Elder Abuse Prevention Interventions (EAPI) Initiative in New York State

Policies and Procedures: Enhanced Multi-Disciplinary Teams **SUPPLEMENT**

Role and Responsibilities of Geriatric Psychiatrists or Geropsychiatrists

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Acronyms and Terms

Acronym / Phrase	Term
ACL	Administration for Community Living
APS	Adult Protective Services
DA	District Attorney
DANY	District Attorney of New York (Manhattan)
EAPI	Elder Abuse Prevention Interventions Initiative
E-MDT	Enhanced Multi-Disciplinary Team
Finger Lakes	Finger Lakes region: Counties participating in EAPI pilot
Geriatric Psych or Geropsych	Geriatric Psychiatry, also known as Geropsychiatry (used interchangeably.)
Lifespan	Lifespan of Greater Rochester
MDT	Multi-Disciplinary Team
NYCEAC	New York City Elder Abuse Center
NYSOFA	New York State Office for the Aging
NYS OCFS	New York State Office of Children and Family Services
WCM	Weill Cornell Medicine

Introduction and Background

The New York State Elder Abuse Prevention Interventions (EAPI) Initiative was launched in New York State in 2012 under a grant from the Administration for Community Living (ACL) to the New York State Office for the Aging (NYSOFA).[1] Project partners convened to implement an intervention designed to prevent and address financial exploitation and elder abuse. By bringing together entities from each unique local project site, coordinated, enhanced multi-disciplinary teams (E-MDTs) were established to provide effective cross-systems collaboration and specialized responses. The overall aim was to effectively restore safety and security to older adults. The E-MDT model is currently being implemented in Manhattan by the New York City Elder Abuse Center (NYCEAC), hosted by the Weill Cornell Medicine (WCM), and in seven counties in the Finger Lakes Region in upstate New York by Lifespan of Greater Rochester Inc. (Lifespan). The model is based on an existing multi-disciplinary team (MDT) structure previously established in Brooklyn, NY. In the E-MDT model, participants include partner agencies and stakeholders representing a range of disciplines, including Adult Protective Services (APS), the aging services network, financial services, law enforcement, legal, social service, victim assistance, health care, mental health, and other agencies and organizations.

The EAPI Initiative in New York targets frail adults aged 60 and over residing in Manhattan and the Finger Lakes region for whom there is evidence of financial exploitation and who also have at least one of the following characteristics: (1) health problems and/or physical impairments; (2) cognitive impairment or dementia; or (3) inadequate social support or a degree of social isolation that places them at high risk for becoming victims of abuse. Significant partners in the EAPI Initiative include: Project Director and additional staff from the New York State Office for the Aging (NYSOFA); key representatives from the New York State Office of Children and Family Services (OCFS) who oversee the Adult Protective Services (APS) program and other adult abuse prevention services and programming; Monroe County Office for the Aging (MCOFA) for project administration; Lifespan, the pilot site team lead for program administration, E-MDT coordination and implementation of the EAPI Initiative in the Finger Lakes; other local Finger Lakes region human service, protective services, health, mental health, legal, and law enforcement agencies; NYCEAC pilot site team lead and other staff from NYCEAC for program administration, E-MDT coordination, and implementation of the EAPI Initiative in Manhattan; New York City APS, and other Manhattan-based aging, elder abuse prevention, temporary shelter, health, mental health, legal, financial and law enforcement agencies.

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1 EAPI Initiative Evaluation: For the EAPI Initiative, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with NORC at the University of Chicago to design and conduct an evaluation of the EAPI interventions. NORC at the University of Chicago is an independent research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions. The purpose of the evaluation was to study the development and implementation of the state grantees' elder abuse interventions and report findings on the characteristics of victims and perpetrators of elder abuse or those at-risk, the use of prevention services, and outcomes. The Report is titled, *Developing and Conducting an Evaluation of AoA's Program to Prevent Elder Abuse: Final Report* (NORC at the University of Chicago, 2016).

The primary aim of the EAPI grant program is to address financial exploitation of older adults. Financial exploitation is a fast-growing and complex form of elder abuse. Under the current structure for addressing such cases, the local E-MDT Coordinators engage in consultation with team members, facilitate E-MDT meetings, and direct active joint investigations and interventions, with an emphasis on investigating potential and existing financial exploitation.

The E-MDTs developed for this pilot program differ from elder abuse multi-disciplinary teams that are emerging elsewhere across the country in two crucial areas: they feature the participation of professional forensic accountants to provide expertise in understanding and identifying action steps required in financial exploitation cases (see Roles and Responsibilities of Forensic Accountants document) and geriatric psychiatrists to assist the team with understanding a broad range of mental health concerns.

The Finger Lakes pilot, encompassing counties representing urban, suburban, and rural locations, also relies on the services of Dr. Elizabeth J. Santos, Associate Professor of Psychiatry at the University of Rochester School of Medicine and Dentistry and Director of the University of Rochester Medical Center's Memory Care Program and Strong Behavioral Health Older Adults Services to support the seven E-MDTs. In Manhattan, the two geriatric psychiatrists with the E-MDT are Dr. Robert Abrams, Professor of Psychiatry at Weill Cornell Medicine and attending psychiatrist in the Division of Geriatrics and Palliative Medicine and Dr. Nancy Needell, Assistant Professor of Clinical Psychiatry at Weill Cornell Medicine and Medical Director of the Weill Cornell Psychiatric Mobile Crisis Unit.

This Supplement focuses on the role of the Geriatric Psychiatrist, also known as a Geropsychiatrist, in the project and on the teams. The following document includes information about geriatric psychiatry, describing the key roles of this discipline and how it contributes to the work of the E-MDTs.

Defining Geriatric Psychiatrist

Geriatric psychiatrists, also know as geropsychiatrists, are physicians specializing in the diagnosis and treatment of mental disorders, including dementia, affective disorders, anxiety and personality disorders, late life addictions and psychoses, in adults aged 60 and older. They are psychiatrists, but the scope of their practice differs from that of other psychiatrists not only with respect to the age range of their patients, but also in the extensive collaborations with patients' other care providers that are required in the course of their clinical work. Geriatric psychiatrists must be knowledgeable about complex medical syndromes as well as the normative life experiences of older adults, notably adjustment to such age-related stressors as diminished social support networks and personal losses. Geriatric psychiatrists are considered expert diagnosticians in this area and are often called upon to certify decisional capacity and testify in court proceedings establishing guardianship and adjudicating testamentary disputes and undue influence cases. Finally, geriatric psychiatrists are experts in the use of psychotropic medications in the elderly, for whom psychopharmacologic indications and dosing procedures differ considerably from those used in the general adult population.

Certification in geriatric psychiatry is awarded after four years of general psychiatric training with at least one additional year of fellowship in geriatric psychiatry. An aspiring geriatric psychiatrist must pass The American Board of Psychiatry and Neurology's certification exams in both general and geriatric psychiatry; both require recertification every decade.

The Role of the Geriatric Psychiatrist at E-MDT Meetings and in Providing Case Consultations

The primary role for a geriatric psychiatrist working with E-MDTs is to provide information on mental health matters relevant to cases being presented to the team. The geriatric psychiatrist listens intently while cases are being presented and offers clarification on questions of mental health diagnosis, treatment and clinical course for the elder abuse victim and in some instances for the perpetrator as well.

This information assists the team in developing a coherent assessment and action plans. During E-MDT meetings, the geriatric psychiatrist routinely reviews psychiatric evaluation reports, as well as medical records provided by Adult Protective Service (APS) or other team members, and offers a professional opinion of the findings in those reports. The geriatric psychiatrist clarifies victims' diagnoses and their implications, describes the purpose of psychotropic medications and their possible side effects, and explains why victims may be using them.

The geriatric psychiatrist also listens for medical and psychological co-morbidities and is then able, when indicated and requested by the team, to coordinate care with the elder abuse victim's primary care physician.

In addition, during case discussions, a geriatric psychiatrist can provide insight into how an alleged abuser might react to various interventions proposed by the E-MDT, which may, in turn, have bearing on the final action plan developed. Other areas for which a geriatric psychiatrist may provide information include the psychiatric consequences of losing a loved one, stress from financial instability, and difficulty coping with age-related setbacks and illness.

In New York City, evaluations for clients' capacity to make specific decisions and the initial recommendations for guardianship are generally the role of Human Resources Administration-affiliated psychiatrists, but the E-MDT psychiatrist is available to offer a second opinion by interviewing the client directly, and during the meeting the geriatric psychiatrist is often called upon to interpret the findings of the APS psychiatric capacity evaluation.

The Manhattan and Finger Lakes geriatric psychiatrists also participate in case consultations and information-gathering activities, such as speaking with victims' psychiatric and medical care providers outside of E-MDT meetings; they are also members of a panel with the E-MDT Coordinator and others to review potential E-MDT cases. The actual time spent on these "offline" functions varies considerably but is greater if a direct client evaluation must be undertaken.

Occasionally the geriatric psychiatrist will present a mental health topic during the E-MDT meeting, for example, a review of post-traumatic stress disorder (PTSD) or schizophrenia in later life. These presentations are usually relevant to a case currently under discussion by the team and are intended to enhance the team's appreciation of the impact of the mental health issue on the victim or alleged abuser; such educational activities may also help guide intervention planning.

The geriatric psychiatrists typically spend about 5-10 hours a month on E-MDT and potential E-MDT cases, including twice-monthly attendance at E-MDT meetings plus case consultations and other activities outside of the regular meetings.

Confidentiality

Confidentiality restrictions have not impeded the ability of geriatric psychiatrists to participate in E-MDT activities. As a rule, the geriatric psychiatrist handles confidentiality of case records in team meetings under the same HIPAA rules that apply to any healthcare workplace in the U.S.

Along with other members of the team, both permanent and guest, geriatric psychiatrists must sign a confidentiality agreement to participate in the E-MDT meetings. As in all patient-care activities, cases and case documents are never discussed with anyone outside the E-MDT room, except in accordance with established medical guidelines about appropriate outreach to a medical practitioner or other care provider. As additional precautions, client names or other unique identifiers are never used in the meetings in the Manhattan E-MDT. Moreover, written notes are rarely taken by E-MDT representatives during E-MDT proceedings in order to avoid the possibility of an inadvertent breach of confidentiality and also to prevent any potential "discovery" of sensitive material that could be subpoenaed in legal proceedings.

The Value of the E-MDT to the Geriatric Psychiatrist

Participation of the geriatric psychiatrist on the E-MDT has been beneficial not only to the functioning of the team but to the professional development of the psychiatrist. Meaningful relationships and collaborations with other professionals and agencies have been established through the shared mission of the E-MDT. With APS in particular, the participating psychiatrists have achieved a greater appreciation of the functions and culture of this "social safety net" for older adult citizens, and they have without question achieved a greater comfort level in referring elder abuse cases to APS. The geriatric psychiatrists have also strengthened and deepened their ties with representatives of the many other disciplines, agencies and systems represented on the team; they have learned about services, supports, and interventions to address elder abuse cases that they would not otherwise have encountered in the course of their clinical work. This working knowledge allows the geriatric psychiatrists to educate their colleagues and students throughout their respective medical centers about elder abuse and potential interventions in their communities.

Onboarding Geriatric Psychiatrists onto Newly Forming or Established E-MDTs

As other communities seek to onboard geriatric psychiatrists onto newly forming or established E-MDTs, it has been suggested that the teams seek out fellows in training programs and encourage training directors of geriatric psychiatry fellowships to include E-MDT participation as part of their curriculum. Also, providing community psychiatrists working in publicly-funded clinics (such as county health programs) with training about elder abuse may prove to be beneficial in promoting awareness, in addition to widening the currently narrow pool of geriatric psychiatrists prepared to serve on E-MDTs.

General Observations and Comments

Geriatric psychiatrists bring a unique perspective to the E-MDTs by virtue of their dual experience in psychological and psychopharmacological medicine as well as knowledge of complicated geriatric medical syndromes. The geriatric psychiatrist is required to be familiar with social, familial and psychological norms as well as psychopathology in the elderly, the latter often touching on how a perpetrator might react to the team's action plan; and he or she must also be an expert in the specific area of geriatric psychopharmacology, in which therapeutic and side effects of commonly used medications differ substantially from those encountered with younger adults. Overall, geriatric psychiatrists are able to contribute expertise and judgment in the development of the team's action plan on a given case and assist the team in understanding the limitations and risks of intervention. Finally, the geriatric psychiatrist can help to resolve the intra-team tensions that can arise in any work group setting.

Summary

Giving the subspecialty of geriatric psychiatry "a seat at the table" has been a vital enhancement to the multi-disciplinary team approach to resolving society's most complex and egregious elder abuse cases. The EAPI Initiative helped to identify the specific advantages of engaging this service to enhance the understanding and the practical reach of the E-MDT members working on cases. For use on a larger scale, however, future E-MDTs should be prepared to consider the most efficient use of what is unfortunately a scarce resource, as the number of Board-Certified geriatric psychiatrists in the U.S. is very small. A plan for both financial compensation and optimal use of geriatric psychiatrists should be developed. E-MDTs may need to seek creative ways of sharing this critical resource consistent with their primary mission of preventing and intervening in complex cases of elder abuse.

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