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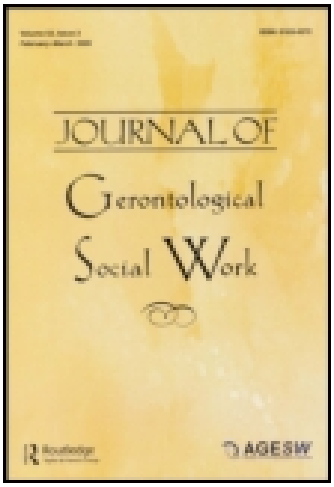

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It Takes a Village: Community Practice, Social Work, and Aging-in-Place

Kathryn E. McDonough [a] & Joan K. Davitt [b]
[a] Capitol Hill Village , Washington, DC, USA
[b] School of Social Policy & Practice, University of Pennsylvania , Philadelphia, Pennsylvania, USA
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PRACTICE FORUM

It Takes a Village: Community Practice, Social Work, and Aging-in-Place

KATHRYN E. McDONOUGH
Capitol Hill Village, Washington, DC, USA

JOAN K. DAVITT
School of Social Policy & Practice, University of Pennsylvania, Philadelphia, Pennsylvania, USA

The US population of older adults will increase significantly in the coming decades. Most of these individuals prefer to age in their homes/communities. However, most communities are not prepared to handle the long-term care needs of an aging population. This article examines one model that communities are using to help older adults age-in-place, the Village. A conceptual lens based in community practice and empowerment theory is offered to explicate this model and critically evaluate social work's role in it. It also presents challenges to social work roles in facilitation and evaluation of the model.

KEYWORDS aging-in-place, community practice, empowerment, intergenerational, long-term care, social work practice

INTRODUCTION

Although many people will age and need little support to remain in their community, the risk of chronic health and functional impairments certainly increases as one grows older (Federal Interagency Forum, 2008; US Administration on Aging, 2009). Medicare's focus on acute conditions and

Received 9 November 2010; accepted 13 April 2011.
Address correspondence to Kathryn E. McDonough, Capitol Hill Village, PO Box 19126, Washington, DC 20003. E-mail: kmcdonough@capitolhillvillage.org

the institutional bias in Medicaid, have resulted in a fragmented, poorly funded long-term care system, which does not address the care needs of older adults with multiple chronic illnesses (Davitt & Marcus, 2008). At the same time, the decreased size of families and their increased geographic dispersion will likely erode the capacity for families to provide long-term care services to older adults (Lave, 2009). Both the *Olmstead vs. LC* (1999) decision and demand from the aging population, have increased pressure on state and local governments, who are facing budget deficits, to modify the delivery of long-term care services from largely facility-based to home and community-based models (Davitt, 2006; Doty, 2010). Although the Affordable Care Act of 2010 introduced the first federally administered long-term care insurance plan, the benefits are entirely consumer financed and only pay an average benefit of $50/day, yet costs for long-term care can average three to four times this amount (Leading Age, 2011; US Department of Health and Human Services 2011).

Thus, many communities are developing initiatives to meet the growing needs of older adults by expanding on existing service systems. This article discusses one community based model burgeoning across the country, the Village model, assisting older adults to age-in-place in their community. The purpose of this article is to frame the conceptual underpinnings of the Village initiative within social work's community practice focus. The article begins with a description of the Village model, highlighting the differences between Villages and the traditional aging service system, and Naturally Occurring Retirement Community-Social Services Programs (NORC-SSP). The article then outlines practice theory supporting the Village initiative and the functions of and related challenges for social work within this model.

Aging-in-Place in Community

The provision of community-based long-term care began with the various programs funded via the Older Americans Act of 1965, to address the long-term care needs of older adults and provide opportunities to remain meaningfully engaged in community life as one ages. The network of services funded under the OAA include: care management, in-home support, senior center service, and nutrition programs. These more formal service systems have historically been underfunded, leaving many in need without adequate assistance to remain in their residences (Doty, 2010). Likewise, this traditional system has relied on a social planning approach, with minimal input from older adults or community members regarding the design and delivery of services (Rothman, 1995).

More recently, a variety of programs have arisen to expand or extend traditional aging services and programs. For example, the NORC-SSP arose out of concern with the rising concentration of older adults in specific

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geographic areas (e.g. high-rise apartment building or neighborhood of single-family homes). The label NORC was first coined in the mid-1980's to describe neighborhoods, which due to migration and other demographic patterns, came to contain mostly older adults (Hunt & Gunter-Hunt, 1985). Although volunteerism and other informal services are characteristic of some NORC-SSPs, they tend to rely on existing social and health services within the community, delivered by formal service agencies, to meet the needs of residents (Bookman, 2008; Ivery, Akstein-Kahan, & Murphy, 2010). The NORC-SSP is basically a coordinating body that employs case management and community partnerships to offer a range of supportive health and social services to older adults residing in a specific locale (Vladeck, 2006).

However, the Village model relies on a more informal network of community members to provide assistance to aging populations within a specific geographic community. Although we recognize that Villages can and have developed through existing social service agencies that use formal services, this article focuses on the more predominate grass-roots, consumer-driven, volunteer-first model that is most prominent in the Village movement. The volunteer-first model is initiated by community residents who have identified their desire to age-in-place, experienced the challenges faced when one ages, and want to establish a self-governed organization that provides assistance to address these challenges. Villages are formed, governed, and served by residents of a community who design the program of assistance to respond to the community's expressed needs (McWhinney-Morse, 2009). Typically, they are membership-based with an annual fee to join and usually have non-profit status. Many of the organization's leaders, including board members, are members themselves, and they actively solicit the participation of members in the development and evaluation of the initiative. Currently, there are over 50 fully operational Villages in the United States with nearly 149 in various stages of development (Village To Village Network, 2010).

Volunteer-first Villages provide a majority of their services through volunteers. Village staff are responsible for the administration of the program (i.e., vetting, training, and managing volunteers), and in some Villages providing care management. In some cases, professional services are accessed through vetted vendor lists, including home health care and professional home repairs. However, volunteers remain the backbone of the model, providing services such as transportation, shopping, household chores, gardening and light home maintenance. In this way, the volunteer-first model relies on the collective abilities of the community to respond to individual and communal challenges faced in the aging process. The theoretical underpinnings of the model incorporate many of the concepts of community social work practice. Framing the Village in community practice helps to explicate the model while understanding the valuable roles and challenges for social work.

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UNDERSTANDING THE VILLAGE INITIATIVE THROUGH A COMMUNITY PRACTICE FRAMEWORK

For this analysis, we have drawn upon several conceptual frameworks from the community practice literature (Chaskin, Brown, Venkatesh, & Vidal, 2001; Rothman, 1995; Weil & Gamble, 2005). The Village initiative evolves out of community-based practice and empowerment approaches, combining elements of locality development, civic engagement, and community capacity building (Rothman, 1995; Weil & Gamble, 2005). Several core community practice concepts are defined in Table 1 and highlighted below in application to the Village model, including: community capacity, empowerment, civic engagement, and critical consciousness.

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TABLE 1 The Village Model Through a Community Practice Lens

Community practice concepts	Volunteer first village model	SW Roles
Community – geographically-based social systems which perform the major social functions, including production, distribution, and consumption of resources as well as socialization, mutual support and social control (Warren, 1972). Network of social relations marked by mutuality and emotional bonds (Bender, 1978, p. 7).	Villages mostly arise in a geographic community but incorporate a network of social relations through volunteering, mutual support, group activities.	Community organizer
Community capacity is "the interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of that community" (Chaskin et al. 2001, 7).	Human capital – use of volunteers, use of members in planning, etc. Organizational resources – village staff expertise; connecting with other vendors/service providers. Social capital – relationships between members, members and volunteers, and members and staff.	Resource broker Mediator Advocate Partner (with members) Strengths assessor Evaluator Organizer
Characteristics of community capacity 1. Sense of community – degree of connectedness among members and mutuality of circumstance including values, norms and vision	Village shared norms and values Aging in community Interdependence Mutuality/reciprocity	Community organizer Facilitator Educator (defining boundaries, ethical issues, etc.)

(*Continued*)

TABLE 1 (Continued)

Community practice concepts	Volunteer first village model	SW Roles
2. Commitment to community – responsibility that individuals, groups and organizations take for what happens to community.	Founded by community members. Members identify as stakeholders, become active participants. Volunteers – engaged in community.	Leadership cultivator Partner Educator
3. Ability to solve problems – to translate community into action	Leveraging community assets, volunteer and member skills/knowledge, member driven, supported, and led	Mobilizer (people and resources) Broker/Bridge Strengths assessor Advocate
4. Access to resources – internal and external to the community. (Chaskin et al., 2001)	Bridging to external resources, vetting vendors/volunteers, information and referral, educational programs.	
Empowerment . . . individual determination over one's life and democratic participation in the life of one's community, often through mediating structures . . . such as voluntary organizations (Rappaport, 1987)	Personal – providing needed assistance to maintain autonomy and age-in-place Interpersonal – relationships between members, volunteers, etc. Social – advocacy for long-term care policies; participation of vols./members. Strengths – volunteer and member	Educator Strengths assessor Partner Advocate
Civic engagement – participation in civil society to address "a public concern or an unmet human, educational, health care, environmental, or public safety need" (Older Americans Act Amendments, 2006);	Grassroots initiative, member initiated, designed and supported; Volunteer and member participation; Local leadership; Educating community, potential volunteers, policy makers, about aging in place challenges, and resources	Partner Educator Enabler Collaborator Educator
Consciousness raising – critical reflection, exposure to multiple views enabling transformed perspectives on the world (Kemp et al., 1997).	Shared vision of aging in place, of community engagement, of assets, of reciprocity and mutuality.	Facilitator Partner

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Community Capacity

The Village focuses on the traditional concept of community as a geographically-based entity (Warren, 1972). For example, most Villages have defined geographic boundaries, which are based on existing community identities or older adult population density. However, also implied in this initiative is a "network of social relations marked by mutuality and emotional

bonds" (Bender, 1978, p. 7) that implies connection, shared beliefs, and affective ties (Chaskin, 2001). For example, Village programs are based in a geographic community, but the membership is typically smaller than the actual population within that geographic space, emphasizing a shared sense of purpose across members.

Sense of and commitment to community. The Village model provides a real life example of community capacity building as described by Chaskin, Brown, Venkatesh, and Vidal (2001). First, there is a clear commitment to civic engagement and capacity building among the founders, members, and volunteers (Weil, 2005). Members and volunteers share a vision of social engagement recognizing the valuable role of older adults in their communities and the importance of helping these individuals to remain in the community. Villages are driven by a philosophy of the fundamental nature of interdependence in human existence and work to build a shared sense of community not only through volunteer/member relationships but through intentional community-building activities. For example, many Villages offer opportunities for community engagement such as potluck dinners, book clubs, and educational programs on relevant and timely topics. These opportunities allow for an increased sense of purpose and greater connectivity among community members, even for those who are isolated, and, in turn, a greater sense of mutual support. A volunteer-first approach increases the initiative's effectiveness and enhances synergy among neighbors, thus increasing the sense of commitment to the community (Chaskin et al., 2001).

Ability to solve problems. Village programs, for the most part, have arisen from grassroots efforts, where community members have come together to modify the detrimental effects of external planning and development (Weil & Gamble, 2005). The focus is on providing support or overcoming barriers to aging-in-place by using assets within the community. Villages offer a variety of services that meet the needs of members to help them remain at home and in the community. In most cases, the service menu is based on the expressed needs of the members, providing valuable flexibility and adaptability (Kettner, Moroney, & Martin, 2008). Likewise, service delivery models are based on community capital, the talents and skills of its volunteers or staff, and the culture of the community (Chaskin et al., 2001).

Access to resources. Villages also focus on external forces or conditioning influences, which affect the community. For example, many Villages and their members become leaders in advocating for better services/resources by highlighting the gaps and fragmentation in formal service systems. For example, Villages may advocate for increased nutritional, or personal care services provided through the Area Agency on Aging. Thus, Villages not only enhance services for their members but also improve the capacity of these systems to serve the greater community (Chaskin et al., 2001). Finally, Villages bolster capacity by vetting vendors (e.g., home repair), garnering

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discounted pricing for members and referrals to more formal service systems when necessary. In this way, the Villages improve the functional capacity of the community by enhancing the production, delivery and consumption of resources (Warren, 1972) to promote the central outcome of aging in place in the community.

Empowerment

Within this community practice frame, the Village model emphasizes an empowerment philosophy that focuses on participation, partnerships, education, critical reflection/consciousness, transformation of perspectives, and competence-building at the individual and community level (Kemp, Whitaker, & Tracy, 1997; Miley, O'Melia, & Dubois, 2004). Members occupy leadership roles in the development and coordination of the Village. Villages focus on enabling members to make choices about their support needs, thus preventing deterioration that might erode personal autonomy (personal empowerment; Kemp et al., 1997). Community assets are tapped directly through volunteers, members, and staff. Some Villages encourage members, even the most frail or disabled, to use their talents and skills to provide services and design programs. In this way, members and volunteers alike develop a sense of personal competence by taking action to solve specific problems (Gutiérrez, DeLois, & GlenMaye, 1995). Such activities promote mutual partnerships between those receiving and giving help, especially when those who receive are able to help others in their unique way. Likewise, Villages generate community capacity (social empowerment) and enhance community competence by using community members' assets to respond to need, all while transforming member perspectives on themselves and the community (Chaskin et al., 2001; Kemp et al., 1997).

Civic Engagement and Critical Consciousness

Villages focus on building social capital, that is, resources stored in relationships, via shared experiences, which encourages active participation in developing a collective definition of the social condition (Gutierrez, Parsons, & Cox, 1998). Villages accomplish this in two ways: (a) through one-to-one interpersonal exchanges among members and volunteers; and (b) through participation in planning and other group-based activities that encourage critical reflection (Kemp et al., 1997). Interpersonal interactions, support increased awareness of issues related to aging, and enhance critical consciousness (Reed, Newman, Suarez, & Lewis, 1997). In the Village model, much of the educational and social programming serve a dual focus; beyond education and socialization, these programs build community by reinforcing the world view and transforming perspectives on aging in place (Kemp

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et al., 1997). Intergenerational characteristics of the model enhance awareness of aging issues and may translate to better advance planning on the part of younger volunteers, reduce ageism across generations, and further involvement of younger citizens to support aging in place (a form of capacity building; Kemp et al., 1997).

The discussion of the volunteer-first Village model highlights the many corresponding theories and concepts between this model and community practice. Social workers are well-versed in community practice and have many skills that can support and enhance the Village model. In the following, we identify social work roles and skills relevant to the Village model and discuss challenges in these roles.

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SOCIAL WORK ROLES IN THE VILLAGE MODEL

Village initiatives are uniquely compatible with social work practice values. Most functioning Villages have, at a minimum, an executive director to coordinate services and day-to-day operations, but may also employ social workers, volunteer coordinators, or other administrative staff. The focus of a Village is empowerment, having community members determine the structure of the program, and the types of services offered. Therefore, beyond the traditionally recognized skills, such as administrative, development and evaluation, social workers act as facilitators, organizers, educators, brokers, and advocates. They assist with community capacity building, need/asset assessment, and provide bridging capital.

Community Organizer

The Village social worker mainly acts as a community organizer, identifying assets and supporting capacity building, community investment, and mutual exchange. The social worker's ongoing role is to foster a sense of and commitment to the Village community among area residents. This requires advanced communication and relationship building skills as new members and volunteers must be continually recruited and buy into the worldview to sustain the community. The social worker, at times, may act as educator as well providing information to Village members, community residents, and external entities.

Broker and Coordinator

Another dominant social work function in Villages is to serve as bridging capital, connecting community members with needed resources/support, by recruiting volunteers and vetting external providers (Gittell & Vidal, 1998; Putnam, 2001; Weil, 2005). Social work brokering skills are well suited to

perform this function within Village programs, including garnering member discounts from vendors. Social workers bring a wealth of knowledge regarding the health, social and economic systems and thus can act as a resource for members, providing information and education as well.

Because empowerment and person-centered approaches are central to their training, social workers proactively engage members and their families as partners. On-going coordination of services is vital in impeding deterioration in health or functional status. For example, the Village often becomes the natural coordinator among various agencies. Social workers manage this coordination by facilitating communication, assessing need and identifying services in partnership with the member. Care coordination also provides the opportunity for social workers to educate members on available Village and external services and to assure that all needs have been addressed.

Assessor

Social workers are trained to administer comprehensive biopsychosocial assessments. In the Village model, the goal of such assessments is twofold, to help members understand and partialize their challenges and to plan for future need. In addition, members and volunteers are evaluated with regard to their strengths, identifying resources they can share with other members. Social workers are involved with community level assessments, incorporating elements of social planning and community development in their role (Rothman, 1995; Weil, 2005). They possess sophisticated research skills that allow them to collaborate with community members in identifying unmet needs and conducting empowerment evaluations by seeking continuous and active feedback from community members (Fetterman, Kaftarian & Wandersman, 1996).

Advocate

Village social workers act as advocates for members at both the clinical and policy levels. At the clinical level, social workers help clients to advocate for their care preferences often involving educating members and their families regarding care and end-of-life options, helping members to communicate their choices and discussing with family members how these options can be safely executed. Also, the Village serves as an ombudsman for its members when navigating the health care system, communicating with physicians, and health care providers.

At the macro level, Village social workers and members together advocate with state and local leaders, social service agencies and health care facilities to increase services for members. Often Village social workers advocate for a more comprehensive continuum of care in the community that affords Village members a variety of options to remain in community.

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This may include establishing long-term care facilities in the neighborhood, or assuring access to primary care practices. Village social workers help represent the needs of members with local political officials in making communities more age and disability friendly, including the inclusion of universal design in new construction, and accessible neighborhoods.

CHALLENGES FOR SOCIAL WORK PRACTICE IN THE VILLAGE MODEL

Because Villages offer social workers the opportunity to redefine their traditional roles in long-term care, this novel organizational model presents social workers with unique challenges that must be strategically identified to assure they are addressed effectively. In the following, we discuss some key challenges that social workers face in individual, community, and policy/research practice.

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Challenges in Individual Practice

At the core of the mission of Villages is the support of relationship-building between volunteers and members, which encourages friendships and attachments and ultimately increases mutual self-worth. At the same time, members and volunteers have boundaries that are unique to each individual. An unhealthy dependency on the part of a member may lead to volunteer burnout, which diminishes a volunteer's capacity to help in the future. Likewise, the overinvolvement of a volunteer may threaten a member's autonomy and personal empowerment and thwart his desire to request future services. Also, Villages rely on confidentiality as a tool to encourage members to request services and form trust with the community. Therefore, breeches of confidentiality cannot only impede the relationships between members and volunteers, but can also become barriers to requesting assistance.

Social workers are tasked with responding at both the organizational and individual level to address these challenges. At the organizational level, social workers can collaborate with leaders and members to develop policies and procedures and implement best practices that address the maintenance of appropriate boundaries and confidentiality. Additionally, social workers must work at the individual-level to help members and volunteers define and communicate boundaries in a person-centered manner. Social workers can help build critical consciousness by training volunteers on the role of confidentiality in empowering the member to request services, reducing unhealthy dependency and fostering reciprocal relationships that bolster feelings of dignity, self-efficacy and mutuality.

Challenges in Community Practice

Although the most successful Villages have arisen from the community itself, social workers are challenged with galvanizing support within the community. During the organization's formation stage, social workers partner with Village initiators to educate the community on the health and long-term care systems, and the organization's response to service gaps. Identifying and recruiting interested and invested community members to actively participate in the design of the program is critical. This type of organizing is what Rothman (1995) referred to as locality development with a focus on mutuality, participation, and community competence to solve problems. The social worker's challenge is to draw leaders from the community and generate wide community participation in the process.

Community buy-in is also essential to develop the organization's membership largely because most Villages rely significantly on membership dues to fund the organization. Social workers must be able to clearly communicate the role, purpose, and function within the community and execute a creative, person-centered approach to helping potential members determine how the Village can help them. Likewise, the need for an adequate number of volunteers and range of volunteer skills requires ongoing education, and consciousness-raising to encourage community residents and members alike to share their skills and talents to support the Village members. Furthermore, because members do not have a vesting period to meet prior to receiving services, Villages often find members who join only upon crisis, which often requires immediate services. Social workers and Village leaders must work to communicate and demonstrate why it is important for members to invest in membership benefits prior to such crises.

Social workers within the Village movement face the challenge of identifying how to expand the model into low and moderate income communities. Reliance on membership dues to support infrastructure and coordinate services is problematic. In lower income communities the dues would have to be subsidized or services scaled back to sustain a Village. Likewise, reliance on volunteers may be more challenging in lesser endowed or historically disempowered communities (Kemp et al., 1997). Social workers need to focus on building external support from public/private sources to expand these initiatives.

Challenges in Policy and Research Roles

Social workers also face challenges in conducting research and using findings to improve Village practices and long-term care policy. Because the Village model is in the developing stage, there is a lack of research on its efficacy. We do not understand the impact of Village services on long-term care outcomes such as: premature institutionalization, quality of

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life, overall health or cost effectiveness. A better understanding of the impact on these outcomes will help Villages to build a case for policy changes at local, state, and federal levels, including access to funding to subsidize Village programs in low-income communities, or for additional in-home support services. Likewise, we do not know the impact of villages at the community level including their ability to build a sense of community, increase civic engagement, enhance personal and interpersonal empowerment, increase social capital, and engage the leadership of older adults. Moreover, we need to understand the impact of a volunteer-first model, which includes the benefits to volunteers and members alike. This research is vital to understand if Villages are meeting the goals set forth in the model's mission.

CONCLUSION

Not all aspects of aging in place can be addressed via volunteer services or at the community-level. Likewise, not all older adults will choose to remain in a particular community and thus a continuum of options is needed. We are not proposing a devolutionary response to long-term care services, whereby the community becomes the focal point and main provider of service. Rather, we are suggesting that Village initiatives have a role to play in supporting aging in place by expanding access to critical resources within communities and raising awareness of the need for long-term care. The rapidly-growing Village movement has presented a new community-based service medium for older adults who choose to age in their communities. Social work's practice philosophy is particularly compatible with the empowerment and community-focused philosophy of the Village model. Additional research is clearly needed to: document the benefits of such models; understand need at the local level; and disseminate best practice strategies to encourage replication. Social work practitioners and researchers should take the lead in both practice and research initiatives to support aging in place in the community.

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