



## Self-Directed Care in Mental Health:

# LEARNINGS FROM THE CASH & COUNSELING DEMONSTRATION EVALUATION

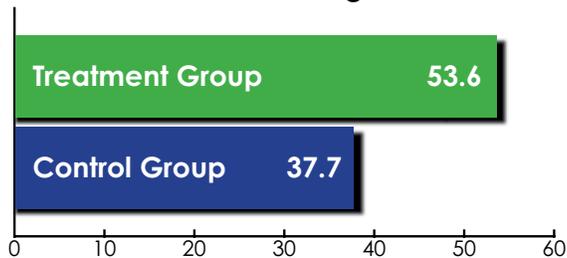
### IN BRIEF

#### Self-directed care works well for persons with mental illnesses.

Adults with mental illnesses in the Cash and Counseling Demonstration and Evaluation program, a self-directed care approach, compared to those receiving usual and traditional Medicaid services experienced the following:

- higher satisfaction with their quality of life;
- higher satisfaction with their paid caregivers;
- fewer unmet needs;
- no more injuries or other adverse health outcomes than other patients;
- no significant differences in total expenditures;
- able to successfully manage the cash option.

#### Percent of "very satisfied with overall care arrangement"\*



## INTRODUCTION

The traditional system of providing services through home care agencies allows persons with disabilities few choices regarding how and when their care is provided. Because of the lack of choice, individuals may not receive the care they need or prefer. Consequently, recipients of services may be dissatisfied with their care, have unmet needs, and have a lower quality of life (Brown, et al. 2005).

Recent years have seen a growing movement toward self-directed services. The Cash and Counseling Demonstration and Evaluation, sponsored by the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation and conducted under Medicaid research and demonstration waivers granted by the Centers for Medicare and Medicaid, was designed as an experiment in shifting the paradigm in home and community-based long-term care from a professional/bureaucratic model of service delivery to one emphasizing consumer choice and control. The program provided Medicaid beneficiaries control over a flexible monthly allowance to purchase services of their choosing instead of using traditional Medicaid covered services. Therefore, more control was given to the individual to direct the type and kind of services that he or she considered necessary to meet disability-related needs.

\* This study was undertaken for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Ce Shen and Kevin J Mahoney, Graduate School of Social Work, Boston College; Michael A. Smyer, Psychology Department, Boston College; Lori Simon-Rusinowitz, Center on Aging and Department of Health Services Administration, School of Public Health, University of Maryland; Judith Shinogle, Department of Health Services Administration, School of Public Health, University of Maryland, and Ellen K. Mahoney, William F. Connell School of Nursing, Boston College under contract number 06M000133 with SAMHSA, U.S. Department of Health and Human Services. Stacey Lesko served as project officer.

The Cash and Counseling program, implemented in three states—Arkansas, Florida, and New Jersey—provided participants a monthly budget with spending limits to choose and hire personal care workers (including family members) and to purchase care-related services and goods. Participants could designate representatives, such as relatives or friends, to help make decisions regarding managing their care. In addition, to help participants handle program responsibilities, the program offered counseling services on fiscal management services and hiring and managing caregivers.

Evaluation of the Cash and Counseling program found that if participants received the allowances that the program offered, the program substantially improved the lives of Medicaid beneficiaries of all ages (Brown et al, 2007, Carlson et al, 2007). The findings also revealed that participants were more likely to receive paid care, had greater satisfaction with their care, and had fewer unmet needs in nearly every state and age group. Personal care service costs were generally higher under the program, largely because those in the traditional system did not get the services to which they were entitled (Dale & Brown, 2007).

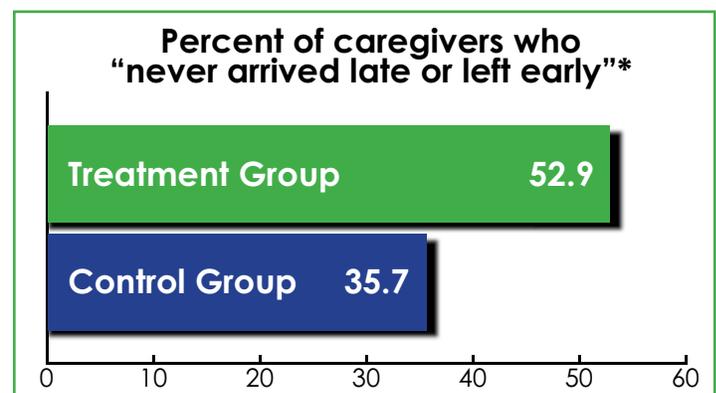
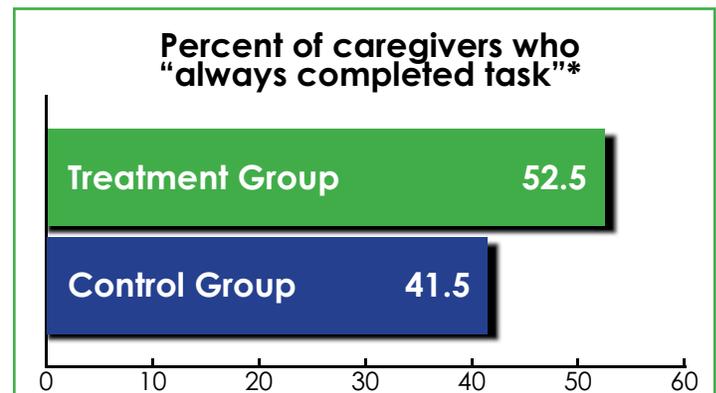
## PERSONS WITH MENTAL ILLNESSES WITHIN THE CASH AND COUNSELING PROGRAM

Since the evaluation of the Cash and Counseling program focused on a cross-disability group of beneficiaries, program outcomes for people diagnosed with mental illnesses were unknown. Considering that Medicaid is the single largest funding source for public mental health services, an important question is whether self-direction is appropriate for persons with mental illnesses.

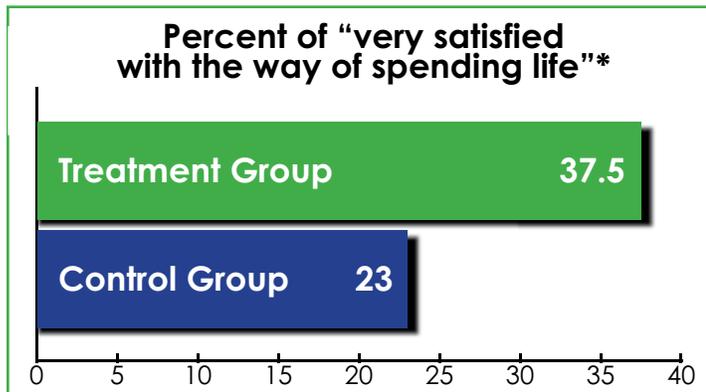
This report describes the results of a Substance Abuse and Mental Health Services Administration funded study on how the Cash and Counseling program affects 1) the use and quality of personal care assistance received by those whose Medicaid claims histories also included payments for mental health services, 2) overall well-being, and 3) Medicaid service use and costs. Individuals in this study consisted of 228 adults, ages 18-64, with mental illnesses from the state of New Jersey. The 228 adults were randomly assigned to either the treatment group (n=109) or the control group (n=119). Individuals receiving the Cash and Counseling program services—consisting of self-directed care—were placed within the treatment group. Those receiving traditional Medicaid services were placed in the control group.

## PERSONAL CARE AND WELL-BEING

Overall, Cash and Counseling (self-directed care) worked well for persons with mental illnesses. These individuals were more likely to receive personal care services and were more satisfied with their paid caregiver's reliability, schedule, performance, and overall care arrangement as the graphs indicate below.



Further, those who used self-directed care were more satisfied with their quality of life as noted in the graph below.

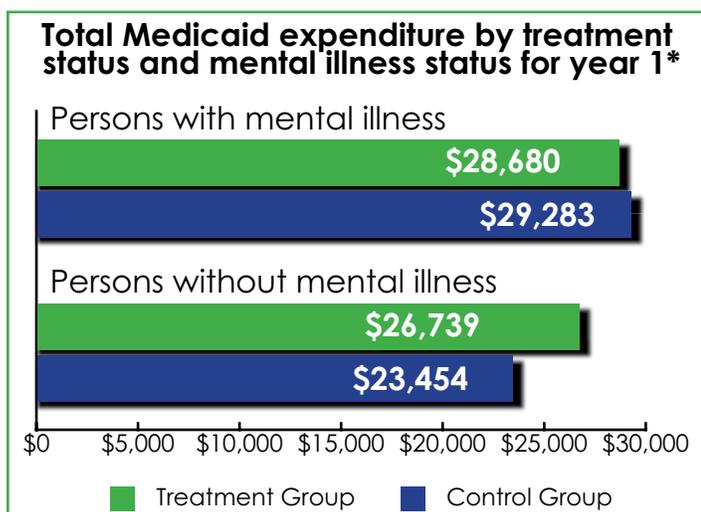


They also had fewer unmet needs related to household activities, transportation, and routine health care at home. Additionally, they had no more injuries or other adverse health problems than those without mental illnesses.

These findings are consistent with the original Cash and Counseling findings and suggest that self-directed care works just as well for a person with a mental illness as for a person without a mental illness. It is important to note that the participants who were interested in directing their own services, but were randomly assigned to the control group (traditional services) fared worst on almost all measures.

### MEDICAID COSTS

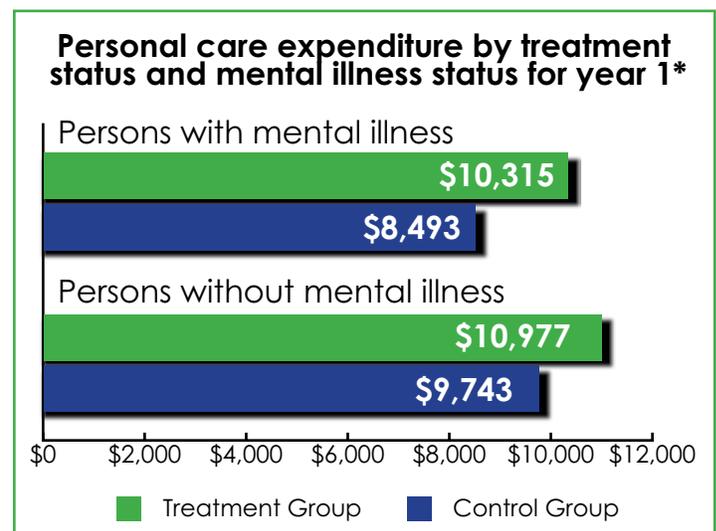
Regarding total Medicaid costs in year one, the expenditures for persons with mental illnesses in self-directed services were not statistically significantly higher than those without mental illnesses in self-directed care as indicated in the graph below.



Further, there are no significant differences in total Medicaid costs for persons with mental illnesses in self-directed care compared to traditional services. These findings suggest that self-directed care is not significantly more expensive for providing community-based care for persons with mental illnesses.

Both persons with and without mental illnesses in self-directed care services (treatment group) were more likely to receive some paid service than those in traditional services (control group). This finding suggests that persons with mental illnesses were able to negotiate the system and receive paid services through the self-directed care approach.

For both those with and without mental illnesses, personal care service costs were higher for those in self-directed services than those in traditional services as noted in the graph below. This may reflect a participant's ability to actually receive services in the self-directed option.



However, for those in self-directed services, no significant differences in personal care service costs were found for both those with and without mental illnesses. If persons with mental illnesses received services of their choosing that fit their treatment plan, they might be more likely to remain stable and prevent cost increases related to the need for more care.

Overall the findings indicate that persons with mental illnesses under self-directed services were able to successfully manage the cash option. If needed, individuals could appoint representatives or were offered consultants to help them manage all cash option responsibilities.

Nothing was found to suggest that self-directed care may not be appropriate or adequate for persons with mental illnesses. There are no significant differences in total costs for persons with mental illnesses in self-directed care compared to those without mental illnesses. Similar to the findings in the original evaluation of Cash and Counseling, use of this approach is not expected to increase Medicaid costs (Dale & Brown, 2007). If individuals with mental illnesses want to manage their own care and opportunities to do so exist, self-directed care is a feasible option.

## POLICY IMPLICATIONS

1. A self-directed option for services can be a valuable approach for persons with mental illnesses.
2. Self-directed care provides a process that may create a better match between an individual with a mental illness and a caregiver than traditional methods. Individuals and their families can choose workers who would be a comfortable fit. This may lead to improved worker recruitment and ultimately better retention of caregivers.
3. With the growing need for long-term care and limited available resources, a self-directed cash option may help avoid institutionalization and other high cost options for persons with mental illnesses.

## REFERENCES

- Brown, R., Carlson, B.L., Dale, S., Foster, L., Phillips, B., & Schore, J. (2005). *Cash and counseling: Improving the lives of Medicaid beneficiaries who need personal care or home- and community-based service*. Princeton, NJ: Mathematical Policy Research.
- Brown, R. & Dale, S. (2007). The research design and methodological issues for the Cash and Counseling evaluation. *Health Services Research* 42(1), 414–445.
- Carlson, B.L., Foster, L., Dale, S., & Brown, R. (2007) Effect of Cash and Counseling on personal care and well-being. *Health Services Research* 42(1), 467–487.
- Dale, S.B. & Brown, R.S. (2007). How does Cash and Counseling affect cost? *Health Services Research*, 42(1), 488-509.

## RESOURCES

- Cash and Counseling Program Office  
<http://www.cashandcounseling.org>
- The Contribution of Self-Direction to Improving the Quality of Mental Health Services  
<http://aspe.hhs.gov/daltcp/reports/2007/MHsfdir.htm>
- Free to Choose: Transforming Behavioral Healthcare to Self-Direction  
<http://mentalhealth.samhsa.gov/publications/allpubs/SMA05-3982/default.asp>
- Robert Wood Johnson Foundation  
<http://www.rwjf.org/>  
Search for cash and counseling.
- Self-Direction in Mental Health Broadcast Series  
<http://www.connective.com/events/samhsa/>
- SAMHSA Health Information Network  
<http://mentalhealth.samhsa.gov/>