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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 2013**

### ***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. This edition focuses on:

### **Exploring the Intersection of Elder Abuse and Mental Health**

In this eNewsletter edition, we explore only some of the issues at the intersection of mental health and elder abuse: the role of primary care physicians, integrating mental health services into elder abuse services, the relationship between older victims and dependent adult children, evaluating older victims with PTSD and the need for advocacy.

But this eNewsletter is brief, touching on just some of the many complex issues related to mental health and elder abuse. This conversation must continue - in our offices with colleagues, during multidisciplinary team meetings, in online conversations, at conferences, with policymakers and legislators, with older adults, with students - and beyond.

## Acknowledgments

Thank you to our esteemed colleagues for their on-going and significant work in the area of geriatric mental health and elder abuse and for their contributions to this eNewsletter:

*Jacqueline Berman, PhD, Pat Brownell, PhD, Ronnie LoFaso, MD, Nancy Needell, MD, Patrick J. Raue, PhD, Aurora Salamone, MPS, Jo Anne Sirey, PhD, Judith Smith, PhD, and Kimberly Williams, LMSW.*

Thank you also to *Sarah Dion* and *Alexandra Pearson* for their assistance in developing this eNewsletter edition. And please scroll down to the end of the eNewsletter for a list of NYCEAC's extraordinary Steering Committee members - to whom we are most grateful.

We hope you find the information provided in this eNewsletter useful and directly relevant to your work. We welcome your feedback and ideas for future editions. Please [email us](#) your thoughts and suggestions - we want to hear from you!

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

Regards,

Risa Breckman, LCSW, Executive Director  
Mark Lachs, MD, MPH, Medical Director  
Robin Roberts, LMSW, Multidisciplinary Team Coordinator



## A Brief Overview of Mental Health and Elder Abuse Issues

by Risa Breckman, LCSW, NYC Elder Abuse Center

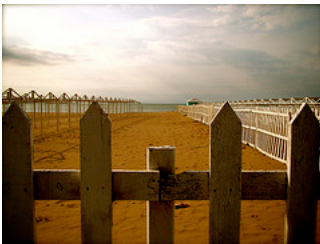


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The intersection of elder abuse and mental health is important and complex.

We know from research that elder abuse victims have a high prevalence of depression. (1) Depression can easily lead to social isolation, a significant risk factor for abuse. What follows? Hopelessness. This, in turn, increases the risk of suicide.

### *Consequences of Abuse*

But the emotional devastation of abuse encompasses far more than depression. Anxiety is common for victims due to the trauma previously experienced, continual fear for their current and future safety and the worry they feel for their abusive family members whom they often care deeply about. Victims feel shame and guilt which also contributes to social isolation. Drug and alcohol use is more common among abused elders than their non-abused

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counterparts. (2)

Victims may suffer from a range of physical complaints, including chronic pain, gastrointestinal complaints, neurological complaints, arthritis, and gynecological problems, such as vaginal bleeding and pelvic pain.(3)

Early death is very often the result of the slow and corrosive nature of abuse. Abused elders are 300% more likely to die a premature death than their non-abused counterparts.(4)

### *Need for Screening and Effective Responses*

In NYC (and the rest of the country), older adults are not routinely screened for mental health problems - or elder abuse - in the many traditional and non-traditional settings where they receive services including, physicians offices, senior centers, social and medical adult day care programs, home health services and case management programs.

Why does this matter? Elder abuse victims who are depressed or have other debilitating mental health problems can't readily protect themselves. Imagine being elderly and isolated, having been physically injured and worn down from abuse, financial exploitation or neglect. Now imagine trying to develop and follow a safety plan, obtain an order of protection or find somewhere else to live while experiencing the fatigue, worthlessness and indecisiveness associated with depression. Or imagine trying to plan for safety while frozen with fear and anxiety about possible retaliation. Depression and other mental health problems may be a consequence of abuse, but these also put elder abuse victims at risk of continued abuse.

So screening elder abuse victims for mental health problems is an important first step. A careful assessment, thoughtful response, and follow-up should follow.

### *Abusers Often Have Significant, Untreated Mental Health Problems*

Abusers also, not infrequently, have mental health problems. Many cases of elder abuse involve adult children or other relatives with significant mental health and/or substance abuse problems and a history of violence dependent on the older adult for housing, money and other support. In other cases, caregivers with depression can find themselves unable to adequately manage the care needs of older adults, which can contribute to neglect. Caregivers feeling anxiety, depression or resentment coupled with anger have been shown to be at risk of exhibiting potentially harmful behavior towards older care recipients.(5) All of these people need assistance to prevent abuse and reduce their suffering.

### *Assisting Friends, Neighbors and Non-Abusive Family Members*

In addition, friends, neighbors and non-abusing family members can be deeply impacted by elder abuse.(6) Consider the following: A neighbor hears cursing and yelling through a shared apartment wall every night but doesn't know how to help the older person living there with her constantly high, drug addicted son; a niece knows a beloved aunt living in another state is being neglected by her husband but, fearing the options, chooses the status quo; a close friend recognizes that something is very wrong when a formerly outgoing confidant is no longer interested in socializing - all of these scenarios can cause significant, on-going distress for the caring, empathic people in an older victim's circle. They often need a responsive, knowledgeable professional to respond to their emotional pain, explain abuse and safety issues, assist in defining a realistic helping role, identify available services, and bolster their support of the older victim, if possible. Because without the

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continued involvement of these concerned people, the victim becomes ever more isolated, increasing the likelihood of further abuse and suffering.

[Click here for references.](#)

## Exploring the Issues

### **The Role of the Primary Care Physician in Assessing and Treating the Mental Health Concerns of Elder Abuse Victims**

*by Veronica LoFaso, MD, Weill Cornell Medical College*

An estimated 72 million persons will be over the age of 65 by the year 2030 and primary care physicians will be seeing larger numbers of older adults in their practices. Sadly, a significant portion of these older adults will be victims of elder abuse that goes undetected. Researchers have found that, in New York State, for every one case of abuse that comes to the fore, 23 cases go undetected. Primary care physicians, at the frontline of care, are well situated to uncover and treat cases of abuse and the emotional sequelae that accompany mistreatment.



#### *Consequences of Abuse*

Elder abuse can have devastating, long-lasting effects on older adults. Depression and anxiety can consume their days and leave them emotionally and physically frail. We know that victims of abuse have poorer health outcomes and increased mortality. Victims of abuse often do not or cannot adhere to medical regimens and basic health maintenance because of their depression or anxiety.

Frequently victims have been subjected to multiple episodes and types of abuse over a lifetime. This so-called polyvictimization can result in a post-traumatic stress like syndrome. Many turn to drugs and alcohol to lessen the emotional pain. Some may manifest multiple physical/somatic complaints without a plausible diagnosis. Some patients can feel so hopeless that they consider suicide.

#### *Importance of Relationship, Detection and Response*

A trusting and non-judgmental relationship with a primary care health provider is extremely important. This is a significant part of the art of the healing and should be at the core of the physician's work with elder abuse victims. The relationship carries the work, increasing the likelihood that the victim and non-abusing family and caregivers will disclose abuse and adhere to recommendations.

Early detection of abuse and prompt recognition and treatment of the mental health issues resulting from it will significantly improve the quality of life of elder abuse victims. Primary care physicians should be routinely screening for mental health issues like depression and anxiety and should consider domestic violence, including elder abuse, when evaluating patients who exhibit these symptoms.

Responses should utilize a multidisciplinary team approach with the recognition that one is treating a family unit. Many primary care physicians feel comfortable treating depression and anxiety. However in more complex cases they may choose to refer to psychiatrists, psychologists and to community or hospital social workers. Pharmacologic interventions and ongoing counseling for patients and families exhibiting post-traumatic stress can support the victims as they begin to rebuild after such an emotional trauma.

Primary care physicians should become informed about community agencies with which to partner in order to formulate comprehensive care plans for their patients who have endured abuse. Creating a supportive social environment for the individual to move forward should be the goal. This might include involving senior centers, elder abuse support groups or other community programs for the elderly where the victim can feel safe and understood. In some cases helping the older victim to relocate is the only option to avoid ongoing stressors impacting on emotional and physical health.

Patients who are refractory to first line behavioral or pharmacologic treatments of depression may require hospitalization for more complex pharmacologic management or to address substance abuse issues that often co-exist with elder abuse.

## **Integrating Mental Health Into an Elder Abuse Service**

*by Jo Anne Sirey, Ph.D., Weill Cornell Institute of Geriatric Psychiatry, Weill Cornell Medical College;*  
*Jacquelin Berman, Ph.D., NYC Department for the Aging;*  
*Aurora Salamone, M.P.S., NYC Department for the Aging;*  
*Patrick J. Raue, Ph.D., Weill Cornell Institute of Geriatric Psychiatry, Weill Cornell Medical College*

There is an emerging research literature documenting a reciprocal link between elder abuse and emotional distress, but there remains a significant gap in services. Emotional difficulties are considered risk factors for abuse; and are found to be negative consequences of abuse.<sup>(1)</sup> Not surprisingly, emotional abuse was found to be associated with poor global mental health even after considering support, health and functioning.<sup>(2)</sup> Depressive symptoms were found to be associated with mortality among abuse victims.<sup>(3, 4)</sup> In the Women's Health Initiative, abuse was associated with depressive symptoms and worse mental health at follow-up three years later.

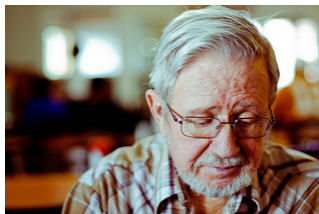


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By contrast, social support and optimism were associated with better mental health outcomes, providing opportunities for intervention.<sup>(5)</sup> To echo the need in the area of mental health and elder abuse, The National Institute on Aging (NIA) and National Institutes of Health (NIH) highlighted; "In the area of mental health and elder abuse, salient findings include the lack of collaboration due to poor coordination and a basic misunderstanding about the goals of different agencies. However, few studies exist with a primary focus on mental illness"<sup>(6: p.11)</sup>

To bridge the gap in services our collaboration between the [Weill Cornell Institute of Geriatric Psychiatry of Weill Cornell Medical College](#) and the [New York City Department of Aging](#) (DFTA) [Elderly Crime Victims Resource Center](#) (ECVRC) is trying to integrate a skill-based mental health intervention

into elder abuse services to improve mental health and promote abuse resolution for older adults in crisis. The program is based on the premise that without tackling the victim's mental health needs, the elder abuse services will be less effective, more costly to provide, and miss an opportunity to improve both mental health and elder abuse outcomes.

As a first step we asked ECVRC staff about their usual mental health practice. While most had mental health training, only 13% often ask about anxiety, 25% often ask about depression, and suicide is not routinely assessed. However, all of the staff felt that managing depression, integrating mental health interventions and screening all fit within the services provided. All of the staff indicated that they were comfortable adding screenings for mental health. To integrate the screening, we held a day long training meeting to discuss both



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how to screen for depression and anxiety using the [PHQ-9](#) and [GAD-7](#) and how to integrate the screening into the services rendered. This training is followed by a booster consultation one month after the screening has begun. The team has regular meetings to discuss screening and its integration into services.

To date, over 180 individuals have been screened as part of the services they received from the Elderly Crime Victims Resource Center. Of those individuals screened, 29 percent were found to be at risk for major depression. Among those screened for depression, 15% reported suicidal ideation for at least several days in the last 2 weeks. In the screening to date, more than 1 in 5 clients (22%) were found to be at risk for anxiety disorder. In sum, to promote mental health among abuse victims, introducing systematically screening and identifying mental health needs concurrent with offering elder abuse services may help bridge the gap. Cross agency collaborations offer unique opportunities to modify practice and build innovative services that are more holistic and integrated.

[Click here for references.](#)

## **Ambivalence as a Factor in Victim Responses to Abuse by Adult Children with Mental Illness**

*by Judith Smith, PhD and Pat Brownell, PhD, Fordham University Graduate School of Social Service*

The New York Post headline screams: EVIL SON! Murders Mother (age 66) Then Murders Father (age 77)! The reading public wonders why the mother didn't force the substance abusing mentally ill adult son from the home, and professionals working with older adults caring for impaired adult children cringe.



Cases like this represent among the most difficult for elder abuse professionals: unimpaired older adult family members of impaired adults who refuse protection for themselves in the interest of helping their abusive loved ones. Crafting interventions for these families means comprehending the complex emotional dynamics binding victims and abusers together.

To understand how to intervene to help older victims of elder abuse who have been abused by their own adult children, it is helpful to examine what is

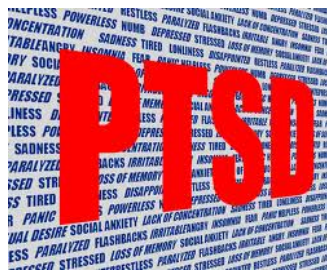
known about parenting in later life, particularly among parents who have dependent and mentally disabled adult children.<sup>(1)</sup> Later life parenting is not guided by legal or social norms, as is parenting relationships for children younger than age 18. Scholars like Karl Pillemer, <sup>(2)</sup> and Ingrid Connidis and Julie Ann McMullin <sup>(3)</sup> have begun to use the theoretical lens of ambivalence to study intergenerational relationships in later life. The theoretical construct of ambivalence allows researchers to study how parents and adult children manage the conflicting poles of autonomy and dependence. Older parents can hold conflicting feelings of wanting to support and protect their older children, while also wanting their adult children to be self-sufficient. Older parents of adult children with mental illness may want to be "free" of the burden of caring for their adult children, but also cognizant of the difficulty in locating appropriate psychiatric care and residents.

The lens of ambivalence can inform clinical work with older parents. Helping older parents acknowledge their dual and conflicting feelings can lead to the client feeling understood and possibly more able to take action to protect themselves. Research shows that older parents with impaired adult children want to protect their children side by side with wishing to be finished with direct parenting and wanting time for "me." Knowledge of available services coupled with the skill of helping an older person examine their conflicting emotions could address the health and well-being of the older person and their adult child.

[Click here for references.](#)

## Evaluating Post-Traumatic Stress Disorder in the Elderly

by Nancy J. Needell, MD, Weill Cornell Medical College



Post-traumatic stress disorder results from having survived or witnessed a severe traumatic event. Because older people are particularly vulnerable to trauma, an understanding of post-traumatic stress disorder (or PTSD) is essential for anyone who works with elderly people, especially victims of elder abuse.

### Diagnostic Criteria

In order to meet the criteria for PTSD, a person has to have survived or witnessed an event that caused them to realistically fear for their lives or the life of someone close to them. The most common events stem from war, accidents, natural disasters, or physical or sexual violence. The person has to have believed that his or her survival was "out of their hands" and that nothing they could do would make a difference. The element of powerlessness is crucial to raising the traumatic incident to the level of a "signal event" that can cause PTSD.

The symptoms of PTSD fall into three main categories. The first is "re-experiencing the event," in which a person can have flashbacks of the trauma, have nightmares about it, or become very upset when exposed to situations or triggers that remind him/her of the event.

The second group of symptoms involves intense avoidance of anything related to the incident; people describe feeling numb or "being outside themselves," saying they feel like they are watching a movie instead of living. This often looks like depression, with a withdrawal from previously enjoyed activities and a sense of hopelessness.

Finally, a person with PTSD will have a heightened sense of arousal - they

may have poor sleep, jumpiness, angry outbursts, or irritability.

In addition to the psychological and behavioral symptoms that make up the criteria, people with PTSD often express physical symptoms. They may have a racing pulse or fast heartbeat, may complain of chest pain or shortness of breath, or may feel like they are dying of a heart attack. They are at risk for developing substance abuse problems (as part of the numbing) and for neglecting their physical wellbeing.

### *Complicating Factors in Diagnosing PTSD in Later Life*

Identifying PTSD in older persons can be quite complicated, as the inciting event can have occurred anywhere in the life cycle. Some people have had lifelong untreated PTSD, while others were traumatized early in life, but do not experience the symptoms until later, especially as they lose physical independence and become more cognitively impaired, needing more "hands on" help and possibly misinterpreting assistance as abuse. Still others experience the traumatic event late in life, sometimes after cognitive impairment has begun.

Some older people are survivors of physical or sexual abuse, either in childhood or adulthood (or both). Some have lived through domestic violence or been the victims of street crime. Many older adults have seen active combat, including the Vietnam War, while others lived through terrifying conditions, such as the Holocaust, the Killing Fields, or the Chinese Cultural Revolution. Still others have seen their worlds torn apart by civil war, gang violence, the AIDS epidemic, or natural disasters.

In some cases, PTSD occurs late in life, via a terrifying fall or witnessing the sudden cardiac arrest and death of a life partner. Older people are often victims of abuse through home invasion, street crimes, or other form of physical or sexual abuse, whether at the hands of a stranger, relative, neighbor, or caregiver.

### *Diagnosis is Important*

Making a diagnosis of PTSD in a person suspected of being a victim of elder abuse is important for many reasons. As with most psychiatric disorders, the most important step is identifying its presence. People with PTSD often seem like "troublemakers" or excessively high maintenance people, when, in fact, they are on constant "inner alert," always guarding against the re-experiencing of a life-threatening event, sometimes one they may not even remember. They may seem paranoid, angry, depressed, or withdrawn. They may have frequent physical complaints with no clear medical cause. They may be unable to work with caregivers and have alienated family. They may drink alcohol and overuse prescription medications. By learning such a person's history and learning to screen for PTSD (through sensitive interviewing and gathering collateral information), a caregiver can identify the possible presence of PTSD and help steer an older person into treatment.



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### *Treatment is Available*

And there are good treatment options available, even for people with mild-to-moderate dementia. Behavioral and environmental interventions can be



made to help reduce the triggers that can cause a person to re-experience the trauma. For example, when bathing or toileting a person known to have survived a physical or sexual assault, caregivers can approach with a more gradual and gentle approach, tailored to the individual with the aim of not having him or her re-experience the assault. At times, medications can be used to help relax such a person before a necessary medical procedure, especially if it is invasive.

Psychotherapy, especially cognitive-behavioral therapy (CBT), has been shown to be extremely effective in reducing the severity of symptoms in PTSD. Through CBT, a person can learn skills to reduce their body's response to the stress signals that the mind sends out when something reminds him/her of the trauma. This, in turn, can train the mind to limit the signals themselves. And, while medication alone does not treat PTSD, it can be helpful in many circumstances, as described above.

Finally, documenting the presence of PTSD can go a long way towards establishing that the abuse actually took place, which can have important legal implications.

Anyone working with an older person exhibiting any of these symptoms should make a referral to a mental health professional, who can perform a full evaluation to assess for the presence of PTSD. The VA system has many treatment programs to address PTSD in our nation's soldiers. Community mental health agencies, psychologists, and social workers are trained to help treat PTSD as well. And, as our nation's population ages, more and more attention (but still not enough) is being paid to the impact of PTSD in our aging population.

## **The Complexity of Elder Abuse and Mental Health Issues: A Call to Action**

*by Kimberly A. Williams, LMSW, Geriatric Mental Health Alliance of NY*

Mental health issues are present with every case of elder abuse - whether experienced by the victim or perpetrator. Elder abuse victims are vulnerable to depression that often leads to social isolation, which is itself a risk factor for abuse. Anxiety also common for victims, due to the trauma of the experience, fears about safety, and worries for their abusive family member. Addressing the mental health needs of victims is key to a comprehensive response to these complex cases and to ensuring improved overall outcomes.

Additionally, perpetrators, who are likely to be family members, sometimes suffer from serious mental illnesses, which are often untreated and co-occurring with substance use disorders. In some cases the abuse takes place due to the stress of caring for an aging parent.

The mental health needs of elder abuse victims and their perpetrators are frequently not adequately addressed. Barriers to treatment include lack of available services, including outreach and engagement; lack of services in the home and community settings; and failure to coordinate care.

In order to improve services for elder abuse victims and their perpetrators, advocacy is needed to

press both public and private sectors to confront these issues. An advocacy agenda to address the complex mental health issues in elder abuse cases would include:

- Improved identification, assessment, and treatment services for elder abuse victims
- High-intensity support programs for people with serious and persistent mental illness
- Mobile crisis teams
- Integrated mental health and substance abuse treatment
- Training and education for adult children on how to care for their aging parents
- Training for mental health and substance abuse providers on elder abuse



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Let's aggressively press for these mental health policy reforms so as to help prevent these incidents from occurring and to improve the quality of life of victims and their perpetrators.

## **NYCEAC's New Brochure: *There is Hope, There is Help***

*by Sarah Dion, NYC Elder Abuse Center*

Last year, several elder abuse cases involving an abusive loved one with serious and persistent mental illness ended tragically in Brooklyn. Soon afterwards, a subcommittee was formed within the [NYC Elder Abuse Center's Brooklyn MDT](#) to develop a brochure, focusing on the special needs of older people living with a relative with untreated mental health issues and a violent history. The [new brochure](#) explains the dangers, warning signs and resources providing help for both the victim and the abuser.



NYCEAC would like to thank Bernadette Delaney, Sarah Dion, Peg Horan, Ronnie LoFaso, Mary Olsen, Robin Roberts - and all of the members of the Brooklyn MDT - for the time, thought and care they gave to the development of this brochure.

Please contact [Sarah Dion](#) if you are interested in receiving copies of this brochure for distribution, or if you are interested in having this brochure adapted to the needs of your borough.

## **A 'Must Read' Blog Post: "Realistic Depictions of Elder Abuse in *Silver Linings Playbook*"**

*by Alexandra Pearson, MA, NYC Elder Abuse Center*



In the Academy Award winning film, *Silver Linings Playbook*, Director David O. Russell explores the tumultuous and at times abusive family dynamics between two older parents trying to take care of their mentally ill son with violent tendencies following his release from a legally mandated period of institutionalization.

Going against medical advice and without the knowledge of her husband Pat Solatano Sr., Dolores Solatano discharges her son, Pat Jr., and brings him home to Philadelphia, where as per the agreement of his release, he must move back in with his parents.

*Silver Linings Playbook* presents the challenges faced by elderly parents caring for a dependent adult child with mental health issues with a history of violence. Through moments of violent outbursts and dark humor, this quirky romantic comedy highlights the importance of properly assessing and treating mental health issues, and the increased risk of elder abuse that comes with caring for untreated, mentally ill adult children with a history of violence.

[Click here for NYCEAC's 'must read' blog post by Jacob Wolk. "Realistic Depictions of Elder Abuse in \*Silver Linings Playbook\*."](#)

## In the Spotlight

This eNewsletter edition shines its spotlight on the dedicated, talented and accomplished Ken Onaitis, a NYCEAC Steering Committee member.

Ken Onaitis, LMSW, is a passionate elder justice advocate and veteran of the frontlines in the fight against elder abuse. Getting his start in social work in a county welfare department, Ken transitioned into construction and residential project management. He returned to the field twenty years later after getting his Masters of Social Work from Fordham University. Ken accepted a position with Safe Horizons and ran their elder abuse program with a small business mentality for two years.



Ken has since been with the [Carter Burden Center for the Aging](#) for 13 years, where he currently serves as the Director of Elder Abuse and Police Relations. Initially he served as the Director of the Safe Streets program, working in tandem with the New York Police Department to create a linkage between the community and the aging network to better meet the needs of stranger crime victims.

Throughout his career at the Carter Burden Center, Ken has had the opportunity to practice social work on all levels, ranging from the political sphere to direct client services. Thanks in part to the Carter Burden Center's interagency work and macro-approach to elder abuse services, he's been able to take on a variety of leadership positions as a social worker. Today, Ken spearheads their [Community Elder Mistreatment and Abuse Prevention Program \(CEMAPP\)](#), where he engages in many collaborative and multidisciplinary efforts throughout his case work.

A partner from day one, Ken describes his participation with the NYC Elder Abuse Center as a natural growth in his work on elder abuse awareness and advocacy. Through the mission and reach of NYCEAC, working professionals

are able to speak to elder abuse to the city as a whole, which according to Ken, "adds more dimension to the world of elder abuse."

Ken is on the Advisory Boards of the William B. Hoyt Memorial Children and Family Trust Fund, the New York State Adult Abuse Training Institute, New York City Elder Abuse Center, and New York City Adult Protective Services. Ken is also the past Co-Coordinator of the New York City Elder Abuse Network (NYCEAN) and NASW's New York City Gerontological Committee.

With his retirement on the horizon this coming month, we would like to thank Ken for his dedication and service in the elder justice field and wish him all the best in his future endeavors.

## Check Out the Elder Justice Events Calendar to Find Out What's Happening in NYC and Beyond



Are you sponsoring a community fair on aging services? A workshop on guardianships? A lecture on social isolation? A conference on caregiving? A webinar on responding to trauma in later life?

**If your event touches on any aspect of abuse, neglect and exploitation - building awareness about it or focusing on prevention, response, education or research - then please post your event on NYCEAC's events calendar.**

The [events calendar](#) was created with you in mind, responding to the need for a central place for the NYC elder justice community to list events related to elder abuse, neglect, and exploitation. This feature allows you to easily and quickly submit information. Check out what's happening on the events calendar, and if you want to [post an event](#), do so in seconds directly through NYCEAC's website.



NYCEAC's no cost eNewsletter is an excellent resource for an in-depth look at some of the most pressing issues in the field of elder justice. Each issue features new guest writers, case studies, and profiles of experts in New York City.

Launched in April 2011, NYCEAC's eNewsletter has explored a number of pertinent topics related to elder abuse:

- Edition 1: Overview of the NYC Elder Abuse Center
- Edition 2: Coming up: Guardianship/Alternatives to Guardianship
- Edition 3: Intimate Partner Abuse in Later Life
- Edition 4: NYC's Temporary Shelter Options for Elder Abuse Victims
- Edition 5: Capacity Evaluations in Elder Abuse Cases
- Edition 6: Social Media
- Edition 7: Exploring the Intersection of Elder Abuse and Mental Health

These editions are [archived](#) on NYCEAC's website. To subscribe at no cost, [click here](#).

We want to hear from you. We are eager to help you in your work to increase the dignity and safety of older adults. If you have an elder justice-related topic

you would like us to write about, please contact us and let us know your idea.

## Inspiration



Alice & Richard Matzkin

Through their nearly 100 paintings and sculptures, Alice and Richard Matzkin celebrate aging with magnificent gusto. The Matzkins became inspired by their own aging process fifteen years ago when Alice was 58 and Richard was 55 years old, and have since explored the experience of growing older through artist expression. Their mission statement reads:

*"As part of our personal growth and our responsibility as elders, our intention is to share what we have learned about growing older. By exhibiting our art, speaking and writing, we intend to spread the important message that aging is not the end of life, but can be a positive new beginning and the crowning culmination of a lifetime."*

Taking to their own mediums, Richard and Alice Matzkin [play off of each other's creativity](#). Richard explored the fears of extreme aging and the weakening male body through his sculptures. One of his pieces from the "Lovers" series was included in UNESCO's book, "The Great Age." Following Richard's work on masculinity and aging, Alice decided to depict the aging female body. In "Women of Age: Portraits in Wisdom, Beauty, and Strength", a documentary they produced, Alice interviews 21 inspiring older women whose portraits she painted for a wall calendar, celebrating the aging female body. Two of her paintings were purchased by the National Portrait Gallery of the Smithsonian Institution and remain in their permanent collection.



Beatrice Wood at 105, painted by Alice Matzkin. Image from <http://www.matzkinstudio.com>

Last year Alice and Richard Matzkin were named two of the National Center for Creative Aging's "beautiful minds." Their book, [The Art of Aging: Celebrating the Authentic Aging Self](#), won the Nautilus and Independent Publishers book awards. To learn more about Alice and Richard's work, please visit their online studio: <http://www.matzkinstudio.com/>

## 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 Date: Wednesday, April 3, 2013  
Time: 9:30-11:00am  
Place: Convenient Manhattan location  
RSVP: Email [Robin Roberts](mailto:Robin.Roberts@nyceac.com) or call at 718-722-4839.

### Brooklyn MDT Meeting

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.

## Acknowledgments

NYCEAC's staff receives guidance from its [Steering Committee](#), comprised of many deeply knowledgeable experts from diverse fields. With considerable contributions of time, talent and expertise from these dedicated professionals, NYCEAC is able to improve the lives of older victims and make substantial contributions to the elder justice field. To these wonderful people: *Thank you.*

The following organizations are represented on **NYCEAC's Steering Committee**:

Alzheimer's Association NYC Chapter, Archaeos, Bronx County's District Attorney's Office, Brookdale Center for Healthy Aging & Longevity, The Carter Burden Center for the Aging, The Council for Senior Centers and Services, CONNECT, Fordham University Graduate School of Social Service, Geriatric Mental Health Alliance of NY, The Harry & Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale, Heights and Hills, JASA, Kings County's District Attorney's Office, Mount Sinai Hospital's Elder Abuse Program, Neighborhood SHOPP, New York County District Attorney's Office, New York-Presbyterian Hospital, NYC Department for the Aging, NYC Housing Authority, NYC Human Resources Administration Adult Protective Services, New York Legal Assistance Group, Queens County District Attorney's Office, Renaissance Economic Development Corporation, UJA - Federation of New York, United Federation of Teachers, and Weill Cornell Medical Center's Division of Geriatrics and Palliative Care.

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*We want to hear from you!* If you have ideas for articles or other suggestions about how this eNewsletter could be helpful to you in your work with elder abuse victims, please [email us](#) or call Risa Breckman at 212-746-1674.

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