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The Evolution of a Multidisciplinary Response to Elder Abuse

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THE EVOLUTION OF A MULTIDISCIPLINARY RESPONSE TO ELDER ABUSE

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Elder abuse is a complicated and disturbing problem. Its broad definitions[1] present many distinct forms, each of which

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The National Committee for the Prevention of Elder Abuse was established in 1988 as a nonprofit membership organization to identify, prevent, and respond to abuse, neglect, and exploitation of older persons and adults with disabilities through interdisciplinary collaboration and action. For over two decades it has helped shape the field of elder justice through research, education and training, public awareness activities, advocacy, and coalition building. It produces The Journal of Elder Abuse & Neglect, a publication of Taylor and Francis, long regarded as a premier scholarly resource on research, policy, and practice regarding elder abuse as a global problem.

1. *See, e.g.*, NAT'L RES. COUNCIL, ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA 34–35 (2003); *How to Answer Those Tough Questions about Elder Abuse*, NAT'L CTR. ON ELDER ABUSE 1, http://www.ncea.aoa.gov (on left navigation panel, under Library click Publications, search "tough questions").

can reflect different etiologies and dimensions. The problem occurs across settings, and there are a wide variety of potential perpetrators. Recent prevalence research on elder abuse[2] suggests that its scope may overshadow either child abuse or intimate partner violence. Finally, the consequences of elder abuse seem staggering in both cost[3] and potential mortality.[4] Under these circumstances, it is little wonder that professionals emphasize a multidisciplinary response for effective problem detection, prevention, and treatment.[5]

There is nothing new about a multidisciplinary response to elder abuse. The approach has its origins with "protective care" more than a half century ago. There also is nothing remarkable about the general enthusiasm that a multidisciplinary response seems to engender among its participants and even the community-at-large. The value placed in building teams of diverse talents and perspectives is a tenet of American culture, illustrated in such areas as business and chronic care. The literature on elder abuse often acknowledges the benefits of a multidisciplinary response. Less frequently discussed are its challenges and limitations.

This article on the multidisciplinary response to elder abuse begins in Part I by examining its origins, development, and widespread appeal. Part II considers various current types of multidisciplinary responses along with their participants. Finally, in Part III, the multidisciplinary response to elder abuse

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2. Ron Acierno et al., *Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study*, 100 AM. J. PUB. HEALTH 292, 293–96 (2010); Edward O. Laumann et al., *Elder Mistreatment in the United States: Prevalence Estimates from a Nationally Representative Study*, 63B J. GERONTOLOGY: SOC. SCI. S248 (2008).

3. METLIFE MATURE MKT. INST. ET AL., BROKEN TRUST: ELDERS, FAMILY, AND FINANCES 7 (2009).

4. Mark S. Lachs et al., *The Mortality of Elder Mistreatment*, 280 JAMA 428, 430 (1998); XinQi Dong et al., *Elder Self-Neglect and Abuse and Mortality Risk in a Community-Dwelling Population,* 302 JAMA 517, 520–21 (2009).

5. *See, e.g.,* BONNIE BRANDL ET. AL., ELDER ABUSE DETECTION AND INTERVENTION: A COLLABORATIVE APPROACH 13 (2007); LISA NERENBERG, ELDER ABUSE PREVENTION: EMERGING TRENDS AND PROMISING STRATEGIES 241–42 (2008) [hereinafter NERENBERG, ELDER ABUSE PREVENTION].

is assessed through existing evaluative research and commentary.

I. HISTORY OF THE MULTIDISCIPLINARY ELDER ABUSE RESPONSE

A. ORIGINS

The need for "protective care" arose during the 1950s out of concern for the growing number of frail or incapacitated older people living alone outside of institutions and lacking family support.[6] Without appropriate community intervention, it was feared that neglect or exploitation could result. Discussions on this need occurred at the local level, principally in large cities like Chicago, Cleveland, and New York. Eventually, these discussions were elevated to national forums in the early 1960s when the National Council on Aging organized a meeting regarding protective services for older people.[7]

> As originally conceived, protective care or services represented a constellation of services, preventive or supportive in nature, given with the purpose of helping these individuals to retain or achieve a level of competence and function to manage their own personal affairs or assets or both to the extent feasible, or with the purpose of acting on behalf of those incapable of managing for themselves.[8]

The combination of problems experienced by protective clients seemed to call for different types of assistance, such as "medical and psychiatric care, legal services, nursing care, hospital and nursing home care, family home care, housekeeper and homemaker services, drugs, ambulance service, and

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6. Helen B. Cole, Older Persons in Need of Protective Services (Oct. 22, 1962) (unpublished manuscript) (on file with author); Hugh A. Ross, *Protective Services for the Aged*, 8 GERONTOLOGIST 50, 50–51 (1968).

7. Gertrude H. Hall, *Protective Services for Adults*, *in* 2 ENCYCLOPEDIA OF SOCIAL WORK 999, 1002–03 (Robert Morris ed., 16th ed. 1971).

8. NAT'L COUNCIL ON AGING, SEMINAR ON PROTECTIVE SERVICES FOR OLDER PEOPLE at xii (Rebecca Eckstein & Ella Lindey eds. 1963).

funds . . . ."[9]

The report of the first White House Conference on Aging, held in 1961, recognized the importance of multidisciplinary cooperation in providing protective services:

> The professions of social work, medicine, and law should make their services available to older persons who are in need of social protection . . . . These professional services should be offered in such a way that they are mutually supportive . . . .[10]

A few years later at the second National Council on the Aging Seminar, participants recommended that the social worker assume the leadership role within the multidisciplinary approach.[11] However pivotal to protective services, social workers still were expected to frequently consult with members of the medical, psychiatric, and legal professions. In this sense, social work can perhaps best be described as first-among-equals with respect to the disciplines involved in protecting older people. The 1963 Arden House Conference captured this quality. It is regarded as one of the first occasions wherein the professions of law, medicine, and social work interacted as equals. "They unanimously agreed on the need for an inter-disciplinary approach."[12]

B. DEVELOPMENT

The original emphasis on a multidisciplinary response to the protective client seemed to dissipate by the 1980s. From 1964 through 1970, demonstration projects sought to develop and evaluate adult protective services as well as further delineate its targeted population.[13] Although the intervention continued to

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9. Mary L. Hemmy & Marcella S. Farrar, *Protective Services for Older People*, 42 SOC. CASEWORK 16, 19 (1961).

10. U.S. DEP'T HEALTH, EDUC. & WELFARE, THE NATION AND ITS OLDER PEOPLE: REPORT OF THE WHITE HOUSE CONFERENCE ON AGING 173–74 (1961).

11. Hall, *supra* note 7, at 1002–03; *see Adult Protective Services – History*, JRANK, http://medicine.jrank.org/pages/29/Adult-Protective-Services-History.html (last visited Feb. 29, 2012).

12. Virginia O'Neill, *Protecting Older People*, 23 PUB. WELFARE 119, 124 (1965).

13. *See Adult Protective Services – History*, *supra* note 11.

recognize the importance of cooperating with other disciplines and systems, protective services were increasingly seen as a social work function, housed in social or aging service agencies. This perception changed, however, with the "discovery" of elder abuse and public recognition of its various forms. As a result, concern about the "protective client" was transposed into interest in the "elder abuse victim" and with it came the elevation of other response disciplines or systems, most notably medicine and criminal justice, and to a lesser extent, the National Aging Network and family violence. The transformation provided the basis for a return to a multidisciplinary problem response, one evident today in elder abuse networks, teams, and centers nationwide, often fostered through funding for research and program demonstrations.

Protective service demonstrations during the 1960s occurred in places like San Diego, Houston, Philadelphia and Cleveland.[14] Among other aims, they attempted to delineate the key components of protective services and how to best organize the program.[15] Although results varied by project, collectively the demonstrations emphasized the importance of: (1) clear program auspice; (2) ability to access a wide range of services; (3) protocols for multidisciplinary diagnosis and service referral; (4) leadership of social work in service organization and delivery; and (5) representation of other disciplines on staff or as consultants, especially medicine, psychiatry, and law.[16] Gideon Horowitz and Carol Estes examined the variation in multi-disciplinary responses among the demonstration projects. They found just a few using an interdisciplinary team approach in case diagnosis and planning. Rather, most "employ[ ] consultants only on the request of the program's social workers . . . . It is notable that the 'appropriateness' of social work as the coordinating, controlling discipline . . . has neither

14. Hall, *supra* note 7, at 1005.

15. *See id.*; *Adult Protective Services – History*, *supra* note 11.

16. Hall, *supra* note 7, at 1005–06; *see also* JOHN J. REGAN & GEORGIA SPRINGER, S. SPEC. COMM. ON AGING, PROTECTIVE SERVICES FOR THE ELDERLY: A WORKING PAPER 24–25 (1977).

been questioned nor studied."[17]

Adult protective services spread across the country in the 1970s, partly fueled by passage of Title XX of the Social Security Act. The legislation provided a public mandate to states to offer services intended to prevent or remedy abuse, neglect, or exploitation of adults unable to protect themselves or their interests.[18] Protective services was one of only two universal services under Title XX, giving the program further importance and states greater incentive to establish adult protective services.[19]

Although adult protective services became a cornerstone of public social services by the late 1970s, it encountered growing criticism for high cost along with perceived ineffectiveness and abridgment of individual rights.[20] According to John Regan of Hofstra Law School, in 1978 nearly 20 states had enacted adult protective services.[21]

> In many instances, however, these states have failed to evaluate and update their existing legal mechanisms for involuntary intervention, particularly their guardianship law. This oversight may change these well-meaning programs into instruments for oppressive intervention, thereby threatening the civil liberties of the very persons the programs are intended to protect.[22]

By 1982, Regan seemed convinced that the worst had come to pass. At that time, nearly all states had adult protective services programs and most state legislatures had enacted adult protective services laws.[23] In his keynote address at the National

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17. GIDEON HOROWITZ & CAROL ESTES, PROTECTIVE SERVICES FOR THE AGED 10 (1971).

18. NERENBERG, ELDER ABUSE PREVENTION, *supra* note 5, at 36.

19. JAMES BURR, PROTECTIVE SERVICES FOR ADULTS 2, 74 (1982).

20. *See, e.g.*, Lola Hobbs, *Adult Protective Services: A New Program Approach*, 34 PUB. WELFARE 28, 28 (1976); ELIZABETH J. FERGUSON, PROTECTING THE VULNERABLE ADULT: A PERSPECTIVE ON POLICY AND PROGRAM ISSUES IN ADULT PROTECTIVE SERVICES 45–46 (1978); John J. Regan, Trends in Protective Services Legislation 8 (April 3, 1979) (unpublished manuscript) (on file with author).

21. John J. Regan, *Intervention through Adult Protective Services Programs*, 18 GERONTOLOGIST 250, 250 (1978).

22. *Id.*

23. *See* NAT'L RES. COUNCIL, *supra* note 1, at 14.

Law and Social Work Seminar "Improving Protective Services for Older Americans," Regan said:

> The state adult protective services acts of the past few years contain so few protections for the client and confer such broad authority on the intervenors that, in many cases, these laws can be viewed as little more than instruments of oppression.[24]

Overall the Seminar represented an attempt, supported by the U.S. Administration on Aging, to delineate roles and discuss conflicts between social work and law in the practice of protective services. The Seminar's conclusions were based on the assumption that the future issues in adult protection primarily related to promoting interdisciplinary and interagency cooperation. As Seminar convener, the University of Southern Maine produced an eight-part National Guide Series on the key roles of social work, legal, Aging Network, community, health care, and family, friends, and neighbors.[25] Together the guides tried to clarify areas of conflict between disciplines and systems and offered principles for conflict resolution at local levels.

Meanwhile, the position of social work as "the center of a universe made up of many other roles and actors"[26] in protective intervention was already declining. Social work began its ascent during the time of President Lyndon Johnson's Great Society, with the Administration's emphasis on federally directed and publicly supported social welfare for disadvantaged or vulnerable populations, clearly the groups of historic interest to social work. Its descent coincided with widespread questions about the effectiveness of this government initiative[27] and the

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24. John J. Regan, *Adult Protective Services: An Appraisal and a Prospectus*, *in* NATIONAL LAW AND SOCIAL WORK SEMINAR: PROCEEDINGS AND PROSPECTS, IMPROVING PROTECTIVE SERVICES FOR OLDER AMERICANS: A NATIONAL GUIDE SERIES 12, 13 (Willard D. Callender ed., 1982).

25. *See*, *e.g.*, *id.*; MARY COLLINS, SOCIAL WORKER ROLE, IMPROVING PROTECTIVE SERVICES FOR OLDER AMERICANS: A NATIONAL GUIDE SERIES 6 (1982).

26. COLLINS, *supra* note 25, at 6.

27. *See*, *e.g.*, WALTER I. TRATTNER, FROM POOR LAW TO WELFARE STATE: A HISTORY OF SOCIAL WELFARE IN AMERICA 300 (3d ed. 1984); BRUCE S. JANSSON, THE RELUCTANT WELFARE STATE: A HISTORY OF AMERICAN SOCIAL WELFARE POLICIES 238–39 (2d ed. 1993).

occurrence of certain societal trends, particularly: (1) various civil rights movements (including those for women, victims, and people with disabilities); and (2) the rise of other systems (notably healthcare and criminal justice, as problems were increasingly medicalized or criminalized).[28] Although the seeds for this change were planted in the 1970s, they took root and spread in later decades.

While physicians discovered "elder abuse" in the mid-1970s,[29] interest in the topic was initially fostered by sociologists who were concerned about family violence. Many early studies and demonstrations originated from those sources. The interest of physicians and family violence researchers likewise spawned involvement from related disciplines and fields—from physicians to nurses and psychologists, from family violence researchers to law enforcement and domestic violence advocates, for example. The spread across disciplines and systems was aided by the characteristic of elder abuse as a concept to continually broaden its meaning, increase its forms, and reframe itself. The wake of such transformation witnessed variation in what is considered to be the dominant elder abuse discipline or system, with difference by preferred elder abuse definition, selected form, or adopted framework. For instance, focusing on financial abuse (including that perpetrated by strangers and acquaintances) under a criminal justice lens elevates the importance of law enforcement (especially police, prosecutors, and the courts) in elder abuse interventions.

During recent decades, many forums on elder abuse have been held. Their focus has varied, from research to policy and advocacy. However, in nearly all of the forums, those assembled represented multiple disciplines or systems, and

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28. *See* PETER CONRAD, THE MEDICALIZATION OF SOCIETY: ON THE TRANSFORMATION OF HUMAN CONDITIONS INTO TREATABLE DISORDERS 4 (2007). *See generally* Erik Luna, *The Overcriminalization Phenomenon*. 54 AM. U. L. REV. 703 (2005); Andrew Ashworth, *Conceptions of Overcriminalization*, 5 OHIO ST. J. CRIM. L. 407 (2008).

29. *See, e.g.*, ROBERT N. BUTLER, WHY SURVIVE? BEING OLD IN AMERICA 300–20 (1975); G.R. Burston, Correspondence, *Granny-battering*, 3 BRIT. MED. J. 592, 592 (1975).

social work no longer dominated. In addition, health care and justice tended to increase their presence over time. To illustrate, the earliest research forum was the 1986 Research Conference on Elder Abuse and Neglect hosted by the University of New Hampshire.[30] Among its twenty-nine participants, twenty-one percent had health or legal backgrounds.[31] At the 2002 National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, fifty percent of participants had health or legal backgrounds.[32] The leadership of the National Institute of Health and the National Institute of Justice have aided in some of this dramatic increase through their funding of elder abuse research and demonstrations. Even more change, however, reflects the growing recognition of elder abuse as a public health issue and a crime as opposed to a social problem,[33] with remedies concentrated on prevention and prosecution respectively, instead of improving social conditions that might represent underlying elder abuse etiologies.[34]

C. WIDESPREAD APPEAL

The justification for a multidisciplinary response to elder abuse is thought to have arisen from the problem's complexity and its detection, prevention, and treatment challenges. Accordingly, no one profession or service system is sufficient for understanding and addressing it. In this sense, the story of blind men describing an elephant might apply. Each man "sees" just the part of the elephant to which he has access. Only together do they understand the elephant as an entire animal.

Still, there may be other explanations for the widespread appeal of a multidisciplinary elder abuse response. One such explanation is that it was inevitable after the establishment of

30. ELDER ABUSE AND NEGLECT: RECOMMENDATIONS FROM THE RESEARCH CONFERENCE ON ELDER ABUSE AND NEGLECT (Karl Pillemer et al. eds., 1986)

31. *Id.*

32. *See* NAT'L RES. COUNCIL, *supra* note 1.

33. NERENBERG, ELDER ABUSE PREVENTION, *supra* note 5, at 9, 47–48.

34. *Id.* at 9, 48.

diverse laws and programs at federal and state government levels. For elder abuse, these include laws relating to adult protective services, long-term care ombudsmen, Medicaid fraud control units, Older Americans Act Aging Network elder abuse prevention activities, domestic violence programs, and so forth.[35] Indeed, the United States seldom has a single public policy or program for any problem. Consider long-term care, for example. At the federal level alone, there are more than a hundred relevant programs spread across various bureaucracies. This largely reflects our political process, which favors incremental or piecemeal change; the influence of special interest groups; the tendency to introduce several bills on any issue; and possible delegation of bill responsibility to more than one legislative committee in any chamber. Returning to our blind men and elephant analogy, this means that with elder abuse, responsibility spread widely across numerous programs by statute. This made it impossible to effectively respond as a single blind man holding just the trunk or ear. Policy and therefore program fragmentation like this requires collective action.

Another possible explanation for the widespread appeal of a multidisciplinary elder abuse response is an unwillingness to allow any single discipline or program to assume the lead role for a nascent field. Accordingly, disciplines compete for dominance, with "jockeying for power" seen as more critical with the availability of increasing resources. Social work typically falls fairly low in professional ranks, measured by pay and public image.[36] As long as elder abuse held little promise of research or program reward, social work was allowed to be lead discipline. Once opportunities began to increase, stimulated by growing problem awareness and an aging population, other

35. For a delineation of elder abuse public policies and programs see Pamela B. Teaster & Georgia J. Anetzberger, *Elder Abuse in Contemporary Society: Programs, Policy and Politics*, 22 J. ELDER ABUSE & NEGLECT 3 (2010).

36. *See* U.S. Dept. Labor, *Occupational Outlook Handbook: Social Workers*, BUREAU LABOR STAT., 3–4, http://www.bls.gov/oco/pdf/ocos060.pdf (last visited Feb. 29, 2012).

disciplines sought elevated roles, particularly medicine and criminal justice, which were well positioned because of certain previously discussed cultural trends. In this explanation, embracing a multidisciplinary response becomes the "fallback" stance when the historic lead discipline refuses to give up the fight, and other disciplines realize that they do not need to acquiesce.

Whatever the explanation for elder abuse's multidisciplinary response, it is widely accepted and fairly well entrenched. Perhaps no recent publication better captures this than ELDER ABUSE DETECTION AND PREVENTION: A COLLABORATIVE APPROACH.[37] Its authors represent the disciplines of social work, law, and medicine as well as the systems of adult protective services, domestic violence programs, law enforcement, health care, and civil justice.[38] They conclude:

> Although elder abuse cases are enormously complex . . . a multidisciplinary collaboration can muster a remarkable and unique array of resources. It is through collaboration that professionals can carry out their mandates and responsibilities to prevent gaps in services and ensure that the multiple needs of vulnerable victims are met.[39]

II. VARIATIONS IN THE MULTIDISCIPLINARY RESPONSE TO ELDER ABUSE

Types of multidisciplinary responses to elder abuse can vary. There is no single category or standard, although there are established models and some have been highly publicized. The chosen type will differ depending on such factors as purpose in coming together and nature of the relationship among group members. Similarly, the composition of a multidisciplinary response can vary, although certain disciplines or systems are

37. BRANDL ET AL, *supra* note 5.
38. *Id*. at xv.
39. *Id*. at 110.

regarded as critical no matter which type of response is used. The systems most likely to be found in these groups are law enforcement, adult protective services, mental health services, aging services, and domestic violence programs.[40] The disciplines usually represented are police or sheriffs, adult protective services workers, geriatric mental health case managers or counselors, prosecutors, senior service providers, public guardians, and domestic violence advocates.[41]

There are at least six dimensions that may be considered in establishing a multidisciplinary response to elder abuse. They can result in numerous potential combinations. The dimensions are described and illustrated below.

A. AUSPICE

The auspice of a multidisciplinary response can be an organization or a community. Organizational responses reflect the needs of a particular agency or institutional setting, most often a hospital or adult protective services agency.[42] Community responses address the collective concerns of several organizations or professionals in a single locale.[43] Two such examples are found in Greater Cleveland, Ohio. The Benjamin Rose Institute formed an elder abuse case consult team in the mid-1990s.[44] Comprised of social workers, nurses, and program administrators, the consult team regularly meets to examine and offer advice on elder abuse situations challenging agency case managers.[45] The Consortium Against Adult Abuse is the nation's longest continually operating community response.[46] Established in the 1980s, it has approximately eighty

40. PAMELA B. TEASTER & LISA NERENBERG, A NATIONAL LOOK AT ELDER ABUSE MULTIDISCIPLINARY TEAMS 9 (2005).

41. *Id*. at 10.

42. Georgia J. Anetzberger et al., *Multidisciplinary Teams in the Clinical Management of Elder Abuse*, 28 CLINICAL GERONTOLOGIST 157, 158 (2005).

43. *Id*. at 159.

44. *Id*. at 158–59.

45. *Id*. at 159.

46. *Id.*

organizational and individual members.[47] The Consortium functions to promote elder abuse awareness, professional education, legislative advocacy, and programming in the five counties of Northern Ohio's Western Reserve region.[48]

B. STRUCTURE

Teams and networks are the usual structures for a multidisciplinary elder abuse response. Teams are comprised of at least three professionals from diverse disciplines assembled for case review and recommendation, and sometimes for the identification of service system problems or gaps as well.[49] Networks go by various names, including coalitions and task forces, and represent collaborations or partnerships formed to facilitate change in elder abuse detection, prevention, or treatment.[50]

Teams and networks can be interrelated, with networks forming multidisciplinary teams for case consultation and teams informing networks of identified system or community issues. This interrelationship is exemplified by the Multidisciplinary Team of the San Francisco Consortium for the Prevention of Elder Abuse.[51] Comprised of several disciplines, the Team meets monthly to provide comprehensive assessment on elder abuse cases that span agencies and reflect complex dynamics.[52] Networks are formed by the National Committee for the Prevention of Elder Abuse through the Area Agency on Aging in Phoenix, Arizona.[53] Using seed money from the National

47. *See* Georgia J. Anetzberger, Networking—At the Heart of Elder Abuse Prevention and Treatment 6 (1984) (unpublished manuscript) (on file with author).

48. Case W. Res. Univ., *Western Reserve Area Agency on Aging*, ENCYCLOPEDIA CLEVELAND HIST., http://ech.case.edu/ech-cgi/article.pl?id=WRAAOA (Jun. 20, 1997) (last visited Feb. 29, 2012).

49. Anetzberger et al., *supra* note 42, at 158.

50. *See Coalitions,* NAT'L COMM. PREVENTION ELDER ABUSE, http://www.preventelderabuse.org/coalitions (last visited Feb. 29, 2012).

51. Rosalie S. Wolf & Karl Pillemer, *What's New in Elder Abuse Programming? Four Bright Ideas*, 34 GERONTOLOGIST 126, 127 (1994).

52. *Id.*

53. NAT'L CTR. ON ELDER ABUSE, CREATING EFFECTIVE LOCAL ELDER ABUSE

Center on Elder Abuse, more than three-dozen networks have been developed nationwide, with the Phoenix Area Agency on Agency providing training and technical assistance in capacity building.[54]

C. LEGAL BASIS

A multidisciplinary response to elder abuse can be either required or optional. Required responses are found in law or administrative regulation. The American Bar Association's Commission on Law and Aging has identified several states with adult protective services law provisions that authorize or mandate multidisciplinary teams.[55] The Florida statute, for instance, authorizes "multidisciplinary adult protection teams" in each district, which may be comprised of trained counseling personnel, law enforcement officers, medical personnel, social workers experienced in adult abuse, and public guardians.[56] The Montana statute mandates "[t]he county attorney or department of public health and human services" to "convene one or more temporary or permanent interdisciplinary adult protective service teams" for the purposes of individual need assessment, treatment plan formulation and monitoring, and service coordination.[57]

D. FORM OF MEMBER RELATIONSHIP

The ties binding those involved in the multidisciplinary elder abuse response can be either formal or informal. Formal ties are evidenced by interagency or membership agreements. They are characterized by written procedures, by-laws or

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PREVENTION NETWORKS: A PLANNING GUIDE 1 (2004–06), *available at* http://www.ncea.aoa.gov/ncearoot/main_site/pdf/EffectiveLocalElderAbusePreventionNetworks.pdf (last visited Feb. 29, 2012).

54. *Id. See Coalitions, supra* note 50.

55. LORI STIEGEL & ELLEN KLEM, AM. BAR ASSOC. COMM'N ON LAW & AGING, MULTIDISCIPLINARY TEAMS AUTHORIZATIONS OR MANDATES: PROVISIONS AND CITATIONS IN ADULT PROTECTIVE SERVICES LAWS, BY STATE (2007).

56. *Id*. at 2.

57. *Id*. at 4.

policies, and structured participation; they are more likely than informal responses to receive financial support.[58] In contrast, informal ties are based on verbal agreement and good will.[59]

Additionally, the form of member relationships can be temporary or permanent. With temporary relations, professionals or agencies come together for a specific and time-limited task.[60] With permanent relations, they commit themselves to addressing a series of issues that are not rigidly bound by either time or scope.[61]

Sometimes multidisciplinary responses evolve from one form of member relationship to another over time. This has been true of the aforementioned Consortium Against Adult Abuse.[62] The Consortium was first established as an ad hoc committee of the Federation for Community Planning in Cleveland, specifically to draft state adult protective services legislation. After the legislation became law, the committee increased its membership in order to provide public and professional education on the problem of elder abuse and newly enacted Ohio adult protective services law. A couple of years later the committee greatly expanded its mission and membership, transforming itself into the Consortium, with written membership agreements and operational procedures.

E. ABUSE ORIENTATION

Abuse orientation in a multidisciplinary response can be either elder abuse specific or non-elder abuse specific. If elder abuse specific, then response can be inclusive or exclusive with respect to a particular form. In the first variation, some responses only focus on elder abuse situations, and others

58. FREDA BERNOTAVICZ, COMMUNITY ROLE: IMPROVING PROTECTIVE SERVICES FOR OLDER AMERICANS: A NATIONAL GUIDE SERIES 11 (1982); JANE K. STRAKER ET AL., NAT'L ASS'N AREA AGENCIES ON AGING, 2007 AGING NETWORK SURVEY: ELDER ABUSE AND LEGAL ASSISTANCE AAA RESULTS 1 (2008).

59. Anetzberger, *supra* note 47, at 6.

60. *Id*. at 7.

61. *Id*.

62. Consortium founded by this author.

consider situations that represent the elderly and other vulnerable populations' broad concerns, including elder abuse. In the second variation, some responses consider elder abuse across all forms, and others focus on just one form of elder abuse.

Elder abuse specific multidisciplinary responses that consider all forms have the longest history. They have existed since the early 1980s and are discussed in many guides to elder abuse practice.[63] The Vulnerable Abuse Specialist Team (VAST) in Orange County, California represents such an abuse orientation, with most of its cases being referred by adult protective services or law enforcement.[64] A non-elder abuse specific team that offers elder abuse consultation is Denver, Colorado's Community Bioethics Committee, which assists adult protective services locally with cases involving incapacitated adults having complex health and social issues.[65] Finally, the most widely recognized multidisciplinary team focused on a single form of elder abuse is the Fiduciary Abuse Specialist Team (FAST).[66] It originated in Los Angeles, California but now is found in communities in other states.[67] The FAST helps to identify and prosecute financial abuse cases as well as prevent or recover victim losses.[68]

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63. *See, e.g.*, NAT'L PARALEGAL INST. ET AL., ELDER ABUSE AND NEGLECT: A GUIDE FOR PRACTITIONERS AND POLICY MAKERS 5–10, 106–08 (Edwin Villmoare & James Bergman eds., 1981); LISA NERENBERG, NAT'L CTR. ON ELDER ABUSE, BUILDING PARTNERSHIPS: A GUIDE TO DEVELOPING COALITIONS, INTERAGENCY AGREEMENTS AND TEAMS IN THE FIELD OF ELDER ABUSE 7–8, 10 (1995) [hereinafter NERENBERG, BUILDING PARTNERSHIPS].

64. Laura Mosqueda et al., *Advancing the Field of Elder Mistreatment: A New Model for Integration of Social and Medical Services*, 44 GERONTOLOGIST 703, 705 (2004).

65. Joanne Marlatt Otto, *Bioethics Committee Aids APS Workers in Making Complex Medical Decisions for Incapacitated Adults*, *in* ABUSE AND NEGLECT OF VULNERABLE ADULT POPULATIONS, 14-8 (Joanne Marlatt Otto ed., 2005).

66. Susan J. Aziz, *Los Angeles County Fiduciary Abuse Specialist Team: A Model for Collaboration,* 12 J. ELDER ABUSE & NEGLECT 79, 79–80 (2000).

67. BRANDL ET AL., *supra* note 5, at 113.

68. Aziz, *supra* note 66, at 80.

F. TASK LEVEL

The task level for multidisciplinary elder abuse responses can be either micro or macro. Micro level tasks tend to be case-oriented and aimed at clinical evaluation and intervention.[69] Macro level tasks tend to be community-oriented and aimed at social change.[70] Texas Elder Abuse and Mistreatment (TEAM) operates at the micro level in assessing referred clients in either home or clinical settings.[71] In contrast, the Scioto County, Ohio Adult Protective Services Task Force operates at the macro level.[72] Since forming in 1993, its projects have included elder abuse awareness campaigns, conferences and trainings, and screening tool and service guide development and dissemination.[73] It should be noted that although most micro level responses involve comprehensive assessment, some have narrower intents. This is perhaps best illustrated in fatality or death review teams, which are becoming more common in the field of elder abuse.[74] It also should be noted that micro level findings can inform macro level activities. For example, death patterns identified by a fatality review team can lead an elder abuse network to seek public policy reform.[75]

III. EVALUATION OF THE MULTIDISCIPLINARY ELDER ABUSE RESPONSE

There has been no rigorous assessment of the multidisciplinary elder abuse response, or most other elder abuse interventions for

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69. *See* NERENBERG, ELDER ABUSE PREVENTION, *supra* note 5, at 41.

70. *See id.*

71. Carmel Bitondo Dyer & Angela M. Goins, *The Role of the Interdisciplinary Geriatric Assessment in Addressing Self-Neglect of the Elderly*, 24 GENERATIONS 23, 24, 26 (2000).

72. Kaye Mason-Inoshita, *Making Appropriate Elder Abuse Referrals* (2008), http://sciotocountymedicalsociety.org/documents/Area.Aging.MAKINGAPPROPRIATE.ppt (last visited Feb. 29, 2012) (presentation of Scioto Cty. Med. Soc'y).

73. *Id.*

74. LORI A. STIEGEL, ELDER ABUSE FATALITY REVIEW TEAMS: A REPLICATION MANUAL 13 (2005).

75. *Id.*

that matter.[76] Evaluations to date have tended to measure participant satisfaction or identify outputs, rather than outcomes. Most findings are favorable. More common in the literature on multidisciplinary elder abuse responses is the simple listing of perceived benefits and challenges of this approach, especially in contrast to a single discipline, organization, or system acting in isolation. Rarely noted are potential limitations to the multidisciplinary response for effective problem prevention and treatment.

A. RESEARCH

An early evaluation of a multidisciplinary elder abuse response was conducted by Rosalie Wolf and Karl Pillemer.[77] They identified the aforementioned San Francisco Multi-disciplinary Team as one of four best practices in elder abuse programming.[78] In making this designation, the researchers undertook in-depth interviews with the project coordinator, other project personnel, and staff members of the sponsoring organization in addition to making multiple project site visits.[79] As reported, best practice designation seemed to reflect the enthusiasm of team members about the experience and the greater number of benefits than problems they could cite surrounding team consultation.[80]

Ten years later, Pamela Teaster and Lisa Nerenberg completed a national survey of elder abuse multidisciplinary teams.[81] Although they asked respondents whether or not their teams had been evaluated, no evaluations were reported in the study findings.[82] Instead, the researchers concluded with a recommendation that teams determine their benefits and costs

76. Jenny Ploeg et al., *A Systematic Review of Interventions for Elder Abuse*, 21 J. ELDER ABUSE & NEGLECT 187, 188 (2009).

77. Wolf & Pillemer, *supra* note 51, at 126.

78. *Id.*

79. *Id.* at 126–27.

80. *See id.* at 127.

81. TEASTER & NERENBERG, *supra* note 40, at 2.

82. *Id.* at 26.

through systematic outcome evaluation.[83]

Three recent evaluations were published on elder abuse multidisciplinary teams. None represent rigorous research. All focus on project outputs and participant satisfaction.

Mary Twomey and her colleagues describe seven multidisciplinary teams formed in California through funding from the Archstone Foundation.[84] An external research group evaluated their first phase (2006–2009) of project development and implementation.[85] As "examples of outcome" the research group identified the following: 369 trainings and 5,575 persons trained; 149 formal presentations and 5,400 individuals in attendance; 103 media events reaching over 400,000 persons; more than 1,000 meetings; 109 volunteers recruited; 957 assessments or screenings completed; and 14 cases filed with the District Attorney.[86]

The other two evaluations target California elder abuse forensic centers. In Orange County, a satisfaction survey found that case review and intervention were considered to be more effective when handled by the forensic center's multidisciplinary team than when an agency or discipline acted independently.[87] However, respondents were unable to decide if case outcomes would have differed.[88] In Los Angeles County, assessment of the forensic center considered its first three years of operations.[89] The researchers noted three "process outcomes."[90] First, there was high attendance at meetings and high satisfaction by case presenters (i.e., 4.4–4.7, with 5.0 indicating the highest level of

83. *Id.* at 19.

84. Mary S. Twomey et al., *The Successes and Challenges of Seven Multidisciplinary Teams*, 22 J. ELDER ABUSE & NEGLECT 291, 292 (2010).

85. *Id.*

86. *Id.* at 302–03.

87. Aileen Wiglesworth et al., *Findings from an Elder Abuse Forensic Center*, 46 GERONTOLOGIST 277, 277 (2006).

88. *See id.* at 283.

89. Adria E. Navarro et al., *Do We Really Need Another Meeting? Lessons from The Los Angeles County Elder Abuse Forensic Center*, 50 GERONTOLOGIST 702, 702 (2010).

90. *Id.* at 706–07.

satisfaction).[91] Second, the number of training events and media events increased over time (respectively 45 and 24 in 2006, 166 and 32 in 2008).[92] Third, specialized assessments (e.g., neuropsychological, conservator) and District Attorney filings and prosecutions were common; however, the researchers acknowledged that benchmarks are lacking to measure performance in either regard.[93]

B. BENEFITS

The literature on the multidisciplinary elder abuse response identifies many benefits to this approach. They include: (1) increased problem awareness; (2) holistic case assessment; (3) more creative and comprehensive case plans and community action; (4) prevention of case dumping on a single agency or system; (5) improved understanding of the roles and limitations of individual disciplines on systems; (6) reduction of inappropriate or duplicative responses; (7) decreased case recidivism; (8) fewer turf issues; (9) better access to information and service options; and (10) improved relations and communication among individuals representing diverse disciplines and systems.[94]

Likewise, the literature suggests essential qualities for an effective multidisciplinary response. Among them are: (1) common purpose and goals; (2) capable leadership; (3) belief in the importance of collaboration; (4) strong infrastructure; (5) valuing the contribution of others; (6) mutual accountability among members; (7) commitment to honest communication and

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91. *Id.*

92. *Id.* at 707.

93. *Id.*

94. Jane R. Matlaw & Doreen M. Spence, *The Hospital Elder Assessment Team: A Protocol for Suspected Cases of Elder Abuse and Neglect*, 6 J. ELDER ABUSE & NEGLECT 23, 36 (1994); MARY JOY QUINN, & SUSAN K. TOMITA, ELDER ABUSE AND NEGLECT: CAUSES, DIAGNOSIS, AND INTERVENTION STRATEGIES 245 (2d ed. 1997); Mary Joy Quinn & Candace J. Heisler, *The Legal System: Civil and Criminal Responses to Elder Abuse and Neglect*, 12 PUB. POL'Y & AGING REP. 8, 13 (2002); NERENBERG, BUILDING PARTNERSHIPS, *supra* note 63, at 9; Anetzberger et al., *supra* note 42, at 160; BRANDL ET AL., *supra* note 5, at 110–15.

openly sharing information; and (8) a results-oriented approach.[95]

It should be noted that the above identified benefits and essential qualities for multidisciplinary elder abuse responses reflect the beliefs, perceptions, and experiences of the persons suggesting them. They do not represent the results of empirical investigation. Therefore, they must be viewed with caution and reservation.

C. CHALLENGES AND LIMITATIONS

Multidisciplinary elder abuse responses can face many challenges. These include: (1) lack of participation by key disciplines or systems; (2) communication problems across disciplines or systems with different philosophies, goals, and professional jargon; (3) law or agency policies that inhibit contact and communication; (4) status differences, misperceptions, and mistrust between disciplines or systems; (5) interpersonal biases or conflicts; (6) competition for recognition and position within the group; (7) insufficient administrative support or other resources; (8) geographic distance and costs associated with meetings; (9) competing work demands and scheduling conflicts; and (10) difficulty in sustaining interest and involvement over time.[96]

Like benefits and essential qualities, challenges for multidisciplinary responses often are "in the eye of the beholder" and can even change over time. However, perhaps the greatest limitation for the multidisciplinary elder abuse

95. *See* BERNOTAVICZ ET AL., *supra* note 58.

96. Ronald Dolon & James E. Hendricks, *An Exploratory Study Comparing Attitudes and Practices of Police Officers and Social Work Providers in Elder Abuse and Neglect Cases*, 1 J. ELDER ABUSE & NEGLECT 75, 75–90 (1989); BRIAN K. PAYNE, CRIME AND ELDER ABUSE: AN INTEGRATED PERSPECTIVE 260 (2d ed. 2005); BRANDL ET AL., *supra* note 5, at 116–17; Maria R. Schimer & Georgia J. Anetzberger, *Examining the Gray Zones in Guardianship and Involuntary Protective Services Laws*, 10 J. ELDER ABUSE & NEGLECT 19, 19 (1999); B.E. Blakely & Ronald Dolan, *The Relative Contributions of Occupation Groups in the Discovery and Treatment of Elder Abuse and Neglect* 17 J. GERONTOLOGIST SOC. WORK 183, 197 (1991); TEASTER & NERENBERG, *supra* note 40, at 16; Twomey et al., *supra* note 84, at 300–01.

response rests in the often-unrealistic expectations of those who promote their use. Like the problem they address, multi-disciplinary responses are complicated and difficult. They are not panaceas, but rather one set of tools to consider in elder abuse prevention and treatment. Whether or not they "work" in part depends upon the fit between the specific response variation selected and the people and setting adopting the response. Even then, there are no guarantees, only the opportunity to try it or something else again. After all, elder abuse is not going away; the problem is too serious to ignore or not intervene, and to date we have not determined what works and what does not in this field. Finding out, of course, is an arena ripe for rigorous research and is essential to moving forward. It is also long overdue.