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Empowering Individuals, Families and Communities:

The "Cash and Counseling" Case Study

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Overview of Empowerment Theory

Jane Addams, once described by FBI director J. Edgar Hoover as the most dangerous woman in America, was born in 1860 to an upper-class family and formally educated (Specht & Courtney, 1994). Abandoning her social class and the privilege it afforded, Addams dedicated her life to serving the poor. She worked hard to promote international peace and to improve the social conditions that caused poverty. Addams became internationally known for creating Hull House, a settlement house located in a poor, working class neighborhood in Chicago. She strongly believed the poor were victims of social and economic conditions so she lived and worked with these neighbors, within their cultural and community contexts, to help them help themselves.

Addams is credited with laying the groundwork for what is now called empowerment-based practice in social work. Building on the work of Addams, contemporary empowerment theory grew out of the progressive social movements of the 1960s and 1970s. These social movements, including the Women's movement, the Black Power movement, and the Welfare Rights movement, were founded to change oppressive social conditions in the United States. Acting in accordance with the principle of self-determination, empowered communities and individuals fought for the right to determine their own fates. Micro and macro level interventions of empowerment were designed to better the lives and communities of oppressed peoples and thus ultimately affect a progressive transformation in society (Guitérrez, Parsons, & Cox, 1998).

Although specific definitions of empowerment abound, it is clear that many social workers are currently examining the significance of power to their clients. Relying on a definition supplied by Solomon (1976), the National Association of Social Workers

(NASW, 2001), as part of their National Committee on Racial and Ethnic Diversity defines empowerment as essentially an individual's ability to do for themselves. This involves fostering a connection between an individual and their own power and reaching across cultural barriers to become further empowered. Lee (1994) adds to this definition by stating that the focus of empowerment should be on members of stigmatized groups. Askheim (2003), Boehm & Staples (2002), and Adams (2003) assert that empowerment deals with the transmission of power such that the disempowered take or receive power. In this case, the individual is the expert at using his/her skills, competencies, and self-determination to act in his/her best interest. The social worker facilitates this process. The World Bank (2002) defines empowerment in terms of poor people and their expansion of assets and capabilities such that they can assert power over the institutions that affect them.

Empowerment theory today is essentially a broad, yet fairly consistent, collection of concepts, methods, and models designed to develop power in individuals, families, groups, and communities (Guitérrez et al., 1998). Empowerment theory asserts that there are numerous, perpetuating problems associated with an absence of power. Unequal access to resources, caused by an unequal distribution of power, prevents individuals and groups in oppressed communities from gaining social goods they need. As a result, vulnerable persons are unable to shield themselves from the negative effects of oppression, including poor functioning in family or community systems.

The absence of power may produce intense feelings and behaviors. Pinderhughes (1994) asserts that individuals who are less powerful may feel less gratified, experience less pleasure and more pain, feel alone, fear their own anger and/ or anger at the more

powerful, fear abandonment, feel inferior, deprived or incompetent, and have a strong tendency towards depression. Common behaviors among the less powerful include an inability to impact an external system or self, projection of acceptable attributes (i.e., smart, attractive, competent) onto the power group, distrust, sensitivity to discrimination, paranoia, isolation, use of passive-aggressive behavior as a defense mechanism, rigidity in behavior to control feelings of powerlessness, striking out or becoming aggressive to avoid feeling powerlessness, and use of deception.

Major empowerment theorists recommend similar intervention strategies to achieve empowerment, most commonly beginning with an individual and expanding to include sociopolitical systems (Askheim, 2003; Cox & Parsons, 1993; Guitérrez et al., 1998; Heumann, McCall & Boldy, 2001; Lee, 1994). At an individual level, a relationship between the worker and client is established, linking families to needed services, raising consciousness, and empowering goals and outcomes are determined. Individual goals may include increasing control over his/her life, increasing self-confidence, and, as a result of increased knowledge and skills, better self-perception. If these items are adequately addressed, the individual should be able to identify barriers to self-realization, increase power, and increase control over his/her life. At a structural level, the focus shifts to community and societal change. Social workers work with clients to gain knowledge about socio-political issues and power structures, develop advocacy skills, learn methods of socio-political change, and engage in social action. Fundamentally, work at this level deals with the social structures and power relations that construct barriers to individual and community empowerment. As a result of these interventions, people and communities resolve disempowering situations and thus rebuild

and reclaim an empowered status in society. Outcomes of empowerment-based interventions may include changes in self-efficacy, self-awareness, feeling that one has rights, self-acceptance, critical thinking, knowledge, skills, assertiveness, asking for help, problem solving, accessing resources, practicing new skills, lobbying, community organization, collaboration, and political action.

It should be noted that, under the empowerment model, the relationship between worker and client is based on collaboration and mutual responsibility, not the traditional professional-client relationship (Cox & Parsons, 1993; Guitérrez et al., 1998; Lee, 1994). Indeed, the success of the empowerment intervention depends heavily on the success of this relationship, also referred to as a balanced partnership or an egalitarian relationship. As problems of disempowerment are rooted in socio-political systems, workers and clients should act as partners with a common interest in addressing the problem. Using dialogue and critical analysis, the worker should both work with the client and facilitate the empowerment process of the client. Clients bring just as much valuable expertise to the problem situation as the worker.

Empowering the elderly

The elderly face a unique set of factors that contribute to a loss of power (Cox & Parsons, 1993; Heumann, McCall, & Boldy, 2001; Thompson & Thompson, 2001). At an individual level, the elderly cope with a decline in physical health, mental stress (frequently as a result of depression, loss, and grief), and loss of social support systems including peers and spouses. Elderly clients may view their problems as unique, personal, and theirs alone to solve. At a social level, many elderly individuals cope with economic loss from retirement, rising health care costs, poor housing, discrimination

resulting from ageism, loss of status and contributory roles (i.e., from work and civic activities), political marginalization, continuing socio-political disadvantages for members of minority populations, and a disempowering social service model. These factors can interact to produce increased dependency, oppression, learned helplessness, internalization, powerlessness, and ultimately limit elders' independence and ability to actively participate in society. Indeed, due to ageism, an assumption may exist that the elderly need to be cared for and looked after, reducing unique needs to a focus on provision of care.

Elderly people in America value independence and privacy as the core of empowerment (Heumann et al., 2001). Many seniors want to age in the homes they have known their entire lives; to own that home and manage that household is empowerment. Many prefer not to depend on visiting service providers that gradually usurp more and more decisions for their own convenience.

Accordingly, when the elderly need care, they want efficient outcomes and concrete results (Boehm & Staples, 2002). In terms of empowerment, the elderly tend to focus on their financial situation and ability to maintain it. They also focus on improvements in health care, social networks, living conditions, and relations with family and friends. In contrast, social workers often focus on the process of empowerment, rather than the results of the process, thus reinforcing a professional-client relationship. In order to be considered worthwhile and effective by consumers, the empowerment process should be cost effective in terms of time and effort and show tangible results.

The Cash and Counseling Demonstration and Evaluation

One approach for capturing and describing some of the ways social workers can work to empower individuals and families is through case example. The Cash and Counseling Demonstration and Evaluation (CCDE) shows how older adults and persons with disabilities who needed Medicaid-funded home and community-based services were given the opportunity to direct and manage those services and the positive results that ensued. Let us begin by describing this intervention and its positive effects and then backtrack to examine the elements and techniques that empowered individuals and families, and the roles that social workers could play.

Today, in most states, whether you are an elderly individual or a younger person with disabilities, if you need Medicaid assistance to perform major activities of daily living like bathing, dressing, toileting, transferring or eating you will rarely have much say over who helps you or when they come, never mind what they actually do. But, for years, persons with disabilities have been saying, “If I had more control over my services, my quality of life would improve and I could meet my needs for the same amount of money or less.” The Cash and Counseling Demonstration is, at its heart, a policy-driven evaluation of this basic belief.

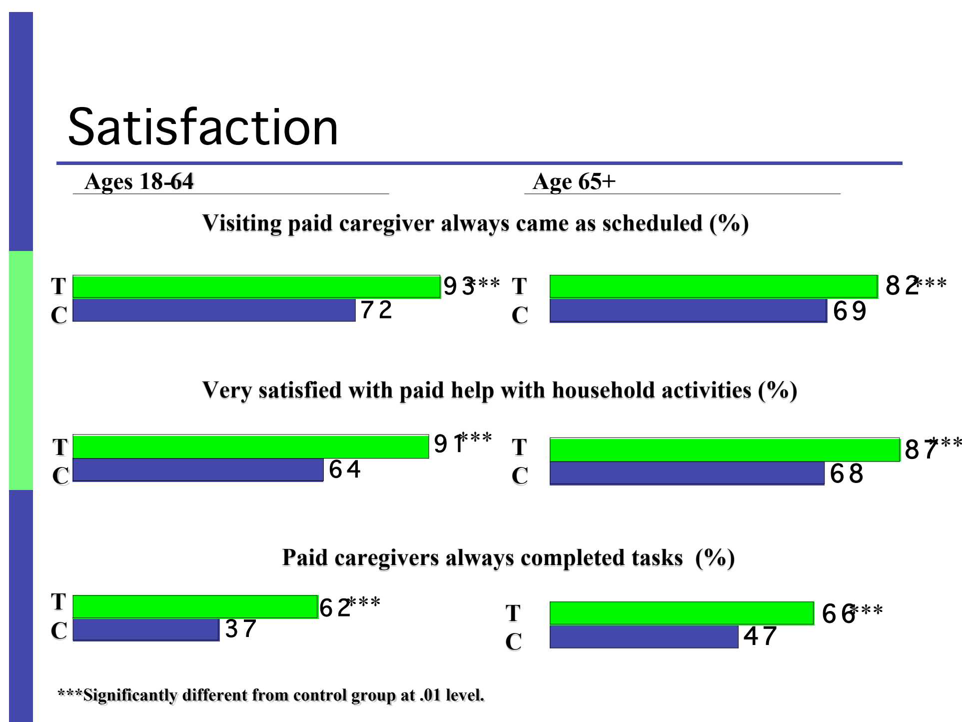
The Cash and Counseling Demonstration and Evaluation (CCDE), funded by the Robert Wood Johnson Foundation (RWJF) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services, is a test of one of the most unfettered forms of consumer direction -- offering elders and younger persons with disabilities a cash allowance in place of agency-delivered services. Operating under a research and demonstration waiver granted by the Centers for

Medicare and Medicaid Services (CMS), 6,700 volunteers from across Arkansas, Florida and New Jersey participate in this large scale test, half of whom were randomly assigned to manage individualized budgets while the other half remained with traditional agency providers.

Consumers who meet project eligibility criteria and express interest in participating in CCDE are randomly assigned to participate in the program, managing a cash allowance to purchase services, or serve as a control group and receive services through the state's existing system. The evaluation compares outcomes for consumers receiving traditional service packages with those receiving cash allowances with respect to cost, quality, and satisfaction. The evaluation also examines impacts on informal caregivers and analyzes the experiences of paid workers.

In the Arkansas Cash and Counseling Demonstration, the first to get underway and therefore the first from which results are available, consumers had the opportunity to receive a monthly allowance, which they could use to hire their choice of caregivers (except spouses) and buy other services or goods (such as assistive devices and home modifications) to meet their personal care needs. Allowances were equal to the value of the number of hours of care consumers were expected to receive under the traditional Medicaid program, averaging about $350 per month. Consumers were required to develop written plans for managing the allowance and have them approved by counselors. In addition, virtually all consumers chose to have the program's fiscal agents write checks for their purchases and withhold payroll taxes for caregivers hired with the allowance. Consumers who were unable or unwilling to manage the allowance themselves could designate a representative, such as a family member, to do so for them.

The resulting analysis showed that when Arkansas Medicaid beneficiaries had the opportunity to direct their personal care services themselves, it significantly increased the proportion of consumers and (paid) caregivers who were very satisfied with their care, thinning the ranks of the dissatisfied in the process. Specifically, consumers were much more satisfied with the timing and reliability of their care, less likely to feel neglected or rudely treated by paid caregivers, and more satisfied with the way paid caregivers performed their tasks. The program also reduced some unmet needs for personal assistance services and substantially enhanced consumers' quality of life. Moreover, it produced these improvements without compromising consumer health or functioning. (Foster et al, 2003), There were no major incidences of fraud or abuse.



Mathematica Policy Research, 2003

Both elderly and non-elderly adults had better experiences under Cash and Counseling than under agency-directed services, though impacts on most outcomes were larger for the non-elderly. In Arkansas, Cash and Counseling users of all ages were more likely than the agency-care group to receive paid care: 95 percent of both elderly and working-age Cash and Counseling participants got paid care, compared with 79 percent of elderly, and 68 percent of younger consumers who were supposed to get care from an agency. Even those who did receive agency care were provided only about two-thirds of the help they were eligible for, often because of agency staff shortages. In terms of Medicaid costs for their care, Cash and Counseling participants averaged about twice the cost of those assigned to agency care during the first year. However, by the second year, savings in nursing home and other long-term care costs offset nearly all of this extra cost. (Dale et al, 2003).

The effects on caregivers were equally dramatic. Caregivers for consumers managing the cash allowance experienced less financial, emotional, and physical strain. Furthermore, even though the workers hired by consumers frequently lacked formal training, they felt well-prepared for their jobs. Most were very satisfied with their pay and working conditions.

The results of the controlled experiment in Arkansas (and preliminary figures on the results in Florida and New Jersey) were so positive, the Robert Wood Johnson Foundation, the DHHS Office of the Assistant Secretary for Planning and Evaluation and the Administration on Aging have authorized funding to add ten states to the demonstration in 2004.

How Does Cash and Counseling Empower?

This case study gives us the opportunity to hone in and examine what the elements and activities are that empower or help to empower consumers. We can then draw lessons, on both the macro and the micro levels, suggesting ways social workers can work to enhance the power of older individuals, their families and their communities.

We believe that the Cash and Counseling model itself empowered consumers. Some of the ways the model was operationalized formed empowerment tools in their own right, namely, providing information to facilitate informed decision-making; designing the role of counselor/consultant to foster empowerment; building in opportunities for peer counseling and support; and introducing technological tools like web-based programs for designing, approving and revising cash plans and recording expenditures against those plans. Let's consider each in turn:

Consumers can be involved in directing their own home and community-based services to varying degrees. Whereas our case example is drawn from the Medicaid world, parallel choices also exist in the private long-term care insurance arena. The levels of consumer empowerment in home and community-based care can be characterized as follows:

Levels of Consumer Empowerment in Home and Community-Based Care			
A. Enlightened Care Management	*B. Consumer as Employer*	*C. Flexible Consumer Budget*	*D. Cash*
Early forms of care management relied on a medical model where professionals made the key decisions as they were assumed to know what was best. But, under the best practice of care management, consumer preferences are elicited in the design of the care plan, and there is a regular feedback loop to ascertain consumer satisfaction.	At this level, we move from consumer involvement to consumer choice. Here the consumer is able to hire, manage, train and even terminate his or her personal care worker.	At this level, the consumer has a choice over his or her whole service package. Instead of being limited to a personal care worker, the consumer has a budget that (s)he can tailor to meet individual personal care needs. Consumers can purchase a variety of goods and services including home modifications or assistive devices.	The ultimate form of consumer direction puts the dollars in the consumer's hands and does not restrict usage.
Less Empowerment ⟶ *More Empowerment*			

Under the original Cash & Counseling Demonstration, the consumer could chose option *C* (and let the bookkeeping/check writing/tax paying/record keeping/ fiscal intermediary handle the paperwork), or they could chose a modification of option *D* as long as the consumer passed a skills test showing they understood their tax and labor law obligations and retained receipts showing they had spent the dollars to meet their personal care needs.

But remember Cash and Counseling was a choice. The consumer could always choose to return to the traditional system. In this way, the design of the program was itself empowering. Consumers also played an active role in program design. Focus groups and surveys of representative samples of consumers provided valuable insights on

who was interested in the Cash and Counseling choice; why; what features were attractive; what information consumers needed to make an informed choice; and what kind of supportive services they needed to manage their own cash allowances. Additional focus groups helped hone outreach messages and make sure program communications were understandable and efficient.

Cash and Counseling systematically involved consumers at three distinct levels: the state level where the model was designed and monitored; the program operation level where forms and training materials were pre-tested; and the individual level where consumers were regularly asked for feedback on their satisfaction with all aspects of the program. Accessibility guidelines were developed (with separate funding) to make sure consumers with disabilities was truly able to take part in planning activities.

The model itself was empowering, but so too were some of the discrete ways the program was run. To put this another way, elements of the program design independently shifted power to the people.

a) Information. Knowledge is Power.

What information does a consumer need and want to make an informed decision? How much information is too much? What formats works best for which consumers? What reading level should be assumed? These questions were regularly re-visited as the Cash and Counseling options were developed. Focus groups were used to get initial impressions about the program and to pre-test program communications. Various approaches to training were tested on a small scale before going public. All materials were available in frequently used languages and in varied formats appropriate for persons

with disabilities. The questions of who to whom, what, when, where, why, and how to share information are critical in the health care and social service decisions.

b) The Consultant: Institutionalizing the Role of Power Broker

The job title for the Counselor/Consultant/Supports Broker could well be renamed "Empowerment Agent". Counselors interacted with consumers to (1) help the consumer think expansively about their personal assistance needs and how best to meet them (this is often referred to as "person-centered planning"), (2) review initial and revised spending plans to ensure that they include only permissible goods and services, (3) assist the consumer in linking up with necessary resources (e.g., how to find personal care workers or what is the best source of other goods and services), (4) help with employer functions, and (5) monitor the consumer's condition and the uses of the allowance. The consultant's role is described in ethnographic studies of Cash and Counseling participants in Arkansas and New Jersey (http://www.cashandcounseling.org/library/index.html). For the counselors' own perceptions one could also read "Consumer and Counselor Experiences in the Arkansas IndependentChoices Program". Final Report, January 2004. Mathematica Policy Research, Inc. Perhaps the best hands-on guide to what counselors actually do can be found in the recently published "Guide to Quality in Consumer Directed Services" (Applebaum et al, 2004) in the pages devoted to Consumer Support Strategies (pp 35-44).

c) Peer Support.

When the Cash and Counseling Program held the focus groups to secure consumer input, the program's designers learned one quick lesson. Consumers stayed after every session and traded phone numbers and ideas on how to manage their personal

assistance needs. Adults like to learn from people that have real life experiences similar to their own. Drawing upon this insight, the Cash and Counseling Demonstration devoted resources to encouraging peer interaction and support.

d) The Increasing Importance of Technology

Finally technology can empower. The flexibility to use the cash allowance for a wide range of goods and services paid dividends. "Non-elderly treatment group members might have received fewer hours of total care because they reduced their need for human assistance. Treatment group members were more likely to obtain equipment to help with personal activities and communications, such as specialized telephones, lifts, or emergency response systems" (Dale et al, 2003).

As Cash and Counseling expands to additional states, one of the most promising activities is the development of a web-based tool to assist in the development, approval and revision of cash plans, and the recording of expenditures made against those plans so consumers can have an up-to-the-minute picture of how much of their cash allowance is still on hand. Focus groups showed that a sizable proportion of consumers or their representatives had access to computers and favored such a web-based tool to expedite communication between themselves and their counselors and fiscal management agencies.

Why Did Cash and Counseling Have Such Significant Effects?

There may be a couple of reasons why the Cash and Counseling model has such dramatic effects on both consumers and their informal caregivers. The first centers on "locus of control" and the ability to effect one's environment.

The second reason this model may have enjoyed such success is because the flexible budget often allowed and encouraged greater integration of the consumer into the family and the community. The flexible budget allows clients to hire family and friends (i.e., individuals with a personal caring relationship with the consumer) to be their personal care workers. It also releases the consumer from many of the restrictions typical of agency-delivered care. For example, agency workers, for liability reasons, are often not allowed to take consumers in their cars. With the flexible cash allowance, a consumer could ask his or her worker to drive her to a grocery store so they could do their own shopping. Consumer-employed workers defined quality in terms of the relationship. Knowing that the consumer is in charge, and providing services according to his/her preferences, was a consistent theme.

Finally, the flexible cash allowance makes it possible for the consumer to reciprocate and maintain some symmetry in their interpersonal relations. In line with exchange and equity theories, there is evidence to believe that "individuals in relationships where they feel respected and valued are less likely to be depressed than their counterparts" (Wolff and Agree, 2004).

Empowering communities

We have seen how social workers, as program designers, can empower individuals and families, and we have seen how social work clinicians, taking on the role of counselor and consultant, can empower individuals and families. Before leaving this section, we also want to mention ways social workers can empower communities. Again, we will draw from home and community-based services experiences. In a recent issue of

Community Living Briefs, Lee Bezanson (2003) describes "Beyond Incremental Change – the Challenge of Inclusion":

> In the model community approach, states' resources are being committed to engaging local communities to become fully accessible and inclusive. Medicaid and the social service network of providers and advocates are at the table, but so too are citizens with disabilities, the Town Selectmen, the Superintendent of Schools, the religious institutions, the Rotary Club, Kiwanis. The dialogue is inclusive of everyone. And from these new dialogues new local initiatives emerge: accessible meetings with accessible materials, accessible voting places, city councils and task forces with members who have disabilities, public education on the need for universal design in new buildings, a Hoyer lift at the town pool ….the list is endless.

Discussion and Conclusion

The Cash and Counseling Demonstration is but one example of how social workers and the elderly can work together in partnership to actualize empowerment-based practice. This program was designed to build upon the assets and capabilities of elderly clients by allowing them to choose their care providers and services. Elderly clients worked with program consultants to put their monetary allowances to good use, often saving money and markedly increasing satisfaction with care in the process. In fact, so powerful were these effects that caregivers of the elderly also felt significant positive effects as a result of program participation. Giving the elderly the power of choice and the resources to make choices about their care reduces feelings and behaviors associated with disempowerment. Having consultants on hand, and the future development of a technology-based allowance management system, also assist in developing client capabilities. In essence, the Cash and Counseling Demonstration respects the independence and dignity of the elderly while delivering tangible results.

This case study has allowed us to see many of the principles and attributes of empowerment described in the first sections of this paper, but it has also put meat on the bones -- giving examples of discrete practices social workers can engage in at both the micro and macro levels to return power to older persons.

Some, fueled by ageism, contended that older persons were not interested in consumer direction. Clearly this is not true. While the Cash and Counseling model is not an option for everyone, it is important to note that in Arkansas fully 72% of those who volunteered to participate were over 65.

Finally, what about social workers? Some had feared that an emphasis on empowerment might undermine the professionalization of social work. In this case study we see evidence that the most empowering assistance social workers can offer the elderly is to work with them where they are, both mentally and physically, and to start with the client's goals and preferences. Consumers are usually "the experts" when it comes to their own lives and life styles. Our overarching goal as social workers is to help them maintain and improve their independence and dignity. In doing so, we revisit the very roots of social work. We work with the community, in their community, to help them help themselves, continuing a tradition that hopefully Jane Addams would embrace today.

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