Financial Management and Elderly People with Dementia in the U.K.: As Much a Question of Confusion as Abuse?

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ABSTRACT
This article explores a range of issues relating to financial management and elderly people with dementia. The law relating to personal finances for those who lack capacity is outlined and discussed with a stress upon its complexity and the key gaps in present coverage. The article goes on to outline findings from research on these issues carried out within a social services authority in the north of England. Professionals were found to have a wide range of anxieties relating to what they felt was the financial abuse of their elderly clients with dementia, as well as more general concern about how best to deal with financial issues for this group on a day to day basis. The financial abuse of elderly people does occur, but the article concludes by arguing that the issues raised by the research are wider for three main reasons. First, relatives and professionals are often ignorant or confused by the options available to them rather than being intent on defrauding elderly people. Second, the desire to hand down and to receive money from the one generation to the next is a powerful force in society and elderly people with dementia may wish their children rather than the state to have their money. And third, fee assessment and collection for this group raise real practical challenges to social services.

KEY WORDS – Elderly people with dementia, elder abuse, financial abuse, community care, charging for services,

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mental incapacity, personal finances, enduring power of attorney, court of protection, appointeeship.

Introduction

Concern about elder abuse emerged in both the UK and the United States in the mid-1970s although for many years it appeared that this had only sparked off sustained research interest in the second of these two countries (Penhale 1993). The situation changed, however, from the late 1980s onwards as the British Geriatric Society began to run conferences on the subject (Tomlin 1989) and as professional journals such as *Community Care* decided the time was ripe for an Elder Abuse campaign.

This article is concerned with one potential form of abuse namely financial abuse and one particular group of elderly people, namely those with dementia. The article begins by looking at definitions of elder abuse and/or financial abuse and goes on to consider the law relating to financial management and elderly people with dementia. The second half of the article not only outlines findings from recent research within one English local authority (Langan and Means 1994a), but goes on to consider whether the issues and dilemmas and practices uncovered can all be addressed with the elder abuse discourse. The argument is that elder abuse campaigns are correct to tackle financial abuse, but that the personal finances of elderly people with dementia raise concerns wider than just those of abuse. These include both questions of inheritance and inter-generational relationships, and questions about how UK local authorities are tackling their charging and fee collection responsibilities under the ‘new’ community care.

Defining elder abuse and financial abuse

There are now a number of useful overviews of the UK and American elder abuse literatures (Eastman 1994; Filinson and Ingman 1989; McCreadie 1991; Decalmer and Glendenning 1993; Ogg and Munn-Giddings 1993; and Penhale 1993), and not surprisingly all of these tackle the issue of what is meant by elder abuse. Penhale, for example, claims that there are variations in how researchers define elderly abuse but that:

Most definitions of abuse, however, include the following categories: physical abuse, sexual abuse; psychological and social abuse...and financial (or
material) abuse and exploitation. The following features appear to be common within the majority of definitions used: physical assault; sexual abuse; involuntary isolation/confainment; financial exploitation; psychological abuse; deprivation of items necessary for daily living...; inappropriate medication... The presence of any of these situations is considered to constitute elder abuse (1993 pp 96–7).

McCreadie generates a similar list and hence claims that the research literature distinguishes between physical, psychological, sociological and financial abuse.

In the UK, Age Concern, the British Association of Social Workers, the British Geriatrics Society, the Carers National Association, Help the Aged and the Police Federation of England and Wales joined together to produce action guidelines based on the following definitions of what represents abuse:
1. Physical abuse – hitting, slapping, pushing, restraining.
2. Psychological abuse – blackmail, blaming or swearing.
3. Deprivation of food, heat, clothing, comfort.
4. Forcible isolation of the elderly person – not letting others see or talk to them.
5. Sexual abuse.
7. Misuse of monies and property (Age Concern et al. 1990).

However, these guidelines have little to say about indicators of financial abuse compared to the other six forms of abuse.

The definitional debate is not restricted to the issue of what categories of abuse to include or exclude. Enmeshed within this debate are, also, issues relating to levels or degrees of abuse. At its simplest, the debate concerns the degree of injury or hurt which would justify the term elder abuse, with some commentators complaining that the definition of abuse is being spread too widely by some researchers and campaigning groups (Ashton 1994a). A more subtle argument relates to whether a distinction can be made between careless or neglectful behaviour and abusive or destructive behaviour, and if so whether or not they are two aspects of the same elder abuse phenomenon (McCreadie 1991). A connected issue is whether intent to injure or harm is an important ingredient in defining abusive situations, or whether it is the injury (physical, emotional, financial, etc) to the elderly person which matters rather than the intent of the perpetrators. Although the tendency in the research literature is to stress the harm done to the elderly person, this is not always backed up in the law. Thus, in terms of financial abuse, Griffiths et al. point out that under UK law ‘a contract entered into by a person “who was so insane at the
time that he did not know what he was doing” will be valid if the other party reasonably believed that a person had the necessary capacity’ (1993 p 72).

The conclusion of most authors who review what is meant by elder abuse is that definitional confusion reigns and that this can be blamed on the fact that the ‘research on elder abuse is sparse, methodologically weak, and theoretically insubstantial’ (Filinson 1989, p 17). However, if this is true of elder abuse in general, it is even more true of financial abuse in particular. McCreadie points out that although widely recognised as the most common form of abuse, it is often not included in research designs. Where it is included, the main examples of such behaviour found by McCreadie were ‘theft or misuse of money, property, possessions and insurance, blocking the access of the elderly person to these assets, and extortion’ (1991:13). Also, ‘it is generally agreed’ within such studies ‘that the abusers must be relatives or acquaintances; robbery or theft by strangers is excluded’ (p 13). In terms of indicators that financial abuse might be happening, Decalmer draws upon Breckman and Adelman (1988) to suggest the following:
1. A sudden inability by the elderly person to pay a bill.
2. The sudden or unexplained withdrawal of money from the account of an elderly person.
3. An apparent disparity between living conditions and the assets of the elderly person.
4. Family members showing an excessive interest in the assets of the elderly person (Decalmer 1993 p 50).

However, the research on financial abuse which underpins such definitions is often quite limited, being based on very small samples and/or a dependence upon the investigation of the case files of those elderly people defined by the statutory agencies as victims of abuse. The latter is a weakness of much of the overall research on elder abuse and not just that relating to financial matters (Phillipson 1992). Thus, Giordano et al. (1992) looked at the case files of 246 elderly people in Florida where overall abuse was deemed to include financial abuse. The researchers concluded that:

the profile of the typical financially abused victim was a white female widow over 75 years old with a physical illness. Financially abused elderly were found to be victimised primarily by friends and relatives. The findings on perpetrators suggest that social workers can detect abuse from social indicators such as unemployment, impairments and relationship problems, and that treatment should be directed towards the stress of care giving (1992 p 18).

UK research on financial abuse is sparse. Marchant (1993) quotes unpublished research by Whittaker in which 68 out of 89 reported cases
of elder abuse related to the misuse of monies, with the most common occurrence being the taking of an elderly person’s pension. Marchant quotes Whittaker as saying that:

The individual nominates someone to act on their behalf: that person goes to collect the money – in law it gives no entitlement for the agent to spend the money, but in practice this is what happens (p 18).

Clearly, this situation raises the issue of intent since Whittaker recognises both informal and paid carers are likely to be unaware that such behaviour is against the law, and Marchant concludes that ‘financial abuse of elderly people is a murky area of law’ (p 18), a point to which the authors will return. Troke (1994) interviewed thirty-three older people and professionals using a focus group methodology. He found that many of the older respondents felt vulnerable to financial abuse, which they called ‘stealing’ or ‘diddling’, but fatalistic about whether this could be confronted, especially if it involved a close relative.

Bennett and Ogg (1993) have used the OPCS Omnibus survey, to ask 593 adults over 60 three questions about their personal experience of abuse. The Omnibus survey is a representative random sampling survey and once every month, interviewers contact households to ask a wide range of questions, mainly on behalf of government departments. Bennett and Ogg explain that:

The question on financial abuse asked whether any close family members or relative had taken money or property from them without their consent. There were nine ‘yes’ replies. These were not the same nine who reported physical abuse (p 6).

They argue that the great strength of the Omnibus Survey is its representativeness of the general population. This leads them to argue that there is a 95 per cent certainty that between 94,000 to 500,000 UK adults over 65 would have answered yes to that question. The Omnibus survey is likely to exclude elderly people with dementia and hence it is important to note that Wilson (1994) found financial abuse to be almost as common as physical abuse amongst those using a community psycho-geriatric service in London.

Finally, research by Rowe et al. (1993) looked at 25 elderly people with dementia, who were geriatric inpatients or attending day hospital, and concluded that only one of this sample was having their affairs appropriately administered with the major source of mismanagement being the collection of pensions from the post office by paid carers and relatives without the proper legal authority to do so. The research of
Rowe and his colleagues brings us to the important question of the administrative and legal frameworks which relate to the financial affairs of elderly people with dementia.

**Personal finances, the law and elderly people with dementia**

The importance of money and control over money within our society should not be underestimated, as the following two quotations graphically illustrate:

The right and ability to manage our own money is a basic source of power in our society (Carson 1993, p 310)

...in many instances, power over the purse is the equivalent of power over the person (Age Concern 1992, p 8).

Thus, the law relating to the personal finances of elderly people with dementia and the process by which someone becomes defined as lacking financial competence are both critical subjects. Unfortunately, it is widely agreed the existing administrative and legal framework within England and Wales in this area is complex, confusing and extremely inadequate (Letts 1990; Langan and Means 1994b; Ashton 1994b; Law Commission 1993, 1995).

Although the focus of this section is elderly people with dementia, it is necessary to outline briefly the present situation with regard to elderly people who retain mental capacity (see figure 1). An elderly person can issue a third party ‘mandate’ to open up access to a bank or building society to the nominated individual. Similarly, the elderly person can appoint an agent to cash their social security benefits at the Post Office. Where this arrangement becomes a more permanent one, then it is advisable for the agent to get an agency card from the local office of the Benefits Agency which provides them with an identification card when drawing benefit.

The above arrangements are essentially informal. A formal legal arrangement occurs where an elderly person takes out a power of attorney in which the nominated person has a legal document to show to others (banks, post offices, etc) which proves they are authorised to act on behalf of the elderly person and which shows the extent of their powers. Powers of attorney can take three forms, namely ordinary, trustee and enduring. There are two forms of ordinary power of attorney, namely general and limited, and as the terms suggest, general gives the attorney absolute control over the donor’s affairs while limited power is restricted to precisely defined authority. Whilst limited
power of attorney is the most difficult to draw up because authority has to be precisely defined, Letts (1990) suggests that donors need to be very wary of handing general authority over their affairs to the attorney. Enduring power of attorney (EPA) is the only type of power of attorney which enables a person to appoint an attorney to continue to look after their affairs after they have lost mental capacity (see below).

Figure 2 profiles the main options when someone lacks mental capacity. With regard to informal arrangements, banks and building societies differ over whether someone (usually close relatives) should be given access to the account or policies of a client who lacks mental capacity, where the person acting or wishing to act has no legal authority. It is clear that acting as an agent for the collection of social security benefits should no longer be possible once the elderly person has dementia. Under these circumstances the appropriate mechanism to use is the more formal one of appointeeship. Such an individual is appointed by the Secretary of State to manage the social security benefits and pensions of those deemed not capable of managing their own affairs. This is usually set in motion by someone close to the elderly person approaching the local benefits office. If the claimant is in residential or nursing home care, and there is no-one else who can act as appointee, the local authority or the proprietor may be appointed (Letts 1990). It is believed that about one per cent of claimants have their benefits collected by an appointee (Law Commission 1991).
As explained above, EPA can allow the chosen attorney to assume complete financial responsibility for the donor and to continue to do so even if the donor becomes mentally incapacitated. Alternatively, EPA can be drawn up so that the power of the attorney to act only comes into force when the donor becomes mentally incapacitated. EPA must always be registered with the Court of Protection once mental incapacity develops. The Court of Protection is an office of the Supreme Court financed by those who use its services with its administrative functions carried out by the Protection Division of the Public Trust Office (Ashton 1994b, chapter 10). Registration requires that the attorney must serve notices on forms obtainable from the Court to the donor and at least three of the nearest relatives. Once this has happened the attorney must send the application for registration to the Court of Protection. Upon receipt of the application form, the Court will wait 35 days from the date that the last notice was served. If there are no objections from either the donor or other interested parties such as relatives, the Court will register the enduring power. No medical evidence is required by the Court for registration and the Court of Protection requires no evidence that the person is or may be becoming mentally incapacitated through mental disorder (Law Commission 1993). However, if there are objections to registration the Court can hold a hearing to consider the matter and can ask for
medical evidence. Whilst the Court has the power to supervise the
attorney’s actions it will only do this in exceptional circumstances, such
as where allegations of financial impropriety have been made.

Where EPA is not in existence before the development of mental
incapacity and where the person has capital assets or income above
£5,000, then receivership under the Court of Protection is the only
other legal avenue. This allows for the appointment of a receiver to deal
with the person’s affairs. In order to grant a receivership, the Court
requires medical evidence that the person has a mental disorder.

Mental disorder is defined under section 1 of the Mental Health Act
1983 as including ‘mental illness, arrested or incomplete development
of mind, psychopathic disorder and any other disorder or disability of
mind’. The Court also requires details of the person’s condition, their
family circumstances, financial assets and liabilities. Whilst the receiver
is usually a close relative or friend, under some circumstances, this may
also be an accountant, solicitor or the local authority. Where no-one
suitable can be found, the Court can appoint the Public Trustee to act
as receiver, although this will incur a charge. There are certain actions
which the receiver cannot take without the agreement of the Court of
Protection, such as using the patient’s savings or capital, buying or
selling property or giving up a tenancy. The receiver has to submit
yearly accounts of all receipts and payments made and the Court has
the power to undertake any investigations which it sees necessary to
ensure that the person’s financial affairs are being handled satisfac-
torily. The receiver does not only receive income and use it for the
benefit of the person but also has a duty to manage that income and
comply with the Court’s directions.

Receivership is subject to legal aid and its costs are met from the
elderly person’s assets. The fees payable are an initial fee, a fee for every
transaction which needs to be agreed by the Court of Protection and an
annual administration charge. However, fees are not payable in all
instances, such as when the person has less than £1,000 annual income
or is receiving income support.

A receiver is not generally appointed for people with funds of under
£5–6,000. In such cases a Short Procedure Order can be used where
the Court does not appoint a receiver but states how and by whom the
person’s financial affairs are to be managed. The Court will charge a
fee and may monitor this arrangement annually.

The work of the Public Trust Office is substantial and growing. The
National Audit Office (1994) in their 1992 examination of the Public
Trust Office discovered it had a caseload of around 30,000 ‘patients’
with assets totalling around £780 million. Some 19,000 (68%) of these
had receivers who were relatives or friends, 4,000 (14%) had professionals such as bank managers and solicitors, 2,400 (9%) had local authority staff while 2,200 (2%) were subject to short procedure orders. The number of elderly people with dementia is not identified although the report does indicate that ‘over 60 per cent of patients live in private nursing homes or in Health Service accommodation; around 20 per cent live in their own homes; and a further 15 per cent live in sheltered accommodation and local authority homes’ (p 6).

There are a number of reasons why the existing framework with regard to the handling of other people’s money is extremely unsatisfactory. In this article, it is only possible to touch upon some of the most obvious. First, both agency agreements and the drawing of powers of attorney assume that the elderly person is in a position to make judgements about who should act on their behalf. One consequence is that there is no monitoring of these arrangements. People acting as agents are under no obligation to inform the Benefits Agency of when or if the claimant is no longer capable of giving the agent the authority to draw their benefit. In the light of ignorance or unwillingness to institute appointeeship there must be a tendency for paid and unpaid carers to retain access to funds without there being the authority to do that. This is, of course, supported by the previously quoted study by Rowe et al. (1993) of the financial arrangements for 25 people with dementia which showed that only one person’s pension was collected using the correct procedure of appointeeship. Two people were accompanied to collect their money from the Post Office themselves and 19 pensions were collected using the agency procedure with six agents being social services department home care assistants. As far as EPA is concerned, the attorney is under an obligation to inform the Court of Protection of deterioration in the person’s mental capacity. However, there has to be doubt about whether this always happens. Relying upon the integrity of agents or attorneys, no matter how many are acting properly, is a weakness in the system.

A second issue is the appropriateness of home owners acting as appointees. Letts (1990) stresses that this is inappropriate, except as a last resort because of the potential conflict of interest. The Law Commission (1993) report on mentally incapacitated adults and decision making argued that home owners should be able to act as appointees when no-one is willing or able, as otherwise it would cause too much hardship to the elderly person where the only other option is the involvement of the Public Trustee which incurs a charge. However, the report also expressed the view that ‘when residential care budgets are transferred from the social security sector to local authorities the

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conflict of interest argument sometimes mounted against residential home managers acting as appointees may be used against local authorities acting as receivers’ (p 49). Since there is no monitoring of DSS appointeeships the report suggested that appointeeship should be reviewed every six or twelve months, and that the appointee should be required to provide, if asked, an account of how the claimant’s benefit has been spent. This would be the case whether people were in residential or nursing home care or living independently (see also Lavery and Lundy 1994).

Third, when deciding that the person is not in a position to act on their behalf in financial matters it is important to note that there is no universally accepted definition of either ‘mental incapacity’ or of what constitutes financial incompetence due to mental incapacity. In deciding whether to nominate an appointee the Benefits Agency has to consider whether the elderly person is someone who is ‘unable to act’ and their only guidance is from the Income Support manual which refers to people unable to act ‘because they do not have the mental ability to understand and control their own affairs, eg because of senility or mental illness’ (quoted in the Law Commission report (1993 p 47)). The Benefits Agency is not required to seek medical evidence and appointeeship can therefore be set up without there being an independent assessment of the person’s mental capacity. This is also the case for EPA.

Rather different issues over defining mental incapacity arise over receivership and the Court of Protection. The medical certificate supporting the receivership application has two elements. First, the medical practitioner states that the person is suffering from a mental disorder under section 1 of the Mental Health Act 1983. Mental disorder is a generic term which is taken to mean mental illness, arrested or incomplete development of mind, psychopathic disorder or disability of mind. None of these conditions are defined – clinical judgement that they are present is sufficient. Secondly, she provides the reasons for her opinion that the person is not capable of managing and administering his or her property and affairs. The guidance notes for medical practitioners accompanying the Certificate of Incapacity state that they should provide ‘a simple statement giving clear evidence of incapacity which an intelligent lay person could understand eg reference to defect of short-term memory ... to reckless spending without regard for the future...’ The medical certificate is scrutinised, not by a suitably qualified medical practitioner, but by a senior officer of the Protection Division of the Public Trustees Office. This supports the view of Age Concern (1986) that ‘the criteria used by both the legal and medical
professions to define “mental disorder” and the incapacity to handle one’s own affairs are imprecise’ (p 82).

In this respect, it should be noted that professionals, and especially non-health ones, often jump to the wrong conclusion that elderly people have dementia. Dementia can be defined as progressive cerebral failure which affects most aspects of mental functioning. Conditions which affect only one or two aspects of mental functioning or which are not progressive, are thus not dementia. Depressive illness, very common in elderly people, is not dementia. Inadequate diet can lead an elderly person to behave in a very confused way and hence open themselves up to the label ‘demented’. Careless diagnosis can have far-reaching consequences:

If it is assumed that an old lady’s failure to cope at home is due to dementia, without considering other possible causes, she may be wrongly placed in residential or hospital care when in fact she is suffering from a simple physical condition or a different psychiatric disorder which could have easily been treated in her own home, or treated better in a different setting (Jacques 1992, p 42).

Clear diagnosis is difficult and hasty labelling is common with the possibility that this in turn leads to the inappropriate removal from the elderly people of their control of their financial resources especially through the use of the appointeeship mechanism.

Fourth, as far as legal arrangements are concerned, the law tends to have a static view of incapacity – that the person concerned either has or has not mental incapacity. Once EPA is registered with the Court of Protection, or receivership is in place the elderly person can only regain control and management of their financial affairs by providing evidence that they are no longer mentally incapacitated. For that reason the assumption of these powers needs to be considered very seriously. This ‘all or nothing’ approach fails to support client autonomy for those who are still capable of managing some of their financial affairs or perhaps experiencing periods of lucidity interspersed by periods of confusion. The view of the report on mentally incapacitated adults and decision making (Law Commission 1993) was that at both the administrative and judicial levels of decision making the emphasis should be on ‘the need to encourage and permit the incapacitated person to participate in any decision making to the fullest extent of which he or she is capable’ (p 34 and p 43).

Finally, there is a general recognition that receivership under the Court of Protection is too time consuming. For example, many respondents to the Law Commission review described it as ‘using a sledgehammer to crack a nut’ (1993 p 45). As a way of making the legal
Financial Management and Elderly People with Dementia in the U.K.

process of financial management easier and less expensive the 1993 report suggested the use of single issue orders and the appointment of court supervised financial managers who could act either indefinitely or only for a limited amount of time (Law Commission 1993 pp 59–63).

Since this article was originally drafted, the Law Commission (1995) has produced a further report on mental incapacity which includes a draft Mental Incapacity Bill which it is claimed would offer a coherent administrative and legal context for decision making and mentally incapacitated adults over issues of finance, health and personal welfare. The proposals are too detailed and too complicated to be outlined in full here, and so only a sketch of some of the main elements is offered. Nor is it clear whether all of the proposals will be proceeded with since some have considerable implications for public expenditure; so the present legal and administrative framework seems certain to continue for some time.

The draft Bill attempts to achieve an improved definition of mental incapacity and proposes the adoption of the sole criterion of ‘best interests’ as the basis for intervening in the life of a mentally incapacitated person. The Law Commission states that the draft Bill is based on the following principles for such people:

i) that people are enabled and encouraged to take for themselves those decisions which they are able to take;

ii) that where it is necessary in their own interests or for the protection of others that someone else should take the decisions on their behalf, the intervention should be as limited as possible and should be concerned to achieve what the person himself would have wanted; and

iii) that proper safeguards should be provided against exploitation and neglect, and against physical, sexual or psychological abuse (Law Commission 1995 p 26).

One of the Commission’s aims is to establish a framework for informal decision-making without judicial intervention or authorisation. It proposes a system of ‘general authority’ (pp 49–64) which would set out more clearly the ‘appropriate limits to informal action’ in such areas as banks accepting instructions from carers, including the release of monies. The Commission also recommends a revised power of attorney to be called a continuing power of attorney and which would cover medical and personal welfare decisions as well as those of finance. There would also be a new court based system incorporating single-issue orders and court appointed managers along the lines proposed by the 1993 report (Law Commission 1993). The Law Commission also proposes a strengthening of the local authority’s
powers to approach the courts for permission to intervene to protect vulnerable adults from harm. Proposed arrangements include the power to enter premises and interview people, entry warrants, assessment orders and temporary protection orders.

Within these proposals, the Law Commission is trying to weigh a number of contentious principles and considerations. The right balance between autonomy and protection is notoriously difficult to reach agreement upon, let alone achieve. The proposals on informal arrangements spring from the laudable desire to develop simple procedures which stand a greater chance of being used by the relatives or carers of elderly people with dementia than do more complex legal procedures. Moreover, any legal system is likely to be overwhelmed if it was seen as the main way of handling the financial affairs of the majority of elderly people with dementia. Yet a simple solution which does not involve court supervision is unlikely to protect those who are at risk of being financially abused or exploited by their carers. Their only protection would then be the investigative, assessment and removal powers of the local authority.

Community care and the financial affairs of elderly people with dementia

Having discussed definitions of elder/financial abuse and the law relating to the handling of other people's money, it is necessary to turn to the policy context within which the authors’ own research was located. The research emerged out of concern within a social services authority located in the North of England about the challenge posed by the growing numbers of elderly people with dementia. More specifically, social services managers were becoming aware that such individuals generate complex issues around the management of their financial affairs for themselves, for their relatives and for professionals. A central research objective was to pull together national and local data on the nature of these financial management issues. A second objective was to advise the local authority on how it might develop a strategy to respond to these emerging needs. In particular, the research addressed the question of whether the establishment of some kind of independent financial advisory or advocacy service might be an appropriate response.

For this particular social services authority, but also for many others, a number of inter-related factors are pushing financial management and elderly people with dementia further up the policy agenda than
TABLE 1. Prevalence of dementia in the community

The figures show the number of people who at any time are suffering definite dementia mostly moderate to severe cases, so they may considerably underestimate the number of mild cases where diagnosis is more difficult.

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Approximate percentage of the age group with definite dementia</th>
<th>Approximate percentage not suffering definite dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-64</td>
<td>0.7</td>
<td>99.3</td>
</tr>
<tr>
<td>65-69</td>
<td>1.4</td>
<td>98.6</td>
</tr>
<tr>
<td>70-74</td>
<td>2.8</td>
<td>97.2</td>
</tr>
<tr>
<td>75-79</td>
<td>5.6</td>
<td>94.4</td>
</tr>
<tr>
<td>80-84</td>
<td>10.5</td>
<td>89.5</td>
</tr>
<tr>
<td>85-89</td>
<td>20.8</td>
<td>79.2</td>
</tr>
<tr>
<td>90-94</td>
<td>38.6</td>
<td>61.4</td>
</tr>
<tr>
<td>95+</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>94</td>
</tr>
</tbody>
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has previously been the case. The first of these is the most obvious, namely the overall growth of elderly people with dementia. There is no absolute agreement on how large this increase is, partly because of the paucity of epidemiological evidence relating to the ill health of elderly people (MRC 1994) and partly because of medical disagreement over where mental deterioration as the result of normal ageing ends and mild dementia begins. However, there is agreement that prevalence rates increase with age as illustrated by Table 1, even if some would dispute the actual percentages used. It is accepted that the overall numbers of elderly people with dementia are increasing because of demographic trends which involve an ageing of the elderly population, that is a significant increase in the numbers of 75 years (Ermisch 1990; Rolfe et al. 1993). This growth in the number of elderly people with dementia has significant implications for social services. One aspect of this is the large percentage of elderly people in residential care who will have dementia – Ineichen (1990) in a review of the main studies concluded that about one-third of the residents of local authority homes will have dementia. However, the growing emphasis upon care at home means that many elderly people with dementia will remain in the community and dependent upon a mixture of support from informal carers and through the provision of health and social care services.
An emphasis upon care at home was one feature of the recent UK community care reforms which provide the second set of factors. The white paper on community care (Department of Health 1989) and the ensuing policy guidance to local authorities (Department of Health 1990) gave social services the lead agency role in community care and defined this not as being the main provider of services, but as being an enabler with a remit to stimulate a market or quasi market in social care provision. In this market, provider agencies from the public, private and voluntary sectors would compete for ‘business’ from the purchasing arm of social services (Hoyes et al. 1994; Means and Smith 1994). As a result of these changes, local authorities are becoming much more involved with the private and voluntary sectors as service providers with growing concerns about how to monitor the welfare of those receiving services who might be vulnerable to abuse. This is particularly true of independent sector residential and nursing homes, when so many residents will have dementia, but it should not be forgotten that those remaining in their own homes will increasingly receive services from a wide range of organisations rather than just from local authorities (Taylor et al. 1995).

A third set of issues relates to the growing importance of fees and charges in the funding of the community care systems and this raises major difficulties when dealing with elderly people with dementia. In terms of institutional provision, elderly residents with dementia will normally be charged on a weekly basis for their residential and nursing home care, unless the facility is directly provided by the National Health Service. This can generate considerable worries for residents as well as for relatives who feel responsible for ensuring that the local authority or the private home proprietor receives the necessary money. It generates potential cash flow problems for proprietors, together with anxieties that they can easily be accused of fraud. The local authority as both a provider of residential care and as a purchaser of residential and nursing home places will have concerns both to collect appropriate monies but also to protect vulnerable elderly people.

It should not be assumed that such charging issues are restricted to elderly people with dementia living in residential care and nursing homes. The whole thrust of the community care reforms is that frail elderly people will increasingly live in the community supported by flexible care packages, and social services will increasingly be expected to charge for these services (Lart and Means 1993). A growing number of these people will have dementia, and some may not even feel that they want the services for which they are being charged.

The final factor relates to the growing resources of elderly people,
both in terms of occupational pensions and other resources such as the 
ownership of property (Rolfe et al. 1993). Although this wealth is often 
exaggerated by commentators (Bosanquet and Propper 1991), more 
erly people do now have levels of resource which might attract those 
keen to exploit a lack of mental capacity. Relatives are often expected 
to take responsibility for the management of these resources while local 
authorities have to take such resources into account when means-
testing for charges.

Research findings

This section presents research findings from the study of a social services 
authority in the North of England (Langan and Means 1994a). It 
draws upon internal documentation, interviews with over 20 profes-
sionals from social services and other agencies, a postal questionnaire of 
independent sector residential and nursing homes and a postal 
questionnaire of community-based social work teams. The emphasis is 
upon the perspective of professionals about what are the key issues 
relating to financial management and elderly people with dementia.

1) Issues relating to residential and nursing homes

This sub section draws upon information from relevant respondents 
including those working in two ‘specialist’ homes run by social services 
for elderly mentally infirm people. It, also, draws upon questionnaire 
responses from 23 private and voluntary nursing and residential homes 
caring for elderly people (this represents a response rate of 33 per cent 
since 70 homes were contacted). Complete data was obtained for 22 of 
the 23 homes which shows that out of 562 residents, 248 (44%) were 
considered to have dementia, by the person completing the ques-
tionnaire. Clear information was provided about the numbers of 
appointeeships administered in 15 of the 23 homes. Of 129 residents 
with dementia in those homes, 37 (29%) had homes acting as 
appointees. If the one home which acted as appointee for over half its 
residents is taken out, the rate is 22 per cent. Seven of the remaining 
eight homes acted as appointees but did not provide enough 
information to establish numbers.

Within the questionnaire sample there were at least eight residents 
subject to receivership and possibly more since one home could not
answer this question. Two respondents thought that home owners should recommend receivership to relatives but doubted that they would do this since relatives might see the suggestion as a criticism of themselves. In some cases homes were not aware of what arrangements were in force, including legal ones in respect of their residents. The two specialist SSD homes for elderly mentally infirm people were between them dealing with 35 long-term residents. There were three residents who were subject to receivership and everyone else had an appointee who in many cases was the local authority.

Private and voluntary residential and nursing homes were asked what the main problems were facing them when dealing with elderly people unable to manage their own financial affairs. Eight did not answer the question, possibly because they did not perceive any problems and two stated that there were no problems. Several homes mentioned the problem of getting access to funds. One said that they wanted easier access to personal allowances – it was assumed that this was to use for the elderly person’s benefit rather than to ‘top up’ fees. Two homes mentioned delays over getting money for essentials and two talked of the difficulty in getting money from relatives, including those who were appointees. Another two homes bemoaned the bureaucracy involved in keeping records and receipts and having to note, for example, that 20p had been spent. The difficulty in getting their fees paid was mentioned by two homes, whether because of the different sources from which those fees were paid or because of the time involved. One home wanted a direct debit from the DSS or social services departments as a way round resolving that particular problem.

Three homes cited the dishonesty of friends or relatives: one home talking of residents who had been swindled of money when they lived in the community. The second home said that the Benefits Agency had not taken any action when they had informed them of a dishonest appointee and the last home said that in two instances they had been unable to recover their fees from dishonest relatives whom the Benefits Agency had insisted on using as appointees. The two specialist homes shared many of the concerns expressed in the private and voluntary sector: money being siphoned off; relatives keeping back some of the personal allowance; difficulty in getting relatives to pay for items like hairdressing or outings. Their level of concern appeared higher than that of independent sector homes.

Reservations about the wisdom of home owners acting as appointees were raised by some respondents. They recognised the potential conflict of interest between having access to the monies of someone from whom payment is required. For example, registration and inspection
staff of the social services department said they would like to be informed when a home owner becomes an appointee so that they could monitor this arrangement to some extent. One home owner had told them that he was not an appointee when in fact he was. The Benefits Agency did start to provide information to the registration unit about which home owners were appointees, but this arrangement only lasted for six months. One respondent said that some homes did not properly separate out residents’ money from the home account and two respondents said that some home owners were acting as agents when the person concerned was mentally incapacitated. A small number of homes have been prosecuted for financial abuse of their residents. Several people interviewed mentioned concern about homes requiring personal allowances to be used to ‘top-up’ fees.

2) The views of respondents working in the community

Comments are drawn from interviews with a wide range of professionals working in the community and from questionnaire responses from three care management team leaders, the individual members of one care management team and one community psychiatric nurse. The returned questionnaires related to 165 individuals considered to have dementia, and responses are set out in Table 2. The main features are that at least nine people appeared to be subject to ordinary rather than enduring power of attorney which is not valid when a person is mentally incapacitated (see previous discussion). Rowe et al.’s (1993) study, also, provided evidence of ordinary power of attorney powers being instituted which were invalid since the person lacked mental capacity. It is impossible to know the full number of people subject to appointeeship since some of those returning the questionnaires were unable to provide information on this. Complete data were available for 102 clients with dementia, yet it seemed only 10 were subject to appointeeship, when it is likely that the majority were receiving DSS benefits. It may be thought legal arrangements were in force which obviated the need for appointeeship such as EPA or receivership but this only appeared to be true for two people amongst this sub-sample, and the authors suspect that agency arrangements were often continuing after the onset of dementia. None of the people concerned were identified as subject to EPA (although it is possible that a few were since this information was not always known) and there were only two cases of receivership under the Court of Protection.

Many respondents spoke of concern about appointees who used
TABLE 2. Responses from community based professionals concerning formal arrangements for managing money

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>No. of People With Dementia</th>
<th>Power of Attorney</th>
<th>Enduring Power of Attorney</th>
<th>Court of Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management Team A</td>
<td>20</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Care Management Team B</td>
<td>56</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care Management Team C</td>
<td>26</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Care Management Team D</td>
<td>65</td>
<td>0**</td>
<td>1**</td>
<td>0</td>
</tr>
<tr>
<td>Community Psychiatric Nurse*</td>
<td>38</td>
<td>D/K</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* The CPN said that social workers usually dealt with financial matters, hence the difficulty of giving full information.

** The responses for care management team D are collated from individual team members, since some answered Don’t know to these questions, the figures shown could be higher.

N/A = Not answered.
D/K = Don’t know.

benefits or pensions for themselves or who refused to pay either for a service considered necessary by professionals or for a higher level of service. Examples of elderly people or carers refusing services because of worry about charges and fees were also given. Where there was concern about the actions of an appointee there could be difficulties in getting the DSS to act upon information about this. Other issues concerned exploitation by friends, neighbours or workmen. Asset-stripping by relatives before entry into residential or nursing home care was also mentioned although the person themselves, if capable of giving an opinion, may have wanted to pass on something to close relatives. One social worker said that she sometimes was suspicious of the information in completed financial assessment forms but felt that she had little authority to do anything about this. The form does not ask for details of insurance policies and apparently if the policies are proposed by relatives money goes to them, rather than the estate, in the event of the elderly person’s death. Several people mentioned the difficulties which elderly people, carers and relatives got into over financial arrangements and felt many would welcome advice.

Some respondents knew of relatives acting as agents when appointeeship was necessary. Sometimes relatives ended up forging signatures although this was not necessarily due to them wanting to siphon off money. It was also mentioned that the Post Office would sometimes accept an X for a signature rather than require appointeeship if they felt that the person cashing the benefit was trustworthy. A major difference between elderly people with dementia in residential care and...
those in the community is that the latter tend to have more substantial and regular access to their own finances. Elderly people were reported as refusing to pay bills, including those for social services; overlooking the payment of bills; keeping large sums of money in their home, which in some cases could not be found or had been thrown out with rubbish, and keeping large amounts of money on their person which exposed them to the risk of theft.

As has already been stated, EPA can only be instituted where the person still has mental capacity. However, it was felt that solicitors do not always know the legal criteria for EPA. It was claimed that a solicitor and relative had tried to sneak onto a hospital ward to get an elderly patient to sign an EPA. The issue of solicitors acting for the relative rather than the elderly person in establishing EPA was also mentioned. For example, where they counter-signed forms brought in by a relative rather than visiting the person in question to establish whether they had the mental capacity to know what they were signing. One solicitor had been known to query the need for EPA since the elderly person was quite willing to sign forms. One respondent suggested that solicitors should have an obligation to ask for psychiatric reports if there is any doubt about the elderly person’s capacity. Indeed the Law Commission (1993) is inviting comments on the proposal that a donor’s ability to execute an EPA should be certified by a registered medical practitioner as well as a solicitor at the time of execution. Examples were given of good practice happening locally where the donor had some degree of mental incapacity. The relevant forms to establish EPA were only completed after several meetings between the person, their relative, solicitor and relevant professionals. This was so that the person was able to understand the significance of what they were doing at the time of signing and that everyone involved was satisfied that this was the case. The point was made that EPAs are not always registered with the Court of Protection once the elderly person has become mentally incapacitated. For these reasons two respondents stressed that only the Court of Protection offered sufficient safeguards to elderly people with dementia.

Nationally, the use of receivership is likely to vary widely depending upon the wealth of the local population. The client financial-affairs service of the case-study local authority was only acting as receiver under the Court of Protection for 10 people, with a few more in the pipeline. A consultant psychiatrist said that the number of receivership cases was increasing. Several people considered receivership to be cumbersome, expensive and slow. We were told of several cases of receivership taking over six months to be set up – a very long period of
time in which it is possible for someone to run up huge debts and/or get rid of all their assets.

Many elderly people with dementia, whether they live in residential care or in the community, have bank and building society accounts. It is not illegal for spouses and carers to have access to the financial resources of elderly relatives with dementia. It is only illegal if it can be proved that this money is subsequently being misused. Practice locally seemed to vary. Two respondents said that some banks or building societies would allow up to £5,000 to be transferred from a person’s account to a carer or relative on the basis of a note from the elderly person. They also said that if banks know the relative or carer some would be reluctant to question the propriety of their accessing the bank account of the elderly person. However, others would not allow access by a relative to the bank account of an elderly person with dementia unless a legal arrangement was operating. This has meant that, in some cases, the social services department could only recover charges from the person’s estate upon their death.

Many people handling or managing the finances of elderly people with dementia were concerned that they could be accused of financial abuse. One person spoke of not having enough personal safeguards when involved with a person’s finances. This was seen as due in part to the lack of guidelines and lack of knowledge about correct action under the law. Working in the community carried additional risks since workers were more likely to work with elderly people on a one-to-one basis without another worker to vouch for the probity of one’s actions, albeit that there may be supervision of their actions.

3) A need for additional advice and advocacy services? Views of respondents

There was little desire for a financial management advice scheme amongst the residential and nursing homes who replied to the questionnaire with only five homes (out of the 23) feeling that such a scheme was necessary for residents in their homes. Another two homes said that they could envisage the need for a scheme but did not believe their home needed one. Positive responses to developing a scheme did not correlate with the replies of owners/managers who had experienced problems. There was even less support from homes that they should pay for such a service. The chair of the local private homes association was equally sceptical about the need for a scheme and doubted whether proprietors would be interested in paying for one.
There was much more enthusiasm for a scheme from the people who were either interviewed or who answered the questionnaire for community-based workers. Whilst not unanimous, most people believed that the scheme should be independent of the social services department. This was considered to enhance its acceptability to both elderly people and carers and the private sector. Many respondents stressed the importance of representing the interests of the elderly person. Several social workers stressed that sorting out financial affairs was complex, and time-consuming. For example, it was difficult to find out about all the client’s sources of income, including bank books and pensions, while people were often reluctant to receive help with their finances. Several said that this should not be part of their social work role and indeed interfered with it. One social worker commented about his lack of knowledge to give advice and to know what the consequences of giving that advice were. The recommendations of the authors to the local authority was that what was required was a co-ordinated response which covered information leaflets, training for staff, clear procedures for staff over the handling of other people’s money, as well as an improved advice and advocacy strategy (Langan and Means 1994a). One reason for arguing this was the view of the authors that what has to be tackled are a range of issues much wider than that of just the deliberate de-frauding of elderly people of their financial assets.

More than abuse?

From the outset, it should be stressed that this is a small-scale study based upon the perceptions of professionals about financial management issues and elderly people with dementia. It is clear that the majority of them believed financial abuse, defined as a deliberate attempt to defraud elderly people of their resources, was quite widespread. They were able to support such views with numerous specific examples. However, these professionals, also, recognised situations were often not that clear-cut. The earlier review of the definitional debate touched upon the issue of intent. In terms of money, the question is whether or not the intent to defraud has to be present in order for financial abuse to take place or whether it is only the consequences for the elderly person which matters irrespective of the intent of the person making the financial decisions. Many of the examples supplied to the authors by the professionals, and much of the material presented from the questionnaire, hinge on the issue of intent in terms of whether the...
activities described can be listed as abuse. Essentially, money is often being ‘mishandled’ from an ignorance of the law rather than by a deliberate attempt to defraud. In other words, relatives and professionals act as agents when they should be appointees because they are not aware this is wrong. Enduring power of attorney is not used correctly as a procedure. And so on. It can certainly be argued that ignorance of the law is no defence and that the consequence of inappropriate procedures being adopted is the mismanagement of the affairs of the elderly person, and hence financial abuse has taken place. However, it needs to be remembered that this is an area of great legal and administrative complexity, and there is wide agreement that the present arrangements are far from satisfactory (Law Commission 1993; Letts 1990; Ashton, 1994b). It has to be asked whether lay people can be expected to steer themselves through this complexity, and when they fail, is it fair or helpful to locate this ‘failure’ within the elder abuse discourse? Perhaps, a compromise is to recognise that the elderly person has been financially abused, but that the perpetrator is as likely to be the complexity of the legal and administrative framework, rather than relatives and professionals, the majority of whom are well meaning. Even then, the location of this issue within an elder abuse discourse seems unhelpful if the aim is to protect the financial interests of the elderly person. It seems much more relevant to place it either within a broad debate about vulnerable adults along Law Commission (1993) lines or to argue that this is a welfare rights issue, and one to which welfare rights specialists have given far too little attention.

However, there are two other important reasons why financial management issues and elderly people with dementia cannot be neatly contained solely within elder abuse debates. The first of these relates to the lack of sensitivity of the word ‘abuse’ to the complexity of intergenerational relations. Some commentators have criticised UK elder abuse campaigns for being too professionally driven (Whittaker 1994). Research reported in this article is open to the same criticism in that it was based upon professional views of what represents financial abuse and what causes financial abuse. Some professionals interviewed seemed to have difficult relationships with the relatives of clients. They were seen as being after mum’s money, and often quite effective at getting hold of or keeping hold of monies which should really be coming to their agency as the provider of services to the elderly person with dementia. However, they rarely seemed to stop to think what might be the view of their elderly clients on this subject, either before the onset of dementia or during moments of sufficient lucidity to reflect on the issues raised. Certainly, research by Baldock and Ungerson
Financial Management and Elderly People with Dementia in the U.K. (1994a, 1994b) on community care provision for stroke patients has illustrated a mixture of confusion and anger about the growing emphasis upon rationing, self provisioning and charging for services:

They would often say to us like ‘well we thought we’d at least be entitled to an hour a week’ or ‘We never expected them to stop the physio right away’ or ‘I kept expecting social services would come round and sort it all out, but there was never a peep out of them’. The fundamental rules of access and the hierarchy of entitlement that they had internalised through a lifetime of citizens of the British welfare state had from their point of view suddenly been turned upside down (Baldock and Ungerson 1994b, p 13).

Although guilty of exaggerating the right to free community care services prior to the 1990 reforms (Means and Smith 1985), Baldock and Ungerson pinpoint a lack of enthusiasm for paying for services from many community care clients. In addition, it is possible to argue on the basis of recent research (Finch 1994, 1995; Finch and Wallis 1994) that many elderly people feel a strong drive to leave their money to their children rather than have it all consumed by the costs of services received in the last few years of their life. Finch with colleagues has carried out a number of linked research projects on how inheritance is handled within contemporary families. This has led her to argue that such processes are not based on a simple principle of economic rationality in that elderly people rarely skip a generation because their children are well set up and they rarely make care bargains over inheritance with those sons or daughters who play the lead role in informal care. Finch explains this by arguing that jumping a generation would be seen as undermining the parenting role of the middle generation and care bargains risk implying that one thinks less of some children than others. Instead, what was clear was that for both elderly men and women passing on inheritances on an equal basis to the next generation remained vitally important to them, and that for women especially this was not only a practical issue of property division but also ‘a way of acknowledging relationships’ (Finch 1994 p 13). The implications of this for the concerns of the authors is not straightforward. It suggests that elderly people will often desire to pass on their often limited resources to their children. But it, also, indicates that most elderly people would not want one child to assume they have a right to such money before other sons and daughters just because that individual was playing or had played the lead care role.

The second reason why an elder abuse framework is inadequate is that it does not help to address the very practical problems faced by social services and other agencies when dealing with financial issues relating to elderly people with dementia. This includes the complex
task of financial assessment for a whole range of services, as well as the anxieties of staff such as home helps and wardens about accusations of fraud when handling the money of elderly people with dementia. A great deal of thought needs to be given to how best to address these challenges. What is the best combination of detailed procedures and more general guidelines? How can the finances of elderly people with dementia be protected without stifling the ability of professionals to be creative in their work with such individuals? For example, it is easy to argue that a lack of capacity to manage all one's finances is not the same as lacking the capacity to retain control over smaller sums of money on a day-to-day basis. But how will social services managers respond when such arrangements breakdown within residential homes and will this be in terms of encouraging or discouraging such arrangements? Locating debates about these challenges within the emotive framework of elder abuse seems less than helpful, unless this is the only way to move such issues up the policy agenda.

Conclusion

The authors believe that the emergence of interest in elder abuse in the UK has had positive consequences for vulnerable elderly people. It has sensitised professionals to a range of abusive situations which in the past have largely been ignored. However, it is important that elder abuse does not become a 'catch all' term for too many diverse situations generated by vulnerable elderly people, such as those with dementia. More specifically this article has argued that the challenges to social services posed by issues relating to the personal finances of elderly people with dementia is much wider than that of just financial abuse, however, defined.

References

Age Concern 1986. The Law and Vulnerable Elderly People. Age Concern (England), London.
Financial Management and Elderly People with Dementia in the U.K. 313


NOTE

1 Although not widely publicised, it is possible for the attorney to request that the donor is not told of the application to register enduring power of attorney on the grounds of the distress that this would cause.

Article accepted 31 July 1995