# *Aging and Wellness*

## *BACKGROUND*

The aging of the U.S. population presents social and political implications for both the social work profession and society. Although ageism remains prevalent, the aging of the baby boom generation is challenging biases toward older people. Social workers, other professionals, and the public increasingly understand that old age is a time of continued growth and that older adults contribute significantly to their families, communities, and society. This shift influences gerontological social work practice, education, and research (Social Work Leadership Institute, 2007).

As the U.S. population ages, it is also becoming more racially and ethnically diverse (U.S. Census Bureau, 2005). The proportion of older people who are minorities will increase from 16.4 percent in 2000 to 23.6 percent in 2030 (Administration on Aging, 2006). In addition to race and ethnicity, cultural diversity among older adults is recognized increasingly in geographical location and living arrangements; national origin and civil status; sex, sexual orientation, and gender identity and expression; religious and political beliefs; and physical, psychological, and cognitive ability, among other factors.

Demographers attribute population aging primarily to declining fertility and mortality rates (United Nations, 2002). From 1950 to 2000 the proportion of adults 60 years of age and older increased from 12.1 to 16.3 percent of the U.S. population; this percentage is projected to rise to 26.9 percent by 2050. Similarly, the median age of the population rose from 30.2 to 35.3 years between 1950 and 2000, and is expected to rise to 40.7 years by 2050 (United Nations, 2002; U.S. Census Bureau, n.d., 2001). Globally, the "oldest old"—those 85 years and older—comprise the fastest growing segment of the population (National Institute of Aging & U.S. Department of State, 2007). By 2050 the world will experience a squaring off of the population pyramid: Ninety-four percent of the global population will survive to 60 years (United Nations, 2002; Wan, Sengupta, Velkoff, & DeBarros, 2005).

Although adults are generally living longer, gains in life expectancy are not equally enjoyed by all. For example, a study by Ezzati, Friedman,

Kulkarni, and Murray (2008), of all counties in U.S. states, plus the District of Columbia, found that life expectancy actually decreased between 1983 and 1999 in almost 1,000 counties, primarily in rural and low-income areas; within those counties, women experienced the greatest increase in mortality rates (Ezzati et al., 2008).

Even among adults who are living longer, whether *healthy life expectancy* —defined by the World Health Organization (2002) as expected years free of illness, disease, or disability—is increasing remains unclear. In 2005, 42 percent of people 65 years and older reported they had at least one functional limitation, with women reporting higher levels of functional limitations than men (Federal Interagency Forum on Aging-Related Statistics, 2008). Although this number constituted a 7 percent decline from 1992, the overall levels of functional limitation among older adults remained fairly steady between 1997 and 2005. Moreover, percentages of disability increase with age. In 1997, 30.0 percent of people 65 years to 74 years of age reported an activity limitation, whereas 50.2 percent of those 75 years and older reported a limitation. Seven years later, 25.5 percent of the younger group and 43.9 percent of the older cohort reported any disability (Centers for Disease Control and Prevention, 2006).

Income security remains another primary concern for many older adults in the United States. The Social Security Act of 1935 (P.L. 74-271) moved a substantial portion of older adults out of poverty, providing a permanent, inflation-protected benefit (Social Security Administration, 2003). Without the Social Security program, the poverty rate among older adults would increase to more than half (National Committee to Preserve Social Security and Medicare, 2008b).

Even with the safety net of social security, almost one in 10 adults age 65 and older lives in poverty (U.S. Census Bureau, 2007b); poverty rates are even higher for older adults who are black, Latino, American Indian, or Alaska Native (U.S. Census Bureau, 2007a, 2007b). Older women, on average, are nearly twice as likely as men to live in poverty (Administration on Aging, 2008); poverty rates among older black and Latina women are especially high (U.S. Census Bureau, 2005). Kinship care also increases the risk of poverty for both women and men: Nineteen percent of the 2.4 million grandparents raising grandchildren who live with them—of which 29 percent are 60 years and older—live in poverty (AARP Foundation et al., 2007).

Aging frequently presents other serious challenges to older women, who comprise almost 60 percent of the population age 65 years and older. Older women constitute about 75 percent of the nursing home population age 65 and older; are more than four times as likely as men to be widowed; and are more than twice as likely to live alone (Administration on Aging, 2006). Because adult women, as a whole, still comprise the majority (61 percent) of

unpaid caregivers in the United States (National Alliance for Caregiving & AARP, 2004), they disproportionately experience the financial, physical, and emotional consequences of caregiving as they age.

The growing importance of gerontological social work manifests in increased foundation investments in gerontological social work education, training, and research. In its 2008 report on the future of the professional health care workforce for older adults, the Institute of Medicine (IOM) affirmed both the increasing need for gerontological social work and the profession's initiatives to address that shortage. Social workers are well positioned to support and advocate for older adults and their caregivers.

# *ISSUE STATEMENT*

## *Health and Behavioral Health Care*

Social workers interact with older adults across the continuum of health and behavioral health care. Chronic illness and functional disability severely affect the health and quality of life of older people. Access to health promotion activities and disease prevention services throughout a person's life span can prevent functional limitations and is essential to healthy aging (United Nations, 2003). The ability to participate actively in, and advocate for, one's own health care is key to health promotion and especially important for older adults, the majority of whom have multiple chronic conditions (Vogeli et al., 2007).

Though frequently overlooked by health care providers and older adults alike, behavioral health promotion and treatment are also crucial to the well-being of older people. Depression is the most common mental health condition among older adults (Administration on Aging, 2004). The suicide rate for adults 65 years and older, especially white men, remains the highest for any age cohort (Adamek & Slater, 2006; Centers for Disease Control and Prevention, 2007). The Substance Abuse and Mental Health Services Administration (SAMHSA) considers substance abuse—particularly the use of alcohol and prescription drugs among older adults—an invisible epidemic and one of the fastest growing health problems in the United States (SAMHSA, 1998). Gambling addiction is also growing among older adults (Administration on Aging, 2007). The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275) eliminates, over a six-year period, the discriminatory co-payment for outpatient mental health services. This legislation, long sought by NASW, eliminates a severe obstacle to mental health diagnosis and treatment for older adults.

The growing need for long-term services and supports presents another challenge to older adults' well-being and quality of life. The Centers for

Medicare and Medicaid Services (2007) estimated that 12 million people will need long-term care services by 2020. Medicare, Medicaid, and other insurance systems have not adequately addressed the need for home, community-based, and nursing home care for older people and their caregivers, and will continue to be challenged to meet this burgeoning need.

## *Housing*

Housing that is compatible with the abilities and needs of older people promotes positive health outcomes and well-being. Government funding for assistive technology and home repair, modification, and redesign, combined with coordinated health and social service programs, can help people age in place, thereby preventing unnecessary and unwanted institutionalization (Cox, 2005). Moreover, an increasing number of housing options are available or under development to meet the needs of older adults in the community and in congregate settings. These include naturally occurring retirement communities (NORCs), shared housing, independent and assisted-living residences, and continuing care retirement communities (Cox; Gonyea, 2006). This continuum of options, if truly affordable and accessible, can enable older adults to live independently as long as possible in their communities based on individual preferences (Gonyea). Within nursing facilities and other long-term care sectors, the culture change movement—of which the Green House Project is one example (Rabig, Thomas, Kane, Cutler, & McAlilly, 2006)—strives to create a social model of care centered on the strengths and preferences of individual residents (Krugh, 2003).

## *Economic Security, Work, and Retirement*

Public policy, employer practices, and societal attitudes affect both employment and retirement opportunities and, subsequently, economic security for older adults (Hudson & Gonyea, 2007). Many older people want or need to continue working beyond the traditional retirement age, at least on a part-time basis; employer bias and social security income restrictions limit their participation and promotion in the workforce, however. At the same time, efforts to privatize social security—which constitutes over half the retirement income for two-thirds of older adults and the sole source of income for at least 20 percent (Social Security Administration, 2003)—persist (National Committee to Preserve Social Security and Medicare, 2008a).

Whether their contributions to society are paid or unpaid, older adults committed to civic engagement increasingly serve as vital resources to their communities and simultaneously experience enhanced well-being as a result

of their efforts. Growing recognition of the individual and societal benefits of older adults' volunteerism, lifelong learning, and political advocacy is transforming the notion of old age and retirement as a period of disengagement (Hinterlong & Williamson, 2006).

## *Caregiving*

Caregiving for family and friends—including physical care, financial assistance, and emotional support—is a major intergenerational role for adults of all ages and has become increasingly common for older adults in later life (Montgomery, Rowe, & Kosloski, 2007). Older adults, especially older women, frequently serve as the primary caregivers for aging parents, aging children with disabilities, adult relatives living with HIV/AIDS, the children of those relatives, and the children of incarcerated relatives (Hooyman, 1999; McCallion & Kolomer, 2003; Poindexter & Boyer, 2003). The pressures of caregiving affect the quality of life of older adults, who often struggle to care for themselves while caring for others (Kropf & Yoon, 2006; Roberts, Allen, & Blieszer, 1999). Although the National Family Caregiver Support Program and other programs provide valuable assistance, many older adults provide care at great cost to their own physical, emotional, and financial well-being.

## *Elder Abuse and Mistreatment*

Mistreatment of older adults includes physical, sexual, and emotional or psychological abuse (National Center on Elder Abuse, 2007; United Nations, 2003); neglect, abandonment, and self-neglect; and financial or material exploitation (National Center on Elder Abuse, 2007). Early studies suggested that elder mistreatment by family caregivers was due to caregiver stress (Steinmetz, 1988); however, later studies have suggested abuser characteristics are more likely to be predictors of abuse (Brownell, Berman, & Salamone, 1999; Reis, 2000).

National efforts to address elder abuse and mistreatment include public education, passage of reporting laws, development of intervention strategies and models (notably interdisciplinary teams), and criminal prosecution of abuses that rise to the level of a crime (Tomita, 2006).

## *Diversity*

Commitment to cultural competence underlies gerontological social work and reflects the core values of both NASW and the Council on Social Work Education (Chadiha, 2006).

Policies and programs frequently do not reflect the cultures and languages of either older adults with a migration background (such as Asians and Latinos) or indigenous older people; consequently, these groups may underuse or fail to benefit from needed services (Barusch, 2006; Min & Moon, 2006). Black older adults, who represent diverse cultures and interests (Chadiha, Brown, & Aranda, 2006), also experience disparities in service access, usage, and outcomes (see, for example, Barton Smith et al., 2007).

Gerontological social work practice reflects growing sensitivity to and knowledge about spirituality and religion (Murdock, 2005). Similarly, social work literature increasingly incorporates the experiences, strengths, and needs of lesbian, gay, bisexual, and transgender older adults and their caregivers (Butler, 2004; Coon, 2007; Hunter, 2005; Schope, 2005).

## *Ethical Issues*

Advances in medical treatment have increased the ability to sustain life, bringing to the forefront ethical concerns regarding quality of life, cultural values, and death with dignity (Galambos, 1998). Questions of self-determination, end-of-life autonomy, and competency have gained increasing prominence among gerontological social workers. Complex issues of autonomy and protection arise in social work practice with older adults receiving protective and guardianship services (Brownell, 2006; Crampton, 2004; Kosberg, Rothman, & Dunlop, 2006; Linzer, 2004).

## *Professional Training*

The social work profession, with its strengths-based, person-in-environment perspective, enhances older adults' quality of life in unique ways. The National Institute on Aging (as cited in IOM, 2008) estimated in 1987 that between 60,000 and 70,000 social workers would be needed by 2010 to provide services to the aging population. Since that time, the profession has undertaken multiple initiatives to promote education, training, and competence in gerontological social work. Nonetheless, a national workforce study conducted by the National Association of Social Workers (Whitaker, Weismiller, & Clark, 2006) found that the social work profession faces significant obstacles in recruiting new social workers to serve older adults, and that training of additional gerontological social workers is needed —a conclusion affirmed by IOM's Committee on the Future Health Care Workforce for Older Americans (2008).

# *POLICY STATEMENT*

NASW supports the following policy principles that promote the well-being of all older adults:

■ continued development and promotion of gerontological social work content and practicum opportunities at the bachelor's, master's, and doctoral levels; expansion and promotion of continuing education, competencies, frameworks, and credentialing in gerontological social work.

■ promotion of optimal physical, mental, emotional, social, spiritual, and functional well-being of people as they age.

■ advancement of policies, programs, and professional behavior that promote self-advocacy, lifelong learning, civic engagement, and intergenerational compatibility.

■ advocacy for the preservation and integrity of social security; expansion of public, private, and commercial systems of economic security for older adults, with special attention to the needs of older women.

■ promotion of wellness, prevention, early intervention, and outreach services in health, behavioral health, and social service programs for older adults and their caregivers.

■ advocacy for a comprehensive health care system (including prescription drug coverage) for all older adults, regardless of ability to pay.

■ advocacy for parity in reimbursement for behavioral health services; support for policies and programs that address depression and substance abuse and reduce the incidence of suicide among older adults.

■ advocacy for a comprehensive and affordable system of long-term services and supports that enables older adults to maintain maximal independence in the setting of their choice.

■ expanded recognition of and reimbursement for the social work role in meeting the biopsychosocial needs of older people and their caregivers, including advance care planning and comprehensive care management.

■ elimination of biases and policies that contribute to poverty, unnecessary nursing home placements, employment discrimination, and health disparities among older adults.

■ recognition of and respect for the role and expertise of caregivers; continued development and funding of psychosocial and financial support

programs for caregivers, including respite services.

■ strengthening of government oversight, requirements, and funding for the protection of vulnerable older people in the home, in communities, and in institutions; passage of a federal elder justice act and federal funding for state-based programs to prevent and address elder mistreatment.

■ expansion of policies and programs that address the transportation, housing, and service access needs of older people in urban, suburban, rural, and frontier areas.

■ support for programs that enable older adults to become formal or informal care providers for children, including financial support and legal guardianship.

■ participation of older adults and caregivers in the design, implementation, and evaluation of programs, policies, and research related to aging; continued intergenerational exchanges between new and experienced or retired social workers within NASW.

■ promotion of policies that support death with dignity.

■ support for additional governmental and foundation funding for research, professional publications, and communication of best practices in gerontological social work; continued development and use of gerontological evidence-based assessments and interventions.

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*Policy statement approved by the NASW Delegate Assembly, August 2008. This policy statement supersedes the policy statement on Senior Health, Safety, and Vitality approved by the Delegate Assembly in 1999 and referred by the 2005 Delegate Assembly to the 2008 Delegate Assembly for revision, and the policy statement on Aging approved by the Delegate Assembly in 1990 and 1977. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 700,*

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