

Elder Abuse Fatality Review Teams: Outcomes

Introduction

An Elder Abuse Fatality Review Team (EAFRT) examines deaths of individuals that may be caused by or related to elder or adult abuse *with the goal of identifying system gaps and improving victim services*.

The American Bar Association Commission on Law and Aging and the University of Texas Health Science Center at Houston collected information about EAFRT outcomes from team coordinators, leaders, and members and by analyzing team documents.

We asked team members about the impact of EAFRT participation on themselves, their organizations, and their community (county, region, or state in which the team operates). Seventy-eight percent (n=62) of the responses were from members who have served on their team for more than one year, with 44% (n=35) of the total having served for four or more years.

Outcomes

1. EAFRT participation enhances members' knowledge and ability to do their jobs.
 - Ninety-three percent (n=75) said participation had increased their knowledge about the other organizations that are represented on the team.
 - Seventy-seven percent (n=60) indicated that they had learned more about organizations that *do not* participate on the EAFRT.
 - Eighty-two percent (n=63) reported feeling more confident in making referrals to other organizations. The same percentage (n=60) indicated that they more often initiate collaboration with other organizations.
 - Eighty-six percent (n=68) indicated improved understanding of how elder abuse can directly or indirectly lead to death.
2. EAFRT members share what they learn at EAFRT meetings with their colleagues.
 - Eighty-two percent (n=65) reported informally sharing their enhanced knowledge with their colleagues.
 - Fifty-four percent (n=37) had trained or arranged training for colleagues about identifying elder abuse.
 - Thirty percent (n=19) had trained or arranged training for colleagues about elder abuse death investigations. That figure may seem low, but most organizations represented on EAFRTs do not conduct death investigations.
3. EAFRT participation may facilitate changes in the policies and practices of the members' organizations.

For more information, see https://www.americanbar.org/groups/law_aging/resources/elder_abuse/elder-abuse-fatality-review-team-projects-and-resources/.

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- Thirty-seven percent (n=26) indicated that their organization had changed its policies and practices regarding services to elder abuse victims due to team participation.
 - Forty-one (n=29) percent reported changes to their organizations' policies or practices regarding collaboration with other organizations to assist elder abuse victims.
4. EAERTs often advance systemic changes in their communities and states.
- Seventy-seven (n=60) percent of the respondents indicated that their team had identified barriers for identifying and responding to elder abuse victims and had made recommendations to improve system-level responses.
 - Seventy-four percent (n=58) reported that their teams had led to improved victim interventions including outreach, education, investigations, or other services.
 - Seventy percent (n=54) reported that the EAERT had led to the identification of risk indicators or lethality factors, with 51% (n=39) indicating that checklists or other detection tools had been developed as a result.
 - Questions about whether the teams had identified gaps or addressed known gaps related to the provision of trauma-informed, culturally competent services received "yes" responses from 57% (n=44) and 52% (n=40), respectively, of respondents.
 - Members reported less success at improving local or state policies to address elder abuse (37%, n=29) and state statutes aimed at preventing the problem (22%, n=17).

Examples of System-Changing Outcomes

- The implementation of processes (e.g., by a memorandum of understanding, or by statute) through which the coroner's or medical examiner's office can learn *before it investigates the death of an older person* whether that person was an adult protective services (APS) client and whether APS staff think the death may have resulted from elder abuse. An example of this process is San Diego's Medical Examiner Review Team (MERT). The MERT was created in 2005 as an offshoot of the county's EAERT after the EAERT determined that the lack of a process inhibited learning about indicators of elder abuse and holding perpetrators accountable. According to San Diego APS staff, information from the MERT led the medical examiner's staff to investigate some cases more thoroughly – including conducting autopsies – than they would have otherwise. Some of those cases resulted in homicide investigations.
- Recommendations made by the Harris County (Houston), Texas EAERT led to establishment of the Senior Justice Assessment Center, which receives VOCA funds to coordinate key organizations that determine whether a crime has occurred, assess whether a victim has capacity, and help protect the victim.

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