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Jennifer Spaulding-Givens and Jeffrey R. Lacasse



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Jennifer C. Spaulding-Givens, PhD, MSW
University of North Florida
Jacksonville, FL

Jeffrey R. Lacasse, PhD, MSW
Florida State University
Tallahassee, FL

Correspondence concerning this article should be addressed to Jennifer C. Spaulding-Givens, PhD, MSW, Assistant Professor of Social Work, Department of Sociology, Anthropology, and Social Work, University of North Florida, 1 UNF Drive, Jacksonville, FL 32224-2645. E-mail: j.spaulding-givens@unf.edu

Abstract

Objective: Self-directed care (SDC) is a mental health service delivery model in which participants budget the state dollars allotted for their care to purchase the goods and services they deem most appropriate for achieving their recovery goals. This study examines the demographic characteristics, service utilization patterns, and outcomes of individuals enrolled in the Florida Self-Directed Care (FloridaSDC) program, which is the oldest and most established SDC program in the United States for individuals diagnosed with a severe and persistent mental illness.

Methods: This is a naturalistic descriptive study in which demographic, service utilization, and outcome data (i.e., Functional Assessment Rating Scores (FARS), days in the community, days worked, monthly income, discharge status) were collected from the clinical and fiscal records of 136 FloridaSDC participants.

Results: Key findings suggest that FloridaSDC participants had very little income and largely utilized their budgets to subsidize their living expenses. Though most participants did not work or earn income and very few left the program due to employment, participants' FARS scores improved modestly and nearly all participants remained in the community throughout the study period.

Conclusions and Implications for Practice: Participants' service purchases were rational given the poverty in which they live, and their outcomes did not suffer when they controlled decisions regarding their service needs. These findings highlight the utility and value of the personalized budgeting and individualized planning components of self-directed care. Findings also point to the need for practitioners to implement innovative strategies to enhance participants' employment readiness and supported employment opportunities.

Recovery-oriented and consumer-directed approaches to community-based service provision are increasingly recommended as integral to the transformation of public mental health systems. This is most notably described in the report of the President's New Freedom Commission on Mental Health (2003), which calls for public mental health services to allow consumers greater autonomy to develop individualized recovery plans and exercise control over service dollars allotted for their care. Although a variety of consumer- or self-directed programs have emerged in recent years, the number and capacity of such programs to serve individuals diagnosed with a severe and persistent mental illness remain relatively small (Alakeson, 2007; National Resource Center for Participant-Directed Services, 2013), and the body of literature examining the impact of such programs is even smaller (Alakeson, 2008; Barczyk & Lincove, 2010; Slade, 2012). The purpose of this paper is to contribute to that literature by reporting the characteristics, service utilization, and outcomes of participants in the Florida Self-Directed Care (FloridaSDC) Program, recognized by the Substance Abuse and Mental Health Services Administration in 2005 as "the only known completely operational self-directed care program in behavioral health" (p. 23).

FloridaSDC utilizes a budget authority model of self-direction in which participants manage an individual budget to purchase the goods and services they deem most appropriate for meeting their mental health needs and recovery goals (National Resource Center for Participant-Directed Services (NRCPPDS), 2013). Per the Federal Centers for Medicare and Medicaid Services, this SDC model includes four key service elements: person-centered planning, individual budgeting, financial management services, and supports brokerage (Cook, Terrell, & Jonikas, 2004). The largest domestic SDC programs of this type are currently operating in Florida, Pennsylvania, and Texas (NRCPPDS, 2013). Other smaller SDC programs are operating

and have been piloted elsewhere throughout the United States (Alakeson, 2007; Alakeson, 2008; Koyanagi, Alfano, & Carty, 2008; NRCPDS, 2013; Office of Program Policy Analysis and Government Accountability (OPPAGA), 2010). SDC programs are also operational in Europe, Australia, and Canada (Alakeson, 2010; NRCPDS, 2013).

Initially established in 2001 by pilot legislation (H.B. 421), FloridaSDC was re-authorized indefinitely by Florida Statute 394.9084 in 2008. The program is publicly funded by the state mental health authority and operates in two service districts, serving on an annual basis eight counties and approximately 300 indigent adults diagnosed with a severe and persistent mental illness. Program participation is voluntary, and participants are enrolled on a “first come, first served” basis. Upon enrollment participants select and work with a recovery coach to identify recovery goals, budget the state dollars allotted for their care, and purchase the goods and services from their preferred vendors and providers that they feel will best help them to achieve their recovery goals. As long as they conform to state purchasing guidelines, participants are free to purchase traditional mental health services (e.g., psychotherapy, medication management) as well as alternative or non-traditional goods and services (e.g., art supplies, gym memberships) that they feel will result in the same or better outcomes. FloridaSDC operates on the philosophy that participants possess the capacity to make decisions regarding their treatment and control allocated funds to purchase the goods and services they need to achieve their individual recovery goals (FloridaSDC Circuit 20, n.d.).

Very few studies have examined SDC programs that exclusively target individuals diagnosed with a severe and persistent mental illness (Alakeson, 2008; Barczyk & Lincove, 2010). Two studies of the Cash and Counseling Demonstration and Evaluation programs in Arkansas and New Jersey reported favorable outcomes for sub-groups of individuals diagnosed

with a serious mental illness, who were allowed to direct their care (Shen, Smyer, Mahoney, Loughlin et al., 2008; Shen, Smyer, Mahoney, Simon-Rusinowitz, et al., 2008). Evaluations of European programs similar to the Cash and Counseling programs have yielded promising findings regarding participants' access to care, satisfaction with services, and quality of life outcomes (NRCPDS, 2013). However, with the exception of an evaluation of Oregon's Empowerment Initiatives Brokerage (Sullivan, 2006) and a report of preliminary findings of an ongoing randomized controlled trial of Texas SDC (Cook et al., 2010), most of the existing domestic literature that examines SDC program explicitly designed for individual diagnosed with a severe and persistent mental illness focuses on FloridaSDC (i.e., Alakeson, 2007; Cook, Russell, Grey, & Jonikas, 2008; Hall, 2007; OPPAGA, 2010; Teague & Boaz, 2003). Available outcome data for FloridaSDC participants are primarily limited to administrative measures (e.g., days in the community, days worked) and provide little insight into participants' functioning or quality of life. This study is unique in its reporting of functional assessment and discharge data as well as its in-depth examination of FloridaSDC participants' characteristics and service utilization.

Methods

Sample

With institutional review board (IRB) approval from [Institution removed for purposes of blinding], data were collected in two waves from the records of 136 (44%) of the 309 FloridaSDC participants served statewide in Circuit 4 and Circuit 20 during the 2009 to 2010 state fiscal year. The first wave was collected in 2011 from 80 participants, who consented in writing to the review of their records. The second wave of data collection occurred in 2012 and entailed the review of an additional 56 participants' records, following the IRB's decision to

grant a consent waiver in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (2002) for participants who were no longer enrolled in the program and for whom contact information was not available. De-identified data were collected from participants' charts and entered into SPSS (v. 19.0) for data analysis.

A majority of the 136 study participants were white (n = 103, 75.7%), female (n = 80, 58.8%), divorced (n = 59, 43.4%) or single (n = 56, 41.2%), and living alone (n = 60, 44.1%). Participants ranged in age from 29 to 83 with a mean age of 50.5 years (SD = 9.44). Many had earned a high school diploma (n = 36, 26.5%) or attended college without completing a degree (n = 35, 25.7%). The vast majority had an employment history (n = 114, 83.8%), although most were classified as disabled (n = 92, 67.7%) during the study period. Participants' annual family income ranged from \$0.00 to \$48,000 with a mean of \$10,560 (SD = \$6,165). Most (n = 92, 67.6%) relied upon federal disability insurance as their primary income source. Only 10.3% (n = 14) were military veterans.

Participants (n = 108, 79.41%) reported living with a psychiatric diagnosis from six to 60 years with an average of 21.83 years (SD = 11.67). At the time of the study, the majority were diagnosed with a mood disorder (n = 91, 68.4%) or a psychotic disorder (n = 34, 25.6%). The few remaining participants were diagnosed with anxiety (n = 7, 5.3%) or somatoform (n = 1, 0.8%) disorders. In addition to their psychiatric diagnoses, 45.6% (n = 62) of participants had a substance abuse history. Participants (n = 76, 55.9%) still enrolled in SDC at the time of the study had been enrolled for an average of 3.19 years (SD = 1.56). Discharged study participants (n = 45, 33.1%) remained in SDC an average of 2.76 years (SD = 1.46).

Given that the sample was comprised of both active and discharged FloridaSDC participants as well as individuals from two service areas located in different regions of the

state, additional analyses were conducted to identify differences between groups. There were no statistically significant differences in demographic characteristics between active and discharged FloridaSDC participants. The inability to detect differences may be a result of low statistical power given the small number of discharged participants. There was a statistically significant difference ($p = .002$) between service areas on race, as 31.2% ($n = 25$) of Circuit 4 clients were black, while only 7.4% ($n = 4$) of those in Circuit 20 were black. There was also a statistically significant difference ($p < .001$) between sites on employment status; 69.6% ($n = 55$) of Circuit 4 clients were disabled as compared to only 29.1% ($n = 16$) of Circuit 20.

Measures

Data were collected from participants' clinical and fiscal records. Data regarding participants' demographics and mental health characteristics were primarily obtained from each participant's Life Analysis, a locally constructed assessment tool completed by the participant at admission and updated annually. Additional data regarding participants' mental health characteristics and outcomes were collected from the Mental Health Outcome (MHO) data form and Functional Assessment Rating Scale (FARS). While the MHO form is an administrative tool developed by the state mental health authority, the FARS has been subject to repeated measurement testing (Schwartz, 1999; Ward, Dow, Penner, Saunders, & Halls, 2006). The FARS includes 18 functional domains. For each domain, the recovery coach indicates the severity of the participant's problem on a scale of 1.0 ("no problem") to 9.0 ("extreme problem"). Both measures are mandated by the state mental health authority and completed by recovery coaches at admission, discharge, and routine intervals during enrollment.

Data Analyses

This was a naturalistic descriptive study in which the dataset was formed by collecting all available cases. Thus descriptive statistics and measures of central tendency were used primarily. Some statistical significance testing (e.g., chi-square and t-tests) were utilized to examine differences between groups of participants, but these tests should be interpreted cautiously due to modest statistical power.

Results

Service Utilization

FloridaSDC participants' service utilization is documented as expenditures in their fiscal records. Expenditures were coded as traditional or non-traditional and sorted into 17 service categories utilized by the financial management entity for accounting and state reporting purposes. Each participant's expenditures were then collapsed by category and amount for the fiscal year. FloridaSDC participants spent a total of \$194,216.16 during the study period. Approximately 20% (\$39,120.04) was spent on traditional services (e.g., medication, counseling). For each individual, total expenditures ranged from \$0.00 to \$3,438.18 with a mean of \$1,428.06 (SD = \$764.89).

Table 1 details participants' expenditures by service category. Participants spent \$28,633.07 (14.7%) on transportation-related expenses (e.g., bus passes, automobile repairs), \$18,805.20 (9.7%) on housing or rent assistance, and \$15,131.68 (7.8%) on utilities (e.g., electricity, internet). Other major expenditure categories included dental services (\$18,193.76, 9.4%), medication (\$13,357.99, 6.9%), mental health counseling (\$13,272.03, 6.8%), and medication management (\$12,490.02, 6.4%). Participants spent \$9,147.80 (4.7%) on adjunct services (e.g., gym memberships, acupuncture, massage therapy) and \$36,756.73 (18.9%) on miscellaneous expenses that did not fit into the other categories. Given that these expenses

amounted to the greatest percentage of total expenditures, additional analyses were conducted to identify seven sub-categories of miscellaneous expenditures: computers and accessories (\$13,633.25, 7.0%), household items and appliances (e.g., washer and dryer, furniture) (\$7,465.69, 3.8%), hobbies (e.g., guitar, fishing pole, gardening supplies) (\$6,807.20, 3.5%), arts and crafts supplies (\$2,435.45, 1.3%), office supplies (\$2,396.51, 1.2%), and health and physical fitness (e.g., bicycle, yoga mat; \$1,846.96, 1.0%). The remaining expenses (e.g., wholesale club memberships, fingerprinting expenses) were categorized as “memberships and miscellaneous expenses” and amounted to \$2,171.67 (1.1%).

Given recent findings demonstrating differences in spending patterns between service areas (OPPAGA, 2010), additional analyses were conducted to examine service utilization by service area. When comparing Circuit 4 and Circuit 20, the mean dollars spent differed by \$100.00 or more in a few service categories. On average Circuit 4 participants spent more than those in Circuit 20 on transportation ($M = \$276.38$, $SD = \$409.57$ vs. $M = \$160.32$, $SD = \$256.26$), medication management ($M = \$167.20$, $SD = \$293.65$ vs. $M = \$39.09$, $SD = \$87.29$), dental services ($M = \256.38, $SD = \$522.07$ vs. $M = \$47.95$, $SD = \$210.39$), and miscellaneous expenses ($M = \$336.01$, $SD = \$487.20$ vs. $M = \$219.05$, $SD = \$317.64$).

Outcomes

FARS. The most severe scores were reported for depression, anxiety, and medical/physical, indicating participants on average had a “slight to moderate ” (4.0) to “moderate” (5.0) problem in these domains during the study period (See Table 2). Scores ranging from 3.0 to 4.0 (i.e., thought process, cognitive performance, traumatic stress, family relationships) indicate “a slight problem” to a “slight to moderate problem.” Participants appear to have had “less than slight” (2.0) to “slight” (3.0) problems with hyper affect, interpersonal

relationships, family environment, social-legal, work-school, activities of daily living (ADL), and ability to care for self. Finally, mean FARS scores suggest that participants had “no problem” (1.0) to a “less than slight problem” (2.0) with the following domains: substance use, danger to self, danger to others, and security management needs.

Participants’ mean FARS scores changed very little from the first administration to the second during the study period; however, mean change scores showed changes in the desired direction in all domains. The greatest degree of improvement occurred in the domains of work-school and depression in which participants’ mean severity rating decreased from 2.99 to 2.52 and 4.47 to 4.04, respectively.

Given that FARS scores indicated that many FloridaSDC participants demonstrated low levels of psychopathology, further analyses were conducted to determine what proportion of participants had FARS domain scores greater than or equal to 6.0, indicating “moderate to severe” impairment. At FARS 1, 44.9% (n = 61) of clients had no domain scores greater than or equal to 6.0, while 24.3% (n = 33) had three or more. At FARS 2, six months later, 55.9% (n = 76) had no domain scores greater than or equal to 6.0, while only 14.0% (n = 19) had three or more.

Days in the community, days worked, and monthly income. Number of days in the community (of the last 30) and days worked (of the last 30) were assessed quarterly. There was little variation across quarters; therefore, the mean value of all four quarters was calculated and used for analysis. All but 11 participants (82.1%) reported that they were in the community for 30 of the last 30 days, resulting in a mean number of days in the community of 29.24 days (SD = 3.42). The majority of participants (n = 97, 72.39%) reported a mean number of days worked <1; the mean number of work days was 2.38 (SD = 4.64). Consistent with the low number of days

worked, mean income was \$88.38 (SD = 201.15), with most participants reporting no earned income.

Discharge status. Of the 48 (35.3%) discharged participants in this study for whom data were available, many (n = 16, 11.8%) were discharged for administrative reasons, including lack of contact with program staff. Another nine (6.6%) participants requested discharge. Other reasons for discharge included relocation out of the service area (n = 7, 5.1%), death (n = 6, 4.4%), employment (n = 3, 2.2%), medical problems (n = 2, 1.5%), change in benefits (n = 2, 1.5%), return to case management (n = 2, 1.5%), and incarceration (n = 1, 0.7%).

Discussion

Although this study relies on a non-probability sample, the sample's demographic characteristics are consistent with those of other studies which examined the entire FloridaSDC population and reported that participants were primarily white females, divorced and living independently, and high school graduates (Cook et al., 2008; Hall, 2007; OPPAGA, 2010). Given previous findings that FloridaSDC participants were more likely to be female (n = 93, 71% vs. n = 2801, 42%; $\chi^2 = 43.4$, $p < .001$), less likely to be of minority status (n = 32, 24.4% vs. n = 3308, 49.6%; $\chi^2 = 32.5$, $p < .001$), and more likely to have graduated from high school (n = 113, 86.3% vs. n = 2294, 34.4%; $\chi^2 = 288.32$, $p < .001$) than their non-SDC counterparts receiving mental health services in the state of Florida (Hall, 2007), this study provides further, albeit tentative, evidence that FloridaSDC participants may be systematically different from non-SDC community-based mental health clients. Whether this is a result of the referral system or participants' self-selection is unclear and merits further examination to determine whether modifications are needed in the program's referral, outreach, and enrollment services in order to make FloridaSDC more accessible to a broader client population.

The vast majority of study participants (n = 91, 68.4%) were diagnosed with a mood disorder. This finding contributes to growing evidence of a shift in the population served by FloridaSDC over time. In the earliest study of FloridaSDC conducted by Teague and Boaz in 2003, a majority of participants (n = 17, 58.6%) were diagnosed with a psychotic disorder. By 2008, 46% (n = 48) of participants were diagnosed with a mood disorder (Cook et al., 2008). This percentage increased to 61% (n = 201) in 2010 (OPPAGA, 2010). This shift is consistent with the documented rise observed nationwide in the prevalence of mood disorders, particularly bipolar disorder (Moreno et al., 2007), but raises questions regarding FloridaSDC's appeal and accessibility to individuals diagnosed with other types of psychiatric disorders.

FloridaSDC participants have very little income and are clearly living in poverty. Nearly 80% (\$155,096.12) of participants' total expenditures were for non-traditional goods and services. This is likely partly due to the fact that FloridaSDC is a payer-of-last resort. This study does not account for participants' Medicaid and Medicare expenditures, which would allow for a more comprehensive understanding of participants' service utilization. However, it is evident that FloridaSDC participants choose to spend a substantial amount of their allotted budgets to meet their basic needs, including transportation, housing, and utilities. One implication of this finding is that participants' expenditures are consistent with their needs as evidenced by their financial demographics. This consistency seems important given common concerns that individuals diagnosed with a severe and persistent mental illness are not capable of making sound financial decisions and require financial guardians to restrict their purchasing power. FloridaSDC participants' purchases seem rational and reasonable given the poverty in which they live.

The authors would be remiss not to acknowledge an alternative implication of these study findings, which is that FloridaSDC may be a de facto public assistance program, in which participants are utilizing dollars allocated by the state for their mental health recovery to subsidize their living expenses. From the authors' perspective, this is not necessarily problematic, given that studies demonstrate a strong inverse relationship between socioeconomic status and the prevalence of mental illness (Hudson, 2005). Documented impediments to recovery include lack of housing, transportation, and nice clothing (Perese, 2007). Spending on such needs to achieve recovery is empirically defensible. However, this study does not suggest that FloridaSDC participants report severe psychopathology. Their FARS scores indicate that their most severe ratings in depression, anxiety, and physical/medical ranged between "slight to moderate" and "moderate." Although most participants lived independently in the community, almost none worked or earned income during the study period. Only three participants left the program due to employment. Certainly participants' high rates of unemployment are consistent with long-standing national trends of unemployment among individuals diagnosed with a severe and persistent mental illness, who are enrolled in a variety of community-based mental health services (Baron & Salzer, 2002). FloridaSDC participants' unemployment may be related to the recent economic recession, to limited access to vocational rehabilitation services or other types of employment readiness training, or to a shortage of supported employment programming in the service areas. It is also possible that participants were routinely engaged in other work-related or productive activities (e.g., attending school, volunteering) as some of their purchases suggest. If so, then it is advisable for program staff to implement a mechanism by which to document these activities to augment existing outcome data in the participants' clinical records. It remains troublesome, however, that so few participants worked, as employment is known to contribute to

recovery in a myriad of psychological, emotional, economic, and interpersonal ways (Marrone & Golowka, 2000). Additional research is needed to examine why participants are not working and to eliminate the possibility that the flexibility to use FloridaSDC funds to meet basic needs creates a disincentive to work and enables dependency. Such dependency, if it exists, could prove harmful to participants if their benefits are reduced, or they feel compelled to modulate goal achievement to ensure their program participation and receipt of benefits.

With the exception of modest improvement in levels of psychopathology, participants' outcomes (i.e., days worked, monthly income) did not seem to improve during the study period. However, it is important to note that participants did not appear to regress either, which is evidenced perhaps most notably by the consistent number of days spent in the community. Despite widespread concerns regarding the decision making capacity and skills of individuals diagnosed with a severe and persistent mental illness, FloridaSDC participants' outcomes did not worsen while they were responsible for managing their individualized budgets and making decisions regarding their service utilization.

These findings should be regarded tentatively given the study's reliance upon a non-probability sample of administrative records. Even with these caveats in mind, however, this study builds on previous studies in its more comprehensive examination of FloridaSDC participants' characteristics and service utilization. It is the only study to examine the severity of participants' symptoms (i.e., FARS scores) and discharge status in addition to conventional outcome indicators (e.g., days in the community).

Conclusions and Implications for Practice

In conclusion, this study is consistent with previous studies, which suggest that FloridaSDC participants may be different from other non-SDC community-based mental health

clients with respect to some demographic characteristics. Programmatic attention to outreach and referral networks as well as the enrollment process may offer explanations for these apparent differences as well as strategies to ensure FloridaSDC is accessible to a broad range of individuals diagnosed with a severe and persistent mental illness. Some potential solutions might include cultivating new referral sources, including organizations that target people of color, in order to diversify the population served by FloridaSDC. Program administrators might also evaluate the literacy level of marketing and enrollment materials to determine whether they present an access barrier to individuals with less education than the average current FloridaSDC participant.

FloridaSDC participants are clearly living in poverty, which is a major barrier to recovery. Participants frequently utilize their individualized program budgets to meet their basic needs, including transportation, housing, and utilities. Although such purchases are inarguably rational and consistent with participants' apparent needs, the fact that participants exhibit relatively low levels of psychopathology and are not working raises important questions for future evaluation studies. Researchers and program administrators may wish to examine the possibility that the program somehow enables dependency or disincentivizes employment and goal achievement and to consider new strategies and community resources to enhance participants' employment readiness and supported employment opportunities. Program administrators might explore innovative ways to link vocational rehabilitation and supported employment services with recovery coaching currently available to participants. Such strategies might include hosting job fairs and employment readiness trainings for participants or recruiting recovery coaches with specialized knowledge of vocational rehabilitation resources and service provision.

While participants' reliance on FloridaSDC funds to meet their basic needs may be perceived by some to be problematic, the authors contend that the rationality of their purchases and decisions regarding service utilization can hardly be questioned given the poverty in which they live. The fact that FloridaSDC participants' outcomes do not seem to suffer when they are allowed the freedom to direct their mental health service delivery provides further evidence of the utility and value of personalized budgeting and individualized service planning in the delivery of mental health services to individuals diagnosed with a severe and persistent mental illness.

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Table 1

Participants' Expenditures by Service Category

Service Category	Total	%	Min.	Max.	Mean	Median	SD
Traditional Services							
Medication (n = 45)	\$13,357.99	6.9	\$7.89	\$1,485.31	\$296.84	\$141.10	\$382.81
Med. Management (n = 50)	\$12,490.02	6.4	\$4.00	\$1,215.52	\$249.80	\$152.40	\$282.56
Counseling (n = 34)	\$13,272.03	6.8	\$15.00	\$1,330.00	\$390.35	\$282.52	\$314.72
Sub-Total	\$39,120.04						
Non-Traditional Services							
Food (n = 38)	\$11,440.44	5.9	\$39.74	\$1,003.40	\$301.06	\$214.15	\$250.47
Housing (n = 40)	\$18,805.20	9.7	\$5.02	\$1,461.20	\$470.13	\$369.50	\$339.21
Utilities (n = 45)	\$15,131.68	7.8	\$23.55	\$967.30	\$280.22	\$231.13	\$238.83
Clothing (n = 40)	\$10,100.60	5.2	\$21.39	\$955.93	\$252.52	\$172.95	\$231.69
Transportation (n = 64)	\$28,633.07	14.7	\$20.00	\$1,449.10	\$381.77	\$318.00	\$319.69
Dental Services (n = 24)	\$18,193.76	9.4	\$85.00	\$2,295.46	\$758.07	\$603.76	\$610.07
Vision Services (n = 19)	\$3,339.35	1.7	\$18.02	\$388.91	\$175.76	\$188.00	\$98.78
Adjunct Services (n = 23)	\$9,147.80	4.7	\$6.35	\$1,603.00	\$304.93	\$166.46	\$387.82
Pet Ownership (n = 4)	\$749.77	0.4	\$52.97	\$480.99	\$187.44	\$107.91	\$197.51
Personal (n = 6)	\$195.39	0.1	\$16.95	\$65.00	\$39.08	\$34.00	\$23.09
Education/ Training (n = 13)	\$1,748.17	0.9	\$12.79	\$223.83	\$109.26	\$103.00	\$57.89
Entertainment (n = 5)	\$854.16	0.4	\$23.49	\$321.00	\$170.83	\$198.69	\$133.04
Miscellaneous (n = 72)	\$36,756.73	18.9	\$4.21	\$1,536.52	\$284.94	\$168.68	\$304.49
Sub-Total	\$155,096.12						

Table 2

Participants' FARS Scores by Functional Domain

Functional Domain	FARS 1 (n=133) ^a			FARS 2 (n=112)			Mean Change
	Mean	SD	Median	Mean	SD	Median	
Depression	4.47	1.58	5.00	4.04	1.54	4.00	-0.43
Anxiety	4.11	1.70	4.00	3.99	1.71	4.00	-0.12
Hyper Affect	2.96	1.68	3.00	2.87	1.66	3.00	-0.09
Thought Process	3.17	1.86	3.00	2.93	1.81	3.00	-0.24
Cognitive Performance	3.37	1.84	3.00	3.24	1.93	3.00	-0.13
Medical/Physical	4.09	2.07	4.00	3.98	2.16	4.00	-0.11
Traumatic Stress	3.07	1.91	3.00	2.96	1.82	3.00	-0.11
Substance Use	1.71	1.46	1.00	1.65	1.24	1.00	-0.06
Interpersonal Relationships	2.62	1.80	2.00	2.26	1.56	2.00	-0.36
Family Relationships	3.37	1.92	3.00	3.00	1.82	3.00	-0.37
Family Environment	2.92	2.01	2.00	2.63	1.87	2.00	-0.29
Social –Legal	2.62	2.16	1.00	2.54	2.21	1.00	-0.08
Work-School	2.99	2.04	3.00	2.52	1.77	2.00	-0.47
ADL	2.78	1.93	2.50	2.49	1.70	2.00	-0.29

SELF-DIRECTED CARE

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Ability to Care for Self	2.05	1.76	1.00	1.84	1.40	1.00	-0.21
Danger to Self	1.61	1.42	1.00	1.53	1.19	1.00	-0.08
Danger to Others	1.20	0.77	1.00	1.16	0.58	1.00	-0.04
Security Management Needs	1.23	0.85	1.00	1.19	0.78	1.00	-0.04
Index							
Disability	3.06	1.34	3.00	2.89	1.23	2.67	-0.17
Emotionality	3.89	1.36	3.67	3.66	1.31	3.33	-0.23
Relationships	2.62	1.17	2.50	2.34	1.01	2.17	-0.28
Personal Safety	1.52	0.92	1.00	1.46	0.76	1.00	-0.06

^aThere were 1-2 cases with missing data on some variables resulting in n=131 or n=132.