Aging, Poverty, and Community Practice in the United States : The Need for Empowerment-Oriented Practice

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I. Introduction

Poverty in late life has several key contributing factors that are perhaps to some extent universal, also have unique characteristics based on the political, economy, and predominant social/cultural values in different societies. Poverty among the elderly in the U.S. is understated in most economic reports for a number of reasons (Gonyea, 2005). For example, poverty defined as adequate resources to support a minimal standard of living raises strong challenges to current methods of determining the numbers of older Americans living in poverty. Evaluation of the poverty experience of older adults must include attention to the weakness of the official poverty rate, the limitations of provision for adequate health care, age discrimination, 'lack of community' and other factors, especially the nature of transportation, housing, types, cost, and location (Libson, 2006). A brief discussion of these factors, followed by an overview of selected programs and interventions designed to address these issues, is presented in the paper.

It is important to note that this array of approaches to address the issues of older Americans have been subject to the on-going radical changes in the political economy. Aging related policies in the United States include privatization, social welfare cuts, devolution, and de-regulation among other social value changes related to the status of older adults such as a challenge to the legitimacy of retirement (Ghilarducci, 2006) and challenge of age status as a factor in social provision (Hudson, 2005). This change is further reinforced by the escalated focus on individual and/or family responsibility versus state or private assistance (Cox, 2008).

These trends have also diminished the resources available to fund advocacy programs that address key issue of older Americans. Those who are serving as advocates face larger numbers of programs who are unable to keep up with needs of their constituencies and unable to develop new resources necessary to meet diverse circumstances of older Americans, especially those with inadequate financial resources (Stone, 2004; Rother, 2004).

The purpose of this paper is to provide an overview of the nature and content of social welfare policy and services concerning older Americans, with particular attention to the older adults in need. In order to have more insights into the understanding of aging issues and policy in the U.S., the larger political economy will be briefly introduced. The second part of the paper discusses the four overall approaches to community practice[1] based on several trends or movements. Finally, with the predominately medical services to meet the needs of aging population, there is presently a great need for the empowerment-oriented community development interventions to improve the quality of life for older adults.

Ⅱ. Key Issues Concerning Older Americans: Income, Health Care and Social Services

According to the U.S. Census, 8.9% of older Americans are below the poverty level and another 3.4 million or 14.3% were classified as near poor (125% of poverty) in 2009 (U.S. Census Bureau, 2010). The 2009 poverty guideline issued by U.S. Department of Health and Human Services (HHS) is $10,830 for one adult and $14,570 for two adults. HHS differs from the US Census that allows persons over 65 only 92 percent of the poverty amount established for younger adults (HHS, 2010). In 2004, the median income for older individuals was $24,323 for males and $14,021 for females (AOA, 2009). A critical look at statistics regarding income and need, especially cost of living, is required to guide future policy advocacy. There are many critics of the extremely low poverty line estimates used in the U.S. Figures related to cost of living far exceed these estimates. They argue that poverty estimates based on these guidelines have little meaning separated from the costs of basic needs (housing, utilities, food, transportation, uncovered medical expense and other necessities). Some estimates suggest that as many as one third of American families have difficulty meeting daily needs (Ehrenreich, 2001; Shipler, 2004). For example, a recent study of all Medicare households' (often with two or more members) expenditures found the average total expenditures budget to be $28,908 in 2006. The significance of this gap between official guidelines for poverty and cost of living for older adults is enhanced by statistics that find 41 percent of persons over 65 with annual income under $15000, and another 12 percent between $15,000 and $24,999 (AOA, 2010). These facts suggest that a larger percentage of older adults are challenged to meet survival living expenses through their regular income. This modified by living in family or other collective settings. However, over 31 % of older women live alone and many older couples combined income do not reach $24,000. Adequate income for older adults is challenged by inflation (especially in health care costs, housing and utility costs), loss of senior tax breaks, age discrimination in employment, physical and mental decline that requires assistance, loss or unavailability of personal support networks, lack of adequate mass transportation requiring auto transport, and other essential supports (Barnett, 2005; Cohen, 2001; Gonyea & Hooyman, 2005).

Another important effect of the extremely low poverty guidelines used in the U.S. is that eligibility for various other health and social services are based on these guidelines. Often these benefits such as food stamps are limited to individuals and/ or elderly couples with income below the poverty line or one hundred and fifty percent of the poverty line. These programs support basic direct income support programs in addressing poverty in late life. A brief overview of key income sources, health care and social services available to older Americans to meet basic needs follows.

1. Primary Income Sources

Since the adaption of retirement as a cultural tradition, the most common sources of income for older adults has been social security, private pensions and savings. However, political and economic conditions in the past decade have fostered an increase in employment among older adults and earned income has become an increasingly critical part of income available to older adults (AOA, 2010). Extremely poor elders who qualify little or no social security have very limited savings and/or other earnings. Supplemental Security Income (SSI) provides a small income to qualified elders ranging from $600 to $950 depending on the state of residence (Social Security Administration, 2009).

Regardless of these programs, many gaps in coverage and adequacy of income are evident and noted

above. Both Social Security and Savings are based on employment and other often inheritance and private investments. These programs are not based on cost of living nor do they establish a minimal standard of living and are supplemented by a variety of state, local and not-for-profit charities that are very diverse and often only able to provide special, temporary and very modest assistance. Consequently poverty prevails for many older Americans.

2. Primary Health Care Programs

Perhaps the most powerful stranglehold on aging policy, the meaning of aging, and the status of older persons in the United States has been and continues to be the widely accepted social construction of aging as a medical problem, often referred to as the medicalization of aging. This view of aging brings with it the need for medical solutions to the issue of aging. Cox (2008) and Estes, Wallace, Linkins, & Binney (2001) note that "the biomedical model emphasizes the etiology, clinical treatment and management of disease of the elderly as defined and treated by medical practitioners while giving marginal attention to the social and behavioral process and problems" (p. 46). The lack of balance between health and social services is of great concern to community practice advocates.

However, even the national Medicare program, which provides health care coverage for older adults 65 and over and for disabled persons, is challenged to provide reliable care. Medicaid (a federally sponsored program) provides among programs for other age groups, additional services for older individuals and other disabled individuals who have incomes near or near the poverty line. A Kaiser Permanente study of Medicare recipients notes the following.

> Medicare provides some measure of financial security for 45 million people, including 38 million age 65 and older and 7 million younger adults with permanent disabilities. Yet out-of-pocket health care spending imposes a financial burden on many Medicare beneficiaries, particularly those in poor health with modest incomes and at older ages. Over time, the financial burden of health care has grown among Medicare beneficiaries, as health care costs have increased more rapidly than income (Cubanski, Damiko, & Newman, 2009).

The limited coverage of Medicare requires participants to obtain additional insurance. Medigap policies designed to help with these additional expenses range from $200 to over $ 500 per month, while Medicare B monthly costs range from approximately $100 to higher amounts for those with higher incomes. No dental insurance is provided by Medicare and/or most Medigap policies. Many insurers require additional payment for drug coverage and often preferred or most effective medications are not available in insurance or health maintenance organizations formularies. A conservative estimate of annual costs for care is approximately $42,200 per year for Medicaid recipients who have most of this cost paid by Medicaid (Cubanski, Damiko, & Newman, 2009). The cost of long term institutional care (average cost is estimated at 52,000 per year), which often is a source of constant fear and worry among many older Americans and their families, is also not represented in this estimate. Finally, a critical challenge is quality of care and appropriateness of care options available though as medical care system focused on acute rather than chronic health care needs (Harrington, Ng, Kaye, & Newcomer, 2009).

Other policy analysts identify several challenges. In addition to this ongoing core issue, there are an increasing number of policy issues surrounding Medicare. Salient issues include: (a) political concerns about the increasing costs of the overall program; (b) increased pressure for privatization of the program

as a whole and in part; (c) ever-increasing premiums, deductibles, and cuts in coverage (as cost-saving strategies); (d) health disparities related to ethnic/racial status and sex; (e) mental health parity; (f) a variety of issues concerning access and quality related to the contracting of health maintenance organizations; (g) early discharge from hospitals related to prospective cost-containment strategies; (h) lack of coverage for dental and eye care; and (i) issues regarding structure, access, and adequacy of the 2003 Medical Prescription and Drug Act (Cox, 2008).

Medicaid, the other most prominent health care program, is a federal program designed to help individuals in poverty. This program is the only public provision for assistance for nursing home care in the U.S. and eligibility requires expenditure of resources to a level near poverty in order to be eligible for assistance. Eligibility for this program is determined at the state level and consequently differs from state to state but remains near 150% of the poverty line and has stringent resource limitations with some provision for home value. Again this program leaves many health care concerns to participants and their families. Access, qualities of services, and availability of care providers are among critical issues. In addition, multiple forms of age discrimination in health care have been documented (Butler, 2006; Harrington, Ng, Kaye, & Newcomer, 2009; Kitchner, Ng, & Harrington, 2007)

3. Most Predominant Government and Private Sponsored Social Service Programs

Social service programs of merit include food stamps, programs that support utility bills, home repairs, transportation, in-home personal services, in-home meals (such as meals-on-wheels), and occasional assistance with yard work. Many of these programs are provided through efforts of the Older Americans Act (OAA) via the national Administration of Aging (AOA) that provides grants to support a wide-variety of programs directly to states, which are part of a national aging network of services, and programs.

Administrations funds are provided to state and local governments, not-for profit organizations, and selected for profit organizations. However, these programs are not adequate to meet needs and are not universally available throughout the country.

The Older Americans Act (OAA) was passed in 1965. It established the following national objectives for all older Americans: (1) an adequate income in retirement; (2) the best possible physical and mental health; (3) suitable housing; (4) full restorative services for those needing institutional care; (5) a broad range of community-based services; (6) employment opportunities without discrimination; (7) retirement in health and dignity, after years of contribution to the economy; (8) access to participation in civic, cultural, educational, and training opportunities; (9) access to a range of community-based supportive services; (10) freedom, independence, and free exercise of individual initiative in planning and managing their own lives; (11) participation in decision making regarding services; (12) immediate benefit of aging-related research (OAA, 1965). This legislation was intended to provide a framework for action of aging related resources and advocacy and funded only for some direct programs and to establish a national network on aging that would work for achievement of these goals through state and local governments as well as private for profit and not –for profit agencies. A strong emphasis of the OAA had consistently been of service and resource provision for those most in need.

These government related services are supported not only by numerous smaller local services often funded by foundations, individual donors, corporations churches, city and county generated funds but by many volunteer programs. Multiple special interest organizations (some with national affiliations such as

the Alzheimer's Association and the National Heart Association) are among these potential resources (O'Shaughnessy, 2008).

The relationship of these services to income and to need is complex. Income policy provides an example of Estes' (2001) contention, noted above, that policy tends to reinforce life-long inequities. Higher income and social status throughout one's life span allow for higher accumulation of social security income, higher savings rates, and better employment opportunities before and after retirement age. In addition to the overall neoliberal policy trends noted above, numerous other key policy strategies and long established parameters are also strongly affecting the situation of poor elderly. The following issues have also increased the challenge of provision for poor older Americans:

- Change from entitlements to charity approaches or work requirements;
- Predominance of medical-model programs and services;
- Services provided by one level of joint efforts or two or more levels of government, with increasing eligibility requirements and cuts in provisions;
- Services provided by for-profit and not-for-profit organizations (funded by a variety of foundations and other charitable efforts, government contracts, and fees for service), with little coordination and leaving many gaps in service;
- Categorical assistance versus universal programs that restricts access;
- Complex and changing eligibility requirements designed to limit access;
- Diversity in programs available, depending on geographical location;
- Lack of attention to special needs and strengths of ethnic/cultural minorities, older women, and others in poverty, and other diverse populations, as well as to the development of cultural competence in program planning and among providers

(Cox, 2008; Butler, 2006; Dressel, P., Minkler, M., & Yen, 1999)

A recent survey of the impact of the current economic crisis on aging programs documents increasing need, long waiting lists for services, staff reductions, and compressed work schedules. Additionally, "strategies that look to protect basic services such as supporting food, shelter and basic medical care" are being incorporated by many states (NCOA, 2009). Within this context, traditional programs and ways of providing services and other resources are unable to meet many critical needs and/or assure a minimal standard of living for older adults who lack sufficient resources. During the past two decades, emphasis has increased at least modestly to the exploration of community related strategies as adjunct to existing services.

Ⅲ. Programs that Focus on Community Development

Throughout the history of development of programs for older Americans through OAA funds and other governmental and private sources have had some degree of focus on community aspects of care. Several trends or movements have been part of this overall effort to enhance the community aspects of late life. Four overall approaches to community work that are apparent will be discussed below: (1) the movement to increase the role of social services vs. medical services and to provide health and social services in the community (usually one's home) vs. institutional based care; (2) volunteer movements (although volunteerism is often integrated to different degrees into other approaches it deserves special focus due to its more comprehensive use and multiple forms); (3) the aging friendly communities movement; (4) programs

that focus more clearly on the development of community capacity to support the needs of older adults and others in need.

1. Community-Based Care Strategy

Focus on community among providers of services for the elderly has been strongly influenced by the medicalization of aging. The long-standing effort to develop social services versus the monopoly of medical services is evident in literature describing the efforts of the AOA and other public policy arenas such as housing, employment and mental health services (See for example, Estes, 2001). Even the AOA services over time became strongly medical offering visiting nurse services and other health options (NCOA, 2009).

However, the strong dislike that older Americans have for nursing homes and other forms of institutional care and the desire to remain in their "own homes" has supported an on-going ever increasing attention to health and social services available in the homes, often referred to community-based services (Mood, 2010). Another important factor in the growth of this movement has assumed to have in most cases accurate cost saving effect provided by assisting individuals to remain in their home of other community settings vs. the extraordinary costs of skilled nursing facilities. (Estes, 2001; Harrington, C., Ng, T., Kaye, H. S., Newcomer, R. J., 2009; Moody, 2010).

A variety of social services strategies have been observable beginning at the end of the l960s that enhanced a community component of older American's services. In addition to provision of direct services that allow individuals to remain in their communities alone or with their families, a number of programs have targeted goals that would increase interaction and mutual support in addition to specific service such as transportation, or visiting nurse services. One significant movement was the multi-purpose senior centers movement, which evolved from what was initially development of center sites primarily for recreational activities.

This early and continuing effort to develop a network of multi-purpose senior centers has lead to the development of between 11,000 to 15,000 centers serving approximately 10 million persons annually (National council on Aging, 2009). Centers include multiple services such as: information and referral, public benefits counseling, education, recreation, transportation, health screening and fitness programs, congregate meal programs, opportunities for volunteerism and community service, employment counseling, and many other services. These centers were and are located in communities and serve older adults (and in some cases other residents) in a specific geographical area and consequently have often been able to generate a sense of community. Several have incorporated intergenerational activities and become of hub of community activity that transcends the center to more interactive communities. This is especially evident when coupled with volunteer activities such as assisting neighbors with snow shoveling (NCOA, 2009).

One struggle related to geographically located centers is the tendency for specific groups to "take over" the centers activities and hence pose a challenge to other who are not 'part of the group'. One group that was often not well received was severely disabled elders. Consequently, many outreach and educational strategies were initiated with somewhat limited success.

In addition to these efforts often initiated by AOA efforts, many local initiatives were in evidence over time. Religious organizations often developed senior programs that included outreach (sometimes door

to door checks to find individuals who may need assistance), meals, visiting programs, and transportation. Also senior memberships such as Older Women's League, Seniors United, Retired Steel Workers, AARP, and others often developed and initiated efforts to strengthen community networking and activities.

2. Older Adults and Volunteerism

Volunteerism has been strong in the U.S. overtime and was the backbone of early social welfare efforts as evidenced by the Settlement House Movement and the Community Organization Society Movement of the mid 1800s prevailed as establishing volunteer effort as a primary component of formal social welfare efforts in the U.S. Volunteerism has gained and lost political emphasis in relation to the on-going struggle concerning the acceptable role of government in providing social welfare to citizens in need. In addition to volunteering time and service, American's have made on-going charitable contributions to provide monetary support for issues and individuals and groups in need. These contributions include small individual contributions as well as large contributions and in some cases the establishment of foundations.

During periods of strong support for privatization and emphasis on private and personal responsibility for meeting human need, support for formal volunteer programs has flourished as well as during periods of community oriented development. The first strong federal support for senior volunteer activity was initiated by President Kennedy in 1963. The U.S. Department of Labor (2007) reported key types of organizations for which senior volunteer 65 and over worked were: religious, social and community services, hospital/other health care, civic, political, professional or international, educational, youth services, sports, hobby and cultural/arts and other.

Volunteer service efforts include both formal agency-based activities, informal community service (including political work) and service to others. Thousands of volunteer programs have provided massive amounts of service often supported by charitable contributions. At the same time, voluntary caregiver service by family and friends are estimated to provide between 70 % and 80 % (many of these caregivers are older adults in their 50's, 60's and 70's) of all caregiving service and thousands of citizens work actively in informal capacities to improve their neighborhoods, participate in governance in their state and local areas, as well as federal governance functions. According to a national study in 2000, "approximately 50% of persons aged 55-64, 47% of adults aged 65-74, and 43% of persons aged 75 and over were volunteering" (Zedlewski & Schaner, 2006).

A wide range of activities have been initiated including the following examples: delivery of meals, providing educational seminars, friendly- visiting for isolated older individuals, foster grand parenting, supplement staff for health and human services agencies as well as for multiple cultural organizations and many governmental programs, caregiving respite, educational and coordinating support groups relative to health issues and other concerns, children and youth counseling and support opportunities, intergenerational programs that seek to develop and improve relationships between people of different age groups, and many other programs that increase efforts to improve communities and increase mutual support. It is important to note that many programs found it necessary to provide stipends and minimal wages to enable older volunteers who were economically challenged to participate.

The programs that support and use volunteers are extremely diverse. Moreover, the contributions involved are almost impossible to measure. For example, one large government supported program, the Retired Seniors Volunteer Program (RSVP), provides the following service summary for 2008. RSVP

provided 21,327 hours of service during 2008 and served 1,014,354 clients. Potential costs saving of these services were estimated to be approximately $500,000. The services provided by this program included educational services, health and nutrition services, housing services, public safety and community and economic development services.

Current program initiatives related to seniors as volunteers build on the successful aging and productive aging movements. The "Successful Aging" movement that gained momentum during the l970's is based on emphasizing the responsibility of older adults to lead healthy and active life styles and stressed the importance of active life styles (Rowe & Kahn, 1997). Caro, Bass & Chen (2010) define productive aging which gained prominence during the l980's as follows: "Productive aging is any activity by a older individual that produces goods or services, or develops the capacity to produce them, whether they are to be paid for or not." Productive aging visions optimum life styles for late life is congruent with current economic circumstances that have fostered increased participation in the work force among older adults as well as a challenge to the legitimacy of retirement as a social institution. Currently, national focus and support is focused on the recently initiated Civic Engagement project.

Reilly (2006) visions a vital role for contributions through civic engagement among the 78 million aging baby boomers. She states "When mobilized, organized effectively, placed in the right roles, and supported in the right way, adults 55+ can have an immensely positive if not transformative impact on complex social problems." This project appears to have merit based on increasing social needs and the apparent number availability of potential volunteers. It is also based on the assumption that the 55-64 aged populations are on the whole, economically stable, well educated, and motivated to engage in civic activity. Others raise caution regarding the normative potential of this movement that might move toward social and perhaps legal enforcement of working elderly as the model for all. Issues of poverty, women's roles, health impediments and the general elitism of this project have been raised (Holstein, 2009; Martinson & Minkler, 2006).

Overall, volunteer efforts have enhanced community spirit by strengthening concern to others. However, most volunteer work has encompassed one-to-one relationships and increased resources that meet specific needs, such as meal provision or the need for social connection rather than stressing development of community and community capacity. Exceptions to this approach have included organization of advocacy groups, development of some neighbor-to-neighbor efforts, development of caregiver support groups, development of organizations and agencies focused around special needs such as the Alzheimer's Association, National Strokes Association, and Older Women's League. The aging friendly communities movement and empowerment-oriented community development movements also rely heavily on volunteer time and effort for their successes.

3. Aging Friendly Communities Movement

During the past two decades, many new trends and initiatives have emerged that seek to in some way enhance "community". Some of these movements began as state and/or local efforts that sought to make identified geographical areas to be more compatible with the needs of older adults. These approaches over time emerged into a more national scope of recognition. Multiple terms have been used to describe this type of approach such as Aging-Friendly Communities. Lehning, Chum, and Scharlach (2007) suggest three primary characteristics of an aging-friendly community: " (1) age is not a significant barrier to

the maintenance of life-long interests and activities: (2) supports and accommodations exist to enable individuals with age-related disabilities to meet basic health and social needs; and (3) opportunities exist for older adults to develop new sources of fulfillment and engagement."

This movement has addressed land use and housing, transportation, to a more limited extent health and social service access, and community opportunities such as employment for older adults and appropriate recreational activities. Lehning, et. al (2007) also note that many structural barriers such as zoning (suburban sprawl, location of necessary goods, e.g. food) housing design, and transportation styles prove barriers to aging friendly efforts, as well as social barriers to acceptance to older adults in many communities. Ageism in various forms often plays a role in development of adequate resources for seniors in communities and mutual support within geographical communities.

More recently, proponents of 'community' as a critical component of late life survival and quality of life have expanded their focus on aging-friendly communities to include more attention to the psycho-social/cultural aspects of communities. For example, Thomas and Blanchard (2009, p.15) define aging in community by the following criteria.

- Inclusive – welcomes people of all ages, ethnicities, and abilities.
- Sustainable – commits to a life style that is sustainable environmentally, economically, and socially size matters. People need to be well-known, and scale determines the nature of human interactions. Small is better.
- Healthy – encourages and supports wellness of the mind, body and spirit. Equally, plans and prepares programs and systems that support those dealing with disease, disability and death.
- Accessible – provides easy access to the home and community. For example, all homes, businesses and public spaces should be wheelchair—friendly and incorporate universal design features. Multiple modes of transportation are encouraged.
- Interdependent – fosters reciprocity and mutual support between family, friends, neighbors, and the community and across generations.
- Engaged – promotes opportunities for community participation, social engagement, education, and creative expression.

This more comprehensive goal leads to a stronger commitment to community development. Current activities related to their approach include a range of planned community developments, co-housing, co-operative housing and more collectivist settings development and other strategies to increase 'community' relationships in senior housing sites. Many of these efforts are initiated and implemented by older adults themselves who work to provide neighborly supports that will enable aging in their current residences. Specific descriptions are available on the Internet for many different models and aging newsletters (See for example, case studies in Public Policy & Aging Report, 2009). These community developments differ in costs, age requirements, target populations (for examples, those developed around universities, frequently target retiring faculty), collective decision making processes and other features.

At the same time, this more comprehensive approach to the role of community in the quality of life for older adults raises a major challenge with respect of how creation and/or recreation of informal community supports can be achieved. The great diversity among older Americans regarding income resources, housing options, and health status requires development of diverse models of community development.

This point will be further elaborated below.

4. Community Capacity/Development Strategies

Another approach with overlapping by unique characteristics is also attempting to further community related interventions focused on older adults. Empowerment-oriented community development interventions rooted often in social work efforts have also made some inroads during the past two decades. These programs have united with efforts to define and enhance social capital as a critical component of social work with older adults. Although the importance of social capital has long been recognized as an important factor in the ability of people to meet their needs, programs designed specifically to develop social support networks have not been prevalent in the U.S. The role of social capital (although not always under the term social capital) has historically and continues to be a key factor in social work literature and related gerontological literature targeting the needs of older adults. Over the past few decades, the role and function of social capital has also been a popular area of study in mental health field across countries (McKenzie & Harpham, 2006). McKenzie and Harpham (2006) found that some parts of social capital have a significant protective effect on mental health. These academic efforts have enhanced the potential for at least beginning funding of a few related programs. What has not been studied in depth is the relationship to social capital and older Americans.

The increasing need by disabled older adults at advanced ages for assistance in order to remain in their communities has stimulated interest in the development of community care-giving capacity such as the Care-Net projects fostered by Rosalynn Carter Institute for Caregiving (Rosalynn Carter Institute for Caregiving, 2004 & 2009). The Care-Net movement seeks to involve communities, caregivers and care-receivers in efforts to increase community capacity to support the effort of caregivers. Other social service agencies have expanded their concept of social support to include neighbors and communities and other component of social capital such as health and social services in their daily efforts to assist older adults in communities. Other programs[2] utilize the strengths of older residents themselves who identify their own needs and potential solutions toward developing their communities to be more response of older adults and others with special needs or skills.

Empowerment-oriented care-receivers efficacy interventions have demonstrated the ability of older adults with severe disabilities to engage in community development activities within elderly housing facilities and within the geographical communities they have access to. The Care Receiver Efficacy Interventions (CREI) Projects developed at the Institute of Gerontology of the University of Denver have used a small group approach to increasing personal, interpersonal, community and political efficacy of older adults. Older participants develop strong support networks, knowledge of and access skills regarding existing resources and engage in helping others and often in social action related to issues of common concern. (Cox, E., Green, K., Seo, H., Inaba, M., & Ayala, A., 2006). The CREI project focused on poor and disabled populations not engaged by the aging friendly community projects. Efforts are being made to integrate this small group model into larger empowerment-oriented community development models.

A final program of note is the Naturally Occurring Retirement Community program (NORC). Originating in New York City, this program gained attention as a national model that focused on locating facilities and later in other parts of the country in geographical areas other than housing facilities. Residents were engaged in self-studies of needs, organizing mutual support efforts, increasing their

awareness of resources and often in community service projects. While some studies have identified many challenges to community organization, overall show strong results in the beginning development of an increased 'sense of community', increased mutual support activities, and other interaction. Older adults served in the NORC projects also represent diversity with a special effort to reach those most in need. AOA has funded a 2009 initiative to support a number of NORC related models throughout the county.

Ⅳ. Conclusion

In summary, the recognition of the need for empowerment-oriented community development interventions to improve the quality of life for older adults, especially those who are poor and otherwise oppressed. Currently, mobilizing financial support for this approach is very challenging. The predominate approach to services as described is based on the effort to meet the needs of our aging population/s by the provision of specific professional services, primarily medical services to older adults in institutions and/or in their homes. Those advocating these services have strong political support that does not facilitate changing models. However, the inability of this approach to provide for many poor elderly and the psych/social needs for genuine and meaningful involvement in communities suggests that community development models of service must play a critical part in the future.

Notes

1) In this paper, the terms 'community practice' and 'community work' are used interchangeably.
2) See for example, Washington Park Cares (2010) and Austin, Camp, Flux, McClelland & Sieppert (2005).

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