



Examples of Problem Statements from Actual Proposals

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Example #1

Foundation: Grossmont Health Care District

Grant seeker: ElderHelp

Grant request: \$75,000

Project summary: To fund the ElderHelp Concierge Club to combine high quality care management services with in-home volunteer services and use an innovative fee-based system – membership program that delivers the support systems seniors need at a price they can afford – that will support ElderHelp to both serve more seniors and better sustain the program over time.

Problem Statement / Needs Assessment

There is a tremendous need for coordinated and accessible home-based services for seniors in the Grossmont Healthcare District. According to the *San Diego County Survey of Older Americans* completed by the County's Aging and Independent Services in December of 2008, the eastern areas of the county have some of the highest populations of seniors in the county with the highest in La Mesa (21%). ElderHelp has identified additional census tracts within the communities of San Carlos, La Mesa, Lemon Grove, Spring Valley, Santee, Lakeside and El Cajon where 35% of the population is over the age of 65. According to the 2000 Census, within these areas there are 10,221 seniors who are over the age of 65 living on their own. Many are female living on less than \$16,000 per year.

As the economy continues to decline and the state cuts services for seniors, the need for more cost effective and coordinated community-based solutions deepens throughout the region and in the Grossmont Healthcare District area.

- According to Aging and Independent Services, 20% of seniors have serious concerns about finding affordable homecare services.
- Of the seniors surveyed, 35% lived alone and nearly 40% felt they did not have enough money to live on.
- Activities seniors rated as difficult or unable to complete included housework, shopping, preparing meals and accessing transportation.
- These services are not just inaccessible but they are also expensive. According to the UCLA Centers for Health, seniors in San Diego will pay on average \$519 per month (\$6,228 annually) for just six hours of services and phone support from a case manager.
- These services seem to be especially out of reach for single women.
- Alternatively, seniors and their families may turn to the newspaper or Internet and hire someone without a background check, which can be dangerous and leave seniors susceptible to elder abuse.



Healthcare issues and chronic disease also compound these struggles. As people age they become more susceptible to chronic disease which is the major cause of death among older adults.

- The top three causes of death for U.S. adults aged 65 or older are heart disease (32% of all deaths), cancer (22%), and stroke (8%).
- These reasons account for 62% of all deaths of older adults.
- In San Diego, 72 % of local seniors receive flu shots annually and 61% are vaccinated for pneumonia, both falling below the “Healthy People” benchmarks.
- According to the *San Diego Senior Health Report* released in May of this year, nearly 21% of San Diego County seniors have heart disease, 31% have had cancer, 15% have been diabetic and more than 50% are overweight.

Chronic disease in older adults can lead to limitations in daily activities, reduce health-related quality of life for seniors and increase the use of emergency healthcare and hospitalizations. Chronic disease can cause disabilities that result in falls and injuries and also contribute to debilitating pain and depression. Certainly there are many health options for seniors in East County, but they are for those seniors who are mobile and able to get places on their own without aid or assistance.

The Concierge Club is an innovative model that addresses these growing health and human challenges that seniors and their families are facing. There are currently no coordinated in home options for seniors that are affordable and community-based. ElderHelp plans to grow the Concierge Club from its current membership and expand its services within the Grossmont Healthcare District.



Example #2

Funder: Fed Government - Department of Health and Human Services

Submitted by: Family Service Association of Western Riverside County (FSA)

(Grant amount not included)

Project Summary: To fund a new program entitled – “No HIV for Me” that will provide realistic, gender-specific prevention education services focused on the intersection between juvenile delinquency and STD/HIV infection for female adolescents. The program will specifically target young women ages 9-17 who are deemed at risk for juvenile delinquency and will provide a gender specific approach that is focused on HIV/AIDS awareness, prevention and support services in a collaborative manner.

Problem Statement: The risk factors and co-occurring issues for girls who are identified as at-risk for juvenile delinquent and/or sexually risky behavior.

Let’s face it, teens are having sex. In high schools across the U.S., nearly one-half (47 percent) of students state they are having sexual intercourse. The average teenager feels invincible and has little fear of becoming HIV+. Most believe that HIV only happens to other people. However, teens and young adults make up the largest number of HIV cases reported in recent years. In fact, the Centers for Disease Control (CDC) estimate that there are at least 15,000 HIV+ young people between the ages of 13 to 24 years old living in the U.S. Yet, most HIV+ teens remain unaware of their infection, or that they were even at risk for HIV.

Adolescent women are at even greater risk than adult women. The vagina and cervix of young women are less mature and are less resistant to HIV and other STIs, such as Chlamydia and gonorrhea. Changes in the reproductive tract during puberty make the tissue more susceptible to penetration by HIV. Also, hormonal changes associated with the menstrual cycle often are accompanied by a thinning of the mucus plug, the protective sealant covering the cervix. Such thinning can allow HIV to pass more easily. Young women produce only scant vaginal secretions, providing little barrier to HIV transmission.

In addition to these increased physiological risk factors, many behaviors put teenagers at risk of HIV/STI.

- Many teens are sexually active and a large percentage of sexually active teens fail to use condoms consistently and correctly.
- Teens have high rates of STI. In fact among American females, teens normally have the highest incidence of reported STI.
- A small minority of teens injects drugs, but teens commonly report using alcohol and/or non-injection drugs which can inhibit their judgment. In fact, drug and alcohol use is



among a cluster of risk behaviors, including unprotected sexual intercourse, that teens frequently report.

The association between disadvantage on the one hand and HIV infection on the other is evident from the statistics. For example, in the United States,

- More than 50 percent of all adolescent AIDS cases occur among female teens, and the overwhelming majority of these cases occur among African Americans and Latinas.
- Youth are at risk for HIV infection, and youth of color, regardless of gender or sexual orientation, are at *disproportionate* risk of HIV infection.
- Latinos were the only minority group to demonstrate a doubling of new HIV infections between 2001 and 2006 – 23 to 51 percent for females. This is of particular relevance to the “No HIV for Me” project, given that over 50% of the population in Riverside County is ethnic minorities (primarily Latinos @ 43.2% and African Americans @ 6.6%).

According to the CDC, following are some of the behavioral and socioeconomic factors that negatively affect sexual risk-taking behavior among young women, especially those of color:

1. **Poverty and access to care**—Young women of color are disproportionately members of the working poor who often lack access to affordable, culturally sensitive, and youth-friendly health services. As a result many receive little preventive health information, including strategies that reduce their risk for HIV infection.
2. **Heterosexual contact**—The largest category for being infected with HIV among women of color is heterosexual contact—having sex with a man who uses injection drugs, is HIV-infected, or whose HIV status is unknown to the young woman.
3. **Communication** — Patterns of communication about sexuality differ by ethnicity, age, socioeconomic status, and level of acculturation. Reticence in discussing sexuality occurs among minority populations as frequently as among the U.S. population as a whole. Some Latino and Asian Pacific Islander cultures prohibit or discourage open discussion of topics like condom use, disease, and sexual behaviors. African American adolescent females, on the other hand, report receiving information about and discussing HIV and sexuality at school and with family. Young African American women also report feeling comfortable in assertively asking about partners' past sexual risks, although they are often reluctant to ask about same-sex sexual behavior or substance use—behaviors of male partners that can put the young women most at risk.
4. **Trust in monogamy**—The safety provided by monogamy is limited by each partner's past and current risk behaviors. Trusting a male partner who is not monogamous is a serious risk factor for *any* woman and may put many young Latina and African American women at risk for HIV and other STIs

5. **Older male partners**—A quarter of sexually active men ages 22 to 26 and 19 percent of males ages 20 to 21 report sexual intercourse with a teenage partner during the last year. A significant proportion of Latina and African American adolescent females also report first sexual intercourse with older male partners. Sexual intercourse with older men can expose young women to a sexual partner who has had sex with multiple partners, varied sexual experiences, and/or a history of injection drug use. Differing age and sexual experience may also create power imbalances that limit the ability of young women, including those of color, to negotiate safer sex. Finally, young women sometimes rely on older sex partners for guidance about protection and may receive misinformation that can negatively affect the young women's sexual health.
6. **Cultural barriers** - Cultural barriers prevent many young women of color from gaining the skills and knowledge they need to lessen their risk for HIV or other STIs. Ethnic groups may face different barriers posed by customs, religion, and history. For example, the African American community did not initially view HIV/AIDS as a threat. Early case reports indicated that high-risk groups included white gay men, injection drug users, hemophiliacs, and Haitians. As a result, many African American women have not recognized their own risk. Today, suspicion of government agencies, worry about genocide, and continuing conspiracy theories remain current among many African Americans. These factors may result in an unwillingness to be tested or treated for HIV.

Latinas often face a significant barrier to negotiating safer sex—Roman Catholicism, the predominant religion of the Latino population. Roman Catholicism does not condone the use of condoms or other contraceptives, even though correct and consistent condom use is the best HIV prevention method for sexually active individuals. In this regard, studies indicate that Latinas are the least likely teens to report condom use.

Catholicism also idealizes female submissiveness to men in relationships and in sexual activities. Cultural imperatives for females' being submissive directly conflict with prevention strategies that ask women to be assertive, to negotiate safer sex, and to be responsible for their own sexual health.

7. **Unprotected Sex** - One of the most common ways HIV is transmitted among teens is through unprotected sex - not using a condom during vaginal and anal intercourse. A reason for this is that teens are less likely to use a condom or other forms of protection during intercourse. Not using condoms also put teens at risk for other sexually transmitted diseases (STDs). In fact, one-fourth of all STDs each year occur among teens. This is especially alarming because the presence of an STD greatly increases a person's likelihood of acquiring or transmitting HIV. People who have an STD such as syphilis, genital herpes, Chlamydia, or gonorrhea are at greater risk for getting HIV during sex with infected partners. Consistently using condoms significantly reduces the chances of getting STDs.

8. **Alcohol and Drug Use** - Young people in the U.S. use alcohol and drugs at high rates. Many teens are curious about drugs and feel pressure from peers to try them. Teens are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol. In 2005, 23 percent of high school students who had sex during the past three months drank alcohol or used drugs. Runaways and other homeless young people are at high risk for HIV infection if they trade sex for drugs or money. Drug use can also increase the risk of HIV infection if needles are shared. This includes using needles for injecting drugs, skin-popping, injecting steroids, piercing the ears and body, and tattooing.

While researchers have concluded that there is no single path to delinquency and note that the presence of several risk factors often increases a youth's chance of offending, studies point to the interaction of risk factors (multiplicative effect) when several risk factors are present. **The Office of Juvenile Justice and Delinquency Programs, in a publication entitled *Risk Factors for Juvenile Delinquency – An Overview*, cites the following risk factors:**

1. **Individual Level Factors** – Several psychological, behavior and mental characteristics seem to be linked to delinquency, for example: aggression, hyperactivity, concentration or attention problems, impulsivity and risk taking. Low verbal IQ and delayed language development have also been linked to delinquency. Children with low academic performance, low commitment to school, and low educational aspirations during elementary and middle grades are at higher risk for delinquency as well.
2. **Social Factors:** Family characteristics such as poor parenting skills, family size, home discord, child maltreatment and antisocial parents are risk factors linked to juvenile delinquency. Additionally, poor parental supervision, parental conflict, and parental aggression, including harsh, punitive discipline increase chances of offending. Peer influences and involvement in a delinquent peer group lead to delinquent behavior.
3. **Community Factors:** Neighborhood and community factors such as poverty, high rates of unemployment, and other adverse environmental factors such as weak social networks, isolation among residents, residential turnover, concentration of delinquent peer groups and gangs, access to weapons, and high crime levels and rates of violence contribute to the risk of delinquent behavior.
4. **Environmental Factors:** Environmental factors play an important role in creating conditions that can contribute to a culture of violence among a particular group of people or in a given community. Some of the factors at this level that have been linked to violence include poverty, media exposure to violence, and the general disenfranchisement of young people in our society. Socioeconomic status has been consistently found to be an important contributing factor to violence in many studies. Depressed economic conditions coupled with individual cases of unemployment and limited economic opportunity contribute to higher

levels of violence in a given community. Researchers have confirmed that youth living in poverty are more likely to engage in violent behavior.

5. Youth often also experience specific barriers when seeking employment, such as employers who would prefer not to hire them, limited job skills or appropriate vocational training, or physical obstacles, such as poor transportation. Other research indicates that exposure to violence in the media, particularly prolonged exposure by children, may contribute to aggressive behavior and desensitization to violence. The media also may contribute to the perception of violence as a normative behavior, reinforcing and sensationalizing violence as an appropriate and justifiable problem-solving strategy.
6. **Finally, many adults have a disregard and mistrust of young people, and our culture has largely failed to recognize youth as a valuable asset.** As a result, many youth may find it difficult to engage in meaningful and substantive relationships with adults both individually and within the larger community. This lack of connection may contribute to youth feelings of alienation and disassociation from mainstream society, thus increasing risk for delinquent or violent behavior.

Community-based organizations such as Family Service Association (FSA) have a special responsibility to protect young people from becoming affected with HIV. The consequences of decisions made too young can lead to the devastation and death from AIDS. Although there are new treatments that have reduced the AIDS death rates for youth, there has been no decline in the number of new HIV infections among young people. Any young person who engages in the normal experimentation and sexual curiosity that mark adolescence as a development period is at some risk for HIV infection, especially in geographic regions with high HIV prevalence (such as California that is ranked second in the nation for AIDS cases). But, as it does with adults, HIV and AIDS most threaten youth who already face poverty, racism, homophobia, gender inequality and other power differentials in relationships, poor access to health care, and homelessness. Homeless and runaway street youth, and those at risk as juvenile offenders and other young people who exchange sex for drugs, money or affection are particularly at risk.

The FSA Project entitled – “No HIV for Me” will benefit from the experience and expertise of the agency in working with youth with multiple risk factors, including those for juvenile delinquency and sexually risky behavior. The project also involves collaboration with two additional CBO’s to ensure that the project reaches additional high-risk youth, the YWCA and Operation SafeHouse, serving both at-risk girls and runaway and homeless youth.



Example #3

Funder: Unnamed Foundation funding senior health

Submitted by: Little Tokyo Service Center (LTSC), Community Development Corporation

Grant request: \$50,000

Project summary: To support the Senior Services Program and its endeavors to serve Japanese and API seniors living in Los Angeles. Three areas of particular need in this senior population are bilingual case management, care giving to delay nursing home care and alleviate isolation, and transportation services.

NEED FOR THE PROJECT

Japanese and API seniors living in Los Angeles and surrounding areas do not have access to needed services either because existing programs do not provide linguistically and culturally competent services or they do not qualify for services due to residency requirements. Even without specific government funding LTSC is attempting to provide services to these seniors because they have nowhere else to go for assistance. Ironically, despite the fact that LTSC is based in Little Tokyo, it currently does not have government funding to serve Japanese seniors living in the Little Tokyo area. More requests for assistance come from this area than any other area mainly because Japanese seniors continue to relate to Little Tokyo as a culturally comfortable and pedestrian-friendly neighborhood, and there are a number of large government-subsidized housing projects for seniors here (including some of LTSC's own housing developments).

Based on LTSC's client intake analysis, of all the seniors that request service from LTSC 22.8% reside in the area surrounding LTSC's office. Based on the population data for this area it is clear why so many requests for service come from this area. In Little Tokyo 52% of the population is Japanese and 60% of the population is 65 years old or older. Further, since many of the seniors live in government-subsidized affordable housing developments, the majority of them are low-income.

The remaining requests for service come from all over the County. In Los Angeles County there are over 150,000 Asian seniors over the age of 65. (U.S. Census 2006 American Community Survey.) Of all Asians in Los Angeles County 79.9% speak a language other than English at home and of those who speak another language at home 42.1% speak English less than "very well." (U.S. Census) There are large populations of Japanese in areas surrounding Los Angeles, including the South Bay and San Fernando Valley.



The seniors LTSC serves are widely dispersed. All of them should have access to needed services, not just those living in areas prescribed by funding sources. Without access to case management, care giving resources and transportation referrals, the health, financial resources and quality of life of monolingual Japanese and API seniors are at risk.

Analysis of client intake information over the past year shows that at least 700 senior clients have sought assistance from LTSC either through telephone calls or as walk-ins. The majority is not “eligible” to be served in LTSC’s existing funded senior service programs. Of these clients, 73% are Japanese speaking and 68% are between the ages of 60 and 74 years. Based on the intake information, the three most requested services are bilingual case management, care giving/companionship and transportation. With support, LTSC’s comprehensive Senior Services Program will be able to meet these three needs of API seniors in Los Angeles and surrounding areas.



Example #4

Funder: Riverside County, California

Submitted by: Family Service Association of Western Riverside County (FSA)

(Grant amount unknown)

Proposal Summary: to fund Prevention and Early Intervention (PEI) services through a program called CARE (Community Assistance and Resources for the Elderly) to older adults in three communities of the East Valley Region of San Bernardino County. Services which will focus on assisting seniors before possible mental health issues escalate to higher levels of treatment will be provided in community-based settings (i.e. Senior Centers and Senior Nutrition sites and in the homes to frail or geographically/socially isolated elders) and will include the prevention and early identification of depression, dementia, substance abuse and suicide and other mental health issues due to the aging process, trauma and/or bereavement.

Needs Assessment: (*Funder asked proposal writer to: Provide a description of the needs of the target population in the service area as they relate to the PEI project.*)

According to data from the San Bernardino County Department of Aging and Adult Services 2000-2009 Area Plan, there are 1,709,434 residents in San Bernardino County (PSA Area 20). Eleven point five-two percent (11.52%) of the County’s population, or 196,941, are over age 60. The 196,000 citizens over the age of 60 in the County had the following characteristics:

Minorities	Low-income minorities	Living in rural settings	Grandparents as caregivers	Non-English language
62,473 32%	11,822 6%	18,930 9.6%	19,737 10%	56,020 29%

The racial/ethnic composition of older adults in PSA 20 is:							
White	Black/AA	AI/AN	Asian	NH/OPI	Other	Multirace	Hispanic
134,468 68%	11,629 6%	1,016 <1%	8,217 4%	229 <1%	230 <1%	3,122 1.6%	38,030 19%
The number of these groups with income below 125% of the poverty level is:							
15,920 8%	2,405 1%	260 <1%	1,115 <1%	45 <1%	60 <1%	690 <1%	8,460 4.5%
The number of these groups with income below 100% of the poverty level is:							
9,355 4.8%	1,409 <1%	165 <1%	750 <1%	25 <1%	40 <1%	415 <1%	5,455 2.8%



A total of 37,130 (19%) were disabled (as defined by federal law), as follows:

Sensory disabilities	Physical disabilities	Other disabilities
6,070 16%	13,260 35%	5,140 14%

According to the Elder Economic Security Standard Index (2007), the following data reflects the economic status of San Bernardino older adults (65+):

	Living Alone (1 per household)	Couples (2 person households)
Income Below Elder Index	58.6%	25.9%
Housing Type:		
Owner with mortgage	71.3%	22%
Owner without mortgage	44.8%	23.3%
Renter	70.9%	52.7%
Gender:		
Women	59.2%	25.5%
Men	57.1%	26.3%
Age:		
65-74	56.7%	23.3%
75+	60.0%	29.7%
Race/Ethnicity		
White	52.3%	22.1%
Latino	83.4%	26.7%
African American	77.2%	18.4%
Asian	14.2%	60.0%

The confluence of decreased fertility, expanded longevity, falling mortality and ongoing redefinition of what it means to be older is creating challenging times for those providing senior services. Stereotypes about aging are slowly crumbling as attitudes about the aging process and what it means to age are changing. Currently, life expectancy in California is 78.8 years, which is about one year longer than the nation as a whole. By 2050, there is a 50% probability that life expectancy in California will reach 84.2 years. (Source data for the preceding section was obtained from California Department of Aging, Administration of Aging and the California Commission on Aging.)

With this extended life expectancy and the many challenges associated with aging, it is incumbent upon the health and human service support system in communities to deliver services to older adults and provide prevention, early intervention and treatment for those that are in need. As in other areas of life, knowledge empowers older adults to achieve physical and mental health as part of the aging process.

Many elderly persons have internalized negative and incorrect beliefs about what aging is or should be, and there is no shortage of "ageism". But there does appear to be limited education about "normal" aging, particularly in the area of mental health. The stigma of mental illness is

particularly troublesome. Significant barriers exist for the elderly in accessing and utilizing mental health services, including misdiagnosis, social isolation, poor coordination between physical and behavioral health care, and Medicare coverage is often inadequate and serves to further the myth that mental illness in the elderly is both to be expected and not responsive to treatment.

Although physical illness is a risk factor for depression, substance abuse and suicidal behaviors among the elderly, primary care providers do not always screen for behavioral health problems among their patients. Older persons with psychiatric illnesses are more likely to receive inappropriate pharmacological treatment and less likely to be treated with psychotherapeutic interventions than younger clients. And finally, social isolation brought about by physical ailments, depression or transportation limitations presents an additional barrier.

Aging experts agree that programs are needed to eliminate these barriers to mental healthcare, and that increased financial resources are necessary to develop, implement, and maintain innovative programs that can reach frail, isolated, hard-to-find persons in need of mental health, medical, and social services. The CARE program provides an excellent community resource, one that will help older adults increase their awareness of mental health issues such as depression and anxiety, substance abuse, dementia and suicide.

According to The American Geriatrics Society, mental illness is an important contributing factor to the disease burdens of the elderly. While the elderly do not appear to suffer a disproportionate share of most classifiable mental illness (depression or schizophrenia, for example), they do have a much higher prevalence of dementing illnesses such as Alzheimer's disease and are subject to higher rates of interpersonal loss. Despite substantial rates of morbidity, the proportion of elderly persons recognized as impaired and who actually receive adequate treatment is markedly lower than in younger groups. This under-provision of services persists despite the fact that treatment of mental illnesses such as depression or paranoia in the elderly has been shown to be as effective as treatment in younger groups.

Mental health problems in older adults are often ignored or denied by family members, service providers, medical professionals, and even by older adults themselves. The majority of older adults do not receive the services they need, as detailed below:

1. **Substance Abuse:** Older adults are uniquely vulnerable to substance use disorders due to a variety of biological, psychological, and social changes associated with aging. Older adults have an increased risk for misuse and abuse of medications, as they use a higher number of prescription and over-the-counter medications compared to younger adults. In contrast to younger persons with substance abuse problems who most often abuse illicit drugs, substance abuse problems among older individuals more typically occur from misuse of over-the-counter and prescription drugs. The rates of illegal drug abuse in the current older adult cohort are very low. However, the interactions between alcohol and medications are of notable concern for older populations. Negative interactions between alcohol and psychoactive medications, such as benzodiazepines, barbiturates, and antidepressants, are of particular importance. Alcohol use can interfere with the

metabolism of many medications and is a leading risk factor for the development of adverse drug reactions. Despite the risks, physical and mental health care practitioners fail to identify most older adults who consume alcohol at risky levels, including any consumption in hazardous combinations with medications, as at-risk or problem drinkers.

2. ***Inadvertent misuse and abuse of alcohol and medications.*** Finally, many older adults see substance abuse as a “moral failing” rather than a legitimate behavioral health problem. There are many myths and stereotypes surrounding the use of alcohol: “It’s just a few glasses of wine, what’s the big deal?” (minimization); “At his age, alcohol is all dad has left to enjoy” (rationalization); “Mom drinks, but her fall was due to tripping over the cat” (denial); “There are no recovery programs for seniors” (inaccuracy). Regardless of whether alcohol is used as a remedy for loneliness, to self-medicate, or to cope with pain, abuse is dangerous.
3. ***Depression and Anxiety:*** Depression is a form of mental illness that when untreated, can lead to disability, worsen symptoms of other illnesses, lead to premature death or result in suicide. Accurate diagnosis of depression among elder persons is often complicated by multiple issues, not the least of which is that older adults generally do not seek mental health services on their own. Those who do generally do so at the request of others. The lessening of social connections with others who might observe increased depressive symptoms further reduces the likelihood that elder people will present for treatment for depression. Yet once properly diagnosed, treatment of depression in an elder person can be very successful (Katona, 2004). Many symptoms of depression (e.g., thoughts of dying, fatigue, loss of libido, reduced sleep, sleeplessness) are often considered normal signs of aging (Katona, 2000). In fact, some physicians still do not consider depression as a potential diagnosis in the elder population because it mimics features of existing physical problems (Katona; Unutzer, Katon, Sullivan, & Miranda, 1999). For example, a stroke can cause many of the same symptoms as depression, as can side effects from medications for heart disease, hypertension, and arthritis (Gottfries, 2001; Unutzer, et al.) and co-occurring disorders of cancer and diabetes mellitus (Bell, 1999). Thyroid dysfunction and low estrogen levels in women can likewise complicate diagnosis of depression (Blazer, 2002). Furthermore, although memory loss is a common symptom of depression in elder people, it is often attributed instead to dementia.

Symptoms of depression in elder individuals vary but can include insomnia, hypersomnia, eating too much or too little, loss of energy, fatigue, and a general diminished ability to concentrate (Blazer, 2002). Irritability is a frequent sign of depression in elder men, as are complaints of stomach problems, palpitations, and shortness of breath (Karel, Ogland-Hand, Gatz, & Unutzer, 2002). Observable signs of depression are changes in appearance, stooped posture, social withdrawal, hostility, suspiciousness, slowed speech and movements, wringing of hands, picking of skin, pacing, and outbursts of aggression (Blazer). Five areas of functioning that are adversely affected by depression tend to exacerbate one another: (1) emotional, (2) motivational, (3) behavioral, (4) cognitive, and

(5) physical aspects of an individual's life (Blazer; Karel, et al). The good news is that properly diagnosed and treated, more than 80% of those suffering from depression recover fully and return to normal lives.

Anxiety is a common illness among older adults, affecting as many as 10-20% of older adults, though it is often undiagnosed. Phobia – when an individual is fearful of certain things, places or events, is the most typical type of anxiety. Among adults, anxiety is the most common mental health problem for women, and the second most common for men, after substance abuse. Older adults do not recognize or acknowledge their symptoms, and when they do, they may be reluctant to discuss their feelings, or believe their feelings are normal. For example, the anxiety suffered by a recently widowed person may be more than normal grieving. Complicated or chronic grief is often accompanied by persistent anxiety and grieving spouses may avoid reminders of the deceased. For many older adults, depression often goes along with anxiety, and both can be debilitating, reducing overall health and quality of life.

4. **Suicide:** Suicide is more common in older people than in any other age group. Suicide attempts or severe thoughts or wishes by older adults must always be taken seriously. (Klausner and Alexopoulos, 2002). While major depression is the main precipitant of suicide at all ages, social isolation is an important risk factor among the elderly. And older men, more so than older women, often become socially isolated. Widowers are especially at risk because older men in the current generation tend to depend on their wives to maintain social contacts. When their wives die, their husbands' social interactions often cease. Many men are poorly prepared for retirement, and don't know how to fill in the hours and maintain a sense of usefulness when they stop working. They often sit around, watching TV, and a lot of older men start drinking heavily, a sign of increased aggression turned inward. Serious personal neglect is another warning sign, and people can commit a kind of passive suicide by failing to eat, letting themselves become dangerously sedentary or not taking needed medication. A large number of older adults who commit suicide have visited their primary care physicians within the same month, week, or even day or their suicide, and have failed to mention any suicidal ideation to their doctors. Senior suicides are expected to swell in coming years as baby boomers reach old age.
5. **Transportation:** Medical and physical conditions may prohibit/limit driving capabilities, promote isolation, reduce independence and diminish quality of life and health. Provision of transportation to help older adults access medical/dental appointments, grocery shopping, banking and social activities is a critical element of effective prevention and intervention programs.
6. **Home Safety:** Each year, many older adults are injured in and around their homes. Last year, the US Consumer Product Safety Commission (CPSC) estimated that over 800,000 people over the age of 65 were treated in hospital emergency rooms for injuries sustained at home. CPSC believes that many of these injuries result from hazards that are easy to

overlook, but also easy to fix. By spotting these hazards and taking some simple steps to correct them, injuries can be prevented. This program component will also focus on two key issues:

- a. **Fall Prevention and Medication Management.** Following is some data on the scope of these problems:
 - **Fall Prevention:** For seniors, the risk of falling and sustaining an injury is influenced by a broad set of health determinants, including physical, behavioral, environmental, social and economic factors.
 - One in three adults, 65 and older, falls each year. Of those who fall, 20% to 30% suffer moderate to severe injuries that make it hard for them to get around or live independently and increase their chances of early death.
 - Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.
 - In 2000, the total direct cost of all fall injuries for people 65 and older exceeded \$19 billion: \$0.2 billion for fatal falls, and \$19 billion for nonfatal falls. By 2020, the annual direct and indirect cost of fall injuries is expected to reach \$54.9 billion (in 2007 dollars).
 - In a study of people age 72 and older, the average health care cost of a fall injury totaled \$19,440, which included hospital, nursing home, emergency room, and home health care, but not doctors' services.

- b. *Medication Management:*
 - Less than 30% of older adults take their medication correctly. 35% of hospital admissions of the elderly are related to either medication non-compliance, under-medication, or over medication.
 - 125,000 elderly DIE each year due to medication mismanagement.
 - By age 65, 2/3 of all seniors have two or more chronic conditions requiring prescription medications; and that figure increases to 70% of elders by age 80. Each chronic condition that is diagnosed adds an additional medication or two. This is a way of life for the elderly and is often too large a task for them to handle without support. Side effects of these medications and interactions with each other require the ongoing study of an alert mind.
 - Over the counter medications are often used by the elderly along with vitamins, minerals, laxatives, herbs and pain remedies. Many of these over the counter medications were once prescription medications with potential drug interactions and side effects. (Data source: Centers for Disease Control)

- 8, **Child Care:** For older adults who are caring for young children such as grandchildren, the FSA Case Manager will work with participants to find child care during early intervention services.



Example #5

Proposal to: Private Regional Foundation (that funds place-based projects) - **Submitted by:** State Association **Project summary:** To fund a two-year intensive capacity building project for 20 youth-serving organizations – tailored to the specific needs of participating organizations – that strengthens and advances their leadership, governance and internal operations and measurably improves their ability to better sustain their organization. (Grant request for \$100,000 a year for two years for a total of \$200,000.) Full proposal not available.

What is the problem your project/program was designed to address?

Most nonprofits need more than money to be successful. Capacity building through technical assistance and organizational development methods has become a valued method for learning how to better manage nonprofit operations and programs. Many of the youth-serving organizations participating in this capacity building project are confronted with significant challenges in managing and securing resources, governing, planning, financial accounting and reporting, accountability, evaluation and measurement. The rural nature of the communities they serve, the high poverty and immigration rates and the seasonal employment of their clients makes it difficult for them to find the time or resources for capacity building services.

In addition the sheer complexity of the social, health, education, economic and racial issues being addressed by many nonprofit organizations in the Central Valley, combined with their own interrelated inter- and intra-organizational dynamics makes it difficult for nonprofits to find time and/or resources to take advantage of capacity building opportunities. Some of the challenges facing the youth-serving groups that will participate in the two-year capacity-building project are outlined below;

1. There appears to be no unified vision or leadership about how the nonprofits of the Central Valley might build their capacity. (Again an exception would be a community-wide capacity building plan developed by the United Way– a joint effort by several human service organizations to think strategically about building capacity.)
2. Finding capacity building opportunities that are culturally competent and sensitive to the unique needs of different communities may also be difficult.
3. Many studies show groups serving young adults age 16 - 24, the age group served by the nonprofits to be served by this project, often struggle to keep young people involved and interested in their program. Once they are not mandated by the courts or school district to stay in the programs, this age cohort often has other things they would rather do than participate in the programs being offered. Nonprofits serving this age group struggle to provide program that sustain involvement.

4. Additional challenges youth serving nonprofits from the Central Valley identified in a recent survey conducted by the Fresno Resource Center include:
 - Valley nonprofits report they have limited resources to use for capacity building. In a survey of 299 youth-serving organizations, the Advancement Council reported that:
 - 45% of organizations identified cost as the top reason they had not engaged in more training or consulting.
 - 33% said they had no budget for professional training (50% of the organizations located in ??? and ??? counties reported no budget for training).
 - 15% identified lack of resources in their region as the top reason they did not engage in more training or consulting.
 - Because the counties are so large the cost of travel in order to participate in learning opportunities can be prohibitive for most small and mid-size organizations.
 - Resource-related constraints also included: tight budgets, time limitations, and competing resource needs that impede organizational ability to be strategic about the type and availability of capacity building assistance that might be needed.
 - Groups reported difficulty finding capacity building options that are meaningful, affordable or of the quality level desired.

Capacity building efforts in the Valley have been hard to sustain, often due to the reluctance of local funders to offer long-term funding of such efforts.)