The Aging Network

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14.1 Introduction

Mr. B, a retired builder, has always prided himself on being independent. Over the years, Mr. B's sight began to decline as a result of worsening glaucoma, and for the past few years he has had difficulty with household chores. Even more troubling, he had to give up his driver's license after he went off the road and hit a tree, causing significant damage to his car. He was subsequently unable to pass the vision test required to reinstate his license. The inability to drive has been a significant inconvenience for him, as he lives in a rural area outside of the city and is now otherwise unable to get to his medical appointments or visit his friends in the city. Mr. B must rely on his 42-year old son for help driving into the city and completing household tasks. At first, this seemed to be a timely arrangement, as his son had recently moved back in with Mr. B after being served by his wife with a restraining order and eviction notice barring him from their home on the grounds of ongoing physical and emotional abuse. Over time, however, Mr. B's son has become increasingly hostile and aggressive toward his father. When Mr. B asked his son to wash the dishes, his son threw a dirty plate at Mr. B, resulting in lacerations to his arm. In another instance, his son came home intoxicated and proceeded to shove and threaten Mr. B, who fled into his room. Concerned about his safety, Mr. B would like to obtain a Restraining order and evict his son, but he is afraid of living by himself with his diminishing vision and is reliant on his son for help with household chores and transportation to medical appointments and social visits in the city. And, he reasons, his son needs his help and is trying to get his life back on track.

Like Mr. B, Mrs. D is an older adult who wants to live independently in the community. Mrs. D was once a buyer for a major department store and lives in an upscale apartment in an affluent area of town. Over the past year, family and friends have noticed some changes and have become increasingly concerned about Mrs. D's well-being. Although throughout her life, she was known for her glamorous appearance and designer clothes, she recently lost weight and is increasingly unkempt, disheveled, and malodorous. Her apartment manager has expressed concerned that she is behind on her rent, even though her family reports that she has sufficient funds in her account. The homeowner's association in her building is complaining about the smell coming from her apartment and her violation of by-laws, including subletting a room in her apartment to someone she met while eating at a fast food restaurant. Mrs. D has severe arthritis affecting her hands and her ability to cook, clean, and care for her personal needs. A few years ago, her husband died after sustaining a hip fracture from a fall. Since then, Mrs. D has become increasingly fearful of falls and avoids taking baths out of concern that she will fall in the tub and die alone. Her loneliness and fear of being socially isolated prompted her to solicit short-term renters who can keep her company. Mrs. D's husband also managed the family's finances; since his death she struggles to pay her bills and, increasingly postpones financial tasks and decisions. She assumes that her renter is a good and honest person who will pay her the correct amount. Several months ago, one of the renters, with Mrs. D's consent, stayed on and appears to have become well entrenched in her home.

The case examples of Mr. B and Mrs. D illustrate the diverse and complex needs of abuse victims and the intricate ecologies and relationships from which these needs emerge. Intervening in cases of maltreatment and self-neglect and preventing further victimization requires interpersonal and professional skills of client assessment and treatment, coupled with an extensive knowledge about available resources and services, including the ability to identify which resources offer the best potential to provide ongoing support to victims.

Most countries have developed unique service delivery structures, public service institutions, and methods of

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accessing supportive resources. In some countries, informal long-term care support systems have traditionally been comprised of family members and neighbors, though such care disproportionately burdens women and is unsustainable [107]. Because addressing each country's individual approach is beyond what can be done in a chapter, we focus primarily on lessons learned by examining the United States' Aging Network, an approach that seeks to balance national standards, a consistent structure, and core services with opportunities for local innovation based on the needs of individual communities.

The Aging Network is an extensive and diverse nationwide network of government-funded providers serving older adults in their local communities. Despite the important role that the Aging Network can play in supporting victims and potentially helping older adults avoid victimization, collaboration between protective services and aging services does not seem to routinely occur in many communities. To examine the role of the Aging Network and the ways in which its diverse services can address the needs of abused, neglected, and at-risk older adults, we begin with a discussion of the background and history of both the Aging Network and protective service programs. We compare and contrast the approaches and services offered by each and discuss ways in which they can effectively work together to prevent abuse, address it when it occurs, and reduce the likelihood that victims will suffer from recurring maltreatment.

14.1.1 Legislative Efforts to Support Older Adults

Both the Aging Network and Adult Protective Services (APS) have been in existence since the 1960s, in one form or another. Although they have a long history and there are potentially promising outcomes through collaborations, in many communities they remain distinct and siloed. Examining their evolution over the years, it appears that their histories do not intersect as much as one would expect. Perhaps this is because they have distinctly different missions, philosophies, approaches, origins, structure, and to some extent different clients, all of which make joint efforts challenging. Both programs grew out of embryonic efforts in the 1960s and both saw infusions of interest and monies in the 1970s. Since their inception both programs have focused primarily on elders living in the community. And importantly, services supplied by the Aging Network and APS are both universal—serving all who require support—rather than need-based—as well as targeted to older adults (most often considered to be people aged 60 and older) as well as adults with disability in the "greatest social and economic need." In other ways, however, the Aging Network and APS are distinctly different.

The foundation for the Aging Network was laid with the passage of the Older Americans Act in 1965 as part of President Lyndon Johnson's Great Society [38, 100]. What came to be known as the Aging Network—the backbone of an intricate web of services shown in Fig. 14.1, began to develop with the passage of amendments in 1973 that created a structure of state and local entities designed to deliver core services to older adults. Under the auspices of the Administration on Aging, the revised act called for designation of a State Unit on Aging in each state. Moreover, based on a formal planning process, service areas were designated within states and Area Agencies on Aging (AAAs) were developed within each locality. This process created a uniform structure to distribute resources, information, and program ideas both up and down organizational hierarchies. Each level (federal, state, and local) is expected to coordinate with other parallel departments and units; thus this network impacts local, state, and national programs and services. However, the structure also funnels monies down to the local level, including funding for meals, senior centers, in-home services, and other programmatic areas, which we discuss below. In this way, structure of the Aging

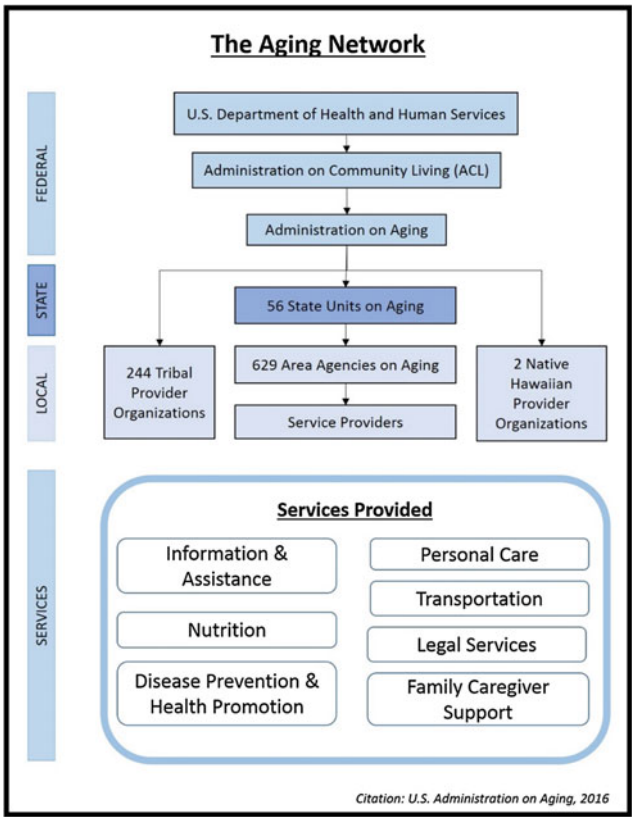

Fig. 14.1 The Aging Network. Citation: U.S. Administration of Aging (2016)

Network allows for local input and innovation based on the specific needs of each community, as well as direction and support from the state and federal level.

At its core, the Aging Network is a system of government agencies and service providers engaging in advocacy, planning, policy and program development, and service provision in order to promote the well-being of older Americans [87]. Under the authority of the U.S. Administration on Aging (AOA), the federal Older Americans Act establishes the Aging Network's infrastructure, identifies basic types of services to be provided through the Network, and provides funding for these services. As of 2012, the AOA and OAA programs were brought together with the Administration on Intellectual and Developmental Disabilities and the Health and Human Services Office on Disability to become the Administration on Community Living, part of the U.S. Department of Health and Human Services. Although there are somewhat disparate goals of the aging and disability communities, the intent of this transition was to meet the needs of people with disability from early to late life.

While the Department of Health and Human Services, the Administration on Community Living, and the Administration on Aging provide key leadership and guidance on aging services, the Aging Network is a federalist program and is, thus, significantly shaped by state and local governments. On the state and local levels, programs are defined and implemented to meet the needs of older adults within specified Service Planning Areas, resulting in a nationwide network of community-centric programs and services that fulfill local needs in a variety of different ways.

In addition, recognizing of the autonomy and needs of indigenous populations, the Administration on Aging provides funding for agencies which serve American Indian, Alaskan Natives, and Native Hawaiian populations. Currently, 244 tribal organizations and 2 Native Hawaiian organizations receive funding to implement Older Americans Act services among their respective communities [95]. This chapter describes services that are generally available in most areas while highlighting notable unique model programs which may be of interest to elder abuse practitioners. Contact information for agencies providing information and assistance with obtaining local services is available through the U.S. Administration on Aging's Eldercare Locator (http://www.eldercare.gov/eldercare.NET/Public/index.aspx; 1-800-677-1116).

A closer look at the OAA shows that the topic of elder abuse has been an increasing focus starting with amendments in 1984 [38]. Title VII of the Older Americans Act authorizes funds for long-term care Ombudsman program, which is described in detail elsewhere in this volume, and the Prevention of Elder Abuse, Neglect, and Exploitation Program, which allocates funds to State Units on Aging to support strategic planning, research, and programs intended to prevent and address elder abuse [61, 98]. Funds can be spent at the state level or distributed to local Area Agencies on Aging for their use or distribution to local service providers. Title VII also authorizes the institution of the National Center on Elder Abuse (NCEA; http://www.ncea.aoa.gov). The NCEA seeks to prevent elder abuse by providing training, technical assistance and support to elder abuse professionals and the general public, serving as a reliable and highly visible clearinghouse of resources and information [61, 97]. While Title VII specifically addresses elder abuse, other provisions offer more general services that nonetheless can be employed to support victims and help reduce the risk of abuse.

The Aging Network has been able to rely on a consistent (although constricting) funding stream over the years. This federal source of authorization is one reason why OAA programs have a comprehensive and standardized structure depicted in Fig. 14.1.

Although the OAA remained in limbo after 2011, past due for reauthorization but unable to pass in a contentious political climate, it was reauthorized in 2016. With the most recent iteration of the OAA, several new program requirements address elder abuse more specifically [20]. Although this chapter does not endeavor to assess these in detail given their very recent implementation, they are worth nothing. First, the recent legislation requires the Office for the Long-Term Ombudsman to collect best practices to respond to elder abuse. Again at the federal level, the AOA must ensure that OAA-supported programs include training to prevent elder abuse, as well as services capable of addressing elder justice. In addition, the AOA is required to ensure grants to State Units on Aging to support health screenings also assess for elder abuse, neglect, and exploitation. State Units should also find ways to promote data submission on reported elder abuse to designated databases, and support communities in developing partnerships addressing elder justice to prevent, investigate, and prosecute in cases of abuse. Finally, the reauthorized OAA requires local AAA plans to include plans to increase awareness about elder abuse, neglect, and exploitation. Each of these measures supports promising ways to prevent and address elder mistreatment at all levels of OAA infrastructure.

In contrast to the Aging Network, Adult Protective Services (APS) appear to have been much more organic and locally driven. APS, described as "the backbone of community-based efforts to respond to elder mistreatment" [8, p. 124], has relied on a variety of funding streams that are not earmarked specifically for protective services. A major catalyst for the development of APS was the Social Service Block Grant program funding through Title XX of the Social Security Act, 1975 [62, 71]. As a block grant, this funding was not designated for specific programs, but was directed

toward a vulnerable target population that included older and disabled adults who were abused, neglected, exploited, or living in dangerous conditions [71]. Thus, for many communities, the Social Security Block Grants (SSBGs) provided a much needed resource for local government, some of which could be directed at what was then called "granny bashing," a term used at congressional hearings to cast light on disturbing cases of abused elders. Because APS had been established in many communities before the SSBGs became available, these grants breathed new life into addressing a long-standing yet newly discovered problem. However, unlike the OAA-funded Aging Network, funds were not designated specifically for older adults, and thus programs had to compete for these monies with other social service entities.

Currently, all states have policies on reporting abuse and the vast majority requires mandatory reporting by most professionals in fields such as health care, social services, and long-term services, and support provision. An ongoing challenge, however, is to make sure that the role of APS is understood by professionals and others who might report abuse.

Bonnie and Wallace [8] note that APS has several core tasks which include:

(1) intake, screen, and determine priorities for future action for reported victims of abuse, neglect, and exploitation
(2) investigate abuse allegations; and
(3) engage in case planning to address and mitigate the abuse.

Given limited funding, much of APS' resources are directed toward meeting the first two functions—taking in and investigating allegations of abuse. However, using information garnered from this task to intervene and stop abuse is challenging for several reasons. Unlike those affected by child abuse, victims of elder abuse can exercise their rights as adults and decline to participate in an investigation or refuse APS services. And like victims of intimate partner violence, elder abuse victims may deny that abuse has occurred because they are conflicted about the situation and/or wish to protect their abuser. In many jurisdictions, APS may also be limited by legislative or procedural constraints which restrict agency activities to largely a crisis management approach. Thus, collaboration with Aging Network agencies may offer APS both a challenge and an opportunity.

A recent study sheds light on the challenges APS faces as it seeks to address abuse and collaborate with other services in the community. Focus groups comprised of APS workers and others with healthcare professionals both identified similar constraints and barriers to abuse reporting and subsequent interagency collaborations to address it [23]. From their perspective, APS workers reported difficulties in transitioning clients to the larger service delivery system, especially given the limited time for care planning and the need to respect the autonomy of victims who do not always want to pursue cases. In turn, health service providers felt frustrated because they did not fully understand the role of APS and the boundaries that APS worked within, especially with regard to maintaining client confidentiality and autonomy. Indeed, in cases involving clients who are unwilling to permit a referral to an outside agency, APS confidentiality mandates make a handoff to an Aging Network organization nearly impossible. It is important to recognize these constraints and at the same time examine how agencies can work together to address elder abuse. We begin this discussion by briefly exploring what APS and other community providers need to know to identify abuse risk.

14.1.2 Risk Factors for Abuse

What makes one older person more at risk of experiencing abuse than another older adult? Researchers have identified risk factors or characteristics that increase the likelihood that an older person will experience elder abuse. Each additional risk factor contributes to increased vulnerability to mistreatment in unique ways, tilting the scales such that an outcome of abuse or mistreatment is more likely. Mosqueda et al. [60] integrated this concept into the Abuse Intervention Model (AIM) framework which categorizes risk factors for abuse into three major categories: characteristics of the potential victim, characteristics of the possible perpetrator, and the contextual environment in which possible victims and alleged abusers interact. While a more extensive review of abuse risk factors is available elsewhere in this volume, we will discuss a few key risk factors that may be addressed by Aging Network services.

14.1.2.1 Social Isolation

Older adults who are socially isolated from formal (e.g., service providers) and informal (e.g., family members, friends, neighbors, etc.) social networks appear to be at greater risk for experiencing abuse and neglect [1, 8]. Social isolation may emerge organically, due to an individual's decline in health, functional ability, or cognition, or even from a death within the victim's existing social network. In other cases, isolation may be intentionally orchestrated and maliciously perpetrated in order to increase the victim's vulnerability to maltreatment by creating a dependency on the perpetrator and preventing would-be interveners from

learning about inappropriate activities [102]. Having higher levels of social support has been found to be protective against abuse [48, 55]. Acierno et al. [1] found an association between not using social services and financial abuse, implying, perhaps, that engagement in formal supportive service networks might reduce isolation and prevent financial abuse.

14.1.2.2 Cognitive Impairment

Cognitive impairment increases an individual's vulnerability by raising their need for support and assistance while simultaneously diminishing their ability to protect themselves from abuse. A review of the literature found that individuals with cognitive impairment are at significantly higher risk of being abused [48]. In their longitudinal analysis, Lachs et al. [52] found that cognitively impaired older adults had two times greater odds of experiencing abuse compared to non-impaired older adults. The odds of abuse increased more than fourfold among those who had recently experienced a decline in cognitive function, compared to those with no cognitive impairment and those who were impaired but had not experienced a change in their cognitive status, suggesting that older adults may be especially vulnerable during and immediately following this period of transition in cognitive status. Possible reasons for this increased risk of abuse among cognitively impaired older adults may include being targeted by perpetrators who assume victim accounts of abuse will be disregarded, but also the need to rely on others who might misuse this trust. More recently, Dong et al. [27] identified declines in Mini-Mental State Examination score, global cognitive functioning, perceptual speed, and episodic memory, specifically, as being associated with having a higher risk of experiencing elder abuse.

14.1.2.3 Functional Limitations

Functional limitations are often defined by an individual's ability to independently perform Activities of Daily Living (ADLs) which include eating, walking, bathing, dressing, grooming, and toileting, and Instrumental Activities of Daily Living (IADLs), such as meal preparation, managing money and medications, completing housework, shopping, use of a telephone, and accessing transportation. Older adults with greater functional limitations have greater risk of experiencing financial, physical, or emotional abuse [1, 13]. There is also evidence to suggest that the level of risk increases with each additional ADL impairment reported [31, 52]. Although it is important to remember that most caregivers are not abusers, functional impairment can cause individuals to seek care from those who may eventually exploit, abuse, or neglect them. Victims of abuse may be reluctant to seek help or leave the situation because their abuser proves instrumental assistance with daily tasks.

14.1.2.4 Abuser Characteristics

Characteristics of the abuser and the relationship between the abuser and victim may also increase the risk of abuse occurrence and are important factors to consider and address [48, 60]. Contrary to what might be expected, studies have found that abusers are often more dependent on their victims than their victims are upon them [8]. Thus, it is not surprising that risk factors for being an abuser include mental health issues, substance or alcohol abuse, and poor abuser–victim relationship quality [48].

Some have proposed multiple abuser typologies to describe the characteristics and modus operandi of abusers [43, 47, 79, 93]. Characteristics which may contribute to risk of abuse vary by the particular abuser typology. For instance, in situations involving extensive caregiver burden, a caregiver's inability to cope with the stressful caregiving situation may increase the likelihood of abuse [48].

14.2 Effects of Abuse

Elder abuse and mistreatment have multiple detrimental effects on victims, who not only endure the direct impacts of abuse (e.g., physical injury and lost assets), but also its reverberating consequences. Victims may face anger, disappointment, or grief following abuse [18]. Abuse can also render a severe blow to independence in later life: victims face an increased likelihood of functional impairments [25] as well as a higher risk of institutionalization than non-victims [28]. Longitudinal work also demonstrates an increased risk of death following abuse [3, 26, 29, 30, 53, 81]. It is important to understand, however, that the effects of abuse will vary by victim [76].

Recognizing the protective and contextual factors surrounding abuse leads one to suspect that elder abuse prevention is enhanced by environmental factors, such as the availability of services and supports provided by the Aging Network. Although the U.S. Administration on Aging is currently funding studies related to the prevention of abuse [99], we were unable to find any studies addressing the role of the Aging Network in directly reducing risk and incidence of abuse. Still, there is some evidence to suggest different mechanisms through which services may prevent elder abuse. For example, in their focus group study, Enguidanos et al. [34] found that participants feared reporting abuse due to fear of nursing home placement. The availability of

supportive services within the home, such as those offered through the Aging Network, could potentially mitigate nursing home placement and thereby increase older adults' willingness to report abuse.

In this chapter, we suggest that the services and supports provided to older Americans via the Aging Network have the potential to counterbalance risk factors for abuse and help to prevent vulnerability in old age. These services also offer support for victims that may help them overcome risk factors once the abuse occurs. The case studies at the beginning of this chapter illustrate needs that Aging Network intervention and support could help address to reduce the risk of abuse. Another consideration in the list of harms caused by elder abuse is the effects abuse can have on others, impacting families, neighbors, and communities who are left to respond to the consequences of elder abuse [74].

Finally, while some survivors of abuse may be able to cope well and recover, others may be less equipped to do so. Providing adequate supports to improve recovery may help to mitigate negative consequences of abuse. For example, older victims of domestic violence reported significant improvements in well-being after attending support groups, including reduced isolation, peace of mind, and even self-reported improvements in health [9]. Earlier research reiterates these findings, suggesting that victims who have higher levels of social support experience less psychological distress than victims with lower levels of social support [18]. Thus, the effects of abuse may, in part, be mediated by the support that follows.

14.3 Long-Term Services and Supports for Secure Community Living

Given the choice, most older adults would prefer to "age-in-place," remaining in their homes and communities. A recent AARP survey found that 87 % of people ages 65 and older indicated they preferred to remain in their current home [44]. While reasons for this preference are vast and vary by individual, there is some indication that such reluctance may stem from strong place attachment [56] and resulting identity formation [84], as well as proximity to existing social networks and familiarity with the existing community.

Home- and community-based long-term services and supports, such as those provided by the Aging Network, are programs intended to provide older adults with instrumental assistance to enable them to continue living in the community. While long-term care can be effectively provided within an institutional setting like a nursing home, and may be appropriate for some, for many, services that support older adults to remain in the community are most suitable. Moreover, depending on the needs of the older adult, home care may also be more cost-effective. For example, whereas 4 h of in-home assistance cost $84 in 2010 on average, 1 day of nursing home care averaged $205 per day for a shared room [57].

Provision of long-term services and supports may enable victims of abuse, neglect, or self-neglect to receive sufficient support to enable them to continue living safely in the community. As in the case studies presented in the introduction, Mr. D may have been reluctant to report the abuse or obtain a restraining order because of his reliance on the abuser for transportation to medical appointments. With the receipt of transportation services through an Aging Network provider, the abused victim may no longer feel dependent on the abuser and be empowered to seek assistance with obtaining a protective order to halt the abuse or agree to report the abuse to law enforcement to facilitate the arrest his abuser. Similarly, Mrs. B may have initially been unwilling to bathe regularly because she is fearful of slipping and falling in the bathtub. However, with the receipt of personal care assistance from an Aging Network provider or through the Aging Network Information and Assistance service, she may be able to bathe safely and manage other personal care, enabling her to remain in the community rather than moving to an Assisted Living Facility.

14.4 The Aging Network: A Key Resource to Address Elder Mistreatment

Aging Network providers offer a wide array of programs and services intended to support community-dwelling older adults. While government agencies sometimes provide direct services, they often contract with local agencies and organizations to provide these services. Providers may be organizations serving older adults at large or may serve specific cultural, social, or religious subpopulations. As described more fully below, these service programs are important resources available to practitioners seeking to assist older victims of mistreatment or self-neglect and those at-risk for these conditions. Programs provide integral support to alleviate the detrimental effects of maltreatment, and can also provide support to reduce dependency and vulnerability, thus preventing/reducing future abuse and self-neglect. The services described below are presented in order of applicability to victims.

14.4.1 Aging and Disability Resource Centers

Aging and Disability Resource Centers were created to assist consumers to access services. In general, social services "networks" are comprised of a variety of service providers who may have different program goals, funding streams, eligibility requirements, and protocols [49, 108]. As a result, it can be difficult for older adults and those helping them to identify programs and services that help them continue living in the community. In the 1980s, Aging Network and Medicaid programs in some areas began to create interagency Resource Centers to improve consumer access to services, adopting consumer-friendly approaches which would increase the likelihood that consumers would be able to obtain necessary information and services [72]. In Centers adopting the "single point of entry" approach, consumer inquiries and requests for information or services were directed to a central entity designed to connect consumers with appropriate and available service providers [58, 72, 94]. Other Centers adopted a "no wrong door" approach in which workers at participating agencies were trained in the types of services available from other member agencies, and were thus equipped to refer clients to providers who might be better able to meet their needs [72, 94]. In this way, consumers could access services from the appropriate providers despite contacting an agency that would otherwise be unsuited to fulfill their service needs.

In 2003, the Administration on Aging and Centers for Medicare and Medicaid Services provided funding to replicate the interagency Resource Center model by establishing Aging and Disability Resource Centers (ADRCs) in twelve states under the Real Choice Systems Change Grants for Community Living [72]. The Centers were designed to bring together and streamline access to providers offering services for elder and disabled adults. In 2006, the Older Americans Act was amended such that each state was required to have an ADRC, and as a result, this model program has been replicated in all 50 states and several U.S. territories [72]. To date, at least 535 ADRCs have been established nationwide with at least 41 states establishing an ADRC presence online to promote greater accessibility [94].

While the individual protocols and participating agencies may differ between ADRC programs, ADRCs are intended to provide an array of services designed to aid consumers of all ages and levels of need. These services may include, but are not limited to, (1) information and referral services, (2) long-term services and supports options counseling, (3) eligibility determination for programs and services, (4) person-centered transition support, and (5) quality assurance and continuous improvement services [94]. Some ADRCs include or are colocated with local Adult Protective Services agencies, thus promoting APS's integration with other aging and disability service providers [63].

The integration of aging and disability resources is a logical step that offers support for agencies serving elder and dependent abuse victims and those at risk for abuse. Traditionally these systems have been operated independently, requiring older adults to identify and access services from each of these systems and personally coordinate eligible services. With the growth of ADRCs, there is increasing potential that practitioners can support at-risk elders or victims as they seek assistance through ADRCs.

14.4.2 Senior Centers

Senior Centers often serve as "one-stop shops," providing services to older adults as well as opportunities for social engagement and interpersonal interaction for community-dwelling elders. In general, Senior Centers have dedicated staff members who plan social, educational, and health-related activities for older adults at little or no cost to participants. Aging Network services typically are available to older adults through their local Senior Centers. For instance, many centers operate congregate nutrition programs. Some offer evidence-based health promotion and disease prevention programs and/or house case managers who can assist older adults with accessing additional services. Many of these programs are targeted to low-income older adults who may have limited ability to pay. Often, programs are supported in whole or in part by federal, state, and local government funds including Older Americans Act funds, although participants are given the opportunity to make a suggested donation if they are able and willing to do so.

By providing services in a centralized location where older adults come together, Senior Centers offer a means to combat social isolation, a noted risk factor for abuse. Older adults who frequent their local Senior Center may develop friendship with other community members, as well as staff. Such opportunities may be particularly important, as positive social engagement and strong social support is associated with lower mortality [82], greater survival after serious health events [5, 39], higher self-rated health [22], and better cognitive functioning [83].

Continued participation in senior center activities may also foster opportunities for informal monitoring of participant well-being and their physical and cognitive functioning. In some cases, program staff may be among the first to suspect that a participant is in an abusive, exploitive, or neglectful situation. When a client has suspicious injuries or begins to arrive disheveled and malodorous, senior center

staff may be the ones who contact APS and/or law enforcement to notify them about their concerns and request that they investigate the situation. In some states this report may be required under mandatory reporting laws [70]. Such referrals can help to ensure that the older adult is safe and able to adequately care for his or her personal needs.

Moreover, Senior Center programs' emphasis on social engagement and encouragement of positive social interactions may be especially beneficial for victims of abuse and neglect who may have experienced social isolation and/or negative and detrimental social interaction. Regular interaction with program staff and participants offers an alternate support system to fill the social and emotional void left by the removal or desertion of the abuser. Such social engagement may also provide sufficient support to empower individuals experiencing abuse to remove their abusers from their life. Additionally, given that abuse has been estimated to recur in 4–33 % of cases [19, 32, 35, 89], senior center staff may be well positioned to act as vigilant observers and to make a report and seek assistance from elder abuse professionals if concerns occur after an investigation is closed [16, 60].

14.4.3 Nutrition

The Older Americans Act funded Title IIIC nutrition program to promote the health and well-being—physical, emotional, and social—of older adults through the provision of nutrition services [17]. To ensure that older adults have access to at least one nutritious meal a day, the Administration on Aging provides funding for Area Agencies on Aging to contract with nutrition providers who prepare and distribute meals to older adults either in the community or at home. In general, programs are required to provide these meals at least five times a week, though there are allowances for programs in rural areas that may be unable to meet this requirement. Program staff is also required to provide participants with nutrition counseling and other nutrition services as needed. Older adults aged 60 and older and their spouses of any age are eligible to participate in the program.

Congregate nutrition programs (IIIC-1) provide older adults with hot meals that meet federal nutrition standards. Meals are offered in a specified physical location, such as a senior center or other program provider. Participants have the opportunity to share a meal, often over friendly conversation and social interaction. Like other Senior Center programs, older adult nutrition programs were developed with a joint goal of providing nutritious food and facilitating social interaction among program participants.

Older adults who are frailer or chronically ill, and therefore unable to attend congregate meals, can receive meals delivered to their homes (III C-2). The Aging Network addresses the unmet need of such individuals through programs providing "Meals on Wheels," which may offer social interaction at the time of the meal delivery or at the very least someone who checks on the older adult's welfare on a regular basis. Volunteers delivering the meal may interact with home-bound older adults and may also be trained to look for signs that the older individual may be in need of added services or supports. For example, volunteers might recognize signs of disarray in the home, or an empty refrigerator. Some pilot programs have sought to partner elder abuse protection with home-delivered meal providers to provide education and training to meal delivery persons about suspicious signs of abuse [66].

14.4.4 Personal Care

Personal care services include providing assistance with a range of ADLs, such as bathing and dressing. These can also include "chore" services addressing IADL needs, including meal preparation and light housekeeping. Personal care may be provided on a temporary basis, as when an older person is returning from the hospital and needs extra assistance while recovering, or long-term, where recovery or return to an independent level of functioning is unlikely.

Although many states have their own state-specific personal care service programs, Area Agencies on Aging oversee the distribution of personal care services in a number of ways. This happens most directly though the Older Americans Act Title IIIB funding meant to support independent living. Often these services are provided to clients who meet certain target criteria (e.g., low income) and are provided via contracted agencies. Under Title III-E, AAAs can also provide respite care services, which frequently entail personal care assistance. Finally, at the most basic level, AAAs may provide information and advice on local business and organizations providing these services. Older adults, including those accessing personal care through Medicaid, out-of-pocket, or with long-term care insurance, may benefit from such information and assistance services.

Personal care services provided by the Aging Network may prevent elder abuse by addressing unmet needs and reducing neglect and self-neglect. In addition these services may also prevent additional loss of functioning, declines in physical health, dependency, and social isolation. For example, assistance with dressing may prevent dangerous falls and other injuries that leave older adults more vulnerable and in need of additional assistance. Interactions with personal care service providers may also buffer against possible social isolation, as these relationships may develop into what is recognized as friendship [73]. Although there are cases implicating the role of home care aides in elder abuse, this is likely the exception; state plans are required to

address quality assurance in home care, a possible safeguard against mistreatment.

14.4.5 Transportation

Data from the 2012 Health and Retirement Survey revealed that one in five older Americans likely needs transportation services [40]. American's heavy reliance on cars shapes communities in ways that pose a challenge to older people who can no longer drive, face constraints when driving (e.g., cannot drive after dark), or cannot afford a car. For example, in some communities, public transport options are disjointed and unpredictable, making these less suitable to meet the needs of older people who do not drive.

Since 1974, the Older Americans Act has addressed these challenges by providing Title III transportation services via state and local agencies [38, 95]. Although these agencies are required to plan for the transportation needs of older adults, they have great flexibility in doing so. Area agencies might meet transportation needs through voucher programs that provide transport at a reduced cost or by providing information on curb-to-curb, escort, volunteer, public transport and taxi services, for example. In fiscal year 2012, states spent $68.8 million on transportation services (e.g., public transport) and $3.3 million on assisted transportation (e.g., escorting to front door), money that was used to serve 31,950 older adults [40]. State and local agencies also are encouraged to advocate and work with communities to systemically address transportation systems to better fit the needs of older adults. Since 2006, Title IV of the Older Americans Act includes a section supporting the creation of more innovative and cost-effective transportation services.

Transportation services can be used to offset potential risk factors for elder abuse by connecting older people to services and supports outside the home and decreasing dependency on less trustworthy others as illustrated in Mr. B's case. Transportation services can enhance access to social activities, such as senior centers. Transportation to certain services may also result in opportunities to screen for abuse, as when older people receive transportation to attend doctors appoints where physical signs of abuse may become evident. Neglect, too, may be offset through the availability of transportation services. Older people who do not drive may need assistance to get to the grocery store or pharmacy, thereby allowing older adults to address nutrition and medication needs independently rather than rely upon less dependable and potentially neglectful caregivers.

It should be noted that transportation services will likely change over time. The advent of the shared economy, including ride-sharing options, will likely transform how transportation needs are met in later life. In addition, the increased availability of delivery options for certain goods, including groceries, will likely lessen some of the need for transportation services among some older people. Still, there is little information on what the future may hold. Continued concerns with rideshare programs is their ability to serve people with disabilities, access in rural communities, as well as their safety for more vulnerable older people—these and related issues will need to be addressed.

14.4.6 Legal Services

The Older Americans Act includes provisions to fund civil legal services for older adults through the Aging Network. Legal providers can offer a range of services, including education, outreach, advice, and support. While elder abuse is often addressed in a criminal context through the arrest and prosecution of the suspected abuser, there are also a number of different civil actions that can be undertaken to address the abuse, protect the victim, and prevent future mistreatment. Aging Network-funded legal services may be able to provide older adults with information about civil legal recourses and, in some cases, even practical legal counsel.

The specific legal services needed to assist victims of elder mistreatment or self-neglect or those at-risk for these conditions may vary by the type of abuse involved and the level of vulnerability of the victim. For example, protective orders, also known as restraining orders, can be instituted to prevent suspected abusers from interacting with the person they are suspected of abusing. Often thought of as an intervention to prevent future physical abuse and promote client safety, protective orders may also be beneficial in cases of undue influence, financial abuse, or emotional abuse as well. In such situations, legally removing the suspected abuser from accessing the older adult disrupts their ability to manipulate, coerce, or otherwise exert control over the client's decision-making and emotional well-being. Moreover, physically removing the suspected abuser from the client's immediate physical environment may restrict access to private financial information and banking documents, preventing future financial loss.

Advance Directives include several different kinds of documents that clients can complete. These can be used to designate a surrogate decision maker, also known as an agent, to make financial or medical decisions on the older adult's behalf if the individual lacks the capacity to make his or her own decisions. Adults with capacity can also designate a surrogate if they need assistance managing a specific issue such as selling property [103]. In situations where clients do not already have an Advance Directive, providers can assist them with information and resources to help them complete the necessary forms and establish a trustworthy agent who can make decisions or act on their behalf. In some

cases of financial exploitation, designated surrogates abuse their influence or Power of Attorney designation for personal gain at the expense of the client's well-being. In such situations, legal service providers may be able to provide information and assistance to modify existing Advance Directives and negate the authority of suspected abusers while helping to see that more trustworthy agents are legally appointed.

14.4.7 Disease Prevention and Health Promotion Services

Many older adults, including victims of abuse and neglect, experience negative health events or health decline over time. Poor health status and/or chronic conditions may not only result from abuse and neglect [3, 26, 29, 30, 53, 81] but also are risk factors that increase the likelihood of such events occurring [1, 48]. Through the Older Americans Act, the Administration on Aging provides funding for disease prevention and health promotion programs and activities (OAA Title IIID). Many such programs are offered through Senior Centers or congregate meal sites. By October 1, 2016, all programs offered through federal Older Americans Act funding will be required to be evidence-based, such they will have to demonstrate effectiveness through scientific, peer-reviewed evaluation and successfully translate this into a community site [96]. This mandate was designed to promote the dissemination and implementation of more effective programs.

As with the other Aging Network services, the availability of specific programs vary across the country. Nevertheless, there are several notable programs that may be useful to victims of abuse or neglect, their friends, family members, and caregivers. These programs are varied and address medication management, chronic disease self-management, fall risks, muscle strengthening, and depression [2, 4, 15, 46, 59, 85, 92]. By helping elderly victims of abuse or neglect and those at-risk better manage their health, elder abuse practitioners may reduce future abuse or neglect. Moreover, use of these strategies may be an effective intervention to help medically self-neglecting older adults better manage their health and care for themselves.

14.4.8 National Family Caregiver Support Program

Family caregivers play an integral role in providing support and services to family members who need care. Recognizing the immense contributions of these informal caregivers, the Administration on Aging provides the Aging Network with funding for programs to provide caregivers with information and assistance, counseling, training, respite, and other services (OAA Title IIIE). Supportive services such as those listed above may help to address caregiver burden and stress, factors that have been associated with abuse by some caregivers [54, 75]. However, the availability of programs and services and their local administration varies greatly between states [36]. Caregiver service providers may include adult day care providers, healthcare organizations, disease-specific service organizations, and general social services providers [101].

In addition to providing services for family members caring for older or developmentally disabled adults, the National Family Caregiver Support Program also strives to provide support for older adult caregivers providing care for minors (OAA Title IIIE). There is an increasing number of grandparents providing care for their grandchildren [45]. Unfortunately, research among grandparent caregivers notes greater stress and difficulty within the caregiving population [45]. Caregiver program services are intended to support such caregivers and provide training and resources to aid them in this role. Victims of abuse or exploitation who are in this role may benefit from services provided by programs supporting grandparent caregivers.

14.4.9 Tribal Organizations

Native populations face social and health-related challenges which stem from their displacement from their lands, ensuing discriminatory attitudes and practices, and exposure to lower socioeconomic conditions throughout their life course [11, 12, 51]. Additionally, studies have noted that some cultural values and approaches to care as well as service provision within indigenous cultures differ from mainstream Western cultures, resulting in the potential provision of services offered in culturally inappropriate or offensive ways [12].

In recognition of the autonomy of indigenous populations and the unique barriers these communities encounter, the Older Americans Act establishes special funding to support the provision of long-term services and supports to Native American, Alaskan Natives, and Native Hawaiians [87]. Funding is available to tribal governments and organizations serving native elders, enabling them to provide Aging Network long-term services and support programs within their communities. These Title VI services, referring to the section of the Act which governs these programs, vary by provider and area but may include information and referral assistance, congregate and home-delivered nutrition services, senior center programs and activities, telephone reassurance or

friendly visitors, health and wellness programs, nonmedical transportation, shopping or commodity distribution, and respite care services [14, 65].

Title VI programs serving indigenous populations have been successful in developing culturally appropriate interventions to support older adults within their communities. The Family Support Center of Jamestown S'klallam is one example of an elder justice program developed with funding from the Administration on Aging's Native American Caregiver Support Program [70]. This restorative justice intervention brings together "talking circles" of individuals supportive of the elder from the older adult's family, friends, and community to educate families about caregiving issues and develop care plans using the culturally significant "medicine wheel" approach to address the physical, emotional, spiritual, and social needs of the elder [70]. The development and implementation of such culturally appropriate interventions may help indigenous communities better identify and address abuse. There is a growing emphasis among indigenous Aging Network providers to prevent and address elder abuse within their communities. The National Indigenous Elder Justice Initiative (NIEJI; www.NIEJI.org) was formed in 2011 to focus on the development and dissemination information, tools, and resources to indigenous communities and their service providers [11, 65]. In addition to these resources, the initiative also provides a compilation of tribal codes regarding elder abuse and a listing of elder abuse reporting hotlines serving tribal populations. Since its establishment in 2011, many Title VI providers have sought to provide elders with elder abuse prevention and intervention services including abuse investigation services, case management for victims and those at-risk for experiencing abuse, neglect or self-neglect, adult guardianship services, community education and training, victim or witness services, and short-term emergency victim services [65]. Providers report partnering with law enforcement, APS, domestic violence advocates, and legal, medical, and social services professionals to identify and respond to abuse, and about 20 % participate in on an elder abuse Multidisciplinary Team (MDT) [65]. Elder abuse MDTs are discussed in greater detail in Dr. Georgia Anetzberger's chapter within this volume.

14.4.10 Cultural Considerations

Building and expanding work with tribal organization and indigenous peoples, it is important to recognize that a client's cultural identity and community may affect their help-seeking behavior and willingness to accept formal services and supports. Seeking to connect clients with service providers who have a specific mission, expertise, history or competency in working with individuals of that cultural group is often key. Such providers may be a part of the Aging Network in the client's local area and can be identified by contacting the local Area Agency on Aging (AAA) or Aging and Disability Resource Center (ADRC). Readers are encouraged to review the textbook chapters on culture in this volume.

14.5 Coordination Between the Aging Network and Service Providers

14.5.1 Collaboration with APS

The work of Title VI Aging Network providers to prevent, identify, and address abuse and neglect (discussed above) is exemplary and demonstrates multiple ways the Aging Network can seek to promote elder justice and safety independently, and in partnership with APS and other service providers. Despite their unique developmental histories, authorizations, and funding sources, the Aging Network and APS have a shared goal and responsibility to promote the physical, emotional, and social well-being and safety of America's older adults. While in the majority of cases, these programs operate in separate silos, interacting primarily when practitioners take the initiative to refer cases between agencies, in some areas, programs have sought ways to better collaborate and establish formal or informal partnerships.

The state of New Mexico has sought to better integrate aging service provision through its Aging and Disability Resource Center (ADRC). New Mexico's APS program is a member agency of the ADRC (a program described earlier in this chapter), and APS Intake staff are co-located in the ADRC facility [63]. ADRC staff is cross-trained in APS intake, enabling them to provide backup support for APS as needed. Once the report is received, it is transmitted to the APS field offices where field supervisors and staff evaluate, investigate, and intervene in cases of abuse according to established program protocols. In cases where the referred individual is deemed ineligible for services or APS is unable to definitively confirm the abuse, APS clients are referred back to the ADRC where a Resource Options Coordinator works with the consumer to provide information, referrals, and resources that may provide some support [63]. In this promising practice, efforts to streamline client intake and establish clear referral protocols help consumers better access APS services and ensure that vulnerable elders continue to receive supportive services after their APS case is closed.

In another promising practice, the Region One Area Agency on Aging and local APS in Maricopa, Arizona have established the Service Coordination Program (SCP) to actively collaborate on serious cases of abuse and

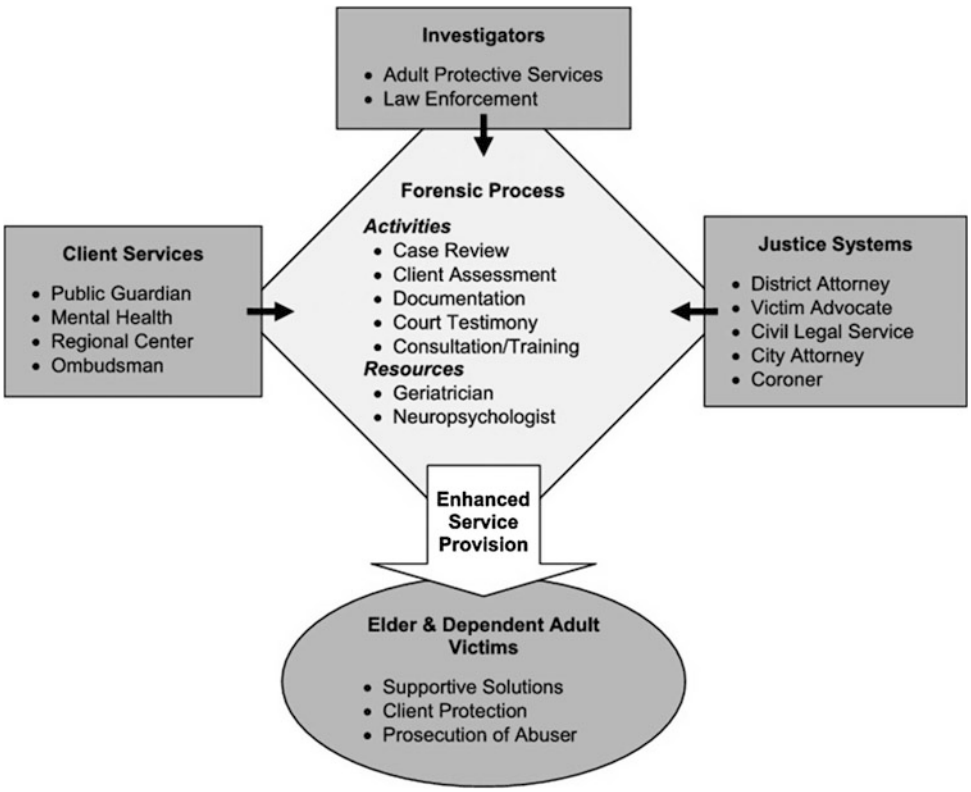

Fig. 14.2 Elder Abuse Forensic Center Conceptual model. *Note* This model builds on an initial model laid out in Navarro et al. [68]. *Source*: Gassoumis et al. [37] Aging and Mental Health, 19, 790–798. doi:10.1080/13607863.2014.962011. Copyright © 2014 Taylor & Francis

neglect [64]. Specifically, community-dwelling APS clients in need of immediate services are enrolled in the 90-day program and are eligible for immediate home- and community-based services through the Area Agency on Aging (AAA). Within 48 hours of a client's referral to the SCP, an AAA case manager visits with the client to assess their needs and develop a service plan. The benefit of this approach is that highly vulnerable older adults are able to meet with program staff who is knowledgeable about the range of services available and access services quickly rather than being placed on waiting lists, resulting in improved service coordination, faster APS investigation, and a lower rate of APS case recurrence [50, 64].

14.5.2 Collaboration with Other Elder Abuse Professionals

Collaboration through elder abuse Multidisciplinary Teams (MDTs) is one way that Aging Network providers work with elder abuse professionals to improve communication and service delivery to victims of abuse and neglect. MDTs are dedicated to preventing, investigating, and addressing cases of abuse and neglect within the community [70, 88]. Teams are comprised of interested professionals who gather together to perform specific tasks related to elder abuse, such as providing consultation to professionals providing direct services to abuse victims, identifying structural or systemic barriers to service delivery, advocacy, member training, or sponsoring educational forums and events [88]. A nationwide survey of AAAs found that in communities with an elder abuse MDT present, 79.3 % of local AAAs participated on the team [86]. And Teaster et al. [88] found that Aging Network providers participate on more than half of MDTs surveyed as part of a nationwide survey. In addition, State Units on Aging and Area Agencies on Aging played key roles in convening and coordinating MDTs, provided key leadership and support through direct funding, in-kind support, technical assistance, and meeting coordination [88]. However, it is important to note that as with Aging Network services, there is no singular MDT model and the availability and functions of local MDTs vary significantly.

While there has not been much standardization of the MDT approach, Congress has sought to support the nationwide development of the Elder Abuse Forensic Center model, a type of MDT, by authorizing their replication under the Elder Justice Act [33]. First developed and introduced at University of California, Irvine [106], the Forensic Center brings together legal (e.g., prosecutors, law enforcement, civil attorneys), medical (e.g., geriatricians, registered nurses, psychologists, mental health professionals), and social services (e.g., APS, Long-Term Care Ombudsman, public guardian) professionals to review complex cases of abuse or neglect and provide services and supports to investigators

and direct service providers already involved in abuse investigation and intervention [37, 68, 80, 106]. The accompanying figures present a conceptual model of the intervention (Fig. 14.2) and a case processing map (Fig. 14.3) outlining the process used by the MDT to assess, investigate, and intervene in cases of suspected financial abuse. The model has demonstrated effectiveness in increasing safety through expanding the use of appropriate conservatorships for vulnerable older adults [37] and decreasing rates of APS case recurrence [104]. Use of the Forensic Center increases abuser prosecution rates [67], which prosecutors attributed to the immediate availability of key decision-makers, provision of forensic medical and psychological assessment and case review, and cross-discipline learning [24]. As with other MDTs, Forensic Centers may integrate Aging Network providers into their multidisciplinary team or may rely on them for coordination and support [80].

14.6 Future Directions

Future directions in applied research may help the Aging Network strengthen their service delivery approach and identify community-based interventions to effectively support efforts to prevent, identify, investigate, and intervene in cases of abuse and neglect.

14.6.1 Research and Practice

As communities seek ways to effectively resolve abuse, scientific evidence evaluating intervention approaches is largely lacking [77, 78].

As previously discussed, the use of the Elder Abuse Forensic Center multidisciplinary team intervention has demonstrated effectiveness in promoting client safety, reducing short-term recurrence, and achieving criminal justice [37, 67, 104]. In addition, in their systematic review of the literature for elder abuse interventions, Ploeg and colleagues [78] identified eight abuse interventions which demonstrated effectiveness in improving victim outcomes. These include providing abuse victims with discussion and support groups, enhanced provision of social or legal services and supports, community education in public housing developments, enhanced police and social services home response following abuse report, caregiver interventions, and provider training and education, many of which can be or are already provided by the Aging Network [78].

In 2013, the Administration on Aging instituted the Elder Abuse Prevention Interventions Program, a three-year demonstration project providing five states with funding to enact and evaluate elder abuse prevention interventions [99]. Although the demonstration has not concluded, the Administration's investment in the establishment and research of these pilot interventions provide an important starting point to inform future abuse prevention research and service provision. Similar investments in translational and evaluation research are needed in order to continue moving the field forward.

Future work may also seek to implement successful interventions with diverse ethnic, religious, or social minority groups. The translation of promising practices into different cultures, countries, and communities may help to address abuse round the world. The creation of novel, culturally tailored, interventions can draw on the unique perspectives, preferences, and practices of these groups. Alternatively, the existing evidence-based interventions can be adapted to be culturally relevant and appropriate for use with diverse populations. Replicating evidence-based programs with fidelity to the evaluated program model has been used within the Aging Network in areas such as health promotion and disease prevention programs with minority populations [90, 91]. This approach may be most efficient and cost-effective for smaller organizations as they have already been rigorously evaluated and demonstrated successful among the general population. Adoption of adapted interventions may be strengthened and encouraged if program planners partner with existing community leaders. We encourage interested parties to consider using Community-Based Participatory Research methods to facilitate this process [6, 10].

14.6.2 Technological Interventions

Technological interventions may also play a role in bridging relationships between Aging Network service providers and elder abuse professionals. The development of mobile phone applications can assist providers in determining whether abuse may have occurred and knowing what to do after these suspicions arise. The Guide for Elder Abuse Response (GEAR) mobile application and website (http://guideforelderabuse.org) equips direct service providers and law enforcement personnel with information on the signs and symptoms of abuse and links them to APS' online abuse reporting system. The app also includes a searchable map with local resources for victims of abuse, including senior centers and other Aging Network resources. Developed through a collaboration between the University of Southern California, Davis School of Gerontology and the Los Angeles County Elder Abuse Forensic Center, the app is designed with providers in mind and even includes an age calculator to quickly determine whether a particular individual meets reporting or program age requirements. Although the app is specifically designed for use in Los

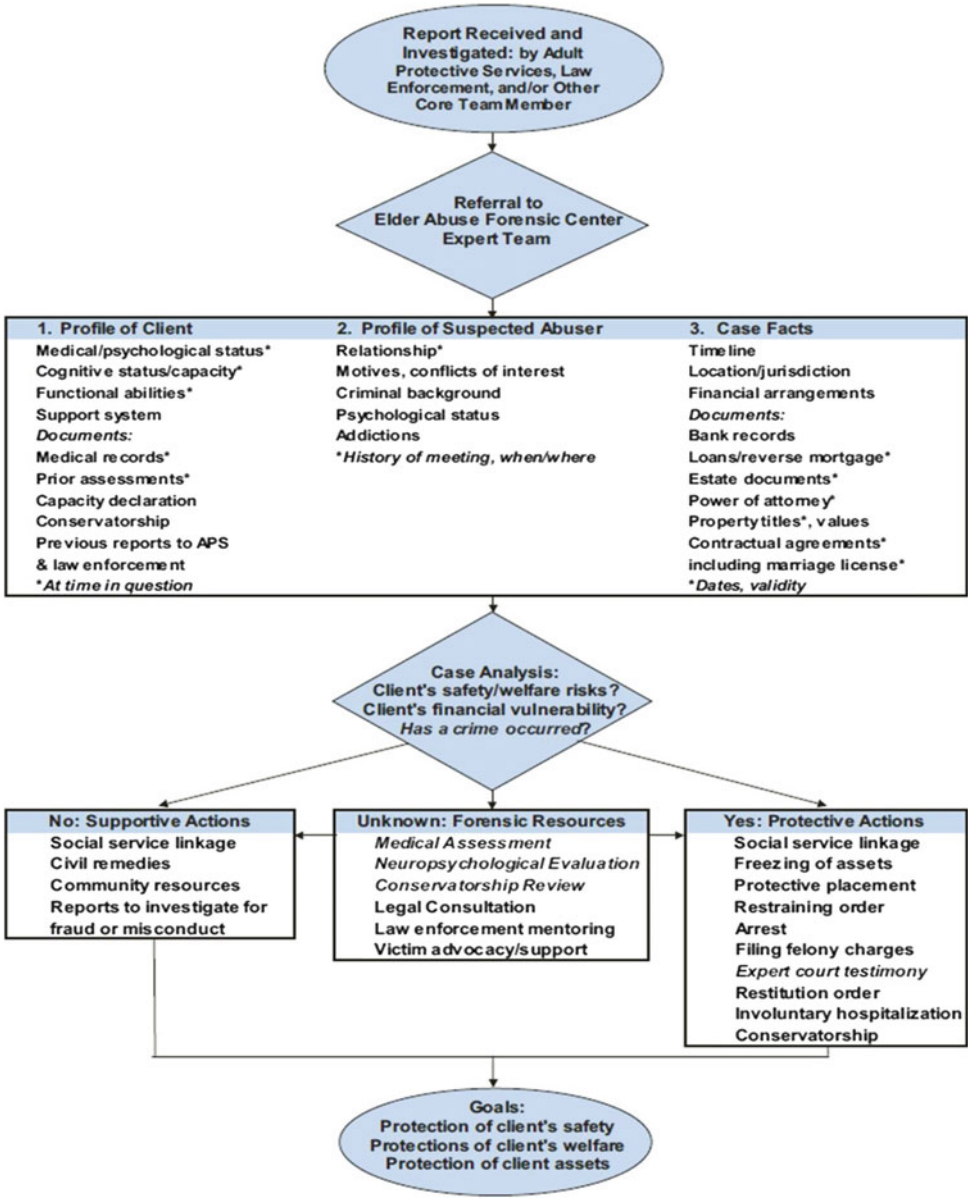

Fig. 14.3 Elder Abuse Forensic Center Case Processing Map. *Source*: Navarro et al. [69], The Gerontologist

Angeles, it is a model intervention that can be replicated in other geographic areas.

The use of telecommunication technologies may also seek to improve interagency collaboration and resource-sharing. In a study of Elder Abuse Forensic Centers in California, Centers reported using teleconferencing technologies to enable practitioners who would otherwise be unable to participate in the multidisciplinary team's meetings [105]. This has been especially important in Los Angeles which serves a large geographic area larger than some states and houses rural providers who need to drive over an hour to reach resources located in the City of Los Angeles.

14.6.3 Data Collection and Analysis

The lack of available data on elder abuse has been cited as a major impediment to work in the field [8]. To date, much of the research on abuse and abuse interventions have been cross-sectional, and the development and use of longitudinal datasets is important to inform the field and evaluate interventions [8].

On the federal level, the Aging Network has taken significant steps to move the field forward in data collection. The U.S. Department of Health and Human Services is in the process of developing a national APS reporting system with

standardized data definitions and services [109]. The National Adult Maltreatment Reporting System (NAMRs) collects data on (1) reporting agency policies and practices and (2) report-level case data on nonidentifiable client and perpetrator characteristics and services or, if report-level data are unavailable, key indicator data on aggregate investigation and victim statistics.

Although participation in the NAMRS will be voluntary, the information collected will provide researchers and policy makers with critical data to inform policies and practices regarding elder abuse. Researchers will be able to identify abuse across states and geographic locations over time. Moreover, data collected through the database may also help practitioners identify promising practices across geographic regions.

14.6.4 Strengthening Systems

Despite efforts by Aging Network agencies and providers, a recent Government Accountability Office [41] report cites a substantial unmet need for services among older Americans. The Aging Network requires sustained funding to support the infrastructure required to serve and support community-dwelling older adults and work with elder abuse professionals to prevent and address abuse. Aging Network funding flows through appropriations made to the Administration on Aging as authorized by the Older Americans Act. Given that the most recent authorization of the Older Americans Act was five years overdue at the time of its passage, it is unsurprising that funding for Aging Network programs has been relatively stagnant during this time despite the increasing size of the older adult population [41, 61]. To support the essential work of these federal, state, and local agencies and their innumerable and integral local service providers, efforts must be made to increase federal Aging Network funding.

In addition to these efforts, the Aging Network may need to identify ways to align with other potential funding streams. The former Assistant Secretary for Aging Kathy Greenlee, once head of the U.S. Administration on Aging, has suggested that the Aging Network should adapt to better collaborate and align with health care, including Medicaid, Medicare, Accountable Care organizations, the Veterans Administration and private insurers [42]. Under the Affordable Care Act of 2010, healthcare providers are required to meet quality standards in order to maintain their current funding levels [7]. Strategic planning, self-assessment, and creativity can enable Aging Network programs and providers to identify means for partnering with healthcare providers to enable them to better serve their patients and provide them with quality health and social service supports and interventions [42].

The Aging Network should also continue to expand its efforts to integrate supports and services across sectors. With the aging of the Baby Boomer population, the Aging Network is more important than ever in its efforts to support older adults and share their lessons learned over decades of service to this population. Through partnerships with legal services providers, housing programs, transportation, mental health services, and elder abuse professionals, the Aging Network can seek to find more efficient and effective ways of serving our nation's older adults. Moreover, through partnership with these groups, providers can gain knowledge and experience to better inform their support and service delivery systems.

14.6.5 Moving Forward

In 2014, the U.S. Department of Justice and U.S. Department of Health and Human Services sponsored an initiative to identify the resources, knowledge, and skills needed to understand, prevent, identify, and respond to elder abuse [21]. The massive, national initiative sought input from over 750 public and private stakeholders representing direct service providers, educators, policy makers, and researchers [21]. The resulting Elder Justice Road map is a strategic plan outlining key priorities needed to move the field forward in the future. These include:

(1) increased public awareness of abuse
(2) research to better understand and assess capacity and mental health issues among victims and perpetrators
(3) caregiving support and training
(4) quantification of elder abuse costs to victims, families and society; and
(5) investment in resources for services, education, and research.

Readers are encouraged to consult the Elder Justice Roadmap for greater insight into the future directions needed to strengthen and expand efforts to prevent, identify, investigate, intervene, and resolve cases of elder abuse and neglect. The Elder Justice Roadmap is available online at: https://www.justice.gov/elderjustice/research/roadmap.html.

14.7 Conclusion

First implemented to deliver in-home supports and services to community-dwelling older American across the country, the Aging Network was not specifically designed to prevent, identify, investigate, or address cases of elder abuse or neglect. Nevertheless, this nationwide system spanning all levels of government and thousands of service providers is

well positioned to support those at-risk for maltreatment and victims of abuse—both while the abuse is occurring and after its cessation. The provision of timely and appropriate resources and services can reduce the risk of abuse by addressing client vulnerabilities (e.g., social isolation, functional limitations, poor physical, or mental health), lowering abuser opportunity (e.g., fostering client dependency and isolation), and instilling protective contextual factors, such as vigilant providers and social support. In situations where abuse or neglect has already occurred, engagement in Aging Network programs and services may provide victims with the support and encouragement needed to report the abuse or seek assistance from those outside the situation. Moreover, the social, emotional, and instrumental support available through the Aging Network may help victims as they recover from the incident and seek to establish a new "normal."

In Mr. B's case, relief came when his doctor contracted with an agency to provide a part-time case manager. The case manager listened to Mr. B's concerns about his inability to drive and difficulty with household tasks. She was able to enroll him in a transportation program that would send a shared-bus driver to his home to transport him to his appointments or social gatherings. The case manager also got him in touch with an Aging Network agency, which agreed to pay for a home attendant to visit his home and help him with household tasks for two hours, twice a week. Mr. B was relieved that he would no longer need to ask his son for help with these tasks. A few months later, during one of his son's drunken outbursts, Mr. B realized that he was no longer dependent on his son for care and called the police for help. When the police arrived, he reported the abuse and agreed to press charges against his son. With his son in jail, Mr. B went down to the courthouse to file for a protective order against his son and begin eviction proceedings. Although he was troubled by this outcome, he believed that he had done the right thing in taking these steps to regain his independence.

For Mrs. D, this adjustment came after receiving supportive services from a host of Aging Network providers after her building manager called Adult Protective Services for help. The APS worker connected Mrs. D with the area's Aging and Disability Resource Center (ADRC). The ADRC was able to enroll Mrs. D in a personal care program, which assessed her needs and sent a personal care assistant to her home three times a week to help her with bathing and personal hygiene. She also received support through a housekeeping program that provided a few hours a week of light housekeeping. In order to determine what other services Mrs. D might need, ADRC staff interviewed Mrs. D and conducted brief cognitive, social, and emotional assessments. The assessments indicated that Mrs. D did not appear to be cognitively impaired but was experiencing severe depression and anxiety. Staff at the ADRC referred Mrs. D to a senior center near her home which offered case management services coupled with an Aging Network-funded evidence-based health promotion and disease prevention program to provide counseling and support for older adults with depression and anxiety. The case manager helped Mrs. D sign up for a Life Alert program and provided her with information about equipment that might help reduce risk of falls in the bathroom. The case manager was also able to refer Mrs. D to a money management program to help her pay her back rent, establish a reasonable budget, and pay her future bills on time. After a several sessions with the case manager, Mrs. D began to feel less depressed and anxious. She began to attend the senior center's congregate meal program and made friends with two other widows in her neighborhood. As she became more social, she also began to pay more attention to her appearance, once again taking the time to style her hair and put on makeup—things she had not done since her husband died. With social support from new friends and formal service providers, Mrs. D no longer felt it necessary to have anyone live with her. The money management company found that the boarder living with Mrs. D had given her less than half of what was actually owed her and she no longer wanted the renter in her home. Mrs. D contacted an Aging Network legal provider to assist with evicting her unwanted tenant. A year after the original APS report was made and she became connected to the Aging Network, Mrs. D is happier and more socially engaged.

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