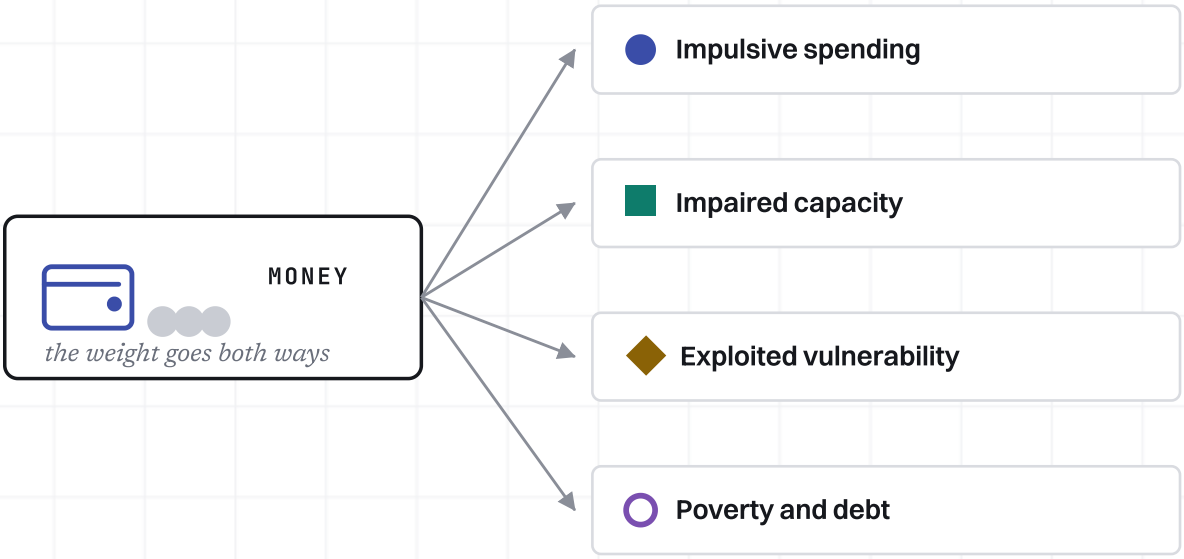


The Weight of the Wallet.

Money is both a casualty of mental illness and a cause of it. ***It goes wrong in patterns: the manic spend, the cost of addiction, the exploited patient, the debt that deepens depression. The skill is recognising the pattern, judging capacity and harm at the bedside, and acting to protect the patient.***

01 The weight of the wallet

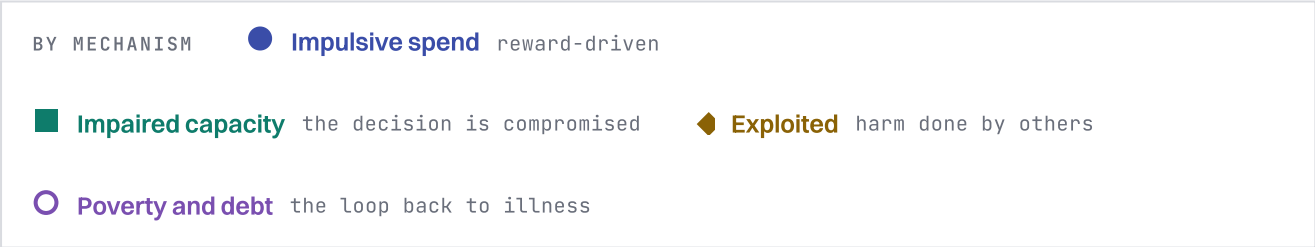
DEFINITIONAL, AND BIDIRECTIONAL

Money is rarely on the problem list, and rarely absent from the problem. A manic episode is often legible in a bank statement before it is legible in a mental state examination. A depression deepens with every demand for a payment that cannot be met. A patient with psychosis hands a pension to a stranger who asked nicely. The wallet is where a great deal of mental illness lands, and the harm is not incidental to the diagnosis. It is one of its most disabling expressions, and one of the least asked about.

The relationship runs in both directions, and that is the organising idea of this issue. Mental illness damages finances: it interrupts work, distorts judgement, and drives spending, debt and exploitation. Finances damage mental health in return: debt, poverty and financial strain are among the most consistent social drivers of depression, anxiety and suicide, and relieving them measurably improves symptoms.[1] The two feed each other in a loop, and a clinician who treats the illness while ignoring the money is treating half of it.

The numbers are not soft. In the largest synthesis, personal unsecured debt is associated with roughly a threefold increase in the odds of any mental disorder, a near-threefold increase in depression, and almost an eightfold increase in the odds of suicide.[2] The cost runs the other way too. In India the treatment gap for mental disorders exceeds 80%, and most of the care that is reached is paid out of pocket, so an episode that is already a clinical event is, routinely, a financial one for the whole household.[3] Money is not a social-work footnote to psychiatric practice. It is a clinical variable that tracks relapse, risk and recovery, and it can be assessed and acted on like any other.

THE CONCEPT CODE USED THROUGHOUT: BY THE MECHANISM OF MONEY-HARM



Each colour is also a shape, so the code survives a greyscale photocopy. The four name the ways money goes wrong, not the diagnoses: one disorder can run through several at once. Two things sit deliberately off this axis, the neuroeconomics that opens the issue and the ordinary financial stress that is a normal-range response to hard circumstances rather than a harm mechanism in itself.

HOLD THIS

Money-harm is a clinical phenomenon, not a character flaw

This issue is about how illness and disadvantage shape money, and it holds one line throughout. Poverty is a determinant of illness, not a diagnosis, and it is never pathologised here. Spending is not moralised: a manic purchase, an impulsive cart, a gambling debt are symptoms to be understood, not failings to be judged. The register is the one used for any other sign. A patient who has lost money to their illness has been harmed, not been weak, and the clinical task is to protect them, not to grade them.

02 A short history of money and the mind

Money is one of the youngest objects the human brain handles, and it is processed by some of the oldest machinery the brain owns. Coinage is a few thousand years old; the credit economy and the smartphone wallet are decades and years old. The valuation systems that respond to them were built over hundreds of millions of years to track food, mates, threat and territory. Money works on the mind because it has quietly captured that ancient apparatus, and the disorders of money in psychiatry are, in large part, disorders of that captured apparatus running too hot, too cold, or in the wrong direction.

Valuation is the brain's basic operation. Before it chooses, the brain assigns value, to internal states, to actions, to time itself, and that act of valuation is arguably its most fundamental computation.[4] Disparate goods are compared on a shared internal scale, a common neural currency that lets a person weigh an apple against an hour against a hundred rupees.[4] Money is the cultural technology that exploits this most directly, because it is built to be exchangeable for everything, and so it plugs straight into the circuitry that values everything.

Money rides the reward system. Anticipating a monetary gain recruits the nucleus accumbens, the same ventral-striatal, dopaminergic node that anticipates food and drugs, and the size of that activation scales with the size of the expected reward.[5] The overlap is not loose analogy. Monetary gains and a primary social reward (an attractive face) are encoded in a common relative-value signal in the ventromedial prefrontal cortex, which means the brain treats money and the things money cannot buy in the same currency.[6] This is why money can become an end in itself, why a windfall feels like a drug, and why, in mania, the reward of spending can outrun every other consideration.

And losses loom larger than gains. The reward system has a darker twin. People are loss-averse: a loss is felt roughly twice as strongly as an equivalent gain, the central asymmetry of Kahneman and Tversky's prospect theory.[8] This asymmetry has a neural signature, a steeper deactivation of the reward circuitry to a potential loss than its activation to an equal gain, and the steepness of that neural asymmetry predicts how loss-averse a person actually is.[7] Loss aversion is why debt is corrosive out of proportion to its size, why a gambler chases a loss rather than walking away, and why the threat of losing money is one of the most reliable everyday triggers of distress.

×2 **A loss is felt roughly twice as strongly as an equal gain** (prospect theory), and the asymmetry has a measurable neural signature that predicts how loss-averse a person is.[8,7]

The future is worth less than the present, and to some minds much less. Offered a smaller sum now or a larger sum later, everyone discounts the delayed reward to some degree; the question is how steeply. Steep delay discounting, a strong preference for the immediate, is one of the most robust transdiagnostic markers in psychiatry, elevated across depression, bipolar disorder, schizophrenia, borderline personality disorder and the addictions.[9] It is the mathematics behind the impulsive purchase, the unpaid premium, the loan taken at a ruinous rate to meet a need that felt urgent. When a patient cannot defer a reward, money flows toward the present and away from the future, and the future arrives anyway.

Money is also a social and symbolic object, not only a reward. It carries status, security, autonomy and shame, and it is bound up with identity in ways that make it one of the hardest things for a patient to talk about honestly. A person will disclose a hallucination before they disclose a debt. The clinical consequence is simple: money has to be asked about plainly and without judgement, because the patient will rarely volunteer it, and the silence is itself part of the harm.

None of this is pathology in itself. Reward sensitivity, loss aversion and discounting are universal features of a normal mind valuing an abstract token with very old hardware. They become clinical when an illness pushes them to an extreme, when mania amplifies reward, when addiction collapses the future, when dementia erodes the judgement that holds them in check. The rest of this issue is what that looks like, disorder by disorder, and what to do about it.

TABLE 1 **The neuroeconomics in four words a clinician can use**

Term	What it means	Where it bites in psychiatry
Reward valuation	The brain prices money on the same internal scale as food, status and safety, in shared reward circuitry[5]	Mania: spending becomes its own reward
Loss aversion	A loss is felt about twice as hard as an equal gain; the asymmetry has a neural signature[7]	Debt distress; the gambler chasing a loss
Delay discounting	The future is valued less than the present; steep discounting means the immediate wins[9]	Addiction, ADHD: impulsive spend, no saving
Mental accounting	Money is mentally sorted into separate pots and treated unequally, not as one fungible sum	Why a windfall is spent but a wage is guarded

These are not diseases; they are the normal levers an illness pulls. Naming them helps a clinician see a manic spree or a gambling debt as a predictable distortion of a shared system, not as a moral lapse.

AT THE BEDSIDE

A man takes a ruinous short-term loan to meet a bill that felt urgent, then spends an unexpected refund the same day. Name it: **steep delay discounting** (the future is valued less)[9] plus **mental accounting** (the windfall is a different pot from the wage). Not a moral lapse, a predictable distortion of a shared system.

The case for asking about money is not compassion alone; it is causation. Poverty and economic adversity are among the best-established social determinants of mental disorder, mapped across hundreds of reviews and built into the global development agenda.[10] In low- and middle-income countries the association is strongest not for income as a headline figure but for its sharp edges, food insecurity, housing instability and financial stress, the dimensions an Indian clinic meets daily.[11] Risk for common mental disorders rises down the social gradient, so the poorest carry the heaviest psychiatric load, across the whole life course.[12]

The arrow points both ways, and both arrows are now well evidenced. Prospectively, financial strain predicts later depression: across longitudinal studies the association is consistent and directional, strain today, low mood tomorrow.[13] And the reverse manipulation works. Giving poor people money improves their mental health: a meta-analysis of cash-transfer trials found significant reductions in depression and anxiety, larger when the transfer was unconditional, which is close to a controlled experiment on the causal arm of the loop.[14,1] Interventions that cushion unemployment and economic shock reduce depression, self-harm and the distress that follows financial loss.[15]

For the clinician, this reframes money as a modifiable variable. If debt and strain drive symptoms, then debt advice, a benefits claim, a payment plan or a protected account are not adjacent to treatment; they are part of it. The mistake is to see the finances as the social worker's department and the symptoms as the psychiatrist's. The loop does not respect that division. The sections that follow take the loop apart disorder by disorder, because the mechanism of money-harm differs, and so does the response.

Most often, though, money reaches the clinic not as a disorder but as a stressor, and that distinction matters. An acute financial shock, a job or income loss, prospectively predicts later psychological distress,[54] and financial stress is consistently associated with worse mental health, one of the clearer correlates of depression and anxiety in younger and student populations.[55] The clinical line is the careful one. Treat the anxiety or depression as you would any other, but address the hardship in parallel, and do not convert a reasonable response to a real problem into a diagnosis. The worry is not the disease; the shortfall is the problem, and it has practical remedies.

WHAT THE LOOP MEANS AT THE BEDSIDE

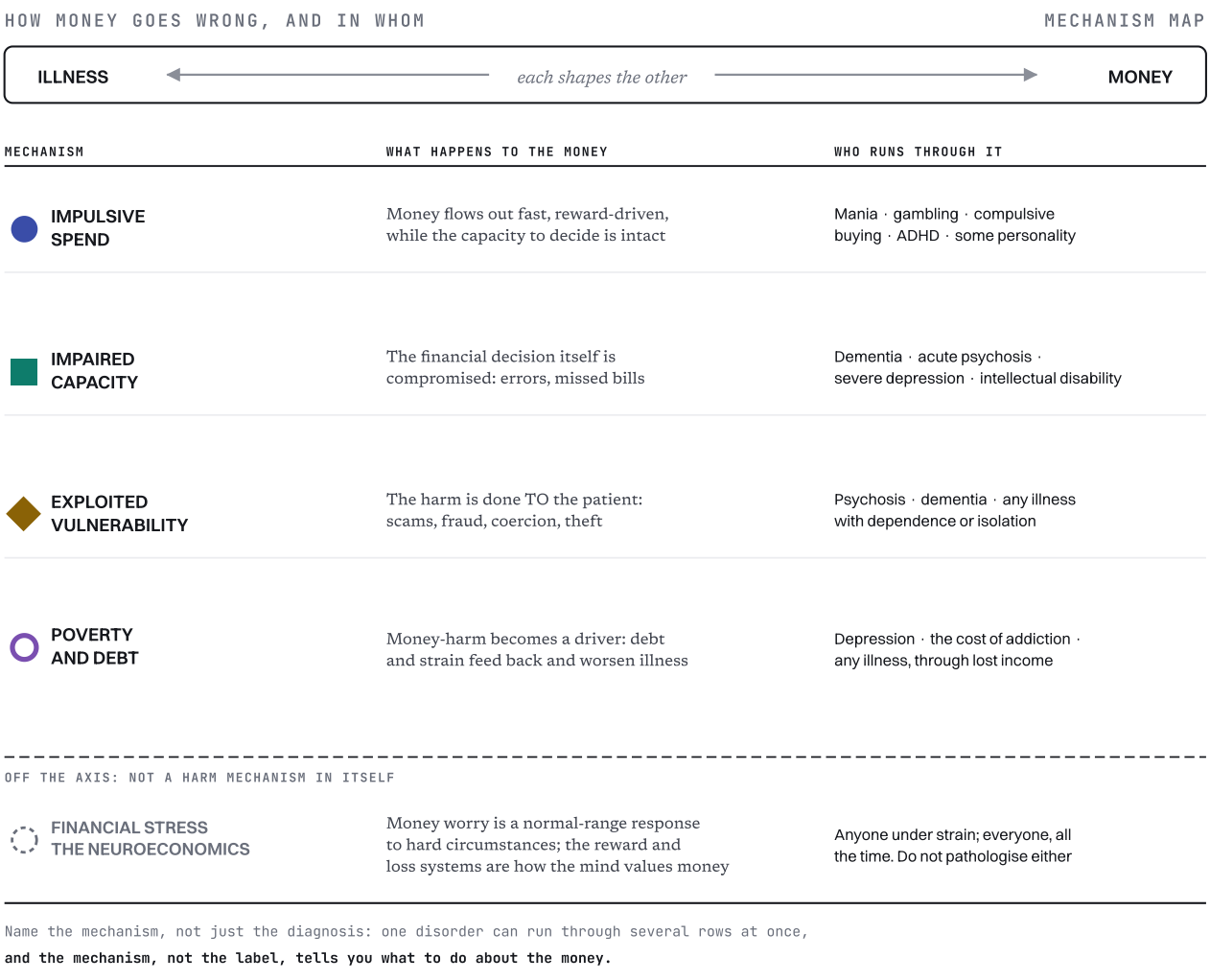
- **Money is a symptom and a cause at once.** Ask about it as you would ask about sleep: routinely, plainly, in every assessment where mood, impulse or cognition is in question.
- **Relieving financial harm is a treatment with an evidence base.** Debt advice, benefits and cash support move symptoms, so a referral to a financial counsellor can be as consequential as a prescription.
- **Never read poverty as pathology.** Hardship is a circumstance that causes illness, not a feature of the patient; the clinical move is to address it, not to diagnose it.

QUICK CHECK

Which moves depression more, a conditional or an unconditional cash transfer?

A Unconditional. The cash-transfer meta-analysis found larger reductions in depression and anxiety when the transfer was unconditional, the closest thing to a controlled experiment on the causal arm of the loop.[14]

FIGURE 1 **The four ways money goes wrong, and the disorders that run through each**



HOW TO READ THIS Read down the four mechanisms, not across the diagnoses. One disorder, psychosis say, lights up several rows at once, and each lit row needs its own response.

A psychotic illness can sit in three rows at once: an acute episode impairs capacity, the patient is exploited by others, and the lost income drags the family toward debt. Read every row that applies, because each one needs a different response.

04 The disorder and money grid

THE TABLE TO REMEMBER

This is the centerpiece. Each row is a disorder a psychiatrist treats; the columns move from how money goes wrong, to the mechanism that drives it, to the single most useful thing to do about it. The mechanism glyph carries the four-code system. The sections that follow expand each row and carry the citations.

TABLE 2 **How money goes wrong across the disorders, and what to do**

Disorder	HOW MONEY GOES WRONG	THE MECHANISM	WHAT TO DO ABOUT IT
Bipolar / mania	Expansive, uncharacteristic spending, debt and risky ventures during (hypo)mania	● Impulsive spend: reward hypersensitivity	**Treat the episode**; protect access to funds while it lasts; restore control on recovery
Depression	Bills go unpaid, debt mounts, and the debt deepens the mood	○ Poverty and debt loop	**Treat the depression**; debt advice; screen the debt-to-suicide link
Substance use	Income is diverted to the substance; money becomes a relapse cue	○ Poverty-debt, with impulsive spend	**Treat the use**; money management integrated into care, not bare control
Gambling disorder	Chasing losses into debt, bankruptcy and acute suicide risk	● Impulsive spend: a behavioural addiction	**CBT**; consider naltrexone; screen debt and suicide
Compulsive buying	Repetitive buying to regulate affect; credit debt and clutter	● Impulsive spend: an addictive pattern	**CBT**; treat comorbid mood and anxiety
ADHD	Impulsive purchases, disorganised bills, debt, little saving	● Impulsive spend: steep delay discounting	**Treat the ADHD**; external structure; automate bills and saving
Psychosis	Money mismanaged; scams, exploitation, assets signed away	◆ Exploited, and impaired capacity	**Assess capacity**; safeguard; supported money management or a payee
Personality disorders	Reckless, impulsive spending and chronic financial instability	● Impulsive spend: capacity usually intact	**Address impulsivity in therapy**; do not assume incapacity
Dementia	Errors, missed bills, scam susceptibility, contested wills	■ Impaired capacity, and exploited	**Assess financial and testamentary capacity**; safeguard; appoint
Financial anxiety	Money worry drives, and is driven by, depression and anxiety	○ Poverty-debt as a stressor	**Benefits and debt advice**; treat the anxiety; never pathologise the hardship
Hoarding	Excessive acquisition, much of it bought, with real financial harm	● Impulsive spend: compulsive acquisition, much of it bought	**Treat the hoarding**; address acquisition and the financial harm

The first two columns are the presentation; the last is the lever. The thread through the table is that the mechanism, impulsive spend, impaired capacity, exploitation or the debt loop, decides the response, and that capacity is intact in most of these rows and must not be assumed away.

05 The mood poles of money

MANIA SPENDS, DEPRESSION LOSES

Mood disorder breaks money at both poles. Where mania spends it, depression loses it, and at each pole the money-harm feeds back into the illness. Uncharacteristic spending is written into the definition of mania, and it is one of the most financially destructive symptoms in psychiatry: a single episode can empty a savings account before anyone reaches a clinic. It is not greed and not stupidity but the visible end of a reward system that has lost its counterweight. The impairment is partly a trait, not only a state: a meta-analysis found medium-sized decision-making impairment and elevated impulsivity across all phases of bipolar disorder,[16] and patients in remission scored higher than controls on behavioural addiction to shopping.[21] The mechanism is reward hypersensitivity, the dysregulated reward system at the core of the leading model,[17,18] and high reward responsiveness and ambitious financial goal-striving prospectively predict the first onset of a bipolar spectrum disorder.[19,20]

At the other pole, depression loses money, and the loss deepens the mood. The illness reduces the capacity to earn and organise, bills go unpaid, debt accumulates, and the debt becomes a continuous stressor that prolongs the mood, the clearest example of the bidirectional street. A systematic review found debt linked to higher anxiety, depression and suicidality through three routes: the strain of going without, the pressure of debt collection, and a corroding sense of control,[22] and prospective data put the arrow in time order.[13] In Indian practice the loop has a particular, lethal shape: among rural agrarian communities, indebtedness and financial loss, classically a failed crop, are among the commonest reasons recorded for a suicide attempt, and the method is often the pesticide close to hand.[23]

almost 8× **Debt raised the odds of completed suicide nearly eightfold** in the largest synthesis, which makes a debt history a risk factor to be asked about in every depressed patient, not a detail to be skipped.[2]

THE MOVE

Protect the money through the episode, return it after

At the manic pole the spending is a symptom, so the first treatment is the treatment of the episode. Around it, the financial task is containment for the duration: with the patient's involvement wherever possible, limit access to credit and large balances, involve a trusted relative or nominated representative, and put a temporary brake on irreversible transactions. Control of the money is borrowed during the episode and handed back on recovery, when capacity returns, not kept a day longer than the illness requires.

AT EITHER POLE, ON MONEY

- **Mania: contain, do not punish.** Limit access to credit and large balances with the patient's involvement, for the duration of the episode only.
- **Depression: ask about debt in the risk assessment.** The debt-to-suicide association is among the strongest in the literature, and the patient will rarely raise it first.
- **Refer the debt, do not only note it,** and treat both halves at once: the mood will not lift under an unmanaged debt.

06 Addiction, and the money addictions

Addiction is, among other things, a disorder of money. Income is diverted to the substance, the future is sacrificed to the present, and the money itself becomes a cue that can trigger relapse. The signature finding is steep delay discounting: people with addictive disorders devalue delayed money far more sharply than controls, an effect that tracks the severity and the quantity-frequency of use across alcohol, tobacco, cannabis, stimulants, opiates and gambling.[24,25] The monetary value of the drug can be measured directly through behavioural-economic demand.[26] The same lever works in reverse: contingency management, modest rewards given for verified abstinence, produces medium-sized improvements in abstinence and retention.[27] The patient's money is consumed by the illness and must be part of the plan, and money used deliberately as a reinforcer is one of the better-evidenced behavioural tools in addiction medicine.

Then there are the money addictions, where money is not the fuel but the substance itself. Gambling disorder is the first behavioural addiction psychiatry formally recognised, its move into the DSM-5 addictions reflecting shared reward circuitry and the same course as substance use.[28] The harm is financial first and then existential: people with gambling problems carry lifetime rates of suicidal ideation around 32% and of attempts around 13%, tied specifically to the debt the gambling creates, so gambling debt is a suicide risk factor, not just a money problem.[30] Cognitive behavioural therapy substantially reduces gambling severity, and where medication is added the opioid antagonists have the most support, though none is licensed.[31,32] Compulsive buying is the quieter sibling: repetitive buying used to regulate internal states affects around 5% of adults, and in the US national survey compulsive buyers were younger, lower-income, and four times less likely to clear a credit-card balance in full.[33,34] The weight of expert opinion treats it as a behavioural addiction, and group cognitive behavioural therapy reduces it with gains that hold.[35,36,37]

Hoarding is the money disorder that hides as a clutter problem. Hoarding disorder is common, around 2.5% prevalence, and its financial dimension is routinely overlooked: much of the accumulation is bought, and excessive acquisition is the part most tightly linked to severity.[56,57] A real financial harm sits underneath the visible clutter.

1.4% → 15.8% **About 1.4% of adults gamble at a problematic level,** rising to 15.8% among online-casino and slots users, the fast formats whose accessibility and speed do the most harm.[29]

ASK DIRECTLY

The money addictions are hidden unless named

Neither gambling nor compulsive buying is volunteered, and the money diverted to a substance is rarely declared in full. Ask every patient with mood, impulse or substance problems whether they gamble and whether their spending feels out of control, in plain words, without a flicker of judgement. Treat the income diverted and the debt left behind as clinical data that track severity, not a separate social problem. In gambling, screen the debt and the suicide risk in the same breath. In compulsive buying and hoarding, look for the comorbid depression or anxiety the buying is medicating. All respond to cognitive behavioural therapy; none responds to being undetected.

07 The impulsive ADHD wallet

DISCOUNTING, DISORGANISATION, DEBT

ADHD is, in financial terms, a slow leak rather than a single flood. The impulsive purchase, the unopened bill, the subscription never cancelled, the saving that never starts, these accumulate over years into a real and measurable disadvantage, and unlike the manic spree it rarely announces itself in a single dramatic event.

The real-world outcomes are now documented at population scale. In a whole-population study linking ADHD to credit records, adults with ADHD showed normal borrowing in early adulthood but steeply rising default rates by middle age, with poor credit scores and reduced access to credit. Financial distress was associated with a fourfold higher risk of suicide, outstanding debt rose in the three years before suicide in men with ADHD, and, soberingly, having a stimulant prescription was not associated with better financial behaviour.[38] The money problem is not solved by the pill alone.

The mechanism is the steep discounting again, plus disorganisation. People with ADHD discount delayed monetary rewards more steeply than controls, the meta-analytic signature of choosing the smaller-sooner over the larger-later.[40] In community samples, adults with ADHD symptoms report more impulsive buying, more avoidant and spontaneous financial decision-making, and less saving, and they report lower financial wellbeing and more money worry even where the objective gap has not yet opened.[39,41] The management follows from the mechanism: treat the ADHD, but build the money around the deficit rather than expecting the deficit to close. Automate bills and saving so they do not depend on attention, externalise the structure, simplify the accounts, and put friction between the impulse and the purchase. Scaffolding, not willpower, is the intervention.

IN A PATIENT WITH ADHD, ON MONEY

- **The pill does not fix the money.** Treat the ADHD, but a stimulant prescription alone was not associated with better financial behaviour, so the structure has to be built as well.
- **Automate around the deficit.** Standing instructions for bills and saving, simplified accounts, and a little friction before a purchase beat relying on attention that is not there to spare.

QUICK CHECK

In the whole-population ADHD study, how much did financial distress raise the risk of suicide, and did a stimulant prescription protect the finances?

A Fourfold. Financial distress carried a fourfold higher suicide risk, and a stimulant prescription alone was not associated with better financial behaviour, the pill does not fix the money.[38]

Capacity intact or impaired

Two disorders sit on opposite sides of the capacity fault line, and telling them apart decides what is done. In psychosis the money problem is double. The first half is hardship: financial difficulty is close to the default state of serious mental illness. Among newly admitted community mental-health patients, 59% reported difficulty obtaining food, shelter or medicine in the past year, and it was linked to more severe symptoms, more self-stigma and more emergency service use.[43] The second half is what the illness does to the handling of money, and here two distinct harms have to be told apart. Financial capacity is a real and assessable decisional capacity, routinely neglected in schizophrenia, that bears on whether a person can live independently and whether their funds are safe.[42] Separately, people with serious mental illness are exploited at strikingly elevated rates, with criminal victimisation running two-fold to many-fold higher than the general population.[44] A patient can be exploited while fully capacitous, and can lack capacity without anyone exploiting them. Impaired capacity is itself a driver of exploitation, so structured assessment can flag the patient at risk before the money is gone.[45]

The personality disorders sit on the other side of the line: impulsive, but capacitous. Reckless spending is one of the named impulsivity criteria of borderline personality disorder, and it is frequently misread, either as moral irresponsibility to disapprove of or as incapacity to manage away. Both readings are wrong. Impulsivity in borderline personality disorder is a cluster of separable impulse-control deficits with identifiable prefrontal dysfunctions, which is why spending can run out of control in a person whose impulsivity elsewhere looks mild,[46] and the financial decision-making is measurably affected on gambling-type tasks.[48] But the capacity is intact, and that is the fault line: the patient understands the transaction, can weigh it, and can express a choice; they act against their own interest under affective pressure, which is a different thing from being unable to decide. The response is therapeutic, not custodial.

ON WHICH SIDE OF THE LINE

- **Psychosis: tell the two harms apart.** A capacitous patient can still be exploited, and an incapacitous one need not be; the safeguards differ, so name which is in play before acting.
- **Psychosis: detection is protection.** Asking about exploitation directly and assessing capacity when the illness is active can stop the loss before the money is gone.
- **Personality disorder: it is impulsive spend, not impaired capacity.** The patient understands the transaction and can decide; they act against their own interest under affective pressure.
- **Personality disorder: treat it, do not seize it.** The impulsivity is a target for psychotherapy; the financial autonomy of a capacitous adult stays with them.

AT THE BEDSIDE

A young woman runs up credit-card debt buying things she does not need. She understands each transaction and can weigh it, so capacity is intact: this is impulsive spending, not impaired judgement, and the move is therapy for the impulsivity, not a guardianship. The pattern keeps its usual company, with compulsive buyers roughly **five times more likely** than others to meet borderline criteria,[47] which points again to therapy, not to seizing the money.

09 Financial capacity in dementia

OFTEN THE FIRST THING TO GO

Of all the money problems in psychiatry, the one in dementia is the most predictable and the most preventable, because the decline follows a known trajectory and the harms can be headed off if they are anticipated. Financial capacity is frequently one of the earliest instrumental abilities to fail, and a money error is often the first thing a family notices.

The decline begins before the diagnosis. In mild cognitive impairment, financial skills are already slipping in the year before conversion to Alzheimer dementia, especially the complex procedural tasks of managing a chequebook and a bank statement, and they fall progressively over the following years while simple skills such as counting coins are preserved longest.[49,50,51] The practical reading is that complex financial capacity should be asked about at the first sign of cognitive change, not after a loss, because it is failing while the diagnosis is still being made.

A new vulnerability to scams is itself a warning sign. Susceptibility to financial exploitation is not only a consequence of dementia but an early marker of it: low scam awareness predicts incident Alzheimer dementia and mild cognitive impairment independent of global cognition, and high scam susceptibility is associated with the onset of dementia some years earlier than in the scam-aware.[52,53] An older patient who has suddenly started falling for scams, or signing things they would once have questioned, is showing a cognitive sign, and the response is a cognitive assessment, a financial-capacity assessment, and a safeguard, before the family savings become the evidence. This is where capacity assessment, the law, and safeguarding all converge, and they are the subject of the sections that follow.

IN A PATIENT WITH DEMENTIA, ON MONEY

- **Ask early, before the loss.** Complex financial capacity is failing while the diagnosis is still being made, so raise it at the first sign of cognitive change, not after the savings are gone.
- **New gullibility is a cognitive sign.** A sudden vulnerability to scams is a prompt for cognitive and capacity assessment and a safeguard, not a lapse of care to be tutted at.

QUICK CHECK

An older patient who has suddenly started falling for scams, but whose global cognition tests normal, is showing what?

A An early cognitive sign. Low scam awareness predicts incident Alzheimer dementia and mild cognitive impairment independent of global cognition, and high susceptibility precedes dementia onset by years. The response is a cognitive and capacity assessment, not a tut.[52,53]

10 Assessing financial capacity

Financial capacity is the skill at the centre of this issue, because almost every management decision turns on it. It is assessed with the same functional model used for any decision: capacity is **decision-specific** and **time-specific**, it is presumed until shown otherwise, and it rests on four abilities, to understand the relevant information, to retain it, to weigh and use it, and to communicate a choice.[58,60] This is the widely taught functional standard; the structured tools, the MacArthur instruments chief among them, operationalise these four abilities into questions a clinician can ask.[59] The base rate is reassuring: most psychiatric patients retain capacity, so incapacity is a finding to be demonstrated, not assumed.[61]

Two cautions specific to money. First, capacity can be eroded by affect, not only by cognition: depression characteristically impairs the **appreciation** of consequences, so a severely depressed patient may understand a financial fact yet be unable to apply it to a future they no longer believe in.[62] Second, financial capacity is its own measurable construct with several sub-components, basic monetary skills, financial judgement, conceptual and procedural knowledge, and it does not track a single cognitive test, which is why a structured financial-capacity assessment is worth more than a global impression.[64]

TABLE 3 **The four abilities, asked of a financial decision**

Ability	WHAT YOU ARE TESTING	THE MONEY QUESTION	WHAT FAILURE LOOKS LIKE
Understand	Grasps the nature and terms of the transaction	What does selling the house, or taking this loan, actually involve?	Cannot describe the transaction or what it commits them to
Retain	Holds the information long enough to use it	Tell me again what we just went through	Loses the key facts within minutes; common in dementia
Weigh and use	Reasons with the information and its consequences	What happens to you if you do this, and if you do not?	Cannot link the choice to its consequences; depression strips the future of weight
Communicate	Expresses a settled choice	Knowing all that, what do you want to do?	Cannot express a stable, consistent decision

FIVE PRINCIPLES **Before you judge anyone unable to manage their money**

01 **Presume capacity.** An adult is assumed to have it until the assessment shows otherwise; the burden is on the clinician, not the patient.

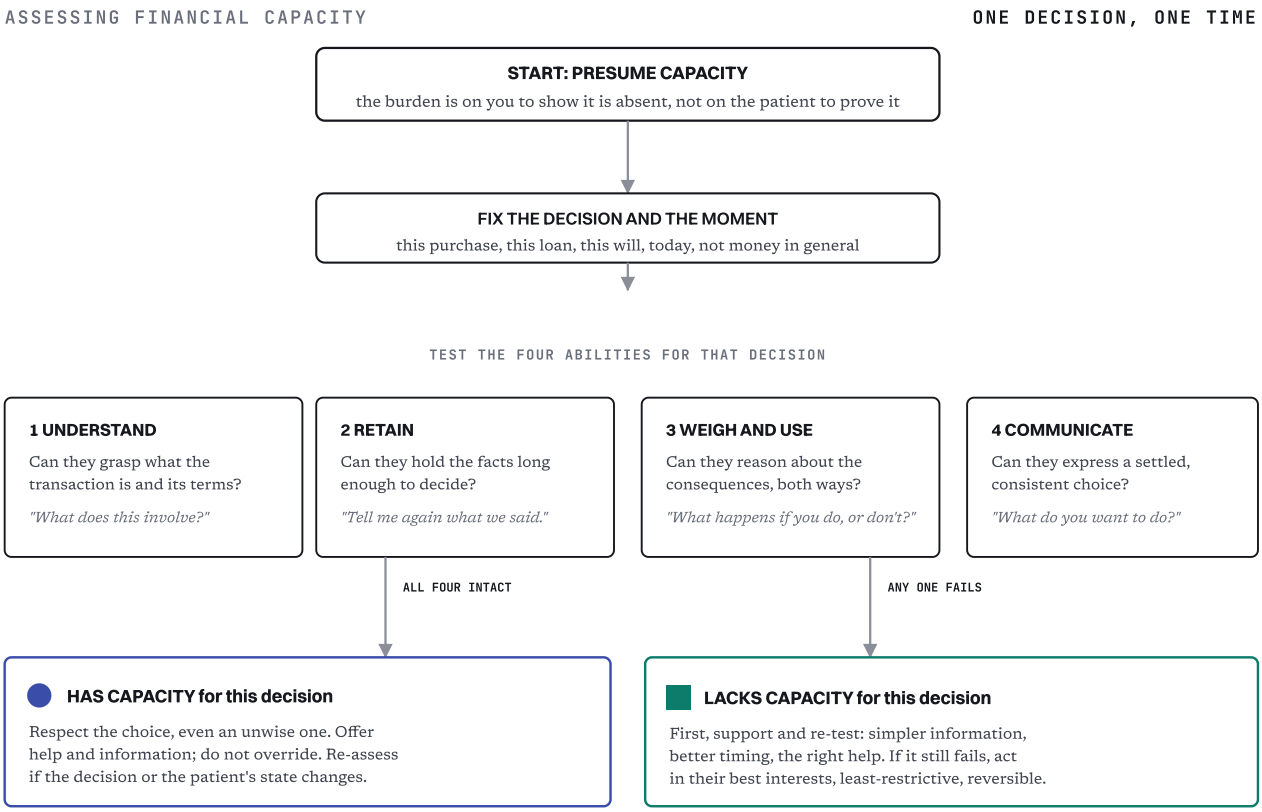
02 **It is decision-specific and time-specific.** Capacity for a small purchase is not capacity for a mortgage, and capacity lost in an acute episode can return on recovery.

03 **An unwise decision is not incapacity.** A capacitous person is allowed to spend foolishly; bad judgement is not the same as the inability to decide.

04 **Support the decision first.** Give information simply, at the right time, with the right help, before concluding the person cannot decide.

05 **Least restriction.** If capacity is absent, do the smallest, most reversible thing that keeps the patient safe, and no more.

FIGURE 2 **Assessing financial capacity: the four abilities, for one decision, at one time**



THREE THINGS THIS FLOW MUST NOT GET WRONG

- Capacity is for THIS decision at THIS time. It is never a global verdict on the person.
- An unwise choice is not incapacity. The test is the reasoning, not whether you agree with the answer.
- Depression can take capacity by stealing the future, not the facts. Re-assess once the mood is treated.

HOW TO READ THIS Run the whole flow for one decision at one time. The same patient can pass it for a weekly allowance and fail it for selling a house on the same afternoon, and that is the point, not a contradiction.

The flow is run once per decision. The same patient may have capacity to manage a weekly allowance and lack it to sell a property on the same afternoon, and that is not a contradiction but the whole point of a decision-specific standard.

Money-harm is almost never volunteered. It is found by asking plainly and by watching for the signs that should stop a clinician and prompt a closer look. The red flags below each point toward a mechanism, and the mechanism decides the response. A relative's quiet worry that something is wrong with the money is one of the most useful of these signs, and it is often the earliest.

TABLE 4 **The red flags, what each may signal, and the first move**

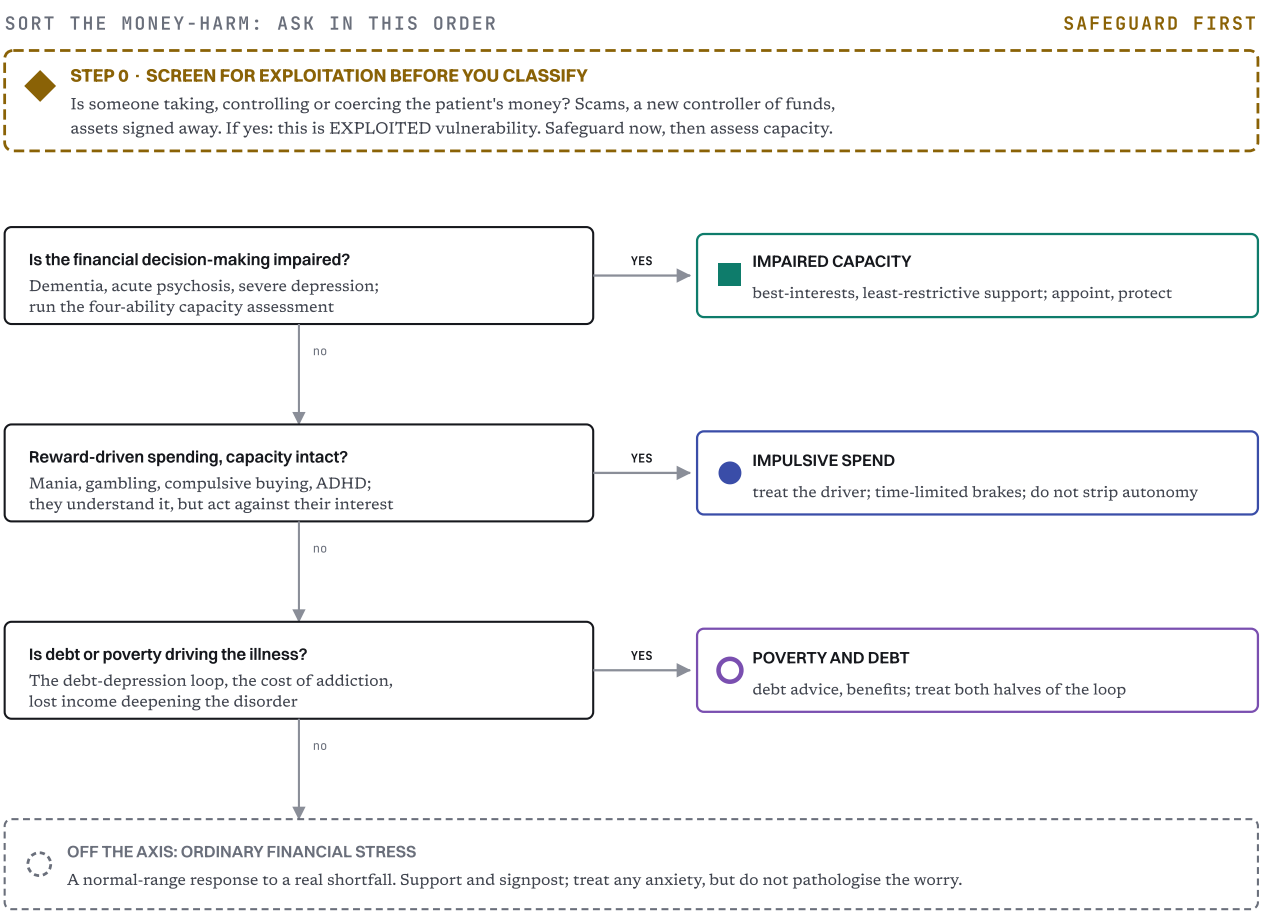
The red flag	What it may signal	The first move
Sudden, uncharacteristic or expansive spending	A manic or hypomanic episode	Assess mood; protect access to funds during the episode
New, mounting debt or borrowing	Depression, gambling, addiction or ADHD	Ask why; screen mood, gambling and substance use; debt advice
A new person controlling the money	Exploitation or coercion[44]	Safeguard; establish who and why; assess capacity
Falling for scams, or paying repeated "fees"	Cognitive decline, or psychosis[52]	Cognitive and capacity assessment; safeguard
Bills unpaid despite having the means	Early dementia, depression, disorganisation	Cognitive screen; assess financial capacity
Signing documents not understood, giving away assets	Impaired capacity or undue influence	Assess capacity, including testamentary; safeguard[45]
A relative raising a concern about the money	Any of the above; often the first signal	Take it seriously; it is frequently the earliest sign

A red flag is a prompt to assess, not a verdict. The figure overleaf puts the assessment in order: safeguard first, then capacity, then the mechanism, because the most urgent harm, someone taking the patient's money, must be caught before anything is classified.

AT THE BEDSIDE

A son reports his mother has a new friend who now signs her cheques, and she has begun paying repeated fees to a caller. Two red flags fire: **a new person controlling the money** (exploitation)[44] and **falling for scams** (cognitive decline or psychosis).[52] First move: safeguard the money now, then a cognitive and capacity assessment to read what lies beneath. The relative's quiet worry was the earliest sign, and taking it seriously was the whole of the clinical skill.

FIGURE 3 **Sort the money-harm: safeguard first, then capacity, then the mechanism**



THREE THINGS THIS SORT MUST NOT GET WRONG

- Screen exploitation FIRST. Someone actively taking the money is the most urgent harm on the page.
- Impulsive spend with intact capacity is NOT impaired capacity. Treat it; do not remove autonomy.
- More than one row can apply at once. Work each that does; the first yes does not close the others.

HOW TO READ THIS Work top to bottom in safety order, and screen exploitation first. A yes does not close the rows below it, because more than one mechanism can apply to the same patient at once.

The order is a safety order. Exploitation is screened before classification because it is the harm a clinic can stop today; capacity is asked next because it changes what is permitted; and the mechanism is named last because it decides the treatment.

Management follows the mechanism, and three principles run under all of it: treat the driver, protect with the least-restrictive instrument that works, and restore autonomy as capacity returns. The protection is borrowed, not seized. It lasts as long as the illness needs it and not a day longer, and the aim throughout is to keep the patient safe without writing them out of their own financial life.

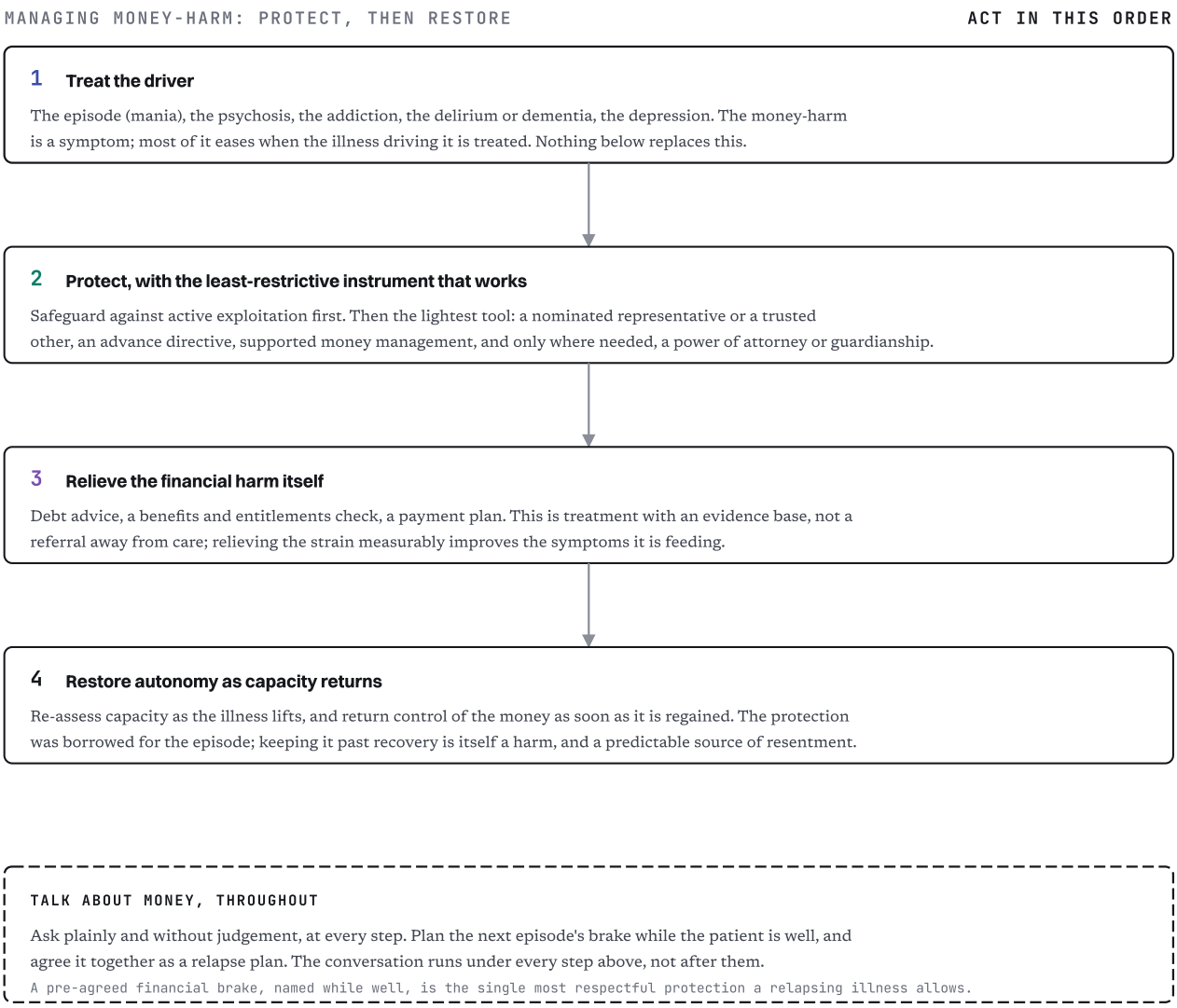
Supported money management has the best evidence, and a clear caveat. A systematic review of finance-based interventions found representative payeeship, where a trusted person or agency receives and manages funds with the patient, carries the strongest evidence for reducing substance use and improving money management.[65] A randomised trial of payeeship integrated into psychiatric care produced gains in substance use, quality of life and money management, and agency payee programmes have been associated with large reductions in hospital days.[66,69] The caveat is essential: a payee bolted on as bare control, without being woven into treatment, does not help, so money management must be a clinical intervention, not a custodial one.[67,68]

And the conversation itself is treatment. Addressing money directly, through benefits advice and debt counselling, relieves psychological distress and is a legitimate health intervention in its own right, not a referral away from care.[70] The instruments below run from the lightest to the most formal; the rule is to reach for the lightest that keeps the patient safe.

TABLE 5 **The instruments, from lightest to most formal, and the Indian route**

Instrument	What it does	The Indian route	When to use it
Nominated representative	A person the patient names to support and represent their decisions	Mental Healthcare Act 2017[75]	Named while well, in any relapsing illness
Advance directive	The patient's stated wishes for care if capacity is later lost	Mental Healthcare Act 2017[76]	Bipolar, recurrent psychosis: agree the brake in advance
Supported money management	A trusted other or agency manages funds with the patient	Family arrangement; agency payee where available	Acute episodes; serious mental illness with hardship
Power of attorney	Legal authority to act on financial matters	Executed while the person is capacitous	Foreseeable, planned capacity loss
Limited guardianship	A guardian for someone who cannot decide, kept as narrow as possible	RPwD Act 2016 / National Trust[77]	Established incapacity, no lesser option works
Debt advice and benefits	Relieve the financial harm itself	Financial counsellor; statutory entitlements	The debt-depression loop; hardship in any disorder

FIGURE 4 **The pathway: treat the driver, protect, relieve the harm, then hand the money back**



HOW TO READ THIS The four steps are an order of priority, not a queue. Protection and debt advice often run at once, and step four, handing the money back, is the step most often forgotten once the crisis has passed.

The four steps are an order of priority, not a queue. A patient may need protection and debt advice at once, and the restoration in step four is the part most often forgotten, because the crisis that prompted the protection has passed and no one revisits it.

The scale of the problem in India is large and the financial cushion is thin. Mental disorders affect around 197 million people, roughly one in seven, and their share of the national disease burden nearly doubled over a generation.[71] Most of the care that is reached is paid out of pocket, with weak financial protection, and medicines are the single largest driver of the catastrophic and impoverishing health spending that pushes households below the line.[72,73] The burden is concrete at the bedside: in first-episode psychosis, families carry substantial direct and indirect costs, most of it lost productivity, often beginning before the diagnosis is made.[74] An episode is a financial event for the whole household, and the clinician who ignores that is missing the part the family feels most.

The legal scaffolding has shifted toward the patient. The Mental Healthcare Act 2017 builds in a presumption of capacity to make decisions, the advance directive, and the nominated representative, instruments that let a patient shape, while well, how money and care are handled if they later lose capacity.[75] They are not without practical difficulty, and the capacity assessments they require are real clinical work.[76] For established incapacity, the Rights of Persons with Disabilities Act 2016 reframes guardianship toward limited and supported decision-making rather than wholesale substitution, the least-restrictive principle written into statute.[77] One financial decision is governed by its own legal test: testamentary capacity, the capacity to make a valid will, is a distinct standard still governed by the nineteenth-century test of Banks v Goodfellow, and is assessed against its own criteria rather than the four-ability model.[63] And the newer money-harms are arriving fast: gambling is a growing problem in India with significant family and financial impact, and the online formats are the ones to watch.[78]

197M / >80%

Mental disorders affect about 197 million Indians, roughly one in seven,[71] while the treatment gap exceeds 80% and most care is paid out of pocket,[3] so the money conversation can be the difference between a family that stays in treatment and one that cannot afford to.

INDIA

The instruments, and the reality around them

Use the Mental Healthcare Act 2017 forward: help a patient with a relapsing illness name a nominated representative and set an advance directive while they are well, so the financial brake in the next episode is theirs, agreed in advance, not imposed in crisis. Reserve limited guardianship under the Rights of Persons with Disabilities Act for established incapacity with no lighter option. And hold the context in view: with an over-80% treatment gap and out-of-pocket costs that impoverish households, the money conversation in an Indian clinic is not a side issue. It is often the difference between a family that stays in treatment and one that cannot afford to.

14 Ways to get it wrong

Moralising the money. The first and commonest error is to read money-harm as a character failing: the manic spender as reckless, the gambler as weak, the indebted patient as irresponsible, the poor patient as the author of their own misfortune. Every one of these is a clinical phenomenon with a mechanism, and the moral framing does active harm, because it shames the patient out of disclosure and substitutes judgement for treatment. Poverty is a determinant of illness, not a diagnosis, and spending under the pressure of an illness is a symptom, not a sin. The register for money is the register for any other sign: neutral, curious, and practical.

Assuming incapacity, and removing autonomy too fast. The opposite error is to leap from a worrying financial decision to taking the patient's financial life away. Most psychiatric patients retain decision-making capacity, capacity is decision-specific and time-specific, and an unwise choice is not the same as an incapable one.[61] Reckless spending in a personality disorder, in particular, is an impulsive-spend problem in a capacitous adult, and the response is therapy, not a guardianship. Incapacity is a finding to be demonstrated for a specific decision, then acted on with the least restriction that works, and undone as soon as capacity returns.

Missing the harm that was treatable. The third error is to look away from the money altogether, and so to miss the things that could have been caught. The new vulnerability to scams that was the first sign of a dementia.[52] The debt that was the strongest predictor of the suicide. The exploitation that a single safeguarding question would have surfaced. The capacity decline that a structured assessment would have shown while the savings were still there.[45] Money-harm is missed not because it is subtle but because it is not asked about, and the cost of the silence falls on the patient and the family.

HOLD THIS

The one lesson, if you keep nothing else

Money is a clinical variable, and the danger lies at both edges: moralising it, and over-controlling it. Ask about money plainly and without judgement, name the mechanism rather than the character, assess capacity for the specific decision rather than assuming it away, and protect with the lightest instrument for only as long as the illness requires. Asked well, money is one of the most useful signs in psychiatry, it predicts relapse, risk and recovery. Left unasked, it is one of the most dangerous, because the harms it hides are so often the ones that could have been prevented.

QUICK CHECK

A patient with borderline personality disorder runs up reckless debt. Do you remove their financial autonomy?

A No. Most psychiatric patients retain capacity, capacity is decision-specific, and an unwise choice is not an incapable one; this is impulsive-spend in a capacitous adult, so the response is therapy, not guardianship.[61]

15 Before they leave

Money is rarely on the problem list and rarely absent from the problem. The skill is to ask about it as routinely as sleep, to name the way it is going wrong, and to protect the patient without writing them out of their own financial life.

WHAT THIS ISSUE COMES DOWN TO

1. **The street runs both ways.** Mental illness damages money, and money-harm, debt, poverty, strain, damages mental health in return, with the strongest single signal running from debt to suicide. Ask about money in every assessment where mood, impulse or cognition is in play, and treat the financial harm as part of the treatment.

2. **Name the mechanism, not the character.** Money goes wrong in four ways, impulsive spend, impaired capacity, exploitation, and the poverty-debt loop, and the mechanism, not the diagnosis or the moral judgement, decides what to do. One patient can run through several at once.

3. **Capacity is specific, and usually intact.** Assess it for the decision and the moment, presume it until shown otherwise, and remember that an unwise choice is not incapacity. Depression can take capacity by stealing the future; reckless spending in a capacitous adult is treated, not seized.

4. **Protect, then restore.** Safeguard exploitation first, treat the driver, relieve the harm with debt advice and benefits, use the lightest instrument that works, and hand the money back as capacity returns. In India, the nominated representative and advance directive let the patient set their own brake while well.

BEDSIDE CHECK

Five questions about the money

01 Is anyone taking or controlling the patient's money? Safeguard the exploitation before you classify anything else.

02 Is the financial decision-making itself impaired? Assess capacity for the specific decision, at this time.

03 Is this reward-driven spending in a capacitous adult? Treat the driver and use a time-limited brake; do not remove autonomy.

04 Is debt or poverty driving the illness? Refer for debt advice and benefits, and treat both halves of the loop.

05 Have you asked plainly, and without judgement? The harm is almost always missed because it was never asked about.

REMEMBER

MONEY · Mechanism · Order · Note · Evaluate · Yield

Mechanism, name it, do not moralise · **O**rder, safeguard first · **N**ote the debt-to-suicide risk · **E**valuate capacity for THIS decision · **Y**ield control back as capacity returns.

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Educational note. This clinical-reasoning essay is for clinicians and students. It is educational, not treatment advice for any individual. Care decisions belong with the treating clinician. At Weave, care is led by Dr. Niharika Reddy, Consultant Psychiatrist.

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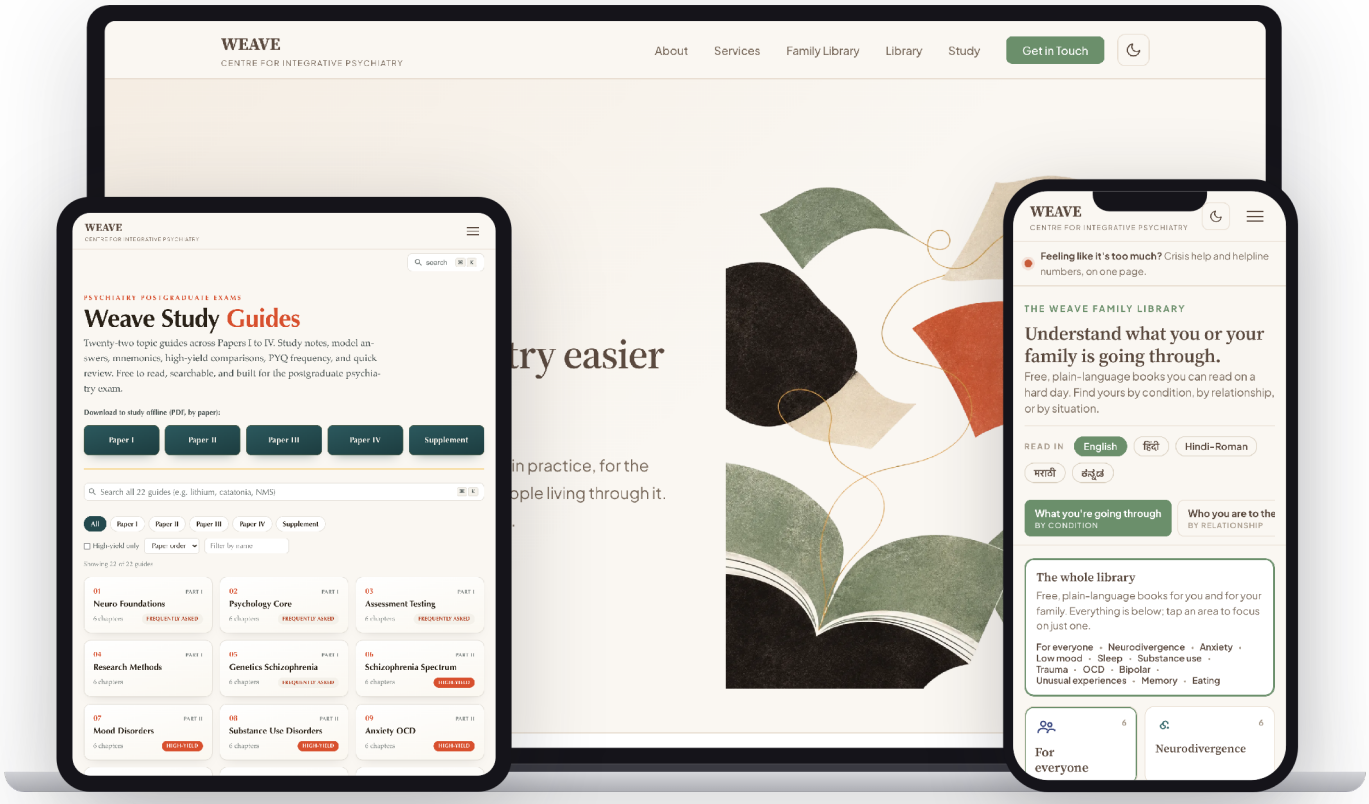

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