

AACP POSITION STATEMENT: REPRESENTATIVE PAYEESHIPS

I. INTRODUCTION AND PURPOSE:

Many people with psychiatric disorders receive federal and other financial support. There is a range of ability among these individuals to manage these funds adaptively. Federal regulations require that in order for a representative payeeship to be conferred to a third party, an individual receiving disability payments must be shown to be unable to manage them. People eligible for payeeships are routinely without means to functionally survive, unable to provide themselves even the basic needs of food and housing.

There are various models for administering representative payeeships. When available and working in the person's best interest, and if the person prefers it, family are the often the best choice to fill this role, but community religious groups and other non-clinical organizations, like local Mental Health Associations, are also excellent resources. In some cases, mental health providers initiate representative payeeships and may consequently also disburse payments to consumers. This arrangement is best viewed as an early rehabilitative step toward independent money management. However, as mental health providers work with consumers, payeeship also presents issues concerning clinical practice, administrative procedures, and ethics.

This AACP position statement outlines these issues and makes practical recommendations to clinical and rehabilitation services whose workers act in a function of representative payee.

II. ISSUES:

A.) CLINICAL:

The most compelling published clinical support for payeeships are a decrease in hospitalization days. There is also some evidence that it does increase housing stability, thus reducing homelessness among people with psychiatric disorders. The effect of representative payeeship on substance abuse is equivocal, although when linked to contingency management techniques, it may offer a constructive role.

Day to day clinical issues are also salient. The technique's effect on the alliance between patients and their clinicians is important. Representative payeeship lies on a continuum of clinical leverage, and if used insensitively, it has potential to negatively affect rehabilitative goals of reducing alienation toward

treatment and of enhancing personal independence. Clinical transference responses noted in the literature are passive dependence, in which patients cease clinical engagement when representative payeeship ends, and outright displays of rage, with harassment and threats to clinical staff.

In turn, clinical countertransference responses occur in which clinicians become fearful of their patients or become hostile, feeling that their patients are ungrateful for efforts made on their behalf. The representative payeeship can become a source of clinician grandiosity, in which the predominant instrument of behavioral management is the payeeship itself.

B) ADMINISTRATIVE:

There are two essential models for management of the payeeship within a clinical relationship. The first is when an individual clinician, usually a primary therapist or case manager, acts as a legally identified payee. Issues concerning this paradigm arise from the payee receiving relatively less supervision. Moreover, the payee can face legal action from the consumer, even in the absence of impropriety or error.

The second model involves a corporate entity assuming payeeship. This model creates greater accountability. Clinicians may act as payee agents or the entity may create a separate role of "payee manager," who directs accounts and disburses payments to the consumer.

A primary advantage in having the casemanager be the payee agent is that coordination of money management within the treatment or service plan is relatively uncomplicated, obviating a necessarily close communication between casemanager and payee manager. This model does require rigorous accounting and bookkeeping on the part of the casemanager. Some clinicians also report greater tension within the alliance with their patients under this arrangement

Alternatively, the role of payee manager may be embraced in a separate job description: a worker who keeps all payee accounts and routinely disburses funds. In some cases, a clinical program director or deputy fulfills that role. In either case, there is centralized accounting and bookkeeping, diminishing the chance of administrative error, or even fraud. However, under these circumstances, there are challenges in building efficient and client-friendly mechanisms to disburse funds. The experience of a person waiting on line for more than a very few minutes to receive his or her own funds is a dehumanizing one. Similarly, it is crucial for payee managers to acquire a clinical role and be in close contact with the rest of the clinical team so there is full coordination concerning changes in money management and other clinical variables that affect the patient's relationship with the program.

Regardless of whether a clinician or designated payee manager is used, there is a necessity to have accountability to the consumer. Representative payeeships demand procedures of accounting, managing, and documenting fund disbursement that are accessible to the person whose funds are being managed.

C) ETHICAL AND LEGAL:

Concerns about legal exposure frequently arise among providers who are contemplating representative payeeships. These fall into two categories.

The most obvious risk for any entity to acquire a representative payee role is that of criminal liability. If an individual or program embezzles disability funds, there are fairly clear cut consequences, and risk arises when consumers believe they have not been paid. On the other hand, civil malpractice liability appears to be virtually unknown regarding responsibility for consumers who engage in self-destructive activities with their allocated funds.

There are related ethical issues. Growing out of controversy concerning the correctness of any person using federal benefits in pursuit of self-destructive or illegal activities, like drinking heavily or buying street drugs, some opine that representative payees ought to withhold benefits in these circumstances. Others note the coercive nature of this position and assert that a harm-reduction approach and contingency management techniques may better advance eventual recovery.

The coercion implicit in representative payeeships is even more ethically questionable without incentives for increasing financial autonomy and higher adaptation, like the optimal learning of money management skills, or establishing objectives around housing or vocational rehabilitation.

III SUMMARY AND RECOMMENDATIONS:

A) GENERAL: If an entity elects to enter into a payee arrangement, it must establish and clearly articulate its rep payee policy. This requires:

- Understanding its own position on coercion and leverage and its ramifications on patient care.
- Being able to articulate its payee policy clearly and responsibly to consumers, with transparent accountability mechanisms.
- Having an administrative structure that can fiscally manage the representative payee arrangement.
- Having clinical and rehabilitation staff that is trained in and comfortable with working within the administrative structure.

B) CLINICAL: The AACCP recommends the following best practice:

- 1) Selection for representative payeeship:

- a) Clear indication that the person cannot manage his or her own funds, finding basic functioning routinely, directly, and significantly affected by this problem.
- This is evidenced by inability to pay bills, frequent borrowing, and lacking money for basic needs, particularly when associated with impulsive or inappropriate expenditures (e.g. alcohol, drugs, lottery tickets).
 - Indication that the person would welcome, or be willing to accept, assistance with money management in the form of a payeeship.
 - Voluntary requests for assistance are so much more respectful of autonomy than coercive payeeship that we recommend extended ongoing negotiation with the patient in order to obtain this result. Such negotiation might include progressive contracts: "if you are unable to pay money for rent for the third month in a row, would you then consider a payeeship?"
 - If, after extended negotiation, a person's difficulty with money management continues to create severe problems (homelessness, lack of food), then guardianship may be required.
 - Consultation with family, especially, or other collaterals is highly desirable throughout this process, and may involve a collective "intervention" with the patient, as well as discussion of the best candidate for being the payee. In the event of guardianship, the patient must be given measurable indicators of what demonstrable skills would be required in order for the payeeship to end, and how those skills would be demonstrated.
- b) There are some patients with whom the clinical relationship will be significantly complicated or compromised if his or her service provider becomes a representative payee. These situations are better managed by using other models of representative payeeships (e.g. through Mental Health Associations or consumer advocacy organizations).

2) Implementation:

Clinical policy must balance the need for appropriate supervision of money management by the payee with the provision of opportunities to help the patient use the payeeship to develop new skills through both learning opportunities and contingency management arrangements within the payeeship structure.

- a) Programs must use available evidence-based factors (e.g. reductions in hospitalizations and homelessness) to help plan clinical objectives and measure the effect of representative payeeship.

- Prioritizing essential bill payments (e.g. rent, utilities) is therefore critical and other matters like amounts for emergency savings and the frequency of disbursements should be individually negotiated.
- a) Programs must consider how representative payeeship influences ongoing rehabilitation planning, highlighting the therapeutic alliance. There must be maximum opportunity for choice and patient involvement in decision-making should always be a primary objective. A critical rehabilitative goal in this regard is either a short or long-term plan for the eventual termination of the payeeship.
- To this end, there should be a mechanism by which the patient earns increased financial responsibility in small yet frequent increments by demonstrating successful accomplishment of certain skills.
 - This necessarily includes money management education, simultaneously introducing specific time frames for reevaluating the patient's representative payeeship. This minimizes exaggerated transference and countertransference responses, establishes accountability, and optimizes consumer satisfaction and autonomy.
- c) Payee managers and clinical workers must receive education and training about the issues in institutional representative payeeships. Important areas are:
- Transference and countertransference issues, including techniques in preventing volatile situations with patients.
 - Budgeting principles and techniques in negotiating with patients.
 - Ongoing individual supervision concerning the challenges of this role. Individual supervision may be augmented by group supervision for creative problem solving

C) ADMINISTRATIVE: AACP recommends the following best practice:

- 1) A corporate model of administration of representative payeeship.
 - a) If a payee manager is used it is important to adopt a team approach to guarantee communication.
 - Payee managers must participate in regular clinical meetings, actively working with the consumer and clinician/casemanager, first helping a person cover necessary basic expenses, then forging a plan for stepwise disbursement of discretionary money, with graduations toward financial autonomy.
 - b) Appropriate human and technological resources to manage the accounting responsibilities inherent in managing representative payeeships include:
 - Centralized records, with computer software capabilities.

- Professional fiscal staffing who are adequately trained and supervised
- c) Accounting procedures must be transparent, assuring the consumer that funds are managed appropriately. Toward this, there must be:
- Foolproof documentation of disbursement of funds, including receipts for the consumer.
 - Formal grievance procedures, both concerning the elements of a treatment plan as it pertains to money management and concerning disbursement itself.
 - Legal consultation available to anticipate areas of liability and audit.
- 2) To enhance consumer satisfaction, the program must routinely survey patients on the representative payee program, making ongoing program modifications.
- 3) If provider safety is of concern, a formal mechanism must be in place to manage it. Administrative management focuses on how to recruit legal supports, like restraining orders, in the relatively rare instances that they are needed.

BIBLIOGRAPHY

1. Brotman AW, Muller JJ: The therapist as representative payee. *Hospital and Community Psychiatry* 1990; 41: 167-171.
2. Dixon L, Turner J, Kraus N, Scott J, McNary S: Case managers' and clients' perspectives on a representative payee program. *Psychiatric Services* 1999; 50: 781-786.
3. Feldman J: Disability payments among schizophrenic cocaine abusers (Letter). *New England Journal of Medicine* 1995; 333: 664.
4. Geller JL: Disability payments among schizophrenic cocaine abusers (Letter). *New England Journal of Medicine* 1995; 333: 664.
5. Luchins DJ, Hanrahan P, Conrad KJ, Savage C, Matters MD, Shinderman M: An agency-based representative payee program and improved community tenure of persons with mental illness. *Psychiatry* 1998; 49: 1218-1222.
6. Ries RK, Comtois KA: Managing disability benefits as part of treatment for persons with severe mental illness and comorbid drug/alcohol disorders: A comparative study of payee and non-payee participants. *American Journal On Addictions* 1997; 6: 330-338.
7. Ries RK, Dyck DG: Representative payee practices of community mental health centers in Washington state. *Psychiatric Services* 1997; 48: 811-814.
8. Rosenheck R: Disability payments and chemical dependence: Conflicting values and uncertain effects. *Psychiatric Services* 1997; 48: 789-791.

9. Rosenheck R, Lam J, Randolph F: Impact of representative payees on substance use by homeless persons with serious mental illness. *Psychiatric Services* 1997; 48: 800-806.
10. Satel SL: When disability benefits make patients sicker. *The New England Journal of Medicine* 1995; 333: 794-796.
11. Shaner A, Eckman TA, Roberts LJ, Wilkins JN, Tucker DE, Tsuang JW, Mintz J: Disability income, cocaine use, and repeated hospitalization among schizophrenic cocaine abusers: A government-sponsored revolving door?. *The New England Journal of Medicine* 1995; 333: 777-783.
12. Shaner A, Roberts LJ, Eckman TA, Tucker DE, Tsuang JW, Wilkins JN, Mintz J: Monetary reinforcement of abstinence from cocaine among mentally ill patients with cocaine dependence. *Psychiatric Services* 1997; 48: 807-810.
13. Stoner, MR: Money management services for the homeless mentally ill. *Hospital and Community Psychiatry* 1989; 40: 751-756.
14. Thornicroft G, Susser E: Disability payments among schizophrenic cocaine abusers (Letter). *New England Journal of Medicine* 1995; 333: 664-665.