

# Multidisciplinary



## **Elder Abuse Prevention Teams A New Generation**

***National Committee for the Prevention of Elder Abuse***

**ncea**

*National Center on Elder Abuse  
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# Multidisciplinary Elder Abuse Prevention Teams

## A New Generation

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### **National Committee for the Prevention of Elder Abuse**

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NCEA exists to provide elder abuse information to professionals and the public; offer technical assistance and training to elder abuse agencies and related professionals; conduct short-term elder abuse research; and assist with elder abuse program and policy development. NCEA's website contains many resources and publications to help achieve these goals. You can find the website at [www.elderabusecenter.org](http://www.elderabusecenter.org). NCEA may also be reached by phone (202.898.2586); fax (202.898.2583); mail (1201 15<sup>th</sup> Street, N.W. Suite 350; Washington, D.C. 20005); and email ([NCEA@nasua.org](mailto:NCEA@nasua.org)).

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## Introduction

**M**ultidisciplinary teams have become a hallmark of elder abuse prevention programs, reflecting growing consensus that no single agency or discipline has all the resources or expertise needed to effectively resolve all forms of abuse and neglect. The term “multidisciplinary team” can refer to a variety of collaborative activities. An Adult Protective Service (APS) unit may negotiate an agreement with a mental health program to have its workers conduct joint investigations and refer to these pairs of workers as multidisciplinary teams. Hospitals and medical centers that bring together personnel from different departments to consult on abuse cases may also be called multidisciplinary teams. For the purposes of this publication, the term is used to describe groups that include representatives from multiple agencies that meet routinely to review cases. Teams may be involved in a variety of additional activities, including advocacy, service coordination, professional training, resource development and outreach.

This manual provides a basic orientation to teams, describing key features and trends. It further highlights specialized teams that have been created to focus on financial abuse, expedite investigations, review deaths and address medical concerns, explaining the rationale, benefits and potential drawbacks of these new models. It is intended to help service providers, policymakers and program planners assess the value of teams for their communities and guide decision making by providing information about teams’ benefits and costs, promising practices, challenges that teams are likely to encounter, and how these challenges are being responded to. It further provides information on useful resources.



# Objectives and Benefits of Multidisciplinary Teams

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**M**ultidisciplinary teams are formed for different reasons. Some are mandated by statute or initiated by local or state policymakers. Others are organized by individuals or groups that have recognized a need for multidisciplinary exchange.

Teams' objectives also vary widely and may include resolving complex cases, identifying systemic problems, expediting cases, aiding in the development of prosecutions, advocating for improved services or public policy, and enhancing members' skills and knowledge. Other common objectives are raising awareness about the problem among professionals and the community, providing support to workers, and contributing to the collected knowledge about abuse. Some of the benefits teams offer clients, members, communities and the field of elder abuse prevention are described below:

## *Benefits to Clients*

- Enhanced autonomy and choice. Teams develop service plans that are tailored to clients' individual needs and preferences and that offer the broadest range of alternative options available.
- Improved access to services and equity of care. Teams provide an opportunity for vulnerable

seniors throughout the community, including members of underserved groups, to benefit from the expertise of the communities' most highly skilled and experienced practitioners.

- Reduced injury or loss. By drawing from the resources and expertise of experts from multiple disciplines and agencies, the review process increases the likelihood that victims will receive needed help.

## *Benefits to Members*

- Enhanced skills and expertise. Teams provide a dynamic, reality-based learning experience that can be professionally and personally enriching.
- Familiarity with the resources, approaches and perspectives of multiple disciplines and service networks. Members learn about adult protective services, the criminal justice system, aging services, victim witness assistance programs, services for younger people with disabilities, domestic violence programs, the mental health system and many more.
- Up-to-date information on community services, resources and developments.

- Community standards of care. Owing to the complexity and sometimes controversial nature of elder abuse casework, workers may fear that their actions will be questioned or challenged by clients' families, other professionals, well-meaning observers or self-interested parties. When workers' conduct is questioned, the standard typically applied by licensing organizations or courts is whether workers acted as "like" professionals would have acted under similar circumstances. Although multidisciplinary teams have no formal standing with courts or licensing bodies, the team review process keeps members informed of how other "like" professionals in their communities handle similar situations, which can instill confidence that their actions conform to accepted standards.
- Support to members. Workers routinely make difficult decisions that have a critical impact on the lives of clients, their families and abusers. Teams can provide a supportive environment in which to voice concerns, frustrations and uncertainty.

### *Benefits to Communities*

- Improved service response. Identifying system gaps or problems is an objective of some teams and an unanticipated outcome for others. Systemic problems include service gaps, breakdowns in communication or coordination between agencies, and the need for education, training and public policy. Teams provide a forum for evaluating, on an on-going basis, how well a community is serving its vulnerable, elderly members and for crafting systems change. Ordinarily, workers are likely to confront systemic problems during crises when it is not possible to explore causes or solutions. Teams provide the continuity and sustained contact that is often needed to do so. In addition, solving problems often requires a "big picture" perspective, which includes an understanding of the limitations and capabilities of multiple agencies and disciplines.

- A "checks and balance" system. There is no single way to handle abuse cases. Because professionals from diverse disciplines have divergent and, in some cases, conflicting goals and perspectives, members may disagree about how cases should be handled. The team provides a forum for balancing the interests and perspectives of professionals from diverse disciplines, clients and society.

### *Benefits to the Field of Elder Abuse Prevention*

- Enhanced understanding of services, interventions and approaches to service delivery. Teams provide a "laboratory" for devising and testing intervention strategies. The volume and range of cases reviewed enable members to observe patterns and outcomes that may not be obvious to single agencies or individuals.
- Increased understanding about elder abuse and its associated risk factors. By providing opportunities for members to share their experiences, insight and perspectives, teams have enriched understanding about a variety of topics including cognitive impairment as it relates to legal decision making, hoarding behavior, self-neglect and undue influence.

# Membership

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Teams' effectiveness depends on their members' expertise, their willingness to contribute time and resources, and their commitment to interdisciplinary exchange and collaboration. Recruiting the right members and clearly defining their roles and responsibilities are critical.

## *Deciding Whom to Include*

The functions teams perform dictate their membership needs. For example, teams that plan collaborative interventions need to include members who have access to information about the clients whose cases are discussed. This requires personnel from all key agencies that are involved. Other teams do not require all professionals involved in a case to be present; the person presenting the case may be the only person with actual knowledge about, or contact with, the client. For these teams, a single representative from each relevant discipline is sufficient to explain that discipline's perspectives, approaches and resources.

A common criterion teams use in selecting members is expertise in various aspects of abuse prevention. However, persons with little or no direct experience may also be included. For example, teams may recruit members who can help forge alliances with underrepresented professional groups (e.g. physicians, domestic violence advocates, etc.). Teams that advocate for policy reform, systemic changes or improved coordination can benefit from having agency executive directors or board members, public policymakers and others who wield influence as members. Teams may further benefit from members who have technical skills in such areas as professional education, advocacy or outreach. Teams may also look for personal qualities in prospective members (e.g. "team players"). Some teams include a mix of experienced workers and less experienced ones who stand to benefit from the educational opportunities, exposure and contacts that the team provides.

Some teams have different categories of membership, each with their own responsibilities and privileges. They may extend certain benefits to some members and not others, including the right to present cases. Some include members who do not routinely attend meetings but who can be called upon for help as needed. Some have "core" membership categories that must be filled at all times, and other categories that are desirable but not required.

Membership on teams may be individual or by agency. Individual members participate for their own benefit and contribute their own knowledge and expertise. When agencies are asked to join, they are typically asked to designate representatives and ensure continuity by replacing representatives whose terms are up or who cannot meet their commitments. They may also be asked to commit agency resources or support.

Some teams deny membership to certain groups. To avoid potential conflicts of interest, for example, some do not permit professionals in private practice or proprietary organizations to join. Others require these entities to sign statements promising that they will not solicit for paid services clients whose cases are discussed, or, in any way, use their participation on the team for financial gain. A few teams only allow public agencies to join.

In addition to participating in meetings, members may be asked to contribute additional time to the team. The Los Angeles Financial Abuse Specialist Team (FAST), for example, requires certain members to provide up to two hours a month of telephone consultation in emergencies and/or to assist with community trainings.

## *Disciplines Represented on Teams*

The range of disciplines represented on teams varies widely, reflecting teams' goals, foci, mandates, resources, setting and other factors. The following disciplines are commonly included (specialized teams,

which are likely to include additional or different disciplines, are discussed in a separate section):

**Adult protective service (APS) workers.** As the agency authorized to accept abuse reports and referrals in most communities, APS workers play a pivotal role on multidisciplinary teams. Many teams are sponsored, supported, administered or coordinated by APS programs (Teaster & Nerenberg, 2003), and APS workers are frequent presenters. On some teams, APS workers are the only members who present cases. APS representatives may include supervisors, administrators or caseworkers. In addition to presenting cases, these members provide expertise in the following areas:

- Statutory requirements for reporting and responding to elder abuse and neglect
- Information about community resources
- Risk factors, profiles of victims and abusers, statistics and other pertinent information about abuse
- Services and resources for the non-elderly, disabled population
- Information about protective service interventions such as protective placements
- Principles of protective service practice

**Aging service providers,** including representatives from public, private, non-profit and for-profit agencies that provide information and referral, day programs, meals, case management and other services to elders. These members can provide information and expertise about:

- Services that can reduce dependency, isolation and vulnerability
- Methods for assessing elders' service needs
- Strategies for enhancing communication with persons who have disabilities

**Mental health professionals** including psychologists, psychiatrists, therapists, counselors, psychiatric social workers and others who work in public or private mental health clinics and hospitals, mental health

centers or day treatment programs. Some teams include mental health professionals in private practice. These professionals provide guidance in the following areas:

- Mental health conditions or illnesses associated with abuse, neglect or self-neglect, including dementias, depression, substance abuse, personality disorders, psychiatric illnesses, stress and post-traumatic stress
- Mental health services or treatment that can reduce the risk of abuse or treat its effects
- Mental or cognitive impairment and its measurement. Cognitive impairment may be a symptom of abuse (e.g. when the victim is deprived of nourishment) or a determining factor in whether or not abuse actually occurred (a transfer of property may constitute abuse because the victim lacked sufficient mental capacity to make legal decisions). Mental capacity assessments may also be needed to assess clients' service needs or their credibility as witnesses.
- Insight into the dynamics between family members that lead to, exacerbate or mitigate abuse
- Undue influence and other psychological dynamics that may contribute to or explain conduct

**Law enforcement,** including local, state and federal law enforcement officials. This category includes police, sheriffs, state attorneys general, U.S. attorneys, Federal Bureau of Investigation agents, and many others. Law enforcement personnel who participate on teams include detectives, first responders, chiefs, and others who work in fraud, domestic violence, senior service or other units that are likely to handle abuse cases. These individuals can provide guidance in the following:

- Federal and state laws pertaining to abuse
- Identifying criminal conduct
- Actions law enforcement personnel can take, which include making arrests, conducting "well-being checks," initiating or enforcing orders of protection, providing standby assistance to other professionals, etc.
- How to make police reports and bring criminal charges

- Investigative techniques
- The role of law enforcement in involuntary mental health interventions

**Prosecutors.** This category may include local, state or federal prosecutors, who provide information and guidance in the following areas:

- How the criminal justice systems works
- The benefits and risks of prosecution
- Theories used to prove elder abuse crimes, what evidence is needed, penalties and how service providers can help build cases
- Guidance in criminal justice remedies including restitution, diversion programs, etc.
- Instruction in providing evidence and testimony in criminal proceedings

**Medical professionals,** including doctors, nurses, paramedics and others who work in public or private hospitals, clinics, home health agencies, skilled nursing facilities, health maintenance organizations and others. Areas of specialization that teams commonly look for include geriatrics, family practice, psychiatry, internal medicine, emergency medicine and pathology. Medical professionals can provide guidance in the following areas:

- Identification and interpretation of fractures, bruises, wounds, medical conditions and health/medical risk factors associated with abuse (e.g. dehydration, electrolyte abnormalities, decubitus ulcers, and improper medication administration)
- Instruction in how to conduct investigations in medical facilities, including what to look for on medical charts, chains of command and staffing patterns

**Civil attorneys** may work for legal aid programs or private law firms. Relevant expertise includes probate, family or elder law. Lawyers and paralegals can provide guidance about the following:

- How the civil justice system works
- Legal remedies and protections, including powers

of attorney, trusts, orders of protection, guardianships and law suits, and the benefits and risks of each

- Eligibility for public benefits, how to apply, appeals processes, etc.
- Sources of legal assistance

**Daily money managers** may work for public, private, non-profit or for-profit agencies. These individuals can explain:

- Informal and formal interventions used to manage money and reduce the risk of abuse, including automatic payments, direct deposits of income, pre-authorizing routine expenses to accounts, trusts, powers of attorney, joint checking accounts and guardianships
- How the devices described above can be used to both reduce vulnerability and to commit abuse
- Indicators of financial abuse

**Guardians (called conservators or other terms in some states)** include public guardians (available in some communities) and private professional guardians. Some private, non-profit and for-profit agencies also provide the service. Guardians can provide expertise in the following areas:

- When guardianship is an appropriate remedy or protection against abuse
- Processes for filing for guardianship and for investigating and remedying abuses by guardians
- What criteria courts use in appointing guardians
- Criteria public guardians and other guardians use in determining eligibility

**Victim advocates.** “System-based” victim advocates are typically located in prosecutors’ offices (some are in law enforcement agencies). Some federal law enforcement agencies, including the U.S. Attorney’s Office and the Federal Bureau of Investigation, have victim advocates or coordinators who assist victims of federal crimes. “Community-based” victim advocates work outside of the criminal justice system providing infor-

mation, assistance and representation to victims. Victim advocates can provide information and guidance to teams in the following areas:

- How the criminal justice systems works, with an emphasis on victims' needs and rights. For example, they can advise the team about what victims can expect when they come to court and what to do if they are threatened by perpetrators.
- Eligibility for victims' compensation and how to apply
- Victims' rights and how to exercise them through impact statements, by enforcing restitution orders, etc.
- Services such as court accompaniment and transportation
- Notification of hearings, trial dates and other important events

### **Domestic violence advocates and professionals**

who work in shelters, public and private, non-profit agencies, educational institutions and for-profit organizations can provide information and guidance in the following areas:

- Domestic violence services, including shelters, support groups, legal services and treatment programs for batterers
- Interventions such as safety planning and options counseling
- The dynamics of domestic violence and patterns of help-seeking

### **Long-Term Care Ombudsman Programs**

**(LTCOP)** Staff and volunteers make routine visits to nursing homes, residential care homes and other facilities to accept and respond to residents' complaints and advocate on their behalf. A few states also designate the LTCOP as the entity responsible for investigating and responding to reports of abuse and neglect under their mandatory reporting laws. Ombudsmen provide expertise and guidance to teams in the following:

- The role of LTCOP volunteers and staff in abuse investigations and how they interact with APS, state

licensing and regulatory agencies, and attorneys general

- The risk factors and indicators of abuse and neglect in long-term care facilities
- Standards of care in facilities
- How to investigate abuse and neglect in facilities

### **Other**

A survey of 31 multidisciplinary teams, conducted by the National Committee for the Prevention of Elder Abuse (Teaster & Nerenberg, 2003), identified the following additional disciplines or service categories represented on teams: ethicists, animal care and control officers, clergy, public administrators, probation and parole personnel, code enforcement personnel, resource specialists, fire fighters, housing managers, housing advocates, personnel from assisted living facilities, members of public utility boards, in-home service providers, realtors, representatives from state long-term care licensing and regulatory agencies, hospital social workers, emergency medical personnel, providers of services for persons with developmental disabilities, media representatives, homeless shelter staff, health department personnel, health advocates, certified public accountants, members of county councils on aging, nursing home employees, city and county attorneys, and representatives from caregiver support programs. One team includes a retired judge and another includes a health statistics specialist. Organizations represented on teams include the Social Security Administration, the Alzheimer's Association, the Veterans Administration, the Humane Society, the National Multiple Sclerosis Society, the American Red Cross, and a state department of insurance.

# The Case Review Process

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## *Case Selection*

The criteria used in accepting cases for review are extremely important as they affect referral rates and influence how challenging, useful and productive meetings are for both presenters and other members. One agency or individual is usually responsible for accepting and evaluating requests for team reviews, using criteria that include the following:

- Types of abuse. Teams may review cases involving all type of abuse and neglect, or they may specialize in certain types. Increasingly, teams are being formed to address financial abuse and fatalities (see Specialized Teams). Cases involving consumer fraud, self-neglect and abuse in institutional settings are reviewed by some teams and not others.
  - Status of cases. Teams may choose to only review “open” (in progress) cases, or they may allow members to present “success stories” or closed cases that were not successfully resolved when doing so is instructive. Some teams require presenters to conduct initial investigations prior to the review so that the team has as much information as possible, while others are willing to assist workers plan or prepare for investigations.
  - Age of victim. Some teams only review cases involving elders, while others also review cases involving dependent adults. Definitions of “elder” vary and may include persons over the age of 60, 62 or 65.
  - Benefits to team. In selecting cases, coordinators must balance the needs of presenters with those of other team members. If the team repeatedly reviews similar cases, members may not find the process challenging or feel that their time is well spent. Cases may be selected for their instructional value or because they promote discussion about ethical, clinical or practical concerns.
- Presenters’ expectations. Consideration should also be given to whether presenters’ expectations are realistic and appropriate. Workers may, for example, want to use the review session to air grievances about other professionals or agencies. In general, disputes between agencies are best addressed in private settings; however, when disputes arise out of misunderstandings about agencies’ mandates or resources, or as a result of service gaps or other systemic problems, the team may provide a useful forum for clarifying expectations and addressing problems.

## *Case Reviews*

Although teams’ processes and procedures vary, reviews generally involve the following steps:

- A worker describes the abusive situation, providing information that will help team members understand what has happened and clients’ needs. Teams typically request information about the following:
  - The abuse incident(s) including the type of abuse, whether it has been substantiated, its impact on the victim and others, history of earlier incidents, and ongoing risk to the victim or others.
  - Victims, including their health, mental health and functional status; formal and informal support systems; resources; and relationships with, and attitudes toward, abusers
  - Victims’ wishes with respect to stopping the abuse
  - Abusers, including their histories of committing abuse; relationships with, and attitudes toward, victims; motives; personal problems such as substance abuse, psychiatric problems or financial problems; on-going access to the victim or other vulnerable persons; and willingness to cooperate in correcting the situation

- Interventions or services that have been used in the past
- Specific questions or issues the presenter wants to raise to the team or individual members
- Members discuss intervention or service options in light of the factors listed above.
- Members make recommendations for any or all of the following:
  - Assessment and investigation. Teams may provide guidance in how to interview victims, abusers and witnesses; collect and interpret evidence; and report abuse to the appropriate law enforcement or investigative agencies.
  - Available services or interventions to stop abuse, prevent its recurrence and reduce vulnerability. Options range from arresting abusers to providing support services that enhance clients' independence. Teams discuss the benefits and limitations of available services, how to access them, eligibility criteria, costs, etc.
  - Systems issues. If the presenter or others have had problems accessing services or systems that are discussed, the group may explore them. Problems may include misconceptions about agencies' policies, procedures or eligibility criteria or reflect breakdowns in coordination or communication.
- Summary and recommendations. The team facilitator (or someone else) may summarize what has been discussed and the team's recommendations. Since it is not always possible or advisable to reach consensus, teams may not recommend a strategy, but rather, summarize options that have been suggested. Teams may also make recommendations for actions to address systemic problems through training, advocacy or meetings.
- Follow-up. It is typically up to the person who presents a case to follow up on the team's recommendations that pertain to clients' needs (presenters may need to discuss the recommendations with their supervisors before presenting options to clients). The responsibility for following up on other recommendations may rest with the team's facilitator or chairperson(s), be assigned to team members, or be referred to another entity (e.g. some teams have special subcommittees, or operate as part of larger groups that focus on advocacy, outreach or training).
- Reporting back to teams. Because team members want to know whether their insights or recommendations were helpful, many teams reserve part of their meeting time for follow-up on cases reviewed at previous meetings. Follow-up reports may be made by the original presenter, the team's chairperson or facilitator, or others. Those responsible for other follow-up activities may also provide updates.

# Team Activities and Accomplishments

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Teams have carried out myriad projects and activities in the areas of professional training, advocacy and outreach. Some have identified and explored emerging issues in the field and disseminated their findings to others. Examples of activities and accomplishments identified through the NCPEA survey (Teaster & Nerenberg, 2003) and discussions with representatives from other teams include:

- The Vulnerable Adult Multidisciplinary Team of Dane County, Wisconsin has explored the issue of hoarding, producing educational brochures, a protocol for handling cases, and a report.
- The Elder Abuse Institute of Maine developed a training video, “Lifetime of Walking on Eggshells,” and participated in a three-part television series on elder abuse.
- The Orange County (California) Council on Aging’s FAST has provided community training on a broad array of topics including the investigation of fiduciary abuse, real estate fraud, gathering evidence of incapacity for guardianships and lawsuits, how to recognize and stop the loss of liquid assets, estate planning, undue influence, living trust mills, Medicare fraud and scams involving long term care insurance and annuities. The team has also developed a brochure on financial protections that is available in English, Mandarin, Spanish, Vietnamese and Korean.
- The Senior Strength M-Team of Peoria, Illinois has conducted judicial training.
- The Pima County Death Analysis Review Team provided information and advice that resulted in grand jury indictments.
- The Texas Elder Abuse and Mistreatment Team conducts conferences and other training events for medical professionals and is developing a website.
- Washington County’s (Oregon) team has conducted training for clergy, APS and law enforcement, and produces a monthly newsletter.
- A team operated by Metropolitan Family Services of Chicago helped plan and participated in an elder rights forum.
- The San Francisco Consortium for Elder Abuse Prevention’s team identified the need for civil orders of protection to remove abusive non-relatives from victims’ residences and keep them away. A member attorney helped draft and successfully advocated for legislation creating a new order.
- Members of the Los Angeles FAST provided input into the drafting of several innovative laws, including a statute that provides guidance to court personnel in evaluating decision-making capacity, a statute that creates incentives for civil attorneys to take abuse cases, and a statute that permits public guardians to “freeze” vulnerable assets while criminal abuse investigations are in progress in certain situations.
- San Diego’s FAST developed a brochure on how to choose caregivers.



## Administration of Teams

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**A**dministrative functions associated with teams include recruiting members, negotiating contracts and memoranda of understanding, fundraising, producing and disseminating materials and minutes, selecting cases, serving as a focal point for questions, arranging for meeting space, and following up on teams' recommendations.

Agencies most likely to administer teams are APS programs and area agencies on aging (Teaster & Nerenberg, 2003). Other teams are administered by private, non-profit agencies, county attorneys, a state attorney general's office, and universities. Some teams operate informally without a designated administrator, relying on the volunteer support of members.

### *Facilitators*

Facilitators are critical to teams' success because they can set a tone of respect and candor, resolve conflicts and make sure that meetings are productive. The responsibility for facilitating meetings may rest with the lead agency or may be assumed by others. Some teams elect facilitators, who serve for designated terms. Individuals selected to facilitate may reflect teams' specific goals or mission. For example, teams whose primary function is developing service plans may choose case managers who are skilled in care planning and knowledgeable about a wide range of services. Teams

may choose facilitators who have access to needed information (e.g. fatality review teams may choose prosecutors or coroners). It is generally advisable to select chairpersons who are objective and impartial.

### *Funding and In-kind Support*

The most common sources of monetary and in-kind support for teams are APS programs and agencies on aging (Teaster & Nerenberg, 2003). Other sources are foundations, state agencies (including state units on aging and APS, attorneys general and public health departments), AARP, universities, medical schools, hospitals, county government and law enforcement.

Calculating the costs of operating teams is complicated by the fact that few teams have dedicated staffing; staffing tasks may be shared by several individuals, fluctuate over time or be carried out in concert with other tasks. Costs also reflect teams' activities and missions, which vary widely (e.g. some only review cases while others conduct community outreach, professional training, research, etc). Few systematically track in-kind costs and contributions. Of the teams included in NCPEA's survey (Teaster & Nerenberg, 2003), some stated that there were no associated costs while one indicated that it operates on an annual budget of \$84,000. Several could not provide estimates.

## *Membership Agreements, Contracts and Memoranda of Understanding*

Most teams ask members to formally agree to serve and to abide by rules with respect to attendance, confidentiality, etc. (Teaster & Nerenberg, 2003). The following provisions are likely to be covered in general membership agreements or in separate documents.

- **Terms of membership.** Many teams ask members to commit to one-year terms, which may be renewable. Some review members' participation and adherence to rules before extending invitations to renew their terms. Some teams only have term limits for chairpersons or facilitators.
- **Attendance.** Teams may require members to attend a certain number of meetings (e.g. ten out of twelve monthly meetings); alternatively, some teams have made missing a prescribed number of meetings (e.g. three consecutive meetings) grounds for dismissal. Some teams require or encourage members to arrange to have alternates take their place at meetings they are unable to attend.
- **Conflicts of interest.** Teams that permit "for-profit" agencies or individuals in private practice to join may require these members to sign statements indicating that they will not solicit for paid services those clients whose cases are discussed.
- **Confidentiality.** Most teams require members to sign agreements stating that they will not share information revealed during meetings to anyone outside the group, and that information shared will only be used for specified purposes. Some teams review confidentiality provisions at the beginning of each meeting to remind members about the provisions and emphasize their seriousness. Some require all guests to sign confidentiality agreements. (See Responding to Challenges for a more in-depth discussion about confidentiality).
- **Member surveys or feedback forms.** Some teams send out routine or occasional surveys soliciting feedback about the teams' usefulness and suggestions for educational presentations. Some ask members about case outcomes; for example,

they may ask members to indicate if prosecutions were successful as a result of team interventions or if assets or property were recovered (and the amount of recoveries). Some ask members to track the hours they contribute during and between meetings and to estimate pro bono contributions.

## *Impact/Outcome Evaluations*

Research on teams is extremely sparse, particularly studies that measure outcomes. An early study on abuse interventions included a qualitative description of the San Francisco Consortium for Elder Abuse's team, one of the first in the country (Wolf & Pillemer, 1994), and another compared the impact of teams whose members were paid with those whose members were not (Hwalek, 1991). A survey currently in progress in California is evaluating APS programs' participation on teams and the benefits of participation. The National Committee for the Prevention of Elder Abuse examined key features of 31 teams through a survey, which revealed that several teams conduct routine self-assessments and member satisfaction surveys (Teaster & Nerenberg, 2003). Three teams included in the survey reported that they had been, or are currently being, evaluated by outside researchers.

## *Sources of Technical Assistance*

Teams receive guidance, information and sample materials from a variety of sources. State agencies, including state units on aging, APS programs, departments of justice and attorneys general, are a primary source of training and materials. Federal agencies also provide support to teams. The Department of Health and Human Services, Administration on Aging, has sponsored demonstration projects, which have yielded materials on teams, and funds the National Center on Elder Abuse, a clearinghouse that develops, collects and disseminates materials. The U.S. Department of Justice, Office for Victims of Crimes, has awarded a grant to the American Bar Association's Commission on Law and Aging to conduct a demonstration project on elder abuse fatality review teams (see Best Practices and Resources).



## Specialized Teams

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**M**uch has been learned about elder abuse and its prevention in the last two decades. New research has enriched understanding of the causes and risk factors associated with abuse, and a wide range of services and interventions have been designed and tested. New forms of abuse have also been observed and explored. The growth and development of the field has created a demand for new and increasingly specialized expertise, which is reflected in the emergence of new and specialized multidisciplinary teams.

### **FINANCIAL ABUSE SPECIALIST TEAMS (FAST)**

Increasingly complex forms of financial abuse have been observed in recent years, including home equity loan scams, the misuse of “protective” legal instruments such as powers of attorney and trusts, confidence crimes, identity theft, investment scams, telemarketing fraud, “sweetheart scams” and homicides that are committed for profit. Effectively responding to these types of abuse requires familiarity with financial institutions, their personnel and practices; an understanding of complex financial transactions; skills in distinguishing legitimate from fraudulent acts; and knowledge about relevant licensing and regulatory entities for financial professionals. It further requires an

understanding of cognitive capacity and vulnerability to undue influence.

The Los Angeles County Financial Abuse Specialist Team (FAST), established in 1993, was the first team to focus on financial elder abuse cases (the team is supported and coordinated by WISE Senior Services and receives additional funding from the County of Los Angeles). The model has since been replicated in other communities in California and other states.

The original FAST model (it has been modified in some communities) established several categories of membership. Consultants (listed below) assist local APS, the Long Term Care Ombudsman Program, and the Public Guardian’s Office with complex financial abuse cases and provide education and training to service providers, members of the financial community, and the public.

### *Key Features of FASTs*

- **Membership.** In addition to the disciplines and professional groups found on traditional teams (e.g. health and social service providers, victim advocates, law enforcement and mental health professionals), FAST consultants include people with expertise in financial matters. This includes bank personnel with expertise in such areas as trust accounts, people with expertise in real estate (e.g. realtors, public interest lawyers who handle real

estate fraud cases, escrow officers or others), people with expertise in insurance (e.g. licensed agents or representatives from state departments of insurance), stockbrokers, trust attorneys, estate planners, financial planners, Medicaid fraud investigators, regional representatives of the Social Security Administration, guardians and providers of daily money management (public, private, non-profit, and for-profit agencies). The role of these consultants is to familiarize members with common practices and approaches used by financial institutions, help them distinguish legitimate from fraudulent transactions, inform them about the scope of services available, and explain available remedies and recourse in financial abuse cases.

- Local law enforcement representatives are likely to include personnel from fraud or financial crime units. However, because financial abuse may occur with other crimes, representatives from other units, including homicide, may also participate. Because many forms of financial abuse fall under state and federal jurisdiction, FASTs are also likely to include representatives from state and federal law enforcement and regulatory agencies, including Attorneys General, U.S. Attorneys, the Federal Bureau of Investigation, the Federal Trade Commission and state departments of health and human services.
- Although the primary focus of FASTs is financial abuse, this type of abuse does not always occur in isolation. It may be accompanied by physical abuse, neglect, homicide, etc. Therefore, persons with expertise in other forms of abuse are also included on the teams.
- A primary goal of many FASTs is to preserve clients' assets during investigations.
- As noted earlier, the need for persons who can assess mental capacity is extremely important in resolving financial abuse. Mental health professionals or social workers employed by agencies and professionals in private practice may provide this type of expertise. As executive function (the "higher level" cognitive skills) and its relevance to

elder abuse becomes better understood, persons with expertise in this area are playing an increasingly important role.

- Recognizing that financial abuse prevention requires the participation of financial institutions, several FASTs provide training to bank personnel.

### *Special Issues or Concerns*

- FASTs are likely to include members from for-profit organizations, heightening concerns about conflicts of interest and confidentiality. These concerns are being addressed by requiring members to sign conflict of interest statements, restricting participation and other methods.
- Several FASTs have encountered systemic problems requiring new laws or policies. Examples include problems securing assets that are in jeopardy and obtaining out-of-state search warrants in a timely manner.

### **RAPID RESPONSE FASTs**

Rapid response financial abuse teams, a variation of the FAST model described above, were designed to respond quickly to financial emergencies. These include situations in which clients' assets are in jeopardy or when a rapid response can prevent the need for costly and protracted criminal and civil litigation. An example is Santa Clara County's (California) FAST, which is composed of five smaller teams, each of which includes an APS social worker, a public guardian investigator, a district attorney investigator, and a deputy county counsel. When a report of financial abuse that requires a quick response is made to APS, an APS worker investigates along with at least one other FAST member. This may be the public guardian investigator if the client appears to have diminished mental capacity or the district attorney investigator if it appears that a crime has been committed. The teams respond to all situations of imminent danger immediately (typically within a few hours) or by the next day if it is not an emergency. Every two weeks, members of all five teams meet to review cases.

Although there has been discussion about broadening the team's membership to include representatives from private, non-profit agencies, the team has not done so in the past owing to concerns about confidentiality. Police have also expressed interest in becoming involved, and plans are currently in progress to extend membership to include them.

### *Key Features of Rapid Response Teams*

- Membership. FAST rapid response team members, and the roles they play, include:
  - Adult Protective Services (APS), the county agency charged with the responsibility for investigating most reports of abuse, typically receives the referrals and participates in most investigations as mandated under state law. The agency operates a toll-free telephone hotline and has the ability to conduct home visits in the evening and on weekends.
  - Public guardian investigators evaluate the need for guardianship or less restrictive alternatives to protect the assets of clients who cannot protect themselves as the result of disability. Under California law, public guardians also have authority to freeze vulnerable assets while financial abuse investigations are in progress.
  - District attorney investigators are likely to participate in investigations when it appears cases will result in prosecutions.
  - County counsel representatives identify the need for, and initiate, civil actions such as securing restraining orders to prevent sales and filing actions for breach of fiduciary duty, fraud, negligence and unfair business practices.
- Examples of when the FAST response is needed are when abusers have access to victims' funds, thefts or fraudulent transactions are about to be committed, or when victims have been, or are at risk of being, abducted.

### *Special Issues or Concerns*

- Establishing close and trusting relationships among members is critical as cases may involve intense collaboration, often during non-business hours.
- Collaboration and coordination among agencies that have not traditionally worked together has been greatly aided by the concrete accomplishments these teams have achieved (the recovery or securing of assets).
- Establishing good working relationships with financial institutions has been important in gaining their cooperation in preserving assets and resolving financial problems.

## **FATALITY REVIEW TEAMS**

Several communities have developed elder "death review" or "fatality review" teams in recent years, which are patterned after child and domestic violence fatality review teams. Because elder fatality review teams have features in common with both, and because teams for elders are relatively new (there is, therefore, little accumulated information on them), these two precursors are briefly described.

### *Child and Domestic Violence Fatality Review Teams*

Child and domestic violence fatality review teams have many common goals and features. Both identify risk factors associated with deaths, problems with policy and practice, and gaps in communication and coordination between agencies. Both include representatives from coroners' or medical examiners' offices, forensic pathologists, law enforcement agencies, criminologists, prosecuting attorneys (from municipal, district or state courts), protective service agencies and medical professionals. They are also both likely to include representatives from mental health agencies, professional associations of member disciplines, fire departments, probation or corrections agencies, and military law enforcement and health and social services, psychotherapists with crime victim experience, members of the judiciary, emergency response personnel,

clergy, court administrators, victim service providers and advocates. Death review teams may be established at the local, regional or state levels and may or may not review near-fatal, as well as fatal, incidents and suicides. Some states have authorized teams to collect data for use in developing state reports.

A primary goal of child death review teams is reducing the number of cases that are mistakenly classified as accidental deaths or deaths by unknown cause (including sudden infant death syndrome). Because children's deaths are relatively rare, some teams are able to review all cases, enabling them to maintain comprehensive databases. Collecting information on all children's deaths in a community can lead to a better understanding of their causes and incidence. The aggregate data is typically reported to public health departments to alert them to trends and patterns.

Domestic violence teams have a slightly different focus. Primary goals include preventing domestic violence through early intervention and improving the response of individuals and systems. This is accomplished by reviewing the events leading up to domestic violence deaths and actions taken by systems and individuals. This information is also collected in databases, which are used to track patterns and trends. This information can also serve to monitor the performance of programs and to develop prevention and long-term intervention strategies.

### *Elder Fatality Review Teams*

Elder fatality review teams draw from both the child abuse and domestic violence models. Like child abuse teams, they seek to develop the information and expertise needed to distinguish accidental from non-accidental deaths. Like domestic violence teams, they attempt to shed light on events leading up to deaths that will help in developing prevention and intervention strategies. Like both, they attempt to identify problems in the service delivery network, including the need for new policy, instruct members in how to evaluate injuries and causes of death, and aid in prosecution.

Among the first elder fatality review teams is the

Elder Death Investigation Review Team (EDIRT), which was formed in Sacramento, California, in 2000 to assist in the identification and prosecution of elder abuse-related deaths that may otherwise have been missed. Another goal was to enhance medical professionals' skills in evaluating cases and making cause of death determinations. According to persons associated with the team, its formation was prompted by concern about a highly publicized case that involved the operator of an unlicensed residential care home who evaded detection for several years while poisoning residents and collecting their public benefits (the operator was eventually convicted of murder). Approximately half of the cases the team reviews involve abuse in long-term care facilities. Other types of cases that the team plans to explore are suicide-homicides, which are deaths that are mistakenly classified as consensual double suicides but are determined, through careful forensic investigation, not to have been consensual.

### *Key Features of Elder Fatality Review Teams*

- Membership. Fatality review teams include many of the disciplines found on traditional teams but are also likely to include the following:
  - Coroners. These elected or appointed officials receive reports of deaths (typically from police or doctors), determine the medical cause of death if it is unknown, and investigate the cause of deaths that are due to violence or that are unnatural. This may involve approving autopsies or initiating inquests. Deaths are typically reported to coroners when no doctor has treated the deceased during his or her last illness or when the death was sudden or unexpected. Coroners' role on death review teams is to provide and/or interpret forensic documentation.
  - Medical examiners (in communities that have them) are physicians. Their role on teams is to provide and/or interpret forensic documentation. In some communities, medical examiners have agreed to routinely contact APS and long

term care ombudsman programs to notify them of elder deaths and determine whether reported cases are known to them.

- Geropsychologists, geropsychiatrists and other mental health professionals. The role of these professionals differs somewhat from their role on other elder abuse multidisciplinary teams. They may, for example, provide guidance in evaluating the pre-death mental state of a decedent to look for signs of suicide (if suspected, alleged or used as a defense). They may also provide guidance in interpreting clients' cognitive status at an earlier period in time.
- Local, state and, in some situations, federal law enforcement personnel and prosecutors
- State offices that license and oversee nursing homes, residential care facilities, etc.
- Other. Some teams include funeral home directors, hospice workers and others who are likely to observe deaths or decedents.
- Some elder fatality teams have instituted membership "tiers." Certain key members attend all meetings, while others only attend meetings when their expertise is required (for example, representatives of state long term care regulatory agencies only participate in reviews that involve facilities they monitor.) Another "tier" includes individuals who only attend when they are involved in cases being discussed.
- Some teams review a relatively high proportion of cases involving suspicious deaths in adult care or nursing homes. This has been attributed to the higher standards of care required by these facilities and the availability of records.

### *Special Issues or Concerns*

- Owing to the high number of elderly deaths, screening is an extremely important consideration. Factors that elder teams may consider in selecting cases to review include:
  - Delays in reporting deaths
  - If the death was unexpected
  - If the decedent was known to APS, long term care ombudsmen, or local law enforcement as a result of previous reports
  - Forensics findings that suggest abuse

- The costs of performing autopsies are prohibitive.
- Teams or individual members have reported being pressured not to explore suspicious deaths in adult care facilities or nursing homes, which comprise a significant number of teams' referrals.
- Confidentiality. Although maintaining confidentiality is an important consideration for all teams, it is of particular importance for fatality review teams, owing to the nature of the cases reviewed. In addition to ensuring decedents' privacy (privacy rights extend into death), team members need assurances that oral or written communication shared in meetings is confidential and not subject to disclosure or discoverable by third parties. Sacramento's team, described above, did not start reviewing cases until the state enacted legislation authorizing teams, which include provisions for confidentiality, even though the team had been organized much earlier.
- Because a primary role of teams is improving systems, teams need to develop or identify mechanisms for affecting needed change. This may include making recommendations to policymakers, keeping statistics or issuing reports based on their discussions and findings.

### **TEAMS WITH A MEDICAL FOCUS**

Hospital-based multidisciplinary teams are not new to the field of elder abuse. As early as the 1980s, several facilities had developed teams that included physicians, nurses, medical social workers and administrators who met to coordinate patient care, perform comprehensive assessments, and develop in-house protocols for handling abuse cases (Beth Israel Hospital Elder Assessment Team, 1986; Wolf & Pillemer, 1994). A more recent development is the emergence of medically oriented teams whose goal is to provide medical

expertise to community agencies that address elder abuse. Examples include the Vulnerable Abuse Specialist Team of Orange County, California (VAST), and the Texas Elder Abuse and Mistreatment Team (TEAM).

Community-based medical teams vary with respect to the specific groups they serve and the processes and procedures they follow. Members may include medical practitioners from a single facility or multiple facilities, including local clinics or hospitals. VAST, which is associated with the University of California, Irvine, and was developed as a research and demonstration project, has made continual modifications as new findings emerge. For example, during the early stages of the project, personnel surveyed local service providers to determine who primary users would be. As a result of these discussions, the team prioritized APS, police and prosecutors. When it became apparent that APS workers made the overwhelming majority of referrals, the team moved its weekly meetings to APS' offices and invited workers to participate in sessions. Cases are typically presented at an initial meeting, during which members make recommendations for further actions such as administering tests or gathering additional information. The results are reported back and discussed at another meeting, during which the team formulates recommendations, which are then reported back to referring parties.

TEAM, which is a collaboration of the Baylor College of Medicine, the Harris County Hospital District, and Texas' APS program, has also modified its model as new needs are recognized. The team originally only included physicians, nurses, nurse practitioners, social workers and APS workers; later, an occupational therapist, a law professor, psychiatrists, a medical examiner, police officers, district attorneys and an ethicist were added. The addition of these members enabled the team to better respond to the complex case referrals they were reviewing, treat a broader range of victims, and offer more varied interventions. Clients referred to TEAM may be evaluated in an outpatient clinic setting, the hospital or in their own homes. The TEAM approach generally involves an initial APS

investigation, comprehensive geriatric assessment and an interdisciplinary meeting where a joint care plan is developed. The TEAM approach is currently being promoted throughout the state of Texas, through conferences, phone consultations and on-site training.

Among the most common types of abuse referred to medically-oriented teams are self-neglect, neglect by others and financial abuse. Referrals are often made for mental status examinations to determine if patients have decision-making capacity (e.g. when guardianship is being considered); determine the causes of cognitive problems; evaluate neglect by examining pressure sores, blood sugar level, etc.; and evaluate injuries and medical conditions. The teams receive frequent requests by community agencies and law enforcement to interpret medical evidence or testimony and to serve as witnesses in court. Although their focus is on medical issues, the teams review related social factors and needs. They further provide training and education to other health and medical providers and contribute to clinical knowledge about abuse.

### *Key Features of Community-Based Medical Teams*

- Medical teams are likely to include physicians, nurses, pharmacists, psychologists, medical social workers, gerontologists, psychiatrists, medical students, geriatricians, family practice residents and ob-gyn residents.
- Contributions made by community-based medical teams include:
  - Research to explore such issues as bruising and depression as they relate to elder abuse
  - Practice experience to students (TEAM, for example, has arranged for hundreds of medical students to accompany APS investigators on in-home investigations.)
  - Training to APS and other community professionals about common medical and health conditions affecting the elders
  - Innovations in medical documentation, including the development of screening tools that

- improve evidence collection in criminal cases
- Bringing the medical community “on board” in terms of recognizing, reporting and treating abuse

### *Special Issues or Concerns*

- Collaboration between medical professionals and other professionals in the elder abuse prevention network can be complicated by differences in the groups’ approaches to practice. Whereas medical practitioners have formalized and accepted procedures which employ objective measures to narrow down possibilities and make diagnoses, many social service providers are typically trained to gather as much information as possible and use subjective criteria and data in assessing situations.
- Cases referred by police or prosecutors pose a variety of clinical challenges, such as distinguishing traumas that are the result of natural causes from those that are inflicted and providing testimony

and evidence that will stand up in court.

- Establishing and enforcing eligibility criteria for referrals has posed problems for some teams because many elders have medical or health needs, unrelated to abuse or neglect, which could benefit from medical attention. As a result, service providers frequently make referrals for non-abuse related problems. Ensuring that resources are used for their intended purposes requires ongoing discussion with, and training for, referring parties.
- Medically focused teams are costly to operate. Successful teams have capitalized on their value to the legal system and in training medical professionals in securing funding.
- Because the teams receive frequent referrals to assess clients’ decision-making capacity, the issue of client consent is problematic, particularly for teams like VAST, which requires client consent to conduct reviews.

## **Recent Trends**

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In the nearly two decades since multidisciplinary elder abuse teams first appeared, there have been several notable trends and developments:

### *Increased Public Support and Oversight*

The importance and benefits of teams have increasingly been acknowledged by federal, state and local governments, as evidenced by increased monetary support, technical assistance and statutory authority. Federal support for teams has included direct funding, demonstration projects and technical assistance. Increasingly, Older Americans Act funds are being used by states to support activities that promote coordination, including multidisciplinary teams. In 1986, the Department of Health and Human Services, Administration on Aging, provided funding to the San Francisco Consortium for Elder Abuse Prevention (Institute on Aging) to replicate

its service delivery model, which included an elder abuse multidisciplinary team. Under the grant, the Consortium developed a video on teams (see Best Practices and Resources) and provided training and technical assistance on team development to other communities. AoA has further promoted the development of teams through the National Center on Elder Abuse (NCEA) and its partner agencies. The Center routinely collects and disseminates training and technical assistance materials on teams (through NCEA partner the Clearinghouse on Elder Abuse and Neglect, which is operated by the University of Delaware), has completed a survey on teams (conducted by NCEA partner the National Committee for the Prevention of Elder Abuse), supported the development of this publication (also developed by NCEA), and implemented the Sentinel Project to support local elder abuse coalitions, some of which operate teams.

The Office for Victims of Crime of the U.S. Department of Justice (OVC) has also supported the development of teams. Under an OVC grant, Santa Clara County's rapid response FAST developed a video (See Best Practices and Resources) and a blueprint for replicating the model nationwide. OVC also provides funding to the American Bar Association's Commission on Law and Aging to conduct a demonstration project on elder abuse fatality review teams (See Best Practices and Resources).

States have played an important role by encouraging or requiring local communities to establish teams, addressing confidentiality concerns, and providing financial and technical support. Illinois, for example, requires all of its protective service programs to have multidisciplinary teams (M-Teams) and has developed a variety of materials and special training programs for them. In Wisconsin, counties must develop teams to qualify for elder abuse direct service funds, and the state has produced "A Guidebook to Elder Abuse Interdisciplinary Teams," which provides direction in team development and contains numerous sample documents such as memoranda of understanding, meeting agendas and case presentation forms (See Best Practices and Resources). California authorized counties to establish elder death review teams and has provided support for the development of an elder death review team protocol (See Best Practices and Resources).

### *Greater Emphasis on Forensics Issues*

As more elder abuse cases are handled by the criminal and civil justice systems, it has created a need for greater knowledge and expertise in forensics assessments, evidence collection and testimony. The potential role of multidisciplinary teams in developing and providing this expertise was acknowledged during a U.S. Department of Justice-sponsored medical forensics roundtable held in 2000, during which 27 participants discussed the interrelated medical, legal and organizational issues involved in preventing abuse. Several participants stressed the importance of teams in promoting this expertise, with one concluding that "forensic pathologists should be the primary people in elder mistreatment multidisciplinary teams, in that they are best able to recognize patterns of abuse, are able to determine the severity of injuries, and are experienced with the legal system and can testify in court (USDOJ, 2000). Areas of specialization that are particularly helpful include forensics auditors and document examiners, forensics psychologists, pathologists, nurses and others.

# Responding to Challenges

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Ensuring that teams operate effectively and efficiently requires constant monitoring, sensitivity to members' needs, and a willingness to confront problems and find solutions. Respondents to NCPEA's survey of 31 teams (Teaster & Nerenberg, 2003) and others who have experience with teams have identified the following challenges and solutions:

## *Lack of Participation by Certain Groups*

The perspectives, expertise and resources of many disciplines are essential to ensuring that case reviews are comprehensive and balanced. Many teams have had difficulty recruiting or retaining members owing to competing demands on professionals' time, geographic barriers (particularly in rural areas, where professionals may need to drive long distances to participate), and lack of awareness about abuse or about teams. Certain disciplines are particularly difficult to recruit. Teams that operate in rural areas and in communities with multiple police and sheriff's departments report difficulties in achieving good representation by law enforcement. Also reported were difficulties recruiting medical professionals, clergy, prosecutors, attorneys, representatives from financial institutions, providers of services to the younger disabled, pharmacists, state long-term care licensing and regulatory agencies, county attorney's offices and mental health workers. Contributing to the problem is frequent staff turnover, particularly among law enforcement and APS workers. Many communities now have more than one team, which may result in competition for members.

Teams have developed a variety of strategies for improving participation. Some recruit retired professionals from underrepresented disciplines, including retired police officers, bank personnel and court personnel (including judges). Some have made presentations to groups of underrepresented disciplines or invited professional associations to assign representatives.

Participation can also be improved by ensuring that meeting time is well spent and productive. This requires that cases be well screened to ensure that they are appropriate and offer adequate variety. Coaching inexperienced presenters or developing guidelines can improve case presentations, making meetings more productive. Some groups have noted improvements in participation over time as teams develop positive reputations in their communities. One team notes, for example, that participation by law enforcement "first responders" improved when officers saw that the team could offer assistance in developing prosecutions.

## *Absenteeism*

Erratic or infrequent participation may result from the factors listed above. In addition, frequent cancellations of meetings due to lack of cases or other reasons can contribute to absenteeism as members are less likely to make an effort to attend if meetings are likely to be cancelled. On the other hand, unproductive meetings can also increase absenteeism. Team facilitators can avoid having to cancel meetings by actively soliciting cases or planning alternative activities when they do not have cases. Alternatives to case reviews may include educational presentations, meetings devoted to "success stories," or facilitated discussions about issues of concern. Some teams have improved attendance by sending out e-mail reminders about meetings or alternating the location of meetings to make them more convenient.

## *Shortage of Appropriate Cases*

Perhaps the most important element in teams' success is having cases that raise challenging clinical or systemic issues with far-reaching relevance, usefulness and application. Variety is also important to sustain members' interest. A shortage of cases may stem from lack of awareness about the team or its benefits, or because potential presenters do not have time to prepare case

presentations or attend meetings. Presenters may find meetings intimidating or unhelpful, feel that other members' expectations are unrealistic, or have predetermined ideas about case outcomes. Some teams have noted reluctance by certain groups, including law enforcement, to present cases. As noted earlier, many communities now have more than one team, which can create competition for cases as well as for members.

Ensuring an adequate supply of cases requires that community professionals know about the team, which can be accomplished through community outreach presentations. Selecting a good facilitator is essential to ensuring that case reviews are supportive and instructive to presenters. In communities with more than one team, clarifying the case selection criteria used by the various teams can result in a more appropriate and even distribution of referrals.

### *Confidentiality*

Confidentiality is a primary concern of teams despite evidence to suggest that serious breaches are not common (When asked if they had ever had breaches of confidentiality, none of the teams surveyed by NCPEA reported any, although one reported a "close call") (Teaster & Nerenberg, 2003). Confidentiality pertains to the protection of information that can endanger or cause embarrassment, distress or other harm to clients. The importance of ensuring that information shared during meetings is used exclusively for its intended purpose is greater than ever before; as more cases are prosecuted, it has resulted in greater pressure on professionals to disclose information about clients. The heightened emphasis on culpability and liability, as well as increasingly severe civil and criminal penalties for abuse, have significantly raised the stakes for breaches.

Some states have passed laws permitting teams to share information, including clients' health and mental health records, elder abuse reports and investigation findings, criminal history information, etc. Some laws further specify that recommendations made by teams can be used to develop education, prevention and prosecution strategies leading to the improved coordi-

nation of services for families and the elderly. However, federal confidentiality laws prevent the sharing of certain types of information, including information about mental health and substance abuse problems, and federal confidentiality provisions take precedence over those of states when the federal laws are more restrictive.

Confidentiality may also pertain to information about team members' handling of abuse cases. Improving individuals' and communities' responses to abuse requires candid discussion and disclosure about problems. If workers fear that information about their actions that is discussed at team meetings can be used against them in lawsuits or disciplinary actions, they may be unwilling to participate or disclose critical information. Some states have passed immunity laws to protect members.

Exceptions to confidentiality provisions may be warranted in certain situations. For example, an advisory group that developed a protocol for California domestic violence death review teams (See Best Practices and Resources) acknowledged that prosecutors who learn new information at meetings may have a constitutional duty to make the information known to the defense in some situations.

Other measures that teams have instituted to protect confidentiality include the use of agreements, which are signed by all members and guests, and restrictions against using clients' names. Some teams have observed that once teams gain experience and members get to know each other, concerns about confidentiality decrease.

### *Unclear or Divergent Expectations*

Team members may have different expectations with respect to the outcomes of case reviews, which can cause confusion or strife. For example, if teams make recommendations that presenters do not follow, other members may feel that their time is not well spent. In reality, there may be a variety of legitimate reasons workers fail to follow teams' advice. For example, a worker may discover after the meeting that a recom-

mentation goes against his or her agency's policies or that events have occurred that require a change in plans. If members believe that the team must always achieve consensus with respect to recommended actions, they may become frustrated when this is not possible. Avoiding these problems requires that teams clearly define their roles and expectations.

### *Inappropriate Use of Teams*

Members may attempt to use team meetings for inappropriate purposes, such as exerting pressure on other agencies to accept referrals that do not meet their eligibility criteria or publicly chastising workers for how they handled situations. For-profit organizations or professionals in private practice may use information shared at meetings to solicit clients or business, or use meeting time or mailing lists to market their services. These problems have been addressed through improved facilitation of meetings and by clarifying the role of teams. Some teams have chosen to exclude for-profit organizations or persons in private practice from teams, and others have restricted their participation (e.g. allowing them to participate in some meetings and not others). Some have developed policies against marketing and conflict of interest agreements.

### *Other Challenges*

Other challenges identified by respondents to NCPEA's survey include:

- Agency representatives who have been delegated to attend meetings do not have the authority needed to make systems changes; those who have the authority, do not attend.
- Lack of funding and support
- Animosity among members
- Lack of follow-through by some members
- Lack of understanding of elder abuse by a team's chairperson
- Failure to achieve "buy-in" from members whose participation is not voluntary (persons mandated by law to participate or members who have been unwillingly assigned to attend by their agencies)



## Checklist for Starting or Revitalizing Teams

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The following recommendations are presented as guidance to groups that are starting teams as well as to existing teams that wish to enhance their performance. The list is not exhaustive, and not all items are applicable to all teams.

### *Defining or Reassessing Teams' Objectives*

During the early stages of developing or revitalizing teams, it is helpful to talk to a wide range of stakeholders, key players and other interested parties, including groups or individuals that are likely to raise objections and opposition to starting a new team or that declined to participate on an existing team. These discussions can identify needs or concerns, prevent duplication of efforts, generate support, identify potential sources of monetary and in-kind support, and anticipate obstacles. Factors to consider include:

- If there is another elder abuse team (or teams) in the community, will a new team complement or compete with the existing one(s)?
- Are there alternatives to creating a new team? For example, could an existing team expand its membership, focus and case review criteria to meet newly identified needs (e.g. by adding additional members). What are the benefits and drawbacks of doing so?
- If the team is not new, is it achieving its stated objectives? Have additional needs been identified that could be addressed through modifications in, or additions to, the teams' objectives?

### *Team Leadership*

Teams' leadership, which includes facilitators, chairpersons or lead agencies, may be mandated by law or dictated by resource considerations. However, to the extent that teams have discretion in selecting leaders, they should consider the following:

- Impartiality. Different disciplines, individuals or agencies may have biases about how abuse should be handled. People in positions of leadership should be respectful of alternative points of view, committed to interdisciplinary exchange, and free of conflicts of interest.
- Demonstrated leadership

- Expertise in elder abuse prevention, including an understanding of the roles that various disciplines play in abuse prevention
- Resources, including staff support, that a lead agency or person can contribute
- Influence. Depending on the team's objectives, it may be helpful to have leaders who have leverage with policy makers, access to needed information, or who are in positions of leadership in key organization or disciplines.

### *Membership*

Being clear and specific about members' roles on teams and what is expected of them can reduce confusion, misunderstanding or even conflict. Factors to consider include:

- Will agencies or individuals (or both) be eligible for membership?
- If membership is by agency:
  - What key agencies in the community should be included?
  - What role will agency representatives play? For example, will they be responsible for keeping other agency staff apprised of pertinent issues discussed at meetings such as new services or developments in the field of elder abuse?
  - Will the team have input into how agency representatives are chosen?
- What disciplines are critical? Which are desirable?
- Which of the following categories/types of members will be included?
  - Employees of public agencies
  - Employees of private, non-profit agencies
  - Professionals in private practice
  - For-profit organizations, including hospitals, nursing homes, financial institutions, private care management or home care agencies, etc.
  - Volunteers, including retired professionals
  - Representatives from professional associations or advocacy groups
  - Others, including clergy, policymakers, ethicists, etc.
- Considerations in selecting members. The skills, expertise and experience required of members depend on teams' goals and objectives. They may include:
  - Professional skills and knowledge:
    - Clinical expertise in relevant areas
    - Knowledge of resources
    - Familiarity with special populations including underserved cultural communities
  - Administrative skills and authority:
    - Skills in systems change, including legislative advocacy
    - Authority to institute changes within their organizations, negotiate agreements, commit resources, etc.
    - Skills in program and resource development
    - Familiarity with local, state and federal administrative structures, regulations, leadership and funding streams
    - Access to information (e.g. coroners and departments of health can provide information that is critical to death review teams)

- Personal/professional traits:
  - Commitment to interdisciplinary exchange
  - Appreciation of diverse points of view
  - Follow through
- Will there be categories of membership that reflect different levels of commitment, privileges and terms? For example, will all members have the right to present cases? Do term limits apply to all or some members?
- What will be the terms and requirements of membership (length of terms, will terms be renewable, grounds for termination, etc.)?
- Are there ways that interested non-members can benefit from, or contribute to, the team (e.g. by receiving minutes or newsletters or serving in an advisory capacity)?
- Who is responsible for replacing members whose terms have expired or who cannot meet their commitments?

### *Case Reviews*

Teams should be clear about the goals of the review process, how cases are chosen, and anticipated outcomes. Factors to consider include:

- What criteria will be used in selecting cases? Specifically:
  - Who can present?
  - What types of abusive situations will be discussed (e.g. will the team review self–neglect, abuse in nursing homes, fatalities, etc.)?
  - Will the team review cases of abuse involving younger disabled adults as well as elders?
  - Will presenters be encouraged to invite other professionals involved in a case to attend case reviews?
  - Case status. Will the team be available to assist members in planning investigations? Will the team only review “open cases”?
- What measures will be taken to protect clients’ privacy and confidentiality?
- Who will receive minutes, and what will they include?
- Who is expected to provide follow-up?
- Will the team be apprised of case outcomes or dispositions?

### *Other Activities and Objectives*

Teams may have multiple goals and objectives, which may change as new needs are identified. Since activities like planning training events or legislative advocacy are extremely time-consuming and can divert attention away from core activities, teams may need to develop processes for responding to needs they identify. They need to consider if new needs will be:

- Discussed by the group (if so, will this be done during regular meetings or will additional meetings be scheduled?)
- Be assigned to subcommittees
- Be referred to other appropriate organizations

## *Redefining Goals and Revitalizing Teams*

Occasionally, teams may need to reassess their goals and objectives, membership categories, processes, procedures or administration. The need to do so may be in response to the following:

- An event, such as the passage of a new law, the allocation of new resources, or retrenchments in services or funding
- Unmet needs are identified
- A new team is formed, creating a need to clarify or redefine the role of an existing team, negotiate agreements or educate the community about changes

## *Next Steps*

Once goals, objectives and processes are established or revised, they should be formalized through:

- New or revised materials such as policy and procedure manuals, membership agreements, confidentiality agreements, case review guidelines, etc.
- Education and outreach to the public and professionals. Avenues for reaching these groups include memos, press releases, announcements at professional forums, training programs, etc.

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# Best Practices and Resources

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## *ABA Study of Fatality Review Teams*

The American Bar Association's Commission on Law and Aging, with a grant from the U.S. Department of Justice, Office for Victims of Crime, has funded four elder abuse fatality review team demonstration projects in Houston, Texas; Maine (statewide); Orange County, California; and Pulaski County, Arkansas. The project will highlight "promising practices," develop a replication guide to assist other programs nationwide, and identify unique problems faced by the teams. For more information, contact:

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Commission on Law and Aging**

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## *California's Statute Authorizing Elder Death Review Teams*

In 2001, California enacted legislation authorizing counties to establish interagency elder death teams to "assist local agencies identify and review suspicious elder deaths and facilitate communication among persons who perform autopsies and persons involved in the investigation or reporting of elder abuse or neglect" (Penal Code Section 11174.4-11174.9). It states that communications shared within meetings, between members, or between team members and third parties, are confidential and are not subject to disclosure or discovery. It specifies what types of information can be shared, including medical records, mental health information, elder abuse reports and investigation findings, criminal histories, firearms and domestic violence reports, information gathered by probation officers in the preparation of their court reports, records regarding in-home support services, and

information subject to attorney-client, physician-patient and psychotherapist-patient privileges. Information gathered by the teams and recommendations made by teams are to be used by the counties to develop education, prevention and prosecution strategies leading to the improved coordination of services.

## *California's Domestic Violence Death Review Protocol*

In 1995, California authorized counties to establish domestic violence death review teams (Penal Code Section 11163.3). Recognizing that teams may need assistance, the state further directed the Attorney General's Office to develop a statewide protocol. To understand teams' role in preventing domestic violence and serving victims, the state convened focus groups; visited teams to review their structures, policies and procedures; and assembled an advisory group to make recommendations for statewide guidelines. Based on discussions with team representatives from around the state, the Advisory Committee identified promising practices and made recommendations, which include the following:

- The most successful teams invite the detective or prosecuting attorney working on a case being discussed to review the facts at the meeting.
- Teams should reflect their communities' cultural and ethnic diversity.
- Lead members or chairs should be from district attorneys' offices, local law enforcement agencies or coroner/medical examiners' offices, as these agencies can obtain homicide or autopsy files. To keep the process balanced, co-chairs should be selected from agencies that serve victims, including health departments or battered women's shelters.
- District attorneys and medical examiners typically choose the cases that are reviewed as they have the most access to case information.

- Most counties convene meetings once a month but it may be more feasible in small counties to meet quarterly.
- Meetings times should be consistent (e.g. the first Monday of the month at a specified time) to encourage attendance, and members should be asked to designate alternates.
- Definitions used should reflect teams' capacity to review cases (in California, the definition used in the family code is broader than that in the penal code). Teams in large communities with many deaths may need to use narrower definitions. The number of deaths may also determine whether cases will review "borderline" cases or cases that do not fall within the statutory definitions.
- Teams should only review recently closed cases and examine the process that led up to the homicide, recommending strategies and interventions to stop future incidents. Teams also need to decide how to address situations that involve more than one county (e.g. the victim does not live in the county in which she was killed).
- Recommended steps in case reviews:
  - The chair sends out information about victims and perpetrators, including names, aliases, Social Security and drivers' license numbers, children's names and dates of birth. This information is faxed or emailed to members (no mention of the team should be made in these communications).
  - Members gather information about their organizations' involvement and report on it at the meeting. Some teams provide their members with worksheets that list core questions and information.
  - At the meeting, the team discusses the facts of the case and identifies policies and procedures that could be strengthened or measures that could have been taken to prevent the death.
  - Written materials generated from the meeting should be collected, inputted into a database, shredded or put into a confidential file.

### *Protocol for Death Review Teams*

Subsequent to the enactment of legislation authorizing California counties to establish elder death review teams (see above), the California Medical Training Center, which provides training for health care providers in how to evaluate and document injuries, manage the health care consequences of abuse, and collaborate with other entities that serve victims, began developing a protocol to assist counties establish and operate death review teams. A statewide advisory committee assisted in the development of the protocol, which will be available by the fall of 2003. For more information, contact:

#### **California Medical Training Center**

University of California, Davis Medical Center  
 FSSB Bldg, Suite 2200  
 4800 2nd Avenue  
 Sacramento, CA 95817  
 Phone: 916.734.4211  
 Fax: 916.734.4150

### *Wisconsin Elder Abuse Interdisciplinary Team (I-Team) Manual*

Produced in 2002 by the Wisconsin Department of Health and Family Services and authored by attorney/elder law consultant Betsy J. Abramson, this 92-page publication draws from a variety of sources. It describes the benefits of teams, obstacles and the role of members. It also provides sample materials including detailed "job descriptions" for members from various disciplines. Although the manual was developed for teams in Wisconsin, much of the information is relevant and easily adaptable for other communities. It is available on-line at: [www.dhfs.state.wi.us/APS/Documents/Elder\\_Abuse\\_Interdisciplinary\\_Team\\_Manual\\_With\\_Explanation.doc](http://www.dhfs.state.wi.us/APS/Documents/Elder_Abuse_Interdisciplinary_Team_Manual_With_Explanation.doc)

### *The Los Angeles Fiduciary Abuse Specialist Team Handbook*

Produced by WISE Senior Services in Los Angeles, the handbook was developed for team members and others who are interested in replicating the model. It includes

detailed information on the team review process, the role of members, and samples materials, including a confidentiality agreement, job descriptions for members, case summary sheets, etc. It is available for \$30. For more information, contact:

**Michele Findler, MPH**  
**Director of Elder Abuse Program**  
**WISE Senior Services**

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## VIDEOS

### *Serving the Victim of Elder Abuse*

Produced by the Institute on Aging (formerly the San Francisco Institute on Aging), this 21-minute video demonstrates the team review process. Disciplines represented include geriatric mental health, APS, daily money management, civil law, geriatric medicine and law enforcement. For more information, contact:

**Terra Nova Films, Inc.**  
9848 South Winchester Avenue  
Chicago, IL 60643  
Phone: 800.779.8491  
Fax: 773.881.3368  
E-mail: [tnf@terranova.org](mailto:tnf@terranova.org)  
Website: <http://www.terranova.org/>

### *Santa Clara County FAST Video*

Produced in 2003 under a grant from the U.S. Department of Justice, Office for Victims of Crime, this video provides general information on elder financial fraud and profiles the Santa Clara County rapid response FAST. It further serves as a template for agencies interested in replicating the FAST model. It is available from the National Criminal Justice Reference Service (NCJ Number: 198153; Item ID: NCJ 198153 and can be ordered online at <http://puborder.ncjrs.org>.



## The National Committee for the Prevention of Elder Abuse

*"...our society must address the abuse of the elderly and disabled persons as a critical social problem. The lessons learned in responding to the needs of these individuals may in turn serve as guideposts for advancing the quality of life for all older adults and their families."*

*Dr. Rosalie S. Wolf*  
Founder

**T**he National Committee for the Prevention of Elder Abuse (NCPEA) is an association of researchers, practitioners, educators and advocates dedicated to protecting the safety, security and dignity of America's most vulnerable citizens. It was established in 1988 to achieve a clearer understanding of abuse and to provide direction and leadership in preventing it. NCPEA is a partner in the National Center on Elder Abuse, which is funded by Congress to serve as the nation's clearinghouse on information and materials on abuse and neglect. NCPEA's mission is to respond to the abuse, neglect, and exploitation of older persons and adults with disabilities through advocacy, research, public and professional awareness, interdisciplinary exchange, coalition building, and professional publications.

NCPEA's goals are to:

- Advocate for needed services, policies, and resources
- Encourage and conduct research regarding the extent and causes of abuse and effective remedies
- Expand scientific knowledge by identifying needs and providing vehicles for disseminating information
- Raise public awareness of the problem of elder abuse and victimization of people with disabilities
- Promote collaboration and exchange between diverse disciplines
- Promote the growth of coalitions at the local, state, national, and international level
- Encourage and provide professional training
- Reach out to diverse populations

Interested in learning more about NCPEA products, services and membership? Please visit us on the web at <http://preventelderabuse.com>; contact us at 202-682-4140; or write to us at: NCPEA, 1101 Vermont Avenue NW, Suite 1001, Washington, DC 20005.

To order additional copies of this or other NCPEA publications, please call our office for further information.