Issues for Initial MDT Discussions

Topic Area	Discussion Issue/Question	Options for Consideration
Referral and Intake Protocols	Referral and intake are intimately linked. For example, the referral might trigger completion of an intake form (see Toolkit item: Sample Intake and/or Referral Forms, for examples). Referral and intake are designed to ensure appropriate cases reach the MDT for review. There is some evidence that more complex and challenging cases are referred to MDTs.[i]	Referral protocols will need to be developed to ensure cases are not lost in the system. The MDT may want to discuss who accepts the referral on behalf of the MDT (e.g., the MDT Coordinator) and what happens to the referral after it has been accepted.
		Intake of case information is an important part of the initial process to ensure that adequate case information is collected and assessed prior to case review (see toolkit item: Sample: Recruitment Invitation). It is common for new MDTs to receive fewer referrals than actual cases eligible for review while trust is being established and procedures are being refined.
Eligible Referral Source	The MDT may want to discuss from whom referrals to the MDT can originate. Referrals may come from:	APS caseworkers only
		MDT members only[ii]
		Restricted sources (e.g., MDT members and community agencies)
		Anyone, although this is uncommon[iii]

Types of Elder Abuse Accepted for Intake	The MDT will want to discuss which types of elder abuse they will review.[iv] The decision regarding which types of cases will be accepted for review (or consultation) by the MDT will depend to some extent on state law. Elder abuse is a term used to represent five types of abuse of older persons, although forms of abuse sometimes co-occur: •Financial exploitation •Physical abuse •Neglect by others/Abandonment •Sexual abuse •Psychological abuse •Other	The MDT may choose to respond to all kinds of elder abuse.
		The MDT may choose to specialize in one form of elder abuse.[v] For example, there are specialized teams that focus exclusively on financial exploitation, such as Financial Abuse Specialist Teams (FASTs).[vi] FASTs may involve cases of financial exploitation, financial fraud, or both.[vii]
		Some MDTs specify exact circumstances under which they will accept a case. For example, the San Diego Help and Outreach to Protect the Elderly (HOPE)[viii] Project accepts cases of "…physical abuse, neglect, or financial exploitation characterized as a misdemeanor or felony conduct, where the first report of abuse comes from a law enforcement agency or elder abuse hotline call."[ix]
		The MDT may choose to review only complex or challenging cases, which are best suited to group decision-making.[x]
		Some MDTs accept self-neglect cases,[xi] while others do not, although there is evidence that self-neglect is related to subsequent and other forms of abuse.[xii] Although typically a forensic MDT does not accept self-neglect cases, there may be occasions when it is useful to be flexible. For example, if the MDT is trying to recruit an agency and the agency refers a self-neglect case to the MDT, it might be useful to make an exception and review the case.
Referral and Location of Abuse	Depending on state law, MDTs may accept cases involving:	Community-residing victims
		Residents of long-term care facilities and other congregate living arrangements
		Both

Jurisdiction	Some MDTs are restricted to a single jurisdiction, while other MDTs function across jurisdictions and include two or more counties/cities. Your statutes may limit your options[xiii], but also consider:	Geography
		Transportation
		Population
		Resources
		Level of interest (some jurisdictions will be more interested in participating in the MDT than others)
	Professionals outside your jurisdiction may request the assistance of the MDT.[xiv]	Your MDT will need to decide whether it has the resources to provide the requested assistance. In other contexts, grants have been obtained to provide pro bono services to localities outside the designated jurisdiction.[xv]
Eligibility Criteria	Most MDTs cannot review all elder abuse cases. Therefore, in addition to the type(s) of cases acceptable for review, the MDT may want to select some other eligibility criteria. Consider the following characteristics:	Age of victim[xvi]
		Vulnerability of the victim[xvii]
		High-risk cases[xviii]
		Clients who refuse services[xix]
		Client unable to leave their home
		Serious mental illness or intellectual disability
		Potential dementia issues
		Complex cases[xx]

Identify a Point-of-Contact Person	Communication is critical to client satisfaction. This is particularly important when a case is being staffed by an MDT comprised of a diverse range of professionals. Victims report greater satisfaction when they know what is going on with their case. Victims want to be kept informed, to be provided status updates on their case, and for someone to return their phone calls in a timely manner.[xxi] Therefore, a member of the MDT should be a designated point-of-contact person for victims.[xxii] Further recommended is the implementation of regularly timed verbal or written updates to families about the status of their case by the point-of-contact person.[xxiii] The point-of-contact person might be:	The lead investigator The victim advocate The MDT Coordinator
Clear Lines of Communication	A question need not wait to be asked until the next case review meeting but at the same time, accountability needs to be built into the system. Delineating clear lines of communication is not intended to control information, but rather is designed to ensure that information is received by its intended target.	The MDT may want to establish both formal and informal lines of communication.[xxiv] Formal lines of communication may include a point of contact person for all communication to the MDT, such as the MDT Coordinator. Informal lines of communication may include communication between MDT members that is not necessary for all MDT members to receive. However, procedures for tracking these communications may be warranted.

Conflict Resolution	It will be important for the MDT to recognize and acknowledge that the process of collaboration can result in frustration and conflict among MDT members.[xxv] Plan ahead for conflict and how conflicts will be resolved.[xxvi] Some common conflict resolution (and prevention) strategies include:	A situation left to fester will not resolve on its own. Acknowledging the frustration and concern is an important step in resolving the conflict.
		Separate the problem from the person. This way, you can discuss issues without damaging relationships.
		At times, when two people cannot agree or come to a compromise, voting is the best solution. If you simply must put a conflict to bed, voting can be an effective method.
Length of Time Following Cases	Your MDT will want to discuss how long to follow cases.[xxvii] APS will have statutory time restrictions[xxviii], but other MDT representatives may be able to maintain contact with the victim,[xxix] depending on resources.	The MDT will want to discuss restrictions on how long a case can be followed and within those restrictions, discuss the pros and cons of tracking cases: 1) to when the MDT ceases to review the case, 2) to the close/resolution of the case, or 3) for some period of time after the case has been resolved.

Assessing for Polyvictimization	Older victims may be experiencing multiple forms of abuse simultaneously, sometimes referred to as polyvictimization[xxx] or co-occurring abuse. Your MDT will need to decide whether it will screen for additional forms of abuse. Knowing whether victims are experiencing multiple forms of abuse matters. A case of financial exploitation co-occurring with physical abuse increased the odds of submission to the District Attorney by a factor of two; increased the odds of charges being filed by a factor of two; and increased the odds of a plea or conviction by a factor of three.[xxxi] Furthermore, outcomes tend to be more severe for victims of polyvictimization.	Discuss the benefits and costs of assessing for polyvictimization. For example, are there services for polyvictims if they are identified? Engage in free online *Polyvictmization in Later Life* training.[xxxii]
Victim Services Referrals	Your MDT will need to determine the degree of involvement/assistance you are able to offer victims. The actual process of linking clients to additional services ranges from:	Encouraging clients to link to the services themselves. Taking the client to an initial appointment and even subsequent ones.
Co-Location	Co-location is not an issue for most MDTs unless you are designing an Elder Justice Forensic Center. If co-location is an option, ensure the MDT members have input into the location, particularly law enforcement and adult protective services, as they are most often at the center of investigations and benefit from proximity. Consider both:	Benefits, e.g., greater collegiality among MDT members. Liabilities, e.g., greater expense.

Joint Signing of Documents	To promote interdisciplinary working, MDTs should consider joint documentation in which at least two team members sign a given report.[xxxiii] Consider both:	Benefits, e.g., greater safety and accountability. Liabilities, e.g., time consuming.
Battery of Assessment Instruments	Your MDT will need to determine which instruments to administer to clients. Each discipline may have its own battery of assessment instruments. Coordination and elimination of duplication will require careful consideration of which instruments to retain and which to eliminate. Consider, for example:[xxxiv]	Medical and pharmacology history Psychosocial intake Cognitive status Mental health[xxxv] Functional assessment

Home Visits and Methods for Contacting Victims	The MDT will need to decide on the methods for contacting and assessing victims. The two primary options include:	Request the victim to come to your office Making home visits[xxxvi] in which physicians and other relevant MDT members visit the victim's home together.[xxxvii] Home intervention programs hold promise during the investigation phase as well as service delivery.[xxxviii] Situations that might warrant a house visit include: [xxxix] • Victims who refuse to be investigated or refuse to leave their home • Hoarders • Problems with the alleged perpetrator • Logistical and health problems • Cases where clinicians need to assess the victim's environment Scholars at the University of Texas at Houston have developed a House Call Program.[xl] House calls are not without peril and therefore a safety manual for making house calls has been developed.[xli]

End Notes

[i] Wilber, K. H., Navarro, A. E., & Gassoumis, Z. D. (2014). *Evaluating the elder abuse forensic center model* (NCJ 246428). Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/246428.pdf

[ii] Dyer, C. B., Heisler, C. J., Hill, C. A., & Kim, L. C. (2005). Community approaches to elder abuse. *Clinics in Geriatric Medicine, 21*, (2), 429-447. doi:10.1016/j.cger.2004.10.007, noting that cases are generally referred to the medical case management team from APS, and cases tend to be medically complex cases (p. 436).

[iii] Rizzo, V. M., Burnes, D., & Chalfy, A. (201320132015). A systematic evaluation of a multidisciplinary social work–lawyer elder mistreatment intervention model. *Journal of Elder Abuse & Neglect, 27*(1), 1-18. doi:10.1080/08946566.2013.792104 (see p. 7 for a list of referral sources), e.g., self, family, friends, social workers, district attorney, police, hospitals and health care providers, clinics, APS, financial institutions, and anonymous sources.

[iv] Most CACs focus on sexual abuse and severe physical abuse and neglect cases, although other variations exist depending upon the community.

[v] Teaster, P. B., Nerenberg, L., & Stansbury, K. L. (2003). A national look at elder abuse multidisciplinary teams. *Journal of Elder Abuse & Neglect, 15*(3-4), 91-107. doi:10.1300/J084v15n03_06 For example, the Elder Abuse Forensic Center in Irvine, CA, provides adult protective services (APS) and criminal justice agencies with access to medical experts (Mosqueda, L., Burnight, K., Liao, S., & Kemp, B. (2004). Advancing the Field of Elder Mistreatment: A New Model for Integration of Social and Medical Services. *The Gerontologist, 44*(5), 703–708.). doi:10.1093/geront/44.5.703

[vi] FAST teams may investigate 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. See Aziz, S. J. (2000). Los Angeles County Fiduciary Abuse Specialist Team: A model for collaboration. *Journal of Elder Abuse & Neglect, 12*(2), 79-84.; doi:10.1300/J084v12n02_08; Malks, B., Schmidt, C. M., & Austin, M. J. (2002). Elder abuse prevention: A case study of the Santa Clara County Financial Abuse Specialist Team (FAST) program. *Journal of Gerontological Social Work, 39*(3), 23-40.; doi:10.1300/J083v39n03_03; Malks, B., Buckmaster, J., & Cunningham, L. (2003). Combating elder financial abuse --A multidisciplinary approach to a growing problem. *Journal of Elder Abuse & Neglect, 15*(3/4), 55-70.; doi:10.1300/J084v15n03_04; Nack, J. R., Dessin, C. L., & Swift, T. (2012). Creating and sustaining interdisciplinary guardianship committees. *Utah Law Review, 2012*(3), 1667-1690 (p. 1685 discussing California FASTs).

[vii] Malks, B., Buckmaster, J., & Cunningham, L. (2003). Combating elder financial abuse–A multi-disciplinary approach to a growing problem. *Journal of Elder Abuse & Neglect, 15*(3-4), 55-70. doi:10.1300/J084v15n03_04 (pp. 65-66).

[viii] The HOPE Project was disbanded in 2014.

[ix] Schneider, D. C., Mosqueda, L., Falk, E., & Huba, G. J. (2010). Elder abuse forensic centers. *Journal of Elder Abuse & Neglect, 22*(3-4), 255-274. doi:10.1080/08946566.2010.490137 (p. 265).

[x] Levi, D. J. (2014). *Group dynamics for teams*. (4th ed.). Los Angeles, CA: Sage. (pp. 165-166).

[xi] Arguing that because self-neglect is the most common reported form of abuse to APS, it is included in their interdisciplinary team. Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team*.

[xii] Dong, X., Simon, M., & Evans, D. (2013). Elder self-neglect is associated with increased risk for elder abuse in a community-dwelling population: Findings from the Chicago Health and Aging Project. *Journal of Aging and Health, 25*(1), 80–96. doi:10.1177/0898264312467373

[xiii] For a list of relevant statutes by state, visit https://www.justice.gov/elderjustice/elder-justice-statutes-0.

[xiv] Schneider, D. C., Mosqueda, L., Falk, E., & Huba, G. J. (2010). Elder abuse forensic centers. *Journal of Elder Abuse & Neglect, 22*, (3-4), 255–274. doi:10.1080/08946566.2010.490137

[xv] The Foothills Child Advocacy Center in Charlottesville, VA, obtained a grant from a local foundation, BAMA Works, specifically to fund child forensic interviews in outlying jurisdictions to accommodate numerous requests for assistance.

[xvi] Some agencies participating on the MDT are responsible for adults age 18 and over, whereas the MDT may focus on older adults (however "older adults" is defined by the state).

[xvii] Anetzberger, G. J., Dayton, C., Miller, C. A., McGreevey, J. F., & Schimer, M. (2005). Multidisciplinary teams in the clinical management of elder abuse. *Clinical Gerontologist, 28*(1-2), 157-171. doi:10.1300/J018v28n01_08 (p. 160, describing Denver's focus on incapacitated adults).; Nerenberg, L. (2003). *Multidisciplinary Elder Abuse Prevention Teams: A New Generation*. Washington, DC: National Center on Elder Abuse. Retrieved February 22, 2017, from http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/EldAbs_complete.pdf.

[xviii] Malks, B., Buckmaster, J., & Cunningham, L. (2003). Combating elder financial abuse–A multi-disciplinary approach to a growing problem. *Journal of Elder Abuse & Neglect, 15*(3-4), 55-70. doi:10.1300/J084v15n03_04

[xix] Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team.*

[xx] A higher percentage of financial abuse cases are referred to the Elder Abuse Forensic Center in Irvine, CA (Mosqueda, L., Burnight, K., Liao, S., & Kemp, B. (2004). Advancing the Field of Elder Mistreatment: A New New Model for Integration of Social and Medical Services. *The Gerontologist, 44*(5), 703–708. doi:10.1093/geront/44.5.703) and the Orange County Elder Abuse Forensic Center (Navarro, A. E., Wilber, K. H., & Schneider, D. C. (November 2009). The Los Angeles County Elder Abuse Forensic Center: Team synergy to advance positive outcomes. Poster presented at the meeting of

Gerontological Society of America, Atlanta, GA.), presumably because of the complexity of financial exploitation cases; Schneider, D. C., Mosqueda, L., Falk, E., & Huba, G. J. (2010). Elder abuse forensic centers. *Journal of Elder Abuse & Neglect, 22*(3-4), 255-274.; doi:10.1080/08946566.2010.490137; Teaster, P. B., Nerenberg, L., & Stansbury, K. L. (2003). A national look at elder abuse multidisciplinary teams. *Journal of Elder Abuse & Neglect, 15*(3-4), 91-107.) doi:10.1300/J084v15n03_06).

[xxi] In the context of CACs, see e.g., Cross, T. P., Jones, L.M., Walsh, W.A., Simone, M., & Kolko, D., Szczepanski, J., Lippert, T., Davison, K., Cryns, A., Sosnowski, P., Shadoin, A. & Magnuson, S. (August 2008). *Evaluating Children's Advocacy Centers' Response to Child Sexual Abuse*. Juvenile Justice Bulletin. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, US Department of Justice.; Jones, L. M., Atoro, K. E., Walsh, W. A., Cross, T. P., Shadoin, A. L., & Magnuson, S. (2010). Nonoffending caregiver and youth experiences with child sexual abuse investigations. *Journal of Interpersonal Violence, 25*(2), 291-314. doi: 10.1177/0886260509334394

[xxii] Schneider, D. C., Mosqueda, L., Falk, E., & Huba, G. J. (2010). Elder abuse forensic centers. *Journal of Elder Abuse & Neglect, 22*(3-4), 255-274. doi:10.1080/08946566.2010.490137

[xxiii] In spite of all the advances the field of child abuse has made, Jones et al. (2010) opine communication between MDT members and families continues to suffer, with 32% of nonoffending caregivers in their study being dissatisfied because of the lack of clear and regular communication regarding the status of the case. (Jones, L. M., Atoro, K. E., Walsh, W. A., Cross, T. P., Shadoin, A. L., & Magnuson, S. (2010). Nonoffending caregiver and youth experiences with child sexual abuse investigations. *Journal of Interpersonal Violence, 25*(2), 291-314.) doi: 10.1177/0886260509334394)

[xxiv] Ensslin, K., & Phillips, N. L. (2013). Best practices for investigating and prosecuting child abuse: Applying lessons learned from Delaware's Earl Bradley case. *Widener Law Review, 19*(1), 51-72.

[xxv]Frost, N., Robinson, M., & Anning, A. (2005). Social workers in multidisciplinary teams: Issues and dilemmas for professional practice. *Child & Family Social Work, 10*(3), 187–196.; doi:10.1111/j.1365-2206.2005.00370.x; Lalayants, M., & Epstein, I. (2005). Evaluating multidisciplinary child abuse and neglect teams: A research agenda. *Child Welfare, 84*(4), 433-458.

[xxvi] Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team*.

[xxvii] Howze, K. A., & White, J. L. (2010). Judicial response to elder abuse. *Juvenile and Family Court Journal, 61*(4), 57-76. doi:10.1111/j.1755-6988.2010.01048.x

[xxviii] The lead investigative agency shall complete its final disposition within 60 calendar days. … (Minn. Stat. § 626.557 Subd. 9c (e) (2014))

[xxix] Schneider, D. C., Mosqueda, L., Falk, E., & Huba, G. J. (2010). Elder abuse forensic centers. *Journal of Elder Abuse & Neglect, 22*(3-4), 255-274. doi:10.1080/08946566.2010.490137 In the context of CACs.

[xxx] Polyvictimization in Later Life online training available at https://www.ovcttac.gov/views/TrainingMaterials/dspOnline_polyvictimization.cfm

[xxxi] Navarro, a. E., Gassoumis, Z. D., & Wilber, K. H. (2013). Holding abusers accountable: An elder abuse forensic center increases criminal prosecution of financial exploitation. *The Gerontologist, 53*(2), 303-312. doi:10.1093/geront/gns075

[xxxii] Polyvictimization in Later Life online training, available at https://www.ovcttac.gov/views/TrainingMaterials/dspOnline_polyvictimization.cfm

[xxxiii] Johansson, G., Eklund, K., & Gosman-Hedström, G. (2010). Multidisciplinary team, working with elderly persons living in the community: A systematic literature review. Scandinavian *Journal of Occupational Therapy, 17*(2), 101-116.; doi:10.1080/11038120902978096; see, for example, Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team*.

[xxxiv] Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team* .Examples include p. 76, 127, 145, 157-158.

[xxxv] Bartels, S. J. (2003). Improving the system of care for older adults with mental illness in the United States: Findings and recommendations for The President's New Freedom Commission on Mental Health. *American Journal of Geriatric Psychiatry, 11*(5), 486-497.; Bartels, S. doi:10.1097/00019442-200309000-00003; Bartels, S. J. (2004). Caring for the whole person: Integrated health care for older adults with severe mental illness and medical comorbidity. J*ournal of the American Geriatrics Society, 52*,(S12), S249–S257.; doi:10.1111/j.1532-5415.2004.52601.x; Bartels, S. J. (2004). *Guidelines for Psychological Psychological Practice with Older Adults. American Psychologist, 59*(4), 236-260. doi:10.1037/0003-066X.59.4.236

[xxxvi] Navarro, A. E., Wilber, K. H., Yonashiro, J., & Homeier, D. C. (2010). Do we really need another meeting? Lessons from the Los Angeles County Elder Abuse Forensic Center. *The Gerontologist, 50*(5), 702-177.711. doi:10.1093/geront/gnq018

[xxxvii] Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team*.

[xxxviii] Johansson, G., Eklund, K., & Gosman-Hedström, G. (2010). Multidisciplinary team, working with elderly persons living in the community: A systematic literature review. *Scandinavian Journal of Occupational Therapy, 17*(2), 101-116. doi:10.1080/11038120902978096

[xxxix] Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team* (p. 60-62).; see also Dyer, C. B., Heisler, C. J., Hill, C. A., & Kim, L. C. (2005). Community approaches to elder abuse. *Clinics in Geriatric Medicine, 21*,(2), 429-447. doi:10.1016/j.cger.2004.10.007 (p. 437).

[xl] Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team* (p. 60-62 and 159-171).

[xli] Reilly, B. A., Trahan, C., Hazelett, S., Istenes, N., Cafalu, C., & Dyer, C. B. (n.d.). *Guidance manual for: Medical professionals forming an interdisciplinary elder mistreatment team* (p. 60-62 and 159-171).