whether kin lived nearby and formal social support for the need to have someone organize services for them. Church attendance, social support and whether kin lived nearby were factors which determined need for assistance with instrumental/activities of daily

living. Respondents who had siblings living nearby had less need, while respondents who used more formal social support had more need to have someone organize or coordinate the kinds of social service help that respondents needed or help them to make arrangements to receive such services. Persons who attended church and had children living nearby, needed less assistance with instrumental/activities of daily living. However, persons who used more familial social support needed more assistance with I/ADL's.

As indicated in the above summary, as well as in the previous section, the results were consistent with other findings which indicate directional (positive or negative) as well as non-directional (neither positive nor negative) associations among service utilization and a wide range of factors. In this context, such factors also provided support for the conceptualization of social service utilization as a multivariate phenomenon.

Limitations

While attempts were made to employ optimal approaches in all aspects of the research process, there is recognition of possible weaknesses. In this regard, the limitations of this study are presented below under sampling procedures, data collection and measurement.

Sampling Procedures

The selection of the sample, mainly through the use of community-action research procedures, caused sampling errors within the population. Since the accuracy of supplying all persons 60 years and older rested on the site leaders, i.e. the directors of the centers or ministers and, in some instances, on elder parishioners, several of the persons identified were underage and had to be dropped from the sample.

Data Collection

A number of limitations are inherent due to the data collection process. First, interviewers were volunteers, consequently, the coordinator had little control in the interview process. Personal interviews presented yet another problem. While the procedure is considered most appropriate for survey research, it may have contributed to biased responses, particularly in relation to items pertaining to need, activities of daily living (toileting), and income. For example, respondents may have been reluctant to express need for services or admit to dependence on others in carrying out instrumental/activities of daily living. Some of the surveys were completed over the telephone as opposed to personal interviews. With such telephone interviews comes potential biases experienced by the interviewer towards some of the questions on the survey. Additionally, there could have been response bias due to error in recall. The respondents were asked a number of questions regarding the provision of formal and informal assistance within the last six

months. While most seemingly were able to provide accurate information, there is no absolute assurance that such information was correct which could have threatened the validity and reliability of some responses.

Finally, it is important to note that the findings reported here reflect social service utilization among African American elderly residing in New Castle County. Therefore, the investigation cannot be generalized to other groups in other areas. The same study conducted with a different elderly population outside of New Castle County may result in dissimilar findings.

Measurement

With regard to measurement, there is concern about validity and reliability of the instrument mainly developed by the researcher. The major reason for this concern is that extensive procedures testing for the above were not employed. While the survey instrument was pilot-tested and reliability tests were performed on scales, there was no attempt for testing for reliability or validity beyond these measures other than testing for external validity. It should be noted that validity and reliability issues are inherent concerns in all survey research. Furthermore, since the conceptual framework of the instrument is based on the Andersen/Newman (1973) behavioral model for service utilization, another limitation of this study is that this particular model does not consider how organizational factors associated with the bureaucratic nature of service delivery settings may impact social service utilization (Ward, 1978). In addition,

psychological variables that may impact social service utilization among black elderly were also excluded. Consequently, the relationship between social service utilization and organizational or psychosocial factors were not explored. Finally, church assistance was measured in terms of formal instead of informal social support which may have affected some of the results.

Chapter VI

IMPLICATIONS OF FINDINGS

This exploratory study was undertaken to provide empirically-oriented information regarding African American elderly and their utilization behavior. Examination of the relatively comprehensive findings of the study suggests a number of implications. These implications are presented in this section in relation to policy, practice and research.

Policy

One of the main reasons for undertaking this study was to use the results to impact the design of social welfare policy as it relates to providing service delivery to African American elderly residing in Delaware. The findings of this study may be helpful in a number of ways with respect to elderly-related social policy. First, from a broad perspective, these findings support other research results which indicate that social service utilization is influenced by a wide range of factors. This suggests that policy and related programs developed must reflect similarities as well as address differences among these individuals. In this context, consideration should be given to such factors as socio-demographic

characteristics, individual needs, support systems and other factors reflecting homogeneity and heterogeneity among these elderly persons. For example, social welfare policy should reflect linking services to actual need within the population targeted. If African American elderly living within the state are in need of more senior assistance or senior health services as opposed to homemaker home health or transportation, such service delivery needs to be addressed in terms of demonstrated need within the context of social support systems and how this support affects the need linkages to social service delivery and utilization and accessibility to services.

Second, there was a functional informal support network found among the respondents, not only in terms of family, but in terms of friends and parishioner support as well. Consequently, consideration should be given to the development, implementation and evaluation of programs that involve informal members in more direct ways. For example, additional funding for Adult Day Care and/or services like respite care for informal network aid reimbursement might be considered. In addition, providing relevant information about service availability could be coupled with educational programs based on the appropriate use of services. Moreover, because of the important role of the church, service providers could be additionally funded to provide linking mechanisms and educational programs to church groups.

Third, if additional funds were given, the amount would have to be weighed against the costs of administration and monitoring of programs. For example, several questions should be answered in this regard. What persons/groups should be considered significant in the informal/formal social support network of African American elderly within the state? How does one divide responsibility among the network of significant informal members? How does one enforce the policy, particularly when relatives live in one state and the older person in another? What are the effects of social welfare policy on the quality of relations between adult children (and perhaps siblings and grandchildren) and their aging parents? Will future policies put generations against one another in terms of financial resources and emotional support?

Regardless of the outcomes, state government can no longer ignore the growing needs of the elderly. Added to the demographic imperatives will be the growing political sophistication of future cohorts and their greater acceptance and expectation of governmental assistance. A systematic state response to the long-term care needs of the elderly and their informal support caregivers will become increasingly unavoidable.

Practice

One of the major providers of formal social support in providing services to the elderly population is social workers (Brody, 1978; Monk, 1987). Until recently, the professions's primary delivery of services has been consistently

limited (Dunkle, 1984). According to Dunkle (1984) this primary focus has been related to economic relief largely influenced by past social welfare policy, the profession's attitudes toward the elderly and its failure to explore their extensive needs and other related areas (Monk, 1987; Lowry, 1986). Consequently, changes in the delivery in services may call for a stronger commitment on the part of the profession.

In order to make improvements in caring for the elderly, the social work profession and other gerontological practitioners should be required to have pertinent information regarding both the general elderly population as well as ethnic and racial subgroups. The findings of this study are helpful in this regard in that the data provide empirically-based information about the African American elderly relative to social service utilization behavior and social support networks. Specifically, the comprehensive examination of factors influencing social service utilization and social support patterns by black elderly reveals a number of findings useful to the social work and other human service professions. For example, the finding regarding the lower current service utilization among married individuals who have other relatives living nearby suggests that practitioners must continually explore the social service needs of the couple. By doing so, they will be able to determine not only the extent to which the spouse is providing the needed services, but whether the spouse and/or the couple needs additional services. Social workers will also be able to access whether other relatives are actually sharing some of the

responsibility of caregiving with the spouse and what type of services they might need in performing such tasks.

Another important finding which has implications for practice concerns the impact that social support has on service utilization. Practitioners would do well to give more consideration to the importance of the informal social support network. For example, the finding regarding older females who have children living nearby using more familial social support than those who do not or persons who attend church and are married using less familial and friend support have different implications on social service utilization behavior. Such findings also may point to the development of different mechanisms through which interfacing between various significant support network members and providers of services can be coordinated.

The low percentages of service utilization suggests the need for additional outreach efforts within African American populations. In addition, to service awareness, it is important to provide extensive information on orientation into the formal service system since persons may be highly aware of the services but lack knowledge about specific eligibility criteria, how to access the service and what types of assistance are provided by each service (McCaslin, 1989; Krout, 1984). In addition, nontraditional approaches like utilizing African American churches, newspapers, radio and television to disseminate such service information should be undertaken. The Division of Aging also could house such information in

the libraries, both upstate and downstate. Furthermore, taking such information into the homes of the black elderly, the local churches and community centers with ongoing updates and practical, simplistic overviews of the information, would demonstrate a continued professional commitment.

Research

The findings reported in this study can serve as a basis for additional exploration among African American elderly. For example, similar investigations can be conducted throughout the state to determine statewide similarities and differences influencing service utilization among African American elderly. In addition, other ethnic minorities can be studied and/or the general elderly population within Delaware to make comparisons between black elderly and other elderly groups in terms of social service awareness and utilization.

Another area of needed research is on factors outside of individual determinants that impact social service utilization. For example, two areas not included in the conceptual framework, but that need further exploration are organizational and psychosocial factors associated with service use. In turn, such studies would provide insightful information about the quality of elderly-related services provided by social service agencies. Direct observation in relation to staff-client interactions at all levels within service agencies could be employed in this regard. In addition, more in-depth studies need to be conducted using psychosocial constructs incorporating groups of elderly into users and nonusers of

services in a longitudinal framework. These studies could broaden the user/nonuser groupings to include potential users (i.e., those showing interest) and former users. By sorting out characteristics of users versus nonusers and determining how these characteristics might vary according to the amount and type of social service, more insightful information can be learned about social service utilization among the elderly.

Finally, using the Newman/Andersen (1973) model, Coulton and Frost (1982) suggest that social service utilization should be studied by type rather than by total service. For example, in addition to conducting investigations involving total service use, various research could be conducted to examine service use based on one service, like nutrition or homemaker home health services. Such investigations would be useful for large samples in major urban settings where multiple needs were identified, but where agencies need to ascertain specific patterns for most used services.

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APPENDIX A: MINORITY OUTREACH SURVEY

NATIONAL CAUCUS AND CENTER ON BLACK AGED - DELAWARE CHAPTER

MINORITY OUTREACH SURVEY
@ 1992

GOOD_____. MY NAME IS_____. I REPRESENT THE BLACK CAUCUS ON AGING WHICH IS RESPONSIBLE FOR CONDUCTING THE MINORITY OUTREACH SURVEY. YOU SHOULD HAVE RECEIVED A LETTER OF EXPLANATION ON THE PURPOSE OF THIS SURVEY. IS THIS A GOOD TIME TO TALK? (IF NOT, ASK WHEN A GOOD TIME IS AND RESCHEDULE.)

(once inside residence)
WE SHOULD BE TOGETHER FOR ABOUT AN HOUR. WHAT YOU SAY WILL BE HELD IN CONFIDENCE. YOUR NAME WILL NEVER BE USED. I WILL ASK QUESTIONS ABOUT YOUR FAMILIARITY WITH CERTAIN AGENCIES THAT PROVIDE SERVICES TO OLDER DELAWAREANS, AND YOUR USE OF SUCH SERVICES. I WILL ALSO ASK YOU FOR A LITTLE INFORMATION ABOUT YOU AND YOUR FAMILY. REMEMBER THIS IS NOT A TEST. THERE ARE NO RIGHT OR WRONG ANSWERS, I JUST WANT YOU TO SHARE YOUR IDEAS WITH ME. ARE THERE ANY QUESTIONS THAT YOU WANT TO ASK ME BEFORE WE BEGIN?

[the box below should be completed before you go into the house]

1. I.D. #_____

2. Female_____ Male_____

3. Sample: Church_____ Senior Center_____
Q-referral _____ Community _____

3a. Do you know the interviewee? _____Yes _____No

3b. Was the interview done in interviewee's home?
_____Yes _____No

4. RACE: AFRO-AMERICAN/BLACK_____ HISPANIC_____
ASIAN AMERICAN_____ NATIVE AMERICAN_____
ANGLO-AMERICAN_____ OTHER_____

5. WHERE WERE YOU BORN?_____

6. DO YOU SPEAK ANY LANGUAGE OTHER THAN ENGLISH?
No_____[skip to #8] Yes_____

[If Yes] what language?_____

7. **WHAT LANGUAGE ARE YOU MOST COMFORTABLE WITH?**_____

8. **I AM NOW GOING TO ASK YOU ABOUT CERTAIN AGENCIES THAT PROVIDE SERVICES TO SENIOR CITIZENS.**

LET'S BEGIN WITH: THE DIVISION OF AGING

The Delaware Division of Aging provides information and referral on most programs for older Delawareans within the state and provides a number of other services.			
	Have you ever heard of:	Have you ever received help from them?	Are you currently receiving help from them?
The Division of Aging?	No _____ Yes _____ ->	No _____ Yes _____ ->	No _____ Yes _____
	\/	\/	\/ \/

THE SECOND CATEGORY OF SERVICES FALLS UNDER HOMEHEALTH/HOMEMAKER CARE

Home Health services include medical needs and personal care like Physical Therapy, Nursing visits and some Health Aide services. Homemaker services are performed by aides who come into your home to provide meal preparation, light housekeeping, laundry, and/or shopping. The following agencies provide the homemaker/home health care I have just described.

	Have you ever heard of:		Have you ever received help from them?		Are you currently receiving help from them?	
Delaware Hospice	No \/	Yes ->	No ✓	Yes ->	No	Yes
Geriatric Services of Delaware, Inc.	No \/	Yes	No ✓	Yes	No	Yes
Kimberly Quality Care	No \/	Yes	No ✓	Yes	No	Yes
Visiting Nurses Association	No \/	Yes	No \/	Yes	No \/	Yes

[[If they say "No, What is it?" please respond, "We can discuss it at the end along with all of your other questions."]]

THE NEXT CATEGORY IS NUTRITIONAL PROGRAMS.

Congregate meals are served at a site other than your home. (Go to #) Meals on Wheels are delivered to your home. (Go to *)						
	Have you ever heard of:		Have you ever received help from them?		Are you currently receiving help from them?	
# Any Congregate Meal Programs?	No \/	Yes ->	No ↓	Yes ->	No	Yes
* Any Meals on Wheels Programs?	No \/	Yes	No \/	Yes	No \/	Yes

NEXT ARE SENIOR ASSISTANCE PROGRAMS WHICH PROVIDE A NUMBER OF SOCIAL SERVICE OFFERINGS AS EACH TITLE THAT I READ SUGGESTS.

Have you ever heard of the Home Weatherization or Heating Bill Assistance program run by the following agencies:

	Have you ever heard of:		Have you ever received help from them?		Are you currently receiving help from them?	
The Catholic Charities Home weatherization or heating bill assistance programs	No \/	Yes ->	No ✓	Yes ->	No	Yes
The Salvation Army's program which helps with heating bills	No \/	Yes	No ✓	Yes	No \/	Yes
Delaware Energy Assistance Program (This is not the Delmarva Power Program)	No \/	Yes ->	No ✓	Yes ->	No	Yes
Subsidized or Rent Assisted Housing for the Elderly/ Handicapped	No \/	Yes	No ✓	Yes	No	Yes
Community Legal Aid's Senior Citizens Legal Assistance Program	No \/	Yes	No \/	Yes	No \/	Yes

OUR NEXT CATEGORY IS SENIOR HEALTH CARE SERVICES

Senior Health Care Services covers a number of programs that are directly related to physical and mental needs.						
	Have you ever heard of:		Have you ever received help from them?		Are you currently receiving help from them?	
Deaf & Hearing Impaired Information Services	No \/	Yes ->	No ✓	Yes ->	No	Yes
Delaware Elwyn Speech & Hearing Clinic	No \/	Yes	No ✓	Yes	No	Yes
Evergreen Center for Alzheimers Day Treatment	No \/	Yes	No ✓	Yes	No	Yes
Mental Health/ Alcoholism Services (Any type of Services)	No \/	Yes	No ✓	Yes	No	Yes
Nemours Health Clinic	No \/	Yes	No ✓	Yes	No	Yes
Veterans Administration	No \/	Yes	No \/	Yes	No \/	Yes

	Have you ever heard of:		Have you ever received help from them?		Are you currently receiving help from them?	
Senior Companion Program	No \/	Yes ->	No \/	Yes ->	No	Yes
Telephone Reassurance Programs (These are groups that call and check on you)	No \/	Yes	No \/	Yes	No \/	Yes

THE NEXT CATEGORY IS TRANSPORTATION

	Have you ever heard of:		Have you ever received help from them?		Are you currently receiving help from them?	
Delaware Administration for Specialized Transportation or DAST	No \/	Yes ->	No \/	Yes ->	No	Yes
Senior Citizen Affordable Taxi or (SCAT)	No \/	Yes	No \/	Yes	No	Yes
Red Cross Emergency Medical Transportation Program	No \/	Yes	No \/	Yes	No \/	Yes

NEXT, IS ASSOCIATIONS

The next several questions pertain to Associations which do not perform social services' types of assistance but provide opportunities for persons to participate in certain educational and social activities based on each organization.								
	Have you ever heard of:			Have you ever received help or information from them?			Are you currently receiving help from them?	
The Association of Retired Persons or AARP	No	Yes ->		No	Yes ->		No	Yes
	\/			\/				
Academy of Lifelong Learning	No	Yes		No	Yes		No	Yes
	\/			\/				
The Retired Senior Volunteer Program or R.S.V.P.	No	Yes ->		No	Yes ->		No	Yes
	\/			\/				
The United Way of Delaware	No	Yes		No	Yes		No	Yes
	\/			\/			\/	

OUR LAST CATEGORY DEALS WITH THE UNITED WAY OF DELAWARE'S HELPLINE AND THE LIONS CLUB EYE GLASS ASSISTANCE PROGRAM.

United Way of Delaware's Helpline provides information and referrals to other agencies that provide services to older persons. (Go to #) The Lion's Club provides eyeglass assistance. (Go to *)						
Programs	Have you ever heard of:		Have you ever received help from them?		Are you currently receiving help from them?	
# The United Way of Delaware's Helpline	No \/	Yes ->	No \/	Yes ->	No	Yes
* The Lions Club eyeglass assistance program	No \/	Yes	No \/	Yes	No \/	Yes

Can you name any other agency or organization which you know about or have called for help that I have not mentioned? (Pause a while) [Please fill in appropriate program/agency name]					
Agency/Organization	Have you ever received help from them?			Are you currently receiving help from them?	
_____ [If Yes, type of help]	No ____ \/	Yes ____	->	No ____ ✓	Yes ____
_____ [If Yes, type of help]	No ____ \/	Yes ____		No ____ \/	Yes ____

9. PLEASE INDICATE HOW MUCH ASSISTANCE OR HELP, IF ANY, YOU NEED IN ORDER TO ACCOMPLISH THE FOLLOWING TASKS.

ARE YOU ABLE TO:

Activity	Without Any Help?		With Some Help?	
Prepare your own meals?	Yes ____ \/	No ____->	Yes ____	No ____
Are you able to: Eat your meals?	Yes ____ \/	No ____->	Yes ____	No ____
Dress and undress yourself?	Yes ____ \/	No ____->	Yes ____	No ____
Take care of your own grooming like haircare, shaving(if male) mouthcare?	Yes ____ \/	No ____->	Yes ____	No ____
Use the telephone?	Yes ____ \/	No ____->	Yes ____	No ____
Get to places out of walking distance?	Yes ____ \/	No ____->	Yes ____	No ____
Go shopping for groceries or clothes?	Yes ____ \/	No ____->	Yes ____	No ____
Do your own housework?	Yes ____ \/	No ____->	Yes ____	No ____
Take your medicine?	Yes ____ \/	No ____->	Yes ____	No ____
Handle your own finances/ money?	Yes ____ \/	No ____->	Yes ____	No ____

	Without Any Help?		With Some Help?	
Get in/out of bed?	Yes \/	No ->	Yes	No
Take a bath or shower?	Yes \/	No ->	Yes	No
Walk?	Yes \/	No ->	Yes	No
Use the toilet/commode?	Yes \/	No ->	Yes	No

10. **DO YOU HAVE ANY KIND OF HEALTH OR MEDICAL INSURANCE?**

2_____No 1_____Yes

11. **[If yes] WHAT KIND OF INSURANCE IS IT?**

_____
Type of Insurance

[If respondent is unsure, ask to see their card]
[The following are not read; mark appropriate boxes based on answer above]

Insurance Categories	1 Yes	2 No	9 Don't Know
Medicaid (white w/pink strip)			
Medicare -- Plan A (red, white & blue, hospitalization only)			
Medicare -- Plan A & B (red, white, & blue, hospitalization and doctor's bills)			
GA Health -- General Assistance First Program (blue)			
Other Insurance -- (hospitalization only) _____ write in to specify the insurance carrier			
Other Insurance -- (extended benefits - hospitalization and doctor, lab, and/or prescription costs) _____ write in to specify the insurance carrier			

12A. **ON AVERAGE, HOW MANY TIMES DO YOU GO OUT TO DO SHOPPING DURING THE MONTH?**
[don't read choices - get response and then code]

1_____not at all (skip to 13)

2_____once every two weeks

3_____once a week

4_____2 or more times a week

5_____once a month

12b. **WHO USUALLY PROVIDES TRANSPORTATION WHEN YOU GO OUT SHOPPING?**

_____
Specify

If "Self", **DO YOU GO BY:** **BUS**_____ **CAR**_____ **WALK**_____

12c. **IS THIS A FAMILY MEMBER?**

2_____No 1_____Yes -> **DO YOU PAY THEM?** 2_____No 1_____Yes
\/ [skip to 13]

12d. **IS THIS A FRIEND?**

2_____No 1_____Yes -> **DO YOU PAY THEM?** 2_____No 1_____Yes
\/ [skip to 13]

12e. **IS THIS SOMEONE YOU OR YOUR FAMILY HIRED?**

2_____No 1_____Yes -> **DO YOU PAY THEM?** 2_____No 1_____Yes
\/ [skip to 13]

12f. **DOES THIS PERSON COME FROM AN AGENCY/CHURCH?**

2_____No 1_____Yes

\/ \/

13. **DO YOU FEEL YOU NEED TRANSPORTATION FOR SHOPPING MORE OFTEN THAN IT IS AVAILABLE TO YOU?**

2_____No 1_____Yes

14a. ON AVERAGE, HOW MANY TIMES DO YOU GO OUT FOR DOCTOR'S APPOINTMENTS DURING THE YEAR?

1_____not at all [skip to 15]
2_____once a year
3_____two times per year
4_____more than monthly
5_____monthly
6_____other _____
[write in]

14b. WHO USUALLY PROVIDES TRANSPORTATION WHEN YOU GO OUT FOR DOCTOR'S APPOINTMENTS?

_____
Specify

If "Self", DO YOU GO BY: BUS_____ CAR_____ WALK_____

14c. IS THIS A FAMILY MEMBER?

2____No 1_____Yes -> DO YOU PAY THEM?
2_____No 1_____Yes
[skip to 15]

14d. IS THIS A FRIEND?

2____No 1_____Yes -> DO YOU PAY THEM?
2_____No 1_____Yes
[skip to 15]

14e. IS THIS SOMEONE YOU OR YOUR FAMILY HIRED?

2____No 1_____Yes -> DO YOU PAY THEM?
2_____No 1_____Yes
[skip to 15]

14f. DOES THIS PERSON COME FROM AN AGENCY/CHURCH?

2_____No 1_____Yes

\/ \/

15. DO YOU FEEL YOU NEED TRANSPORATION FOR GOING TO THE DOCTOR'S MORE OFTEN THAN IT IS AVAILABLE TO YOU?

2_____No 1_____Yes

16a. **ON AVERAGE, HOW MANY TIMES DO YOU GO OUT TO PICK UP MEDICINE DURING THE MONTH?**
[don't read choices - get response and then code]

1_____NOT AT ALL [SKIP TO 16B]
2_____THAN ONCE A MONTH
3_____TWICE A MONTH
4_____ONCE A WEEK
5_____OTHER_____

16b. **ON AVERAGE, HOW MANY TIMES DO YOU HAVE SOMEONE PICK UP MEDICINE FOR YOU DURING THE MONTH?**
[don't read choices - get response and then code]

1_____NOT AT ALL [SKIP TO 17]
2_____LESS THAN ONCE A MONTH
3_____TWICE A MONTH
4_____ONCE A WEEK
5_____OTHER_____

16c. **WHO USUALLY PICKS UP YOUR MEDICINE OR PROVIDES TRANSPORTATION FOR YOU TO PICK UP YOUR MEDICINE?**

_____
Specify

If "Self", **DO YOU GO BY:** **BUS_____ CAR_____ WALK_____**

16d. **IS THIS A FAMILY MEMBER?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 17]

16e. **IS THIS A FRIEND?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 17]

16f. **IS THIS SOMEONE YOU OR YOUR FAMILY HIRED?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 17]

16g. **DOES THIS PERSON COME FROM AN AGENCY/CHURCH?**

2_____No 1_____Yes

17. **DO YOU FEEL YOU NEED TRANSPORTATION TO GET MEDICINE OR HAVE SOMEONE PICK UP MEDICINE FOR YOU MORE OFTEN THAN IS AVAILABLE TO YOU?**

2_____No 1_____Yes

18a. **DO YOU USE PUBLIC TRANSPORTATION (BUS SYSTEM) LESS OFTEN THAN YOU WOULD LIKE?**

2_____No 1_____Yes [if No, skip to 19a]

18b. **DO YOU USE PUBLIC TRANSPORTATION (BUS SYSTEM) LESS OFTEN THAN YOU WOULD LIKE TO BECAUSE: (check as many as apply)**

[read each choice and wait for a yes or no]
and check if yes was indicated

1_____IT IS NOT CONVENIENT TO USE?
(FEW SCHEDULED STOPS IN YOUR AREA
2_____THE BUS DOES NOT COME IN OR NEAR YOUR NEIGHBORHOOD?
3_____IT IS TOO EXPENSIVE (COSTS TOO MUCH) TO USE?
4_____IT IS TOO CONFUSING TO USE (TRANSFERS)?
5_____YOU ARE UNFAMILIAR WITH HOW TO USE THE BUS?
6_____THERE IS NO ONE TO HELP YOU GET IN OR OUT OF THE VEHICLE?
7_____THERE IS NO ONE TO HELP YOU GET IN OR OUT OF YOUR HOUSE?

19a. **DURING THE PAST SIX MONTHS, DID ANYONE HELP YOU WITH PERSONAL CARE? FOR EXAMPLE, DID ANYONE HELP YOU BATHE, DRESS OR PREPARE YOUR MEALS?**

2_____No (skip to 20a) 1_____Yes (go to 19b)

19b. **[If yes] WAS IT A FAMILY MEMBER WHO HELPED YOU WITH YOUR PERSONAL CARE?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 20a)

19c. **WAS IT A FRIEND?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 20a)

19d. **WAS IT SOMEONE YOU OR YOUR FAMILY HIRED?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 20a)

19e. **DID THIS PERSON COME FROM AN AGENCY?**

2_____No 1_____Yes

20a. **DURING THE PAST SIX MONTHS HAS ANYONE CHECKED ON YOU REGULARLY BY TELEPHONING TO MAKE SURE THAT YOU WERE ALRIGHT?**

2_____No (skip to 21a) 1_____Yes (go to 20b)

20b. **[If yes] WAS IT A FAMILY MEMBER?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 21a)

20c. **WAS IT A FRIEND?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 21a)

20d. **WAS IT SOMEONE YOU OR YOUR FAMILY HIRED?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 21a)

21a. **DURING THE PAST SIX MONTHS, HAVE YOU HAD ANYONE REGULARLY COME BY YOUR HOME TO MAKE SURE THAT YOU WERE ALRIGHT?**

2_____No (skip to 22a) 1_____Yes (go to 21b)

21b. **[If yes] WAS IT A FAMILY MEMBER?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 22a)

21c. **WAS IT A FRIEND?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 22a)

21d. **WAS IT SOMEONE YOU OR YOUR FAMILY HIRED?**

2____No 1_____Yes -> **DO YOU PAY THEM?**
2_____No 1_____Yes
\/ [skip to 22a)

22a. DURING THE PAST SIX MONTHS, HAS ANYONE HELPED YOU WITH ANY LEGAL OR PERSONAL MATTERS, LIKE HELPING YOU MAKE A WILL OR PAYING YOUR BILLS?

2_____No (skip to 23) 1_____Yes (go to 22b)

22b. [If yes] WAS IT A FAMILY MEMBER?

2____No 1_____Yes -> DO YOU PAY THEM?
2_____No 1_____Yes
\/ [skip to 23)

22c. WAS IT A FRIEND?

2____No 1_____Yes -> DO YOU PAY THEM?
2_____No 1_____Yes
\/ [skip to 23)

22d. WAS IT SOMEONE YOU OR YOUR FAMILY HIRED?

2____No 1_____Yes -> DO YOU PAY THEM?
2_____No 1_____Yes
\/ [skip to 23)

23. DURING THE PAST SIX MONTHS HAS A DOCTOR OR A NURSE TALKED TO YOU ABOUT YOUR HEALTH?

1_____Yes 2_____No

24a. DURING THE PAST SIX MONTHS HAS A SOCIAL WORKER TALKED TO YOU ABOUT HOUSING?

1_____Yes 2_____No (skip to 25a)
\/

24b. [If yes] WAS S/HE ABLE TO GET THE HELP IN HOUSING THAT YOU NEEDED?

1_____Yes 2_____No

25a. DURING THE PAST SIX MONTHS HAS A SOCIAL WORKER TALKED TO YOU ABOUT MEDICAID WAIVER?

1_____Yes 2_____No (skip to 26a)
\/

25b. [If yes] WAS S/HE ABLE TO GET THE HELP THAT YOU NEEDED?

1_____Yes 2_____No

26a. **DURING THE PAST SIX MONTHS DID A SOCIAL WORKER TALK TO YOU ABOUT A NURSING HOME OR NURSING HOME PLACEMENT?**

1_____Yes 2_____No (skip to 27a)
\/

26b. **[If yes] WAS S/HE ABLE TO GET YOU THE HELP THAT YOU NEEDED?**

1_____Yes 2_____No

27a. **DURING THE PAST SIX MONTHS DID ANYONE HELP YOU GET INFORMATION ABOUT RECEIVING HELP FROM SOCIAL SERVICES?**

1_____Yes 2____No (skip to 28a)
\/

27b. **[If yes] WAS S/HE ABLE TO GET YOU THE HELP THAT YOU NEEDED?**

1_____Yes 2____No

28a. **DURING THE PAST SIX MONTHS DID YOU NEED TO HAVE ANYONE ORGANIZE OR COORDINATE THE KINDS OF HELP YOU NEEDED OR MAKE ARRANGEMENTS FOR YOU TO RECEIVE HELP?**

1_____Yes 2____No (skip to 29a) 9_____Don't know
\/

28b. **[If yes] WAS S/HE ABLE TO GET THE HELP THAT YOU NEEDED?**

1_____Yes 2____No 9_____Don't know

29a. **DURING THE PAST SIX MONTHS HAVE YOU ATTENDED A SENIOR CENTER?**

1_____Yes 2____No [if No go to 31]
\/

29b. **[If yes] WHY DO YOU GO TO THE SENIOR CENTER?**
[write down exactly what they say verbatim]

_____

_____
(reasons)

29c. **[If Yes] HOW OFTEN DO YOU ATTEND A SENIOR CENTER?**

1_____LESS THAN MONTHLY
2_____1 OR 2 TIMES A MONTH
3_____ONCE A WEEK
4_____2 OR 3 TIMES A WEEK
5_____4 TIMES A WEEK OR MORE

29D. **DO YOU GO TO THE SENIOR CENTER.....**

1_____ALONE or 2_____WITH OTHER PEOPLE?

29e. **HOW DO YOU GET THERE?**
[don't read responses, just fill in appropriate answer]

1_____drive self
2_____someone picks him/her up Specify_____
3_____use public transportation

30. **DO YOU GENERALLY SPEND YOUR TIME AT THE SENIOR CENTER DOING THINGS.....**

1_____alone or 2_____with other people?

(skip to 32a)

31. **[If response to question 29a was No] Why don't you go to a senior center?**

_____

_____
(reasons)

32a. **DURING THE PAST SIX MONTHS HAVE YOU ATTENDED CHURCH?**

1_____Yes 2____No (skip to 32d)

32b. **[If Yes]**
HOW OFTEN DO YOU ATTEND? [don't read choices - code responses]

1_____LESS THAN MONTHLY
2_____ONCE OR TWICE A MONTH
3_____SEVERAL TIMES A MONTH
4_____ALMOST DAILY
5_____ONCE A WEEK

32c. [If yes to question 32a]
WHY DO YOU GO TO CHURCH?

_____

_____
(reasons)
[skip to 33]

32d. [If no to question 32a]
WHAT ARE THE REASONS THAT YOU DO NOT ATTEND CHURCH?

_____

_____
(reasons)

33. COMPARED TO ONE YEAR AGO, WOULD YOU SAY THAT YOUR HEALTH IS NOW ABOUT THE SAME, BETTER NOW, OR WORSE?

1_____about the same
2_____better now
3_____worse now
4_____don't know

[If response is "2" or "3", "Can you explain how it has changed?"]

_____
_____

WE ARE ALMOST FINISHED. THE LAST PART OF THE SURVEY IS FOR US TO GET TO KNOW YOU AND YOUR FAMILY A LITTLE BETTER.

---

34. WHEN YOU PAY YOUR BILLS DO YOU PAY THEM WITH.....?
[these should be read waiting for a yes/no answer after each one]

a.	CASH?	____Yes	____No
b.	MONEY ORDER?	____Yes	____No
c.	CHECK?	____Yes	____No
d.	Does your bank do it for you?	____Yes	____No

35. DO YOU.....
1_____RENT YOUR HOUSE?
2_____OWN YOUR HOUSE?
3_____OR SOMETHING ELSE?_____
(EXPLAIN)

36. WHAT IS YOUR PRESENT LIVING ARRANGMENT? DO YOU LIVE:

[check all that apply as you read each choice, waiting for "yes" or "no"]

1_____ALONE? (SKIP TO 37)
2_____WITH YOUR HUSBAND/WIFE?
3_____WITH ONE OR MORE OF YOUR CHILDREN?
4_____WITH ONE OR MORE OF YOUR GRANDCHILDREN?
5_____WITH OTHER RELATIVES?
6_____WITH A FRIEND?
7_____WITH A ROOMMATE?
8_____WITH A PAID HELPER?

37. HOW MANY PEOPLE INCLUDING YOURSELF GENERALLY LIVE IN YOUR HOME MOST OF THE TIME?

_____
total

[give them time to answer]

38. DO YOU HAVE CHILDREN/OTHER CHILDREN WHO LIVE WITHIN AN HOUR'S DRIVING TIME FROM YOU?

1_____Yes 2____No

39. DO YOU HAVE ANY BROTHERS OR SISTERS LIVING WITHIN AN HOUR'S DRIVING TIME FROM YOU?

1_____Yes 2____No

40. DO YOU HAVE ANY OTHER RELATIVES LIVING WITHIN AN HOUR'S DRIVING TIME FROM YOU?

1_____Yes 2____No

41a. HOW OLD ARE YOU? _____
His/Her age

41b. [Only if the respondent refuses to give his/her age or doesn't know]

WHAT CATEGORY DO YOU THINK IS CLOSEST TO YOUR AGE?
ARE YOU OLDER OR YOUNGER THAN 75? .....

1_____60 to 64
2_____65 to 69
3_____70 to 74

[start at this point asking them if they are older or younger than this category]

4_____76 to 79
5_____80 to 84
6_____85 to 89
7_____90 and over

42a. **WHAT IS THE HIGHEST GRADE OF SCHOOL THAT YOU COMPLETED?**

_____
If less than 11 skip to 43b

42b. [Only if response was "11" or "12" in 42a]
DID YOU RECEIVE A HIGH SCHOOL DIPLOMA?

1_____Yes 2____No

43a. **DID YOU RECEIVE A CERTIFICATE OR DEGREE BEYOND HIGH SCHOOL?**

1_____Yes 2____No

[If "Yes" go to 43b, if "No" go to 44]

43b. **WHAT WAS THE HIGHEST DEGREE OR CERTIFICATE YOU RECEIVED?**

1_____HIGH SCHOOL DIPLOMA
2_____2-YEAR BUSINESS/TRADE SCHOOL
3_____SOME COLLEGE
4_____COMPLETED A 4-YEAR COLLEGE
5_____SOME GRADUATE SCHOOL
6_____GRADUATE DEGREE

44. **ARE YOU CURRENTLY WORKING AT A PAID JOB?**

1_____Yes 2____No

45a. [Only if "no" to question 43]
DO YOU HAVE A JOB THAT YOU ARE NOT WORKING AT RIGHT NOW?

1_____Yes 2____No

45b. [If yes] WHAT IS THAT? _____

46. ARE YOU CURRENTLY RETIRED?

1_____Yes 2____No

47. WHAT KIND OF PAID WORK HAVE YOU DONE OR DID YOU DO MOST OF YOUR LIFE?

_____

48. ARE YOU CURRENTLY MARRIED?

1_____Yes 2____No

[If married go to Question 51]

49. HAVE YOU EVER BEEN MARRIED?

1_____Yes 2____No _____Member of unmarried couple

50. [If yes] ARE YOU:

1_____widowed?
2_____divorced?
3_____separated?

[skip to 54]

51. IS YOUR WIFE/HUSBAND CURRENTLY WORKING FOR PAY?

1_____Yes 2____No

52. IS YOUR WIFE/HUSBAND CURRENTLY RETIRED?

1_____Yes 2____No

53a. [If No to question 49]
DOES YOUR WIFE/HUSBAND HAVE A JOB THAT S/HE IS NOT WORKING AT RIGHT NOW?

1_____Yes 2____No [skip to 53]

53b. [If yes] WHY?_____
reason

54. WHAT KIND OF PAID WORK HAS S/HE DONE OR DID S/HE DO MOST OF HIS/HER LIFE?

_____

55. IS YOUR MONTHLY HOUSEHOLD INCOME ABOVE OR BELOW $1250.00?

1_____ ($0 - $249)

2_____ ($250 - $499)

3_____ ($500 - $749)

4_____ ($750 - $999)

5_____ ($1,000 - $1,249)

below [Start with the following figure and either go up or down the intervals] $1250.00

above

6_____ ($1,251 - $1,499)

7_____ ($1,500 - $1,749)

8_____ ($1,750 - $1,999)

9_____ ($2,000 - $2,249)

10_____ ($2,250 - $2,499)

11_____ ($2,500 - $2,749)

12_____ ($2,750 - $2,999)

13_____ ($3,000 - $3,249)

14_____ ($3,250 or more)

56. HOW MANY PERSONS DEPEND ON THIS INCOME FOR SUPPORT?

_____
Total

57. **WHICH OF THE FOLLOWING DO YOU RECEIVE INCOME FROM? [check all that apply - read each choice and wait for "yes" or no" answer]**

Yes	No	
1_____	_____	SOCIAL SECURITY?
2_____	_____	SUPPLEMENTAL SOCIAL SECURITY (SSI)?
3_____	_____	PENSION?
4_____	_____	RAILROAD RETIREMENT?
5_____	_____	UNEMPLOYMENT BENEFITS?
6_____	_____	GENERAL ASSISTANCE?
7_____	_____	VA PENSION?
8_____	_____	DISABILITY INCOME (FROM SOCIAL SECURITY)?

\/

[If yes,] Is that for:
Visual_____ Hearing_____
or something else_____
(specify)

9_____	_____	INTEREST FROM STOCKS AND BONDS?
10_____	_____	_____

[Others, please list]

---

58. **DO YOU KNOW OF SOMEONE, 60 YEARS OR OLDER, WHO DOESN'T GET OUT MUCH ANYMORE BECAUSE OF THEIR HEALTH?**

1_____Yes 2____No (skip to next page)

\/

59. **[If yes] DO YOU THINK THAT S/HE (THEY) WOULD BE INTERESTED IN RECEIVING INFORMATION ABOUT SERVICES THAT S/HE (THEY) MAY BENEFIT FROM?**

1_____Yes 2____No (skip to next page)

\/

60. **[If yes] DO YOU THINK THAT S/HE (THEY) WOULD BE INTERESTED IN TALKING TO ME ABOUT THE SERVICES THAT THEY FEEL THEY MAY NEED?**

1_____Yes 2____No (skip to next page)

\/

61. **[If yes] COULD YOU GIVE ME HIS/HER/THEIR NAME(S) AND TELEPHONE NUMBER(S) SO THAT I MIGHT CONTACT THEM?**

1_____Yes 2____No (skip to next page)

\/

[Take name and telephone number on a separate sheet of paper]

WELL, THAT IS THE END OF OUR SURVEY. I WOULD LIKE TO THANK YOU FOR ALLOWING ME (INTO YOUR HOME) OR (TIME TO TALK WITH YOU). THE INFORMATION THAT YOU AND OTHERS HAVE SHARED WILL HELP MAKE IMPORTANT PROGRESS IN THE BLACK CAUCUS ON AGING'S ASSESSMENT OF HOW WELL OLDER PERSONS WITHIN YOUR COMMUNITY ARE INFOMRED ABOUT AND USE THE SERVICES THAT WILL KEEP YOU AND OTHERS LIVING MORE INDEPENDENT LIVES.

THE MATERIALS THAT I AM LEAVING WITH YOU WILL SERVE AS A HANDY RESOURCE FOR FINDING OUT MORE INFORMATION ON THE SERVICES THAT WE HAVE ALREADY MENTIONED AS WELL AS GIVE YOU ADDITIONAL NAMES OF SERVICE AGENCIES. (show them how to use the Division of Aging's Guide to Older Delawareans) DO YOU HAVE ANY QUESTIONS ABOUT THESE MATERIALS OR HAVE ANY COMMENTS ABOUT THE SURVEY?

AS I STATED AT THE BEGINNING OF THE SURVEY, THE INFORMATION THAT WE ARE GATHERING IS STRICTLY CONFIDENTIAL, SO IF YOU WOULD LIKE TO RECEIVE A COPY OF THE RESULTS OF THE SURVEY, ONCE IT HAS BEEN COMPLETED, PLEASE WRITE TO THE NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC., DELAWARE CHAPTER, P.O. BOX 2061, WILMINGTON, DELAWARE 19899, INDICATING THAT YOU WANT A COPY ALONG WITH YOUR NAME AND MAILING ADDRESS, OR WE WILL HAVE COPIES OF THE RESULTS AT YOUR CHURCH OR SENIOR CENTER.

HAVE A (NICE DAY) or (NICE EVENING).

[Leave this page with respondent]

Detach here

IF YOU KNOW A FRIEND OR FAMILY MEMBER INTERESTED IN PARTICIPATING IN THIS SURVEY, PLEASE HAVE THEM FILL OUT THE FORM BELOW AND MAIL TO:

THE NATIONAL CAUCUS AND CENTER ON BLACK AGED
P.O. BOX 2061, WILMINGTON, DELAWARE 19899

NAME:_____

ADDRESS:_____

_____

PHONE:_____

[] YES, I WOULD LIKE TO PARTICIPATE IN THE MINORITY OUTREACH SURVEY.

APPENDIX B: TEAR-OFF POSTCARD

ATTENTION SENIOR CITIZENS

The National Caucus and Center on Black Aged, Incorporated, Delaware Chapter is conducting a survey to determine whether minority elderly community residents are aware of and use agencies that help older Delawareans. If you are a senior citizen and wish to participate in the survey (questionnaire) please fill out the back of the attached postcard and mail it back to us free of charge.

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
First Class Mail Permit 694 Wilmington, DE

POSTAGE WILL BE PAID BY ADDRESSEE

NATIONAL CAUCUS AND
CENTER ON BLACK AGED,
DELAWARE CHAPTER
P. O. BOX 2061
WILMINGTON, DE 19899-9751

APPENDIX C: SITE LETTERS

THE NATIONAL CAUCUS & CENTER ON BLACK AGED, INC.

Delaware Chapter

September 22, 1992

Dear Colleagues:

In our mission statement, one of the goals of the National Caucus and Center on Black Aged, Incorporated, Delaware Chapter is:

> To focus public attention on the problems and challenges confronting the elderly, especially as they pertain to Blacks.

The Caucus's Minority Outreach Survey will serve as an important vehicle for accomplishing the above goal. Data from this survey will provide us with information on formal versus informal utilization of services within the aging network as it pertains to minority elderly community residents. In instances of underutilization of services, the research will also document whether respondents were unaware of the services or simply chose to use informal support systems like their family, friends or church.

Your site was chosen as one of the participating organizations because of your strong commitment to the well-being of Delaware's older population. Participating sites include: People's Settlement, Ezion Mt. Carmel United Methodist Church, Kingswood Community Center Senior Program, Bethel African Methodist Episcopal Church, St. Matthews Episcopal Church, the Salvation Army Senior Program and Scott African Methodist Episcopal Church.

As the community leader, we are asking you to identify eight persons from your organization who will serve as volunteer interviewers who will administer the questionnaire. The names should be secured by October 9, 1992. Training of the volunteers will take place before the end of October. The Caucus will be responsible for contacting the volunteers to inform them of the training dates.

We will also need a full list of your senior citizen (60 years and older) participants/members. They do not have to be active. The list should include their names, addresses and telephone numbers. From this list we will conduct a random sample group of tentative interviewees. We intend to interview persons in their homes so that we can create a more relaxed environment and establish a rapport. The entire survey process, however, will be kept confidential. Final analysis will not include any names.

A full explanation of the survey and research design will be given on October 13th at the Holiday Inn on King Street (formerly the

Radisson). Please come as our guest for breakfast at 9:30 a.m. This meeting is extremely important!!!!!! If you cannot attend, please let Paulette Austin, Black Caucus member, know the name of your substitute. Mrs. Austin's number at Geriatric Services is 658 - 6744.

In order for this project to be successful, your input and cooperation are vital. Enclosed is a copy of the survey that we plan to use in this project. Please review it before you/your substitute attend(s) the meeting and be prepared to discuss any matters as they relate to the: purpose of the project, research design, survey questions, data collection and analysis and any other procedural concerns surrounding the methodology.

We look forward to meeting and working with you throughout this worthwhile endeavor.

Sincerely,

Naomi Winchester
President

APPENDIX D: PARTICIPANT LETTERS

(Name of church or senior center) will be working with the Black Caucus on Aging to find out whether persons within our community are (please underline the one that you think is more appropriate for the audience that the letter will be going to) familiar with or know about and utilize agencies that provide assistance to persons 60 years and older. We are also interested in exploring the extent to which older persons (rely or depend - please underline one) on family, friends, neighbors and or church members for help.

Your participation is needed! We intend to use the collective information that we get from this research to advocate for increased awareness of and availability to existing agencies and organizations that serve you.

Someone from the Black Caucus on Aging may soon call you to ask if he or she can visit you at home in order to ask you questions about the assistance that you feel that you need or to find out about the help that you are already receiving. The visit should not take any longer than one hour. All of your (responses or answers - please underline one) to the questions will be kept confidential. No names will ever be used. However, what you say will be helpful to us and may make a positive impact on the quality of assistance that older community residents receive in the future.

After the Black Caucus member finishes asking you questions, he or she will also provide you with information on types of assistance and how to contact those agencies that provide them.

Your participation is voluntary but would be greatly appreciated.

Sincerely,

Naomi Winchester
President

Signature of minister or director

The National Caucus and Center On Black Aged, Inc.
Delaware Chapter
P. O. Box 2061 - Wilmington, DE 19899

Date:

Dear Participant:

I trust that you received a letter dated November 16 informing you about the Black Caucus on Aging as an organization and letting you know the purpose of our research project.

Your input is very important! I would like to schedule a date and time that I can come to your home and ask you questions about the assistance that you feel that you need or to find out about the help that you are already receiving. All of your answers will be kept confidential. No names will ever be used but we will use the information collectively to find out whether persons within our community are familiar with and utilize agencies that provide assistance to persons 60 and older. What you say will be helpful to us and make a positive impact on the quality of assistance that older community residents receive in the future.

I assure you, I will not try to sell you anything, I just want to ask you some questions in the warm setting of your home. I will try to keep the survey to a minimum of one half hour. Once the interview has been completed, I will also leave you information on types of assistance and how to contact those agencies that provide them.

In order for me to contact you to schedule a visit, I need your telephone number or if you have a date and time in mind for me to interview you write that down on this letter and send it back in the enclosed, stamped envelope. I hope to chat with you soon.

My telephone number is_____

You can come visit me on_____(date) at_____(time).

Thank you.

Sincerely,

Black Caucus on Aging Representative

APPENDIX E: THANK YOU LETTERS FOR IN-KIND SUPPORT

THE NATIONAL CAUCUS & CENTER ON BLACK AGED, INC.

Delaware Chapter

November 4, 1992

Chief Thomas P. Gordan
New Castle County Police Department
3601 N. DuPont Highway
New Castle, DE 19720

Dear Chief Gordan:

We wish to thank you for the use of New Castle County Police Department's training room. The facility more than met our needs in terms of audiovisual equipment and room set up.

Your staff is also to be commended on the prompt, professional and friendly way that they interacted with Black Caucus members. We are indeed indebted to Lt. Smith and Corporal Porter for handling the many details that went into the planning of this training as well as to Corporal Arterbridge and Officer Brandt who provided us with an instant video copy of the sessions. The refreshments were also deeply appreciated.

With the perception of the police department being deeply affected by the recent unfortunate Rodney King incident, it is quite refreshing to know and coordinate training activities with a department such as yours. The National Caucus and Center on Black Aged, Inc. - Delaware Chapter was glad to be a part of this positive exchange of cooperation and community outreach.

Thank you for making it possible.

Sincerely,

Gloria James
Program Coordinator

Naomi Winchester
President

The National Caucus and Center On Black Aged, Inc.
Delaware Chapter
P. O. Box 2061 - Wilmington, DE 19899

November 17, 1992

Mr. Alex J. Smalls
Chairman, Trustee Board
Ezion-Mt. Carmel United Methodist Church
800 North Walnut Street
Wilmington, DE 19801

Dear Mr. Smalls:

The Black Caucus on Aging deeply appreciates the use of Ezion-Mount Carmel's lovely facility. The Minority Outreach Project is progressing very nicely. Letters were mailed yesterday which will introduce the Black Caucus as well as explain the research process to our potential interviewees, some of whom, no doubt, will come from your church.

Thank you once again for contributing to this very needed survey.

Sincerely,

Gloria P. James
Project Coordinator

November 24, 1992

Joan Lynch
RSVP
Carvel State Office Building
820 N. French Street
Wilmington, DE 19801

Dear Ms. Lynch:

On behalf of the Black Caucus on Aging, I wish to thank you and your group for diligently organizing and following through with the Minority Outreach mailing on November 16 at St. Albans Church.

Your effort saved our organization a lot of time and cost associated with such a large mailing. When I returned to pick up the letters they were indeed separated into the different sites as had been previously requested.

Thank you for contributing to the success of our research project.

Sincerely,

Gloria James
Project Coordinator

The National Caucus and Center On Black Aged, Inc.
Delaware Chapter
P. O. Box 2061 - Wilmington, DE 19899

September 9, 1993

Mr. Gary Fullman
Delmarava Power
800 King Street
Wilmington, DE 19899

Dear Mr. Fullman:

Thank you for providing the copies of the Minority Outreach Survey Key Guide and Sheet. As you are aware, the National Caucus and Center on Black Aged, Delaware Chapter is on a limited budget. And by Delmarva Power's generous contribution of providing the xeroxed materials, our organization can move forward in the data entry process by transferring the numerical information from the completed surveys onto the key sheets. This will, no doubt, assist us in the research process.

I also want you to know that I am deeply appreciative of your suggestion to solicit funds from the mayor's office. Following your recommendation, Ms. Winchester, our president, was able to get $2,000 from Sills' office.

Lee Perkins is also to be commended for her promptness in delivering the completed forms to my office.

Again, my sincerest thank you to you and Delmarva Power for assisting the community with outreach.

Respectfully,

Gloria James
Program Coordinator

APPENDIX F: LETTERS OF FINANCIAL SUPPORT

The National Caucus and Center On Black Aged, Inc.
Delaware Chapter
P. O. Box 2061 - Wilmington, DE 19899

August 30, 1993

Mr. James Baker
President of the City Council
409 West 5th Street
Wilmington, DE 19801

Dear Mr. Baker:

Thank you for your support of the Delaware Chapter, National Caucus and Center On Black Aged, Inc's. Minority Outreach Survey. I am pleased to accept your contribution of $1,500.

Your contribution will be used to code, analyze survey information, and develop an analytical report documenting the effectiveness of services provided to inner city black elderly. We appreciate your continued interest in the Caucus. As our minority aging population increased, the need for effective community based support will continue to grow.

The Caucus members and I are grateful for your support of the Minority Outreach Survey Project.

Sincerely,

Naomi G. Winchester
President

JAMES H. SILLS, JR.
MAYOR

City of Wilmington
Delaware

LOUIS L. REDDING - CITY HALL
800 FRENCH STREET
WILMINGTON, DELAWARE
19801-3537

September 2, 1993

Ms. Naomi G. Winchester, N.S.W.
President
The National Caucus and Center on Black Aged, Inc.
Delaware Chapter
P.O. Box 2061
Wilmington, DE 19899

Dear Ms. Winchester:

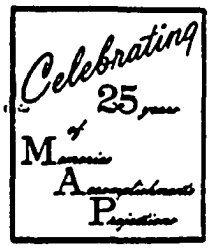
I have reviewed your proposal for funding assistance in support of your organization's project to survey the needs of African Americans in Delaware. On behalf of the City of Wilmington and all our older black citizens, I am pleased to commit $2,000, (which will be mailed under separate cover) towards this most needed documentation. As I understand, this survey will be used to define specific programs to help solve the unique problems that our elders face. Please send us a copy of your completed survey results.

Best wishes and success in this project. If you should have any questions, please feel free to contact me or Brenda Phillips, Director of Community Affairs, at 571-4100.

Sincerely,

James H. Sills, Jr.
Mayor

JHS/fs



METHODIST ACTION PROGRAM

The Methodist Mission and Church Extension Society, Inc.
of Wilmington District - Peninsula Conference

REV. DR. JAMES T. SEYMOUR, President, Board of Directors

Rev. John F. Holden
Executive Director

October 1, 1993

Mrs. Naomi G. Winchester, President
The National Caucus and Center on Black Aged, Inc.
Delaware Chapter
c/o Peninsula United Methodist Homes
Suite 101
Centre Road
Wilmington, Delaware 19805

Dear Mrs. Winchester:

The M.A.P. Board of Directors at its regular meeting on September 21, 1993 considered your request for for funding for the second phase of your project to address the need of older Black citizens. The Board approved support of your request in the amount of $1,000.00. A check for that amount is enclosed.

The Methodist Action Program is very interested in studying the results of your survey and its interpretation. Please forward any materials you have to share to the M.A.P. office.

The M.A.P. Board of Directors and I wish you continued success with Phase II of your project.

Sincerely yours,

John F. Holden
Executive Director

900 Washington Street • Wilmington, Delaware 19801 • Phone (302) 654-3101

The National Caucus and Center On Black Aged, Inc.
Delaware Chapter
P. O. Box 2061 - Wilmington, DE 19899

October 13, 1993

Dr. Roberta K. Tarbell
504 Beechtree Lane
Hockessin, DE 19707

Dear Doctor Tarbell:

I thank you for your gift of $500 to the National Caucus and Center on Black Aged, Inc.

Your gift will make it possible for us to complete the data entry phase of the project and analyzed data collected from the survey. Thank you for your recognition of the importance of The Minority Outreach Survey and for your support of this project.

Sincerely,

Naomi Winchester
President

APPENDIX G: LETTERS TO VOLUNTEERS

THE NATIONAL CAUCUS & CENTER ON BLACK AGED, INC.

Delaware Chapter

October 19, 1992

Dear Participant:

Thank you for volunteering to serve as one of the Minority Outreach Survey interviewers. The information that we receive from the research will help us determine whether local, minority elderly are aware of and utilize agencies that provide services within the aging network. The data will also provide information on the types and numbers of persons who provide informal assistance to our minority elderly.

The research will come from the collective responses from the attached questionnaire that you will be discussing with each interviewee. Each interview should take no longer than one hour to complete (average time is one half hour). Names will not be used on the questionnaire. Interviewees have been chosen from: Ezion Mt. Carmel, Bethel A. M. E., Scott A. M. E., People's Settlement, Kingswood, the Salvation Army and St. Matthews Episcopal Church. Scheduled times of the interviews need to be handled over the telephone with you asking those respondents for permission to go into their homes along with setting up the time for the interview.

Training on how to use the attached questionnaire and Guide to Services for Older Delawareans will be on October 26, October 28, and November 2 from 5:30p.m. - 7:30p.m. at the New Castle County Police Headquarters' training room, 360 N. DuPont Highway, New Castle. **Please note that you must attend October 26 and November 2 or October 28 and November 2 so you either can come the 26th or the 28th but everyone has to attend November 2 and spend four hours in training.**

Light refreshments will be served. The training will be provided by Dr. Terri Cooney from the University of Delaware, Department of Individual and Family Studies.

When you arrive at the New Castle County Police Headquarters, please park in E, F, or G lots. Once you have parked your car, walk in the parking lot in the direction like you are leaving (headed towards the original entrance). The training room is at the set of double doors where the sign facing you will say 'buckle up'.

Please review the questionnaire (Minority Outreach Survey) and

Guide to Older Delawareans so that if you have any particular questions, Dr. Cooney can answer them during the training sessions (please bring the questionnaire and Guide to Services for Older Delawareans with you to the training).

Again, the Black Caucus on Aging wishes to thank you for volunteering to assist in conducting the research. If you have any questions and to indicate which days you will be particpating in the training, please call Gloria James, coordinator at 577-4791.

Sincerely,

Naomi Winchester/bg.

Naomi Winchester
President

November 4, 1992

Dear Participant:

Thank you for volunteering to serve as one of the interviewers for the National Caucus and Center on Black Aged, Delaware Chapter's Minority Outreach Survey. Your time and effort thus far, are greatly appreciated.

As a review to those who attended the November 2 meeting and as an update for those who were unable to attend, the following activities need to be completed before we meet again as a group:

Approximately 1,000 names will be entered into a computer with names, addresses and telephone numbers along with what organization or church they belong to.

Black Caucus stationery has to be printed so that a letter of introduction under the signature of Naomi Winchester the president along with the minister or site director from the seven organizations that we are working with explaining who the Caucus is and what the Minority Outreach Survey is. The letter (see the enclosed) will also mention that someone might be calling them soon about scheduling an interview. This letter is slated to go out on the 16th of this month.

We will meet December 3 at 5:30p.m. at Ezion Mt. Carmel Church on Walnut Street. At this meeting you will be given the newly revised questionnaires, Guides to Services for Older Delawareans and a sheet of paper with the names, addressees and telephone numbers of those persons that you will be responsible for calling and setting up an appointment so that you can interview them. You will be responsible for about 30, dependent upon how many volunteers are still interested in carrying out this project. Along side of the names that you will receive will be an I. D. or code number. Once you call the people on your list and they agree to be interviewed, this in when you transfer the code to the questionnaire. This procedure will be explained again at the December 3rd meeting.

In order for me to get an accurate count of the volunteers so that I can begin to divide the number of potential participants up, I need to know by November 12 if you are not going to participate. Otherwise, I assume that you will and divide the counts up accordingly, so with the exception of Paulette Bryan and Marjorie Scott, if you are not going to participate, please call me at 577 - 4791 or leave a message on my answering machine at home at

The function of the liaison persons is to also provide coordination and transportation, if needed, for those persons who have volunteered from the seven individual sites. Liaison persons include: Victoria Adkins for the Salvation Army, Gloria James for Bethel A. M. E., Paulette Austin for St. Matthews, Bertha Koeller for Kingswood, Jean Wallace for People's Settlement and Eldridge Waters for Ezion Mt. Carmel and Robin Fisher for Scott A. M. E. so as problems occur or if you need transportation to the interviews you would call those persons listed above. Again this will be explained at our December 3rd meeting. However, if you have any additional questions before that time please call me at

Thank you again for your participation.

Sincerely,

Gloria James

Gloria James

APPENDIX H: INTERVIEWER TRAINING

THE INTERVIEWER TRAINING FOR
BLACK CAUCUS STUDY OF MINORITY ELDERS

10/26/92

I. Introduction of the study. ( )
   A. Purpose
   B. Sampling
   C. Funding

II. Description of the research Process ( )
   A. Structured interview -- there is a series of specific questions that will be asked of everyone meeting a given set of conditions, and those questions generally will be answered with one of a set of pre-designated choices.

1. This format is your typical stimulus-response format:

We. give people the exact same stimulus (question) and see how they respond, and later try to determine factors that predicted the various responses we got.

2. Our assumption is that the subjects' responses are due to some attribute they possess or experience they have had.

****NOTE, WE DO NOT WANT TO THINK THAT THE ANSWER THEY GAVE WAS ACTUALLY DUE TO SOME ASPECT OF THE INTERVIEW SITUATION.**

-for example, the way the question was asked by one interviewer versus another

-the fact that one interviewer often forgets to read choice d in a given question, so for that interviewer that answer is never given

-the fact that the subject gave rushed, often erroneous answers because the interviewer seemed to be in a hurry.

****THE POINT HERE IS THAT WE NEED TO EXERT CONTROL OVER THE INTERVIEW PROCESS SO THAT WE CAN CONCLUDE THAT DIFFERENCES IN RESPONSES GIVEN BY THE SUBJECTS ARE TRULY DUE TO DIFFERENCES IN THE SUBJECTS' CHARACTERISTICS OR EXPERIENCES. (AND NOT DUE TO THE PARTICULAR INTERVIEWER WHO HAPPENED TO CALL ON THEM)**

In a few minutes I will go over the procedures we use to ensure that you are all doing the interview in the exact same standardized manner.

III. Gaining Entry and Rapport

A. Pay attention to your appearance: you want to dress professionally to give yourself and the study legitimacy, but you should be careful not to overdress. You want your subject to feel comfortable with you -- not intimidated or out-done.

-wear what you usually wear to work - a skirt/sweater or pants/sweater

-don't wear any jewelry/buttons etc...that make a statement, because these may influence the subject's answers

-for example, a cross around your neck may seem pretty innocuous, but it may inhibit a non-religious person from admitting to it.

-also, in this season, it is not appropriate to wear a political button, etc....

***Also, do not schedule an interview until you have fully familiarized yourself with the interview tool, how it flows, the wording of the questions, etc...

B. Gaining entry:

1. Arrive on time -- too early may result in your catching someone unprepared (in robe, etc....), too late will leave your subject feeling as if they are not important enough for you to be on time. If you are running late, call and see if you should reschedule, or if arriving late is o.k.

2. Give your subject time to get to the door before giving up. If no one answers, try to go to a nearby phone and tell them you are calling on them, and what you look like or are wearing so they will feel safe to come to the door and let you in.

3. After your subject answers the door, introduce yourself and identify your purpose, and ask if this is still a good time to do the scheduled interview.

4. In terms of manner, act professionally, and be sure to be pleasant, relaxed and friendly. It's o.k. to make small talk to build rapport before you begin. Try not to discuss anything related to the survey, however. Also, don't make the subject feel like you are in a hurry, too busy, bored with the study, etc....

C. Setting up for the Interview

1. Find a comfortable place to do the interview--away from any noise or distractions (turn off t.v., radio, etc...)

2. Make sure the subject will be able to see you, since some may be hard of hearing and will need to read lips a bit.

3. You should be alone in the room to ensure confidentiality and honesty. If they want someone nearby, ask the non-participant to stay in the next room.

D. The Interview Process

1. Read everything that is indicated to be read on your forms, verbatim. Do not substitute words, add words, etc... unless directed on your forms or here today. Do not read the choice number beside each answer.

2. Set a comfortable pace and voice level for the interview. If you go too slowly, you may put someone to sleep (I've seen this happen!). If you go too quickly, the subject may feel rushed to respond or may miss important info in the question. In the end, rushing will only result in a longer interview because you'll end up repeating yourself a lot.

3. Use clear articulation. If there are words that cause you trouble, practice them ahead of time. If you are unsure of a particular word, ask about it beforehand.

If the subject is asking you to repeat a lot of questions, take it as a hint: **slow down, be more articulate and speak a bit louder. It is o.k. to repeat questions or even answer choices.

4. Record the subject's responses exactly as they tell you. Don't condense answers or reword them -- that is part of analysis and will be done later.

5. If the subject gives you an answer that is not exactly one of the choices, give them the choices again so they can put it right. If they still don't answer within the choices, write their answer down verbatim and it will be coded later.

--if the subject says "I don't know" probe with:
"If you had to pick one of the answers, which comes closest to your feelings or opinion?"
--"I would appreciate if you could make a guess as to which is closest..."

**NOTE: IN-PERSON INTERVIEWS SHOULD RESULT IN ALMOST NO MISSING DATE OR "I DON'T KNOW RESPONSES"

6. If the subject need to take a break, let them.

7. If the subject's comments diverge from the interview and they get off on another tangent, telling stories, etc... let them go a little (you are asking them to spend a lot of time with you so give something back!), but then try to get them back on track with comments like the following:

"That's interesting, we'll get to that more later", or "maybe we can talk about that some more later..."

"....we've got some other important questions to ask too... how about if we move along to those and discuss this more later if we have time?"

8. Only clarify things if you have instructions on your interview schedule to do so.

9. Make sure you give them a chance to ask questions at the end.

***Do role playing with me as the subject

***Pair up and do role playing

MINORITY OUTREACH SURVEY

Good_____. My name is_____. I represent the Black Caucus on Aging whose responsible for conducting the Minority Outreach Survey. We hope that you and other respondents will provide us with information on whether persons like yourself are aware of and utilize services that benefit older Delawareans and their families. Having access to such assistance can enhance the quality of one's life as well as allow persons to continue to live independently within their communities. Is this a good time to talk? (If not, ask when a good time is and reschedule).

We should be together for about an hour. What you say will be held in confidence. Information that we gain from this survey will be presented in terms of how people responded in general. No specific names will be used in our data. I will cover questions that will provide information on your familiarity of certain agencies that provide services to older Delawareans, explore questions that determine whether you use such services or feel that you need additional assistance and ask you questions that will tell us a little more about yourself and your family. Remember this is not a test. There are no right or wrong answers, I just want you to share your ideas with me. Are there any questions that you want to ask me before we begin?

I am now going to ask you about certain agencies that provide services to senior citizens. Each agency will come under a specific category based on the type of service provided. The first category is Homemaker/Home Health Care. **Homemaker** services are performed by aides who come into your home who may provide personal care, meal prepraration, light housekeeping, laundry and/or shopping. Home Health services, on the other hand, include medically-oriented care like physical therapy. The following agencies provide the homemaker/home health care that I have just described. As I name each of the four agencies could you tell me if you have ever heard of them and if so the extent to which you have used them. The first is Delaware Hospice.....

The next category is **nutritional programs** which come under two types. One is congregate meals which are served at a site other than your home. The other is meals on wheels which are meals delivered to your home.

Next are the **senior assistance programs** which provide a number of social service offerings as each title that I read suggests.

Senior health care provides a number of services that are directly related to physical and mental functioning.

The next category is **transportation.**

Next, is **associations** which do not perform social services' types of assistance but provide opportunities for persons to participate

in certain educational and social activities based on each organization.

Under miscellaneous is the United Way of Delaware's helpline which provides information and referrals to other agencies that provide services to older persons.

The last category we have called, "other". Here, I would like for you to name any other agency or organization which you know about or have called for assistance that has not already been discussed.

APPENDIX I: FOLLOW-UP LETTERS TO INTERVIEWERS

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Aging

January 12, 1993

Mrs. Mildred R. Holmes
2013 N. Franklin Street
Wilmington, DE 19805

Dear Mrs. Holmes:

Happy New Year! By now, I hope that you have successfully gotten into the process of the interview surveys. After having completed the first twenty, I can honestly say that interviewing depends on timing, establishing a rapport and staying focused while maintaining a sense of friendliness while you're in respondents homes.

Well, it's time for us to get together to share some of those experiences surrounding the Minority Outreach Survey. When we meet please have your completed interviews ready to hand into me (remember to have them completely filled out with your interview code, the date of the interview and all possible responses filled in with appropriate comments). If people refused to answer certain questions please note it in writing. For example, two of my respondents refused to give their income so I wrote "refused" by the answer.

Our meeting will be at the Division of Aging, 1901 N. DuPont Highway on February 3, Wednesday at 4:00 p.m. in the auditorium. The Division of Aging is on the grounds of Delaware State Hospital. Once you're on campus follow the signs that say Southwest Street. Turn right on Southwest. Look for the sign that says South Loop and park in the parking lot where you first see this sign. The building will be the Administrative Annex. Go through the first set of double doors (far left facing the building to the Second Floor. Ask the receptionist where the auditorium is. It is important to be on time in that the receptionist leaves at 4:30 p.m.

For those who are unable to climb the stairs follow the same directions except you must continue to drive around to the side of the building and take the elevator by using the basement entrance. If you have questions please call me a few days before the meeting at 577-4791.

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I appreciate the time and effort that you have put into this much needed research project. The experience, though labor intensive, has been quite rewarding thus far and we have ourselves to thank for its success.

I'll see you on February 3 at 4:00 p.m. Remember to bring your completed surveys.

Sincerely,

Gloria James

Gloria James
Coordinator

GJ:flw

APPENDIX J: LIAISON LETTERS

November 5, 1992

Dear Liaison Representative:

I am getting excited about the project that is currently before us. As you are well aware, the Minority Outreach Survey requires extensive coordination. The Caucus could have not progressed this far without your help.

To continue the momentum and ongoing success in executing the research, it is important that volunteers under our leadership remain informed about the process and feel comfortable to come to us with any questions concerning the project. As a liaison representative, it is our responsibility to: keep in weekly contact with those persons assigned to us, collect the completed questionnaires or devise your own system which works for you, in getting completed questionnaires, act as both a motivator and good example in progressing with completing the questionnaires, provide transportation for your volunteers, if they need it to complete the surveys and call me a minimum of once every two weeks or ideally, every week to report on the progress of your group. This procedure will help us get finished more quickly, plus it will foster team work so that volunteers feel that they are a part of a larger whole. My telephone number is 577 - 4791 at work and 737 - 2673 at home. I respond to calls left on my answering machine. If you have any questions or are in a slump, please feel free to call me.

Sometime before all of the questionnaires are completed, a code book will be devised which simply means that all responses for each question have to be given a numerical value before those values are entered into a computer. Once questionnaires are completed and all values are entered into the computer, then analysis can take place, resulting in descriptive and inferential statistics.

Once again, I would like to thank you for your interest and displayed leadership in this historical event.

Sincerely,

Gloria James

Gloria James
Project Coordinator

APPENDIX K: DIVISION OF AGING SUPPORT LETTER

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Aging

July 27, 1993

Ms. Naomi Winchester, President
Delaware Chapter NCBA
PUMH
Suite 101, Charter Building
1013 Centre Road
Wilmington, DE 19805

Dear Naomi:

This is a follow-up to the town meetings I have held throughout the state focusing on Delaware's State Plan on Aging. Under the section "Minority/Ethnic Issues," we intend to use the data from the survey you are conducting in the older African/American community. This data will be very important to us as we plan and target funds to this older community. There has never been a study done like this in our community, and the results will be very important and useful to the Division of Aging.

I look forward to working with you and your committee.

Sincerely,

Eleanor Cain

Eleanor L. Cain
Director

ms

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