Ageing & Society **31**, 2011, 93–109. doi:10.1017/S0144686X10000747

Managing older people's money: assisted and substitute decision making in residential aged-care

CHERYL TILSE*, JILL WILSON*, LINDA ROSENMAN†, DAVID MORRISON‡ and ANNE-LOUISE MCCAWLEY*

ABSTRACT

Current approaches to the assessment of cognitive capacity in many jurisdictions seek to balance older people's empowerment with their protection. These approaches incorporate a presumption of capacity, a decision-specific rather than global assessment of that capacity, and an obligation to provide the support needed for adults to make or communicate their own decisions. The implication is that older people are assisted to make decisions where possible, rather than using substitute decision makers. For older people, decision making about financial matters is a contentious domain because of competing interests in their assets and concerns about risk, misuse and abuse. In residential-care settings, older people risk being characterised as dependent and vulnerable, especially in relation to decisions about financial assets. This paper reports an Australian study of the factors that facilitate and constrain residents' involvement in financial decision making in residential settings. Case studies of four aged-care facilities explored how staff interpreted the legislative and policy requirements for assisted and substitute decision making, and the factors that facilitated and constrained residents' inclusion in decisions about their finances. The observed practices reveal considerable variation in the ways that current legislation is understood and implemented, that there are limited resources for this area of practice, and that policies and practices prioritise managing risk and protecting assets rather than promoting assisted decision making.

KEY WORDS – capacity, substitute decision making, financial management, residential care.

Background

Policy and practice interest in older people's decision-making capacity for financial matters has arisen from broad concerns around preserving and

* School of Social Work and Human Services, University of Queensland, Brisbane, Australia.
† Deputy Vice Chancellor (Research), Victoria University, Melbourne, Australia.
‡ School of Law, University of Queensland, Brisbane, Australia.

protecting assets for later life. Financial resources are central to older people exercising choice in living and care arrangements. Access to and control over decision making about money and property in older age also have psychological, cultural and social meaning, provide security, and symbolise continuing independence. Decision making about how assets are preserved or spent generates complex issues for older people, family members, formal carers, professionals and service providers (Langan and Means 1996; Tilse *et al.* 2007*a*). The complexities around the assessment of capacity for decision making in relation to financial matters and concerns about prevention and intervention in relation to financial abuse of older people have stimulated research and policy and practice interest (Letts 2009; McCawley *et al.* 2006).

Making decisions about assets requires a broad range of cognitive and procedural skills (Moye and Marson 2007). Diverse tasks, such as basic cash transactions when shopping, banking, paying bills and securing personal valuables, differ from long-term decision making about the conservation of financial resources. Impairment in cognitive capacity, communication difficulties and/or health, mental health or mobility problems can all affect an older person's capacity and willingness both to participate in some of the decisions and to implement decisions once made. The natures of the impairment and of the available support interact and affect an older person's capacity to engage with particular financial tasks.

Legislative changes in several countries have reflected changes in thinking about capacity assessment and the context in which decisions are made. A recent legal development is the shift from a global determination of capacity, based on the presence of a diagnosis alone, to a consideration of key functional abilities relevant for specific domains, including decision making about financial matters, entry into residential care, and consent for health-care treatment (Dwyer 2005; Grisso 2003). Legislative changes in Australia (Queensland Government 2000: *Guardianship and Administration Act 2000*, Chapter 2, Section 5), England and Wales (United Kingdom (UK) Department of Constitutional Affairs 2007: *Mental Capacity Act 2005*, Section 2, Principles 1 and 2), Scotland (Mackay 2009), Canada (Ontario Ministry of the Attorney General 2005), and the United States of America (Moye 2003) reflect this shift in principle. The new policy approaches incorporate a decision-specific approach which recognises that capacity to make decisions differs according to the nature and extent of the impairment, the type of decision to be made and the available support. The legislation seeks to achieve a balance between protection and empowerment based on a presumption of capacity and an obligation to provide the support needed to help adults make or communicate their own decisions (Johns 2007). The legislative intent appears to be that capacity to make a particular decision

in a particular context is assessed in relation to each matter. Where possible, the older person is assisted (or supported) in making their decision rather than having that decision referred to a substitute decision maker.

Some research has challenged whether this changed approach to decision-making capacity is appropriately understood and enacted in professional practice with older people. In an American study of health-care professionals, Ganzini *et al.* (2003: 241) noted that one pitfall in assessing decision-making capacity was little understanding that capacity or incapacity is not 'all or nothing' but rather specific to the particular decision. These authors made the point that if a clinician conceptualises a patient as globally lacking capacity, it is likely the patient will not be given the opportunity to make various decisions that he or she in fact has the capacity to make. In the Australian context, Bennett and Hallen (2006) called for greater understanding by medical practitioners of guardianship and financial management legislation. Wilson *et al.* (2009) argued that social workers need to open up opportunities for older people to be involved in making decisions about their financial assets. In the UK, the *Mental Capacity Act 2005 Code of Practice* (UK Department of Constitutional Affairs 2007: Chapter 3, 3.5) proposes that providing 'appropriate help with decision-making forms [is] part of care planning processes for people receiving health or social care services'. This includes providing relevant information, communicating in an appropriate way, making the person feel at ease and exploring who might support the person to make choices or express a view. The extent to which everyday practices in community and residential aged-care reflect these legislative principles is currently poorly understood across a range of disciplines.

Practice that is in keeping with these legislative and policy principles requires not only an assessment of capacity to make a particular decision but also an understanding of the nature of substitute and assisted (or supported) decision making together with a willingness and ability to retain the older person's involvement. Substitute decision making in relation to financial matters may be a formal or informal process (Tilse *et al.* 2005). In all cases there is a moral and, under some legislation such as the UK *Mental Capacity Act*, a legal imperative for decision makers to act in the best interest of the older person and, as far as possible, to take their wishes into account. Formal substitute decision-making instruments (commonly called enduring, durable or lasting power of attorney, financial guardianship, or administration orders) address impairments in decision-making capacity by providing legal authority for others to make financial (and other) decisions for older people. Jurisdictions vary, first in the type of decisions covered by the power (*e.g.* financial property, health and/or personal

care), second in their ability to specify what decisions are and are not to be made, and third in determining whether the power comes into effect immediately, at a specified time, or when incapacity to make the decision is established. What is common is that an enduring or lasting power of attorney is made when the donor (or principal) is capable of making his or her own decisions and is able to understand the consequences of preparing the document and its contents; and for the power to endure if the donor loses capacity. Criticisms of these instruments are based on concerns about whether their use achieves a balance between empowerment and protection (Wilbur 2001). Under the United Kingdom *Code of Practice for the Mental Capacity Act*, attorneys acting as a 'lasting power of attorney' have a legal duty to have regard to this *Code of Practice*, which describes their responsibilities when acting or making decisions on behalf of individuals who lack the capacity to act or make these decisions for themselves.

Many decisions about an older person's involvement in financial management are also made informally (Ganzini *et al.* 2003), by family carers (Tilse *et al.* 2005), and by managers and staff in community and residential care. Family members and formal carers may not understand or act in response to the duties that run alongside the power they have either been formally given, as by an enduring or lasting power of attorney, or have informally assumed. Research that explores the experiences of community care staff in relation to 'money handling' for clients has identified the need to improve training, support and good practice guidelines (Means and Langan 1996). Although the importance of assisted (or supported) as well as substitute decision making is a key implication of current policy, how this operates in various care settings is not well understood. Effective assisted decision making means determining and taking into account the wishes of older people and offering them the resources that make the difference between what they can do for themselves and what needs doing by others to reach or execute a decision (Wilson *et al.* 2009). Assisted and substitute decision making should take account of the context in which the asset management takes place and negotiate the fit between the tasks or decision to be made, the older person's wishes, the formal or informal carer's willingness and ability to respect the views of the older person, and the available support. Providing this form of support is not always easy, in part because professionals usually become involved in older people's lives at important decision points such as entry into residential care when the situation 'is not conducive to facilitating and respecting decision making by older people' (Dwyer 2005: 1089).

Older people are diverse and their interest in financial decision making varies. Research exploring the perspectives of older people receiving assistance with managing assets has highlighted the variation in older

people's wishes in relation to decision making (Tilse *et al.* 2007*b*). These range from a preference for either assisted decision making with help to implement and monitoring the decisions (including being consulted and having access to accounts), to ceding decisions to substitute or proxy decision makers on a basis of trust that their assets will be well managed. Research with informal carers in relation to asset management has identified a range of practices, attitudes and environments that include or exclude older people in decision making about their assets (Tilse *et al.* 2005*a*). Inclusive practices can be described in terms of the level of the involvement of the older person in decision making and the degree of fit with their preferences (Tilse *et al.* 2005, 2007*b*). A strong issue for carers is the dilemma of balancing the independence and self-determination of the older person with the need to protect their assets, and reconciling this aim with the carer's need to have effective and time-saving practices in place. In response to these pressures, some carers continued with assisted decision-making approaches, and others found acting as a substitute decision maker more convenient. How care staff in residential settings manage these tensions is little understood.

Residential-care facilities are important environments for understanding care practice in relation to current legislation. Older people in residential care are likely to be defined in terms of 'complex needs' and 'dependency' at the expense of being seen as adults capable of making a range of decisions (Scourfield 2007: 1136). The tasks and responsibilities of residential-care staff in relation to managing money and property differ from those of informal carers. The Australian Government Department of Health and Ageing *Aged Care Act 1997* and *User Rights Principles 1997* recognise, through a *Charter of Residents' Rights and Responsibilities*, the resident's right 'to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions' and 'to have access to services and activities which are available generally in the community' (Australian Government Department of Health and Ageing 1997: Section 10.13). Unlike family, residential-care staff members do not have a decision-making role in managing residents' finances. Their responsibilities are first, to support residents who are able and wish to self-manage their assets or participate in tasks such as banking, shopping and consulting with financial advisers, and second, to help residents keep their money and valuables safe.

Assisting older people to remain involved in decision making about money and property poses particular challenges in residential aged-care environments. These include: the high level of impairment of many of the residents and the high prevalence of dementia (Australian Institute of Health and Welfare 2007; Knapp and Prince 2007); that the communal

setting means that cash, valuables and documents are at particular risk of loss, misuse and abuse; and the constraints on the roles of formal care providers in the financial affairs of residents. Little is known about how residential-care staff members manage these tensions or about the extent to which the spirit of the current legislation is reflected in day-to-day practices. The paper draws on findings from an in-depth study in Australian aged-care facilities of the residents' participation in decision making about their assets. It specifically explores assisted and substitute decision making in this context.

Research overview

The Assets and Ageing Research programme at the University of Queensland comprises eight interlinked projects on the management of older people's assets in Australia (Tilse *et al.* 2007*a*). The programme defines asset management as having some control over access to, organising, making decisions about or using an older person's financial or capital assets or valuables. Older people are defined as those aged 65 and over, but in the majority of studies most participants have been aged 80 or more years. All studies have taken place across urban and rural locations in South East Queensland, Australia. The data reported in this paper were collected through case studies of four residential facilities. This in-depth study explored policies and practices relating to residents' participation in accessing, managing and decision making about their finances and property. All facilities had a mix of residents requiring high and low levels of care, and all were subject to Australian government regulations and the *Charter of Residents' Rights and Responsibilities*. The sample of aged-care facilities (ACFs) in South East Queensland was selected to ensure inclusion of urban and rural locations, large (more than 150 residents) facilities that were part of a chain and small (less than 60 residents) facilities that were not and so had fewer levels of management. One facility specifically provided for people from culturally and linguistically diverse backgrounds.

The data were collected using semi-structured interviews with 102 participants. These consisted of 10 care managers and business managers, 48 care staff including registered nurses, personal care assistants and support staff, 12 residents and 32 residents' family members. In addition, there was an analysis of written policies and handbooks relating to residents' assets. This paper utilises data from interviews with care and business managers and direct care staff. Understanding the policies and practices from the perspective of staff is a vital first step in charting how changes in legislative principles and codes of practice are understood and implemented. While

the case studies of four facilities do not allow generalisations, they provide an in-depth exploration of this complex arena of care provision in specific contexts. The case study analysis provided the basis of a survey of a representative sample of aged-care facilities in the next stage of the project. The thematic analysis of the interviews sought to answer the following questions:

1. How do ACF staff interpret the legislative and policy requirements for assisted and substitute decision making?
2. What factors facilitate and constrain ACF residents' inclusion in decision making about their finances and property?

Findings

The case studies showed that although asset management was most commonly undertaken on behalf of residents by family members or public and private trust organisations, all facilities reported having a small number of residents who self-managed all or some of their banking, shopping, bill paying and investment transactions. Most of them were described as having no cognitive impairment or having family support to remain actively involved in managing their financial affairs. Across the four facilities, a range of opportunities for and constraints on assisting residents to remain involved in some of the tasks of managing assets were identified. These arose from how the legislative requirements that relate to substitute decision making were understood and used, in particular 'enduring powers of attorneys' (EPA); how the responsibility to assist residents to continue to make some decisions was viewed and resourced; and the concern to minimise risk of loss or and allegations of misuse of assets.

Interpreting legislative requirements

Various interpretations of existing legislation were evident in the interview data. In Queensland, a donor of an EPA can specify a time when it comes into effect. If no time is specified, then the attorney is able to exercise their financial decision-making power immediately but is nonetheless required to consult with the donor if the donor has capacity for the decision (Queensland Government, Department of Justice and Attorney General 2010). All facilities requested copies of EPAs upon the admission of the older person, but how these were understood and then used in respect of financial matters varied. Apart from the time of admission, only one facility had a system in place for checking the conditions of the EPA when

an attorney sought to use it. In one facility, the business manager reported that the holder of the EPA (the attorney) was the preferred point of contact and viewed as the primary decision maker regardless of whether or not the resident had capacity to make that decision. An example of this was consulting the attorney about a resident's decision to buy clothes when the resident clearly had the capacity to make that decision. A business manager commented:

> We become accustomed to dealing with the [person who has] the power of attorney. Our first instinct is to [contact] the power of attorney but they usually … say, 'oh well, mum and dad still look after their own affairs'.[1]

This approach does not reflect a decision-specific assessment of capacity or an understanding of substitute decision making. Some staff also reported that some family members assumed a substitute decision-making role when the resident was willing and able to retain involvement. As one explained:

> [the resident] has been placed into care, has established his enduring power of attorney and the family seem to have taken over. They are making the major decisions for him and he's angry. He's a very angry person because he feels that everything has been taken away from him, like the whole dignity of his life has been taken away.

An alternative view from a manager in another facility reflected a clearer understanding of the principles underpinning substitute decision making: 'if the person [the resident] has cognitive capacity we would take whatever their wish is over the EPA [the attorney]'. The manager, reflecting on the practices in some facilities of referring to the holder of the EPA for all decisions commented, 'I can see why that happens but it is not right all the same. Because it is a cop out. It is easy to do that'.

Responsibility and resource constraints

A second barrier to assisting residents who were able and wished to have some involvement in managing their financial affairs arose from how the facility role was viewed and resourced. Some facilities took the view that assisting residents to retain an interest in managing some tasks of asset management was not part of their role and very much in the domain of families. These facility managers were much more likely to refer automatically to substitute decision makers for any decisions involving money. As one manager noted, 'we have care responsibilities, not financial responsibilities'. From this perspective, all financial matters and tasks – not only managing fees and charges and the more complex tasks of asset management – were seen to be the concern of families or trust organisations rather than of the resident or the facility's staff.

An alternative approach that acknowledged that the facility had responsibilities in this domain was also evident. In these facilities, managers and most personal care staff reported that it was important to support independence in asset management, especially in the situation where a resident had no family member to assist them. Diversional therapists or others who organised outings reported taking residents shopping or to the bank. One diversional therapist described her involvement:

> Well he is in a wheelchair, okay, so we go over and I just stand beside him at the ATM [automatic teller machine] in case he has a problem. … If he has a problem, he will ask me and I will help him sort it out like maybe he hasn't pressed the numbers properly. … Then we go into the stores. I push him. He says what he wants … then we will go to the checkout. He has the money in his wallet. He takes it out and pays … and gets the receipt and the change and puts it back in his wallet. So he has control of that. I don't touch it at all.

Care managers who supported this approach reported that it was resource intensive and could be difficult to facilitate. For example, assisting a resident to visit a bank required a staff member to escort the resident to the bank, arrange transport, and organise back-up staff to replace the absent staff member. As one care manager reported, 'It's all very well for us to say that the resident should have total independence but I've got to release a staff member for an hour at least. They have got to have transport and who pays for that?' In one case where an escort could not be arranged through the diversional therapy programme, the resident herself provided the funding for staff costs and transport to enable her to manage her own banking. Not all residents could afford this. In another facility, residents could access a bank only if they were able to do so without facility support. The rural facility reported a range of practices that included a front-line staff member taking a resident to a local bank. The manager said:

> It's not our role. … I've taken her down to the bank to sort out getting monthly bank statements now that … her one eye is done [has been operated on] so that she can see. … We were going to do phone banking with her but we decided that she could get monthly statements and she was happy with that. So I just walked down to the bank with her one afternoon. But most of the time, we hand it over to families or a person holding the EPA.

Managing 'risk'

Managing risk also presented a barrier to supporting residents to remain involved in decision making about money and property. Risk in relation to a resident's involvement in banking and other asset management tasks was primarily handled by referring financial decisions to family members or appointed attorneys rather than supporting the resident to remain

involved. The day-to-day management of money and valuables in the facility was, however, a core concern of the care managers, all of whom sought to minimise the risk of money and valuables being mishandled, lost or stolen and to reduce allegations against staff of theft or undue financial influence. All senior staff saw the management of such allegations as extremely difficult and time consuming. They reported that the best option they have found is to ask residents to keep no or very small amounts of cash in their rooms. All the facilities actively discouraged bringing valuables, especially jewellery and money into the home, and all had transparent and well-developed practices around handling residents' money and to protect the residents' cash and valuables. Policies and practices that promoted resident involvement in decision making, however, were much more limited because the facilities managed risk by reducing residents' access to money and valuables. A business manager summed up his approach:

> The families are always advised when their family member comes in to keep their personal property down to a very minimum. … I think it should be a regulation that they leave those sorts of personal belongings at home. Even though it should be their right to bring them in.

Cash was most commonly held at the office rather than in residents' rooms, and/or any incidental expenses for outings or shopping were often debited to the resident's account so that cash was not directly handled. For example, one care manager indicated that money is debited to the account 'when the resident has their hair done etc., newspaper and any other ongoing things so that makes life a lot easier for the resident'. A personal care worker explained the procedures associated with outings:

> We get a blank cheque from [the general manager]. We order the meals and we order drinks and it is just one cheque and the receipt comes back to the office. The names are recorded of the people who went on that bus trip and they work out … how much is owed [and then it is taken from the accounts].

Removing access to cash and valuables is an appropriate practice for protecting older people's assets and property and reducing the likelihood of allegations against the staff, but it pays scant attention to the residents' independence. Some staff, however, recognised the importance of access to cash for some residents. As one carer said:

> But if they get very worried about that then I usually get the office to … give them a bit of cash so they do have some money and it stops playing on their mind that they have got nothing … it could just be $5 or $20 … as long as they have some money there in their pocket, that seems to be important.

This was particularly apparent in one facility that accommodated people from culturally and linguistically diverse backgrounds where it was understood that having cash was especially important for post-World War

II refugees who had arrived in Australia with few possessions. Over all the facilities, however, practice indicated that the priority was to manage risks by protecting assets and protecting staff from allegations of misconduct. One care manager recognised some of the moral and ethical dilemmas of encouraging capable residents to remain involved with their assets:

> We are aware that in a lot of cases you are taking away people's independence and their ability to manage. It is done from, hopefully, you know, taking the high moral ground that this is the best thing for that [managing concerns about loss and allegations of theft].

A manager in an extra-services facility that charged higher fees and provided for residents with significant assets also noted the challenges to independence in current policies and the variation is resident responses:

> I mean they lose their homes, they lose their life and they also to a degree lose their money. Some of them are quite happy to. Some are quite happy to come and act like it is a bank and some – I think – there should be more of an avenue where they can have some sort of banking structure [independent access to a bank] so that they can maintain that financial independence, especially for the boys. It is very important for the men.

Discussion

Across the four case studies, there were two consistent findings about older people's involvement in financial decision making in residential aged-care settings. Firstly, that constraints were placed upon their ability to be involved in decision making, both at the level of managing assets and in the day-to-day handling of money and valuables. Secondly, that only limited support was provided for the residents who were capable and wanted to be involved. The frequent outcome was the use of substitute decision makers as the easier option. These findings indicated the impediments to implementing a task-specific approach to the assessment of the capacity to make financial decisions. The analysis of the case studies suggested that the opportunities and constraints in residential settings for implementing the current legislative principles that promote assisted decision making are defined by three intersecting factors: staff attitudes towards older people's rights to manage their assets, staff levels of knowledge of how to support substitute decision making, and the level of resources required to implement supported decision making.

The primary drivers of current policies and practices in the four ACFs were risk minimisation and resource constraints, together with a view that managing residents' financial assets is primarily the concern of family members. Staff involvement in supporting residents with their financial

assets was generally viewed as a risky and resource-intensive area of care practice. For some, it was simply was not regarded as part of their role. As a result, protection of staff time and reputation and the older person's assets were prioritised over empowerment and inclusion of the older person in decision making about their resources.

Substitute decision making mechanisms such as EPAs facilitate ease of asset management on behalf of older people and the identification of people with authority to act as proxy decision makers. This was an important resource for care providers, family members and for residents who were unwilling or unable to participate in decisions about financial matters, but the case studies show the limited understanding of the legislation and the principles underpinning the EPA instrument. While some staff had a sound understanding, inappropriate interpretations of EPAs were also noted. Some staff viewed the attorney as the primary decision maker regardless of any assessment of the nature of the asset management task or decision and the resident's capacity to make that decision or complete that task. In these situations, the older person's preferences were not explored. This misunderstanding and misuse of EPAs has been noted in earlier research on the practices of family members involved in managing older people's assets (Tilse *et al.* 2007*b*; Wilson *et al.* 2009). Resorting to using a substitute decision maker for all financial decisions provides informal and formal carers with a simple and convenient alternative to the more time-consuming practice of assisting older people to remain involved in decision making. In residential settings it can also reduce the risk of misuse and avoid potential conflict with residents' families at the expense of older people's rights.

The implementation of assisted decision making requires resources and support. The environmental and resource constraints revealed by this study showed the limitations of the support available and that this area of practice is under-developed. Although substitute decision making is well developed in legislation in Queensland, in many cases the strategies to achieve this and the resources associated with promoting assisted decision making and involving older people in asset management are inadequate (Tilse, Wilson and Setterlund 2009; Wilson *et al.* 2009). All facilities in the case studies provided safe areas for valuables. There was only limited evidence, however, of other environmental accommodations to assist older people to stay engaged in the tasks and decisions they were able to make (*e.g.* provision of accounts in large print, access to telephone and computers in aged-care facilities to assist the minority who seek to self-manage, transport to financial institutions and shopping). An understanding of day-to-day assessment of decision-making capacity in relation to a particular task also appears to be limited, with residents often viewed in a

dichotomous way – as either being able to self-manage or as requiring family or trustee assistance.

Resource constraints affected opportunities to include older people in decision making. Taking time to assess capacity to make a decision in relation to a particular task, check that information is understood and communicate preferences creates extra tasks for residential-care staff. There was limited support for such tasks and few resources for innovative or experimental practices. Although the right to remain involved in financial affairs is recognised in the *Charter of Residents' Rights and Responsibilities* (Australian Government Department of Health and Ageing 1997), the regulators do not have specific guidelines on what this means in practice and do not assess this when accreditating facilities. In aged-care facilities where managing costs is a significant issue, providing the additional support needed for residents who wish to remain engaged with managing their financial matters is likely to be low priority and dependent on the particular interest and good will of staff members. In residential care facilities, the staff need the support of management to engage with time-consuming assisted decision making especially in relationship to financial matters where there can be risk of suspicion regarding the motives of care staff and possibly also family discord to be dealt with. Some staff in the smaller facilities provided examples of an individualised approach to assisting residents. Such tasks were often undertaken outside working hours in the staff member's own time.

Conclusions

Protection and risk management dominate current practice in aged-care residents' financial decision making, and limited attention is given to developing the skills and the resources required to assist older people to participate in the decisions they are able to make. Legislative principles are clearly not sufficient to ensure inclusive practice. Effecting change will require diverse strategies and commitment from a range of services and groups. To enact the spirit of substitute decision-making legislation in care contexts, all parties need to be aware of their rights and obligations, and all stakeholders need to be prepared and resourced to attend to older people's individual needs and capacities – in this case in relation to asset management – and to understand and respond to those needs and capacities as an integral part of their wider care. In communal environments such as residential care, providing individual attention, assessment and support in this domain of decision making can be easily overlooked and is poorly resourced.

In the UK, Chapter 3 of the *Mental Capacity Act 2005 Code of Practice* (UK Department of Constitutional Affairs 2007) provides practical guidance on how to support people to make decisions for themselves, or to maximise their role in decision making. This advice needs to be viewed in the wider context of resource allocation and service priorities. Johns (2007) and Manthorpe, Rapaport and Stanley (2008) noted the time and resource issues for professionals and informal carers resulting from their changing roles and responsibilities. Dwyer (2005: 1089) provided one example of time and resource constraints impacting on social workers' ability to work with the decision-making processes of some older people when decisions are to be made about permanent care. This example predates the introduction of the *Mental Capacity Act 2005* in the UK. It does suggest, however, that exploring how supported decision making is practised and resourced in line with the principles of this Act is an important area for further scrutiny by this profession.

Appropriate practice in line with current legislation involves an assessment of the context and the decision, an assessment of capacity to make the decision or the support needed to participate in decision making and the adult's wishes and beliefs and values (Letts 2009). For care providers, the need to be clear about when such practice is a moral and ethical responsibility and when identifying best interests is also a legal duty adds to the complexity of practice in this domain of care. These constraints on carers, paid or otherwise, need to be considered by government in the context of current regulatory requirements and funding arrangements in health and social care.

Practice in relation to assisted decision making involves skills in balancing power and risk, protection and independence in particular contexts. It also requires skills in assessing decisional capacity in relation to particular asset management tasks and resources to support and sustain the desired level of involvement of the older person. Improving practice will therefore need a commitment from residential care providers, funding and regulatory bodies, and adult protective services to challenge environmental and attitudinal barriers to the involvement of older people. In addition, education and support is needed for formal and informal carers in assessing capacity for a particular task and ensuring resources are available to support older people to make decisions or carry them out. Education and services that assist in recognising undue influence and resolving disputes between different players will also form part of an array of responses needed to improve practice.

Current and accurate knowledge of the principles underpinning legislation in relation to capacity and substitute decision making, attention to the attitudes and practices that restrict older people's involvement, and

resources to support innovative practice in residential care are urgently needed. The first steps are to recognise what constitutes inclusive practice in this contentious area of care provision and to develop the resources needed to support such practice. The challenge is to develop a range of practices around assisted and substitute decision making that truly reflect the diverse needs and interests of older people. Listening to the voices of people in their 'fourth age' and therefore treating them as citizens requires special effort (Scourfield 2007). This entails avoiding broad assumptions with respect to older people's interest and capacity to be involved in decision making about their finances and property and instead rising to the challenge of finding ways to represent older people in all their diversity.

Acknowledgements

The research was supported by the Australian Research Council Linkage Grant LP0667810 in partnership with BlueCare, TriCare and the Office of the Adult Guardian in Queensland. The authors wish to acknowledge the contributions of the industry partners, the residential-care staff and Mary Rose Miller to the case studies.

NOTES

1 In presenting the interview data, the formatted paragraphs are direct quotations, with the authors' glosses in square brackets. Some short direct quotes are embedded in the main narrative.

References

Australian Government Department of Health and Ageing 1997. *Charter of Residents' Rights and Responsibilities*. Department of Health and Ageing, Canberra. Available online at http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-resicharter.htm [Accessed 15 April 2009].

Australian Institute of Health and Welfare (AIHW) 2007. *Australia's Welfare*. AIHW, Canberra. Available online at http://www.aihw.gov.au/publications/aus/aw07/aw07.pdf [Accessed 15 April 2009].

Bennett, H. and Hallen, P. 2006. Guardianship and financial management legislation: what doctors in aged care need to know. *Internal Medicine Journal*, **35**, 8, 540–1.

Dwyer, S. 2005. Older people and permanent care: whose decision? *British Journal of Social Work*, **35**, 7, 1081–92.

Ganzini, L., Volicer, L., Nelson, W. and Derse, A. 2003. Pitfalls in the assessment of decision making capacity. *Psychosomatics*, **44**, 3, 237–43.

Grisso, T. (ed.) 2003. *Evaluating Competencies*. Second edition, Plenum, New York.

Johns, R. 2007. Who decides now? Protecting and empowering vulnerable adults who lose capacity to make decisions for themselves. *British Journal of Social Work*, **37**, 3, 557–64.

Knapp, M. and Prince, M. 2007. *Dementia UK: Summary of Key Findings*. Alzheimer's Society, London. Available online at http://alzheimers.org.uk/site/scripts/download_info.php?fileID=2 [Accessed 9 May 2010].

Langan, J. and Means, R. 1996. Financial management and elderly people with dementia in the UK: as much a question of confusion as abuse? *Ageing & Society*, **16**, 3, 287–314.

Letts, P. 2009. Capacity and financial abuse in adults. In Pritchard, J. (ed.), *Good Practice in the Law and Safeguarding Adults*. Jessica Kingsley, London, 122–58.

Mackay, K. 2009. Scottish legislative framework for supporting and protecting adults. In Pritchard, J. (ed.), *Good Practice in the Law and Safeguarding Adults*. Jessica Kingsley, London, 33–52.

Manthorpe, J., Rapaport, J. and Stanley, N. 2008. Expertise and experience: people with experiences of using services and carers' views of the Mental Capacity Act 2005. *British Journal of Social Work*, **16**, 1, 1–17.

McCawley, A., Tilse, C., Wilson, J., Setterlund, D. and Rosenman, R. 2006. Access to assets, older people with impaired capacity and financial abuse. *Journal of Adult Protection*, **8**, 1, 20–32.

Means, R. and Langan, J. 1996. Money 'handling', financial abuse and elderly people with dementia: implications for welfare professionals. *Health and Social Care in the Community*, **4**, 6, 353–8.

Moye, J. 2003. Guardianship and conservatorship. In Grisso, T. (ed.), *Evaluating Competencies*. Second edition, Plenum, New York, 309–90.

Moye, J. and Marson, D. C. 2007. Assessment of decision-making capacity in older adults: an emerging area of practice and research. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, **62**, 1, 3–11.

Ontario Ministry of the Attorney General (MAG), Capacity Assessment Office 2005. *Guidelines for Conducting Assessment of Capacity*. MAG, Toronto. Available online at http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity/2005-05/guide-0505.pdf [Accessed 15 April 2009].

Queensland Government 2000. *Guardianship and Administration Act 2000*. Chapter 2, Section 5, Queensland Government, Brisbane. Available online at http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf [Accessed 15 April 2009].

Queensland Government, Department of Justice and Attorney General (DJAG) 2010. *Enduring Power of Attorney*. DJAG, Brisbane. Available online at http://www.justice.qld.gov.au/justice-services/guardianship/enduring-power-of-attorney/enduring-power-of-attorney [Accessed 9 April 2010].

Scourfield, P. 2007. Helping older people in residential care remain full citizens. *British Journal of Social Work*, **37**, 7, 1135–52.

Tilse, C., Setterlund, D., Wilson, J. and Rosenman, L. 2005. Minding the money: a growing responsibility for informal carers. *Ageing & Society*, **25**, 2, 215–27.

Tilse, C., Wilson, J., Setterlund, D. and Rosenman, L. 2007*a*. The new caring: financial asset management and older people. *Annals of the New York Academy of Science*, **1114**, 355–61.

Tilse, C., Wilson, J., Setterlund, D. and Rosenman, L. 2007*b*. Managing the financial assets of older people: balancing independence and protection. *British Journal of Social Work*, **37**, 3, 565–72.

Tilse, C., Wilson, J. and Setterlund, D. 2009. Personhood, financial decision making and dementia: an Australian perspective. In O'Connor, D. and Purves, B. (eds), *Decision Making, Personhood and Dementia: Exploring the Interface*. Jessica Kingsley, London, 133–44.

United Kingdom Department of Constitutional Affairs. 2007. *The Mental Capacity Act 2005 Code of Practice*. Department of Constitutional Affairs, London. Available online at

http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf [Accessed 15 April 2009].

Wilbur, K. 2001. Decision-making, dementia and the law: cross national perspectives. *Aging and Mental Health*, **5**, 4, 309–11.

Wilson, J., Tilse, C., Setterlund, D. and Rosenman, L. 2009. Older people and their assets: a range of roles and issues for social workers. *Australian Social Work*, **62**, 2, 155–67.

Accepted 10 August 2010; first published online 17 September 2010

Address for correspondence:
Cheryl Tilse, School of Social Work and Human Services,
University of Queensland, St. Lucia,
Queensland 4072, Australia.

E-mail: c.tilse@uq.edu.au