Center on Mental Health Services Research and Policy

Research on Self-Directed Care (SDC) Fact Sheet

What is SDC?

In SDC, public funds ordinarily paid to service provider agencies are controlled by service recipients who develop person-centered plans for recovery along with individual budgets that allocate dollars to achievement of the plan's goals. Support is provided by service brokers who help individuals purchase goods and services, and arrange supports using their approved budget allocations. Fiscal intermediaries handle billing, payroll, taxes, & other administrative functions.

How well does it work?

A randomized evaluation of Cash & Counseling (a Medicaid-funded SDC approach) in Arkansas for individuals with developmental and physical disabilities as well as the elderly was conducted by Mathematica Policy Research, Inc. and found the following.[1,2]

- Medical outcomes of SDC participants were as good or better than participants receiving regular care under fee-for-service (FFS) arrangements.
- SDC participants received more services than their fee-for-service counterparts.
- Budget neutrality prevailed by end of 2nd year so that SDC programs did not cost more than traditional FFS financing.
- Consumer satisfaction was significantly higher among those served in SDC than FFS.
- Incidences of fraudulent behavior in SDC were low.
- Hiring (& firing) friends and family members was not problematic.

A pretest-posttest study of SDC for people with psychiatric disabilities in Florida found the following.[3]

- SDC participants spent a significantly higher number of days in the community after joining the program than they did in the year prior to program enrollment.
- Participants also scored significantly higher on global functioning in the year following program participation than the year prior.
- Only 16% of participants were hospitalized and the resort to involuntary inpatient commitment was especially rare, with only 5% hospitalized involuntarily.
- Notable proportions of participants engaged in productive activity including paid employment (34%), vocational skills training (19%), volunteer activities (16%), post-secondary education (7%), and General Equivalency Diploma classes (3%).

1. Dale, S., Brown, R., Phillips, B., Schore, J., & Carlson, C.L. (November 19, 2003). The effects of cash and counseling on personal care services and Medicaid costs in Arkansas. Health Affairs, (Web Exclusive), W3-566-575.
2. Foster, L., Brown, R., Phillips, B., Schore, J., & Carlson, C.L. (March 26, 2003). Improving the quality of Medicaid personal assistance through consumer direction. Health Affairs, (Web Exclusive) W3-162.
3. Cook, J.A., Russell, C., Jonikas, J.A., Grey, D.D. (2008). A self-directed care model for mental health recovery. Psychiatric Services 59(6) 1-4.

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