

How the Federal Government Can Encourage and Facilitate the Development of Interdisciplinary Team Responses to Elder Abuse

Introduction

Elder abuse takes many forms: physical, sexual and psychological abuse, financial exploitation, and neglect by paid and unpaid caregivers. It cuts across all races, gender, ethnic and religious groups and occurs in every part of this country. It is inflicted in homes and facilities, and causes untold suffering. Called the “gorilla in the room” of elder abuse work, dementia also looms large as we experience demographic growth of the two groups known to be most vulnerable to abuse: adults over 85; and adults with dementia. The medical, legal, social, and ethical complexities of elder abuse cases exceed the boundaries of any single discipline or agency. Effectively resolving cases of elder abuse takes a team effort at every level.

Background

Separately, agencies face insurmountable obstacles in addressing the abuse of elders. Adult Protective Services and Ombudsman agencies are mandated to respond to allegations of abuse by assessing living conditions, injuries, and decision-making capacity but are mostly unable to conduct medical and/or cognitive assessments (Falk et al., 2010). Physicians and psychologists can provide needed assessments of cognition but lack the mandate and legal knowledge to navigate the criminal justice system. Law enforcement officers are able to gain access to victims and investigate allegations of abuse but require DAs to file cases. DAs can prosecute cases but require the case preparation of law enforcement and expertise of the medical community. Collaborations between differently trained professionals help to better identify, intervene and prevent elder abuse. In fact, the need for multiple areas of expertise to address and deal with individual cases of elder abuse is so great that informal community collaborations often form where formal networks are nonexistent (Dyer, Heisler, Hill, & Kim,

2005) and these informal collaborations evolve into interdisciplinary teams.

Types of Interdisciplinary Teams in Addressing Elder Abuse

Response to elder abuse and neglect requires collaboration between adult protective service workers, law enforcement officers, social workers, long-term care ombudsmen, clinical psychiatrists, nurses, geriatricians, public guardianship deputies, criminal justice investigators, and prosecutors. The team approach to elder abuse grew out of a need to address social, legal, medical, ethical issues central to most elder abuse cases. Types of interdisciplinary teams include *Multidisciplinary Teams (MDTs)*, *Financial Abuse Specialist Teams (FASTs)*, *Elder Death Review Teams (EDRTS)*, *Elder Abuse Forensic Centers*.

Multidisciplinary Teams (MDTs): Emerging in the 1980s, MDTs formed to review cases and address elder abuse at the local level. MDTs connect professionals and enable them to learn about other agencies in order to better link elder clients to appropriate services.

Financial Abuse Specialist Teams (FASTs): FASTs convene to investigate and intervene in cases of financial abuse and can improve elders' access to needed legal services (Reeves & Wysong, 2010).

Elder Death Review Teams (EDRTs): EDRTS bring together law, medicine, social services, and coroner/medical examiners to analyze suspicious elder deaths. Some EDRTS analyze individual cases to help with decisions regarding prosecution, while others look at systemic issues to identify breakdowns in care, detection, and treatment.

Elder Abuse Forensic Centers: Established by the Program in Geriatrics at the University of California, Irvine in 2003, Elder Abuse Forensic Centers grew out of efforts to further integrate services. The centers focus on action-oriented collaboration in which each team member is willing to provide service for a given case. The model has been replicated across California and at a number of sites around the country and are shown to increase filing, prosecution, and conviction of elder abuse cases (Navarro et al 2012).

Key Factors that make an Effective IDT

As we approach our 1000th elder abuse case at the Orange County Elder Abuse Forensic Center, our observation on the factors that make for a high functioning interdisciplinary team echo those of teams across the nation: consistent representation across the spectrum of agencies/disciplines; agreed upon (often negotiated) goals; the ability to provide timely response; and rigorous case follow-up.

Factor 1: Consistent representation from social services, law enforcement, the legal system, medicine, mental health, and the public guardian is essential. Without this collaborative integration, the response is often inadequate, ineffective, and at times, harmful.

Factor 2: Elder abuse case requires the willingness to engage/challenge one another. Through this dynamic, often confrontational process, an effective interdisciplinary team arrives at integrated goals that are complementary rather than conflictive.

Factor 3: Timely response is critical. Operating separately (the typical response), requires countless phone calls between agencies and significant waiting while conditions worsen, bank accounts drain, victims continue to suffer, and sometimes die.

Factor 4: Elder Abuse interdisciplinary teams will not be effective without rigorous case follow-up. Because sequential steps by various agencies are required, timely follow-up ensures that cases move forward and proceed in a manner consistent with the goals negotiated and articulated by the team. This follow-up assures accountability that agencies carried out their part of the solution.

Systemic Barriers that Impede the Effectiveness of an IDT

When all the components of an effective IDT and the necessary factors that support good team integration are present, there are still significant barriers to effective prevention and intervention in elder abuse. Systemic barriers are those that are built into policies and regulations specific to the multiple agencies involved in the process.

Barrier 1: Ambiguity in laws protecting the confidentiality of victims of elder abuse hinders interdisciplinary team responses making it more difficult to protect them. IDT's function well when all the stakeholders share a common goal and have access to all relevant information in order to act in the victim's best interest. Adult Protective Service Agencies vary in their understanding of what information can be shared with law enforcement agencies. Health professionals may be unsure how HIPAA regulations and confidentiality protections are applied to elder abuse reporting and may have inaccurate knowledge (Schmeidel, Daly, Rosenbaum, Schmuck, & Jorgerst. 2012).

Barrier 2: We currently have "nuclear war" vs "nothing" responses to the most complex cases. A specific area where this occurs is what happens when gaps in services are identified between the broad domains of mental health and dementia. There is little coordination between the agencies, laws, policies and resources that are available to elders who suffer from dementia (Anetzberger et al., 2000), as opposed to mental health disorders . This lack of coordination

causes our most vulnerable clients who may have both types of disorders to “fall between the gaps”. We need mechanisms to respond to the needs of these very complex clients with interventions that are more nuanced and targeted.

Barrier 3: The tension between an individual’s right to autonomously decide how to live and the community’s wish to intervene when those choices lead to mistreatment, abuse, or neglect is central to elder abuse cases. Clarification of these policies as they apply to elder abuse is important so that the duty to protect is not unnecessarily or inadvertently limited. Issues of privacy and confidentiality are specific examples of where this balance is relevant.

Barrier 4: Large geographical areas and limited expertise in all area make team collaboration and cross-state work challenging. Existing technology, such as videoconferencing capabilities, have the potential to connect expert teams of MDTs to communities in need of expertise, however, sufficient infrastructure needs to exist in order for these technologies to work.

Barrier 5: Lack of geriatric training across disciplines hinders the ability of teams to address medical, legal, social, and ethical issues surrounding the abuse of older adults. Without understanding, ageist attitudes color perceptions of what is considered “normal” in old age and prevent recognition of elder abuse.

Recommendations

Growing interest in collaborative team approaches at local, state, and federal levels has created a ripe environment in which MDTs can form and thrive. Additionally, many communities have the necessary components to build the infrastructure for an MDT. It is in the context of these untapped opportunities that the following recommendations are proposed:

1. Clarify existing HIPPA language to ensure different agencies are allowed to talk to each other.
2. Create guidelines to promote sharing info among/across agencies.
3. Build the infrastructure for use of existing and innovative technology.
4. Endorse the use of evidence-based best practice models of Interdisciplinary teams.
5. Integrate EA responses into existing programs (respite care, meals on wheels).
6. Support research agendas, specifically in the area of standardized measurement, data collection instrumentation, evaluation, and translational research.

Summary

It is truly important to have national leadership on this issue. Just as we have found that moving from a silo mentality to a village mentality at the local level has been vitally important, the same is likely to apply at the federal level. Communication among the agencies will promote understanding, efficiency, and coordinated action. This may require the hiring of one person who serves as the identified mover, shaker, prodder, and leader. However this coordination is accomplished, its importance and urgency are clear. Too many of our nation's elders are becoming impoverished, are suffering, and are dying as a result of abuse. Without swift, thoughtful action the problem will only grow.

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