ELDER ABUSE FATALITY REVIEW TEAMS
OUTCOMES

INTRODUCTION

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

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

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

OUTCOMES

1. **EAFRT participation enhances members’ knowledge and ability to do their jobs.**
   - Ninety-three percent (n=75) said participation had increased their knowledge about the other organizations that are represented on the team.
   - Seventy-seven percent (n=60) indicated that they had learned more about organizations that do not participate on the EAFRT.
   - Eighty-two percent (n=63) reported feeling more confident in making referrals to other organizations. The same percentage (n=60) indicated that they more often initiate collaboration with other organizations.
   - Eighty-six percent (n=68) indicated improved understanding of how elder abuse can directly or indirectly lead to death.

2. **EAFRT members share what they learn at EAFRT meetings with their colleagues.**
   - Eighty-two percent (n=65) reported informally sharing their enhanced knowledge with colleagues.
   - Fifty-four percent (n=37) had trained or arranged training for colleagues about identifying elder abuse.
   - Thirty percent (n=19) had trained or arranged training for colleagues about elder abuse death investigations. That figure may seem low, but most organizations represented on EAFRTs do not conduct death investigations.
3. **EAFRT participation may facilitate changes in the policies and practices of the members’ organizations.**
   - Thirty-seven percent (n=26) indicated that their organization had changed its policies and practices regarding services to elder abuse victims due to team participation.
   - Forty-one percent (n=29) reported changes to their organizations’ policies or practices regarding collaboration with other organizations to assist victims.

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

### EXAMPLES OF SYSTEM-CHANGING OUTCOMES

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