Helping Patients with Severe Mental Illness Manage Money

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For many with severe mental illness, money management presents a major obstacle to independent living. One VA program has begun to break down this barrier by integrating community-based financial services into the total mental health care plan.

With the VA's shift in focus from inpatient to outpatient care, there has been an increasing emphasis on helping veterans with severe mental illness (SMI) lead stable lives within the community.[1] For such patients to succeed in this venture, however, they must overcome obstacles in several different domains. One model, which was developed for patients with substance use disorders but easily could apply to other types of SMI, identifies four problematic areas, or four "L"s: liver (health-related issues), lover (personal relationships), legal (law enforcement), and livelihood (financial support).[2,3] These areas can be thought of as the four legs of a table, each integral to the stability of the structure.

The last of these "legs," financial issues, is rarely a major focus of clinical care for SMI. Unfortunately, the reality is that, without help, some patients with SMI may misuse their money as a result of, for example, delusions, lack of skills, or impulsive behavior. Furthermore, a severely compromised mental state or reliance on drugs or alcohol can make individuals more susceptible to financial victimization. All of these factors put such patients at higher risk for homelessness, hospitalization, and other negative consequences.

Recognizing these problems and the lack of adequate interventions to solve them, staff members at the North Chicago VA Medical Center (NCVAMC) in North Chicago, IL developed a pilot program that combines coordinated clinical care with community-based money management services. In this article, we'll explain why such programs are necessary, detail the steps that led to this program's creation, describe its basic functions, and discuss its advantages over other options that exist for mentally ill patients who need assistance managing their finances.

REPRESENTATIVE PAYEES

A person's ability to manage his or her own finances is affected by many factors. Some of these are physical, such as disabilities that result from accidents or disease; others are social, such as the death

Continued on page 41

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Continued from page 32

of a family member who formerly handled money management activities; and still others are cognitive, such as delusions and uncontrolled cravings[4] or cognitive decline, which can increase susceptibility to victimization. In addition, community resources—such as support services, training programs, hospital resources,[5,6] and shelters—may be inadequate to assist those who already have trouble managing their money. And finally, when patients are released from institutional care after a long stay, during which others looked after their affairs, they may not receive sufficient training to handle the sudden increase in financial and other responsibilities.[7,8]

In order to protect recipients of social security and VA benefits who, for any of these reasons, are unable to manage their own financial affairs, Congress has authorized the Social Security Administration (SSA) and the VA to pay the benefits directly to a designated representative.[9–13] This representative payee (RP)—who may be a friend, a relative, another individual, or even an organization—is then responsible for expending the funds appropriately on behalf of the beneficiary.

In the SSA, experience has indicated that this practice most often succeeds when the beneficiary is a child or older person and the RP is a close family member. In most of these cases, the RP is in frequent contact with the beneficiary and demonstrates a desire to act in the beneficiary's best interests.

Problems seem to arise more frequently in the cases of disabled adults—especially those with substance use disorders. Such beneficiaries are more likely to be living on their own without the support of responsible family members, and the closest individual who could serve as an RP often is a distant relative or acquaintance who has only sporadic contact with the beneficiary.

Studies by the SSA's Office of the Inspector General (OIG) have suggested that these RPs pose a greater risk to the beneficiary, and an audit report by the OIG in 1997 recommended, among other improvements, more thorough screening of potential RPs and the development of a system to educate RPs about their responsibilities.[14] Current SSA policy identifies "a community-based nonprofit social service agency licensed or bonded by the State" as the RP of first choice for disabled adults with concurrent drug or alcohol addiction when a close family member is not available.[9]

RP assignment in the VA

Unlike the SSA, the VA itself may supervise and assist beneficiaries in handling their funds in certain situations. In other cases, the VA can assign a fiduciary or seek a state-appointed guardian. Despite these procedural safeguards, however, problems occur. These can be as malicious as RPs spending benefits for their own purposes or as seemingly benign as a private bank RP being unable, by its very nature, to recognize and meet a beneficiary's social and psychological needs.[15]

A contributing factor in these problems is the severe underutilization of the VA's current fiduciary program, a result of staffing limitations and budget constraints. In Illinois, for example, the August 1998 VA Fiduciary and Field Examination Activity Estate Administration Summary listed 2,188 fiduciaries and 12 staff, for an average caseload of 182 fiduciaries per staff person.[16] The VA fiduciary program has a goal of one yearly field exam, to determine whether funds are being spent properly, for each beneficiary. With such a heavy workload, and an average of 54 miles to travel for each field exam, this goal becomes very difficult to accomplish.

Furthermore, the VA fiduciary program is reactive in nature, responding to acute problems identified by clinical staff in the course of treatment. For example, the treatment team may notice that a patient has been admitted to the hospital as homeless on repeated occasions, despite having a regular income. Based on this information, the team could conclude that the patient is having serious problems with money management and take steps to have the patient enrolled in the VA fiduciary program. Ordinarily, however, when formulating psychiatric care plans VA health care teams don't perform financial assessments for the purpose of identifying individuals who could benefit from money management assistance or a designated RP.

THE CO-RP PROGRAM

In response to these weaknesses in the VA's existing fiduciary program, staff from the psychiatry service at the NCVAMC developed a pilot program that combines traditional psychiatric case management and financial services offered by a community-based, nonprofit RP agency, with the goal of making money management an integral component of patient care. This initiative was named the "CO-RP" program, with the "CO" standing for the coordination between VA case management and the community-based agency.

Continued on next page

Continued from previous page

The ultimate aim of the CO-RP program is to assist adults with SMI in their efforts to maintain stable community residence. When appropriate, the program also seeks to help them become more financially autonomous by providing training, offering support, and gradually decreasing the agency's role. In addition, both agency and VA staff assume a "protector" role, to help reduce the incidence of financial victimization among adults with SMI.

HOW CO-RP EVOLVED

The need for an RP program was recognized in 1995, when the VA's Intensive Psychiatric Community Care (IPCC) program was implemented at the NCVAMC. IPCC organizers at this facility realized that financial stability was necessary for patients with SMI to maintain residential stability in the community. Therefore, they developed a relationship with the Independent Positive Living Under Supervision (I-PLUS) RP program in Waukegan, IL.

The I-PLUS program

I-PLUS was created by a group of Lake County residents, who were active in the social services community as both employees and volunteers, after they realized that one third to one half of the individuals who were chronically homeless also were receiving SSA or VA benefits—and sometimes both. Many of these individuals were mentally ill, often dually diagnosed with developmental disabilities and chemical dependence. Frequently, the I-PLUS volunteers felt, the VA and SSA benefits were going to the underground "street economy" of drug dealers, bar owners, and others who took advantage of the individuals' compromised mental state. Without the motivation, support, or financial stability necessary to acquire more permanent living situations, these individuals would rely on overnight emergency shelter resources, thus continuing the cycle of destructive behavior. In other cases, benefits were being misused by family members or other designated RPs.

In response, this group of volunteers formed an organization to manage and disburse monetary benefits for chronically homeless clients. In so doing, they hoped to offer this population an opportunity to obtain and retain stable living arrangements, which would prevent them from becoming institutionalized or going back on the street. Starting in 1994 with only eight clients and a staff of volunteers, I-PLUS has evolved over the years into a computerized banking system that currently serves 209 clients, including 92 veterans. In fiscal year 2000, the organization managed over $1.4 million in client funds.

Today, I-PLUS employs a full-time executive director, a full-time office manager, an accountant at eight hours per week, and 10 volunteers who represent a total of two and a half full-time equivalent staff. These volunteers provide about half of the direct services offered by the organization. Funds to pay employees and maintain the rented offices in a retail building are obtained through grants from corporations, churches, foundations (such as the United Way), Community Development Block Grants, a VA research project, and individual donations.

I-PLUS is a 501(c)(3) not-for-profit social service agency, and charges its clients no fees. Its philosophy is that since the community benefits from the services it provides, the community should support it. Charging clients also could create the negative impression that I-PLUS is profiting from the service. The lack of fees is considered a selling point to clients—as well as agency participants, such as the VA.

The VA site

The NCVAMC is located in Lake County, IL approximately 45 miles north of Chicago. This area has numerous low income pockets and an extensive system of overnight emergency shelters run by churches.

The mental health program at the NCVAMC consists of 50 treatment providers from various disciplines. Customarily, mental health care is provided through the use of multidisciplinary teams, which are composed of a psychiatrist, a case manager (who can be from any discipline), and at least one other provider (determined based on the patient's specific treatment needs). The mental health care teams provide direct care and coordinate the delivery of additional services with other VA providers or with community-based organizations.

Until the initiation of the CO-RP program, the NCVAMC had no system in place to help patients with SMI manage their money. Usually, individuals who were recognized to require assistance with money management were already living in nursing homes or supervised residences. Residence staff would receive the patients' benefit checks directly as payment for services. There was little recognition of money management as a key component in enabling the individual to reenter stable community living.

Continued on page 44

Continued from page 42

IDENTIFYING AND ENROLLING PATIENTS

Under the NCVAMC's CO-RP program, mental health care providers screen their patients using clinical judgment and refer those who appear to need money management services to the CO-RP coordinator, an NCVAMC staff member who serves as a liaison between the treatment team and the RP agency. In addition, patients who hear about the program from providers or other patients sometimes present themselves to the CO-RP coordinator for assessment. The CO-RP coordinator evaluates the severity of psychiatric illness and the need for a designated RP—the latter of which is accomplished using the Determination of Need for Representative Payeeship scale.[8] If the patient is found to need an RP, the CO-RP coordinator confers first with the treatment team and then with the patient regarding this decision.

Enrollment in the CO-RP program requires either an agreement between VA staff and the patient, acknowledging that money management through an agency is appropriate, or a medical judgment of financial incapability. Patients nearly always enter into the CO-RP program voluntarily. In the rare instance that a patient refuses to give consent, the treatment team confers and may begin proceedings for involuntary RP enrollment.

INITIAL STEPS

Once the patient is enrolled successfully into the CO-RP program, the VA case manager notifies the CO-RP coordinator and receives the internal CO-RP package, which includes:

- a referral form, which is used by the RP to identify the services needed by the patient and allows the RP to open an account;
- a money management information sheet, which outlines the rules of the program and—once it's signed by a representative of the funding agency (VA, SSA, or both), the RP, and the patient—serves as the official document declaring I-PLUS as the RP;
- a monthly budget form, which details income, expenses, and cash needs; and
- special request forms, which are completed by the VA staff when the patient needs funds beyond the monthly budget.

VA staff members ensure that this paperwork is completed and filed with the I-PLUS office. This involves working with the patient and I-PLUS staff to develop a monthly budget. In addition, the VA staff will help the patient locate housing as needed.

For those patients who are making the transition from institutional to community living (the majority of CO-RP enrollees), I-PLUS volunteers work with the VA staff to expedite the transfer of benefits to enable prompt rent payment, which prevents homelessness at the critical point of discharge. Even before the transfer of benefits is accomplished, I-PLUS helps enrolled patients resolve debt and credit issues—for example, by providing security deposits on rental units and assuring creditors that payments will be made.

Once the benefits are successfully transferred, I-PLUS opens an account for the patient at a commercial bank, the National City Bank of Illinois/Michigan in Waukegan, IL. I-PLUS staff act as liaison between the bank and the patient, receiving the bank's regular statements and generating monthly statements for patients and for funding agencies upon request.

WEEK-TO-WEEK PROCEDURES

I-PLUS assumes responsibility for paying patients' major bills, but most patients also receive weekly allowances for groceries, transportation, and other miscellaneous expenses. These allowances are distributed in the form of checks—I-PLUS never provides cash to clients as a matter of policy. CO-RP patients may pick up their checks either at the NCVAMC or at the I-PLUS center during open office hours (11:30 AM to 1:30 PM every Wednesday). Every Tuesday from 8 AM to noon, I-PLUS volunteers visit the NCVAMC, bringing checks for the CO-RP patients and meeting with VA staff on various issues.

If patients choose to pick up their allowance checks directly from I-PLUS, they meet with the agency's volunteers, who use these meetings to greet the patients, update their files, and determine whether their needs have changed. Patients visiting the I-PLUS office during regular Wednesday hours also may participate in open Narcotics Anonymous or Alcoholics Anonymous meetings, held in a room adjacent to the reception area.

When a patient needs additional funds for a special purchase, the patient fills out a form with the VA case manager. The case manager then contacts I-PLUS, usually by phone. As a general rule, I-PLUS requires its clients to provide a receipt after making these kinds of purchases. VA case managers also can arrange special appointments for patients who need to meet with I-PLUS staff outside the agency's usual office hours, as well as special times for dropping off checks at the NCVAMC.

Continued on page 48

Continued from page 44

ONGOING SUPPORT, TRAINING, AND PROTECTION

The CO-RP program can help patients avoid the loss or misuse of funds by budgeting most of their money for basic survival needs. Since funds go directly to I-PLUS, the agency assumes the role of debtor, freeing patients of this stress and reducing the chances of victimization.

Grasping the concept of money management requires a cognitive and conceptual awareness of budgeting, responsible spending habits, and bill paying skills. While some individuals with SMI manage their money well, others need skills training. This is particularly true of patients who've had long or frequent periods of institutionalization (in hospitals or nursing homes). During these periods, there's no opportunity to perform such tasks as securing a private apartment, paying rent, or buying groceries. Upon discharge, these tasks can be quite daunting, especially considering the relatively small amount of money available to people who depend on VA or SSA benefits for their basic needs.

Since the range of deficits and problems among patients in the CO-RP program is quite broad, skills training is individualized. VA staff members work with patients on skill development in counseling sessions and in the field—for example, by accompanying the patient on shopping trips. While these are customary VA case manager functions, they are made more meaningful in the CO-RP program because the VA staff is receiving feedback from I-PLUS about the patient's financial situation.

Due to the chronic nature of most types of SMI, no specified length of time exists for enrollment in the CO-RP program. For many, leaving the program and assuming complete financial independence is an unrealistic goal. For others, it may be attainable—but may happen gradually over many years.

The program is designed to be flexible in this regard. Patients can continue with their weekly allowances indefinitely, or they can increase their responsibilities slowly as they become ready. Allowances can be adjusted from weekly to biweekly and then to monthly intervals. Patients who progress further can begin to pay some of their own bills. Eventually, some patients may take responsibility for their rent payments or even become their own payees.

COLLABORATION IS KEY

The heart of the CO-RP program is the coordination of clinical care with financial management. As liaison between the patient and the RP agency, the VA case manager plays a pivotal role in such coordination, providing a link between the patient's budget and treatment plan and ensuring that money management by the agency enables the patient to maintain a stable community residence. In this way, financial issues are integrated fully into the care plan.

Why doesn't the VA case manager simply serve as RP for the patient? Besides the fact that VA regulations prohibit this dual role, it would be neither practical nor desirable for either party. When a clinical provider takes a direct role in controlling a patient's finances, the potential for confusion, error, and abuse is increased. Additionally, many VA providers who've handled their patients' money have reported that it was detrimental to the clinical relationship. For example, Dixon and colleagues found that 44% of therapists acting as RPs reported verbal abuse from patients over money management.[17] But though the roles of the case manager and RP are clearly separate under the CO-RP program, communication and collaboration between the clinical provider and the community-based RP agency remains a key feature.

This collaboration begins when the VA staff first contacts I-PLUS about a new patient. Both parties help the patient develop a budget, and an I-PLUS staff member must approve any exceptions to that budget.

It continues as ongoing communication between I-PLUS and VA staff guides counseling, skills training, and budgetary changes. For example, the RP may call the VA case manager when a clinical problem arises—such as a patient showing up intoxicated to get money. I-PLUS policy prohibits the dispensing of money to clients who are unruly or under the influence of drugs or alcohol. Once notified, the VA case manager can address the problem behavior during a regular therapy session or in a specifically designed intervention. In addition, the receipt of a weekly allowance check is contingent upon the patient attending regular treatment visits with the VA case manager.

In this way, the CO-RP program assists patients with both money management and treatment needs. The VA case manager performs such crucial roles as medication monitoring and ongoing assessment of the ability of the service plan to meet the patient's needs while being freed from those financial tasks—such as accounting, distribution, and safekeeping of funds—that could compromise the

Continued on page 50

Continued from page 48

patient-provider relationship. And to ensure patients are receiving the best care possible, NCVAMC staff receive orientation and education about the CO-RP program through regular continuing education programs.

THE CO-RP ADVANTAGE

There are several potential advantages to the CO-RP program as compared to customary care and other forms of representative payeeship. First, the integration of a reputable, well organized, not-for-profit RP agency with the VA's trained, professional mental health care teams results in more effective care coordination because it makes money management a linchpin of the therapeutic process.

Next, working with a single RP agency for many veterans improves the ability of the SSA and VA fiduciary programs to monitor and control the provision of RP services. When problems arise, there is one source to investigate—which not only streamlines the investigation process but also makes it possible to apply solutions programwide, thus improving the delivery of care to all. If the agency is unresponsive to calls for improvement, it can be dropped and a relationship with a new agency forged. Outside of the CO-RP program, examiners in the VA fiduciary program have to ensure that beneficiaries are protected from a variety of inappropriate RPs.

Another benefit of the program is that it gives clinical staff at an individual VA medical center most of the responsibility for supervising patients' RPs, rather than VA or SSA fiduciary examiners. Since the NCVAMC staff members have regular contact with both the patient and RP agency, it's much easier for them to monitor the situation than it would be for the examiners.

Having an organization such as I-PLUS serve as the RP also facilitates the gathering of information on the patient's financial situation, thanks to the RP's relationship with a commercial bank, which keeps reliable records and sends monthly statements. The RP also generates its own statements, which can be sent to both the funding agency's fiduciary staff and the patient. And when patients receive monthly statements, they're more secure in the knowledge that their money is safe. Patients also are empowered through participation in monthly budgeting and ongoing training in the management of their money.

Additionally, the CO-RP program is willing to handle the accounts of very poor patients, whom many commercial banks wouldn't consider as customers. These include patients with poor or no credit and those receiving less than $1,000 per month.

Prior to the CO-RP program, VA case managers had to find and recruit a responsible party to serve as the RP for any patient with SMI in need of money management assistance. Given the current staffing constraints on the VA fiduciary program, it's extremely difficult to gain access to this program. Even then, enrollment is slow—it can take six to 12 months or longer to find an RP—and the quality of available RPs is questionable. The SSA has had similar problems and has stated that it prefers agency RPs when responsible family members aren't available.

To improve on customary care, the CO-RP proactively enrolls eligible patients, under the authority of the VA fiduciary program or the SSA, and promptly designates the I-PLUS agency to serve as the RP. The VA has established that I-PLUS is a well supervised and scrupulous agency, and therefore is able to cut through the red tape for a speedy and efficient enrollment, usually within about two months.

When patients who receive VA or other benefits are making the transition from nursing home residence to community living, advocacy often is required. Without intervention, it's not unusual for benefit checks to continue to be sent to the nursing home after the patient has been discharged. In customary care, VA staff members lack the coordinated advocacy to obtain all entitlements and assist in their patients' transition to the community. Under the CO-RP program, however, I-PLUS works with VA staff to anticipate discharges and expedites the transfer of benefits from the nursing home to the patient's I-PLUS account.

Finally, the CO-RP program has a good track record of patient retention. Throughout its eight-year history at the NCVAMC, only 7% of enrollees have dropped out of the program before completing their first year.

SUCCESSFUL MAINTENANCE IN THE COMMUNITY

The CO-RP program is designed to help patients maintain stable community residence by avoiding the loss or misuse of their funds. The RP agency serves as a liaison to landlords and ensures that the patients' basic needs, such as food and clothing, are met. For the very poor, the CO-RP program has established relationships with board and care homes and with pharmacies to ensure accessibility of medication. Theoretically, the program establishes a productive cycle in

Continued on page 54

Continued from page 50

which reputable financial management and regular access to medical treatment, counseling, and support combine to create an environment that fosters adherence to prescribed therapies. This, in turn, reduces the chances that patients will return to destructive behavioral patterns and increases the stability of the living situation.

On the surface, then, it would appear a good idea for the SSA and the VA to utilize community mental health and social service agencies for assistance in managing veterans' benefits. There is, however, little guidance available in medical literature regarding the proper coordination of VA psychiatric care with agency RP programs. It's likely that well managed, properly functioning programs are scarce. Additionally, some RP agencies are reported to collect fees from their clients—despite the fact that they act as little more than a "pass through" to clients, providing few if any of the services detailed in the CO-RP program.

Nevertheless, the strong potential for improving the effectiveness of mental health care, as well as for reducing abuses to the system, suggests that collaborative programs between clinical providers and community-based RP agencies deserve careful study. In 1989, the chair of the U.S. Senate Select Committee on Aging's Subcommittee on Housing and Consumer Interests noted, "In light of the anticipated growth in demand for surrogate decision making services, coupled with the corresponding increase in individuals and organizations providing such services, this is an appropriate time to improve this nation's capacity to ensure that guardianships and representative payeeships are ordered only when appropriate; that once imposed, they are monitored adequately; and that guardians and representative payees are expected to adhere to reasonable standards of practice and ethical principles."[13] Although this statement was made more than a decade ago, it still applies today. Now, more than ever, the time has come to shore up the fourth leg on the table of community living, in order to better serve both patient and community. ●

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REFERENCES

1. Statement to the media: NMHA statement on treatment for veterans with mental illness/substance abuse disorders [news release]. Alexandria, VA: National Mental Health Association; May 18, 2000. Available at: www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=202. Accessed August 5, 2003.
2. Weisner C. The social ecology of alcohol treatment in the United States. In: Galanter M, ed. *Recent Developments in Alcoholism*. Vol 5. New York, NY: Plenum; 1986:203–245.
3. Finney JW, Moos RH. Entering treatment for alcohol abuse: A stress and coping model. *Addiction*. 1995;90:1223–1240.
4. *Disability Benefits for Drug Addicts and Alcoholics are Out of Control: Testimony Before the Subcommittees on Social Security and Human Resources, Committee on Ways and Means House of Representatives*. Washington, DC: U.S. General Accounting Office; February 9, 1994. Publication No. T-HEHS-94-101.
5. Shaner A, Eckman TA, Roberts LJ, et al. Disability income, cocaine use, and repeated hospitalization among schizophrenic cocaine abusers—A government-sponsored revolving door? *N Engl J Med*. 1995;333:777–783.
6. Grossman LS, Willer JK, Miller N, Stovall JG, McRae SG, Maxwell S. Temporal patterns of veterans' psychiatric service utilization, disability payments, and cocaine use. *J Psychoactive Drugs*. 1997;29:285–290.
7. Wilbur KH, Buturain L. Daily money management: An emerging service in long-term care. In: Larue GA, Bayly R, eds. *Long-Term Care in an Aging Society: Choices and Challenges in the '90s*. Buffalo, NY: Prometheus Books; 1992: 93–117.
8. Conrad KJ, Matters MD, Hanrahan P, Luchins DJ, Savage C, Daugherty B. Characteristics of persons with mental illness in a representative payee program. *Psychiatr Serv*. 1998;49:1223–1225.
9. Social Security Act Amendments of 1939, ch 666, §205(j)(1), 53 Stat 1371, as amended by the Omnibus Budget Reconciliation Act of 1990, Pub L No. 101-508, §5105, 149 Cong Rec H 12, 497–501.
10. Veterans Benefits Act, 38 USC §3201–3204, 3501 (1988).
11. Part VIII, section I: Fiduciary and field examination program. In: *Department of Veterans Affairs Manual M21-1—Adjudication Procedures: Compensation and Pension, Dependency and Indemnity Compensation, Accrued Amounts, Burial Allowance, Special Benefits*. Washington, DC: Department of Veterans Affairs; April 2000:ch 1–10.
12. Part VIII, section II: Fiduciary program and field operations. In: *Department of Veterans Affairs Manual M21-1— Adjudication Procedures: Compensation and Pension, Dependency and Indemnity Compensation, Accrued Amounts, Burial Allowance, Special Benefits*. Washington, DC: Department of Veterans Affairs; April 2000.
13. *Surrogate Decision Making for Adults: Model Standards to Ensure Quality Guardianship and Representative Payeeship Services. A Report Presented by the Chairman of the Subcommittee on Housing and Consumer Interests of the Select Committee on Aging*. Washington, DC: U.S. Government Printing Office; 1989. Comm. Publication No. 100-705.
14. U.S. Social Security Administration, Office of the Inspector General, Office of the Audit. *Monitoring Representative Payee Performance: Roll-Up Report*. San Francisco, CA: U.S. Social Security Administration; March 28, 1997. Audit Report A-09-96-64201.
15. Conrad KJ, Hanrahan P, Matters MD, et al. *A Representative Payee Program for Individuals with Severe Mental Illness at Community Counseling Centers of Chicago*. Chicago, IL: University of Illinois at Chicago Health Policy and Administration, School of Public Health; 1998.
16. *VA Fiduciary and Field Examination Activity Estate Administration Summary*. Washington, DC: Department of Veterans Affairs; August 1998.
17. Dixon L, Turner J, Krauss N, Scott J, McNary S. Case managers' and clients' perspectives on a representative payee program. *Psychiatr Serv*. 1999;50:781–786.