



**21st CENTURY SENIOR CENTERS:
CHANGING THE CONVERSATION**
A Study of New York City's Senior Centers

**TECHNICAL REPORT:
Methodology, Literature Review
and
References**

February 2010

Purpose of Study

The purpose of this study was to examine the impact of senior centers on the lives of its participants; to evaluate how senior centers are evolving to meet the challenges of the 21st century; and to examine the challenges faced by administrators in meeting the demands of their constituents, their communities and their funders (public and private). The purpose of this study was four-fold:

- A. Evaluate the relevance and impact of senior centers for current participants
- B. Explore the interests and needs of non-participants and investigate how senior centers can meet their needs
- C. Assess the response of senior center directors and administrators to the changing demands of the aging services field
- D. Incorporate a grassroots, community-based model of inquiry and engagement to help design a plan of social action and advocacy to influence senior center policies and funding decisions

The project was a grassroots, community-based, city-wide initiative that engaged senior centers, older adults and stakeholders in New York City to discuss the future of senior centers. At this critical juncture in the New York City history of senior center policy and services, it is imperative that we assess the impact of senior centers on the lives of its participants, and explore the efforts of administrators and directors to respond to the changing demographics and needs of the aging population. CSCS planned to utilize the study findings to develop a data-informed plan for social action and advocacy to ensure the future sustainability of senior centers in New York City.

Findings

The findings have been summarized into three salient issues:

1. Senior centers need to serve a diverse population.

The traditional senior center participant is female, 70 years or older, widowed or living alone, with limited education and living on a fixed, low income. Participants are increasingly ethnically and racially diverse, including many first-generation immigrants and bilingual seniors. Senior centers are reaching out to and effectively meeting the needs of these traditional consumers. However, as the older adult population grows more diverse, it increases the challenges for senior centers. On one hand, there is a growing cohort of older adults between the ages of 60 and 65 (the boomer generation) and, on the other end of the spectrum, there is a near doubling in the 85+ cohort as well. The “younger” older adults are thought to have limited needs and lack interest in the current program offerings of senior centers. However, this does not take into account low income, minority and immigrant seniors in this age group who may have significant need and interest. On the “older” end of the aging spectrum, this study revealed that participation peaks in the mid-80s and then drops due to increasing frailty and lower levels of functioning. However, the needs and interests of this population with regard to senior centers do not dissipate with age. On the contrary, this cohort constitutes an at-risk, vulnerable group that is most in need of services. However, lack of access and limited resources negatively impacts services for this population.

2. Senior centers need to diversify programs/services and hire qualified staff

Meals continue to be the core service of the majority of senior centers. Most participants and administrators also highlighted the traditionally popular recreational programs offered at senior centers such as arts & crafts, dance, bingo, trips, parties, and movies. Additionally, participants and administrators emphasized the continued popularity of health screenings, health fairs, educational workshops and fitness programs like exercise, yoga and tai chi. However, several participants and non participants identified programs that they would like to attend if available. These included recreational programs, computer classes, continuing education courses, health promotion workshops, evidence-based interventions, and several fitness programs. Problems meeting these needs arise when centers may have limited resources, equipment or trained staff that can adequately or effectively provide these services. One major concern that participants and non- participants identified was the need for several social service programs such as case assistance, counseling, support groups, food pantry, housing assistance and transportation services. It should be noted that these services play an important role in enhancing the health and wellbeing of the participants. However, these services require trained and qualified staff who are capable of conducting comprehensive assessments and linking the participants to critical services. As noted earlier, many participants desire culturally relevant and bilingual programming. Additionally, the frail older adult participants may have increased need for health maintenance, assistance with daily activities and social services. Thus, recruitment of trained and bilingual, professional staff such as care coordinators, social workers, mental health counselors and healthcare professionals would enhance the capacity of senior centers to address these diverse needs.

3. Senior Centers need to enhance their capacity to meet the challenges of the twenty-first century.

Surveys and focus group discussions with the varied stakeholders illustrated several strengths and some weaknesses of senior centers.

The strengths as revealed in this study are:

- a) Senior centers work hard to be responsive to the needs of their communities.
- b) Senior centers are often the only conduit for socialization, recreation, meals, and linkage to life-enhancing services in a community.
- c) Senior centers are recognized by older adults as providing a significant and valuable service to community-dwelling older adults.
- d) Senior centers provide quality service and are cost-effective for participants.
- e) Senior centers provide a safe, inviting space for older adults to socialize in and receive services.
- f) Senior centers are recognized by aging-service and other community providers as a critical component in the aging continuum of care.

The weaknesses as revealed by this study are:

- a) Community members, agencies, educational institutions, healthcare organizations and other stakeholders lack a clear understanding of the role, relevance and impact of senior centers.
- b) The general population may have a negative image of senior centers

- c) Senior centers have aging facilities and lack adequate spaces.
- d) Senior centers mostly offer lunch meals only and have limited hours of operation.
- e) “Younger seniors” or those from middle income backgrounds may view senior centers being for “older” seniors with disabilities or low-income consumers, making them less attractive.
- f) Senior centers have the ability to offer a wide range of programs and services, but lack the resources, equipment and staff that are essential to their successful implementation.
- g) Funding is inadequate and severely hampers the functioning of senior centers.
- h) Collaboration between centers on programming and other initiatives is limited.

Conclusion

As we enter into the second decade of the 21st century, the time has come, and is perhaps long overdue, to give back to older adults, and to show them in a meaningful, tangible fashion our gratitude for their contribution to society. Senior centers play a critical role on the aging continuum of care providing comprehensive and vital services to the aging community. It is our civic and moral responsibility to ensure that these centers are modern, offer diverse programming, have adequate resources and support, and staffed appropriately to meet the needs of this population. The modern model of senior centers was developed in New York City in 1943 and changes have occurred since then. It is time that the city seizes the opportunity to support, re-design, re-conceptualize and innovate senior centers for the new millennium. New York City can once again be at the forefront for defining the new model of an urban senior center.

Recommendations

1. Initiate new senior center models that change the conversation about senior centers to one of building on current strengths and successes (Charter Senior Centers)
2. Ensure adequate base funding to strengthen senior center capacity
3. Implement a small capital construction and repair program
4. Provide workforce support for professional staff
5. With DFTA taking a leadership role, maximize collaborations between a variety of resources and senior centers
6. Provide an adequate number and diversity of nutritious meals
7. Provide social work services and mental health programs in senior centers
8. Provide health promotion services and programs at senior centers
9. Bring lifelong learning opportunities to senior centers
10. Provide seniors with accessible, reliable and affordable transportation
11. Develop older adult and staff leadership in social action and advocacy
12. Increase funding and collaborations of creative arts in senior centers
13. Provide volunteer opportunities for seniors and training for volunteer coordinators
14. Encourage development of intergenerational programs that have proven to be beneficial to older adults and young people

METHODOLOGY



METHODOLOGY

CSCS Senior Center Planning Group

Council of Senior Centers and Services, Inc. convened a Senior Center Planning Group in January 2008, comprised of senior center administrators, consultants and a researcher from Fordham University. The Senior Center Planning Group met to discuss the aims of the study and its scope. They jointly developed the survey instruments for the study, as well as the focus group questions. They also participated in discussions about the conduct of the study, the selection of respondents and the review of the study report.

Study Design

The study incorporated a mixed-methods design, utilizing empirical (quantitative) and qualitative data collection. This study utilized two surveys (multiple-choice items) and multiple focus groups. There were three data gathering mechanisms utilized by this study:

- Survey Instrument for Current Participants and Non-Participants
- Survey Instrument for Senior Center Directors and Administrators
- Focus Groups with participants, non-participants and senior center directors

(a) Survey Instrument for Current Participants and Non-participants

This instrument comprised 17 multiple choice questions and 2 open-ended questions.

- Six questions about participation (if they attend senior centers, frequency of attendance, languages spoken, preference for programs in languages other than English, and disabilities or conditions that act as barriers to participation).
- One question offered a list of 79 programs or services grouped into 4 categories (recreational, health and fitness, social services, education and other) for respondents to review. Respondents were asked to highlight which programs they preferred, how often they attended them or allowed them to highlight a program/services that they would patronize if offered.
- One question explored the barriers to participation.
- Nine questions explored the demographic characteristics of respondents (gender, age, ethnicity, educational level, sexual orientation, residential neighborhood, living status, walking ability and caregiver status).

- One open ended question asked respondents how senior centers could be improved.
- The second open ended question asked non-participants what factors would make them attend senior centers.
- *In order to reach out to a diverse sample, the survey was also translated into Spanish, Cantonese, Mandarin and Korean.*

(b) Survey Instrument for Senior Center Directors and Administrators

This instrument comprised 23 multiple-choice items and 4 open ended questions. This survey elicited information on opinions, experiences and perspectives of administrators of senior centers.

- One question offered a list of 79 programs or services grouped into 4 categories (recreational, health and fitness, social services, education and other) for respondents to review. Respondents were asked to highlight which programs they offered, their degree of utilization, and explored the types of programs/services they would offer if resources were made available.
- Additional questions explored the most significant barriers to operating senior centers, outreach methods, rationale and priorities for additional funding and culturally diverse program offerings.
- Several questions explored the demographic characteristics of senior center participants.
- Five questions explored the demographic characteristics of the administrators (title, experience, education, gender and ethnicity).
- Four open ended questions explored the in-depth perspectives and opinions regarding the purpose and impact of senior centers, as well as the challenges faced by them on a daily basis.

(c) Focus Groups with participants, non-participants, and senior center directors

Three sets of focus group questions (for participants, non-participants and administrators respectively) were developed by the Senior Center Planning Group. Each set comprised 6-8 questions that assessed the perspectives, experiences and opinions of the various participants. For participants and administrators, the questions revolved primarily around the impact and relevance of senior centers, rationale for participation, barriers to participation, and suggestions for improvement. For non-participants, the questions revolved around reasons for non participation, factors that might make them change their minds about senior centers, and current preferences for community engagement. The focus group sessions were held with 8-10 respondents each and took approximately one and half hours to complete.

Data Collection

(a) Senior Center Directors and Administrators: The survey was made available in two formats. It was printed and faxed or mailed to all 282 senior center members of CSCS. Additionally, the survey was posted on Survey Monkey and request for participation were mailed via email to all members of CSCS. 94 surveys in paper format and 61 online surveys were obtained from directors and administrators.

(b) Current Participants and Non-participants Survey: The survey was made available in English, Spanish, Cantonese, Mandarin and Korean. These surveys were printed and distributed to participants at over 282 senior centers in New York City. Most participants completed the survey anonymously independently. In some cases, staff assisted participants in completing the surveys. No names or contact information was collected. Survey responses could not be matched with individual participants.

Study Sample

(i) The Senior Center Directors and Administrators: The sample comprised 155 senior center directors. This represented a 55.3% response rate.

- (a) An overwhelming majority of senior center directors are women (89.5%).
- (b) More than two-thirds of all directors are Caucasian (71.7%), followed by Latino/a (11.7%), African American (9.8%) and Asian American (5.9%). The sample was representative of the diversity of New York City, especially the senior center administrator pool.
- (c) Over half the respondents were Directors (53.6%), followed by Executive Directors (9.8%) and Program Managers (9.8%).
- (d) Over half the respondents (56.2%) had a college degree (Bachelors or Masters). An additional 9% had a post masters certification or a doctoral degree.
- (e) The area of study for the administrators was very diverse. The most common area of study for administrators was social work, followed by education, psychology and public administration.
- (f) Nearly one-fourth (26.8%) of administrators had been in their position for less than 3 years. But nearly one in 5 administrators (19%) had been in their position for more than 10 years.

(ii) The Senior Center Participants and Non-participants: The sample comprised of 3,663 older adults from the five boroughs of New York City. 3,249 senior center participants and 414 non-participants completed the survey in this study.

- (a) A majority of senior center participants are female. 23.2% of the respondents were male, while 57.6% - more than double were female.
- (b) 34.6% of the respondents were between the ages of 65-74. This was followed by 30% of respondents between the ages of 75 and 84, and 10% over the age of 85. With respect to younger respondents, 10.1% of the sample was between the ages of 60 and 64, while only 2.5% of the sample was between 55 and 60.
- (c) 35.9% of the respondents identified themselves as Caucasian/White, 16.7% identified as Hispanic, 16.6% identified as Asian/Pacific Islander and 13.2% identified as African American/Black.

(iii) Focus Groups: Nine (9) focus groups were held at various locations around New York City.

- (a) Four (4) focus groups were held with senior center participants (Caucasian, Asian, African American and Hispanic older adults respectively).
- (b) Three (3) focus groups were held with non-participants (Asian Indian, Hispanic and Caucasian older adults respectively)
- (c) One focus group was held with non participating gay, bisexual and lesbian older adults.
- (d) One focus group was held with senior center administrators and managers.

TABLES

SENIOR CENTER SURVEY FINDINGS
Senior Center Directors

I. TABLE OF PROGRAMS AND SERVICES

PROGRAMS	OFFER	POPULAR	SOMEWHAT POPULAR	NO INTEREST	WOULD OFFER IF AVAILABLE
RECREATIONAL					
Arts	87 / 56.9%	74 / 48.4%	9 / 5.9%	24 / 15.7%	15 / 9.9%
Therapeutic Arts	26 / 17%	21 / 13.7%	4 / 2.6%	42 / 27.5%	6 / 3.9%
Dancing	106 / 69.3%	97 / 63.4%	3 / 2.0%	22 / 14.4%	9 / 12.4%
Painting and/or Sculpture	63 / 41.2%	58 / 37.9%	5 / 3.3%	43 / 28.2%	7 / 4.6%
Knitting, Crocheting, Sewing	90 / 58.8%	69 / 45.1%	16 / 10.4%	18 / 11.8%	10 / 6.5%
Bingo	125 / 81.7%	112 / 73.2%	4 / 2.6%	3 / 2.0%	16 / 10.8%
Mah Jong	38 / 24.8%	25 / 16.3%	17 / 11.1%	13 / 8.5%	7 / 4.6%
Go	2 / 1.3%	2 / 1.3%	15 / 9.8%	9 / 5.9%	2 / 1.3%
Billiards	59 / 38.6%	49 / 31.4%	9 / 5.9%	14 / 9.2%	10 / 6.5%
Dominoes	74 / 48.4%	49 / 32%	21 / 15.8%	4 / 2.6%	15 / 9.8%
Cards	104 / 68%	80 / 52.3%	13 / 8.5%	1 / 0.7%	9 / 5.9%
Drama	32 / 30.9%	32 / 20.9%	12 / 7.9%	38 / 24.9%	4 / 2.6%
Choral Group	58 / 37.9%	52 / 34%	4 / 2.6%	33 / 21.6%	12 / 7.8%
Creative Writing	36 / 23.5%	22 / 14.4%	19 / 12.4%	26 / 17%	2 / 1.3%
Movies	113 / 73.9%	27 / 17.6%	13 / 8.5%	40 / 26.2%	6 / 3.9%
Foreign Language Classes	43 / 28.1%	27 / 17.6%	13 / 8.5%	40 / 26.2%	6 / 3.9%
Spa	3 / 2.0%	5 / 3.3%	3 / 2.0%	51 / 33.3%	1 / 0.7%
Beauty Parlor	28 / 18.3%	24 / 15.7%	3 / 2.0%	40 / 26.1%	6 / 3.9%
Fashion Show	25 / 16.3%	23 / 15%	5 / 3.3%	25 / 16.4%	4 / 2.6%
Storytelling	27 / 17.6%	20 / 13.1%	14 / 9.2%	25 / 16.4%	4 / 2.6%
Gardening	32 / 20.9%	21 / 13.7%	12 / 7.9%	34 / 22.2%	1 / 0.7%
Chinese Chess	15 / 9.8%	7 / 4.6%	22 / 14.4%	6 / 4.0%	2 / 1.3%
Cultural Events	104 / 68%	82 / 53.6%	9 / 5.9%	12 / 7.8%	21 / 13.7%
Trips	126 / 82.4%	113 / 73.95	1 / 0.7%	12 / 7.9%	15 / 9.8%
Book Club	36 / 23.5%	22 / 14.4%	16 / 10.5%	25 / 16.3%	2 / 1.3%
Piano Lessons	12 / 7.8%	8 / 5.2%	9 / 5.9%	4.0 / 26.2%	2 / 1.3%
Poetry Club	30 / 19.6%	21 / 13.7%	21 / 13.8%	26 / 17.1%	5 / 3.3%
Parties	126 / 82.4%	110 / 71.9%	1 / 0.7%	5 / 3.3%	17 / 11.1%
Bowling	26 / 17%	22 / 14.4%	6 / 4.0%	33 / 21.6%	2 / 1.3%
Discussion Groups	91 / 59.5%	74 / 48.4 %	10 / 6.6%	8 / 5.2%	13 / 8.5%
Intergenerational Programs	74 / 48.4%	51 / 33.3%	9 / 5.9%	19 / 12.5%	8 / 5.2%
Box Office	14 / 9.2%	11 / 7.2%	7 / 4.6%	30 / 19.7%	2 / 1.3%
Radio Station	4 / 2.6%	4 / 2.6%	11 / 7.2%	25 / 16.4%	1 / 0.7%

PROGRAMS	OFFER	POPULAR	SOMEWHAT POPULAR	NO INTEREST	WOULD OFFER IF AVAILABLE
Programs for Blind Seniors	12 / 7.8%	8 / 5.2%	11 / 7.2%	29 / 19%	_____
Programs for Deaf Seniors	7 / 4.6%	3 / 2.0 %	11 / 7.2%	31 / 20.3%	_____
HEALTH & FITNESS					
Evidence Based Health Programs	59 / 38.6%	42 / 27.5%	5 / 3.3%	24 / 15.8%	8 / 5.2%
Health Screening	93 / 60.8%	69 / 45.1%	6 / 4.0%	11 / 7.2 %	16 / 10.5%
Blood Pressure Screening	121 / 79.1%	98 / 64.1%	2 / 1.4%	9 / 5.9%	17 / 11.1%
Cancer Screening	19 / 12.4%	9 / 5.9%	10 / 6.6%	42 / 37.5%	2 / 1.3%
Annual Mammography	26 / 17%	21 / 13.7%	7 / 0.6%	42 / 27.5%	2 / 1.3%
Vision Testing	41 / 26.8%	30 / 19.6%	6 / 3.9%	43 / 28.2%	8 / 5.2%
Hearing Testing	39 / 25.5%	28 / 18.3%	5 / 3.3%	45 / 29.5%	6 / 3.0%
Alzheimer's Programs	40 / 26.2%	31 / 20.3%	7 / 4.6%	28 / 18.3%	6 / 3.9%
Nutrition Education	132 / 86.3%	93 / 60.8%	17 / 11.1%		20 / 13.1%
Health Fairs	64 / 41.8%	43 / 28.1%	5 / 3.3%	17 / 1.2%	7 / 4.6%
Programs with local Medical Providers	87 / 56.9%		5 / 3.3%	19 / 12.5%	15 / 9.8%
AA Meetings	9 / 5.9%	6 / 3.9%	14 / 9.1%	29 / 19%	
Weightwatchers	11 / 7.2%	2 / 1.3%	7 / 4.6%	49 / 32.1%	2 / 1.3%
Yoga	89 / 58.2%	76 / 49.7%	10 / 6.5%	24 / 15.7%	6 / 3.9%
Tai-Chi	88 / 57.5%	73 / 47.7%	10 / 6.5%	22 / 14.4%	16 / 10.5%
Walking Club	99 / 64.7%	67 / 43.85	25 / 16.3%	2 / 1.3%	9 / 5.9%
Aerobics	64 / 41.8%	49 / 32%	11 / 7.2%	24 / 15.7%	8 / 5.2%
Massage Therapy	16 / 10.5%	13 / 8.5%	4 / 2.6%	51 / 33.3%	2 / 1.3%
Tennis	5 / 3.3%	5 / 3.3%	14 / 9.1%	22 / 15.1%	1 / .7%
Weight Training	9 / 5.9%	8 / 5.2%	6 / 3.9%	14 / 9.25	1 / .7%
SOCIAL SERVICES					
Case assistance	115 / 75.2%	91 / 59.5%	5 / 3.3%	10 / 6.5%	24 / 15.7%
Transportation	66 / 43.1%	57 / 37.3%	3 / 2.0%	34 / 22.3%	2 / 1.3%
Escort for chores	20 / 13.1%	15 / 9.8%	6 / 3.9%	41 / 26.8%	5 / 3.3%
Assistance to immigrants	45 / 29.4%	20 / 13.1%	10 / 6.6%	32 / 20.9%	12 / 7.8%
Counseling	53 / 34.6%	33 / 21.6%	6 / 3.9%	23 / 15%	5 / 3.3%
Support Groups	50 / 32.7%	41 / 26.8 %	8 / 5.3%	21 / 13.7%	7 / 4.6%
Telephone Reassurance	66 / 43.1%	43 / 28.1%	5 / 3.3%	16 / 10.5%	7 / 4.6%
Friendly Visiting		25 / 16.3%	7 / 4.6%	30 / 19.7%	4 / 2.6%
Food Pantry	34 / 22.2%	25 / 16.3%	3 / 2.0%	32 / 21%	3 / 2.0%
Caregiver Services	29 / 19%	21 / 13.7%	7 / 4.7%	28 / 18.3%	4 / 2.6%
Legal Services	37 / 24.2%	28 / 18.3%	5 / 3.3%	32 / 21%	4 / 2.6%
Housing Assistance	65 / 42.5%	41 / 26.8%	5 / 3.3%	21 / 13.8%	13 / 8.5%
Tax Assistance	52 / 34%	42 / 27.5%	4 / 2.6%	29 / 19%	7 / 4.6%
EDUCATION &					

PROGRAMS	OFFER	POPULAR	SOMEWHAT POPULAR	NO INTEREST	WOULD OFFER IF AVAILABLE
OTHER					
HIV/Sexuality Education	53/34.6%	25 / 16.3%	23 / 15%	23 / 15%	5 / 3.3%
HIV Testing	14 / 9.2%	3 / 2.0%	16 / 10.4%	21 / 13.7%	
Educational classes	65 / 42.5	48 / 31.4%	8 / 5.2%	20 / 13.1%	11 / 7.2%
Computer Classes	84 / 54.9%	72 / 47.1%	6 / 4%	29 / 19.0%	10 / 6.5%
ESL/Citizenship classes	43 / 28.1%		6 / 3.9%	29 / 19%	13 / 8.5%
College-level Courses	4 / 2.6%	3 / 2.0%	11 / 7.2%	40 / 26.25	1 / .7%
Volunteer Opportunities	110 / 71.9%	81 / 52.9%	9 / 5.9%	7 / 4.6%	15 / 9.8%
Advocacy/Social Action	73 / 47.7%	52 / 34%	10 / 6.6%	7 / 4.6%	33 / 21.6%

II. LANGUAGES SPOKEN AT SENIOR CENTERS (OTHER THAN ENGLISH)

LANGUAGES SPOKEN	FREQUENCY
Albanian	1
Arabic	2
Cantonese	8
Creole	4
Chinese	41
DFGSOG	1
Farsee	1
French	14
German	1
Greek	5
Gujarathi	1
Hebrew	8
Hindi	5
Italian	13
Korean	9
Mandarin	9
Portuguese	1
Polish	20
Punjabi	1

Romanian	1
Russian	34
Serbo-Croatian	1
Spanish	117
Telugu	1
Tagalog	8
Yiddish	9

III. MOST MAJOR CHALLENGE FACED BY SENIOR CENTERS

MOST MAJOR CHALLENGE	RESPONDENTS
Attendance	2
Attracting younger senior population	1
Budget concerns	55
Center does not have transportation	1
Closing centers	1
Cut off from the homebound	1
Funding for food	4
Funding for programming	3
Growing poverty among participants	1
Have members participate in more exercise classes	1
Inadequate facility	1
Inadequate space	10
Lack of staff	5
Need for physical improvements	5
Low lunch attendance	1
Maintaining site location	1
Meet increasing demand	1
Mental Illness	1
Mixing ages together	2
Need for more congregate meals because of over utilization	1
Neighborhood	1
Nutrition awareness	1

Providing adequate activities with a limited budget	1
Reading request number for lunch program	1
Resources to market center	2
Retention of members	1
Seniors not engaged	2
Seniors increasingly frail	1
Shortage of food pantry	2
Site safety problems	1
Staff issues	1
Staying with in the budget	1
Increase utilization (meals(3
Too many steps for seniors	1
Transportation	3
Not considered a traditional senior center	1

IV. SECOND MOST MAJOR CHALLENGE FACED BY SENIOR CENTERS

SECOND MOST MAJOR CHALLENGE	NUMBER OF RESPONDENTS
Accommodating large number in a small space	3
Acquiring new members	8
Adequate staffing and training	11
Aging facility	3
Better/more activities	4
Budget cuts to food	3
Budget cuts with increased services	1
Cannot offer Alzheimer's program due to budget cuts	1
Census	1
No case assistance	1
Competing with other organizations	1
Consultants	1
Counseling services	1
Dealing with dementia	1
Demographics of the community	1
Equipment	2
Funding	16
Generating interest	2
Getting driver for van	1
Getting Hispanic community involved	1

Having to rely on volunteers	1
Hiring a Chinese social worker	1
Increased costs	1
Increased demand for middle income seniors	1
Insufficient hours for casework	1
Lack of funding due to over utilization of meals	1
Lack of professional instructors	1
Lack of updated kitchen	2
Language appropriate program	1
Limited control	1
Limited resources	1
Loss of facility	1
Lunch issues	1
Maintaining member diversity	1
Maintaining building	2
Mayoral cuts	1
Meeting contracted units when neighborhood and center changes	1
Need for more casework staff	1
New chairs	1
Not enough senior volunteers	1
Racism	1
Rent costs	1

V. MEAL PROGRAMS

BREAKFAST

BREAKFAST	NUMBER	PERCENTAGE
Serve breakfast	36	23.5
Do not serve breakfast	117	76.5

B. LUNCH PROGRAMS

LUNCH	NUMBER	PERCENTAGE
Serve lunch	117	76.5
Did not answer	36	23.5

C. DINNER PROGRAMS

DINNER	NUMBER	PERCENTAGE
Provide dinner	4	2.6
Do not provide dinner	149	97.4

D. WEEKEND MEALS

WEEKEND MEALS	NUMBER	PERCENTAGE
Serve weekend meals	22	14.4

Do not serve weekend meals	131	85.6
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E. THE DEMAND FOR MEAL PROGRAMS

DEMAND	NUMBER	PERCENTAGE
Oversubscribed	32	20.9
Undersubscribed	36	23.5
Neither	43	28.1
Underserving on acquired contract	1	0.7
Depends on time of year	1	0.7
Did not answer	40	26.1

VI. WHAT WOULD DIRECTORS DO WITH ADDITIONAL FUNDING?

WHAT WOULD DIRECTORS DO WITH ADDITIONAL FUNDING?	RESPONDENTS
Activities (includes more staffing)	155
Capital Improvements	88
Health promotion	26
Food (includes more meals and better food choices)	69
More hours	6
Operating Costs	6
Transportation	24

VII. SENIOR CENTER DIRECTORS

The sample was representative of the diversity of New York City, especially the senior center administrator pool.

- An overwhelming majority of senior center directors are women (89.5%).
- More than two-thirds of all directors are Caucasian (71.7%), followed by Latino/a (11.7%), African American (9.8%) and Asian American (5.9%). The sample was representative of the diversity of New York City, especially the senior center administrator pool.
- Over half the respondents were Directors (53.6%), followed by Executive Directors (9.8%) and Program Managers (9.8%).
- Over half the respondents (56.2%) had a college degree (Bachelors or Masters). An additional 9% had a post masters certification or a doctoral degree.

- The area of study for the administrators was very diverse. The most common area of study for administrators was social work, followed by education, psychology and public administration.
- Nearly one-fourth (26.8%) of administrators had been in their position for less than 3 years. But nearly one in 5 administrators (19%) had been in their position for more than 10 years.

GENDER

GENDER	NUMBER	PERCENT
Male	16	10.5
Female	137	89.5

RACE/ETHNICITY

RACE/ETHNICITY	NUMBER	PERCENT
Caucasian/White	110	71.9
African American/Black	15	9.8
Latino/Latina	18	11.7
Asian American/Pacific Islander	9	5.9
Other	1	0.7

TITLE OF RESPONDENT

TITLE ON JOB	NUMBER	PERCENT
Executive Director	15	9.8
Director	82	53.6
Assistant/Associate Director	3	1.9
Board Member	1	0.6
Coordinator	2	1.3
Program Manager	15	9.8
Did not answer	35	22.9

HIGHEST DEGREE EARNED

HIGHEST DEGREE	NUMBER	PERCENT
High School	7	4.6
Associate	1	0.7
Bachelors	36	23.5
Masters	50	32.7
Post Masters	9	6.0
PhD	6	3.9
Did not answer	44	28.6

AREA OF STUDY

AREA OF STUDY	RESPONDENTS
Art	3
Associate Degree	2
Associate in Business	4
Culinary Arts	1
BA (Bachelor of Arts)	3
BS (Bachelor of Science)	2
BSW (Bachelor of Social Work)	1
Business Administration	2
Drafting Engineer	1
Drama	1
Early Childhood	3
Economics	1
Education	2
Fine Art Graphic Design	1
Government	2
Human Services	3
JD (Juris Doctor)	1
LMSW (Licensed Masters of Social Work)	14
MA Nursing Theory and Education	1
MD (Medical Doctor)	1
MS Adult Learning and development	1
MA (Masters)	2
MA in Psychology (post masters in Gerontology)	1
MA in Urban Profession (specialty Gerontology)	2
MA in Public Administration	5
Medical Technologist	1
MPH (Masters in Public Health)	1
MS in Recreation Education/Administration	1
MSW and MS in Dance Therapy	1

Musicology	1
PHD (Doctor of Philosophy)	2
Physics	1
Psychology	4
Social Science-Urban Studies Ind. Engineer	1
Social Work	14
Social Work Administration	1
Sociology	4
Sociology and Social Work	1

SENIOR CENTER PARTICIPATION SURVEY – FINDINGS

I. PROGRAMS OF INTEREST

PROGRAMS	ATTEND	NO INTEREST	WOULD ATTEND IF AVAILABLE
RECREATIONAL			
Arts	29.7%	14.7%	7.9%
Therapeutic Arts	75.3%	16.4%	8.2%
Dancing	39.9%	12.9%	7.4%
Painting and/or Sculpture	17.9%	17.8%	9.0%
Knitting, Crocheting, Sewing	19.8%	18.7%	7.8%
Bingo	39.1%	14.3%	4.1%
Mah Jong	12.9%	22.0%	5.0%
Go	6.0%	19.7%	4.1%
Billiards	13.1%	23.2%	5.7%
Dominoes	15.1%	21.6%	5.1%
Cards	24.4%	16.3%	6.1%
Drama	11.6%	18.5%	8.5%
Choral Group	16.2%	18.6%	8.1%
Creative Writing	10.7%	18.1%	9.0%
Movies	38.0%	8.9%	8.7%
Foreign Language Classes	13.0%	16.5%	13.8%
Spa	6.2%	16.0%	15.1%
Beauty Parlor	9.6%	17.6%	12.5%
Fashion Show	10.9%	17.4%	11.7%
Storytelling	9.4%	17.7%	9.3%
Gardening	9.7%	18.2%	11.4%
Chinese Chess	6.5%	22.2%	5.9%
Cultural Events	22.6%	10.0%	12.1%
Trips	44.0%	6.1%	11.5%
Book Club	13.3%	15.4%	10.9%
Piano Lessons	6.3%	20.0%	12.2%
Poetry Writing	7.8%	20.1%	7.9%
Parties	39.8%	7.5%	6.7%
Bowling	11.0%	16.5%	11.8%
Discussion Groups	23.0%	11.8%	10.2%
Intergenerational Programs	11.6%	15.5%	9.1%
Box Office	7.6%	17.7%	8.9%
Radio Station	7.8%	17.9%	9.0%
Programs for Blind Seniors	4.8%	21.8%	6.6%
Programs for Deaf Seniors	5.1%	21.0%	6.7%

PROGRAMS	ATTEND	NO INTEREST	WOULD ATTEND IF AVAILABLE
HEALTH & FITNESS			
Evidence Based Health Programs	20.1%	9.7%	10.6%
Health Screening	28.0%	8.0%	10.9%
Blood Pressure Screening	44.1%	6.6%	8.8%
Cancer Screening	16.8%	10.3%	14.1%
Annual Mammography	19.7%	12.0%	12.1%
Vision Testing	24.0%	8.9%	16.9%
Hearing Testing	21.5%	9.1%	6.8%
Alzheimer's Programs	13.5%	13.9%	12.5%
Health Education Seminars	26.9%	8.7%	14.4%
Health Fairs	27.1%	8.6%	14.6%
Nutrition Education	31.4%	6.2%	11.0%
Programs with local Medical Providers	25.3%	10.3%	10.9%
Cognitive Strengthening (like memory exercises, puzzles, etc.)	13.5%	13.0%	12.3%
AA Meetings	6.6%	23.9%	4.7%
Weightwatchers	10.4%	17.2%	12.1%
Exercise Classes	43.6%	8.8%	9.7%
Yoga	24.4%	14.0%	9.0%
Tai-Chi	24.7%	13.4%	9.3%
Walking Club	25.0%	13.1%	8.9%
Aerobics	17.1%	15.0%	9.4%
Massage Therapy	12.2%	13.4%	18.1%
Tennis	6.0%	20.8%	9.3%
Personal Training	8.3%	17.0%	12.6%
Swimming	10.3%	16.3%	14.6%
SOCIAL SERVICES			
Case assistance	19.3%	13.3%	6.7%
Transportation	16.2%	15.7%	8.2%
Escort for chores	7.9%	18.7%	7.5%
Computer Classes	21.2%	13.6%	13.7%
Assistance to immigrants	7.2%	21.5%	6.7%
Counseling	13.0%	16.8%	8.3%
Support Groups	12.2%	15.8%	8.9%
Telephone Reassurance	9.4%	18.4%	6.7%
Friendly Visiting	14.2%	16.8%	8.4%
Food Pantry	15.9%	14.9%	9.6%
Caregiver Services	10.1%	17.6%	7.9%
Legal Services	13.0%	14.5%	12.1%

PROGRAMS	ATTEND	NO INTEREST	WOULD ATTEND IF AVAILABLE
Housing Assistance	13.9%	16.2%	9.7%
Tax Assistance	13.2%	15.9%	8.9%
EDUCATION & OTHER			
HIV/Sexuality Education	7.5%	22.1%	5.8%
HIV Testing	5.9%	22.9%	5.8%
Educational classes	13.7%	14.9%	10.7%
ESL/Citizenship classes	8.7%	21.7%	5.7%
College-level Courses	7.2%	18.2%	12.8%
Volunteer Opportunities	18.0%	15.0%	10.7%
Advocacy/Social Action	13.1%	15.8%	10.3%

IIA. DO YOU ATTEND A SENIOR CENTER?

	FREQUENCY	PERCENT
Did not answer	50	1.4
No	400	10.9
Yes	3213	87.7
Total	3663	100.0

IIB. HOW OFTEN DO YOU ATTEND?

	FREQUENCY	PERCENT
Did not answer	554	15.1
2 or 3 times a week	1353	36.9
4 times a year	1	.0
Daily	1365	37.3
Once a month	112	3.1
Once a week	278	7.6
Total	3663	100.0

IIC. FLUENT IN LANGUAGES OTHER THAN ENGLISH?

	FREQUENCY	PERCENT
Did not answer	227	6.2
No	1751	47.8
Yes	1685	46.0
Total	3663	100.0

NAME OF LANGUAGE	NUMBER OF RESPONDENTS
Albanian	1
Amharic	1
Arabic	3
Armenian	2
Bengali	2
Cantonese	55
Castellano	2
Chinese	430
Croatian	1
Czech	1
Danish	1
Dutch	4
English	9
Farsi	1
Filipino	10
French	52
Fu-Zhou	2
German	50
Greek	14
Hebrew	9
Hindi	13
Hungarian	8
Irish	1
Italian	42
Japanese	7
Korean	10
Lithuanian	1
Malayalam	1
Maltese	1
Mandarin	37
Myanmar	2
Oromo	1
Polish	32
Punjabi	2
Roman	1

Romanian	7
Russian	8
Sign Language	1
Slovak	3
Spanish	517
Swedish	1
Tagalog	9
Taiwanese	11
Tamil	1
Telugu	2
Tibetan	1
Turkish	11
Ukrainian	2
Vietnamese	2
Yiddish	56
Vlach	1

IID. WOULD YOU LIKE TO SEE PROGRAMS IN OTHER LANGUAGES?

	FREQUENCY	PERCENT
Did not answer	434	11.8
No	1647	45.0
Yes	1582	43.2
Total	3663	100.0

IIE. Do you have a condition, disability or circumstance that makes it difficult for you to participate in a senior center?

	FREQUENCY	PERCENT
Did not answer	308	8.4
No	2888	78.8
Yes	467	12.7
Total	3663	100.0

Please describe the nature of your disability:

	FREQUENCY	PERCENT
Age-Birthday Jan	1	.0
Always Busy	1	.0
Arthritis	1	.0
Arthritis - diff	1	.0
Arthritis, cane	1	.0
Asthma, High blo	1	.0
Bad eyesight	1	.0
Balance problem	1	.0
Bipolar disorder	1	.0
Blind	2	.1
But I come anyway	1	.0
Can't walk too well	1	.0
Can't walk, have	1	.0
Can not walk up stairs	1	.0
Diabetes	1	.0
Diabetes, leg	1	.0
Difficulty walking	1	.0
Epilepsy	1	.0
Facing eviction	1	.0
Had a stroke	1	.0
Hard of hearing	1	.0
Hard of hearing.	1	.0
hard to breathe	1	.0
have MS	1	.0
Hearing disabled	1	.0
Hearing loss	1	.0
I attend a school	1	.0
I currently have	1	.0
I do very much a	1	.0
I have CUPD	1	.0
I have high blood pressure	1	.0
I have Parkinson	1	.0
I love the center	1	.0
I need transport	1	.0

	FREQUENCY	PERCENT
I use a cane for	1	.0
Lack of time	1	.0
leg pain, right	1	.0
Legally blind	2	.1
M.S. in wheelchair	1	.0
My eye-sight	1	.0
Need cane	2	.1
No Interest	1	.0
Parking	1	.0
Parkinson's Dies	1	.0
Severe hearing l	1	.0
shoulder pain an	1	.0
sight and other	1	.0
Spinal Stinosis	1	.0
Still trying to	1	.0
Too Old	1	.0
Transportation	1	.0
Trouble walking	1	.0
Unable to participate	1	.0
use a walker	1	.0
Walk -cane	1	.0
Weak back	1	.0
Weak back I am 9	1	.0
Total	3663	100.0

III. BARRIERS TO PARTICIPATION

BARRIERS	FREQUENCY	PERCENT
Lack of overall interest	116	29%
Lack of adequate transportation	34	8.5%
Inability to access services	24	6%
Lack of need	86	21.5%
Senior Centers are not for you	73	18.25%
Lack of programs you need	1	.25%
Lack of programs of interest	73	18.25%
Barriers of language	30	7.5%
Lack of culturally specific programs	32	8%
Quality of facilities	33	8.25%

Responsiveness of staff	12	3%
Level of knowledge and skills of staff	18	4.5%

IV. OVERALL SAMPLE

Gender of Respondents

GENDER	FREQUENCY	PERCENT
Did not answer	702	19.2
Female	2110	57.6
Male	851	23.2
Total	3663	100.0

Age of Respondents

AGE	FREQUENCY	PERCENT
	468	12.8
60-64	370	10.1
65-74	1269	34.6
75-84	1098	30.0
Over 85	367	10.0
Under 60	91	2.5
Total	3663	100.0

Race of Respondents

RACE	FREQUENCY	PERCENT
Did not answer	605	16.5
African American/Black	483	13.2
Asian American	609	16.6
Caucasian/White	1316	35.9
Hispanic	613	16.7
Other	37	1.0
Total	3663	100.0

V. REASON FOR NON PARTICIPATION

REASON FOR NON-PARTICIPATION	NUMBER OF RESPONDENTS
Aging Issues	23
Medical Issues	19
Social Issues	10
Facility Issues	1
Psychiatric Issues	1

LITERATURE REVIEW

LITERATURE REVIEW

Significance of Senior Centers

The population of Americans aged 65 and over is rapidly expanding and is expected to double to 70 million by 2030 (AARP, 2002). With the exponential growth in the senior population, senior centers have gained a prominent role in the provision of services for older adults. According to the Administration on Aging (2000), senior centers are community focal points and are “both the first and the foremost, source of vital community-based social and nutrition supports that help older Americans remain independent in their communities”(p. 1). Senior centers are supposed to play a significant role in community-based services for older adults by providing opportunities for recreation, socialization, volunteer development, information and referral, advocacy, education, outreach, nutrition and health promotion (Aday, 2003; AoA, 2000; Harris & Associates, 1975; Krout, 1982, 1988, 1994, 1998; Strain, 2001). Senior centers are believed to be an integral component of the continuum of long term care, allowing older adults to retain their independence and self-reliance for the longest extent possible (AoA, 2000; Krout, 1998; Leanse & Wagener, 2975; Leest, 1995). The National Institute of Senior Centers (2008) reports that there are currently 11,000 senior centers serving older adults in the US. Krout (1998) and NISC (2005) estimate that nearly 4-5 million senior citizens utilize a senior center program or service annually. However, this estimate is misleading as it refers to all adults who may have made contact with a senior center and does not take into account whether they actually participated in the programs and services offered. Nationally, most senior centers have reported declining participation and attendance rates, thereby threatening their continued survival (Aday, 2003; Gross, 2008; Ryzin, 2005; Turner, 2004).

Senior Centers: The Evolution

Since the opening of the first senior center, the William Hodson Senior Center, in 1943, senior centers have expanded, diversified and evolved significantly in terms of programs and services (AoA, 2000; Krout, 1998; Leest, 1995). The numerical growth of senior centers in the last few decades is matched by a growth in the number and diversity of programs and services offered by senior centers (Pardasani, 2004b; Strain, 2001). Programming has evolved in relation to changing needs and user characteristics (Calsyn & Winter, 1999; Demko, 1979; Harris & Associates, 1975; Lun, 2004; Mitchell, 1995; Miller et al., 1996; Netzer et al., 1997; Ralston 1982, 1983, 1984, 1991; Tuckman, 1967). However, the programs and services do not seem to meet the needs of the diverse older adult population of the twenty-first century (Krout, 1998, Young, 2006). Senior centers, depending on their size, budget and programmatic focus, may range in design from recreational clubs or nutrition sites, to traditional community-based senior centers and large, multipurpose senior centers (Krout, 1985; Leanse & Wagener, 1975; Ralston, 1983; Taietz, 1976). The five most common categories of senior center programs are nutrition, health and fitness, recreational, volunteer opportunities and social services (Aday, 2003; Gavin & Meyers, 2003; Gelfand, Bechil and Chester, 1992; Krout, 1985; Leanse & Wagener, 1975; Pardasani, 2004b; Skarupski & Pelkowski, 2003).

Characteristics of Senior Center Participants

Senior center administrators are concerned that their participant pool is aging and that the “younger” seniors are not utilizing their services (Aday, 2003; Krout, 1998, Turner,

2004; Walker, Bisbee, Porter & Flounders, 2004). As participation rates fall, so does the fiscal reimbursement from funders. Regular attendees of senior center tend to be single or widowed, older women with medium to low incomes and minimal physical disabilities (Calsyn, Burger & Roades, 1996; Calsyn & Winter, 1999, Krout, Cutler & Howard, 1990; Pardasani, 2004a; Turner, 2004). Researchers have found that men, married couples, and individuals with a higher level of education and income, are less inclined to participate in senior center activities (DFTA, 2002; Eaton & Salari, 2005; Krout, 1982; Ralston & Griggs, 1985; Turner, 2004). Younger seniors with a higher level of education and income were found to be less inclined to participate in senior center activities (Carey, 2004; Eaton & Salari, 2005; Krout, 1982; Turner, 2004). A study of Canadian senior center participants reported that senior center participants were most likely to be older, rural-based, female, living alone and have fewer limitations with their activities of daily living (Strain, 2001). A DFTA (New York City Department for the Aging) study revealed that the average senior center participant is 77 years old, more likely to be female, born in the U.S., English speaking, and to have completed high school. In addition, a majority of the participants were relatively healthy, widowed, and lived alone, although they were socially active within their communities (DFTA, 2002).

Studies regarding differences in utilization patterns between minority and non-minority elderly have been inconclusive. Some researchers have found that race was not a significant predictor of participation (Calsyn & Winter, 1999; Demko, 1979; Lun, 2004; Miller et al., 1996; Tuckman, 1967). Other studies have revealed that race does influence patterns of participation among older adults, and that minorities are generally less likely to participate in or utilize senior centers (Harris & Associates, 1975; Mitchell, 1995; Netzer et al., 1997; Ralston 1982, 1983, 1984, 1991).

Rationale for Participation

Reasons offered generally for participation center around the theme of social interaction and companionship, whereby an increase in participation is linked to a greater need for companionship and enhanced quality of programs (Eaton & Salari, 2005; Krout, 1988; Pardasani, 2004; Turner, 2004; Walker, Bisbee, Porter & Flanders, 2004). Decreased involvement was found to be linked to health problems and lack of transportation to sites (Aday, 2003; DFTA, 2002; Pardasani, 2004; Strain, 2001; Walker, Bisbee, Porter & Flanders, 2004). Two common reasons given for the lack of involvement were “being too busy” and “lack of interest” (Krout, 1982; Pardasani, 2004; Turner, 2004). Other reasons for lack of participation have been found to be directly impacted by variables such as gender, income, marital status and contact with friends, specifically, men, older adults with higher levels of income and education, and those with an extensive social circle were least likely to participate (Krout 1988; Lun, 2004; Walker, Bisbee, Porter & Flanders, 2004). Duration of attendance was found to be dependent on health, age, income levels, age of other participants and the diversity of programming (Gavin & Meyers, 2003; Turner, 2004). Pardasani (2004c) found that participation was significantly related to both the type of senior center and programs offered, whereby greater participation was positively correlated with greater availability and diversity of programs (mainly provided at multi-purpose senior centers).

Benefits of Participation

The notion that activity is related to well-being has a long history (Menec, 2003). Rowe and Kahn (1997) and Fry (1992) identified social activity or engagement as an essential component of “successful aging”. Engaging in social activities has been associated with enhanced well-being among community-dwelling older adults (Everard, 2000; Lemon et al., 1972), an increase in physical function and a slower decline in functional status (Ungar, Johnson & Marks, 1997), and reduced mortality among older adults (Everard et al., 2000; Penninx et al., 1997). Indulgence in leisure activities, especially those that involve interpersonal interactions, has been shown to increase social support (Berkman & Syme, 1979; House, Robins & Metzner, 1982), happiness and life satisfaction (Everard, et al., 2000; Lemon et al., 1972) and subjective well-being (Okun et al., 1984).

Some studies have found that senior center participants have better psychological well-being across several measures than non-participants, including depressive symptoms (Choi & McDougall, 2007), friendship formations and associated well-being (Aday, Kehoe, and Farney, 2006), and stress levels (Farone, Fitzpatrick and Tran, 2005, Maton, 1989). Skarupski and Pelkowski (2003) found that structured health and nursing programs offered at senior centers increased social support and improved diet and nutrition among participants. Participants in this study also reported a perception of better general health and greater commitment to healthy lifestyles (p. 132). Seong (2003) found that self-esteem, social support and stress significantly affected leisure activity. Maton (2002) found that senior center participation contributed to a heightened perception of general well-being, but no direct benefit of participation was evaluated. Eaton and Salari (2005) reported that senior center programs provide volunteer opportunities that empower older adults. Meis (2005) and Carey (2004) found that senior centers members felt less isolated and experienced a greater level of social support than their non-participating counterparts. Fitzpatrick, et al (2005) identified increased social support as key to better health and greater life satisfaction. However, all four studies cited were cross-sectional studies and thus, it is not clear whether the participants’ level of social support increased as result of their participation in senior center activities, and consequently, if their enhanced health and level of life satisfaction was correlated to their participation.

Senior Centers and Health

Health and wellness programs are at the core of many large, multi-purpose senior centers (Beisgen and Kraitchman, 2003; Pardasani & Tjhomson, 2008; Ryzin, 2005). A recent nationwide study of emerging senior center models highlighted the “health and wellness” model as a popular and critical trend (Pardasani, Sporre & Thompson, 2008). Most studies of health promotion in senior centers have focused prevention of falls and minimization of injury risks among older adults (Baker, Gottschalk & Bianco, 2007; Reinsch, MacRae, Lachenbruch & Tobis, 1992; Li et al, 2008). Other studies have evaluated the impact of specific health programs on seniors’ physical activity and functioning, including Tai Chi (Li, et al., 2008), physical activity and exercise (Fitzpatrick, et al., 2008), falls and injury prevention (Reinsch, MacRae, Lachenbruch and Tobis, 1992), walking (Sarkisian, Prohaska, Davis and Weiner, 2007), resistance training (Manini, et al., 2007), and line dancing (Hayes, 2006), increasing healthy eating habits (Hendrix, 2008a) and diabetes self-management (Hendrix, 2008b). All these studies used pre and intervention assessment models and posited improvement in such health related outcome measures as walking speed, chair stands, physical function, step counts, consumption of fruits and vegetables, pain

levels, and sleep quality. Despite their presumed need, very few studies have evaluated senior center programs aimed at improving the mental or cognitive health of participants (Choi and McDougall, 2007; Persky, Taylor and Simson, 1989)

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212-398-6565
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