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**MONEY MANAGEMENT FOR THE SEVERE AND
PERSISTENTLY MENTALLY ILL**

by
Simone Nicole Kurtz-Dougherty

A Thesis

Submitted to the
Department of Psychology
College of Science and Mathematics

In partial fulfillment of the requirement
For the degree of

Master of Arts in Applied Psychology & Professional Mental Health Counseling

at
Rowan University

April, 2014

Thesis Chair: Mary Louise Kerwin Ph.D.

Dedication

I would like to dedicate this manuscript in memoriam to my grandmother, Ethel M.

Kurtz.

Acknowledgements

First and foremost I would like to thank Dr. Mary Louise Kerwin for her infinite patience and statistical brilliance. I owe a debt of gratitude to Rachael Hartnett for her dedication as my research assistant. Finally, I would like to thank my family for their support and sacrifice during my work.

Abstract

Simone Nicole Kurtz-Dougherty

MONEY MANAGEMENT FOR THE SEVERE AND PERSISTENTLY MENTALLY ILL 2013/14

Mary Luise Kerwin, Ph.D.

Master of Arts in Applied Psychology & Professional Mental Health Counseling

Five men diagnosed with Severe and Persistent Mental Illness (SPMI) were recruited from a partial care program to participate in a study on the efficacy of teaching money management skills. The participants were also assessed on perceived stress, financial strain, and symptomology. The men were randomly assigned to either an experimental group or a waitlist control group; both groups received an intervention for money management consisting of a workshop on budgeting and weekly coaching based on expenses. Participants in the experimental group received the money management class immediately after a pretest baseline was established and the wait-list control group received the intervention three weeks later. No significant findings emerged; however, trends revealed improvement in budgeting skills and a reduction in perceived stress.

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Chapter 1

Introduction

In the United States, approximately 10 million people (4.4% of the adult population) are coping with serious mental illness (Substance Abuse and Mental Health Services Administration (SAMHSA), 2009). When a serious mental illness lasts more than 12 months and interferes with an individual's ability to work, the individual is considered to have a disability resulting from the mental illness (U.S. Social Security Administration (SSA), 2011). Disability due to a mental disorder accounts for 36.2% of all disabilities in the United States (SSA, 2011). Unfortunately, individuals with disabilities are three times more likely to live in poverty, resulting in financial stress (Hartnett, Morris & Stengel, 2008). The relationship between financial stress and mental illness is complex for this population of individuals. Some research suggests that financial stress may precede the onset of mental illness and may even cause it (Ritsher, Warner, Johnson, & Dohrenwend, 2001; South & Krueger, 2011). In addition, poverty and unemployment may prolong the occurrence of mental illness (Weich & Lewis, 1998). Therefore, improving the fiscal literacy of individuals with mental illness receiving payments for disability may result in enhanced financial stability as well as symptom reduction.

Improving money management skills includes key components of budgeting, such as creating a spending plan, being able to distinguish needs from wants, and knowing how to save. In addition, reducing financial exploitation includes learning how to obtain trustworthy financial advice, recognize it, and avoid financial scams (Elbogen, Tiegreen,

Vaughan, & Bradford, 2011). A methodology used to teach these skills must address all of these factors.

Because of the complicated relationship between lower socioeconomic status and serious mental illness, a common approach for assisting these individuals with financial management is to remove this responsibility from them and assign another individual to oversee their finances. About 27% of Americans receiving social security benefits as a function of a disability are assigned a representative payee who manages most, if not all, of the individual's finances (U. S. Social Security Administration (SSA), 2000). A representative payee may be assigned if the beneficiary is judged legally incompetent; however, assignment may also be made if it is deemed in the "best interest" of the recipient regardless of legal competency (Federal Register, 1996). In fact, there are no set criteria for determining when an individual might need or be assigned a representative payee.

A number of characteristics have been associated with having a representative payee including history of homelessness (Conrad et al., 1999), frequent and long term hospitalizations (Luchins et al., 1998), a diagnosis of schizophrenia or schizoaffective disorder (Ries & Comtois, 1997a), receiving Medicaid (Christy, Boothroyd, Petril, & Poythress, 2003), receiving Supplemental Security Income (Conrad et al., 1998), and co-occurring substance abuse (Hanrahan et al., 2002). This system of supporting these individuals' financial welfare with a payee results in improved financial status (Conrad et al., 1999), fewer days of hospitalization (Luchins, et al., 1998), decreased homelessness (Stoner, 1989), improved compliance with recommendations for outpatient treatment

(Ries & Comtois, 1997b) and decreased rates of financial exploitation (Luchins, Roberts, & Harahan, 2003).

Despite these possible benefits, the assignment of a representative payee is also associated with some disadvantages as well. A significant number of consumers in a community mental health center reported feeling coerced into the assignment of a representative payee (Rosen, et al., 2002). Often funds are withheld involuntarily as a method of getting consumers to comply with treatment (Ries & Dyck, 1997; Rosen et al., 2002). Perhaps the biggest disadvantage of this system is that the individual is not learning the skills necessary to manage their own finances in the future. While some consumers are able to achieve financial independence (Conrad et al., 1999); many others continue to depend upon payees. A comprehensive literature search revealed no studies examining how these individuals fair once they are removed from payee assignment and put in charge of their own finances. In fact, despite an emphasis on independent living within the psychiatric rehabilitation community (Palmer-Erbs & Anthony, 1995), little research has been done on the effectiveness of teaching money management skills to people with serious mental illness, and no studies have attempted to standardize money management teaching techniques.

Addicted individuals with co-occurring mental health issues were participants in an Advisor-teller-money management (ATM) study designed by Marc Rosen and colleagues (2003). ATM was developed as a means to voluntarily engage consumers in learning budgeting skills. The core components of ATM are described as the “three T’s”: teller, training, and treatment-linked spending. The “teller” refers to the administrator that acts like a representative payee and limits the client’s access to funds, except to pay

for essentials such as rent or groceries. “Training” refers to teaching clients successful ways to budget their money. Lastly, “treatment” linked spending encouraged clients to spend money in ways that reward behavior corresponding to therapy goals (Rosen, Desai, Bailey, Davidson, & Rosenheck, 2003). The primary goal of ATM was not to develop responsible money management. Instead, ATM was originally developed to treat the symptoms of substance abuse by encouraging individuals to budget and spend their money on activities and events that supported abstinence. As a result, ATM has only been tested for individuals dually diagnosed with mental illness and addiction.

Results of ATM are mixed. In a recent study, participants addicted to cocaine, alcohol, or both showed a reduction in cocaine abuse, but not alcohol abuse (Rosen, Rounsaville, Ablondi, Black & Rosenheck, 2010). In addition, there was a worsening of psychotic and paranoid symptoms in clients participating in the ATM treatment group compared to the control group; however, the small and heterogeneous sample may have contributed to this finding. An earlier study found no reduction in either alcohol or cocaine use as evidenced through a self-reported inventory and toxicology screenings (Rosen, Carroll, Stefanovics & Rosenheck, 2009). The findings from this study are limited because a large number of participants were already abstaining from cocaine prior to the start of the study thereby artificially creating a ceiling effect in the control group.

Implementation of money management interventions have shown to be effective in improving financial status of populations without mental health diagnoses. A study by Varcoe and Wright (1991) showed increased savings, less financial problems, and improved perception of financial status in people participating in a peer led Money Sense

curriculum. By teaching budgeting skills to a population with severe and persistent mental health issues we may see similar results.

The purpose of this study was twofold. The first objective was to determine the efficacy of teaching budgeting skills to clients with Severe and Persistent Mental Illness (SPMI) who receive disability benefits. Efficacy was measured by mastery of basic budgeting skills evidenced by improved scores on a budgeting test. The second objective was to explore if there is a relationship between improved budgeting skills, stress levels, and symptoms of mental illness.

Chapter 2

Method

Participants

Participants were clients diagnosed with chronic schizophrenia or schizoaffective disorder attending the partial care program at Delaware House. Inclusion criteria were that the participants received SSDI and did not have a representative payee, that they agreed to attend a two hour class on budgeting plus individual weekly sessions of follow-up coaching, and that they agreed to provide all receipts spending at each coaching session. Five males ranging in age from 30 to 58 years participated in the study. One identified as Caucasian, two as African American and one as more than one race.

Materials for Intervention

Materials for teaching fiscal management were obtained from Practical Money Skills, an award winning personal financial management website ("Practical money skills," 2000). Budget sheets for weekly practice and tracking were provided.

Measures

The dependent variables were scores on a budgeting test, symptoms, perceived stress level, and perceptions of financial strain.

The budgeting skills measure (shown in Appendix A) was taken from the Practical Money Skills lesson plan for special needs students Lesson 3: Budgeting your money ("Practical money skills," 2000). The measure, which was hand scored, consists of five multiple choice questions. Each question is worth 20 points and a score of 80 points or better is considered mastery.

The Symptom Checklist 90-Revised (SCR-90-R; Derogatis, 1997) is a 90 item inventory measuring nine dimensions of psychological symptoms as well as symptom severity. Each item is rated on a five point scale. Good reliability and validity have been established for this measure (Derogatis & Melisaratos, 1983).

The Brief Cognitive Status Exam (BCSE; Weschler, 2009) consists of twelve weighted questions covering seven domains of cognitive functioning. The measure can be hand scored using a conversion table. Total BCSE scores can then be converted into a classification level of Average, Low Average, Borderline, Low, or Very Low. The BCSE is a subsection of the Wechsler Memory Scale, which has been well established as a reliable measure (Iverson, 1990).

The Perceived Stress Scale (PSS; Cohen, 1994) is a ten questionnaire that examines the degree to which an individual's view of life events is considered stressful. Each question is rated on a five point scale. Good validity has been established (Cohen, 1994).

The Financial Strain Questionnaire (FSQ) is a six question measure that was adapted by Coley and Chase-Lansdale (2000) from scales developed by Conger, Ge, Elder, Lorenz and Simons (1994) and McLoyd, Jayaratne, Ceballo and Borquez (1994). FSQ measures the amount of difficulty the individual has paying bills on time, buying and putting off buying necessities, saving money, affording to participate in leisure activities, and needing to borrow money to pay bills. Each question is coded on a 4 level scale. Scores were standardized and averaged.

Experimental Design

The experimental design was a two (group) by three (time) split plot ANOVA performed on budgeting test scores, the SCL-90-R (Derogatis, 1997) the PSS (Cohen, 1994), and the FSQ (Coley & Chase-Lansdale, 2000) to determine if the experimental and control groups performed differently across time.

Chapter 3

Procedure

Prescreening

Participants were asked their source(s) of personal income (e.g., work, child support, disability payments). All participants indicated receiving SSDI as their only source of income. None of the participants were assigned a representative payee. Participants took a multiple choice budgeting quiz meant to measure their budgeting knowledge. For example, a sample question on the quiz was “Which one of these is not part of a personal budget?” All participants scored 80% or below on the budgeting quiz. In addition, the participants were given the BCSE (Weschler, 2009) to measure cognitive ability. The participants were then randomly assigned to either the experimental group or the wait list control group.

Pretest

Participants met with one of the researchers in an unoccupied office at Delaware House. They were initially given the Budgeting Skills measure. Next they were given the SCL90-R (Dergotis, 1997), the PSS (Cohen, 1994) and the FSQ (Coley & Chase-Lansdale, 2000), respectively. Participants independently completed these measures as well. The researcher was available to answer any questions while the measures were being completed.

Intervention

Budgeting Workshop. During the first week, participants in the experimental group simultaneously attended a two hour class on financial literacy and personal budgeting. The four sections of the class included budgeting terms, spending categories

and choices, record keeping and creating a personal expense diary, and creating and maintaining a personal budget. Lessons were modified to reflect income from SSDI benefits. Activities included group discussions, brainstorming, and games. Quizzes for each lesson were distributed, corrected and reviewed before moving forward to the next lesson. Participants were given packets used in class and additional budgeting sheets for practice outside of class.

Coaching. Once a week, for the next six weeks, all participants met with a researcher in a private office to discuss their budget. Participants who had received the intervention provided a researcher with weekly budgeting sheets. All participants were asked to bring their receipts from any and all purchases made during the previous week. The researcher noted the receipts, and then asked a series of eight “yes or no” questions from the Money Management Survey (as shown in Appendix B). The researcher reviewed the materials presented. When participants in the intervention group were able to follow their budgets and make appropriate choices based on the Money Management survey, the researcher offered praise and encouragement. Poor choices were simply acknowledged in a “matter of fact” tone.

Waitlist Control Group

The researcher also collected receipts weekly from participants in the waitlist control group as well as administered the Money Management Survey. No feedback was provided during these sessions.

Posttest

At the third week individual coaching meeting, after the Money Management Survey and budget review, participants in both groups were given post-tests. Participants

were first given the Budgeting Skills measure followed by the SCL90-R (Dergotis, 1997), the PSS (Cohen, 1994), and the FSQ (Coley & Chase-Lansdale, 2000). Participants completed each measure independently, and were permitted to ask the researcher clarifying questions.

Financial Class II/Coaching II/Post testing II

The waitlist control group then received the same treatment, using the same protocols. At the end of 6 weeks, all participants were again administered the Budgeting Skills measure, the SCL-90-R (Dergotis, 1997), the PSS (Cohen, 1994), and the FSQ (Coley & Chase-Lansdale, 2000) following the same procedures as the three week post-test.

Chapter 4

Results

Participants in this study were tested for cognitive ability utilizing the Brief Cognitive Status Exam (BCSE; Weschler, 2009). The scores are based upon age and level of education and range from Average at the highest level of cognitive functioning, to Low Average, Borderline, Low, and Very Low respectively. One client fell into the Average range, three clients fell into the Low range, and one fell into the Very Low range.

All remaining data collected were examined for outliers before statistical analysis. Table 1 shows pretest scores on budgeting, stress level, and symptomology as a function of group. Using independent *t*-tests, there were no significant differences between groups on these measures at baseline.

Table 1

Summary Statistics on Pretest Scores

	Experimental Group		Waitlist Control Group		<i>t</i>	<i>p</i>
	Mean	SD	Mean	SD		
Budgeting	53.33	30.55	60.00	28.28	-0.25	0.84
SCLR-90	1.80	0.78	1.36	1.04	0.55	0.57
FSQ	12.33	6.03	11.00	2.83	0.28	0.41
PSS	22.67	5.03	31.50	4.95	-1.93	0.98

Note: SCLR-90 is Symptom Checklist 90-R; FSQ is Financial Strain Questionnaire; PSS is Perceived Stress Scale

As indicated in Table 2, a 2 (group) x 3 (time) split plot ANOVAs resulted in no statistically significant interactions or main effects for all dependent variables. In addition, a 2 (group) x 2 (time) split plot ANOVAs analyzing differences between pretest and the 3 week measure resulted in no statistically significant interactions. No significant differences for main effect were found for any dependent variables. Trends indicate improvement in budgeting and perceived stress scores.

Table 2

Summary Mean Scores

Measure	Experimental Group			Control Group		
	Pre	Week 3	Week 6	Pre	Week 3	Week 6
Budget	53.33	93.33	80.00	60.00	90.00	100.00
SCLR-90	1.80	1.39	1.05	1.36	1.44	1.24
FSQ	12.33	10.00	10.33	11.00	9.00	9.00
PSS	22.67	19.00	16.00	31.50	31.50	19.00

Note: SCLR-90 is Symptom Checklist 90-R; FSQ is Financial Strain Questionnaire; PSS is Perceived Stress Scale

Similar to the Rosen et al. (2010) study, an increase in psychotic symptoms were noted. The Psychoticism measure of the SCLR-90 (Derogatis, 1997) was examined independently. Table 3 shows the control group nearly doubled their score between weeks three and week six after receiving the intervention.

Table 3

Mean Scores SCLR-90 Psychoticism

	Experimental	Control
Pre	19.33	12.50
3 Week	11.67	12.50
6 Week	15.67	24.00

Chapter 5

Discussion

Although statistical analyses revealed no significant differences between groups on the dependent variables, some interesting trends did emerge. Both the experimental and control groups' scores on the budgeting measure improved at the three week mark. As expected, once the control group was given the intervention at Week 3, their scores on the budgeting measure continued to show improvement at the six week point, nearly doubling their pretest score. However, the experimental group's scores on the budgeting measure decreased, which may be an indication of the treatment effect "wearing off." Both the experimental and control groups' scores for perceived stress decreased over time. Consistent with what was expected, the control group's scores decreased by nine points after receiving the intervention, suggesting that the intervention may have contributed to the reduction in perceived stress. The experimental group's mental health symptoms decreased across time whereas the control group's scores increased across time. However, these conflicting data may be a result of the small sample size.

A comprehensive literature search revealed no studies examining the efficacy of teaching money management skills to the Severe and Persistently Mentally Ill (SPMI) population. While Rosen et al. (2002, 2003, 2009; 2010) conducted several studies in which money management skills were taught to a population with co-occurring substance use and mental illness, the goal of those treatments were to encourage abstinence, not money management. As a result, no outcome data on money management skills were reported in those studies. With respect to mental health, Rosen et al. (2010) reported a trend in increased paranoia and psychoticism over time as measured by the Brief

Symptom Inventory (BSI; Derogatis, 1992). Similar trends were found in the current study for the control group. In Rosen's et al. (2010) study, the participants were assigned payees, but in the current study they were not. The results of the current study, therefore, suggest that coercion may not be the cause of increased psychotic symptoms, but rather simply money management itself. This finding certainly merits future research.

Although people with SPMI may not conform to the traditional ideal of what would be considered good money management within a population of individuals without chronic mental illness, the participants in this study proved to be quite savvy with their money. The highest paid participant in this study received only \$1,140 per month, and yet despite this very limited income, he managed to survive; maintaining rent, utilities, groceries and other essentials. Most learned very quickly with whom they could trust to lend and borrow money. They avoided using banks because the banks require minimum balances to avoid a bank fee and charge for printing checks and any overdrafts.

However practical they may be as consumers surviving on such a limited income, there is a sense that they are simply one financial misstep away from disaster. Although some of the participants in this study were able to save a limited amount of funds to last them throughout the month, none were able to maintain any type of substantial savings. Living "check to check" made the participant vulnerable to lenders who charge extraordinary interest rates and fees, or worse still, unsavory characters who prey on the less fortunate.

The difficulty with saving is also in part influenced by the environment. Most of the participants in this study did not drive, and lived in neighborhoods with limited public transportation, which sometimes forced participants to pay expensive cab fares when they

needed to travel to destinations not on bus routes. They relied on case managers to take them food shopping, which is typically once a month. This made it difficult for consumers to replenish perishable items. Because most do not live within walking distance of a supermarket, they often spent their money at take-out and fast food establishments, which are prevalent in their neighborhoods.

In addition, for consumers receiving Social Security Disability Insurance (SSDI) and not working, they paid a premium for their Medicare health insurance, which was more than 20% of their income. Consumers wanting prescription drug medication coverage (Medicare part D) were charged even more, and were responsible for any copays. Furthermore they paid out of pocket for medications not covered by Medicare.

The participants in this study welcomed the money management intervention. Several other consumers at the agency who were excluded from the study because they were not their own payee, showed interest in the project and asked for copies of the materials reviewed in the class. Yet there are no studies of money management skills within the SPMI population despite their need and desire to learn.

Having few participants was problematic for the study and so conclusions must be interpreted with caution. The small sample size affected the statistical power of the analyses. In addition the measures themselves may not have been sensitive enough to the intervention. Because the majority of the clients in the partial care program at Delaware House were assigned a representative payee, it was difficult to recruit participants from that program. Although efforts were made to recruit participants from the outpatient department, all referrals received came from the partial care department, which may indicate reluctance on the part of consumers to discuss their finances.

Because all of the participants were recruited from Delaware House, diffusion of treatment was a possible confounding variable. As a result of the physical arrangement of Delaware House, consumers had the opportunity to discuss the study with other clients during their treatment. In addition to all participants receiving treatment at Delaware House, they lived nearby each other in group homes, supported housing, or low income housing. They also attended local community gatherings together. Having such a close knit community provided plenty of opportunities for information sharing. Future research could recruit from multiple sources, providing a larger and more diversified sample. Moreover, sampling from an outpatient population only, could reduce the likelihood of diffusion of treatment.

Participants recruited from the partial care program tended to be less independent and require more intensive treatment which may explain the limited cognitive ability of these consumers. Surprisingly all participants within the low to very low cognitive ability range were able to improve their budgeting scores. It would be interesting to clarify the cognitive range in which money management training would be ineffective. In addition, researchers could determine modifications for teaching money management skills based on cognitive ability.

Although the participants in this study were able to improve their budgeting scores, it is unclear if they would be able to maintain these gains over time. Longitudinal studies could assess the likelihood that money management training is effective long term. Furthermore they could determine if additional supports maybe necessary to sustain treatment effects.

Although no significant findings were evident in this study, trends revealed improvement in budgeting skills, perceived stress and symptomology, indicating that the teaching of money management skills may be beneficial to the SPMI population. In addition, there is a lack of scientific research despite an interest for and need within this population for assistance with financial management. Future studies should focus on the effects of cognitive ability on money management, the possible changes in psychotic symptoms as a function on learning to managing money better, and the long-term effects of teaching money management skills to the SPMI population.

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Appendix A

Budgeting Skills Questionnaire

Name:

Date:

Choose the correct answer.

1. A budget can be made by:
 - a. keeping a diary of your expenses.
 - b. copying your friend's budget.
 - c. deciding what to buy when you go to the store.
 - d. checking how much money is in your pocket.
2. Which one of these is a responsible spending practice?
 - a. Spending more money than I have planned.
 - b. Buying an item that I like, even if I do not need it.
 - c. Buying an item that is included in my budget.
 - d. Always shopping at the most expensive stores.
3. Which one of these is not part of a personal budget?
 - a. Savings
 - b. Giving to a church or charity
 - c. Overspending
 - d. Income
4. An example of a fixed expense is:
 - a. clothing.
 - b. car insurance.
 - c. food.
 - d. educational expenses.
5. An example of a flexible expense is:
 - a. rent
 - b. car payment
 - c. home insurance
 - d. entertainment

Appendix B

Money Management Survey

1. Do you have a bank account?

- Yes
- No

2. Did you save any money?

- Yes
- No

3. Did you use a check cashing service to cash your check?

- Yes
- No

4. Did you borrow money?

- Yes
- No

5. Did you lend any money?

- Yes
- No

6. Did you pay your bills in full and on time?

- Yes
- No

7. Did you bounce any checks?

- Yes
- No
- N/A

8. Did you take out any loans (including credit cards, car notes, etc.)?

- Yes
- No