# A Systematic Review of Health Outcomes Associated With Provision of Representative Payee Services

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**Objective:** The Social Security Administration's Representative Payment Program appoints payees as financial managers for individuals determined incapable of managing their funds. The aim is to afford stability and increase clients' ability to meet health and behavioral priorities. This systematic review examined literature on the effect of representative payee services on identified outcomes.

**Methods:** A search of academic databases and gray literature was conducted in November 2015 and repeated in December 2017. Included studies had a comparison group; excluded studies examined services other than representative payee. Primary outcomes included substance use, symptoms of mental illness, housing stability, quality of life, and other health-specific outcomes. Secondary outcomes included the client-payee relationship and client satisfaction with services.

**Results:** Eighteen articles met inclusion criteria. Studies assessing primary outcomes found several positive and few negative effects of representative payee services. Studies examining secondary outcomes indicated that receipt of such services may affect the client-provider relationship, increase conflict and violence, and increase clients' perceptions of financial leverage (i.e., a payee's use of control over funds to encourage, incentivize, or otherwise coerce certain behaviors). Most studies were of poor or moderate quality. Studies spanned nearly two decades, and results may have been confounded by the evolution of service delivery modalities.

**Conclusions:** Representative payee services are largely beneficial or neutral in terms of health and behavior outcomes. Negative findings mainly involved the client-payee relationship. Given that more than five million individuals have a representative payee, assessing the impact of these services with more rigorous research designs is worthwhile.

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More than 60 million people in the United States receive Social Security benefits, including 11 million who receive Social Security Disability Insurance (SSDI) and another eight million who receive Supplemental Security Income (SSI) (1). Both programs provide benefits to individuals with disability determinations related to musculoskeletal disorders (42% of disability beneficiaries); psychiatric disorders, including intellectual disability, mood disorders, and schizophrenia or other psychotic disorders (35%); and injury (15%) (categories are not exclusive) (2). Approximately 7% of disability beneficiaries also report substance use disorders, although a change in federal law in 1996 terminated drug or alcohol use disorders as primary reasons for disability determination (3).

Nearly 9% of people who receive Social Security benefits have their funds managed through the Social Security Administration's Representative Payment Program (1). In this program, the Social Security Administration (SSA) appoints a person or an organization to manage payments on behalf of the beneficiary (4). Of beneficiaries with representative payees (approximately 5.3 million individuals in 2017), 31.8% have a disability determination (1). Of the 1.7 million people

### HIGHLIGHTS

- Of the 1.7 million Americans with disabilities whose Social Security benefits are managed through the SSA's Representative Payment Program, 77.5% are classified as having mental disorders.
- Studies assessing primary outcomes, such as substance use, psychiatric symptoms, and housing stability, found several positive and few negative effects of having a representative payee.
- Studies of secondary outcomes indicated that having a payee may affect the client-provider relationship and increase conflict and clients' perceptions of coercion.
- Most studies were of poor methodological quality, and more are needed, particularly of familial payee relationships and of the degree to which services are client centered and include clients in decision making.

with disabilities who have representative payees, the vast majority (77.5%) are classified by SSA as having mental disorders. Of this group, 47.6% have intellectual disability and 41.8% have psychiatric disorders (mood disorders, organic mental disorders, and schizophrenia or other psychotic disorders) (5). There are other ways of helping vulnerable individuals with their money management, such as power of attorney; financial mentoring programs at nonprofit organizations; advisor-teller money manager therapy; and support of decision making, in which beneficiaries receive informal support from friends or family members (6). However, the Representative Payment Program is unique in that it is a federal program for individuals determined by SSA to be incapable of managing their benefits (5, 7).

The Representative Payment Program (often referred to as representative payee services) ensures that benefits payments are used each month for housing, utilities, and other basic needs for individuals who receive SSI or SSDI and who are incapable of managing their benefits (4). When representative payees have been assigned to beneficiaries, entitlement funds can no longer be accessed by the beneficiary but are instead paid directly to the payee, who then ensures that the individual's basic needs are met (8). Approximately 85% of beneficiaries with representative payees have relatives serving in that capacity, but SSA may also appoint social service or fee-for-service organizations as organizational representative payees when no appropriate family member is available (7, 9). In addition to financial management, representative payees may provide budgeting education, advocacy regarding funds, and funding reporting to SSA on behalf of the client (9, 10). The program has been in place for decades as a mechanism to manage benefits, and providers have recognized the program's potential to produce positive outcomes for people served.

Although SSA does not report on the effects of representative payee services on the health of beneficiaries, several studies have tested the program's effects on a variety of client-level outcomes, including substance use, various indicators of health and mental health, homelessness, client-provider relationships, and client satisfaction (11–17). Investigators have also reported negative experiences of payee services, including perceived coercion, wherein representative payees threaten to withhold money if beneficiaries do not adhere to treatment or comply with other demands (15, 16). Other negative experiences may include misuse of funds by representative payees and loss of individual autonomy and agency (18, 19). Because of these concerns, some studies have examined secondary outcomes related to quality of life, client satisfaction, and relationships with providers (14, 19, 20).

In the past decade, behavioral health researchers have developed a more comprehensive understanding of the consequences of being financially vulnerable. For example, experiencing chronic poverty is associated with a diminished capacity to make financial decisions and with diminished executive processes (21–23), creating a downward spiral of exacerbating circumstances. People with a mental illness or a physical disability who struggle with managing their money because of their illness may fall into a cycle of reduced capability as they become more financially unstable. Having a representative payee may help stabilize the finances of people with mental illness and so cushion them from the adverse effects of living in chronic poverty. By stabilizing the finances of these individuals, representative payee services can address not only immediate financial needs but also long-term health and mental health consequences.

However, literature on the effectiveness of representative payee services is fragmented across multiple fields of study and multiple types of outcomes. Studies have usually focused on a small set of outcomes and have not explored the effect of representative payee services on health through a holistic lens. Furthermore, most studies have involved small samples and have not used control groups or other rigorous study designs. Therefore, the degree to which use of representative payee services is associated with physical, behavioral, and other health outcomes is not definitively known. The aim of this research was to summarize the literature on the effect of receipt of representative payee services on identified outcomes.

## METHODS

The aim of this systematic review was to compare outcomes for individuals who received representative payee services and those who did not. Primary outcomes of interest included substance use, symptoms of mental illness, housing stability, quality of life, or other health-specific outcomes. Secondary outcomes included client satisfaction with services, financial leverage (i.e., a payee's use of control over funds to encourage, incentivize, or otherwise coerce certain behaviors), or therapeutic or other relationship with providers. The systematic review was conducted in accordance with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (24). To identify relevant articles, a search was conducted by using three electronic databases (PubMed, Scopus, and Web of Science) with the term "representative pay*." Because the topic was so specific, additional search terms were not needed, and this exact terminology was used to constrain results so that other methods of financial management were not included. No restrictions were placed on date of publication. Once duplicate articles were removed, citations were mined for additional relevant studies. The search was conducted in November 2015; because some time had elapsed between the original search and analysis of studies, the search was rerun in December 2017 to capture any new publications. Inclusion criteria were quantitative, qualitative, or mixed-methods studies that were peer reviewed and conducted in English and in the United States, with aims specific to representative payee and not another financial assistance program.

The same term (representative pay*) was used to conduct a gray literature search of past abstracts from annual meetings of the American Public Health Association, the National Institutes of Health's (NIH) database of Health Services Research Projects in Progress, and the Web site of the Substance Abuse and Mental Health Services Administration. Again, there were no restrictions on date of publication. Citations of studies identified during the gray literature search were also mined for additional publications. Because the gray literature search produced two links to NIH-funded studies, the NIH Research Portfolio Online Reporting Tool was also searched.

References and abstracts were uploaded to and deduplicated via DistillerSR, which was used for workflow management, article screening, and data abstraction. All the uploaded studies were independently screened for eligibility on the basis of titles and abstracts by two authors (SMK, MH). Conflicts were discussed by the two authors until consensus was reached, and unclear cases were moved forward to full-article review. Articles that met screening criteria included reports of studies conducted in the United States with the target population of adults who received representative payee services and that addressed the primary and secondary outcomes noted above. Articles were excluded if they addressed only a form of money management other than representative payee.

The full texts of all articles not excluded at the screening level were assessed by all authors with the same method of adjudication as described above when disagreement occurred. At this level of review, studies retained were those that evaluated or measured the effects of representative payee services as a primary independent variable or a primary factor under investigation and that assessed primary or secondary outcomes of interest. To be included, studies thus had to include a comparison or control group, either via a separate cohort of individuals who did not receive representative payee services or a pre-post comparison of the same cohort. Studies that described only numbers or characteristics of individuals receiving representative payee services were excluded. When necessary, additional information was requested from study authors. Finally, additional studies that met these criteria were identified by peer reviewers and abstracted as described below.

The selected studies were reviewed to extract study information by using a form developed specifically for this study in DistillerSR. We initially extracted and compared data from three studies to ensure consistency. Data from the remaining studies were extracted independently by two authors (SMK, MH), including study location and setting (clinic, mental health agency, etc.); who served as payee (friend, family member, or provider); and study design elements, including sampling frame, recruitment methods, inclusion and exclusion criteria, sample size, comparison groups, dates of study, and outcomes of interest.

Methodological quality of the studies was evaluated with the Quality Assessment Tool for Quantitative Studies. This tool, developed by the Effective Public Health Practice Project, has been shown to have high interrater reliability and construct and content validity (25, 26). We used this tool to assess each of the abstracted articles for quality of sample selection, study design, confounders, blinding, data collection methods, withdrawals, and dropouts. These items were rated on a 3-point Likert scale (1, strong; 2, moderate; and 3, weak). We (SMK, SLC, MH) each independently rated the final 18 studies, scoring a study as strong if there were no weak ratings, moderate if there was one weak rating, and weak if there were two or more weak ratings. We each gave the studies the same rating.

## RESULTS

The initial database search yielded 546 articles, of which 107 were unique. Other search methods (citation mining and gray literature) resulted in 119 articles, of which 95 were not duplicated in either the database or other search strategies. Thus, a total of 202 articles were initially screened, and 57 were retained for full-text review. Three additional articles were identified by peer reviewers after our manuscript was submitted for publication. Ultimately, 18 articles, representing 11 unique participant samples, met full inclusion criteria and were included in data abstraction. [A PRISMA diagram illustrating this process is available in an online supplement to this article.]

### Primary Outcomes

Table 1 summarizes our results, including the main findings from each study that was included in data abstraction. Overall, 12 of 18 studies reported on at least one primary outcome.

*Housing stability.* Five studies examined representative payee services' association with housing stability (11–13, 27, 28). Representative payee services do not appear to decrease housing stability and may increase it. One study found that representative payee services were associated with fewer days of homelessness (27), another found a trend toward significance between representative payee services and fewer homeless days (12), and two studies did not find any association (11, 13). Rosenheck et al. (27) analyzed data from a study of assertive community treatment with 1,348 homeless individuals in 18 U.S. cities. They compared individuals who had a representative payee for the entire observation period, individuals who acquired a representative payee during the observation period, individuals who did not have a representative payee but who received public support, and individuals who did not have a representative payee and did not receive public support. They compared self-reported number of days literally homeless at baseline and at 3 months and calculated percentage change. Although all four groups reported fewer days of homelessness at 3 months, the two groups that received representative payee services for at least part of the observation period reported a greater decrease in days of homelessness, compared with the other two groups. The percentage change in homelessness days for the groups was as follows: newly acquired

**TABLE 1. Details and findings of studies of outcomes associated with provision of representative payee services**

| Study | Population and location | Intervention | Representative payee | Outcome: Primary | Outcome: Secondary | Main findings |
|---|---|---|---|---|---|---|
| Angell et al., 2007 (14) | Individuals receiving services from a large, urban community mental health center | Case management services and representative payee services managed in a nonclinical department. Case managers served as fiduciary authority ("clinician payee"). Clients with a clinician payee (N=84) were compared with those with a noninstitutional payee (N=23) and those without a payee (N=94). | Mental health or other service agency | | Client-provider relationship, financial leverage, perceived coercion | In bivariate analyses, having a clinician payee was associated with experiencing financial leverage ($p<.001$) and with client-provider conflict ($p<.001$) but not with client-provider bond. Client-reported experiences of financial leverage mediated the relationship between having a clinician payee and reporting client-provider conflict. |
| Conrad et al., 2006 (12) | Individuals receiving care from the VA in Chicago | Individuals were randomly assigned to receive representative payee services through a community agency that coordinated services with the VA (N=94) or general case management through the VA, where they could receive representative payee services through usual channels but not in a coordinated fashion (N=90). Individuals were followed for 12 months. | Mental health or other service agency | Housing stability, health-related quality of life, symptoms of mental illness, substance use | Money management | At 12 months, participants in the intervention arm reported significantly fewer drinks ($\beta=-16.0$, $p=.04$) and drug months ($\beta=-.5$, $p=.02$), higher quality of life ($\beta=.5$, $p=.03$), and lower money mismanagement ($\beta=-.5$, $p<.001$), compared with participants in the control arm. Intervention participants reported fewer days of homelessness, but results did not reach significance. Not all intervention participants and some control arm participants received representative payee services. |
| Elbogen et al., 2003 (16) | Individuals with serious mental illness in nine counties in North Carolina | Individuals were randomly assigned to receive mandated involuntary outpatient commitment (OPC) to avoid hospitalization and followed for 12 months. Analyses compared those who received OPC and representative payee services (N=62), those who received representative payee services but not OPC (N=46), those who received OPC but not representative payee services (N=85), and those who received neither OPC nor representative payee services (N=65). | No detail provided. Study tracked only whether participants had representative payee assignment. | Treatment adherence | Financial leverage, perceived coercion | Compared with individuals who did not have a representative payee at any point in 12 months, those who added a new representative payee during the year had 3.85-higher odds of better treatment adherence ($p=.003$). Having a representative payee alone (odds ratio [OR]=3.44, $p=.004$) or in conjunction with OPC (OR=3.82, $p<.001$) was associated with perceived coercion. |

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**TABLE 1,** *continued*

| Study | Population and location | Intervention | Representative payee | Outcome: Primary | Outcome: Secondary | Main findings |
|---|---|---|---|---|---|---|
| Elbogen et al., 2003 (33) | Individuals with serious mental illness in nine counties in North Carolina | Individuals were randomly assigned to receive mandated OPC to avoid hospitalization. Analyses used baseline assessment data and compared individuals who were receiving payee services at baseline (N=109) and those who were not (N=149). | No detail provided. Study tracked only whether participants had representative payee assignment. | | Financial leverage, perceived coercion | Individuals with a representative payee had 5.14-higher adjusted odds of reporting perceived coercion ($p<.001$). |
| Elbogen et al., 2003 (28) | Individuals with serious mental illness in nine counties in North Carolina | Individuals who were awaiting discharge on outpatient commitment from one of four hospitals and receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) (N=240) were recruited into a randomized trial. Analyses used baseline data prior to randomization. Individuals receiving representative payee services (N=70) were compared with those who had another money management arrangement (N=33). | No detail provided. Study tracked only whether participants had representative payee assignment. | Substance use, insufficient funds for housing | | Compared with individuals with informal money management arrangements, those receiving representative payee services had greater odds of comorbid substance use disorders (OR=4.28, $p<.01$) and lower odds of reporting insufficient funds for housing (OR=.13, $p<.05$). |
| Elbogen et al., 2005 (18) | Individuals with serious mental illness in nine counties in North Carolina | Individuals were randomly assigned to receive mandated OPC to avoid hospitalization and followed for 12 months. The study assessed 245 individuals who were followed through four follow-up time points (0, 4, 8, and 12 months). Those whose family member served as a payee (N=75) were compared with those with a nonfamily payee or no payee (N=170). | Family member or non–family member payee | | Family violence | Having a family representative payee was associated with family violence (bivariate: OR=1.93, $p=.05$; multivariable: OR=2.11, $p=.04$). |
| Hawk et al., 2016 (17) | Individuals living with HIV and receiving supportive housing | Representative payee services were offered to individuals living in a supportive housing program for people living with HIV. Individuals (N=18) were followed for 6 months. | Mental health or other service agency | HIV viral load suppression | | The number of individuals who were virally suppressed significantly increased 6 months after enrollment in representative payee services ($p=.004$). |

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| Study | Population and location | Intervention | Representative payee | Outcome: Primary | Outcome: Secondary | Main findings |
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| Herbst et al., 1996 (31) | Individuals who received an initial SSI or SSDI check while in treatment in a methadone maintenance treatment program in San Francisco | An observational study of 26 individuals; of those for whom payee status could be ascertained (N=18), eight had a representative payee. They were compared with the ten without a payee. | No detail provided. Study tracked only whether participants had representative payee assignment. | Substance use, treatment adherence | | No association was found between receipt of representative payee services and substance use outcomes, but individuals without a payee missed significantly more clinic attendance days after check receipt, compared with before check receipt (median increase of missed days from 4 to 14, p=.02). |
| Labrum, 2017 (36) | U.S. adults who reported having a relative with a psychiatric disorder and responded to an online survey | Respondents were included if they were age 55 or older (N=243). Whether the family member served as an official representative payee was assessed in a regression model predicting violence. | Family member | | Physical, financial, or psychological abuse perpetration | Serving as a representative payee was associated with experiencing financial abuse ("In the past 6 months how many times has s/he [the relative with a psychiatric disorder] misused or stolen any of your funds, property, or assets?"; OR=2.76, p=.05) but was not associated with physical or psychological abuse. |
| Labrum, 2018 (30) | U.S. adults who reported having a relative with a psychiatric disorder and responded to an online survey | Respondents (N=573) were asked if they provided money management on behalf of their relative in the past 6 months. Those who provided "official" money management (representative payee) (N=101) were compared with those who provided "unofficial" money management (N=155). | Family member | Psychiatric hospitalization, treatment adherence, substance use, arrest history | | Among relatives with a psychiatric disorder, 57% of those whose family member served as a representative payee had a psychiatric hospitalization in the past year, compared with 35% of those whose family member provided unofficial money management services (p<.001). Those receiving representative payee services were more likely to have attended regular mental health treatment in the past 6 months, compared with those receiving unofficial assistance (78% versus 61%, p=.005). No difference between the two groups was found in rates of substance use in the past 6 months or adulthood history of arrest. |

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**TABLE 1,** *continued*

| Study | Population and location | Intervention | Representative payee | Outcome: Primary | Outcome: Secondary | Main findings |
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| Labrum and Solomon, 2016 (35) | U.S. adults who reported having a relative with a psychiatric disorder and responded to an online survey. | Respondents (N=573) were categorized by whether their family member with a psychiatric disorder had enacted any violence against them in the past 6 months (N=124). Whether the family member served as an official representative payee (N=101) was assessed in a regression model predicting violence. | Family member | | Violence perpetration | In a multivariate model controlling for all factors significantly associated with family violence, family members who served as representative payees had 2.93-higher odds of experiencing violence perpetrated by their family member with a psychiatric disorder ($p<.001$). |
| Luchins et al., 1998 (10) | Individuals with serious mental illness receiving services at a community mental health center in Chicago | Services provided by the Community Counseling Center of Chicago included case management, day treatment, budgeting assistance, and assistance locating housing. Representative payee services were delivered at the agency. Analyses compared the 12 months before and 12 months after representative payee enrollment of center clients (N=56). | Mental health or other service agency | Health care utilization | | A reduction was noted in the mean number of days of state hospitalization (length of stay reduced by 61.1 days, $p<.001$) and the frequency of admissions (reduced by .8, $p<.001$) after receipt of services that included representative payee services. Similar reductions were observed for a subsample of individuals for whom data were available on Medicaid-funded private hospitalizations. |
| Moore, et al., 2016 (34) | Adults receiving SSI or SSDI who were receiving services from one of five outpatient mental health programs in Connecticut | A secondary analysis of baseline data from a randomized trial that assessed money management–focused treatment (N=107) | No detail provided. Study tracked only whether participants had representative payee assignment. | | Money management | Receipt of representative payee services was not associated with self-reported money mismanagement (measured by the problems with managing money scale from the Money Management Questionnaire). |
| Ries and Comtois, 1997 (13) | Individuals with co-occurring serious mental illness and an alcohol or drug use disorder receiving services in a large, urban, outpatient, and university-linked program for treatment of co-occurring disorders | The program included staff and treatment modalities from systems that provided alcohol and drug treatment and systems that provided treatment for persons with serious mental illness. Individuals (N=275) received care from case managers, nurses, and doctors, who used a harm reduction approach. Analyses compared those who received representative payee services from the program (N=116) and those without payee services (N=159). | Mental health or other service agency | Housing stability, health care utilization, substance use treatment, incarceration | | Representative payee services were associated with higher outpatient service utilization; total hours of services used in the past 90 days was higher by an average of 30.3 hours for individuals with representative payee versus not ($p<.002$). There were no significant differences in housing stability measures, psychiatric hospitalization, addiction treatment, or days incarcerated in the past 90 days. |

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**TABLE 1,** *continued*

| Study | Population and location | Intervention | Representative payee | Outcome | | Main findings |
|---|---|---|---|---|---|---|
| | | | | Primary | Secondary | |
| Rosen et al., 2007 (11) | Individuals from multiple locations with serious mental illness who were experiencing homelessness | As part of the Access to Community Care and Effective Services and Supports (ACCESS) demonstration project, individuals in 18 communities in 9 states received assertive outreach and case management services. A total of 1,457 received Social Security benefits and completed at least 1 follow-up assessment within 12 months after enrollment. The analysis compared those who did not receive representative payee services (N=969) with those who were newly assigned a payee between months 0 and 3 (N=174) and between months 4 and 12 (N=314). | No detail provided. Study tracked only whether participants had representative payee assignment. | Substance use, housing stability, health care utilization | | Having a representative payee was not associated with housing measures or substance use outcomes. Individuals who obtained a representative payee between months 4 and 12 used significantly more days of psychiatric services (p=.07) and significantly higher numbers of health and social services (housing, mental health, substance abuse, general health, and vocational) in the past 60 days (p=.006), compared with individuals who were not assigned a representative payee and those who were assigned a payee between months 0–3. |
| Rosenheck et al., 1997 (27) | Individuals from multiple locations with serious mental illness who were experiencing homelessness | As part of the ACCESS demonstration project, individuals in 18 communities in 9 states received assertive outreach and case management services. Analyses compared data from individuals at baseline to 3-month follow-up (N=1,348). Those who obtained a payee during the 3 months (N=144) were compared with 3 other groups: public support beneficiaries who had a payee for the entire 3-month period (N=125), public support beneficiaries who were never assigned a payee (N=663), and those who received neither public support nor payee services (N=416). | No detail provided. Study tracked only whether participants had representative payee assignment. | Substance use, symptoms of mental illness, housing stability | | The two groups that received representative payee services for at least part of the observation period reported a greater decrease in homeless days, compared with the other groups. Percentage changes in homeless days were as follows: newly started representative payee services (N=140), −56%; continued representative payee services (N=115), −58%; public support only (N=623), −48%; no public support and no payee (N=400), −51% (p=.001). Representative payee services were not associated with substance use outcomes or severity of mental illness symptoms. |

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**TABLE 1,** *continued*

| Study | Population and location | Intervention | Representative payee | Outcome: Primary | Outcome: Secondary | Main findings |
|---|---|---|---|---|---|---|
| Swartz et al., 2003 (32) | Individuals from Chicago, Los Angeles, and Seattle, whose SSI disability benefits for drug and alcohol dependence were terminated in January 1997 | An observational study of the effect of termination of SSI disability benefits for individuals with drug and alcohol addiction. Individuals (N=740) were randomly selected and interviewed between December 1996 and April 1997 and then followed for 12 months. Among those who requalified for SSI in the 12 months after termination (N=247), those who received representative payee services were compared with those who did not (Ns not reported). | No detail provided. Study tracked only whether participants had representative payee assignment. | Substance use | | Representative payee services were not associated with substance use outcomes. |
| Weiser et al., 2006 (29) | Men who were homeless or marginally housed and living with HIV in San Francisco | Respondents (N=239) were surveyed every 2 years; data were from the 1999–2000 survey wave. Whether the person received representative payee services was assessed in a regression model predicting depressive symptoms. | No detail provided. Study tracked only whether participants had representative payee assignment. | Depression | | Individuals receiving representative payee services had higher adjusted odds of reporting depressive symptoms on the Beck Depression Inventory, compared with those who did not receive representative payee services (adjusted OR=2.37, $p<.05$). |

representative payee (N=140), −56%; continued representative payee services (N=115), −58%; public support only (N=623), −48%; and no public support (N=400), −51% (p=0.001).

Conrad et al. (12) studied 184 clients receiving care from the U.S. Department of Veterans Affairs (VA) who were randomly assigned to receive representative payee services through a community agency that coordinated services with the VA or who received general case management through the VA; the latter group could receive representative payee services through usual channels but not in a coordinated fashion. Participants were assessed at baseline and at 6 and 12 months. In the main analyses, the authors compared the experimental group (coordinated representative payee) to the control group (general case management). Individuals in the experimental group had 14.2 fewer days of homelessness (p=0.07) at 6 months and 10.9 fewer days (p=0.06) at 12 months, compared with the control group. However, not all participants in the experimental group received representative payee services; therefore, post hoc analyses compared individuals in the experimental group who received representative payee services, individuals in the experimental group who did not receive representative payee services, and individuals in the control group. At 12 months, those in the experimental group with representative payees had 14.9 fewer days of homelessness than those in the experimental group without a representative payee (p=0.08) and 21.2 fewer days of homelessness than those in the control group (p=0.02). Of note, however, some members of the control group also received representative payee services; therefore, post hoc results did not represent the independent effect of receiving representative payee services.

An analysis by Elbogen et al. (28) of baseline data from a cohort of 103 individuals with serious mental illness who were awaiting discharge from an inpatient setting before random assignment to a study arm showed that those who were receiving representative payee services had lower odds of reporting insufficient funds for housing, compared with those not receiving such services (odds ratio [OR]=.13, $p<0.05$).

Rosen et al. (11) analyzed data from the same intervention as Rosenheck et al. (27), looking at timing of representative payee enrollment. Specifically, the authors compared individuals who were not assigned a representative payee with those who were assigned a payee between months 0 and 3 and those who were assigned a payee between months 4 and 12. No differences between the groups were noted in number of days housed in the past 60 days. Similarly, an analysis by Ries and Comtois (13) of data from 275 individuals with serious mental illness and alcohol and other drug use who were receiving treatment services did not find a significant difference in housing stability measures between those who received representative payee services from the agency and those who did not.

*Mental health outcomes.* Only one study found an association between representative payee services and symptoms of mental illness. Weiser et al. (29) analyzed one wave of data from a longitudinal study of 239 homeless or marginally housed men living with HIV in San Francisco. The authors found that those receiving representative payee services had higher rates of depressive symptoms on the Beck Depression Inventory, compared with those not receiving services, after adjustment for other covariates (adjusted OR=2.37, $p<0.05$). However, because the study was cross-sectional, there was no way to assess the direction of the association, because experiencing depressive symptoms may have increased the likelihood that a person would receive representative payee services in the first place.

Two studies examined changes in symptoms of mental illness (12, 27). Conrad et al. (12) assessed participant results on the Colorado Symptom Index (CSI) and found no significant difference in CSI change over time between the experimental and control groups or, in post hoc analyses, between the experimental group with a representative payee, the experimental group without a representative payee, and the control group. Rosenheck et al. (27) assessed the depression symptom score from the National Institute of Mental Health Diagnostic Interview Schedule, the psychosis symptom score from the Psychiatric Epidemiology Research Interview, and the Addiction Severity Index psychiatric composite score. No association was found between receipt of representative payee services and depression symptoms, psychosis symptoms, or addiction severity.

There is stronger evidence that receipt of representative payee services reduces inpatient utilization and increases outpatient utilization. Four studies examined mental health service utilization (10, 11, 13, 30). Luchins et al. (10) studied a cohort of 56 individuals with serious mental illness receiving services at an urban mental health center, including representative payee services, case management, and day treatment. The authors compared the 12 months preenrollment with the 12 months postenrollment and observed a reduction in the frequency of state hospitalizations (number reduced by 0.8, $p<0.001$) and duration of state hospitalizations (number of mean days reduced by 61.1, $p<0.001$) after receipt of services. Similar significant reductions were observed for a subsample of individuals for whom data were available on Medicaid-funded private hospitalizations. Even though Ries and Comtois (13) found that among individuals with serious mental illness and co-occurring substance use disorders, those who received representative payee services had higher illness severity than those who did not, the authors found no significant between-group difference in psychiatric hospitalization. Instead, individuals receiving representative payee services used significantly more hours of outpatient services than those without payee services, including case management (14.54 versus 6.27, respectively; $p<0.002$), group treatment (32.17 versus 15.93; $p<0.002$), and day treatment (13.26 versus 7.41; $p<.05$).

In post hoc analyses, Rosen et al. (11) found an increase in receipt of outpatient psychiatric services among individuals who acquired a representative payee in months 4–12, compared with other groups. Labrum (30) surveyed 573 U.S. adults who reported having a family member with a psychiatric disorder. Compared with individuals who received informal money management services from a family member (N=155), those with a family member who served as their representative payee (N=101) attended regular mental health treatment in higher proportions (78% of those with a representative payee versus 61% of those receiving informal money management services; $p=0.005$) and were more likely to have had a psychiatric hospitalization in the past year (57% versus 35%; $p<0.001$) (30). However, the data were cross-sectional, and the direction of the relationship between representative payee services and use of mental health care could not be distinguished.

*Substance use.* Three of eight studies that examined the association of representative payee services and substance use found some significant relationships (12, 28, 31). Conrad et al. (12) reported that the experimental group (not all of whom received representative payee services) had significantly fewer drinks and drug months at 12 months, compared with the control group. Post hoc analyses showed that the experimental group that received representative payee services had significantly fewer drinks and drug months than the control group. Again, however, because some individuals in the control group may have also received representative payee services, the results did not represent the pure effect of having a representative payee. Elbogen et al. (28) found that individuals with serious mental illness receiving representative payee services had greater odds of comorbid substance abuse, compared with those not receiving payee services (OR=4.28, $p<0.01$), but the cross-sectional nature of the analysis limited interpretation of this association. Herbst et. al. (31) compared urine test results and clinic attendance days before and after receipt of an initial retroactive SSI or SSDI check for a group of 18 individuals receiving methadone treatment. Although no difference in positive urine screens was found in either group, those who did not receive representative payee services missed significantly more clinic days after check receipt ($p=0.02$). No other study reported significant differences between individuals receiving representative payee services and those who were not, regardless of the substance used or whether measures were self-reported (11, 27), clinician reported (11), reported by a family member (30), measured by urinalysis (32), or defined as drug treatment utilization (13).

*Other primary outcomes.* Representative payee services may be associated with better quality of life. Conrad et al. (12) found that the experimental group rated their quality of life higher by an average of 0.5 points at 12-month follow-up, compared with the control group, on a single question with seven possible responses ("How do you feel about your life in general?") ($p<0.03$). In post hoc analyses, the two experimental groups (with and without a representative payee) were not significantly different in quality-of-life ratings, but quality-of-life ratings of the experimental group with a representative payee were higher by 0.6 points than those of the control group (p=0.04). Again, however, the control group used in this study also included individuals with a representative payee.

Representative payee services may also be associated with mental health treatment adherence. Elbogen et al. (16) examined the impact of involuntary outpatient commitment (OPC), in which individuals with serious mental illness are mandated to receive community treatment to avoid hospitalization. Mental health treatment adherence, a composite variable computed as average frequency of adherence to all planned treatment (medication and scheduled visits with a mental health clinician) as reported by two interview sources, was assessed every 4 months over the course of 12 months. Compared with individuals who did not have a representative payee at any point in the 12 months, those who added a new representative payee during the year had 3.85-higher odds of better treatment adherence (p=0.003). Treatment adherence did not differ between those who had a representative payee all year or who terminated representative payee services during the year and those without a representative payee.

HIV viral suppression has been examined as an outcome. In a study of representative payee services offered as part of a supportive housing program to 18 people living with HIV, Hawk et al. (17) found that viral load suppression significantly decreased 6 months after enrollment in representative payee services. However, this was a pre-post study design without a control group.

Two studies looked at incarceration and arrest as outcomes. Ries and Comtois (13) examined differences in days incarcerated in the past 90 days between participants with and without a representative payee and found no significant difference between groups. Labrum (30) surveyed adults who served as a representative payee for a family member with a psychiatric disorder and compared them with adults who provided informal money management services and found no association between receipt of formal representative payee and arrest history in adulthood.

**Secondary Outcomes**

Eight of 18 studies assessed the effect of representative payee services on secondary outcomes (12, 14, 16, 18, 33–36).

*Therapeutic relationship.* Two studies examined representative payee services' effect on various aspects of the therapeutic relationship between the client and his or her provider and provided mixed evidence that representative payee services have an effect on the client-provider therapeutic relationship (13, 14). Angell et al. (14) surveyed 201 individuals receiving services in a large urban community mental health center that also offered representative payee services in which the mental health clinician had fiduciary authority. The client-provider relationship was compared between clients who had a clinician representative payee through the community mental health center and clients who had a noninstitutional representative payee (such as a family member) or clients without a representative payee. The authors looked at two subscales from the Working Relationship Scale: the client-provider bond subscale and the client-provider conflict subscale. Payee status was not associated with the client-provider bond. Having a clinician representative payee was associated with higher levels of client-provider conflict (p=0.04), but the experience of financial leverage (e.g., the client reported that the payee threatened to withhold or withheld money until the client complied with treatment) mediated the relationship between payee status and client-provider conflict. In addition, Ries and Comtois (13) assessed clients' satisfaction with their case manager, treatment with respect and privacy, and condition and comfort of the building and found no significant differences between those with and without a representative payee.

*Financial leverage.* Three studies examined the extent to which individuals with a representative payee reported experiencing financial leverage, and findings suggest that receipt of representative payee services is associated with financial leverage (14, 16, 33). Financial leverage was operationalized in various ways in each study but was generally defined as a representative payee's use of control over an individual's funds to encourage, incentivize, or otherwise coerce certain behaviors. In an analysis by Angell et al. (14) of individuals receiving mental health treatment and payee services in a community mental health clinic, financial leverage was defined as whether the client reported that the payee had ever withheld money until the client followed through on mental health treatment, alcohol or drug treatment, or medication adherence or whether in the past 6 months anyone had made the client feel as though he or she would not receive spending money if he or she did not attend treatment appointments or take medications. In bivariate analyses, having a clinician payee was associated with perceiving financial leverage ($p<0.001$). As discussed above, financial leverage mediated the relationship between payee status and client-provider conflict.

Elbogen et al. (16), in a study of individuals receiving OPC, used 12-month follow-up data to categorize participants into four groups: representative payee plus OPC, representative payee only, OPC only, and neither representative payee nor OPC. Financial leverage was assessed in three ways: an overall rating of perceived coercion as measured by the MacArthur Perceived Coercion Scale (self-reported by client), a single question about perceived coercion self-reported by the client ("Did you feel that if you did not keep your appointment at the mental health center or take your prescribed medications that someone would not give you your spending money?"), and a single question about "money warnings" asked of providers or family members ("Did you or anyone else tell the subject that if s/he did not keep her/his appointment at the mental health center that s/he would not get her/his spending money?"). An analysis found no significant differences between overall perceived coercion scores of those with only a representative payee or only OPC and those with neither a representative payee nor OPC (reference group); however, clients who had both a representative payee and OPC scored significantly higher (greater perceived coercion), compared with the reference group (OR=3.44, p=0.004). For the single question about perceived financial coercion, the group with only a representative payee (OR=3.59, p=0.003) and the group with both a representative payee and OPC (OR=3.82, $p<0.001$) had higher odds of reporting perceived coercion, compared with the reference group. Finally, clients with both a representative payee and OPC were significantly more likely than clients in the reference group to be given "money warnings" (OR=6.02, p=0.001), although no differences were found between those with a representative payee only or those with OPC only and the reference group.

Using only data from baseline assessments of the same sample, Elbogen et al. (33) reported results for 109 individuals who were receiving representative payee services at baseline and 149 who were not. The authors used the same single questions as above for perceived financial coercion and "money warnings." In bivariate analyses, having a representative payee was associated with perceived financial coercion (48% of those with a representative payee perceived coercion versus 16% of those without a payee; $p<0.001$) and with receiving a money warning (24% of those with a representative payee got a warning versus 7% of those without a payee; $p<0.001$). In an adjusted regression model, having a representative payee remained associated with perceived coercion (OR=5.14, $p<0.001$) but not with receipt of a money warning.

*Other outcomes.* Another outcome examined was money mismanagement (12, 34). Conrad et al. (12) used a 22-item Money Mismanagement Measure to assess money management skill change over time (a lower score indicated better money management). For the main analyses, on average, the experimental group had a 0.3-point lower score than the control group at 6 months (p=0.02) and 0.5-point lower score than the control group at 12 months ($p<0.001$). Post hoc analyses showed no difference in money mismanagement score change between the experimental groups with and without a representative payee; however, the experimental group with a representative payee had a 0.5-point lower score than the control group over the 12-month period (p=0.02). Moore et al. (34) analyzed baseline data of 107 participants in a randomized trial assessing a money management intervention. At baseline, those receiving representative payee services were no different than those not receiving such services in terms of self-reported money mismanagement.

Three studies looked at violence as an outcome of receipt of representative payee services (18, 35, 36). In another analysis of the sample of individuals randomly assigned to OPC, Elbogen et al. (18) divided the sample into two groups: those whose representative payee was a family member and those who received representative payee services from a nonfamily member or who did not receive representative payee services. At each time point, clients were asked whether they engaged in any physical fighting or actions causing bodily injury to a family member or whether they used a lethal weapon, such as a stick, club, blunt object, knife, sharp object, firearm, or explosive, to harm or threaten a family member in the previous 4 months. In bivariate and multivariable analyses, having a family representative payee was significantly associated with family violence (bivariate analysis: OR=1.93, p=0.05; multivariable analysis: OR=2.11, p=0.04). Additional analyses attempted to disentangle the amount of client contact with family (low versus high) from the relationship between having a family representative payee and violence. In multiple models that compared having a family representative payee plus high family contact with having a family representative payee plus low contact, with having no family representative payee plus high contact, and with having an family representative payee plus low contact, the results showed that having a family representative payee remained a significant predictor of family violence, regardless of the amount of client contact with the family.

Two cross-sectional studies also found an association between FRP and violence, using data from respondents to a survey of U.S. adults who reported having a relative with a psychiatric disorder (35, 36). Labrum and Solomon (35) estimated adjusted ORs for factors associated with experiencing family violence and constructed multivariate models for each independent variable, controlling for all other variables that were significantly associated with family violence. Family members who served as a representative payee had 2.93 higher odds of experiencing violence perpetrated by the person with a psychiatric disorder ($p<0.001$), compared with family members who did not serve as a representative payee. In a subsample of family members ages 55 and older (N=243), those who served as a representative payee to a family member with a psychiatric disorder had 2.76 higher odds (p=0.05) of experiencing financial abuse, compared with family members who did not serve as a representative payee. Financial abuse was assessed by the question, "In the past 6 months how many times has s/he [the relative with a psychiatric disorder] misused or stolen any of your funds, property, or assets?" No difference was found between groups in experiences of physical or psychological abuse (36).

**Methodological Quality**

Although this systematic review included only studies with a control or comparison group, methodological quality was limited. On the basis of the Quality Assessment Tool for Quantitative Studies, two studies were rated as having moderate quality and 16 were rated as having poor quality, largely because of issues related to selection bias and study design.

## DISCUSSION

Findings from our review of literature on the effect of representative payee services indicated that these services are largely neutral or beneficial in terms of the primary outcomes identified (substance use, symptoms of mental illness, housing stability, quality of life, and other health-specific outcomes). Negative findings were mostly associated with secondary outcomes involving the client's feelings and perceptions about representative payee services (e.g., financial leverage) and the relationship between the client and the payee.

To our knowledge, this is the first comprehensive review of representative payee services, and it is unique in that we distinguished between the impact of such services on health and health behaviors versus the client-payee experience of these services. Few negative effects and several neutral or positive effects on primary outcomes were found, and thus it appears that the model is at best beneficial and at worst not harmful to the health of vulnerable populations. However, findings related to secondary outcomes suggest that there is room for improvement in the process by which representative payee services are delivered. Experiences of financial leverage and violence are concerning but are potentially mitigatable. Additional research about the process of delivering representative payee services—e.g., the degree of client centeredness and rules regarding disbursement of funds—is needed to better understand whether secondary outcomes are the result of the representative payee model itself or of how the services are delivered.

A number of limitations that affect interpretation of results should be noted. Specifically, only three databases were searched, and thus it is possible that some studies were missed. Just 18 studies met all inclusion criteria, and their outcomes were heterogeneous, which means that we were unable to conduct a meta-analysis, limiting our findings to a descriptive review. In addition, several studies were more than a decade old, which may indicate that provision of representative payee services does not reflect current thinking in the field or modes of health service delivery systems. Many of the treatment models studied included representative payee services as one of several service components, and in one study, the independent effect of representative payee services was not able to be teased out because some participants in the control group also received representative payee services (12).

It is also important to consider the nature of research that is conducted on the SSA's Representative Payment Program, which also affected our interpretation of results. As noted above, 85% of payee services are provided by family members of beneficiaries; however, we found only three studies that specifically examined family-provided representative payee services. The bulk of research on this topic centers on organizational providers, especially those in mental health service settings. Of the 11 unique samples represented in the studies reviewed, seven were from mental health or substance use treatment settings even though our search terms did not specify these issues. Given the fact that more than 550,000 individuals in 2017 who received representative payee services had a psychiatric disorder, the focus on this population is warranted; however, a breadth of diagnostic categories is not covered by the current body of research (5). In addition, family-provided representative payee services would likely focus on bill payment rather than on therapeutic aspects, client education, and client advocacy, which are areas of study in representative payee programs in mental health and other social service organizations. Therefore, familial arrangements are likely to have different effects on beneficiaries. For a full understanding of the effects of representative payee services, additional studies should be conducted on familial payee relationships and on representative payee services provided by housing programs, non–mental health services, and fee-for-service providers.

We restricted our search to include studies that used comparison or control groups in an effort to isolate the effects of representative payee services. Our focus on studies describing direct effects of these services provides an important contribution to the field. Nonetheless, our criteria necessarily excluded some studies with important findings, such as those demonstrating associations between receipt of payee services and conflict with individuals or agencies serving as a representative payee (37–39). It would be difficult to conduct a study of representative payee services with true experimental and control groups, because randomization to these arms would mean denying services to people who need them. However, the studies highlighted in our review demonstrate that rigorous research on representative payee services is both possible and necessary.

## CONCLUSIONS

More than five million Social Security beneficiaries utilize representative payee services, and some studies suggest positive associations between representative payee services and client-level outcomes. Additional research is warranted to understand the full effects of this approach. Recent studies investigating the link between chronic poverty and diminished executive processes demonstrate the need for a deeper understanding of how the provision of financial management support can affect health outcomes for those who have mental or other disabilities and whose symptoms are exacerbated by living in poverty. In addition, research on representative payee services should expand beyond services provided in mental health treatment settings. Future studies should use more rigorous research designs to reduce bias and strengthen interpretation of results. No studies to date have discussed conceptual approaches to describe how representative payee services are provided to clients. The noted associations between representative payee services and financial leverage and the overall impact of these services on the therapeutic relationship suggest the need for a better understanding of the degree to which services are client centered and nonjudgmental and include clients in decision making about how disability benefit checks are spent.

## AUTHOR AND ARTICLE INFORMATION

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