

The Geriatric Social Work Labor Force:

Challenges and Opportunities in Responding to an Aging Society

Judith G. Gonyea, Robert B. Hudson, Alexandra Curley

As a profession dedicated to working with disadvantaged and vulnerable groups, social work has a long history of work with older people. From the profession's early days of "friendly visiting" and settlement houses, social work aided those who were alone, poor, and frail. Growing awareness of the "aging of America" has increasingly led the social work profession to focus on the development and implementation of geriatric social work services. Throughout the 20th century the percentage of older Americans tripled. In 1900, people over 65 accounted for approximately 4 percent of the United States population—less than one in twenty five. At that time the average life expectancy was 47 years. In 2000, people over the age of 65 represented 12.8 percent of the U.S. population. Today, life expectancy at birth in the U.S. has risen to 72.5 years for men and 79.3 years for women. Indeed the fastest growing segment of America's older population is the "oldest old" or those persons aged 80 and older (U.S. Census Bureau, 2002).

The Baby Boom generation's entry into middle age has heightened the public's awareness of the coming health policy challenges of caring for larger cohorts of frail elders. Although the 65 and older population represents only approximately 13 percent of the U.S. population, as a group they accounted for almost one-quarter of all physician visits—200.3 million visits—and 48 percent of hospital days in 2001 (National Center for Health Statistics, 2002). These higher physician and hospital utilization rates clearly reflect the fact that many older Americans are coping with chronic diseases and long term illnesses. Approximately 58 percent of persons age 70 and older report having arthritis, 45 percent report having hypertension, 21 percent cite having heart disease, 19 percent report having cancer, and 12 percent cite having diabetes (O'Neill & Patrick, 2003). People age 75 and older experience an average of three chronic health problems at any one time and use more than 4.5 prescription drugs (Alliance for Aging Research, 2002). These chronic health conditions can lead to declines in older adults' functioning and negatively affect their ability to remain in the community. These diseases pose not only significant health and financial burdens for the affected individuals but also impact their families and the nation's long term care system. Persons age sixty-five and older use 69 percent of home health services and represent 83 percent of nursing home residents (National Association for Home Care, 2002).

In addition to being at greater risk for chronic physical ailments, a significant proportion of older adults also confront mental health disorders. The U.S. Surgeon General's first report on our nation's mental health notes that one of every five persons age 55 and older experiences mental health disorders that are not part of the normal aging process. The three most common disorders are anxiety disorders (i.e., phobias and obsessive-compulsive disorder), severe cognitive disorders (i.e., Alzheimer's disease), and mood disorders (i.e., depression) (U.S. Department of Health and Human Services, 1999). Moreover, the suicide rate for persons age 65 and older is higher than for any other age group—and the rate for elders age 85-plus is the highest of all—nearly twice the overall



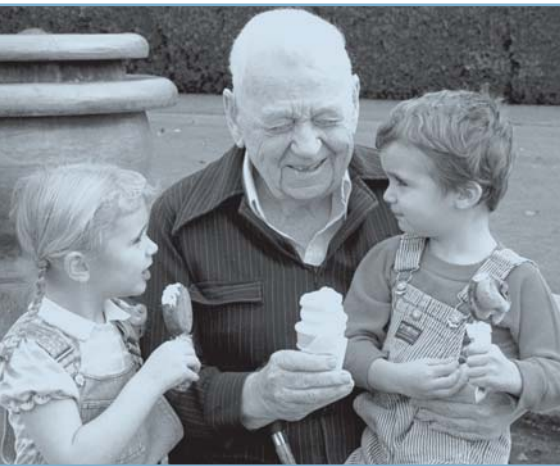
ISSUE BRIEF



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national average (Center for Disease Control, 1999). Yet, older adults with psychiatric disorders are less likely to both be diagnosed as having a mental health disorder and receive treatment than are younger adults (Valenstein et al., 1998). Using U.S. Census Bureau population projections, Shea (2003) notes that even assuming no increase or underreporting in mental health disorder prevalence rates, America will have more than 9 million older adults with mental illness in 2030. Yet, Shea suggests that this figure is probably an underestimation given higher mental illness and substance abuse rates, coupled with lower mortality rates from mental illness, among the baby boomer generation than prior generations. The Administration on Aging (2001) stresses that the “design and delivery of mental health services to older persons is a vital societal challenge in light of the enormous increase in the elderly population that is projected to occur during the first half of this century.”



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A central health policy challenge is therefore assuring that there are appropriately trained personnel in place to meet the complex health needs of this growing number of older Americans. Yet, recent data suggests that the health professions—medicine, nursing, social work, and psychology—are meeting neither the current nor the projected demographic challenge. Two concerns have been registered about this perceived health care professional gap. The first centers on the older clients who are not receiving the health and social work services that could be critical to promoting their well being and independence. The second revolves around the health professions themselves, both why they are not moved more actively toward geriatric practice and why practitioners appear not to be availing themselves of possible career opportunities by working with a growing older population.

This brief explores how social work as a profession is responding to this “aging demographic imperative.” We first address the roles of social work in geriatric care and how these roles affect our understanding of the current make-up of geriatric social work labor force. A principal contribution social work makes to geriatric care lies in its emphasis on the social context in which the care is provided, a perspective well-suited to elders’ complex and multiple health needs and their frequent transitions across types of care settings (e.g., hospitals, rehabilitative care, assisted living). Since this contribution takes place across many settings it complicates determining both the number of social workers in geriatric care and identifying the precise contribution that they are making. Assessing social work’s contribution is further complicated by the difficulty of the profession’s being able to control its own practice or “brand” (i.e., determination of “who is a social worker”). These role and certifica-

tion issues confound both quantitative and qualitative assessment of the social work labor force.

The article’s second section presents estimates of the current size and future demand for the geriatric social work labor force. Despite the growing demand, based on both the expected growth in the older population and the ancillary need for social work services, the profession does not appear to have been adequately responding. Methodological and data limitations stand in the way of firm estimates of future unmet demand, but these may be intensified if the profession is unable to respond. In the third section, we explore how the political environment impacts both the supply and demand for the geriatric care workforce. The article’s concluding section speaks to the profession’s commitment to promoting the field of geriatric social work, with a particular emphasis on current educational and training initiatives. In fact, there are several national enterprises currently underway that are devoted to demonstrating social work’s contributions in geriatrics and in expanding both the numbers and impact of those workers.

The Social Work Mission

The breadth of the profession’s approach to health and social problems is critical to understanding the composition and contributions of the social work labor force. The approach is variously described as “holistic” (Scharlach et al. 2000), “fluid” (Gibelman, 1999), and “comprehensive” (Rosen and Zlotnick, 2001). Such breadth allows the profession to lay claim to graduate social workers’ having been trained in the “physical, mental, and social aspects” of clients (Rosen and Zlotnick, 2001) and to be versed in “diagnostic assessment, community resource expertise, individual counseling, group psychotherapy, liaison and advocacy, and case management” (Howe, et al, 2001). The breadth of practice is such that it can be conceptualized along multiple dimensions: fields of practice, practice settings, agency types, functions performed, client populations served, methods used, and services provided (Gibelman, 1999).

This practice breadth affords social work the ability to make manifold contributions to the well-being of older people. Through its practice and as defined by the National Association of Social Workers code of ethics, social work sees itself as client-centered and better positioned than other professionals to assist and empower individuals and groups. Thus, social workers engaged in clinical practice are attuned to larger resource issues such as housing and employment problems of clients as well as particular cognitive, psychic, or decision-making issues they may face. From the other end of the practice spectrum, social workers engaged in so-called “macro-practice,” helping individuals negotiate among health, mental health, community, and family “systems,” undertake this work with a firm familiarity with older adults’ personal challenges and strengths.

Social work contributions are equally strong in the case of geriatrics. Strengths that geriatric social

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workers bring to health care settings and interdisciplinary teamwork include an ability to work across institutional and community settings with both “formal” participants (physicians, nurses, administrators) and “informal” supports (family members, friends, neighbors, volunteers). Both the clinical and mediating functions of social work, as clients/consumers move among systems and settings, can be critical to individual and family health and well being. Damon-Rodriguez and Corley (2002), for example, note that within the interdisciplinary geriatric health team, attention is directed to how the biological aspects of normal aging, chronic illness and functionality interact with the psychosocial domains. They identify physicians, nurses and other rehabilitation professionals as critical in the biological domain; whereas social work is viewed as “the key discipline to address the social domain of role changes in late life, socioeconomic issues and most importantly, family and social support” (p.40). Moreover, social work is seen as playing an important role in planning interventions that recognize the interaction of the three domains—biological, psychological and social.

This breadth of roles and settings, however, raises issues for the profession, and these issues are no less pressing for geriatric social work than for the profession in general. Both the divergent levels of client need and the variety of settings in which geriatric social work can be practiced – across the entire continuum of care from acute health care to supportive social care – highlight the variation found in such practice. The particular skills required of the geriatric social worker might be a different mix from other health practitioners, but the breadth of such practice is surely as wide-ranging.

A particular challenge raised by the scope of social work’s role lies around its practice boundaries. Two sets of boundaries come into play. The first centers on geriatric social work’s ties to other health care professions and the degree to which social work functions overlap with those performed

by other health care professionals. Clinicians, managers, organizers, and policymakers with formal training in other fields (psychology, nursing, counseling, public administration, planning, and policy analysis) lay claim to some of the domains that also constitute social work’s range of practice. A strong case can be made that professional social workers work in and negotiate between these domains more readily than do other professionals, but they may do so at the risk of being perceived as “generic” (Gibelman, 2000).

The second boundary issue is quite different but perhaps more troubling. Here the question is to what extent do policymakers and others believe that “social work” roles can be played by individuals who have little or no formal training in social work. Currently, a large but unknown number of jobs –

informally understood to be “social work” or that are formally classified as “social work” – are held by individuals who are not recognized by the National Association of Social Workers (NASW) and the Council on Social Work Education (CSWE) as social workers. The profession sees these individuals as failing to meet professional standards by virtue of lack of formal education in social work (either at the BSW or MSW level) or licensure or certification in social work at the state level. Perhaps most starkly, Gibelman (2000) notes that in the 38 states without title protection acts, almost anyone can call themselves a social worker.

Geriatric social work may suffer less from the boundary definition problems associated with lack of formal training or inappropriate job classification than is the case in other social work/welfare venues, such as public welfare. Health care settings require quite clearly delineated skill-sets for various job functions, whether from social workers or other professionals. However, geriatric social work does encounter the boundary issues involving other health care professions. In this regard, the major professional challenge for geriatric social work in health care settings lies in demonstrating to various stakeholder groups that social work can perform clinical, case management, and administrative functions as effectively and/or as efficiently as other professional groups. Clarifying these role issues would bode well for the future growth and enhancement of geriatric social work, and, indeed, efforts are now underway directly addressing them.

The Geriatric Social Work Labor Force

The demographic imperative of an aging society is often cited as evidence of the need for greater numbers of geriatric social workers. The National Institute on Aging’s 1987 report, *Personnel for Health Needs of the Elderly through the Year 2020*, for example, estimated that by 2000 approximately 40,000 to 50,000 social workers would be needed to serve the nation’s aging population and that these numbers would rise to 60,000 to 70,000 social workers by 2020. In recent years, the U.S. Bureau of Labor also has consistently identified social work as a growth profession. In 1992, the Bureau of Labor Statistics (BLS) projected that the need for social workers would increase by 39 percent during the next decade. The BLS currently estimates that the employment of social workers will grow by 45 percent between 2000 and 2015 (BLS, 2002).

The anticipated rising need for social workers to serve older adults and their families—particularly with the aging of the baby boom generation—is cited as one of the critical factors in the profession’s projected growth in the BLS 2002–3 *Occupational Outlook Handbook*:

The elderly population is increasing rapidly, creating greater demand for health and social services, resulting in particularly rapid job growth among gerontology social workers. Social workers also will be needed to help the large baby-boom generation



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deal with depression and mental health concerns stemming from mid-life, career, or other personal and professional difficulties... The number of social workers in hospitals and long-term care facilities will increase in response to the need to provide medical and social services for clients who leave the facility. . . Social worker employment in home healthcare services is growing, in part because hospitals are releasing patients earlier than in the past. However, the expanding senior population is an even larger factor. Social workers with backgrounds in gerontology are finding work in the growing numbers of assisted-living and senior-living communities.

In the face of this demographic imperative, one would expect to find geriatrics to be a significant growth area within social work professional practice. However, there is some evidence of a mismatch between the social trend and the social work profession's response. The National Association of Social Workers (NASW), the profession's primary professional organization, has repeatedly surveyed its membership to gain insights into their demographic and work characteristics. Comparison of NASW data for the available study years of 1988, 1991, 1995, and 2000 reveals that the percentage of members who identify aging as their primary practice area has remained slightly below five percent throughout the past twelve years. Similarly, the percentage of NASW members who identified aging as a secondary practice area has not grown over time; it too has hovered around the five percent mark (Gilberman and Schervish, 1997; PRN, 2001).

Several caveats must be stressed, however, in interpreting this data. First, NASW is a voluntary professional organization. A bachelor's degree in social work (BSW) is the minimum requirement for entry-level professional jobs; a master's in social work (MSW) is typically required for certification for clinical practice as well as most health and mental health positions and supervisory roles; and the Ph.D. or DSW degree is most often found in academic and research institutions. Although NASW represents all post-secondary degree graduates, nine out of every ten members has a MSW degree. (PRN, 2001). In fact, the under representation of BSW social workers in NASW may mask to a certain degree social work's labor force presence in geriatrics. In 1995, 16.7 percent of BSW members cited aging as their primary practice area compared to only 4.2 percent of MSW members and 3.7 percent of PhD-DSW members (Gilberman and Schervish, 1997). BSW social workers are most often employed in nursing homes and assisted living sites.

Determining geriatric social work labor force trends is made more difficult because of the use of multiple definitions to describe the social work profession as well as variations in states' standards for the accreditation and licensure of clinical social workers. Although all 50 states and the District of Columbia have licensing, certification, or registra-

tion requirements regarding social work practice and the use of professional titles, these standards vary by jurisdiction. Typically, states may legally regulate four categories of practice: Basic (BSW degree upon graduation), Intermediate (MSW degree with no post-degree experience), Advanced (MSW with two years post-master's supervised experience), and Clinical (MSW with two years post-master's direct clinical social work experience). It is important to note that some states offer social work licenses to non-BSW or MSW individuals who possess degrees in related fields.

Moreover, the majority of states lack title protection acts; therefore, almost anyone can call themselves a “social worker.” The Association of Social Work Boards currently estimates the number of accredited clinical social workers nationally as totaling 350,000. Yet, given the lack of state certification in subspecialties (i.e., geriatrics, substance abuse, child and family practice) the number of currently licensed clinical social workers with a proficiency in geriatrics cannot readily be ascertained.

The U.S. Census Bureau's Current Population Survey (CPS) and the Bureau of Labor's Occupational Employment Statistics (OES) are also two valuable data sources for assessing social work labor force trends. The CPS has the advantage of being a stratified probability sample of the nation's noninstitutionalized civilian population aged 16 and older. A key limitation of the CPS data, however, is that individuals determine their own occupational category. In 2001, 782,000 CPS respondents chose to self-identify as a “social worker.” Yet, as economist Michael Barth (2003) notes, almost 30 percent of respondents who self-reported as a social workers had less than a bachelor's degree education. Piecing together these two data sources—NASW and CPS statistics—into a detailed analysis of the social work labor market, Barth (2003) points out,

Given that CPS data include education, however, some idea of the potential limitations of NASW's database as a reflection of the population of social workers as defined by NASW is possible... it is unlikely that almost three out of every four people who appear eligible for membership on the basis of CPS data would actually prove ineligible on the basis of the information they would furnish on NASW's membership application form (p.10).

The Bureau of Labor Statistics OES data offer additional insights into the social work labor force. The OES program collects data from employers (versus individuals) on wage and salary workers in nonfarm establishments in order to produce employment and wage estimates for over 700 occupations. Yet, use of the OES 2001 data to determine the current numbers of employed geriatric social work is also limited due to its classification of the 446,180 employed social workers into three broad categories: child, family and school social workers (257,100), medical and public health social workers (103,480) and mental health and substance abuse social workers (85,550). It may be reasonable to

assume, however, that a significant share of geriatric social workers is captured in the medical and public health category. In fact, social workers in the medical and public health realm have the highest median annual wages, \$34,790, as compared to child, family and school social workers (\$31,470) and mental health and substance abuse social workers (\$30,170) (OES, 2000). Yet, even within the medical and public health salaries vary significantly with setting. Median annual salaries for social workers in 2000 were: hospitals, \$40,020; health and allied health, \$36,230; local government (except education and hospitals), \$35,300; nursing and personal care facilities, \$31,580; and individual and family services, \$29,730.

The NASW membership survey, currently the only available national data source on geriatric social workers, is a valuable tool for beginning to identify both labor force trends and characteristics of social workers who focus their practice in aging. Yet, as NASW notes, there are significant limitations in generalizing from their membership to the larger social work labor force. For example, CPS “social workers” is approximately 72 percent female, 62 percent White, 25 percent Black, and 8 percent of Hispanic origin. In comparison, the NASW membership is approximately 80 percent female, 88 percent White, 6 percent Black, and 3 percent of Hispanic origin. Moreover, as previously noted almost one-third of the CPS respondents who identified as “social workers” lacked even a bachelor’s degree.

Gaining a greater understanding of the size and characteristics of the social work labor force—including geriatric social workers—will require the commitment (e.g., funding) of a national probability longitudinal study of BSW and MSW graduates. The NASW, in surveying its membership, has attempted to answer their question of “who we are” as a professional organization; however, significant questions remain about the social work national labor force.

Economic and Policy Issues Impacting Geriatric Social Work

Although the profession often cites the demographic imperative of an aging society as creating a need for a growing number of social workers with expertise in geriatrics, economist Michael Barth (2003) raises an important distinction between “need” and “demand.” The primary differentiating factor is ability to purchase. Although many may have a need of social work services, only those willing to pay for these services are included in the economist’s notion of ‘effective demand’ for social work services... The need for social work services, which is ongoing, does not become demand until there is money to pay for the services (p.14)

Clearly, Medicare reimbursement policies have an enormous impact on the utilization of social work services and thus the demand for geriatric social workers. It is generally recognized that the current Medicare payment system is weighted

heavily towards medical tests and procedures and technology-directed care. This technological bias is reflected, for example, in the lack of billing codes for comprehensive assessments and care coordination services (O’Neill and Barry, 2003). Although physicians recognize the need for patient care coordination, counseling and education—roles that can be performed by social workers—the current Medicare system generally does not offer reimbursement mechanisms for these functions. Inadequate Medicare reimbursement policies are also cited as a critical factor in the current withdrawal of managed care organizations (HMOs) from Medicare. This retreat is of considerable concern as managed programs typically provide more preventive and support services than do traditional fee-for-services programs.

Several proposed pieces of federal legislation have the potential to impact the “effective demand” for social workers with geriatric expertise. The first, the “Geriatric Care Act of 2003” (S. 587, HR.102) would authorize Medicare coverage of care coordination and assessment services for individuals with serious and disabling chronic conditions. As stated in the proposed legislation, Medicare coverage would be provided for the following services under the auspices of a “plan of care”:

- (A) An initial assessment of an individual’s medical condition, functional and cognitive capacity, and environmental and psychological needs and an annual reassessment of such condition, capacity, and needs, unless the care coordinator determines that a more frequent reassessment is necessary based on sentinel health events (as defined by the Secretary) or a change in health status that may require a change in the individual’s plan of care.
- (B) The coordination of, and referral for, medical and other health services, including—
 - (i) multidisciplinary care conferences;
 - (ii) coordination with other providers (including telephone consultations with physicians); and
 - (iii) the monitoring and management of medications, with special emphasis on the management on behalf of an individual with a serious and disabling chronic condition that uses multiple medications (including coordination with the entity managing benefits for the individual).
- (C) Patient and family caregiver education and counseling services (through office visits or telephone consultation), including self-management services and risk appraisal services to identify behavioral risk factors through self-assessment.
- (D) Such other services for which payment would not otherwise be made under this title as the Secretary determines to be appropriate, including activities to facilitate continuity of care and patient adherence to plans of care.

Many of the care plan roles identified in the leg-



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isolation—particularly care coordination across multiple providers as well as patient and family education and counseling—are functions the profession would argue that clinical social workers are well-suited to perform.

Passage of the proposed “Clinical Social Work Medicare Equity Act” (S. 343, HR. 707) and the “Medicare Mental Health Copayment Equity Act” (S. 853) may also influence future demand for clinical geriatric social workers. Although clinical social workers have participated in the Medicaid Program since 1987, the Balanced Budget Act (BBA) of 1997 removed social workers as a professional group that could bill Medicare Part B directly for psychotherapy services to clients residing in skilled nursing facilities. Effective as of April 2001, only psychiatrists and psychologists are able to bill Medicare directly for psychotherapy in nursing home settings. The Clinical Social Work Medicare Equity Act seeks to rectify this professional inequity. Advocates for this legislation note that as the single largest group of mental health providers in the nation, social workers’ current exclusion ultimately hurts vulnerable institutionalized seniors who need mental health services, particularly those in rural and other medically underserved areas.

Similarly, advocates for the Medicare Mental Health Copayment Equity Act argue that Medicare currently discriminates against older individuals seeking outpatient treatment for mental health service by requiring them to pay fifty percent of their cost of care out of pocket. This proposed legislation would require such patients to pay only the same twenty percent coinsurance required for all other Medicare Part B services. Advocates for mental health parity stress that it will reduce the financial burden on Medicare beneficiaries and ultimately contribute to early intervention and treatment. The National Association of Social Workers has actively joined with a number of health and mental health organizations to advocate passage of these three Acts along with broader reforms of the Medicare system.

The political climate also influences the supply of the geriatric care workforce. The “crisis” in the lack of an adequate healthcare workforce to deliver care to current and future older Americans has increasingly been recognized by the federal government and private philanthropic organizations. Due to professional certification in geriatrics, demonstrating the level of the “geriatric care workforce crisis” is perhaps easier in medicine and nursing than in social work. For example, of the 650,000 U.S. licensed practicing physicians, less than 9,000 have met qualifying criteria for geriatrics, which translates into 2.5 geriatricians for every 10,000 older adults. Among the nation’s 2.2 million practicing registered nurses less than one percent, or 21,500, are certified in geriatrics (Kovner, Mezey, & Harrington, 2002). Although lacking specific esti-

mates, perceived demand led U.S. News & World Report in 1995 to identify geriatric social work as one of the top ten growth fields.

Beginning in the 1960s and 1970s the federal government started to fund a series of initiatives through the Administration on Aging (AoA), the National Institute of Child Health and Human Development (NICHD) Adult Development and Aging Branch, and the National Institute of Mental Health (NIMH) to promote training, research and services in aging. In fact, fourteen of the sixteen funded NIMH Training Programs in Aging were awarded to social work programs (Greene & Galambos, 2002). The Department of Veterans Affairs, through its Geriatric Education and Clinical Center (GRECC) program, has also had a longstanding commitment to support social work and other health care professionals working in interdisciplinary team settings. Finally, the Health Resources and Services Administration has funded Geriatric Education Centers (GECs) since 1985; 34 such centers were awarded funding by HRSA in 2000.

Private philanthropic organizations have also increasingly identified older adults as a priority population and a growing number of foundations are providing leadership in addressing the emerging geriatric care professional workforce crisis, most notably the John A. Hartford Foundation, the Donald W. Reynolds Foundation, the Atlantic Philanthropies, the Robert Wood Johnson Foundation, the Retirement Research Foundation, and the Hearst Foundation. Attention is also being directed to the shortage in frontline and paraprofessional workers in geriatric care. The Atlantic Philanthropies and the Robert Wood Johnson Foundation, for instance, have recently partnered to launch “the Better Jobs for Better Care” initiative specifically focused on addressing strategies to recruit and retain front line workers in nursing facilities and community-based long-term care.

Current Initiatives Promoting Geriatrics in Social Work

Within social work, several significant initiatives are underway to address the need for competently trained geriatric practitioners. These efforts involve both the social work community itself and philanthropic organizations interested in strengthening the contributions made by geriatric social workers. There has been growing recognition of mutuality of interests and needs across both geriatrics and social work. The relevant geriatric organizations – the Gerontological Society of America, the Association for Gerontology in Higher Education, and the American Society on Aging—have each increasingly highlighted social work research and training issues in recent meetings and publications. In complementary fashion, the Council on Social Work Education (CSWE) and the National Association of Social Workers (NASW) are giving new prominence to aging-related activities. In 2003, the CSWE held its first National Conference on Gerontological Social Work Education, the



...an opportunity exists within the social work profession to address the critical shortage in geriatrics-prepared social workers.

Baccalaureate Program Directors' annual meeting focused on aging, and the National Association of Deans and Directors created an Aging Task Force. Both the national membership group AGE-SW (Association for Gerontology Education for Social Workers) and the CSWE projects SAGE-SW (Strengthening Aging and Gerontology Education for Social Work) and GeroRich (Geriatric Enrichment in Social Work Education) represent the institutionalization of these efforts, a critical step as both social work and geriatrics move to build social work capacity.

Many of these efforts have been spurred and supported by two philanthropic organizations—John A. Hartford Foundation and the Atlantic Philanthropies. The John A. Hartford Foundation has supported the development of America's geriatric care service capacity since 1981. In 1998, under the leadership of Laura Robbins, Senior Program Officer, the Hartford Foundation launched a national initiative focused specifically on strengthening the social work profession's capacity to serve older adults and their families. The Hartford Foundation's Geriatric Social Work Initiative (GSWI) represents a multiyear commitment to develop an "expanded infrastructure in academic and professional organizations which can sustain a focus on the needs of America's older adults" (Robbins & Rieder, 2002, p.72). Working in collaboration with social work and aging organizations, the GSWI seeks to: increase the number of faculty leaders in geriatric social work through a Faculty Scholars Program and a Doctoral Dissertation Fellows Program (with the Gerontological Society of America), create new models of geriatric social work internships through a Practicum Partnership Program (with the New York Academy of Medicine); and promote the geriatric social work curriculum and faculty development to at both the BSW and MSW levels a Faculty Development Program and a Geriatric Enrichment Curriculum Infusion Program (with the Council on Social Work Education) (Robbins & Rieder, 2002). In addition, the GSWI is committed to promoting social work's collaboration with the other health professions.

The Atlantic Philanthropy's recent funding of the Institute for Geriatric Social Work (IGSW) at Boston University also represents a significant multiyear commitment to aid social work in its efforts to expand the profession's capacity to respond to the needs of vulnerable older adults and their families. Complementing the Hartford Initiative's focus on transforming undergraduate and graduate social work education, the Atlantic philanthropy-supported IGSW seeks to become a national leader in innovative educational strategies targeted toward B.S.W and M.S.W. practitioners. Recognizing that the large majority of practicing social workers "out in the field" received little or no geriatric train-

ing, IGSW is creating novel and wide-reaching continuing education opportunities to provide social workers with the knowledge and skills to improve the lives of older people. IGSW is also committed to expanding practice and reimbursement options for geriatric social workers through the conduct of research to demonstrate the effectiveness of geriatric social work practice. Thirdly, IGSW seeks to inform and influence policy-makers through the dissemination of pragmatic, timely information that documents the efficacy, benefits and outcomes of empirically-based geriatric social work practice.

Other foundations, through the funding of demonstration programs, are supporting efforts to increase the numbers of skilled geriatric social workers. The Retirement Research Foundation (RRF), for example, funded the Geriatric Education Model (GEM) Program at Boston University School of Social Work that created "a placement without walls" internship experience for masters of social work students. Focusing on an urban neighborhood, the GEM program formed a consortium of agencies to provide students with a broad exposure to the continuum of services needed to support older adults in maintaining their dignity and independence in the community. Through a monthly integrative seminar for consortium agencies and students, as well as student assignments across agencies, the students gained in depth understanding of the complexities of the aging service network.

Together, these grant-funded initiatives are creating an environment of experimentation for creating new curriculum models and educational tools to prepare future generations of competently trained geriatric social workers who are able to help older clients and their families enter and negotiate multiple systems of care. (i.e., health, social services, housing).

Conclusion

In 1961, at the first White House Conference on Aging, an alarm was sounded about the small numbers of professionals trained in the field of aging. At each subsequent White House Conference on Aging the shortage of appropriately trained persons to meet the complex health needs of the growing number of older Americans has been raised. Yet, despite the perceived need for geriatric social workers, the National Association on Social Work statistics suggests that slightly less than five percent of members identify aging as their primary practice area—a figure that has remained unchanged for over a decade. Currently, an opportunity exists within the social work profession to address the critical shortage in geriatrics-prepared social workers. The infusion of new resources has revitalized the profession's commitment and created a number of wide-reaching enterprises to produce well qualified geriatric social workers and design effective geriatric social work services to address the "demographic imperative."



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About the Institute

The Institute for Geriatric Social Work (IGSW) is dedicated to advancing social work practice with older adults and their families. Located at Boston University School of Social Work, IGSW will build upon the School's historical commitment to the aging field and current strength in gerontological teaching, research and training.

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