Predictors of Financial Capacity Performance in Older Adults using the Financial Capacity Competence Assessment Instrument Inventory

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ABSTRACT

Background: Declines in financial capacity in later life may arise from both neurocognitive and/or psychiatric disorders.

Objective: The influence of socio-demographic, cognitive, health, and psychiatric variables on financial capacity performance was explored.

Methods: Seventy-six healthy community-dwelling adults and 25 older patients referred for assessment of financial capacity were assessed on a variety of pertinent cognitive, psychiatric and financial capacity measures, including Addenbrooke’s Cognitive Examination – Revised (ACE-R), Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE), the Geriatric Depression Scale (GDS), the Geriatric Anxiety Inventory (GAI), selected Neuropsychiatric Inventory (NPI) items, the Financial Competence Assessment Inventory (FCAI), and the Social Vulnerability Scale (SVS).

Results: The psychometrics internal consistency of the debt management subscale of the FCAI were relatively poor in our sample. Financial capacity performance differed between controls and patients. In our sample performance on as measured by the FCAI was predicted by MMSE, IQCODE and the GAI, but not by the ACE-R, GDS, NPI items or the SVS (adjusted $R^2 = 0.7059$).

Discussion: Anxiety but not depression predicted financial capacity performance, possibly reflecting relatively low variance in depressive symptoms in this sample. Current cognitive decline as measured by the informant-rated IQCODE was more highly correlated to financial
capacity than either educational attainment or ACE-R scores. This result points to the danger of assumptions of financial capacity based solely on educational attainment and reflects the value of informant data. Lack of significance of ACE-R data may reflect the instrument’s decreased sensitivity to domains relevant to financial capacity, compared with more detailed neuropsychological assessment tools. The FCAI displayed fairly robust psychometric properties apart from the debt management subscale.

**Key Words:** capacity assessment, financial issues, rating scales, anxiety, aging

**Key Words:** financial capacity, capacity assessment, social vulnerability, aging
Running head: Predictors of financial capacity

Background

The ability to manage one’s finances is an important aspect of functional independence. In later life, the ability to competently manage finances may be questioned due to incipient cognitive impairment as a result of neurocognitive decline, or impaired cognitive or decision-making capacity due to psychiatric disturbance (Moye et al., 2013). Questions concerning financial capacity often arise from concerned family members, health care professionals, or in some cases, the patient him or herself. There is real potential for loss of assets due to mismanagement or financial exploitation or abuse if an individual’s financial capacity is impaired (Acierno et al., 2010; Pinsker et al., 2006).

Determinations of financial capacity are often not straightforward and have the potential to cause distress to all parties involved. Assessment of financial capacity may be carried out by a variety of health care professionals, but ideally, should be undertaken using both interview strategies as well as objective assessment data (Moye et al., 2013). Clinical judgement alone may prove unreliable if not well supported by objective data, for example, if clinicians hold different values from those of their patients (Braun et al., 2009). Discrepancies in the clinical judgements of health professionals with respect to patient capacity are also well documented (e.g. Marson et al., 1997).

A variety of instruments to assist with determinations of financial capacity have been either developed for older adults or validated in older populations. These include semi-structured interviews, vignettes, and direct assessment of performance on items targeting financial management abilities (Griffith et al., 2003; Marson et al., 2000; Marson, 2001; Moye et al., 2013). Assessment of global or domain specific aspects of cognitive functioning may be important, particularly if cognitive decline is suspected. Such declines have been shown to predict reduced performance of financial management tasks, for example, in
patients with amnestic mild cognitive impairment (MCI) and mild Alzheimer’s Disease (AD) (Griffith et al., 2003; Sherod et al., 2009). When assessing financial capacity, informant reports should also be sought, as collateral information can provide useful information to inform clinical judgements of financial capacity (Sherod et al., 2009; Pinsker et al., 2006). Finally, assessment of psychiatric conditions such as depression and anxiety is recommended (Moye et al., 2013), as financial capacity may be affected by the cognitive, affective, or behavioural sequelae of such conditions.

Although objective assessment of financial capacity, relevant cognitive and psychiatric domains of functioning, and informant reports are considered important in making a determination of financial capacity, in clinical practice, such a strategy may not be carried through. Indeed, even in research contexts, not all relevant domains may be assessed with respect to financial capacity; for example, no measures of depression or other symptoms of psychiatric conditions were assessed by Sherod et al. (2009). Given the important interpersonal and financial ramifications of a determination of impaired financial capacity in the patient, and the need for appropriate actions to be taken (which could range from education about options to transferal of decision-making to another party through to obtaining treatment for a mood disorder), the need for the assessment of financial capacity to be wide-ranging and thorough is clear from the research (e.g. Triebel et al. 2009). With respect to education of the patient and their family about options, health practitioners but particularly primary care physicians have an important role to play (Widera et al., 2011).
assessments of financial capacity. In addition, a purpose-designed instrument aimed at measuring social vulnerability (inability to gauge intentions of others) was administered.

**Methods**

**Participants**

Participants included 76 healthy older adults (aged 60-95, $M = 69.74; SD = 7.37$), and 25 clinical older adults (aged 56-93, $M = 69.49; SD = 9.74$). Participants in the healthy group (36 males, 40 females) were community dwelling older adults recruited from a healthy participant register (the 50+ Registry) of approximately 2,500 persons over age 50 residing in the southeast portion of Queensland, Australia. The majority of healthy participants were born in Australia (67.1%), lived with their spouse (61.8%) or resided alone (29.0%), had completed tertiary education (59.2%) or high school (17.1%), and lived in their own home (90.8%). Healthy participants were asymptomatic for dementia or memory impairment at the time of testing.

Participants in the clinical group (14 males, 11 females) had received a diagnosis of dementia (Alzheimer’s disease, vascular dementia or mixed dementia) or another cognitive disorder not otherwise specified. Clinical participants were referred by their treating practitioner, nursing staff or key recruitment contacts from three major hospital sites in Brisbane (The Royal Brisbane and Women’s Hospital, The Princess Alexandra Hospital, and The Prince Charles Hospital), as well as the Queensland Alzheimer’s Australia service. Inclusion criteria for the clinical group included community dwelling individuals aged 55 years and over with identified memory impairment potentially affecting financial capacity; exclusion criteria for all groups included active psychosis and lack of basic English language.
skills. The majority of clinical participants were born in Australia (60%), lived with their spouse (48%), alone (28%) or with other family members (12%), lived in their own home (84%), and completed tertiary education (56%) or high school (12%).

Each study participant nominated an informant (spouse or other relative/friend) as a source of collateral information regarding financial affairs. Informants for the healthy participants (26 male, 47 female, 56.6% spouses) consisted of 73 adults ($M = 59.90; SD = 14.78$) aged between 21-89 years old. The majority were Australian born (67.1%) and had completed tertiary education (46.6%) or high school (24.7%). Clinical informants (7 male, 15 female, 48% spouses) consisted of 22 adults ($M = 61.86; SD = 13.22$) aged between 35-79 years old. The majority were born in Australia (68.2%) and had completed tertiary education (36.4%) or high school (13.6%). All informants were interviewed either face-to-face at the time of testing the participant, or over the telephone.

The University of Queensland’s Human Research Ethics Committee (HREC), as well as the HRECs at each of the participating hospitals, approved the study protocol. All participants and informants provided written informed consent.

**Procedures**

Basic demographic information (age, gender, living arrangements) was obtained at the interview. Participants nominated a suitable informant to be contacted, and informants were then assessed at a time that was convenient for them. Participants completed one cognitive screening measure, namely the Addenbrooke’s Cognitive Examination – Revised (ACE-R; Mioshi et al., 2006), from which the Mini-Mental Status Examination score could also be calculated (MMSE; Folstein et al., 1975). Symptoms of depression and anxiety were assessed
Financial capacity was measured with the 38-item Financial Competence Assessment Inventory (FCAI; Kershaw and Webber, 2008), an instrument specifically developed in Australia to determine strengths and weaknesses which samples across six domains of financial capacity: everyday financial abilities, financial judgment, estate management, cognitive functioning related to financial tasks, debt management, and support resources. We chose the FCAI for our study based on its ability to sample across domains, to offer strengths and weaknesses (felt to be important in giving feedback to patients which went beyond simple deficits), and based on the fact that our sample was Australian and this was an Australian measure with good psychometric properties. Kershaw and Webber reported the overall internal consistency (Cronbach’s alpha) of the FCAI as $r = .96$, with the subscales ranging from $r = .91$ to $r = .54$, with the support resources subscale having the poorest internal consistency. Inter-rater reliability and test-retest correlations (at 5-9 weeks) were good (Cohen’s $K = .86$ and $r > .93$ for all subscales, respectively). Significant correlations between the full FCAI total score and MMSE scores in persons with dementia ($r = .76$, $p < .01$) were also reported by Kershaw and Webber.

Informants completed the Instrumental Activities of Daily Living Scale for the Elderly (IADL-E; Mathuranath et al., 2005), the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE; Jorm, 1994), the delusions, hallucinations, anxiety and depression questions from the Neuropsychiatric Inventory (NPI; Cummings et al., 1994), and the Social Vulnerability Scale (SVS; Pinsker et al., 2006). The assessment of participants took approximately 90 to 150 minutes to complete; all participants were debriefed regarding the specific aims and expected outcomes of the research.
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**Statistical Analysis**

We generated descriptive statistics for all variables and measured the internal consistency of the FCAI using Cronbach’s alpha. The FCAI debt management subscale (FCAI-dm) was omitted as it had limited variance and a low item-total correlation. The FCAI total score distribution was negatively skewed (-2.20; \( p = 0.0000 \)) and leptokurtic (8.01; \( p = 0.0000 \)), and not significantly improved following transformation. Distribution-free correlation coefficients were estimated with Spearman’s \( r \). Logistic regression using group (0 = control; 1 = patient) as the outcome variable was used to identify those FCAI subscale scores that independently predicted membership of the patient group. The Kruskal-Wallis equality-of-populations rank test was used to determine if there was a significant difference in mean FCAI scores between the clinical and control groups. Robust linear regression was used to estimate the independent association of covariates with FCAI scores. All tests were two-tailed and the critical value of alpha was set at 0.05. Bonferroni corrections were applied where relevant to control the Type I error rate. Analyses were conducted in STATA/SE 12.1 (StataCorp, College Station, TX).

**Results**

Table 1 summarizes the socio-demographic and clinical characteristics of the patients and control participants. Patients and controls did not differ significantly on age, gender or education. However, as expected, controls performed significantly better than patients on the three measures of cognitive function (MMSE, ACE-R, IQCODE).

**INSERT TABLE 1 ABOUT HERE**
In the sample, the internal consistency of the FCAI scale including the debt management (DM) subscale (FCAI-a) was 0.87 with a mean inter-item covariance of 7.8. The internal consistency of the FCAI scale without the DM subscale (FCAI-b) improved to 0.91 and the mean inter-item covariance increased to 11.7. Summary statistics (mean, SD, range) for the FCAI-a and FCAI-b were 114.2, 18.0, 39-134 and 110.3, 18.0, 35-130, respectively. Mean FCAI-b score was lower in the patient group than in the control group, indicating reduced worse financial management abilities capacity in the former: 90.5 (SD 25.3), 116.8 (SD 7.3), Kruskal-Wallis $\chi^2 = 28.9$, df = 1, $p = 0.0001$.

Next, we used a logistic regression model (see Table 2) to investigate which FCAI subscales independently predicted group membership with group coded “0” for control participants and “1” for patients. Scores on the FCAI-cf (cognitive functioning in relation to financial tasks) and FCAI-sr (support resources) subscales were independently associated with group membership, with odds ratios of 0.42 (95% CI: 0.21-0.82) and 0.73 (95% CI: 0.57-0.93), respectively. Thus, patients were judged to have poorer cognitive functioning and fewer support resources than control participants. In contrast, patients and control participants did not differ significantly on everyday financial abilities (FCAI-efa), financial judgment (FCAI-fj), or estate management (FCAI-em). Debt management (FCAI-dm) could not be assessed as it was automatically dropped from the regression model, along with four participants, as all clinical cases (25/25) and most controls (72/76) were assigned the same score of “4”. There were 97 participants with complete data for this analysis.

Finally, we employed a robust linear regression model (STATA rreg) to estimate the independent associations of socio-demographic (gender, age, education), psychological (anxiety, depression, total neuropsychiatric symptom burden, social vulnerability), and neurocognitive variables (ACE-R, MMSE, IQCODE) with FCAI-b score (see Table 3). There
were 93 participants with complete data for this analysis. The overall model was statistically significant \( F(10, 82) = 23.5, p = 0.0000; \text{adjusted } R^2 = 0.7059 \), with MMSE \( p = 0.000 \), IQCODE \( p = 0.002 \) and GAI \( p = 0.040 \) showing significant independent associations with FCAI-b.

Discussion

The current study examined predictors of financial capacity (as measured by the FCAI) in healthy older participants as well as those referred specifically for financial capacity assessment. Financial capacity was measured by the FCAI (Kershaw and Webber, 2008), which boasts high internal consistency \( r = .96 \), inter-rater reliability \( \text{Cohen’s } K = .86 \) and test/retest reliability (for four of the six subscales and for the total score > .93), as well as being developed and validated in Australia (Kershaw and Webber, 2008). However, while the overall internal consistency of the FCAI was relatively close to that cited by Kershaw and Webber (2008), a majority of the FCAI subscales were adequate for the purposes of the present study—the debt management subscale (FCAI-dm) performed poorly in the current study and we note that it had also performed relatively poorly in the original FCAI validation study involving diverse clinical populations (Kershaw and Webber, 2008). In the present study, a modified version of the FCAI (without the FCAI-dm subscale) demonstrated sound internal consistency and correlated with several measures of neurocognitive function. We suggest that further work on the subscale of debt management may be warranted.

In the present study, a modified version of the FCAI (without the FCAI-dm subscale) demonstrated sound internal consistency and correlated with several measures of neurocognitive function. In bivariate analyses, this modified FCAI score was not significantly...
associated with gender, age or education. Patients referred for capacity assessment had lower scores on the modified FCAI than control participants. The FCAI subscales of cognitive functioning in relation to financial tasks (FCAI-cf) and support resources (FCAI-sr) were independently associated with patient status. In a multivariable robust regression model, MMSE, IQCODE and GAI were independently associated with modified FCAI scores, but the socio-demographic and remaining cognitive and psychological variables were not. Lower cognitive function and greater anxiety were associated with reduced performance of financial management tasks.

Interestingly, social vulnerability to financial exploitation, as measured by the Social Vulnerability Scale (SVS, Pinsker et al., 2010), was not associated with financial capacity performance in this sample. It may be that the most sample-participants in the was-current study were relatively high functioning; Pinsker et al., 2010 note that older adults with intact cognition are no different to younger persons with respect to social vulnerability to exploitation or abuse. Furthermore, acts of exploitation typically involve deception or coercion within a social context. To this extent, avoiding exploitation potentially encompasses a distinct subset of abilities including social reasoning, and skills of this nature are not directly targeted by the FCAI.

The data showing a lack of correlation between depressive symptoms and financial capacity are somewhat unexpected, if for no other reason than depressive symptoms have been shown to be associated with declining cognitive capacity (Moye et al., 2013). Lack of variance in our sample with respect to scores on the depression scale could partially explain the lack of a significant relationship in our sample. However, to our knowledge there has not been specific exploration of the impact of symptoms of depression or anxiety on financial capacity abilities in later life. The prevalence of both depression and anxiety symptoms, as
well as co-morbid depression and anxiety in geriatric clinical samples, and the impact of such symptoms on the ability to live independently, supports the notion that in at least a subset of such patients’ financial capacity could be impaired (Beattie et al., 2010). In light of this our positive finding of a relationship between increased anxiety symptoms and poorer performance of financial management tasks warrants further study.

The lack of a correlation between financial ability and level of education in this sample points reflects other research suggesting that education is not a good proxy for financial literacy (Lusardi & Mitchell, 2011), to the danger of making assumptions about current financial capacity based solely on educational attainment. The significant correlation between financial abilities and scores on the IQCODE demonstrates the potential value of gaining an informant perspective on matters of financial capacity. While important, it may be that the informants’ rating of cognition or other domains should be considered only one source of data, given that other research with patients with MCI has shown that informants were not as accurate as the patients themselves in gauging financial capacity abilities (Okonkwo et al., 2008). Interestingly, in this study by Okonkwo and colleagues, the patients with MCI and depression underestimated their financial capabilities, whereas MCI patients with more global deterioration in cognitive capacity overestimated their financial capabilities.

As other authors (e.g. Kershaw and Webber, 2008; Moye et al., 2013; Widera et al., 2011) suggest, a variety of indicators, including informant reports, objective testing results and a careful history are superior to any one source of data alone, including over-reliance on screens such as the MMSE; to this list we would add the potential of psychiatric variables such as anxiety to add important information about a patient’s current financial capacity.

Finally, the lack of a strong correlation between current cognitive functioning as assessed with the ACE-R and financial capacity performance may reflect the ACE-R’s
decreased sensitivity to domains relevant to financial capacity, compared with more detailed neuropsychological assessment tools. There is a plethora of research indicating a strong relationship between cognitive functioning and financial capacity (e.g. Griffith et al., 2003; Sherod et al., 2009). To our knowledge, the current study is the first to directly examine the ACE-R’s relationship to financial capacity in older persons; further research using a more recent revision of the ACE-R, the ACE-III, in a larger clinical sample may be more sensitive in detecting relationships between cognitive test scores and specific financial management abilities.

Study strengths and limits to generalisability are worth noting. A strength of the current study is that it simultaneously tested the financial capacity of healthy community-dwelling persons as well as a clinical sample identified because of questions regarding the ability to manage their own finances. Often perceptions of abilities in so-called “healthy” persons may be inflated, and in clinical practice health care professionals may not appreciate that a number of contextual issues (e.g. experience with handling finances, size of the estate) can influence actual functional capacity to manage finances. A similar argument may be made for using any single tool (for example the MMSE) without reference to a specific normative sample; several reports (e.g. Tombaugh and McIntyre, 1992) have been published regarding pitfalls of a lack of reference to normative data. Finally, the potential for psychiatric symptoms such as anxiety to influence financial decision-making in later life is suggested by our data; having a larger clinical sample of older participants with symptoms of depression and anxiety would help clarify the impact of such symptoms on financial capacity.

Potential limitations of the study include the relatively small sample size obtained and the predominance of relatively highly educated participants within the sample. The recruitment process for clinical participants was protracted, and complicated by
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unforeseeable changes in the procedures and requirements of the public health system. Longitudinal data to follow healthy older adults with relatively lower scores would add to our knowledge of the natural course of progression of financial management abilities, and the relative contributions of disease, age, and other factors.

Conflict of Interest: None.

Description of author roles: N.A. Pachana, G.J. Byrne, J. Wilson, C. Tilse and D. Pinsker designed the study, supervised the data collection and wrote the paper. D. Pinsker, K. Vearncombe, B. Massavelli and L. Mitchell collected the data and assisted with writing the paper. G.J. Byrne and N.A. Pachana were responsible for the statistical design of the study and for carrying out the statistical analysis.

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References


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**TABLE 1** Socio-demographic & Clinical Data By Group

<table>
<thead>
<tr>
<th></th>
<th>Clinical Group N = 25</th>
<th>Control Group N = 76</th>
<th>Statistical Test</th>
<th>P-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender (N, %)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>14 (56%)</td>
<td>36 (47.4%)</td>
<td><strong>χ² = 0.56</strong></td>
<td>0.4540</td>
</tr>
<tr>
<td>Female</td>
<td>11 (44%)</td>
<td>40 (52.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age, in years (Mean, SD, range)</strong></td>
<td>69.7 (7.4, 60-95)</td>
<td>69.5 (9.7, 56-93)</td>
<td><strong>KW χ² = 0.140</strong></td>
<td>0.7086</td>
</tr>
<tr>
<td><strong>Education (N, %)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>14 (56%)</td>
<td>45 (59.2%)</td>
<td><strong>χ² = 0.08</strong></td>
<td>0.7780</td>
</tr>
<tr>
<td>No University</td>
<td>11 (44%)</td>
<td>31 (40.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MMSE (Mean, SD)</strong></td>
<td>25.4 (2.8)</td>
<td>29.2 (1.1)</td>
<td><strong>KW χ² = 18.527</strong></td>
<td>0.0001</td>
</tr>
<tr>
<td><strong>ACE-R (Mean, SD)</strong></td>
<td>72.8 (17.2)</td>
<td>92.9 (5.36)</td>
<td><strong>KW χ² = 28.254</strong></td>
<td>0.0001</td>
</tr>
<tr>
<td><strong>IQCODE (Mean, SD)</strong></td>
<td>4.06 (0.70)</td>
<td>3.06 (0.15)</td>
<td><strong>KW χ² = 34.813</strong></td>
<td>0.0001</td>
</tr>
</tbody>
</table>

MMSE: Mini-Mental State Examination; ACE-R: revised Addenbrooke's Cognitive Examination; IQCODE: Informant Questionnaire for Cognitive Decline in the Elderly. χ²: Pearson chi squared test; KW χ²: Kruskal-Wallis equality-of-populations rank test; a: Unadjusted p values (the Bonferroni adjusted critical value of alpha is 0.0084).
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TABLE 2 Prediction Of Group Membership By FCAI Subscale Scores

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Odds Ratios</th>
<th>SE</th>
<th>z</th>
<th>p value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>FCAI-efa</td>
<td>0.8984</td>
<td>0.1551</td>
<td>-0.62</td>
<td>0.535</td>
<td>0.6405, 1.2601</td>
</tr>
<tr>
<td>FCAI-fj</td>
<td>1.2642</td>
<td>0.1984</td>
<td>1.49</td>
<td>0.135</td>
<td>0.9295, 1.7194</td>
</tr>
<tr>
<td>FCAI-em</td>
<td>0.7629</td>
<td>0.1692</td>
<td>-1.22</td>
<td>0.222</td>
<td>0.4940, 1.1781</td>
</tr>
<tr>
<td>FCAI-cf</td>
<td>2.9500</td>
<td>1.2323</td>
<td>2.59</td>
<td>0.010</td>
<td>1.3009, 6.6900</td>
</tr>
<tr>
<td>FCAI-dm</td>
<td>Omitted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCAI-sr</td>
<td>1.6498</td>
<td>0.2825</td>
<td>2.92</td>
<td>0.003</td>
<td>1.1794, 2.3077</td>
</tr>
</tbody>
</table>

N = 97, LR $\chi^2 = 60.28$, $p = 0.0000$, pseudo $R^2 = 0.5444$, log likelihood = -25.2175

Logistic regression using group (coding: 0 control, 1 clinical) as the outcome variable and FCAI subscale raw scores as the predictor variables; FCAI-dm dropped from the model & 4 scores not used; FCAI: Financial Capacity Competence Assessment Inventory; efa: everyday financial abilities; fj: financial judgment; em: estate management; cf: cognitive functioning; dm: debt management; sr: support resources.
### TABLE 3 Prediction Of FCAI Score By Socio-Demographic And Clinical Variables

<table>
<thead>
<tr>
<th>FCAI-b Variable</th>
<th>Coefficient</th>
<th>SE</th>
<th>t</th>
<th>p value</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>2.8488</td>
<td>1.5415</td>
<td>1.85</td>
<td>0.068</td>
<td>-0.2178, 5.9154</td>
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<tr>
<td>Age</td>
<td>0.0157</td>
<td>0.0967</td>
<td>0.16</td>
<td>0.871</td>
<td>-0.1767, 0.20815</td>
</tr>
<tr>
<td>Education</td>
<td>2.6554</td>
<td>1.5460</td>
<td>1.72</td>
<td>0.090</td>
<td>-0.4200, 5.7308</td>
</tr>
<tr>
<td>GDS</td>
<td>-0.2493</td>
<td>0.4414</td>
<td>-0.56</td>
<td>0.574</td>
<td>-1.1273, 0.6287</td>
</tr>
<tr>
<td>GAI</td>
<td>-0.5602</td>
<td>0.2685</td>
<td>-2.09</td>
<td>0.040</td>
<td>-1.0944, -0.0260</td>
</tr>
<tr>
<td>NPI</td>
<td>1.7542</td>
<td>1.2287</td>
<td>1.43</td>
<td>0.157</td>
<td>-0.6901, 4.1985</td>
</tr>
<tr>
<td>SVS</td>
<td>0.0757</td>
<td>0.1401</td>
<td>0.54</td>
<td>0.591</td>
<td>-0.2031, 0.3545</td>
</tr>
<tr>
<td>ACE-R</td>
<td>0.0898</td>
<td>0.1412</td>
<td>0.64</td>
<td>0.527</td>
<td>-0.1911, 0.3706</td>
</tr>
<tr>
<td>MMSE</td>
<td>2.5829</td>
<td>0.5853</td>
<td>4.41</td>
<td>0.000</td>
<td>1.4184, 3.7473</td>
</tr>
<tr>
<td>IQCODE</td>
<td>-6.0457</td>
<td>1.8032</td>
<td>-3.35</td>
<td>0.001</td>
<td>-9.6328, -2.4587</td>
</tr>
</tbody>
</table>

N = 93, F (10, 82) = 23.87, p = 0.0000; adjusted R² = 0.7059

Robust regression using the STATA command `rreg`, with FCAI-b score (see text) as the dependent variable. Education: university or no university education; GDS: Geriatric Depression Scale; GAI: Geriatric Anxiety Inventory; NPI: Neuropsychiatric Inventory; SVS: Social Vulnerability Scale; ACE-R: revised Addenbrooke’s Cognitive Examination; MMSE: Mini-Mental State Examination; IQCODE: Informant Questionnaire for Cognitive Decline in the Elderly.