המוסד לביטוח לאומי
האגף למחקר ותכנון

"קבוצות תיכנון של מטופלים" כאמצעי ליישום "צרכנות"
בשיקום מקצועי

מאת: לוריין שפירא

מחקר מס' 27

ירושלים, אייר התשמ"ב
מאי 1982

מ ח ק ר י ם

(בעברית או באנגלית לפי המצויין)

מס' 1 — "סקלה אקויולנטית למבוגר סטנדרטי, ממצאים ישראליים" (באנגלית), מאת: יעקב חביב ויוסי טויל, 1974 (אזל).

מס' 2 — "השפעת ההוצאה הציבורית לשרותים סוציאליים על החלוקה מחדש של ההכנסות" (בעברית), מאת: מוריה אבנימלך, 1974.

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מס' 5 — "דפוסי תזונה ויעילות בצריכת מזון בישראל" (בעברית), מאת: יוסי זמירי, 1974.

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מס' 23 — "יחסי הגומלין בין הביטוח הסוציאלי לבין המיסוי הישיר: סוגיות עיקריות" (באנגלית), מאת: לאה אחדות ויוסי תמיר, 1979.

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מס' 27 — "'קבוצות תכנון של מטופלים' כאמצעי ליישום 'צרכנות' בשיקום מקצועי" (באנגלית), מאת: לוריין שפירא, 1982.

המנסד לביטנח לאומי
האגף למחקר נתכנון

"קבוצות תיכנון של מטופלים" כאמצעי ליישום "צרכנות"

בשיקום מקצועי

מאת: לוריין שפירא

מחקר מס' 27

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מאת: לוריין שפירא

מטרת המחקר היא לבחון את נושא הצרכנות וחשיבותו לשיקום מקצועי. בלום והולצמן[1] המליצו, במחקר שהתפרסם ב-1980, להגדיל את מעורבות המטופל בכל הפעילויות של תהליך השיקום. אולם כדי לבצע המלצה זו, יש צורך להבין את מושג הצרכנות. דהיינו מה זאת צרכנות, מה התועלת שמפיקים המטופלים ממנה בשיקום מקצועי, וכיצד ליישם אותה הלכה למעשה.

צרכנות מוגדרת כזכות הפרט להיות מעורב בהחלטות שמשפיעות על חייו במסגרת טיפול רפואי, חינוך, איכות הסביבה, שירותים מסחריים ועוד. מנקודת ראות איש המקצוע שמספק שרות לחלק מסויים של האוכלוסיה, צרכנות היא הכרת הצרכים, הציפיות, המטרות והערכים של המטופל. צרכנות היא יותר מלתת למטופל לבחור בין תוכניות אלטרנטיביות כפי שאיש המקצוע הגה ויזם אותן. צרכנות היא גם מתן אפשרות למטופל להציע אלטרנטיבות נוספות.

מנקודת ראות המטופל, צרכנות היא יותר מההזדמנות להישמע. עליו להיות גם מצויד בידע הנחוץ כדי להגיע להחלטות ותוכניות בנות ביצוע. המטופל משתמש בידע שלו, בנסיונו וביכולתו. נוסף לכך, הוא צריך שתהיה לו גישה לאותם מקורות המידע שעומדים לרשות אנשי המקצוע. הרעיון המרכזי היא שהמטופל <u>פעיל</u>, ואינו המקבל הפסיבי של רעיונותיהם של אחרים.

הצרכנות בשירותים אנושיים התפתחה בשנות ה-60 בארצות הברית כתוצאה מעליית הצרכנות בשוק המסחרי וכתוצאה משינויים שחלו במגמות חברתיות. קבלת ערכי הצרכנות בשירותים האנושיים גרמה לשינויים כמו אחריות גדולה יותר של איש המקצוע לגבי המטופל מבחינת הקניית מידע, העברת סמכויות למטופל בקבלת החלטות, וקבלת הרעיון ששרות הוא זכות.

עליית הצרכנות הביאה למיגוון רחב של קבוצות צרכנים, כגון התנועות להגנת הצרכן, להגנת הסביבה, וקבוצות מיעוטים עם צרכים מיוחדים (מקבלי סעד, נכים אסירים לשעבר, דיירים, הומוסכסואלים ועוד). לרוב הקבוצות האלה ניתן להצמיד את התוית של "עזרה עצמית". האיפיונים הבולטים של הקבוצות לעזרה עצמית הם שהיוזמה להקמתן היא מצד החברים, הן ממוקדות בבעיה מסויימת וכוללת הן את נותן העזרה והן את מקבל העזרה. המוקד של הקבוצות לעזרה עצמית הוא בסיפוק שירותים ישירים לחברי הקבוצה ולמשפחות של החברים. באמצעות שיחות על חוויות משותפות ובאמצעות תמיכה הדדית, המשתתפים רוכשים את היכולת להתגבר על קשייהם ולהסתגל. ישנן גם קבוצות שמעורבות במחקר, בחינוך הציבור ובחקיקה במטרה לקדם את הענין המשותף לחבריהן.

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1) Blum, A. & Holtzman, M. <u>Client and Worker Perceptions of the Helpfulness of Bituach Leumi, Rehabilitation Services: An Exploratory Study</u>. University of Tel Aviv, 1980.

:מות שתי מחלוקות לגבי הקבוצות לעזרה עצמית. מהדגשת הסטייה של הפרט מהנורמות משתמע פרט עצמו הוא הבעייה והוא האחראי לשינוי, במקום התפיסה שעל החברה מוטלת האחריות לשינויים נאים. המחלוקת השנייה נוגעת לתפקיד איש המקצוע. יש בקשר לכך דעות מגוונות החל מאי- תתפות דרך מעורבות בשלבים הראשונים בלבד ועד למעורבות מלאה ותרומת מלוא הכישורים וההשכלה.

גדני נכים לעזרה עצמית בישראל עדיין נמצאים בשלב התחלתי אבל המצב משתפר ומתקדם. ההוכחה א שלאחרונה הוקם ארגון גג על ידי קבוצת נכים בתל-אביב. המטרות העיקריות של הארגון החדש :נו לשנות את הדימוי של הנכה והנכות בקרב הציבור, לשפר את החקיקה בנושאים הקשורים לנכות :נהל מאבקים ציבוריים לקידום זכויות הנכים.

:י לבדוק כיצד עקרונות הצרכנות, הבאים לידי ביטוי על ידי קבוצות לעזרה עמצית, עשויים זועיל לשיקום מקצועי, יש צורך לזהות ראשית את בעיות המטופלים, עמן אנו מנסים להתמודד. התבסס על ממצאים מחקריים, להלן האיפיונים העיקריים שנחשבים כגורמים בעיות בתהליך השיקום מקצועי:

) חוסר הנעה לשיקום.
) מטרות תעסוקתיות לא-ראליסטיות (המטופל אינו מקבל את מגבלותיו)
) תכונות אופי לא רצויות (תוקפנות, עוינות, חוסר בגרות ועוד)
) דרישה נמוכה בשוק העבודה לשירותים שהמטופל יכול להציע.

זבעיה הרביעית אינה נשלטת על ידי היועץ והמטופל, אבל שלוש הבעיות הראשונות מושפעות מגישתו יעמדותיו של המטופל עצמו. עם ידע והבנת עקרונות הצרכנות, דינמיקה קבוצתית ועזרה עצמית, ניתן פתח שיטה קונסטרוקטיבית וחיובית להתמודדות עם בעיות אלה.

בהתבסס על עקרונות הצרכנות, עזרה עצמית ודינמיקה קבוצתית, מוצע לנסות וליישם "קבוצות תיכנון של מטופלים" במסגרת תוכניות השיקום המקצועי של הביטוח הלאומי שתתמודדנה עם הבעיות הנזכרות לעיל. מטרות הקבוצות האלה תהינה : להעניק למטופלים הרגשה של מעורבות, לסייע להם לעמוד על כישוריהם ועל מגבלותיהם; לעודד התקדמות אישית ובסופו של דבר לתכנן ולבצע את השיקום שלהם עצמם. לרשות הקבוצה יועמדו כל האמצעים והחומרים העומדים בדרך כלל לרשות פקידי השיקום המקצועי. העובד הסוציאלי יתפקד כמספק של אינפורמציה ושל שרותים בהתאם לבקשת הקבוצה. לרשות הקבוצה גם יהיה מנחה שקיבל הכשרה בדינמיקה קבוצתית. המנחה מדריך את הקבוצה ומכוון אותה למטרותיה, אבל אינו מנסה להשפיע על המשתתפים או להכתיב להם התנהגות מסויימת. מומלץ מאוד להשיג את שרותיו של מנחה נכה. מנחה שעבר את אותו התהליך יכול לתרום יותר להבנת צרכי המשתתפים. נוסף לכך, מחקרים קודמים מוכחים שמטופלים מרגישים נוח יותר עם מנחה נכה בהשוואה למנחה בריא.

" ערכנות המשתקם" הוא מושג שהשתרש עמוק בארצות אחרות, וכל הסימנים מראים שהוא הולך ומתפתח גם בישראל. המגמה הזו תשפיע על הביטוח הלאומי, כאחד הגופים העיבודיים החשובים שמחלטותיו משפיעות על חיי הנכים. תגובה מיידית וחיובית מצד הביטוח הלאומי לשינויים אלה תעזור להמשך התחסים הטובים עם הנכים. יזדמת " קבוצת תיכנון" של מטפלים" כחלק מהתרכניות של שיקום מקצועי תתרום לרגישות מרובת לצרכי המטופל ותעמיד את הביטוח הלאומי בין הגופים שמעודדים את מגמת "ערכנות המשתקם".

המאמר דלהלן, בשפה האנגלית,מחולק לארבעה פרקים : הפרק הראשון מתייחס לאיפיונים של שיקום מקצועי ומסקנה. הפרק השני מתייחס לעיל, שנחשבים כגורמים לבעיות התהליך השיקום המקצועי.

מנקודת מוצא זו המאמר ממשיך לפרק השני עם הסברה של המושגים הבאים : ערכנות, דינמיקה קבוצתית וקבוצות לעזרה עצמית. בפרק זה אנו לומדים מה זה ערכנות; מה תקע החברתי והכלכלי ממנו הוא התפתח; אולי הם היתרונות של טיפול קבוצתי לעומת טיפול אינדיבידואלי במסגרת שיקום מקצועי; כיצד מתפקדות קבוצות לעזרה עצמית ; מהם האיפיונים של קבוצות אלה; מה הן בעיותיהן של הקבוצות; ומה מצבן של קבוצות לעזרה עצמית של נכים בארץ כיום.

הפרק השלישי מתאר את הפרוייקט הנסיוני עצמו. הוא מתחיל עם הנמקת המחקר המבוססת על הממצאים של חוקרים אחרים. המתודולוגיה כוללת תיאור מטרת המחקר, קבוצת הניסוי וקבוצת הביקורת והקף הפרוייקט, משך זמן ומקומו. סוף הפרק השלישי דן במשאבים האנושיים והחומריים הדרושים, דהיינו: מנחה, עובד סוציאלי, מרחיב ושאלונים המודדים התקדמות או נסיגה מהבריאות הפיסית והנפשית, ציפיות לעבודה, התנהגות בעבודה, יחסים משפחתיים, התנהגות חברתית ושיכורים במצב הכלכלי במשך תקופת הפרוייקט.

הפרק האחרון מתייחס לחשיבות הערכנות במסגרת השרותים החברתיים ובמיוחד לתפקיד הביטוח הלאומי כמספק שירותים אלה.

NATIONAL INSURANCE INSTITUTE

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CLIENT PLANNING GROUPS AS A MEANS OF IMPLEMENTING CONSUMERISM IN VOCATIONAL REHABILITATION

by

Lorraine Shapiro

Discussion Paper 27

Jerusalem, May 1982

DISCUSSION PAPERS
(In English or Hebrew as stated)

No. 1 — "Equivalence Scales for Family Size: Findings from Israel Data" (In English), by Jack Habib and Yossi Tawil, 1974 (out of print).

No. 2 — "The Effect of Public Expenditures for Social Services on the Redistribution of Income" (In Hebrew), by Morla Avnimelech, 1974.

No. 3 — "The Effect of Child Allowances on Fertility" (In English), by Marjorie Honig, 1974 (out of print).

No. 4 — "Poverty in Israel Before and After Receipt of Public Transfers" (In English), by Jack Habib, 1974 (out of print).

No. 5 — "Nutrition Patterns and Efficiency in Food Consumption in Israel" (In Hebrew), by Yossef Zamir, 1974.

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No. 27 — "Client Planning Groups as a Means of Implementing Consumerism in Vocational Rehabilitation" (In English), by Lorraine Shapiro, 1982.

NATIONAL INSURANCE INSTITUTE

Bureau of Research and Planning

CLIENT PLANNING GROUPS AS A MEANS OF IMPLEMENTING CONSUMERISM IN VOCATIONAL REHABILITATION

b y

Lorraine Shapiro

Discussion Paper 27

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Client Planning Groups as a Means of Implementing Consumerism in Vocational Rehabilitation

"Recommendation

Future evaluative research and service planning should include within the design and process greater involvement of clients in providing direct evaluative judgements and in suggesting changes and directions in service delivery. Client input is a rich and, as yet, under-utilized potential source of suggestions and knowledge and efforts should be made to integrate the clients more effectively in all places of research and service planning decisions. Workers' professional knowledge should be utilized to find ways to maximize effectively client involvement in all phases of the rehabilitation department."

from: Client and Worker Perceptions of the Helpfulness of Bituach Leumi, Rehabilitation Services: An Exploratory Study, by Arthur Blum and Maya Holtzman, 1980.

I. The Problem

Rehabilitation counselors are sometimes confronted with clients who cannot be "reached" by the traditional client-counselor relationship. These are clients with specific presonality characteristics and problems that subvert the rehabilitation process. What can a counselor do in such a situation? He can decide that the individual's chances of a successful rehabilitation are very low and cancel his participation or he can seek some method of treatment that will help him to overcome his problems and increase his chances of a successful

rehabilitation. Based on the research of Thoreson et al. (1968), the following client characteristics and problems were judged to be the most prevalent in the rehabilitation process:

1. Lack of motivation to be rehabilitated.
2. Unrealistic vocational goals. (The client does not accept his disability).
3. Undesirable personal characteristics (aggressiveness, hostility, immaturity, etc.).
4. Low demand within the labor market for the client's skills.

The fourth problem is out of the hands of both the counselor and the client, but the first three problems are within the power of the client himself, and not just the counselor, to solve.

II. The Issues

A. Consumerism

Definition. In general, consumerism, also known as citizen participation or advocacy, is the right of the individual to be involved in the decisions that affect his life, whether it be in the area of health care, education, environmental quality, commercial services, and so on. It is a means of creating a "balance between the demands of an ever-increasing central bureaucratic control and the unique concerns of specialized interests." (Davidoff, 1965). Campbell's (1979) interpretation of consumerism is that it is a mechanism for offering knowledge of the system.

From the point of view of the professional who provides any kind of service to a particular segment of the population, consumerism is a recognition of the needs and desires of the client. No decision is made from a position of value neutrality (Davidoff). The question is,therefore, "Whose values should be represented?" Proponents of consumerism would agree that it is the client's values that must influence the decision-making process. One cannot presume that the professional holds the same values as the client, especially if the two groups differ in socio-economic background, education, life experiences, etc. Therefore, to ensure that the decisions realistically meet the needs of the client, and that the client will accept those decisions and work towards their realization, it is often necessary to work within a framework that includes the client's own definition of values, goals, needs, etc. In this respect, consumerism is more than choosing among alternative plans as pre-conceived by the professional. The alternatives themselves must come from the clients (Perin, 1970). In that case, the role of the professional is to motivate, educate and support the client to excercise his rights whether through independent actions or through the efforts of an organized group of clients with similar needs (Campbell). But consistent with the principles of consumerism, the professional's role is not to attempt to decide for the client, or to lead, guide or persuade him. According to Batten (1967), the role of the professional is that of "stimulating a process of self-determination and self-help."

From the client's point of view, consumerism offers not only rights, but also responsibilities. First of all, consumerism is more than the opportunity to be heard, but also to be well informed (Davidoff). In order to arrive at workable decisions and plans, the client not only uses personal knowledge, experience and ability, but must also have access to the same information sources as do the professionals. Most importantly, the client is <u>active</u>, and not a passive recipient

of the ideas of others. Active participation in decision-making results in a decrease in apathy, anonimity and de-personalization. For, to be active in changing one's life is to use power in its most positive sense. In other words, power is re-aligned so that the consumer can define his own goals and negotiate for them (Campbell; Alinsky, 1972). An individual who has the opportunity to use this power can only benefit from the experience.

Campbell believes that the social service system as a whole benefits as well when the consumer exercises his rights in that the system acquires a new perspective on social needs and service preferences. Also, consumerism has a positive effect on changing the system so that services and programs more completely meet the consumer's needs. On a more practical level, the implementation of consumerism enables an agency to accomplish more with limited resources, since the clients themselves are, in fact, providing the services.

Development of consumerism. According to Gartner (1979) and Gartner and Riessman (1974), the rise of consumerism in the market place is accredited to the influence of post-industrial capitalism and its production-related values. Consumers have become an effective and powerful force due to a number of factors. Firstly, they are needed for purchasing the over-produced goods. Secondly, they are encouraged to be continuously dissatisfied so that new needs are always being created that must be filled by new products. Thirdly, there has been a significant expansion of credit to assist in the development of consumer demand. Finally, there has been an increase in the amount of leisure time due to advanced technology, increased unemployment, underemployment, etc. This has enabled consumers to interact and to consider their dissatisfactions and common interests.

The influence of this new consumerism in the market place carried over to the human services sector in the 1960's. This was made possible by certain emerging trends. For instance, in the United States twice as many people work in the service sector as in the producing sector. These workers have a broad sphere of influence, for there is no segment of society that is not touched by some component of the human services. Another trend has been labelled "service consciousness" and is the result of the growing media and public attention given to the human services. In addition, there has been a growth of alternative institutions such as the Women's Movement, minority rights, youth and so on, who feel alienated and disenfranchised. They, in turn, have re-examined and challenged the existing value system. Consumerism is based on their desire for societal change through the redistribution of income, wealth and power, the re-definition of roles, and greater equality and respect.

The expanded role of the consumer and of consumer values in the human services is in evidence in a number of ways. There is an increased concern for accountability. That is, the service provider is expected to be answerable to the client group. Based on this belief, the client can expect to receive adequate information so he can make informed choices. Information should be provided about services offered, prices charged and results achieved. There is also an attempt to create adequate grievance redress machinery to give the client an opportunity to question decisions that affect him. The current trend is also to introduce changes in licensing procedures so that lay persons are included. This stems from the demand that a qualified practitioner is one who meets the public's need as well as conforms to professional requirements.

Another result of consumerism in the human sevices is the acceptance of the idea of service as a right. This idea originated in the field of education and

then expanded to health care, legal services and finally to the treatment of the disabled and mentally ill. Included in this idea is the belief that a client is not a "second-class citizen" but an individual who has a right to equal services. And finally, consumerism has resulted in the increased involvement of the consumer as the service giver. This is the basis of the many consumer-based groups that have gained power in the last ten to fifteen years, such as the consumer protection movement, environmentalists, the demand for community control (citizen participation) and the expansion of the rights of minority groups (welfare recipients, disabled, tenants, prisoners, women, homosexuals, etc.).

B. Group Dynamics

Group dynamics is an intricate and wide-ranging field of study. Researchers are involved with the examination of many aspects of the group process, such as inter-personal relations, the decision-making process, leadership, attitude influence, behavior change, and the quality of group decisions. Vocational rehabilitation can benefit from the findings of such researchers as Faust (1959), Collins and Guetzkow (1964), Benjamin (1978), and Vinokur-Kaplan (1981, וינוקור-קפלן). The following conclusions, taken from their studies are relevant:

1. Participation in groups may be important because it motivates individuals in situations in which motivation may otherwise be inadequate.

2. It is more likely that a decision will be accepted if it is made by the group as a whole.

3. In some circumstances group products are superior to individual products.

4. In a dyadic, client-professional relationship, the client learns from himself and from the authority figure, whereas in a group he learns from his peers.

5. The dyad provides an opportunity to develop personal competence, whereas the group emphasizes social competence, as well as personal competence.

6. Dyadic situations that can vicariously benefit others, are created in groups.

7. Feedback on one's behavior and attitudes is more restricted in a dyad.

8. The group process develops a sense of belongingness.

C. Self-Help Groups

A combination of consumerism and group dynamics is expressed in the phenomenon of self-help groups. Sidel and Sidel (1976) define self-help groups as "consumer-initiated, peer-oriented, problem-centered bodies, where the participant is both the helper and the recipient." This is an interchange of roles rarely experienced in our highly structured society, and especially important to those who are usually on the receiving end. Self-help groups assume that one can be effectively helped by those who have been or who are currently in similar circumstances(The Women and Mental Health Project, 1976). The self-help movement is seen as a way of being more responsive to the needs of the client and of balancing the relation between the client and the professional within the human services system (Borkman, 1976).

The general focus of self-help groups is to provide direct services to a particular special needs group, and to the relatives of group memebers. The services

usually emphasize coping skills, peer encouragement and other supportive activities to aid adaptation. Many groups are also involved with education of the general public and of relevant professionals. There are also groups who are involved in various research endeavors in order to advance the state of knowledge of their particular problem (Tracy and Gussow, 1976).

According to Sidel and Sidel, Borkman and Jertson (1975), self-help groups have made major contributions in dealing with problems that other institutions have failed to solve. Sidel and Sidel report that there are over one half million self-help groups in the United States, most of them dealing with problems that professionals have had the least success in handling, such as chronic illness, addictions, slow-learners, child abusers, ex-prisoners, and former mental patients.

According to Borkman, the critical component that distinguishes self-help groups from their professional counterparts is "experiential knowledge", defined as "truth based on personal experience". He goes on to state that with the help of experiential knowledge, the group as a whole develops "experiential expertise" which is "competence or skill in handling or resolving a problem through the use of one's own experience". The self-help group structure provides for the sharing of a relatively large amount of knowledge. The participant learns how his problem is both similar to and different than the problems of others and finds appropriate solutions. Through the process of feedback, the group is protected from inapplicable or ideosyncratic knowledge. The group is also protected from persuing inappropriate solutions by the fact that its structure is both voluntary and pragmatic. In other words, the model is being constantly tested by the simple fact that if it is unsatisfactory, the participants will drop out and the group will disintegrate.

As well as "experiential knowledge", Riessman (1976) would add a number of other characteristics that make the self-help process an effective tool. Firstly, there is the previously discussed "helper-therapy principle". This principle states that in the process of helping others to learn a new role, you help yourself as well. More than that, a deeper commitment to a position is created. In addition, the group participant learns about his own behavior by observing the behavior of others. The playing of the helper role also contributes to greater independence and increased feelings of self-esteem.

The second aspect of the self-help process that Riessman identifies is "consumer intensivity". Riessman believes that the productivity and quality of human services can be enhanced by fuller use of the consumer because so much of the human services is dependent upon the involvement and motivation of the consumer. A consumer intensive self-help approach affords much greater opportunity to connect with the client's world view, expectations, and system of beliefs.

A third characterization is the aprofessional dimension that emphasizes subjectivity and peer initiative, resulting in a sharing of informal disclosures. Aprofessionalism is immediately relevant instead of depending on accepted theories and analyses. Such an approach is also directly accountable to the consumer.

The fourth aspect that makes self-help effective is the implicit demand that the individual can do something for himself and gain autonomy and independence by taking an active role in relation to his life situation.

Lest it be thought that self-help is without problems, it must be stated that there are two on-going controversies. One is the tendency of self-help groups to "blame the victim" (Gartner, 1976; and Sidel and Sidel). The focus on individual deviance from the norm in self-help groups makes it the individual's responsibility

to change instead of society's responsibility to modify conditions. There is a certain acceptance of societal stigmatization and the implication that the individual is the problem and not the victim of the problem.

The second controversy concerns the role of the professional. There are those, like Katz (1972), who believe that there is no role for the professional in self-help. He states that a group initiated by a professional body, such as a social service agency or a university, is not really a self-help group. Then there are those who hold the opinion expressed by Jertson that the professional does indeed have a role to play in the early stages as a facilitator and catalyst. Then when the group is in operation, the professional should withdraw. The Women and Mental Health Project observes that in actual fact no program can be strictly designated as self-help because there is always an element of professionalism in the form of organizers, leaders and administrators. They suggest that the optimal group integrates paid professionals who contribute their skills, professional volunteers who contribute their energy, and former clients who contribute their understanding of the recovery process.

At this point, it would be worthwhile to examine the actual workings of a self-help organization. Probably one of the most multi-faceted organizations is the Center for Independent Living (CIL) in Berkeley, California, as described by Kirshbaum et al. (1976). It is a disabled self-help organization with seventy-five workers, more than half of whom are disabled. A variety of services are provided, such as counseling, education, health care, housing, job placement, wheelchair repair, attendant referral, transportation, sex counseling, financial advocacy, and legal assistance. The CIL was organized and is operated by disabled people with the financial support of government and private grants. It serves as a significant model for the disabled who are a particularly disenfranchised minority.

It provides them with an example of how to assert their needs, interests and strengths.

The CIL arose in response to inadequacies that the disabled themselves perceived in professional understanding, theoretical models and treatment perscriptions. The organizers reacted to these inadequacies by devising a treatment system that prevents the development of a dependency relationship that so often occurs with professionals, even when the proclaimed goal is the client's independence.

All services are provided by peers who convey not only knowledge and understanding of problems, but also of feelings and emotional reactions. The CIL approach states that work is not the only criterion for successful participation in society. Instead, "self-discovery" is encouraged. That is, the participant learns what his capacities, interests and needs are; how to go about serving these needs; and what resources and supports are available to him.

Another major activity of the CIL is the training of professionals and of the public at large in understanding the physical and psychological needs of the disabled through public meetings conferences, seeking to influence legislation, establish programs, and secure civil rights on behalf of the disabled. The community outreach has advanced to the point that the CIL is the co-sponsor of a university program leading to a Master's degree, that emphasizes health services administration and counseling of the disabled. (Over half of the student body and faculty are disabled).

In the final analysis, feedback from the participants in the CIL emphasizes the fact that it instills self-confidence, social competence, a sense of belonging, a feeling that one can openly discuss one's problems without trying to formulate

them according to a professional's guidelines, a belief in the right of the individual to make decisions that affect his life, and a mutual acceptance of others.

The state of self-help organizations for the disabled in Israel is still developmental[1]. Two organizations for mastectomy and colostomy patients respectively, are very active in post-operative volunteer counseling. The remaining organizations for the various disabilities do not actually have a self-help orientation. But this situation is changing rapidly and further developments are expected.

Recently, a group of disabled people in Tel Aviv has begun a process of establishing an "umbrella organization" for the disabled which will attempt to co-ordinate and centralize the many activities and organizations designed for the disabled. The significance of this new organization is that it is being initiated by the disabled themselves. Its establishment is in response to a feeling that the many scattered organizations in Israel sometimes operate at cross purposes. There is currently a lack of communication and co-ordination between these organizations,resulting in over-lapping and wasted resources. It is also felt that there could be greater "strength in numbers" in their contacts with public bodies.

The goals of this new organization have been set down as follows:

1. To implement a public education program that will aid in changing the image of the disabled.

2. To provide counseling to the disabled and their families in order to improve their self-image.

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(1) Information on self-help organizations in Israel is based on an interview with Irit Berman, Department of Family and Community Services, City of Jerusalem.

3. To promote legislation that advances the rights of the disabled in Israel.

4. To represent the disabled in contacts with government bodies and other organizations whose decisions affect the disabled.

5. To provide legal representation in order to correct deficiencies in the legal system's treatment of the disabled.

6. To co-ordinate a public campaign on such important issues as the elimination of architectural and street barriers and the increase in the amount of information that reaches the disabled from decision-making bodies.

7. To establish an information resource center for the diabled.

8. To co-ordinate the official response to public events that affect the disabled.

III. Project Proposal

A. Rationale

The purpose of this proposal is to devise a means of increasing the potential for success in Vocational Rehabilitation for those clients who display a lack of motivation, unrealistic vocational goals, undesirable personal characteristics, and other related tendencies. It is hypothesized that by using the principles of consumerism,specifically self-help and group dynamics, it is possible to increase rehabilitation potential, to offer the client greater responsibility and autonomy, and to heighten the client's awareness of the rehabilitation process (Threlkeld, 1979).

More specifically, in response to the above-mentioned client problems, the positive effects of consumerism and of the group experience have been noted. For instance, Safilios-Rothschild (1970) believes that motivation is the central concept in rehabilitation. She defines motivation as:

> "the disabled's ability and willingness to mobilize physical and psychological resources to cope with his disability; that is, his desire for and co-operativeness in rehabilitation and, more specifically, in the prescribed goals which he must realize in order to be successfully rehabilitated".

Saflios-Rothschild explains, that there are two basic ways of increasing motivation. Firstly, the client must be given adequate information about his disability and about the rehabilitation process. Jeffrey (1981) also agrees that motivation to be rehabilitated is influenced by the amount of information and by the clarity of that information that the client receives. Secondly, the client must be directly involved in the decisions that affect him and his future adjustment. (Both of these requirements can be recognized as the pre-requisites of effective consumerism).

In general, as we have learned in relation to self-help groups, a client's motivation level can be expected to rise if he increases his sense of involvement, that is, if he places more personal investment in or accepts more responsibility for his own rehabilitation, instead of merely following the directions of others. Kriegsman and Celotta (1981) point out that the group has proven to be a very effective means of increasing the motivation of rehabilitation clients to follow through on their rehabilitation plans. This could be due to the fact that the client is answerable, not to an authority figure, but to his peers, and

consequently to himself. In other words, decisions require more justification and commitment since they stem from the client himself. Motivation is also aided by the fact that the client can consider his alternatives from a position of strength and not weakness because the principles of consumerism,as well as the characteristics of the group setting, emphasize equality and not coercion.

As for the second and third problems relating to unrealistic goals and undesirable personal characteristics, the group setting offers the client the opportunity to share his experiences.This was previously refered to as "experiential knowledge" and the "helper-therapy principle". Through peer group support he can come to realize his abilities and limitations more clearly and to learn that he is not alone in his fears and frustrations (Lasky and Dell Orto, 1979). The client has the opportunity to relate to a group of people with whom he can identify due to their common purpose and common experiences. The group experience also helps to improve his social skills through constructive feedback and meaningful and stimulating inter-personal relations (Alissi, 1980). In general, the client's self-image is enhanced by the increased control that he has over his own affairs. His status and feelings of self-respect increase, and he becomes an active participant in society (Batten). He no longer conveys Lasky and Dell Orto's image of the "victim" with "limited control of and participation in critical incidents which shape, determine, alter or even deteriorate his life."

Two recent projects in the field of rehabilitant consumerism reveal the positive effects on clients. Threlkeld instituted a number of "client planning groups" as an alternative to the one counselor - one client model. The goal of the group was to give its members a sense of involvement, to help them to understand their assets and limitations, to encourage personal progress, and ultimately to plan and implement their own rehabilitation. The clients were selected

on the basis of the judgement that they would benefit from a group experience, but were having difficulty formulating vocational plans. Clients were also chosen who displayed psychological or social problems and who were judged to have a low chance of success in their rehabilitation. Those selected were divided into groups of eight. Each group had a leader who was a trained group facilitator, but had no knowledge of Vocational Rehabilitation. The Rehabilitation Counselor functioned as a consultant to the group, providing it with information or information sources. The group was given all the materials, tools, resources, training aids, manpower and funds that a Rehabilitation Counselor alone would receive. Each group was responsible for developing and approving rehabilitation plans and their costs for each group member.

The feedback on this client involvement project was positive. The clients reported an increased awareness of the pressures and limitations placed on the Rehabilitation Counselors. Based on client's self evaluations and counselor and facilitator ratings, it was concluded that the client's self-image improved; they expressed greater degrees of self-confidence and motivation; and they felt that they had gained increased knowledge of the rehabilitation process. The counselors reported that they came to a better understanding of the needs of the clients.

More recently, Kriegsman and Celotta reported on the use of unstructured group counseling for disabled women. The women were responsible for deciding on the goals of their meetings and on the course of each discussion, based on their own definition of needs. The discussion topics ranged from emotional adjustment to disability to the acquiring of information and the arrangement of specialized training.Group facilitators were present, but the discussions were initiated and led by the clients themselves.

The results of this method proved to be very positive. The women reported that they felt more comfortable talking about their disabilities to other disabled women as opposed to able-bodied counselors. They came to accept their disabilities and their related dependencies and limitations. Their self-image improved as their feelings of self-esteem increased. Finally, the women also reported improved abilities in managing social situations. For instance, they felt a lessening of hostility toward others and a reduction in the fear of rejection. In general, they felt they acquired more confidence in their ability to solve their own problems.

B. Methodology

Goal. Using the guidelines of the Threlkeld study, described above, it is proposed to initiate a Client Planning Group. This is seen as an appropriate method of expressing the principles of consumerism and group dynamics in order to bring about a successful vocational rehabilitation of clients of Bituach Leumi. As in Threlkeld's project, the intent is to give clients a chance to become involved in their own rehabilitation, to help them to understand their own abilities and limitations, to encourage personal progress, and to ultimately plan and implement their own rehabilitation.

Experimental group. As discussed previously, the Client Planning Group is aimed at those clients who are having difficulties in their rehabilitation. These difficulties could be caused by a lack of motivation, by unrealistic vocational goals, by an inability to accept one's disability, and by inappropriate behavior. The selection of such clients for participation in the project will be based on the recommendation of social workers from the Rehabilitation Department who are familiar with the cases.

Control group. A matched sample of clients (similar demographic characteristics and problems) who will continue to receive the traditional one-to-one treatment will be evaluated at the same points as the group participants. This will afford the opportunity of comparing progress under the two methods of treatment.

Size, duration and location of project. Two groups will be organized in this initial phase. Each group will consist of seven to ten participants. It is recommended that the two groups operate in two different branches of the Bituach Leumi, in locations where sufficient job and training opportunities exist. The groups will meet weekly for one year. The duration of one year should be considered a maximum time limit. If participants reach their goals in less time then the project will be terminated earlier.

C. Resources

Personnel

a) Group Facilitator - The role of the facilitator is to direct the group members' energies in the direction of their agreed-upon goals. He creates opportunities for reciprocal relationships to develop and acts as a model for the group. But in no way should he influence the group's decisions or prevent the participants from initiating their own activities. In general, it is the facilitator's responsibility to maintain a balanced "group climate" that is neither completely positive nor completely negative (וודנר, 1981). It is a specialized field that requires training in group dynamics techniques. Therefore, it is recommended that a trained group facilitator be hired on a contract basis.

It is not only important to consider what the facilitator's job is, but also

who he should be. Katan (1973) presents a strong case for utilizing the services of "indigenous" personnel. He identifies two aspects that can be considered indigenous. Firstly, it is assumed that cultural affiliations with the client group will result in insights into values, beliefs, morals and customs. Also, someone with a common cultural background will be able to communicate with the clients more effectively because they share the same frame of reference. He will, therefore, be more "acceptable" from the clients' point of view and will be more effective in the delivery of services. The second aspect is the result of shared problems and experiences. A facilitator who has gone through the same process has a better understanding of the clients' needs. Therefore, based on Katan's findings, it is proposed to make every effort to use the services of a disabled facilitator. The previously discussed findings of Kriegsman and Celotta would support this notion that disabled clients felt more comfortable talking to other disabled people rather than to an able-bodied counselor. The disabled facilitator himself may also benefit from the experience, finding it therapeutic and strengthening his self-image due to the active role he is required to play.

In practical terms, the facilitator will be responsible for organizing and leading the groups for their entire duration. If at that time, the project proves to be worthwhile, specialized group dynamics training can be arranged for social workers in the Rehabilitation Department so that future groups will be under their responsibility.

b) Social Worker - A member of the rehabilitation staff in each of the two selected branches will be available to the Client Planning Group as resource people. It is the role of the resource person to act as a consultant or advisor on information matters. For instance, if clarifications are needed relating to administrative procedure for arranging rehabilitation services that are available, the social worker would supply answers to the group's questions.

c) Interviewer. Pre- and post-experiment interviews will be carried out with the group participants, as well as with the facilitator and the social workers. The purpose of the interviews is to determine attitude and behavior changes in the clients (see below, the section on Research Tools).

Materials

In order to help the group participants to understand the Vocational Rehabilitation process, they will have access to all the manuals, guidelines, and other material aids that the rehabilitation staff ordinarily use.

Research Tools

a) Questionnaires: Wozner advises groups to set a base line when they begin as a point from which to measure change. Such a base line also provides a focus for discussion on the potential outcome of the group experience. This base line is established by administering a series of questionnaires at the beginning, mid-way and at the end of the group process. Each set of results is discussed by the group. The use of the following questionnaires is recommended:

1) A Scale of Rehabilitation Gain (Appendix 1). This scale is designed to assess gain or deterioration in physical health, mental health, job expectations, work behavior, social behavior,, and financial status (Reagles et al., 1970).

2) Progress Evaluation Scales (Appendix 2). This is a simple, brief questionnaire that consists of 7 scales: family, job, social behavior, feelings and mood, use of free time, problems, and attitude toward self. The client will be required to judge where to place himself on a continuum

from "problematic" to "well-adjusted", for each scale (Ihilevich et al., 1981).

b) Interviews: As previously stated, interviews will be carried out before and after the project to determine the changes that have taken place in the clients. Clients will be questioned as to their level of knowledge of the rehabilitation process and their understanding of the Rehabilitation Counselor's role. The purpose of these questions is to discover if there has been an improvement in the client's understanding of rehabilitation, and of the challenges and problems with which the counselor is confronted.

Questions will also be asked relating to the three previously discussed problem areas (motivation, unrealistic goals, and problematic behavior). In this respect, the facilitator and social workers will also be questioned. The main purpose will be to ascertain if there has been an increase in motivation and self-confidence, and a greater acceptance of one's disability.

c) Project Monitoring. According to Benjamin, recording does not play a crucial role in the group because so much takes place simultaneously. He recommends that instead, personal diaries be kept. This could be a suggestion upon which the groups themselves would have to decide. Monitoring will also take the form of regular reporting meetings with the facilitator and the researchers.

IV. Conclusion

Consumerism and self-help approaches are changing the meaning of "client". They imply increased personal responsibility and involvement in the decisions that affect the quality of one's life. It is not a question of whether or not society needs such an approach. It is a necessary step in societal development.

The social welfare state cannot continue to expand without it becoming more responsive to the actual needs of the public it is designed to serve.

All indications show that the disabled in Israel have come to realize these implications and to act upon that realization. Bituach Leumi, being one of the main public bodies whose decisions influence the lives of the disabled, stands to be affected by the changes that are taking place in the disabled community. An early and positive response on the part of Bituach Leumi would aid in the continuation of a productive relationship with the disabled. Therefore, the initiation of Client Planning Groups as part of the Vocational Rehabilitation program would not only be a contribution to the heightening of responsiveness to the needs of the client, but would also place Bituach Leumi among those bodies who are encouraging a trend that is already firmly established in countries outside Israel, and is gaining acceptance and power in Israel.

APPENDIX 1

A Scale of Rehabilitation Gain

1. How is your general physical health? Aside from any disability that you might have, how would you describe your physical health?

   1) excellent; 2) good; 3) fair; 4) poor; 5) don't know.

2. How is your general mental health or emotional adjustment?

   1) excellent; 2) good; 3) fair; 4) poor; 5) don't know.

3. Are you having trouble finding a job at this time?

   1) no; 2) not looking; 3) yes.

4. If the work you prefer were available, what would be your chances of getting such a job?

   1) almost certain; 2) very good; 3) 50 - 50; 4) not so good;

   5) very little chance.

5. We realize you do not know exactly what you will be doing in the future; however, which of the following do you feel you will be most likely to be doing one year from now?

   1) employed full-time; 2) employed part-time; 3) self-employed;

   4) training or schooling; 5) unemployed.

6. Which of the following activities do you take part in by yourself? And how may hours per week do you spend on each activity?

   1) Outdoor activities such as hiking, jogging, cycling etc. by yourself;

   2) Attending school, classes, taking courses or training of some type;

   3) Hobbies and crafts such as carpentry, photography, gardening, stamp

or coin collecting, playing a musical instrument, painting, drawing, etc. 4) Reading books, magazines, newspapers; 5) Watching television by yourself; 6) Other individual activities (describe)_____ .

7. Which of the following activities do you take part in along with other members of your family? And how many hours per week do you spend on each activity?

1) Social activities such as visiting other people, going to parties or clubs together, etc.; 2) Family games; 3) Family discussions; 4) Attend synagogue with family; 5) Outdoor or sports activities with family, picnics, visiting parks, hiking, going to the beach, etc.; 6) Watching television with family; 7) Other family projects (describe) _____.

8. If you work, which of the following activities do you take part in with your fellow-workers? And how many hours per week do you spend on each activity?

1) Attend Union and Workers' Committee meetings; 2) Socialize after work hours with fellow-workers; 3) Hanukkah or Purim parties for the whole family; 4) Group trips; 5) Other activities related to your work (describe) _____.

9. Which of the following activities do you take part in with other people in your community? And how many hours per week do you spend on each activity?

1) Sports such as football, basketball,tennis, exercise classes, etc.; 2)Outdoor activities such as hiking, jogging, cycling, etc.; 3) Indoor activities such as table tennis, folk dancing, cards, chess, etc.; 4) Organized social activities such as social clubs, community centers,

service clubs, etc.; 5) Other social activities (describe) _____.

10. We are interested in the different clubs and organizations that people may belong to. Which of the following do you belong to? And how many hours per week do you spend on each activity?

1) School parent committees; 2) University graduate association; 3) Neighborhood clubs and community centers; 4) Swimming pools; 5) New immigrants clubs; 6) Professional or business groups; 7) Charity and service organization such as WIZO, Na'amat, services for soldiers, Red Magen David, hospital volunteers, etc.; 8) Participation in political activities; 9) Sports team supporters; 10) Other organizations (describe) _____.

11. How many hours do you work per week, including the time it takes to go to and from your work?

1) not working now; 2) less than 20 hours; 3) 20-40 hours; 4) over 40 hours.

12. What is the main source of financial support for you and your family? And how much is your monthly income from this source?

1) Current earnings, dividends, interest, income from rental properties; 2) Family and friends; 3) Welfare; 4) Workman's compensation; 5) Old-age benefits; 6) Disability, sickness, survivors or retirement benefits; 7) Annuity or other non-disability insurance benefits (private insurance); 8) Disability or sickness benefits (private insurance); 9) Savings; 10) Other sources _____.

13. What is your work status?

1) Wage earner in the competitive labor market; 2) Wage earner in a

sheltered workshop; 3) Self-employed; 4) Housewife; 5) Student; 6) Unemployed.

APPENDIX 2

Progress Evaluation Scales

Instructions: Please circle one statement for each item that best describes how you were in the last two weeks.

1. Family Interaction

   a) I often must have help with basic needs (e.g., feeding, dressing, washing);
   b) I take care of my own basic needs but must have help with everyday plans and activities;
   c) I make my own plans but without considering the needs of other family members;
   d) I try to consider everyone's needs but somehow decisions and actions do not work well for everybody in the family;
   e) I usually plan and act so that my own needs as well as needs of others in the family are considered.

2. Occupation (job, school or homemaking)

   a) I do not hold a job, or care for a home, or go to school;
   b) I seldom hold a job, or attend classes, or take care of the home;
   c) I sometimes hold a job, or attend some classes, or do limited housework;
   d) I hold a regular job, or attend classes regularly, or do housework, but with difficulty;
   e) I hold a regular job, or attend classes, or do housework with little or no difficulty.

3. Getting Along With Others

a) I always fight; or I am always alone;

b) I seldom am able to get along with others without quarreling; or am often alone;

c) I sometimes quarrel; I have difficulties in making friends;

d) I get along with others most of the time; I have occasional friends;

e) I get along with others most of the time; I have regular close friends.

4. Feelings and Moods

a) I almost always feel nervous, or depressed, or angry and bitter, or no emotions at all;

b) I often feel nervous, or depressed, or angry and bitter, or I hardly show any emotion for weeks at a time;

c) I frequently am in a good mood but occasionally feel nervous, or depressed, or angry for days at a time;

d) I usually am in a good mood, but occasionally feel nervous, or unhappy, or angry all day;

e) I am in a good mood most of the time, or sad, or angry as the situation calls for.

5. Use of Free Time

a) I participate in almost no recreational activities or hobbies;

b) I only occasionally participate in recreational activities or hobbies;

c) I participate in some reacreational activities or hobbies;

d) I often participate in recreational activities or hobbies;

e) I participate in as well as create a variety of my own recreational activities and hobbies for myself and others.

6. Problems

a) I have severe problems most of the time;

b) I have severe problems some of the time or moderate problems continuously;

c) I have moderate problems most of the time, or mild problems almost continuously;

d) I have occasional moderate problems;

e) I have occasional mild problems.

7. Attitude Toward Self

a) I have a negative attitude most of the time;

b) I have a negative attitude much of the time;

c) I have almost equal positive and negative attitudes toward myself;

d) I have a positive attitude toward myself much of the time;

e) I have a positive attitude toward myself most of the time.

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