Establishing & Evaluating Elder Abuse MDTs: Tips for Communicating Team Function & Effectiveness

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Agenda

• Multidisciplinary Teams (MDTs) & Evaluation Overview
• Example 1: Los Angeles Center
• Example 2: Denver Forensic Collaborative
• Group Discussions
  – When and how to use MDTs?
  – What data and outcomes should be tracked?
  – How to integrate person-centered approaches?
• Lessons Learned & Recommendations
What are Multidisciplinary Teams?

• Broad term: elder abuse “Networks”
• MDT is a type of elder abuse network
  – A team that is comprised of professionals from a variety of disciplines working together on an ongoing basis to combat elder abuse.
• Specifically look at case review elder abuse MDTs

Who’s in the Audience?

• Role?
  – APS caseworker
  – APS supervisor
  – Other agency
• State?
• Experience with elder abuse case review MDTs?
  – Core team member
  – Presented/attended
  – Aware of one near you
MDT Types (some examples)

- Hospital-based (e.g., Geriatric/Medical Assessment Team)
- Financial Abuse Specialist Team (FAST) – sometimes “Fiduciary”
- Vulnerable Adult Specialist Team (VAST)
- Elder Abuse Forensic Center (EAFC)
- Fatality Review Team
- Hoarding Team
- “Multidisciplinary Teams” (also I-Teams)
  – Wide variation
- Enhanced Multidisciplinary Team (E-MDT) in New York & elsewhere

- What others models are you aware of?
Establishing an MDT

- Department of Justice’s Elder Justice Initiative
  - MDT Technical Advisor: Talitha Guinn-Shaver
  - https://www.justice.gov/elderjustice/mdt-tac

- **Mission**: to provide tools, resource materials, and individualized consultations to facilitate the expansion of elder abuse case review multidisciplinary teams (MDTs) across the nation.

  - Info on establishing, running, and evaluating an MDT

Support for MDT Activities

- DOJ’s MDT TA Center
- New York City Elder Abuse Center (NYCEAC)
  - TA, including monthly Peer Leadership Group
  - https://nyceac.org/clinical-services/mdts/technical-assistance/

- Soon to come: OVC-funded MDT Training & TA Center
Evaluation of MDTs

• Why evaluation?
  – Tell the story of MDTs
  – Justify collaboration across organizations
  – Improve effectiveness and functioning
  – Often needed for funding & sustainability
  – Offers guidance throughout development of MDTs

  • Needs assessments say ‘why needed’
  • Formative Evaluation say ‘how developed’
  • Process evaluations say ‘how done’
  • Outcome evaluations say ‘what impact’
  • Implementation evaluations say ‘how others may do’

Evaluation Process

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<tbody>
<tr>
<td>Who needs?</td>
<td>Who involved?</td>
<td>How would one describe the MDT?</td>
<td>Does the MDT work?</td>
<td>Questions of:</td>
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<tr>
<td>What safety, health, &amp; well-being needs are unmet?</td>
<td>Who leads and what coordination support is needed?</td>
<td>What does the MDT do?</td>
<td>Does the MDT cause any harm?</td>
<td>- Acceptability</td>
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<td>What services already exist?</td>
<td>What expectations for participation?</td>
<td>How is the MDT monitored?</td>
<td>What outcomes are improved?</td>
<td>- Cultural adaptability</td>
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<td>What motivations drive starting a MDT?</td>
<td>What structures of meetings?</td>
<td>How is quality assurance tracked?</td>
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<td>- Accessibility</td>
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<td>What agreements are needed (MOU’s, confidentiality agreements)?</td>
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<td>- Feasibility</td>
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<td>- Fidelity</td>
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<td>- Expansion, spread, &amp; scaling up</td>
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<td>- Sustainability</td>
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Evaluation Consideration #1:

Hierarchy of Evaluation Design Rigor

1. Systematic reviews & meta-analyses
2. Multi-site replications of randomized experiments
3. Randomized experiments (with control group)
4. Quasi experiments (with comparison group)
5. Correlational Studies
6. Others (Anecdotal case reports, pretest-posttest studies without comparison group, qualitative descriptions of client experiences, client satisfaction surveys)

Evaluation Considerations #2:

Sources of Data

- **Who?** victim-focused, collaterals, existing service data, MDT service providers, other
- **How?** surveys, interviews, observation, abstracting from existing data
- **When?** frequency: baseline/pretest, post-test, follow-up (3 months, 6 months, 12 months)
- **What outcomes?** Health, safety, well-being, prosecution Result, service use
  - Use of standardized measures for outcomes
Evaluation Consideration #3: 
**Resource & Competing Demands**

- What is feasible?
  - Example: Client Satisfaction Surveys are really popular and feasible in health & social services, yet may be limited in effectiveness or appropriateness for MDTs
  - Donabedien (1988): **Structure -> Process -> Outcome** indicates that client satisfaction may be a ‘necessary process’ to achieve the outcome.
  - Data collection & analysis staff and consultants may be needed

- Given multiple organizational partners in MDTs, what do each of their organizations prioritize as an outcome?
  - Health, safety, well-being, prosecution results, service use, cost, & person-centeredness

Evaluation Consideration #4
**Person-Centered Approaches**

- Institute of Medicine (2001) major aim of increasing patient-centered care:
  - “… respectful of and responsive to individual patient preferences, needs, & values and ensuring the patient values guide all clinical decisions”
  - For MDTs: client acceptance of services, tensions between safety and self-determination, consideration of least restrictive environments, considerations of competency and capacity for decision-making
  - For Evaluation: Goal Attainment Scaling (Burnes, 2018)

Have client rate goal attainment as:

<table>
<thead>
<tr>
<th>Much less than expected</th>
<th>Somewhat less than expected</th>
<th>Expected client outcome</th>
<th>Somewhat better than expected</th>
<th>Much better than expected</th>
</tr>
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<tbody>
<tr>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>+1</td>
<td>+2</td>
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</table>
Example 1:
Los Angeles County Elder Abuse Forensic Center

- **Research Collaborators:**
  - Kate Wilber, PhD, LCSW
  - Diana Homeier, MD
  - Adria Navarro, PhD
  - Jeanine Yonashiro-Chot, PhD
  - Julia Rowan, PhD
  - Melanie Gironda, PhD
  - Gerson Galdamez, BSG
  - Liz Avent, MS

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**Forensic Center Goals & Activities**

- **Health Services**
  - In-home Medical Evaluations
  - In-home Neuropsych Evaluations
  - Medical Record Reviews
  - Capacity Declarations
  - Expert Testimony

- **Legal Services**
  - Prosecution
  - Appropriate Conservatorships
  - Civil Litigation
  - Restraining Orders
Structure/Process: Conceptual Model v1

Structure/Process: Conceptual Model v2
Time for Outcomes

- Ideal approach: RCT
- APS powers-that-be signed off on it
- Grant proposal was submitted
- Funds received
- But then... County Counsel!!!
Quasi-experimental approach

• Propensity score matching
  – Group of Forensic Center cases
  – Match them with usual care cases based on:
    • Age
    • Gender
    • Race/ethnicity
    • APS Office (geographic categories)
    • Service dates
    • Type(s) of abuse
    • Referral source(s)

Promising Results from the Forensic Center Model

• Looked at two outcomes:
  – Prosecution
  – Conservatorship (a.k.a. Guardianship)

• But what aspect of each process?
Prosecution Process

- APS worker or law enforcement officer works on a case to achieve closure.
- If deemed appropriate, the case is sent to the DA for review and to evaluate appropriateness.
- The APS worker or law enforcement officer does not feel the perpetrator can be or needs to be referred for prosecution.
- The DA files a case with the court and takes it to trial if they believe they can successfully prosecute the perpetrator.
- The perpetrator enters a plea of guilty, avoiding a trial, or a jury finds the perpetrator guilty.

Similar for Conservatorship

Outcomes Results

- Higher “odds” of referral for:

![Graph showing comparison between EAFC and Usual Care for Prosecution and Conservatorship referrals.]

EAFC: EAFC
Usual Care: Usual Care
Comparing California’s 4 Forensic Centers

• Shared core professional groups:
  – FC Program Coordinator
  – FC Program Assistant
  – Geriatrician or Healthcare Provider
  – Geropsychologist or Neuropsychology
  – Adult Protective Services
  – Law Enforcement Agencies
  – Prosecutorial Agencies
  – Public Guardian
  – Victim Advocate

• Not pervasive, but very common:
  – Senior Legal Aid (Non-Profit)
  – Community Mental Health Services

Example 2:
Denver Forensic Collaborative

Acknowledgements

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– Denver City Attorney’s Office, Linda Loflin Pettit
– Denver Adult Protective Services, Whitney Nettleton & Juanita Rios-Johnston

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Denver Forensic Collaborative: MDT

- Mandated reporting law started in 2014, as did the Denver Forensic Collaborative (DFC)
  - City Attorney’s Office, District Attorney’s Office, Police, Adult Protective Services, Geriatrician, Victim Advocates, Social Services, Community Mental Health, and many more

- Staffed cases on abuse, neglect, and/or financial exploitation affecting an older adult (60+ years) and involved an alleged perpetrator in a position of trust

Evaluation: The Design

**Evaluation Goal:** To test the impact of a forensic collaborative on responses to the abuse, neglect, and/or financial exploitation of older adults.

Arm 1

Arm 2
Interviews with Older adults

ARM 1

Figure 1. Recruitment flow since project start.
### Arm 1 Procedure

- Consent “quiz” to assess understanding of consent materials
- **Time 1 (T1):**
  - Demographics, social support, physical and mental health, cognitive function, alcohol use, and service use and needs.
- **Time 2 (T2; 1 month):**
  - Maltreatment history, post-traumatic symptoms, post-trauma appraisals, and beliefs and participation in the criminal justice system.
- **Time 3 (T3; 6 month), Time 4 (T4; 9 month):**
  - Social support, physical and mental health, cognitive function, alcohol use, post-traumatic symptoms, post-trauma appraisals, beliefs and participation in the criminal justice system, and service use and needs.

- Retention: 75% at T2, 70% at T3, and 58%

### Arm 1 Participants

- 76 years (average)
- 75% female
- 53% retired
- 38% Ethnic Minority
- 89% at least some college

*Who participated in the interview part of the study?*

*N = 40*
Who participated in the interview part of the study? Cont.

MARITAL STATUS

Cont.

Arm 1 Results

What were older adults’ experiences of maltreatment?

51% reported lifetime physical mistreatment by family members
  – 15% describing incidents in the previous year

43% reported neglect
  – Majority faced unmet needs in the last month

52% reported financial exploitation (close friend or family member taking money or property without permission)
Did not detect effects of DFC on victim-focused variables, such as:

- Mental Health (e.g., depression and PTSD symptoms),
- Criminal Justice (post-crime appraisals, victim engagement, & perceptions of the criminal justice response, and
- service use and helpfulness

But, recall...

- Small sample size
  - Analyses compared 19 older adults reviewed by DFC and 19 older adults in UC

Arm 1 Results

**Did outcomes differ for DFC cases relative to Usual Care?**

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<thead>
<tr>
<th>Service Needs</th>
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<tr>
<td><strong>82% reported physical health limitations</strong></td>
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<tr>
<td>• “impairment in moderate activities and climbing several flights of stairs”</td>
</tr>
<tr>
<td>• 24% reported limitations “all of the time”</td>
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<tr>
<td><strong>70% reported pain interfering with normal activities</strong></td>
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<tr>
<td>• 24% reported pain “extremely” interfering with normal activities.</td>
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<td><strong>55% reported doing less due to emotional problems (e.g., feeling anxious or depressed).</strong></td>
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<tr>
<td>• At T2, 52% endorsed moderate to severe depression symptoms and 44% endorsed moderate to severe PTSD symptoms.</td>
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Arm 1 Results

**What service needs did older adults describe?**
Arm 1 Results: Older Adult Needs

What service needs did older adults describe?

68% reported needing “some” to “a lot” more help than currently received.

Help needed to find help

- Older adults described not knowing where to seek assistance or whether services existed to meet their needs.
- Nearly 1 in 5 (19%) reported needing assistance finding and navigating services.

Arm 1 Results: Older Adult Needs

What specific service needs did older adults describe?

28%: mental health needs & social isolation, including help with depression and trauma symptoms

25%: financial assistance (e.g., help paying bills, managing taxes)

22%: household chores, yard work, and home maintenance

19%: transportation services (including help moving) due to inability to drive, scarcity of/distance to public transportation, and/or physical limitations
Arm 1 Results: Older Adult Needs

**What specific service needs did older adults describe?**

Nearly one in four participants also faced challenges obtaining housing (23%) and food (28%).

Older adults described problems including:
- finding affordable or accessible housing
- long waitlists for housing
- food too expensive
- food stamps did not cover needs
- food inadequate (e.g. charity meal services not meeting nutritional needs).

**What barriers to services did older adults describe?**

22%: don’t know about existing services

22%: unable to afford services (e.g., surgeries or medications, home health care)

14%: found services inadequate when attempted to use

19%: did not engage in services even when aware of them

8%: felt too guilty or ashamed to engage services
Collateral Surveys & Administrative Data

ARM 2

220 Cases

N = 220
Female (72%)

White, 57%
Latino, 14%
Asian, Pacific Native American, 5%
Black / African American, 19%

ETHNICITY
Cases (cont.)

Alleged Offenders
- 53% (n = 94) adult child of older adult
- 77% (n = 183) close friend or family member of older adult

Arm 2: Victim Advocate Reports
What kind of contacts did these cases have across systems?

- 96% of cases had police contact
- 53% had medical provider contact
- 21% had community provider (e.g. community clinics) contact

- Relatively less contact with criminal justice offices:
  - 11% of cases had interaction with DA’s office
  - <4% received any kind of legal services
Arm 2: Victim Advocate Reports

**What kind of contacts did these cases have across systems?**

- **Two-thirds** of older adults were lost to additional contact with advocates (e.g., phone numbers changed, moved).

- **Prognosis** of whether older adult would be in need of their services again
  - 53% responded either “guarded” or “poor” within the next month
  - 58% responded either “guarded” or “poor” within the next year,

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Arm 2: Victim Advocate Reports

**What was impact of DFC relative to UC over time?**

- Relative to usual care, DFC linked with:
  - Greater likelihood of non-reoccurrence in the next month; and next year
  - Higher across-agency coordination
  - Greater service types engaged in case
  - Nearly 3 times (2.8) higher odds of learning about cases through other means (e.g., coworker, other team members, consultation)
Arm 2: Criminal Justice Case Outcomes

- New police reports
  - 16% of cases had a new police report
    - 17 of 118 DFC cases; 17 of 105 UC cases
    - Suggests ongoing justice and support needs for older adults involved in these cases

- Prosecution
  - Of 202 cases for which prosecution information was available, charges were filed in 19 (10%) of cases.
    - 67% were not presented to the DA
      - 23% were refused by the DA
    - Of those charged, prosecution outcome information was available for 13 cases.
      - Majority of cases resulted in a guilty plea or verdict (77%); the remaining cases were dismissed.

Arm 2: APS Administrative Data

- De-identified APS data from 669 APS case reports resulted in 302 cases that were screened in for investigation/assessment during the Arm 2 period.

- From these, 146 cases met study criteria, with 156 cases excluded for self-neglect only.

- APS data provided minimal demographic information beyond gender (female=58%, n=84) and age (average=77.24, SD=7.00).
• APS reports were available for 64 (66%) out of the 97 cases included in Arm 1. Only 6 (4 DFC; 2 UC) resulted in newly open APS cases and investigation, and therefore, documented outcomes.

• Challenges to APS involvement include:
  • Need to meet eligibility criteria for APS
  • Client’s right to refuse APS services, when competent
  • That APS involvement may have preceded DFC response, sometimes by many years
  • Thus, APS may offer historic information, yet face barriers to engaging in current response

IMPLICATIONS FOR DFC AND OTHER MDTS
Plan for Severity of Cases in MDT and Evaluation

- Arm 1 Cases typically identified by a police report with severe & complex needs greater than our needs assessment (e.g., Gagnon et al., 2015)
  - PTSD and depression symptom severity appears to exceed national prevalence estimates
  - Older adults in this sample were living with physical health problems, cognitive difficulties, and/or unsafe home environments.
  - While challenges to engaging older adults who have cognitive impairment in services and outreach are well-documented (Anetzberger, et al., 2000; Dong et al., 2014), additional challenges related to housing safety and instability that have not yet been directly addressed in the older adult maltreatment literature.

Coordination is Important

- Older adults were isolated with multiple service needs as well as reticent or uninformed about how to engage services by the time their cases came to DFC attention.
  - They had diverse service needs that went unmet, including housing concerns (e.g., affordability, availability).
- Per Victim Advocates, DFC clients had greater service coordination than usual care clients.
- MDTs often prioritize ‘the most severe cases’. Yet, could coordination help prevent and reach older adults at-risk of mistreatment earlier?
Prosecution Outcomes Matter

- Though prosecution rates were low overall, the involvement of the multidisciplinary team did not have a negative impact on prosecution, which can sometimes be a concern for communities establishing community-coordinated responses.

Follow-Up Services are Needed

- Building on the positive coordination findings, communities may also want to consider protocols for follow-up and engagement with older adults over time, with particular attention to the role that community-based providers can play.
  - Arm 2 revealed that the majority of cases that initially came to the attention of the DFC did not have contacts a few months later. And yet, the older adults we interviewed face ongoing isolation, mental and physical health problems, and service needs.
Discussion

• Your Questions?

• What influences decisions of when and how to create an MDT?

• What outcomes and data are important for evaluating MDTs?

• How could you integrate in the person-centered approach into evaluation of MDTs?

• Proposed discussion groups: needs assessment, new MDTs, more “mature” MDTs

Summary

• Lessons Learned
  ─ Severity of cases & competing demands complicate evaluation of MDTs
  ─ Collaborating organizations want process, outcome, & implementation data
  ─ Evaluation is possible and often leads to more questions

• Recommendations
  ─ Get creative with designing comparison groups
  ─ Plan for multiple data sources and embed in existing contacts with clients, if possible
  ─ Incorporate Goal Attainment Scaling to improve acceptability and person-centeredness
More Resources

• Georgia Anetzberger, 2011 – The Evolution of a Multidisciplinary Response to Elder Abuse
  – http://scholarship.law.marquette.edu/elders/vol13/iss1/1
• Schenider, Mosqueda, Falk, & Huba, 2010 – Elder Abuse Forensic Centers
  – https://doi.org/10.1080/08946566.2010.490137
• Secure Old Age lab at USC:
  – Publications: https://gero.usc.edu/secure-old-age/publications/
  – Resources: https://gero.usc.edu/secure-old-age/resources/

Thank you!

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