'Not a penny to call my own'

Poverty amongst residents in mental illness and mental handicap hospitals

Martin Bradshaw
& Ann Davis

Martin Bradshaw is a social worker with the City of Birmingham Social Services Department.

Ann Davis is a Lecturer in Social Work and Social Policy, Department of Social Administration, University of Birmingham.

'Not a penny to call my own'

Poverty amongst residents in mental illness and mental handicap hospitals

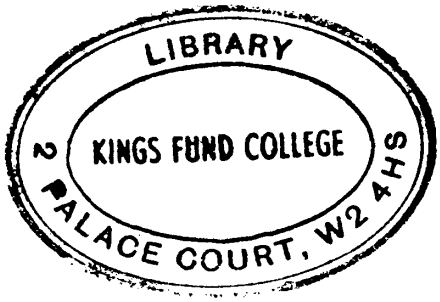
Martin Bradshaw and Ann Davis

'When I came in here they took my pension book away and I've not had a penny to call my own since.'

seventy-year-old woman, resident in a psychiatric hospital for nine months

King's Fund and Disability Alliance

Typeset by Prototype, Kenton, Harrow
Printed by G S Litho, London



Disability Alliance E.R.A.
25 Denmark Street
London WC2 8NJ

King's Fund Publishing Office
2 St Andrew's Place
London NW1 4LB

Acknowledgements

The authors would like to thank those who assisted them in the preparation of this pamphlet, in particular Eve Brook, Helen Duffy, Linda Lennard, Teresa Leo, Tom McAusland, Clive Martin, Sally Robertson, Professor Peter Townsend, Alan Walker and the staff of Calderstones Hospital and the King's Fund Centre Library.

Contents

Introduction

When the topic of poverty is raised in relation to residents in our mental illness and mental handicap hospitals, it is usually the poor physical facilities which are the focus of discussion. Deteriorating buildings, lack of privacy, poor diets, staff shortages, segregation from the surrounding community – these and many other aspects of institutional care are, quite rightly, highlighted as contributing to impoverished lives, particularly for long stay residents.

Surprisingly, one area which is given scant attention is precisely the one which is normally central to any debate about poverty in our society – personal income. An adequate income which ensures individual choice and independence is as important to hospital residents as it is to other citizens.

In this pamphlet, which is based on our recent research, some of the issues surrounding residents' incomes are discussed so that those who provide and develop mental health and handicap services can place the topic more centrally on their agendas. We outline the nature of the problems faced by residents and go on to examine ways in which these can be tackled so that the maximum benefit from incomes is guaranteed to all those living in mental illness and mental handicap hospitals. This pamphlet has been written for staff working in all areas of the hospital service.

We know that the majority of the 112,500 or so people living in mental illness and mental handicap hospitals are dependent on social security benefits for all or part of their weekly income. We do not know exactly how many this is or what benefits they draw. There are no national figures available and individual hospitals do not normally collect such information. When the recent Social Services Committee on community care for adults with mental illness and mental handicap

asked the DHSS for data on social security provision, figures on only a minority of adults suffering mental illness or handicap could be provided – those claiming disability benefits.[1]

The amount of weekly income available to any hospital resident is determined by a variety of factors. Some are external to the hospital and its administration; these include eligibility for state benefits, household status, the type of benefit being claimed on admission to hospital, and the length of time spent in hospital. However, the hospital also determines weekly income in a number of ways. Social security legislation and the guidelines contained in the *Hospital Memorandum on Patients' Moneys,* issued by the DHSS (HM71(90)) give medical officers powers to recommend the reduction or withdrawal of social security income if in their opinion the patient cannot benefit from it.[2] Hospitals can provide some residents with opportunities to enhance their weekly income through 'therapeutic earnings' derived from work. The ways in which hospitals administer patients' money and provide residents with access to their income play a large part in controlling the amount of money a resident can use.

Because so little attention has been paid to the financial position of residents in mental illness and handicap hospitals we cannot say with any certainty how these factors affect the income levels of residents. The last substantial study of this subject was *The Poor in Hospital,* a Disability Alliance pamphlet written in 1975 by Ann Shearer.[3] Eleven years later we still have little knowledge of the impact the situation has on residents. We do not know what constraints are placed on their lives, their sense of themselves and their futures. These are all issues which need urgent examination if serious attempts are to be made to improve the quality of life of hospital residents and if active policies of rehabilitation and integration with the community are to be pursued.

Part 1
Why is there poverty in long stay hospitals?

There are three major elements which contribute to poverty in mental illness and mental handicap hospitals:
1) low income levels;
2) failure to claim benefits;
3) limited access to income.

Several factors contribute to each of these elements. These are outlined and illustrated with examples from our recent research and the work of advisers based in hospitals, and take-up projects such as that at Rubery Hill Hospital, Birmingham.[4]

1) Low income levels

The income which residents in mental illness or mental handicap hospitals have to manage on depends on whether they are entitled to claim a social security benefit and what rates the government sets for those benefits. These rates are invariably set too low to provide an adequate standard of living. It is not surprising, therefore, that like other claimants, hospital residents find it difficult to meet their needs on the income they receive. Some hospital residents face additional difficulties:

a) No right to benefit – hospital 'pocket money'

Some of the elderly residents in mental illness and mental handicap hospitals have no rights at all to state benefits. They are people who were admitted to hospital before November 1975 and were already over pensionable age on 20 November 1975 when non-contributory invalidity pension was introduced. They are thus excluded from NCIP and its successor, severe disablement allowance. If they have been

receiving in-patient treatment in a special hospital continuously since before 17 November 1975 and were under 80 on 24 November 1980, they are also excluded from supplementary benefit as their requirements are specifically defined as 'nil'. There are no national figures on how many residents are debarred from claiming since hospitals are not required to notify the DHSS about them. However, they live in all our large hospitals and find their need for income ignored by the benefit system.

A national survey which we undertook in 1983 of 270 mental illness and mental handicap hospitals in England and Wales suggested that between 4 per cent and 8 per cent of residents in these institutions were dependent on hospital funds for their incomes. This means that 4,500 to 9,000 people are forced to depend on 'charity' for any cash they have to spend. The Disability Alliance, MIND and MENCAP have always had objections to this system. Firstly, it is discriminatory, reducing elderly people to the level of children with no income as of right and denying them rights which are taken for granted in the community as a whole. Secondly, while hospitals can pay these residents at the same rate as that provided by state benefits, they are not obliged to do so. Administrators are free to decide whether to provide incomes or not and determine any level they wish.

One hospital in our survey stated that if residents on 'indigent allowances' accumulated more than £100 in their accounts, their income from hospital funds was stopped and only reinstated when there was a 'significant drop in their balances'. In contrast, residents in receipt of state benefits could accumulate savings without any such loss of weekly income.

This system continues because there is no clear legal entitlement to benefit for this group of residents. The result is that a significant number of residents are treated as second class citizens within our hospitals. For these residents poverty, uncertainty and dependence

are continuously reinforced by the operation of the hospital 'pocket money' system.

b) Benefits cut – the personal allowance

When people who claim state benefits become hospital residents they find that their income is reduced. This is because the state considers that some of their needs (for example, food) are being met by the hospital. The size of this reduction and its timing varies according to the benefit(s) claimed and the period of residence in hospital. Table 1 provides a summary of the complex and confusing rules which operate in this area. These rules mean that residents receive different incomes depending on the type of benefit they draw. However, the distinction between people drawing contributory and means-tested benefits gradually disappears when a person remains in hospital for a long time. After one year the weekly amount available to all residents claiming state benefits (except mobility allowance and war and disablement pension) is £7.75 (1986-7 rates).

This basic allowance is meant to cover personal expenditures such as newspapers, sweets, cigarettes, trips out of hospital, holidays, stamps, entertainment, and gifts for friends and family – a great deal to cover on just over £1.10 a day! Of course, residents who have lived in hospital for a long time are likely to have to replace items of worn clothing. Help from the state to meet clothing costs is only available through supplementary benefit single payment regulations and these virtually exclude claimants who are hospital residents. Hospitals are not obliged but simply have the power to provide new items of clothing for residents. In these circumstances the personal allowance becomes a source of money on which residents have to draw to buy themselves clothing.

Many hospitals have developed 'savings schemes' to help residents put by regularly for such items as clothing or holidays. These schemes may ensure that residents get particular items but in doing so they reduce the disposable weekly income of residents.

Table 1 The effects of admission to hospital on income from Social Security Benefit

	Supplementary Benefit (NB. If these reductions mean a person comes off Supplementary Benefit, it may be possible to claim Housing Benefit instead)	*Sickness & Invalidity Benefits, Retirement Pensions, Severe Disablement Allowance, Widows Benefits (except War Widows pensions)*	*Child Benefit*	*Attendance Allowance*
At least one day	Benefit for single people without children is reduced from the first payday after entering hospital. Where a couple are both in hospital their benefit is reduced. Some of their additions stop (eg, diet, heating on health grounds).	Allowance for an adult dependant (except a wife) may stop. Benefit reduced for some people from special kinds of accommodation eg, L.A. Homes.	No change	No change
4 weeks	Some heating additions stop	No change	No change	Stops if disabled person is still in hospital.
8 weeks	Benefit for a couple reduced if one is in hospital. Benefit for single parent in hospital is reduced but amount for eldest or only child may be increased if still regarded as dependent on parent.	Benefit reduced in respect of person in hospital (except for a child).	No change	
12 weeks	Amount for child in hospital reduced. Some of its additions stop (eg, diet, heating on health grounds).	Addition for child in hospital stops unless money is still being spent on him/her.	Can continue only if parent spends money on child.	
13 weeks	Some heating additions stop	No change	No change	
20 weeks	No change			
28 weeks	No change			
One year	No change	Person in hospital gets a 'Personal allowance' only. But also money can be saved up for their discharge or paid to a dependant.		

For more detailed information, see Disability Rights Handbook 1986/87, Disability Alliance E.R.A., 1986.

Mobility Allowance	*Invalid Care Allowance*	*War or Disablement Pension*	*Housing Benefit (rent/rates rebate)*	*Statutory Sick Pay (SSP)*
No change	No change	May be increased if you qualify for 'hospital treatment allowance'.	No change for S.B. claimants. Rent/rate rebates may increase for other claimants if their benefits are reduced.	This benefit is paid by employers for the first 28 weeks of incapacity for work. It is not reduced because of a stay in hospital.
No change	Stops if disabled person loses Attendance Allowance through being in hospital.	No change	As above	No change
No change		No change	If claimant has come off S.B. Housing Benefit has to be re-claimed on other income. Other claimants – as above.	No change
No change	No change	No change	As above	No change
No change	Stops if Invalid Care Allowance claimant has been in hospital 12 weeks.	No change	As above	No change
No change		No change	As above	
			As above	Transfer to Invalidity Benefit Scheme at reduced rate.
No change		No change	Housing Benefit stops.	

Hospital X's 'voluntary savings scheme' requires residents who have been in hospital over a year to put £2 a week aside for an annual holiday and £1 a week aside for personal clothing. This leaves long stay residents with 67p a day to cover personal expenses. The administrator at Hospital X is concerned about the number of patients who beg in the hospital corridors for cigarettes or money from staff and visitors.

The level of the personal allowance and the schemes which hospitals have devised to help residents manage their money result in residents being confined to an impoverished environment. Given the poor quality of life provided by hospitals for most long stay residents, their individual needs for variety, travel, entertainment and comfort are greater rather than smaller than the rest of us, and yet their benefit is being drastically cut.

2) Failure to claim benefits

'Evidence suggests that take-up of benefits is low among both mentally handicapped and mentally ill people and their families. Many witnesses have urged most strongly that greater priority be given to informing people about their entitlement to benefits and to helping them to obtain them and to educating professionals working with mentally handicapped and mentally ill people in this field. *We recommend a departmental initiative to examine ways of ensuring greater take-up of benefit entitlements by mentally ill and mentally handicapped people.'*

– Second report from the Social Services Committee (Session 1984-85) on 'Community care with special reference to adult mentally ill and mentally handicapped people', Volume 1, paragraph 143.

Many residents of hospitals, like other people with mental illness and mental handicap, are not receiving the social security benefits they are entitled to. As a result they are living on incomes below the minimum levels set by Parliament. Our work suggests that there are at least five reasons for low take-up by hospital residents:

a) hospitals failing to claim benefits
b) delays in processing claims
c) failing to claim partial attendance allowance
d) failing to claim mobility allowance
e) clothing costs.

a) Hospitals failing to claim benefits

While benefit rates are decided by central government and are beyond the control of individual hospitals, the take-up of benefits by residents is affected to a great extent by hospital policy and the attitudes and knowledge of staff. When non-contributory invalidity pension (now severe disablement allowance) was introduced in 1975, there was a substantial incentive for hospitals to claim it on behalf of eligible residents, because each pound claimed was a pound saved from hospital funds. The current situation is very different. Our research indicates that many administrators feel they are under pressure from auditors not to claim benefits which could lead to higher balances in residents' accounts. In addition there is considerable ignorance about the benefit system among staff at all levels of the hospital. This is hardly surprising given the complexity of the benefits scheme and the failure to provide hospital staff with adequate training on social security benefits.

Benefit take-up exercises, like the one at Rubery Hill Hospital, Birmingham have shown that many benefits are not claimed by the residents and day patients of mental illness and mental handicap hospitals.

Mrs C was on an admission ward at Rubery Hill Hospital when staff began a weekly benefits advice session for patients. She went to talk about her financial problems which were worrying her. As the result of staff checking her benefit it was found that she was entitled to £479.50 as back payment of supplementary benefit on the grounds that she had good cause for late claim, a £102.30 furniture grant, clothing grant, and housing benefit supplement.
Mrs C was one of 39 patients who were helped on this ward. Overall they were found to be entitled to £2,800 in lump sum payments and their total income was increased by £200 a week.

Citizens Advice Bureau advisers based in mental illness hospitals have found that individuals seeking their help are often entitled to more benefit than they realise.

Mr E was very worried on his admission to hospital about his mounting debts. He feared he would lose his new flat because he could not afford the rent. He went to the CAB at the hospital and the adviser found he was entitled to housing benefit supplement. As a result of this advice Mr E received £178.00 as back payment of housing benefit supplement, a £105.95 single payment for furniture, and his weekly income was increased by £4 because of the payment of housing benefit supplement.

There is clearly a great deal of scope for increasing the income levels of newly admitted patients and day patients who may be entitled to a range of benefits and additions, as well as benefit back payments and income tax refunds. *Our national survey revealed that only one hospital out of the 270 replying offered all new admissions a benefit check and advice on claiming.*

In most hospitals it is left to individual residents to make their concerns known, and even then there is no guarantee that expert help will be available. This 'hit and miss' system leaves individuals worried about their money and discharges people into financial circumstances which have worsened during their spell in hospital. The consequences of this can be catastrophic:

When Miss D, who is 60 years old, was admitted to psychiatric hospital, the long-standing sick note which covered her benefit claim was cancelled and replaced by short-term notes. She was discharged without her long-term sick note being reinstated and therefore received no benefit. For three months she lived in the community on her meagre savings. When they ran out, she was re-admitted to hospital, suffering from malnutrition as well as depression.

b) Delays in processing claims

Some individuals are receiving less benefit than they are entitled to because of delays by the DHSS in processing claims. This problem occurs particularly for those who move between hospital and the community, and adds to their poverty and distress. Hospitals are sometimes forced to make loans from charitable sources to tide residents over.

Miss W was admitted to psychiatric hospital in March. Three days after admission she made a claim for supplementary benefit. She was discharged in May but re-admitted a week later. She finally left hospital in July. Throughout this period she did not receive any benefit at all and she feels that her anxieties about money contributed to her illness: 'I'm sure I wouldn't have taken so long to get better if I hadn't been so worried about my money – it really gets you down, having to borrow from other people all the time'.

For some people the delays undermine long-standing rehabilitation and resettlement plans.

The following story was shared with us by a nursing officer on the rehabilitation unit of a mental handicap hospital.

'Mr S has been a resident in this hospital for 20 years. For the past 12 months he has been on our programme here in the rehabilitation unit. He has surprised us all by how well he has progressed. Five months ago we decided he could probably cope alright in a flat in a sheltered housing scheme and he was keen to try. We nominated him for a flat and he got an offer – he should have moved into it eight weeks ago. However the local DHSS office has not dealt with his claim for supplementary benefit and single payments for furniture and household goods. The delay in moving has made him anxious and we can't give him any reassurances about when he will get a decision and be moving out of hospital; we just don't know. It's as if the last 12 months has been for nothing. By the time they get round to sorting what Mr S is due, he'll have lost his confidence that he can cope on the outside and if he has not lost his confidence he may have lost his chance of a flat!'

Given the government's commitment to 'community care' policies, this failure on the part of the DHSS to ensure that adequate income support is provided efficiently for vulnerable people who are moving in and out of hospitals is unacceptable. While much of the blame for delayed payments lies with the low priority given to hospital residents by DHSS staff, hospitals need to make sure that their own policies do not make matters worse. For example, many hospitals in our survey said that they encourage liaison schemes, with visiting officers from the local DHSS office spending something like an afternoon a fortnight sorting out benefit problems on the wards. This may work to the advantage of ward-bound residents, but for others it is punitive.

When claimants in the community have benefit queries, they can go to the local DHSS office and complain or ask for an emergency payment if benefit has been delayed. Hospital residents who contact the DHSS about delays may be told to wait and see the visiting officers when they come to the hospital. This adds to delays, particularly if the visiting officer is too busy to deal with all residents during the fortnightly visit.

Hospitals need to ensure that DHSS visiting officers are used as an additional safeguard for residents. They should not agree to any arrangement which robs residents of their right to visit their local DHSS office if they so wish.

c) Failing to claim partial attendance allowance

Our contacts with hospitals through the survey and at King's Fund conferences on patients' money, suggest that hospital staff are often unaware that this benefit can be claimed by residents, or do not bother to claim it on their behalf.

While attendance allowance cannot be paid to people needing constant care and supervision after four weeks of a hospital stay, it can be paid on a pro rata basis when they go home on leave. This benefit can considerably increase the individual's ability to contribute towards household expenses. Moreover, if attendance allowance had not been in payment on their entry to hospital, the receipt of just one day's payment in respect of a temporary absence on leave will lead to a further four weeks of attendance allowance on their return to hospital after the break. Pro rata attendance allowance is payable for both the days of discharge from and re-entry to hospital as well as for full days away. A person qualifying for the lower rate receives £2.95 for each day spent at home (1986-87 rates).

There is similarly a failure to claim supplementary benefit on a pro rata basis for temporary leaves of absence – particularly where severe disablement allowance is normally in payment at the 'pocket money' rate.

On one rehabilitation ward at Rubery Hill Hospital nine of the 22 patients were helped to claim partial attendance allowance. They started to spend more time with their relatives and were benefiting a great deal from this increased contact.

d) Failing to claim mobility allowance

This benefit is paid at full rate regardless of length of stay in hospital. At £21.65 a week (1986-87 rates) it is a considerable boost to residents' incomes. In spite of the tremendous difference which this allowance can make to a resident's quality of life, it is still heavily underclaimed by some hospitals.

Following our national survey in 1983 we looked at take-up of mobility allowance in a sample of 29 mental illness and mental handicap hospitals with over 14,000 residents. The number of residents in the mental illness hospitals who were claiming this benefit was very small – only 25 out of 7,418 residents. This may reflect the relatively small number of residents between the ages of 5 and 66 years who are unable to walk.

In contrast, 12.8 per cent of residents in the mental handicap hospitals surveyed claimed mobility allowance. However, this figure masks wide variations between the hospitals. In hospitals which were committed to the use of the allowance between 15 per cent and 25 per cent of residents were receiving it. Other hospitals reported as few as 3 per cent of residents claiming the allowance. It seems unlikely, even taking into account differences in the numbers of disabled residents, that this variation reflects the needs of residents. Rather, it seems to reflect the attitudes of hospital staff to claiming. The fact that of the 954 mobility allowance claims referred to in the survey, 170 had been made within the past year and another 100 applications were pending, suggests that in some hospitals staff are beginning to recognise that they can enhance residents' income by claiming this

benefit. Mental handicap hospitals with less than 15 per cent of residents receiving this allowance should review how much low take-up of mobility allowance plays a part in keeping the most disabled residents in poverty.

e) Clothing costs

In the section on personal allowance we refer to the difficulties residents face in keeping an adequate set of clothes on limited resources. It is clear that the personal allowance is not intended to purchase clothing. However, hospital authorities are not required to make good this deficiency, and schemes have been developed which channel personal allowance money into clothing funds, leaving little room for residents to choose alternative ways of spending income or savings.

> In Hospital A a personal clothing scheme has been devised which lays down that any resident with over £400 in a personal account should be asked to contribute £250 towards new clothing.

All too often hospital residents have no alternative other than heavily used items of clothing from hospital clothing stocks. Such schemes are an affront to individual dignity and provide no opportunity for choice and expression of self through clothing.

There are very real constraints placed on residents who turn to the state benefit system for help in this area. All supplementary benefit claimants have a right to claim a single payment (under SB Regulation 27(1)(b) SB (SP)) for clothing *prior* to hospital admission, but this is often difficult to establish and local DHSS offices take time to make decisions on such claims.

Once an individual has gone into hospital then the right to a single payment for clothing effectively disappears. Indeed, although under

supplementary benefit law there does appear to be provision for single payments to be made for clothing where the need is not due to ordinary wear and tear and in the normal course of events, for example where an item has been lost or damaged in hospital, the 'S Manual' which provides guidance to DHSS staff instructs adjudication officers to turn down claims made by hospital residents.

3) Limited access to income

While issues of basic income levels and low take-up are fundamental to the problem of poverty in long stay hospitals, it is equally true that many residents are denied access to their own money.

One of the few available government statistics on residents' money, set out in Table 2, shows that large sums have been accumulating in *some* residents' accounts since the introduction in the mid 1970s of non-contributory benefits such as NCIP (now SDA) and mobility allowance.

Table 2 Monies in residents' accounts (mental illness and mental handicap)*

1975	£9.7 million
1980	£25.8 million
1982	£37.5 million
1983	£43.5 million
1984	£46.0 million

* This money should not be confused with that managed by the Court of Protection, which deals with larger sums of capital and income.

Source: Bradshaw, M. 'Residents' money: a study of the control and use of residents' money by psychiatric and mental handicap hospitals', unpublished MSc dissertation, University of Birmingham, 1985.

There is a tendency among politicians, health administrators and health staff to cite these figures on accumulating balances as evidence that too much money is being paid to hospital residents. However, large sums of capital lying idle in hospital bank accounts are not symptoms of affluence but of an outdated and restrictive system which allows residents little say in how their own money is used. It is a system which encourages saving rather than sensible spending to enhance the quality of residents' lives. The power to decide how, and if, the money should be spent is vested in nurses, doctors and administrators, not in residents or their representatives.

Why do residents in our mental handicap and mental illness hospitals have so little control over their own money? Why does hospital admission strip people of their rights in relation to their income? Our research has highlighted six major reasons for this situation. They are related to both national policy and local practice.

a) relinquishing order books
b) problems withdrawing money
c) benefit reductions – the technicalities
d) benefit reductions – the practice
e) access to patients' 'banks'
f) deliberate non-claiming
g) appointeeship

a) Relinquishing order books

Our national surveys and interviews with residents and staff have revealed that it is almost universal practice for nursing staff to remove order books from residents on admission. The reasons given are that it is necessary to keep the books 'safe' or to send them to the DHSS for benefit reduction.

Claimants living in the community who have a change in benefit entitlement continue to cash orders (which are technically invalid) until a new 'book' comes through. They do not usually surrender a book until a replacement is issued. Income is maintained throughout

the change-over period, and any overpayments sorted out later. When a claimant becomes a resident of a mental illness or mental handicap hospital, this right and the control over income which it brings, are lost. The order book is relinquished and there is no choice but to wait, perhaps for months, until the new claim comes through.

There is a danger of clerical or administrative staff working for the convenience of the DHSS rather than the interests of residents. It is very worrying that several finance officers interviewed during our research saw themselves as 'keepers of the public purse' and were as concerned about overpayment as they were about low take-up of benefits. Demonstrating this concern by removing order books from residents takes no account of the hardship which results when residents have no income. Benefit downrating and the consequences of overpayment can be explained to residents on admission and the DHSS notified of a change in circumstance without order books being taken away. When residents retain their order books and bank books the provision of some form of lockable personal storage space would help them take responsibility for their own affairs.

b) Problems withdrawing money

Residents' problems start as soon as money goes into a hospital bank account for 'safekeeping'. This is because different staff have different ideas about what is reasonable for a resident to spend money on.

Mrs Y is 73 years old and has been in hospital for three years. Her granddaughter was getting married and Mrs Y was invited to the wedding. She was very pleased to have the opportunity to be with her family on this occasion. One of the nurses on Mrs Y's ward spent several hours talking to her about what she would like to wear, how she would travel to the wedding and back and what kind of present she would like to give the young couple. The nurse costed the day carefully and estimated that £80 would cover a hairdo, a new dress, coat and shoes, taxi fares and a present. With Mrs Y's agreement the nurse applied to the patients' accounts

department for £80 from Mrs Y's account; she enclosed details on how it would be spent. Several days later the nurse received a memorandum from the hospital administrator saying that the sum requested was 'excessive' for an elderly woman to spend on a day's outing and that £30 was the maximum that he would allow. Mrs Y has £350 in her account.

Such restrictions are not just applied to large sums of money. In all 15 mental handicap hospitals surveyed by the authors in 1984, residents had to get the signature of a member of staff before withdrawing *any* of their own money from the hospital bank or cashier. This restriction is imposed *irrespective* of a resident's ability to handle cash. To be forced to justify your need to use your own money is degrading and leads to a considerable loss of dignity and self-respect. It undermines any wider therapeutic efforts to increase residents' independence and ability to manage their own lives. Even in some of the mental illness hospitals where residents are allowed to draw a certain amount of money weekly it is generally nursing staff who set the limit.

Mrs A is 80 years old and has been in hospital for a year. She approached the Citizens' Advice Bureau based in the hospital because she was very anxious to discover whether her bills were being paid and she wanted to know how much money she had. She said that her pension book and savings had been taken from her when she was admitted to hospital. She understood that they were in the patients' bank, but said that she had been unable to get the information she wanted from the staff in the bank.

Mrs W was also concerned about access to her money. The hospital procedure is that patients have to obtain a 'chit' from the ward staff if they wish to withdraw more than £2 at any one time. Mrs W was upset and angry as the nurses always asked her what she wanted the money for, and sometimes would not give the authorising 'chit'. She said that when she did manage to get a 'chit' the staff in the patients' bank would also quiz her about why she needed the money:

'It's my money, isn't it? It's none of their business what I do with it. Why can't I have my pension book and pay the bills myself like I used to? I don't like the way it's all been taken out of my hands – I worry about how much I've got and whether I'm in debt. The patients' bank never tells me anything and the nurses say I shouldn't worry about it. But I do. I've always taken care of the money, even when my husband was alive.'

c) Benefit reductions – the technicalities

One of the most striking examples of the power which hospital staff have over residents' incomes is their role in decisions to reduce or stop an individual benefit at source. This power is quite separate from the procedures hospitals have developed to restrict the amount of money which residents can withdraw from their accounts.

It is important to realise that there are three different ways in which decisions restricting the amount of benefit a long stay hospital patient receives can be made:

i) where the responsible medical officer has full powers to make and implement decisions restricting or withdrawing the personal expenses the long stay resident receives. This power affects only those who are not entitled to any contributory or non-contributory social security benefit and who are excluded from supplementary benefit by regulation 12 of the Supplementary Benefit (Transitional) Regulations 1980. To be excluded from supplementary benefit the resident must have continuously been receiving in-patient treatment since before 17 November 1975 and on 24 November 1980 must have been over pensionable age but aged less than 80. 'Pocket money' for these residents is payable under section 133(1) of the Mental Health Act 1959 or under section 101 of the Mental Health (Scotland) Act 1960.

The DHSS memorandum HM(71)90, which provides guidance in this area, gives the responsible medical officer (usually the consultant) discretion to reduce benefit if 'the full standard weekly allowance

cannot be used by or on behalf of the patient for his personal comfort or enjoyment'. Similarly the accumulation of 'substantial savings in excess of his reasonable requirements' can be grounds for downrating or withdrawing benefit.

ii) where the responsible medical officer is not in law formally responsible for making a decision to reduce or withdraw benefit but where the practical effect is similar to i) above. This power affects only those who are entitled to contributory or non-contributory social security benefits. It does not extend to supplementary benefit. Regulation 16 of the Social Security (Hospital In-Patients) Regulations 1975 effectively passes to the medical officer treating the resident decision-making powers which do not appear to have been conferred by any regulations made under the Social Security Act 1975. Decisions under regulation 16 are legally the responsibility of the adjudication officer, with a right of appeal to a Social Security Appeal Tribunal. However, where the resident is unable to act on his own behalf and benefit is payable on his behalf to the hospital authorities, and the medical officer treating the resident issues a certificate stating that no sum, or that a sum less than the personal expenses rate, can be used for the patient's personal comfort or enjoyment, then the adjudication officer must adjust the weekly rate of benefit. The adjudication officer, and therefore the Social Security Appeal Tribunal, has no discretion in this matter.

iii) where the responsible medical officer's role is restricted to issuing a certificate stating that all or part of the resident's benefit cannot be used by him or on his behalf and where the adjudication officer has effective decision-making powers. This applies only to supplementary benefit. After the resident has been a patient for a continuous period of more than one year, paragraph 2(e) of Schedule 3 to the Supplementary Benefit (Requirements) Regulations 1983 triggers a review of the resident's right to benefit. If the resident is unable to act on his own behalf, and his benefit is paid to the hospital authority as, or at the request of,

his appointee, and the responsible medical officer treating him certifies that all or part of his benefit cannot be used by him or on his behalf, the resident's entitlement to supplementary benefit becomes 'nil or such amount as the adjudication officer considers reasonable having regard to the views of the hospital staff and the patient's relatives if available'.

Thus in supplementary benefit cases alone the adjudication officer is free to have proper regard to the hospital staff's views that the resident cannot use all or part of his benefit but nevertheless go ahead and award benefit at the full personal expenses rate. The adjudication officer's power to do this does mean that a successful claim to supplementary benefit could be made following the reduction or withdrawal of a social security benefit under regulation 16 of the hospital in-patients regulations.

However, although supplementary benefit law formally gives the adjudication officer independent decision-making powers, the nature of the guidance to adjudication officers is blunt and restricts their role so that the practical effect is similar to the effect on the social security side. Paragraph 3761 of the 'S Manual' says:

'If a certificate limiting the amount of hospital personal expenses allowance which may be paid is in operation, only reassess the case if a medical officer treating the patient revokes the certificate in writing.'

The standard letter advising the hospital authorities (where they are the resident's appointee) or the resident's actual appointee (on forms DLSB/A8 and A9 respectively) of the reduction or withdrawal of supplementary benefit similarly reflects this narrow view of the adjudication officer's role.

Paragraph 3759 of the 'S Manual' instructs adjudication officers to seek the views of the responsible medical officer treating the resident using a standard letter, DLSB/A7. The reverse side of the letter acts as the 'certificate'. The medical officer is asked to state how much (nil if appropriate) could be used each week 'for the personal comfort or enjoyment of the patient'.

Adjudication officers are given no guidance on seeking the views of the patient's relatives. Even where a relative is the appointee (and benefit is being paid via the hospital authorities at that appointee's request), the DLSB/A9 notification does not specifically seek the appointee's views. The appointee is simply advised of the right to appeal. The onus is on the relatives to make their views known.

d) Benefit reductions – the practice

The legal powers and the practical implementation of those powers described above reinforce a strong paternalism which came across to us again and again in the comments of the staff in hospitals we surveyed. The notion that 'we know what is best for our patients' was applied to all residents irrespective of their abilities or legal status. From our findings it would appear that the practice of reducing and withdrawing benefit is widespread, with some exceptions.

Of the 14,846 residents in our sample survey of 29 hospitals, 723 had their income reduced at source following a medical recommendation. This is almost 5 per cent of residents. However, there was substantial local variation. Almost half of the hospitals (14) did not reduce benefits – nine mental handicap and five mental illness hospitals. In the other establishments between 5 per cent and 46 per cent of residents had reduced benefits.

One mental handicap hospital in our survey with 770 residents reported that all residents were on full benefit. Another mental handicap hospital surveyed said that 161 of their 489 residents had had their benefit reduced by the responsible medical officer. There was no evidence of any great differences in the age structure or disabilities suffered by residents in these two hospitals.

It is most unlikely that the populations of our long stay hospitals differ greatly in their ability to 'appreciate' cash or 'comforts'. We are forced to conclude that there is great variation between hospitals in the use of powers to reduce income, due to differences in local policy which are unrelated to resident need.

The Disability Alliance along with MIND and MENCAP see benefit reduction as a gross infringement of an individual's right to a guaranteed basic income. They have long advocated the abolition of medical officers' powers to reduce benefits, which our research suggests are being used in a haphazard fashion. Residents have a legal right to appeal against any decision taken by an adjudication officer. In practice this right is redundant where the appeal concerns benefits under the Social Security Act 1975. Regulation 16 of the Social Security (Hospital In-Patients) Regulations 1975 specifically provides that where the claimant is unable to act and his benefit is payable on his behalf to the hospital as his appointee, the adjudication officer can only award such amount as is recommended by the medical officer treating the resident. In supplementary benefit cases, though, the adjudication officer (and thus a Social Security Appeal Tribunal) is free to come to his own decision, having taken note of the views of the hospital staff and the patient's relatives. However, in practice where the hospital authorities are also acting as the patient's appointee for supplementary benefit purposes they are unlikely to exercise their duties as his appointee and appeal against a decision made on their own recommendation. It is fair to say that the legal structure is in a mess.

It is unfortunate that, rather than remedy this situation, government ministers, together with hospital auditors and administrators, continue to focus their concern on the the capital sums accumulating in hospital accounts. Instead of viewing the £46 million of unspent benefits as a massive failure on the part of the health service to ensure that residents' lives are enhanced, it is seen as a justification for reducing residents' incomes still further.

In 1983 the Oglesby report which reviewed attendance and

mobility allowances recommended that a limit of £1000 be imposed on the amount of mobility allowance that could be saved in patients' accounts.[5] This recommendation would, quite wrongly, extend the power of the hospital staff to request the DHSS to withdraw the allowance when this limit was reached.

In our view accumulated balances reflect problems of institutional management, not the inability of residents to appreciate extra income. Difficulties in spending mobility allowance do not arise for claimants who live in the community, because they have a much greater scope for spending and often have an advocate (friend or relative) who can support and advise them. Hospitals must confront this problem and help residents use this allowance, not evade the issue by withdrawing the right to benefit.

e) Access to patients' 'banks'

Many mental illness and mental handicap hospitals have established 'banks' or cashier systems following the recommendations of HM(71) 90 for reducing fraud and misuse of cash. These banks are very different from the high street banks which most people are accustomed to. If you are a hospital resident you cannot use the hospital bank to withdraw your own money on demand.

> On the day Miss B was being discharged from hospital she needed to find private rented accommodation. She had contacted a couple of housing advice agencies who had given her some addresses and she had bought copies of the local papers. She wanted to draw out her money from the patients' bank – approximately £350 – to have enough money to pay for a deposit on a flat.
> Miss B had been told by the patients' bank that she could have £50 and the rest would be forwarded to her by cheque. Miss B was annoyed and upset about this as she had calculated that she would need about £150 in order to pay a deposit. She contacted the CAB for advice and when they telephoned the district treasurer's department on her behalf they were

told that it was health authority policy that withdrawals over £50 required authorisation from the district finance officer. After some discussion it was agreed that in the circumstances Miss B could draw out as much as she required. Miss B subsequently withdrew £150 which she considered was enough cash to be carrying around.

In the mental handicap hospitals we surveyed, residents not only needed a signature from the ward staff to get access to their own money, they were also restricted to a limit on the amount they could withdraw and had to give notice of a withdrawal. Some hospitals required one to two days notice of a withdrawal, most between two and five days and one asked for *at least* five days notice before a withdrawal. In addition, bank opening hours were restricted – in three of the hospitals to a maximum of two hours a day. In these circumstances spontaneity is impossible. Residents are unable to go out shopping or for a meal without sufficient prior notice.

The banking systems which operate in our long stay hospitals meet the needs of the institution by reducing the handling of cash by ward staff, but do not meet the need of residents for a flexible and accessible method of controlling their own money.

f) Deliberate non-claiming

A further aspect of income control which is closely linked to the issue of low take-up is the deliberate non-claiming of benefits for residents, particularly mobility allowance. The second report of the Development Team for the Mentally Handicapped (1978-9) notes 'it is clear that many hospitals who are acting on behalf of patients not capable of handling their own affairs are not claiming mobility allowance to which patients are entitled. Among the reasons given are administrative indecision in providing the opportunity for spending the money or in designing a method of accounting for it'.[6] These criticisms are still valid on the evidence we have gathered. The variation in claims presented in the earlier section on mobility allowance

demonstrates marked differences in hospital practice. Some of our conversations with hospital administrators suggest that it was not ignorance about mobility allowance that prevented staff claiming it on behalf of residents but a deliberate decision to avoid the 'problem' of accumulating balances. Without advice and representation, residents in hospitals where benefits are deliberately not claimed, are left unable to question policies which are not in their interests.

g) Appointeeship

Many hospital administrators, acting as appointees for residents, clearly believe that they are safeguarding the financial interests of residents by not allowing them to spend their income, instead leaving it to accumulate. Fears of fraud and misuse of residents' money were shared with us by administrators. The problem with all money systems which are developed purely because of fear of fraud is that they emphasise saving and careful accounting at the expense of ensuring that residents are able to use their own money to improve their quality of life. The checks such systems build in not only keep residents from their own money, they discourage staff from developing practices which would enable residents to use their incomes to the full.

A ward sister responsible for 30 elderly women in a psychogeriatric ward of a mental illness hospital described the system which she has to use in order to obtain any money for her residents.

'It's all forms and signatures and accounting for every penny. I don't mind that, there needs to be checks, after all you must make sure it's the patients who benefit. What annoys me is that the finance people make you feel it is *their* money you're spending. They've got all the forms and the receipts but they are still hassling you about whether it is "necessary expenditure". Some of my patients wanted their own special soap and talc, something they could choose and use that wasn't hospital issue. They've all got money

of their own in the bank, but the questions I got asked about those toiletries – in the end, I'm ashamed to say I gave up. The patients are disappointed, but I didn't have the time or energy to keep battling away at the administrator.'

One way of separating appointeeship from the hospital administration is to use 'external' appointees (usually a relative) for those residents who cannot manage their own affairs. However, this solution has its drawbacks. In our 1983 national survey, 18 per cent of the hospitals reported that relatives acting as appointees often did not provide cash or comfort for their residents. It is difficult to quantify the scale of abuse in this area. In our 1984 follow-up survey administrators reported that 7 per cent of residents had external appointees. It was estimated that around 14 per cent of these external appointees did not fulfil their obligations. Again, there were wide variations in estimates between hospitals – one mental illness hospital reported problems with almost half of the 87 external appointees while at another no problems were mentioned. In our discussions with finance officers it seemed that problems tend to occur with the more economically active residents. When ward staff want to arrange a trip or holiday and find there is no cash in a resident's account, administrative staff are left to 'chase up' appointees and can experience considerable friction with relatives.

It is unclear, however, how many relatives were actually withholding money; some may have been using it to cover the not inconsiderable costs of visiting or saving cash for when a resident returned home.

While some external appointees can provide a much needed antidote to bureaucratic inertia and accumulating balances they are clearly not the answer to all the problems residents experience with their finances.

Part 2
Action to combat poverty in long stay hospitals

It is clear from our discussion of the factors which combine to exacerbate the financial problems faced by hospital residents that the policies, attitudes and procedures found in hospitals as well as national policies, all play a part. This suggests that there are a number of levels at which action can be taken to improve the financial circumstances of hospital residents.

The first important step which staff in the health and social services need to take is to recognise the importance of income as an issue for residents. If staff are concerned to provide the best service possible with the limited resources available they cannot afford to treat residents as if their social and economic circumstances were irrelevant. They need to confront the facts of poverty directly, talk about them to residents and work to tackle the problems poverty creates. Residents should be able to expect that their financial circumstances are not treated as 'side' issues or 'irrelevancies' by staff. Choice, control and a feeling of well-being are all influenced by access to adequate income and residents should receive recognition of this from staff who are prepared to advise and help them.

In the next section we outline the action which hospital staff can take to tackle this issue. We look at the three main areas we have highlighted as contributing to patient poverty, and draw on examples of good practice which have been developed up and down the country.

Raising income levels

Hospital 'pocket money'

In cases where no social security benefits are available, hospitals

should establish a clear policy with regard to the money they provide for individual use. Such a policy should not only specify income level but also clarify patients' rights in regard to withdrawing and spending money.

Personal allowance

Hospitals must regularly review the policies and practices they have developed about the use of residents' personal allowances. The consequences for residents of 'voluntary' savings schemes for such items as clothing, holidays and funeral expenses need to be examined in detail. Any scheme which reduces residents' weekly income needs to be fully explained and discussed with residents.

Claiming benefits

The failure to ensure that every hospital resident is receiving the maximum income available from the state reflects the lack of an adequate information and benefit advice service to residents. The DHSS does not make sufficient provision for claimants in this area, and hospital staff must recognise this. While it is a matter of debate whether it is the job of a hospital to provide information, advice and support in relation to benefits, the fact remains that without such a service many residents are living on less income than they are due. This results in insecurity and worry about what is happening both inside and outside hospital.

A variety of approaches to increasing benefit take-up have been devised by hospital staff. Some of these rely on hospital resources while others draw on staff from voluntary organisations, social services departments, law centres and social work courses. All hospitals should give serious consideration to what combination of these approaches would suit their needs. They include:

a) *A specialist hospital finance officer* to assess the income of newly admitted residents and help them claim their full entitlement.

b) *A hospital welfare rights worker* to provide benefit advice and assistance to residents; liaise with the DHSS, fuel boards and local authority departments; provide regular benefit training to staff and residents. Such a person could be appointed by the hospital or the relevant social services department.

c) *Hospital take-up campaigns* to publicise available benefits and involve staff in helping residents and relatives increase their incomes.[1,7]

d) *A Citizens Advice Bureau* or similar independent advice agency based in the hospital to provide specialist advice and advocacy to residents and staff. (The recent Good Practices in Mental Health publication gives detailed information on existing projects of this kind.[8])

Residents' income will not be maximised until hospitals take action on clothing costs. If residents are unable to claim additional benefit for clothing then hospital staff need to develop clothing systems which do not deprive residents further by reducing income and dignity.

Three steps which avoid the use of residents' personal allowance for clothing

a) Establish a main budget bid for residents' clothing on the grounds that individual clothing is as important an item as food or building maintenance.

b) Ensure that clothing money is available for residents to spend themselves (that is, money credited to individual accounts, not vouchers).

c) Provide opportunities for residents to choose clothing and express their tastes. This will include staff help and encouragement for the most disabled residents.

Improving access to income

Action on income control needs to take place on a number of fronts in any hospital. All too often the focus of hospital concern in this area is savings accumulating in residents' accounts rather than the more widespread and often related problem of denying patients access to their own income. On the basis of our findings we consider that all action has to be directed at evolving a 'resident-centred' system of income management. Such a system can be developed using the following checklist to assess policy and procedures from a resident's point of view.

Twelve questions to ask about any residents' money system

1 Do residents retain their benefit order books on admission? If not, why not?

2 Is secure storage available for residents to keep cash and valuables safe?

3 What banking facilities, inside and outside of the hospital, are available to residents?

4 What assistance is provided to help residents choose and use a banking system?

5 What services does the hospital-based banking system provide for residents – for example, bank statements, regular opening hours, withdrawal on demand?

6 If the hospital banking system does not provide equivalent services to a commercial bank, why is this the case?

7 What restrictions are placed on residents' use of their own money and why?

8 What happens when residents begin to accumulate large balances in their accounts? Why?

9 How many residents have their benefits reduced at source? Who takes these decisions? What are the grounds on which they are taken? Are residents involved in such decisions?

10 How many residents have appointees outside the hospital? For how many residents is the hospital acting as appointee? How are the interests of the residents being protected in both situations?

11 What opportunities do residents have to spend their income on items of their own choosing?

12 What group is responsible in the hospital for reviewing residents' income and ensuring that each resident is able to exercise choice and control in this area? Are residents represented in this group?

In addition, action has to be taken to ensure that residents, often the most immobilised and deprived, make the maximum use of money which all too often accumulates. There are a number of schemes which can be developed here. They include:

Mobility aides – increasing the use of a resident's mobility allowance to pay an individual to come regularly into the hospital to take the resident out.
Transport hire – increasing the use of residents' money to hire cars or coaches to provide individuals or groups with opportunities to get out of the hospital.
Holidays – the development of a greater range of choice in holidays which are offered to residents, breaking away from the standard packages for ward groups in seaside boarding houses.

Calderstones Hospital, Lancashire, which has pioneered the take-up and imaginative use of mobility allowance, has a travel agency in the hospital. The agency is open all year round and staffed by a nurse. The agency has a world-wide range of holidays to offer residents and all residents are

encouraged to visit the bureau and choose where they would like to go. Guidance is provided by the nurse at the agency about cost and suitability. The agency does the paperwork as a service to the ward staff who remain fully responsible for their residents. For the more severely disabled residents who are unable to express their preferences nursing staff draw up holiday proposals which are then submitted to a committee of staff and residents for consideration.

Calderstones considers that no resident is too disabled to appreciate a holiday, and the aim of this service is to provide one for every resident. This means making maximum use of the mobility allowance to supply the most disabled residents with individual escorts, either staff or relatives and friends. Staff have noted a marked decrease in disturbed behaviour and the need for medication when residents are relaxed away from the wards.

Personal items There is considerable scope for increasing opportunities for residents to buy items for their own use and pleasure. This will involve the time of staff, volunteers or advocates in assisting residents to determine their needs and how these can be met. Wherever possible, residents should have opportunities to choose from a range of goods outside the hospital.

Advocates The use of volunteer advocates working with residents on a one-to-one basis leads to increased control and better use of patients' money. The Advocacy Alliance has pioneered the use of advocates in this country and their work to date demonstrates some of the benefits which residents experience.

John Hadley, a resident at St Ebba's Hospital, has chosen Maureen Monksley as his advocate. In Maureen's words, 'Before John had an advocate he didn't have a social life apart from outings with the ward, but now he does. He goes swimming and horse-riding. He comes to my home

once or twice a week. I'm his appointee now, which means I look after his money, so John has ready access to his money whenever he decides to go out'. *It's my life anyway*[9]

Conclusions

The topic of poverty amongst the 112,500 or so residents of our mental illness and mental handicap hospitals has been absent from professional and administrative agendas for too long. Lack of rights to income, low income levels and lack of control of and access to income is the reality of life for too many hospital residents. The consequences for individuals are deeply felt yet all too often ignored or dismissed as 'irrelevant' by those involved in caring for them.

A great deal of the blame for the present state of affairs can be laid at the door of central government, which has failed to provide clear guidelines to hospital staff on how residents' money can be used to improve the quality of life. The overwhelming impression gained by surveying some of the largest long stay hospitals in the country is one of confusion and a wide variety of procedures and attitudes. A few hospitals were quite exemplary in their approach to residents' finances. They had carefully researched the issues, established good banking systems and employed teams of nursing and advice staff to assist residents to maximise income and spend it wisely. Others displayed attitudes which were more appropriate to poor-law institutions of the 19th century; claim rates were low, opportunities for spending were minimal, and there was a large measure of ignorance about the benefit system and the possibilities of using the mobility allowance for purposes other than mobility.

Recommendations

At hospital level

1 Hospitals should be required to compile and publish statistics on

the sources, expenditure, accumulation and downrating of residents' incomes.

2 Residents' finance committees should be established in every hospital to oversee the control of residents' money. These should be multi-disciplinary bodies with residents and relatives represented, and chaired by someone from an independent agency such as MIND, MENCAP or Advocacy Alliance.

3 Residents should be encouraged to retain their own order books wherever possible, and provided with secure storage for these and other valuables.

4 Hospital banks should be improved to give maximum flexible access to savings. Full statements of benefit details, debts and capital should be available to residents on request.

5 Central NHS finance should be made available to provide a reasonable standard of clothing for all long stay residents.

At government level

1 The following recommendation of the Social Services Committee which looked at community care with special reference to adult mentally ill and mentally handicapped people should be implemented:

That the Government provide an analysis of the likely effects of the proposals contained in the social security reviews on the benefit entitlements of mentally handicapped and mentally ill people.[10]

2 A revised version of HM(71)90 should be published as soon as possible, giving clear guidelines about the control and use of residents' money. In particular, all restrictions on the use of mobility allowance should be removed.

3 Medical discretion to reduce income at source should be ended.

4 All residents should have a legal right to state benefits. Payment of supplementary benefit and social security benefits at the personal expenses rate should be put on a common footing with the standard amount payable being the full personal expenses rate and, if it is felt necessary, giving the adjudication officer the power to reduce that rate having regard to the views of the hospital staff and any relatives. Such a power should in all cases be subject to a formal reference to a Social Security Appeal Tribunal. The latter requirement would avoid the invidious position hospital authorities may find themselves in where they cannot properly both recommend a reduction in benefit and exercise their duties as the claimant's appointee.

5 The Oglesby proposals to allow downrating of mobility allowance should be rejected.

Useful addresses

The following agencies provide relevant publications, information and advice on the income of people in long stay hospitals. In addition, hospital staff and residents should compile a list of local advice and representation agencies which offer information, training and support. Your local Citizens Advice Bureau should be able to help with this.

Advocacy Alliance
115 Golden Lane
London EC1 0TJ

Campaign for People
with Mental Handicaps
12a Maddox Street
London W1R 9PL

Child Poverty Action Group
1 Macklin Street
London WC2B 5NH

Court of Protection
Staffordshire House
25 Store Street
London WC2

Department of Health
and Social Security
Mental Health Division
Alexander Fleming House
London SE1 6BY

Disability Alliance
25 Denmark Street
London WC2H 8NJ

Good Practices in Mental Health
380-384 Harrow Road
London W9 2HU

King's Fund Centre
126 Albert Street
London NW1 7NF

MENCAP
123 Golden Lane
London EC1Y 0RT

MIND
22 Harley Street
London W1N 2ED

References

1 House of Commons. Community care with special reference to adult mentally ill and mentally handicapped people. Second report from the Social Services Committee, session 1984-5. (Chairman, Mrs Renée Short.) London, HMSO, 1985.

2 Department of Health and Social Security. Hospital memorandum on patients' money. DHSS, 1971. HM(71)90.

3 Shearer A. The poor in hospital: a study of the incomes of people living in long-stay hospitals and residential homes. London, Disability Alliance, 1976.

4 Davis A and Hayton C. Who benefits? The Rubery Hill benefits project. Birmingham Tribunal Unit and Department of Social Administration, Birmingham University, 1984. A video on the project is also available.

5 Oglesby P R. Review of attendance allowance and mobility allowance procedures. DHSS, 1983.

6 Development Team for the Mentally Handicapped. Second report 1978-1979. London, HMSO, 1980.

7 Davis A. Welfare rights and mentally ill people. Social Services Research, volume 13, number 5, 1984: 77-92.

8 Good Practices in Mental Health. Advocacy information pack: advice and advocacy services for people with psychiatric disabilities. London, GPMH, 1986.

9 Advocacy Alliance. It's my life anyway. Open Space, 1984.

10 See 1 above, volume 1, paragraph 147.

Good Practices in [illegible]
advice and advocacy [illegible]
disabilities. London, [illegible]
Advocacy Alliance, [illegible]
See 1 above, volume 1, [illegible]

Some of the poorest people in Britain today live in our mental illness and mental handicap hospitals. They face considerable hardship because they do not have enough money to meet their needs — a position which may well get worse as a result of impending changes in the social security system.

This lamentable situation in long stay hospitals has never received adequate attention from government, health professionals or researchers. 'Not a penny to call my own' describes the predicament faced by so many hospital residents and examines the reasons why their income is inadequate.

Drawing on the findings of a national survey of residents' money in mental illness and mental handicap hospitals, the authors demonstrate how welfare benefits policies and the administration of residents' money in hospital play a part in creating poverty. They also suggest steps that staff working in the health service can take to tackle this problem and thereby improve the quality of hospital residents' lives.

King Edward's Hospital Fund for London

DISABILITY ALLIANCE EDUCATIONAL AND RESEARCH ASSOCIATION

£3.00

ISBN 0 946336 21 0