NASW

National Association of Social Workers California Chapter

November 19, 2019
Secretary Mark Ghaly, MD
California Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, California 95814

Re: Input for the California Master Plan for Aging

Dear Secretary Ghaly:

The National Association of Social Workers, California Chapter, is providing input to the Master Plan for Aging in the form of the attached policy statements and recommendations for Aging and Wellness and for Long-Term Services and Supports (LTSS). These statements and recommendations were developed by social workers across the country and approved by the National Association of Social Workers (NASW) 2017 Delegate Assembly. Both statements are broad and include recommendations for federal and state action. LTSS was deemed particularly important and as such has its own policy statement and recommendations. Professional social workers are unique among the helping professions in that their training and education focuses on the person in the environment or sometimes known as whole person care.

Most of the recommendations require funding or additional funding and it is recognized that the area of aging services including LTSS is seriously unfunded or underfunded.

The National Association of Social Workers is ready and prepared to any assistance needed in the development of the California Master Plan for Aging.

Sincerely,

Janlee Wong

Janlee Wong, MSW
Executive Director

Attachments

1016 23rd Street • Sacramento, CA 95816-4910 • (916) 442-4565 • (800) 538-2565
(E-mail) naswca@naswca.org • FAX (916) 442-2075 • http://www.naswca.org

Long-term Services and Supports

ISSUE STATEMENT

Long-term services and supports (LTSS) help individuals with disabilities and older adults to maximize their independence and quality of life. Though typically defined as assistance with activities of daily living and instrumental activities of daily living (Commission on Long-Term Care [Commission, hereinafter], 2013), LTSS are intended to form a comprehensive continuum that maximizes both physical functioning and psychosocial well-being, building on community, individual, and family strengths. Individuals use LTSS in a variety of locations, including in their own homes and in a range of community-based and residential care settings. Families—including both legally recognized family and family of choice—provide the majority of LTSS in the United States, usually on an unpaid basis (O'Shaughnessy, 2013a). Family caregivers' efforts are supported and complemented by an interdisciplinary workforce that includes professional social workers.

The number of people relying on LTSS has grown dramatically as the population ages and the number of people living with chronic conditions increases. LTSS users number more than 12 million (Commission, 2013), a figure anticipated to more than double by the year 2050 (Henry J. Kaiser Family Foundation, 2013). Although the mounting prevalence of Alzheimer's disease and related disorders contributes greatly to LTSS need (Alzheimer's Association, 2013), people of all ages and conditions depend on LTSS.

Across LTSS settings, numerous policy strategies to coordinate and improve access to services, enhance quality, and increase participant and family involvement and satisfaction are being implemented, many as a result of the Patient Protection and Affordable Care Act (ACA) of 2010 (P.L. 111-148). However, much work remains to create a comprehensive, integrated system of high-quality, affordable LTSS. Many LTSS continue to be based on a deficit-focused, medical model that does not fully support the self-determination of participants and families. Fragmentation and lack of monitoring, navigation, coordination, advocacy, and psychosocial supports can prevent many people with disabilities and older adults from living to their fullest potential. Furthermore, LTSS access, coordination, and quality are limited by disparities related to a variety of cultural factors, including (but not limited to) class, ethnicity, gender, gender identity, geography, health conditions, immigration status, language, race, and sexual orientation.

The lack of a sustainable system of LTSS financing is widely recognized as a crisis—one that is inseparable from both access and quality. Public, private, and out-of-pocket spending for LTSS in the year 2011 totaled more than \$210 billion, and this figure is far from exhaustive (O'Shaughnessy, 2013b). The private longterm care insurance market, once thought to be the solution to LTSS financing, is dwindling (Gleckman, 2012). Those policies that do remain are unaffordable for most people in the United States (Kassner, 2013)—especially people of color (Rhee, 2013) and women (Gross, 2013)—and a significant number don't cover many integral LTSS (Commission, 2013). In 2010 the ACA created a voluntary, national long-term care insurance system, Community Living Assistance Services and Supports (better known by its acronym, CLASS), but the program was subsequently deemed financially unsustainable and was withdrawn (Appleby & Carey, 2011; Span, 2011). In 2013 Congress established the bipartisan, independent Commission on Long-Term Care, which was charged with developing a national LTSS plan within six months (Commission, 2013; Norman, 2013). When the commission failed to generate substantive recommendations to address the LTSS financing crisis, a subgroup of commissioners published a separate report advocating for a publicly financed social insurance program (Butler, Claypool, Feder, Ruttledge, & Stein, 2013).

Financial pressures have contributed to the continued growth of managed care within Medicaid, Medicare, and entire service sectors. Managed care plays a particularly prominent role in initiatives to improve care and decrease costs for dually eligible beneficiaries. However, the implementation of these initiatives has raised ethical concerns, such as elimination of beneficiary choice (Community Catalyst, 2012; Musumeci, 2013). Thus, managed care's success in improving the quality, coordination, and integration of LTSS remains in question.

On the other hand, the most critical LTSS receive almost no funding whatsoever. Families remain the primary providers of LTSS in home and community-based settings and provide invaluable support in residential care settings, as well (O'Shaughnessy, 2013a). Such caregiving—which has been valued at \$450 billion per year but is usually uncompensated—places significant physical, emotional, and financial stress on families, especially women (Feinberg, Reinhard, Houser, & Choula, 2011; National Alliance for Caregiving, 2009). Despite growing attention to the contributions and strains of family caregiving, neither the public nor the private sector has implemented sufficient changes to support families in their caregiving roles. Moreover, decreasing fertility rates, shifting family structures, and changes in population health will likely decrease the availability of family caregivers (Feinberg et al., 2011). This decreased availability contrasts with the increased need for family caregiving, as the population experiencing functional limitations grows.

Although the Program of All-Inclusive Care for the Elderly (better known as PACE), home health, and hospice have long provided LTSS in home and community-based settings, few home and community-based services (HCBS) have been publicly funded until recently. Changes in public policy have increased the availability of publicly funded HCBS over the past two decades, but these efforts have been limited by insufficient resources and infrastructure. Spurred by the disability rights movement, the Supreme Court's *Olmstead v. L.C.* decision (1999), and the ACA, a growing proportion of publicly funded LTSS are now provided in home and community-based settings. Thanks to various rebalancing initiatives, such as Money Follows the Person, the proportion of Medicaid funds spent on HCBS grew from 20 percent in 1995 to 45 percent in 2011 (Henry J. Kaiser Family Foundation, 2013). However, HCBS availability under Medicaid waivers and state plan amendments (SPAs) varies greatly by state, and access to such services is both limited and inequitable (Isaacson, Carlson, & Rich, 2012). Moreover, though waivers and SPAs may enhance LTSS access for certain beneficiaries, they may also introduce other changes that can negatively affect beneficiaries (Families USA, 2012). In addition to Medicaid, numerous programs authorized by both the Older Americans Act (OAA) most recently amended in 2006 (P.L. 109-365) and the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L. 106-402), among other funding streams, support community living for individuals with disabilities and older adults. However, inadequate funding, federal budget cuts, and difficulty securing congressional reauthorization have limited older adults' and families' access to OAA-funded services.

Beyond these traditional public funding sources for HCBS, other resources and initiatives have emerged to support people with disabilities, older adults, and family caregivers. For example, employer-based eldercare programs and professional geriatric care management have become increasingly popular, and social workers play strong roles in both. Innovative initiatives to create supportive environments for people with disabilities and older adults include age-friendly communities, Communities for All Ages, Livable Communities, NORC (naturally occurring retirement communities) Supportive Service Programs, and Villages. Such initiatives may be more difficult to implement in rural and frontier communities, however. Technology also plays an increasingly important role in enabling individuals with disabilities and older adults to live in their communities, though assistive technology and other tools remain unaffordable to many (Commission, 2013). Lack of affordable, accessible housing and transportation also poses a barrier to community living.

The limitations of government, the private sector, and communities notwithstanding, the shift toward HCBS over the past quarter century reflects some movement toward a person-centered LTSS system. The social work profession has long promulgated a person-centered approach, which promotes each individual's choice and dignity. Enabling people to live in the least restrictive setting possible is one indicator of such an approach. At the same time, residential care settings, such as nursing homes, remain an integral component of the LTSS continuum, and the social work profession has been at the forefront of advocacy for nursing home residents and families (Kane, 2008). The Omnibus Budget Reconciliation Act of 1987, popularly known as OBRA '87 (P.L. 100-203), marked a watershed in federal policy to ensure the rights and safety of nursing home residents. Yet, much work remains to realize the law's goals, such as reducing the use of physical and chemical restraints (Centers for Medicare & Medicaid Services, 2013; National Consumer Voice for Quality Long-Term Care, 2007, 2011b). Meeting residents' psychosocial needs also remains an ongoing problem; although the revised Resident Assessment Instrument Minimum Data Set (MDS 3.0) includes enhanced psychosocial screening requirements, insufficient training and high caseloads preclude meeting resident needs identified therein (Simons et al., 2012). Other efforts to improve the quality of nursing home care include the culture change movement, which has strived to transform services—across settings, but with a historical focus on nursing homes—in accordance with person-directed values (National Consumer Voice for Quality Long-Term Care, 2011a; Pioneer Network, n.d.). This work has not only spawned the development of various socially oriented care models, but has also begun to influence federal requirements for nursing home care. Nonetheless, the quality of nursing home care remains problematic, in part because of insufficient staffing, cuts in reimbursement, lack of financial accountability, and inadequate state regulatory enforcement (Alliance for Quality Nursing Home Care, 2012; Bern-Klug et al., 2009; Harrington, 2013; U.S. Department of Health and Human Services Office of Inspector General, 2014; U.S. Government Accountability Office, 2008, 2009).

Numerous workforce concerns also affect access to high-quality LTSS. Providers are diversifying their service offerings and supporting people with increasingly complex needs, sometimes without proper training or planning. Although teamwork among provider organizations and within interdisciplinary teams has never been more critical, many struggle to collaborate amid growing demands and shrinking resources. An insufficient supply of well-trained, well-compensated, experienced practitioners constitutes a growing challenge (Congressional Budget Office, 2013; Institute of Medicine, 2008, 2012). The demand is particularly high for direct-care workers, who provide essential LTSS with minimal training, low wages, limited access to insurance, and few advancement opportunities (Paraprofessional Healthcare Institute, 2013). Improved working conditions for direct-care workers are integral to the provision of quality LTSS.

Workforce shortages and challenging working conditions also affect the social work profession's ability to provide high-quality LTSS. The supply of social workers has not kept pace with the need (Assistant Secretary for Planning and Evaluation, 2006; Institute of Medicine, 2008, 2012; Whitaker, Weismiller, & Clark, 2006a, 2006b). Many within the profession's predominantly female workforce have unmanageable student debt, often combined with low salaries (Whitaker, 2008; Whitaker et al., 2006a, 2006b, 2006c). The social work role in LTSS is not always well defined, and many social workers struggle with conflicting role expectations. Furthermore, the deprofessionalization of social work roles in a variety of LTSS settings compromises individuals' and families' access to high-quality psychosocial care (Herman, 2012; Zimmerman, Connolly, Zlotnik, Bern-Klug, & Cohen, 2012). Thus, the continued development of LTSS presents both opportunities and challenges to the profession to define and strengthen its role in service delivery, planning, and administration; expand its evidence base; and engage in policy advocacy on behalf of, and in collaboration with, people with disabilities, older adults, and family caregivers.

POLICY STATEMENT

NASW advocates for each individual's right to attain and maintain optimal biopsychosocial functioning in the least restrictive environment. Accordingly, NASW supports legislation, policies, practices, programs, regulations, and research that promote person-centered LTSS based on the following principles:

- a comprehensive, integrated continuum of supports, services, settings, and delivery models to meet each individual's and family's biopsychosocial needs related to aging, chronic conditions, disability, cognitive impairment, functional limitations, and caregiving

- equitable access to high-quality, affordable LTSS for all who need them, without regard to age, disability, ethnicity, gender, gender identity, geographic location, immigration status, income, language, medical diagnosis, preexisting health conditions, race, sexual orientation, or other factors

- collaboration with clients in all aspects of LTSS planning and provision (including advance care planning) to maximize dignity and self-determination

- educational, emotional, financial, and physical support for family caregivers, including recognizing each individual's definition of *family*

- coordinated assessment, service planning, and service delivery by well-trained interdisciplinary teams, with particular attention given to client transitions between LTSS practitioners and settings

- access to professional social work services in all settings, regardless of medical diagnosis, payer, or involvement of other disciplines

- recognition of, and support for, the integral role of direct-care workers in LTSS

- protection of consumer rights, including privacy and confidentiality, and application of ethical principles throughout the LTSS system

- strengthening the regulatory enforcement system to ensure high-quality care and protect individuals from harm

- expansion of specialized education, training, standards, and staff development—both within and beyond the social work profession—to enhance the quality of LTSS

- expansion and integration of tools, training, and research to facilitate culturally and linguistically appropriate LTSS

- expansion and integration of research on LTSS systems, service delivery, and participant needs

- development of research infrastructure to expand the evidence base for social work in LTSS

- incorporation of program evaluation findings in advocacy efforts and service delivery, to improve LTSS access and quality

- promotion of a comprehensive social insurance financing system that provides universal access to affordable, high-quality LTSS

- preserving the integrity of social security, Medicare, Medicaid, and other economic and social support programs

- increased federal and state funding to enable individuals to access high-quality, cost-effective LTSS in the setting of their choice

- implementation of innovative models to support individuals, families, and communities in preparing for and responding to LTSS needs

- increased compensation for the LTSS interdisciplinary workforce, especially for social workers and direct-care workers.

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Policy statement approved by the NASW Delegate Assembly, August 2014. This policy statement supersedes the policy statement on Long-Term Care approved by the Delegate Assembly in 2005. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 800, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: press@naswdc.org

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, *Washington, DC 20002-4241. Telephone: 202-408-8600 or 800-638-8799; e-mail: press@naswdc.org*