Issues to Discuss for Cross Training

Issue	Discussion	Possible Options and/or Solutions
Confidentiality	Members of the MDT should understand each member's legal mandates regarding confidentiality. Without exception, every MDT grapples with issues related to confidentiality and for some communities wishing to start an MDT, confidentiality can be the greatest barrier to collaboration. Confidentiality is also invoked as an explanation/excuse for not forming an MDT.[i] Confidentiality (which is about data, while privacy is about people) involves restricting the flow of information. Confusion over privacy requirements has resulted in some organizations denying requests for information[ii] or refusing to share information, but clarification has been offered in the context of HIPPA[iii] and financial institutions,[iv] while some state statutes permit release of information. (For more details see the Toolkit item titled: Statutory Review of Multidisciplinary Teams and Information Sharing).[v] After a discussion, the members should establish confidentiality policies and procedures for the MDT, including definitions of what information is considered confidential and how to treat confidential information that is shared. Also, as teams gain experience and members get to know and trust each other, concerns about confidentiality inevitably diminish. **Exceptions to confidentiality**. There are exceptions to confidentiality, such as mandatory reporting (see the Toolkit item titled: Statutory Review of Multidisciplinary Teams and Information Sharing). It is important to inform victims about these	Some issues of confidentiality are addressed in statutes. For example, Illinois' Elder Abuse and Neglect Act (Illinois Public Act 85 - 1184) provides immunity to any appropriate provider of services who consults with the elder abuse provider agency in the development of a service case plan for a victim of substantiated abuse. California's statute expressly allows MDTs to share information with one another.[vi] Maine's Elder Abuse Fatality Review Team relies on a Maine statute which allows team members to obtain information from other team members and also provides immunity to team members who share that information and thereby avoid a HIPAA violation.[vii] However, very often other solutions are needed, which might include:[viii] • A confidentiality provision in the MOU. • Signing a confidentiality pledge prior to the meeting for individuals who attend case review meetings but are not part of the formal MDT (see Toolkit item: Sample Confidentiality Forms). • Asking clients to sign consent forms to share case information with other service providers. • Having all MDT members sign confidentiality agreements at each meeting. • Using pseudonyms or initials when

	exceptions.	discussing cases. • Including written reminders about confidentiality (with applicable state code sections) on monthly meeting agendas. • Prohibiting note taking during case review meetings except for the MDT Coordinator. • Establishing procedures to protect documents shared during a meeting, such as collecting all paper documentation after the meeting and shredding duplicate documents. • Ensuring that any paper or digital files are appropriately kept confidential and safe. Locked file cabinets and password protected files stored behind a firewall are good practices. • Verbal reminders not to use names during case review meeting. • Reminding MDT members not to present "discoverable" information. • Having an agency's attorneys submit a ruling (interpretation) permitting the agency representative to share information with other MDT members.
Conveying MDT Recommendations to the Victim	Information discussed during the MDT case review meeting and any recommendations resulting from the discussion will need to be conveyed to the victim.	The team should agree who is going to convey MDT information to the victim.[ix]

Jargon	Jargon should be avoided as it contributes to misunderstandings and makes people feel left out. In order to understand one another, your MDT will want to settle on a common language.[x] For example, law enforcement might refer to an act of hitting another person as an assault, while social workers might refer to the action as physical abuse.[xi] Consider another example: Think of the word "prevention." What does it mean? Law enforcement might think of locking someone up while APS might think of providing services to an adult to keep any abuse, neglect, and/or financial exploitation from recurring. As can be seen, using the term "prevention" without having a common definition can result in misunderstandings and loss of trust among team members.	Develop a list of terms the MDT will need to grapple with and begin the process of cross learning. The MDT members may not adopt the terms of another profession, but they will at least have a better understanding that a term may have a different meaning for different MDT members.
Agency Constraints	At face value, MDTs represent individuals from different disciplines. However, the function of those professionals is to intervene in various ways in the lives of older individuals. Each discipline has been given authority to do so by their respective agencies. MDTs are granted the power to introduce interventions and propose solutions. As experts, they are part of the knowledge class. They define, interpret and manage problems experienced by older adults. Ask team members to articulate their feelings of oppression within broader systems of influence (legislation, statutes, local policies) that stunt their ability to work more effectively with these cases.[xii] Consider discussing: • The respective agency's policies that limit a number of functions (e.g., time limitations for investigations or	Only through discussion of these issues can the team develop a common understanding of each other's constraints.

	providing services[xiii]) • Funding limitations (e.g., an agency is unable to pay for their employee's time at an MDT meeting due to "billable" hours) • The time consuming nature of providing services • Lack of appropriate providers • Limitations on in-home investigations/service provisions[xiv] • Right to refuse services	
Conceptualizing Elder Abuse	There is no consensus among professionals as to how to conceptualize elder abuse.[xv] Many agencies represented on the MDT will hold different conceptualizations of elder abuse, and the team will need to struggle with coming to a consensus on this.	Discuss the many ways in which elder abuse has been conceptualized and how your agency perceives elder abuse: • Older adults in need of protection[xvi] • A form of family violence[xvii] • A crime[xviii] • A public health problem[xix] • A medical issue[xx] • A human rights violation[xxi] • A civil rights violation[xxii]
Defining Elder Abuse	Elder abuse has been defined in different ways.[xxiii] These definitions vary by victim and by offender characteristics, by the types of actions committed, and/or by the harms incurred by victims, with some definitions including victim age, victim vulnerability, and the presence of a trust relationship.[xxiv] Many agencies on the MDT must follow their statutory definition of elder abuse. State statutes likewise differ, as do policy interpretations of state statutes by different agencies. These various parameters should be discussed thoroughly among the MDT	*Elder Justice Act of 2009*: ''(1) ABUSE.—The term 'abuse' means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.[xxv] *CDC (website)*: Elder abuse is any abuse and neglect of persons age 60 and older by a caregiver or another person in a relationship involving an

	members, although each agency representative will have to adhere to their agency's definition. Elder abuse has been defined by federal agencies and statutes as well. For example:	expectation of trust.[xxvi] *National Research Council (2003)*: Elder mistreatment is defined in this report to refer to (a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm.[xxvii] *WHO (2002)*: Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.[xxviii] *National Center on Elder Abuse (funded by the Administration on Community Living)*: Domestic elder abuse generally refers to any of the following types of mistreatment that are committed by someone with whom the elder has a special relationship (for example, a spouse, sibling, child, friend, or caregiver).[xxix] *Administration on Aging*: In general, elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.[xxx] *Elder Justice Roadmap Report (June 2014)*: Elder abuse is physical, sexual or psychological abuse, as well as neglect, abandonment and financial exploitation of an older person by another person or entity, that occurs in any setting (e.g., home, community or facility), either in a relationship where there is an expectation of trust and/or when an older person is targeted based

		on age or disability.[xxxi]
Causes of Elder Abuse	Different disciplines hold different perceptions and assumptions about the causes of elder abuse.[xxxii] Chiefs of police compared to nursing home employees hold different perceptions of elder abuse, due in part to their experiences working with offenders in these two systems, and differences in the systems themselves (organizational culture[xxxiii], goals, rules, etc).[xxxiv]	Behaviors perceived by one discipline may be viewed as immoral but not criminal, but may be perceived by another discipline as criminal.[xxxv] This is important because one's framework has implications for how one responds.[xxxvi]
Philosophy and Ethics	Each agency represented on your MDT may hold a different philosophical orientation and operate under different professional ethics (see the Toolkit item titled: List of Professional's Code of Ethics, for more details) regarding older adults, elder abuse,[xxxvii] and ethical decision making. [xxxviii]	The MDT members will need to openly and honestly articulate and express their world view (or personal biases)[xxxix] and how they balance autonomy/self-determination with protection.[xl] Your team will need to grapple with concepts such as self-determination[xli] and beneficence, and how much risk the MDT can tolerate.[xlii] Members who defer to a belief in personal autonomy at the expense of victim safety may conflict with those who emphasize victim safety above all else. Part of the process of becoming a team will be to align these varying philosophies. Therefore, the team members will need to acknowledge these differences, talk through these differences, and arrive at a consensus. It is widely acknowledged and somewhat documented that elder abuse victims decline services. How is your MDT going to handle these cases? Is the goal harm reduction or harm elimination? Even if your community does not have an ethicist, the MDT should carve out time annually to discuss these ethical issues.

Acceptable Outcomes	The team will need to decide upfront what they consider a sufficiently good outcome to justify ongoing investment in a case.[xliii] Differences in the perception of acceptable outcomes can impede investigation and the actual outcome of the case.	For example, law enforcement and prosecutors may perceive evidence collection, arrest, and prosecution of the offender as a good outcome. However, many older victims may not perceive the outcome in a similar way. They may prefer help for the offender rather than incarceration or probation. There is some evidence that MDTs are associated with a higher likelihood of conservatorship.[xliv] Is that a good outcome?
Media Coverage	Some MDT members might be concerned about media coverage. Although each agency likely has a media policy, the MDT will need to discuss how the MDT will respond to media attention.	Consider designating one or two MDT members to be the spokesperson for the MDT, limiting other MDT members from contact with the media.
Testifying in Court	There may be situations in which a member of the MDT will be required to testify in a legal proceeding.[xlv]	The MDT will need to plan for this possibility.

Endnotes

[i] Nerenberg, L., Davies, M., & Navarro, A. E. (2012). In pursuit of a useful framework to champion elder justice from California's Elder Justice Coalition: Lessons in coordination, collaboration, and advocacy. *Generations, 36*(3), 89-96.

[ii] Dyer, C. B., Heisler, C. J., Hill, C. A., & Kim, L. C. (2005). Community approaches to elder abuse. Clinics in Geriatric Medicine, 21, 429-447.

[iii] See Center on Elder Abuse letter clarifying HIPPA in the context of adult protective services http://www.centeronelderabuse.org/docs/HIPAAGIVES.pdf

[iv] On September 24, 2013, eight federal agencies issued Interagency Guidance on Privacy Laws and Reporting Financial Abuse of Older Adults, available at http://files.consumerfinance.gov/f/201309_cfpb_elder-abuse-guidance.pdf

[v] Cal. Welf. & Ins. Code S 15633.5 "(a) Information relevant to the incident of elder or dependent adult abuse may be given to an investigator… who is investigating a known or suspected case of elder or dependent adult abuse." [California Welfare and Institutions Code]

[vi] Cal. Welf. & Ins. Code 10850.1 "(a) Notwithstanding any other provision of law, for purposes of Section 10850, the activities of a multidisciplinary personnel team engaged in the prevention, identification, management, or treatment of child abuse or neglect, or of the abuse of elder or dependent persons are activities performed in the administration of public social services, and a member of the team may disclose and exchange any information or writing that also is kept or maintained in connection with any program of public social services or otherwise designated as confidential under state law which he or she reasonably believes is relevant to the prevention, identification, management, or treatment of child abuse or neglect, or of the abuse of elder or dependent persons to other members of the team. All discussions relative to the disclosure or exchange of any such information or writing during team meetings are confidential and, notwithstanding any other provision of law, testimony concerning any such discussion is not admissible in any criminal, civil, or juvenile court proceeding." [California Welfare and Institutions Code; Cal. Welf. & Ins. Code 10850 regards confidentiality]

Cal. Welf. & Ins. Code S 15633: "(b) Reports of suspected abuse of an elder or dependent adult and information contained therein may be disclosed only to the following: … (2) (A) Persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records that are relevant to the prevention, identification, or treatment of abuse of elderly or dependent persons. …" [California Welfare and Institutions Code]

Cal. Welf. & Ins. Code 15754 (2011) "(a) Notwithstanding any provision of law governing the disclosure of information and records, persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records which are relevant to the prevention, identification, or treatment of abuse of elderly or dependent persons." [California Welfare and Institutions Code - Adult Protective Services]

[vii] Maine Revised Statutes Annotated Title 5, Part 1, Chapter 9, §200-H. Maine Elder Death Analysis Review Team. "5. Access to information and records. In any case subject to review by the team, upon oral or written request of the team, notwithstanding any other provision of law, any person that possesses information or records that are necessary and relevant to a team review shall as soon as practicable provide the team with the information and records. Persons disclosing or providing information or records upon request of the team are not criminally or civilly liable for disclosing or providing information or records in compliance with this subsection." The complete statute is available at http://www.mainelegislature.org/legis/statutes/5/title5sec200-H.html

[viii] Teaster, P., Nerenberg, L., & Stansbury, K. L. (2003). A national look at elder abuse multidisciplinary teams. Journal of Elder Abuse & Neglect, 15(3-4), 91-107.

[ix] Lamb, B. W., Taylor, C., Lamb, J. N., Strickland, S. L., Vincent, C., Green, J. S. A., & N. Sevdalis (2013). Facilitators and barriers to teamworking and patient centeredness in multidisciplinary cancer teams: Findings of a national study. Annals of Surgical Oncology, 20(5), 1408-1416.

[x] Nack, J. R., Dessin, C. L., & Swift, T. (2012). Creating and sustaining interdisciplinary guardianship committees. Utah Law Review, 2012(3), 1667-1690.

[xi] Payne, B. K. (2002). An integrated understanding of elder abuse and neglect. Journal of Criminal Justice, 30, 535-547 (p. 539).

[xii] Maxine Jacobson (2001). Child sexual abuse and the multidisciplinary team approach: Contradictions in practice. Childhood, 8(2), 231-250.; Koenig, T. L., Leiste, M. R., & Spano, R. (2013). Multidisciplinary team perspectives on older adult hoarding and mental illness. Journal of Elder Abuse & Neglect, 25(1), 56-75.

[xiii] Koenig, T. L., Leiste, M. R., & Spano, R. (2013). Multidisciplinary team perspectives on older adult hoarding and mental illness. Journal of Elder Abuse & Neglect, 25(1), 56-75 (p. 73).

[xiv] Koenig, T. L., Leiste, M. R., & Spano, R. (2013). Multidisciplinary team perspectives on older adult hoarding and mental illness. Journal of Elder Abuse & Neglect, 25(1), 56-75. Mental health services might be more effective if delivered in-home rather than in the clinic.

[xv] Joan Harbison & Marina Morrow (1998). Re-examining the social construction of 'elder abuse and neglect': A Canadian perspective. Ageing & Society, 18(6), 691-711.

[xvi] Dessin, C. L. (2000). Financial abuse of the elderly. *Idaho Law Review, 36*, 203–226.

[xvii] Acierno, R., Hernandez, M. A., Amstadter A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. American Journal of Public Health, 100(2), 292-297.

[xviii] Goergen, T., & Beaulieu, M. (2010). Criminological theory and elder abuse research—Fruitful relationship or worlds apart? Ageing International, 35(3), 185-201.; Payne, B. K. (2011). Crime and elder abuse: An integrated perspective (3rd ed). Springfield, IL: Charles C. Thomas.; Setterlund, D., Tilse, C., Wilson, J., McCawley, A., & Rosenman, L. (2007). Understanding financial elder abuse in families: the potential of routine activities theory. Ageing and Society, 27, 599-614.

[xix] WHO (2002). World report on violence and health. WHO, Geneva, Switzerland, available at: http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf?ua=1; Summers, R. W., & Hoffman, A. M. (eds.) (2006). Elder abuse: A public health perspective. Washington, DC: American Public Health Association.

[xx] Lachs, M. S., & Pillemer, K. (2004). Elder abuse. The Lancet, 364, 1263-1272.; WHO (2008). A global response to elder abuse and neglect: Building primary health care capacity to deal with the problem worldwide: Main report. Geneva, Switzerland, WHO. Available at http://books.google.com/books?hl=en&lr=&id=Pa0z1Bd_xBsC&oi=fnd&pg=PR3&dq=world+health+organization+elder+abuse+is+a+human+rights+violation&ots=4YM4Kd4dEC&sig=yIUBn-Vcyv6JD5iya6ypYffuzJQ#v=onepage&q&f=false

[xxi] WHO (2002). World Report on Violence and Health. Geneva, Switzerland: WHO (see Chapter 5: Elder abuse), available at http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf?ua=1

[xxii] Kohn, N. A. (2012). A Civil Rights Approach to Elder Law. In I. Doron & A. M. Sodenpp (eds.), Beyond Elder Law: New Directions in Law and Aging (pp. 19-34).; see also, the Department of Health in the United

Kingdom, defining elder abuse as 'a violation of an individual's human and civil rights by another person or persons'. United Kingdom Department of Health. (2000). No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (p. 9). available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486

[xxiii] Goergen, T., & Beaulieu, M. (2013). Critical concepts in elder abuse research. International Psychogeriatrics, 25(8), 1217-1228. See also Mysyuk, Y., Westendorp, R. G. J., & Lindenberg, J. (2013). Added value of elder abuse definitions: A review. Ageing Research Reviews, 12(1), 50–57.; Payne, B. K. (2002). An integrated understanding of elder abuse and neglect. Journal of Criminal Justice, 30, 535-547 (pp. 538-541).

[xxiv] Dong, X., Simon, M., Rajan, K., and Evans, D.A. (2011), "Association of cognitive function and risk for elder abuse in a community-dwelling population," Dementia and Geriatric Cognitive Disorders, Vol. 32, pp. 209–215.

[xxv] Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[xxvi] Available at http://www.cdc.gov/violenceprevention/elderabuse/definitions.html

[xxvii] National Research Council. Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. Washington, DC: The National Academies Press, 2003.

[xxviii] WHO (2002). World Report on Violence and Health. Geneva, Switzerland: WHO, available at http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf?ua=1

[xxix] Available at http://www.ncea.aoa.gov/faq/index.aspx

[xxx] Available at http://www.aoa.gov/AoA_programs/elder_rights/EA_prevention/whatisEA.aspx

[xxxi] Available at http://ncea.acl.gov/Library/Gov_Report/docs/EJRP_Report_and_Appendices.pdf

[xxxii] Hickey, T. & Douglas, R.L. (1981). Neglect and abuse of older family members: Professionals' perspectives and case experiences. The Gerontologist, 21(2), 171-6.; Payne, B. K. (2002). An integrated understanding of elder abuse and neglect. Journal of Criminal Justice, 30, 535–547.; in the context of child abuse, see Feng, J., Fetzer, S., Chen, Y. W., Yeh, L., & Huang, M. C. (2010). Multidisciplinary collaboration reporting child abuse: A grounded theory study. International Journal of Nursing Studies, 47, 1483-1490, finding that nurses and CPS blame society and mothers for child abuse, while law enforcement officers blame offenders.

[xxxiii] The shared values, beliefs, and norms of an organization (see Levi, D. (2014). Group dynamics for teams (4th ed). Las Angeles, CA: Sage (p. 265).

[xxxiv] Payne, B. K., Berg, B. L., & James, L. F. (2001). Attitudes about sanctioning elder abuse offenders among police chiefs, nursing home employees, and students. International Journal of Offender Therapy and Comparative Criminology, 45, 363-382.

[xxxv] Payne, B. K. (2002). An integrated understanding of elder abuse and neglect. Journal of Criminal Justice, 30, 535–547 (p. 539).

[xxxvi] For an excellent example in another context, see Ilkiw-Lavalle, O., Grenyer, B.F.S. and Graham, L. (2002). Does prior training and staff occupation influence knowledge acquisition from an aggression management training program? International Journal of Mental Health Nursing, 11(4), 233-239.

[xxxvii] See e.g., Connors, H. L. (2008). Autonomy vs. protection: A comparison of physicians, elder law attorneys, and protective service case managers. Dissertation.

[xxxviii] Velasquez, M., Moberg, D. Meyer, M.J., Shanks, T., McLean, M.R., DeCosse, D., André, C. and Hanson, K.O. (2009). A Framework for Thinking Ethically. Markkula Center for Applied Ethics at Santa Clara University, available at https://www.scu.edu/ethics/practicing/decision/framework.html.; Beauchamp,

T. L., & Childress, J. F., (2001), Principles of biomedical ethics. 5th edition. New York: Oxford University Press.; Colero, L. (2002). A framework for universal principles of ethics. Crossroads Programs, Inc., available at http://www.ethics.ubc.ca/papers/invited/colero.html.; see Karel, M. J. (2011). Ethics. In V. Molinari (Ed.), Specialty competencies in geropsychology (pp. 115–142). New York, NY: Oxford.; Office for Victims of Crime's Ethics in Victim Services curriculum, available at https://www.ovcttac.gov/Ethics/

[xxxix] Horning, S. M., Wilkins, S. S., Dhanani, S., Henriques, D. (2013). A Case of Elder Abuse and Undue Influence Assessment and Treatment From a Geriatric Interdisciplinary Team. Clinical Case Studies, 12(5), 373-387.

[xl] Koenig, T. L., Chapin, R., & Spano, R. (2010). Using multidisciplinary teams to address ethical dilemmas with older adults who hoard. Journal of Gerontological Social Work, 53(2), 137-147.

[xli] Bergeron, L. R. (2006). Self-determination and elder abuse: Do we know enough? Journal of Gerontological Social Work, 46(3-4), 81-102.; Oetjen, D., & Oetjen, R. (2006). The moral and ethical implications of elder abuse. In R. W. Summers & A. M. Hoffman (Eds.), Elder abuse: A public health perspective (pp. 77-96). Washington, DC: American Public Health Association.

[xlii] Karel, M. J. (2011). Ethics. In V. Molinari (Ed.), Specialty competencies in geropsychology (pp. 115–142). New York, NY: Oxford.

[xliii]Crotty, M., & Ratcliffe, J. (2011). If Mohammed won't come to the mountain, the mountain must go to Mohammed. Age and Ageing, 40(3), 290-292.; see also Levi, D. (2014). Group dynamics for teams (4th ed). Las Angeles, CA: Sage, Chapter 2, Defining team success.

[xliv] Gassoumis, Z. D., Navarro, A. E., & Wilber, K. H. (2015). Protecting victims of elder financial exploitation: The role of an elder abuse forensic center in referring victims for conservatorship. Aging & mental health, 19(9), 790-798.

[xlv] Kistin, C., Tien, I., Bauchner, H., Parker, V., & Leventhal, J. M. (2010). Factors that influence the effectiveness of child protection teams. Pediatrics, 126, 94-100.; Navarro, A.E., Wilber, K.H., Yonashiro, J., & Homeier, D.C. (March 2010). Do we really need another meeting? Lessons from the Los Angeles County Elder Abuse Forensic Center. The Gerontologist, 50(5), 702-177.