Abstract

Objectives: This review aims to identify factors that facilitate the establishment of Enduring Powers of Attorney (EPOAs), and those factors that create a barrier to their establishment. The primary aim was to provide guidance as to how future-planning might be encouraged while people are cognitively able to make such important decisions.

Method: A detailed search of the literature was conducted to identify research looking at the motivating factors behind putting in place future-planning strategies.

Results: The literature highlighted a number of broad areas motivating the establishment of EPOAs, including demographic factors; intrapersonal & personality factors; health & psychological factors; cognitive factors; and socio-emotional factors.

Conclusions: While a number of factors play a role in determining whether or not a person establishes an EPOA, the factor most malleable to change is that of increasing the awareness and knowledge of older adults and their families with regards the utility of EPOAs.

Key words: power of attorney, older adults, substitute decision making

Introduction

As people age, they become increasingly at risk of health and medical issues that can have an impact upon cognitive function beyond that of normal ageing [1]. Deficits in cognitive function can have a range of consequences in terms of everyday function, and for the purposes of this paper, the focus is on one such example, diminished capacity. Diminished capacity, however, does not necessarily imply global dysfunction. There may be specific domains in which an individual lacks capacity and targeted assessments can reveal under what circumstances an individual is, or is not, able to contribute to their own decision-making processes. One such example of a specific domain of functioning is that of financial capacity.

Financial capacity assessment aims to measure how well an individual can manage their own financial affairs, ranging from tasks such as the management of complex share portfolios, to more day-to-day financial activities such as paying bills, shopping, and counting coins. Where financial incapacity is identified (whether for more complex financial activities alone or at a more global level of dysfunction), there are formal and legal
arrangements that can be put in place. This means that any person of the individual’s choosing can be involved in financial decision making processes (and other financial activities) to help counter such deficits in functioning. Despite the availability of such arrangements, they are often not well utilised by older adults. The fundamental aim of this review is to explore the disinclination towards such future planning, beginning with a brief overview of Enduring Powers of Attorney (EPOAs).

In Australia, an EPOA can be put in place as a formal and legal means of ensuring that the financial affairs of an older adult continue to be well managed and in keeping with decisions that the older adult might make if they were capable of doing so themselves. It is executed at a time when the person is still considered to have the capacity to make such a decision and to put in place such a plan. In brief, an EPOA is a legal document in which an adult authorises one or more people to act on their behalf, with regards financial matters, where they are unable to act on their own behalf. The person taking out an EPOA may specify under what circumstances the power to manage financial matters becomes active, or if no such information is provided, the EPOA comes into effect once the EPOA is created. There are slight variations between Australian states as to how, for example, EPOAs are enacted, however the underlying principle as to the function of an EPOA remains the same. Where the situation arises in which an individual is no longer able to manage their financial affairs and a substitute decision maker must be determined for them, it is often a Guardianship Tribunal (or similar body) who is asked to authorise an appropriate person. This means that the person allocated may not be the same person who the individual themselves would have chosen. This can result in decisions being made that are not in the best interest of the person, that the person themselves would not have made, and in some situations to financial abuse [2]. A Guardianship Tribunal can only intervene in the situation of financial abuse if they are made aware of the situation [3]. Similarly, such tribunals can only work with the information they are presented with and so omission of details, as well as inaccurate information, may inadvertently affect the tribunal’s final decision. It is therefore considered advantageous to have an EPOA, or other such method of future planning in place while an individual can make such decisions for themselves.

Despite such issues, a qualitative study by Brown indicated that few participants had actually put in place an EPOA, despite being familiar with the term and the reasons for having an EPOA [4]. Setterlund, Tilse, and Wilson noted that only 40% of older adults in the community and 57% of older adults in aged care had put in place EPOAs [5], while in their
2002 study, the results were 34% and 73%, respectively [3]. Fowler & Fisher’s research indicates that people are more inclined to put in place EPOAs once an urgent need to do so arises [6]. The urgency of such decisions often leaves little time for consideration of who would be the best person to choose, which can result in a number of potentially less than optimal outcomes, as already noted. Those involved in this process are often already experiencing a high level of distress, which does not necessarily form a sound basis upon which to make informed decisions [7]. In addition, the pattern of research to date is such that a high proportion of research focuses specifically on financial abuse, rather than on how older adults and their families might be encouraged to put in place such things as EPOAs at a time when the older person is still cognitively able to make well-informed and reasoned decisions about their future and that of their family. This is considered particularly important because cognitive deterioration can be insidious in nature.

The overall aim of this paper then is to provide a review of the reasons people choose to have in place an EPOA while still cognitively healthy, with a view to providing information as to how this might be encouraged further in older adults. Motivational research tells us that in looking at the behaviour of individuals, it is akin to telling half the story if we look only at why an individual chooses to plan, in this case, for a dependent future. Therefore, consideration will also be given as to why an individual might choose not to put in place such plans, to have an appreciation for what hinders such behaviour. As such, it is appropriate to briefly explore models relevant to encouraging future planning.

Theoretical Basis of Planning for a Dependent Future

Research highlights a variety of models to help explain why some people are more inclined to choose to plan for a dependent future than others. Fundamentally, motivation plays a role in such a decision and so, rather simplistically, while the balance of motivational forces lies with the side of not putting plans in place, an individual will not actively seek out concrete ways of planning for a dependent future.

Theory of planned behaviour

The theory of planned behaviour captures the idea that the intention to carry out behaviours is reliant on an individual’s attitude towards the behaviour, their subjective norms, and their perception of control over the behaviour [8].
In the context of planning for a dependent future, the theory of planned behaviour suggests that if an individual has the attitude and subjective norms in place that encourage the completion of an EPOA, then they are more likely to carry out that behaviour. In addition, if the individual believes that they have some degree of control in terms of putting in place an EPOA, they will also be more inclined to enact a forward planning strategy.

**Curvilinear model of planning and control**

Scholnick and Friedman proposed that a curvilinear relationship exists between the processes of planning and control [9]. Specifically, they suggest that individuals who have a high sense of control may not plan because they hold a false sense of security in regards to how much control they have. Similarly, individuals who have a low sense of control tend not to plan because they fail to see what influence they might have. Those who are most likely to plan are those with a moderate sense of control, who are planning in an attempt to increase their sense of control.

This model suggests that those older adults, who either feel they have a good level of control over their future or no control, are less likely to put in place such things as EPOAs, failing to see the benefit given their perception of degree of control. Instead, it is those older adults who have some sense of control, but also recognise that there are limits to that control, who are the most likely to choose to put in place an EPOA.

**Socioemotional selectivity theory**

The socioemotional selectivity theory [10] highlights the notion that time plays a part in what types of goals a person looks to achieve. If time is seen as open-ended, people tend to focus on goals of knowledge acquisition. When time becomes more precious, the focus turns to emotional goals.

In thinking specifically about future planning, socioemotional selectivity theory would suggest that it is only when the sense that time is running out becomes quite palpable that the motivation to put in place plans for a dependent future are enacted. The preciousness of time highlights that the status of family relationships, preparations for their financial future, and the like, are important things for consideration.

The theoretical basis of planning for a dependent future offers hypotheses as to what might motivate an older adult to put in place such plans. In addition, it helps to establish what
forms of interventions might be best to consider if such positive actions towards being prepared for the future are to be encouraged. The following review of the literature contributes further by identifying what specific strategies might be utilised to encourage such forward planning behaviours from within an applied perspective.

Method

A comprehensive literature search was carried out within the electronic databases of PsycINFO, PubMed and Google Scholar. The inclusion criteria were: peer-reviewed articles on the topic of putting in place planning for a dependent future, with a specific focus on financial-based enduring powers of attorney; no time limit; written in English. Key search terms included ‘enduring power of attorney’; ‘power of attorney’; ‘future planning’; ‘substitute decision making’; ‘older adults’; and ageing, with both individual and combinations of keywords used to identify relevant literature.

It became readily apparent that the research was limited with regards the establishment of financial-based EPOAs (or their equivalent in other countries), and so the inclusion criteria was broadened to include establishing Advance Care Plans (ACPs) or Advance (Health) Directives (ADs). Given that each form of future planning is designed to put in place strategies to help compensate for a time when a person is no longer able to make decisions for themselves, the research in this area was considered relevant in identifying methods that could encourage older adults to put in place such future-oriented plans. A total of 65 articles were identified based on a title and abstract search. A careful review of each article identified 13 papers specifically dealing with the topic of why older adults do or do not put in place formal plans to manage a dependent future.

Results

It was interesting to note that in some cases, families had not considered putting in place formal plans for the future, despite caring for a relative with dementia and seeing the progressive deterioration [11]. This was also despite reporting that they were concerned about the future and the associated uncertainty. Across time and with further deterioration, the implementation of plans (for health care, property management, living wills, etc.) did, however, increase. This was in keeping with more recent research by both Fowler and Fisher, and Samsi and Manthorpe, which indicated that people were inclined to wait until there was an actual and concrete need to put in place such plans [6,12]. A diagnosis of dementia was
likely to prompt planning, while a more acute diagnosis such as an illness likely to result in death within a short period of time was less likely to inspire future planning, with living for the moment being the focus instead [12]. Other research showed that seeing other people experience issues with their health or cognition did promote the establishment of future plans [13,14].

Brechling and Schneider noted that part of the reason for not implementing future plans seemed to be a lack of knowledge, going on to suggest that it may be the responsibility of doctors, social workers, and other such professionals (who characteristically have direct contact with an older adult and their families) to provide information on such things [11]. Similarly, given the increased opportunity for general practitioners (GP) to interact with older adults, these professionals were considered well-placed to initiate discussions of future planning [12]. Other research has also highlighted that discussion about advance planning with legal and health professionals prompts such plans to be put in place [14]. There was also a suggestion, however, that if the individual’s relationship with their GP was limited in any way, such as not seeing the same GP each visit or having a lack of trust, the older adult would be less open to such discussions [12]. Rosnick and Reynolds found that discussions with family and friends about the topic of future planning tended to increase the chances of people actually putting such plans in place [15]. Consideration must also be given to culturally-diverse groups who tend to have limited knowledge of the strategies they might put in place to help cater to future changes in capacity [3,5]. Clearly there is merit in not only discussing the topic as a means of promoting the idea of putting in place plans for a dependent future, but also as a means of educating older adults and their families with regards the legal options that are available.

Brown found that participants were disinclined to put an EPOA in place because they saw this as opening up the potential for abuse of power by the person(s) chosen to be their agent [4]. Fear of abuse and being exploited has also been identified by Setterlund et al. as being a contributing factor against establishing an EPOA [5]. In particular, complex family relationships often made it difficult for individuals to determine who would be the best person, if any, to allocate to the role of substitute decision maker.

Research has also established that participants were less inclined to put in place formal future planning arrangements if they had family who they felt could be relied on as informal substitute decision makers [12,16]. This removed the need for formal arrangements,
which were considered too restrictive and subsequently not thought to offer an ideal solution to the issue of future planning. Setterlund et al. pointed out, however, that if the family unit was complex in nature (such as step-children, difficult relationships, and the like), future plans were not as likely to be considered at all given the difficult nature of identifying someone to act on the individual’s behalf [5].

Individuals who had a higher desire for control were more likely to put in place future plans [17,18]. Conversely, it was found that people who avoided thinking about planning for their future care needs also avoided the levels of depression and worry that people who actively thought about the future experienced, indicating avoidance as a coping strategy, albeit suboptimal [19]. People thought planning for the future was a good idea, but they would wait until they “… got older, in worse health or when it seemed ‘more appropriate’ to do so” [12, p.56].

Finally, planning for a dependent future was also influenced by more concrete factors such as socioeconomic status. People who had little money to worry about felt that planning for the future was not warranted [12]; a result also supported by other research in the area [5].

By way of summary, Table 1 highlights those factors identified in the research to date as increasing the likelihood of older adults putting in place such things as EPOAs or ACPs.

{INSERT TABLE 1 HERE}
Discussion

While offering the opportunity to put in place firm strategies towards managing a dependent future, EPOAs are not as commonly used as might be expected. In addition, there is little research in the area to help guide how the use of such strategies might be encouraged. The theoretical underpinnings of planning help highlight potential factors that may impede future-focused plans, providing atheoretical basis upon which decisions about how planning for a dependent future might best be encouraged. In addition, they help to guide research in the area, providing good foundations upon which to not only continue developing such theories, but also to attempt to utilise them at a more practical level.

Table 1 highlights a number of characteristics associated with an increasing likelihood of future planning. It is interesting to note that the decision to put in place an EPOA is not necessarily reliant on the motivation levels of the individual per se, but may also be related to the context in which a person finds themselves, including cultural considerations, socioeconomic status, and marital situation. However, only some of those are relevant to consider in looking at how this might be applied to everyday practice.

Specifically, factors appearing in the ‘Socio-emotional Factors’ column are noted to lend themselves more readily to developing strategies to encourage forward planning. In summary, these include discussions with others and discussions with legal or health professionals on the topic of forward planning. In terms of everyday practice then, encouraging legal and health professionals to raise the topic of future planning would be a useful starting point. In addition, more structured education sessions offered at a community level may also prove useful.

Conclusions

Clearly, a range of factors come into play when older adults are deciding whether or not to take the formal step of putting in place such future planning options as EPOAs. With increasing life expectancy and the impact of changes in cognitive functioning (both in the presence and absence of an organic issue), it is worthwhile considering the notion of putting in place plans that will make for a more manageable future.

This review has highlighted those factors that have been found to increase the likelihood of an older adult putting an EPOA into effect. Some lend themselves more readily to an intervention-based strategy to encourage implementation, while others are not so readily
utilised in this manner (e.g., demographic and personality factors). It is noteworthy, however, that the mere act of educating an older adult about EPOAs has a positive impact on their willingness to put such a strategy in place.

Key Points

- Future-focused planning is often guided by a range of contextual and cultural factors.

- A lack of awareness and knowledge of the benefits of EPOAs contributes to their lack of implementation.

- Legal and health professionals can help to raise awareness of future planning strategies such as EPOAs
References


### Table 1. Factors increasing the likelihood of future planning in older adults

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Type of Planning</th>
<th>Demographic Factors</th>
<th>Intrapersonal/Personality Factors</th>
<th>Health/Psychological Factors</th>
<th>Cognitive Factors</th>
<th>Socio-emotional Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bravo et al [13]</td>
<td>Advance care plan</td>
<td>Older in age</td>
<td></td>
<td>Family history of dementia</td>
<td>Good underlying beliefs and attitudes towards ACPs</td>
<td>Know someone with a cognitive impairment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Women</td>
<td></td>
<td>Mod-sev AD at baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No depressive disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Poor physical health or recent hospitalisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garand et al [17]</td>
<td>Advance care plan</td>
<td>Older</td>
<td>Desire for control</td>
<td>Family history of dementia</td>
<td>Good underlying beliefs and attitudes towards ACPs</td>
<td>Positive relationship with significant other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Married</td>
<td></td>
<td>Mod-sev AD at baseline</td>
<td></td>
<td>Religious affiliation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td></td>
<td>No depressive disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>White</td>
<td></td>
<td>Poor physical health or recent hospitalisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Well-educated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High [16]</td>
<td>Advance directives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lack of family or close social contacts to rely on as informal surrogate decision makers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hirschman et al.</td>
<td>Future planning</td>
<td></td>
<td></td>
<td>Changes in health status</td>
<td></td>
<td>Discussions with legal or health professionals about advanced planning</td>
</tr>
<tr>
<td>[14]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Perceived negative impact of life events on other family members or friends</td>
</tr>
<tr>
<td>Lachman &amp; Burack</td>
<td>Future planning</td>
<td></td>
<td>Sense of personal control rather than putting things down to fate or luck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[18]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lingler et al. [22]</td>
<td>Durable power of</td>
<td>Increasing age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author/Year</td>
<td>Type of Planning</td>
<td>Demographic Factors</td>
<td>Intrapersonal/Personality Factors</td>
<td>Health/Psychological Factors</td>
<td>Cognitive Factors</td>
<td>Socio-emotional Factors</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>McGrew [21]</td>
<td>Future planning</td>
<td>Higher level of education</td>
<td></td>
<td></td>
<td>Conception of future self as being dependent</td>
<td>Associated perception of the effects of such dependency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>European American descent</td>
<td></td>
<td></td>
<td>Concern today about future events</td>
<td></td>
</tr>
<tr>
<td>Morrison &amp; Meier</td>
<td>Advance care plan</td>
<td>Personal experience with mechanical ventilation</td>
<td></td>
<td></td>
<td>Physician’s willingness to discuss ACPs</td>
<td>Knowledge of ACPs</td>
</tr>
<tr>
<td>[23]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosnick &amp; Reynolds</td>
<td>Advance directives</td>
<td>Increasing age</td>
<td>High sense of control in one’s life</td>
<td>Higher number of medications</td>
<td>Social interactions that include discussion of such topics</td>
<td></td>
</tr>
<tr>
<td>[15]</td>
<td></td>
<td>Higher income bracket</td>
<td></td>
<td></td>
<td>Discussions about current circumstances and the need for legal plans with trusted or respected others</td>
<td></td>
</tr>
<tr>
<td>Samsi &amp; Manthorpe</td>
<td>Future planning</td>
<td>Life-long planners</td>
<td>Onset of illness, such as</td>
<td></td>
<td></td>
<td>Living alone with</td>
</tr>
<tr>
<td>Author/Year</td>
<td>Type of Planning</td>
<td>Demographic Factors</td>
<td>Intrapersonal/Personality Factors</td>
<td>Health/Psychological Factors</td>
<td>Cognitive Factors</td>
<td>Socio-emotional Factors</td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>----------------------------------</td>
<td>----------------------------</td>
<td>------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>[12]</td>
<td></td>
<td></td>
<td>dementia</td>
<td></td>
<td>no relatives and friends who are also getting older</td>
<td></td>
</tr>
</tbody>
</table>