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**Achieving safety, dignity and respect  
for all NYC's elders through  
steadfast commitment to collaboration  
and inspired solutions.**



**NYC Elder Abuse Center's eNewsletter**

**March/April 2012**

### ***Greetings from the NYC Elder Abuse Center!***

The [NYC Elder Abuse Center](#) (NYCEAC) is a highly collaborative initiative. It brings together government and nonprofit organizations to develop innovative responses to the problem of elder abuse and provide practitioners with pertinent and relevant information to make their interventions more efficient and effective.

NYCEAC's eNewsletter provides concise, practical information and resources on topics related to elder justice to help providers better assist elder abuse victims. In this issue, we highlight the topic:

### **Capacity Evaluations in Elder Abuse Cases**

We hope you find the information provided in this eNewsletter useful. We welcome your feedback and ideas for future editions. Please [email us](#) your thoughts and suggestions.

Together we can prevent elder abuse - and increase victim safety, reduce suffering and improve the quality-of-life of older New Yorkers.

Regards,  
Mark Lachs, MD, MPH, Director  
Risa Breckman, LCSW, Deputy Director  
Robin Roberts, LMSW, Multidisciplinary Team Coordinator

### **Acknowledgments**

NYCEAC is comprised of many deeply knowledgeable experts in the field of aging and elder abuse.

We are fortunate that many of our partners are willing to lend their time and expertise to write articles and contribute to our eNewsletter.

We thank Valerie Abel, PsyD - our dedicated and enormously talented colleague - for her valuable contributions to this eNewsletter edition. (Please see the section below, *In the Spotlight*, for more information about Dr. Valerie Abel.)

We also extend a heartfelt thank you to the following people for their important contributions to this edition: Matt Kudish, LMSW, Director of Education, Outreach & Caregiver Services, Alzheimer's Association, New York City Chapter; Arlene M. Markarian, Esq., Bureau Chief, Kings County District Attorney's Office; Peg Horan, LMSW, Elder Abuse Unit Coordinator, Kings County District Attorney's Office; and Mary Olsen, NYCEAC's Social Work Intern, Silberman School of Social Work, Hunter College.

## Overview: Capacity Evaluations in Elder Abuse Cases

Professionals working with older adults usually have concerns about decision-making capacity of some of their clients given the complex array of bio-psycho-social issues that older adults can experience.

For some older adults, the development of deficits in cognitive and functional abilities can increase their vulnerability to dangerous situations, including abuse. For example: an older person with diminished capacity who has been physically abused may be unable to execute safety planning, which requires sequential thinking, preventing an older person from responding appropriately in a crisis. While elder abuse can (and does) occur even when cognitive functioning is intact, the evaluation of decision-making capacity is necessary in many elder abuse cases.



## Understanding the Terminology

Professionals working with elder abuse victims and families of suspected victims often find themselves explaining uncommon terminology.

Distinctions between "dementia" and "Alzheimer's disease" have achieved some general recognition, but other terms such as "capacity" and "competency" or "[undue influence](#)," "retrospective capacity," and "testamentary capacity" can be confusing and are often perceived as jargon. In addition, it is advised that practitioners become familiar with such terms to better understand the complex issues surrounding elder abuse cases and to communicate with others about the needs of clients experiencing abuse. [Click here](#) for a list of definitions of these terms.



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## Reasons to Seek a Capacity Evaluation

The context of each case will determine the need for a capacity evaluation and the selection of the particular capacity concerns to evaluate.

For example, **an evaluation of a person's ability to manage finances** may suggest a need for a power of attorney. In such a case, an evaluation might be prompted when a family member notices an older relative purchasing financial



## Capacity Evaluations in Elder Abuse Cases

Overview: capacity evaluations in elder abuse cases

Reasons to seek a capacity evaluation  
Signs of diminished capacity

Clarifying legal and clinical capacity

How to locate an evaluator

Assessing mental capacity

In the spotlight  
Inspiration

## Quick Links

Keep current about events in the elder justice field - [Click here!](#)

Visit the VA New York Harbor Healthcare System - Brooklyn Campus where Valerie Abel, PsyD - author of this eNewsletter edition - serves as the Clinical Psychologist/Neuropsychologist [Click here!](#)

products of dubious value from unknown sales people, or making outside donations beyond their means to random solicitors.



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In cases brought to the attention of APS, **an older person's capacity to make medical decisions** might initially be indicated by signs of self neglect, such as a significant lack of attention to hygiene. Depending on the severity of the impairment, a need to invoke a health care proxy may result.

A social worker or other practitioner, when planning for hospital discharge, may have concerns about **the ability of an older adult to live independently**. If a patient seems confused or unable to perform activities of daily living, a capacity evaluation can help guide a safe and appropriate discharge plan.

These issues are particularly germane when there is concern about **the older adult's vulnerability to abuse**. A capacity evaluation can inform intervention planning or discharge planning so that autonomy and safety from harm is properly balanced.

In some situations, it is clear from the outset that **the reason for a capacity evaluation is to determine the need for a guardian**. An individual, a family member, friend, agency or institution might petition for guardianship when concerned that someone will be harmed without one. Capacity evaluations for guardianship are important in determining retained functioning to therefore recommend domains in which a guardianship order may be limited. Practitioners should always seek to balance the fundamental ethical principle of autonomy/self-determination and protection from harm. ([Click here](#) for NYCEAC's eNewsletter on guardianships and alternatives to guardianships.)

**Capacity evaluations may also come into play in civil or criminal proceedings if undue influence or a crime against an older adult is involved.** These cases may involve current or retrospective determinations of capacity. The following case illustrates the role of a retrospective testamentary capacity evaluation:

### Case Study - Martha

Martha is 85 years old with moderate Alzheimer's disease. Ruth, Martha's daughter, while routinely helping her mom organize bills and paperwork, came across her mother's will, this version drafted one year ago. Ruth was shocked that this will designated her bother, Fred, the sole heir to her mother's brownstone home, as an earlier version left the property to both children. Ruth confronted her brother and he stated that their mom had requested this change.

Ruth called her mom's primary care physician who suggested that Ruth talk with an elder law attorney. She brought with her copies of previous wills and other legal transactions dating back five years. The lawyer agreed with Ruth that the earlier documents consistently indicated Martha had a history of preferring equal treatment for each of her two children. Matters became more complicated as Martha suddenly passed away.

Ruth brought the matter to civil court. The elder law attorney

arranged to have a geropsychologist complete a capacity evaluation which was presented to the court. The comprehensive evaluation indicated there was evidence that sharing the property equally between the siblings was consistent with Martha's lifelong values. In addition, the opinion that Martha's current cognitive status and previous medical history was consistent with Alzheimer's disease implied that Martha would have been too cognitively impaired one year ago to have testamentary capacity to change her will, according to the state's legal definition.

The judge determined the will benefiting only Fred was null and void.

## DISCUSSION

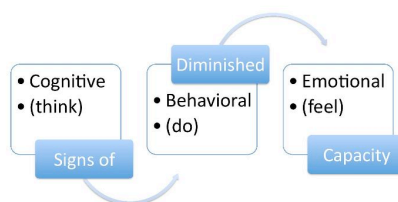
In the above case, there was sufficient documentation which made it possible to showcase the lifelong values held by Martha. All too often, families are not in possession of such detail. Advance directives and planning and documenting financial transactions are important considerations for everyone, but especially important for those suffering from Alzheimer's disease and other dementing illnesses. Such clarity can serve as a way to preserve the client's self-determination if legal capacity is later in question.

## Signs of Diminished Capacity

The signs of incapacity are not always evident as they may present initially as ordinary absentmindedness. Thus, practitioners will provide better care and information if they are attuned to the possible signs of incapacity that would warrant a capacity evaluation. These signs fall into 3 categories: cognitive, emotional and behavioral:

**Cognitive** - These signs include: short-term memory loss, communication problems, comprehension problems, lack of flexibility, calculation problems, and mental disorientation.

Cognitive changes indicating a need for an evaluation often include difficulty in planning or problem solving, such as an impaired ability to follow a familiar recipe or difficulty tracking monthly bills.



**Emotional** - These signs include: significant emotional distress and/or emotional lability/inappropriateness, and/or changes in mood or personality, such as confusion, suspicion, depression, anxiety or the expression of fear that seems unwarranted. Emotional distress or inappropriateness may become noticeable as the person reacts to even subtle changes in their environment. For example, a family member placing familiar items in unusual places might result in the person becoming angry or accusatory of others for stealing items that have gone missing.

**Behavioral** - Behavioral changes might first be observed as withdrawal from work or social activities. Changes in grooming are often noticed,

particularly a lack of attention to cleanliness. Behavioral changes also present as impairments in judgments, such as giving large sums of money to telemarketers or as difficulty in driving to a familiar location.

## Clarifying Legal and Clinical Capacity

Legal capacity and clinical capacity are intertwined in terms of assessment standards, as indicated below in the case study focusing on financial capacity.



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For example, financial capacity from a legal perspective conceptually encompasses a range of financial capacities, such as contractual capacity, donative capacity, and testamentary capacity that have varying levels of standards depending on the state. An understanding of the legal definition of capacity is necessary to conduct a clinical evaluation. (Legal definitions can differ from state to state.)

But from a clinical standpoint, financial capacity is the ability to exercise particular skills in various domains (e.g. basic monetary skills, financial conceptual knowledge, cash transactions, checkbook management, bank statement management, financial judgment (detecting fraud), bill payment, knowledge of assets/estate, investment decision making). All of these domains are cognitively mediated (some requiring more complex cognitive skills than others) and are vulnerable to neurological, medical and psychiatric conditions that affect cognition.

Thus, capacity assessments must take into consideration the legal and functional definition of that capacity as well as the clinical determinants and factors that impact the area in question.

## Collaboration between American Psychological Association and American Bar Association

The need to improve the manner that clinical professionals, lawyers and judges communicate with each other about capacity matters led to a collaboration between the American Psychological Association and the American Bar Association. These two organizations formed a working group on the Assessment of Capacity in Older Adults in 2003 with the aim of improving communications.

An outcome of this working group was the publication of three handbooks which offer extensive information about capacity assessment and the interplay of legal and clinical concerns:

[Judicial Determination of Capacity of Older Adults in Guardianship Proceedings](#)

[Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers](#)

[Assessment of Older Adults with Diminished Capacity: A Handbook for Psychiatrists](#)

The following case study profiles an older person with intact financial capacity according to the legal definition, but impaired capacity from a clinical standpoint.

### Case Study - John

John is a 90-year old financially secure man with three adult children. He has been healthy and active until last year. John's middle daughter, Sandy, is 60 years old and has been unemployed for 3 years. Due to Sandy's unemployed status, she convinces her dad and her two brothers that she is in the best position to care for him following his recent fall and resulting health complications. Once Sandy moved into her dad's apartment, she told her dad that she would be taking over the management of his finances for him. He stated he didn't want her to do that, and she threatened to poison his food if he did not comply.

The bank manager observed Sandy doing all the talking when she and her dad visited the branch to add Sandy's name to John's accounts. The manager became concerned, as John was known to her, and he had always been friendly and outgoing. Now he was quiet, withdrawn and looked fearful. The manager checked John's account and noticed that John had recently begun writing large checks to Sandy each month that were significantly out of the range of John's normal spending patterns. John refused the manager's request to meet with her privately for a few minutes to discuss his banking needs.

The bank manager made a referral to Adult Protective Services (APS). The APS investigator sought a psychiatric evaluation to determine if John had the cognitive and functional capacities to manage his financial affairs in a manner that would protect his personal self-interest. That evaluation revealed that John had legal and clinical capacity and could execute the tasks of money management.

The APS caseworker contacted the District Attorney's Office to ascertain if this case could be prosecuted. The Assistant District Attorney (ADA) explained to the caseworker that according to New York State law, Sandy's behavior - threatening John if he did not add her name to his savings account and writing outsize checks for her own benefit under the pretense of covering expenses - is coercion/grand larceny by extortion, a felony crime in the state.

With the help of APS, John decided to move in temporarily with one of his sons, leaving his daughter in his apartment after she refused to leave. With assistance from a day time home health aide, they are managing. John is back in charge of his own finances. He and his sons are working on how to ensure his safety before he moves back home. They are in discussions with the ADA about the best way to resolve the financial abuse. John wants to be repaid, but he does not want to prosecute his daughter. The ADA is helping John and his sons seek a solution that respects John's wishes but also addresses Sandy's criminal actions.

## Discussion

Once John experienced a decline in his physical health and required assistance with money management, he became vulnerable to financial exploitation, in this case, by a daughter. As was true in this case, practitioners working with older adults may need to seek the assistance of a qualified expert to determine if a person's decision-making capacity in one or more areas is impaired. While elder abuse can occur even when decision-making is intact, given the complex array of medical, psychiatric and cognitive issues that can impact older adults, the development of deficits in cognitive and functional abilities may leave older adults in dangerous situations. The evaluation of decision-making capacity informs case planning that balances the fundamental ethical principles of autonomy/self-determination and protection from harm.

## How to Locate an Evaluator

Many different types of professionals are qualified to conduct capacity evaluations. These include physicians, geriatricians, geriatric psychiatrists or geropsychologists, forensic psychologists/psychiatrists, neurologists, neuropsychologists and geriatric assessment teams. The most important criterion in determining who should conduct the evaluation is the clinician's knowledge of and experience in the capacity assessment of older adults.



Psychologists specializing in working with older adults (geropsychologists) and neuropsychologists with expertise in brain/behavior relationships are uniquely trained in the ability to use standardized assessment tools. A comprehensive evaluation that incorporates objective data about cognitive strengths and weaknesses as well as functional abilities is especially important in complex cases and can help identify strengths and weaknesses in various areas and can be honed to directly address the questions at hand.

In NYC, APS facilitates the referral to a psychiatrist for their clients requiring a capacity evaluation.

**For a general referral to diagnostic centers in NYC and for more information about the diagnostic process,** call the Alzheimer's Association's NYC Chapter's 24-hour Helpline: 800-272-3900.

## Assessing Mental Capacity

The following outlines the components of the mental capacity assessment.

**I. Clinical Interview** - A clinical interview allows the clinician to gain information on the client's medical and cognitive presentation, everyday functioning, individual values and preferences, risk of harm and means to enhance capacity. Functional information can be gained from family and/or staff as well as the client with an understanding that the client's report may differ from others. An assessment of medical diagnoses (medical, psychiatric or neurological) is important as these are often determined to be causes for deficits in cognition that contribute to functional or decisional disability.

Assessment of values and preferences is always



Assessment of values and preferences is always important in capacity assessment. An individual's decisions should be understood within the context of their lifelong values and ways of living. Some individuals make choices that seem outside the norm and may not appear to be "in good judgment", however, they are consistent with the individual's lifelong patterns and preferences. Assessment of values is important in determining capacity and in formulating interventions (e.g. guardianship plans) that will respect the individual's values and preferences.

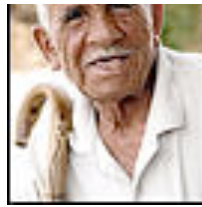


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**II. Objective Testing** - The development of standardized assessment tools to objectively measure functional abilities as well as cognitive abilities has contributed significantly to the ability to complete comprehensive capacity assessments.

**III. Functional Assessment Tools** - These tools have been developed to operationalize the legal standards for specific capacities into direct functional assessment instruments. Some specific tools have been developed in the following capacity areas: medical consent capacity, financial capacity, driving, and independent living. These tools are performance-based instruments in which individuals are asked to perform a series of pragmatic tasks equivalent to those performed in the home or the community. These measures are standardized, quantifiable, repeatable and norm referenced and can therefore be generalized across patients and settings.

**IV. Cognitive Assessment** Psychologists/Neuropsychologists are trained in the use of cognitive assessment tools which can identify strengths and weaknesses in cognitive domains which impact functional abilities. Areas of cognition which can be assessed with formal standardized measures include the following seven domains:

**A. Attention:** inability to attend to a task may be an indication of a delirious state which would significantly impact decision-making abilities.

**B. Language:** ability to express a choice and make complex medical and financial decisions requires speech production, language comprehension, reading and writing. Assessment of language abilities is a key component of a dementia assessment and can contribute to making that diagnosis.

**C. Memory:** memory impairment reduces decision-making by impacting the individual's ability to recall previously learned information and to integrate new information across choice options.

**D. Visual-perceptual:** impairment in this area can impact an older adult's ability to drive or to complete financial computations.

**E. Speed of processing:** slowed speed of processing can interfere with an individual's ability to make decisions specifically when under duress or pressure from another party (can contribute to undue influence).

**F. Executive Functioning:** includes more complex cognitive processes such as planning, thinking flexibly, reasoning, and inhibiting impulsive responses which all contribute to effective decision-making.

**G. Judgment and Reasoning:** the ability to use abstract reasoning and problem-solving is important when assessing an individual's capacity to make decisions in their best self interest



capacity to make decisions in their best self-interest.

**V. Psychopathology:** assessment of psychopathology should be conducted with instruments that have been determined to be effective with older adults. The focus should be on determining the impact that psychiatric or emotional factors have on capacity. This influence may be through cognitive processes (e.g. delusions, impaired judgment/insight) or cognitive deficits (poor attention, poor memory, poor executive functioning) or through particular behaviors associated with the psychiatric diagnosis (e.g. disinhibition).

**VI. The Conclusion Section** of the report should include diagnostic impressions, an opinion on the capacity being assessed (yes/no) and recommendations that may help optimize decision-making abilities or improve care for the individual.

For a list of assessment tools, refer to *Appendix C, page 164* of the [Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists](#). (This is the same link referenced in the preceding section of this eNewsletter entitled, *Collaboration between American Psychological Association and American Bar Association*.)

## In the Spotlight

This eNewsletter edition shines its spotlight on two dedicated, talented and accomplished professionals, Dr. Veronica LoFaso and Dr. Valerie Abel.

The NYC Elder Abuse Center's staff receives guidance from its Steering Committee, comprised of representatives from government agencies and non-profit organizations. With considerable contributions of time, talent and expertise from these dedicated Steering Committee members, NYCEAC is able to improve the lives of older victims and make substantial contributions to the field of elder justice. In each edition, NYCEAC's eNewsletter will spotlight a member of its Steering Committee. To these wonderful people: *Thank you*.

**Veronica LoFaso, MD**  
**Director of Medical Student Education**

**Division of Geriatrics and Gerontology**  
**Weill Cornell Medical College**  
**Associate Professor of Clinical Medicine**



**Veronica (Ronnie) LoFaso, MD** began her medical career as a nurse practitioner. Through her early practice she developed a keen awareness of the many ways the elderly are an underserved and unappreciated population. After she completed medical school, a specialization in geriatric medicine offered a natural progression for her interests.

Immediately following medical school in 1997, Ronnie joined New York-Presbyterian Hospital/Weill Cornell Medical College's Division of Geriatrics and Gerontology where she developed and directed the Division's Medical Housecall Program, serving elderly homebound patients. She not only

provided medical care in patients' homes, but also used the housecalls as a venue for teaching medical students and residents about chronic illness care. Ronnie also co-developed an innovative humanism-in-medicine program that requires all of Weill Cornell Medical College's third year medical students to go on a housecall visit and then create a project using any artistic medium they choose to express their feelings and reactions after the housecall exposure. (For abstracts of articles describing this work, click [here](#) and [here](#).)

In 2010, Ronnie left the housecall program to devote more time to elder abuse prevention. Ronnie is motivated by being an active member of NYCEAC's Steering Committee and its two multidisciplinary teams - and finds the effectiveness of the collective efforts of her esteemed colleagues energizing. Her work on the MDTs provides her with a sense of hope given the meaningful client interventions that result. A master educator, she brings her considerable teaching talents to NYCEAC through providing training to professionals throughout NYC on elder abuse detection, assessment, intervention and prevention.

In addition, Ronnie is an attending physician with the Division of Geriatrics and provides medical care through the Division's ambulatory care practice in Manhattan. Ronnie, motivated by helping to make her patients' lives more meaningful, feels inspired and privileged to hear the stories of her patients that often include, in rich detail, first hand accounts of historic events such as World War II, the Holocaust or The Civil Rights Movement.

Ronnie is also the Director of Medical Education for the Division of Geriatrics and Gerontology at Weill Cornell Medical College where she is an Associate Professor of Clinical Medicine. She is faculty advisor to the medical students in the Geriatric Fellowship Program there and finds this role enormously rewarding as she enjoys the Fellows' fresh enthusiasm. She has received numerous teaching awards including the prestigious Roland Balay Clinical School Award for Education in Housecalls. She is a leader in curriculum development, taking a particular interest in promoting humanism in the curriculum. Ronnie is further distinguished by having received the Leonard Towe Humanism in Medicine Award.

Ronnie received a B.A. from Fordham University, an M.S. from Pace University and an M.D. from Albert Einstein College of Medicine of Yeshiva University.

Sincere thanks to **Valerie Abel, PsyD** - our incredibly knowledgeable and deeply dedicated colleague - for her enormous contributions to this eNewsletter edition.



**Valerie Abel, PsyD**  
**Clinical Psychologist/Neuropsychologist**  
**VA New York Harbor Healthcare System**  
**Brooklyn Campus**

When Dr. Valerie Abel first decided to become a clinical psychologist, she wasn't thinking about developing a specialization in working with older adults. However, one of her first jobs in a nursing home changed that. Valerie was taken with the determination and will of most older adults to

Valerie was taken with the determination and will of most older adults to gain something from each day and also by the amazing stories and wisdom imparted in older adults' life stories. In hindsight, she believes that her close relationship with her grandmother, who lived with her family as she grew up, likely influenced her affinity for this population as well. Valerie felt that it was a unique privilege to be privy to the personal narratives of individuals in the last phase of their life and to be able to offer her services as a psychologist.

Valerie continued to work in various settings with older adults as well as in her private practice. She found that she greatly enjoyed the collaborative work with medical teams that was often required in treating this population. Her additional training to become a neuropsychologist was prompted by her awareness of the importance of understanding the interplay of cognitive and psychological functioning in people as they age. She is a strong proponent of healthcare models that integrate behavioral/mental health with medical health and sees this as vital in the future of healthcare overall. She is actively involved in advocacy and training for psychologists to be prepared for changes in healthcare delivery models that will result from healthcare reform.

More recently, Valerie has worked at the Brooklyn VA New York Harbor Healthcare System where she helped to develop a postdoctoral fellowship program for psychologists who are seeking specialty training in geropsychology. Her work there has focused on the growing population of older adults across the age range in primary care, the oncology service and in the nursing home setting. The VA recognizes the vast experiences of different cohorts of veterans and supports this with various projects such as the Veterans Oral History Project. This congressionally mandated program within the Library of Congress' American Folklife Center collects, preserves, and makes accessible the personal accounts of American war veterans. Valerie encourages her clients to participate in this program, believing that future generations will benefit from hearing the poignant stories of those that served our country in the military, and how that experience shaped and impacted their lives.

Valerie is inspired by veterans' stories. She notes the numerous women veterans who served in World War II as part of the Women's Army Auxiliary Corps (WAAC). Valerie has observed these pioneering women, who were the first women other than nurses to serve with the Army, to very often possess superior leadership skills and a demonstrated ability to navigate their way through their post war life with an irrepressible spirit and determination significantly in advance of the women's movement.

Valerie received her PsyD in clinical psychology from Ferkauf Graduate School of Psychology/Yeshiva University and a post-doctoral certificate in neuropsychology from Fielding University. She is actively involved in professional psychology organizations. She served as the President of the Division of Adult Development and Aging of New York State Psychological Association (NYSPA) in 2010, and in 2011 she was the Chairperson of the Task Force on Integrated Healthcare for NYSPA. She is employed as a clinical psychologist/neuropsychologist at the Brooklyn VA New York Harbor Healthcare System and she maintains a private practice in neuropsychological assessment in Park Slope, Brooklyn. Dr. Abel can be contacted by email at [Valerie.Abel@va.gov](mailto:Valerie.Abel@va.gov).

## Inspiration

**Athol Fugard**

Playwright, Novelist, Actor, Director, Teacher

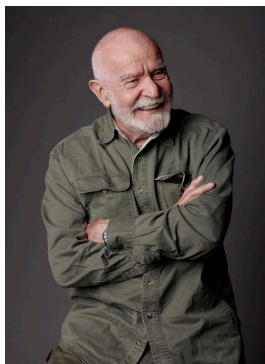
## Playwright, Novelist, Actor, Director, Teacher

Athol Fugard - a distinguished South African playwright, director, actor and social activist - was "a key figure in the cultural struggle against apartheid."

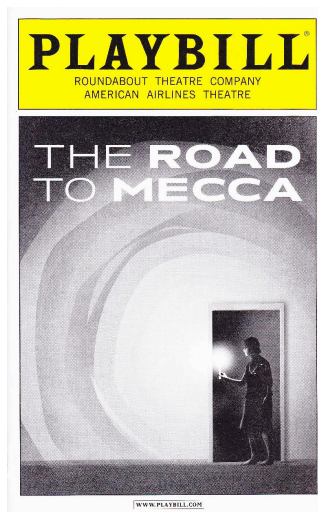
The Road to Mecca, one of Mr. Fugard's most famous plays, was produced by the [Roundabout Theater Company](#) in New York City in 2012.

Elder justice advocates recognize the dynamic at work in this play when a main character is admonished for taking the "grossest advantage" of the protagonist's supposed "confusion and helplessness."

If you missed The Road to Mecca, but want to see other plays by Mr. Fugard this year, check out the [Signature Theater](#) website for scheduling information.



SIGNATURE THEATRE COMPANY  
Pictured: Playwright Athol Fugard  
Photo © 2011 Gregory Costanzo



**Mr. Fugard will celebrate his  
80th birthday in 2012  
Happy Birthday, Mr. Fugard!**

## Upcoming Events

### Upcoming Multidisciplinary Team Meetings

Professionals throughout Brooklyn and Manhattan have an opportunity to present complex elder abuse cases to the NYCEAC's multidisciplinary teams in Manhattan and Brooklyn to receive recommendations on assessment and interventions from the teams. For more information, please refer to the individual sections of NYCEAC's website re: the MDTs: [EACCRT](#) and [Brooklyn MDT](#).

The following are the upcoming dates for these MDT meetings:

#### **Elder Abuse Case Coordination and Review Team (EACCRT) Meeting**

Next Meeting Dates: May 2, 2012  
Time: 9:30 AM -11:00 AM  
Place: Convenient Manhattan location  
RSVP: Email [Robin Roberts](#) or call at 718-722-4839.

#### **Brooklyn MDT Meeting**

Date/Time: Wednesday, May 2, 2012, 9:00 -10:00 AM, 9 meetings/year/month

Date/Time: wednesday mornings, 9:00-10:30 AM, 3 meetings/per month  
Place: Downtown Brooklyn location  
RSVP: Email [Robin Roberts](mailto:Robin.Roberts@nyceac.com) or call at 718-722-4839.

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