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Social Workers' Ideas on Health Promotion among Older Adults

Submitted by Kaylee Olson

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

The purpose of this study was to explore the role and experience of social workers who provide services to older adults in the community. With the unprecedented demographic shift and multitude of challenges, problems and barriers traditionally associated with aging, a paradigm shift from a problem-based focus to one that emphasizes health promotion is gaining visibility. This shift in focus is relevant for social workers who work with older adults in a variety of social service settings. Eight licensed social workers working in community-based agencies were interviewed to include social workers' voices with a focus on how they utilize the health promotion framework of Vital Involvement to identify and assess older adults' strengths, structural and environmental barriers and levels of engagement with activities and support systems. Findings showed that these community-based social workers' practice reflects principles and processes congruent with health promotion. Implications for practice suggest that future social workers who work with older adults, living in the community, could benefit by utilizing the Vital Involvement Framework, because it guides them through a systematic exploration and assessment of all areas of the older adult's life.

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Introduction

The Stanford Center for Longevity (Peacock, 2009) reported that the number of people age 65 and over will double over the next 30 years, from 40 million to 80 million, and the percentage of older people in the population will increase from 13% to 20%. The Administration on Aging (2011) indicated that there are currently 39.6 million people who are 65 or older, with depression affecting more than 6.5 million of the aging population. Depression is one of the conditions most commonly associated with suicide in older adults (Conwell & Brent, 1995). The National Institute of Mental Health reported that in 2004 people age 65 and older made up 12% of the U.S. population and accounted for 16% of suicide deaths (National Institute of Mental Health, 2010). With the unprecedented demographic shift and multitude of challenges, problems and barriers traditionally associated with aging there is need for a paradigm shift for social workers to focus on health promotion and psychosocial models in working with older adults.

Even though the United States has a large population of older adults, ageist views are still predominant in the general population. Ory et al. (2003) reported that 84% of Americans age 50 and older reported at least one incident of ageism and more than 50% reported multiple incidents. This type of view is often illustrated through media where older adults are portrayed with physical and cognitive decline (Montepare & Zebrowitz, 2002). Hess et al. (2003) demonstrated that the negative messages older adults were exposed to contributed to declines in their memory performance. Hess (2003) also found that negative stereotypes contributed to older adults experiencing poor health. For example, Levy, Slade and Gill (2006) found that older adults who were exposed to negative age stereotypes demonstrated a decline in their hearing. Stereotypes are found to

effect older adults' perceptions about longevity and Levy, Ashman and Dror (2002) demonstrate that older adults who had been exposed to negative stereotypes were less likely to accept life-prolonging interventions.

Aging is a natural and unavoidable part of human life and as people age; more of them are burdened with diseases and disabilities (Topinkova, 1999). Diseases and disabilities can be linked to older adults experiencing social isolation. Roberson and Litchenberg (2003) found that older adults with depression reported that they were receiving inadequate social support and had more physical disabilities than older adults who were not depressed and had a sufficient amount of social support. Similarly, Levasseur et al. (2004) found that social interaction was a determinant of quality of life as illustrated by a positive association between social interactions and quality of life among older adults with physical disabilities.

A connection between social isolation and depression has been documented in a number of studies over the past 15 years. Potts (1997) found older adults who received social support have decreased rates of depression and improved physical health. Freyne et al (2005) also found that when older adults lacked social support they had an increased risk of being socially isolated and that social interaction had a positive impact on reducing depression rates among older adults. Depression can be associated with suicide and Cheng (1995) found that diagnosable psychiatric disorders occurred in 71% to 90% of older adults who committed suicide and Schmidtke et al. (1996) found older adults were at higher risk for completing suicide. Social workers need to focus on this mounting problem of depression with older adults and make it a priority.

Older adults who are isolated and depressed are also at risk for experiencing a decline in their cognition. Collins (1996) reports that there is a significant relationship found between subjective memory complaints and levels of depression. Similarly, Berkman (2008) found that social interaction is associated with predicting a slower rate of memory decline. Furthermore, cognitive impairments affect 1 in 5 elderly Americans (Arehart-Teichal, 2008) and it is estimated that as many as 5.1 million Americans may have Alzheimer's disease (Alzheimer's Foundation of America, 2010).

To address these problems, health promotion programs have been created to improve older adults' health and quality of life. Muramatsu, Yin and Hedeker (2010) found that older adults who received Home and Community Based Services (HCBS), which includes services that promote social interaction such as meals on wheels, transportation, spiritual enrichment, educational programs, home health aides etc., have experienced health benefits. They have had reduced the risk of nursing home admissions and increased chances of living in the community until the end of their life. Muramatsu et al. (2010) also found that older adults who received support from friends and relatives or HCBS had lower rates of depression.

This evidence suggests that strategies for overall healthy aging may result in physical, mental and emotional health. Staying socially connected may even offer some protection against developing Alzheimer's or related disorders. As demonstrated in these studies social support can alleviate the problems of depressions, suicide, physical disabilities and cognitive impairments among older adults. Gladden (2000) explains that social workers have the role in building a relationship with their client. Haber et al.

(2000) expresses that support from family, friends and age peers is important, but support from health professionals is also important.

The purpose of this interview is to explore the role and experience of social workers who provide services to older adults in the community. This study will contribute to the literature by including social workers' voices with a focus on how they identify and assess older adults' strengths, structural and environmental barriers and levels of engagement with activities and support systems.

Literature Review

The literature review will begin by presenting myths and stereotypes about aging followed by presenting a lens of what normal aging looks like for older adults. The effects of social isolation on four main areas that include: physical health, depression, suicide and cognition will also be discussed. The idea of enforcing health promotion through the vital involvement practice model will be presented, with a specific focus on how social workers are utilizing these practices.

Myths and Stereotypes of Aging

Ageism is alive and well in the United States. Ageism is defined as discrimination against people on the grounds of age; specifically, discrimination against the elderly. Unlike other groups who are stereotyped, social sanctions against the expression of negative attitudes towards older adults are almost completely nonexistent (Levy & Banaji, 2002). This form of discrimination continues to be ignored and in many cases is reinforced through the use of different types of media such as, television and birthday cards. Taking into account how pervasive aging stereotypes are, older adults themselves are buying into these negative characterizations. Hummert, Garstka, Shaner and Strahm (1994) reported that older adults had similar stereotypes around aging as did younger adults.

One of the ways that negative stereotypes of aging are portrayed in society is through media. Montepare and Zebrowitz (2002) noted that older adults were more likely to be portrayed in comical roles that reflected stereotypes around physical and cognitive decline and sexual impotence. Ellis and Morrison (2005) when analyzing 150

commercially available birthday cards targeted at individuals between 40 and 100 years of age found that the majority of the messages represented aging in a negative manner.

Loneliness is another predominant stereotype associated with older adults.

Wadensten and Carlson (2002) found that older adults are often negatively stereotyped by the general public as passive, depressed, lonely and useless. Victor et al. (2002) found that the primary image of older adults in the general public is that they are a lonely group. Similarly, Tornstam (2005) found through surveys, carried out among the general public ages 15- 85 years old that, older adults suffer from loneliness, boredom and dissatisfaction with life.

Stereotypes also affect seniors' performance. Levy (1996) exposed older adults to either negative or positive words of aging while they were playing a computer game. These stereotypical words of aging were flashed at speeds fast enough to bypass conscious awareness leaving participants unaware that they were being primed. Older adults who were exposed to negative words (e.g., senile, Alzheimer's) performed worse on a subsequent memory task than those who received positive words (e.g., wise, sage). Hess et al. (2003) also found that negative stereotypes affected the memory performance of older adults, because older adults who were exposed to a negative stereotype showed a decline in their memory performance. Hausdorff et al. (1999) utilized the same priming methodology to examine the effect on walking speed of older adults. They found that older adults, after being primed for 30 minutes with positive stereotypes of aging improved their walking speed.

Primed stereotypes also appear to affect older adults' health. Levy, Hausdorff, Hencke and Wei (2000) gave older adults mathematical and verbal tasks after exposing

them to either positive or negative aging primes. Those who were negatively primed showed a heightened cardiovascular response to stress. Older adults who received the positive aging stereotypes showed a muted cardiovascular response. Levy, Slade and Kasl (2002) found that older adults who had more positive perceptions of aging reported better functional health than those with more negative self-perceptions of aging. Levy, Slade and Gill (2006) found that older adults who had more negative age stereotypes related to physical appearance demonstrated worse hearing after the initial assessment. They also found that for older adults who had suffered an acute myocardial infarction (AMI) and were exposed to more positive age stereotypes displayed better physical recovery. Likewise, those who had more positive age stereotypes scored significantly higher on their physical performance than individuals with more negative age stereotypes.

Aging stereotypes have also been demonstrated to affect older adults' perceptions about longevity. Levy, Ashman and Dror (2000) found that participants' will-to-live could be influenced through aging primes. Older adults who were exposed to negative primes were less likely to accept life-prolonging interventions and those who received positive primes were more likely to accept medical treatment, regardless of the cost. In addition Levy et al. (2002) found that self-perceptions of aging appear to have an effect on longevity. They found that those who had positive self-perceptions of aging lived 7.5 years longer than those with more negative self-perceptions of aging.

Normal Aging and Health

Aging is a natural and unavoidable part of human life and past research has shown that as people age more of them are burdened with diseases and disabilities (Topinkova,

1999). Levasseur, Desrosiers and Noreau (2004) found that each year, functional decline appears in 12% of older adults aged 75 and over. Behar (2011) explained that loss of muscle strength, speed and the ability to perform tasks were common repercussions of aging. These outcomes of aging have also been established as risk factors for death, disability and dementia. These risk factors have contributed to the importance of understanding how participation in social activities may provide a defense against disability, dementia and an early death (Behar, 2011).

The Centers of Disease Control and Prevention (2009) found that in the United States 22.1 million or 61% of adults 65 years and older have at least one basic action difficulty or complex activity limitation. Over 48 million adults in the United States, who are otherwise healthy and able bodied, can be classified as not physically active. An inactive lifestyle only places extra strain on the body, increasing risk for cardiovascular problems, cancer and many other diseases (Goldman, 1997).

Loss of motor function, vision and hearing are more prominent among older adults and can have a negative impact on their ability to remain physically active in the community. Heine and Browning (2002) found that overall the onset of these sensory impairments drastically reduces an individual's ability to maintain functional independence and participation skills, specifically from a communication perspective. Savikko, et al. (2005) found that visual impairment, much like hearing loss, has been shown to contribute to social isolation among older adults. Dupuis, et al. (2007) found that age-related changes in hearing can have a negative impact on communication, which has shown that older adults with hearing loss are less likely to interact with their friends.

As the population is getting older new challenges have appeared in respect to health policies to ensure that the additional years are lived with an optimal quality of life. Quality of life can be defined as having life satisfaction or physical and psychological wellbeing (Szalai & Andrews, 1980). Chronic health problems, psychological disorders, ineffective coping and difficulties in social interaction will affect quality of life (Levasseur, Desrosiers & Noreau, 2004). Molzahn, Skevington, Kalfoss and Makaroff (2010) found older adults ranked relationships with family and friends, having energy, freedom from pain, ability to perform activities of daily living and to be able to move around as the most important quality of life aspects.

Dijkers (1997) found that older adults with severe disabilities who participated in social activities improved the outlook on their quality of life. Hawton et al. (2011) found that on a scale measuring the Health Related Quality of Life (HRQL), older adults who reported that they were socially isolated had lower scores than expected in the general population for people of the same age. Based on this finding the researchers determined that social isolation was negatively associated with the HRQL of older adults.

Social Isolation

This section of the literature review will present studies that have demonstrated the relationship between social isolation and health outcomes among older adults that include: physical health, depression, suicide and cognition. Social isolation typically refers to objective physical separation from other people (Ernst & Cacippo, 1999). In addition to discussing social isolation and its health outcomes this section will also present its counterpart social support which Tomaka, Thompson and Palacios (2006)

defines as the functional content of social relations such as emotional, instrumental and appraisal support.

Physical Health

Physical disabilities can contribute to older adults becoming socially isolated, which may increase the rate of decline of their physical health. LaVeist, Sellers, Elliot-Brown and Nickerson (1997) examined the effect of extreme social isolation and use of community-based senior services on longevity in a national sample of African American elderly women ages 55-96. They found that the risk for 5-year mortality is roughly three times higher for those who are socially isolated relative to those who are not socially isolated. Heffner et al. (2011) found that social isolation among older adults was related to higher levels of C-reactive protein (CRP), a marker of inflammation, which suggests a biological link between social isolation and coronary heart disease (CHD). They examined relationships among social isolation, CRP and a 15 year CHD death in a community sample of 2321 US adults age 40 years and older (Heffner et al., 2011). During a household interview, participants provided a serum sample and responded to a series of questions assessing health, psychosocial, demographic, and behavioral information. Death information was obtained from the United States Centers for Disease Control and Prevention. Their results demonstrated that socially isolated individuals had two and a half times the odds of elevated CRP levels compared to those who were socially integrated (Heffner et al., 2011).

Supporting this view of social isolation as a factor related to older adults' health, Sapolsky, Alberts and Altmann (1997) found that social isolation is related to elevated hypothalamic-pituitary activity, which is a major part of the neuroendocrine system that

controls reactions to stress and the release of cortisol. Similarly, Cacioppo, et al. (2002) found that loneliness contributed to altered regulation of blood pressure and cortisol levels. Tomaka, Thompson and Palacios (2006) assessed 755 older adults who were 60 years and older, 72% Caucasian and 23% Hispanic. Using the UCLA loneliness scale, which measured perceived loneliness, they found an overall pattern, which suggested that isolation and loneliness were positively related to diseases in older adults. Similarly, Luanaigh and Lawlor (2008) found that loneliness was associated with immune stress responses that may account for the excess cardiovascular morbidity seen in people who are lonely. More recently, Hawton et al. (2011) found that respondents who reported little social interaction were more likely to report their health status to be at poorer levels.

Levasseur, et al. (2004) assessed 46 participants between 60 and 90 years old who were living in the community with a physical disability. Quality of life was measured through the use of the Quality of Life Index (QLI) and social participation was evaluated by the Assessment of Life Habits (LIFE-H) scale. They found that social participation was a determinant of quality of life and that for older adults with physical disabilities who participated, social interaction was positively associated with their quality of life.

Depression

Several studies have found an association between lack of social support and depression in late life. Potts (1997) sought to examine the degree to which social support from friends both within and outside of a retirement community would be related to depression. She sampled 99 older adults from a large planned retirement community; all participants demonstrated the ability to live independently. Potts (1997) found that in general, higher levels of social support were associated with lower levels of depression;

likewise, lower levels of social support from friends outside the retirement community predicted higher levels of depression.

Prince et al. (1997) sampled 654 older adults, 65 years and older to explore the relationships between social support deficits, loneliness and life events as risk factors for depression in the older adults. They found that frequent loneliness was one of the strongest cross-sectional associations with depression. Rogers (1999) found that older adults who were the most depressed had the least adequate and least satisfying social relationships. Similarly, Forsell and Winblad (1999) sampled 875 older adults with a mean age of 85 years to assess their social networks, which included having frequent visitors, friends, and the ability of being able to talk openly with someone. They found a significantly greater incidence of long-term depression among older people who had insufficient social networks than among those who had adequate social networks.

Oxman and Hull (2001) sampled 307 patients 65 years of age and older of whom 61% were male and 76% were Caucasian. These participants were recruited through referrals and screenings at the Community Veteran Affairs Centers. They found that among older adults reports of a large and close supportive network was related to the perception of high social support and that lower levels of perceived social support predicted depression. Similarly, Freyne et al. (2005) found that when older adults lacked social support they had an increased risk of loneliness and that social interaction had a positive impact on reducing depression rates in older adults. Luanaigh and Lawlor (2008) found that loneliness was a consistent and strong risk factor for depression among older adults.

Older adults who have physical disabilities can also have an increased chance of becoming isolated, which can contribute to the development of depression and feeling unsatisfied with their quality of life. Murtan et al. (1995) sampled 214 white females, all of whom were hip fracture surgery patients, over the age of 59 over a period of six months. Their results indicated that women with more chronic illnesses were more depressed than those who had fewer illnesses. They also found that measures of insufficient amount of social support had a significant effect on depression. Similarly, Roberson and Litchenberg (2003) found that older adult patients with depression reported that they were receiving inadequate social support and that they had more physical disabilities than older adults who were not depressed and had a sufficient amount of social support.

Adams et al. (2004) found that loneliness was significantly associated with depression; specifically, less participation in organized social activities and lower church attendance were related to depression. They also found that those who were depressed tended to be older, and have more health problems than those who were not depressed. Freyne, et al. (2005) found significantly high depression scores at initial assessment for those who were housebound and could not get out as often they liked; they also reported feeling lonely. Likewise these older adults' health status correlated with depression outcomes – poorer health was associated with poorer outcomes and higher levels of disability at initial assessment were associated with higher depression scores. Finally, Freyne et al. (2005) found that deterioration in health status was associated with a significantly worse outcome of depression.

Suicide

Rates of suicide among older adults in the United States are higher than that of other age groups. The National Institute of Mental Health reported that in 2004 people of age 65 and older accounted for 14.3 of every 100,000 suicide deaths (National Institute of Mental Health, 2004). Conwell (1994) found that there were more suicidal acts among older adults, and posited that because they had fewer physical reserves they were less likely to survive self-damaging acts. Social and physical factors also played a key role; because they were more isolated they were less likely to be rescued after afflicting self-harm.

Cheng (1995) found that diagnosable psychiatric disorders occur in 71% to 90% of older adults who committed suicide and Conwell and Brent (1995) found older suicide victims were more likely to have suffered from a depressive illness. Schmidtke et al. (1996) found older adults were at higher risk for completing suicide. Turvey et al. (2002) sampled 14,456 people ages 65 and older. Through the use of interviews they collected information about whether the older adults had a relative or friend present to confide in. They found that older adults showed depressive symptoms when there was an absence of a relative or friend to confide and that out of 14,456 older adults, 21 of them committed suicide over the 10 year observation period. This finding led them to the conclusion that depression was the strongest predictor of late life suicide among older adults. Cukrowicz et al. (2009) reported that depressive symptoms contributed significantly to changes in thoughts of suicide early in treatment for depression among the 343 older adults who were 60 years of age or older.

Keeler et al. (1982) found that physicians typically spent less time with older patients than with younger patients, which contributed to psychiatric illnesses not being diagnosed. Conwell (2001) found that up to 75% of older adults who committed suicide had visited a physician within a month before death. Preville et al. (2005) reported that 42.6% of the suicide cases among older adults aged 60 years and over had mental disorders at the time of their death, mainly depression. They also found that 53.5% of the people who committed suicide had consulted a physician or specialist during the two week period preceding their death.

Health problems have been related to suicidal ideation. Blazer and Koenig (1996) reported that at least one-third of older adults who committed suicide had a physical illness. Turvey et al. (2002) and Waern, Rubenowitz, and Runeson (2001) found if a person suffering from poor health was also depressed, the risk of suicide was even higher.

Older adults who commit suicide are typically socially isolated, with less involvement with neighbors, friends and family members. Inadequate emotional support and social interaction are especially predictive of suicide in later life. Beautrais (2002), Bartels et al. (2002) and Turvey et al. (2002) documented that suicide rates increased among older people when they lacked confidantes or other close relationships. An older person who lived alone was at especially high risk for suicide and in addition, older adults with health problems are less likely to survive an attempt (Beautrais, 2002, Bartels et al. 2002 & Turvey et al. 2002).

Cognitive Impairment

Social interaction can be cognitively stimulating and may help older adults preserve their cognitive abilities. Gallo, Robins and Hopkins (1999) found that

depression contributed to cognitive decline, which could be an early manifestation of dementia among seniors. There have also been a number of studies that examined loneliness as a risk factor for cognitive decline. Tilvis et al. (2004) found that older adults who experienced loneliness were at greater risk for experiencing cognitive decline. Wilson et al. (2007) found that the risk for developing Alzheimer's dementia substantially increased in those who were lonely as compared to those who were not lonely.

Saczynski et al. (2010) followed a cohort of 947 depressed and non-depressed but cognitively normal older adults with a mean age of 79 for up to seventeen years. Over the 17 years, 21.6 percent of the participants who were depressed at baseline eventually developed dementia, mostly Alzheimer's disease, while only 16.6 percent of initially non-depressed participants developed dementia. Similarly, Dotson, Beydoun and Zonderman (2010) investigated the association between recurring episodes of major depression and the risk of developing dementia among 1,239 older adults with a mean age at baseline of 55. These participants were followed for 25 years and the researchers found a positive correlation between recurring episodes of depression and risk for dementia. Meeting the criterion for depression once was calculated to increase the risk for developing dementia by about 90%, while meeting the criteria twice or more nearly doubled the risk (Dotson et al, 2010).

Social interaction has been demonstrated to have a positive impact on cognitive impairment. Seeman, Luisgnolo, Albert and Berkman (2001) found that greater emotional support from a network of social relationships was associated with better cognitive functioning. Similarly, Beland et al. (2005) found that cognitive declines were associated with a lack of social interaction among older adults. Saczynski et al. (2006)

also found that for older adults a decline in social interaction between mid life and late life was predictive of dementia.

Atkinson et al. (2007) using a mixed model that consisted of a Modified Mini-Mental Status Examination (3MS) and a 10-item Depression scale, found that participants who had poor physical function scored lower on the cognitive test and had higher depressive symptoms. Berkman (2008) found that among seniors, high levels of social interaction predicted a slower rate of memory decline. Andrew and Rockwood (2010) found that increasing social vulnerability was associated with cognitive decline among older adults 65 and older. They used a social vulnerability index that was constructed by using self-report variables relating to potential social deficits and also used a 3MS cognitive screening tool with possible scores of 0 to 100. The researchers found that for every additional social deficit experienced by older adults, the odds of experiencing a clinically meaningful decline in cognition increased by 3%.

In addition to the studies that have been discussed above, two other areas have been identified in relationship to memory and cognition, namely satisfaction with and quality of social support. Hughes, Andel, Small, Borenstein and Mortimer (2008) found that among the older adults in their study, satisfaction with the social support they were receiving was correlated with better memory performance. Green, Rebok and Lyketsos (2008) also found that the quality of social engagement was more important than quantity in improving cognition.

Health Promotion

Health promotion is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease infirmity” (World Health Organization,

1948, p. 2). Levin (1987) discussed the idea that lifestyle is the same as health promotion, which consists of a selective pattern of health promoting behaviors based on choices available to persons according to their life chances. Another definition of health promotion can be described by O'Donnell defined health promotion as “the science and art of helping people change their lifestyle to move toward a state of optimal health... a balance of physical, emotional, social, spiritual, and intellectual health” (1989, p. 3). Chappell's definition expanded on O'Donnell's definition and included “the role of psychosocial and environmental factors in health” (2008, p. 129).

There has been an increased interest in promoting health and preventing disease and disability in older adults over the past 20 years. This is due to the accumulating evidence that modifying behavioral risk factors can reduce morbidity and mortality and forestall cognitive decline (McLeroy & Crump, 1994; Nolan & Blass, 1991; Salthouse, 1991). Barrett (1993) found that interventions that include exercise, nutrition and other complementary therapies have shown to improve the health status among older adults.

The purpose of health promotion is to engage individuals in activities that alter their lifestyles, to maintain and enhance a state of wellbeing. Goetzel et al. (2007) illustrated that health promotion programs are aimed at keeping healthy those people who have an increased risk for developing diseases and disorders if they do not take certain actions or fail to avoid certain behaviors. These kinds of programs include: exercise and fitness, healthy diet, weight management, stress management, and maintaining positive social support networks. Health promotion also includes prevention programs directed at individuals who are at high risk for disease but may not yet be sick. Programs in this

category would include: hypertension screening, management instruction and medication and weight management interventions.

There is evidence that illustrates that investing more in health promotion programs directed at older adults may achieve improving older adults health and quality of life and by doing so shortening or even eliminating an extended period of illness and disability prior to death. Studies have shown that physical activity is now known to be important at any age. Christmas and Andersen (2001) found that older adults who are physically active have reduced risk of falls, reduction in body mass index and improved mood. Kokkinos, Narayan and Papademetrio (2001) found that older adults who remained physically active had reductions in hypertension. Taylor et al. (2004) also found that older adults who remained physically active had an enhanced ability to manage stress and greater feelings of self- efficacy. Finally, Fried et al (2004) found that when older adults engaged in activities like volunteer work there were benefits that included significant increases in physical fitness, strength, social support, cognitive processes, and reduced delays in walking speed.

For the purpose of this study Chappell's definition will be used in conjunction with the Vital Involvement framework as a framework for understanding how health promotion gets operationalized in practice. The Vital Involvement Framework includes the integration of psychosocial development and environmental factors and also goes a step further by including a person's strengths and the framework of occupational science.

Vital Involvement Framework

Vital involvement is a framework for understanding a person's meaningful engagement with the world outside the self (Kivnick & Kavka, 1999). Vital involvement

may be expressed through explicit behaviors that link a person's internal processes to entities in the external world. It may be also expressed in the unobservable processes through which a person thinks, plans, and experiences feelings both physical and emotional. The Vital Involvement Framework conceptualizes an integration of psychosocial development and occupational science.

Occupational science is the study of the reasons people choose one set of occupations over another, the effects of occupation on health, the ways in which individuals experience joy in the world of activity, and how people express their sense of life's meaning through their occupational choices (Clark et al., 1998). Occupational science can be expressed as a person's meaningful patterns of activity or "occupations" (Yerxa, 1988). Occupations include ordinary things that we may do every day as well as more extraordinary things that we do more occasionally. Occupations include things we do because we must, and things we do because we choose to. Occupations may also be understood as contributing to the overall social and physical environments in which people live and grow (Kivnick & Stoffel, 2005).

In addition to occupational science, the Vital Involvement Framework incorporates Erickson's model of psychosocial development. Psychosocial development describes a process through which supports and obstacles in the environment influence individual development. (Kivnick et al. 2003). The environment also provides supports and obstacles for who we become and what we do (Erickson, Erickson, & Kivnick, 1986). Erikson et al. (1986) explained that healthy psychosocial development in the later years requires the renewing of earlier-life balances around themes of care, love, commitment, competence, purpose, autonomy and hope. According to their model adults

develop in a healthy way by engaging in age-appropriate vital involvement with the people, creatures, materials, organizations, ideas, institutions and relationships that represent his/her world in the present as well as by reviewing the relationships, interactions and commitments of earlier life (Erikson et al., 1986).

Strengths and weaknesses of a person's occupations are closely tied to the internal systems of meaning that are central to each person's self-identity. This may be also understood as contributing to the overall social and physical environment in which people live and grow (Clark et al., 1997).

These concepts of personal strengths, occupation (occupational science), environmental factors and psychosocial development are operationalized through the vital involvement framework (Figure 1). In this model Kivnick et al. include: (A) The person's strengths, weaknesses, abilities and disabilities, (B) Occupational Performance: a person's activities and interests, (C) Environmental supports and obstacles and (D) Psychosocial Development (Figure 1). Each of these dimensions will be defined to set a context for their applicability for social work practice.

(A) Person

Based on Kivnick' et al. vital involvement as a framework (Figure 1) for practice, the person's strengths and weaknesses would first be identified through a relevant assessment administered by a worker at a community-based agency. Based on the premise that a person's strengths are central to promoting health in aging Kivnick (1993) emphasized the importance of strengths. Older adults can maximize everyday health by reinforcing existing strengths, developing new strengths, and using existing personal strengths to balance out their weaknesses and environmental deficits. These strengths are

incorporated into the next step of assessing activities and interests or occupational performance (B).

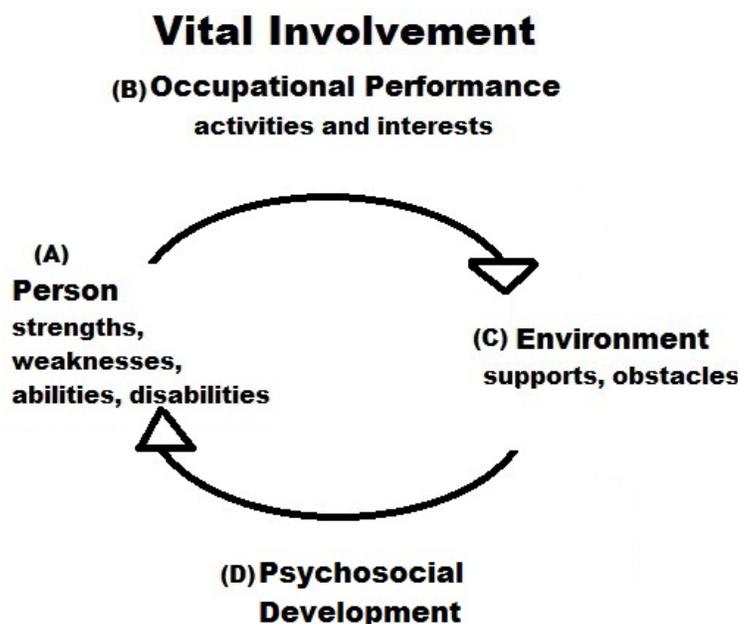


Figure 1. Vital Involvement (adapted from Kivnick, Stoffel & Hanlon, 2003, p. 40)

(B) Occupational Performance

According to Kivnick (1993) strengths contribute to the process of identifying meaningful activities and interests, also known as occupational performance. Kivnick and Stoffell (2005) proposed that occupations are closely tied to the internal systems of meaning that are central to each person's identity.

(C) Environment

Based on the older adult's interests and what activities they find meaningful, the community-based agency uses the appropriate assessment to identify the supports and obstacles posed by the person's environment. After identifying the supports and obstacles the worker and older adult work together to determine how to overcome the

environment's obstacles by obtaining necessary support to enhance the older adult's desired activities and interests.

(D) Psychosocial Development

The plan to address supports and obstacles is implemented to meet the needs of the older adult by using the framework of psychosocial development. Erikson's framework of psychosocial development illustrates the process through which supports and obstacles in the environment influence individual development (Erickson, Erickson, & Kivnick, 1986). Kivnick, Stoffel and Hanlon (2003) emphasized that older adults express who they are through meaningful activities and interests. Psychosocial health in old age develops in the course of fully engaging in one's environment, utilizing the multiple dimensions of one's self (Erikson et al., 1986).

Vital Involvement in Promoting Health

Old age brings a number of constraints on opportunities for individual vital involvement. Maintaining psychosocial health through old age therefore requires the individual to take full advantage of existing opportunities for vital involvement (Kivnick, Stoffel & Hanlon, 2003). Vital involvement guides those who work with older adults to provide services that enable clients to live their lives to the fullest, drawing on strengths and values to overcome realistic problems, weaknesses, and obstacles (Kivnick & Stoffel, 2005)

Applying the vital involvement framework to social work practice, it can be operationalized as a set of skills that workers can learn to use when working with older adults by using the domains of life and health. Life exists in four domains, defined by two perpendicular axes (Figure 2). The top half of the axis identifies the Person and the

be someone or something in the environment that allows or encourages a person's strengths, skills or interests. An environmental obstacle would be someone or something that stops a person from exercising their strengths and interests and experiencing wellbeing.

After these skills are utilized and these concepts are identified the worker would then help the older adult identify what strengths he or she has that can be used to overcome any obstacles and weaknesses in order to promote the older adult to engage in a meaningful activity. A plan would be created between the worker and the older adult to promote vital involvement in the older adult. Vital involvement practice can be applied to health promotion programs because it seeks to identify strengths and barriers, both personal and environmental. Once these are identified goals can be set to promote meaningful engagement with the environment and health promotion programs can be essential to environmental supports.

Health Promotion Programs

A wide variety of programs can address the benefits of health promotion, some of which are evidence based and vary by community and by agency. Community workers frequently encounter people at risk for loneliness, isolation, and emotional health problems. Smith et al. (1994) compared the effects of congregate and home dinners in a Senior Nutrition Program on older adults. They found that a significantly higher proportion (82%) of participants receiving home delivered meals listed their health as fair or poor compared to only 50% of the congregate dinners. They also measured loneliness and found that percentages of those who reported loneliness was substantial – 38% among those who had meals delivered compared to 22% of those who received meals at

the congregate sites. Older adults who participated in the congregate diners expressed that this program provided them with the opportunity to form relationships and be a part of a social group. Congregate diners experienced significantly greater socialization and showed a much higher participation rate with 72% taking part in physical and social activities contrasted with only 13% of the home meal group.

Moore and Schultz (1987) found that encouraging older adults to take responsibility for their loneliness had a positive effect on them. This is supported by the correlations between perceived responsibility for loneliness and shorter duration of loneliness, less frequent periods of loneliness and greater happiness and life satisfaction. Cheung and Ngan (2000) collected data from 139 isolated and frail older adult participants of the social (volunteer) networking project of Hong Kong. Participants had an average age of 76.9 years and two-thirds of them were female. They found that the use of volunteer matches improved the isolated and frail older adult's psychosocial quality of life and that volunteers helped decrease anxiety among older adults.

Gottlieb (2000) found that self-help/support groups can supplement support from depleted natural networks and play a significant role in decreases of psychological distress in older adults following spousal bereavement. Stewart et al. (2001) found that a support group intervention for widows decreased emotional isolation, social isolation, emotional loneliness and social loneliness. Widows also reported that the support groups enhanced their confidence and hope. They reported a greater sense of competence and self-esteem following the support group intervention and indicated that the support groups helped them gain a fresh perspective and a more positive outlook on life.

DeLeo et al. (1995) tested a program called Telehelp/Telecheck, which provided telephone-based outreach, evaluation, and support services to more than 18,000 older adults with a mean age of 80 years. Over 84% were women. The older adults who were being identified as at risk for suicide by social services and other providers were provided with a portable alarm system and participated in regular supportive telephone contacts by trained staff members. After four years of service there was only one death by suicide, which was a significantly lower rate than would have been expected in the older adult population of that region (DeLeo et al., 1995).

Dupuis -Blanchard, Neufeld and Strang (2009) found that social interaction created feelings of security for older adults, because they no longer felt alone. Muramatsu, Yin and Hedeker (2010) found that older adults who received caregiving from relatives or friends had lower rates of depression than those who were not receiving those social supports. They also found that those who participated in Home and Community-based Services (HCBS) decreased depression among those who lacked informal support. Knight, Haslam and Haslam (2010) found that when workers empowered (gave power to) older adults they were more likely to be more engaged with their environment and the people around them, to be generally happier and have better health.

Cohen et al. (2008) conducted a comprehensive research program called The Creativity and Aging Study had the goal of measuring the impact of professionally conducted community-based cultural programs on the general health, mental health and social activities of older adults aged 65 and older. This study used two groups: an intervention group that participated in arts programs and a control group that did not.

Data revealed that the participants who participated in the intervention group had better health, fewer doctor visits and less medication usage, along with more positive responses on the mental health measures and a high level of social engagements in comparison to those who did not participate in the program.

Noice and Noice (2009) aimed to determine whether one month of intensive training in theater could raise various measures of cognitive and affective (mood) health among older adults. Three types of cognitive tests were administered: a word recall task, a listening span task, and a problem-solving task. Two mental health measures, a self-esteem scale and a psychosocial well-being scale, were conducted. The control group consisted of visual arts and theater course and a no-intervention group. They found that the older adults that participated in the courses improved significantly from pre-test to post-test over the no-treatment group on two out of three cognitive variables – recall and problem solving. They also improved significantly on the psychological well-being scale (Noice and Noice, 2009).

Health Promotion and the Social Workers' Role

Social workers in particular have a key role to play in the health promotion of older adults with the use of a psychosocial perspective. In 2006, 24 % of social workers reported that older adults constituted at least 50 % of their caseload, which is likely to grow in the upcoming years (NASW, 2006). Morrow-Howell, Becker and Judy (1998) evaluated the Link-Plus, a social work program used by community crisis agency. This program provided case management and supportive services by telephone to older adults ages 62-92, who were depressed, socially isolated and needed assistance. These efforts reached the most vulnerable older people in the community. After four months they

found that the amount of social contact was improved and that there was a reduction in depressive symptoms among the older adults.

In order to focus on the social determinants of health, social workers need to build a social relationship and a sense of wholeness with older adult client (Gladden, 2000). Information and education are important but insufficient to convince people to change their lifestyles. Support from family, friends and age peers is important, but support from health professionals is also important (Haber et al. 2000).

There is a need for an equitable balance of knowledge, respect and power in the care relationship; a need to listen to what the client perceives as her/his need; thus, health care professionals are not the only ones with expertise (McWilliam et al., 2000). Chappell (2008) reported that clients have expertise as well; this speaks to empowerment of clients to take control over their own lives. Social workers can assist clients by bringing together support groups for those with similar conditions and circumstances and for family members of client. Chappell (2008) explained that interventions designed to provide individuals with coping skills can lead to improved self-esteem and self efficacy. Such strategies aim at building life skills that are generalizable to several areas of life and provide the foundation for enhancing overall quality of life.

Current Study

The current study will explore social workers' perspectives on health promotion among older adults that are working in community-based agencies. The literature presented above does not present social workers' ideas on how to promote health among older adults. The current study will contribute to the literature by giving social workers a voice by asking them about their ideas on health promotion among older adults.

Conceptual Framework

The vital involvement framework provides a conceptual guide for this study (Figure 3). The framework of vital involvement illustrates a synthesis of fundamental principles from occupational science and psychosocial development into an ongoing process that links person to community (Kivnick & Stoffel, 2005). Kivnick (1991) demonstrated the use of assessments to identify the persons' strengths, weaknesses, abilities and disabilities in order to maximize their potential in engaging in their interests and activities while meeting their needs.

Occupational science emphasizes that individuals express themselves through meaningful activities. Therefore, a person's occupational performance (activities and interests) may be understood as the person's expression of a unique self in a specific community environment (Kivnick, Stoffel & Hanlon, 2003). According to Kivnick and Stoffel (2005) the environment provides supports for and obstacles to each person's psychosocial development and in doing so the environment influences who that person becomes.

Kivnick, Stoffel and Hanlon (2003) presented vital involvement as a lifelong, circular process through which person and community interact with and influence one another (Figure 3). The community influences who an individual becomes. That individual through occupational performance influences elements of the community. And the community in turn continues to influence the person's ongoing growth and change. The power of this process lies in its essential connections between person and the community and between identity and behavior. Through occupational performance the

older adult connects with the dimensions of life that he or she finds meaningful (Kivnick, Stoffel & Hanlon, 2003).

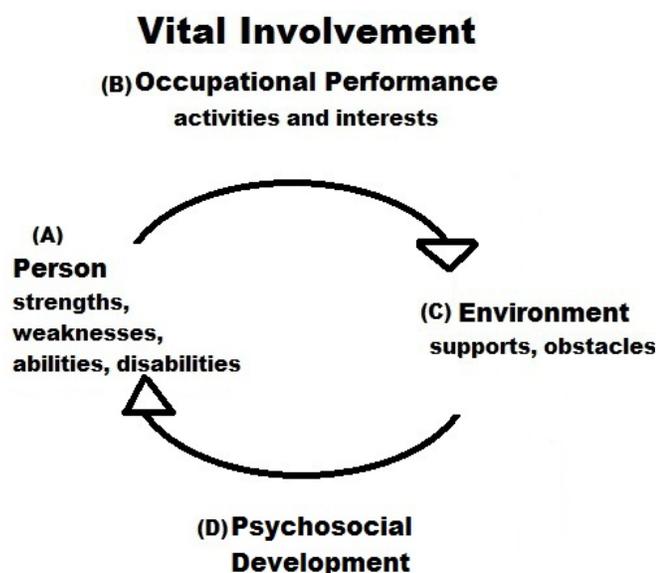


Figure 3. Vital Involvement (adapted from Kivnick, Stoffel & Hanlon, 2003, p. 40)

Using the vital involvement framework (Figure 3) as a guide for social work practice who work with older adults there are four key components which include: (A) Person's strengths and weaknesses, (B) Occupational Performance, (C) Environmental supports and obstacles, and (D) Psychosocial Development.

The social worker would first determine the strengths and weaknesses of a person (A). Kivnick & Stoffel (2005) presents personal meanings, abilities and disabilities, strengths and weaknesses as qualities that represent a person's self (A). According to Kivnick (1993) identifying personal strengths can also balance out personal weaknesses and every day obstacles. Having knowledge of a person's strengths can contribute to identifying their meaningful activities and interests (B) (Kivnick, 1993). The person expresses that self through occupational performance (B) which simultaneously affects the environment (C). Erikson et al. (1986) illustrated that the social and physical

environment provide supports and obstacles for doing age-appropriate work (C), which has an ongoing influence on who the psychosocial person continues to become (D) (Kivnick & Stoffel, 2005).

Each of the points of the vital involvement framework from above will be addressed in this study. For example, regarding the area about the (A) Person, social workers will be asked about what assessments are used to establish the older adults' strengths, how do they identify obstacles that hinder older adults from engaging in activities that are meaningful to them and what their role is in helping older adults overcome these obstacles.

The area of (B) Occupational Performance will be reflected in the interview process by asking social workers about the types of activities older adults express as being the most meaningful to their aging. Another question will also ask about the social workers role in supporting older adults to engage in these activities.

This area of (C) Environment will be reflected in the interview process by asking social workers what types of environmental factors are seen as obstacles for older adults living in the community, what they have seen as the impact of these environmental factors on older adults' health, and about their role in addressing these environmental obstacles including their assessment of the types of support systems that are important to older adults.

This area of (D) Psychosocial Development will be reflected in the interview process by asking social workers how they promote the relationship between these support systems and older adults.

Methods

The purpose of this interview was to explore the role and experience of social workers who provide services to older adults in the community. The findings of this study include social workers' voices with a focus on how they identify and assess older adults' strengths, structural and environmental barriers and levels of engagement with activities and support systems.

Sample

A non-probability convenience sample was used and included a list of agencies (Appendix A) providing case management for older adults obtained through the Senior Care Guide Book 2011, which contained a list of case management agencies throughout the metro area. Agencies were contacted by phone and by email to identify whether they had social workers that fit the criteria of this study and to record how many social workers each agency had (Appendix A). Using this public list of agencies (Appendix A) and referrals from committee members, social workers were invited to participate by sending a flyer (Appendix B) outlining the study's purpose and procedure along with the researcher's contact information. It was expected that 8-10 participants would volunteer to participate in the interview process.

Protection of Human Subjects

This study was reviewed by a research committee and by the Institutional Review Board (IRB) at St. Catherine University prior to the beginning of data collection. Participants were invited to participate in this study by sending flyers (Appendix B) and distributed by committee members to each agency (Appendix A). This flyer included the purpose of the study and contact information of the researcher. There were no direct

benefits for participating in this study. The voluntary nature of the study was also addressed in the flyer.

After obtaining approval from the IRB, the flyer (Appendix B) was sent and distributed by committee members to each agency on the list (Appendix A) and invited social workers to participate in this study. Once participants contacted the researcher to participate in the study, the researcher scheduled interviews that lasted for approximately 45 minutes to one hour. Before the interview began, questions were asked to ensure the participant understood the purpose of the study by asking the subject to explain the purpose of the study, what they were being asked to do and what would happen if they decided to withdraw (Appendix D). The interview contained questions that were created by the researcher to gain relevant and useful information for this study (Appendix D). Interviews were recorded for transcription by the researcher and the transcripts were done in an anonymous format with no names being included on the transcripts by the researcher; any other identifying information of the participants was kept in a locked file. Consent forms (Appendix C) were signed by each participant at the scheduled interview. Any identifiable data was stored in a locked file in the researcher's home and all identifiable data was destroyed at the end of the study no later than June 1, 2012.

Data Collection

The research design for this study was qualitative utilizing both quantitative and qualitative questions through the use of interviews. Quantitative questions (Appendix D) were used to categorize information based on areas such as race, ethnicity, gender, age, level of social work licensure, age range of older adults receiving services and years of experience working with older adults. Qualitative questions (Appendix D) were used in

this survey in order to get more in-depth information regarding how social workers perceive the role of the social worker in promoting health among older adults who are living in the community.

The instrument that was used for this study is an interview guide consisting of questions that the researcher created (Appendix D). This instrument was developed using themes from the literature review as well as concepts from the conceptual framework. The first section contained three questions (questions 1-3) and was asked before the interview began to assure the participant understands what he/she has been asked to do. Questions 4-9 consisted of demographic information about the participants' race, ethnicity, gender, age, level of social work licensure, age range of older adults receiving services and years of experience working with older adults.

Questions 10 was created to gather basic information in what the social worker's role is in working with older adults that live in the community. Question 11 asked the participant to identify if they use any tools or assessments in their agency to establish older adults' strengths and question 12 asked the participant in how they use the information gathered from these tools and apply it to their work with older adults. Questions 13-16 asked what activities older adults express to be meaningful activities, how social workers identify obstacles that hinder older adults to engage in these activities, how social workers help older adults overcome these obstacles and how social workers support older adults to engage in these activities.

Questions 17-19 asked what types of environmental factors are seen as obstacles for older adults living in the community, what impact these environmental factors have on older adults' health, and what the social workers' role in addressing the environmental

obstacles. Questions 20 and 21 asked social workers what type of social supports they saw as most important to older adults and how they promoted the relationship between support systems and older adults. Question 22 asked participants to identify areas that are not addressed in their agency in promoting older adults' health in order to gain information of what is missing and what agencies can do to improve the kind of services they provide. Question 23 offered participants an opportunity to share any other comments.

The chair, committee members and classmates checked the validity of these questions to ensure that they are clear and easy to understand. The face validity of these questions appeared to demonstrate that there is a logical relationship that exists between the variable and the proposed measure.

Process

The research was conducted through interviews with participants that voluntarily want to participate. Once approved by St. Catherine University's IRB, the flyer (Appendix B) was sent and distributed by committee members to each agency on the list (Appendix A) to invite social workers to participate in this study. Participants contacted the researcher to participate in the study; the researcher scheduled interviews that lasted for approximately 45 minutes to one hour and were completed in February 2012. The interview contained questions that were created by the researcher to gain appropriate and useful information for this study (Appendix D).

Interviews were recorded for transcription by the researcher and the transcripts were done in an anonymous format with no names included on the transcripts by the researcher and any other identifying information of the participants was kept in a locked

file. Consent forms (Appendix C) were signed by each participant at the scheduled interview. After the month of February 2012 no more interviews were completed and data analysis began. Any identifiable data was stored in a locked file in the researcher's home and all identifiable data was destroyed at the end of the study no later than June 1, 2012.

Data Analysis

Descriptive analysis and content analysis was used for this study. Descriptive statistics for close ended questions (1-6) regarding gender, age, race/ethnicity, level of social work licensure and years of experience.

Content analysis was used for open-ended questions (7-18) to analyze the data. Content analysis is a thorough interpretation of material to identify patterns, themes, biases, and meanings (Berg, 2009, p. 338). Content was ordered by question and color coded and themes were pulled out of each interview. Open coding was used to code for themes. Open coding is a process used to identify themes and topics in a systematic manner (Berg, 2009, p. 228). Each interview was organized by the questions and combined to find overarching themes that multiple interviewees supported. Direct quotes were reported in italics.

Strengths/Limitations

A major strength of this interview study was the focus on documenting social workers' perspective about how to promote health among older adults. Specifically, social workers working in the community with older adults had an opportunity to identify older adults' strengths and how social workers promote these strengths through meaningful activities and addressing barriers through engaging the older adults' support systems.

Finally, input from the respondents provided further understanding of people, groups and organizations within the full context or situation in which they act.

By including social workers in this study other important perspectives such as community-based nurses were excluded. Further research is needed to draw upon the wisdom of larger samples of social workers providing services to older adults in their communities.

Findings

The findings will present the demographics of the participants and the themes that connect to the Vital Involvement Framework, which include Person, Occupations, Environment Factors and Psychosocial Development.

Demographics

Participants were asked to share basic information to assist in contextualizing their points of view. The first section of the interview identified demographics. As noted in Table 1, all but one of the 8 participants were female. A broad range of ages was represented: 4 of the participants were 25-35; and 3 participants were 46-55. Most of the participants were Caucasian; one was African American and one was Asian. Members of three licensure groups participated in this study, LSWs (n=3), LGSWs (n=4) and LISW (n=1).

Table 1. Demographics	Total
Gender	
Female	7
Male	1
Age	
25-35	4
36-45	1
46-55	3
Race/Ethnicity	
Caucasian	6
Hispanic	0
African American	1
Asian	1
Social Work Licensure	
LSW	3
LGSW	4
LISW	1
Years of Experience	
1-10 years	4
11-20 years	2
21-30 years	2
Job Position	
Case Management	3
Care Coordinator	3
Caregiver Support	2
Age Range of Older Adults	
55 and up	2
60 and up	2
65 and up	4

Participants had a broad range of experience working with older adults; 4 participants had 1-10 years of experiences working with older adults, 2 participants had 11-20 years of experience working with older adults and 2 participants had 21-30 years of experience working with older adults. The age range of older adults that they work with included 55 and older (n=2), 60 and older (n=2) and 65 and older (n=4). The job positions of the participants included case management (n=3), care coordinator (n=3) and caregiver support (n=2).

An analysis of the interviews as a whole yielded four major themes that align with the Vital Involvement Framework. These four major themes include: Person (strengths and weaknesses), Occupations (activities), Environmental Factors and Psychosocial Development. Participants discussed how they utilize this framework in their practice, which will also be presented.

Person

When asked if the participants had a process or used a tool to identify the strengths and problems of their clients, all the respondents responded affirmatively and described both formal assessment processes as well as informal processes for assessment.

Formal Assessment

Three of the eight participants reported that they used a formal assessment tool with questions that asked specifically about the older adult's strengths. One care coordinator stated that the assessment used with older adults at admission *asks that very question: "what are the client's strengths right now?"* The same form has the question *that asks about their needs*. Two participants use the same tool, which is part of a comprehensive assessment called the Vital Involvement Practice Worksheets.

We also offer a vital involvement assessment, which is a very lengthy assessment tool. If the participants are interested in pursuing it, we can work on that together. It is a tool that takes several visits and [involves] goal setting and looking at strengths and barriers and how to get weaknesses to become strengths and to promote their strengths.

They use a Strengths Identification Assessment, which is included in the Vital Involvement Practice Worksheets to identify what a person is good at and what they used to be good at. The Strengths Identification Assessment also identifies how a person overcomes difficult situations and what kind of coping skills they use. This assessment was described as a tool being used to *learn about their family, their social supports, who they live with and [includes] questions about their hobbies, their skills, and things that they enjoy doing and how they spend their time each day.* Overall, the tool helps the worker identify the person's abilities, assets and specific personal strengths that the client has or potential strengths that the client could develop.

The participants who have an assessment tool to identify strengths and weaknesses use the information that is obtained and apply it to their work with older adults.

We try and determine through the assessment itself, and just conversation, if they are able to engage in what they stated that their strengths and interests are or if there are any barriers that are preventing them from engaging in those things that they enjoy doing.

Questions are also asked to see if a client is able to engage in their strengths and interests or if the client would like to change anything about their day.

The answers to those questions help to inform us if there are any supports that we can put into place [for the client] that will enable them to continue engaging in the things they like doing or get them re-engaged in those type of things.

Finally, one care coordinator stated that the information is used to promote the strengths of people. *I think our society, especially the medical field is problem oriented in solving*

problems, while we really try and be strengths oriented: looking at people's strengths and helping them use their strengths. Other participants in this study use an informal process to acquire the same information about a client's strengths and weaknesses.

Informal Process

Five of the eight participants had an informal process to identify older adults' strengths. They all had an assessment that would include issues such as *depression level, functional status, social history and if they are connected in the community.* They did not have any specific questions that addressed a person's strengths. After collecting the information, they *used an informal process by looking at all these pieces and then assessing.* One Caregiver Support worker who works with older adults who are ages 55 and up stated that

As part of my social work practice I use the strengths based perspective and I think a lot of times what we do through our program is trying to meet the client where they are at. So, while we don't necessarily have a specific tool that we use I think we are trying to pull from what they think that their strengths are and build on those.

The participants who use an informal process use this information and apply it to their work with older adults by *helping them make the changes that would give their life more satisfaction.* Two Case Managers working with older adults who are ages 65 and older use the information to determine the needs of an older adult and what services and equipment would benefit the older adult. *I put together a care plan, which summarizes the client's needs and then connect them to the appropriate services that will fulfill those needs.* Another Caregiver Support worker described how important using a strength-based perspective in his/her social work practice is:

It is important to me knowing what peoples' strengths are in a particular situation. I think is vital to seeing them succeed and for them to really learn how

to help themselves as well. It is a part of the work we do. We use it to try and build confidence with the older adults we work with.

Knowing clients' strengths are incorporated into understanding what types of activities (occupation) they are interested in and how to promote the engagement of these clients in those activities that are important to them.

Occupation/Activities

Participants were asked to identify what types of activities older adults found to be most meaningful to their aging. All eight participants in this study emphasized how important it is to older adults to have socialization. *Socialization is one of the most important activities and to be with peers that are the same age.* Three participants identified the importance of older adults having their family connections, especially if they have *positive family connections that are meaningful to them.* Two participants also identified the importance of older adults having friends and *a lot of them enjoy being with friends.* Finally, two participants identified how *older adults like to remain connected to their community and connected to other people.*

Three participants also acknowledged that older adults identify religion and spirituality as essential to their aging. One case manager stated that *it is beneficial for them to stay connected to the community, especially faith-based communities.* For some older adults their *faith is really a big piece of what's important to them.*

Two participants stated that older adults who are minorities describe the benefit of staying connected to their own culture. Both of these participants described how important it is for minority older adults to attend community settings that serve people of their same race/ethnicity and culture. One Caregiver Support worker noted in particular that *African Americans, Native Americans and Hispanic all like to continue going to*

celebrations that are traditional festivals, so they remain engaged with their culture and history.

Social Workers' Role

When asked about their role in supporting older adults to engage in the activities that they found meaningful for their aging, five participants stated that connecting older adults to services and coordinating these services was their main support role. A volunteer or companion could be an example of a service that a social worker would connect the older adult with.

We have volunteers that can help bring the world to them a little bit more if they are isolated in their homes. If they have specific hobbies or enjoy doing certain things and want to get out we have volunteers that can do things of that nature.

Two case managers indicated that it was their role to set up services such as, *meals on wheels, nurse, homemaker and home health aides* to be delivered in the client's home. These services were determined to be necessary to keep the older adult safe and to provide some connection to other people. Three participants identified the importance of connecting older adults to transportation to ensure that they have opportunities to participate in the activities that are important to them: *We also help to coordinate transportation to get people to those events or activities that they might be interested in.*

Many older adults have a difficult time engaging in the activities that are important to them because of environment factors that hinder their participation. It is essential for a worker to identify these environmental factors in order to promote the older to facilitate that engagement.

Environmental Factors

When asked about the most common environmental factors that are seen as obstacles for older adults living in the community environmental factors were identified: transportation, weather, accessibility, low income and physical health.

Transportation

Five participants identified transportation as one of the biggest environmental factors for older adults living in the community. One Caregiver Support worker stated that *Transportation is always a big obstacle and since many of our participants no longer drive it lessens that independence they feel when they are able to get to places or engage in the activities that are important to them.* A care coordinator pointed out that even though the agency that he/she works for has a volunteer driver program *transportation is a huge obstacle and that not all rides [that our clients need and sign up for] can be picked up.* All the participants recognized and stated that there are not enough transportation services.

Weather

Four participants identified weather as an environmental factor for older adults living in the community. One case manager stated that *especially in the winters it's harder for people to get out of their homes and to get to places.* Another care coordinator expressed that *weather is a huge obstacle and sometimes people can't get someone to shovel and so they can't get out of their homes, which makes the person very isolated in their home during the winter.* In addition to weather being an environmental factor, accessibility is also seen as another obstacle for older adults.

Accessibility

Three participants identified accessibility in the home as an environmental factor. One caregiver support worker stated *that the way the home is set up may not be allowing them to do ordinary daily living functions* [such as toileting, bathing, cooking, laundry and cleaning]. Another case manager stated *that older houses are not made for wheelchairs so a lot of safety checks need to be made and most times older adults are told they can't be in their homes because the house is too difficult for the older adults to navigate*. Two participants identified accessibility in the community as an environmental factor and discussed that many older adults do not have accessible places to go because of curves, sidewalks and distances that have to be walked. Buildings are also not always accessible and older adults may struggle with stairs and chairs. In order for an older adult to make the home an accessible place it takes money to do so. Income was also another environmental factor that was identified as being an obstacle for older adults.

Income

Three participants identified low income as an environmental factor for older adults who wish to continue living in the community. Participants commented on how low income makes it difficult for older adults to pay for services that are necessary to keep them living independently in their homes. One care coordinator stated that when older adults have low income *it might be harder for them to pay for any services that might be beneficial to them that will keep them living at home*. Some participants also reported that when older adults are low income they may not be able to afford health services, which can have a negative impact on their health.

Physical Health

Two participants identified physical health and disabilities as environmental factors for older adults living in the community. *Some people need physical assistance to get out of their house or just in general are not feeling well.* It can be difficult to find services that can meet the needs of those who have limited ability and often can result in isolation and can have a negative impact on an older adult's health.

Environmental Factors and Health

When participants were asked to identify environmental factors that impact older adults' health, three areas related to isolation were noted: depression, an increased risk for falls and medication misuse.

Depression

The environmental factors that were mentioned in the findings can result in hindering older adults from participating in the community. There is a concern when older adults have a lack of participation in the community. Six of the eight participants identified the risk of older adults being isolated and as a result are more likely to develop depression. One care coordinator stated that *isolation can cause depression, so just that piece if someone is at home and not going anywhere, depression can then factor in.* Another caregiver support worker discussed that *studies show the more withdrawn a person is the more likely they will develop depression. And just the quality of life is, impacted because you are limiting yourself as to who you are spending time with.* Four participants also identified how isolation does not just affect the mental health but can also lead to other problems with a person's physical health. One case manager stated that *isolation and depression don't just affect your mood, they affect your body and health*

system and can contribute to a decline in health as well. In addition to depression being identified as a result of being isolated, the risk of falls was also another theme that was identified.

Falls

Three participants also identified that older adults experience an increased risk of falls when they are isolated. One care coordinator stated that *falling with injuries is one of the big concerns and when people fall and they don't have any supports in their life or a lifeline, they can end up laying on the floor for hours or even days.* Another caregiver support worker described that some people will isolate themselves if they are afraid of falling; this caregiver support worker stated that *even if people aren't falling and there is the risk of falling a lot of people will isolate themselves because they don't even want to have that risk, because if you fall you might lose your independence.* Another area that was identified as an area related to isolation was medication misuse.

Medications

Isolation can also result in the misuse of medications. Three participants identified not taking medications appropriately as a result of being isolated, because there is no one to remind the older adult or to check in on them. One care coordinator stated that *when people are at home and not eating appropriately and not taking medications appropriately and just not having daily interaction it can lead to very poor health and can be a downward spiral. When people are in that spiral there is an increased risk of hospitalization.* Participants also acknowledged that older adults who are isolated can more easily mix up their medications and have an increased risk in overdosing or accidentally not taking medications.

Assessing Obstacles

When asked how the participants identified obstacles that hindered older adults from engaging in activities that were meaningful to them, all the respondents indicated that they were either identifying obstacles through a formal assessment tool or were informally identifying them based on the information that was gathered in talking with the older adult.

Formal Assessment

Four of the eight participants used a formal process to identify the obstacles that older adults were experiencing. Two care coordinators had a specific question on their Interest Inventory assessment that asked what types of barriers are preventing the older adult from doing the things they really enjoy doing. These two participants also used the Vital Involvement Practice Worksheet to identify and list environmental problems, personal problems, risks and barriers. One of the care coordinators who uses the Vital Involvement Practice Worksheets stated that through the assessment that is used:

We would ask if there are any barriers or if there is anything that they would like to be doing that they are not doing. [We would] try and gather more information that way about what those barriers are [and] what's hindering someone from engaging in something that is important to them.

Two case managers use a tool known as the Long Term Care Consultation Tool (LTCC), which has a specific question on their assessment that asks how the older adult gets around to do things and what is stopping them from participating in the activities they enjoy.

The participants who have an assessment tool to identify obstacles use the information to help the older adults overcome these obstacles. One care coordinator explained that *we would probably want to make a goal on their action plan* [a plan that

balances strengths versus barriers to create strategies for achieving goals] *and think of different interventions or different steps that we can take to accomplish that goal so that they can remain engaged or re-engage in something that is important to them.* Two case managers use the information for their assessment to educate the older adults about the options that are available to them and what the benefits are of the different options. If the older adults are interested in any of the options the participants would then make referrals to agencies or connect them with services that will meet the needs of the older adults.

Another participant discussed how important it is to use the information that was gathered in the assessment to be aware of these obstacles early on and then *appropriate supports can be offered to help resolve the problem or before it becomes a problem.*

Other participants used an informal process to identify obstacles and then applied their process in helping the older adults to overcome these obstacles.

Informal Process

Four of the eight participants used an informal process to identify the obstacles that older adults were experiencing. One care coordinator used care plans to identify the obstacles and stated:

I use leading question like “How are you doing at home?” “What are some of the problems you are having right now with your health?” “Have you had any falls?” and “How are the services going that are currently set up?” So we ask a lot of questions at the care plan that help to dig out if there is a problem and then figure out the need.

Two participants identify obstacles by listening to the older adults and asking questions about why they are not participating in activities. Communication was said to play a key role in identifying some of the barriers and obstacles for older adults by all four participants who used an informal process.

The participants who use an informal process to identify obstacles use this information and apply it to their work with older adults by *bridging the gap and connecting older adults to services*. Two participants discussed the importance of thinking creatively and coming up with alternative solutions to overcome obstacles. One Caregiver Support worker *evaluates what the obstacles are and then I think creatively [about] how to navigate around those and try to eliminate as many as I can*. Another case manager expressed how important it is to use the resources in the community to find services that can meet the needs of the clients. Resources can include support systems to promote engagement in activities and can be meaningful to older adults' health, so it is essential for workers to help older adults identify the support systems that are important to them.

Support Systems

Participants were asked what types of support systems are seen to be most important to older adults and four main types of support systems were identified that included: family, friends, social workers and community resources.

Family and Friends

All participants identified that family is seen to be an important support system for older adults. A care coordinator stated that it is important for older adults to have family, *whether it be a spouse or even an adult child, someone to help in that sort of informal caregiver role*. Five of the eight participants identified friends as important support systems for older adults. A caregiver support worker indicated that *friendships and having that connection to that social piece and peers is important*.

Social Workers

Four of the eight participants identified social workers (care coordinators, case managers and caregiver support workers) as important support systems for older adults.

One care coordinator stated that:

I like to say that care coordinators are right up there on top, because we can really help support people in their homes and help coordinate so that hopefully they are staying healthy, because we are checking in with them and if we notice that people are not as healthy or showing decline, we can get them connected to the doctor or communicate with a medical person to prevent those hospitalizations.

Another participant pointed out that care coordinators have been beneficial to older adults in the community.

[It is helpful] just to have the extra support of a care coordinator to identify resources in the community and to support them in their goals as they age. [They can also] be a resource to their families who may not know how to navigate or identify [support] systems as their parents' age.

In addition to social workers being identified as an important support system for older adults, community resources was also identified as an important support system.

Community Resources

Four of the eight participants identified community resources as an important aspect of support systems for older adults. Some examples of community resources that the participants listed include: adult day care, home health agencies, nurses, doctors, churches, community centers, volunteers and support groups. One care coordinator stated *volunteers become a really important lifeline for older adults.* Another participant described the importance of an adult day care and noted that *adult day health programs give older adults a wealth of support, because within the program they have a clinic located at their site, a nurse on staff, a social worker on staff [as well as] all the program*

staff. They provide a safe environment and structured support to help the older adults get better and get them out of the house.

Promoting Support Systems

Four participants emphasized that communicating with their clients as the best way to promote the relationship between the client and their support systems. Two care coordinators described the importance of having ongoing communication or through the use of completing check in calls with their clients. According to one care coordinator, *through our on going communication and check in calls and the relationship that we build with our participants, we are able to see if there are any new needs or new barriers. We are also able to see if they are remaining engaged and connected to what's important to them.*

Four participants saw a role in helping older adults connect to support systems and resources is the best way to promote the relationship between their clients and the support systems. One participant stated *I advocate for those services to be there for them when people need it and then work with the older adults to get them connected to that support, whatever it might be.* A case manager stated that he/she *determines the need, recommends the services and if the older adult is accepting then helps them get connected with the services.*

Two participants identified the importance of including the older adults' family into their care plan. One care coordinator stated:

I think we found that [including a client's family] is an important piece of the relationship [when] working with the older adult participants [and] with their family members as well. [Including] their spouse or their children, or anyone else who is involved in their care is a very important system to have [included].

Another care coordinator described how important it is for the family of the older adult to be invited to the care plans and stated *I help connect all the people that are involved in the person's life so that we can all be on the same page and all be notified about what the concerns are so we can be watchful and helpful.*

Two participants expressed that part of their role is to encourage the older adults to be connected to the support systems that are important to them. A caregiver support worker stated *I think a lot of it is just really stressing the importance of staying connected, not isolating yourself, staying active and being social. We also talk about the more you isolate the more health conditions can show up, the more you stay engaged and active the better.* A case manager stated that *I encourage them to get together with other people and encourage them to get out and engage with the community.*

In addition to social workers promoting the relationship between older adults and the support systems mentioned above; social workers have also played a role in implementing evidence based health promotion programs. These health promotion programs encompass all parts of the Vital Involvement Framework (person, occupation, environmental factors) that have been discussed thus far and promote psychosocial development.

Psychosocial Development

Four of the eight participants described health promotion programs as beneficial for older adults because they are able to use their strengths, engage in meaningful activities and have support systems. These programs include: Chronic Disease Self-Management Program, Matter of Balance Program, Healthy Eating and a anti-depression program. One caregiver support worker stated that *I think the more opportunities there*

are for older adults to take classes that will help them or teach them the tools to help manage different parts of their lives. Another participant stated that these programs are evidence based so they have been tested and proved that these classes are beneficial for seniors' healthy aging. Chronic Disease Self-Management program was identified as a class that promoted health in older adults.

Chronic Disease Self-Management

The Chronic Disease Self-Management Program, an evidence based program, is for older adults who are managing chronic conditions. One care coordinator who works with older adults 65 and older stated:

If an [older adult] tells us when we are leaning about their health that maybe they're managing like arthritis and they have a really hard time with pain; referring them to this class might be a good option. Then they can learn skills to manage their pain or have the support of the other class participants. [The older adult can] get tips of communicating with their doctor or trying to find other treatments that will benefit them.

Another participant who works with older adults who are 55 and older expressed that clients enjoy these kinds of programs and stated *that clients have the chance to talk about how it feels to be dealing with, for instance a stroke, and all the ramifications of losses from a stroke.* Two participants are trained instructors for the Chronic Disease Self Management program and one care coordinator stated that as part of the class each older adult *sets small, attainable goals to work on throughout the 6 week class.* The other participant stated *this program is designed to look at people's strengths to help them feel more empowered. We also talk about positive thinking and reframing and reshifting a negative thought into a positive thought.* In addition to the Chronic Disease Self Management program being identified as a class that can help promote health in older

adults, Matter of Balance class was also identified as a class that is seen to be beneficial to older adults' health.

Matter of Balance

Matter of Balance is another evidence based health promotion program that four participants described as being important in promoting older adults' health. Matter of Balance is a falls prevention class to which older adults would be referred if they had had a fall, are at risk for falling or are worried about falling. One care coordinator, working with older adults 65 and up stated that *clients have testified that the exercises have really helped them a lot and that they notice how their range of motion and strength has improved.* Another care coordinator described that a health professional will go into an older adult's home to help them with the exercises and stated *the person works one on one with them and encourages them to do the exercises.* A caregiver support worker working with older adults 55 and up stated that exercise classes help *older adults feel like they are being proactive about either their health or their well being. I think sometimes it can give them a little more confidence to feel like they're actively trying to maintain their health and well being so they are able to maintain their independence for a longer period of time.* Another class that was identified to promote the health of older adults is the Healthy Eating class.

Healthy Eating

Healthy Eating is another evidence-based program that has been demonstrated to promote healthy aging in older adults. One care coordinator identified that nutrition is important to older adults and stated *if an [older adult] identifies that nutrition or healthy eating or watching their diet is important to them, there is an evidence based health*

promotion program centered around health eating. So, that might be a trigger that [the healthy eating class] might be an important class that I could refer that person to.

Another program that addresses the psychosocial development of older adults is the anti-depression program that was identified by the participants in this study.

Depression Program

The final evidence based program that two care coordinators from the same agency identified as an important class for promoting the health for older adults is Healthy Ideas, which is a program to treat depression. The care coordinators first do an initial screening by administering a geriatric depression scale (GDS) to the older adult. If the older adult has a score that indicates he/she is depressed the care coordinator will then assist the older adult in completing a behavior activation process, which includes the older adult setting goals around an activity that is meaningful to him or her.

One participant stated that if a client is identified as having depression *we would work with them more thoroughly through this depression program we are a part of and help the client create goals that are centered around alleviating his/her depression.* The other participant who promotes refers clients to this program talked about educating the clients about their mental illness who met the standards of having depression. This care coordinator stated *we have a several visit process and then we engage them in some goal setting for behavior modification that the client has identified will help them. We can also refer them to a psychologist on staff who is available to talk to them. It's a wonderful program, it's very specific and my role is to work with them through that program.*

Within the context of existing programs that address health promotion for older adults, participants also identified gaps in services delivered.

What's Missing in the Agency?

When asked if there were any areas of need for older adults that were not addressed by their agency in promoting their health, three participants indicated that all areas in promoting older adults' health were addressed by the agencies they worked in. One care coordinator stated that *we have no barriers and when someone is in need and we don't know all the answers, we are going to work very hard to find the connections.* Another participant stated *I think our assessment is pretty thorough, so I guess I can't think of anything related to one's health that we might not ask about or identify.*

Three participants indicated that often there is not enough funding. A case manager stated that:

With all the funding changes, sometimes one of the frustrations I have is that there used to be an ILS workers that could be, at a moments notice, set up to help somebody with all their paper work and sorting through bills, even setting up things like a grocery shopping list and helping them with groceries. Today everyone is cutting back and things are squeezing in tighter and tighter and so there's sometimes some holes.

Two caregiver support workers expressed that there are not enough mental health services provided to older adults. One participant stated:

We don't do therapy for older adults. I don't think I know of any agency that does therapy for older adults and that's like a special type of social work that I don't think anyone not that I can think of in the Twin Cities is doing. No one is doing actual therapy with older adults, recognizing the issues, trying to meet them where they are at and trying to work with them on their issues and helping them with their thinking. A lot of older adults are really good at holding things in and taking those things to their grave, so we definitely don't provide that.

Overall, participants indicated the importance of assessing older adults' strengths, structural and environmental barriers and levels of engagement with activities and support systems, whether using a formal or an informal process. These findings

demonstrate that the Vital Involvement Framework is utilized by social workers in community-based settings to promote health among older adults.

Discussion

Overall, results of this study indicated the importance social workers attribute to their role and experiences as they provide services to older adults in the community. These community-based social workers provide a critical service as they identify and assess older adults' strengths, structural and environmental barriers, and levels of engagement with activities and support systems. In this section seven areas will be addressed that include: demographics, strengths, social participation, physical health and disabilities, importance of social workers, health promotion programs and implications for social work.

Demographics

This study included eight social workers working with older adults in community-based settings. Participants' experience working with older adults ranged from 4 years to 30 years, and they defined *older adults* in different age ranges: 55 and older, 60 and older, and 65 and older. There were no previous studies found that included information from social workers.

Strengths

This study indicates social workers' perspectives on being able to identify and assess older adults' strengths. Kivnick (1993) emphasized the importance of strengths. Older adults can maximize everyday health by reinforcing existing strengths, developing new strengths, and using existing personal strengths to balances out their weaknesses and environment deficits. This study's findings demonstrate that all the respondents use either a formal assessment tool or an informal process as an assessment to identify and assess older adults' strengths. Social workers using a strength based perspective and identifying

older adults' abilities, assets and their personal strengths or potential strengths that they could develop is vital for promoting healthy aging in older adults.

Social Participation

All participants in this study emphasized the importance of older adults participating in activities that included socialization. Levasseur et al. (2004) found that social participation was a determinant of quality of life and that for older adults with physical disabilities who participated, social interaction was positively associated with their quality of life. Molzahn, Skevington, Kalfoss and Makaroff (2010) found older adults ranked relationships with family and friends as the most important quality of life aspects. Social workers in this study identified the importance of older adults being connected to family, friends and their community.

Physical Health and Disabilities

Participants in this study identified physical health and disabilities as an environmental factor for older adults living in the community and often can result in isolation and can have a negative impact on older adults' health. There was a finding that demonstrated the relationship between physical health, social isolation and depression in this study, which correlated with past research. Behar (2011) explained that loss of muscle strength, speed and the ability to perform tasks were common repercussions of aging and have been established as risk factors for death, disability and dementia. Roberson and Litchenberg (2003) found that older adult patients with depression reported that they were receiving inadequate social support and that they had more physical disabilities than older adults who were not depressed and had a sufficient amount of social support. The majority of the participants in this study are concerned when older

adults are not participating in the community because there is the risk of older adults being isolated and then increasing their chances in developing depression. Participants in this study also identified that isolation not only affects the mental health but can lead to older adults experiencing a decline in their physical health.

Importance of Social Workers

Participants in this study identified social workers as important support systems for older adults, because they can help support older adults in their home by coordinating services that will help them live in their homes as long as possible. Social workers can also identify resources in the community that will support older adults' goals as they age. Past research has demonstrated that social workers are an important support system for older adults. Marrow- Howell, Becker and Judy (1998) found that a social work program used by the community to provide case management and supportive services to older adults who were depressed, socially isolated and needed assistance decreased depressive symptoms among older adults.

Health Promotion Programs

Health promotion programs directed at older adults may improve their health and quality of life. Social workers in this study indicated that it is important for older adults to have opportunities to participate in health promotion programs that will teach them the tools to help manage their lives. Gotzel et al. (2007) illustrated that health promotion programs are aimed at keeping healthy those people who have an increased risk for developing diseases and disorders. Christmas and Andersen (2001) found that older adults who are physically active have reduced risk of falls, reduction in body mass index and improved mood.

Participants in this study expressed that when older adults engage in health promotion programs such as Matter of Balance that provides exercises to older adults, they feel they are being proactive about their health they can gain confidence, because they are trying to maintain their health and independence. This also related to Taylor et al. (2004) research; they found that older adults who remained physically active had an enhanced ability to manage stress and greater feelings of self-efficacy. Muramatsu et al. (2010) found that older adults who received Home and Community Based Services (HCBS) which includes services that promote social interaction had lower rates of depression. This study demonstrated that programs like Chronic Disease Self-Management can be a support group for older adults that are struggling with managing their chronic conditions. It gives older adults the opportunity to talk about how it feels to be dealing with a chronic condition and be supported by peers that are enduring the same experience.

Implications for Social Work

Practice

Based on this study, future social workers who work with older adults, living in the community, could benefit by utilizing the Vital Involvement Framework, because it guides them through a systematic exploration and assessment of all areas of the older adult's life. This includes the social worker assessing the strengths and weaknesses of a person, identifying activities that are important to the older adult and identifying supports and obstacles in the environment. Once these areas are assessed and identified the social worker can assist the older adult to create goals to assist them in engaging in the activities that are most meaningful to them. The social worker's role is to identify support systems

and connect older adults to the support systems and resources in the community that will promote their overall health. Using the Vital Involvement Framework to promote older adults health shifts the paradigm from having a focus on deficits to a focus on strengths, a focus consistent with social work principles and values.

Policy and Research

One policy implication identified by the participants in this study was a lack of sufficient funds for resources and programs that promote health for older adults living in the community. Social workers should advocate for further funding of health promotion programs for older adults. Likewise social workers have a role in analyzing how to incentivize involvement in health promotion through health care programs and to advocate for funding for agencies to provide the health promotion programs.

Future research should aim towards gaining more knowledge on ideas for promoting older adults' health including the insight from both social workers and older adults themselves. Researchers can gain insight by using qualitative research in order to better understand what is important in promoting older adults' health as well as how social workers can better meet the needs of older adults living in the community. In order to attain valid and reliable results, more participants should be included, using a survey to include more.

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Appendix A**Agency List**

1. Consortium at Carondelet Village
2. Amherst H. Wilder Foundation, Community Services for Aging
3. DARTS
4. AgeWell Homecare
5. HealthEast MSHO

Appendix B

Are you a social worker who works with older adults in a community-based agency?



Social Workers' Perspectives on Working with Older Adults in the Community

You are invited to participate in an interview study to explore the role and experience of social workers who provide services to older adults in the community.

This study is being conducted by Kaylee Olson, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas.

What is will you do?

- 45-minute audio taped interview
- Interview will take place at location convenient to the participant
- Participation is voluntary and all identifying information will remain anonymous and confidential

Interested in participating or for more information please contact:
Kaylee Olson, MSW Student

Appendix C**Social Workers' Perspectives on Working with Older Adults in the Community****Research Information and Consent Form****St. Catherine University/ University of St. Thomas****Introduction:**

You are invited to participate in a research study to explore the role and experience of social workers who provide services to older adults in the community. This study is being conducted by Kaylee Olson, Master of Social Work student at St. Catherine University/University of St. Thomas School of Social Work under the supervision of Carol F. Kuechler, Ph.D. You were selected as a possible participant in this research because you are a social worker working with older adults in a community based agency. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of this study is to explore the role and experiences of social workers who provide services to older adults in the community. The goal of this study will contribute to the literature by including social workers' voices with a focus on how they identify and assess older adults' strengths, structural and environmental barriers, levels of engagement with activities and support systems

Procedures:

If you decide to participate, you will be asked to participate in a face-to-face audio taped interview that will last approximately 45 minutes to an hour in a location that is convenient to you. Interviews will be transcribed and analyzed to identify themes for this study that can contribute to the literature.

Risks and Benefits:

There are no known direct risks or direct benefits to you for participating in this research.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. Interviews will be recorded for transcription by the researcher and the transcripts will be done anonymously (without names) by the researcher. Any identifiable data will be stored in a locked file in the researcher's home and all identifiable data will be destroyed at the end of the study no later than June 1, 2012.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University/University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

Contacts and questions:

If you have any questions, please feel free to contact me. You may contact Dr. Carol F. Kuechler, my research advisor at 651-690-6719 or by email cfkuechler@stkate.edu. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study and I agree to be audiotaped.

Signature of Participant

Date

Signature of Researcher

Date

Appendix D**Interview Questions****Assurance of Participant Understanding**

1. What is the purpose of the study?
2. What are the procedures that you are being asked to do?
3. What happens if you decide to withdraw from participating in this study?

Demographics

4. Race/Ethnicity?
5. Age?
6. Gender?
7. Level of Social Work Licensure?
8. How many years of experience do you have working with older adults?
9. What is the age range of older adults that you work with?

Basic Information

10. What is your role in working with older adults that live in the community?

Strengths

11. Do you have a tool or a process to assess older adults' strengths? If yes how do you do this?
12. How do you use the information that was obtained with the tool or process and apply it to your work with the older adults?

Activities

13. What types of activities do older adults express to be most meaningful to their aging?
14. What is your role in supporting older adults to engage in these activities?

Obstacles

15. How do you identify obstacles that hinder older adults from engaging in activities that are meaningful to them?

16. What is your role in helping older adults overcome these obstacles?

Environmental Factors

17. What types of environmental factors are seen as obstacles for older adults living in the community?

18. What have you seen to be the impact of these environmental factors on older adults' health?

19. What is your role in addressing these environmental obstacles?

Support Systems

20. What types of support systems are seen to be most important to older adults?

21. How do you promote the relationship between these support systems and older adults?

What is Missing

22. Are there any areas in working with older adults that are not addressed by your agency in promoting their health?

23. Is there anything else you would like to say?