



## **Framing the detection of elder financial abuse as professional bystander intervention: Decision cues, pathways to detection and barriers to action**

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## **Structured Abstract:**

### **Purpose**

This qualitative study explored the detection and prevention of elder financial abuse through the lens of a 'professional bystander intervention model'. We were interested in the decision cues that raise suspicions of financial abuse, how such abuse comes to the attention of professionals who do not have a statutory responsibility for safeguarding older adults, and the barriers to intervention.

### **Methods**

In-depth interviews were conducted using the critical incident technique. Thematic analysis was carried out on transcribed interviews. Twenty banking and twenty health professionals were recruited. Participants were asked to discuss real cases which they had dealt with personally.

### **Findings**

The cases described indicated that a variety of cues were used in coming to a decision that financial abuse was very likely taking place. Common to these cases was a discrepancy between what is normal and expected and what is abnormal or unexpected. There was a marked difference in the type of abuse noticed by banking and health professionals, drawing attention to the ways in which context influences the likelihood that financial abuse will be detected. The study revealed that even if professionals suspect abuse, there are barriers which prevent them acting.

### **Originality**

The originality of this study lies in its use of the bystander intervention model to study the decision-making processes of professionals who are not explicitly charged with adult safeguarding. The study was also unique because real cases were under consideration. Hence, what the professionals actually do, rather than what they might do, was under investigation.

**Keywords:** elder financial abuse, older adults, decision-making, bystander intervention, safeguarding, decision cues

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## **Framing the detection of elder financial abuse as professional bystander intervention: Decision cues, pathways to detection and barriers to action**

### **INTRODUCTION**

Financial abuse appears to be either the most, or second most, common, type of elder abuse (e.g., Acierno et al, 2010; Biggs et al 2009; Clare et al, 2011;; Feally et al, 2012; Lauman et al 2008; Naughton et al, 2010; Wu et al, 2012). In the United Kingdom (UK) government guidance document *No Secrets*, financial abuse is defined as ‘theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits’ (Department of Health and Home Office, 2000: Section 2.7, p. 9). However, it must be kept in mind that there is no standard definition of financial abuse, nor does the term have any legal status in the UK (House of Commons Health Committee, Second Report, 2004; Crosby et al, 2008).

Because there is no standard definition of the term financial abuse, and because financial abuse may co-exist with the other types of elder abuse (physical, sexual, psychological, neglect and acts of omission, and discriminatory abuse), determining the prevalence of financial elder abuse is problematic. Research to date has revealed prevalence figures for elder financial abuse ranging from around 0.7% (O’Keefe et al) to 3.5% (Lauman et al 2008) in national representative surveys. Garre-Olmo et al (2009) reported a figure of 4.7% for financial abuse in a study in rural Spain, and Cohen et al (2007), in a study of 730 patients in hospitals in Jerusalem, reported financial exploitation ranging from 8.9% to 14.4% of the sample. It is also generally believed that these figures only represent the ‘tip of the iceberg’. The National Elder Abuse Incidence Study in the United States (National Center on Elder Abuse, 1998) revealed the existence of a previously unreported level of elder financial abuse, confirming the “iceberg” theory. The study estimated that for every abused and neglected elder reported and substantiated, there were more than five additional cases that had not been reported. If that is the case, why does some elder financial abuse come to the attention of those who could intervene and some does not? And why is action taken when suspicions are raised in some cases but not in others?

Although there has been research on the perpetrators of elder abuse, (de Donder et al 2011), and risk factors (Choi et al, 1999; Dong and Simon 2010; Marmaleho and Penhale, 2011), with attempts to develop screening tools (Cohen, 2011; Yaffe et al 2008), risk factors are not the same as the signs or cues of abuse, nor does this research tell us about the decision-making processes that may, or may not, bring suspicions to the attention of professionals who might be in a position to intervene, or what happens in the sequence of decision-making that may prevent individuals from assuming responsibility and taking action.

Unlike other countries, in England there is no mandatory reporting requirement for suspected elder financial abuse. Within the *No Secrets* policy guidance, social services departments are required to co-ordinate multi-agency responses at the local level to allegations of abuse or neglect, but there is no absolute requirement for reporting or acting on suspected elder abuse even for those working in adult safeguarding. This raises interesting issues about how those who do *not* work in adult safeguarding, but who might encounter cases of suspected abuse, make decisions in relation to reporting their suspicions or taking action.

### ***Professional bystander intervention***

Although there have been efforts to develop broad conceptual frameworks to study elder financial abuse (Kemp and Mosqueda, 2005; Conrad et al., 2011), these models have been primarily about risk factors (Wilber and Reynolds, 1996) for financial abuse and micro process such as power and exchange dynamics (Rabiner et al 2004). Because explanatory approaches to elder abuse modelled on child abuse and intimate partner violence do not explain financial exploitation (Wilber and McNeilly, 2001), a different framework for understanding the detection of such abuse is required (Hafemeister, 2003). The proposal explored in this paper is to adapt a framework from outside the general area of abuse research. The framework we propose to adapt is that of the *bystander intervention model* (Darley & Latane, 1968; Latane & Darley, 1968, 1970, 1976; Latane, 1981). This model involves the following five stages for bystander intervention in emergencies:

- (1) noticing the event,
- (2) construing the situation as an emergency,
- (3) developing a feeling of personal responsibility,
- (4) believing that he or she has the skills necessary to succeed, and
- (5) reaching a conscious decision to help.

Complex judgements must be made at each of these stages and, consequently, decisions might be made at each stage that militate against intervention.

In the same way that a number of stages must be negotiated in cases of bystander intervention in emergencies, we argue that in detecting and acting on elder financial abuse, similar stages must be negotiated. The cues for financial abuse must be noticed and interpreted as serious, responsibility for intervening must be assumed, and finally, some action must be carried out. The professionals in our study who may come across cases of financial abuse are not, of course, in exactly the same position as bystanders in emergencies. Although involved in the elder person's welfare, banking and health sector workers are not specialists in financial abuse detection. Therefore, they are similar to emergency bystanders with regard to financial abuse.

The '*professional bystander intervention model*' we propose for detecting and acting on suspected elder financial abuse may be spelled out as follows:

- (1) noticing relevant cues,
- (2) construing the situation as suspected financial abuse,
- (3) deciding the situation is a personal responsibility,
- (4) knowing how to deal with situation and
- (5) deciding to intervene.

Deciding that the cues available are indicative of financial abuse is more complex than is often realized. In addition, there are often many subtle and not so subtle barriers to taking action even if it is decided that financial abuse is taking place. Where there is so much uncertainty it might be expected that no action will be taken, especially when there is no statutory requirement to report. Moreover, where many other people are involved – social workers, health care professionals, bankers, family - action might be even less likely due to diffusion of responsibility. Thus, the model explains some of the possible causes of the "iceberg" effect, as it suggests some of the reasons for under-reporting. The study reported below gathered data from reports of real cases and assessed the utility of our professional bystander intervention model in interpreting the obtained data.

## AIM

The aim of this study was to explore the detection and prevention of elder financial abuse through the lens of a 'professional bystander intervention' model. We were particularly interested in identifying the cues that raise suspicion of financial abuse, how elder financial abuse comes to the attention of professionals who do *not* work in adult safeguarding and, finally the barriers to intervening in cases of suspected elder financial abuse. Two groups likely to encounter financial abuse are banking staff and health care professionals.

We do, of course, recognize that financial abuse does not just happen to older people, that the various types of elder abuse co-exist, and that what counts as 'old' is contested. However, because the focus of this research was on the value of the professional bystander intervention model in relation to decision making in detecting elder abuse, we narrowed the focus of the research to financial abuse. Financial abuse of elderly people was chosen for our research because it is believed to be more prevalent than the financial abuse of younger people.

## METHODS

### Sample

Following research ethics approval from Brunel University (Ref 08/09/STF/18) and the UK National Research Ethics Service (REC Ref 08/H0206/57), twenty banking and twenty health care professionals were recruited in England and Scotland. Only those who had at least one experience of suspected elder financial abuse were included in this phase of the project.

Professionals in banking and health care were chosen because they are not required by UK law to report suspected financial abuse, yet are two professional groups likely to encounter elder financial abuse. Cashiers and bank managers have ready access to financial information. Banks also have the potential to be the "first line of defence" (Hughes, 2003) against financial abuse, by identifying the abuse at the outset, before the older person's assets have been used. Health professionals such as general medical practitioners have the potential to identify cases of elder financial abuse because of regular contact with older patients (Tung *et al*, 2007) and because older people are often prepared to reveal problems to health care professionals, knowing that health care professionals will maintain confidentiality. Because English local authority social services have been mandated to deal with elder abuse, findings from our interviews with social care professionals have been reported separately (Davies *et al* 2011).

#### *Banking staff*

Banking professionals were recruited from branches and building societies in London (n = 7), Berkshire (n = 6), Kent (n = 4), Newcastle (n = 1), West Midlands (n = 1) and West Yorkshire (n = 1). Participants were aged 20-60 and included 15 females and 5 males. Participants' length of service ranged from 9 months to 25 years. Participants' ethnic origin was White (n = 20). Job roles varied across participants including Branch Managers, Cashiers, Team

Managers, Financial Crime Staff, a Senior Case Reviewer, an Investment Administration Manager and a Customer's Advisor.

#### *Health care workers*

Health professionals were recruited from various Primary Care Trusts (PCTs) across England and Scotland: 10 from two PCT's in London; 4 from Berkshire PCT; 2 from West Kent PCT and 4 from PCT's in Devon, Coventry, Forth Valley and Lanarkshire (the latter 4 were recruited via the College of Occupational Therapist Specialist Section- Older Adults). Participants were aged 27-58 and included 18 females and 2 males. Participants' length of service in their job role ranged from 2 to 28 years. Participants ethnic origin were White (n = 19) and Black-Other (n = 1). Job roles varied across participants including Occupational Therapists, General medical practitioners, District Nurses, and a Service Manager.

#### **Procedures**

In-depth interviews were carried out using the critical incident technique (CIT) (Flanagan, 1954) to generate an understanding of factors influencing decision-making about suspected cases of financial abuse. The critical incident technique (CIT) involves a set of procedures used for obtaining systematic and detailed reports of human behaviour that have critical significance and meet methodically defined criteria. Critical incidents can be gathered in a number of ways, but typically respondents are asked to provide a narrative about an experience they have had in which relevant decisions had to be made. The critical incident technique was chosen because we were interested in *real* cases and in actual decision-making, rather than in what banking and health professionals said they 'normally' do.

Participants were asked to describe their most recent experiences (one or more critical incident) of elder financial abuse, rather than the most interesting or difficult case experienced. Only incidents in which participants had been involved (cases that were identified by them or reported to them) were included. Prompting was used to acquire details of the incident. Participants were asked to provide as much detail as possible about the case/s they were describing from the time when they first became suspicious to the point they believed the situation to be resolved. Although the critical incident itself involved the whole of the case, the following give a flavour of the nature of the critical incidents explored with the study participants:

*Banking Critical Incident* – A branch manager, age 58, reported a case involving an older gentleman living in a nursing home. Power of attorney had been given to two men who had befriended the man. The victim's daughter lived abroad and when she visited became suspicious about the befrienders and the award of power of attorney. The case went to court and one of the befrienders went to prison. The banks was sued for paying out money on false statements, but won the case because the signatures were not false and power of attorney had genuinely been set up with the consent of the victim.

*Health Critical Incident* – A general practitioners partner, age 44, dealt with a case of an 88 year old female with dementia. The lady lived with her son who was clearly not taking care of her needs. The general practitioner contacted social workers and the district nursing team.

Participants were required to give informed consent, and were provided with an information sheet highlighting that any case examples would be referred to anonymously in reporting. Thirty five interviews were conducted in the participant's place of work; five interviews were conducted over telephone at the participants' request. At the end of each interview participants were also asked to complete a demographic information sheet. Thank you gift vouchers of £10 were provided for involvement.

Each interview was transcribed verbatim. To ensure an accurate representation of the interview content, the transcripts were cross-referenced against the taped recording, providing a second opportunity for familiarisation with the data for the researchers (Braun & Clarke, 2006).

#### **Data analysis**

Thematic analysis was carried out to identify the types of financial abuse encountered, and subjective cue usage (Caelli *et al.* 2003). The procedure followed was guided by similar research involving thematic analysis of interview data (Graneheim & Lundman, 2004; Silén, Svantesson & Ahlström, 2008).

Each interview was read a number of times to identify key case details, such as the nature of the incident. All quotes identified from each incident of elder financial abuse were considered by the research team. Quotes with similar features were then formed into themes.

The results across all of the interviews were then reviewed to establish the coding structure that would best represent the data. One author (DC) carried out individual analysis of all the interviews (n=40). Authors MD and EN carried out a separate analysis of a sub-set of the interviews (n=20) to ensure group validation of emerging cues.

As a further measure of the validity of the findings, the cues and categories were reviewed by the study Project Management Board, which included experts from the field of health and banking. This is a technique used to evaluate cue coverage (Kemp & Mosqueda, 2005), enabling discussion of cue use with individuals with appropriate sector experience. The final stage of analysis involved returning to each interview transcript and collating quotes to fit the finalised coding structure of cues, categories and sub-categories.

## RESULTS

### Cues that raise suspicions of financial abuse

The first stage of the bystander intervention requires that the event be noticed. Thus, we were interested in the nature of the decision cues (case features) that raise suspicions of financial abuse. We were also interested in whether different cues are noticed by those in banking and those in health care.

A total of 77 cases of suspected elder financial abuse were described by the study participants. Thematic analysis revealed that a large number of different decision cues were found to raise suspicions of financial abuse. The cues that emerged from the critical incidents were, therefore, clustered into four cue categories (1) type of suspected financial abuse (2) mental capacity, (3) physical capacity and (4) money controller.

#### (1) Type of suspected financial abuse

The critical incidents reported by those in banking and staff in health and social care highlighted the complex and diverse nature of suspected financial abuse of older adults. Five types of suspected financial abuse were drawn from the analysis of the interviews with banking professionals and six from health and social care. The types of suspected financial abuse are shown in Table 1 below. As can be seen, the types of abuse detected by participants in banking were quite different from health and social care participants. Participants from banking and social care also described fewer incidents (n=35) than those from health care (n=42). Each of the types of abuse will now be outlined.

**Table 1**  
Types of suspected financial abuse reported

Banking Professionals		Health and Social Care Professionals	
Types of abuse	Banking N	Types of abuse	Health N
Suspicious third party	11	Stealing from the home or person	16
Large cash withdrawal	10	Anomalies between living conditions and financial assets	12
Financial anomalies in accounts or bills	9	Unknown befriender or rogue traders	9
Scams	3	Exerting influence to change a will	2
Protecting inheritance	2	Financial anomalies in accounts or bills	2
		Misuse of Power of attorney	1
<b>Total</b>	<b>35</b>	<b>Total</b>	<b>42</b>

#### BANKING PROFESSIONALS

**Suspicious third party** - This type of critical incident was the most common method of suspected abuse reported by banking professionals (n = 11). Study participants from banking were especially likely to become suspicious when a third party attempted to take control of an older customer's bank account. The National Banking protocol (2010) informs staff to be particularly attentive when an older customer is accompanied by someone who is unknown to the bank. It is therefore unsurprising that suspicious third parties were identified frequently by banking staff (British Banking Association 2010)

**Large cash withdrawal** - Requesting to withdraw a large sum of money often raised concern for banking staff and many branches had systems in place where staff members were alerted to an unusual transaction being made, which was then followed up. Participants often talked about taking customers to one side or speaking to them over the telephone to raise their concern about the cash withdrawal and to query what the money was for. These measures resonate with the National banking protocol which states that:

*'When an older or vulnerable customer wishes to make a withdrawal, which is outside their normal routine (e.g. unusually large)...tactfully enquire why the cash is needed; point out the dangers of carrying large amounts of cash' (British Banking Association, 2010).*

**Financial anomalies in accounts or bills** - For banking professionals, financial anomalies in accounts or bills were identified in 9 of the 35 critical incidents reported. A change in any customer's behaviour or habits was often seen as a warning signal for financial abuse:

**Scams** - A number of banking professionals perceived that older people were at risk of various forms of scams. In terms of critical incidents identified, this type of abuse was reported on 3 occasions. Participants talked about cases

where the older customer had paid money to a fraudster in anticipation of receiving something of greater value. Examples of scams included winning the lottery abroad and being asked to transfer money into an overseas bank account to claim the cash prize. An increasing number of financial scams are targeted at vulnerable older people and while not all the banking participants reported experience of this type of abuse, most raised scamming during the interviews as a particular concern for older and vulnerable customers.

**Protecting inheritance** – Participants from banking described two cases where family members were perceived to be more interested in protecting their inheritance than making sure that their ageing relative was receiving the very best care.

HEALTH CARE PROFESSIONALS

**Stealing from the home or person** – Critical incidents involving stealing were reported only by health professionals. These cases were problematic because participants were not sure whether such claims were in fact true or the older person had in fact mislaid their money. Such incidents were often explored further before formal allegations were made by professionals.

**Anomalies between finances and living conditions** - Health professionals identified suspicious living conditions in terms of lack of day-to-day necessities such as food, clothing and household utilities as a cue for abuse. Living conditions were a cue of financial abuse both where standards were considered poor, as well as where quality of living had suddenly deteriorated. In some instances, health care professionals reported that poor living conditions indicated other types of abuse that then alerted them to financial abuse. A number of participants identified general neglect as occurring alongside financial abuse.

**Unknown befriender or rogue traders** - Abuse by befrienders and rogue traders were categorized together because both involved a more calculated intentional abuse, and were usually committed by someone previously unknown to the older person. Examples of rogue traders included builders who carried out work that was not required or cleaning companies that overcharged. One critical incident involved a company who charged £2000 to clean an older lady's house where she had been living in sub-standard conditions.

Befriender abuse was reported in one critical incident by a general medical practitioner who was suspicious about a man who had moved in with an older lady (his patient) and was taking partial control of her finances. Befriender abuse has the potential to be difficult to identify given that it will most likely appear from an outsider's perspective to be a reciprocal friendship. The critical incidents of this type of abuse also highlighted the complex nature of decision-making in such cases. For example, in the above case, the General medical practitioner was also aware that the lady was very much reliant on the man residing with her for support in daily activities. Thus, determining the best form of action was problematic.

**Financial anomalies in accounts or bills** - Critical incidents involving financial anomalies in accounts or bills were rarely reported by health professionals (n = 1). The only case reported involved a district nurse visiting a patient at home who noticed a number of financial statements lying around which caused her some concern. It could be said that this finding is unsurprising given that health professionals are generally not directly involved in dealing with aspects of an individual's finances.

**Exerting undue influence to change a will** - This type of abuse was where there was perceived pressure of coercion from a third party to change a will. Only two critical incidents of this nature were reported, both by health professionals. These incidents involved a sudden change to the older person's will. Although no critical incidents of this nature were reported by banking professionals, many raised concerns about older adults being coerced by family members into changing their wills.

**Misuse of power of attorney** - Misuse of power of attorney (POA) involved a nominated person with lasting powers of attorney managing an older customer's finances whilst taking advantage of their position of trust. Only one critical incident of this type was reported. In the UK health professionals (mainly general medical practitioners), are often asked to certify Lasting Power of Attorney (LPA) certificates to confirm that the donor (older person) understands what an LPA is and understands what powers they are giving to the Attorney(s) in their LPA. Thus, health professionals are also in a position to identify if the older person is being pressured, tricked or placed under duress by someone else to make the LPA. However, as the following quote highlights, health professionals may miss the initial signs of financial abuse and only realise this on hindsight:

*"so I did go and see her with her nephew who I had never met before and I asked her you know, if she was happy to sign over her...but I did feel within that context that she was bulldozed and...she did give me some concern in that she sort of said after that it was all signed ...not in those so many words but she gave me an indication that she was not 100% happy with it." (General medical practitioner)*

Although this type of elder financial abuse was one of the least reported by health professionals, a number of study participants raised concern about this type of abuse.

## **(2) Mental capacity**

Mental capacity was reported in 25 of the 42 critical incidents reported as an important case feature by the health professionals, but was rarely mentioned in the critical incidents described by banking participants. Interestingly, the analysis identified differences in opinion as to how capacity impacted upon professionals' experiences of identifying and addressing financial abuse. In some cases, making decisions when older people lacked capacity was seen to be difficult:

*"I think people find it very difficult if somebody's got severe cognitive impairment and they say 'I have £500 in that cupboard and it's disappeared and 2 of my cups have been stolen as well and 6 eggs'..."*  
(District Nurse)

Professionals also indicated that decision-making was just as problematic when the older person had full mental capacity:

*"..it was decided that he did have capacity, that he knew that she was taking the money and he was actively allowing her back in even though he knew she may take more money, which meant we couldn't override him, he'd already said he didn't want it reported to the police even the ex-wife had spoken to the police, he then refused to report it and refused to pursue it, he felt that this lady was a friend; you know she'd been helping him and it was just a misunderstanding, she behaved badly but it was a misunderstanding." (Service Manager)*

## **(3) Physical Capacity**

Physical capacity was considered a key cue in 14 of the 42 critical incidents reported by health professionals, but was rarely mentioned by banking participants (n=2). Some health professionals reported seeing a number of older patients daily and reported that with increasing physical health problems their ability to act independently was reduced, resulting in dependency on others for shopping and other things involving money. This vulnerability was found to be a particular concern for health professionals and clearly influenced their interpretations of the cues surrounding suspected abuse.

## **(4) Money Controller**

The fourth cue category was 'money controller' This was a cue category only used by banking professionals, and only three examples of this cue category were reported. This was considered an important way of identifying potential abuse particularly when the older person managed their own money or where someone else had some or full control of their finances. For example, one banking professional described a case of financial abuse which involved a lasting power of attorney managing an older customer's finances and taking advantage of their position of trust:

*"His family were previously on as...a power of attorney...and he had a lot of money in his account and they transferred the money out of the account into their account in their own name." (Bank Manager)*

## **Cue pathways: How elder financial abuse came to attention**

In traditional bystander intervention experiments the study participant observes an event which he or she must then judge as an emergency or not. In the cases of real world elder financial abuse reported by study participants there were two ways in which the 'event' came to the attention of a banking or health professional, namely direct observation or reports by others. Although both the banking and health professionals described critical incidents where they directly observed signs of abuse (n=38); a similar number of cases were reported to them by other people (n=39). Those who reported cases included family members, friends, other professionals and the older person at the centre of the abuse.

Banking professionals directly observed more cases of abuse (n=20) than those reported to them by someone else (n=15). The higher number of directly observed cases is unsurprising given that these professionals work within the financial sector, deal with monetary issues and work very closely with customers on a day-to-day basis. These professionals are also trained, as part of their role, to identify any unusual financial behaviors or transactions made by a customer:

Health professionals directly observed 18 cases of elder financial abuse. However, more cases were reported to them by someone else (n = 24). Health professionals are not only in a position to witness cases of potential abuse (for example, general medical practitioners or district nurses visiting patients at home) but they are also likely to be informed about cases of abuse. Patients are seen to hold them in a position of trust where sensitive information can be disclosed to them under the confines of patient confidentiality.

## Deciding to intervene: Barriers to acting

Participants reported occasions when they wanted to intervene, but were inhibited from doing so. Banking and health professionals each reported a number of barriers in the decision-making process when dealing with a case of suspected elder financial abuse. The barriers reported can be seen in Table 2.

**Table 2**  
 Barriers to reporting suspected elder financial abuse.

<b>Banking Professionals</b>	<b>N</b>	<b>Health Professionals</b>	<b>N</b>
Issues surrounding policy and legislation	40	Issues surrounding policy and legislation	8
Work environment	14	Work environment	4
Family member	11	Family member	14
Lack of experience	7	Lack of experience	6
Identifying elder financial abuse	6	Identifying elder financial abuse	14

### **Issues surrounding policy and legislation**

The most frequently mentioned barrier reported by banking professionals concerned issues surrounding policy and legislation. Banking professionals highlighted the restrictions they faced particularly as a result of the Data Protection Act (1998) and the inability to report their suspicions for fear of consequences:

*"well the problem we have is Data Protection. Now we are very concerned you know, if we breach that, you know, it's all very well and good if it turns out to be a genuine case but if we've misread the signs then...whether we're in breach of Data Protection. So, you know, we're a bit unsure of what exact procedures we can take"* (Investment Manager)

Health professionals reported a general lack of legislation with regards to and limited knowledge of knowing exactly what financial abuse was and what to do in such circumstances:

*"I think it would have been easier had we had a policy that would deal with these kind of issues so it would give you indicators of a.) what is and b.) what would you do in that situation, who do you report it to and what are your responsibilities there"* (District Nurse)

Health professionals also reported that they were restricted by policy and legislation in reporting financial abuse because of the confines of patient confidentiality as described earlier.

### **Work environment**

Both banking and health professionals reported that the environment in which they worked and the (in)ability to work with other agencies was a barrier to initiating action in relation to a case of suspected financial abuse.. For banking professionals the working environment was often a barrier due to the pressures of the job. For example, staff often reported being too busy deal with elder financial abuse:

*"If I could have dealt with it myself I would have brought her into an interview room but there's no way I can leave the counter..."* (Cashier)

For health professionals elder financial abuse rarely had a positive outcome often due to a lack of evidence to prosecute the perpetrator. Part of the problem involved working with various agencies (e.g., banks) which were often unable to share information to support a case. The need for more collaborative interagency working when detecting and preventing elder financial abuse to address this difficulty was noted by both banking and health care professionals.

### **Family member**

Dealing with a case of involving family members who were suspected of committing the abuse was problematic for both those in banking and health.

*"..if it was the neighbour or a paid carer, then I'm sure Mrs X would no qualms in reporting it as financial abuse and I wouldn't hesitate in reporting it to my manager but this case (with a family member) was complicated"* (General medical practitioner)

*"I think it's quite difficult, especially when family are involved and they're trying to help them out and trying to get them to move money into certain places, the older person sometimes they don't know what's going on...so it's hard...it's a fine line to see whether they're helping them out or not"* (Bank manager)

### **Lack of experience**

Lack of experience in identifying and dealing with cases of financial abuse, as well as knowing how to appropriately deal with the victim of abuse and potential abusers (particularly family members), were also reported as barriers faced by banking and health professionals. Each group reported a need for guidance and training tools to be developed to enable them to improve their ability to accurately identify and to make the appropriate decisions:

*"...it would be helpful to have some guidance I think ... because that vulnerable population will be coming into contact with us more"* (Occupational Therapist)

*"...those of us in the banking industry would really appreciate some form of signposts to find us some more direction as to you know, what we should do what we shouldn't do"* (Senior case reviewer)

### **Identifying elder financial abuse**

Both health and banking professionals also reported identifying elder financial abuse as a barrier:

*"... we're GPs, we're medical doctors, we're not sort of financial advisors and you know a person's finances are not really any of our business. However, you know, if someone's being abused; physically, mentally, psychologically, financially, there's someone who's taking advantage of somebody else, then you know we do have a duty of care, but it is a very, very difficult thing to pick up"* (General Medical Practitioner)

## **DISCUSSION**

In this paper we proposed a 'professional bystander intervention model' to help us understand why elder financial abuse does not come to the attention of those with the power to intervene – the 'tip of the iceberg' effect. According to the model, five stages must be negotiated. Firstly the cues must be noticed (Step 1) and then be interpreted as representing elder financial abuse (Step2). Secondly, the observer must assume personal responsibility for acting (Step 3), must feel able to act (Step 4) and then must do something (Step 5). At each of these stages decisions can be taken which mean that no action is taken.

### **Noticing cues and construing them as elder financial abuse**

The marked differences in types of suspected abuse described by study participants from banking and health care draws attention to the ways in which context influences the likelihood that elder financial abuse will even be noticed. Cashiers, managers and others in banking are focussed on fraud and protecting their customers' money; it is, therefore, perhaps unsurprising that they did not report mental and physical capacity as important cues in detecting elder financial abuse. It was, however, interesting that study participants from banking used fewer cues than those from the health care sector. Health professionals are focussed primarily on the physical and mental well-being of older people, including providing services to enable them to remain in the community and are less likely to be concerned about who controls the money. Thus, each professional group 'sees' different aspects of an individual's life and, as a consequence, will notice some cues of financial abuse, but either not have access to other cues or will just not notice the other cues. Because health care workers do not in normal circumstances work closely with staff in banks, it is easy for financial abuse to go both undetected and even if detected, unconfirmed.

Although the 'signs' of financial abuse are listed on many organisation web pages and leaflets, our study appears to be the first UK research aimed at identifying the cues that actually raised suspicions amongst banking and health care professionals in real world cases. The cases described by our study participants indicated a wide range of types of suspected abuse and a large number of cues used in coming to a decision that financial abuse was likely taking place. However, what was common to all cases was a discrepancy between what is normal and expected and what is abnormal or unexpected. Examples described included relatively well off people having no food in the house, sudden withdrawals of large sums of cash from bank accounts, or changes in a will. Importantly, like the bystanders in emergencies, banking and health professionals reported difficulties in deciding if the cues represented something

normal or abnormal, i.e. if something was going on that definitely represented elder financial abuse, particularly at a level at which they needed to go beyond normal practice and report their suspicions to those with the authority to act.

Our study revealed that a high proportion of suspected cases of financial abuse are not directly observed but are brought to professionals' attention by other people. This is a major difference between the typical case of bystander intervention and decision-making about elder financial abuse. Interestingly, participants from banking were more likely to describe cases that they observed themselves compared to those reported to them, whereas the study participants from health professions were somewhat more likely to describe cases that were reported to them, rather than directly observed. There may be a number of reasons for these differences. It could be that because of perceptions of doctors, nurses, occupational therapists, etc as members of the 'helping professions', with high levels of 'confidentiality', people who were concerned that an older person might be being financially abused would be more willing to approach health care professionals than members of staff in banks. On the other hand, since the cues reported as important were different for those in banking, it may be that these differences have more to do with the nature of the jobs represented in the study. People in banking are trained extensively to detect fraud and are, therefore, constantly vigilant in relation to types of financial irregularities (BSA, 2010).

The findings revealed that many cases of financial abuse are not directly observed by those in a position to intervene. This reliance on being informed about suspected abuse by third parties raises an important issue, namely how to ensure that the suspicions of third parties can most effectively be brought to the attention of safeguarding officials.

### **Assuming responsibility, knowing what to do and barriers to acting**

Difficulty in identifying abuse was itself reported as a barrier to intervention. Thus, participants were implicitly acknowledging that there are many places in the decision-making process where blockages might occur. Given that elder financial abuse can take many forms, and without a universally accepted definition, it is unsurprising that there is uncertainty over recognising it and therefore reporting it (Wilber et al., 1996; Rabiner et al., 2004).

Several participants reported that even when they were sure that an older person was being financially abused they did not know what to do because of a lack of guidelines and training. On the other hand, guidance related to other aspects of professional practice seemed to inhibit action. Participants from banking stated that the Data Protection Act prevented them acting. However, there was generally an inability to explain what the Data Protection Act (1998) stipulated to prevent them from reporting a case of suspected abuse. According to the British Banking Association (2010) only the refusal of the customer's consent will prevent a case from being reported. If a bank suspects financial abuse, but the customer either does not or is not prepared to admit they may be a victim, this is a difficult area for banks in terms of the customer mandate. There is only one reporting route, and that is via the Suspicious Activity Reports (SARs) regime to the Serious Organised Crime Agency (SOCA) under the Proceeds of Crime Act (2002). Contacting any other organisation or person, whether it be the customer themselves, law enforcement, social services or the victim's family, before a SAR has been made to SOCA, constitutes an offence for which the bank is criminally liable. Similar to reports by participants from banking, confidentiality in the patient/health care professional relationship prevented the reporting of suspected abuse.

The UK has strong social norms which inhibit people from intervening in family matters so it is perhaps unsurprising that both bankers and health care professionals found it particularly problematic when they suspected a family member of financially exploiting a relative. Other countries, notably the United States of America, have passed mandatory reporting laws to help ensure that suspected abuse is reported (Pearson and Cowart 2011). Whether or not such laws are needed in the UK is an issue that is gradually coming to the attention of policy makers.

Unlike bystander intervention in real-world emergencies, or even in experiments aimed at testing the impact of different variables on likelihood of bystander intervention, intervention in cases of suspected elder financial abuse appears to depend on a more complex process with responsibility having to be assumed by different people at different levels of relationship to the abused person. For many cases to come forward other people must also go through the five stages of the professional bystander intervention model before they present information to the banking or health care professional to assess further. This 'sequential-bystander intervention' means that at each stage a decision can be taken which would either lead to intervention or prevent intervention. If two or more people must progress through the bystander stages, the chances of intervention are reduced. At each of these different levels there may be barriers, organizational and personal, that militate against individuals taking responsibility for acting on their suspicions.

Finally, because so many different people see so many different parts of an older person's life, there may also be 'diffusion of responsibility'. In research on bystander intervention in emergencies a key finding is that the greater the number of people who witness the emergency, the less likely it is that anyone will take action (Latane and Nida, 1981). The issue of the number of bystanders and likelihood of taking action would be an interesting one to pursue.

## CONCLUSION

This study has provided useful information about the nature of the cues that trigger professionals' suspicions of abuse, as well as insights as to how this information reaches those in a position to intervene to stop the abuse. We also found interesting barriers to taking personal responsibility for reporting the suspected abuse. Framing the detection and prevention of elder financial abuse in terms of what we have called the 'professional bystander intervention model' provides a new way of conceptualizing and exploring professional decision-making and intervention.

Unlike other countries, most professionals in England are not required by law to report suspicions of elder abuse. It is often argued that most financial abuse goes unreported, and that prevalence figures only represent the 'tip of the iceberg'. The professional bystander intervention model has, we believe, considerable potential for helping us to research and understand why elder financial abuse does not always come to the attention of those in a position to intervene and why, even when it does, action is often not taken. In addition, the bystander intervention model has potential for exploring other issues such as the neglect of older people and lack of dignified care in hospitals, as well as decision-making by professionals who deal with the abuse of other groups, for example, people with learning disabilities.

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