# Chapter 1
# Social Problems: A Cost-Effective Psychosocial Prevention Paradigm


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The cost of social problems and the negative consequences are extensive and well documented. From a cost-benefit perspective, the largely remedial, as opposed to practice, interventions the social service system has chosen are extremely costly and highly unproductive for both client and practitioner in terms of targets, timing of intervention, ages, and contexts. Social, cognitive, and academic skills that individuals must master should provide the focus for intervention from a life-span development perspective. A review and analysis centering on social problems underscores the need for cost-effective, evidence-based, and preventive efforts. First, the personal and societal costs of child abuse, educational outcomes, violence in the schools, teenage sexuality, HIV/AIDS, drug abuse, crime, urban decline and homelessness, unemployment, marital conflict, race, retirement, and hospice are analyzed. Subsequent chapters review the personal, social, economic, and political benefits of prevention. Preventive models of service delivery are elucidated. The chapter concludes with specific applications and discussions.

## Prevention Versus Remediation

Much has been written about many problem behaviors of the young and the undesirable consequences thereof. Teenagers' experimentation with drugs and alcohol can lead to overindulgence and abuse. Serious short-term and long-term effects include risk taking and daredevil behaviors that increase risks to mental and physical health, including accidents, which are a leading cause of death among adolescents. Likewise, risk taking may increase the incidence of irresponsible sexual activity, which eventuates in venereal disease, unwanted pregnancy, and premature

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parenthood. Prevention during the adolescent developmental period would reduce these serious physical and social problems (Sood & Berkowitz, 2016; Tremblay, 2006).

These problems usually intensify later and become harder to alter, thereby increasing the need for investments of time and money. Prevention provides a view of the person that is optimistic. The approach is economic and mass-oriented rather than individual-oriented, and it seeks to build health from the start rather than to repair damage that has already been done.

The life skills training intervention model is proposed as the treatment of choice. This model has rationale and elements in common with other prevention programs that are based on a public health orientation. Such prevention programs consist of three essential components: education, skills training, and practice in applying skills. The Teams-Games-Tournaments (TGT) model consists of the same components as other prevention programs, except for an additional component: It uses peers as parallel teachers (Buckholdt & Wodarski, 1978; Wodarski, Wodarski, & Parris, 2004). Data to support social workers' use of the life skills and Teams-Games-Tournaments models are reviewed later in this chapter. Other applicable intervention models will also be mentioned. For example, the use of the Internet and games as a way of helping adolescents prepare for life (McGonigal, 2011).

The prevention approach to intervention has implications for the traditional role of the human services practitioner and for the timing of the intervention. The prevention approach places major emphasis on the teaching and skills-building components of the intervention process (Benson, Leffert, Scales, & Blyth, 2012; Catalano et al., 2012; Swearer, Espelage, Vaillancourt, & Hymel, 2010). Practitioners do not take a passive role in the intervention process, but instead attempt to help clients learn how to exert control over their own behaviors and over the environments in which they live. Professional knowledge, expertise, and understanding of human behavior theory and personality development are used by the practitioner in the conceptualization and implementation of intervention strategies. Since their training equips them to evaluate scientifically any prevention procedure they have instituted, there is continual assessment of the prevention process.

## Need for Prevention Programs

Deficit-ridden state and local governments are cutting back prevention programs in order to balance their budgets. However, this proves to be cost-ineffective on every level. One informative example of this unfortunate policy is the curtailing of family planning services and teen pregnancy programs. Specifically, savings in public medical costs alone are estimated to be $5.68 for each $1 spent in contraceptive services to the typical clinic patient (Frost, Zolna, & Frohwirth, 2013). Savings in income support and social services are greater yet. Approximately 13.9% women of reproductive age have no insurance (Guttmacher Institute, 2015). State insurance commissioners should pressure planning services. Teens, single women, and poor

women, who have the highest incidence of low-birth-weight (LBW) babies, are most likely to use publicly funded family services (Guttmacher Institute, 2016a) and these women tend to have far more unwanted pregnancies (Guttmacher Institute, 2016b).

## Examples of Incidence and Cost of Social Problems

### *Child Abuse*

When the battered child syndrome was first promulgated, it was estimated to be affecting about 300 hospitalized children (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). This proved to be a gross underestimation of the true extent of the problem. Since the 1960s, the number of reported victims of all types of maltreatment has steadily increased. By 1984, 1.7 million children were reported as victims, 2.4 million were reported in 1989, and 2.9 million were reported in 1993 (Ards & Harrel, 1993; Curtis, Boyd, Liepold, & Petit, 1995; McCurdy & Daro, 1993; National Center on Child Abuse and Neglect (NCCAN), 1988; NCCAN, 1995). Allowing for duplicated counts, an estimated 2.3 million individual children were subjects of report in 1993 (NCCAN, 1995). Of these, just over 1000 were fatalities related to child maltreatment (NCCAN, 1995). Curtis and his colleagues have estimated, based on several national reports, that approximately 18,000 serious disabilities and 141,000 serious injuries arise annually from maltreatment (Curtis et al., 1995). In 1993, about 24% of victims suffered from physical abuse and about 48% from neglect (NCCAN, 1995). The most recent national statistics estimated 1670 children die of abuse or neglect at a rate of 2.25 per 100,000 children (U.S. Department of Health and Human Services (U.S. DHHS), 2017). In relation to age groups of those reported as maltreated, the youngest group, aged birth to 1 year, is more likely than any other age group to be subjected to maltreatment, composing 24.2% of the victims (U.S. DHHS, 2017). Children from families with low socioeconomic status were five times more likely to experience child maltreatment than children from families with higher incomes (Sedlak et al., 2010); children in a single parent home have over a 70% chance of being victimized than children with both parents in the home. Other risk factors have been identified as well.

### *Educational Outcomes*

The future economic viability of the USA is in jeopardy due to poor educational outcomes for a large percentage of its young citizens. With 25% truancy and dropout rates for elementary, middle, and high school students, we can expect that not

enough educated individuals will be available to fill the jobs in the twenty-first century (Cabrera & LaNasa, 2001).

Furthermore, a number of reports, e.g., *Measuring Up: The National Report Card on Higher Education* (National Center for Public Policy and Higher Education, 2008), *A Nation at Risk: The Imperative for Educational Reform* (The National Commission on Excellence in Education, 1983), *The Death and Life of the Great American School System* (Ravitch, 2010), *Winning the Future: A 21st Century Contract with America* (Gingrich, 2006), *Waiting for "Superman"* (Chilcott & Guggenheim, 2010), and *Time to Start Thinking: America in the Age of Decent* (Luce, 2012), document the number of US citizens who enroll in post-secondary education and graduate at 33%. These numbers are sorely inadequate to fill 20 million jobs expected to be available by the year 2030 for individuals with college degrees (Friedman & Mandelbaum, 2011; Moore et al., 2010).

## *Violence in Schools*

Since 1992, the rates of violent crimes in America's schools have steadily declined (Bureau of Justice Statistics, 2008; Hahn et al., 2007; U.S. Department of Justice, 2007; University of Virginia, 2007). Violent crimes rarely occur in schools (Hahn et al., 2007). However, the Department of Health and Human Services (2008) identifies youth violence as a significant public health problem. Despite the hint that violent crimes are more prevalent in communities as opposed to school houses, which have been beefed-up with armed, resource officers, the National Center for Education Statistics (2016) indicates that in the 2013–2014 academic year 65% of public schools reported one or more serious violent incidents. In 2014, among students ages 12–18, there were about 850,100 nonfatal victimizations at school, which included 363,700 theft victimizations and 486,400 violent victimizations (Morgan, Musu-Gillette, Robers, & Zhang, 2015). Furthermore, research indicates that 740,000 violent crimes were committed against children at school in 2003 (Hahn et al., 2007). Therefore, the portion of youth violence that does occur in schools warrants attention.

## *Teenage Sexuality*

Each teenage pregnancy translates into a significant cost to the taxpayer, which is a major cause for concern. In 1985, for example, teenage pregnancy cost each US taxpayer $16.65 in Aid to Families with Dependent Children, Medicaid, and food stamps (Guttmacher Institute, 1985). In another example, the city of Baltimore spent about $179,500,000 in 1987 on AFDC, Medicaid, and food stamps for families that were begun when the mother was a teenager. Had these births been delayed until the mother was at least 20 years old, Baltimore would have saved almost

$72,000,000 in public outlays (Santelli, Rosenblatt, & Birn, 1990). The cost borne by Medicaid for a birth to a teenager age 14 or younger has been calculated as $3494; the cost for 15–17 year olds is $3224; and for 18–19 year olds, it is $2696, exclusive of pediatric care (Armstrong & Waszak, 1990). While the prevalence of teenage pregnancy has steadily declined since the late 1980s, the cost of this social problem to taxpayers continues to be of major concern. In 2010, taxpayers spent a total of $10.9 billion on costs related to teenage pregnancy, birth, and teenage motherhood. Each child born to a teenage mother today costs US taxpayers $1682 (The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011).

## *HIV/AIDS*

There are approximately 33.4 million people living with HIV/AIDS worldwide (UN, 2010). In the most vulnerable countries, less than 10% of those living with AIDS are even aware of their status. Currently, in sub-Saharan Africa, 22.5 million people are living with HIV. This is two-thirds of all people with AIDS and of this number 59% are women (WHO, 2011). In Eastern Europe and Central Asia, the percentage of people living with HIV/AIDS has increased over 20% between the years of 2003 and 2005 (WHO, 2006). There are now over one million individuals living with the HIV infection in the USA (CDC, 2012). Since the first cases of HIV/AIDS were seen in the USA nearly 30 years ago, over 575,000 Americans have lost their lives to AIDS (The White House Office of National AIDS Policy, 2010). Fortunately, with the use of medications such as highly active antiretroviral therapy (HAART), the mortality and morbidity related to HIV/AIDS has experienced a reduced rate of increase (Montaner et al., 2014).

Within the USA, the youth population has seen an increasing number of infections. There were 4205 adolescents diagnosed with HIV in 2002, and by 2009 the number had doubled to 8300 new infections in adolescents aged 13–24 years (CDC, 2012). In addition, adolescents are the fastest growing segment of the population newly diagnosed with HIV in the USA. Many adolescents may acquire the infection and are not diagnosed until later. The latency period for the HIV infection can be as long as 10 years (CDC, 2010a, 2010b). In 2008, the CDC estimated that of the 68,600 adolescents living with HIV, nearly 60% were unaware they were infected (CDC, 2012). Within the adolescent population in the USA, males tend to acquire the virus more often than females. White men who have sex with men (MSM) accounted for 61% of the new HIV diagnoses in 2009 (CDC, 2011). While gay and bisexual men continue to be the most affected population, the trend toward more transmissions occurring through heterosexual activity and intravenous drug use has occurred for several decades. Females most often acquire the disease through heterosexual activity (71%). Most startlingly in the USA, the disproportionately large number of HIV/AIDS infections found in African Americans. In 2009, this race accounted for more than 44% of new HIV/AIDS cases. Minority races, women, and children are becoming more and more represented in those with

the virus. Considering geographic data within the USA, urban areas contain large proportion of HIV infections; however, rural area infection rates are increasing. New York City houses 13.6% of the adolescents with HIV. Other epicenters in descending order are Houston, Los Angeles, Miami, Philadelphia, Washington, D.C., and Chicago.

There are certain groups of adolescents who are at particular risk for HIV infection such as economically vulnerable adolescents, female, gay and bisexual males, homeless and runaway adolescents, and other high risk homosexuals and intravenous drug users (Bermudez et al., 2016; Dellar, Dlamini, & Karim, 2015; Gallagher, Denning, Allen, Nakashima, & Sullivan, 2007). The number of studies related to prevention of HIV infections in these populations have increased in the past decade.

## *Drug Abuse*

In the President's Report of The Economic Costs of Drug Abuse in the United States (Office of the President, 2004) conducted by The Lewin Group, statistics were compiled from years 1992–2002 and costs reported for this period. The reported overall cost of drug abuse exacts more than $740 billion annually (National Institute on Drug Abuse, 2017). This is a 5.34% annual increase. A breakdown looks like this: health care costs comprising treatment, prevention programs, and medical consequences (HIV/AIDS, Hepatitis B and C, and drug-exposed infant) total more than $15.8 billion; productivity losses (premature death, abuse related illness, institutionalization, etc.) more than $128.6 billion; and costs of other effects which addresses the criminal costs (police protection, supply reduction measures, and state and federal corrections) comprised an additional $36.4 billion (Lewin Group, 2004, pp. ix–xi). However, careful scrutiny of these figures suggests gross exaggeration, e.g., they include private legal defense, abuse related figures in both the health care table and the productivity table; incarceration is listed in the productivity table and in the other effects table; and there is a category listed as crime careers accounting for more than $27 billion that appears to be a mystery. One possible explanation for these dubious figures might be to justify the costs incurred in the President's War on Terrorism.

In another study sponsored by the National Institute on Alcohol Abuse and Alcoholism, Sacks, Gonzales, Bouchery, Tomedi, and Brewer (2015) put the total economic costs at $$249.0 billion in 2010. 88,000 deaths are attributed to AOD problems. In 2012, there were estimably 23.1 million Americans in need of AOD treatment, and only about 2.5 million people (1%) were able to receive treatment (National Institute on Drug Abuse).

## *Crime*

The Federal Bureau of Investigation's Uniform Crime Reporting Program (UCR), which captures 94% of the US population, found that in 2010 there were 1,246,248 violent crimes and 9,082,887 property crimes (Federal Bureau of Investigation [FBI], 2011). In 2010, the rate of violent crime victimization (excluding murder) for US residents age 12 or older was about 15 in 1000. The rate for property crime victimization was about 120 in 1000 (Bureau of Justice Statistics [BJS], 2011). The rate for intimate partner violence was 0.8 per 1000 for men and 3.1 per 1000 for women.

There are estimated to have been 13.1 million arrests (except traffic violations), which translate to 4257.6 arrests per 100,000 people for those 29 offenses tracked (FBI, 2011). For violent crimes, the arrest rate was 179.2 per 100,000 people, whereas for property crimes, the rate was 538.5 per 100,000 persons. In 2010, the clearance rate for violent crime was 47.2% and for property crimes, 18.3% (FBI, 2011).

Looking at several kinds of crime committed between 1996 and 2001, there were 1,551,143 occurrences of family violence according to the UCR program. Of these, 29.6% were within girlfriend/boyfriend relationships, while 24.4 occurred between spouses. Between 1996 and 2001, there were 20,955 people assaulted who were related to the perpetrator (National Criminal Justice Reference Service [NCJRS], 2006). In 2015, the number of children victimized by sexual and physical abuse and neglect was approximately 700,000, with younger children being at greater risk (National Children's Alliance, 2015).

Substance abuse is implicated in this relative-as-perpetrator category of crime, as it is in many other kinds of crime. In a study conducted by the Arrestee Drug Abuse Monitoring Program, 60% of arrestees tested positive for one or more drugs at the time of arrest (Office of National Drug Control Policy [ONDCP], 2011). In 2002, perpetrators of violent crimes were believed by their victims to have been drinking in approximately one million instances. Multiple studies have consistently revealed the high rates of alcohol use among perpetrators (Cafferky, Mendez, Anderson, & Stith, 2016).

The costs of crime include those which are tangible and hence calculable monetarily, such costs being related to property loss, medical expenses, public safety programs, and private security strategies. Much more difficult to calculate are the intangible costs, such as the pain and suffering caused by the criminal events, as well as the subsequent diminishment of the quality of life for victims and their families.

Tangible costs are considerable. Crime cost victims as much as $15 billion in economic losses for victims and $179 billion in assorted government expenditures in 2007. In 2003, nearly half of the billions that victims received went to medical expenses while 12% went to mental health counseling (National Center for Victims of Crime [NCVC], 2004). Considering the costs of domestic or intimate partner violence alone, the Centers for Disease Control and Prevention (CDCP) determined

that the 2003 health-related costs stemming from physical assault, rape, homicide, and stalking were at least $5.8 billion annually (CDCP, 2003). The UCR also found that in 2010, the tangible costs of property crimes other than arson were approximately $16.21 billion (FBI, 2011). A single serious violent crime could cost up to $17 million (DeLisi et al., 2010).

There are many other costs as well, such as the costs to keep the US corrections system going. In 2001, this was estimated to be in excess of $38 billion (NCVC, 2004). In 2000, the national budget for reduction of drug use alone was 9936.6 million, with an anticipated request for fiscal year 2007 being 12,655.8 million (BJS, 2007). This is just part of the annual cost of alcohol abuse, at about $150 million, and drug abuse, at about $96 million (McDonald & Finn, 2000).

## *Urban Decline and Family Homelessness*

One of our most serious social problems, which has worsened in the recent decades, is the deterioration of housing and other living conditions in central cities and the resulting homelessness, especially among families with children. The number of the homeless is a matter of dispute between governments and advocates for the homeless due to inconsistent definitions, methodologies, and samples studied (Kondratas, 1991; Mihaly, 1991; Morrison, 1989; Newman, 2001; Tsemberis, McHugo, Williams, Hanrahan, & Stefancic, 2007). The number may not be in the millions, as estimated by homeless advocates, but most parties agree that it is as least in the hundreds of thousands, even without counting the rising number of families living doubled up with friends or relatives (Dyrness, Spoto, & Thompson, 2003). Other homeless families can be found living in cars and abandoned buildings (Fertig & Reingold, 2008). Moreover, all data indicate that poor families, headed up mostly minority, young, single mothers with children, people with mental health and substance use problem, occupy an increasing share of the rank and file of the homeless (Brown et al., 2016; Eisenberg & Keil, 2000; Rossi, 1994). A major cause of homelessness is poverty. Families make up approximately one-third of all homeless and are the fastest-growing group of homeless (Rosenheck, Bassuk, & Solomon, 2001). Children are estimated to make up between one-third and one half of the members of homeless families (Mihaly, 1991). Most studies of the homeless indicate that the number of homeless families and extremely poor families with children who are precariously housed and thus at risk of homelessness is also increasing.

The cost of human suffering due to homelessness is manifested in tens of thousands of poor families with children sleeping in temporary shelters or living doubled up with equally poor relatives or friends. Homeless children exhibit a host of academic, physical, and psychological problems that interfere with their proper development (Bassuk & Rosenberg, 1990; Bassuk, Richard, & Tsertsvadze, 2015;

Chiu, DiMarco, & Prokop, 2013; National Alliance to End Homelessness, 2000; Rafferty, 1995; Schanzer, Dominguez, Shrout, & Canton, 2007; Thompson, Zittel-Palamara, & Maccio, 2004). Insecurity, instability, and uncertainty about the next meal and bed undoubtedly cause enormous stress and anguish and overwhelm adults and children alike. Homeless and near-homeless families who move from one dangerous neighborhood to another in deteriorating central cities are also susceptible to crime and violence on the city streets. The overall physical health of children and adults alike living the shelters can lead to health problems such as respiratory and intestinal infections (Schanzer et al., 2007).

### *Unemployment*

Unemployment refers to the inability to gain entry into the labor market or to the "involuntary withdrawal from the workforce due to plant closures, layoffs, or other types of dismissals" (Leana & Feldman, 1991, p. 65). Since the mid-1970s, the US economy has undergone dramatic changes, contributing to relatively high unemployment rates and large numbers of workers confronted with job loss. Between 1981 and 1988 alone, estimates are that 10.8 million US workers experienced unemployment (Fraze, 1988). In July 2012, the Bureau of Labor Statistics found that 12.8 million people were unemployed. In the 1980s and 1990s, it has also become increasingly difficult for young people to negotiate the transition from school to work (Mann, Miller, & Baum, 1995; Sum, Fogg, & Taggert, 1988). This is particularly true for young people with little education or training, but even those with college degrees find job acquisition more challenging (Sum et al., 1988). The current employment rate is 4.4% in 2017 (U.S. Department of Labor, 2017). A 5.2% unemployment rate in 2024is projected by US Department of Labor (2015), meaning many more individuals will face unemployment.

Efforts to put a dollar amount on costs of unemployment typically include estimates of lost productivity, reduced consumption, and additional subsidy provided by taxpayers for unemployment compensation and other benefits for the unemployed. Needless to say, any such estimate runs into billions of dollars quickly. One recent study found that counties with higher unemployment rates had higher rates of depression hospitalizations as unemployment appeared to be risk factor for hospitalization. These high cost hospitalizations add to the overall social costs for the unemployed (Fortney et al., 2007). A 1% rise in unemployment, for example, has been estimated to add $55 billion to the federal deficit. Given the range of health, social, and psychological problems associated with unemployment, such dollar estimates fall short of representing the full impact of unemployment on individuals, their families, and the larger community.

## *Marital Conflict*

Presumably, all marriages involve some degree of marital conflict, given that life is inherently stressful and that all relationships involve some degree of dissension. According to the National Survey of Family Growth, 48% of marriages will end in divorce before the 20th anniversary (CDC, 2010a, 2010b). The majority of these cases will involve at least one child under the age of 18 (Ganong, Coleman, Markham, & Rothrauff, 2011).

For several years now, marital conflict has been identified as a risk factor for health and mental problems and a major disruption in the workplace (Snyder, Heyman, & Haynes, 2005). Choi and Marks (2008) suggest that separation and divorce have strong negative consequences for the mental and physical health of both spouses. Lower marital quality has been linked to high levels of depression and a lower quality of life (Amato, 2014; Choi & Marks, 2008). Bray and Jouriles (1995) discussed the cost-effectiveness of marital therapy and noted that the majority of marital therapies that have been empirically evaluated are relatively brief in duration and below the standard 20-session limit imposed by health insurance companies. Using an average cost of $60 to $100 per session, an average course of marital therapy would cost between $600 and $1000. As stated by Bray and Jouriles, "Even twice this amount seems certainly less than the cost of a divorce and pales in comparison to the costs of many medical procedures" (1995, p. 469).

## *Race*

Social work has historically emphasized the importance of diversity in the worker client relationship. However, most of the recent research in the profession has emphasized the study of other aspects of social work practice. At the same time, disciplines such as psychology and psychiatry have produced research with greater emphasis on relationship factors such as race and gender, on the therapeutic alliance, and on counseling outcomes. Greene, Jensen, and Harper-Jones (1996) indicate that "virtually all therapeutic approaches are equally effective and that the one thing essential to therapeutic success, regardless of theoretical orientation, is a good working relationship between the clinician and the client" (p. 172). Coady (1993) notes that "over the past two decades, the most striking and consistent empirical findings in individual psychotherapeutic research have been the nonsignificant outcome differences among various therapies" (p. 292).

Empirical evidence indicates that race and gender are key variables that affect the helping relationship and can produce clinician bias. For example, psychiatric evaluations are primarily based on a patient's history, basic personality, and current mental state. According to Wade (1993), the emphasis given to one item of information or the importance attached to an incident is dependent on the beliefs, value judgments, understanding, and knowledge of the psychiatrist. Diagnosis and subsequent

care can often be a result of the differences in race, gender, age, and ethnicity between worker and client (Krieger, 2014).

Cultural conditioning, which even social workers are not immune from, has been shown to create racial biases that people may or may not be aware of (Abelson, Dasgupta, Park, & Banaji, 1998; Banaji, Hardin, & Rothman, 1993; Thyer, Myers, Wodarski, & Harrison, 2010). Other studies have supported the contention that racial bias exists in the assessment, diagnosis, and treatment of mental illness (Jenkins-Hall & Sacco, 1991; Jones, 1982; Whaley, 2001). Accumulating research has revealed that racial and cultural bias significantly contributes in the psychiatric misdiagnosis of African Americans (Whaley & Geller, 2003, 2007).

For example, some studies indicate that white professionals may misconstrue uncooperative behavior among Latinos as evidence of psychosis (Rendon, 1974; Smith Kline Corporation, 1978). Others suggest that instances of paranoid behavior exhibited by blacks when interacting with white therapists are indicative of coping behavior exhibited by many African Americans in response to discriminatory life experiences (Pavkov, Lewis, & Lyons, 1989). Trierweiler et al. (2006) found that Non-African American therapists generally rated their black clients as more psychologically impaired than did black therapists. Furthermore, when diagnosed with psychotic or affective disorders, minority-race clients are more likely to be labeled as having a chronic syndrome than an acute episode (Sata, 1990).

## *Retirement*

Since the turn of the last century, the increase in the number of older adults has been dramatic. In the early 1900s, when the current cohort of elders was born, only 5% of the population was over the age of 65 (Aging America, 1991). In 2010, there were nearly 50 million people over the age of 62, which is 16.2% of the population. That is a 21.1% increase from 2000 (U.S. Census Bureau, 2010). The trend toward an increasingly older population is expected to continue, as a greater number of adults live into late life. Because of their multiple needs that often include medical, social, and financial assistance, social work practitioners in all service settings can expect to work with greater numbers of older adults in coming years.

Due to the diversity of practice issues in work with older clients, various approaches focus on different practice outcomes. Certain interventions have prevention objectives, with goals of keeping older adults as physically, socially, and psychologically healthy as possible. Other intervention approaches are remedial, with the goal of restoring functioning after the onset of a certain type of problematic condition (e.g., death of a spouse, onset of chronic health problem). Finally, some approaches provide support in progressive and irreversible situations, such as dementia care or terminal illness. Intervention approaches discussed in this chapter are practice with individual clients, groups and families of older adults, and community prevention programs.

### *Hospice*

The National Hospice and Palliative Care Organization released a hospice census in 2012 which estimates various pieces of demographic data for hospice patients. It is estimated that 1.58 million patients were served by hospice in 2010, and 41.9% of all deaths in the USA occurred under the care of a hospice program. In 2010, the average length of time that a patient received hospice care was 67.4 days; 56.1% of hospice patients were female, and 43.9% were male; 82.7% were 65 years of age or above, and 17.3% were 64 or below; 77.3% were White/Caucasian; 5.7% reported Hispanic or Latino origin; 35.6% maintained a cancer diagnosis, and 64.4% maintained a non-cancer diagnosis (National Hospice and Palliative Care Organization, 2012).

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