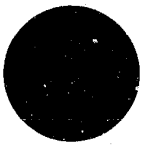

ELDER ABUSE

AWARENESS

ILLINOIS DEPARTMENT ON AGING

ABUSE AND NEGLECT PROGRAM

Comparison of Paid vs. Volunteer Multi-Disciplinary Teams in Providing Community-Based Care to Elder Abuse Victims

FINAL REPORT

Grant No. 90AR011502

COMPARISON OF PAID VS. VOLUNTEER MULTI-DISCIPLINARY TEAMS
IN PROVIDING COMMUNITY-BASED CARE TO ELDER ABUSE VICTIMS
GRANT NO. 90AR011502
GRANT RECIPIENT:
ILLINOIS DEPARTMENT ON AGING

PROJECT ABSTRACT

This research examined the implementation and impact of four Multi-disciplinary teams (M-teams) in providing community-based care to elder abuse victims. Two urban and two rural M-teams were established in Illinois. One rural and one urban team were given the opportunity to pay members for their attendance at team meetings, in order to examine whether voluntary teams are more committed to their involvement than paid teams.

M-teams were composed of professionals from the following disciplines: medicine, mental health, finance, clergy, law enforcement and legal. In addition to their competency in their respective professions, team members were also selected based on their commitment to serving the aging population, willingness to be a team member for at least one year, interest in gerontology, and past history with the coordinating agency.

The evaluation consisted of collecting data from those who refused the invitation to join the team, M-team members themselves, team meeting operations, cases discussed at team meetings, and case workers from the coordinating agencies. The major hypotheses were that there would be no geographic differences in the implementation of the teams, that voluntary teams would be more committed, and that workers who used the M-teams would report lower levels of burnout.

The results from the evaluation rejected two of the three hypotheses. With regard to geographic differences, implementation of the teams was similar in urban and rural sites. However, urban sites appeared to have more difficulty recruiting members while rural sites showed lower commitment levels at three different points in time. With regard to voluntary versus paid teams, there were no differences in levels of attendance, turnover, commitment or satisfaction over the course of the project. With regard to worker burnout, there were no differences between workers who used M-teams and those who did not.

In spite of the lack of support for the study's hypotheses, the research provided formative data about the implementation of M-teams. A job analyses resulted in job descriptions for team members and for the M-team coordinator. Results from various phases of implementation provided information needed to develop policies, procedures and training materials for other agencies to use in the implementation of M-teams.

Rejecting the hypothesis of paid versus voluntary differences in commitment was actually a positive finding for the future of M-teams. It indicates that being paid is not a major motivating factor for recruiting professionals to be involved with M-teams. Member surveys showed that most team members intend to remain on the team after funding is terminated. And, an analysis of the time members spend outside of the team in elder abuse activities suggests that M-teams offer agencies informal access to professional expertise, and assist in promoting community awareness about the problem.

Because of the impact of the M-teams on supporting the coordinating agencies, the state of Illinois has decided to make the implementation of M-teams mandatory for all elder abuse provider agencies with service populations greater than 7,200. Results from this study were used to institute job descriptions, to develop training materials for training M-teams throughout the state, and to prepare an M-team Coordinators' Guidebook, an M-team Members' Handbook and a training videotape on the roles and benefits of M-teams.

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COMPARISON OF PAID VS. VOLUNTEER MULTI-DISCIPLINARY TEAMS IN PROVIDING COMMUNITY-BASED CARE TO ELDER ABUSE VICTIMS

FINAL REPORT
GRANT NO. 90AR011502

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EXECUTIVE SUMMARY

This research examined the implementation and impact of four Multi-disciplinary teams (M-teams) in providing community-based care to elder abuse victims. Two urban and two rural M-teams were established in Illinois. One rural and one urban team were given the opportunity to pay members for their attendance at team meetings, in order to examine whether voluntary teams are more committed to their involvement than paid teams.

This project represents the first known systematic research on intervention-based M-teams. Previous published literature on M-teams described hospital-based teams whose major focus was in the assessment and identification of elder abuse. This study provided objective information about how teams are developed, issues involved in their implementation, and the potential impact of the teams on elder abuse in the community.

To standardize the methods used to recruit team members and implement M-teams, a project steering committee was formed. The committee was composed of representatives from each of the agencies coordinating the M-teams, from the Illinois Department on Aging and SPEC Associates, the research firm contracted to implement the evaluation. The committee made major decisions about the composit 'he team, team training, data collection instruments, and the selection of cases to be discussed. The committee also provided input into the analysis of the data and the interpretation of the results.

M-teams were composed of professionals from the following disciplines: medicine, mental health, finance, clergy, law enforcement and legal. In addition to their competency in their respective professions, team members were also selected based on their commitment to serving the aging population, willingness to be a team member for at least one year, interest in gerontology, and past history with the coordinating agency.

Each M-team was managed by an M-team coordinator, who was also an employee of the coordinating agency. The coordinator arranged meeting schedules and locations, developed meeting agendas, selected cases to be discussed, provided written information about cases discussed and took the minutes from team meetings. The coordinators were also responsible for collecting data during team meetings and assisting the elder abuse case workers implement suggestions made by the teams.

The evaluation of this project consisted of collecting data from several sources. The following studies were conducted over the two years of the project, yielding the following results:

Mail Survey of Refusals: Those members who refused the invitation to join the M-team were surveyed by mail about the reasons for their refusal. A total of 13 professionals refused the invitation to join the M-team. Twelve of these individuals returned the mail survey.

Results indicate that offering payment for participation does not appear to be related to acceptance or refusal to become an M-team member. However, the results suggest that it is more difficult to recruit team members in urban areas. Nine of the twelve refusals in the survey were from urban sites, while only three were from rural sites. It may be that professionals in urban areas have many more activities consuming their time. Alternatively, rural-area professionals may feel more compelled to cooperate with other agencies, since there are fewer social service providers in the region which can be called on for reciprocal favors.

Tracking M-team Activities: An M-Team Meeting Report Form was created to obtain information about members present and absent, turnover in team membership, number of clients discussed at the meeting, number of different case managers presenting cases and the types of activities conducted during the meeting. M-team coordinators completed the form after each team meeting.

Compilation of the data from this form shows that most team members attended most team meetings. Representatives from the legal profession were most likely to be absent, regardless of their geographic location or whether they were paid for their time. There was very little turnover in team membership over the 18 months of team operations. Reasons for leaving the team were more related to personal issues than to dissatisfaction with the team.

On the average, only one or two case managers presented cases at a team meeting. About 20 minutes were spent discussing each case. Most of the time during team meetings was spent in case discussions, advising the case manager and assisting with care planning.

Contrary to expectations, team activities rarely involved filling gaps in services. Only 5% of the meetings involved resource development to fill gaps in services. In only 9% of the cases were unmet needs a problem.

Measuring External Activities of Team Members: An M-Team Registration and Reimbursement Sheet was created to measure the number of minutes per month each team member spent on one or more of the following activities: (1) Making public presentations about elder abuse, (2) Client-specific activities related to one or more clients discussed at an M-team meeting, (3) Other activities related to the M-team, and (4) Other activities related to elder abuse not directly related to the M-team (eg. talking to professional groups about elder abuse, donating money to an agency serving victims, etc.).

Results from this study revealed that over the 18 months of team operations, approximately 500 hours of team members' time was contributed to elder abuse-related activities outside of team meetings. Assuming a moderate value of $50 per hour for each professional's time, this in-kind contribution is valued at $25,000.

Longitudinal Study of Changes in Commitment and Satisfaction of M-Team Members: Semi-annual telephone interviews were conducted with all members of the M-teams. A commitment measure was generated by modifying the organizational commitment scale of Porter et al. (1974). In addition, five satisfaction questions were generated by the steering committee to measure member satisfaction with the M-team.

Results from the analyses of these interviews showed that by the end of the project, three-quarters of the team members indicated that "on the whole" they were very satisfied with the M-

team. When asked if they planned to continue being a member of the M-team after funding was discontinued, 96% of the members responded "yes" after one year of operations, and 87% said "yes" after 17 months of team operations.

In spite of their intent to stay, there was a significant decline in commitment scores over time. Change in commitment scores was not related to either geographic location or payment for team attendance. However, consistently the rural team members reported lower levels of commitment than their urban counterparts. This finding, in conjunction with the finding that there were fewer refusals for team membership in rural regions suggests different dynamics of M-teams in rural regions compared to urban regions. These findings of geographic differences warrant further investigation in future studies.

The highest levels of reported satisfaction among M-team members were with their perceptions of their teams' productivity. When asked what they found to be most beneficial about being involved with the teams, members cited the increased awareness about problems of elderly and elder abuse, contact with other professionals, gaining knowledge they can use in their regular jobs, satisfaction when progress is made on cases, feelings of team cohesion and team input from various professions focusing on the same problem.

Lowest levels of satisfaction were with training and with the success rate of the cases. These results suggest that members feel the need for more training, especially in the areas of legal issues, community resources, creativity, preventing financial abuse, terminology and community government. These requests for training underscore the frustration voiced by several members about their inability to resolve cases brought to the team.

Description of Cases Discusse 'he M-Team: An Individual Client Form was created to obtain information about the demographics of the client, why the case was selected for team discussion, whether there were gaps in services needed for the victim and/or the abuser, and recommendations made by the team. The M-team coordinator completed one form for each case discussed at each team meeting.

Results from the analyses of these forms indicates that a total of 111 different cases were discussed by the teams. However, there were 279 case discussions by team members. There does not appear to be any difference in the number of cases brought to paid versus voluntary teams.

Over 40% of the case discussions were updates provided to the team about cases discussed previously. Besides providing updates, the most frequent reason why cases were brought to the team was because the case manager needed the specialized expertise of one or more team members to implement an intervention or to make a decision about a case. Chronic cases and cases involving ethical issues of self-determination were also frequent reasons why cases were brought to the teams for discussion. These results suggest that the case manager sought team input when there were no alternatives left to pursue, or when they wanted confirmation about ethical decisions made about a case. In only 20% of the cases were the care plans changed.

Elder abuse victims discussed by the team appear to be similar in profile to the victims reported to the statewide elder abuse program. However, the greater percentages of physical abuse, deprivation, financial abuse and confinement present among clients discussed by the teams

suggests that cases brought to the team are more complex and involve more coexisting types of abuse than the "typical" case reported to the state's elder abuse program.

The majority (80%) of the teams' recommendations were for services to the victim. Most frequently recommended services for victims were legal (26% of cases), mental health (21%) and medical (21%). Financial recommendations were made in 12% of the cases.

In 19% of the cases, services were recommended for the abuser. Mental health services were recommended most frequently for abusers (32%), followed by medical (18%) and financial (18%).

Job Analysis of M-Team Members: A systematic job analysis was conducted to develop job descriptions of M-team members. Using a standardized interview guide, team members were personally interviewed about their roles on the M-team. The interview identified the key areas of responsibility, information and resources used, and the knowledge, skills and abilities required to perform their jobs successfully.

Results from the job analysis indicate that job descriptions for M-team members are both similar and different. Members with the same position and similar occupations share very similar roles and responsibilities. There were no differences between urban and rural sites, nor between voluntary and paid teams. Job descriptions differed across professions in the resources used and the knowledge, skills and abilities needed to perform their jobs.

The M-team members have primary responsibility for providing advice and information to the team and to the elder abuse worker in their particular areas of expertise. The work context of the team members is the same across profession - major duties and responsibilities are carried out at monthly M-team meetings which last approximately two hours. In addition, members may be requested to provide expertise to the elder abuse workers outside of team meetings.

Longitudinal Study of Burnout Among Elder Abuse Case Workers: To examine whether using the M-team for assistance with cases would reduce case worker burnout, a longitudinal survey of all case managers at the coordinating agencies was completed. Every six months, for two years, the case managers completed the Maslach Burnout Inventory. The surveys were distributed by their supervisors, but each case worker was provided with a confidential envelope for returning their results. The burnout inventory measured three components of burnout: personal accomplishment, emotional exhaustion and depersonalization.

Results from this study indicate that overall, case managers' reports of burnout are lower than the normative data from other social service workers. These low scores may attest to the quality of the support from the coordinating agencies, or may be the result of social desirability. In spite of the efforts made to assure confidentiality of the results, the fact that the supervisors managed data collection may have caused biased underreporting of burnout felt by the workers. On the other hand, case workers with high levels of burnout may have left their agencies prior to the last survey.

There was no significant difference in burnout between those who presented cases to the team and those who did not. The lack of difference may be due to the fact that only 18 of the initial 36 workers surveyed at the beginning of the study completed the survey two years later. This

resulted in longitudinal data available for only 10 case managers who presented cases to the team and 5 who did not.

In summary, the results from this evaluation both confirm and reject initial expectations about the implementation of community-based M-teams. Initially, it was expected that the M-teams' roles would involve finding creative alternatives for serving cases, filling in gaps in services that were identified, becoming educated about the issues facing both victims and abusers, and assisting in raising their communities' consciousness about elder abuse and neglect. While the findings support the expectation that team members' own consciousness and that of their communities was raised, the teams had little impact on the success of the cases. Team members appear to serve more of a supportive role to case workers than an ameliorative role in resolving cases. Team members provide advice on the mechanics of implementing interventions related to their own areas of expertise, and offer psychological support to case managers facing ethical dilemmas.

Because of the impact of the M-teams on supporting the coordinating agencies. the state of Illinois has decided to make the implementation of M-teams mandatory for all elder abuse provider agencies. Results from this study were used to institute job descriptions in the standards and procedures manual for the state's elder abuse program. Results were also used to develop training materials for training M-teams throughout the state, including an M-team Coordinators' Guidebook, an M-team Members' Handbook and a training videotape on the roles and benefits of M-teams.

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DISSEMINATION AND UTILIZATION PAPER

As a result of this project the State of Illinois was able to produce all necessary materials needed to implement M-teams statewide: policies and procedures, job descriptions, training materials, training programs, an M-team coordinator's guidebook and a member handbook. State funding has been allocated to support the implementation of M-teams in designated elder abuse provider agencies.

Information obtained from this demonstration project has been presented at several professional conferences. For the past two years, the status of this project has been one focus of the state's Elder Rights Conference. This conference is attended by hundreds of social service providers from Illinois each year. At the 1989 conference, a presentation was made about the goals and status of this project. At the last conference in August, 1990, the Member's Handbook and Coordinator's Guidebook were distributed to interested participants, in addition to the evaluation results.

In addition to the Illinois Elder Rights conference, information from this research was presented at several other conferences, including the Annual APS Conference in San Antonio, Texas, the Gerontological Society of America's Annual Scientific Meeting in Minnesota, and the Ohio APS Conference in Columbus. Also, the information gleaned from this project has been integrated into other training and key note addresses provided in several states by the Project Co-Director, including New York, Wyoming and Pennsylvania.

The demonstration site staff and M-team members have, themselves, engaged in dissemination efforts. Local newspaper articles were published at two demonstration site locations. Members, themselves, made presentations to several organizations, including hospital discharge planners and a case coordination council.

Finally, several professional papers are in the process of being written, based on the results from this research. One paper will be submitted to the Journal of Elder Abuse & Neglect on the job analysis of M-team members. Another will be submitted on the job analysis of elder abuse case worker that was conducted tangentially to this study.

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POLICY/PROGRAM IMPLICATIONS PAPER

The results from this research had a substantial impact on the State of Illinois' policies on the implementation of M-teams. Because of their perceived impact on community awareness and support to the elder abuse provider agencies, the statewide elder abuse program mandated that M-teams be implemented in each designated elder abuse provider agency with service populations greater than 7,200. Along with the mandate, the Department has been authorized to provide grants to these agencies to support M-team activities. Statewide implementation of M-teams has been progressing to the extent allowed by the current state appropriations.

Many results from this project were used to assist in the implementation of M-teams in elder abuse provider agencies that were not a part of this demonstration project. The training materials developed through this project were used as the basis for the development of a standardized training program to be used to train M-teams statewide. These training materials also included a videotape about the M-teams that was created as an addendum to this project.

Through the project, an M-team Coordinators' Guidebook was written, utilizing materials developed in the implemen of the demonstration teams. The guidebook contains information on the benefits of M-teams as identified through this research. The book also contains a model member-agency agreement and recruitment script created by the project steering committee. It contains job descriptions which resulted from the job analysis, and descriptions of the cases that resulted from the content analysis of the Individual Client Forms. Finally, the guidebook has sample minutes from team meetings, and an outline of procedures involved in implementing M-teams.

As a result of this project, all supervisors who are implementing funded elder abuse programs have been trained on how to implement M-teams. The coordinators from the demonstration sites actually conducted the training, in order to share their insights about team development and maintenance. The videotape developed through this project was part of the supervisor training.

Through this project, an M-Team Member Handbook was also developed. This document is intended to be used as a resource and training guide for M-team members. The handbook included much of the same information about M-team roles and case studies that were included in the coordinator's guidebook. In addition, it included information about the statewide elder abuse program.

These dissemination efforts indicate Illinois' strong commitment to continue the use of M-teams statewide, on an on-going basis. The state's commitment is evidenced by the programmatic institutionalization of M-teams in agencies serving abused elderly. This commitment is substantiated by state appropriations to support the continuation of these community-based teams throughout Illinois.

INTRODUCTION

Research Goal and Objectives

The goal of this research was to examine the issues involved in implementing multi-disciplinary elder abuse consultation teams (M-teams) and to determine their impact on the services and outcomes of elder abuse victims. Specifically, the project sought to meet the following objectives:

(1) To document the processes involved in developing and implementing two voluntary and two paid M-teams in two rural and two urban case coordination units (CCUs) of the Illinois Department of Aging (IDOA).

(2) To describe similarities and differences between urban and rural sites, and between paid and voluntary teams in the ways teams function and their impact on providing services to victims.

(3) To develop job descriptions for M-team members.

(4) To investigate the outcome of cases having M-teams compared with similar geographic areas in Illinois which do not have M-teams.

Statement of the Problem

The concept of M-teams in protective services began with the treatment of child abuse and neglect.[1] Within the field of adult protective services (APS), M-teams began in hospital settings, mainly for the purpose of assessing older persons suspected of being abused or neglected.[2] Once the assessment was made, the M-team's role in the case ended. The Administration on Aging (AoA) funded one community-based M-team project in 1980, but the purpose of this M-team was also primarily one of assessment rather than intervention.[3]

Only in the past few years have community-based M-teams been used for the purpose of enhancing intervention in substantiated APS cases. In 1983, the state of Tennessee initiated its first M-team for handling those elder abuse cases in which the APS caseworkers determined that further progress could not be made. More recently, AoA funded demonstration projects for the implementation of intervention-based M-teams in Ohio, Wisconsin, North Carolina and California.

Prior to this project, there had been no systematic research on the implementation or impact of this type of community-based M-team. There was no systematic information about how teams are developed, issues involved in their implementation, nor whether they have an impact on the elderly clients they discuss.

This project was funded by AoA in order to investigate the roles and impact of M-teams in both rural and urban areas. It was hypothesized that M-teams would be more effective than individual case workers in resolving APS cases, because group decision making has been shown to be superior to individual decision-making.[4] Further, the gerontological literature indicates that APS cases are often complex, involving functionally impaired

victims, the co-existence of several types of abuse or neglect, and dysfunctional family dynamics.[5] Given the complexity of cases, it was hypothesized that having a group of professionals from diverse backgrounds discussing a case would lead to more alternative strategies and thus greater success compared with one or two workers from the same agency strategizing on a case, as is typical of most APS agencies.

It was also hypothesized that community-based M-teams would help to fill gaps in services needed to assist victims. Previous gerontological literature had documented the existence of service gaps for assisting APS cases.[6] Since M-team members were also members of their local communities, it was believed that identified gaps would be filled creatively by these community representatives.

Finally, it was hypothesized that M-team members who volunteered their services would be more committed over time than those who were paid for their participation. This hypothesis stems from the "cognitive dissonance" theory of attitude change, which suggests that internal commitment to an issue or activity is greater when there is no external reinforcement. Since volunteer team members are not getting payment, they would justify their activities by feeling more committed to the team than those whose justification for team membership could be the fact that they were being paid.

METHODOLOGY

Site Selection

To meet the research goal and address this study's objectives, four CCUs within IDOA's case management program agreed to implement M-teams at their agencies. The CCUs are agencies responsible for assessing and coordinating services needed by frail elderly living at home. When Illinois established its statewide elder abuse program, the CCUs were frequently selected to also provide elder abuse services. Thus, these elder abuse provider agencies were the appropriate location for implementing M-teams because they are responsible for investigating and intervening in cases of elder abuse and neglect.

To test the research hypotheses, two CCUs from rural areas and two CCUs from urban areas were included in this project. One rural and one urban CCU were given the opportunity and funding to offer payment to M-team members for the time they spent on team-related activities. The other two sites were expected to find team members willing to be involved on a voluntary basis.

Table 1 lists the four selected elder abuse agencies that participated in this research.

TABLE 1
CHARACTERISTICS OF THE FOUR M-TEAM COORDINATING AGENCIES

SITE #	AGENCY NAME	GEOGRAPHIC LOCATION	TEAM TYPE
1	ALTERNATIVES FOR THE OLDER ADULT	URBAN	VOLUNTARY
2	TRI-COUNTY COUNSELING CENTER	RURAL	VOLUNTARY
3	VISITING NURSE ASSOCIATION	URBAN	PAID
4	SHAWNEE ALLIANCE FOR SENIORS	RURAL	PAID

Alternatives for the Older Adult is a not-for-profit, private agency on the northwestern border of Illinois. The agency is designed to provide case management services to over 3,000 elderly clients in a ten-county area. Alternatives' elder abuse program began in 1987, with local funding. By 1990, 135 elder abuse victims were served by the program. In addition to case management and elder abuse services, the agency has a guardianship program, an ombudsman program, friendly visitors for the homebound elderly, and geriatric training services.

Tri-County Counseling Center is a mental health service which is also the designated Case Coordination Unit serving Jersey and Greene counties in west-central Illinois. The agency's two elder abuse workers, who are also case managers, investigate about 17 cases of elder abuse annually. In addition to elder abuse services, Tri-County Counseling Center provides information and referral, case management, assessment for in-home services, and nursing home prescreening.

The Visiting Nurse Association is a not-for-profit home health agency in southwestern Illinois. In addition to home health case, the agency provides day care services for children, a healthy kids program and case management services for the elderly. The case coordination unit of the agency is also the designated elder abuse provider agency for 5 counties.

Shawnee Alliance for Seniors is a social service agency serving the frail elderly in the lower thirteen counties of southern Illinois. Shawnee has been the designated case coordination unit for IDOA's in-home care services for the past five years. The agency also operates a protective service division, which includes both elder abuse and nursing home ombudsman services. Additional programs developed and implemented by the agency include the Wellsprings Program providing health screening and education at multipurpose senior centers, an alcohol and substance abuse program and a home dental program.

Project Steering Committee

To guide the research activities, a steering committee was created. The committee included representatives from IDOA, SPEC Associates (the evaluation consultant), and each of the four sites that were to implement M-teams. At first, monthly meetings were held. After the teams were implemented, the steering committee met on the average of bimonthly. The steering committee made all major decisions about the project, and assured that the teams were implemented consistently across sites.

Selection of M-team Members

In order to document the process of M-team selection, it was important that all sites select their M-team members in the same way. The steering committee first generated the characteristics they expected M-team members to have. As a group, the committee decided that any M-team member should have, at a minimum, the following characteristics:

(1) Committed to positively serving the aging population,
(2) Willing to work as an M-team member for at least one year,
(3) Interested in gerontology,
(4) Competent in their profession,
(5) If possible, a past history with the coordinating agency.

The committee also decided that the following professions would be represented on each M-team:

(1) Medicine (preferably a physician, a nurse if a physician was not available)
(2) Mental health
(3) Financial (banking or financial management)
(4) Clergy
(5) Law enforcement
(6) Legal (attorney)

In addition, one person from the elder abuse agency would serve as the M-team coordinator. This person would be responsible for arranging a time and place for

meetings, assuring that M-team members and the program evaluator receive copies of team meeting minutes, and selecting cases to be discussed by the team.

The M-team members would represent themselves, as individuals, and not act as representatives of their agencies. In this way, the projects could assure that the selected individuals would be committed to the team, and not interchangeable with other representatives of the agency.

Members of the paid teams would be reimbursed for the time they spent attending team meetings, but not for any activities related to the M-team that were completed away from team meetings. Members of both paid and voluntary teams would be reimbursed for travel expenses related to training and to attendance at team meetings.

In order to estimate the typical refusal rate in M-team member selection, each site was asked to bring a list of potential team members to the steering committee meeting. Each site was asked to bring at least two names for each discipline. Within each discipline, the list was randomly ordered. Site coordinators were asked to invite team members in the selected order, to remove biases.

Roles of M-team Members

Initially, the steering committee decided that the M-teams would have four major goals:

(1) To find creative alternatives for serving cases,

(2) To help fill gaps in services that were identified,

(3) To become educated about the issues facing both victims and abusers,

(4) To assist in raising their communities' consciousness about elder abuse and neglect.

Each M-team member would be required to sign a member agreement between themselves and the coordinating agency. The agreement would commit them to serving on the team for at least one year. It also committed them to abide by client confidentiality requirements. A copy of a typical member agreement is included in the M-team Coordinator Guidebook that is part of the appendix to this report.

Selection of Cases to be Discussed

Because it would not be possible for the M-teams to discuss all elder abuse cases reported to the agency, the steering committee decided that cases for discussion would be selected by the M-team coordinator. The following policies were developed to assist the coordinator in the selection of cases:

(1) Only cases of abuse or neglect that had been assessed and substantiated would be discussed at the M-team.

(2) Only case managers in the pilot counties served by the M-teams would have the opportunity to bring substantiated cases to the coordinator for consideration.

(3) The case manager would describe reasons why the case would benefit from M-team discussion.

(4) The final selection of cases would be made by the coordinator.

(5) The case manager must agree to present the selected case to the M-team so that questions about the case could be answered.

Implementation of M-teams

Once the team members were selected, the first step in team implementation was training team members. The steering committee decided on a common training agenda for all sites, as well as the materials and presenters. Training consisted of two programs.

The first program was conducted by the coordinating agency, and included the following topics:

* Purpose of the grant
* Commitment expected of team members
* General tasks expected to be accomplished by the teams
* Profiles of elder abuse victims and abusers in Illinois
* Theories of elder abuse
* Overview of the current Illinois laws related to team operations
* Coordinating agencies' protocols for handling elder abuse cases
* Resources available in the community to serve victims and abusers

The second training was provided by Lisa Nerenberg, from the San Francisco Consortium on Elder Abuse. The Consortium had been a recipient of an AoA grant on M-teams, which resulted in the development of training materials and a training videotape. Training was provided in three different locations (two teams were combined for one training program). The topics of this training included:

* Purpose of M-teams
* Roles of M-team members
* Ways M-team members could be supportive
* Handling unresolved issues
* How to make case presentations
* Discussion of simulated cases

Once training was completed, the M-teams began regular operations. At all four sites, the teams met once each month, with the exception that some teams did not meet during one of the summer months.

Evaluation and Data Collection Strategies

In order to document the process and impact of M-teams, several data collection strategies were implemented. This section describes the data collection strategies. The appendix contains the data collection instruments used for each component of this research.

Survey of Refusals

During the selection of M-team members, a total of 13 professionals refused an invitation to be M-team members. The steering committee believed it would be informative to survey these professionals to determine reasons for their refusals.

A mail survey was conducted of M-team members, using the Dillman method. This survey technique utilizes several rounds of mailed surveys and postcards, and has been known to result in high response rates. Twelve of the 13 professionals responded to the mail survey.

Tracking M-team Activities

In order to describe the activities of the M-team over the course of the project, the coordinators were asked to complete an M-Team Meeting Report Form after each team meeting. The form obtained information about members present and absent, additional professionals involved in the meeting, turnover in team membership, number of clients discussed at the meeting, number of different case managers presenting cases, and types of activities conducted during the meeting.

M-team meeting data were collected between January, 1989 and June, 1990. A total of 18 months of team activities were tracked using this form.

Measuring Team Activities Outside of Team Meetings

One measure of impact of M-teams was the extent to which team members engaged in team-related activities outside of the team meetings. To assess the level of external activities, an M-Team Registration & Reimbursement Sheet was created. This form measured the number of minutes per month each team member spent in one or more of the following activities:

(1) Making public presentations about elder abuse.

(2) Client-specific activities related to one or more clients discussed at an M-team meeting.

(3) Other activities related to the M-team.

(4) Other activities related to elder abuse not directly related to the M-team (eg. talking to professional groups about elder abuse, donating money to an agency serving victims, etc.).

Tracking Commitment and Satisfaction of M-Team Members

In addition to describing activities of the entire team, semi-annual telephone surveys were conducted with individual members of the M-teams. The surveys provided data on the commitment levels of team members as well as their opinions on various issues that arose during the implementation of this project. A total of 3 rounds of telephone surveys were completed with M-team members over the course of this project.

The same measures of member satisfaction and commitment to the M-team were included on each of the survey instruments. Additional questions were generated by the steering committee members prior to each of the surveys. This flexibility of adding unique questions on different surveys allowed the steering committee to obtain feedback from team members that were relevant at the particular stage of the project.

A M-team commitment measure was created for this study by adapting the organizational commitment scale of Porter et al. (1974) to the M-team. This measure has been validated on many samples of employees, and is used often in studies of organizational commitment. The final measure included the following items, to which respondents were asked to respond: strongly agree, agree, disagree and strongly disagree.

I feel little loyalty toward the m-team.

I talk up the M-team to my friends as a great group to be a part of.

I feel a sense of pride being part of the M-team.

Moving ahead in my career is more important than being a member of the M-team.

I value being an M-team member because it identifies me with concerns about the elderly.

My loyalty is more to my work than to the M-team.

If asked, I would do more for the M-team than attend monthly meetings.

As long as I'm doing the kind of work I enjoy, it does NOT matter if I belong to the M-team.

If asked, I would serve on a committee for the M-team.

I doubt that I would do any special work for the M-team.

I find that my values and the values of other M-team members are very similar.

I am proud to tell others I am part of this M-team.

I am willing to put forth a great deal of effort beyond that normally expected in order to help this M-team be successful.

I would accept almost any type of job assignment in order to stay a part of this M-team.

The M-team really inspires the very best in me, in the way of job performance.

I really care about the fate of this M-team.

I intend to remain a member of the M-team as long as it exists.

If I had to do it over again, I would still join this M-team.

Satisfaction with the M-team was measured by asking the respondents to respond to the following five questions:

How satisfied are you with the productivity of the M-team?

How satisfied are you with the success rate of the cases that the M-team has processed?

How satisfied are you with the commitment of other members of your team?

How satisfied are you with team training?

On the whole, how satisfied are you with the M-team?

In addition, over the course of the longitudinal survey, various questions were asked to team members about their intention to remain on the team, reasons why they continue to attend team meetings, and any other comments they would like to make about the team and/or their involvement.

Tracking Cases Discussed by M-teams

In order to describe the types of cases brought to the team for discussion, and the types of decisions made by the team about each case, an Individual Client Form was created. The coordinator completed one form for each client discussed at each team meeting.

The form collected information about the demographics of the client, why the case was selected for team discussion, gaps in services needed by the victim and/or abuser, and actions taken by the M-team.

Job Analysis of M-team Members

To describe the actual "job" of the M-team members, a systematic job analysis was conducted. A job analysis is the process of obtaining task-related information about a job or position. It identifies the key areas of responsibility, information and resources, knowledge, skills, and abilities required to perform a job successfully. The outcome of a job analysis is a written description of each position analyzed. The information can then be used to select, evaluate, and train future M-team members.

The objectives of the job analysis were to identify:

(1) The specific roles and responsibilities of each M-team member, including knowledge, skill, and ability requirements.

(2) Similarities and differences between the roles and responsibilities of members on different teams who have the same position.

(3) Any differences between urban vs. rural and paid vs. voluntary teams in terms of the roles and responsibilities of members.

The job analysis research was designed to include on-site and telephone interviews with all M-team members. An interview guide was developed to provide the following job-related information about each position:

* **M-team Process.** The first few participants interviewed in each site were asked to describe the M-Team process, including meeting attendance, participation by various disciplines, use and role of designated alternates.

* **General Responsibilities.** Participants were asked to describe their role on the M-team -- what they do and their major areas of responsibility as members. They were also asked to identify what they spend the most and least amount of time on.

* **Information Input/Resources.** Participants were asked where and how they get the information they need to perform their roles on the M-team. This discussion topic also identified contacts required and available resources.

* **Knowledge, Skills, Abilities.** Each participant was asked to identify the key knowledge, skills, and abilities required of them as members of the team. In addition, they were asked for their recommendations regarding the education, experience, training, and licensing requirements of members who would serve in the same role on future M-teams.

* **Job Context and Output.** Participants were asked to identify the context in which their tasks are performed, including any equipment, tools, and devices required, working environment, stressors, etc.

* **Enhancements/Comments.** Each participant was asked to identify the changes that should be made to the team process and their role in an effort to enhance M-team effectiveness.

The same general questions and format were used for interviewing all team members. Initially, a letter of introduction was prepared and mailed to M-team members. Team members were given an honorarium for their participation.

After completion of all interviews, the information was synthesized to form a draft job description of each position. A third letter was then sent to each member thanking them for their participation in the research and requesting that they review the draft, edit it, and send back any revisions.

Only three team members were unavailable for interviewing. However, they were given an opportunity to give their input by reviewing the draft description and forwarding their comments.

Case Managers' Levels of Burnout

An expectation of the steering committee was that case managers who had access to M-teams would experience less stress in their jobs compared with those who did not have access to M-teams. The steering committee decided to track the levels of burnout of all case managers at their agencies. At three of the four sites, there were case managers who were not providing services in the counties targeted for this project. Therefore, these case managers did not have access to M-teams to discuss difficult cases. The burnout levels of these two groups of case managers were tracked over 24 months of the project.

After an extensive review of the literature, the Maslach Burnout Inventory was selected to measure burnout among case managers. This inventory was developed for the human services profession and extensive research has been done on its validity and reliability.[7] There are three subscales to this inventory:

(1) **Personal Accomplishment**: the extent to which the respondent feels competent and successful in his/her work involving people.

(2) **Emotional Exhaustion**: feeling emotionally overextended and exhausted by one's work.

(3) **Depersonalization**: taking an impersonal response toward clients.

Prior to collecting data from case managers, the steering committee members completed the survey and the results were analyzed. The Steering Committee scores on all three subscales were approximately normally distributed, indicating the applicability of the instrument for the case managers.

The case managers' burnout scores were measured every six months, beginning in December, 1988. The surveys were mailed to the site coordinators who distributed them to the case managers, along with envelopes marked "confidential" for the case managers to seal their completed surveys to return to the evaluator. It was expected that the individual envelopes would assure the confidentiality of the responses.

Comparison of Client Outcomes: M-team Counties versus Non-M-team Counties

To determine whether clients had improved outcomes if their case managers had access to an M-team, data were to be examined from IDOA's statewide elder abuse management information system. The original intent was to abstract two

years of data: 1988 data (prior to the implementation of the M-teams) and 1989 data (after M-teams had been implemented for approximately one year). It was hypothesized that if the M-teams had an impact on client outcomes, the rate of institutionalization of elder abuse clients should be less in 1989 compared to 1988, in those areas with M-teams. In comparison, the rate of institutionalization should remain the same in both years for those areas without access to M-teams.

Unfortunately, examination of the data bases indicated that the client level data assessed the location of the client at the time the substantiation decision was made, rather than after interventions had been instituted. Further, the service data was not coded by county. Therefore, it was not possible to analyze these data bases to test the study's hypotheses.

RESULTS

Team Selection and Survey of Refusals

Results from the M-team member selection process indicate that neither paid nor voluntary sites had difficulty obtaining team members. Physicians were most difficult to solicit for team membership. Being paid may have been a factor in soliciting physicians to join the team. By the end of the second month of the project, the two paid sites were able to find physicians willing to participate. On the other hand, neither voluntary site had obtained a physician for a team member. The voluntary sites were eventually able to get nurses to represent the medical community on the teams.

Table 2 illustrates the number of refusals received by each site. Each of the four sites had refusals. Site #1 (N=4) and Site #3 (N=5) had more refusals than Site #2 (N=1) and Site #4 (N=2). It does not appear that offering payment for participation results in fewer refusals. The total number of refusals from the voluntary teams was slightly less (N=5) than the number of refusals from the paid teams (N=7).

On the other hand, it appears that urban areas had considerably more difficulty obtaining team members than the rural areas. The urban areas had a total of 9 refusals, compared to only 3 in the rural areas.

TABLE 2
NUMBER OF REFUSALS BY TYPE OF SITE

VOLUNTARY SITES			
SITE NUMBER	#1 (URBAN)	#2 (RURAL)	TOTAL VOLUNTARY
# REFUSALS	4	1	5
PAID SITES			
SITE NUMBER	#3 (URBAN)	#4 (RURAL)	TOTAL PAID
# REFUSALS	5	2	7
TOTALS BY GEOGRAPHIC LOCATION	9	3	

Eight of the 12 refusals were from the medical profession. When asked why they refused, most of the respondents indicated the lack of time. Either they had too many commitments (N=5), or were too busy at their regular places of employment (N=2). Poor health and having a young child were the other reasons given for refusing the invitation to join an M-team.

Most (N=8) respondents said that if these problems could be resolved, they would reconsider becoming an M-team member. Most (N=7) felt they had enough information about the M-team to be able to make a good decision concerning joining. On the other hand, almost one half (N=5) said they would have liked to receive information in writing before receiving the invitation by phone.

One-half of the respondents knew about the agency prior to receiving an invitation to join the M-team. Most (N=8) would like to receive more information about the M-team. Nine respondents said that the M-team could call them again in the future.

On the other hand, one-half of the respondents had not heard of the agency prior to receiving the invitation. Therefore, the invitation, itself, served to educate these professionals about the agencies.

M-team Activities

Tables 3 through 8, on the following page, illustrate the results from the data collected on M-team activities using the M-team Meeting Report Form. As Table 3 shows, over the eighteen months during which data were collected, there were a total of 61 M-team meetings.

Table 4 shows the attendance rates by profession. In general, most team members attended most team meetings. Representatives of the legal profession were most frequently absent from team meetings, followed by representatives from law enforcement. There does not appear to be any relationship between the type of team (paid versus voluntary) and absence from team meetings. Neither does there appear to be a relationship between geographic location and absence. Sites #2 and #3 both have high absenteeism of the legal representatives. Site #2 is a rural, voluntary site, while site #3 is an urban, paid site.

The low attendance rate for law enforcement appears to be related to only one site, where the law enforcement representative attended only one meeting. Site representatives indicated that sometimes this individual, a sheriff, missed meetings because of emergencies. At other times, he would indicate his plan to attend but would still not be present. Regardless of the reason for absence, the overall low rate of attendance of the law enforcement representatives is the result of the very low attendance of one person, rather than a pattern of low attendance of law enforcement representatives across sites.

Table 5 shows the number of times team members changed. As the table shows, team membership changed vary rarely. In site #4, the change was the result of a new coordinator being assigned to the team, rather than a change among team members. One of the changes in site #2 was due to one team member leaving the area. In no case was the change in team membership reflective of the member's disenchantment with his/her role on the team.

As illustrated in Table 6, a total of 230 clients were discussed during team meetings. As will be illustrated in the client data, not all of these discussions were different clients. In Site #1, for example, many of the case discussions were merely updated information provided on clients discussed at previous meetings.

Usually, only one or two case managers presented a case at a team meeting. Sites #1 and #4 averaged more case managers per team meeting than sites #2 and #3. These differences probably reflect the fact that sites #1 and #4 are larger agencies, with more case managers involved with elder abuse clients.

Table 8 delineates the activities of the teams over the eighteen months of data collection. Contrary to expectations, team activities rarely involved filling gaps in services. Only 5% of the meetings involved resource development to fill gaps in services. The reason the original hypothesis was not supported is that, according to the team coordinators, cases are brought to the team for reasons other than lack of availability of services. Reasons cases are brought to the team will be discussed under client characteristics.

TABLE 3
TOTAL NUMBER OF MEETINGS BY SITE

	ALT	TRI-CO	VNA	SHAWNEE	TOTALS
MEETINGS	15	15	14	17	61

TABLE 4
M-TEAM ATTENDANCE BY PROFESSION AND SITE

	NUMBER OF MEETINGS ATTENDED					
PROFESSION	ALT	TRI-CO	VNA	SHAWNEE	TOTALS	PERCENTS
M-TEAM COORDINATOR	14	15	14	16	59	97%
LEGAL	12	6	5	13	36	59%
FINANCIAL	13	11	9	16	49	80%
CLERGY	13	13	14	15	55	90%
MENTAL HEALTH	15	10	13	12	50	82%
MEDICAL	13	9	13	16	51	84%
LAW ENFORCEMENT	12	1	11	16	40	66%

TABLE 5
CHANGE IN MEMBERSHIP BY SITE

	ALT	TRI-CO	VNA	SHAWNEE	TOTALS
NUMBER OF CHANGES	1	2	0	1	4

TABLE 6
TOTAL NUMBER OF CASE DISCUSSIONS BY SITE

	ALT	TRI-CO	VNA	SHAWNEE	TOTALS
NUMBER OF CLIENTS	90	39	50	51	230

TABLE 7
AVERAGE NUMBER OF CASE MANAGERS PRESENTING AT MEETING BY SITE

	ALT	TRI-CO	VNA	SHAWNEE
AVERAGE PER MTG	1.73	1.07	1.14	1.35

TABLE 8
ACTIVITIES OF M-TEAMS BY SITE

ACTIVITY	ALT	TRI-CO	VNA	SHAWNEE	TOTALS	PERCENTS
ADVISING CASE MGR	8	8	6	15	37	61%
CASE DISCUSSION	14	11	12	14	51	84%
TEAM EDUCATION	13	3	4	13	28	46%
PROCEDURAL	2	1	2	10	15	25%
COMMUNITY EDUC.	2	3	3	3	11	18%
CARE PLANNING	14	5	4	13	36	59%
NETWORKING	5	2	2	15	24	39%
RESOURCE DEVELOP.	0	0	1	2	3	5%
ADVOCACY	3	2	3	8	16	26%
EVALUATION	7	9	5	8	29	48%
OTHER	4	5	6	2	17	28%

As would be expected, case discussions (84% of meetings), advising the case manager (61% of meetings) and assisting with care planning (59% of meetings) are the major activities of the M-teams. This finding reflects the original goals of the M-teams and supports the roles of M-team members outlined in their training.

By the end of 18 months, 65% of the respondents to the telephone survey indicated that the team could use additional training. Topics mentioned for additional training included:

* Resources in the community
* Legislative and legal issues (mentioned most frequently)
* Creativity (ie. alternatives to difficult situations not thought about previously)
* How to prevent financial abuse
* Medical terminology
* Community government aspects of case resolution

External M-team Activities

M-team activities outside of team meetings were monitored through questions asked in the telephone surveys of team members, and through analysis of the M-Team Registration & Reimbursement Sheets completed by team members at each team meeting.

During the first telephone survey, respondents were asked whether they do much talking on their own to generate public support for elder abuse programs. Almost three-quarters of the M-Team members said they do generate support for elder abuse outside of the M-team. Team members generated support for elder abuse programming in a variety of ways. Among the most common ways team members generate support are:

* Talking with peers, colleagues and friends (N=11)
* Working with clients (N=5)
* Through work with church groups and church members (N=4)
* Through other organizations respondents are members of (N=3)

One respondent indicated that his/her organization formed a committee to initiate financial services for the elderly. Two respondents said they address elder abuse in the writing they do, and one said s/he generated support "through my job."

By the time of the third survey, 61% of the respondents still indicated that they did talking outside of team meetings to generate public support for elder abuse programs. Most frequently, respondents mentioned talking to other organizations or other professionals about elder abuse and the elder abuse program at the agency. For example, one physician reported talking to people at nursing homes, the state medical society, and at the county. This physician also reported that s/he was getting a group of physicians together to talk to senior's groups.

Other external activities of team members reported during the third survey were the development of a brochure on the topic to distribute in libraries and doctor's offices, speeches, newspaper articles, and public speaking to community groups. One respondent served on a committee drafting proposals for gubernatorial candidates and placed elder abuse on the list of issues.

The final source of information about external activities of M-team members comes from an analysis of the data collected using the M-Team Registration & Reimbursement Form. Table 9 shows that team members devoted about 500 hours to external activities related to team membership or to elder abuse.

TABLE 9
TOTAL HOURS SPENT ON OUTSIDE ACTIVITIES BY TEAM MEMBERS

TYPE OF ACTIVITY	HOURS	VALUE
PUBLIC PRESENTATIONS	38.22	$1,911
CLIENT-SPECIFIC ACTIVITIES	148.00	$7,400
OTHER M-TEAM ACTIVITIES	97.50	$4,875
OTHER ELDER ABUSE ACTIVITIES	218.82	$10,941

Since these team members are all professionals in their own areas of expertise, it is realistic to value their time at $50 per hour. Using this as the average cost of each team member's time, Table 9 shows that the total contributed value of M-team time is $25,127.

Table 9 also illustrates that most of the team members' time was spent on other M-team or elder abuse-related activities. These activities included:

* home visits with case managers to new referrals,
* establishing a bill-paying service for elderly,
* out-of-team consultation with case managers,
* providing legal representation for victims,
* arranging for police protection,
* talking with colleagues,
* talking with community representatives,
* consultation with nursing homes or other community agencies,
* counseling victims and abusers,
* reading materials related to elder abuse, and
* participating in the telephone survey and job analysis.

Team Members' Satisfaction with M-teams

In general, the team members appear to be satisfied with their M-teams after 18 months of operations. As illustrated in Table 10, three-quarters of the respondents to the third telephone survey indicated that "on the whole" they were very satisfied with the M-team. Their highest satisfaction was with their perceptions of the team's productivity. Their lowest satisfaction was with training and with the success rate of the cases.

These findings highlight the fact that many cases discussed by the team are complex and difficult. Team members may feel that greater training may lead to a higher success rate with cases.

TABLE 10
MEMBERS' SATISFACTION WITH THEIR M-TEAMS
AFTER 18 MONTHS OF TEAM OPERATIONS

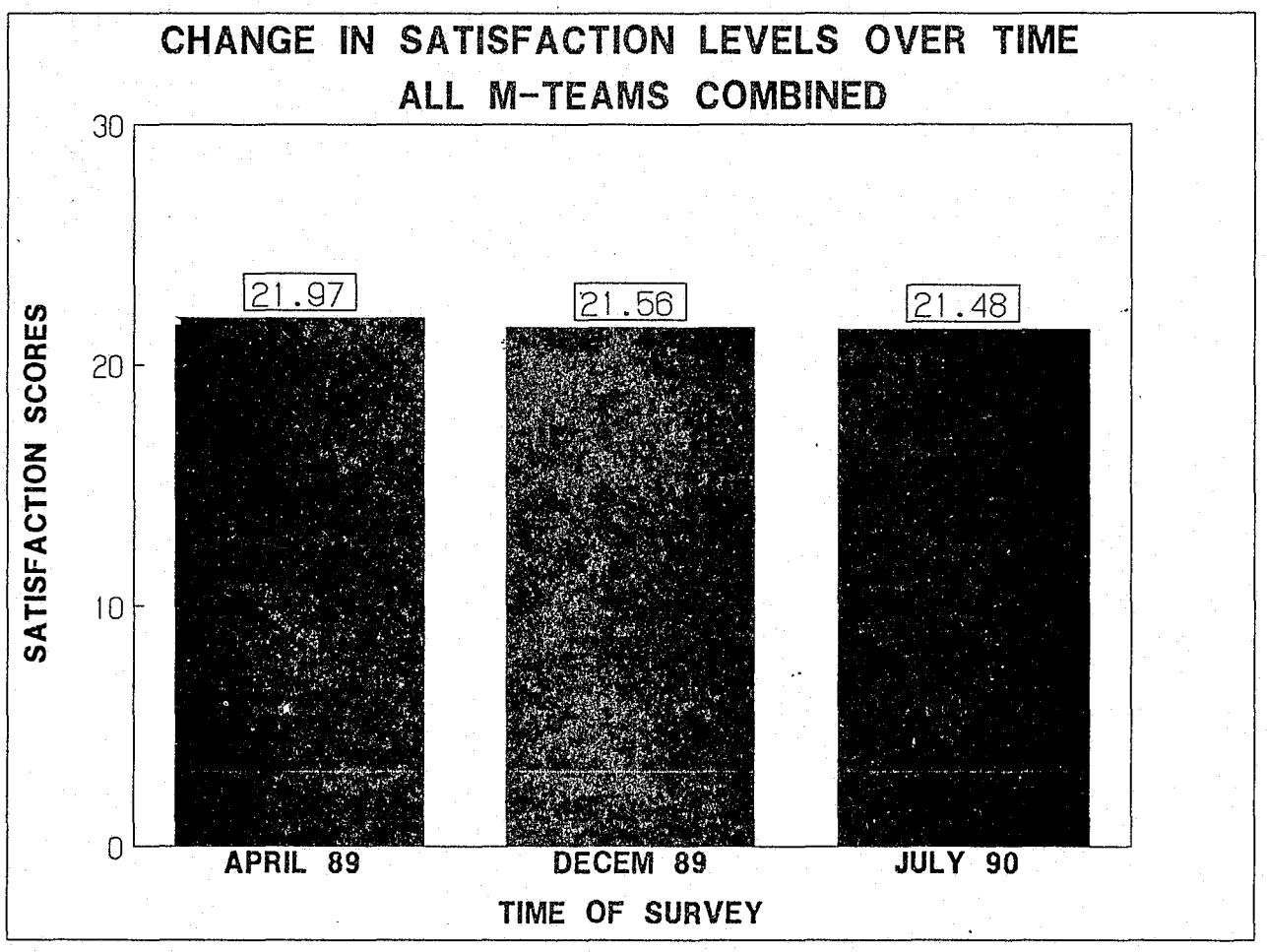
COMPONENT OF TEAM OPERATIONS	VERY SATISFIED	SOMEWHAT SATISFIED	SATISFIED	SOMEWHAT DISSATISFIED	VERY DISSATISFIED
How satisfied are you with the productivity of the M-team?	18 (72%)	4 (16%)	1 (4%)	2 (8%)	0 (0%)
How satisfied are you with the success rate of the cases that the M-team has processed?	12 (48%)	5 (20%)	6 (24%)	2 (8%)	0 (0%)
How satisfied are you with the commitment of other members of your team?	14 (56%)	8 (32%)	2 (8%)	1 (4%)	0 (0%)
How satisfied were you with team training?	9 (36%)	7 (28%)	7 (28%)	1 (4%)	1 (4%)
On the whole, how satisfied are you with the M-team?	19 (76%)	3 (12%)	2 (8%)	1 (4%)	0 (0%)

Team members' satisfaction with the M-team remained the same over time. When total satisfaction scores are generated by summing responses to all of the five items, the average scale scores for the respondents remain virtually the same over the three time periods of the study. As illustrated in Figure 1, team members satisfaction scores are 21.97, 22.56 and 21.48, respectively, over the three time periods. Total scale scores can range from 5 to 30. These differences in satisfaction scores were not statistically significant ($F_{2,48}=0.314$, $P \leq 0.732$).

During the second telephone survey, team members were asked why they keep coming to team meetings. A variety of answers were given to this question. Analysis of the responses suggest the following reasons why members continue to attend meetings:

* See the need for M-teams
* Want to be of help/service
* Nice to be paid
* Commitment/obligation
* Team does good
* Contacts made with other people/agencies
* Enjoy the group/have fun
* Challenge/stimulation
* Educational
* Feel its worthwhile
* Interest in elder abuse

FIGURE 1



By the time of the second survey, most of the respondents had been involved with the M-teams for approximately one year. At this time, there were approximately 6 months remaining before the termination of the grant. When asked if they planned to continue being a member of the M-team after funding was discontinued, 24 of the 25 respondents answered "yes."

When asked why they intend to continue, a variety of answers were given. Common themes are apparent in the open-ended responses to this question. Respondents intend to continue with the M-team because they feel M-teams are needed and are worthwhile. Other reasons for continuing are interest in the elderly and in elder abuse, feeling the team has been useful and enjoying the other members.

Over time, the team members' comfort in their roles appears to increase. When asked if they feel more comfortable giving advice now, compared with when they first started, 88% of the respondents answered "yes." Reasons for increased comfort included:

* Feelings of team cohesion, including greater trust of other team members, feeling more comfortable that brainstorming has no wrong answers, not being afraid to speak out, and familiarity with others on the team.

* Having more knowledge and experience than when they first began.

* Feeling that they are taken more seriously than initially.

* Overcoming the initial shock experienced when listening to case histories.

* Knowing more about what's expected of them on the team.

During the third survey, team members were asked about the progress that is made on the cases discussed at the team meetings. Responses on this issue were mixed. Some team members felt they were making good progress. Others felt that progress was made on some cases but not on others.

Ambivalence among the responses to this question are illustrated by the following comments from respondents:

"Some cases get pretty frustrating. I find real satisfaction in others."

"Progress had been made in almost all of the cases."

"For the most part, it has been good. There are a few cases that have been disappointing, but most have been resolved satisfactorily."

"With some, a great deal has been done. Generally, they work out well, with good, positive results. On others, we can't do anything and our hands are tied. These are very frustrating."

"In most cases there's not much progress."

"Progress is good and not so good. There's not anything that one person can do. The staff benefit from the experts sitting around and supporting them."

"Occasionally there is a solvable problem, most of them are not solvable,"

By the third survey, the grant was within one month of ending. When asked if they are still planning on staying on as an M-team member, 87% of the respondents answered "yes." The things found to be most beneficial about being involved on the M-team included:

* Increased awareness about problems of the elderly and elder abuse.

* Contact with other professionals, including learning about other disciplines' perspectives.

* Gaining knowledge that can be used in their regular employment.

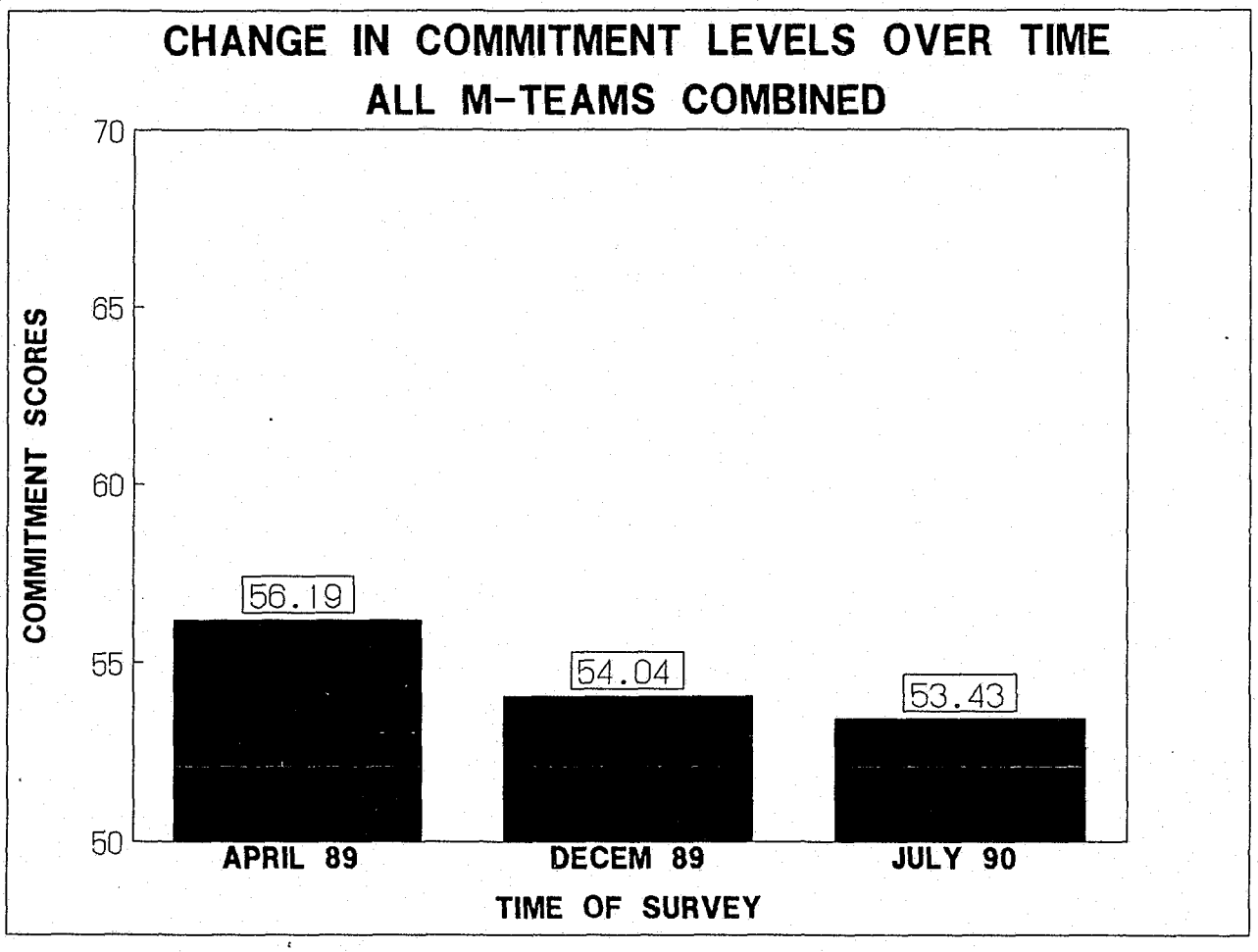
* Feelings of satisfaction that progress can be made with cases.

* The team involvement in decision making, with team members from various disciplines bringing their expertise to bear on the problem.

It is interesting to note that in spite of their intent to remain on the team, overall scores on commitment to the M-team decline over time. Figure 2 illustrates the results from the scale scores generated by summing respondents scores over the 18 commitment items. As the figure shows, overall scale scores

decline from 56.19 after 3 months of operations, to 54.04 after 11 months, to 53.43 after 18 months. This difference is statistically significant ($F_{2,40}$=3.248, P≤0.049). On the other hand, it should be noted that the average decline in commitment scores was less than 5 points, or less than 10% of the possible range of scores.

FIGURE 2



Cases Discussed by M-teams

Tables 11 through 22 on the following pages present the results describing the characteristics of the cases discussed at team meetings. Table 11 shows the number of clients that were discussed each month by each team. The number of cases discussed varies widely. This reflects the fact that some teams provided regular updates on clients while others provided updates only as they felt were needed. Some variation in the number of cases discussed is also the result of unique cases in which an entire group of elderly were victimized by the same situation. For example, in one case, a board and care home was cited for financially abusing several of the tenants.

As Table 12 shows, over the eighteen month period, the teams discussed a total of 111 different clients. Considerable time during team meetings is spent updating team members about clients discussed previously. Forty-one percent of the cases discussed were updates on clients previously brought to the team. According to the team coordinators, providing updates is important because team members are anxious to know the status of cases they discussed.

Almost 20% of the case discussions involved follow-up consultation on cases discussed previously. In these cases, team members were asked for additional advice on how to proceed with a case. This substantial activity of the team reflects the difficult nature of many cases brought to the teams for discussion.

There does not appear to be any difference in the number of cases brought to paid versus voluntary teams. The voluntary teams (Site #1 and Site #2) discussed a total of 57 different cases, compared to 54 cases discussed by the paid teams (Site #3 and Site #4). Overall, the voluntary teams had more case discussions (N=167) compared with the paid teams (N=112). However, this difference appears to be due to the large number of updates provided by Site #1. This site passed out written updates on cases at each team meeting.

Rural teams appear to have discussed slightly more cases (N=64) than urban teams (N=47). Overall, as Table 18 shows, 59% of the clients were from rural areas and 41% were from urban areas. The greater number of cases discussed by rural teams may be a reflection of the fact that Site #4 had been doing elder abuse assessments and interventions for many more years than the other three sites. This site received more reports of elder abuse and neglect, and also brought more cases to the team than the other sites.

As Table 19 illustrates, most of the cases are brought to the team for reasons other than unmet needs. This unanticipated finding rejects the hypothesis that a major impact of M-teams is the creation of gap-filling services. In 90% of the cases, unmet needs are not the reason for bringing a case to the team for discussion.

In only 20% of the cases did the team change the care plan developed by the case manager. These data suggest that a major role of the M-team is one of confirmation of the case manager's actions, rather than modification of strategies.

CLIENT-LEVEL DATA FROM M-TEAMS

TABLE 11
TOTAL NUMBER OF CLIENTS BY SITE AND MONTH

	#1		#2		#3		#4		
MONTH	1989	1990	1989	1990	1989	1990	1989	1990	TOTALS
JANUARY	0	8	0	2	0	0	0	8	18
FEBRUARY	4	4	2	2	2	0	2	6	22
MARCH	5	6	2	1	3	3	4	3	27
APRIL	6	1	1	1	3	5	5	4	26
MAY	7	5	6	0	6	3	3	3	33
JUNE	9	6	11	2	3	3	2	2	38
JULY	8		3		4		4		19
AUGUST	9		0		0		2		11
SEPTEMBER	5		3		5		0		13
OCTOBER	10		1		6		2		19
NOVEMBER	13		4		4		3		24
DECEMBER	12		4		6		3		25
MONTH MISSING	2								2
									277

TABLE 12
TOTAL NUMBER OF CLIENTS BY TYPE AND SITE

	#1	#2	#3	#4	TOTALS	PERCENT
INITIAL	32	25	15	39	111	39.8%
FOLLOW-UP	33	12	2	3	50	17.9%
MULTIPLE REPORT	0	0	4	1	5	1.8%
UPDATE	57	8	35	13	113	40.5%
TOTALS	122	45	56	56	279	

TABLE 13
TYPE(S) OF ABUSE SUBSTANTIATED OR SUSPECTED BY SITE (TOTALS)

TYPE OF ABUSE	#1	#2	#3	#4	TOTALS	PERCENT
PHYSICAL	45	11	21	25	102	36.6%
CONFINEMENT	7	10	23	9	49	17.6%
SEXUAL	7	0	0	1	8	2.9%
DEPRIVATION	2	14	29	10	55	19.7%
FINANCIAL	70	31	26	27	154	55.2%
NEGLECT	37	21	21	16	95	34.1%
PSYCHOLOGICAL	34	13	17	32	96	34.4%

CLIENT LEVEL DATA FROM M-TEAMS

TABLE 14
TYPE(S) OF ABUSE SUBSTANTIATED OR SUSPECTED – INITIAL REPORTS ONLY

TYPE OF ABUSE	#1	#2	#3	#4	TOTALS	PERCENT
PHYSICAL	13	6	5	17	41	36.9%
CONFINEMENT	1	2	7	6	16	14.4%
SEXUAL	1	0	0	1	2	1.8%
DEPRIVATION	1	11	5	8	25	22.5%
FINANCIAL	16	16	9	19	60	54.1%
NEGLECT	12	6	4	12	34	30.6%
PSYCHOLOGICAL	6	9	6	24	45	40.5%

TABLE 15
SEX OF CLIENT BY SITE (INITIAL REPORTS ONLY)

	#1	#2	#3	#4	TOTALS	PERCENT
MALE	5	10	0	9	24	21.4%
FEMALE	27	15	14	31	87	77.7%
MISSING	0	0	0	1	1	0.9%

TABLE 16
AVERAGE AGE OF CLIENT BY SITE

	#1	#2	#3	#4	OVERALL AVERAGE
AVERAGE AGE	76.7	76.4	73.2	78.6	76.0

TABLE 17
RACE OF CLIENT BY SITE

RACE	#1	#2	#3	#4	TOTALS	PERCENT
WHITE	24	25	12	40	101	89.4%
BLACK	7	0	3	1	11	9.7%
HISPANIC	1	0	0	0	1	0.9%
ASIAN	0	0	0	0	0	0.0%
OTHER	0	0	0	0	0	0.0%

TABLE 18
LOCATION OF CLIENT BY SITE

ACTIVITY	#1	#2	#3	#4	TOTALS	PERCENT
URBAN	31	0	15	0	46	41.1%
RURAL	1	25	0	40	66	58.9%

TABLE 19
NUMBER OF VICTIMS/ABUSERS WITH UNMET NEEDS BY SITE

UNMET NEED PRESENT?	#1	#2	#3	#4	TOTALS	PERCENT
YES	7	3	2	13	25	9.0%
NO	114	42	54	42	252	90.3%
MISSING	1	0	0	1	2	0.7%

TABLE 20
 # CLIENTS FOR WHOM CARE PLAN WAS CHANGED BY SITE

CARE PLAN CHANGED?	#1	#2	#3	#4	TOTALS	PERCENT
YES	35	7	3	12	57	20.4%
NO	28	25	18	33	104	37.3%
NA	58	9	35	10	112	40.1%
MISSING	1	4	0	1	6	2.2%

TABLE 21
 # CLIENTS FOR WHOM INSTITUTIONALIZATION WAS RECOMMENDED BY SITE

INST. RECOMENDED?	#1	#2	#3	#4	TOTALS	PERCENT
YES	9	9	13	7	38	13.6%
NO	52	23	8	38	121	43.4%
NA	59	9	35	11	114	40.9%
MISSING	2	4	0	0	6	2.2%

TABLE 22
AVERAGE TIME SPENT ON INITIAL CASES BY SITE

	#1	#2	#3	#4	OVERALL AVERAGE
MINUTES PER CASE	20.7	20.8	36.0	32.6	27.0

According to the statistics available from IDOA's statewide programs, the types of cases brought to the M-team are largely reflective of the types of cases reported to the statewide elder abuse program. Table 23, below, compares the reports of abuse received by the statewide program and those brought to the team for discussion.

TABLE 23
COMPARISON OF STATEWIDE CASES AND CASES BROUGHT TO M-TEAMS

TYPE OF ABUSE/NEGLECT	STATEWIDE PROGRAM	BROUGHT TO M-TEAM
PHYSICAL	28%	37%
CONFINEMENT	6%	14%
SEXUAL	1%	2%
DEPRIVATION	10%	23%
FINANCIAL	43%	54%
NEGLECT	37%	31%
PSYCHOLOGICAL	40%	41%

As this table illustrates, the overall pattern of types of abuse and neglect is similar for the statewide program and for cases brought to the M-teams. However, among the cases brought to the M-teams there are slightly higher proportions of cases of physical abuse, confinement, deprivation and financial exploitation. Statistical tests are not available to examine the statistical significance of these differences. However, since many types of abuse and neglect can be present in the same case, the pattern of differences suggests that cases brought to the M-teams may have more coexisting types of abuse, neglect and/or exploitation compared to the "typical" elder abuse case reported in Illinois.

The cases brought to the team are also similar to the statewide caseload in terms of age (76 years in both) and sex (75% female in statewide program compared with 78% female among cases discussed by M-teams).

Reasons Why Cases are Brought to the M-teams

Table 24 shows the results from the content analysis of the responses of the M-team coordinators about why each case was selected for discussion by the M-team. For each reason, coordinators were allowed to assign up to three codes.

TABLE 24
REASONS WHY CASES ARE SELECTED FOR M-TEAM DISCUSSION

CODE	TITLE	DEFINITION	FREQUENCY	PERCENT
01	CHRONIC CASE	Case has been involved with the agency for a long period of time and case manager cannot seem to resolve it.	47	11%
02	ETHIC RE: SELF-DETERMINATION	The case was brought to the M-team because the case manager faced ethical dilemmas about pursuing interventions that may conflict with the victim's right to self-determination.	42	10%
03	TEACHING ISSUE FOR TEAM	The case has interesting issues that will teach the M-team members more about elder abuse.	12	3%

TABLE 24 REASONS WHY CASES ARE SELECTED FOR M-TEAM DISCUSSION				
CODE	TITLE	DEFINITION	FREQUENCY	PERCENT
04	EASY CASE	The case was brought to the team because it had an easy solution and would give the M-team members feelings of success. To help prevent burnout of M-team members.	22	5%
05	NEEDED SPECIALIZED EXPERTISE	The special skills/knowledge of particular M-team member(s) is/are needed in order to implement an intervention or to make a decision about an intervention.	93	21%
06	UPDATE	The case was previously discussed by the M-team and the worker is providing information about the current status.	114	26%
07	FOLLOW-UP	The case was previously discussed and the worker is seeking follow-up discussion from the M-team.	31	7%
08	ACCESS DENIED	The major reason the caseworker brought the case to the team was for assistance in gaining access to the victim.	23	5%
09	VICTIM REFUSED SERVICES	The major reason the case was brought to the M-team was because the VICTIM refused all interventions offered by the case manager.	20	5%
10	ABUSER REFUSED SERVICES	The major reason the case was brought to the team was because the ABUSER refused all interventions offered by the case manager.	14	3%
11	CAREGIVER REFUSES SERVICES	The major reason the case was brought to the team was because the caregiver (who is not the abuser) refused all interventions offered by the case manager.	10	2%
12	ENVIRONMENTAL PROBLEMS	The victim has unmet needs for heat, water, or other housing/environmental problems.	7	2%

As the table indicates, a substantial proportion of cases discussed by the M-teams were updates on cases previously discussed. Only 7% of the cases were brought to the team for follow-up discussion where the case manager needed additional input from the team.

Besides updates, the most frequent reason why the case was brought to the team was because the case manager needed the specialized expertise of one or more team members to implement an intervention or to make a decision about a case. Twenty-one percent of the cases were brought to the team because of the need for specialized expertise. Examples of client situations requiring the specialized expertise of M-team members included:

> "Case manager was unsure as to which direction to go with this case. Possible public aid fraud and the disappearance of several thousand dollars, needed advice from M-team member."
>
> "Physical abuse reported with a confused victim. Access to the abuser was denied."
>
> "Difficult situation - abuser is caregiver and alcoholic."

Chronic cases (11%) and cases involving the ethics of self-determination (10%) were also frequent reasons why cases were brought to the M-team for discussion. Examples of situations coded as "chronic cases" include:

> "Client wants to return to an unsafe/dangerous situation. The physician and psychiatrist believe she needs a guardian. There has been difficulty finding legal help for her guardianship."

"Client says she is abused by neighbors. It is evident in this case that the client has mental health problems. It is difficult to get her to accept counseling."

"Client was resistant to follow-through on care recommendations. There have been previous incidents of abuse in the past."

Examples of cases involving the ethical issues of self-determination include:

"A difficult client to work with, living in poor conditions. Case has been reported in the past. The client prefers to live this way, appears alert."

"Victim is mentally competent but physically unable to care for herself. Client does not realistically see that she cannot care for herself. Daughter is alleged abuser. Both client and daughter are alcoholic. Daughter realizes her inability to care for her mother."

"The victim's home is filthy and has roaches. It is a difficult situation between the victim and her son (the alleged abuser). She is very attached to him and supportive of him."

Recommendations About Cases Made by M-Teams

Recommendations made by the M-team were also coded by the M-team coordinators. Figures 3 through 5 present the results from the content analysis of M-team recommendations.

As Figure 3 illustrates, the majority of the recommendations (80%) made by the M-team were for services to the victims. Recommendations concerning the abuser constituted 19% of the recommendations, and recommendations about services to caregivers who were not abusers constituted only 2% of the total suggestions made.

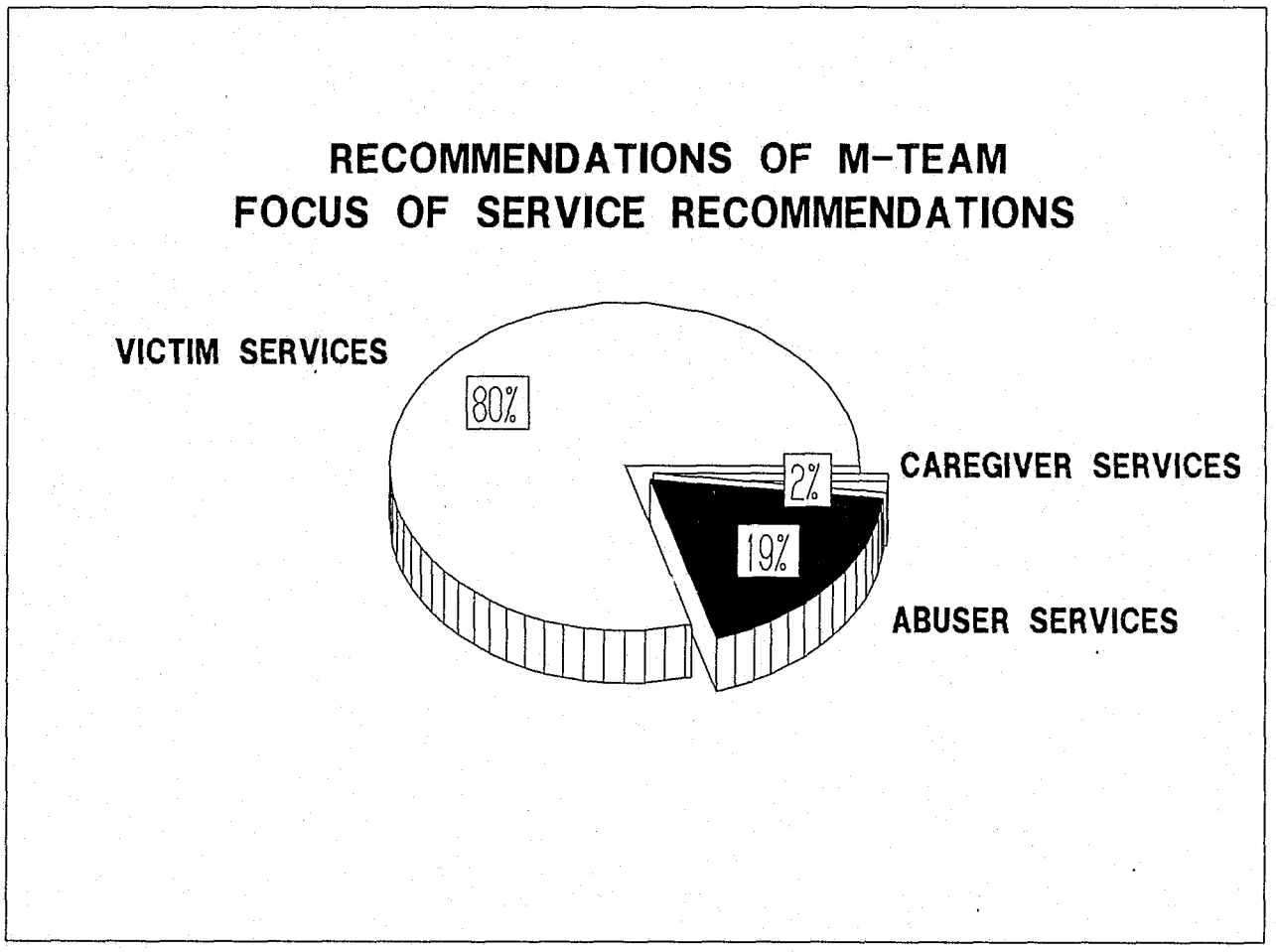
Figure 4 shows the types of services recommended for victims. As the figure suggests, the team made a variety of different recommendations. Most frequent recommendations were for legal services (26%). Examples of legal recommendations included:

"Provide an order of protection, but client would have to admit that nephews were (abusing)."

"Do a title search to find out what kinds of liens exist. Deal with client's personal privacy. Talk with workers who go into the home to get their impressions. Find out exactly what the client wants done. Hold a family conference to iron out differences and problems."

"Follow-up to see that the will was changed. Write a letter to the home health agency in regard to their employee financially abusing this client."

FIGURE 3



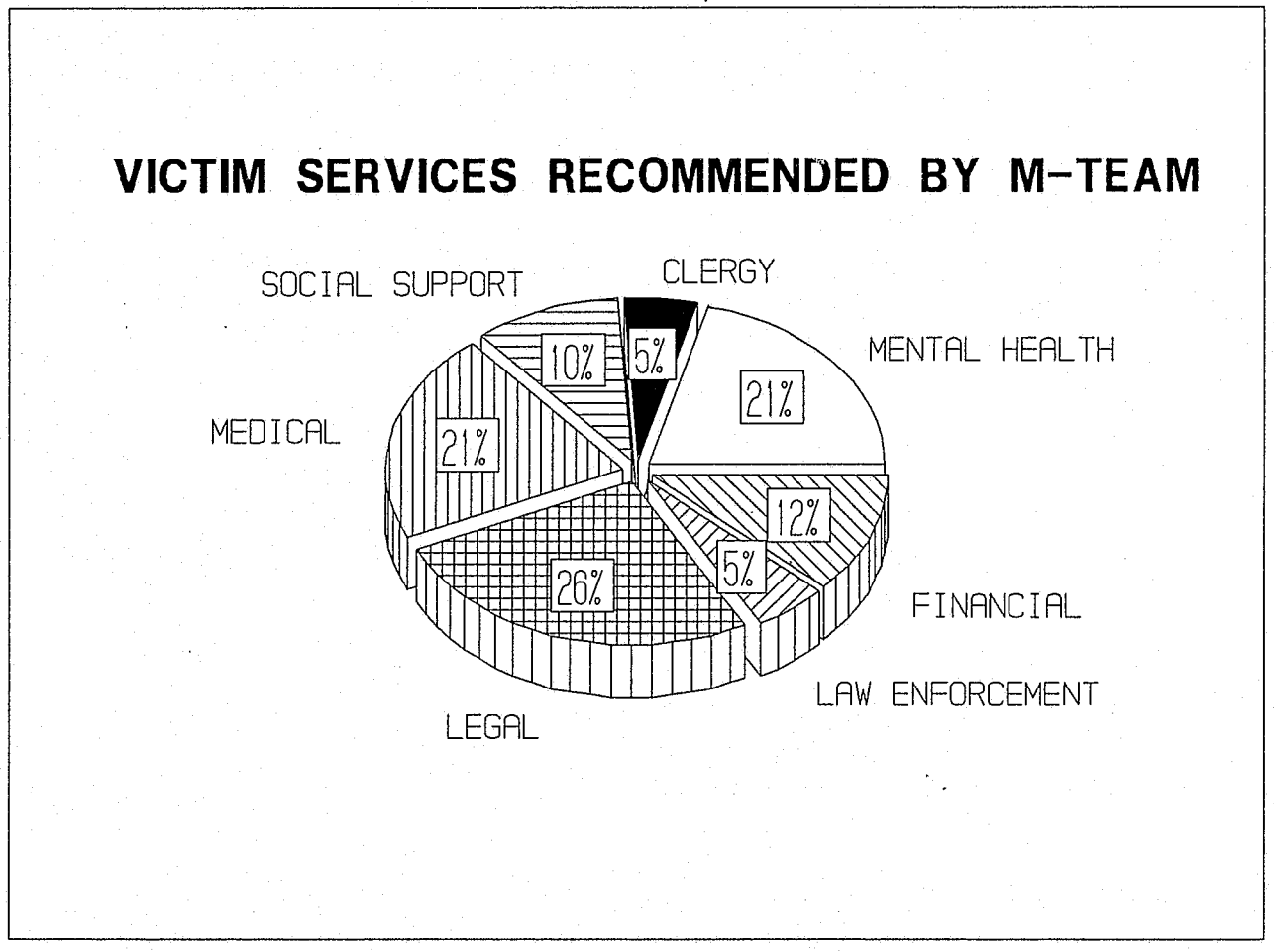
Mental health (21%) and medical (21%) were the next most frequent types of recommendations made. Most of the mental health service recommendations concerned obtaining mental health evaluations. Examples of medical recommendations are:

"Talk with client's physician about the abuse situation."

"Take the client to the university clinic for a physical and psychiatric evaluation. After taking her to see her doctor, see if hospitalization can be arranged and have her placed in senior housing."

"Talk with the doctor about placing client in a nursing home. Ask doctor whether client could benefit from occupational therapy and physical therapy. Explain to doctor that guardianship is being considered. Ask whether she is able to make competent decisions."

FIGURE 4



Financial recommendations were made in 12% of the cases. Types of financial recommendations made about victims included:

> "Talk to the bank to see if they will repossess the car and get it out of the abuser's possession. Notify the insurance company to make payments co-payable to all three parties."
>
> "Provide a list of all bills to the bank, and have all bills sent to the bank for payment, including an 'allowance' for the alleged abuser."
>
> "Talk to the client about direct deposit to the bank, so that the bank could pay the gas and water bills."

Figure 5 shows the types of recommendations made concerning services to the abuser. Among the 19% of recommendations that involved the abusers, mental health (32%) was the most frequent type of recommendation. Examples of mental health recommendations are:

> "Continue to encourage outpatient counseling."

"Discuss with the family how much stress they are under. Review with them alternative placement for the client. Offer respite care to the family."

"Recommend an alcohol program for the abuser."

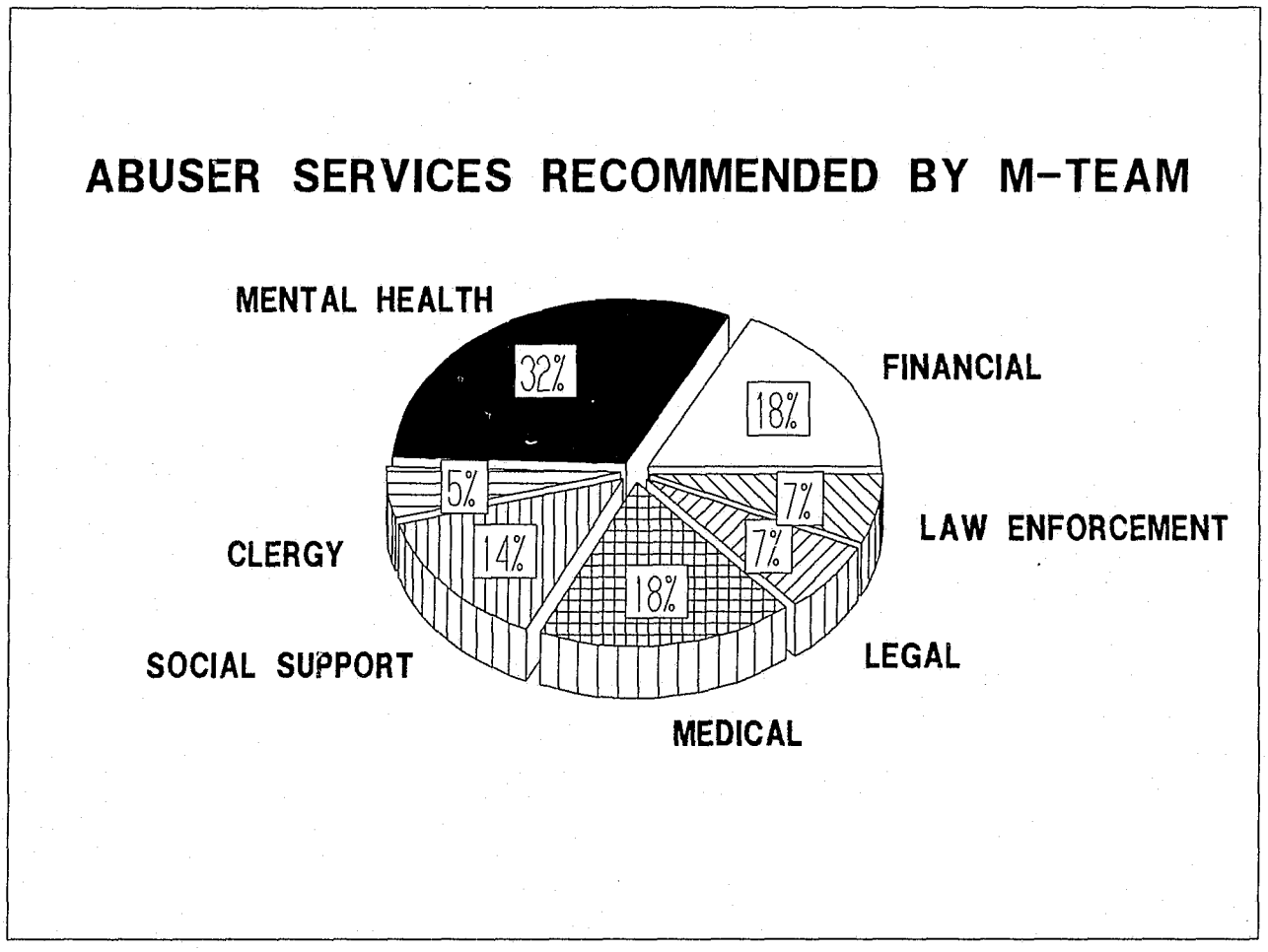
Medical (18%) and financial (18%) were the next most frequent service recommendations made for the abuser. Examples of these include:

"The daughter (abuser) can open a checking account for the client to show how the money is being spent."

"Talk to group home owner (abuser) about medication and personal care issues of client."

"Refer abuser to a neurologist."

FIGURE 5



Results from the Job Analysis

The results from the job analysis indicate that the job descriptions for M-team members are both similar and different. Not surprisingly, members with the same position and similar occupations, but working on different teams, share very similar roles and responsibilities. There were no differences between rural and urban sites, nor between voluntary and paid teams.

The community-based M-team members have primary responsibility for providing advice and information to the team and to the elder abuse case workers regarding their particular areas of expertise as it relates to individual cases presented. The work context of M-Team members is the same across profession, except for the work context of the M-Team coordinator. Major duties and responsibilities are carried out at monthly M-team meetings which last approximately two hours. In addition, team members may be requested to provide expertise to elder abuse case workers outside of M-team meetings.

The job descriptions of each type of M-team member are presented on the following pages. This includes the members representing various professions, as well as the M-team coordinator. In addition, the job description of the elder abuse case worker is also included, to provide an understanding of how M-team operations fit within the roles and responsibilities of those who investigate and resolve cases of elder abuse and neglect.

LAW ENFORCEMENT

The Law Enforcement member of the M-team has primary responsibility for providing expertise, advice, and information to the M-team and elder abuse case workers regarding the law enforcement process, such as: what the police could do, releases needed, getting someone in the alleged victim's home, getting the abuser out of the house, rights of privacy, theft by the caretaker, etc.

MAJOR DUTIES/RESPONSIBILITIES: The major duties and responsibilities of the Law Enforcement M-team member are to:

* Advise elder abuse case workers on specific investigative techniques.

* Provide opinions and recommendations about what can be done from a law enforcement perspective.

* Interpret state, city, and county laws and identify those aspects of a case which may involve violation of civil and criminal laws.

* Investigate allegations of abuse, as necessary, and/or refer elder abuse case workers to the police department.

* Obtain involuntary commitments or criminal charges, suits, or defend someone.

* Educate M-team members and elder abuse case workers on law enforcement-related issues. Common examples include: definitions of legal terms and law enforcement terms, technical procedures involved in bringing criminal or civil charges against someone, types of penalties for specific infractions of the law, and types of violations the States Attorney will prosecute.

* Contact other members of the law enforcement community, as necessary, to obtain information needed by the elder abuse case worker in investigating a case or to alert them to possible violations of the law occurring in their jurisdiction.

* Assist in the development and fulfillment of M-team policies, goals, and objectives, as necessary.

* Maintain confidentiality of information.

INFORMATION INPUT/RESOURCES: The Law Enforcement member of the M-team uses the following information and resources in carrying out his/her responsibilities:

* M-team members and meeting documentation - minutes, summary case reports, relevant articles.

* Elder abuse case workers input on cases.

* State, city, and county laws, statutes, ordinances

* State's Attorney's Office

* Police Department/Sheriff's Office

EDUCATION, EXPERIENCE, TRAINING: There were various opinions as to the educational requirements for the role of Law Enforcement M-team member. Some respondents recommended a college degree, a minimum of an Associates Degree in Criminal Justice or other areas in the social sciences (Psychology, Sociology, etc.).

Others felt experience was more important than education. These respondents recommended five years law enforcement experience, including experience with abuse cases, domestic violence cases, or felony cases through one or more of the following: 1) the State's Attorney Office, 2) a detective of law enforcement, 3) experience as a criminal investigator, 4) private practice attorney from a small county.

KNOWLEDGE, SKILLS, ABILITIES: To provide high-quality services to the M-team, it was recommended that the Law Enforcement representative have:

* Knowledge of criminal investigative techniques and how the criminal justice system works in the area served by the elder abuse provider agency.

* Knowledge of family dynamics.

* Knowledge of patterns of substance and alcohol abuse.

* Knowledge of basic principles of Psychology and Sociology.

* Familiarity and rapport with high-ranked law enforcement officials in the areas served by the M-team.

MEDICAL

The Medical member of the M-team has primary responsibility for providing expertise, advice, and information to M-team members and elder abuse case workers regarding: (1) available resources and information (medical care, physicians, ways that different doctors treat patients, hospitals in the county, transportation services, etc.), (2) home health nursing services and limitations, (3) licensed room and board facilities and problems, (4) involvement and limitations of the state's health department, (5) medicare insurance coverage, (6) medical aspects of substance abuse, and (7) medications and the effect of their interactions on victim's mental state.

MAJOR DUTIES/RESPONSIBILITIES: The Medical member of the M-team serves to:

* Review elder abuse case information provided by the M-team Coordinator focusing on medical-related issues. This includes: (1) how the victim's level of functioning may be contributing to the abuse, (2) the abuse victim's level of physical and mental functioning, (3) information regarding victim's medication, including identifying the purpose for medication and assessing the victim's physical state.

* Assist in determining if the alleged victim should go into a nursing home by assessing the victim's ability to carry out daily life functions independently and if the victim's situation includes needed assistance.

* Assist in determining the level of mental functioning and/or possible substance abuse problems of alleged abuser and other persons who live in the home.

* Provide a visiting nurse view or home visit perspective.

* Educate others, as necessary. This includes sharing relevant, non-confidential information with colleagues and coworkers about elder abuse and the M-team, and promoting public awareness of elder abuse (e.g. writing articles for the local newspaper.).

* Follow-up medical-related recommendations, as requested.

* Assist in the development and fulfillment of M-team policies, goals, and objectives, as necessary.

* Maintain confidential information.

INFORMATION INPUT/RESOURCES: In order to function effectively, the Medical member of the M-team uses the following information:

* M-team members and meeting documentation: minutes, summary case reports, relevant articles.

* Elder abuse case workers who present cases at the meetings.

* Local visiting nurse association

* Local physicians, hospitals, and nursing homes

* State departments/offices: primarily Health, Environmental Health and the Attorney General.

EDUCATION, EXPERIENCE, TRAINING: There are two types of educational backgrounds sufficient for the role of Medical M-team member. One type is a nursing education, including a registered nurse or nurse social worker. The nursing type of Medical team member should also have a minimum of five years as a Registered Nurse or experience working in the home health care field. Some respondents noted that a doctor's office/clinic experience was acceptable, but home care was especially preferable.

The other type of Medical educational background was certification by the American Board of Family Practice and/or by the American Board of Internal Medicine. In addition, the physician should have a minimum of two years post-graduate experience in internal medicine or family practice.

For both types of Medical team members, it was recommended that he/she be a current or prior resident of the community, and presently employed so as to keep abreast of services. It was recommended that this person have experience working with the elderly, although this was seen as highly desirable, but not necessary.

KNOWLEDGE, SKILLS, ABILITIES: The Medical representative of the team must have knowledge about:

* Medical terms, physical conditions, diseases and aging processes, treatment and diagnoses.

* A wide variety of drugs, their indications, contraindications, and effects of their interactions.

* The psychological status of patients and how it affects them medically.

* Medicare insurance coverage and limitations.

* Nursing homes within the community and available community resources (e.g. people that could transport the patient for medical care, licensed room and board facilities, physicians, hospitals).

* Family dynamics and issues involved in family violence and exploitation.

In addition, the respondents suggested that this person be interested in and like people, especially the elderly, and be willing to work on a multi-disciplinary team.

LEGAL

The Legal member of the M-team has primary responsibility for providing legal counsel/expertise, advice, and information to M-team members and elder abuse case workers regarding the role that the abused or his/her family, as well as the elder abuse case worker, can take to resolve problems. One of the legal member's role is to make a preliminary decision regarding behavior reaching criminal proportions. The elder abuse case worker would then be referred to the prosecuting attorney's office.

Typical legal advisory areas include: (1) confidentiality and privacy issues (eg. obtaining records from court systems and doctors), (2) wills and estates, (3) guardianship, (4) financial power of attorney (estate, property, deeds, checks and bonds), (5) health care power of attorney, (6) substandard housing, according to city guidelines, (7) relevant state and local legislation, (8) complaints of inadequate or inappropriate care.

MAJOR DUTIES/RESPONSIBILITIES: The Legal M-team member is responsible for:

* Reviewing case notes and team minutes, paying special attention to any legal aspects or remedies which may apply.

* Advising the elder abuse case worker on steps involved in specific legal options and remedies to help resolve a case (e.g., setting up guardianships, obtaining protection orders, initiating civil and criminal actions against parties involved in cases.)

* Making presentations to the M-team, as requested, on topics such as guardianship, power of attorney, and domestic violence.

* Acting as a liaison to social service agencies, as necessary.

* Maintaining confidentiality of information presented.

INFORMATION INPUT/RESOURCES: In order for the Legal M-team member to carry out his/her roles, the following information is required:

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder abuse case workers who present cases at the meetings.

* Internal legal memoranda keeping the member updated on current laws and statutes.

* Materials put out by the State Bar Association.

* State statutes and administrative department rules.

* County rules, regulations and ordinances.

* Medicare and Medicaid administration rules.

EDUCATION, EXPERIENCE, TRAINING: The Legal member of the M-team should be licensed to practice law in the state, a minimum of one year experience as a practicing attorney with broad exposure

especially in terms of issue spotting and experience working with various types of legal cases. It was reported that experience working with elder abuse cases would be nice, but not necessary. However, without this experience, the legal M-team member must be highly committed to "getting up to speed" on the unique needs and issues of the aged. Further, domestic violence experience would be very helpful.

The Legal member should also have experience or working knowledge in public benefits, Medicare eligibility and programs. He/she should be a member of the State Bar Association, and local Bar Association (for networking purposes).

KNOWLEDGE, SKILLS, AND ABILITIES: In order to perform effectively, the legal member of the M-team should have a working knowledge of:

* Legal issues, case law, strategies, etc., involving clients who require substitute decision making (e.g., guardianships, trusts, etc.).

* Social and political environments of the agencies responsible for responding to reports of elder abuse and skilled at applying this knowledge to develop appropriate legal strategies for each case.

* City housing guidelines, such as who to contact, and what to do about substandard housing conditions.

* Local social service agencies.

In addition to this knowledge base, the Legal M-team member should have problem solving abilities, good judgement, and the ability to work effectively with others in a group or team setting.

CLERGY

The Clergy member of the M-team has primary responsibility for providing input and advice from a humanistic, pastoral perspective to M-team members and elder abuse case workers.

MAJOR DUTIES/RESPONSIBILITIES: The Clergy on the M-team is responsible for:

* Participating in M-team discussions of cases, making comments and recommendations based on background and experience as a clergy person.

* Seeking services or support from the client's church, as required, including contacting the minister, pastor, or priest.

* Assisting the team in promoting community awareness of elder abuse through writing articles, and making presentations to hospitals, schools, police departments, etc.

* Maintaining the confidentiality of information presented.

INFORMATION INPUT/RESOURCES: To perform effectively, the Clergy on the M-team needs:

* M-team members and meeting documentation (minutes, summary case reports, relevant articles).

* Elder abuse case workers input about cases.

* Community churches and schools' staff, families, and students.

* Community newsletters and newspapers.

* Elder abuse legislation.

EDUCATION, EXPERIENCE, TRAINING: The recommended educational and experiential backgrounds of Clergy on the M-team include a minimum of a Bachelor's degree in Theology, Psychology, Communications, or Education, and a minimum of 10 years pastoral experience with at least three years experience working with the elderly. It was mentioned that new pastors can be effective if they are enthusiastic about working with the elderly. A counseling background is helpful, as is an understanding of both psychology and geriatrics through educational courses or seminars.

KNOWLEDGE, SKILLS, AND ABILITIES: The Clergy on the M-team should be able to take an ecumenical point of view in analyzing cases and understanding that the pastor's role on the team is not to condemn or convert. He/she should be able to listen to others and remain non-judgmental. The clergy representative should not hold religious beliefs that might encourage abuse or support the maintenance of an abusive situation. He/she should be able to independently analyze situations to let people choose what would be best for themselves - be protective of the victim's freedom of choice. This person should be genuinely interested in serving the elderly community and able to relate well to elderly people.

According to the respondents, personality (care and concern) is more important than years of experience. The Clergy should have compassion and sensitivity for the victim, and the sentiment or drive to help case workers deal with thorny cases. He/she should be familiar with and able to tap community

resources, and be self-confident and willing to share ideas. This position requires clergy who are open-minded, and understanding and accepting of the religious faith of others and different views of the world.

FINANCIAL

The Financial member of the M-team has primary responsibility for providing expertise, advice, and information to elder abuse case workers in their efforts to resolve their clients' financial problems and conflicts. This is done by providing information and/or services in the areas of (1) direct deposit of social security checks, (2) prevention of fraud through pre-authorized charges to the account, e.g. utility bills, insurance payments, (3) authorization of financial institutions and insurance company payments to be paid directly from the account to prevent access to funds and ensure that payments are made, (4) verification of transactions through microfilm checks and by identifying what is going on in the account, and (5) trust services (working with the legal expert on the M-team to set-up trust and guardianship for clients).

MAJOR DUTIES/RESPONSIBILITIES: The Financial member of the team is responsible for:

* Reviewing team meeting notes and minutes to become familiar with financial resource requirements.

* Analyzing the financial status and needs of the client, as necessary, and develop strategies that facilitate case resolution. Analysis considerations include the amount and sources of a client's income, relationships with banks and credit unions, indebtedness and financial history, people other than client who have legal access to client's bank accounts, social security checks, etc., and people in the household in charge of spending the money.

* Following-up on recommendations after team meetings and feeding back the results to elder abuse case workers, as required. For example, checking on banking problems brought up at the meeting, and setting up bank records.

* Educating elder abuse case workers and team members on banking issues, as necessary. This includes Federal banking law, meeting credit and housing needs in the community, how to handle checking accounts, how to get information, depositing checks in a timely manner and how to facilitate this.

* Contacting other members of the financial community, as necessary, to obtain information regarding the client.

* Maintaining the confidentiality of information presented.

INFORMATION INPUT/RESOURCES: In order to perform effectively, the Financial M-team member needs the following:

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder abuse case workers for input on the cases.

* National Association of Banking.

* Banking industry - local and county bankers.

* Federal Reserve System (FDIC).

* State Commissioner of Banks.

* Federal banking laws.

EDUCATION, EXPERIENCE AND TRAINING: There was some disagreement about the educational background necessary to fulfill the M-team role as a representative of the financial community. Some Financial team members felt that having a current, high-level position in bank management was necessary, with attendant experiences in such positions as loan officer, bookkeeper or teller supervisor. Educationally, only a high school diploma was recommended, but also a minimum of five years banking experience with an emphasis on bank operations.

Alternatively, other respondents recommended a minimum of an Associate Degree in banking with at least two years banking experience.

The third recommendation was for this member of the team to have a Business Administration degree with a concentration in finance and two years banking experience.

KNOWLEDGE, SKILLS, ABILITIES: In addition to educational and experiential backgrounds, the Financial M-team member should be involved in the banking community through board membership, committees, or network of firmly established relationships with influential members in the banking community. He/she should have a general knowledge of the commercial loan area, and of the types of information banks can release with regard to confidentiality. This member should know about alternative sources of income available to the elderly clients and how to access these sources.

In addition to specific banking information, Financial representatives on the M-team should have good problem analysis skills, in order to think the situation through and identify specific actions/strategies. They should have good human relations skills, and a sincere interest in and genuine care/concern for the well-being of the elderly. They should be willing to help with elder abuse -- committed to helping, to attending meetings regularly on time, and to devoting attention to team discussions. Finally, they should be willing to work with other people, as a team.

MENTAL HEALTH

The Mental Health member of the M-team has primary responsibility for providing expertise, advice, and information to elder abuse case workers from a mental health perspective.

MAJOR DUTIES/RESPONSIBILITIES: Duties and responsibilities of the Mental Health representative are:

* Reviewing case notes, updates, new case notes, agenda received from the M-team Coordinator each month and examining each case for mental health diagnoses, such as severe depression, or difficulties adjusting to stressors in the client's life.

* Identifying emotional problems and psychosocial issues involved in each case, focusing on both the abuser and the victim. It involves determining the client's needs based on family composition and structure, the history of family interactions, the client's willingness for services, strategies that have already been tried, and/or the need for certification of the victim or abuser as a danger to self or others. In this role, the client's rights to self-determination and the need to keep the family intact are major considerations. This diagnostic role of the Mental Health team member also includes preliminary elder abuse diagnoses using established guidelines and evaluation criteria, and preliminary mental health diagnoses, based on information given, to help decide what is the problem.

* Providing advice and recommendations, such as: how to approach the abuser/victim; how they can be seen, and how to get them to agree to be seen while not jeopardizing the situation; available community resources and adjunct services to assist with case management and resolution.

* Sending copies of the patient's progress notes to members, (if relevant and with the client's permission).

* Assisting the M-team establish an educational program to address elder abuse in the community.

INFORMATION INPUT/RESOURCES: To function effectively, the Mental Health member of the M-team needs the following:

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder abuse case workers for input on cases.

* DSM-IIIR (publication of diagnoses, symptoms - American Psychiatric Association).

* Clients' physicians and family doctors.

* Local hospitals and mental health treatment facilities.

EDUCATION, EXPERIENCE, TRAINING: Two alternative educational backgrounds were recommended for the Mental Health representative on the M-team. One recommended background is a Masters in Social Work or mental health field, or Registered Nurse, and a minimum of five years experience in social work, counseling, or closely related human services field and two years of psychiatric experience. It was

recommended that this M-team member be certified as a Clinical Social Worker, and have a minimum of two years experience working with the elderly, abuse cases, elder abuse, or domestic violence. Educational courses in gerontology were seen as highly desirable. And, the Mental Health representative should be state-licensed with recertification testing, as required.

The alternative educational background for the Mental Health representative is an M.D. with some experience in geriatric psychiatry. Board certification as a gero-psychiatrist was not seen as necessary. However, it was recommended that this team member should have taken educational courses/seminars in geriatric psychiatry through the American Psychiatric Association, Continuing Medical Education, etc. It was also recommended that the Mental Health representative be a member of the American Psychiatric Association and involved with community organizations.

KNOWLEDGE, SKILLS, ABILITIES: In order to perform effectively, the Mental Health representative should know about general case management, state mental health codes, and medications. This member must be able to make reasonably accurate diagnoses of mental health conditions and to determine when hospitalization is required. He/she must also have some feeling for which forms of therapy would be most appropriate for which type of disorder. He/she must know about the legal issues regarding protective services and self-determination, family dynamics and the ways in which dysfunctional families operate. This member must have knowledge of available community resources in a variety of areas (legal, medical, etc.).

In addition to professional expertise, personality characteristics are also important in this role. The Mental Health representative must be able to empathize with the unique perspectives of the elderly, have an interest in geriatric psychiatry, and have good interpersonal and communication skills. They must be able to get along with groups of people from different disciplines, and to listen well and be comfortable voicing opinions and presenting information to others.

M-TEAM COORDINATOR

The M-team Coordinator has primary responsibility for planning, organizing, and facilitating the monthly M-team meetings. This includes notifying all members of any changes in the meeting schedule, preparing, reviewing and finalizing minutes and agenda for each meeting, summarizing cases to be discussed and finding relevant articles to be presented to the team. The Coordinator must ensure that all members receive the information needed for each meeting, which entails coordinating the mailing of information and materials. He/she must also set up the meeting room and facilitate team meetings.

MAJOR DUTIES/RESPONSIBILITIES: The duties and responsibilities of the coordinator include:

* Meeting with elder abuse case workers and supervisors to determine which cases to present to the M-team and to prepare for presentations.

* Acting as liaison between M-team and elder abuse case workers. This entails soliciting feedback, informally, from both groups regarding reactions to team meeting process and outcomes.

* Planning for and organizing team meetings. This includes progress reports on old cases and developing brief scenarios of new cases. It involves overseeing mailing of the meeting announcement letter and agenda prior to meeting, contacting members prior to the meeting to request presentations on a topic in their area of expertise, ensuring that there is a full agenda with an appropriate amount of information, and reviewing and finalizing minutes and agendas. It also involves obtaining copies of the minutes, and may also require taking minutes at the meeting.

* Following-up on recommendations from team members. This involves consulting with M-team members outside of meetings to obtain additional information and referral sources.

* Preparing monthly and quarterly reports regarding the M-team and cases reviewed.

* Attending meetings with the statewide Elder Abuse Steering Committee, the Executive Director of the elder abuse provider agency to review team issues, and the agency bookkeeper to discuss financial issues related to team implementation.

WORK CONTEXT: Amount of time required to complete duties and responsibilities per month varies considerably, based on such factors as: presence of an elder abuse case worker interested in discussing a case, elder abuse case load, staffing and clerical assistance available from the agency. On a monthly basis, the M-team Coordinator's time is spent preparing materials/information (3 to 30 hours), in M-team and related meetings (3 to 6 hours), writing reports and following-up on recommendations (2 to 8 hours).

INFORMATION INPUT/RESOURCES: To be effective, the Coordinator needs the following:

* M-team members and meeting documentation (minutes, summary case reports, relevant articles).

* Elder abuse case workers and case files.

* Agency staff and resources.

* State Department on Aging for Elder Abuse legislation and information.

EDUCATION, EXPERIENCE, TRAINING: It was recommended that the M-team Coordinator have a minimum of a Bachelor's in a human services field and two years experience working with the elderly or with abuse cases. Experience with crisis intervention would be helpful, but not essential. Other recommended experience includes networking with other agencies, and some administrative and supervisory experience. Training backgrounds of the M-team coordinator should include educational workshops and/or seminars on elder abuse. Training in group facilitation is also recommended, through work experience or an educational course/workshop.

KNOWLEDGE, SKILLS, ABILITIES: The M-team Coordinator must know legal issues and constraints of elder abuse case work. They must have some knowledge of legal issues (e.g. guardianship and power of attorney), and of available community resources. They must have good oral and written communication skills, including active listening, and must be able to communicate with people from different professions. They must understand group dynamics, and must be good observers and group facilitators. They must be able to keep discussions on track, to bring in everyone's opinion and give everyone an opportunity to voice their opinions, to summarize points made in a discussion and shift the discussion when necessary. Finally, they must have good administrative, planning, and organizing skills, being able to analyze situations and facts to come up with appropriate solutions.

ELDER ABUSE CASE WORKER

The Elder Abuse Case Worker is primarily responsible for the initial intake and investigation, care planning, and follow-up of elder abuse and neglect cases within a specified geographic region.

Overall about 90% of the time is spent doing assessments, monitoring cases, conducting follow-ups and revising care plans. The remaining 10% of time is spent doing reports and attending meetings.

The most important area of responsibility is the **home visit**, even if the Elder Abuse Case Worker does not accomplish what she/he wants to. These visits communicate an awareness and concern of the elder abuse problem.

The case load will vary. On average, the Elder Abuse Case Worker makes at least 10 home visits per week. A lot of time is spent on the telephone.

The Elder Abuse Case Worker may also function as a Case Manager within the Case Coordination Unit. The following information focuses only on the Elder Abuse Case Worker position.

MAJOR DUTIES/RESPONSIBILITIES:

* Determine and implement the best strategy for successfully gaining initial entry into the home of the alleged victim, and determine how to keep getting into the home. Evaluate all relevant circumstances related to own personal safety, gaining the trust of those involved, and possible negative consequences for alleged victim.

* Conduct in-home interviews with alleged victim, alleged abuser, and other persons living in the home to determine whether alleged abuse is substantiated and to assess whether abuse victim is in immediate danger. Use tact, diplomacy and good interviewing techniques to extract necessary information.

* Complete a face-to-face evaluation/assessment (social, psychological, physical, environmental, functional, and financial) on each case using a number of different instruments and forms:

    1. Comprehensive assessment tool (University of Iowa)
    2. Determination of need (State functional assessment tool)
    3. Susan Tonita's protocol (adapted with permission)
    4. SPMSQ - Short Portable Mental Status Questionnaire (a cognitive screening tool)
    5. Sketch or Trauma Sheet (documents injuries)
    6. Release of information forms (obtains client consent)

* Conduct thorough investigation of alleged abuse circumstances by questioning relatives, friends, or any other persons who may have knowledge of the alleged abuse, and locating relevant documents from other agencies to construct an accurate depiction of family history and events, etc.

* Evaluate the level of functional impairment of the victim in areas related to daily life activities such as, eating, dressing, shopping, managing money, bathing, etc. Determine if there is unmet need in any area.

* Develop an individualized service delivery care plan to address the specific unmet needs. This plan might include:

  - In-home services
  - Social and environmental supports
  - Medical interventions
  - Counseling (e.g. domestic violence)

* Identify available community agencies and resources to provide a variety of needed services to clients such as recreation, home delivered meals, in-home nursing care, legal assistance, etc. Use resourcefulness and persistence in extracting assistance from other agencies.

  This responsibility entails determining which agencies to contact, making contacts and referrals to the proper authorities, explaining services and programs to the client, and completing release of information forms and reports.

* Attempt to persuade the elderly client to accept assistance by building rapport with the client, raising his/her awareness, gaining the support of other friends and family members, and, when necessary, encouraging the client to pursue remedies which may be contrary to the desires of some family members. Recognize the client's rights to self-determination.

  (Note: Take a family approach -- work with the family during the assessment and care planning process. If interests conflict, go with the needs of the elderly.)

* Prepare and maintain complete narrative documentation of case progress and status (e.g. every phone call made and things discussed, each visit, etc.).

* Complete a four page report on each case and submit copies of the report to relevant sources: IDOA, Area Agency on Aging, Case Coordination Unit files.

* Follow up on each case to ensure that the care plan is carried out successfully. Monitor progress and revise care plan, as needed.

  Depending on the severity of the case, may monitor cases by telephone or in person. The number of visits required varies from once a week to once quarterly. Priority is given to high-risk cases.

* Appear in court to testify and present facts about cases, when required.

* Act as liaison between various agencies and clients.

* Conduct an annual re-assessment which entails making a site visit and updating the original assessment.

* Drive clients where they need to go, e.g. to the bank.

* Prepare for and attend monthly M-team meetings. Includes verbally presenting abuse cases to the team for their input and recommendations.

* Attend additional meetings with:

  - Elder Abuse Steering Committee - every other month

  - Area health providers (nursing homes, hospitals, ambulance services, private nursing services - quarterly)

  - Interagency county case coordinators - monthly

* Attend conferences on elder abuse.

* Promote community awareness of elder abuse and the role of the Case Coordination Unit through:

  - Attending various meetings
  - Writing articles for the local newspaper
  - Being a guest speaker on the radio, as required
  - Verbally presenting information to state and local police departments, local hospitals, etc.

WORK CONTEXT:

There is no physical exertion. The job is more emotional, than physical. There are time pressures, emergencies sometimes, time-consuming cases and some stress/frustration (due to such factors as the gray areas where the client's competency is not clear cut, not being able to investigate without the client's release, etc.).

Potential risks/hazards include:

* Dogs

* Possibility of weapons

* Seeing the elderly when the caretaker is not home. The risk involves not knowing what to expect from the caretaker when he/she finds out that the elderly has been seen by an Elder Abuse Case Worker.

* Physical condition and cleanliness of client's home (e.g. foul odors).

Typical equipment used include:

* Car
* Telephone
* Typewriter
* Camera
* Tape recorder
* Rubber gloves
* Calculator to estimate annual income and assets
* Measuring device (size of bruises and injuries)

INFORMATION INPUT/RESOURCES:

* Case Coordination Unit and case files.

* Contacts and referrals through IDOA 800 number, the State gatekeeper program (utility companies), family members, neighbors, community residents, hospitals, physicians, clergy, police, school nurses, in-home providers.

* Available resources include:

  - M-team members
  - State and local departments and officials
  - Public Health
  - Housing authority, FHA
  - Law enforcement officials
  - Physicians
  - Medicaid/Medicare
  - Meals on Wheels
  - Salvation Army
  - Township supervisor (handles payment of utilities, gives vouchers for food and clothing).
  - Illinois Valley Economic Development Corporation (program funds/resources for the elderly; transportation to pick the elderly up and take them to doctor's appointments. With some restrictions, also organize trips out of town and to grocery stores.)

EDUCATION, EXPERIENCE, TRAINING:

* Bachelor's degree in Social Work or other human service fields such as Psychology or Nursing:

  - Licensed Practical Nurse with 2-3 years prior work experience with the elderly. Certified Nurses Aide with equivalent experience is acceptable.

  - A Registered Nurse with some additional experience or training in interviewing.

OR

* Associate's Degree with some elder abuse training through IDOA and relevant work experience.

****

* 2-3 years experience working with the elderly in a human services setting, a psychiatric setting, or a setting that requires working in or visiting clients' homes. Experience should include short-term counseling, crisis intervention, family therapy, and behavior modification.

* Six months experience doing intakes/assessments.

* Six months on-the-job training with a Elder Abuse Case Worker.

KNOWLEDGE, SKILLS, ABILITIES:

* Able to drive and has ready access to a car.

* Knowledge of fundamental principles of social work, professional ethics and rules.

* Knowledge of physical and mental aging processes.

* Knowledge of family dynamics.

* Familiar with area resources, eligibility criteria for programs such as Social Services, SSI, Medicaid and Medicare.

* Basic knowledge of local and state systems and how to access legal assistance for the elderly.

* Good oral and written communication skills, including listening skills and the ability to write concise behavioral observations.

* Good interpersonal skills:

  - Tactful

  - People-oriented

  - Able to build rapport with people that are guarded

  - Objective, non-judgmental

* Willing to work on a team.

* Good interviewing skills - effectively interview and counsel victims, abusers, and family members.

* Maintain objectivity and avoid emotional involvement with clients and their families, which may hinder effectiveness.

* Good problem analysis and decision making skills -- use good judgment; able to take behavioral observations and draw conclusions; react quickly in emergency situations.

* Able to work independently, show initiative, and follow through with minimal supervision.

* Able to work under stress encountered in dealing with the trauma and pain of elder abuse and handling heavy case loads.

Comparison of Paid versus Voluntary M-teams

A major hypothesis of this study is that there would be significant differences between paid and voluntary teams in terms of the activities, satisfaction and commitment of team members. This hypothesis was examined by analyzing data from the M-Team Registration & Reimbursement Form and from the longitudinal survey of team members' satisfaction and commitment to their teams. It was originally hypothesized that there would be greater outside involvement, satisfaction and commitment among the voluntary team members because they received only internal gratification for their team membership, as opposed to the paid members who were paid for time spent during team meetings.

Table 24 shows the results from the analysis of the differences between paid and voluntary teams in the number of hours team members devoted to team-related or elder abuse-related activities outside of the team meetings.

TABLE 24
AVERAGE NUMBER OF HOURS SPENT ON OUTSIDE ACTIVITIES
PER TEAM MEMBER PER MONTH
BY TEAM TYPE

TYPE OF ACTIVITY	VOLUNTARY TEAMS	PAID TEAMS	T-TEST
PUBLIC PRESENTATIONS	0.22	0.81	2.29
CLIENT-SPECIFIC ACTIVITIES	1.51	0.93	1.41
OTHER M-TEAM ACTIVITIES	0.47	0.61	1.21
OTHER ELDER ABUSE ACTIVITIES	1.44	1.54	0.19

NOTE: Shaded cells indicate t-test is significant for $P \leq .05$ or less.

Results from this analysis are contrary to expectations. For three of the four types of activities, there were no statistically significant differences between paid and voluntary teams in the number of hours each team member devoted to outside activities each month. In the fourth type of activity (public presentations), the paid team members spent significantly more time than the voluntary team members.

This difference between paid and voluntary teams in hours spent in public presentations may be a spurious finding. One paid site had two team members who were professionally involved with elder abuse cases apart from their team membership. Since their activities were included on the M-Team Registration & Reimbursement Form, these activities could have skewed the data from the paid teams to the extent that the difference was statistically significant.

Figures 6 and 7 illustrate the results from comparing voluntary and paid teams in levels of satisfaction and commitment over time. Figure 6 compares the average satisfaction scores of the paid and voluntary teams at the times of the three phone surveys. As this figure shows, there is no difference in the pattern of change in either satisfaction or commitment over time. For all three time periods, the paid teams' satisfaction scores averaged 22 out of a possible 25 points. The voluntary teams' satisfaction scores were 22, 21 and 21, respectively. Thus, the paid and voluntary teams remained virtually the same in their satisfaction scores over time. ($F_{TIME*TYPE(2,46)}=0.486$, $P \leq 0.618$; $F_{TYPE(1,23)}=0.857$, $P \leq 0.364$).

FIGURE 6

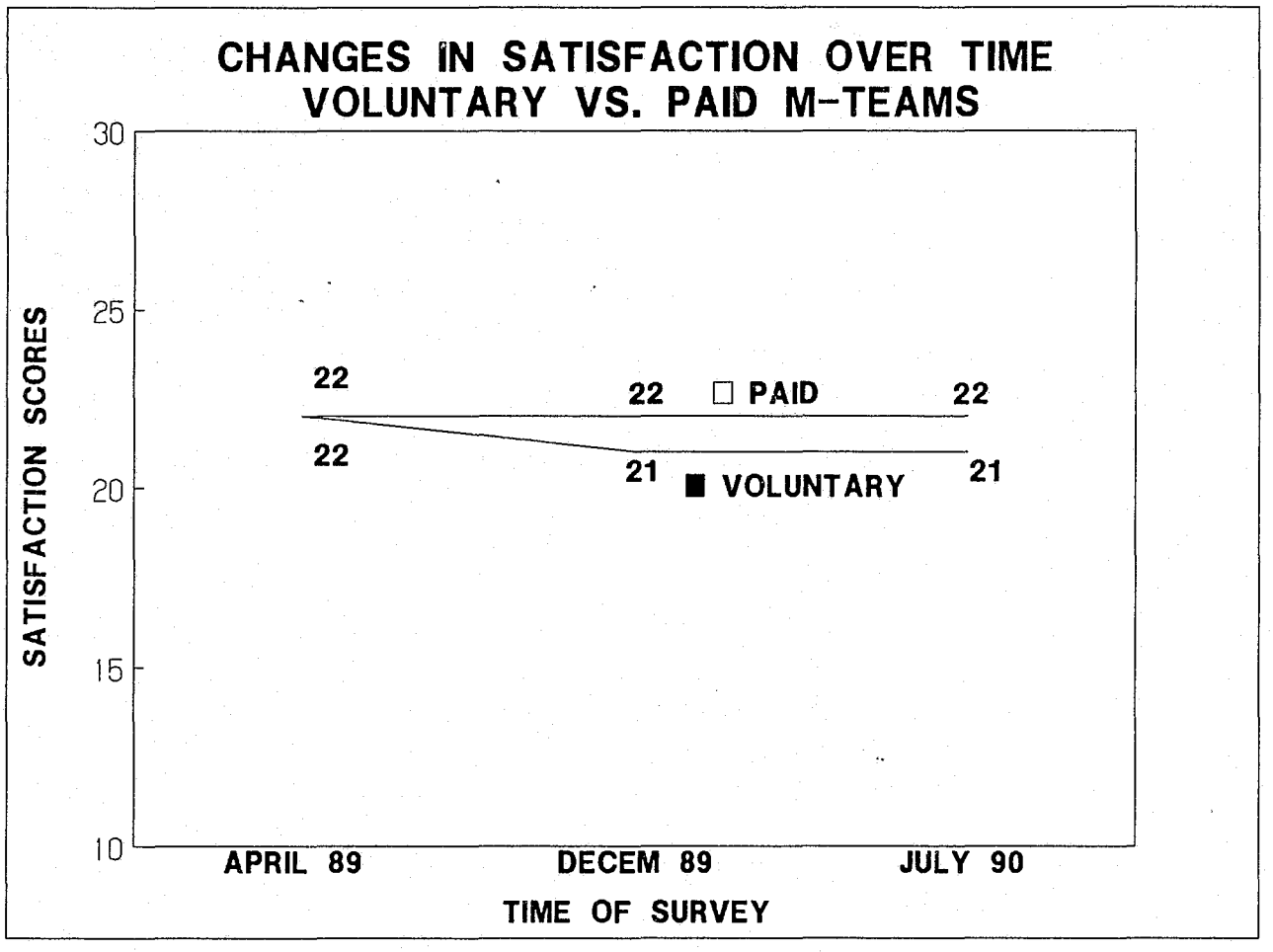
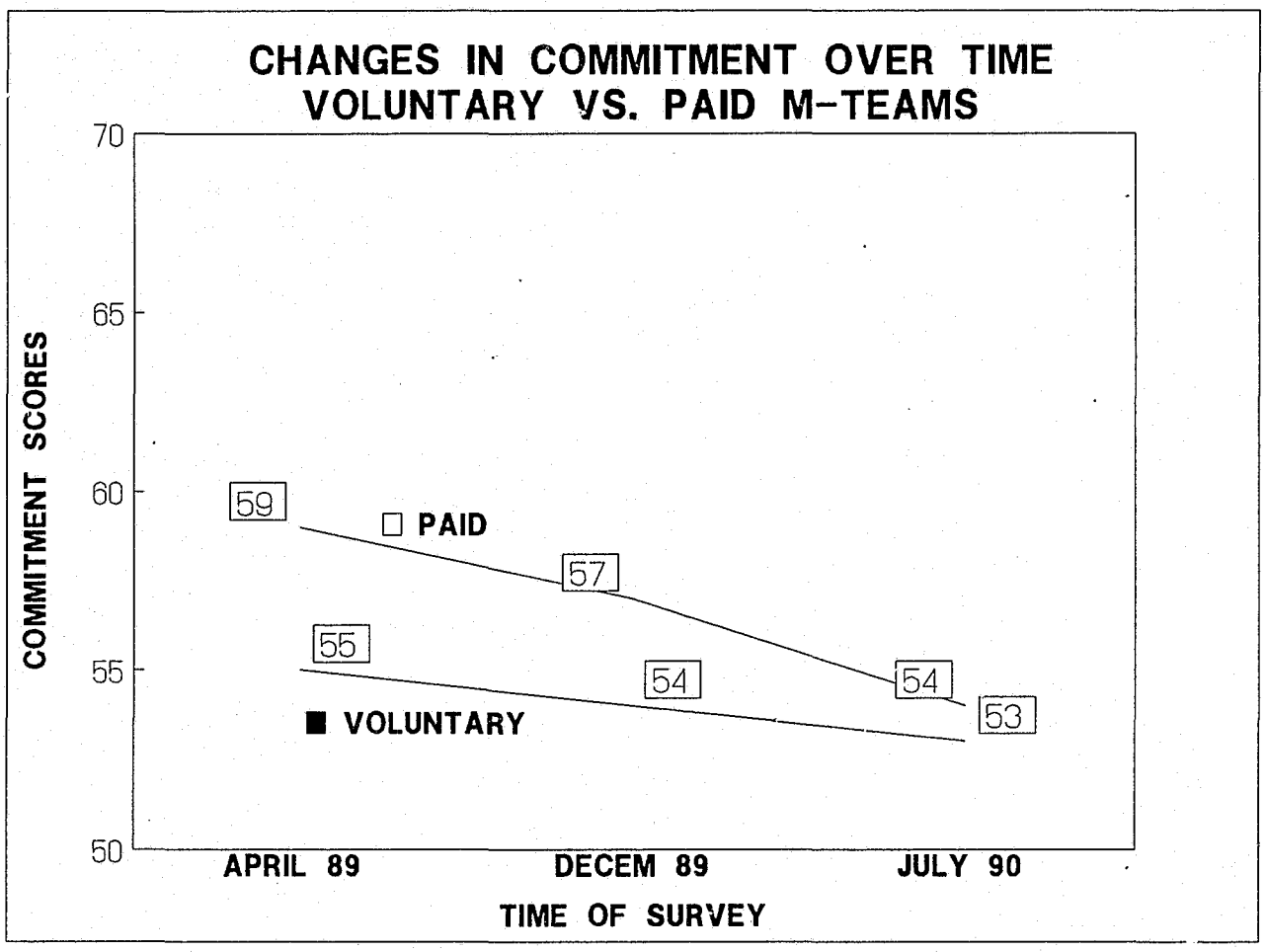

CHANGES IN SATISFACTION OVER TIME
VOLUNTARY VS. PAID M-TEAMS
SATISFACTION SCORES
30
25
20
15
10
22
22
22
□ PAID
22
21
■ VOLUNTARY
21
APRIL 89
DECEM 89
JULY 90
TIME OF SURVEY

FIGURE 7



Similarly, as shown in Figure 7, there is no difference between voluntary and paid teams in changes in commitment. For both groups, commitment scores declined about the same amount over time ($F_{TIME*TYPE(2,38)}=0.391$, $P\leq0.679$; $F_{TYPE(1,19)}=0.911$, $P\leq0.352$). Out of a total possible score of 72, the paid teams' commitment scores declined from 59 in April, 1989 to 57 in December, 1989 and 54 in July, 1990. Similarly, the voluntary teams' commitment declined from 55 to 54 and then to 53 over the 16 month period.

While there are no differences between the groups in the pattern of declining commitment, the fact that commitment scores declined for both groups is worth noting. The statistical test for the significance of this decline over both groups approached statistical significance ($F_{TIME(2,38)}=2.671$, $P\leq0.082$). There is a trend toward declining commitment among the teams. These results may reflect the beginning of team burnout, and is worthy of future investigation.

In summary, the results reject the major hypothesis that voluntary members would be more committed to the M-team than paid members. Apparently, offering reimbursement for attendance at team meetings is not an important reason for staying committed to the M-teams.

Comparison of Urban versus Rural M-teams

One research question in this study was whether there were any differences in the implementation of the teams in rural versus urban areas. As mentioned previously, there were no differences in the roles of team members in urban versus rural regions, as assessed by the job analysis. As was also mentioned previously, one rural site discussed more cases during team meetings than the other three sites. However, this difference appeared to be more specific to the length of time the agency had been handling elder abuse cases than the geographic location of the site.

Results from the refusal survey suggest that it is more difficult to recruit team members in urban areas. On the other hand, once recruited, there does not seem to be any geographic difference in keeping members on the team. Results from the analyses of the M-team Meeting Report Form indicates that there was no geographic difference in attendance rates.

Table 25 shows the comparison between urban and rural teams in the number of hours team members devoted to team-related or elder abuse-related activities outside of the team meetings. As this table shows, the geographic location of the team is related to only one type of activity - client specific activities.

TABLE 25
AVERAGE NUMBER OF HOURS SPENT ON OUTSIDE ACTIVITIES
PER TEAM MEMBER PER MONTH
BY LOCATION

TYPE OF ACTIVITY	RURAL TEAMS	URBAN TEAMS	T-TEST
PUBLIC PRESENTATIONS	0.63	0.41	0.83
CLIENT-SPECIFIC ACTIVITIES	0.53	1.83	3.27
OTHER M-TEAM ACTIVITIES	0.55	0.56	0.05
OTHER ELDER ABUSE ACTIVITIES	1.22	1.88	1.30

NOTE: Shaded cells indicate t-test is significant for $P \leq .05$ or less.

To examine whether this difference is due to geographic location or to the specific characteristics of the agencies, the number of hours of outside activities were analyzed by the individual sites. Results indicate that the two urban sites both averaged more team member time on client-specific activities than the two rural sites. This suggests that the difference is more related to the urban location than to specific characteristics of the individual agencies ($F_{3,122}=4.77$, $P \leq 0.004$).

Interpretation of this finding is difficult, in light of the fact that there is no statistically significant difference between the geographic locations for the other three types of activities.

Figures 8 and 9 illustrate the results of comparing the satisfaction scores and commitment scores for the urban versus rural sites. While there is no significant difference in the pattern of change over time, the rural sites consistently had lower satisfaction and commitment scores than the urban sites. (Satisfaction results: $_{TIME*LOCATION(2,46)}=1.102$, $P \leq 0.34$; $F_{LOCATION(1,23)}=4.631$, $P \leq 0.042$. Commitment results: $F_{TIME*LOCATION(2,38)}=1.351$, $P \leq 0.27$; $F_{LOCATION(1,19)}=6.104$, $P \leq 0.023$)

FIGURE 8

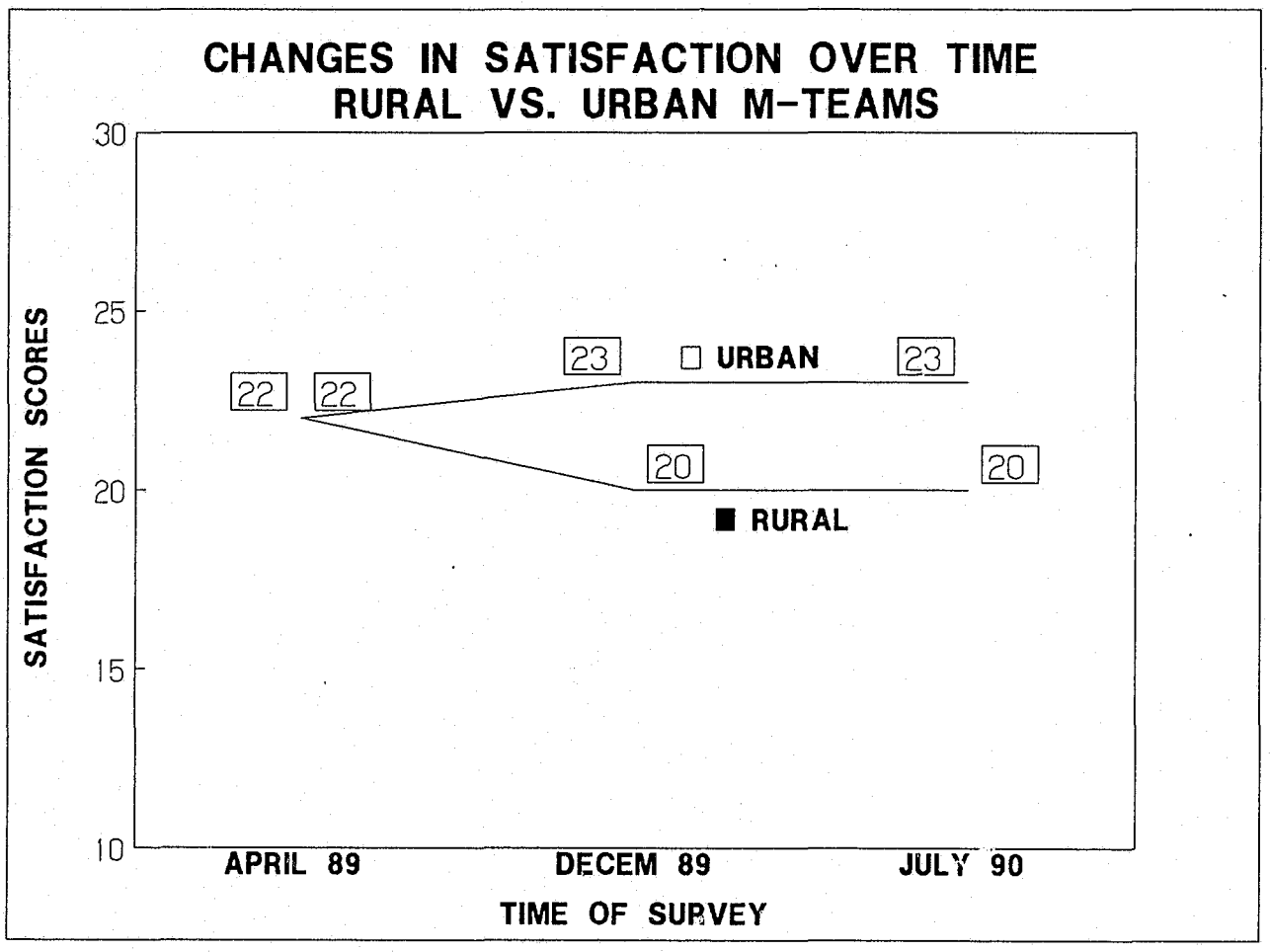


Figure 8 compares the satisfaction scores of urban and rural sites over the three time periods of the telephone surveys. As the figure shows, the urban sites' satisfaction scores were 22, 23 and 23 respectively. The rural sites were very similar, with average satisfaction scores of 22, 20 and 20 respectively. To test whether these differences were due to very low satisfaction scores at one site, the satisfaction scores of each site were analyzed separately. The findings were that both rural sites had lower satisfaction scores than the urban sites. This suggests that the difference was due more to geographic location than to the specific characteristics of the individual sites.

FIGURE 9

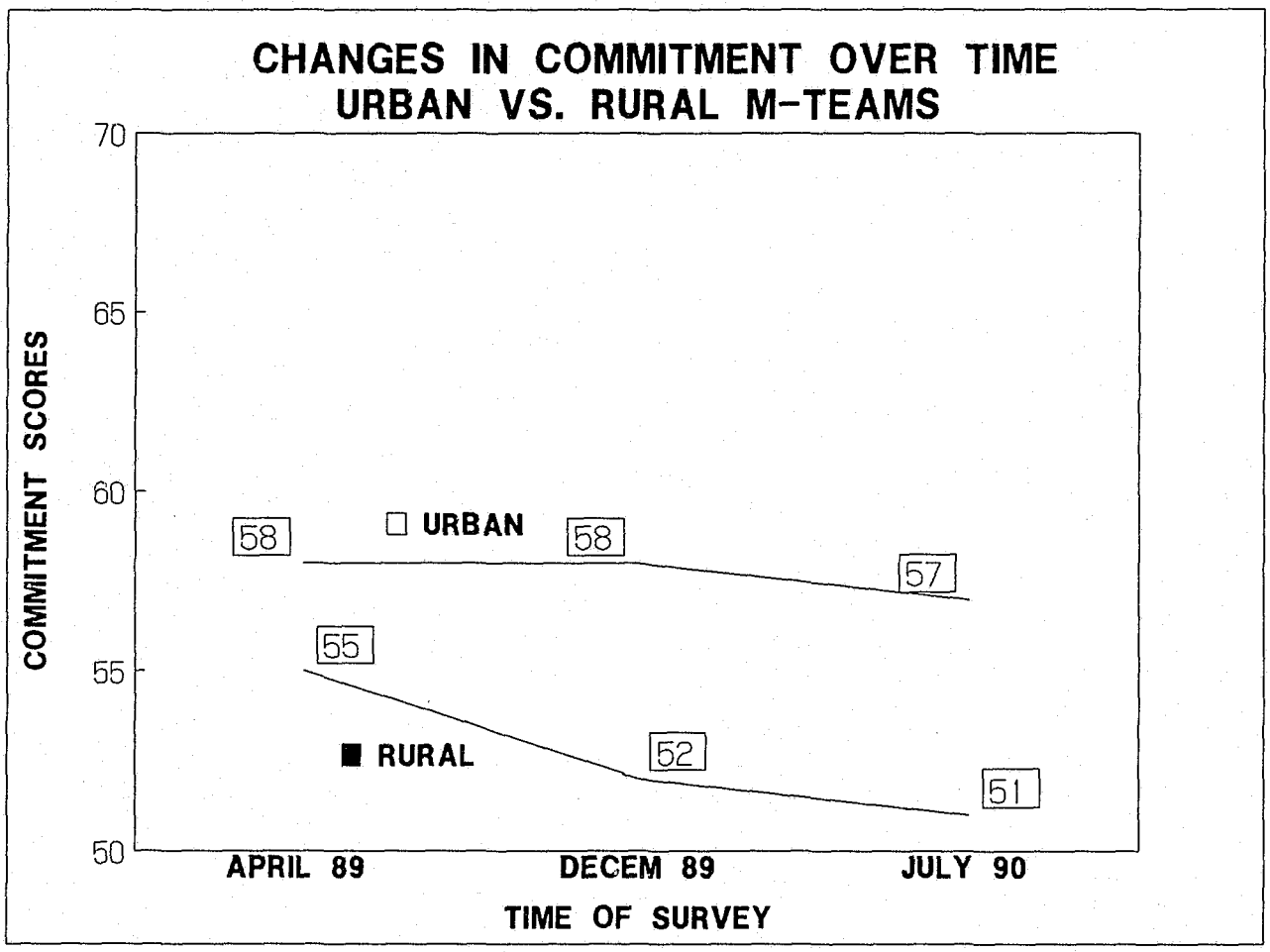


Figure 9 shows the analysis of geographic differences in levels of commitment. As the figure shows, the commitment scores for the urban sites averaged 58, 58 and 57, respectively over the three time periods. For the rural sites, commitment scores averaged 55, 52 and 51. As mentioned previously, the rural sites consistently reported lower commitment than the urban sites. Yet, when analyzed separately, both rural sites reported lower commitment than the two urban sites.

These results are difficult to interpret. It may reflect the fact that in rural areas, professionals feel more obligated to work together because of the scarcity of professionals in the area. The feeling of obligation may not necessarily translate into a feeling of commitment. Rather, these professionals may feel that their contribution to the M-team may be recompensed by the elder abuse provider agency at some time in the future.

Longitudinal Study of Case Managers' Levels of Burnout

To test whether the use of M-teams is related to case manager burnout, all case managers at the four sites were surveyed four times over the course of the project. It is interesting to note that only 18 (49%) of the case managers who completed the Time 1 burnout survey also completed the Time 4 survey. This suggests substantial turnover among the case managers. Table 26 compares the demographics of the total sample of case managers who completed the Time 1 burnout survey with those who completed the Time 4 survey.

TABLE 26
COMPARISON OF CASE MANAGER DEMOGRAPHICS: TIME 1 VS. TIME 4

DEMOGRAPHIC CHARACTERISTICS	TIME 1 (N=37)	TIME 4 (N=36)
SEX		
MALE	2 (5%)	5 (14%)
FEMALE	34 (92%)	31 (86%)
MISSING	1 (3%)	0 (0%)
RACE		
BLACK	4 (11%)	2 (6%)
WHITE	33 (89%)	34 (94%)
EDUCATION LEVEL		
COMPLETED HIGH SCHOOL	0 (0%)	1 (3%)
SOME COLLEGE	2 (5%)	4 (11%)
COMPLETED 4 YEARS OF COLLEGE	17 (46%)	20 (56%)
SOME POST GRADUATE WORK	7 (19%)	4 (11%)
POST GRADUATE COURSES	5 (14%)	3 (8%)
OTHER	5 (14%)	4 (11%)
MISSING	1 (3%)	0 (0%)

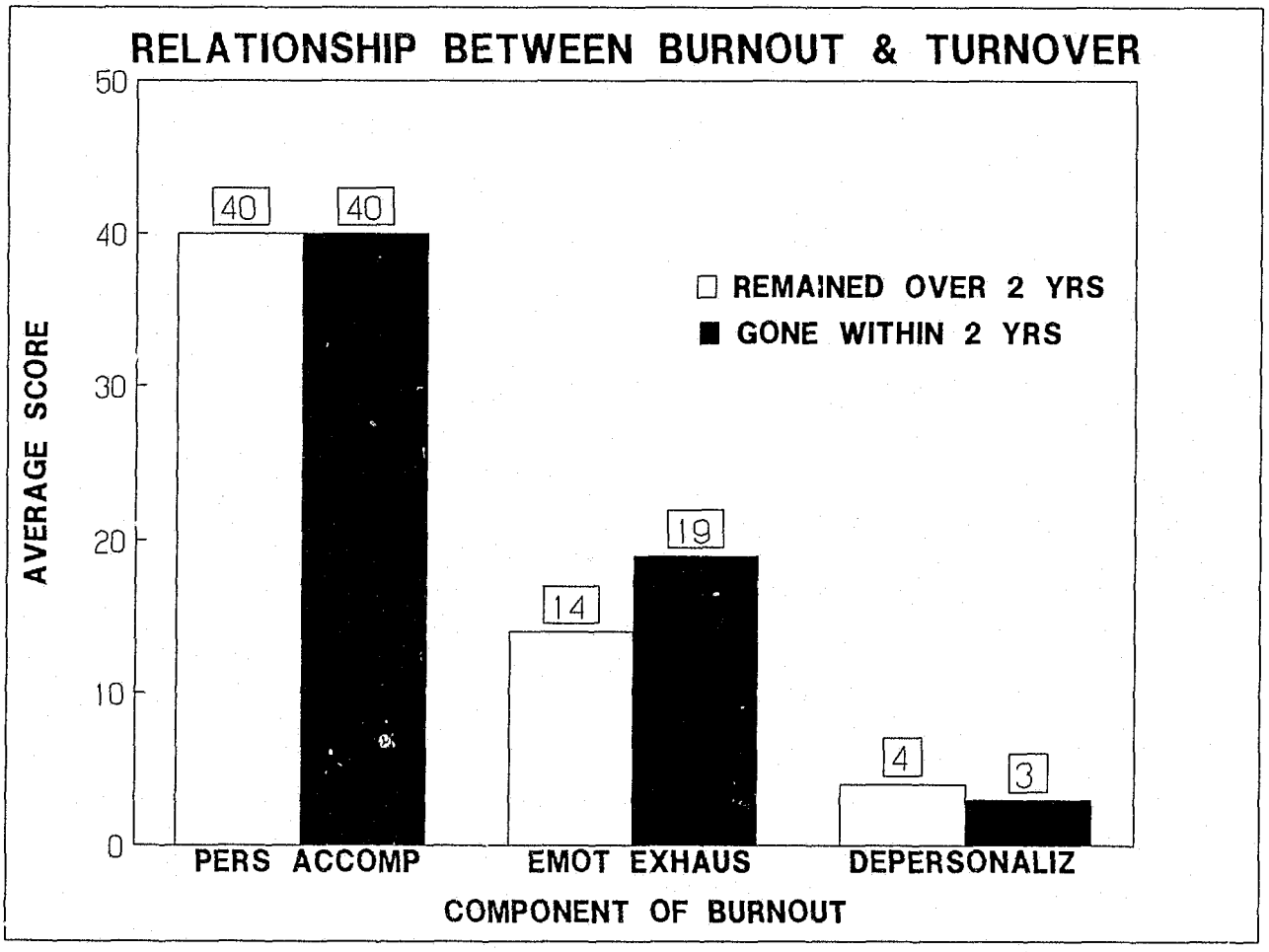
The length of time case managers reported working for the agency also supports the hypotheses that there is high turnover among case managers. In the Time 1 survey, 11 case managers (30%) reported working for their agencies 1 year or less. Two years later, in the Time 4 survey, 14 case managers reported working for their agencies one year or less.

The data also revealed that the case managers, as a whole, are not expressing feelings of burnout. Table 27 shows the average scores of the case managers at Time 4 of the survey, and compares the scores with the normative data provided by Maslach for the social services profession.[8] As the table shows, the case managers who responded to the survey reported low levels of burnout on all three subscales compared to the average of 1,538 other social service workers (including both social workers and child protective service workers).

TABLE 27: COMPARISON OF CASE MANAGERS' BURNOUT WITH NORMATIVE DATA		
SUBSCALE OF BURNOUT	CASE MANAGERS' AVERAGE SCORE AT TIME 4	NORMS FOR SOCIAL SERVICES FROM MASLACH (1986)
PERSONAL ACCOMPLISHMENT	39.86	LOW = ≥ 37 MIDDLE = 30 - 36 HIGH = ≤ 29
EMOTIONAL EXHAUSTION	15.83	LOW = ≤ 16 MIDDLE = 17 - 27 HIGH = ≥ 28
DEPERSONALIZATION	3.78	LOW = ≤ 5 MIDDLE = 6 - 10 HIGH = ≥ 11

This low level of reported burnout may have been related to the high turnover rate among the elder abuse workers. To test this hypothesis, the Time 1 scores of those who were still at the agency at the end of the study were compared with the Time 1 scores of those who had left the agency by Time 4. Figure 10 shows the results from this analysis.

FIGURE 10



As Figure 10 shows, those who left the agency within two years had virtually the same scores as those who remained on feelings of personal accomplishment and depersonalization. However, the scores on emotional exhaustion of those who left the agency averaged 5 points higher than the scores of those who remained at the agency for the two years of the study. These data indicate that the lower than normal scores of the workers at Time 4 were probably due to the turnover among those more emotionally exhausted. This also suggests that worker burnout is significantly related to turnover among elder abuse workers.

Table 28 shows the correlations between the three subscales of the Maslach Burnout Inventory and the number of hours per week case managers reported working on elder abuse cases. As the table shows, there is no statistically significant relationship between the number of hours a case manager works with elder abuse cases and feelings of personal accomplishment, emotional exhaustion or depersonalization. However, the relationship between hours of elder abuse work and emotional exhaustion approaches statistical significance, suggesting a trend of greater emotional exhaustion among those who spend greater amounts of time working on elder abuse cases.

TABLE 28
CORRELATION BETWEEN HOURS OF ELDER ABUSE WORK AND BURNOUT

	PERSONAL ACCOMPLISHMENT	EMOTIONAL EXHAUSTION	DEPERSONALIZATION
HOURS/WK ON ELDER ABUSE CASES	0.024	0.248	0.196

NOTE: Correlations of 0.275 or higher are statistically significant for the sample size (N=35).

Another interesting finding is the relationship between reports of burnout and the length of time the case managers worked for their agencies. Table 29 shows that the more years the worker worked for the agency, the lower his/her scores on the emotional exhaustion subscale of the burnout inventory. This suggests that either the emotionally strong workers are more likely to remain doing elder abuse case work, or that over time, agencies provide adequate support to boost the morale of their elder abuse workers.

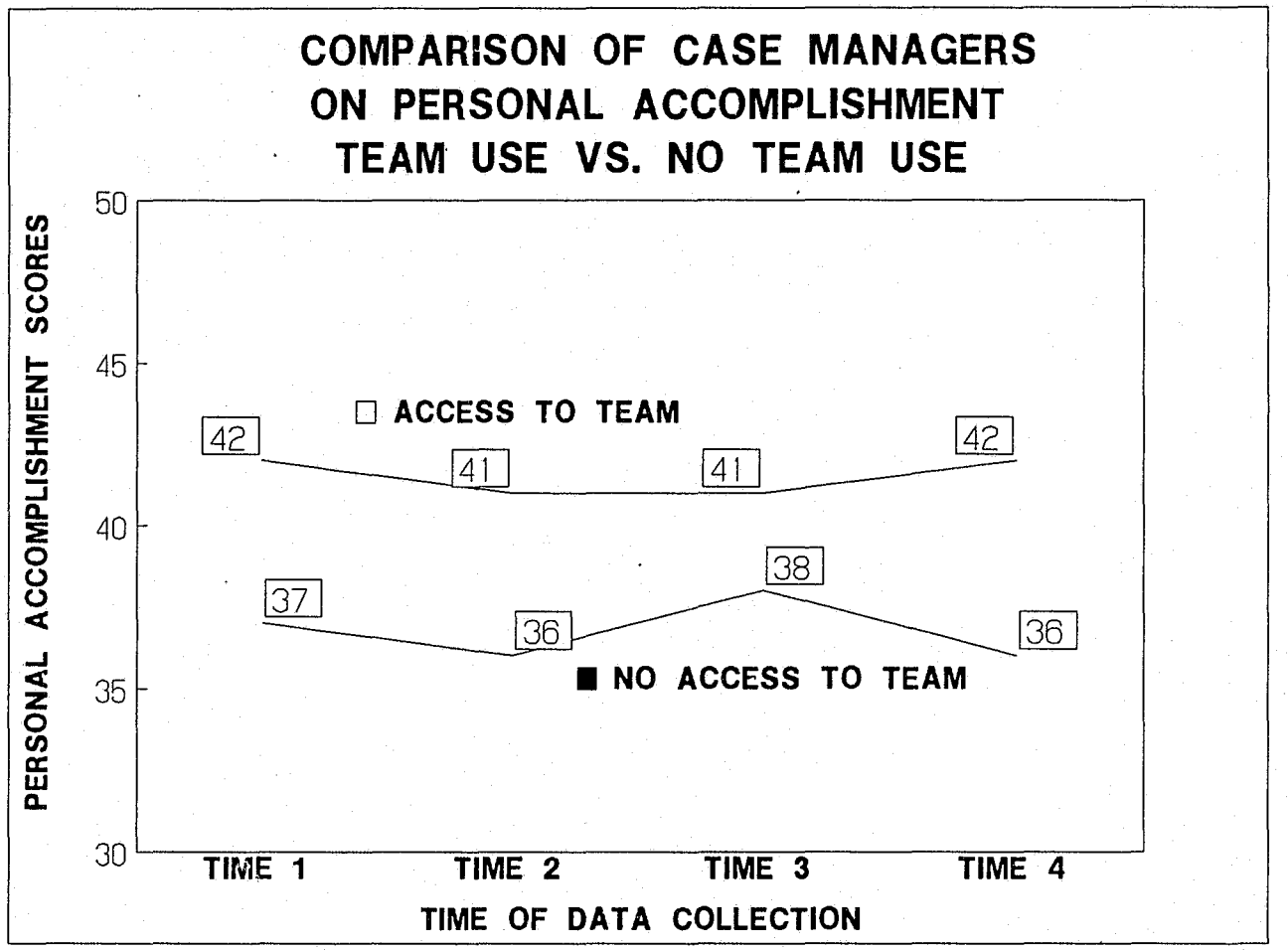
TABLE 29
CORRELATION BETWEEN HOURS OF ELDER ABUSE WORK AND BURNOUT

	PERSONAL ACCOMPLISHMENT	EMOTIONAL EXHAUSTION	DEPERSONALIZATION
# YEARS WORKED FOR AGENCY	-0.089	-0.304	0.027

NOTE: Correlations of 0.275 or higher are statistically significant for the sample size (N=35). Shaded cell indicates correlation is significant at $P \leq .05$ or less.

One major hypothesis of this study was that workers who used the M-teams for case discussions would feel less burned out over time compared with workers who did not use the M-team. This hypothesis was tested by examining changes in burnout over time, comparing those who used the team with those who did not. Figures 11, 12 and 13 show the results from this analysis for personal accomplishment, emotional exhaustion and depersonalization.

FIGURE 11



When the data were analyzed over all 4 time periods, there were only 10 case managers who used the M-teams who also completed all four rounds of the burnout index. Similarly, there were only 5 case managers who did not use the M-teams who also completed all four rounds of the burnout survey.

Figure 11 compares the two groups on scores of personal accomplishment. As the figure shows, those who had access to the team had personal accomplishment scores of 42 or 41 at each time period. In comparison, those without access to the M-teams had personal accomplishment scores hovering around 37. While the scores of those with access to M-teams are slightly higher at each time period, these differences are not statistically significant (Time 1: $t=1.48$, $P \leq 0.162$; Time 2: $t=1.71$, $P \leq 0.11$; Time 3: $t=1.17$, $P \leq 0.26$; Time 4: $t=1.85$, $P \leq 0.08$).

FIGURE 12

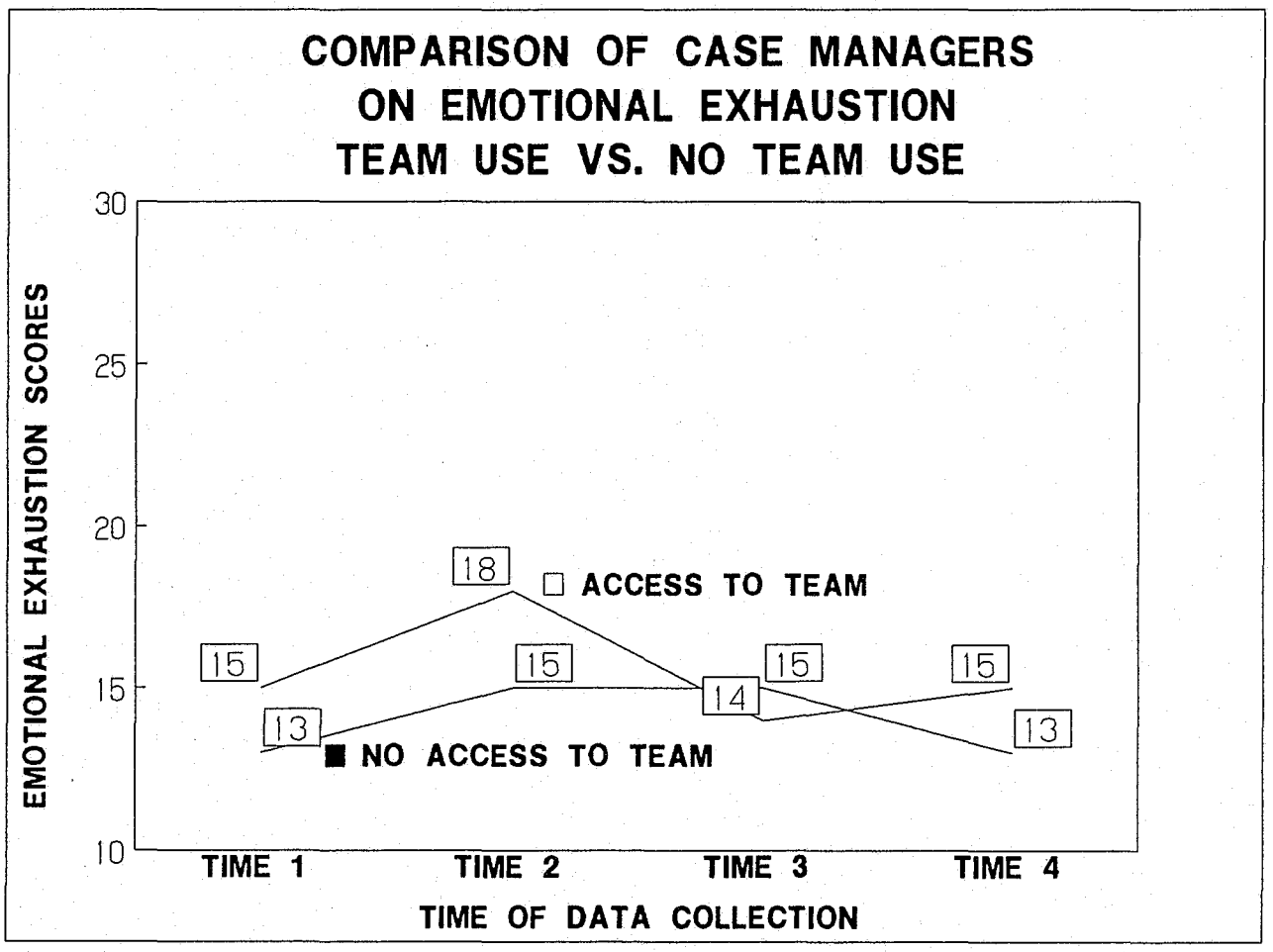
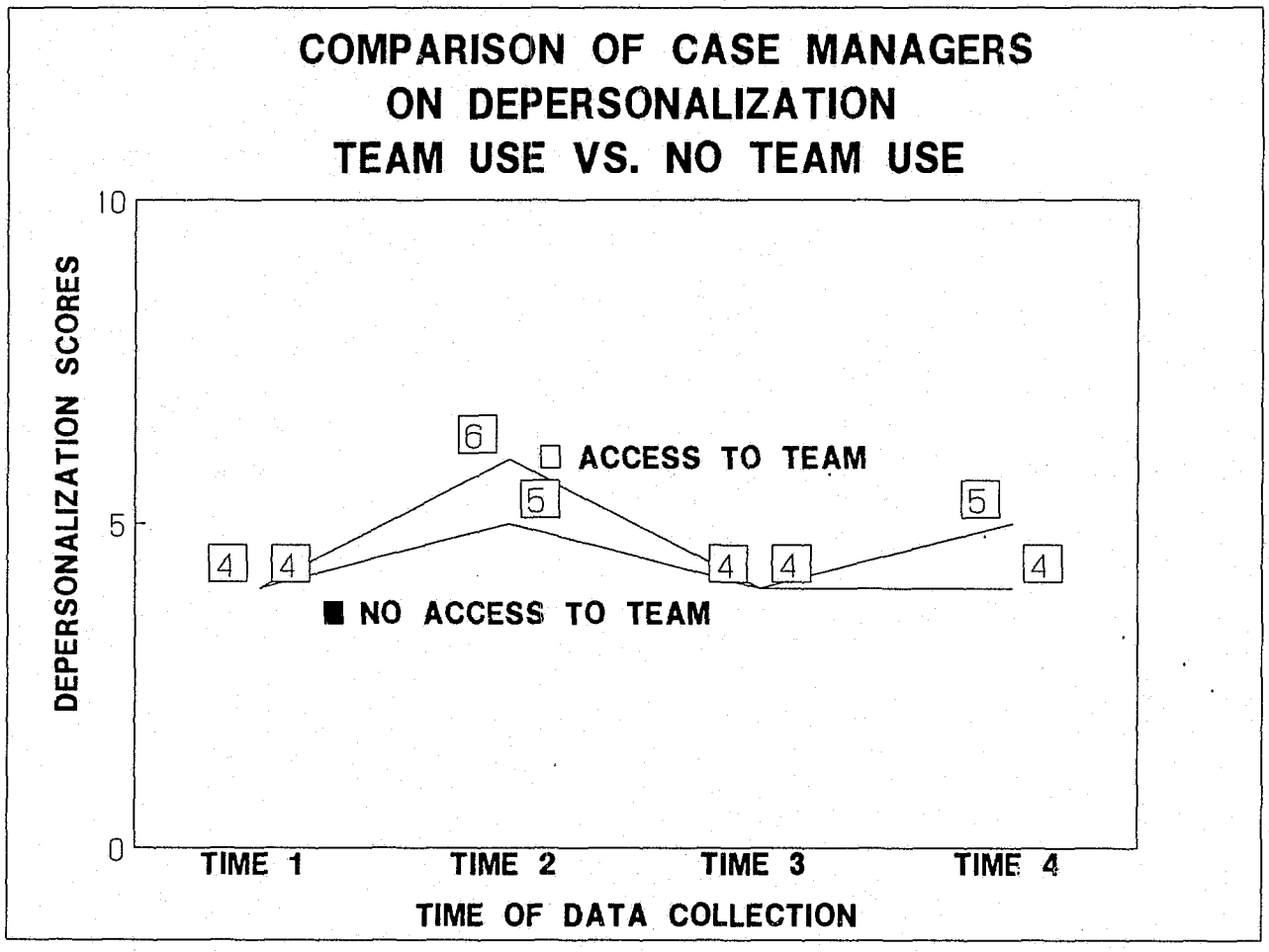


Figure 12 compares the two groups on scores of emotional exhaustion. For those who had access to the team, the scores on emotional exhaustion were 15, 18, 15 and 15, respectively. For those without access to the team, the scores on emotional exhaustion were 13, 15, 14 and 13 over the four time periods. Again, the differences between these two groups were not statistically significant.

FIGURE 13



Finally, Figure 13 shows the comparison of the two groups on scores of depersonalization over time. Like the other dimensions of burnout, the workers with access to the team reported virtually the same depersonalization scores over time (4, 6, 4 and 5) as those who did not have access to the team (an average score of 4 at each time period).

Inspection of the four figures also suggests that there does not appear to be a downward trend in burnout scores over time. It appears that feelings of burnout are related to other events besides the use of the M-team.

This research examined the implementation and impact of M-teams against several preliminary hypotheses. First, it was hypothesized that the M-team roles would involve resolution of problems with cases, filling gaps in services, educating team members and raising the community's consciousness about elder abuse. Results from this study indicate that the team members' were less involved in resolving problems with cases or filling gaps in services, but more involved in providing advice in implementing interventions and supporting ethical decisions made by case workers. Case managers used M-teams mostly for their professional input on the mechanics of implementing interventions, such as repossessing materials in cases of financial exploitation, or obtaining orders of protection. According to the site coordinators, while team discussions did not tend to change the types of services offered to victims, they did have an impact on the strategies and approaches used by elder abuse workers on these difficult cases.

The teams' expected roles in increasing their own awareness and that of their communities were supported by the evaluation data. The majority of the team members reported being involved in outside activities related to elder abuse, including speaking to colleagues, writing articles and placing elder abuse on political agendas. These results suggest that in spite of the fact that the M-teams do not tend to bring about case resolutions, their impact on their communities may be substantial. A future study should examine community awareness of elder abuse prior to and after M-team implementation.

A second expectation of this research was that voluntary team members would feel more committed to team membership than their paid counterparts. This hypothesis was rejected by the evaluation data. There were no differences between paid and voluntary teams in accepting the invitation to join the team. Neither were there differences in attendance rates, turnover rates, or feelings of commitment over time. These results indicate that it is not necessary to offer payment to professionals in order to successfully implement M-teams. Apparently professional commitment to social issues, such as elder abuse, is sufficient to gain their cooperation. In fact, many of the professionals actually refused the payment offered to them for their attendance at M-team meetings.

A third expectation was that there would be no differences between urban and rural areas in the implementation or impact of the M-teams. Overall, this hypothesis was supported by the data. Geographic location of the teams was not related to the attendance or turnover of team members or the types of cases discussed. On the other hand, urban areas appear to have more difficulty recruiting members while rural areas showed lower commitment levels of team members at all three times of data collection. These results are difficult to interpret. It may be that rural areas feel more obligated to become involved with such an inter-agency effort, because of the potential need to reciprocate a request in areas with so few social service providers. This issue should be examined in future research on the topic.

A fourth expectation was that case managers who brought cases to the M-teams would feel less burned out over time compared with those who did not have access to M-teams. Unfortunately high turnover among case managers resulted in a very small sample of case managers who completed all four phases of this longitudinal study. Using the small number of cases, the analysis did not support the hypotheses. This finding may be due to the lack of statistical power associated with small sample sizes. Or, it may be due to the fact that having access to the M-team was different from using the M-team. Among those who did not use the M-team, some could not use the team because they served elder abuse victims outside of the demonstration area. Others had access to the M-teams but chose not to use them. This difference was not measured in the longitudinal study. It may be that those who did not use the M-team had access to them, but elected not to use them. If this were the case, differences in burnout may not result, because those who did not use the M-teams may not have felt the need to do so. Given the availability of a standardized measure of burnout, this issue should be explored in future research on elder abuse.

SUMMARY

This research examined issues related to the implementation and impact of elder abuse M-teams on the clients they served. Through this project, two rural and two urban M-teams were implemented and evaluated. One rural and one urban M-team were also provided the opportunity to pay team members for their attendance at team meetings.

Data were collected from several sources. A mail survey was conducted of those professionals who refused the invitation to be team members. M-team meetings were tracked, as were cases discussed at each team meeting. Elder abuse and M-team-related activities outside of team meetings were measured. A job analysis and three telephone surveys were completed with M-team members. Finally, four surveys of case managers were conducted by the supervisors, with results mailed back to the evaluators.

The results indicate that physicians were most likely to refuse membership to the M-teams. Reasons for refusals were more related to lack of time than lack of interest. Urban areas had three times as many refusals than rural areas. There was no difference in the ability to recruit team members in paid versus voluntary sites.

Once involved, members tend to attend team meetings and stayed on the team for the 18 months of the project. Well over 80% of the team members intended to remain on the team after the completion of the project. In spite of their intent to stay, commitment scores of team members declined over time. There was no difference between paid and voluntary teams in levels of commitment. On the other hand, rural teams consistently reported lower commitment scores compared with urban teams.

Team activities consisted mostly of team discussions, providing advice to case managers and discussing care plans. Only about 20% of the case discussions involve changes in the care plans originally proposed by the case managers. Cases are brought to the teams primarily to solicit the advice of various professionals on implementing interventions. Recommendations for interventions are most often made for victim services, and primarily involved legal, mental health and medical services.

Team members reported the greatest satisfaction with their perceptions of their teams' productivity. Over time, the team members enjoyed the camaraderie that developed among the members and the stimulating discussions of various disciplines about individual cases. They also felt they gained insights about the problems of the elderly and elder abuse cases, and learned things that they could use on their regular jobs.

Outside of team meetings, members were involved in about 500 hours of in-kind activities. These included talking with colleagues and other professionals about elder abuse, as well as providing assistance on individual cases. The conservative estimate of the value of their contributions is $25,000.

Cases brought to the M-teams appear to be similar, but probably more complex, than the typical case reported to the statewide program. Cases involved the coexistence of many types of abuse or neglect. They were brought to the teams because they are chronic, needed the specialized expertise of a particular team member, or involved ethical issues of self-determination.

The longitudinal study of case managers showed no difference in burnout over time between those who used the M-teams and those who did not. However, there were only 15 case managers with sufficient data over the four phases of the study on which these differences could be tested.

One conclusion reached by this evaluation is that implementing M-teams in rural and urban areas involves similar dynamics. Urban areas can expect greater refusal rates than rural members. However, once recruited, both types of geographic locations can expect long-term and high attendance rates.

Another conclusion reached by this study is that although the teams appear to have little impact on individual case outcome, they are beneficial in many other ways. Team members, themselves, reported learning much about elderly and elder abuse through team membership. They helped to increase community awareness of the issues because of their out-of-team activities such as writing articles, speaking to professional groups, and talking with colleagues. They also provided needed professional advice to the case managers outside of the team meetings. Agencies can benefit from implementing M-teams not only because of the advice they provide at team meetings and to the case workers outside of team meetings, but also because of the goodwill they promote for their agencies in the community.

Future research should examine reasons why rural teams report lower commitment scores than urban teams. Future research should also provide more in-depth information about the case manger's perceptions of the impact of the M-teams. A longitudinal study of community awareness is also needed to objectively determine whether the M-teams impact on the community's level of awareness about elder abuse.

Another area of research identified through this study is that of case worker burnout. There is a need to investigate the high rate of turnover among elder abuse workers. The relationship between turnover and emotional exhaustion suggests that interventions aimed at reducing emotional exhaustion may have an impact on turnover among these professionals. The impact of high turnover on the cost and quality of caring for elder abuse victims should also be examined.

Still another area of inquiry is an investigation of the reasons why a large number of cases were brought to the M-teams because of ethical dilemmas. Was training for elder abuse workers lacking in this area? Or, is it because elder abuse cases often involve situations where there is no clear-cut decision? Perhaps workers bring these cases to the team so that they can feel a diffusion of responsibility for the difficult decisions they face.

Finally, the high percentage of recommendations for mental health services warrants further investigation. What is lacking in the community in terms of mental health services? Are there gaps in mental health services, or are their problems with the utilization of existing services? What, exactly, makes these services inaccessible to victims and abusers?

In summary, this research provided a wealth of information about the operations and impact of community-based M-teams on elder abuse cases in both rural and urban areas. Much was learned about this community-based system of care, yet much is left to be discovered.

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AN ACT in relation to the abuse and neglect of elderly persons.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act shall be known and may be cited as the "Elder Abuse and Neglect Act".

Section 2. Definitions. As used in this Act, unless the context requires otherwise:

(a) "Abuse" means causing any physical, mental or sexual injury to an eligible adult, including exploitation of such adult's financial resources. Nothing in this Act shall be construed to mean that an eligible adult is a victim of abuse or neglect for the sole reason that he or she is being furnished with or relies upon treatment by spiritual means through prayer alone, in accordance with the tenets and practices of a recognized church or religious denomination.

(b) "Department" means the Department on Aging of the State of Illinois.

(c) "Director" means the Director of the Department.

(d) "Domestic living situation" means a residence where the elderly person lives alone or with his or her family or a caretaker, or others, but is not a licensed facility as defined in Section 1-113 of the Nursing Home Care Reform Act of 1979, as now or hereafter amended.

(e) "Eligible adult" means a person 60 years of age or older who is abused or neglected by another individual in a domestic living situation.

(f) "Emergency" means a situation in which an eligible adult is living in conditions presenting a risk of death or physical, mental or sexual injury and is unable to consent to services which would alleviate that risk.

(g) "Neglect" means failure by another individual to provide an elderly person with the necessities of life

Originated in the Senate

Secretary of the Senate

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including, but not limited to, food, clothing, shelter or medical care.

(h) "Provider agency" means any public or nonprofit agency in a planning and service area appointed by the regional administrative agency with prior approval by the Department on Aging to receive and assess reports of alleged or suspected abuse or neglect.

(i) "Regional administrative agency" means any public or nonprofit agency in a planning and service area so designated by the Department, provided that the designated Area Agency on Aging shall be designated the regional administrative agency if it so requests.

(j) "Substantiated case" means a reported case of alleged or suspected abuse or neglect in which a provider agency, after assessment, determines that there is reason to believe abuse or neglect has occurred.

Section 3. Responsibilities. (a) The Department shall establish, design and manage a program of services for persons 60 years of age and older who have been victims of elder abuse or neglect. The Department shall contract with or fund regional administrative agencies or provider agencies, or both, for the provision of those services pursuant to this Act.

(b) Each regional administrative agency shall designate provider agencies within its planning and service area with prior approval by the Department on Aging, monitor the use of services, provide technical assistance to the provider agencies and be involved in program development activities.

(c) Provider agencies shall assist eligible adults who need agency services to allow them to continue to function independently. Such assistance shall include but not be limited to receiving reports of alleged or suspected abuse or neglect, conducting face-to-face assessments of such reported cases, determination of substantiated cases, referral of substantiated cases for necessary support services, and

provision of case work and follow-up services on substantiated cases.

Section 4. Reports of abuse or neglect. (a) Any person wishing to report a case of alleged or suspected abuse or neglect may make such a report to an agency designated to receive such reports under this Act. A physician or other provider of medical services who believes it is in his patient's best interests to make such a report may do so notwithstanding any requirements concerning the confidentiality of information with respect to such patient which might otherwise be applicable. Law enforcement officers shall continue to report incidents of alleged abuse pursuant to the Illinois Domestic Violence Act, notwithstanding any requirements under this Act.

(b) Any person, institution or agency making a report or assessment under this Act in good faith, or taking photographs or x-rays as a result of the assessment, shall be immune from any civil or criminal liability on account of making such report or assessment or on account of submitting or otherwise disclosing such photographs or x-rays to any agency designated to receive reports of alleged or suspected abuse or neglect.

(c) The identity of a person making a report of alleged or suspected abuse or neglect under this Act may be disclosed by the Department or other agency provided for in this Act only with such person's written consent or by court order.

(d) The Department shall by rule establish a system for filing and compiling reports made under this Act.

Section 5. Procedure. A provider agency designated to receive reports of alleged or suspected abuse or neglect under this Act shall, upon receiving such a report, conduct a face-to-face assessment with respect to such report. The assessment shall include, but not be limited to, a visit to the residence of the eligible adult who is the subject of the report and may include interviews or consultations with

service agencies or individuals who may have knowledge of the eligible adult's circumstances. If, after the assessment, the provider agency determines that the case is substantiated it shall develop a service care plan for the eligible adult. In developing the plan, the provider agency may consult with any other appropriate provider of services, and such providers shall be immune from civil or criminal liability on account of such acts. The plan shall include alternative suggested or recommended services which are appropriate to the needs of the eligible adult and which involve the least restriction of the eligible adult's activities commensurate with his needs. Only those services to which consent is provided in accordance with Section 9 of this Act shall be provided, contingent upon the availability of such services.

Section 6. Time. The Department shall by rule establish the period of time within which an assessment shall begin and within which a service care plan shall be implemented. Such rules shall provide for an expedited response to emergency situations.

Section 7. Review. All services provided to an eligible adult shall be reviewed by the provider agency on at least a quarterly basis for not less than one year to determine whether the service care plan should be continued or modified.

Section 8. Access to records. All records concerning reports of elder abuse and neglect and all records generated as a result of such reports shall be confidential and shall not be disclosed except as specifically authorized by this Act or other applicable law. Access to such records, but not access to the identity of the person or persons making a report of alleged abuse or neglect as contained in such records, shall be allowed to the following persons and for the following persons:

(a) Department staff, provider agency staff and regional administrative agency staff in the furtherance of their

responsibilities under this Act;

(b) A law enforcement agency investigating known or suspected elder abuse or neglect;

(c) A physician who has before him an eligible adult whom he reasonably suspects may be abused or neglected;

(d) An eligible adult reported to be abused or neglected, or such adult's guardian unless such guardian is the alleged abuser;

(e) A court, upon its finding that access to such records may be necessary for the determination of an issue before such court. However, such access shall be limited to an in camera inspection of the records, unless the court determines that disclosure of the information contained therein is necessary for the resolution of an issue then pending before it;

(f) A grand jury, upon its determination that access to such records is necessary in the conduct of its official business;

(g) Any person authorized by the Director, in writing, for audit or bona fide research purposes;

(h) A coroner or medical examiner who has reason to believe that an eligible adult has died as the result of abuse or neglect.

Section 9. Authority to consent to services. (a) If an eligible adult consents to services being provided according to the service care plan, such services shall be arranged to meet the adult's needs, based upon the availability of resources to provide such services. If an adult withdraws his consent or refuses to accept such services, the services shall not be provided.

(b) If it reasonably appears to the Department or other agency designated under this Act that a person is an eligible adult and lacks the capacity to consent to necessary services, the Department or other agency may seek the appointment of a temporary guardian as provided in Article

XIa of the Probate Act of 1975 for the purpose of consenting to such services.

(c) A guardian of the person of an eligible adult may consent to services being provided according to the service care plan. If a guardian withdraws his consent or refuses to allow services to be provided to the eligible adult, the Department may request an order of protection under the Illinois Domestic Violence Act of 1986 seeking appropriate remedies, and may in addition request removal of the guardian and appointment of a successor guardian.

(d) If an emergency exists and the Department or other agency designated under this Act reasonably believes that a person is an eligible adult and lacks the capacity to consent to necessary services, the Department or other agency may request an order from the circuit court of the county in which the petitioner or respondent resides or in which the alleged abuse or neglect occurred, authorizing an assessment of a report of alleged or suspected abuse or neglect and the provision of necessary services including relief available under the Illinois Domestic Violence Act of 1986.

Section 10. Rules. The Department shall adopt such rules and regulations as it deems necessary to implement this Act.

Section 11. Annual Reports. The Department shall file with the Governor and the General Assembly, within 90 days after the end of each fiscal year, a report concerning its implementation of this Act during such fiscal year, together with any recommendations for future implementation.

Section 12. Implementation. The Department shall implement this Act Statewide, beginning in such areas of the State as it shall designate by rule, as appropriated funds become available.

APPENDIX

M-TEAM MEETING REPORT FORM INSTRUCTIONS

1. SITE:
   Check site that M-Team is affiliated with

2. REPORTER NAME:
   Name of person completing this form.

3. PHONE #:
   Telephone number of person completing this form.

4. DATE:
   Date M-Team meeting was held.

5. MEMBERS PRESENT:
   Check for each type of member present.

6. MEMBERS ABSENT:
   Check for each type of member absent.

   NOTE: IF AN ALTERNATE MEMBER IS PRESENT, LIST THIS PERSON AS "OTHER" AND WRITE "Alternate for (DISCIPLINE TYPE)" IN SPACE PROVIDED.

7. ANY CHANGE IN TEAM MEMBERSHIP SINCE LAST MEETING?
   Check YES and list in 7a any people (by discipline) who left the M-Team and/or any people (by discipline) who joined as a regular team member since the last meeting.

   Check NO if no changes were made in membership and skip to #8.

8. TOTAL NUMBER OF CLIENTS DISCUSSED AT MEETING:
   This number should equal the number of individual client forms completed and submitted.

9. TOTAL NUMBER OF CASE MANAGERS REPRESENTING CASES:
   This number should equal the number of case managers who presented cases at this meeting.

10. PLEASE CHECK ACTIVITIES CONDUCTED BY THE M-TEAM DURING THIS MEETING:

a ☐ ADVISING IN SERVICE DELIVERY -helping case managers decide on services to pursue for victim or abuser.

b ☐ DISCUSSION OF SELECTED CASES-presenting of cases to team by case mgr.

c ☐ EDUCATION OF TEAM MEMBERS-presentations about elder abuse, community services, etc.

d ☐ DEVELOPMENT/IMPLEMENTATION OF PROCEDURES-discussion of how the M-Team will operate; rules, meeting times, etc.

e ☐ EDUCATION AND INFORMATION TO COMMUNITY-discussion of M-Team members making presentations to the community, PSA's, mailings,pamphlets,etc.

f ☐ CARE PLAN DEVELOPMENT-assistance in selecting specific agency or service provider to assist victim or abuser.

g ☐ NETWORKING OF SERVICES-discussion of which agencies to provide types of services or ways M-Team members can help specific victims.

h ☐ GENERATED NEW RESOURCES-discussion of how to fill gaps in services, actual development of new services, fund raising, etc.

i ☐ ADVOCATING-looking out for the best interests of the victims.

j ☐ EVALUATING PROGRESS-evaluating how well the team is doing its job.

k ☐ OTHER: any other activity not listed above.

IDOAMT12/SPEC89

M-TEAM MEETING REPORT FORM

1. SITE:
- 1 ☐ ALTERNATIVES
- 2 ☐ TRI COUNTY
- 3 ☐ VNA- ST CLAIR
- 4 ☐ SHAWNEE

2. REPORTER NAME:

3. PHONE # - ( )

4. DATE:

5. MEMBERS PRESENT:

- ☐ M-TEAM COORDINATOR
- ☐ LEGAL REP.
- ☐ FINANCIAL REP.
- ☐ CLERGY
- ☐ MENTAL HEALTH REP.
- ☐ MEDICAL REP.
- ☐ LAW ENFORCEMENT REP.
- ☐ OTHER (LIST DISCIPLINE): _____
- ☐ OTHER (LIST DISCIPLINE): _____

6. MEMBERS ABSENT:

- ☐ M-TEAM COORDINATOR
- ☐ LEGAL REP.
- ☐ FINANCIAL REP.
- ☐ CLERGY
- ☐ MENTAL HEALTH REP.
- ☐ MEDICAL REP.
- ☐ LAW ENFORCEMENT REP.

7. ANY CHANGE IN TEAM MEMBERSHIP SINCE LAST MEETING? 1 ☐ YES 2 ☐ NO

7a. EXPLAIN: _____

_____

8. TOTAL NUMBER CLIENTS DISCUSSED AT MEETING _____

9. TOTAL NUMBER OF CASE MANAGERS REPRESENTING CASES _____

10. PLEASE CHECK ACTIVITIES CONDUCTED BY THE M-TEAM DURING THIS MEETING:

- a ☐ ADVISING IN SERVICE DELIVERY
- b ☐ DISCUSSION OF SELECTED CASES
- c ☐ EDUCATION OF TEAM MEMBERS
- d ☐ DEVELOPMENT/IMPLEMENTATION OF PROCEDURES
- e ☐ EDUCATION AND INFORMATION TO COMMUNITY
- f ☐ CARE PLAN DEVELOPMENT
- g ☐ NETWORKING OF SERVICES
- h ☐ GENERATED NEW RESOURCES
- i ☐ ADVOCATING
- j ☐ EVALUATING PROGRESS
- k ☐ OTHER: _____

INDIVIDUAL CLIENT FORM

1. CLIENT ID #:

2. DATE: / /

3. REPORT TYPE: 1 ☐ INITIAL 2 ☐ FOLLOW-UP 3 ☐ MULTIPLE REPORT 4 ☐ UPDATE

4. SITE: 1 ☐ ALTERNATIVES 2 ☐ TRI-COUNTY 3 ☐ VNA-ST CLAIR 4 ☐ SHAWNEE

5. TYPE(S) OF ABUSE/NEGLECT SUSPECTED OR SUBSTANTIATED: (check all that apply)

	SUSPECTED, NO EVIDENCE		SUBSTANTIATED	
a. PHYSICAL ABUSE	☐	1	☐	2
b. CONFINEMENT	☐	1	☐	2
c. SEXUAL ABUSE	☐	1	☐	2
d. DEPRIVATION	☐	1	☐	2
e. FINANCIAL ABUSE	☐	1	☐	2
f. NEGLECT	☐	1	☐	2
g. PSYCOLOGICAL/ VERBAL ABUSE	☐	1	☐	2

6. CASE MANAGER CODE:
(LAST 4 DIGITS OF SS#) # — — — —

CLIENT DEMOGRAPHICS (ONLY ON INITIAL CASES)

7. SEX: 1 ☐ MALE 2 ☐ FEMALE

8. AGE: ☐

9. RACE: 1 ☐ WHITE 2 ☐ BLACK 3 ☐ HISPANIC 4 ☐ ASIA 5 ☐ OTHER: _____

10. CLIENT'S LOCATION: 1 ☐ URBAN 2 ☐ RURAL

11. # MINUTES SPENT DISCUSSING CASE: _____ (MINUTES)

12. DESCRIBE WHY THIS CASE WAS SELECTED:

_____

_____

_____

13. WAS ANYTHING IDENTIFIED THAT VICTIM OR ABUSER NEEDED THAT WAS NOT AVAILABLE?

1 ☐ YES 2 ☐ NO - SKIP TO Q.14

13a. WHAT SERVICES AND WHY IS IT NOT AVAILABLE TO VICTIM OR ABUSER?

VICTIM	ABUSER

14. WAS THE ORIGINAL CARE PLAN CHANGED?

1 ☐ YES 2 ☐ NO 3 ☐ NA (UPDATE ONLY)

If YES, please explain changes and reason(s):

_____

15. WAS INSTITUTIONALIZATION RECOMMENDED?

1 ☐ YES 2 ☐ NO 3 ☐ NA (UPDATE ONLY)

16. DID THE M-TEAM MEMBERS REACH A CONSENSUS ON THEIR RECOMMENDATION(S)?

1 ☐ YES 2 ☐ NO 3 ☐ NA (UPDATE ONLY)

17. WHAT PROBLEMS WERE FACED IN TRYING TO REACH A CONCENSUS?

_____

18. FINAL RECOMMENDATION MADE: (LIST IN ORDER OF PRIORITY)

_____

_____

_____

_____

_____

19. WHAT WAS THE CASE MANAGER'S REACTION TO THE DISCUSSION OF THIS CASE?

_____

_____

_____

IDIVIDUAL CLIENT FORM INSTRUCTIONS

1. CLIENT ID#:
   This should be the same number that your agency assigns to the client for the statewide elder abuse reports.

2. DATE:
   Date of the M-Team meeting at which this client was discussed.

3. REPORT TYPE:
   1 ☐ INITIAL:
   This is the first time this client is being discussed by the M-Team.
   2 ☐ FOLLOW-UP:
   This client was discussed at a previous meeting and action was taken. The case manager is looking for new recommendations.

   3 ☐ MULTIPLE REPORT
   This case was discussed at a previous meeting. Another report of abuse/neglect has been made on this client since the case was discussed and the case manager is looking for further recommendations.

   4 ☐ UPDATE:
   The case manager is sharing outcomes of a case with M-Team members and is NOT expecting feed back or new recommendations.

4. SITE:
   Self-explanatory

5. TYPES OF ABUSE/NEGLECT:
   Check those types of abuse/neglect that have been substantiated or are suspected to be involved in this case. These types should be the same as those listed on the statewide elder abuse report.

6. CASE MANAGER CODE:
   Enter the last four digits of the social security number of the case manager who is presenting the case to the M-Team.

CLIENT DEMOGRAPHICS - COMPLETE THIS SECTION FOR INTITAL CASES ONLY.

7. SEX:
   Check sex of the client being discussed.

8. AGE:
   Check age of the client being discussed.

9. RACE:
   Check one race which best represents the ethnic background of the client.

10. LOCATION:
    Check whether the client lives in an urban or rural geographic area.

11. MINUTES SPENT DISCUSSING CASE:
Enter the total number of minutes, during the M-Team meeting, that were spent discussing this case.

12. DESCRIBE WHY THIS CASE WAS SELECTED:
Briefly describe why you selected this case to be discussed by the M-Team.

13. WAS ANYTHING IDENTIFIED THAT VICTIM OR ABUSER NEEDED THAT WAS NOT AVAILABLE?
Check YES if you feel that victim or abuser could benefit from services not available to them. On 13a, list each service and describe why it is not available.

14. WAS THE ORGINAL CARE PLAN CHANGED?
Check YES if the case manager made any change in the original care plan as a result of the M-Team's recommendations.

Check NO if the recommendations of the M-Team did not result in changes to the original care plan.

Check NA if this was only an update on this case.

15. WAS INSTITUTIONALIZATION RECOMMENDED?
Check YES if the M-Team reached consensus that placement of the victim in an institution (nursing home, home for the aged, psychiatric hospital, etc.,) was recommended for this client.

Check NO if institutionalization of the client was not a recommendation on which the M-Team reached a consensus.

Check NA if this was only an update on the case.

16. DID THE M-TEAM REACH A CONSENSUS ON THEIR RECOMMENDATION(S)?
Check YES if M-Team members were able to agree on how to prioritize the recommendations they made on this case.

Check NO if consensus was not reached when their should have been some prioritization of the recommendations.

Check NA when consensus was not relevant because this was only an update on this case or for some other reason.

17. WHAT PROBLEMS WERE FACED IN TRYING TO REACH A CONSENSUS?
Describe why you believe the M-Team was not able to agree on prioritizing recommendations.

18. FINAL RECOMMENDATION MADE:
List the recommended actions suggested by the M-Team. If consensus was reached, number each recommendation to reflect the highest priority (#1), next highest (#2), etc.

TELEPHONE INTERVIEW WITH M-TEAM MEMBERS

☐ APRIL 1989 ☐ OCT. 1989

☐ JULY 1989 ☐ JAN. 1990

INTERVIEW #: _____

RECORD # _____

DATE: _____

I'D LIKE TO BEGIN BY ASKING YOU SOME QUESTIONS ABOUT YOUR SATISFACTION WITH THE M-TEAM AND ITS PROCEDURES.

1. First, how long have you been a member on this M-Team?

_____ (MONTHS)

FOR THE NEXT SET OF QUESTIONS I WOULD LIKE YOU TO SELECT YOUR ANSWER FROM THE FOLLOWING: VERY SATISFIED, SOMEWHAT SATISFIED, SATISFIED, SOMEWHAT DISSATISFIED, OR VERY DISSATISFIED:

	VS	SS	S	SD	VD
2. How satisfied are you with the productivity of the M-Team?					
3. How satisfied are you with the success rate of the cases that the M-Team has processed?.					
4. How satisfied are you with the commitment of other members of your team?					
5. How satisfied were you with team training?					
6. On the whole, how satisfied are you with the M-team?					

7. On your own, do you do much talking to generate public support for elder abuse programs?

☐ YES ☐ NO

7a. In what way?

_____

_____

_____

_____

8. What other topics, relevent to the M-Team, would you like training in?

_____

_____

_____

9. What are some of the reasons why you decided to join this M-Team?

_____

_____

_____

_____

FINALLY, I WOULD LIKE YOU TO RESPOND TO THE FOLLOWING STATEMENTS BY ANSWERING WITH: STRONGLY AGREE, AGREE, DISAGREE, OR STRONGLY DISAGREE.

	SA	A	D	SD
10. Being on the M-Team requires full use of my skills.				
11. On the M-Team, I get a chance to learn new things.				
12. My role on the M-Team is a challenging one.				
13. I feel little loyalty toward the M-Team.				
14. I talk up the M-Team to my friends as a great group to be a part of.				
15. I feel a sense of pride being part of the M-Team.				
16. Moving ahead in my career is more important than being a member of the M-Team.				
17. I value being an M-Team member because it identifies me with concerns about the elderly.				
18. My loyalty is more to my work than to the M-Team.				
19. If asked, I would do more for the M-Team than attend monthly meetings.				
20. As long as I'm doing the kind of work I enjoy, it does NOT matter if I belong to the M-Team.				
21. If asked, I would serve on a committee for the M-Team.				
22. I doubt that I would do any special work for the M-Team.				
23. I find that my values and the values of other M-Team members are very similar.				

	SA	A	D	SD
24. I am proud to tell others I am part of this M-Team.				
25. I am willing to put forth a great deal of effort beyond that normally expected in order to help this M-Team be successful.				
26. I would accept almost any type of job assignment in order to stay a part of this M-Team.				
27. The M-Team really inspires the very best in me, in the way of job performance.				
28. I really care about the fate of this M-Team.				
29. I intend to remain a member of the M-Team as long as it exists.				
30. If I had to do it over again, I would still join this M-Team.				

THAT CONCLUDES OUR SURVEY. ARE THERE ANY OTHER COMMENTS, EITHER PRO OR CON THAT YOU WOULD LIKE TO ADD AT THIS TIME?

M-TEAM REGISTRATION & REIMBURSEMENT SHEET

DATE OF MEETING: _____

NAME: _____

DISCIPLINE: _____

TELEPHONE #: ( ) _____

PLEASE INDICATE THE APPROXIMATE NUMBER OF MINUTES YOU SPENT SINCE THE LAST M-TEAM MEETING ON THE FOLLOWING ACTIVITIES (EXCLUDIING TIME SPENT IN M-TEAM MEETING):

	MINUTES
MAKING PUBLIC PRESENTATIONS ABOUT ELDER ABUSE	
CLIENT - SPECIFIC ACTIVITIES RELATED TO ONE OR MORE CLIENTS DISCUSSED AT AN M-TEAM MEETING.	
OTHER ACTIVITIES RELATED TO THE M-TEAM: PLEASE SPECIFY: _____	
OTHER ACTIVITIES RELATED TO ELDER ABUSE NOT DIRECTLY RELATED TO M-TEAM: (i.e.: talking to professional groups about elder abuse, donating money to agency serving victims, etc.)	

_____

_____

_____

_____

Human Services Survey

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN 0 - 6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

(Administrative use only)

		cat.		cat.		cat.
EE:	_____	_____	DP: _____	_____	PA: _____	_____

Christina Maslach • Susan E. Jackson

Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way *about your job.* If you have *never* had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

HOW OFTEN
0 - 6 Statement:

_____ I feel depressed at work.

If you *never* feel depressed at work, you would write the number "0" (zero) under the heading "HOW OFTEN." If you *rarely* feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a "5."

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ELDER ABUSE

AWARENESS

The Illinois Department on Aging

Elder Abuse and Neglect Program

Multidisciplinary Team Coordinator Guidebook

ILLINOIS DEPARTMENT ON AGING

MULTI-DISCIPLINARY TEAM TRAINING GUIDEBOOK

This handbook is funded by the U.S. Administration on Aging, grant number 90 AR 0115/01 and by the Illinois Department on Aging. The views expressed in this handbook do not necessarily reflect the official position of the Administration on Aging.

#1 ILLINOIS DEPARTMENT ON AGING

MULTI-DISCIPLINARY TEAM TRAINING

#2 ADMINISTRATIVE DETAILS

BREAKS

BATHROOMS

TELEPHONES

SIGN-IN SHEET

#3 TRAINING MATERIALS

* ELDER ABUSE STANDARDS AND PROCEDURES MANUAL - CHAPTER 9

M-TEAM COORDINATOR GUIDEBOOK

* M-TEAM MEMBER HANDBOOK

#4

AGENDA

9:30 AM • **Welcome and Introductions**

9:45 AM • **Overview of M-Teams**

Purpose and Goals of the M-Team
Benefits of Utilizing M-Teams
Lessons Learned from the Discretionary Grant
Standards and Procedures Manual Requirements
Confidentiality

10:45 AM • **Recruiting M-Team Members**

M-Team Membership (which professionals)
Recruitment Script
Job Descriptions
Written Agreement

12:00 PM • **Lunch**

1:00 PM • **Conducting M-Team Meetings**

When to Schedule Meetings
Selection of Cases
Preparing Advance Materials
Conducting the Meeting - Role of the M-Team Coordinator
Presenting a Case - Role of the Elder Abuse Case Worker
Minutes of the Meeting

2:30 PM • **Training M-Team Members**

Orientation Topics and Materials -
- Your Agency
- Aging Network
- Elder Abuse - characteristics of the problem & interventions
- Elder Abuse and Neglect Program (Act and Standards)
- M-Team Video
- M-Team Goals and Responsibilities

Involving the Case Workers in the Training/Orientation
Training New Members after Group is Formed

4:00 PM • **Adjourn**

#5 OVERVIEW OF M-TEAMS

PURPOSES AND GOALS OF M-TEAMS

* PROVIDE CONSULTATIONS ON COMPLEX CASES

* ACT AS A SOUNDING BOARD FOR CASE WORKERS

* PROVIDE DIFFERENT PERSPECTIVES ON PROBLEM

* NETWORK BUILDING AMONG PEERS

#6 BENEFITS OF M-TEAMS

* SUPPORT/VALIDATION FOR CASE WORKERS

* INCREASED KNOWLEDGE OF RESOURCES

* WIDER RANGE OF ALTERNATIVE SOLUTIONS

* BETTER COORDINATION OF INTER-AGENCY EFFORTS

* "DOOR OPENING"/NETWORKING

#7 PROBLEMS TO AVOID WITH M-TEAMS

* CASE WORKERS FEELING DEFENSIVE
* BREACH OF CONFIDENTIALITY
* FAILING TO PROVIDE FEEDBACK TO TEAM
* NON-ATTENDANCE BY SOME MEMBERS

#8 LESSONS OF DISCRETIONARY GRANT

* PAYMENT APPEARS TO BE IRRELEVANT
* VALUE TO CASE WORKERS
* POSSIBLE FOR ONE TEAM TO SERVE MULTI-COUNTY AREA
* ADVANCE PREPARATION ESSENTIAL
* NETWORKING BENEFITS NOTABLE & PUBLIC AWARENESS ENHANCED
* MEDICAL MEMBERS HARDEST TO RECRUIT
* CASE SOLUTIONS NOT ALWAYS IMMEDIATE
* TEAM MEMBERS FEEL COMMITTED

#9 REQUIREMENTS OF ELDER ABUSE STANDARDS AND PROCEDURES MANUAL

* FUNDED AGENCIES MUST HAVE M-TEAM, UNLESS EXEMPTED DUE TO SMALL SIZE OF SERVICE AREA (7,200)

* MEETINGS TO START IN OCTOBER, 1990 (NEW EAPA HAS 120 DAYS TO IMPLEMENT)

* MEETINGS TO BE HELD MONTHLY (10/YEAR)

* MEMBERSHIP AS DESIGNATED

* RAA STAFF AND M-TEAM COORDINATORS TO BE TRAINED BY IDOA

* M-TEAM MEMBERS AND CASE WORKERS TO BE TRAINED

* EAPA MUST HAVE PROCEDURES IN PLACE

#10 CONFIDENTIALITY

ALL M-TEAM MEMBERS MUST AGREE TO PROTECT

CASE WORKERS AND COORDINATOR MUST SHIELD CLIENT IDENTITIES IN REPORTS AND RECORDS

MARK ENVELOPES SENT THROUGH MAIL "CONFIDENTIAL"

BE CAREFUL RE FAXED MATERIAL

#11 RECRUITING AND RETAINING M-TEAM MEMBERS

M-TEAM MEMBERSHIP:

LEGAL

MEDICAL

MENTAL HEALTH

LAW ENFORCEMENT

FINANCIAL

CLERGY

M-TEAM COORDINATOR

#12 LEGAL --

TITLE III LEGAL ASSISTANCE PROVIDER

LEGAL SERVICES ATTORNEY

PRIVATE ATTORNEY

(ELDER ABUSE, OR DOMESTIC VIOLENCE, AND PUBLIC BENEFIT KNOWLEDGE HELPFUL)

#13 MEDICAL --

PHYSICIAN (INTERNIST OR FAMILY PRACTICE PREFERRED)

REGISTERED NURSE (HOME HEALTH CARE EXPERIENCE PREFERRED)

#14 MENTAL HEALTH --

MASTER'S IN SOCIAL WORK

REGISTERED NURSE WITH PSYCHIATRIC EXPERIENCE

(EXPERIENCE WITH ELDERLY &/OR ABUSE PREFERRED)

#15 LAW ENFORCEMENT --

POLICE/SHERIFF WITH 5 YEARS EXPERIENCE

STATE'S ATTORNEY OR ASSISTANT

(KNOWLEDGE AND ACCESS TO AREA SYSTEM & KNOWLEDGE OF FAMILY PATTERNS AND SUBSTANCE ABUSE PREFERRED)

#16 FINANCIAL --

LOCAL BANK MANAGER/OFFICER

FINANCIAL MANAGEMENT SPECIALIST

(ACCESS TO BANKING COMMUNITY; KNOWLEDGE OF LOANS AND CONFIDENTIALITY)

#17 CLERGY --

LOCAL PASTOR; MUST NOT HAVE BELIEFS THAT SUPPORT ABUSIVE RELATIONSHIPS

(COUNSELING EXPERIENCE, TOLERANT ATTITUDE, KNOWLEDGE OF LOCAL COMMUNITY AND THREE YEARS EXPERIENCE PREFERRED)

#18 RECRUITMENT PROCESS

CHARACTERISTICS TO LOOK FOR

BRAINSTORM POSSIBLE MEMBERS

PERSONAL KNOWLEDGE HELPFUL

PERSONS TO ASK FOR SUGGESTIONS

HAVE THREE POSSIBILITIES FOR EACH SLOT

INTRODUCTORY LETTER

RECRUITMENT SCRIPT

CLEAR EXPECTATIONS

OVERCOMING RESISTANCE

RECRUITMENT SCRIPT

Good (morning/afternoon), (name of potential member). This is (your name) from (your agency's name). If you have a few minutes right now I'd like to talk with you about a new initiative our agency is undertaking.

(Your agency name) is the designated elder abuse provider agency for this area. This means that our case workers receive and respond to reports of elder abuse, neglect or exploitation within the home. Sometimes we have complex cases which require additional resources and professional expertise. To help us with these difficult cases we are developing a volunteer multidisciplinary team of persons from different professional groups. The team members will help our case workers by recommending strategies on intervention, developing or providing guidance on the development of care plans, and assuring that the older persons' rights are not violated.

The core group of members will be composed of individuals from the following fields: medical, legal, law enforcement, mental health, clergy, and the financial community. As you can see, this is a well-rounded group which will be able to provide a great deal of assistance to the elder abuse case workers.

(Since you have been an active advocate on elder rights/since you are a well respected member of the _____ community/since you have experience with abuse cases), I am extending an invitation to you to be a member of the M-team. By accepting, you would be obligated to attend a training on M-teams, attend monthly meetings, and serve on the committee for a minimum period of one year. Persons who have served on M-teams in other areas have found it to be a very rewarding experience.

Would you be interested in this commitment? Do you have any questions? Would you like me to send any information on the Elder Abuse and Neglect Program? If you need a little time to think this request over, call me back in a day or two. I would be most honored if you would accept our invitation.

#19 KNOWLEDGE, SKILLS AND ABILITIES REQUIRED FOR ALL MEMBERS:

COMMUNICATION SKILLS, ESPECIALLY ACTIVE LISTENING

PROBLEM ANALYSIS SKILLS

HUMAN RELATION SKILLS

GENUINE CARE AND INTEREST IN THE ELDERLY

ABILITY TO TAP COMMUNITY RESOURCES

COMMITMENT TO TEAM GOALS -- WILLINGNESS TO ATTEND FOR ONE YEAR, TO BE ON TIME AND TO MAINTAIN CONFIDENTIALITY

"TEAM PLAYER"

COMPETENT IN PROFESSION

WHERE POSSIBLE HAS A HISTORY OF SERVICE WITH PROVIDER AGENCY

SAMPLE WRITTEN MEMBER AGREEMENT

The goal of the multidisciplinary team (M-team) is to advise planning of comprehensive services to older persons who are abused or neglected, to coordinate with the service delivery system, and to work with the M-team members and other local agencies to provide and implement care plans for victims of abuse and neglect.

As a member of the multidisciplinary team I agree to:

1. Commit the time to fully participate.

2. Attend the required training developed for members.

3. Attend monthly M-team meetings for a period of one year, except where an unavoidable conflict occurs.

4. Learn as much as possible about the problem of elder abuse, neglect and exploitation and how to respond to its victims.

5. Provide my professional opinion and advice on how to proceed with the cases presented and attempt to find the answers to questions in my field of expertise.

6. Advise and assist in the development and implementation of procedures designed to integrate the efforts of the M-team and other local agencies.

7. To the extent possible, assist in educating my profession and the public about the problem of elder abuse and the Elder Abuse and Neglect Program.

8. Advocate for better alternatives for older persons in need of protective services.

9. Respect and maintain the confidentiality of all clients in the Elder Abuse and Neglect Program.

11. Not miss more than three consecutive meetings. If this happens due to circumstances beyond my control I understand I may be replaced as an M-team member.

12. I also understand that, if I represent an agency on the M-team, this agreement will become void if I no longer am associated with the agency at a future date.

Signature of M-team Member	Signature of Provider Agency Representative
Address	Effective Date

#20 JOB DESCRIPTIONS

MAJOR DUTIES AND RESPONSIBILITIES

INFORMATION AND RESOURCES

EDUCATION, EXPERIENCE AND TRAINING

KNOWLEDGE, SKILLS AND ABILITIES

JOB DESCRIPTION: LAW ENFORCEMENT

The Law Enforcement member of the Elder Abuse M-Team has primary responsibility for providing expertise, advice, and information to the M-team and Elder Abuse Case Workers regarding the law enforcement process, such as: what the police can do, releases needed, getting someone in the alleged victim's home, getting the abuser out of the house, rights of privacy, theft by the caretaker, etc.

Major Duties/Responsibilities:

* Advise Elder Abuse Case Workers on specific investigative techniques.

* Provide opinions and recommendations about what can be done from a law enforcement perspective.

* Interpret state, city, and county laws and identify those aspects of a case which may involve violation of civil and criminal laws.

* Investigate allegations of abuse, as necessary, and/or refer Elder Abuse Case Workers to the police department.

* Obtain involuntary commitments or criminal charges.

* Educate M-teams members and Elder Abuse Case Workers on law enforcement-related issues. Common examples include: definitions of legal terms and law enforcement terms, technical procedures involved in bringing criminal charges against someone, types of penalties for specific infractions of the law, and types of violations the State's Attorney will prosecute.

* Contact other members of the law enforcement community, as necessary, to obtain information needed by the Elder Abuse Case Worker investigating a case or to alert them to possible violations of the law occurring in their jurisdiction.

* Assist in the development and fulfillment of M-team policies, goals, and objectives, as necessary.

* Information Resources

  The Law Enforcement member of the M-team uses the following information and resources in carrying out his/her responsibilities:

  * M-team members and meeting documentation - minutes, summary case reports, relevant articles.

  * Elder Abuse Case Worker input on cases

  * State, city and county laws and ordinances

* State's Attorney's Office

* Police Department/Sheriff's Office

Education, Experience and Training Requirements

* Minimum of an associate's degree in criminal justice or another social science

* Five years law enforcement experience

* Experience with abuse or domestic violence cases and felony cases desirable.

Knowledge, Skills and Abilities

* Knowledge of criminal investigative techniques and how the criminal justice system works in the area served by the elder abuse provider agency.

* Knowledge of family dynamics

* Knowledge of patterns of substance and alcohol abuse

* Knowledge of basic principles of psychology and sociology

* Familiarity and rapport with high-ranked law enforcement officials in the areas served by the M-team.

JOB DESCRIPTION: MEDICAL

The Medical member of the Elder Abuse M-team has primary responsibility for providing expertise, advice, and information to the M-team members and Elder Abuse Case Workers regarding:

* Available resources and information (medical care, physicians, ways that different physicians treat patients, hospitals in the area, transportation services, etc.)

* Home health nursing services and limitations

* Involvement and limitations of the state and local health departments

* Medicare insurance coverage

* Medical aspects of substance abuse

* Medications and their effect on the victim's mental state.

Major Duties/Responsibilities:

* Review elder abuse case information provided by the M-team Coordinator (through minutes from the previous team meeting) focusing on medical-related issues, including:

  -how the victim's level of functioning may be contributing to the abuse
  -the victim's level of physical and mental functioning
  -information regarding the victim's medication, including identifying the purpose for medication and assessing the victim's physical state

* Assist in determining if the alleged victim should go into a nursing home by assessing the victim's ability to carry out daily life functions independently and if the victim's situation includes needed assistance.

* Assist in determining the level of mental functioning and/or possible substance abuse problems of alleged abuser and other persons who live in the home.

* Provide a visiting nurse view or home visit perspective.

* Educate others, as necessary, including sharing relevant, non-confidential information with colleagues and coworkers about elder abuse and the M-team and promoting public awareness of elder abuse.

* Follow-up on medical-related recommendations, as requested.

* Assist in the development and fulfillment of M-team policies, goals, and objectives, as necessary.

Information and Resources

* M-team members and meeting documentation: minutes, summary case reports, relevant articles.

* Elder Abuse Case Workers who present cases at meetings.

* Local visiting nurse association.

* Local physicians, hospitals, and nursing homes.

* State and local health departments/offices

Education, Experience and Training

The Medical M-team member could be either:

A Registered Nurse or Nurse Social Worker, with 5 years experience, preferably with some of it in home health care; or

A Physician with certification by the American Board of Family Practice and/or by the American Board of Internal Medicine, with at least two years experience in either field.

Knowledge, Skills and Abilities

* Medical terms, physical conditions, diseases and aging processes, treatment and diagnoses.

* A wide variety of drugs, their indications, contraindications, and effects of their interactions.

* The psychological status of patients and how it affects them medically.

* Medicare insurance coverage and limitations.

* Nursing homes within the community and available community resources (e.g. people that could transport the patient for medical care, licensed room and board facilities, physicians, hospitals).

JOB DESCRIPTION: LEGAL

The Legal member of the M-team has primary responsibility for providing legal counsel/expertise, advice, and information to M-team members and Elder Abuse Case Workers regarding the role that the abused or his/her family, as well as the Elder Abuse Case Worker, can take to resolve problems. One of the legal member's roles is to make a preliminary decision regarding behavior reaching criminal proportions. The Elder Abuse Case Worker would then be referred to the prosecuting attorney's office.

Typical legal advisory areas include: confidentiality and privacy issues (e.g., obtaining records from court systems and doctors); wills and estates; guardianship; financial power of attorney (estate, property, deeds, checks and bonds); health care power of attorney; substandard housing; relevant state and local legislation; and complaints of inadequate or inappropriate care.

Major Duties/Responsibilities

* Reviewing case notes and team minutes, paying special attention to any legal aspects or remedies which may apply.

* Advising the Elder Abuse Case Worker on steps involved in specific legal options and remedies to help resolve a case (e.g., setting up guardianships, obtaining protection orders, initiating civil and criminal actions against parties involved in cases.)

* Making presentations to the M-team, as requested, on topics such as guardianship, power of attorney, and domestic violence.

* Acting as a liaison to social service agencies, as necessary.

* Maintaining confidentiality of information presented.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* Internal legal memoranda keeping the member updated on current laws and statutes.

* Materials published by the State Bar Association.

* State and local rules, regulations and ordinances.

* Medicare and Medicaid administrative rules.

Education, Experience and Training

The Legal member of the M-team should be licensed to practice law in the state, and have a minimum of one year's experience as a practicing attorney with broad exposure especially in terms of issue spotting and experience working with various types of legal cases. Experience with the needs of the elderly and/or with domestic violence cases would be helpful, as would knowledge of public benefits, Medicare eligibility and programs. He or she should be a member of the State Bar Association, and of the local Bar Association for networking purposes.

Knowledge, Skills and Abilities

* Legal issues, case law, strategies, etc., involving clients who require substitute decision making (e.g., guardianships, trusts, etc.)

* Social and political environments of the agencies responsible for responding to reports of elder abuse and skills at applying this knowledge to develop appropriate legal strategies for each case.

* City housing guidelines, such as whom to contact, and what to do about substandard housing conditions.

* Local social service agencies.

JOB DESCRIPTION: CLERGY

The Clergy member of the Elder Abuse M-team has primary responsibility for providing input and advice from a pastoral perspective to M-team members and Elder Abuse Case Workers.

Major Duties/Responsibilities

* Participating in M-team discussions of cases, making comments and recommendations based on background and experience as a clergy person.

* Seeking services or support from the client's church, as required, including contacting the minister, pastor or priest.

* Assisting the team in promoting community awareness of elder abuse through writing articles, and making presentations to hospitals, schools, police departments, etc.

* Maintaining the confidentiality of information presented.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* Community churches and schools' staff, families, and students.

* Community newsletters and newspapers.

* Elder abuse legislation.

Education, Experience and Training

The recommended educational and experiential backgrounds of Clergy on the M-team include a minimum of a Bachelor's degree in theology, psychology, communications, or education, and ten years pastoral experience with at least three years experience working with the elderly. Less experience is acceptable if the person is enthusiastic about working with the elderly. A counseling background is helpful, as is an understanding of both psychology and geriatrics through educational courses or seminars.

Knowledge, Skills and Abilities

The Clergy member should be able to take an ecumenical point of view in analyzing cases and understanding that the pastor's role on the team is not to condemn or

convert. He or she should be able to listen to others and remain non-judgmental. The clergy representative should not hold religious beliefs that might encourage abuse or support the maintenance of an abusive situation. He or she should be able to independently analyze situations to let people choose what would be best for themselves -- be protective of the victim's freedom of choice. This person should be genuinely interested in serving the elderly community and able to relate well to elderly people.

Personality (care and concern) is more important than years of experiences. The clergy should have compassion and sensitivity for the victim, and the sentiment or drive to help case workers deal with thorny cases. He or she should be familiar with and able to tap community resources, and be open minded and accepting of the religious faiths of others.

JOB DESCRIPTION: FINANCIAL

The Financial member of the Elder Abuse M-team has primary responsibility for providing expertise, advice, and information to Elder Abuse Case Workers in their efforts to resolve their clients' financial problems and conflicts. This is done by providing information and/or services in the areas of: direct deposit of social security checks; prevention of fraud through pre-authorized charges to the account, e.g. utility bills, insurance payments,; authorization of financial institutions and insurance company payments to be paid directly from the account to prevent access to funds and ensure that payments are made; verification of transactions through microfilm checks and by identifying what is going on in the account; and trust services and guardianships.

Major Duties/Responsibilities

* Reviewing team meeting notes and minutes to become familiar with financial resource requirements.

* Analyzing the financial status and needs of the client, as necessary, and suggesting strategies that facilitate case resolution. Analysis considerations include the amount and sources of a client's income, relationships with banks and credit unions, indebtedness and financial history, people other than client who have legal access to client's bank accounts, social security checks, etc., and people in the household in charge of spending the money.

* Following-up on recommendations after team meetings and feeding back the results to Elder Abuse Care Workers, as required. For example, checking on banking problems brought up at the meeting.

* Educating Elder Abuse Case Workers and team members on banking issues, as necessary. This includes federal banking laws, meeting credit and housing needs in the community, how to handle checking accounts, how to get information, depositing checks in a timely manner and how to facilitate this.

* Contacting other members of the financial community, as necessary, to obtain information regarding the client.

* Maintaining the confidentiality of information presented.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* National Association of Banking

* Banking industry - local area bankers

* Federal Reserve system (FDIC)

* State Commissioner of Banks

* Federal and state banking laws.

Education, Experience and Training

* Five years experience in high-level bank positions as loan officer.

* Business Administration degree with a concentration in finance and two years banking or financial planning experience.

Knowledge, Skills and Abilities

In addition to educational and experiential backgrounds, the Financial M-team member should be involved in the financial community through board membership, committees, or network of firmly established relationships with influential members in the banking community. He or she should have a general knowledge of commercial loan area, and of the types of information banks can release with regard to confidentiality. This member should know about alternative sources of income available to the elderly clients and how to access these sources.

JOB DESCRIPTION: MENTAL HEALTH

The Mental Health member of the Elder Abuse M-team has primary responsibility for providing expertise, advice, and information to Elder Abuse Case Workers from a mental health perspective.

Major Duties and Responsibilities

* Reviewing case notes, updates, new case notes, and agenda received from the M-team Coordinator each month and examining each case for mental health diagnoses, such as severe depression or difficulties adjusting to stressors in the client's life.

* Identifying emotional problems and psychosocial issues involved in each case, focusing on both the abuser and the victim. It involves determining the client's needs based on family composition and structure, the history of family interactions, the client's willingness for services, strategies that have already been tried, and/or the need for certification of the victim or abuser as a danger to self or others. In this role, the client's rights to self-determination and the desire to keep the family intact are major considerations. This diagnostic role of the Mental Health team member also includes preliminary elder abuse diagnoses using established guidelines and evaluation criteria, and preliminary mental health diagnoses, based on information given, to help decide what is the problem.

* Providing advice and recommendations, such as: how to approach the abuser/victim; how they can be seen, and how to get them to agree to be seen while not jeopardizing the situation; available community resources and adjunct services to assist with case management and resolution.

* Sending copies of the patient's progress notes to members, (if relevant and with the client's permission).

* Assisting the M-team establish an educational program to address elder abuse in the community.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* DSM-IIIR (Publication of diagnoses, symptoms - American Psychiatric Association).

* Clients' physicians and family doctors.

* Local hospitals and mental health treatment facilities.

Education, Experience and Training

* Master's degree in Social Work, with certification as a Clinical Social Worker, with at least five years total experience, and two years experience working with the elderly and/or abuse cases.

* Registered Nurse with five years experience, with two in psychiatric work.

* State licensed therapist with an advanced degree in a mental health field and at least five years experience, with two years in working with the elderly and/or with abuse cases.

* Physician with experience in geriatric psychiatry and a member of the American Psychiatric Association.

Knowledge, Skills and Abilities

In order to perform effectively, the Mental Health representative should know about general case management, state mental health codes, and medications. This member must be able to make reasonably accurate diagnoses of mental health conditions and to determine when hospitalization is required. He or she must also have some feeling for which forms of therapy would be most appropriate for which type of disorder. He or she must know about the legal issues regarding protective services and self-determination, confidentiality, family dynamics and the ways in which dysfunctional families operate. This member must have knowledge of available community resources in a variety of areas (legal, medical, etc.).

#21 CONDUCTING M-TEAM MEETINGS

#22 SCHEDULING MEETINGS

* GET CONSENSUS FROM GROUP
* ASK PREFERENCE DURING RECRUITMENT
* EAPA MUST BE FLEXIBLE
* ATTEMPT TO ACCOMMODATE MEMBER WITH MOST RESTRICTIVE SCHEDULE
* SAME DAY AND TIME EACH MONTH
* OPTIONS:

    BREAKFAST

    LUNCH

    DINNER

    EVENING

#23 SELECTION OF CASES

* CHRONIC CASE
* ETHICS RE SELF-DETERMINATION
* TEACHING ISSUE FOR TEAM
* EASY CASE
* NEED SPECIALIZED EXPERTISE
* UPDATE
* FOLLOW-UP
* ACCESS DENIED
* VICTIM REFUSED SERVICES
* ABUSER REFUSED SERVICES
* CAREGIVER REFUSES SERVICES
* ENVIRONMENTAL PROBLEMS
* LIMITED NUMBER OF CASE WORKERS REQUIRED TO BE AT MEETING

WHY CASES ARE SELECTED

*	CHRONIC CASE	Case worker cannot think of any other direction to help resolve case.
*	ETHICS RE SELF-DETERMINATION	Case Worker faces ethical dilemmas re interventions that may conflict with self-determination
*	TEACHING ISSUE FOR TEAM	Case had interesting issues that will teach the team members more about elder abuse.
*	EASY CASE	Case has an easy solution and would give M-team feeling of success to prevent burn-out.
*	NEED SPECIALIZED EXPERTISE	Special skills or knowledge of particular M-team members are needed.
*	UPDATE	Current status of previously discussed case (information only, not discussion required).
*	FOLLOW-UP	Worker seeks follow-up discussion on previously discussed case.
*	ACCESS DENIED	Worker needs assistance gaining access to victim.
*	VICTIM REFUSED SERVICES	Victim refuses all interventions offered by case worker.
*	ABUSER REFUSED SERVICES	Abuser refuses all interventions offered by case worker.
*	CAREGIVER REFUSES SERVICES	Caregiver (who is not abuser) refuses all interventions offered.
*	ENVIRONMENTAL PROBLEMS	Victim has unmet needs for heat, water, housing or other environmental problems

#24 ADVANCE PREPARATION: M-TEAM COORDINATOR

* EXTREMELY IMPORTANT
* BEGIN PLANNING TWO TO THREE WEEKS AHEAD
* DECIDE TOPIC FOR EDUCATION (OPTIONAL)
* SELECT CASES TO DISCUSS WITH SUPERVISOR(S)
* MAIL REMINDER NOTICE, MINUTES OF PREVIOUS MEETING AND AGENDA ONE WEEK AHEAD
* PLAN REFRESHMENTS
* TELEPHONE TO REMIND ON DAY OF MEETING

#25 HAND-OUT MATERIALS AT MEETING

* INFORMATION RE EDUCATION TOPIC (WHERE APPLICABLE)
* CASE SUMMARIES
* TRAVEL REIMBURSEMENT FORMS
* SIGN-IN SHEET
* EXTRA AGENDAS AND MINUTES OF PREVIOUS MEETING

#26 WRITTEN CASE SUMMARIES

* BRIEF NARRATIVE
* DESCRIPTION OF ABUSE SITUATION
* SUMMARY OF CLIENT STATUS
    - ENVIRONMENTAL CONCERNS
    - MEDICAL CONCERNS
    - LEGAL CONCERNS
* INTERVENTIONS USED
* FORMAL & INFORMAL SUPPORT SYSTEMS IN PLACE
* WORKER'S QUESTIONS AND CONCERNS RE CASE

Client Number: 340-50-0981

Date of Presentation: 03-13-90

Case Worker: Rachel Stone

CASE SUMMARY: Mrs. S

A referral was made to the IDoA 800 Unit by Representative Mathis' office concerning Mrs. S, an 82 year old woman. The report stated that Mrs. S has been living with another lady, Mrs. R, sharing expenses. The client owns the home and has a building out back that she rents to the alleged abuser, who works as a case worker for the Illinois Department of Public Aid.

Recently, Mrs. S has changed doctors, lawyers, and insurance. It is suspected that the alleged abuser, Mr. ML (37 years old) has persuaded her to do this. Mr. ML has also had an eviction notice service on Mrs. R. Mrs. R has lived with Mrs. S for approximately 31 years.

When the initial investigation was conducted, the Case Worker found that Mrs. S was living in the back building that is rented out to Mr. ML. Mrs. S's reasoning for doing this was because she was afraid that Mrs. R was trying to put her into a nursing home or would poison her food. She stated that she no longer trusted Mrs. R.

Mrs. S did not make a mistake on the SPMSQ, she was very clear and responded well to several questions. She feels that Mr. ML is acting in her best interest and she would do anything to help him. When she came back from the hospital in November,1989, she signed a Power of Attorney so that Mr. ML could handle her finances. Mrs. S also has had Mrs. R's name taken off the checking account and Mr. ML's put on. Mrs. S cashed in her insurance policy and has Mr. ML's name put on the burial account.

The eviction notice for Mrs. R to leave the house went to trial last week. The case was continued and Mrs. R has asked for a jury trial. Since that time Mrs. R has changed the locks on doors and according to Mrs. S has moved five rooms of furniture out of the house.

Mrs. S states that when Mrs. R is evicted, she and Mr. ML will move back into the big house and he will continue to handle her finances and help her out.

Psycho/Social

Mrs. S is alert and oriented. She did not miss any questions on the SPMSQ. She does not appear to be afraid of the alleged abuser. No known history of mental illness.

Environmental

Mrs. S now lives in a small one story home with alleged abuser. Home is neat and clean, but small.

Medical

Mrs. S has a lower back injury which causes a great deal of pain and discomfort.

Medications: Propoxyphene

Formal/Informal Supports

Strong informal support. Mrs. S has someone from her church stay with her on a daily basis. The alleged abuser stays with her in the evenings and on the weekends.

QUESTIONS:

1. How much emphasis should be placed on Mrs. S's decision to involve the alleged abuser in finances and personal care?

2. Is it the consensus of the M-Team that we have the right abuser (Mr. ML)?

3. What would be some ways to establish credibility of both caregivers?

#27 CONDUCTING A MEETING: M-TEAM COORDINATOR

* SERVE REFRESHMENTS
* DISTRIBUTE HAND-OUTS
* CONVENE MEETING
* INTRODUCE EVERYONE IF NECESSARY
* INTRODUCE GUEST SPEAKER, IF APPLICABLE
* FACILITATE DISCUSSIONS:
    - -LET EVERYONE BE HEARD
    - -KEEP TO AGENDA
    - -PRIORITIZE USE OF TIME
    - -SUMMARIZE RECOMMENDATIONS
    - -ASSIST CASE WORKER IF NECESSARY

#28 SAMPLE AGENDA

* INTRODUCTIONS

* ANNOUNCEMENTS, GENERAL INFORMATION & THANK YOU'S

* EDUCATIONAL PRESENTATION (IF APPLICABLE)

* UPDATES ON EARLIER CASES (WRITTEN OR VERBAL)

* DISTRIBUTE NEW CASE SUMMARIES AND DISCUSS (20 TO 30 MINUTES EACH)

* DISCUSS NEXT MEETING DATE, TIME AND LOCATION

* ADJOURN

#29 PRESENTING A CASE -- ELDER ABUSE CASE WORKER

* UNDERSTAND M-TEAM'S ROLE

* KNOW CASE WELL:

  WHAT SHE/HE KNOWS AND DOES NOT KNOW ABOUT CASE

  WHAT QUESTIONS AND CONCERNS SHE/HE HAS

* PRESENT 2 TO 5 MINUTE VERBAL CASE SUMMARY

* AVOID PROVIDING TOO MUCH INFORMATION

* STATE CONCERNS AND FRUSTRATIONS

* LISTEN RESPECTIVELY TO ALL SUGGESTIONS

* FIGHT DEFENSIVENESS

* REMEMBER NOT EVERY RECOMMENDATION HAS TO BE USED

#30 JOB DESCRIPTIONS

* M-TEAM COORDINATOR

* ELDER ABUSE CASE WORKER

JOB DESCRIPTION: M-TEAM COORDINATOR

The M-team Coordinator has primary responsibility for planning, organizing, and facilitating the monthly M-team meetings. This includes notifying all members of any changes in the meeting schedule, preparing, reviewing and finalizing minutes and agenda for each meeting, summarizing cases to be discussed and finding relevant articles to be presented to the team. The Coordinator must ensure that all members receive the information needed for each meeting, which entails coordinating the mailing of information and materials. He or she must also set up the meeting room and facilitate team meetings.

Major Duties and Responsibilities

* Meeting with Elder Abuse Case Workers and Supervisors to determine which cases to present to the M-team and to prepare for presentations.

* Acting as liaison between M-team and Elder Abuse Case Workers. This entails soliciting feedback, informally, from both groups regarding reactions to team meeting process and outcomes.

* Planning for and organizing team meetings. This includes presenting progress reports on old cases and developing brief scenarios of new cases. It involves overseeing mailing of the meeting announcement letter and agenda prior to meeting, contacting members prior to the meeting to request presentations on a topic in their area of expertise, ensuring that there is a full agenda with an appropriate amount of information, and reviewing and finalizing minutes and agenda. It also involves obtaining copies of the minutes, and may also require taking minutes at the meeting.

* Following-up on recommendations from team members. This involves consulting with M-team members outside of meetings to obtain additional information and referral sources.

* Preparing monthly and quarterly reports regarding the M-team and cases reviewed.

* Meeting with the Executive Director of the elder abuse provider agency to review team issues, and with the agency bookkeeper to discuss financial issues related to team implementation.

Work Context

The amount of time required to complete duties and responsibilities per month varies considerably, based on such factors as:

-the presence of an Elder Abuse Case Worker interested in discussing a case, elder abuse case load, staffing and clerical assistance available from the agency. On a monthly basis, the M-team Coordinator's time is spent preparing materials/information (3 to 6 hours), in M-team and related meetings (3 to 6 hours), writing reports and following-up on recommendations (2 to 8 hours).

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers and case files.

* Agency staff and resources.

* State Department on Aging Elder Abuse and Neglect Program standards, reports and related information.

Education, Experience and Training

* Bachelor's degree in a human services field and two years experience working with the elderly and/or with abuse cases, and specific training in elder abuse, including the Department on Aging's Elder Abuse Case Worker Training and M-Team Training workshops.

* Crisis intervention, networking with other agencies, some administrative and supervisory experience and training in group facilitation helpful.

Knowledge, Skills and Abilities

* Must understand the legal issues and constraints of elder abuse case work, including some knowledge of guardianship and power of attorney.

* Must be familiar with community resources.

* Good oral and written communication skills, including active listening.

* Must understand group dynamics and be able to facilitate discussions.

* Must have good administrative, planning and organizing skills.

JOB DESCRIPTION: ELDER ABUSE CASE WORKER (SUMMARY)

The Elder Abuse Case Worker is primarily responsible for the initial intake and investigation, care planning and follow-up of elder abuse and neglect cases within a specified geographic region. The most important area of responsibility is the **home visit**, where the case worker meets with the victim and in many cases the abuser as well. The case worker's responsibilities include:

* Conducting a thorough assessment of each report of elder abuse, neglect or exploitation, including a face to face interview with the alleged victim, alleged abuser and other relevant persons to determine whether the reported abuse is substantiated.

* Building rapport with the victim and with persons who can help the victim in order gain support for accepting help.

* Development of an individualized care plan to address the victim's needs, which can include in-home services, social and environmental supports, medical interventions, legal interventions and other services. Identify community resources to provide services.

* Prepare and maintain complete documentation of the case.

* Follow-up on each case to ensure that the care plan is carried out successfully.

* Prepare for and attend monthly M-team meetings. With supervisor and/or M-team Coordinator, decide which cases should be presented for M-team consultation. Prepare summary of case and verbally present case to the team for their advice. Provide follow-up information on previous cases to M-team for their information.

#31 CONTENTS OF MINUTES

* DATE AND LOCATION OF MEETING

* PERSONS IN ATTENDANCE

* BRIEF SUMMARY OF EDUCATIONAL PRESENTATION (IF APPLICABLE)

* CASES DISCUSSED:

  -SUMMARY

  -SYSTEMS ISSUES IDENTIFIED

  -RECOMMENDATIONS MADE

  -DATE AND LOCATION OF NEXT MEETING

* SIGNATURE OF PERSON WHO PREPARED

MINUTES

M-TEAM MEETING

March 13, 1990

Those in attendance were:

Steve Schauwecker	Kathy McKinney
Mark Schloemann	Patsy Jensen
Dr. Robert Tiffin	Ken Yordy
Rev. Marlin Otte	Pam McCowen
Ron Swafford	Elana Floyd-Kennett
Jennifer Boyd-Cole	Don Wilkerson

The meeting was opened with the presentation of Jennifer Boyd-Cole's abuse case involving Mrs. S. Mrs. S is an 82 year female who lives in her own home and has another lady, Mrs. R, and Mrs. R's son living with her. They have lived together for the past 31 years, sharing living expenses. Mrs. S also owns a house out back of her home which she rents to Mr. ML who is the alleged abuser. Mrs. ML works for the Illinois Department of Public Aid.

When Mrs. R reported the case to Representative Richmond she stated that Mr. ML has persuaded Mrs. S to change doctors, lawyers, and insurances, along with having Mrs. R's name taken off of Mrs. S's bamk accounts and having his name placed on them. She also reported that while she (Mrs. R) and her son are away from the home Mr. ML is coming into the home and overmedicating Mrs. S. Mrs. R stated that Mr. ML uses very abusive language towards the church women and women in general, constantly calling them names. Mrs. R also stated that Mr. ML is trying to have Mrs. S added as one of his dependents for income tax purposes.

When the Case Manager made the investigation it was discovered that Mrs. S was living in the house behind her home with Mr. ML. Mrs. S had previously been in the hospital and before she entered the hospital she stated she heard Mrs. R and her son plotting to place her in a nursing home. Mrs. S stated that she was afraid to return home that they would either place her in an institution or possibly poison her. Once she returned to the house which she rents to Mr. ML she filed for the eviction of Mrs. R and her son.

While on good terms with Mrs. R, Mrs. S had a Quik Claim Deed drawn up leaving the house to Mrs. R upon her death.

Rev. Otte raised the question as to what happened to cause these two women to feud after 31 years of sharing the same household.

Jennifer stated that Mrs. R and Mrs. S had a good relationship up until Mrs. R wanted Mrs. S to start sharing in the bill paying. Mrs. R also did not want her son to have to pay any more rent for living in the apartment above Mrs. S's home.

Mrs. S stated she has known Mr. ML for over 15 years and that he is acting in her best interest. She stated that she did have her accounts changed to his name, and that he helped her arrange a pre-arranged burial plan with the funeral home. Mrs. S stated that she has had the same physician since 1987, and she still has the same attorney. Mrs S. believes that Mrs. R is the abusive person not Mr. ML. Ron Swafford questioned Mr. ML paying Mrs. S a years rent in one payment per year. Jennifer stated that is questionable.

Jennifer stated that Mr. ML was a teacher and lost his tenure. The reasons are unknown, and he has his name listed in the phone- book but spelled backwards! She also stated that Mr. ML plans to transfer to the Springfield DPA office and that he is planning on taking Mrs. S with him. Team members suggested that if this does happen that the CCU should be notified in Springfield so that they can keep an eye on the situation. Jennifer also stated that Mr. ML's co-worker are very skeptical of him.

The M-Team members questioned who is really the abuser. Ken stated that Mr. ML seems to be very knowledgeable and his record is fairly clean. As for Mrs. R, it is possible that she feels threatened by Mr. ML. He is trying to move in on her territory. Ken stated that Mrs. R now owns the house with Mrs. S having a life estate in the house. Steve Schauwecker explained that the term Life Estates means that Mrs. S has transferred ownership of the home over to Mrs. R but Mrs. S has the right to live there until she dies.

While meeting with the lawyers, Mrs. R stated that she and her son would leave the home within 30 days. When the meeting was about over, Mrs. R demanded a trial by jury. Mrs. R and her son have moved the all valuables out of the home, even things that belonged to Mrs. S.

Dr. Tiffin raised the question as to whether there is anyone involved who could be non-partial and serve as a mediator? Ken stated that there was no one but Shawnee Alliance for Seniors.

Mark Schloemann questioned as to whether the medications given to Mrs. S in the hospital could have caused all this paranoia? Dr. Tiffin suggested a full psychiatric evaluation be completed on Mrs. S.

Steve Schauwecker suggested that Mrs. S's life be simplified and Mr. ML, Mrs. R and her son be removed from the property.
Jennifer stated that with minimal assistance Mrs. S could be maintained at home by herself.

The Team members recommended that the Case Manager suggest to Mr. ML that he should have his name removed from the accounts, that this reflects negatively for him in the public light.

Patsy stated amongst all the confusion she feels that Shawnee Alliance for Seniors should stay involved. Ken stated that there is enough indication to keep the case open. Jennifer stated she will encourage Mrs. S to accept CCP services.

Mr. BS was the next case presented by Pam McCowen and Don Wilkerson. The case was reported to Shawnee Alliance for Seniors by Bi-County Health Department. The nurse reported that while hospitalized, Mr. BS's daughter had him sign papers and that she had him sign over his power of attorney for his brother (Mr. CS) to her so that she could handle his affairs. Mr. BS is a 73 year old male who lives with his 2nd wife Mrs. BS. It is apparent that the daughters do not like the new Mrs. BS.

At the time of the investigation it was found that Mr. BS was not competent to make decisions. Mr. BS was satisfied with the signing over the power of attorney for his brother to his daughter, but was not satisfied with the signing over of his home. He feared that when he passed away his daughter would cause a great deal of problems for Mrs. BS. Mr. BS called the Case Manager in December and at that time seemed to be of sound mind, and he expressed concerns for the property and caregiver. Mr. BS was referred to SIU Legal Clinic and SIU Legal has had a difficult time determining competency due to occasional confusion.

Mr. BS had a quik claim deed drawn up and signed over the property to two of his daughters. One daughter had moved into the home forcing him to move into Mrs. BS's trailer which is located on a parcel of land which Mr. BS deeded over to another daughter. The other daughter which owns this land, but whose name is not on the quik claim, is threatening eviction of the trailer. At that time the Case Manager and Protective Service Supervisor went to the home to confront the daughters and explain elder rights. Since that time the daughter who was living in the home has moved to South Carolina taking several items belonging to Mr. BS and his late wife (the 1st Mrs. BS). Ken stated that he happened to be there the night they were moving and was able to keep some of the items there.

Ken stated that Mr. BS originally signed over the house to the daughters in 1977. In 1985 the daughters gave the house back to him and then once again he signed over the house to them retaining life estate. Don stated that Mr. BS wants to move back into the house but the daughters do not want him there and that they are threatening to cut off the utilities. Dr. Tiffin stated that they cannot legally tamper with public utilities.

Ken stated that Social Security is requesting a Representative Payee be appointed for Mrs. W and her retarded son and that Social Security wants to cut the disabled daughter-in-law's disability if they are getting all of this extra income.

Elana stated that Mrs. W and retarded son are receiving the basics and that they deserve more than this especially with their income. Dr. Tiffin stated that it is quite possible that even if there was food in the home, Mrs. W probably would not be able to fix the food.

Ken suggested CCP services and allow the son to be appointed Representative Payee this way he could get a monthly accountability of all finances. Patsy stated that the family has not done anything for the two so far and that they probably will not do any more for them. Dr. Tiffin stated that the family has done a few things he has suggested. Patsy gave the go-ahead for representative payee.

Rev. Otte suggested nursing home placement. Elana stated that with proper care Mrs. W can be maintained at home.

Ken stated that the conversation with the alleged abusers was a very good one but he felt that the son's temper could erupt easily like he was on the edge all the time. Ken stated that the other family members do not want to get involved because of the sons temper problem.

Elana stated that Mrs. W is not aware of what is going on and that she does not even know she is a victim.

Mark Schloemann questioned as to how the son was when he was at the workshop and he suggested a release of information so that the Case Manager can talk with the workshop about the son. Maybe this could give a little more insight on the situation.

#32 TRAINING M-TEAM MEMBERS

ORIENTATION -- FIRST TWO MEETINGS

SUGGESTED PRESENTERS

ELDER ABUSE PROVIDER STAFF

AREA AGENCY STAFF FOR AGING NETWORK DESCRIPTION

USE A VARIETY OF PRESENTERS AND VISUAL AIDS!

PREPARE PACKETS WITH:

-AGENCY BROCHURES

-AGING NETWORK INFORMATION

-M-TEAM MEMBER HANDBOOK

-LIST OF M-TEAM MEMBERS

#33 SAMPLE ORIENTATION AGENDA

ORIENTATION -- FIRST MEETING

- INTRODUCTIONS
- OVERVIEW OF AGING NETWORK
  - WHAT SERVICES ARE AVAILABLE
  - IDOA -- AAA -- EAPA
  - HOW YOUR AGENCY FITS IN

#34 FIRST ORIENTATION MEETING CONTINUED

- OVERVIEW OF YOUR AGENCY
  - HISTORY
  - MISSION
  - SERVICES
  - STAFF

#35 ORIENTATION -- FIRST MEETING CONTINUED

ELDER ABUSE INFORMATION

VIDEO -- *A SAFER PLACE*

DESCRIPTION OF ELDER ABUSE PROGRAM

GUIDING PRINCIPLES OF PROGRAM

TYPES OF ABUSE

CHARACTERISTICS OF VICTIMS

POSSIBLE INTERVENTIONS

#36. ORIENTATION -- SECOND MEETING

VIDEO -- *MULTI-DISCIPLINARY TEAMS: ALTERNATIVES TO ELDER ABUSE*

M-TEAM GOALS

CONSULTATION ON COMPLEX CASES

SOUNDING BOARD FOR WORKERS

DIFFERENT PERSPECTIVES ON PROBLEMS

NETWORK BUILDING AMONG PEERS

#37 ORIENTATION -- SECOND MEETING CONTINUED

M-TEAM RESPONSIBILITIES AND PROCESS

ATTENDANCE

CONFIDENTIALITY

TYPES OF CASES

MEETING DATES, TIMES & LOCATIONS

#38 INVOLVE ELDER ABUSE CASE WORKERS IN ORIENTATION!

#39 TRAINING NEW M-TEAM MEMBERS AFTER GROUP IS FORMED IS DONE INDIVIDUALLY

#40 BRING NEW CASEWORKERS TO AN M-TEAM MEETING BEFORE THEY HAVE TO PRESENT A CASE AS PART OF THEIR ORIENTATION

#41 USE OF SUBSTITUTES

TEMPORARY/SHORT TERM ONLY

HAS PRO'S AND CONS

SUBSTITUTE MUST BE PRIOR APPROVED BY COORDINATOR

SUBSTITUTE MUST AGREE TO CONFIDENTIALITY

AVOID ROUTINE USE

ELDER ABUSE

AWARENESS

The Illinois Department on Aging

Elder Abuse and Neglect Program

Multidisciplinary Team Member Handbook

CONTENTS

INTRODUCTION

The use of Multi-disciplinary Teams (M-Teams) to assist elder abuse provider agencies in addressing issues related to victims of abuse is fairly new; although, M-Teams are often used in child abuse cases and in the medical setting. The Illinois Department on Aging received an Administration on Aging Discretionary Grant in 1988 to test the use of M-Teams in elder abuse. The grant will discontinue on July 31, 1990.

This two year research grant compared and contrasted the use of paid versus voluntary M-Teams in urban and rural settings. Two urban and two rural elder abuse agencies developed M-Teams that were monitored and evaluated for the two year period. One urban and one rural agency paid their members while the other two agencies used voluntary teams. During the research period, information was gathered from telephone interviews, site visits, and M-Team minutes that described how teams were organized, solved problems, filled service gaps, and supported the elder abuse provider agencies in assisting victims of elder abuse, neglect, and exploitation. The collected information enabled the Department to examine the differences among sites in the length of time cases stayed open, the outcomes of the service planning, turnover of the team members, costs and benefits of using M-Teams, and satisfaction of team members.

Although the research grant has yet to be completed and the final results of the project continue to be tabulated, the Department and the agencies participating in the grant have long recognized the benefits of the M-Team approach. Some of the lessons learned from the grant include:

- team members feel committed
- advice and support is valuable to case workers
- networking benefits notable and public awareness enhanced
- possible for one team to serve a multi-county area
- payment of members appears irrelevant
- case solutions not always immediate

The handbook has been developed with input and insight from the participating agencies in the grant and represents what has been learned over the past two years on utilizing M-Teams effectively in addressing elder abuse. The purpose of this handbook is to familiarize volunteer professionals who agree to serve on an Elder Abuse Multi-disciplinary Team with:

- the goals and purposes of M-teams
- the responsibilities of M-team members
- the Illinois Department on Aging's Elder Abuse and Neglect Program
- information about elder abuse, its victims and perpetrators
- the range of services available to elder abuse victims
- strategies for successful elder abuse intervention
- the Elder Abuse and Neglect Act

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May 18, 1990

IMAGES OF ABUSE

An anonymous report was made about two elderly sisters living together in a one room flat. The case worker made a visit to the apartment and found Susan, one of the sisters, laying on the floor, incoherent. The other sister, Marian, who was the primary caregiver, stated that nothing was wrong. The case worker contacted a physician who made a home visit and examined Susan. Susan was immediately admitted to the hospital and had to be quarantined because maggots were found all over her body as well as four types of vermin. Susan was also extremely malnourished and dehydrated because she had diarrhea continuously. Marian was tired of caring for her sister and no longer would clean up her messes. Upon release from the hospital, Susan wished to return to her apartment and live with her sister. The case worker arranged for respite care, in-home services, and is making periodic visits to the apartment to assure the neglect does not occur again.

Frances, age 67, suffered from chronic renal dysfunction, hypertension, glaucoma, and arthritis. Frances could ambulate only short distances primarily using a wheelchair for mobility; yet, was able to attend Adult Day Care. Frances lived with her daughter, Janice, in a rented house. All of Frances' income which was managed by her daughter and used for the family's rent and other bills. Janice left her mother alone for a brief visit out of state. At this time, Frances finally expressed her concern at the Adult Day Care center. She had very little food left in the house and no money until her next social security check arrived. She began receiving wt-off notices from the utilities, learning her daughter had not been paying bills for months. Her water had just been shut off the day before. The elder abuse agency arranged to have the water turned back on and provided food from a local food pantry. The daughter returned to the house only long enough to gather her belongings and tell her mother she was getting married and moving out of state. The elder abuse agency relocated Frances to a boarding home where housekeeping and meals were provided. She continued her attendance at Adult Day Care. When her social security check was direct deposited at the bank a few days later, Frances' case worker took her to the bank to withdraw money for her housing, only to learn the daughter had withdrawn all but $5.00 from the joint account before she left the state. Early Intervention Service funds were used to pay for Frances' first month's rent.

A nun contacted the local elder abuse agency late one evening concerning Martha, 87, who was living with her grandson, Charles. The home was very dirty and rat infested, with broken windows, spoiled food, garbage, and newspapers stacked throughout the house. The reporter stated that Charles had kicked and hit Martha, had thrown out Martha's medication, and in the past, had taken her Social Security check. The elder abuse staff immediately arranged for emergency housing at a local domestic violence shelter and were able to replace the needed insulin and medications using Early Intervention Service funds. While in the shelter, home delivered meals and home health services were provided. When the case worker met with Martha she was weak and disoriented, her clothes were dirty, and she had no shoes. Martha was obviously afraid of her grandson, who stated he was coming back to kill her, but was also worried about him. The case worker was able to reach a granddaughter who agreed to become Martha's guardian. Martha is now living with her granddaughter in another town, receiving in-home services, and appears to be adjusting well. Charles is receiving therapy from a mental health agency.

MULTI-DISCIPLINARY TEAM INFORMATION

▸ Goals and Purposes of M-Teams

A Multi-disciplinary Team is a group of selected professionals from a variety of disciplines who meet monthly to discuss and provide consultation on specific cases of elder abuse, neglect or exploitation. The purpose is to use the varied backgrounds, training and philosophies of the different professions to explore the best service plan for the cases involved.

The Illinois Department on Aging funds an Elder Abuse Provider Agency in each geographic area to receive and respond to reports of elder abuse, neglect and exploitation. Each provider agency, with a few exceptions, is responsible for creating and supporting a multi-disciplinary team. The specific goals are to improve each Elder Abuse Provider Agency's response to its elder abuse and neglect clients by:

- Providing consultations on complex cases
- Acting as a sounding board for case workers
- Providing different perspectives on problems
- Improving networking among peers within each professional group

Studies have shown that decisions made by groups are more effective than those made by individuals when no one person has the solution, but each person can contribute to a solution. Elder abuse cases often include highly functionally impaired victims, more than one type of abuse or neglect, and complex family dynamics. Given the complexity of these cases, and the fact that there are often gaps in the services needed to assist victims, a broad range of professionals looking at a case and planning possible interventions is more likely to arrive at effective results.

M-teams provide many benefits, including:

- Support and validation for case workers
- Increased knowledge of community resources
- Wider range of alternative solutions to consider
- Better coordination of interagency efforts
- Networking and "door opening" among professional groups.

▸ M-Team Membership

The following professionals are represented on M-teams in Illinois:

Law Enforcement: The law enforcement member provides expertise and information the to the M-team and Elder Abuse Case Workers regarding the law enforcement process, such as what the police can do, getting into an alleged victim's home, removing the abuser from the home, theft by a caretaker, etc.

Medical: The medical M-team member (a nurse or physician) provides advice and information regarding such things as available medical resources, home health services and their limitations, Medicare and Medicaid, and the effects of medications.

Legal: The attorney on the M-team offers legal advice and information on issues such as confidentiality and privacy; wills and estates; guardianship; power of attorney, when acts are criminal in nature; and relevant statutes and regulations.

Clergy: The clergy representative on the M-team gives advice from a pastoral

perspective and may seek services or support from the client's church, as required.

Financial: The M-team financial expert, generally a banker, provides information regarding direct deposit of income checks; prevention of fraud through pre-authorized charges to bank accounts; verification of transactions through microfilm, etc., and trust services and guardianships.

Mental Health: The mental health professional on the M-team, either a social worker or psychiatric nurse, offers expertise in case management, mental health diagnoses and state codes, forms of therapy and medications.

Detailed job descriptions for each of these positions can be found in Appendix B of this handbook.

Each M-team member should be genuinely interested in working on behalf of the elderly, have good communication and problem solving skills, be tolerant of different attitudes and perspectives, be competent in his or her profession, and be able to access community resources. In addition, the member must be able to commit to meet for one to two hours each month for a period of at least a year, and to prepare for and follow-up on meetings as required.

▸ M-Team Process

M-teams meet once a month for one to two hours. The date, time and location of the meeting are determined by each local group according to their own schedules and convenience. The minimum number of yearly meetings to be held is ten, which accommodates vacation and holiday schedules.

The Elder Abuse Provider Agency appoints a M-team Coordinator to carry out the following responsibilities:

- Recruit and train M-team members
- Work with Elder Abuse Case Workers on case selection and presentation
- Facilitate M-team meetings
- Arrange for meeting minutes to be taken
- Send meeting notices, agenda and previous minutes to members before each meeting.
- Provide updates on previously selected cases.

Brief written and verbal summaries of new cases to be discussed are presented to the team by the Elder Abuse Case Worker assigned to the case. Each new case is discussed for a period of 20 to 30 minutes. At the end of each discussion the Coordinator summarizes the recommendations made.

M-team members may be asked to follow-up on issues raised during the discussion, and to report back either to the team at its next meeting or to the Coordinator or Case Worker in the interim. In addition, members may be asked to make brief educational presentations to the team on matters in which they have expertise. M-team members may also have the opportunity to make educational presentations on elder abuse to their own professional groups or civic organizations. The extent to which members get involved in such community education activities varies from team to team and among members on a team.

Upon occasion the M-team may have a guest speaker to provide information on relevant issues. Also, the Coordinator may sometimes ask another professional to attend a meeting to discuss a specific case.

The Coordinator also provides updates on previous cases in order for the team to know the outcome of the interventions and the success of the recommendations made.

▸ Immunity

The Elder Abuse and Neglect Act (Public Act 85 - 1184), provides immunity from civil or criminal liability to any person, institution or agency who in good faith makes a report or assessment of elder abuse, neglect or exploitation or who takes photographs or x-rays in connection with an assessment. In addition, the act also provides immunity to any appropriate provider of services who consults with the elder abuse provider agency in the development of a service care plan for a victim of substantiated abuse. Thus M-team members who provide consultations on cases are immune from liability. To insure protection under this provision the M-team member should have a signed written agreement in effect with the provider agency.

▸ Confidentiality

Each M-team member must commit to keeping the discussions of specific elder abuse and neglect cases confidential. Although members will not be given client names, the identity of some clients may become evident, especially in less populated areas. Because elder abuse and neglect is so personal and sensitive in nature, clients must have total confidence that the details of their lives will not be made known in the community if the program is to be successful in preventing further abuse.

ELDER ABUSE AND NEGLECT PROGRAM

▶ Elder Abuse and Neglect Program

On October 1, 1989, Suburban Cook (PSA 13) and eight surrounding counties (PSA 02), along with nine northwestern (PSA 01) and 13 southern Illinois counties (PSA 11), began implementing the first phase of the Department on Aging's statewide Elder Abuse and Neglect Program. The City of Chicago began providing services under the program on February 1, 1990. The implementation of the Elder Abuse and Neglect Program is the culmination of years of work on the part of the Department and other aging advocacy and provider organizations to establish a program and obtain funding to assist a very vulnerable group of older persons.

The Elder Abuse and Neglect Act (Public Law 85-1184) was signed into law by Governor Thompson in August, 1988. The legislation was based on recommendations made by the Department on Aging as a result of administering four pilot projects for a three year period under the Elder Abuse Demonstration Program Act. The Elder Abuse and Neglect Act directs the Department on Aging to establish an intervention program to respond to reports of alleged elder abuse, neglect, and exploitation (ANE) and to work with the older person in resolving the abusive situation. The Act also provides immunity for persons who report ANE and to case workers who respond to those reports from civil and criminal prosecution as long as they act in "good faith".

▶ Defining Elder Abuse

Physical Abuse means causing the infliction of physical pain or injury to an older person.

Sexual Abuse means touching, fondling, or any other sexual activity with an older person when the older person is unable to understand, unwilling to consent, threatened, or physically forced to engage in sexual behavior.

Emotional Abuse means verbal assaults, threats of abuse, harrassment, or intimidation so as to compel the older person to engage in conduct from which s/he has a right to abstain or to refrain from conduct which the older person has a right to engage.

Confinement means restraining or isolating an older person for other than medical reasons.

Passive Neglect means the failure by a caregiver to provide an older person with the necessities of life including, but not limited to, food, clothing, shelter, or medical care, because of failure to understand the older person's needs, lack of awareness of services to help meet needs, or a lack of capacity to care for the older person.

Willful Deprivation means willfully denying an older person who requires medication, medical care, shelter, food, therapeutic device, or other physical assistance, and thereby exposing that person to the risk of physical, mental, or emotional harm; except with regard to medical care or treatment when the dependent person has expressed an intent to forego such medical care or treatment.

Financial Exploitation means the misuse or withholding of an older person's resources by another to the disadvantage of the elderly person and/or the profit or advantage of a person other than the older person.

▶ Services Offered

The Elder Abuse and Neglect Program provides the following services to victims of abuse, neglect, and exploitation.

Intake of Reports. A screening process to determine if there is reasonable cause to suspect that elder abuse, neglect, or exploitation has occurred and the urgency of the report.

Assessment. A systematic, standardized system to respond to reports of abuse, neglect, and/or exploitation for the purpose of determining whether abuse has occurred, the degree of risk to the older person of further harm, and if the need exists for immediate interventions.

Case Work. Intensive case work activities on substantiated cases of ANE. Case work would include working with the older person on the development and implementation of a care plan for the purpose of stabilizing the abusive situation and reducing risk of further harm to the older person. The care plan could include legal, medical, social service and/or other assistance needed.

Follow-Up. Because abuse, neglect, and exploitation is sometimes a recurring problem even after intervention, a systematic method of follow-up on substantiated cases is essential to this program. Follow-up may be effective in preventing further abuse by working with the older person in detecting recurring signs of abuse before the situation becomes life-threatening.

Early Intervention Services. While an array of services are usually available in communities, often older persons who are victims of abuse face unique barriers which prevent access to available resources. Early Intervention Services are available for short term and/or emergency services where resources are not available for the victim. These services include: legal assistance, housing and relocation assistance, respite care, and emergency aid (i.e. food, clothing, medical care).

There are two additional components of the Elder Abuse and Neglect Program that provide support to the program's service delivery activities:

Multi-Disciplinary Teams. A Multi-Disciplinary Team allows representatives from the legal (law enforcement, attorney), clergy, mental health, medical, banking, and social work fields to be involved with the elder abuse provider agency. A M-Team acts as a support system for provider agency staff by providing for case conferencing to occur on the most difficult cases. (To be implemented in FY 1991.)

Public Awareness/Education. Public awareness and education focused on prevention efforts and identification of abuse, neglect, and exploitation. In addition to general public awareness through posters, brochures, and public service announcements, education efforts will focus on those professional groups most likely to come into contact with victims of abuse.

▶ Basic Principles of Illinois' Program

Voluntary Reporting. Illinois is one of the States to adopt a voluntary reporting law to report suspicions of elder abuse, neglect or exploitation. The law does encourage persons to report and provides immunity from liability for making such a report in good faith; however, it does not mandate the reporting by specific groups such as health care providers or social workers. Voluntary reporting was selected because Illinois' experience in testing reporting models has shown that voluntary reporting will achieve the goals envisioned by the proponents of mandatory reporting without the unnecessary intrusion on an older person's right to self determination.

Self Determination. The concept of self determination adopted by the State of Illinois includes certain civil rights to which

competent adults are entitled. These rights do not change by virtue of aging. Competent older persons have the right to:

- Decide where and how they will live.
- Choose whether to accept social services or other community assistance.
- Make decisions different from those society would make, including "bad" decisions which are not harmful to others.

There are times, however, when a disabled older person is incapable of protecting himself, and under the law, has the right to have protective measures taken in his behalf. Protective measures are contained in the Mental Health Code and the Probate Act.

Intervention Principles. The principles below have been written in support of an older person's right to self determination.

- Involve the older person in the development of the intervention/care plan. Take the time to explain the range of legal, medical, and social service options to the older person, beginning with the least restrictive alternatives in treatment and placement so that the older person can exercise his or her maximum decision-making ability for his or her competence.
- Intervene with the family unit support system whenever possible. Most abused older persons live with a family member or receive some form of care from the family.
- Recommend community based services rather than institutional placement, whenever possible. Institutions are considered a very restrictive environment. Often an older person fears placement more than abuse. The older person may refuse services if placement is the only option presented.
- Be direct in discussing the situation and alternatives, but avoid placing blame. Assigning blame can be dysfunctional and reduce the chances of stopping abuse.
- Respect the older person's right to confidentiality. Information about the older person's affairs should only be shared as authorized by the older person or guardian and as it pertains to obtaining assistance and guidance.
- Recognize that inadequate or inappropriate intervention may be worse than none at all. Assistance that over-promises may be rejected by the older person and the abuser. Inadequate or inappropriate intervention may greatly increase the risk to the victim.
- The older person's interests are to be the first concern of the program. The older person comes before his or her family or members of the community. The older person's safety is also the foremost concern when he or she is unable to decide or act on his or her own behalf.

SUMMARY OF ELDER ABUSE OCCURRENCES

▶ Types of Abuse and Neglect Reported

General Categories. During the first six months of the funded program there were 603 reports of elder abuse, neglect, and exploitation. The total compares with 221 reports made in the participating service areas during the same period of time in FY 1989. This represents a 172% increase in the total number of reports received.

Financial exploitation was reported most frequently (43% of the reports) and is highly associated with emotional abuse (40% of the reports), followed by passive neglect (37%), physical abuse (28%), willful deprivation (10%), confinement (6%), and sexual abuse (1%). As Figure 2 illustrates, there is generally more than one type of abuse suspected.

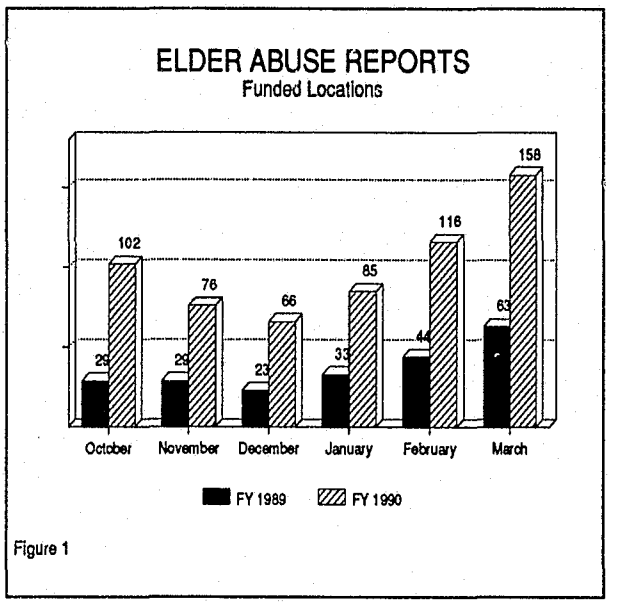


Figure 1

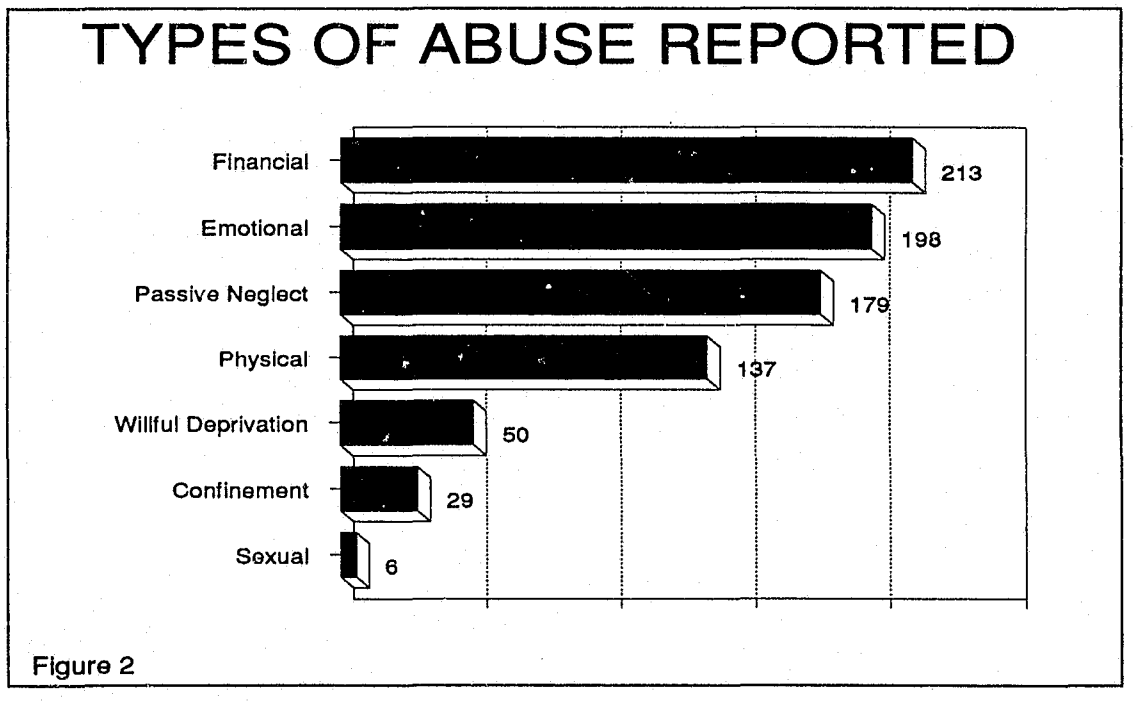


Figure 2

Receipt of Reports

Reports of elder abuse, neglect, and exploitation are received at the local elder abuse provider agency or by calling the Department on Aging's toll-free 800 number. Upon receipt of a report, the elder abuse provider agency will initiate an assessment by conducting a face-to-face visit with the older person within a specified period of time. The timeframe for initiating an assessment is determined by the nature of allegations made by the reporter. An assessment is initiated within twenty-four hours on a **priority one** report, where the most serious allegations such as sexual abuse or severe physical abuse have been made. A **priority two** report is investigated within seventy-two hours and the provider agency is required to conduct the initial face-to-face visit with the alleged victim within seven days of receiving a **priority three** report. A priority one status has been assigned to 15% of the reports received since October 1, 41% have been priority two reports, and 44% have been categorized as priority three (see Figure 3).

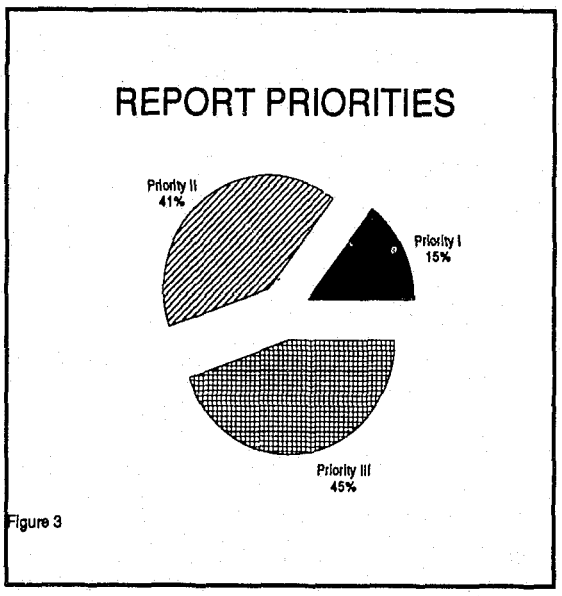


Figure 3

Figure 4 shows the sources of the reports received during the first six months of the Elder Abuse and Neglect Program. Agency representatives such as medical personnel and social workers have been the primary sources of reports. The alleged victim contacted the program in 13% of the reports received.

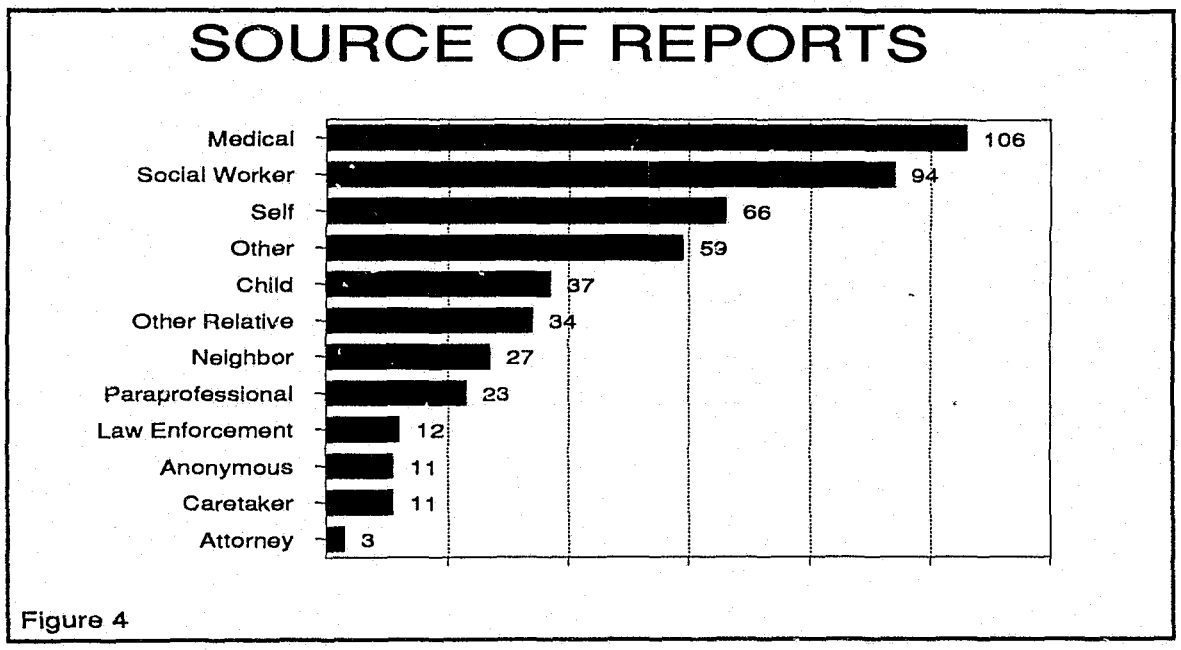
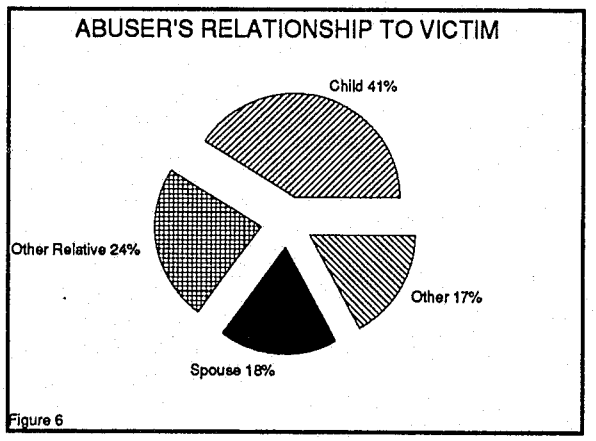


Figure 4

▶ Victim and Abuser Characteristics

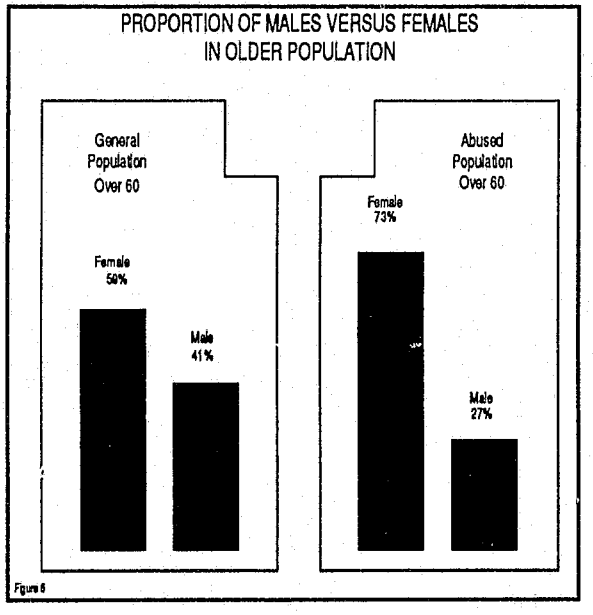
The alleged victims were older persons between 60 and 102 years of age. The average age of the alleged victims has been 76 years old. About three-fourths of the victims were female although women represent only 59% of the general population over sixty (Figure 5).

Figure 6 illustrates that elder abuse is clearly a family problem. Over 83% of the abusers were either the spouse (18%), child (41%), or other relative (24%) of the victim. The abusers are as likely to be a male (54%) as female (46%).



▶ Status of Reports Received

Every report of abuse, neglect, and exploitation is assessed and within thirty days the elder abuse provider agency is required to make a decision about the report. There are three classifications that may be assigned to a report: 1) **substantiated** means that one or more of the alleged types of abuse, neglect, or financial exploitation had occurred; 2) an **unsubstantiated** report means all the alleged abusers were determined to lack credible evidence that indicated abuse, neglect, or exploitation; and 3) **unable to substantiate** means the elder abuse provider agency was unable to locate the victim, was unable to access the victim, or the agency had no jurisdiction over the report. "No jurisdiction" classifications would occur when the alleged victim was under sixty and/or when the alleged victim resides in a long term care facility or state operated facility. "No jurisdiction" reports are referred to the appropriate agency for response. The overall substantiation rate is approximately 80%, meaning some type of abuse was found in the vast majority of reports received by the program. Only 16% of the reports were unsubstantiated and 4% of the time the elder abuse provider agency was unable to substantiate the report.



Of the reports substantiated, 89% of the time the victim was able to stay in the community and consented to work with the elder abuse provider agency in finding interventions to stop the abuse from recurring. In only 6% of the substantiated reports, the victim refused further assistance of the elder abuse provider agency. The victim entered a long term

care facility in 5% of the cases, the victim moved out of the area 1% of the time, and the victim was deceased in only 2 substantiated cases to date.

For every substantiated report of abuse, the elder abuse provider agency evaluates the potential risk of the older person from further harm or injury. A risk assessment is made every three months as long as the victim is a client of the program. This assessment of risk level enables the elder abuse provider agency to develop an individualized care plan based on the functional abilities of the victim, the relationship between the victim and abuser, the abuser characteristics, and the type of abuse, neglect, or exploitation substantiated. Figure 7 depicts the assigned level of risk of victims within thirty days after the report of abuse and the initial response by the elder abuse provider agency was made. **Low Risk** means, in the judgement of the elder abuse provider agency, the situation is not likely to recur or to escalate in severity. **Medium risk** means there is some possibility that the situation will continue and possibly escalate. **High risk** means that it is very likely the abusive situation will continue and probably escalate in the future.

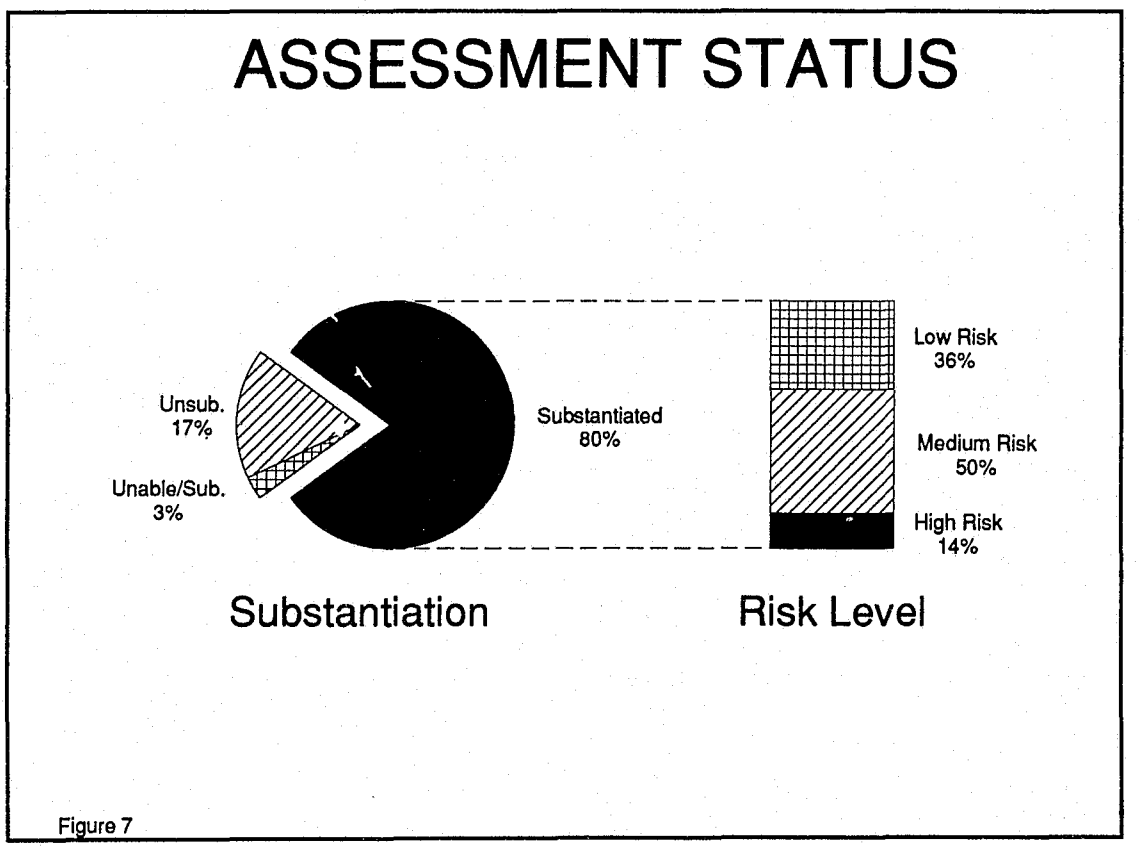


Figure 7

INDICATORS OF ABUSE, NEGLECT, AND EXPLOITATION

The following indicators do not signify abuse, neglect, or exploitation per se. They can be clues however, and thus helpful in assessing the client's situation.

▸ Physical Indicators

. Injury that has not been cared for properly

. Any injury incompatible with history

. Pain on touching

. Cuts, lacerations, puncture wounds

. Bruises, welts, discoloration:
- Bilaterally on upper arms
- Clustered on trunk, but may be evident over area of the body
- Morphologically similar to an object
- Presence of old and new bruises at the same time

. Dehydration and/or malnourishment without illness-related cause; loss of weight

. Pallor

. Sunken eyes, cheeks

. Evidence of inadequate care (e.g., gross decubiti without adequate medical care)

. Evidence of inadequate or inappropriate administration of medication

. Eye problems, retinal detachment

. Poor skin hygiene

. Absence of hair and/or hemorrhaging below scalp

. Soiled clothing or bed

. Burns: may be caused by cigarettes, caustics, acids, friction from ropes or chains, from confinement, or contact with other objects.

. Signs of confinement (tied to furniture, bathroom fixtures, locked in a room)

. Lack of bandages on injuries or stitches when indicated, or evidence of unset bones.

Injuries are sometimes hidden under the breasts or on other areas of the body normally covered by clothing. Repeated skin or other bodily injuries should be noted and careful attention paid to their location and treatment. Frequent use of the emergency room, and/or hospital or heath care "shopping" may also indicate physical abuse. The lack of necessary appliances such as walkers, canes, bedside commodes; lack of necessities such as heat, food, water, and unsafe conditions in the home (no railings on stairs, etc.,) may indicate abuse or neglect.

▸ Behavioral Indicators

These behaviors in themselves, of course, do not indicate abuse or neglect. However, they may be clues to the worker to ask more questions and look beyond the obvious.

. Fear

. Withdrawal

. Depression

. Helplessness

. Resignation

. Hesitation to talk openly

. Implausible stories

- Confusion or disorientation
- Ambivalence/contradictory statements not due to mental dysfunction
- Anger
- Denial
- Nonresponsiveness
- Agitation, anxiety

▸ Indicators From the Family/Caregiver

- The older client may not be given the opportunity to speak for him or herself, or to see others without the presence of the caregiver (suspected abuser)
- Obvious absence of assistance, attitudes of indifference, or anger toward the dependent person
- Family member or caregiver "blames" the client (e.g., accusation that incontinence is a deliberate act)
- Aggressive behavior (threats, insults, harassment)
- Previous history of abuse to others
- Problems with alcohol or drugs
- Social isolation of family, or isolation or restriction of activity of the older adult within the family unit
- Conflicting accounts of incidents by the family, supporters, victim
- Unwillingness or reluctance to comply with service providers in planning for care and implementation
- Withholding of security and affection

▸ Possible Indicators of Financial Exploitation

This list is not intended to be exhaustive. Likewise, the reader is cautioned to fully evaluate a situation before coming to the conclusion that there is financial exploitation. This list is intended to convey POSSIBLE exploitation.

- Unusual activity in bank accounts
- Activity in bank accounts that is inappropriate to the older person, i.e., withdrawals from automated banking machines when the person cannot walk or get to the bank
- Power of attorney given when person is unable to comprehend the financial situation, and in reality is unable to give a valid power of attorney
- Unusual interest in the amount of money being expended for the care of the older person, concern that too much is being spent
- Refusal to spend money on the care of the conservatee. Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills
- Recent acquaintances expressing gushy, undying affection for wealthy older person
- Recent change of title of house in favor of a "friend" when the older person is not capable of understanding the nature of the transaction
- Recent will when the person is clearly incapable of making a will
- Caretaker asks only financial questions of the worker, does not ask care questions
- Placement not commensurate with alleged size of the estate

- Lack of amenities, i.e., TV, personal grooming items, or appropriate clothing when the estate can well afford it
- Personal belongings such as art, silverware, jewelry missing
- Housekeeper tries to isolate older adult from old friends and family; tells older person no one wants to see him/her, and older person then becomes isolated and alienated from those who care for her/him; comes to rely on housekeeper alone who then has total control
- Promises of life-long care in exchange for willing or deeding of all property/bank accounts to caretaker
- Checks and other documents signed when older person cannot write

SERVICES/RESOURCES USED IN ELDER ABUSE

The following are examples of the range of services which elder abuse clients may need. Most of these services will be available in all parts of the State; however, some may not be available in your local community. On the next page, the possible services or resources that may be appropriate for each type of abuse is provided. Although the listing is not exhaustive, it provides a beginning in understanding the types of resources available to assist victims of abuse, neglect, and exploitation and their abusers.

▸ Service/Resource Listing

CORE SERVICES

Intake and assessment
Case Work
Follow-Up
Case review by M-Team
Early Intervention Services

EMERGENCY

Temporary financial support
Emergency shelter
Emergency caretaker
Crisis intervention

HOME SUPPORT & HOUSING

Respite
Alternative housing
Homemaker/chore worker
Home repair
Boarding Home
Nursing Home Placement

LEGAL & FINANCIAL

Daily money management
Guardianship
Civil commitment
Orders of Protection

MEDICAL AND PERSONAL CARE

Hospitalization/Health care
Health screening
Home health care
Drug information
Mental health services
Dental care
Adult day care
Health education
Medical Evaluation

SOCIAL SUPPORT

Outreach
Information and referral
Crime Prevention
Telephone reassurance
Recreation/socialization
Friendly visitor
Support group
Transportation
Religious organizations
Congregate or Home Delivered Meals
Counseling

Legal services and representation
Law enforcement
Durable Power of Attorney
Income stretching benefits

▸ Physical or Sexual Abuse

- *Victim Centered:* Medical evaluation; hospitalization; nursing home placement; emergency shelter; law enforcement; order of protection; divorce; mental health commitment of abuser; alternative housing; counseling though mental health, domestic violence, or rape crisis center; respite care.

- *Abuser Centered:* Counseling through mental health, substance abuse, sexual offenders; alternative housing; respite care for victim.

▸ Emotional Abuse

- *Victim Centered:* Respite care; home health; adult day care; alternative housing; telephone reassurance; counseling; resocialization through senior center, church, or club.

- *Abuser Centered:* Respite care, home health, or adult day care for victim; counseling; socialization though senior center while victim is cared for by another.

▸ Confinement

- *Victim Centered:* Legal information about rights; order of protection; law enforcement; transportation; adult day care; home health; friendly visiting or telephone reassurance. See also emotional abuse and financial exploitation.

- *Abuser Centered:* See emotional, financial exploitation.

▸ Passive Neglect

- *Victim Centered:* Home health; homemaker; chore; adult day care; medical equipment or supplies; home delivered meals; transportation; medical evaluation; respite; guardianship.

- *Abuser Centered:* Information about services; respite care for victim; training on how to provide care; counseling; see financial exploitation, emotional.

▸ Willful Deprivation

See financial exploitation, passive neglect, confinement, physical abuse.

▸ Financial Exploitation

- *Victim Centered:* Help applying for income stretching benefits (OASDI, SSI, VA, General Assistance, Food Stamps, Circuit Breaker, Homestead Exemption, IHEAP, subsidized housing); emergency aid (i.e. food bank); power of attorney; guardianship of the estate; direct deposit; representative payee; law enforcement; civil relief from the criminal financial exploitation law; small claims court.

- *Abuser Centered:* Help abuser apply for income stretching benefits (those listed under "victim" may be appropriate, but also think of AFDC); job training programs (JTPA, Displaced Homemakers); subsidized employment (SCSEP - Title V).

ELDER ABUSE INTERVENTION STRATEGIES

The following discussion will focus on how the "combinations and permutations" of the victim, the abusive situation, and the stage of the victim helps to determine what interventions are likely to be effective. Although situations and clients are unique, and the elder abuse system needs to be flexible and creative; there are also commonalities and some interventions that are usually effective in certain situations.

First, information is collected by the elder abuse case worker throughout the assessment, casework, and follow-up process. One primary tool used to collect and document the details of the case is the ANE Risk Assessment. The Risk Assessment examines 23 key points related to: 1) Client Factors (health status, mental capacity); 2) Environmental Factors; 3) Support Services Factors (availability and adequacy); 4) Current and Historical Abuse Factors (severity, frequency); and 5) Perpetrator/Abuser Factors (relationship with victim, financial status, mental health/substance abuse). The Risk Assessment is completed at the substantiation decision point, at the completion of casework, and every three months thereafter. The assignment of a risk level (high, medium, low) is a clinical judgement made by the elder abuse case worker, in consultation with their supervisor, based on the assessment of the 23 key points. The primary purpose of the Risk Assessment is to determine the extent to which the older person is in danger of future harm, injury, or loss and lead to the development of intervention options.

Second, there are a number of characteristics to consider which will help define what interventions will be needed and accepted. These characteristics are examined through the risk assessment process and include:

▸ Types of Abuse Substantiated

The type of abuse, neglect, and/or exploitation occurring is one factor which helps define the interventions needed. Different types of alternatives will be offered to a victim of one type of abuse than of a different one. Certainly, the type of interventions put in place for a victim of sexual abuse (medical evaluation, law enforcement, emergency shelter) will be different than the interventions with passive neglect (home health, adult day care, respite). However, the same service may be appropriate for several different forms of abuse (i.e. orders of protection for physical abuse, willful deprivation, confinement, sexual abuse; adult day care for emotional abuse, passive neglect, willful deprivation, etc.) as illustrated on the previous page. In addition, different services under one type of abuse may not be appropriate for every case of that type. Therefore, looking at the types of abuse gives some indication on the type of effective interventions, but must be reviewed in combination with the other characteristics.

▸ Characteristics of the Situation

Instead of correlating interventions directly to the type of abuse, it may be more helpful to also look at certain characteristics of the abusive situation as it relates to the abuser. Generally, the abuser characteristics can be categorized into one of the following:

- *Caregiver Stress* - the abuser has recently become abusive to the older person due to the stress created from the burden of caregiving.
- *Domestic Violence Grown Old* - the abuser has been abusive to the older person long before the victim became sixty years old (i.e. victim of spouse abuse for years).
- *Dysfunctional Abuser* - the abuser has mental health problems or is a substance abuser (drugs, alcohol).
- *Paid Caregiver* - the abuser is being paid, either directly by the victim or victim's family or through a publicly supported service program, to provide a service to the victim.

The same interventions are probably not going to be as effective working with a dysfunctional abuser versus working with a caregiver under stress.

▸ Characteristics of the Victim

In addition to examining the physical health, functional abilities, and financial status of the victim, to effectively plan interventions, there are four client categories that have proved to be useful in understanding victims of abuse. These four categories were created by Legal Research and Services for the Elderly of Boston, in 1979, and have as their point of reference the client's ***right*** and ***ability*** to determine the system's response to her or his problems.

- *Competent, consenting client* - the client who appears to be mentally competent and who consents to assessment and assistance.

- *Competent, nonconsenting client* - the client who appears to be mentally competent, who may refuse assessment, and who does refuse assistance.

- *Incompetent client* - the client who (regardless of degree of cooperation) appears to lack sufficient mental capacity to make informed decisions concerning his or her care.

- *Emergency client* - the client who is in immediate danger of death or serious physical or mental harm, and who may not consent to help, and may or may not be mentally competent.

If an older person appears mentally competent, then he or she has the right to decide what to do about the situation, including what interventions to pursue and what services to decline, no matter how serious it is. The victim's rights and wishes will bring the service system to a halt, time and again, unless preplanned responses are available for each client type (Bergman, 1989). Below is a discussion on the different stages a victim may follow which may assist in planning appropriate interventions that the victim will accept.

▸ Stage of the Victim

Risa Breckman has developed a theory that elder abuse victims who are competent are in one of three stages in dealing with the abuse. When developing intervention strategies with an older person to address the abuse, neglect, and/or exploitation, the stage of the victim should be a factor considered. This Staircase Model has the following stages:

- *Reluctance stage* - the victim is denying the abuse, neglect, and/or exploitation. There is self-blame and ambivalence. The case worker will be informing the client of alternatives, but the client may not be ready to accept any. Services to address physical or medical needs may be accepted (i.e. in-home services) and will reject service which would acknowledge the abuse (i.e. orders of protection). It is especially important for the case worker to maintain access to the victim and keep to the victim's pace.

- *Recognition stage* - the victim begins to recognize that the problem is serious and complex and cannot be managed alone. There is a lessening of denial and self-blame. The victim wants to share the problem with someone. The case worker will explore intervention options extensively with the victims. Services to address the abuse may or may not be rejected.

- *Rebuilding stage* - the victim has diminished self-blame, high self-acceptance, and seeks lifestyle alternatives. There is no longer denial that abuse took place or ambivelence about seeking help. There is the development of a support system (formal and/or informal).

It is important to note that the Staircase Model may also work in descending order. A victim may be in the recognition or rebuilding stage, acknowleging the abuse and seeking interventions, and revert back to the reluctance stage by denying the abuse.

▸ Summary

The elder abuse case can be generally categorized according to the four characteristics described above. In determining intervention options and strategies for working with the victim and the abuser, a thorough examination of the type of abuse, the characteristics of the situation, the characteristics of the victim, and the stage of the victim (if competent) is critical to effectively assisting an older person who is a victim of abuse.

Although this may sound complicated, the main ingredient is common sense. The elder abuse case worker uses common sense in observing and analyzing the case. Together, the case worker, the supervisor, and, oftentimes, the Multi-disciplinary Team will review the characteristics of the case, recognize the stage of the victim in dealing with the abuse, and formulate interventions which will have a good chance of success. By recognizing early in the case that there will be an extended period of reluctance for a particular type of client, frustration on the part of the case worker, the elder abuse provider agency, and M-Team members can be reduced and agencies accepting referrals can be prepared for possible client ambivalence.

Above all else, the goal in elder abuse and neglect cases should be: Whatever you do, do not make it worse (Bergman, 1989).

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APPENDICES

APPENDIX A

SAMPLE MEMBER AGREEMENT

SAMPLE MEETING AGENDA

WHY CASES ARE SELECTED

SAMPLE M-TEAM CASE SUMMARY

SAMPLE MEETING MINUTES

SAMPLE WRITTEN MEMBER AGREEMENT

The goal of the multi-disciplinary team (M-team) is to advise planning of comprehensive services to older persons who are abused or neglected, to coordinate with the service delivery system, and to work with the M-team members and other local agencies to provide and implement care plans for victims of abuse and neglect.

As a member of the multidisciplinary team I agree to:

1. Commit the time to fully participate.
2. Attend the required training developed for members.
3. Attend monthly M-team meetings for a period of one year, except where an unavoidable conflict occurs.
4. Learn as much as possible about the problem of elder abuse, neglect and exploitation and how to respond to its victims.
5. Provide my professional opinion and advice on how to proceed with the cases presented and attempt to find the answers to questions in my field of expertise.
6. Advise and assist in the development and implementation of procedures designed to integrate the efforts of the M-team and other local agencies.
7. To the extent possible, assist in educating my profession and the public about the problem of elder abuse and the Elder Abuse and Neglect Program.
8. Advocate for better alternatives for older persons in need of protective services.
9. Respect and maintain the confidentiality of all clients in the Elder Abuse and Neglect Program.
11. Not miss more than three consecutive meetings. If this happens due to circumstances beyond my control I understand I may be replaced as an M-team member.
12. I also understand that, if I represent an agency on the M-team, this agreement will become void if I no longer am associated with the agency at a future date.

Signature of M-team Member	Signature of Provider Agency Representative
Address	Effective Date

SAMPLE M-TEAM MEETING AGENDA

* INTRODUCTIONS

* ANNOUNCEMENTS, GENERAL INFORMATION & THANK YOU'S

* EDUCATIONAL PRESENTATION (IF APPLICABLE)

* UPDATES ON EARLIER CASES (WRITTEN OR VERBAL)

* DISTRIBUTE NEW CASE SUMMARIES AND DISCUSS (20 TO 30 MINUTES EACH)

* DISCUSS NEXT MEETING DATE, TIME AND LOCATION

* ADJOURN

WHY CASES ARE SELECTED

* CHRONIC CASE	Case worker cannot think of any other direction to help resolve case.
* ETHICS RE SELF-DETERMINATION	Case Worker faces ethical dilemmas re interventions that may conflict with self-determination
* TEACHING ISSUE FOR TEAM	Case had interesting issues that will teach the team members more about elder abuse.
* EASY CASE	Case has an easy solution and would give M-team feeling of success to prevent burn-out.
* NEED SPECIALIZED EXPERTISE	Special skills or knowledge of particular M-team members are needed.
* UPDATE	Current status of previously discussed case (information only, not discussion required).
* FOLLOW-UP	Worker seeks follow-up discussion on previously discussed case.
* ACCESS DENIED	Worker needs assistance gaining access to victim.
* VICTIM REFUSED SERVICES	Victim refuses all interventions offered by case worker.
* ABUSER REFUSED SERVICES	Abuser refuses all interventions offered by case worker.
* CAREGIVER REFUSES SERVICES	Caregiver (who is not abuser) refuses all interventions offered.
* ENVIRONMENTAL PROBLEMS	Victim has unmet needs for heat, water, housing or other environmental problems

Client Number: 340-50-0981

Date of Presentation: 03-13-90

Case Worker: Jennifer Boyd-Cole

CASE SUMMARY: Mrs. S

A referral was made to the IDoA 800 Unit by Representative Mathis's office concerning Mrs. S, an 82 year old woman. The report stated that Mrs. S has been living with another lady, Mrs. R, sharing expenses. The client owns the home and has a building out back that she rents to the alleged abuser, who works as a case worker for the Illinois Department of Public Aid.

Recently, Mrs. S has changed doctors, lawyers, and insurance. It is suspected that the alleged abuser, Mr. ML (37 years old) has persuaded her to do this. Mr. ML has also had an eviction notice service on Mrs. R. Mrs. R has lived with Mrs. S for approximately 31 years.

When the initial investigation was conducted, the Case Worker found that Mrs. S was living in the back building that is rented out to Mr. ML. Mrs. S's reasoning for doing this was because she was afraid that Mrs. R was trying to put her into a nursing home or would poison her food. She stated that she no longer trusted Mrs. R.

Mrs. S did not make a mistake on the SPMSQ, she was very clear and responded well to several questions. She feels that Mr. ML is acting in her best interest and she would do anything to help him. When she came back from the hospital in November,1989, she signed a Power of Attorney so that Mr. ML could handle her finances. Mrs. S also has had Mrs. R's name taken off the checking account and Mr. ML's put on. Mrs. S cashed in her insurance policy and has Mr. ML's name put on the burial account.

The eviction notice for Mrs. R to leave the house went to trial last week. The case was continued and Mrs. R has asked for a jury trial. Since that time Mrs. R has changed the locks on doors and according to Mrs. S has moved five rooms of furniture out of the house.

Mrs. S states that when Mrs. R is evicted, she and Mr. ML will move back into the big house and he will continue to handle her finances and help her out.

Psycho/Social

Mrs. S is alert and oriented. She did not miss any questions on the SPMSQ. She does not appear to be afraid of the alleged abuser. No known history of mental illness.

Environmental

Mrs. S now lives in a small one story home with alleged abuser. Home is neat and clean, but small.

Medical

Mrs. S has a lower back injury which causes a great deal of pain and discomfort.

Medications: Propoxyphene

Formal/Informal Supports

Strong informal support. Mrs. S has someone from her church stay with her on a daily basis. The alleged abuser stays with her in the evenings and on the weekends.

QUESTIONS:

1. How much emphasis should be placed on Mrs. S's decision to involve the alleged abuser in finances and personal care?

2. Is it the consensus of the M-Team that we have the right abuser (Mr. ML)?

3. What would be some ways to establish credibility of both caregivers?

MINUTES

M-TEAM MEETING

March 13, 1990

Those in attendance were:

Steve Schauwecker
Mark Schloemann
Dr. Robert Tiffin
Rev. Marlin Otte
Ron Swafford
Jennifer Boyd-Cole
Kathy McKinney
Patsy Jensen
Ken Yordy
Pam McCowen
Elana Floyd-Kennett
Don Wilkerson

The meeting was opened with the presentation of Jennifer Boyd-Cole's abuse case involving Mrs. S. Mrs. S is an 82 year old female who lives in her own home and has another lady, Mrs. R, and Mrs. R's son living with her. They have lived together for the past 31 years, sharing living expenses. Mrs. S also owns a house out back of her home which she rents to Mr. ML who is the alleged abuser. Mr. ML works for the Illinois Department of Public Aid.

When Mrs. R reported the case to Representative Mathis's office, she stated that Mr. ML has persuaded Mrs. S to change doctors, lawyers, and insurance, along with having Mrs. R;s name taken off of Mrs. S's bank accounts and having his name placed on them. She also reported that while she (Mrs. R) and her son are away from the home, Mr. ML is coming into the home and over-medicating Mrs. S. Mrs. R stated that Mr. ML uses very abusive language towards the church women and women in general, constantly calling them names. Mrs. R also stated that Mr. ML is trying to have Mrs. S added as one of his dependents for income tax purposes.

When the case worker made the investigation, it was discovered that Mrs. S was living in the house behind her home with Mr. ML. Mrs. S had previously been in the hospital and before she entered the hospital she stated sh heard Mrs. R and her son plotting to place her in a nursing home. Mrs. S stated that she was afraid to return home that they would either place her in an institution or possibly poison her. Once she returned to the house which she rents to Mr. ML, she filed for the eviction of Mrs. R and her son.

While on good terms with Mrs. R, Mrs. S had a Quik Claim Deed drawn up leaving the house to Mrs. R upon her death.

Rev. Otte raised the question as to what happened to cause these two women to feud after 31 years of sharing the same household. Jennifer stated the Mrs. R and Mrs. S had a good relationship up until Mrs. R wanted Mrs S to start sharing in the bill paying. Mrs. R also did not want her son to have to pay any more rent for living in the apartment above Mrs. S's home.

Mrs. S stated she has known Mr. ML for over 15 years and that he is acting in her best interest. She stated that she did have her accounts changed to his name, and that he helped her arrange a pre-arranged burial plan with the funeral home. Mrs. S stated that she has had the same physician since 1987, and she still has the same attorney. Mrs. S believes that Mrs. R is the abusive person not Mr. ML. Ron Swafford questioned Mr. ML paying Mrs. S a years rent in one payment per year. Jennifer stated that is questionable.

Jennifer stated that Mr. ML was a teacher and lost his tenure. The reasons are unknown, and he has his name in the phone book but spelled backwards. She also stated that Mr. ML plans to transfer to the

if this does happen, that the CCU should be notified in Springfield so that they can keep an eye on the situation. Jennifer also stated that Mr. ML's co-workers are very skeptical of him.

The members questioned who is really the abuser. Ken stated that Mr. ML seems to be very knowledgeable and his record is fairly clean. As for Mrs. R, it is possible that she feels threatened by Mr. ML. He is trying to move in on her territory. Ken stated than Mrs. R now owns the house with Mrs. S have a life estate in the house. Steve Schauwecker explained that the term Life Estates means that Mrs. S has transferred ownership of the home over to Mrs. R; but, Mrs. S has the right to live there until she dies.

While meeting with the lawyers, Mrs. R stated that she and her son would leave the home within 30 days. When the meeting was about over, Mrs. R demanded a trial by jury. Mrs. R and her son have moved all the valuables out of the home, even things that belonged to Mrs. S.

Dr. Tiffin raised the question as to whether the medications given to Mrs. S in the hospital could have caused all this paranoia? Dr. Tiffin suggested a full psychiatric evaluation be completed on Mrs. S.

Steve Schauwecker suggested that Mrs. S's life be simplified and Mr. ML, Mrs. R, and her son be removed from the property. Jennifer stated that with minimal assistance, Mrs. S could be maintained at home by herself.

The M-Team members recommended that the case worker suggest to Mr. ML that he should have his name removed from the accounts, that this reflects negatively for him in the public light.

Patsy stated amongst all the confusion she feels that Shawnee Alliance for Seniors should stay involved. Ken stated that there is enough indication to keep the case open. Jennifer stated she will encourage Mrs. S to accept CCP services.

The next meeting was scheduled for April 10, 1990, at Shawnee's Hurst offices, beginning at 5:30 p.m.

The meeting adjourned at 7:00 p.m.

APPENDIX B

JOB DESCRIPTIONS

JOB DESCRIPTION: LAW ENFORCEMENT

The Law Enforcement member of the Elder Abuse M-Team has primary responsibility for providing expertise, advice, and information to the M-team and Elder Abuse Case Workers regarding the law enforcement process, such as: what the police could do, releases needed, getting someone in the alleged victim's home, getting the abuser out of the house, rights of privacy, theft by the caretaker, etc.

Major Duties/Responsibilities:

* Advise Elder Abuse Case Workers on specific investigative techniques.

* Provide opinions and recommendations about what can be done from a law enforcement perspective.

* Interpret state, city, and county laws and identify those aspects of a case which may involve violation of civil and criminal laws.

* Investigate allegations of abuse, as necessary, and/or refer Elder Abuse Case Workers to the police department.

* Obtain involuntary commitments or criminal charges.

* Educate M-teams members and Elder Abuse Case Workers on law enforcement-related issues. Common examples include: definitions of legal terms and law enforcement terms, technical procedures involved in bringing criminal or civil charges against someone, types of penalties for specific infractions of the law, and types of violations the State's Attorney will prosecute.

* Contact other members of the law enforcement community, as necessary, to obtain information needed by the Elder Abuse Case Worker investigating a case or to alert them to possible violations of the law occurring in their jurisdiction.

* Assist in the development and fulfillment of M-team policies, goals, and objectives, as necessary.

Information Resources

The Law Enforcement member of the M-team uses the following information and resources in carrying out his/her responsibilities:

* M-team members and meeting documentation - minutes, summary case reports, relevant articles.

* Elder Abuse Case Worker input on cases
* State, city and county laws and ordinances
* State's Attorney's Office
* Police Department/Sheriff's Office

Education, Experience and Training

* Minimum of an associate's degree in criminal justice or another social science
* Five years law enforcement experience
* Experience with abuse or domestic violence cases, or felony case desirable.

Knowledge, Skills and Abilities

* Knowledge of criminal investigative techniques and how the criminal justice system works in the area served by the elder abuse provider agency.
* Knowledge of family dynamics
* Knowledge of patterns of substance and alcohol abuse
* Knowledge of basic principles of psychology and sociology
* Familiarity and rapport with high-ranked law enforcement officials in the areas served by the M-team.

JOB DESCRIPTION: MEDICAL

The Medical member of the Elder Abuse M-team has primary responsibility for providing expertise, advice, and information to the M-team members and Elder Abuse Case Workers regarding:

* Available resources and information (medical care, physicians, ways that different physicians treat patients, hospitals in the area, transportation services, etc.)
* Home health nursing services and limitations
* Involvement and limitations of the state and local health departments
* Medicare insurance coverage
* Medical aspects of substance abuse
* Medications and their effect on the victim's mental state.

Major Duties/Responsibilities:

* Review elder abuse case information provided by the M-team Coordinator (through minutes from the previous team meeting) focusing on medical-related issues, including:

  -how the victim's level of functioning may be contributing to the abuse
  -the victim's level of physical and mental functioning
  -information regarding victim's medication, including identifying the purpose for medication and assessing the victim's physical state

* Assist in determining if the alleged victim should go into a nursing home by assessing the victim's ability to carry out daily life functions independently and if the victim's situation includes needed assistance.
* Assist in determining the level of mental functioning and/or possible substance abuse problems of alleged abuser and other persons who live in the home.
* Provide a visiting nurse view or home visit perspective.
* Educate others, as necessary, including sharing relevant, non-confidential information with colleagues and coworkers about elder abuse and the M-team and promoting public awareness of elder abuse.
* Follow-up on medical-related recommendation, as requested.

* Assist in the development and fulfillment of M=team policies, goals, and objectives, as necessary.

Information and Resources

* M-team members and meeting documentation: minutes, summary case reports, relevant articles.

* Elder Abuse Case Workers who present cases at meetings.

* Local visiting nurse association.

* Local physicians, hospitals, and nursing homes.

* State and local health departments./offices

Education, Experience and Training

The Medical M-team member could be either:

A Registered Nurse or Nurse Social Worker, with 5 years experience, preferably with some of it in home health care; or

A Physician with certification by the American Board of Family Practice and/or by the American Board of Internal Medicine, with at least two years experience in either field.

Knowledge, Skills and Abilities

* Medical terms, physical conditions, diseases and aging processes, treatment and diagnoses.

* A wide variety of drugs, their indications, contraindications, and effects of their interactions.

* The psychological status of patients and how it affects them medically.

* Medicare insurance coverage and limitations.

* Nursing homes within the community and available community resources (e.g. people that could transport the patient for medical care, licensed room and board facilities, physicians, hospitals).

JOB DESCRIPTION: LEGAL

The Legal member of the M-team has primary responsibility for providing legal counsel/expertise, advice, and information to M-team members and Elder Abuse Case Workers regarding the role that the abused or his/her family, as well as the Elder Abuse Case Worker, can take to resolve problems. One of the legal member's roles is to make a preliminary decision regarding behavior reaching criminal proportions. The Elder Abuse Case Worker would then be referred to the prosecuting attorney's office.

Typical legal advisory areas include: confidentiality and privacy issues (e.g., obtaining records from court systems and doctors); wills and estates; guardianship; financial power of attorney (estate, property, deeds, checks and bonds); health care power of attorney; substandard housing; relevant state and local legislation; and complaints of inadequate or inappropriate care.

Major Duties/Responsibilities

* Reviewing case notes and team minutes, paying special attention to any legal aspects or remedies which may apply.

* Advising the Elder Abuse Case Worker on steps involved in specific legal options and remedies to help resolve a case (e.eg., setting up guardianships, obtaining protection orders, initiating civil and criminal actions against parties involved in cases.)

* Making presentations to the M-team, as requested, on topics such as guardianship, power of attorney, and domestic violence.

* Acting as a liaison to social service agencies, as necessary.

* Maintaining confidentiality of information presented.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* Internal legal memoranda keeping the member updated on current laws and statutes.

* Materials put out by the State Bar Association.

* County rules, regulations and ordinances.

* Medicare and Medicaid administrative rules.

Education, Experience and Training

The Legal member of the M-team should be licensed to practice law in the state, and have a minimum of one year's experience as a practicing attorney with broad exposure especially in terms of issue spotting and experience working with various types of legal cases. Experience with the needs of the elderly and/or with domestic violence cases would be helpful. In addition, knowledge of public benefits, Medicare eligibility and programs. He or she should be a member of the State Bar Association of the local Bar Association for networking purposes.

Knowledge, Skills and Abilities

* Legal issues, case law, strategies, etc., involving clients who require substitute decision making (e.g., guardianships, trusts, etc.)

* Social and political environments of the agencies responsible for responding to reports of elder abuse and skilled at applying this knowledge to develop appropriate legal strategies for each case.

* City housing guidelines, such as whom to contact, and what to do about substandard housing conditions.

* Local social service agencies.

JOB DESCRIPTION: CLERGY

The Clergy member of the Elder Abuse M-team has primary responsibility for providing input and advice from a pastoral perspective to M-team members and Elder Abuse Case Workers.

Major Duties/Responsibilities

* Participating in M-team discussions of cases, making comments and recommendations based on background and experience as a clergy person.

* Seeking services or support from the client's church, as required, including contacting the minister, pastor or priest.

* Assisting the team in promoting community awareness of elder abuse through writing articles, and making presentations to hospitals, schools, police departments, etc.

* Maintaining the confidentiality of information presented.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* Community churches and schools' staff, families, and students.

* Community newsletters and newspapers.

* Elder abuse legislation.

Education, Experience and Training

The recommended educational and experiential backgrounds of Clergy on the M-team include a minimum of a Bachelor;s degree in theology, psychology, communications, or education, and ten years pastoral experience with at least three years experience working with the elderly. Less experience is acceptable if the person is enthusiastic about working with the elderly. A counseling background is helpful, as is an understanding of both psychology and geriatrics through educational courses or seminars.

Knowledge, Skills and Abilities

The Clergy member should be able to take an ecumenical point of view in analyzing cases and understanding that the pastor's role on the team is not to condemn or convert. He or she should be able to listen to others and remain non-judgmental. The clergy representative should not hold religious beliefs that might encourage abuse or support the maintenance of an abusive situation. He or she should be able to independently analyze situations to let people choose what would be best for themselves -- be protective of the victim's freedom of choice. This person should be genuinely interested in serving the elderly community and able to relate well to elderly people.

Personality (care and concern) is more important than years of experiences. The clergy should have compassion and sensitivity for the victim, and the sentiment or drive to help case workers deal with thorny cases. He or she should be familiar with and able to tap community resources, and be open minded and accepting of the religious faiths of others.

JOB DESCRIPTION: FINANCIAL

The Financial member of the Elder Abuse M-team has primary responsibility for providing expertise, advice, and information to Elder Abuse Case Workers in their efforts to resolve their clients' financial problems and conflicts. This is done by providing information and/or services in the areas of: direct deposit of social security checks; prevention of fraud through pre-authorized charges to the account, e.g. utility bills, insurance payments,; authorization of financial institutions and insurance company payments to be paid directly from the account to prevent access to funds and ensure that payments are made; verification of transactions through microfilm checks and by identifying what is going on in the account; and trust services and guardianships.

Major Duties/Responsibilities

* Reviewing team meeting notes and minutes to become familiar with financial resource requirements.

* Analyzing the financial status and needs of the client, as necessary, and develop strategies that facilitate case resolution. Analysis considerations include the amount and sources of a client's income, relationships with banks and credit unions, indebtedness and financial history, people other than client who have legal access to client's bank accounts, social security checks, etc., and people in the household in charge of spending the money.

* Following-up on recommendations after team meetings and feeding back the results to Elder Abuse Care Workers, as required. For example, checking on banking problems brought up at the meeting, and setting up bank records.

* Educating Elder Abuse Case Workers and team members on banking issues, as necessary. This includes federal banking law, meeting credit and housing needs in the community, how to handle checking accounts, how to get information, depositing checks in a timely manner and how to facilitate this.

* Contacting other members of the financial community, as necessary, to obtain information regarding the client.

* Maintaining the confidentiality of information presented.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* National Association of Banking
* Banking industry - local area bankers
* Federal Reserve system (FDIC)
* State Commissioner of Banks
* Federal and state banking laws.

Education, Experience and Training

* Five years experience in high-level bank positions as loan officer, bookkeeper or teller supervisor.
* Business Administration degree with a concentration in finance and two years banking experience.

Knowledge, Skills and Abilities

In addition to educational and experiential backgrounds, the Financial M-team member should be involved in the banking community through board membership, committees, or network of firmly established relationships with influential members in the banking community. He or she should have a general knowledge of commercial loan area, and of the types of information banks can release with regard to confidentiality. This member should know about alternative sources of income available to the elderly clients and how to access these sources.

JOB DESCRIPTION: MENTAL HEALTH

The Mental Health member of the Elder Abuse M-team has primary responsibility for providing expertise, advice, and information to Elder Abuse Case Workers from a mental health perspective.

Major Duties and Responsibilities

* Reviewing case notes, updates, new case notes, agenda received from the M-team Coordinator each month and examining each case for mental health diagnoses, such as severe depression or difficulties adjusting to stressors in the client's life.

* Identifying emotional problems and psychosocial issues involved in each case, focusing on both the abuser and the victim. It involves determining the client's needs based on family composition and structure, the history of family interactions, the client's willingness for services, strategies that have already been tried, and/or the need for certification of the victim or abuser as a danger to self or others. In this role, the client's rights to self-determination and the need to keep the family intact are major considerations. This diagnostic role of the Mental Health team member also includes preliminary elder abuse diagnoses using established guidelines and evaluation criteria, and preliminary mental health diagnoses, based on information given, to help decide what is the problem.

* Providing advice and recommendations, such as: how to approach the abuser/victim; how they can be seen, and how to get them to agree to be seen while not jeopardizing the situation; available community resources and adjunct services to assist with case management and resolution.

* Sending copies of the patient's progress notes to members, (if relevant and with the client's permission).

* Assisting the M-team establish an educational program to address elder abuse in the community.

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers who present cases at the meetings.

* DSM-IIIR (Publication of diagnoses, symptoms - American Psychiatric Association).

* Clients' physicians and family doctors.

* Local hospitals and mental health treatment facilities.

Education, Experience and Training

* Master's degree in Social Work, with certification as a Clinical Social Worker, with at least five years total experience, and two years experience working with the elderly and/or abuse cases.

* Registered Nurse with five years experience, with two in psychiatric work.

* State licensed therapist with an advanced degree in a mental health field and at least five years experience, with two years in working with the elderly and/or with abuse cases.

* Physician with experience in geriatric psychiatry and a member of the American Psychiatric Association.

Knowledge, Skills and Abilities

In order to perform effectively, the Mental health representative should know about general case management, state mental health codes, and medications. This member must be able to make reasonably accurate diagnoses of mental health conditions and to determine when hospitalization is required. He or she must also have some feeling for which forms of therapy would be most appropriate for which type of disorder. He or she must know about the legal issues regarding protective services and self-determination, family dynamics and the ways in which dysfunctional families operate. This member must have knowledge of available community resources in a variety of areas (legal, medical, etc.).

JOB DESCRIPTION: M-TEAM COORDINATOR

The M-team Coordinator has primary responsibility for planning, organizing, and facilitating the monthly M-team meetings. This includes notifying all members of any changes in the meeting schedule, preparing, reviewing and finalizing minutes and agenda for each meeting, summarizing cases to be discussed and finding relevant articles to be presented to the team. The Coordinator must ensure that all members receive the information needed for each meeting, which entails coordinating the mailing of information and materials. He or she must also set up the meeting room and facilitate team meetings.

Major Duties and Responsibilities

* Meeting with Elder Abuse Case Workers and Supervisors to determine which cases to present to the M-team and to prepare for presentations.

* Acting as liaison between M-team and Elder Abuse Case Workers. This entails soliciting feedback, informally, from both groups regarding reactions to team meeting process and outcomes.

* Planning for and organizing team meetings. This includes progress reports on old cases and developing brief scenarios of new cases. It involves overseeing mailing of the meeting announcement letter and agenda prior to meeting, contacting members prior to the meeting to request presentations on a topic in their area of expertise, ensuring that there is a full agenda with an appropriate amount of information, and reviewing and finalizing minutes and agenda. It also involves obtaining copies of the minutes, and may also require taking minutes at the meeting.

* Following-up on recommendations from team members. This involves consulting with M-team members outside of meetings to obtain additional information and referral sources.

* Preparing monthly and quarterly reports regarding the M-team and cases are viewed.

* Meeting with the Executive Director of the elder abuse provider agency to review team issues, and with the agency bookkeeper to discuss financial issues related to team implementation.

Work Context

The amount of time required to complete duties and responsibilities per month varies considerably, based on such factors as:

-the presence of an Elder Abuse Case Worker interested in discussing a case, elder abuse case load, staffing and clerical assistance available from the agency. On a monthly basis, the M-team Coordinator's time is spent preparing materials/information (3 to 6 hours), in M-team and related meetings (3 to 6 hours), in M-team and related meetings (3 go 6 hours), writing reports and following-up on recommendations (2 to 8 hours).

Information and Resources

* M-team members and meeting documentation (minutes, summary case reports, and relevant articles).

* Elder Abuse Case Workers and case files.

* Agency staff and resources.

* State Department on Aging Elder Abuse and Neglect Program standards, reports and related information.

Education, Experience and Training

* Bachelor's degree in a human services field and two years experience working with the elderly and/or with abuse cases, and specific training in elder abuse, including the Department on Aging's Elder Abuse Case Worker Training and M-Team Training workshops.

* Crisis intervention, networking with other agencies, some administrative and supervisory experience and training in group facilitation helpful.

Knowledge, Skills and Abilities

* Must understand the legal issues and constraints of elder abuse case work, including some knowledge of guardianship and power of attorney.

* Must be familiar community resources.

* Good oral and written communication skills, including active listening.

* Must understand group dynamics and be able to facilitate discussions.

* Must have good administrative, planning and organizing skills.

JOB DESCRIPTION: ELDER ABUSE CASE WORKER (SUMMARY)

The Elder Abuse Case Worker is primarily responsible for the initial intake and investigation, care planning and follow-up of elder abuse and neglect cases within a specified geographic region. The most important area of responsibility is the **home visit**, where the case worker meets with the victim and in many cases the abuser as well. The case worker's responsibilities include:

* Conducting a thorough assessment of each report of elder abuse, neglect or exploitation, including a face to face interview with the alleged victim, alleged abuser and other relevant persons to determine whether the reported abuse is substantiated.

* Building rapport with the victim and with persons who can help the victim in order gain support for accepting help.

* Development of an individualized care plan to address the victim's needs, which can include in-home services, social and environmental supports, medical interventions, legal interventions and other services. Identify community resources to provide services.

* Prepare and maintain complete documentation of the case

* Follow-up on each case to ensure that the care plan is carried out successfully.

* Prepare for and attend monthly M-team meetings. With supervisor and/or M-team Coordinator, decide which cases should be presented for M-team consultation. Prepare summary of case and verbally present case to the team for their advice. Provide follow-up information on previous cases to M-team for their information.

APPENDIX C

ELDER ABUSE AND NEGLECT ACT

Section 13. This Act takes effect upon becoming law.

Philip J. Rock
President of the Senate

Michael J. Madigan
Speaker, House of Representatives

APPROVED

this 13th day of August, 1985 A.D.

James R. Thompson
GOVERNOR

The Illinois Department on Aging

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