Building on the Successes of Voucher Models to Promote Self-Direction

Service Use Impacts of a Utah Pilot Program

The Study

HSRI researchers looked at 2 years of data to compare the amounts of mental health services used by people before and after they began participating in a **self-direction program in Utah.** They also compared those results against service use for a similar group of people who did not self-direct.

What Is Self-Direction?

Self-direction is a promising model of service delivery for people with serious mental health conditions, and one that aligns with the federal focus on using individualized, person-centered care to effect recovery. Under the model, individuals who use publicly funded mental health services, and have an interest in selecting their supports, control a portion of funds normally spent on their mental health treatment. Using an individual budget, self-directing participants have the flexibility to purchase goods and services—including nonclinical goods and services like gym memberships, public transportation passes, computers, and clothing—that help them achieve their mental health and wellness-related goals.

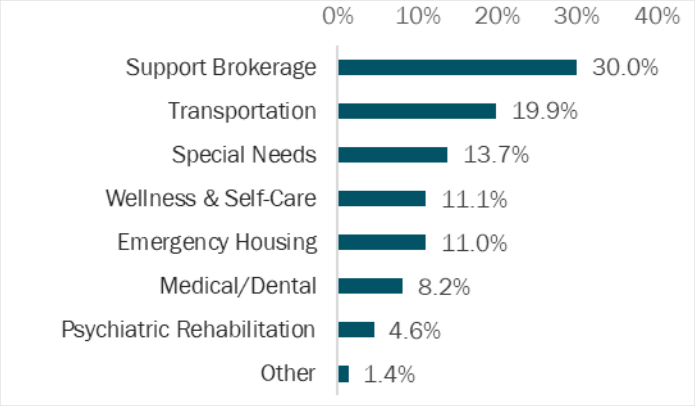
But does it get people connected to and engaged with services and resources in their communities that can help with their recovery? To find out, we looked at data from 94 participants in a self-direction program in Utah. In this program, participants worked with a support broker to come up with a plan that would help them meet their recovery goals. As part of this, they could allocate funds from a $2,000 flexible budget for nonclinical goods and services. The program was based on the state's successful Access to Recovery program, a voucher-based model that connects people in recovery from substance use problems to non-traditional goods and services.

The Findings

Looking at hours of service use for four categories of mental health services (see table on the next page), we found:

- Self-directing participants had greater increases than non-participants in their use of rehabilitation and outpatient treatment services.
- Self-directing participants used an average of 63 more rehabilitation service hours than non-participants, and an average of 22 more outpatient treatment hours.
- No differences between participants and non-participants in use of residential and emergency services.

Participants could spend up to $2,000 in project funds, but on average they spent less than half that amount, $902. The mandatory Support Brokerage service amounted to the largest of their expenditures, but participants also used their budgets to purchase a range of goods and services to support their recovery:



The Special Needs category includes items such as birth certificates, ID cards, one-time utility payments, etc.

What's the Importance?

It's well-documented that people with serious mental health conditions have difficulties getting the services they need to recover. In a given year, two in five adults with serious mental health conditions receive no care,[1] and over half of people with co-occurring mental health and substance use disorders receive no care[2]. Given these high levels of unmet need, it's notable that even with a modest budget, self-directing participants were more likely to make use of community-based services.

Beyond that, self-direction is associated with a number of positive outcomes—including enhanced quality of life, greater community engagement, improved functioning, and positive housing and employment outcomes.

Utah's 2-year mental health self-direction pilot was modest in many respects, but it still had an impact on participants' service use:

Category	Services	We Observed…
Rehabilitation	Rehabilitation vocational training, rehabilitation skill building, personal care or caregiving activity, case management, and other adjunctive services	Self-directing participants used an average of 63 more rehabilitation service hours
Outpatient Treatment	Diagnosis and assessment, individual treatment, individual behavior management, family treatment, group treatment, medication management from a physician, and medication management from a nurse	Self-directing participants used an average of 22 more outpatient treatment hours
Residential	Adult residential treatment, residential support services, and in-home treatment	No significant differences between the self-direction and control groups
Emergency Services	Inpatient treatment and emergency services	No significant differences between the self-direction and control groups

Methods

Study participants included 94 people participating in Utah's Mental Health Access to Recovery (MHATR)—a one-time grant-funded pilot program. Approximately 95% of all MHATR participants met the state-defined criteria for serious mental illness. To be eligible for the program, individuals needed to be age 13 and older (though our study was limited to adults 18 and older), be residents of Salt Lake County, and have incomes at or below 300% of the federal poverty level. Participants also needed to be referred by mental health providers. Approximately 90% of MHATR participants were enrolled in Medicaid.

In addition to accessing traditional treatment and rehabilitation services through the publicly funded system, MHATR participants could spend up to $2,000 in MHATR funds, although average per-person expenditures were only $902.

To conduct this matched comparison study, we matched our sample of MHATR participants to 529 non-participants with similar characteristics.

Learn More

Future studies will continue to examine self-direction's relationship to service use, cost, and other outcomes that are important to people who use publicly funded mental health services. Currently, we're examining six states as part of the *Demonstration and Evaluation of Self-Direction in Mental Health*. To learn more about the project, access additional mental health self-direction resources, and keep up-to-date about our work, visit mentalhealthselfdirection.org.

For more information on this study, see "Service Utilization Before and After Self-Direction: A Quasi-experimental Difference-in-Differences Analysis of Utah's Mental Health Access to Recovery Program" in the journal *Administration and Policy in Mental Health and Mental Health Services Research*.

Or contact the author:
Bevin Croft is a research associate with HSRI's Behavioral Health team (bcroft@hsri.org)

[1] Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2015). Insurance status, use of mental health services, and unmet need for mental health care in the United States. Psychiatric Services (Washington, D. C.), 66(6), 578–584. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400248.

[2] Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. Health Affairs, 36(10), 1739–1747. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0584.