The Context of Social Work Practice with Older Adults

AGING IN THE TWENTY-FIRST CENTURY

One of the greatest challenges of the twenty-first century will be the tremendous increase in the number of older adults in both the United States and throughout the world. By 2030 when most baby boomers (those born between 1946 and 1964) have moved into older adulthood one in every five persons in the United States will be over the age of 65. Social institutions, including the health-care system, education, income maintenance and social insurance programs, the workplace, and particularly social services, are bound to be radically transformed by these staggering numbers. Current and future generations of older adults will undoubtedly forge new approaches to the aging process itself and demand services that reflect positive and productive approaches to this time in their lives. As major providers of service to older adults and their families, social workers need a wide variety of skills and resources to meet these demands. Working with older adults is the fastest-growing segment of the social work profession. The National Institute on Aging estimates that between 60,000 and 70,000 new social workers will be needed to meet the demands of this growing population. This book is intended to provide a solid knowledge base about aging as a process and to introduce practitioners to a broad range of assessment and intervention techniques.

Diversity within the Older Adult Population

Age 65 is generally agreed on as the beginning of older adulthood only because until recently it has been the traditional retirement age, not because there is a special social or biological reason for this choice. The population between 65 and 74 is generally referred to as the “young-old.” Many young-old do not consider themselves to be old. The young-old may still be working or newly retired, have few if any health problems, and remain actively engaged in the social activities of life. These older adults may stay in the labor market for many years beyond retirement age or...
transfer their energy and interests to creative writing, painting, music, or travel. They are most likely to continue to be engaged in their communities through volunteer work or political involvement.

The group of older adults aged 75 to 85, “the middle-old,” may begin to experience health problems more frequently than their younger cohort. They may face some mobility restrictions and are more likely to openly identify as older adults. Most of these older adults are out of the workforce and may have experienced the loss of a life-partner or spouse. There is often a growing need for some type of supportive service to help these older adults remain in their own homes, if that is what they choose to do. It is among the “oldest old,” those over 85, that the greatest needs exist. This group is most likely to have serious health problems and need assistance in more than one personal care area, such as bathing, eating, dressing, toileting, or walking. The needs of newly retired and healthy older adults to continue active and productive lifestyles are appreciably different from the needs of frail older adults forced into special living situations due to failing health. Somewhere in between the newly retired and frail older adults is the largest group of older adults, those who remain independent and function well in most areas of their lives but need specific social, health, or mental health services to maintain and maximize that independence.

Culture, ethnic group membership, gender, life experiences, and sexual orientation add to the uniqueness of the aging experience for each older adult. Some older adults have struggled with racial, gender, or sex discrimination throughout their adult years, factors that have a long-term effect on their socioeconomic well-being. Others bring significant health-care problems into old age, the result of inadequate health care since childhood. The dramatic rise in the number of divorces and fewer traditional family structures have created a complex web of blended families, stepchildren, multiple grandparents, and former spouses and partners expanding (and limiting) the support systems available to help an individual. Some older adults are “tech smart” while others have not had the opportunity or resources to access digital technology. While some older adults have used traditional social services at other times in their lives, many have never had to seek help until they reached their later years. The social work profession’s commitment to recognizing and valuing the uniqueness of every individual is especially important in work with this population as will become apparent throughout this book.

The Focus of This Chapter

This chapter is designed to introduce you to the demographic characteristics of older adults in the United States. This chapter also describes the variety of professional social work roles both as direct service providers and in macro-level settings. Direct service roles include work in community social service settings, home health-care agencies, geriatric case management, independent and assisted-living communities, adult day health settings, nursing homes, and hospitals. New social work roles are being defined in legal settings and in the field of preretirement planning. Macro-level roles include local, state, and regional planning; legislative advocacy; public education; research; education; and consultancy in business and industry. These roles will be explored in depth later in this chapter along with the unique challenges that make this area of social work practice both rewarding and challenging.
THE DEMOGRAPHY OF AGING

The Growth of the Older Population

As of 2009, one in eight Americans was over the age of 65, or 12.9 percent of the general population (Administration on Aging, 2010). By 2030, when the last of the baby boomer cohort reaches age 65, older adults will comprise over 20 percent of Americans, or 72 million people (U.S. Census Bureau, 1996) (see Figure 1.1.). The largest growth within the older population will be among those over the age of 85, those older adults with the greatest health and social service needs.

The most notable growth in the older population will be among older adults of color, who will constitute 25 percent of the older adult population by 2030, as compared to 18 percent in 2000 (Federal Interagency Forum on Aging-Related Statistics, 2010) (see Figure 1.2). This growth is due to improvements in childhood health care—increasing the likelihood that persons of color will even reach age 65—and improvements in the control and treatment of infectious diseases throughout the life cycle. Yet, the consequences of a lifetime of economic challenge combined with a greater probability of developing chronic health problems will follow these older adults into this longer life expectancy. For older adults of color, living longer does not directly translate into living better. The special problems and challenges of growing older as a person of color are recurrent themes throughout this book.

Life Expectancy and Marital Status

A child born in 2007 can expect to live to 77.9 years of age, compared to a life expectancy of 47.3 years for a child born at the beginning of the twentieth century (National Center for Health Statistics, 2011). Women have a life expectancy of 80.4 years compared to

Figure 1.1 • Number of Persons 65+ Years Old, 1900–2050 (numbers in millions)

Chapter 1

Figure 1.2 • Percent of Population over 65 Years: By Race and Hispanic Origin, 2006 and 2050


75.4 years for men. The projection of life expectancy changes as individuals get older. In other words, under current mortality conditions, if an individual lives until age 65, he or she can expect to live an average of 18.5 more years (Federal Interagency Forum on Aging-Related Statistics, 2010). If an individual lives to age 85, a woman can expect to live another 6.8 years and a man another 5.7 years. Just reaching the milestones of 65 or 85 suggests the individual is healthier in general and more likely to live longer than the general projections for the population as a whole. This is particularly noteworthy when looking at racial differences among black and white older adults. If a black older adult reaches age 85, the life expectancy is higher for him or her than it is for a comparable white older adult by 1.5 years.

In 2009, men between 65 and 74 were more likely to be married than were older women, 72 percent and 42 percent, respectively, reflecting the differences in life expectancy between the genders (Administration on Aging, 2010). Although those men and women not married are most likely to be widowed, the twofold increase in divorced older adults from 5.3 percent in 1980 to 10.8 percent of the population by 2009 suggests that the number of single older adults will increase as well into the twenty-first century. The presence or lack of a family support system has a dramatic effect on an older adult’s ability to remain living independently.

Living Arrangement

Older men are more likely than older women to live with their spouses, 72 percent and 40.7 percent, respectively (Administration on Aging, 2010). Women are twice as likely to live alone than older men. This difference reflects the differences in life expectancy with
older women being more likely to have outlived their spouses than older men. One of the most significant shifts in living arrangements for older adults in recent years is the increase in the number of grandparents raising grandchildren. Often this is due to death or disability of the older adults’ grown children. Approximately 716,000 grandparents over the age of 65 were the head of households in which grandchildren lived, with two-thirds of these grandparents bearing the primary financial and child-rearing responsibilities (Administration on Aging, 2010). These numbers are proportionately higher among African-American and American Indian or Alaska Native and Hispanic older adults, populations already at risk for being low income and in poorer health. This increase in the number of grandparents raising grandchildren presents a formidable challenge in terms of meeting the parenting needs of the children at a time when the older adult's economic and personal resources are often challenged by their own needs.

In 2009, 56.5 percent of older adults lived in just 11 states: California, Florida, New York, Texas, Pennsylvania, Ohio, Illinois, Michigan, North Carolina, Georgia, and New Jersey. Thirty percent of older adults lived in areas considered “central cities,” with 53 percent living in suburban areas. The remaining one-fifth of older adults lived in small cities and rural areas, those areas of the country most likely to have fewer health and social services available to the aging population (Federal Interagency Forum on Aging-Related Statistics, 2010).

Although 90 percent of nursing home residents are over the age of 65, they represent only 4.1 percent of the older population, according to the Administration on Aging (2010). This small percentage challenges the common perception that large numbers of older adults end up in nursing homes due to failing health. Women comprise 75 percent of the nursing home population, another reflection of their longer life expectancy (National Center for Health Care Statistics, 2011).

Poverty

The change from Old Age Assistance to Supplemental Security Income in 1972 and the expansion of government-funded health-care programs for older adults have reduced the overall poverty of older adults since the 1960s, when 35 percent of persons over the age of 65 had incomes below the poverty line (Federal Interagency Forum on Aging-Related Statistics, 2010). In 2009, 10.7 percent of older women and 6.6 percent of older men still had incomes that categorized them as poor (National Women’s Law Center, 2010). A closer look at the poverty statistics indicates that individuals who have low incomes throughout their working lives are those most likely to continue to have low incomes or drop into poverty in their later years. Older women are more likely to be widowed or living alone than are their male counterparts—thus relying on one income, rather than two. However, poverty is not a new experience for many women. Women experience higher poverty rates throughout their lives whether due to the financial demands of raising children as single mothers, disrupted labor market histories, or low-wage occupational choices (National Women’s Law Center, 2010).

There are disproportionately high poverty rates among older adults of color, with 19.5 percent of African-American older adults showing incomes below the poverty line. Hispanic and Asian/Pacific Islander older adults have poverty rates of 18.3 and 15.8 percent, respectively (Administration on Aging, 2010). The low lifetime earnings of both women and persons of color are reflected in lower Social Security benefits after retirement (National Women’s Law Center, 2010). Limited incomes do not enable individuals
to accumulate assets, such as property or personal savings accounts, and low-wage jobs rarely have pension or retirement plans. When a low-wage worker retires, he or she simply does not have the financial resources to ensure an income much above the poverty line. On the other hand, high-wage workers have higher Social Security payments, have greater asset accumulation, and are more likely to have private pensions or employer-supported retirement savings. Older adults’ retirement incomes mirror their lifetime earnings.

**Employment**

About 16.2 percent of the current population of older adults remains in the workforce beyond the traditional retirement age of 65, with over half working part time either out of financial necessity or because of a continued interest in employment (Administration on Aging, 2010; Bureau of Labor Statistics, 2010). Baby boomers are expected to remain in the workforce at much higher numbers than the current cohort of older adults, with “more than three-quarters of boomers seeing work as playing some part in their retirement” (Merrill Lynch, 2005, p. 1). However, these workers are likely to seek “bridge jobs,” those employment arrangements that allow them to work fewer hours with more workplace flexibility as they transition into full retirement (Cahill, Giandrea, & Quinn, 2006). Changes in the retirement age under Social Security, the decrease in the number of guaranteed retirement pensions, and a decrease in the amount of private savings for retirement contribute to both the interest in and necessity of baby boomers remaining connected to the workforce longer (Munnell, Webb, & Delorme, 2006).

**Health Status and Disability**

By age 85, over half of older adults need some assistance with mobility, bathing, preparing meals, or some other activity of daily living (Centers for Disease Control and Prevention & The Merck Foundation, 2007). However, in 2009, three-quarters of persons between ages 65 and 74 and two-thirds of persons over age 75 self-rated their health as good or very good (Administration on Aging, 2010), despite a high incidence of chronic health conditions within this population. Heart disease, arthritis, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, and diabetes are the most frequent chronic health conditions found in persons over the age of 65 (Federal Interagency Forum on Aging-Related Statistics, 2010). Older adults are more likely than their nonaged counterparts to visit a physician or enter a hospital, which is consistent with the prevalence of chronic health-care problems.

Economic well-being and health status are intricately linked in the population. Chronic poverty restricts access to quality medical care, contributes to malnutrition, and creates psychological stress, all of which influence an individual’s health status. For low-income older adults of color, late life becomes the manifestation of a lifetime of going without adequate medical care. Chronic conditions become more disabling. Prescriptions cannot be filled or glasses purchased because of limited financial resources. Poor older adults may have to choose between food and medicine.

The economic burden of an acute or chronic illness can devastate middle-class older adults’ financial resources, quickly moving them from economic security to poverty. Much of this is due to the mechanics of financing health care for older adults. Medicaid, the health insurance program for low-income persons, is available to those older adults
who qualify on the basis of low income and limited assets. Low-income older adults may be eligible to combine Medicaid coverage with Medicare, the federal health insurance program that covers 95 percent of persons over age 65 and does not have a means test. With the combination of both programs, most major health-care costs are covered, although accessibility to health-care services may still be a problem for low-income older adults (Administration on Aging, 2010). Medicare covers only a portion of health-care costs for older adults and is not sufficient to provide adequate coverage. For middle- and upper-income older adults, Medicare is frequently supplemented with what are known as medigap policies—private insurance that covers what Medicare does not. For those older adults who do not qualify for Medicaid and cannot afford supplemental policies, a significant gap in coverage exists. The National Center for Health Statistics estimates that almost 10 percent of older adults, most of whom are poor, female, and of color, have unmet health-care needs due in part to the gaps in the Medicare system (National Center for Health Care Statistics, 2011). This population is least likely to have routine physical exams, be immunized against the flu and pneumonia, have early screening for diabetes and hypertension, or take medications that prevent the development of more serious medical conditions. Therefore, when illness occurs, it is more likely to be serious. Prevention costs less than treatment for most chronic conditions, but a portion of the older population cannot afford preventative measures.

This overview of the demographics of aging shows a population of persons over the age of 65 that is growing and will continue to grow rapidly during the twenty-first century. Despite a higher incidence of chronic health problems, most older adults are not sick, not poor, and not living in nursing homes. The vast majority of older adults struggle with occasional health problems but continue to be active, involved, and productive members of society, defying the stereotype of sick, isolated, and miserable old people. The economic picture, however, is bleakest for older adults of color, women, and the oldest of the old in the United States. If current trends continue, older adults will continue to live longer but not necessarily healthier lives unless chronic poverty and health-care inadequacies are addressed.

**USING THE STRENGTHS PERSPECTIVE IN WORK WITH OLDER ADULTS**

The demographic overview of the older adults may leave you wondering how the social work profession can even begin to help this population, which faces so many problems with limited income and chronic health problems. If a social worker focuses on all the things that are “wrong” in an older adult’s life, the challenges are indeed overwhelming both to the social worker and the older adult. This book uses the strengths perspective, which focuses on what is “strong” in an older adult’s ability to rally personal and social assets to find solutions to the problems he or she faces in the aging process. The strengths perspective is based on the philosophy that building on strengths, rather than problems and personal liabilities, “facilitates hope and self-reliance” (Fast & Chapin, 2000, p. 7). To work effectively with older adults, the social worker has to believe that older adults continue to have the power to grow and change as they face challenges of aging and that they want and need to continue to be involved in decisions and choices about their care.
The focus of this book is on very specific challenges facing older adults, including health and mental health issues, substance abuse, abuse and neglect, family relationships, and end-of-life issues, but incorporates the strengths perspective as an underlying theoretical approach to practice. The strengths perspective focuses on the ways in which clients have overcome challenges throughout their lives using a broad repertoire of coping and problem-solving skills (Glicken, 2004). An older adult who is experiencing the difficult decision to sell a much cherished family home and move into independent or assisted living has had to make painful decisions before and found the inner strength and social support to do so. An older adult struggling with a late-onset drinking problem has the physical and emotional ability to overcome an unhealthy reliance on alcohol. The strengths perspective affirms a basic tenet of social work practice: self-determination. If the social worker sets the goals for an intervention and those goals are not those of the older adult, the worker should not be surprised when the older adult is resistant or uncooperative. “Clients create change, not helpers” (Glicken, 2004, p. 5). The social worker’s roles are to help older adults identify strengths, resources, and goals, connect the older adult with personal and community resources to meet those goals, and facilitate and coordinate the process, if necessary. You will see how this approach is used throughout the book in specific areas of gerontological social work. There are other excellent resources that present the strengths perspective in more detail and you are encouraged to consult those sources for a more in-depth discussion of this approach (Fast & Chapin, 2000; Glicken, 2004; Saleebey, 1992).

SETTINGS FOR GERONTOLOGICAL SOCIAL WORK

Older adults’ need for social services falls along a broad continuum from the need for a limited number of support services such as housekeeping and meal services to extensive needs in a long-term or rehabilitation setting. Likewise, social workers’ roles range from the traditional assistance as broker, advocate, case manager, or therapist to nontraditional roles such as exercise coach, yoga teacher, and spiritual counselor. Nursing homes and hospitals are often seen as the most familiar settings for gerontological social work practice, but these settings represent a small part of the variety of opportunities available for social workers with passion for and knowledge about the older adult population. With only 4.1 percent of the older population in nursing homes, social service agencies, home health-care agencies, geriatric care management, adult day health, and independent and assisted-living settings are more common settings for direct service or clinical practice. Social work roles in legal settings and in the expanding field of preretirement planning are additional settings for gerontological social work that function in a complementary role to the existing social service system. Social workers serve important roles in macro-level settings that serve older adults such as community organizations and public education, local, state, and regional planning agencies, and organizations that engage in legislative advocacy. The future roles of social workers in the field of aging are limited only by practitioners’ imagination and initiative.

Community Social Service Agencies

In large communities, social service agencies offer a wide range of counseling, advocacy, case management, and protective services specifically designed for older adults. These services may be housed in the local Council on Aging, Area Agency on Aging, or Department
of Social Services, or may be provided by sectarian agencies, such as Catholic Social Services, Lutheran Social Services, Jewish Family and Children’s Services, and so forth. Older adults or their families may feel more confident working with agencies that reflect their own religious affiliation. In small communities or rural areas, services to older adults may be contained within a regional agency that serves as an Area Agency on Aging (AAA) or an agency serving other populations that has a social worker with particular expertise in working with older adults. The purpose and organization of AAAs will be discussed in detail in Chapter 13.

Contact with a social worker at a social service agency is frequently initiated by a concerned family member who is unsure about how to begin the process of obtaining services for a family member. In addition to conducting the assessment process to determine what services might be helpful to an older adult, social workers can play an important role in initiating and coordinating services from a variety of agencies in a care management role. In some cases, the family of a frail older adult becomes the client. Although families can successfully provide caregiving, they may feel the strain of this responsibility and benefit from a support or educational group and respite services. As the contact is often precipitated by a crisis, families and older adults may need reassurance and support as well as solid information to stabilize a chaotic situation.

**Home Health-Care Agencies**

Home health-care agencies, such as the Visiting Nurses Association, often have gerontological social workers on staff as part of a team approach to providing services to older adults. Although the primary focus of home health care is to provide health-related services, such as checking blood pressure, changing dressings following surgery, or monitoring blood sugar levels for diabetic older adults, social workers can also play an important role in addressing older adults’ psychosocial needs. An older adult who has suffered a stroke may not only need medication and blood pressure monitoring from a health-care provider but also need help with housekeeping, meal preparation, or transportation. The social worker can arrange for these support services and coordinate the total care plan. Older adults who are essentially homebound due to chronic health problems often experience intense isolation and may benefit from regular phone calls from an older adult call service or friendly visitor volunteer. Gerontological social workers who work in home health care often provide supportive or psychotherapeutic counseling services or arrange for those services from another agency in the community.

Social workers also play an important role in helping older adults work out the financial arrangements for home health care. Advocating for the older adults to receive the care they are entitled to under private insurance, Medicare, or Medical Assistance can involve myriad phone calls and personal contacts that are difficult for an ill older adult to handle. When older adults are not eligible for needed services under existing insurance coverage, creativity is often needed to obtain additional financial resources, including working with older adults’ families or identifying low-cost community services that older adults can afford. If an older adult’s illness becomes more debilitating, the social worker may need to work with the older adult to identify care arrangements that offer greater support, such as assisted-living services or adult day health care. It is the social worker’s knowledge of community services and financial aid programs that makes him or her a valuable asset to home health care.
Geriatric Care Management

Families in the twenty-first century are increasingly juggling the demands of full-time employment, hectic family schedules, and geographical separation from aging family members. An option available to families who may not have the time, knowledge, or availability to negotiate with community social services agencies or home health-care agencies is that of using a geriatric care manager. Geriatric care management has emerged as one of the newest and most rapidly growing professional settings for gerontological social work.

Most geriatric care managers are social workers, nurses, or other specially trained counseling or health-care workers who may work as independent professionals or in conjunction with a health-care facility or social service agency. Geriatric care managers offer family members or other caregivers services in planning, implementing, and coordinating a wide range of services for older adults (National Association of Professional Geriatric Care Managers, 2011). These professionals have a specialized knowledge in assessing the biopsychosocial needs of an older adult and in locating the appropriate service in the community to meet those needs.

The overall responsibilities of the geriatric care manager are to suggest the most appropriate supportive services needed to enhance the older adult’s well-being. This may be as simple as arranging for health-monitoring services for an older adult who is recuperating from surgery or as complex as relocating the older adult to an assisted-living facility or a nursing home (Stone, Reinhard, Machemer, & Rudin, 2002). Geriatric care managers provide assessments and screening, arrange and monitor in-home help, provide supportive counseling to the older adult and the family, support crisis intervention, and even offer family mediation and conflict resolution when families have opposing views of what an aging parent needs or wants. They may also act as liaisons to families separated by long distances to report on the older adult’s well-being or alert the family when an older adult’s physical, psychological, financial, or social health changes.

The cost of geriatric care management can be substantial, with fees running between $60 and $90 per hour, depending on the type, complexity, and location of the services provided and the credentials of the care manager (National Association of Professional Geriatric Care Managers, 2011). These care management fees are typically not covered by Medicare, Medicaid, or traditional private health insurance, although the cost of the support services identified by the care manager are often part of the home health-care services financed by public and private health insurance programs.

Independent and Assisted-Living Settings

Specialized independent living settings for older adults in the community, such as low-income or moderate-income housing, frequently have social workers on staff to provide a variety of services. Helping older adults secure transportation to appointments or shopping centers, arranging opportunities for social activities such as plays and concerts, and promoting on-site activities are frequently under the auspices of a social worker in an independent living center. The social worker may be instrumental in helping the older adult to make the decision to add additional home care services or transition to a housing setting that offers more support as the older adult’s needs change with changing health conditions.

Another option in the range of services available to older adults in the community is the assisted-living center. Assisted living is defined as a residential, long-term arrangement designed to promote maximum independent functioning among frail older adults while
providing in-home support services (Assisted Living Federation of America, 2011). The assisted-living model fits in between completely independent living and the intensive care provided in a skilled nursing home. Some assisted-living facilities are part of a larger complex known as a continuum of care facility. Older adults may purchase or rent an apartment while they are still completely independent. As their health changes, necessitating increasing levels of support, older adults may need to move within the same complex to semi-independent living and perhaps eventually into an adjacent skilled nursing facility.

It should be noted that the quality and quantity of services available to older adults to support independent living varies widely among assisted-living facilities (Assisted Living Federation of America, 2011). Although some facilities are more accurately described as “real estate commodities with food service and social activities,” others are comprehensive healthcare settings offering a wide range of physical, health, and social supports that truly do offer seniors healthy, high-quality care (Franks, 2002, p. 13). The assisted-living industry does not require nor regulate the use of professional social workers, although positions such as the care or service coordinator utilize the skills associated with professional social work practice.

In high-quality assisted-living facilities, the focus is on as much self-maintenance as possible for each resident. Residents live in private or semiprivate rooms that have a private bathroom and, in some facilities, a small kitchen. The monthly fees include rent, utilities, a meal plan, and housekeeping services. Other services such as laundry, personal care services, and transportation are provided on an individual basis as part of a total care plan. Assisted living is expensive, usually between $3000 and $5000 a month, making it affordable only for middle- and upper-income older adults (Metlife Mature Market Institute, 2006). However, some states are working to obtain Medicaid waivers to demonstrate the cost-saving effect of using the assisted-living model for low-income persons as opposed to placing these older adults in skilled nursing facilities (Salmon, Polivka, & Soberson-Ferrer, 2006).

The purpose of assisted living is to help older adults maintain and improve their psychosocial functioning through a variety of activities that maximize choice and control. Social workers conduct intake assessments to review the medical, functional, and psychological strengths and weaknesses of incoming residents. These assessments play an important role in identifying those areas in which an older adult may need supplementary services, such as chore services, assistance with bathing or dressing, or social activities to ease isolation.

Families and residents may need both information and support to make a successful transition to the facility. The decision to leave one’s own home, even to move into the privacy of an apartment, is a traumatic experience for older adults and may require professional support to work through the grief and depression (Edelman, Guihan, Bryant, & Monroe, 2006). Assisted-living centers can offer a variety of challenging social and recreational activities that help older adults make the center their new home. Helping a resident find the right balance between private time and social activities is another important role for a social worker in this setting. In assisted-living centers, social workers often function as part of a multidisciplinary team composed of nurses and occupational, physical, and recreational therapists (Vinton, 2004).

**Adult Day Health Care**

A setting for older adult care that falls between independent living and skilled nursing care is adult day health care. Adult day health care can provide individually designed programs of medical and social services for frail older adults who need structured care for some
portion of the day. Older adults who live with their families or other caretakers or even live in semi-independent living situations and have some physical, cognitive, emotional, or social disability are typical users of adult day health care. These older adults do not need full-time nursing care or even full-time supervision but do require assistance with some of the activities of daily living. This type of care provides a valuable role as respite care for caregivers as well. Adult children may be willing and able to have older adults live with them if they can obtain supplementary care during the day while they work or for occasional respite (National Adult Day Services Association, 2011).

Many adult day health centers only take older adults who are able to be active participants in the development of their own service plans and consent to placement in the adult day health center. This type of care focuses on maximizing an older adult’s sense of choice and control in their own care. A smaller number of centers work exclusively with older adults who suffer from dementia, including Alzheimer’s disease, who may be less able to be full participants in the decision-making process.

Social workers are involved with an older adult from the extensive preplacement process through the execution of a service plan. Social workers and older adults explore the older adult’s needs and interests together and select from a variety of rehabilitative and recreational services available at the adult day health center. An older adult may need physical or occupational therapy to compensate for losses due to a stroke or heart attack. Others may need supervision to take medication. The social worker in adult day health care is instrumental in coordinating all the physical needs frail older adults require during the day. In this setting, social workers may serve as care managers.

Group work is an essential role for social workers in adult day health centers. In most centers, older adults belong to a specific group that meets on a regular basis to talk about the issues they face. This may involve problems with families and caregivers, concerns about friends and members of the group, or more structured topics such as nutrition, foot care, or arthritis. The group becomes a focal point for older adults in the adult day health setting. It gives them an opportunity to maintain social skills or renew them if they have been socially isolated. The group is helpful in making new older adults feel welcome and helping them access all of the services available to them.

In addition to running a therapeutic group and a variety of social and recreational activities, the social worker meets individually with each older adult for counseling, advocacy, or problem solving. This individual attention plays an important role in maintaining the dignity of the older adult in what is predominately a group setting and in helping the worker monitor the older adult’s mental and physical health status. At times, older adults may be reluctant to share deeply personal issues such as family problems, depression, and incontinence with members of their group and benefit more from a private discussion with the social worker.

When older adults are not meeting with their group or social worker, they are usually involved in a wide variety of activity groups geared to their special interests. Physical fitness, music, education, current events, arts and crafts, and creative writing are among the types of groups found in adult day health centers.

**Nursing Homes**

One of the greatest fears of older adults is that they will end up living in a nursing home. This fear explains why older adults fight so hard to maintain their independence. Nursing homes are seen as a place older adults are sent to die, neglected and forgotten by their
families. Although this fear may be legitimate for some older adults, nursing homes serve an important role in the continuum of care for frail older adults. When independent living becomes impossible and more structured nursing care is needed, a nursing home may be the most appropriate service.

With a growing older population, it would be expected that the number of nursing homes would be increasing proportionately. However, between 1995 and 2004, the actual number of nursing homes decreased by 16 percent. The number of beds has increased by 9 percent, meaning that today’s nursing home is likely to be bigger than in previous years and that nursing home care is available in fewer locations (National Center for Health Care Statistics, 2004). The decrease in the overall number of nursing homes reflects the improvement in choices available to older adults for health care. Older adults are opting to stay in their own homes longer with the help of less-costly home-based alternatives to skilled nursing care.

The primary role of the social worker in a nursing home is to serve in both a supportive and an educational role to older adults and their families (Vourlekis & Simons, 2006). Social workers begin to work with older adults and their families prior to admission to a nursing home—arranging preadmission visits, doing a preliminary assessment of what kinds of services will best meet the needs of the older adult once admitted, and working out financial arrangements. Nursing home care can cost more than $6000 a month and is not routinely covered by private insurance or Medicare. (Metlife Mature Market Institute, 2006). Some older adults will spend only a few months in a skilled nursing facility—for instance, recovering from an acute illness or surgery—so the social worker’s job may include discharge planning as well.

Nursing home social workers also assume a supportive role in their work with the friends and families of residents. Placing a family member in a nursing home frequently generates guilt and anxiety among family members. They may feel they are abandoning their older adults, despite the fact that less drastic measures have already failed. Maintaining the relationship with the resident, identifying resources for handling the financial demands of placement, and processing the conflicting feelings that accompany placement are common responsibilities for nursing home social workers.

Hospitals

Over one-third of hospital admissions are persons over the age of 65, and this population used 44 percent of the total days of care in the hospital setting (DeFrances & Podgornik, 2004) due primarily to the presence of chronic health-care problems in this population. The complexities of chronic health problems make hospital social work with older adults an essential part of the recovery process. Hospital social workers provide a wide variety of services, including crisis intervention, patient advocacy, patient education, family liaison work, care management, and discharge planning (Volland & Keepnews, 2006).

Hospitalization is a crisis for anyone of any age, but with older adults there is always the fear that the hospital is the gateway to either a nursing home or the grave. Older adults may be anxious about upcoming surgery or be lost in the maze of medical jargon they hear. They may be concerned about what happens to them during the recovery process when they return home by themselves. Families may be concerned that their loved ones will receive too little care or be hooked up to life-sustaining equipment against their will. In sum, the hospital setting can be a very chaotic environment for older adults and
their families. Crisis counseling in a hospital setting involves helping the older adult and families reestablish an emotional equilibrium, begin to understand the medical condition, prioritize tasks, and develop a short-term action plan. The primary focus of the social worker is to help with the psychosocial needs of the older adult in the hospital setting while medical personnel attend to physical health.

Patient advocacy is another appropriate role for hospital social work with older adults. Older adults may find the cold, impersonal atmosphere of the hospital frightening and confusing. They may need help in making their needs known or advocating on their own behalf. For example, a Chinese woman may need a translator, require a special diet, or wish to meet with an herbal healer. Social workers can work with other health-care professionals to find the best match between what the client wants and what the health-care system can tolerate. A part of patient advocacy is patient education, working with older adults and their families to better understand the presenting illness and its course of treatment. Patient education is aimed at empowerment of the older adult. The more older adults know and understand about their illness, the better their own sense of control. When they feel they are part of the treatment process, they are more likely to be active participants in their own healing.

Social workers may also serve as family liaisons for the hospitalized older adults. The older adult’s family needs to understand what is happening to the older adult, the prognosis for the illness, and what plans need to be made following the hospitalization. For many families, contact with a hospital social worker is the first contact they have had with the social services system. Up until that point, they may have struggled to provide care on their own, unaware of the range of community services available to them. The process of discharge planning, another important hospital social work role, involves developing and coordinating the support services for post-hospitalization. Meals-on-Wheels, home health care, chore services, and homemaking services can be very effective in helping older adults to maintain their independence while providing invaluable support.

Social workers can provide both educational and supportive presence in helping older adults and their families make difficult end-of-life decisions. Helping older adults make choices about what circumstances warrant being connected to life-support equipment, whether they want to be resuscitated after a heart attack, or who should make those choices when they are unable to are sensitive issues. Facilitating the discussion between an older adult and the family about these questions may be among the most difficult tasks in hospital social work.

DEVELOPING AREAS FOR DIRECT PRACTICE

Although social workers will be needed in the most traditional areas already discussed, there is unlimited potential for direct practice in other areas with older adults with the growth of this population. Two specific areas that will need a greater number of social workers are the legal services area and preretirement planning programs in both the public and private sectors.

Legal Services

Law and social work have had a long and sometimes tumultuous history. Although the professions share the joint goal of problem solving, the clash between legal and social work professions’ foci in the resolution of problems is a major challenge to interprofessional
cooperation. Whereas law uses strict interpretations of existing laws and legal precedents, the confines of administrative rules and regulations, and a much more factual, not feeling, approach to problems, social work’s approach is more deeply rooted in the consideration of the biopsychosocial factors that influence the development and perpetuation of a problem facing a client (Madden & Wayne, 2003; Taylor, 2006). However, these professions can work together very effectively once each profession’s expertise is clarified. This is particularly beneficial in areas of elder law. Helping an older adult and his or her family make provisions for Durable Powers of Attorney for Health Care or determine competency in the case of dementia are good examples of the necessity of social workers and lawyers working collaboratively. When an older adult is competent but needs assistance in managing property or finances, lawyers and social workers are both important members of a team that will set up (and explain) guardianship (Joslin & Fleming, 2001; Sember, 2008). Another example is when an older adult is facing a problem that has very distinct social and legal implications, such as housing. What may have started out as an occasional lapse in the older adult’s ability to remember to pay the rent may escalate into an eviction proceeding. The immediate legal action necessary to halt the physical removal of the older adult from the residence is the lawyer’s role. The social work role involves long-term solutions to the housing crisis, such as finding a way to pay back rent, identifying another party to act as a fiscal agent, or considering the move to a safer, more structured living situation. One of the fastest-growing areas of elder law is that of the legal issues facing grandparents raising grandchildren. Issues in custody of dependent grandchildren, financial support, and discrimination in housing lead the list of sociolegal challenges facing this population (National Academy of Elder Law Attorneys, 2011; Wallace, 2001). Lawyers are invaluable in navigating the complex system of child welfare law, whereas social workers are better prepared to handle the social and mental health challenges facing these older adults and their dependent grandchildren. The best solutions to these challenges will come only by interprofessional teamwork.

Preretirement Planning

Preretirement planning often is equated with financial planning; however, an adequate income is only half of the challenge of retirement. It is easy to see how the demand for services in this area is growing as the first group of baby boomers is facing retirement. The area of preretirement planning that receives the least attention is the psychosocial aspect of the transition from full-time employment to whatever is next. For people who have defined themselves in terms of their jobs or have relied almost exclusively on the workplace for social contacts, retirement can be very challenging. What do people do now? How will they redefine their lives to create a balance between the joys of leisure activities and continued productivity? How will couples manage relationships when they are together all the time as opposed to having separate lives at work? Most important, what challenges face individuals who simply cannot afford to retire, even in the face of serious chronic health conditions? These questions embody the very essence of social work’s expertise in the biopsychosocial dimensions of people’s well-being. The social work profession is only now beginning to define its role in this process, usually in the context of Employee Assistance Programs available in both the public and private sector. The most exciting aspect of this area of practice is that the roles for social workers are yet to be clearly defined. How social workers can facilitate a healthy adjustment to retirement will be shaped by the next generation of gerontological social workers.
MACRO SETTINGS FOR GERONTOLOGICAL SOCIAL WORKERS

The role of social workers in direct service settings is readily apparent, but gerontological social workers also play an invaluable role in macro settings, such as community practice, planning, and legislative and political advocacy. The United States has a well-developed federal aging services and programs network, authorized by various titles of the Older Americans Act of 1965. These include an authorization for a national, regional, state, and local structure to plan and deliver a wide range of services to older adults as well as to systematically plan for the future needs of older adults and advocate on behalf of this population in the legislative setting. Some of the macro practice roles for social workers fall directly within this network. The aging services network and the programs it oversees will be discussed in detail in Chapter 13. Other gerontological social workers practice within private and community agencies specifically dedicated to the planning and legislative advocacy interests of older adults.

Community Practice

The major foci of community practice with older adults is to mobilize and empower the older adult population to take an active role in their own problem solving by emphasizing the shared concerns of a community, rather than solving one individual crisis at a time. Community work with older adults encompasses a wide variety of settings. Community can mean something as specific as a congregate housing setting or as broad as a city or town. In smaller community settings, organizers can be instrumental in mobilizing older adults to get improved public transit, organize a building crime watch network, or improve snow removal in front of a housing development (Massachusetts Senior Action, 2011). Social workers can also help mobilize older adults to petition a city government to grant a property tax exemption, improve access to health and social services through development of neighborhood centers, or develop an emergency plan for weather or health-related emergencies.

Public education is another function within the general category of community practice for macro social workers. For example, when Medicare Part D, the prescription drug program, was being implemented in 2006, older adults desperately needed simple, clear information about the program. Providing this education either on an individual level or within the context of a community setting was often the responsibility of a social worker, who had a strong knowledge base in all aspects of Medicare and was particularly sensitive to older adults’ needs and concerns. Likewise, social workers are currently involved in offering educational campaigns about HIV/AIDS, fraud and financial abuse prevention, home safety, and advance directives, all of which are discussed later in this book. Public education is not just “telling” people what they need to know. It involves a comprehensive and understandable presentation of why the information is crucial and the patience to listen to the questions and concerns of older adults.

Planning

Social workers also practice in the planning offices of State Offices on Aging and Area Agencies on Aging. Social planning involves the process of exploring both community needs and assets, developing plans of action, and evaluating future and existing policies
The Context of Social Work Practice with Older Adults

and programs (Wacker & Roberto, 2008). The answer to the growing population of aging baby boomers is not to simply build lots of new senior centers. The real crisis lies in areas such as developing alternative housing, health, and leisure programs that reflect the needs of a very different generation of older adults. Planning involves comprehensive needs assessment, an in-depth understanding of changing demographics, and sensitivity to how new and existing services will be financed. How do the needs of urban older adults differ from those of suburban older adults? What kinds of emergency programs need to be designed to adequately protect older adults in case of natural disaster, a health epidemic, or weather crisis? What kinds of programs need to be developed to meet the needs of older adults who still need to work but require more flexible work arrangements or training to keep up with technological advances? These are the challenges to public planning officers who must not only know what is currently working but what will be needed in the future.

Legislative and Political Advocacy

Advocacy and empowerment are central tenets of the social work profession, both in their role of acting on behalf of individuals and on behalf of specific vulnerable client populations in the political arena. Most programs and services for older adults are funded by federal and state funds and thus require both supporting legislation and administrative authority to operate. The social work role in legislative advocacy involves creating public awareness among older adults about pending legislation that may affect them and mobilizing this population to pressure legislators to act on their behalf. The legislative process is complex and may be confusing to older adults without access to the inside issues around the legislation. State chapters of the National Association of Social Workers (NASW) have rallied both member and client support for such issues as mental health coverage parity laws, loan forgiveness for social work education, immigration rights, age and gender discrimination, and property tax relief for older adults.

NASW’s Political Action for Candidate Election (PACE), the political action arm of the organization, works on behalf of candidates whose views on a variety of social welfare issues support the organization’s policy agenda. They support these candidates through fund-raisers, campaign contributions, and public endorsement of the candidates during the elective process (National Association of Social Workers, 2011). The social work profession’s role in legislative and political advocacy is a combination of local, state, and national efforts, all aimed at advocating for and empowering clients who are directly affected by the policy framework affecting policies and programs.

PERSONAL AND PROFESSIONAL ISSUES IN WORK WITH OLDER ADULTS

Although deeply rewarding both personally and professionally, work with older adults requires a high level of self-awareness on the part of the social worker. In all intervention efforts, workers bring their own emotional baggage to the helping process. However, in gerontological work, the issues are more complex. Unlike social work practice in the areas of alcoholism, drug abuse, family dysfunction, or domestic violence—social problem areas that may or may not personally affect the worker—everyone must eventually face
the experience of aging and death for themselves and their families. Aging is not a social problem; it is a developmental stage. The universality of the aging experience influences work with older adults on both a conscious and subconscious level. Among the most significant issues workers will face are the subtle influences of lifelong social and personal messages about ageism, countertransference of feelings toward older adults, and conflicting issues surrounding independence versus dependence.

**Ageist Personal and Social Attitudes**

The term *ageism* refers to the prejudices and stereotypes attributed to older persons based solely on their age (Butler, 1989). These stereotypes are usually negative and convey an attitude that older adults are less valuable as human beings, thus justifying inferior or unequal treatment. These attitudes develop early in life as children observe parental, media, and social attitudes toward older adults. Parents may unintentionally send the message that aging parents and grandparents are a nuisance to care for, demanding, needy, or unpleasant. Even simple comments, such as “I hope I never get like Grandma” or “Put me to sleep if I ever get senile,” may be interpreted literally by children. Every time parents refer to aches and pains as “I must be getting old,” the subtle message becomes clear that aging is destined to be painful and debilitating. Although ageism is an attitude that hinders everyone’s ability to adjust to the normal changes of aging, it also serves a more destructive social justification. Ageism rationalizes pushing people out of the labor market in the name of maintaining productivity without much thought to what happens to people when their lives are no longer centered on work as an organizing principle. Ageism justifies segregated living arrangements, substandard medical care, and generally derogatory attitudes toward older adults. Blatantly racist or sexist comments and open discrimination would not be tolerated in today’s business and social arenas, yet ageist attitudes and comments are rarely challenged.

**Countertransference**

*Countertransference* is defined as the presence of unrealistic and often inappropriate feelings by the social worker toward the older adult that distort the helping relationship (Nathan, 2010; Reidbord, 2010). The worker displaces feelings or attitudes onto the client based on a past relationship rather than on the real attributes of the older adult with whom he or she is working. Countertransference develops from two primary sources in working with older adults. Internalizing ageist attitudes reflected in society can lead a social worker to intensively dislike working with older adults because they are subconscious reminders of death and illness. On an unconscious level, the social worker may believe his or her work is wasted because the older adult will soon die, benefiting minimally from the social worker’s time and attention. Countertransference can also develop when a social worker is unaware that positive or negative relationships from the past are distorting the present relationship.

For example, a young social worker is assigned to work with an older woman in identifying an appropriate assisted-living facility, a painful but necessary move for the older woman. When she goes to the woman’s house, the older woman insists on serving cookies and tea to her and they end up visiting for several hours rather than attending to the task at hand. When her supervisor inquires as to the decision about assisted living, the young
woman hesitates and responds that she thinks it is “mean” that the family is making her go to assisted living, that this older woman wants to stay in her home and maybe with enough services she could stay there. She hasn't actually had the discussion about which assisted-living facility the older woman might select as it is just too awkward to bring up the topic. After the supervisor explores the situation with the worker, it becomes apparent that the worker overheard her own mother arguing with her grandmother a few years ago about the same kind of decision. She remembers her grandmother saying “if I have to leave my house, I might as well just die!” which in fact she did shortly after moving into assisted living. The older woman struggling with the decision to leave her own home was a subconscious reminder to the social worker of a painful situation in her own life. In order to alleviate her own pain and guilt, the worker was trying to avoid her client facing the same situation. The worker's need to “save” the older adult may rob the older adult unintentionally of his or her self-respect and personal dignity. It is essential to explore issues in countertransference with supervisors.

Ageism and Death Anxiety

Internalized negative attitudes toward the process of aging and older adults contribute to a pervasive presence of “death anxiety” in contemporary society. Death anxiety is a highly agitated emotional response, invoked by reference to or discussion of death and dying (Peck, 2009). Working with older adults is a constant reminder to the social worker of the logical progression of the life cycle—from youth to aging and death. American society does not deal well with death or any discussion of death. Consider all the phrases used to avoid saying the word death, such as “passed on,” “expired,” “gone on to the next world,” and many others not quite so polite.

Facing a variety of situations surrounding death is an inevitable part of work with older adults. Many older adults will admit that death does not frighten them as much when they are older as it did when they were younger. They see friends and family members dying. Throughout their lives, they have thought about what death means to them, whether they believe there is an afterlife, and what their lives have been all about. If they have escaped the discomfort of chronic medical problems, they consider themselves lucky. If they live with a disabling or painful condition, they may welcome death as an end to the physical discomfort. Older adults often want to talk about funeral arrangements or make plans for disposing of their personal possessions even when family members do not. Although older adults’ families may cling to denial as a means of warding off a critically ill older adult's death, hospital policy may simultaneously ask the family to make difficult end-of-life decisions. All these issues are examples of how social work with older adults requires some level of comfort on the part of the social worker in acknowledging and processing death not only with clients but also in one's own work in self-awareness.

The Independence/Dependence Struggle

One of the most frequently stated goals older adults voice is their desire to maintain their independence for as long as possible. This desire coincides with the social work profession's commitment to promote self-determination and preserve the dignity of the individual. On the surface, there appears to be no conflict. In reality, as older adults require more and more support services and experience increasing difficulties in maintaining
independent living, tensions between older adults’ desires and families’ and social workers’ perceptions of need are inevitable. A worker can appreciate the desperate efforts on the part of an older adult to stay in his or her own home. Yet when an older adult is struggling with stairs or a deteriorating neighborhood, and difficulties in completing the simple activities of daily living challenge the feasibility of that effort, professional and personal dilemmas abound. Who ultimately must make a decision about an older adult’s ability to stay in his or her own home? Who decides that an older adult is showing poor judgment about financial decisions? When does Protective Services step in to remove an older adult from a family member’s home due to neglect or abuse, despite the older adult’s objections? When do the wishes of the family supersede the wishes of the older adult, or do they ever? These are difficult questions for which there are no simple answers.

While functioning an entire lifetime as an independent adult, a single illness can reduce an older adult to dependency more quickly than he or she can emotionally process. In an effort to counteract a diminished sense of self-esteem, older adults may fight dependency to the point that they put themselves in physical jeopardy rather than risk relying on others. They may act out, show extreme anger, or make excessive demands on both social workers and family members that cannot be met. Maintaining independence should be a critical goal of all gerontological social work, and throughout this book, various ways of promoting independence, even among the most disabled older adults, will be presented.

Other older adults react by assuming dependent roles sooner than they need to and become more passive and resistant than their physical condition warrants, assuming a kind of “learned helplessness.” Rather than fighting for their own independence, they give up and willingly relinquish the decision-making issues in their own care. Although giving up their own rights to decision making may make case planning easier for workers and families, this situation lends itself to the development of other, more subtle problems. One of the fundamental concepts of social work practice is the importance of clients’ choice of goals for intervention and their personal commitment to work on those goals, a basic tenet in adapting the strengths-based perspective discussed earlier in this chapter. For example, a social worker may decide an older adult needs to attend a senior center program to decrease personal isolation. Even though the older adult may agree so as not to offend the social worker and out of gratefulness for all the worker has done for the older adult, the older adult will not go to the senior center and participate if he or she does not want to go. The older adult may not blatantly refuse to go, but rather will make appropriate excuses for nonattendance. Although well intentioned, the social worker has decided on a goal for the older adult that is the social worker’s goal, not the client’s. It is not surprising that family and workers become frustrated when older adults find ways to avoid doing something that is not their goal in the first place.

The process of relinquishing independence is the beginning of a very delicate process, even among those older adults who are sincerely willing to let others make decisions for them. Older adults become reactors rather than actors in their lives. Perceiving that they have little control over their lives, older adults may fall into a deep depression and relinquish their will to live along with their independence. Families and caregivers, who perceive that older adults have given up even when they are capable of some independent activities, may react with anger and hostility. The social worker’s role is to help the older adult and family find common ground that promotes self-determination and meets the need for services.
Self-Awareness and Supervision

The challenges of working with older adults within a societal context of ageist attitudes—which contribute to deeply seated fears about one's own aging and death—may seem a bit overwhelming at this point in the book, but there are resources for resolving these issues. Through developing self-awareness with professional supervision, social workers can effectively work through these issues. They are discussed early in the text because they should be clearly present in your mind as you study this field of practice. Developing self-awareness is a process that takes time and continues to challenge professionals throughout their careers. It may take a lifetime of working with older adults (and one's own relatives) to recognize your own personal triggers for problematic feelings.

Workers need to take a critical look at any concurrent challenges they are facing in their own lives that could contribute to professional problems. A social worker who is also balancing the demands of an aging spouse, parents, or grandparents may feel such excessive demands on his or her own resources that working effectively with older adults may not be possible. Although such experiences may be helpful to the worker in developing compassion for an older adult's family, it may be counterproductive in the intervention process.

The ability to keep feelings at a conscious level is one of the most important parts of the process of developing self-awareness in working with older adults. One's personal feelings toward a client, family members, and the quality of the professional relationship are important clues to the worker about his or her own emotional issues. Supervisors can be helpful in diversifying tasks for the worker in an effort to defuse the emotions generated by intense cases. Working exclusively with highly dependent older adults or those with Alzheimer's disease can tax even the most well-adjusted, experienced workers.

Most gerontological social workers, including this author, would emphasize that working with older adults has tremendous rewards. It is a professional and personal joy to work with older adults who have lived through the most interesting of times and delight in retelling their life stories. Seeing the power of the human spirit in older adults who have survived and thrived through raising families, struggling with careers inside and outside the home, and reframing the meaning and purpose of their lives during the later years is a very positive and revitalizing experience for any professional. Older adults can be delightfully humorous, frustratingly stubborn, amazingly persistent, but always the most powerful reminder of the resiliency of the individual to grow and flourish throughout the life span.

SUMMARY

One of the greatest challenges to society and the profession of social work is the dramatic increase in the number of persons over age 65 in the twenty-first century. Although the baby boomer generation will no doubt forge new ways to meet the demands of this developmental stage, quality health care, a productive postretirement lifestyle, and adequate financial resources pose challenges to today's and tomorrow's older adults. For some older women and older adults of color, the devastating effects of a lifetime of poverty and substandard health care will follow them into old age. These groups are the most vulnerable older adults.
The future of gerontological social work is bright not only because of the growing demand for specially trained practitioners but also because of the variety of settings in which social workers will be needed. In addition to traditional settings, such as hospitals and nursing homes, social workers can be found in community settings, legislative offices, and legal settings. These settings will demand a high level of skill in specific practice techniques and a willingness to engage in the self-awareness necessary for professional work with older adults. Working with older adults can trigger powerful feelings about death, the aging of family members, and one’s own attitudes about helping this vulnerable population. However, this population is also one of the most rewarding for social workers.

References
The Context of Social Work Practice with Older Adults


CHAPTER 1 REVIEW QUESTIONS

The following questions will test your application and analysis of the content found within this chapter.

1. Professional supervision is critical to social workers but especially to those working with older adults because
   a. many older clients will die and increase the likelihood of depression for the social worker.
   b. older adults are the most difficult client population to work with.
   c. every social worker will need to confront the reality of his or her own and family members' aging.
   d. there are few solutions to the problems of older adults.

2. A geriatric care manager has been working with an 85-year-old man who is able to live alone but needs housekeeping and home health services. Suddenly, he becomes very hostile and refuses to let the care manager into his home. The first thing the social worker should do is
   a. call Adult Protective Services to force the man to let her in his home.
   b. call the man’s physician to get a prescription for antidepressants.
   c. contact a family member to alert him or her to the recent change.
   d. see if one of the neighbors has a key to the man’s home.

3. An older adult with many physical and cognitive problems adamantly insists on staying on in her own home despite her family’s wishes that she consider an assisted-living facility or a nursing home. The family cannot provide direct assistance but can pay for services. What should the social worker do?

4. A wealthy older woman is facing nursing home placement but her family wants to keep her assets from being spent for her care to protect their inheritance. If she has fewer assets she will be eligible for medical assistance and her care will be free in a nursing home. The family asks you for advice. What should the social worker do?