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Financial Capability: Clinicians' Assessment of Beneficiaries with Dual Diagnoses

Thomas A. Thornhill, IV, BA¹,

Department of Psychiatry, Yale University, and VA Connecticut Healthcare,
thomas.thornhill@yale.edu

Anne C. Black, Ph.D., and

Department of Psychiatry, Yale University, and VA Connecticut Healthcare, anne.black@yale.edu

Marc I. Rosen, M.D.

Department of Psychiatry, Yale University, and VA Connecticut Healthcare, marc.rosen@yale.edu

Abstract

Introduction: Adults with mental health disorders whose ability to work is sufficiently impeded are entitled to financial supports from the Social Security Administration. Beneficiaries determined to be incapable of managing these funds are supposed to be assigned a representative payee to assist beneficiaries in meeting their needs. However, patterns of payee assignment suggest that payee assignment is impacted by factors other than those the Social Security Administration instructs clinicians to consider. In this study, we tested the association between clinicians' judgments of their clients' financial capability and hypothesized predictors (demographic characteristics, psychiatric diagnosis, recent alcohol and other substance use, self-rated money mismanagement, recent homelessness, and provider characteristics). We posited that predictors might act indirectly on capability judgment, via their impact on beneficiaries' money management.

Methods: Altogether, 261 people receiving intensive mental health care who did not have payees or fiduciaries were enrolled after providing written informed consent. These beneficiaries completed in-person assessment interviews, reporting demographic characteristics, treatment history, substance use, and homelessness. Mental health clinicians identified by the beneficiaries were enrolled in the study and asked to judge their clients' financial capability with standard Social Security instructions for determining capability. Bivariate associations between hypothesized predictors and clinicians' determinations of incapability were tested. In multivariate probit regression models, incapability determination was modeled as a function of all beneficiary and clinician characteristics that had significant bivariate associations with the outcome.

Results: Providers identified 24% of their clients as financially incapable. Determinations of financial incapability were unrelated to any beneficiary or provider demographic characteristics,

Corresponding author: Marc I. Rosen, M.D., VA Connecticut Healthcare System, 950 Campbell Avenue 116A-4, West Haven, CT 06516; TEL: 203-932-5711 x2112, FAX: 203.479.8119 marc.rosen@yale.edu.

Change of Affiliation: Thomas A. Thornhill IV is now at School of Public Health, Yale University

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but were positively associated with money mismanagement, homelessness and having a psychotic disorder. Alcohol and other substance use were only significantly associated with capability determinations indirectly, through their effects on money mismanagement.

Conclusion: Providers' judgments of beneficiaries' capability to manage their funds were associated with factors that were consistent with Social Security Administration guidelines, and were, importantly, not associated with personal characteristics. This finding suggests that guidelines can be fairly applied by clinicians, and that reported inconsistencies in payee assignment are accounted for by other factors. Social Security Administration is currently considering other approaches to standardize capability determinations.

Keywords

Social Security; disability; financial; payee; assessment

1. Introduction

The Social Security Administration (SSA) provides benefits to adults with disabilities by administering the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. In 2015, 3.6 million adults disabled by mental health disorders received benefits averaging \$945 per month (Social Security Administration, 2016).

For many individuals disabled by mental health disorders who rely on monthly financial benefits, the same disability that interferes with their ability to work also interferes with their ability to manage or direct the management of their benefits to meet their basic needs, such as shelter, food, and clothing. The SSA is mandated to appoint a person or an organization as a representative payee to manage the current and future needs of any beneficiary found to be incapable of these tasks. In 2015, approximately 1.7 million of the 3.6 million people with disabling mental disorders were assigned a representative payee (Social Security Administration, 2016).

The assignment of a representative payee to support an SSA beneficiary entails potential benefits and risks (Rosen, 2011). The potential benefits include improved housing stability (Luchins, Roberts, & Hanrahan, 2003; Rosenheck, Lam, & Randolph, 1997; Stoner, 1989); decreased inpatient hospitalization (Luchins et al., 1998), increased adherence to mental health treatment (Ries & Anne Comtois, 1997), and empowerment through supported decision making (Serowik, Bellamy, Rowe, & Rosen, 2013). The risks of having a representative payee include financial mismanagement by the payee (National Research Council, 2007), interpersonal conflict (Angell, Martinez, Mahoney, & Corrigan, 2007; Elbogen, Swanson, Swartz, & Van Dorn, 2005; Elbogen, Wilder, Swartz, & Swanson, 2008), perceived stigma (Elbogen et al., 2008), and loss of autonomy (Appelbaum & Redlich, 2006; Dixon, Turner, Krauss, Scott, & McNary, 1999; Elbogen, Soriano, Van Dorn, Swartz, & Swanson, 2005). The effects of being assigned a payee on substance use have not been consistent across locales. In general, a decrease in substance use after payee assignment was reported when payees affiliated with clinical programs were assigned (Conrad et al., 2006a; Ries & Anne Comtois, 1997), while payee assignment had no such effect when payee

practice was not specified (Rosen, McMahon, & Rosenheck, 2007; Rosenheck et al., 1997; Swartz, Hsieh, & Baumohl, 2003).

Prior studies have found wide variability between sites in the likelihood that an SSA beneficiary would be assigned a payee (Appelbaum & Redlich, 2006; Rosen et al., 2007), and it is unclear within sites what criteria clinicians use to determine financial capability. An Institute of Medicine workgroup reviewing SSA's financial capability determination procedures argued that real-world financial performance, how someone manages money day-to-day in their environment, and not specific diagnoses or demographics, is the most proximate indicator of financial capability (National Academies of Sciences, 2016) and theoretical models from others have also emphasized day-to-day functioning (Lazar et al., 2016; Sen, 1993).

SSA procedures also emphasize real-world functioning in determining financial capability. When adjudicating an applicant's request for disability benefits due to a mental disorder, the SSA asks the treating clinician to complete Form 787, an assessment of financial capability (Social Security Administration, 2017). Form 787 asks whether the beneficiary is capable of managing his/her own benefits, using the following language to define financial capability:

- Is able to understand and act on the ordinary affairs of life, such as providing for own adequate food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

In defining who needs a representative payee, the Form provides the following information: *“Examples of impairments which may cause incapability are senility, severe brain damage or chronic schizophrenia.”*

In addition to these directed considerations, clinicians also consider the information they are most likely to have—demographics, diagnoses, hospitalizations—in making capability determinations. The only measure of clinician criteria for recommending payee assignment was based on a study comparing beneficiaries assigned a representative payee to a comparison group, in which having a payee was associated with psychiatric diagnoses (a diagnosis of schizophrenia or schizoaffective disorder), benefits received (receipt of SSI instead of SSDI, receipt of Medicaid), and illness severity (proportion of beneficiary's life since first psychiatric hospitalization, having had a long-term hospitalization, history of frequent hospitalizations). Assignment of payees has been associated with factors that more directly reflected day-to-day financial functioning, such as lack of financial support from family and lack of rent money (Conrad et al., 1998), as well as factors that more indirectly reflected day-to-day financial functioning, such as homelessness, psychotic disorders, and substance use (Rosen, 2011). A reason for clinicians' use of non-financial information to decide capability is that, notwithstanding the Recovery Movement emphasis on treating people and not diagnoses, clinicians treating people with severe mental illnesses may know about clinical history and symptoms but less about day-to-day financial management. In a study by our research group enrolling 78 clinicians for 134 beneficiaries, clinicians often endorsed “don't know” when asked Likert-scaled questions about how often, in the last six months, the beneficiary had borrowed money to meet living expenses (47% don't know),

had problems related to failing to pay a bill (53%), and impulsively spent an SSA check as soon as they got it (43%) (Black et al., 2014).

Our group has described other reasons that the process of financial capability determinations may involve inconsistencies, even when determinations are based on all available data about the beneficiary (Lazar, Black, McMahon, O'Shea, & Rosen, 2015). The SSA Form 787 instructions require a dichotomous decision about a construct, financial capability, which likely exists on a continuum. Clinicians have to determine both what exactly constitutes directing someone else to spend money and what standard to apply for spending in one's best interests. This process is further complicated given that self-reports of past spending are often imprecise and money is fungible. Consequently, it can be challenging to determine whether goods or services were paid using a beneficiary's SSA benefits or from another source or individual. The question of whether a particular purchase is in one's best interest often depends on a beneficiary's financial and social resources and goals. For example, given limited means, it may be in the best interest of an individual's self-worth to purchase a gift for their grandchild at the expense of paying down their hospital debt. Finally, there is the issue of how to consider expenditures on alcohol and drugs in capability determinations. The Institute of Medicine's workgroup (National Academies of Sciences, 2016) noted that addiction might account for why people who appear able to manage their finances in a controlled setting are unable to do so in their usual settings (Rosen & Rosenheck, 1999), and in fact substance use is often a proximate cause of inability to meet basic needs, but disentangling the connection between financial difficulties, addiction and difficulty managing funds is not always possible.

In this study, we assessed whether clinician and beneficiary characteristics were associated with clinicians' judgments of financial incapability on the SSA Form 787. The sample was composed of SSA beneficiaries in intensive psychiatric treatment who were managing their own finances and their treating clinicians. We began with an exploratory analysis of factors that we hypothesized were associated with judging financial capability and developed a model predicting clinical judgment of incapability.

2.0 Methods

Beneficiaries and clinicians enrolled in a study to develop and validate a new clinician-rated instrument to determine beneficiaries' capability to manage SSA payments (Black et al., 2014; Claycomb et al., 2013; Lazar et al., 2015; Lazar et al., 2016; Serowik et al., 2013). This study was approved and monitored by the Yale University Institutional Review Board and was conducted in accordance with relevant ethical standards (American Psychological Association, 2017). Written informed consent was obtained from all beneficiaries. Prior to written consent, there was a complete discussion of the study with all potential participants.

2.1. Participants

2.1.1 Beneficiaries—Beneficiaries were recruited from six participating intensive psychiatric clinics (four clinics were outpatient only, one was inpatient only, and one offered both outpatient and inpatient services). Participants were required to be between 18 and 65 years old, receiving and managing their own SSA benefits, have had a substance use

disorder diagnosis at some point in their life, and have a current clinician who was willing to assess their financial capability. Participants were compensated \$20 for their eligibility screening and \$40 for their baseline assessment.

A total of 302 beneficiaries enrolled in the study. Participants with incomplete data ($n = 18$) or whose clinicians rated “unsure” about the beneficiaries’ financial capability ($n = 23$) were excluded from these analyses. Participants rated “unsure” were excluded because they presented neither a unique third category nor a sub-category to either “yes” or “no”. Thus, analyses are based on a sample of 261 participants, of whom 199 were rated financially capable by their clinicians and 62 were rated financially incapable. Sample characteristics are summarized in Table 1.

2.1.2 Clinicians—Beneficiaries identified their current mental health clinicians. Researchers then recruited these clinicians for the study. Altogether, 132 clinicians completed assessments of the 261 beneficiaries’ financial capability. Of the 132 clinicians, 90 evaluated financial capability for a single beneficiary. Among the 42 clinicians who assessed multiple beneficiaries’ financial capability, the median number of beneficiaries per clinician was 3 (range 2–13). The majority of clinicians were employed as social workers (60.9%), followed by mental health workers (16.5%), nurses (8.3%), psychologists (9.8%), psychiatrists (3.0%), and primary care physicians (1.5%). Clinicians were compensated \$25 for each completed assessment, except when employer restrictions limited payment to \$10.

2.2 Assessments

2.2.1 Clinician’s judgment of financial capability—Clinicians were instructed to complete the assessment of financial capability using all information available to them, including personal communications, chart review, and information from other treaters. The assessment began with the SSA’s Form 787 question of financial capability, with the same explanatory sentences, but without the clinicians being told they were answering the SSA Form 787 question. The remaining portion of the assessment consisted of a battery of twenty-five items from a questionnaire our group is developing to measure financial capability (Black et al., 2014, questionnaire available upon request).

2.2.2 Beneficiary characteristics—Beneficiary characteristics (reported in Table 1) were collected by structured assessments completed by interview, and by medical chart review.

- *Demographics*: Beneficiaries reported their age, sex, race and ethnicity, and marital status.
- *Psychotic Disorder*: Current psychotic disorder was determined by chart review.
- *Recent Substance Use*: Recent substance use (past 28 days) was assessed using a Timeline Followback (TLFB) interview technique (Sobell & Sobell, 1992) that uses a calendar with memory aids (key and anchor dates) to cue accurate recall of daily occurrence of events. Participants provided retrospective reports of their use of alcohol and illicit drugs. Prior research has shown that the test-retest reliability of 30-day TLFB-recorded daily substance use among adults with

severe mental illnesses ranged from .73 to 1.00 (Carey, Roberts, Kivlahan, Carey, & Neal, 2004). The 6-week test-retest reliability of self-reported daily drinking using this method was $r = .79$ (Sobell, Maisto, Sobell, & Cooper, 1979). In a sample of adults receiving outpatient psychiatric treatment, alcohol use recorded by TLFB was strongly correlated ($r = .65$) with past 30-day use recorded by the Addiction Severity Index (Carey, Cocco, & Correia, 1997). In the current study, substance use in the past 28 days was separated into three distinct categories:

- *Alcohol use* was measured as days of risky use, defined as four or more drinks in a single day for women and five or more drinks in a single day for men (Dawson, 2011; Saitz, 2005).
- *Cannabis use* was measured as the number of days of any use. Cannabis use was separated from other illicit drugs due to its change in perceived harmfulness (Keyes et al., 2016).
- *Other illicit drug use* was measured as the number of days of any illicit drug use, excluding cannabis. The most common other illicit drugs used were cocaine (25%) and opioids (6%).
- *Homelessness*: Past 28-day homelessness was collected using the TLFB technique whereby beneficiaries reported the number of nights spent in each location. Homelessness was defined as any night spent in the outdoors, an abandoned or public building, an automobile, or shelter.
- *Money Mismanagement*: Past 28-day money mismanagement was assessed using the Money Mismanagement Measure (M3) (Conrad et al., 2006b). The M3 is a 28-item self-report assessment for people with serious mental illnesses. Questions ask about difficulties meeting basic needs, budgeting, paying bills, and keeping track of funds over the past month. The sum of items ranges from 0 to 36, with higher scores indicating more mismanagement.

2.2.2 Clinician characteristics and clinical history

- *Demographics*: Clinicians reported their gender and professional role.
- *Treatment History*: Clinicians reported their clinical history with each beneficiary as both the total number of months they had worked together and the number of times they had ever met.

2.3 Analyses:

Bivariate correlations between each measured beneficiary and clinician characteristic and clinicians' capability judgments were estimated. A dichotomous indicator of the match between clinician and beneficiary gender was created and tested for its association with capability judgments. Then, variables significantly correlated with capability judgments were entered into a multivariate probit regression model of clinician judgments.

Because homelessness, psychotic disorders, and substance use have been associated with both financial outcomes and with assignment of a payee (Rosen, 2011), we hypothesized

that these predictors would be associated with money mismanagement which in turn would be associated with clinicians' capability judgments. Thus, we then tested whether the effects of these predictors on capability judgments were mediated by money mismanagement (M3), regardless of their direct effects (MacKinnon & Fairchild, 2009). For all estimates, standard errors were corrected for non-independence of observations by specifying clinician as a clustering variable (ICC=.05). All analyses were conducted using Mplus software and weighted least squares estimation (the default procedure for binary outcomes in Mplus).

3.0 Results

3.1 Bivariate Correlations

Clinician judgment of financial capability was significantly correlated with the M3, having a psychotic disorder, days of recent homelessness, days of risky alcohol use, and days of other illicit drug use (Table 1).

3.2 Probit Regression Model

In the multivariate model, clinician judgments were significantly associated with M3, psychotic disorder, and days of recent homelessness (Figure 1).

3.2.1 Mediation Analysis—The M3 significantly mediated the relationship between clinician judgments of financial capability and both risky alcohol and other illicit drug use; controlling for the M3, neither substance use measure was directly associated with clinician-judged capability (Figure 1). The M3 did not mediate the relationship for either psychotic disorder or recent homelessness.

4.0 Discussion

Of the beneficiary and clinician characteristics included in these analyses, only beneficiaries' self-rated money mismanagement, having a psychotic disorder, and days of recent homelessness were directly associated with clinicians' judgments of financial capability. Alcohol and substance use were not directly associated with clinicians' capability judgments, controlling for other factors, but as hypothesized, were associated through their effects on money mismanagement.

Contrary to our hypothesis, the effects of having a psychotic disorder and recent homelessness were not mediated by money mismanagement. These results appear to reflect the fact that the SSA Form 787 presents "chronic schizophrenia" as an example of an impairment that may lead to financial incapability and instructs raters to consider a beneficiary's ability to meet basic needs, whereas substance use is not explicitly addressed. Published reports that clinicians consider substance use in determining need for a payee (Hanrahan et al., 2002) may reflect what is a more nuanced consideration of substance use by beneficiaries who consequently mismanage their funds, and are thus considered financially incapable, as distinguished from beneficiaries in whom substance use has fewer financial consequences.

None of the tested clinician or beneficiary demographic characteristics (age, gender, and race/ethnicity) was associated with clinicians' capability judgments. One interpretation of the overall findings is that the clinicians completing SSA Form 787 were able to understand and follow its guidelines without bias, and that systematic differences in the assignment of payees may reflect aspects of the system rather than as a function of the criteria themselves, as codified in Form 787.

Despite clinicians having rated almost one quarter of our study participants as not capable of managing their funds, none of the study participants had a payee and no procedure to assign a payee had, to our knowledge, been initiated. One possible explanation for this discrepancy is that many people who are incapable of managing their funds never reach the stage of having SSA ask for a clinician's opinion. In real life, clinicians' initiation of fiduciary assignment may not even relate to theoretical judgments of capability but may relate to practical considerations such as availability of someone to serve as a representative payee. A report from Illinois indicated that payee assignment was far more likely at mental health centers that had payee programs than those that did not (Hanrahan et al., 2002) and our group has described clients' willingness to be assigned a payee was a factor in their being assigned one (Rosen, Ablondi, Black, Serowik, & Rowe, 2014). Overall, the results suggest that there is a gap between clinicians' tutored conclusions of who is incapable of needing a payee and what criteria they apply.

There are several limitations to our study. Although our analyses included most of the measures that have been associated with capability determination in research literature, it is possible we omitted confounding variables that are important in clinicians' judgment, such as intelligence or specific money management skills. Another limitation is that the findings were limited to SSA beneficiaries in intensive psychiatric care and may not generalize to those in other settings, or to those in other parts of the world. Finally, it is likely that aspects of the way the capability choices were presented to clinicians in this research study differ from the way these choices are presented in other settings.

Notwithstanding these caveats, the study findings suggest that the factors clinicians consider in rating financial capability track reasonably well with those suggested by SSA guidelines.

5.0 Conclusion

There is currently no criterion standard for assessing financial capability. Recently, the Institute of Medicine (IOM) with the support of the SSA, convened a committee to evaluate SSA's capability determination process (National Academies of Sciences, 2016). The committee's primary recommendation was to develop a systematic data driven approach that weighed evidence of beneficiaries' history of meeting their basic needs. Our data do not reveal any untoward biases in the way clinicians, when presented with the standard SSA guidelines, decide their clients' financial capability.

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Figure 1.

Regression of Clinicians' Financial Capability Judgments

Note. M3 = Money Mismanagement Measure

* $p < .05$; ** $p < .01$

Table 1:

Sample Characteristics and Correlations with Clinicians' Judgment of Financial Capability

Beneficiary & Clinician Characteristics	Capable (n = 199)	Incapable (n = 62)	Total	r	p
Age					
Years (mean centered)	45.9 ± 9.9	43.8 ± 10.1	45.4 ± 10.0	-0.12	0.14
Sex					
Female (0)	108	31	139	0.06	0.53
Male (1)	91	31	122		
Race & Ethnicity					
White, not of Hispanic origin (0)	115	29	144	0.16	0.12
Other race & ethnicity (1)	84	33	117		
Marital status					
Not married (0)	177	57	234	-0.1	0.48
Married (1)	22	5	27		
Psychiatric diagnoses					
No psychotic disorder(s) (0)	151	37	188	0.27	.01**
Psychotic disorder(s) (1)	48	25	73		
Substance use (past 28 days)					
At-risk alcohol use (# of days)	0.8 ± 2.6	2.2 ± 5.7	1.2 ± 3.6	0.19	.01**
Cannabis use (# of days)	2.0 ± 6.0	1.7 ± 5.0	1.9 ± 5.8	-0.03	0.71
Other illicit drug use (# of days)	1.1 ± 3.4	2.6 ± 4.8	1.5 ± 3.8	0.19	.01**
Homeless (past 60 days)					
Homeless (# of days)	2.1 ± 8.9	6.7 ± 16.1	3.2 ± 11.2	0.2	.00**
Money Mismanagement Measure (M3)					
M3 (composite score)	8.6 ± 6.9	14.2 ± 10.5	9.9 ± 8.2	0.36	.00**
Clinician's sex					
Female (0)	154	44	198	0.12	0.32
Male (1)	45	18	63		
Clinician-Beneficiary sex match					
Matched (0)	103	33	136	-0.02	0.83
Not-Matched (1)	96	29	125		
Clinical history, lifetime					
Number of times met (#)	10.3 ± 9.3	10.0 ± 7.8	10.3 ± 9.0	-0.02	0.81
Number of months met (#)	9.4 ± 19.5	11.2 ± 25.5	9.8 ± 21.4	0.05	0.56

Note. M3 = Money Mismanagement Measure

* $p < .05$;

** $p < .01$