# Elder Financial Abuse: Tips for the Medical Director

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Financial abuse against older individuals is estimated to be the second most common form of abuse, following only selfneglect in terms of incidence. 1 Estimates of financial abuse range from 20% to 30% of all abuse against older people. 1,2 Financial abuse is predicted to continue to increase in the future, because the population of older people is still increasing and because older people have a variety of conditions of which others may take advantage. These conditions include cognitive, physical, psychological, and social problems that make older people vulnerable. Older individuals have become common targets of financial abuse because they own a disproportionately large percentage of the wealth in the United States. 3 Having lived a number of decades, many older individuals own their own home, have significant money in the bank, have reasonably good credit, and may also have other assets such as stocks and bonds. Together, these features make older people likely targets of financial abuse.

Financial abuse is especially devastating to older individuals. They often feel as though they are at fault and often believe that they were careless or stupid. In fact, perpetrators have become increasingly sophisticated about how to take advantage of older people and continually come up with new ways to do so. Elder financial abuse is also devastating in other ways. It robs the victim of important resources they need for their own health and well-being. Older people generally have fixed incomes. Unlike younger people, they do not have as much ability or time to regenerate the money they have lost. Having been robbed of one's financial assets may lead to many deleterious outcomes, such as a change in residence, less money for food and medicines, postponing medical care, and

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creating fewer opportunities to visit with friends and family. In addition, there is often an emotional consequence in the form of guilt, depression, and anxiety.

There are 3 types of perpetrators who prey upon older individuals. The first type is the "opportunistic" perpetrator who discovers a person he or she can take advantage of. This includes paid caregivers, accountants, contractors, clergy, neighbors, stockbrokers, and attorneys who happen upon a situation they cannot resist because of greed or a lack of ethics. A second type of perpetrator is the family member. Typically, in these cases one family member takes advantage of the older person's vulnerabilities and tries to get a lion's share of the family estate or an earlier distribution of wealth. When a family member is the perpetrator, there is often a history of family discord either among siblings or between parent and child. The perpetrating family member (eg, a niece or nephew) often feels "entitled" to the money because of real or supposed transgressions by others. The third type of perpetrator is the professional scam artist: people who make a living by designing scams to take advantage of older people. Examples of these scams include being told one has won a foreign lottery, solicitation from false charities, proposed fraudulent house repairs, and being sold worthless assets.

Legal resolution of cases of elder financial abuse through either the criminal or civil systems is difficult. The abuse is usually not discovered or reported until some time after the event, records may or may not reflect the state of the victim at the time, the older person's condition may not be the same at the time of discovery as at the time of the abuse, or the older person may be deceased. Moreover, there have been few systematic methods validated for scientifically studying financial abuse to help support legal actions. While several elements in abuse have been pointed out, such as that the victim is usually vulnerable<sup>2</sup> and that the victim often "irrationally" trusts the perpetrator, 4 these were not scientifically validated.

Recently, Kemp and Mosqueda<sup>5</sup> developed and validated an evaluation framework for assessing cases of financial abuse that takes into account the vulnerabilities of the older person as well as the actions of the alleged perpetrator. That framework contains 8 elements. They include the following: (1) the presence of a vulnerable elder (due to lack of capacity or other conditions), (2) a trusting relationship with the perpetrator, (3) isolation and control of the older person and/or transaction, (4) the exertion of undue influences, (5) a lack of

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concern for the welfare of the older person, (6) a lack of ethics in the transactions, (7) secretiveness, and (8) a change of assets during the period of vulnerability. The framework was validated by having it rated by 159 deputy district attorneys, sheriff investigators, and senior Adult Protection Service supervisors. The results showed high reliability and high validity.

Physicians are in a position to help prevent financial abuse by attending to 2 issues. One issue is whether the older person had the cognitive capacity to enter into the financial arrangements at the time they were made. Capacity refers to whether the person could sufficiently understand and appreciate the decisions they were asked to make. The other issue is whether the older person was unduly influenced by others in making financial decisions. A person may have adequate cognitive capacity and yet still be unduly influenced by others. To be unduly influenced by another person, the older person typically has some form of vulnerability by which the perpetrator takes advantage. For example, the older person may be isolated and have few friends or family members still remaining alive. A paid caregiver can take advantage of this isolation by forming an especially close and dependent emotional bond with the older person and end up exerting influence over the older person's decisions. Likewise, an older person may highly trust his or her minister, but the minister may exert undue influence over the older person in the form of inappropriately pressuring the older person to leave assets to the church rather than in the manner the older person had originally planned. Other forms of undue influence include intimidating or threatening the older person, deceiving the older person or making false promises, or simply withholding information.

### **CASE PRESENTATION**

Mr D was a recently widowed, 86-year-old gentleman living in a skilled nursing facility. Mr D's 2 adult children, both of whom lived in another state, placed him in the facility after his care at home was deemed inadequate. He was a successful businessman before the deterioration of his health and the onset of his cognition problem that led him to require caregiving. Nevertheless, Mr D did not believe that he needed this level of care as he felt there was nothing wrong with him. For the 6 months after his wife's death and before coming to the nursing facility, Mr D had a live-in caregiver, a 48-yearold woman. This woman visited Mr D in the nursing facility approximately 3 times a week. The staff overheard this woman tell Mr D that he did not need to be in the nursing facility, and he should simply get up and leave and go home with her and she would look after him. There were reports that she had brought paperwork into the skilled nursing facility and had him sign them while no one else was in the room. When asked about this, she denied that anything like that had happened. The staff was getting increasingly concerned, because they also overheard her making romantic overtures toward him and promising to go on a honeymoon with him as soon he was able to leave the facility. Mr D did not have a conservatorship, but he was admitted from a psychiatric hospital where he was evaluated for his third

episode of psychosis. When this case is compared to the 8 elements, all of the elements are potentially present.

### **DISCUSSION**

The following discussion is based on the 8-element framework.

### 1. The Presence of a Vulnerable Elder

This gentleman is vulnerable both because of his cognitive impairment and his emotional dependency on the caregiver. The extent of his cognitive impairment is unknown and needs to be determined. His history of psychosis and lack of insight as to why he needs to be in a nursing facility make him further vulnerable. Psychologically he may also at an increased vulnerability because of his active grief over his wife's death.

The resident's capacity to make decisions is the key to clarifying this case and to deciding between protecting his welfare and respecting his autonomy. The medical director should educate the staff, the resident, the resident's family, and the caregiver about the importance of determining the resident's capacity. The medical director could either assess the resident's capacity, ask the primary physician to assess his capacity, or ask for a consultation, eg, psychiatrist or psychologist, to assess his capacity. If not done already, the social worker should determine if a durable power of attorney for finances has been executed. If a durable power of attorney does not exist and he does not have capacity, a conservatorship will be needed to protect the resident. Declaration of incapacity from 2 licensed physicians may be necessary to activate the durable power of attorney or apply for conservatorship. The medical director may need to be one of these physicians. The family should be informed of the emotional dependency of the resident on the caregiver and of his vulnerability.

#### 2. A Trusting Relationship With the Perpetrator

The caregiver is able to gain access to the resident because of her relationship to the resident. However, since he is now in a facility, her access to the facility (and therefore to him) can be limited or restricted. She should be informed that her visitations are a privilege that can be revoked. If her visitations are felt to be harmful to the resident, either the primary care physician or the medical director can write a physician order to limit her visits to certain hours or restrict her visitation to locations where she can be observed. The facility may also obtain a restraining order to keep her from coming onto the premises.

### 3. Isolation and Control of the Older Person and/ or Transaction

The caregiver is able to control the resident through his vulnerability, his trust of her, and her isolation of him during the transaction. By reducing or eliminating the isolation, the control can be broken. Again the visitation of the caregiver can be restricted or observed. The ombudsman can play an effective role in breaking the isolation by serving as an objective, third-party advocate. Referral to the ombudsman in these cases is mandated by law (in some states) and in accord

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with the ethical and professional obligation of both the medical director and the facility administration. Such referrals also protect both the facility and the medical director from liability.

### 4. The Exertion of Undue Influences

This trust relationship goes beyond the bounds of a normal paid caregiver role. When such role violations occur, they often set the stage for financial abuse. The fact that the resident is somewhat confused makes him even more of a candidate for abuse. The romantic overtures of the caregiver toward the older patient, especially in a skilled nursing facility, are a demonstration of her difficulties to stay within the bounds of a paid caregiver relationship. Additionally, she plays upon his desire to leave the facility, his poor judgment, and lack of insight.

## 5. A Lack of Concern for the Welfare of the Older Person

The caregiver's desire to take the resident out of the facility does not appear to have his best interest in mind. Had she been able to provide adequate 24-hour care for him at home, the nursing home placement would not have been necessary. Forms of elder mistreatment often overlap. Financial abuse is often related to neglect. Although the perpetrators are unable or unwilling to provide adequate care, they often express overtures to give care or make attempts at partial caregiving in order to gain access or control over the victim.

### 6. A Lack of Ethics in the Transactions

As mentioned above, the romantic suggestions are unethical in that they overstep professional caregiving bounds. Often, perpetrators are unwilling or are fearful of having the victim's decision-making capacity evaluated, because they do not truly wish to respect the victim's autonomy. The transactions are under duress, through undue influence, or without informed consent or full disclosure. As discussed above, the caregiver does not wish to protect the resident's best interest (beneficence) and certainly does not wish to keep him from harm (nonmaleficence). The transactions are therefore often not above board.

### 7. Secretiveness

This is an essential feature. Perpetrators are afraid of accountability and scrutiny. They do not want "interference." The caregiver therefore has Mr D sign papers in secret and then subsequently lies about it. The medical director's best intervention may be to open up the entire situation to the full

light of day. If everything is on the "up and up," neither the resident nor the caregiver has anything to fear from full disclosure. This disclosure should include informing the family of all transactions.

Both the patient and the caregiver may say to the facility or to the family that their transactions and interactions are "none of your business." However, the protection of the resident is the "business" of both the facility and the family. If financial abuse occurs and the resident is deprived of the money he needs to pay his room and board costs, the resident will not be able to pay the facility. Either the facility will lose out or the family will have to step up to pay to keep him there.

# 8. A Change of Assets During the Period of Vulnerability

In this particular case, because what papers were signed is unknown, an actual change of assets may not have yet occurred. This is the final element necessary to confirm financial abuse. Although abuse is not yet confirmed, this case should be reported, since the obligation to report is at the level of reasonable suspicion, not absolute certainty. There are more than enough elements in this case to meet reasonable suspicion to report this case to the ombudsman. If this final element is then demonstrated, a report to law enforcement should be made.

#### CONCLUSION

Elder financial abuse is a growing problem in the United States. In suspected cases, the medical director now has a framework with which to assess the situation. Many of the elements of this framework are amenable to interventions by the medical director. Determining the resident's cognitive abilities and capacity to make decisions is critical to keeping the ethical balance of respecting the resident's autonomy and protecting his welfare. At the very least, such cases should be reported to the proper authorities (ombudsman or police).

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