Combating Elder and Dependent Adult Mistreatment: The Role of the Clinical Psychologist

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ABSTRACT. Among the many different professionals who work to address elder and dependent adult mistreatment, the clinical psychologist performs a function that is not well documented. The experiences of a clinical psychologist attached to a medical response team and an elder abuse forensic center provide insight into this complex and multifaceted role. Case examples from an elder abuse forensic center illustrate the breadth of referral questions that a clinical psychologist addresses. This information may be of use to those who would argue that these services be made widely available to elder abuse professionals such as social workers, public guardians, and those in the criminal justice system. The case studies also may be useful for training purposes.

KEYWORDS. Abuse, mental status, capacity assessment, undue influence, autonomy

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INTRODUCTION

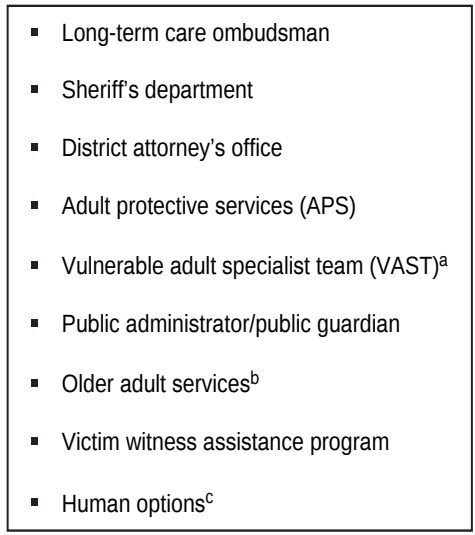
The multidisciplinary nature of elder abuse case management is widely recognized; multidisciplinary teams are meeting and collaborating to address difficult cases. Typically these teams are composed of first responders such as adult protective service (APS) workers, long-term care ombudsmen, and law enforcement officers, as well as specialized professionals such as nurses, physicians, public guardianship deputies, criminal justice investigators, prosecutors, and mental health professionals. In Orange County, California, we have introduced effective multidisciplinary approaches to address elder mistreatment including a medical response team and an elder abuse forensic center (Mosqueda, Burnight, Liao, & Kemp, 2004; Wiglesworth, Mosqueda, Burnight, Younglove, & Jeske, 2006). Our experience has taught us that elder-mistreatment professionals place a high value on having access to a clinical psychologist who specializes in assessing mistreatment victims, and that these experts utilize the psychologist's skills to address a broad range of issues that can occur in complex cases.

The literature on elder mistreatment refers to the need for mental status assessments to determine cognitive or decision making capacity and susceptibility to undue influence. Physicians and/or psychologists typically perform these assessments, which often are used to address allegations of financial abuse or inform conservatorship proceedings (Blum, 1999; Kemp & Mosqueda, 2005; Quinn, 2002; Spar, Hankin, & Stodden, 1995). The medical literature on decision making capacity focuses on patients' capacity to consent to medical treatment or medical research (Cairns et al., 2005; Dunn, Nowrangi, Palmer, Jeste, & Saks, 2006; Ganzini, Volicer, Nelson, & Derse, 2003; Grisso, Appelbaum, Mulvey, & Fletcher, 1995; Kim, Karlawish, & Caine, 2002). Other literature focuses on legal professionals who need to recognize and address capacity issues with older adults, for example, testamentary capacity and guardianship (American Bar Association Commission on Law and Aging & American Psychological Association, 2005; Marson, Huthwaite, & Hebert, 2004; Peisah, 2005; Shulman, Cohen, & Hull, 2005; Simon, 2002), or the clinicians who assist them in making these determinations (Kim et al., 2002; Moye, 1999; Raymont, 2002; Simon, 2002; Sullivan, 2004). Although there is overlap in the roles played by physicians and psychologists in these kinds of assessments, this article emphasizes the breadth of the clinical psychologist's usefulness to elder and dependent adult mistreatment victims and professionals from standardized screening for

cognitive deficits to expert observation and assessment of the complex relationships that constitute undue influence. A psychologist with expertise and training in elder mistreatment can attest to a wide array of decision making abilities that dictate ongoing independence when they are present and promote vulnerability when they are absent. In addition, a psychologist who works in elder mistreatment can recognize and testify to the psychological consequences of abuse. Based on a psychologist's evaluation and suggestions, APS workers have a better understanding of their clients' needs for services, especially mental-health treatment. The role of the clinical psychologist in elder mistreatment is invaluable whether it be as a consultant to a case worker looking for direction in meeting the needs of his or her client, a criminal investigator looking to establish the vulnerability of an alleged victim, or a prosecutor assessing the ability of an alleged victim to serve as a witness to his or her own mistreatment.

In a previous study (Wiglesworth et al., 2006), responses to follow-up surveys for cases referred to the Elder Abuse Forensic Center (EAFC) during one year (November 2003–2004) were statistically analyzed to assess satisfaction with the center. Cases referred by APS workers, long-term care ombudsmen, law enforcement, or a district attorney were discussed in biweekly meetings of the EAFC collaborators (see Figure 1). The outcomes of the discussions were recommendations for specific follow-up activities. The survey responses indicated that the collaborators assigned to these cases agreed that the EAFC made a significant difference in their efficiency and effectiveness as elder-mistreatment professionals (Wiglesworth et al., 2006). Qualitative analysis of free-form comments on these surveys showed that the most frequently occurring category of statement was a report of improved efficiency or effectiveness, or a positive outcome that was the result of the availability of a timely mental-status evaluation conducted by a clinician from our medical response team (also called the Vulnerable Adult Specialist Team [VAST]). The cognitive-status evaluation was the most frequent type cited, but many other types of psychological or functional capacity assessments also were mentioned. These preliminary findings inspired a more comprehensive study of text materials from EAFC case files regarding the role of the VAST clinicians, especially the clinical psychologist for the EAFC (BK). The physicians (all geriatricians) were more likely to focus on medical than mental health issues, and their work overlapped with that of the clinical psychologist, especially in the area of assessing mental capacity when a dementing illness was suspected.

FIGURE 1. Elder abuse forensic center member groups.



[a]A medical-response team (geriatricians and clinical psychologists) described elsewhere (Mosqueda et al., 2004). [b]County mental-health services. [c]Domestic-violence services.

METHODS

The Study Sample

Throughout a 21-month period (December 2003–August 2005), 238 cases were referred to the EAFC. Of the 238 cases, 124 (52%) were referred to the VAST to request services such as a home visit for the purpose of investigating a specific referral question or a review of medical records. Of these 124 cases, 93 (75%) resulted in completed home visits by medical professionals—a geriatrician (33), a psychologist (44), or both together (16). Of the 93 home visits, 87 called for a mental-status evaluation of the alleged victim or, in several cases, of the alleged perpetrator.

The Research Data

A researcher with broad experience of elder mistreatment cases (AW) conducted qualitative analysis of both 93 home-visit reports written and filed by the VAST clinicians and free-form comments from 353 EAFC

surveys of the expert collaborators (multiple surveys were associated with a single case given that more than one collaborator typically was involved in the EAFC referral). From these texts, a comprehensive list of the categories of mental and psychological status assessments conducted during 87 home visits (an average of 1.67 assessment types per case) was produced (see Table 1). The first item in Table 1 (the most frequent referral reason) concerned financial abuse cases that required an expert opinion about the mental capacity of the alleged victim. Such an opinion can be the trigger for moving to protect a victim's assets and instigating criminal prosecution or abandoning the case when the alleged victim is found to retain capacity for financial decision making. Additionally, the psychologist often provided a preliminary assessment of a client's need for psychological services (although it was seldom the primary impetus for the referral), and social workers utilized this information as they developed care plans for services for their clients. For example, an APS client originally referred for a capacity assessment was discovered to have a psychotic disorder as well as a cognitive impairment. This important and previously unrecognized information assisted with developing an appropriate care plan. Each of four other referral reasons was important in about one quarter of the cases. (1) Pursuit of conservatorship in California requires a documented declaration of capacity from a qualified

TABLE 1. Reasons for referral for psychological consultation

Reasons for referral	Number of cases
Assess mental capacity regarding vulnerability to financial exploitation.	42
Assess need for psychological services.	28
Assess capacity regarding conservatorship.	22
Assess capacity as witness and/or historian.	22
Assess for undue influence.	22
Assess capacity to live independently.	20
Assess relationship with alleged perpetrator for evidence of abuse.	10
Assess for psychological consequences of abuse.	6
Assess capacity to select caregiver or caregiving situation.	5
Assess client's status as a dependent adult under the law.	3
Assess capacity to decide to marry.	2
Assess capacity to refuse medical services.	2
Assess dementia versus delirium.	2
Assess capacity to choose to have a sexual relationship.	1
Assess capacity to mange finances.	1

professional, ordinarily provided by the older adult's physician. However, when a vulnerable adult in the community has no physician or medical coverage or simply refuses to leave his or her home, a home visit to assess capacity can make it possible both to move conservatorship proceedings forward and to build a case for placing the adult in a safer environment. Whether to pursue a criminal case of elder abuse may depend on (2) the reliability of the victim to testify as witness to the alleged crime, or (3) the prosecution's ability to prove that the elder was unduly influenced rather than freely choosing to dispose of assets. Although (4) capacity to live independently might be best assessed by specialists in other disciplines, such as occupational therapy, a clinical geriatric psychologist can assess not only functional abilities but also whether psychological dysfunction impairs the ability to live safely in the community. Nine additional reasons for referral listed in Table 1 address the referring parties' need for expert assistance as they investigate allegations, provide services, and protect the client's rights. The case studies that follow, derived from deidenitified EAFC documents, depict these referral types and focus on the assessments needed to address them.

Conducting assessments in the home environment while partnering with social services professionals places certain constraints on the psychologist's methods and requires him or her to select assessment procedures that are not only relatively quick and portable but also as reliable and valid as possible. The case studies illustrate the psychologist's general approach: an interview plus screening for specific conditions. The interview begins with the client's social and medical history followed by an assessment of functional status (activities of daily living and instrumental activities of daily living), a typical day, and social activities. The cognitive assessment follows and includes tests of abilities related to capacity for processing information and making decisions. Examples of processing abilities are orientation, short- and long-term memory, and language skills. The ability to make decisions is associated with executive functions such as logic, judgment, planning, organizing, and insight. Additional tests of ability may be dictated by the referral question, for example, managing one's own financial affairs requires reading comprehension. Screening tools, such as a mental-status exam, clock drawing, proverbs (common proverbs are read and the subject is asked to explain the general meaning), or similarities (the subject is asked to indicate the similarities between pairs of things), provide information on specific capacities as well as for categorizing and staging of dementias. Screening

instruments also aid in diagnosis of focal deficits, such as stroke and brain trauma, as well as developmental disabilities. Finally, emotional status is assessed. Mental status is affected by psychoses and mood disorders, such as major depression, and these are diagnosed through observation and diagnostic interviewing techniques as per the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). The assessment of undue influence draws from the overall interview; the psychologist seeks to uncover current or past sources of vulnerability such as social isolation, poor health, functional disability, or grief. Although each of the cases involved an extensive interview and screening, typically lasting from one to two hours, the narratives focus on the exposure of deficits and vulnerabilities.

CASE EXAMPLES

Case 1

Mr. L, a 91-year-old White male, was referred to the EAFC for a mental-status evaluation related to allegations of financial abuse. Mr. L was an apparent victim of a foreign lottery scam. He had received several phone calls telling him that he had won a sweepstakes lottery and that he needed to send in money to take care of some parts of the claim. He had reportedly mailed more than $43,000 throughout several months. He never received the promised sweepstakes payoff. The purpose of the evaluation was to determine if Mr. L had impaired mental capacity and was subject to undue influence that contributed to his victimization.

Mr. L was interviewed at home by the VAST clinical psychologist in the presence of an APS social worker.

Mr. L's wife had died 2.5 years prior and he was still having difficulty adjusting to her loss. His home was paid for and more than adequate for his needs, but he needed some assistance and this was provided by a combination of paid and voluntary workers. Although one of his two children lived in the vicinity, there appeared to be some tension in the relationship. He had a few friends in the neighborhood but mostly kept to himself. He recently stopped attending church and had received some support and guidance from APS.

Mr. L's medical history included diabetes and hypertension. He had a primary physician, kept regular appointments, and took several medications. He denied having seen a psychiatrist or psychologist in the past and believed that his health status was fairly good.

Mr. L reported needing no help with activities of daily living (eating, ambulating, making transfers, bathing, toileting, dressing, and grooming) but he exhibited a shuffling gait and a decreased ability to do transfers. He needed help with some instrumental activities of daily living (those assessed included shopping, doing chores, managing financial affairs, transportation, making and keeping appointments, dealing with emergencies, housekeeping, and preparing meals).

Mr. L was cooperative but argumentative during the mental-status evaluation. He thought that he could answer some of the questions more easily than he actually did. He was able to recite adequately the months of the year both forward and in reverse. He could register three words with no difficulty and he could recall three out of three words after two minutes. However, he had difficulty with higher-order tasks. He could not adequately draw a clock and he demonstrated impaired judgment on similarities and proverbs. He had difficulty recalling his personal history. His language for the most part was intact and he still did math calculations well (he had been a high school math teacher).

Emotionally, Mr. L was still grieving from the death of his wife. He had difficulty sleeping, had lost interest in some of his activities, ruminated about the loss of his wife, and claimed to be more irritable than he used to be. He had not sought counseling or received medication to help him deal with this grief. The psychologist believed Mr. L did not have a major depression but a prolonged grief reaction. From Mr. L's reports, it appeared that his wife had been the primary decision maker and he felt she would have advised him against investing in the lottery. He was very upset with himself for losing money to a scam.

The psychologist assessed Mr. L with a mild cognitive impairment marked primarily by deficits in judgment and reasoning. He was also in a prolonged state of grief following the death of his wife. Both contributed to Mr. L's vulnerability to making unwise transactions with people who passed themselves off to be from a foreign lottery. The psychologist recommended that Mr. L be treated for his prolonged grief reaction and followed periodically to prevent further victimization and reevaluate his safety living alone.

Case 2

Mrs. F, a 69-year-old White female referred to the EAFC, was known to have a history of psychiatric disorder and the APS worker suspected that she also had an undiagnosed dementing illness. In addition to the

concerns about her self-care, there were reports that people had taken advantage of her financially and possibly robbed her bank account of about $8,000. The psychologist was asked to assess Mrs. F's capacity to live independently, as well as her need for psychological services. The psychologist also was to assess whether a decline in her cognitive functioning might have contributed to her vulnerability to the alleged financial exploitation.

The psychologist interviewed Mrs. F in her home with an APS social worker and an investigator from the sheriff's department present. Mrs. F was cooperative but guarded and difficult to interview because of her tangential thinking and her distractibility.

The psychologist observed that Mrs. F's small condominium was in a terrible state of repair with debris strewn about the house; food on the floor, in the cupboards, and on the counters; trash heaped up; broken tiles in the ceiling; and clothes piled up everywhere. Mrs. F appeared to be estranged from much of her family; few people visited her and she alluded to difficulties with family members. She said she had friends who were neighbors nearby in the complex, but the quality of these relationships was hard to evaluate. Her son had recently taken over management of her financial affairs, but she was resistant to further assistance.

Mrs. F reported that she was in good health. Her medical history included glaucoma and kidney stones. Mrs. F also had a significant psychiatric history and reported being hospitalized at least twice. The diagnoses at the times of her admissions were not clear. Her most recent psychiatric hospitalization was 1.5 years prior. She had a primary care doctor and reported that the only medicines she took were for her glaucoma. She was not taking any psychotropic medicines. She denied using alcohol.

Mrs. F was physically able to perform activities of daily living independently but did not regularly bathe, dress, or attend to personal hygiene. She was unable to perform most instrumental activities of daily living; she could not handle emergencies, shop for herself, manage finances, make and keep doctor's appointments, or drive.

On short-term memory testing, Mrs. F registered three out of three words but only after five trials because of her tangential and uninhibited thinking processes. After two minutes she was unable to recall any of the three words. Her language was intact and although she was able to name most gross objects she had difficulty with fine detail. She was unable to correctly draw a clock diagram; she used Roman numerals, only used part of the circle to make the numbers, and was unable to put the hands at the

indicated hours. Mrs. F could not do similarities and had difficulty even grasping the concept of the task. She could not logically sequence a series of numbers. Her thought processes were very concrete and tangential. She used a lot of clanging, rhyming jargon in her speech; she discussed her "shabby" house and then rhymed words with "shabby." She was unable to solve everyday problems.

Mrs. F displayed delusions involving broadcasts from the radio, communications with the neighbors, and misunderstanding of what some of the next-door neighbors were doing. She also experienced auditory hallucinations; she would stop the interview and pay attention to other messages coming through the radio. She believed that some of the neighbors were trying to annoy her by making excess noise such as with their washing machines, although washing machines were not allowed in the building. Mrs. F also periodically was agitated during the interview and at times became verbally aggressive toward the sheriff. Mrs. F did not appear to be depressed or especially anxious. She said she was lonely and missed involvement with her family.

The psychologist concluded that Mrs. F had a severe dementia characterized by prominent frontal, executive deficits. It was difficult to determine the underlying etiology without a further work-up. Additionally, Mrs. F had a delusional, paranoid disorder that seemed to be independent of her dementia but could not be diagnosed without a further work-up.

The psychologist recommended hospitalization (if necessary, involuntarily) to help work up Mrs. F's problems, give her proper treatment, and lead to proper placement. He advised that she should not continue to live as she was and believed that she would do well if discharged from a hospital to an assisted-living facility. Additionally, he suggested that the sheriff's department and the district attorney investigate the allegations of financial abuse because Mrs. F was quite vulnerable.

Case 3

Mr. G, a White 86-year-old male, was referred for an evaluation of his mental status because of concerns about possible perpetration of abuse of his 84-year-old wife, Mrs. G. Mrs. G had been referred to APS for reports of emotional abuse and possible physical abuse by her husband. While her status was fairly well known, little appeared to be known about Mr. G. The referral request was to determine the alleged perpetrator's mental status in regard to the allegations, observe his relationship with his wife for evidence of abuse, and assess Mr. G's need for psychological services.

The evaluation was done at Mr. and Mrs. G's home and was attended by the APS social worker as well as the psychologist. Mrs. G was also present.

Mr. G related his personal history, stating that his current marriage of 13 years was a second marriage and that he has adult children from his first marriage who live elsewhere. Mrs. G's medical history was significant for a major depression following the death of her mother who had lived with Mr. and Mrs. G up to the time of her death. Mrs. G was treated with a number of medications and eventually with Electroconvulsive therapy (ECT). She had subsequent repeated episodes of depression and repeated treatments with ECT and medications. She appeared to be in partial remission at the time of the interview. She had a very flat affect. Mrs. G required partial assistance with activities of daily living and mostly full assistance with instrumental activities of daily living. She needed supervision with meal preparation, bathing, and ambulation. She could not drive, shop, or pay the couples' bills. When the psychologist briefly and informally assessed her separately, it was evident that she also had cognitive impairments, needed a lot of care, and constantly asked Mr. G for assistance.

In addition to the onset of his wife's major depression and disability, Mr. G had recently experienced the death of his brother. Also, he had been forced to cut back on his social life, giving up his weekly poker games and visits with his friends in order to concentrate his attention on the care of his wife.

The living situation was adequate for the couple's needs in that it provided adequate shelter and was clean and well cared for. Mr. and Mrs. G received minimal support from others. Their families were either deceased or out of the area, and because of her illness, they did not have much of a social life. Their primary source of support seemed to be each other.

Mr. G reported that he was in good health and that he took no medications. He said that he had some history of heart problems that were under good control. When asked more specific questions, he retrieved a bottle of medication, which he said he had taken previously for depression; however, the medication was an antipsychotic. Mr. G was independent in all activities of daily living as well as instrumental activities of daily living. He was cooperative but guarded and moderately hostile during his mental-status evaluation. He was cognitively intact including good recall, memory, judgment, reasoning, and both comprehension and expression of language.

Emotionally, Mr. G had a history of irritability, temper outbursts, feeling highly stressed, and depression. His problems with his temper had brought the couple to the attention of law enforcement on several occasions. He was on probation for spousal abuse and had been required to take anger-management classes as part of the terms of his case. Although he stated that the curtailing of his social life because of his caregiver duties did not bother him, the psychologist found reason to doubt this. It was also evident that he was irritated, somewhat stressed by the living situation with his wife, and somewhat agitated. He reported that he needed to go out for walks periodically to calm down. At one point in the interview, when the psychologist asked to see his medications, Mr. G became visibly agitated and appeared to be about to lose his temper. He got up from the table abruptly and went over and read the medication in an angry tone. He presented no symptoms of hallucinations or delusions and the psychologist surmised that his treating psychiatrist or physician gave him the antipsychotic medication to help him with the agitation. At times during the interview Mr. G became more irritated, as well as saddened by some of the content, but quickly tried to pull himself together to show that there was no real problem. Mr. G said that after only two sessions of a court-ordered anger-management course he figured out his problem and stopped attending.

The psychologist diagnosed Mr. G as having an agitated depression, which was in need of treatment. Mr. G also had very low social support and a high level of stress. While these issues may be risk factors for abuse, the psychologist did not determine that any abuse was present. The psychologist recommended that Mr. G be referred back to probation with an indication that he should complete the anger-management course and that he should be referred to his psychiatrist for treatment. He suggested that Mrs. G appeared to have a moderate dementia and would do well in an adult-day health center, while Mr. G needed more social services and social outlets.

Case 4

Mr. N was a 38-year-old White male with a severe traumatic brain injury of approximately 7-years duration. He was referred to VAST for an evaluation of his mental status because of concerns about possible financial abuse by his girlfriend, with whom he lived. In addition, Mr. N stated that he would like to marry his girlfriend and the question arose as to whether he had capacity to make this kind of decision. His mother, who

reported the alleged financial abuse, was considering having him conserved and expressed her desire to both manage his finances and extract him from his current living situation. This raised additional referral questions regarding his capacity to select a caregiver or caregiving situation and to manage his own finances, as well as the larger question of his need for the protections afforded by conservatorship in lieu of the autonomy he currently experienced. In addition, there was a concern that his girlfriend was encouraging him to withdraw from a rehabilitation program and it was unclear whether he had the capacity to make decisions about his own medical care.

The psychologist conducted the evaluation at a rehabilitation center with the APS social worker in attendance. Mr. N was cooperative, open, and friendly throughout the entire process.

When he gave his personal history, Mr. N alluded to alcohol use and some illegal substance use that led him to have the automobile accident that gave him a traumatic brain injury. Through rehabilitation, he had regained many functions and had the ability to live semi-independently. He reported that his injury gave him a changed perspective on life and that he had discovered Christianity. After rehabilitation, he lived at home with his divorced mother until moving in with his girlfriend six months prior to the interview. Mr. N was attending a rehabilitation center four days a week. He was exploring returning to some level of work and was taking prevocational courses at his rehabilitation center. He was actively involved with his church.

Mr. N had known his girlfriend, M, for a year and a half before moving in with her. Other occupants of the apartment included M's daughter and P, a woman with a disability. M provided care for both P and Mr. N. They lived in a two-bedroom apartment and Mr. N reported sometimes sleeping on the couch or on the floor. However, this did not seem to bother him. Mr. N stated that he preferred the apartment to living at home with his mother because he described his mother as being in conflict with him and not accepting his friendship with his girlfriend. Rather than subjecting himself to the conflict, Mr. N moved in with M. Mr. N's estranged parents both lived within the county where he resided and he appeared to maintain relationships with both of them and with two brothers who did not live nearby.

Mr. N was blind because of his brain injury and saw only shapes and outlines. He was ambulatory, without obvious weakness, and he walked with a white cane. Mr. N also had a seizure history that began approximately eight years prior to the interview. He denied a psychiatric history

but admitted to past substance abuse. He had not seen a psychiatrist or a psychologist other than in his rehabilitation care soon after his injury. Mr. N said that he did not take any medications other than the antiseizure medications prescribed for him.

Mr. N was independent in all activities of daily living. On the other hand, because of his brain injury and his blindness, he needed assistance with shopping, transportation, making and keeping appointments, handling emergencies, and dealing with finances.

Mr. N's mental-status evaluation revealed not only cognitive impairments from his traumatic brain injury but also his substantial remaining abilities. Although his brain injury had made him slow in processing information and made it more difficult for him to deal with learning as well as retrieval, it nonetheless left him with fairly good reasoning, problem solving, and common sense. Mr. N was able to recite the months of the year forward but not in reverse order. However, he could reverse the numbers from 10 to 1. He was able to register three words after two trials and could recall two out of three words after two minutes. He was accurate with similarities up to a fairly high level after he was given an adequate number of trials to grasp the concept. His primary deficits were in complex problem solving, math computation (because he cannot see), and long-term planning. His language was intact and his knowledge of everyday events and his comprehension were just below average for someone with his level of education. Because of his blindness, Mr. N's mental-status evaluation omitted some visual items that are commonly used.

Emotionally, Mr. N was doing well. He was not depressed or anxious. He seemed content with his life. He attended church regularly and found great satisfaction in it, in his rehabilitation center activities, and in his relationship with M. He stated that he and M did not have an intimate relationship and would not until after they were married, consistent with his religious beliefs. He demonstrated an understanding of the marriage relationship and what it means to be married and expressed his reasons for wanting to marry. Furthermore, he had enough insight to seek counseling from a psychologist for both he and M in regards to decisions about marriage. The biggest issue in his life was the conflict that he faced between his mother's position regarding his girlfriend and his own feelings toward his girlfriend.

The psychologist concluded that although Mr. N had significant cognitive impairments, he did not meet the criteria for dementia. Mr. N had the capacity to make decisions involving his living arrangements, marital status, and health care. However, he apparently lacked the ability to manage

his everyday finances and was vulnerable to possible financial abuse. The psychologist recommended the least amount of intrusion in Mr. N's life that would protect his assets and his finances. The psychologist also recommended that Mr. N remain in rehabilitation because it was doing him a great deal of good. The psychologist did not believe that conservatorship would be in Mr. N's best interests because he was continuing to make improvements in his own life.

Case 5

Mr. R, a 58-year-old Hispanic male, was referred for a second opinion regarding his mental status. A VAST geriatrician did a medical evaluation at the request of APS. The physician was concerned about Mr. R's mental status and requested that the psychologist also assess him. This case involved alleged financial abuse by a neighbor. It had been reported that the neighbor misused some of Mr. R's checks and not only forged his name to cash the checks for her benefit but also used his PIN number to gain access to his accounts. Both APS and law enforcement were investigating the case. The purpose of this evaluation was to determine both Mr. R's status as a dependent adult under the law and his mental status in regards to his vulnerability to financial abuse (owing to both his cognitive status and his susceptibility to undue influence). In addition, there was a concern that Mr. R was experiencing psychological consequences from the abuse and was in need of psychological services.

The psychologist evaluated Mr. R in his home in the presence of the APS social worker and an interpreter. The interview was conducted primarily in Spanish, Mr. R's native and preferred language.

Mr. R was born into a large family in Mexico. He obtained no education because the family needed him to work for income. He claimed that his father frequently scolded him and beat him, often by hitting him on the head. He moved to the United States 35 years prior to the interview to work as a farm laborer. An early marriage in Mexico had ended in divorce and a subsequent 16-year relationship had ended with the woman's death approximately two years prior. Mr. R had lived in his apartment for about two years. Although sparse, the apartment was well kept and more than adequate for his needs. Mr. R was receiving 75 hours per month of publicly funded in-home supportive services.

Mr. R was estranged from much of his family and had few friends. He turned to his neighbors and apartment manager for occasional help with his finances and other needs. The alleged perpetrator in this case

befriended Mr. R by offering him help, bringing him meals, and inviting herself over to his place. Later, she allegedly took advantage of him financially. At the time of the interview, Mr. R's primary sources of support were the apartment manager, APS, and weekly phone contact with one sister.

Mr. R was diagnosed with diabetes and he had back and a leg injuries. He suffered from dizziness. He had a psychiatric history dating back to approximately 1983, when he reported that he first developed a major depression and subsequently, psychotic symptoms. He was treated by a psychiatrist at that time, and he continued to be on a variety of psychotropic medications to treat his depression and anxiety disorder with psychotic features. He also took medicine for his diabetes.

Mr. R needed assistance with some activities of daily living. He was able to eat and use the toilet by himself but he had fallen repeatedly while taking a shower and was in need of grab bars or possibly a bath bench to prevent further injury. His ambulation was limited, because of his back injury, to about 25–30 yards.

Mr. R required assistance with most instrumental activities of daily living. He knew how to dial 911 for an emergency but could no longer drive, could not manage his finances, and needed help making and keeping his appointments, managing his medications, and doing his household chores.

During the mental-status evaluation, Mr. R was somewhat guarded, possibly because of his lack of education, but he tried most of the items he was asked to perform. He declined to take a clock-drawing test, reporting that he was not able to write. He was not able to copy pentagons or do math problems but his short- and long-term memory were intact. He could neither read nor write. He was unable to complete any reasoning questions, such as why crops grow better in the summertime than in the wintertime, or to answer basic questions, such as why someone needs a driver's license in order to drive.

Emotionally, Mr. R was depressed and highly anxious, both preexisting and at the time of the interview. These conditions appeared to be further exacerbated by financial problems resulting from the alleged financial abuse. The stress of the recent financial difficulties also had increased his physical symptoms and he reported more pain in his head, back, and neck. Mr. R also reported ongoing psychotic symptoms including constant voices in his head, some of which he knew were not real, and visual hallucinations. His sleep often was disturbed by visual hallucinations and he reported seeing people coming into his room and

trying to direct him. Mr. R was not drinking alcohol but said that he drank approximately three to four beers each day up until three months prior to the interview.

It was the psychologist's opinion that Mr. R had multiple factors affecting his cognitive capacity: traumatic brain injury, low level of education, depression, and psychosis. Although he did not meet criteria for either delirium or dementia, he was certainly impaired. The psychologist concluded that Mr. R met the legal definition of *dependent adult* because of his psychiatric disability of many years duration. He lacked basic understanding of many things and was highly vulnerable to both undue influence and financial abuse. The psychologist recommended some therapy activities such as an adult-day health care center, physical therapy, occupational therapy, increased socialization, and referral back to his psychiatrist.

Case 6

Mrs. E, a 78-year-old White female, was reported to APS for neglect by others. She seemed to lack the capacity to look after herself, her dwelling, or her medical needs. The psychologist was asked to assess Mrs. E's cognitive status and, in particular, whether she had the capacity to refuse medical care and to stay safely in her own environment.

The psychologist conducted the evaluation of Mrs. E in her home with the APS social worker present.

Mrs. E could not state where she was born or where she went to school, if she was married, or how long she had lived in the current residence. The home was filthy and had the stench of old urine, there were animal feces, and there did not appear to be proper food in the house. It appeared as though Mrs. E's only source of support was the alleged abuser in this case.

Mrs. E could not give information about her medical status or state who her physician was or whether she took any medication.

Mrs. E was semi-independent in activities of daily living. She was semiambulatory and her hygiene was poor. She was completely dependent in instrumental activities of daily living. She could not drive, shop, make or keep appointments, do housekeeping tasks, manage her medications, or handle her finances.

During the mental-status evaluation, Mrs. E was confused and disoriented. She did not know the date, her location, or her current address. She could not remember any of three words after two minutes and she became

easily confused with too much information. It was not possible to go much further in the evaluation.

Mrs. E had a severe cognitive impairment, most likely a delirium, and she needed immediate attention for a medical evaluation. She did not have the capacity to make this decision on her own. The psychologist recommended that an evaluation be performed through her physician, an emergency room, or a hospital admission. The psychologist was not optimistic about her capacity to live on her own but recommended that this situation be reassessed once her medical condition was adequately addressed.

Case 7

Mrs. B, an 80-year-old White female, was referred to the EAFC by the long-term care ombudsman for an evaluation of her psychological status in regards to allegations of possible sexual abuse. The circumstances of the case were as follows: Mrs. B had a male friend who visited her frequently in the assisted-living facility and they reportedly had sexual relations. Mrs. B's daughter and the facility were concerned about the male friend taking advantage of Mrs. B because her cognition was impaired. Another implied referral question concerned her capacity to choose to have a sexual relationship.

The psychologist met first with Mrs. B's daughter and the ombudsman to gain some background. Then he saw Mrs. B at the assisted-living facility where she resided.

The psychologist asked Mrs. B about her history, noting that she was able to relate details of her career and marriage and to state her children's names and where they lived. Mrs. B met her male friend many years ago when she was still married and he was a neighbor. Following her husband's death, they continued their friendship. Mrs. B had few friends from her past and although she had met a couple of people in the facility, she reported that she was closest to her daughter and male friend.

Mrs. B was on medication to lower her blood pressure and she had a history of alcohol abuse. She and her daughter both stated that she no longer drank. Mrs. B was independent in activities of daily living and required assistance in instrumental activities of daily living.

During her mental-status evaluation, Mrs. B was able to recall one of three words after a two-minute delay with cueing. She made some slight errors in construction on the clock-drawing test. Her knowledge of world events was somewhat impaired even though she said that she watched

television. She had no difficulty naming gross objects but had difficulty naming fine details. She was poor at explaining similarities and failed a task of logically sequencing numbers. Repeat testing of her memory indicated some improvement, thus she did have some ability to learn.

Mrs. B was not depressed or anxious. Although she mentioned her male friend, she did not volunteer any information on the nature of the friendship.

In a subsequent conversation with the daughter about her concerns, the daughter denied that there was any physical or psychological abuse on the part of male friend. It became obvious that the daughter and the owners of the long-term care facility did not like Mrs. B's male friend.

The psychologist concluded that Mrs. B had a mild to moderate dementia, possibly of vascular origin because her deficits were not typical of Alzheimer's disease. Despite her cognitive impairment, Mrs. B still had good everyday reasoning and insight and was capable of making choices about her own relationships. The psychologist could not find psychological evidence that Mrs. B was being abused sexually.

Case 8

Mr. S was an 84-year-old male originally from the Middle East. He was referred to the VAST psychologist and geriatrician for an evaluation of his mental status and physical and psychological well being in connection with a case of alleged physical and financial abuse. It was alleged that Mr. S's grandson, who had been living with him at the time, choked and assaulted Mr. S and took several hundred dollars from him. The police were called and the grandson was arrested and jailed. The alleged abuser had subsequently been bailed out by his mother. It was necessary to determine Mr. S's mental health after the alleged assault and his need for psychological (and medical) services as well as his ability to serve as witness at his grandson's trial.

The psychologist conducted a mental status evaluation of Mr. S in his home. A police investigator, an APS social worker, a geriatrician, and an interpreter were present. Mr. S spoke Farsi, but no English.

Through the interpreter, Mr. S related his personal history including growing up in Iran and coming to the United States to live nine years prior to the interview. He had no formal education and was illiterate. His wife of 50 years had died about two years prior. Mr. S resided in a two-story, rented condominium and depended on public assistance for his income and housing. The condo was mostly adequate for his needs but his having to go upstairs to the bedrooms was a source of concern.

Mr. S's grandson had lived with him prior to the incident that led to his arrest. Mr. S's daughter (the grandson's mother) had been Mr. S's primary source of support at that time. However, it appeared that subsequently the daughter had withdrawn her support and was siding with the grandson in the case. Mr. S was relying primarily on formal rather than family support at the time of the interview. Mr. S reported that he and his friends would go daily for walks to the end of the street and to the park. He spent his time with his friends as well as watching television and listening to the radio.

Mr. S was in very frail condition because of chronic obstructive pulmonary disease and he was on oxygen. He used a nebulizer and other medicines but his compliance was in question. Mr. S had been hospitalized involuntarily a few weeks prior to the interview for extreme agitation subsequent to the alleged assault. It appeared that he was not taking any medicine as a result of that hospitalization. He reported that he took no over-the-counter medicines for pain or for sleep. Mr. S did not drink alcohol.

Mr. S was mostly independent in activities of daily living. He ambulated with great difficulty. He was able to shower independently and to help prepare his own meals and eat independently. He required assistance in instrumental activities of daily living. He had never driven; he needed assistance with shopping, managing his finances, taking his medicines, making and keeping appointments, and taking care of household chores.

Mr. S was cooperative but highly excitable during the mental-status exam. Cognitively, his short- and long-term memory were intact. However, he did have some executive function deficits. He was not able to say the months of the year forward or in reverse even in his native language.

During the interview, Mr. S was tangential in his thought processes and he displayed a lot of impulsivity and poor judgment. At many points, he had to be brought back to the topic and became agitated when the topic turned to the alleged assault. He was extremely upset and terrified at the abuse that he said he suffered at the hands of his grandson. According to Mr. S, he never expected that someone he had trusted as much as he did his grandson could abuse him. His extreme agitation made it difficult for him to stay on target in conversation and further impaired his thought process. The psychologist could elicit from him no symptoms of hallucination or delusions. He was more frightened to go out than he used to be and watched the neighborhood and checked things carefully before going outdoors. Mr. S was obviously greatly agitated and terrified by what happened to him.

The psychologist diagnosed Mr. S with an acute agitation that was the result of the alleged trauma that he sustained. Despite his deficits in executive function and lack of education, he was a reliable historian. The psychologist recommended that Mr. S be referred to a geriatric psychiatrist who spoke his language in order to be further evaluated for medications. Finally, the psychologist advised that social services would be needed to compensate for the difficult conflicts that were occurring in Mr. S's family as a result of the allegations of abuse.

RESULTS

In the study sample, at least 12 of the 87 cases referred for mental status assessments were determined by the local deputy district attorney to be criminal, with 11 resulting in convictions (12 felony convictions, some on multiple counts, for a total of 12 felonies and 4 misdemeanors). Six of the cases resulted in probate conservatorships but the follow-up data are not available on many cases referred for conservatorship because private conservatorships may not be reported back to the EAFC. Feedback from social workers indicates that the mental-status assessments often result in alerting families or other responsible agents to provide appropriate support and services for the alleged victims of abuse. In addition, capacity assessments are crucial to protect the autonomy of those who retain decision making capacity.

DISCUSSION

The case studies were selected for the breadth of referral questions and assessments represented. The researchers conducted an analysis of a sample of referrals designated for the clinical psychologist as they come into the EAFC. Although most are submitted by APS workers (78%), all of the other EAFC agencies that are allowed to refer cases (ombudsman, law enforcement, and district attorney) also have requested the clinical psychologist's services. Similarly, all types of abuse (physical, sexual, psychological, financial, and neglect by others and self) are represented, but the clinical psychologist's expertise is called for most often in cases of financial exploitation (55%). The clients the psychologist assesses are most often elders (83%), but the remainder are dependent adult clients (17%).

The reasons that trigger the EAFC referral may differ from the referral questions that ultimately guide the home visit assessments because of the

more thorough consideration of the issues of the case that occurs in the EAFC. Analysis of the reasons for the initial referral indicate that APS refers cases when there are questions about the following.

- The client's underlying psychological status
- How severely impaired the client is cognitively
- Whether the client is safe to stay at home based on their mental health conditions
- Approaches to care

On the other hand, when the referral comes from the criminal justice system the need may be to collect evidence regarding the mental status of the victim or perpetrator to complete the investigation or to evaluate witnesses who are historians of the abuse event but who may have cognitive or psychological deficits. It also may be important to establish the psychologist as an expert witness for the planned prosecution.

Some of the psychologist's skills are specific to a specialist in elder abuse, for example, the assessment of undue influence. Others are more generally available, for example, through a primary care physician (e.g., a capacity declaration to support conservatorship proceedings), but may not be available to victims of elder abuse who have no physician, refuse to leave their homes, or whose need for protection calls for prompt attention that is not available through their own medical coverage. A frequent concern in referring the clinical psychologist for a home visit is the willingness of the person targeted for the call to consent to being assessed. However, the well being of elder abuse victims is the paramount concern and the potential for failure seldom drives the decision to dispatch the psychologist on a home visit. Only a small fraction of attempted home visits are unsuccessful because of refusal or inability to locate the client.

CONCLUSION

The experience of an Elder Abuse Forensic Center with access to the services of a clinical psychologist illustrates the value and importance of mental-status assessment of victims and sometimes perpetrators of elder mistreatment. The authors' primary purpose was to highlight the usefulness to those who manage, investigate, and prosecute elder and dependent adult mistreatment cases of a detailed mental-status evaluation that

addresses specific referral questions related to cognitive status, decision making capacity, and emotional states.

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