Cash and Counseling: A Model for Self-Directed Care Programs to Empower Individuals With Serious Mental Illnesses

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Mental illness is the country’s leading cause of disability. However, approximately 60 percent of individuals with serious mental illness (SMI) are not receiving stable, ongoing treatment (Carper, 2005). One approach to combat this problem is to actively involve consumers in their treatment. Personal assistance services (PAS) assist individuals with disabilities with their daily living activities, and some, such as cash and counseling (C&C), empower individuals to make their own treatment decisions. Self-directed care programs have recently adapted from C&C programs targeting individuals with physical disabilities to models targeting individuals with SMI. The purpose of this article is to examine the effectiveness of these programs, explore their impact on individuals with SMI, and discuss the role of social workers in this new service delivery approach.

KEYWORDS personal assistance services, cash and counseling, self-directed care, serious mental illness, empower

INTRODUCTION

According to the Surgeon General’s Report on Mental Health, approximately 20% of adults in the United States are affected by a mental health disorder in...
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According to a given year. The prevalence rates for children, adolescents, and the elderly are not as well documented. It is estimated that in any given year, 20% of children have a mental health disorder with at least mild functioning impairment, and 20% of elderly individuals have a diagnosable mental health disorder (U.S. Department of Health and Human Services, 1999). It has been stated that mental illness is the country’s leading cause of disability. In spite of this, more than 60% of people with serious mental illness (SMI) are not receiving ongoing, stable treatment (Carper, 2005).

Despite an epidemic-level incidence of mental health problems, utilization of mental health services is very low in the United States (U.S. Department of Health and Human Services, 1999) particularly among minority populations (Flaskerud, 1986). The majority of individuals with a diagnosable mental illness are not receiving treatment (U.S. Department of Health and Human Services, 1999). Given the large numbers of individuals suffering from mental health problems without treatment, new and innovative strategies are needed to increase utilization and treatment success. One innovation is new delivery models for personal assistance services (PAS), including cash and counseling (C & C).

C & C was conceived as a way to allow individuals with disabilities to make their own treatment decisions. While many consumer-directed service models exist, C & C is unique in that it gives consumers financial control over public funds allocated for disability related goods and services. C & C does not replace existing services, but provides an additional option available to consumers who can benefit from a more consumer-directed model (Simon-Rusinowitz et al., 2001). Consumer-directed services of this kind originated more than three decades ago with the goal of assisting adults with disabilities (DeJong, Batavia, & McKnew, 1992). C & C is a thoroughly evaluated consumer-directed service. The majority of the research studies cited on this program come from the “Cash and Counseling” Demonstration/ Evaluation, a large-scale public policy experiment aiming to evaluate a consumer-directed approach to financing and delivering PAS to individuals with disabilities, including persons with mental illness (Doty, 1998). The Robert Wood Johnson Foundation awarded a $7 million four-year grant that initially was used to begin C & C in Arkansas, Florida, and New Jersey (Doty, 2004), and twelve additional states are currently implementing similar programs (Alliance for Health Reform, 2006).

C & C represents a significant departure from institutional norms in the delivery of health and mental health services. In the past, policy obstacles have complicated efforts to give consumers greater control. Medicaid rules required states to certify and approve all providers, which created a significant obstacle in the movement toward consumers’ choice. States wanting to implement these programs had to rely on state funding or partner with private donors. Since 2002, a federal policy changed to allow Medicaid to support self-directed care, including C & C programs. States can now apply
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for an expedited Medicaid waiver under the Independence Plus program, which allows greater flexibility in the standards used to certify providers, thus expanding options for consumers (Crowley, 2003). Although the waiver process is still burdensome for states, this policy change overcomes a significant obstacle by opening up the possibility of federal funding.

The purpose of this article is to inform social workers of the consumer-directed C & C model. The article will provide an explanation of the model and its relationship to the empowerment theory. The results of the evaluation research conducted with the elderly and individuals with disabilities will be reported. In addition, self-directed care programs, which have adapted the principles of C & C to empower individuals with SMI, will be discussed as the first attempt to utilize the C & C model with individuals with SMI. Finally, the article will discuss the possibility of expanding the self-directed care model to more mental health systems and the impact this will have on social workers.

EMPOWERMENT

According to Rappaport (1987), empowerment means that an individual has control over his or her life and is able to participate in several communities including schools, churches, and neighborhoods. Empowerment has also been defined as, “a process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situations” (Gutiérrez, 1990, p. 149). The philosophy of empowerment underlies the Cash & Counseling approach to treatment. Empowerment theory forces health care professionals to “think in terms of wellness instead of illness, competence instead of deficit, and prevention as well as treatment” (Peterson & Hughey, 2002, p. 42). In an empowerment model, social workers facilitate, collaborate, and focus on learning about their consumers. They no longer take the role as counselor or expert. The role of the social worker is not to advocate for the client, rather they are to empower their clients to advocate for themselves and they serve as participants in the process (Zimmerman, 2000).

At an individual level, the empowering process includes participants exerting control, making decisions, and solving the problems that they face. By experiencing the empowering process, the individual gains a sense of control, critical awareness, and participatory behaviors from working with others instead of having others work on his or her behalf (Zimmerman, 2000).

One of the main goals of C & C is to give each consumer more control over services he or she receives. The self-directed financing structure is designed to empower consumers to make their own decisions regarding their treatment. Studies have shown that individuals with severe disabilities
and cognitive impairments are capable of expressing their preferences for quality of life and everyday living decisions (Squillace Mahoney, Shoop, Simon-Rusinowitz, & Desmond, 2001). Research has shown that patients fare better when they are actively involved in their treatment (Selo, 2003). Often, consumer-driven services focus only on involving the consumer in a treatment program that was designed by professionals. The Cash & Counseling Demonstration/Evaluation also involved consumers in every step of program design and implementation. This expands the concept of empowerment to participation in policy design and ensures that implementation reflects consumer preferences.

The defining characteristic of C & C programs, as opposed to traditional service delivery, is that participants have financial control of funds allocated for their treatment. The model has demonstrated success with populations with physical disability. Adapting this model to empower individuals with SMI would enable them to have similar or even greater benefits.

CASH AND COUNSELING

The Model

In the traditional clinical model, social workers and/or nurses develop treatment plans based on their assessment of the client’s disability, often with a limited number of service options. The health care professionals would then notify the agencies of the treatment plan, and Medicaid would be billed for a reimbursement upon the delivery of a service (Doty, 1998). C & C functions differently than typical services. C & C is a type of personal assistance services that extends treatment options with a range of human and technological assistance to assist Medicaid eligible individuals with disabilities, including those with mental illnesses. PAS can include traditional treatment, as well as services that support daily living activities (Doty, 1998; Mahoney & Rusinowitz, 1997). Three methods have been utilized to finance PAS:

1. Cash benefits are paid directly to the beneficiary or their representative payee (surrogate).
2. Vendor payments enable the nurse and/or social work case manager to arrange and pay for authorized services to be delivered by PAS providers.
3. Consumers receive vouchers, coupons, stamps, or debit accounts to purchase services (Mahoney & Simon-Rusinowitz, 1997; Mahoney, Simon-Rusinowitz, Loughlin, Desmond, & Squillace, 2004).

C & C programs utilize the third approach, giving consumers control over an account of funds for their own treatment. This financing strategy requires redefinition of the roles of health care professionals. Health care professionals
provide an intake assessment to identify needs. As consumers select services, professionals act as financial gatekeepers and allocate an appropriate level of benefits. Consumers are then able to purchase a range of disability related goods and services, as long as they address disability-related needs within the allocated benefit level. As consumers access services, professionals offer advice on recruiting, hiring, training, supervising, and firing service providers (Phillips et al., 2003; Doty, 1998). For example, in the disability context, services selected by the consumer include transportation services, assistive technologies, adult day care, respite services, home and vehicle modifications, and services that assist individuals with their daily living activities such as bathing, toileting, eating, and dressing (Doty, 1998; Mahoney & Simon-Rusinowitz, 1997). While receiving the cash benefits, a counselor will be available to assist in developing a cash management plan and provide other advice. The consumer maintains a benefit account and can carry over benefits from month to month to create an emergency fund in case of a crisis (Doty, 1998). While consumers have the choice to hire whomever they desire to provide services, they are required to document compliance with Federal Insurance Contributions Act (FICA) and other tax requirements. In addition, they must turn in worker time sheets and check requests before funds will be disbursed in order to prevent abuse of the allowance (Doty, 1998; Phillips et al., 2003).

As previously mentioned C & C was not intended to replace existing services, but is an available option (Simon-Rusinowitz et al., 2001). C & C programs have been targeted for older adults with disabilities 65 years of age, as well younger adults. Florida also targeted their program to children with disabilities and their parents (Doty, 1998).

Consumers Preferences

Prior to implementing C & C, researchers conducted pre-survey focus groups, telephone surveys, and post-survey focus groups with individuals with disabilities receiving personal care services in order to:

1. determine preferences for consumer-directed services in general, and specifically for a cash option;
2. determine the percentage of consumers or surrogates choosing the cash option versus traditional services;
3. identify reasons for consumer or surrogate preferences;
4. identify demographic and background characteristics of consumers and surrogates with specific preferences;
5. identify cash-option features that are attractive or unattractive to consumers and surrogates;
6. identify what information consumers and surrogates need to decide whether to choose the cash option;
7. identify consumer and surrogate needs for counseling and support services; and
8. develop strategies to market the cash option (Mahoney et al., 1998, p. 77).

Approximately 40% of the New York consumers participating in the focus groups and telephone surveys indicated that they were interested in the cash option. Interest in the program varied across groups (Mahoney et al., 1998, 2004). For example, individuals in their late twenties were found to have less interest in the cash option when compared to individuals slightly older. It was speculated that this may have to do with younger individuals not having the confidence to deal with tasks associated with the cash option such as managing finances (Mahoney et al., 2004).

Upon evaluating the role of surrogates, it was found that surrogates adequately represented the views of the consumers regarding satisfaction with personal care (Squillace et al., 2001). Responses from surrogate decision makers answering for consumers with communication difficulties or cognitive impairments indicated that

- 41% believed the consumer would be interested in the cash option (Mahoney et al., 1998; Squillace et al., 2001).
- 56% percent stated that they liked the idea of a cash option (Mahoney et al., 1998).

Similar findings regarding consumers/surrogates were found in Arkansas, Florida, and New Jersey (Simon-Rusinowitz, 1997; Simon-Rusinowitz et al., 2001; Simon-Rusinowitz, Mahoney, Marks, Zacharias, & Loughlin, 2005b).

Many of the consumers with disabilities liked the idea of taking more control in their lives and having more independence. However, some consumers were skeptical about C & C. Consumers reported the following opinions and concerns:

- Consumers were attracted the idea of selecting their own workers, but had concerns about finding appropriate candidates.
- Participants were confident about their ability to create schedules for their workers.
- Participants had mixed views on the option to hire friends or family members as workers.
- Some consumers did not believe money mixed well with family or friends.
- Some consumers believed it would be good to be able to pay their friend or family member who was already assisting them.

When consumers and surrogates were asked about the services they were most interested in purchasing, transportation services were the most desired service
followed by someone to keep them company, exercise equipment, more hours of personal care, and housekeeping services (Simon-Rusinowitz et al., 2001).

Researchers asked consumers with disabilities who participated in focus groups to discuss their current PAS in addition to their interest in participating in C & C. In general, older consumers and their surrogates were more satisfied with PAS than younger consumers. Younger consumers did not believe their current PAS was designed to meet their needs and did not facilitate independence. In addition, younger consumers were frustrated by not having a say in the services they were provided or their workers’ schedule. Younger and older consumers had a general distrust for their agencies and believed personal care workers were not always adequately trained and supervised (Simon-Rusinowitz et al., 2005b).

**EFFECTIVENESS**

Greater consumer satisfaction with services has been reported in programs giving consumers control over managing and hiring attendants (Doty, 2000). The consumers with disabilities participating in C & C were found to be highly satisfied with their care arrangement (Schore, Foster, & Philips, 2007). The quality of life of consumers was also reported as improving due to C & C (Foster, Dale, & Brown, 2007). Very few workers or consumers reported being exploited and the fraudulent use of the cash benefit was extremely rare (Schore et al., 2007). The Arkansas C & C evaluation team has found that participation in the program resulted in good health outcomes (Krahn & Drum, 2007; Simon-Rusinowitz, Mahoney, Loughlin, & Sadler, 2005).

C & C has been found to be slightly more expensive than traditional agency-based services. After the first two years, total Medicaid costs were 8% to 12% higher for participants of C & C. However, C & C has various extra benefits when compared to traditional agency-based services including the fact that C & C empowers consumers to make their own service decisions. This is likely to benefit the consumer’s recovery more so than traditional agency-based services. For example, it is expected that for older adults the additional cost of services will decline significantly as fewer participants in C & C are being admitted to nursing homes, which would generate a 18% cost savings (Alliance for Health Reform, 2006). With a greater number of older adults having the ability to choose services and remain at home for care due to the C & C program, the number of individuals admitted to nursing homes may decline further in the future.

**Family Members as Workers**

The majority of C & C consumers used their allowance to hire workers. Of the consumers who hired workers with their allowance, most used their
workers to assist with housework and personal care. Between 73% and 93% received assistance with routine health care needs such as taking medication. Another common service was transportation assistance (Schore et al., 2007). The majority of consumers who hired workers selected a family member, often an adult child or parent. Black consumers were found to be more likely to hire a family member compared to consumers of other race/ethnic backgrounds (Simon-Rusinowitz et al., 2005a). In general, when hiring any worker, family member or not, hired workers were much more likely to be of the same race as the consumer when compared to agency workers assigned to consumers (Foster et al., 2007). From this information it is evident that cultural issues play a role satisfaction and preference of C & C.

It was reported that family members did more for consumers overall and did not complain about working extra hours (San Antonio, Eckert, & Simon-Rusinowitz, 2006). Consumers who hired a family member to be their caregiver received care during non-traditional hours more often than consumers who did not hire a family member to be their caregiver. Despite working non-traditional hours, consumers who had family members as their hired workers still continued to receive the same amount of unpaid care as the consumers who did not hire a family member (Simon-Rusinowitz et al., 2005a).

Health and quality-of-life benefits resulted when a family member was hired by the consumer. When a family member was hired as a worker, consumers had fewer bed sores or pressure sores, respiratory infections, and falls compared to workers who were not family members. Consumers also reported that they had fewer unmet needs. Some areas did not differ based on whether the worker was a family member or not. For example both family and non-family workers in C & C reported high levels of worker satisfaction. In addition, consumers reported being equally satisfied with their relationship with the family and non-family workers, but family workers were more likely to indicate that the client lacked respect (Simon-Rusinowitz et al., 2005a). It appears that having the option to hire a family member is extremely appealing to consumers and therefore is a vital component to the success of C & C.

Utilizing family members as workers is a controversial topic both in C & C programs and other consumer-directed models. These providers are not necessarily licensed or trained, fall outside of the supervisory capacity of state agencies, and are not subject to professional codes of ethics. The issue of oversight is a serious concern, and cases of physical abuse, neglect, and financial exploitation have been reported. Financial fraud is one of the most common types of abuse and occurs when a family member collects payment for services that were not delivered or takes the pension or Social Security check of the consumer (Blaser, 1998). However, consumers experiencing abuse or fraud has been rare (Simon-Rusinowitz et al., 2005a), and with proper training and monitoring, the possibility of exploitation or abuse can be decreased (Blaser, 1998).
Adaptation to the Mental Health System

The New Freedom Commission on Mental Health was announced by President Bush in February 2001 with the goal of breaking the barriers individuals with disabilities face in America. One of the goals outlined was to have mental health care be consumer and family driven (White House Domestic Policy Council, 2004). The Commission recommended expanding consumers’ and family members’ roles in managing the funding for their supports, treatments, and services, which would lead to an increase in their choices (New Freedom Commission on Mental Health, 2003). Through President Bush’s New Freedom Initiative, the Centers for Medicare and Medicaid Services are working with the Substance Abuse and Mental Health Services Administration and constituent representatives to organize a self-direction initiative (White House Domestic Policy Council, 2004). One component of these reforms is added flexibility in Medicaid rules to allow self-directed care models. Despite this interest in self-directed care at the federal level, fewer than 400 consumers are participating in self-directed care programs in the United States (Alakeson, 2008). Given the effectiveness of C & C when targeted at individuals with disabilities, restructuring C & C to specifically target individuals with mental illnesses may increase the utilization of self-directed care programs.

The New Freedom Commission facilitated the spread of self-directed care programs by developing the Independence Plus program, which relaxes stringent provider certification requirements to allow Medicaid funds to support C & C models. States can apply for a waiver of provider certification requirements opening up the possibility of using family members and other nontraditional providers. Medicaid funded programs must continue to meet other federal requirements including providing state matching funds and demonstrating adequate checks and balances to prevent fraud. The programs must also demonstrate “budget neutrality,” meaning that C&C services must not be more expensive than traditional service delivery and that all Medicaid caps continue to apply.

Adapting C & C for individuals with mental illnesses requires attention to the specific needs of the population. While an individual with a physical disability may need assistance getting dressed, eating and preparing food, and bathing, an individual receiving behavioral support may need the assistance of a counselor or a peer support group (Nerney, 2004). A key difference between individuals with physical disabilities and psychiatric disabilities is that individuals with psychiatric disabilities are subject to short-term acute crises. While in a crisis, the individual’s decision-making skills may be impaired for a short time and particularly his or her ability to assess long-term consequences. However, the crises are often brief and the individuals are likely to resume their previous level of functioning. While this is a concern, advanced planning can alleviate worries about the individual.
A plan of action can be developed by the individual in and a surrogate decision maker can be selected in case a crisis occurs (Stefan, 2004).

Some states have already begun implementing programs aimed at empowering consumers and their family members to play a larger role in mental health recovery (Hendry, 2008; Michigan Department of Community Health, 2003). Florida, Maryland, Oregon, and Tennessee currently have self-directed care pilot programs, Iowa recently completed one and Texas and Pennsylvania are in the process of developing new programs (Alakeson, 2008). States programs differ in eligibility criteria. While some researchers believe self-directed care should not exclude individuals based on their functioning or symptomatology, others exclude individuals who are under guardianship, and often concerns are raised about an individual consumer’s ability to participate in the program. For example, an individual may be excluded if he lacks the capacity to manage choices (Stefan, 2004). In addition, each state program differs in the amount of control consumers have. Florida, Maryland, and Michigan allow consumers broad freedom to select services and providers, while Oregon and Iowa allow consumers to purchase recovery supports, but do not allow consumer-directed changes to an existing, traditional service plan.

The Florida self-directed care program, supported by the Florida Department of Children & Families, is similar to a C & C program and is the largest such program in the United States, with approximately 200 consumers (Alakeson, 2008). Participants are provided with a life/recovery coach who familiarizes the consumer to the program, provides referral information, assists the consumer in developing personal recovery goals and assists the consumer to prioritize and plan the budget. A Life Analysis is then conducted, which is a self-assessment that helps the consumer create a plan of life activities and a path to reach his or her goals. A Life Action Plan is then created, which provides the details of the budget and plan to achieve the consumer’s goals. Clinical Recovery Services (i.e., traditional mental health services), Recovery Support Services (i.e., alternatives to traditional mental health services), and Recovery Enhancement Services (i.e., clothes, personal hygiene products, tuition, car repairs, and office supplies) are all eligible to be included in the budget Hendry, 2008).

The following is a breakdown of how participants in Florida’s self-directed care program utilized their funding:

- 47% was spent on traditional clinical recovery services (e.g., counseling, therapeutic, and psychiatric services)
- 13% was spent on recovery support (e.g., self-help, wellness, and exercise)
- 29% was spent on tangible services (e.g., food and clothing)
- 5% was spent on dental services
- 3% spent on ophthalmology or optometry services
- 3% was spent on transportation
Participants in this program on average only spent about a third of the funds allocated to them, which alleviated concerns that consumers would overspend the allocated budget (Cook, Russell, Grey, & Jonikas, 2008).

Findings

The Cash & Counseling Demonstration/Evaluation provides preliminary evidence that C & C is effective for individuals with mental health problems, as some demonstration programs included this population as well as individuals with physical disabilities. Results from the Arkansas evaluation showed that C & C worked as well for individuals with mental illness as it did with individuals without mental illness along outcome measures including: satisfaction with paid caregiver’s relationship and attitudes; satisfaction with life; satisfaction with care arrangements and unmet needs; and adverse events, health problems, and general health status (Shen et al., 2008). These positive outcomes suggest that adapting the model to be targeted toward individuals with SMI is not only possible but will likely yield positive results.

Self-directed care programs are the first attempt to create a program equivalent to the C & C program within the mental health system. Self-directed care programs are designed to serve uninsured and low-income adults with serious mental illness (Coakley, n.d.). They give the consumer control of his or her budget to choose goods and services that will meet his or her individual needs (Alakeson, 2008). The Federal Centers for Medicare and Medicaid Services (CMS) developed services and supports that are used in conjunction with Medicaid programs in order to provide the self-directed care options. CMS believes four elements are necessary when implementing a self-direction program including: person-centered planning, individual budgeting, financial management services, and supports brokerage (Cook, Terrell, & Jonikas, 2004).

An evaluation of Florida’s self-directed care program showed positive outcomes for participants in terms of residential stability and community integration. Participating consumers utilized less crisis stabilization and other crisis support services when compared to non-participants. Participants also had a higher number of assessments and medical services including supported employment, outpatient psychotherapy services, and psychiatry (Hendry, 2008). Participants of the Florida self-directed care program spent significantly less time in criminal justice settings, spent significantly less time in psychiatric inpatient settings, and showed significantly improved functioning (Cook et al., 2008). According to a review of the literature by Alakeson (2008), satisfaction levels have also increased in consumers of the self-directed care program in comparison to consumers of traditional services.

While self-directed care programs appear to be effective, the evaluation of the program and the involvement of consumers in the process have been
minimal in comparison to the C & C program. In order to successfully implement this program, it will be beneficial to use C & C as a model, including the process through which C & C was implemented and evaluated. Consumers preferences should be assessed in pre-surveys to ensure consumers are in fact interested in the cash option and to determine whether age, race/ethnicity, or gender have an impact on their interest. In addition, evaluation tools will need to be developed to evaluate where consumers used their money, consumers satisfaction, family/caregivers satisfaction, employment stability, residential stability, medical services utilized, hospitalization rates, and other factors that would indicate the effectiveness of the program.

**IMPLICATIONS FOR MENTAL HEALTH SERVICES AND SOCIAL WORKERS**

As noted from the research in this article, C & C has been extremely successful for the individuals with disabilities. Is it possible to transfer this model to other populations? Evaluations of current self-directed care programs for SMI indicate that it is possible to provide C & C for this population with significant benefits. Traditional perceptions of SMI were not supportive of the empowerment model, and may have prevented the implementation of consumer-driven models such as C & C. However, recently more emphasis has been placed on dispelling assumptions that individuals with mental health problems are incapable of making their own treatment decisions. Increasing attention has been given to benefits of having a consumer-driven system. Social workers have responded to empowerment theory by transitioning to a recovery-based model of case management, where the traditional treatment approach is replaced a focus on consumer independence and self-sufficiency. This approach also alters the practice of social work to fit new consumer-directed models of service delivery.

Consumer-driven services are advocated by mental health advocates, social workers, and many other mental health professionals. For instance, the Mental Health Transformation Grants awarded by the Substance Abuse and Mental Health Administration to states require consumer participation throughout the process of transforming the mental health systems in their states (National Governors Association Center for Best Practices, 2007). C & C and self-directed care are the first steps in changing our current system to one that is more consumer-driven.

The role of social workers will change in a consumer-driven system. Social Workers will work to actively involve consumers in every step of the recovery/treatment process. No longer will decisions be made on behalf of the clients, rather the clients will be making their own decisions. Treatment plans will continue to be a joint effort but consumers will take more of a
leadership role while social workers will take the role of an educator and inform consumers about treatment options in order to assist the consumer in deciding which treatment option is most appropriate for them.

The role of social worker will also change in response to the new regulations allowing Medicaid funding for self-directed care. If Medicaid funds are included, social workers will need to understand federal caps and oversight requirements. In addition, social workers can educate consumers to prevent fraud and abuse by providers.

It is well documented that social workers have an extremely large case loads. By changing the role of the social worker this caseload may become more manageable, as some consumers will choose to take more control of their treatment freeing up time for the social worker to work with their other consumers. This could be beneficial to all consumers, as social workers may also have more time to dedicate to traditional consumers. Despite the changes that will be necessary to fully integrate C & C/self-directed care into the mental health system, it is a necessary step toward creating a system that focuses on recovery and empowering individuals to controlling their own recovery.

CONCLUSION

Social Workers need to be aware of the effectiveness of consumer-driven services, such as C & C. Therefore, it is imperative that schools of social work begin to expose social workers to C & C as well as other effective consumer-driven services. As mentioned previously, C & C is not meant to replace existing services but rather to be an option for consumers who choose to take more control of their treatment. C & C has been evaluated for providing services to individuals with disabilities and consumers have shown an increased quality of life and satisfaction with the services. Enabling consumers to hire family members as their workers is an added benefit that has attracted many consumers to C & C. Self-directed care programs have begun implementing a similar model to individuals with SMI. The preliminary results of self-directed care programs are showing the same effectiveness but further evaluation is necessary.

Given the large number of individuals in the United States with mental health problems, adapting this model to treat individuals with SMI may significantly improve their quality of life and satisfaction with services. In order for this to occur, social work will need to focus on empowering consumers to control their own treatment. With consumers making more of their own treatment decisions, social workers, nurses, and other health care professionals will be able to better handle their growing case loads. This is not to say there is no role for social workers in the treatment process. Rather, social workers need to change their existing role to a more
consumer-directed approach which may enable consumers to be more satisfied with services and have a higher quality of life.

REFERENCES


