CLIENTS AS VOLUNTEERS*

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We are familiar with such phrases as "the missile gap", "the communications gap", "the generation gap", but seldom do we hear about what I would characterize as "the human services gap". Yet if we were to count the people who reside in our mental institutions, prisions, and nursing homes and add to these the 4.5 million who are severly disabled and the 14 million whose existence depends on welfare payments we would begin to get some measure of the human suffering and disability which indeed indicate that there is a gap in our human services delivery systems. Many of these millions who are so desperately in need of a variety of human services are offered only custodial and institutional care and become subjected to coercion and intimidation which serves to alienate them from society and to dehumanize their individuality. By any measure used, the disparity between the social, psychological and rehabilitative needs of people and the available financial and human resources to meet these needs is horrendous.

My assigned topic suggests a possible solution to the dilemma of "the human services gap". Why not simply convert clients, who have time on their hands to volunteer who could then provide the needed services? This notion sounds simple enough and we might well wonder why such an obvious arrangement is not more widely utilized. But the obvious often ignores the forces that operate in the practical application of an idea. Nevertheless, I am one who holds the view that the potential for clients to participate in our service delivery systems is largely overlooked by the helping professions in health, welfare, and rehabilitation agencies. I want to explore some of the professional attitudes and practices which inhibit such participation on the part of clients and to offer some guidelines, and principles and conditions which, I believe, can serve to unlock this human resource potential.

Historically, our culture has emphasized individual achievement in a laissezfaire competitive environment. We have never been sufficiently tolerant of people who do not achieve this norm and tend to perceive them as deviant. As our technology advances amid many complex social changes, the support and care of this vast pool of humanity become an ever increasing problem. Dr. Werner Mendel, Professor of Psychiatry at

the University of Southern California School of Medicine, has characterized these groups as the "resourceless people." He is highly critical of the traditional solution of "storing" these individuals in "monuments of chronicity" which carry the labels of hospitals, nursing homes, and prisons. One could add the welfare system and maybe even some rehabilitation centers to his "monuments of chronicity."[1]

But labels are elusive and even dangerous when applied to people. For example, the late Whitney M. Young, Jr., Executive Director of the National Urban League, often emphasized the fact that people living in our ghettos and impoverished areas are anything but resourceless. Their ability to survive under the adverse conditions which characterize our inner cities points to the great strength, resiliency, and courage of these people who have learned out of desperation and necessity to support and sustain each other in circumstances which would defy the resourcefulness of any suburban dweller.

No human service gap is fully explained solely by the magnitude of the problem alone. On one bank of the gap are the people. On the other bank are the resources and delivery systems which we have established to meet the social and rehabilitative needs of various client groupings. Aside from the issues of public fiscal support, national commitment, and ordering of priorities, which are subjects in their own right, let us examine some of the methods and approaches we have hit upon in our service delivery systems.

Our institutional care systems tend to categorize people into providers and consumers--those who have something to give and those who receive. The relationship is usually a vertical one with a one-way flow from the giver to the receiver. Too often, the professionals and trained specialists among us regard themselves as sole possessors of the knowledge and skills to be used in the helping process. Professionals tend to retreat behind academic curtains and to justify their exclusiveness by accumulating scientific and technical knowledge to be shared by a chosen few. This proclivity of the professional along with the usually implied superiority of the provider over the consumer has served to separate the professional from the client. This professional distance--another gap!--is extended by the class differential between the provider and his client. The vast majority of our providers are in the middle and upper classes while our clients generally tend to be in the lower social and economic classes. Yet their resourcefulness, their ability to survive, their innate understanding of problems common to welfare clients, are invaluable qualities. Thus, these clients constitute a rich but neglected source of volunteer workers whose services could well be of enormous help to the professionals.

An issue for our consideration of the client as a volunteer is the one raised by the National Organization for Women of the women's liberation movement. In a resolution adopted at their Fifth National Conference in September 1971, they raised the issue of exploitation of women through volunteer work which, as they claim, "serves to reinforce the second class status of women and buttresses the social structures which keep women in a subordinate role." While they have no quarrel with voluntarism directed toward social change, they do view service-oriented voluntarism as unpaid labor used to alleviate social ills and which in turn lowers public pressure for a more equal distribution of the nation's resources.[2]

This issue can and must be raised even more pointedly with regard to the client volunteer, particularly if we look to a group of clients who are themselves without financial resources and whom we, in turn, would ask to contribute valued services without pay or without opportunity to advance toward income-producing work. This would seem to me to be a blatant form of exploitation which would be most difficult to defend.

Whenever one seeks to engage the services of people toward some common objective, one must consider what motivates people to act in ways which will achieve that objective. Maslow who has provided a concept of human behavior, was among the first to develop a dynamic theory of motivation.[3] He views motivation in terms of a hierarchy of needs with the higher level needs activated to the extent that the lower ones are satisfied. He views man as an aspiring animal; as soon as a basic need is satisfied, a higher level need appears in its place. The process is unending and continues from birth until death.

At the lowest level are man's *physiological needs* for food, shelter, rest, and exercise. "Man lives for bread alone when there is no bread," but according to Maslow, a satisfied physiological need is not a motivator of behavior.

When physiological needs are reasonably satisfied, needs at the next higher level begin to motivate man's behavior. These are called *safety needs*–for protection against danger, theft, and deprivation. In common parlance, these constitute the need for the "fairest possible break." When man is confident, he risks more. When he feels threatened, his greatest need is for protection and security from harm.

When man's physiological needs are satisfied and he is no longer fearful about his physical welfare, his social needs become the important motivation for behavior--the needs for belonging, for acceptance, for giving and receiving friendship and love. Experience

bears out the fact that a closely knit, cohesive staff or family group can be more effective than separate, individual efforts in achieving organizational goals.

Above the social needs are the *egotistic*, relating to one's self-esteem and self-confidence--the need for independence, for achievement, for knowledge. Egoistic needs also include the need for recognition, for appreciation, and for the deserved respect of others. Unlike the lower needs, these are rarely satisfied but they do not emerge to any noticeable degree until physiological, safety, and social needs are reasonably satisfied.

Finally, and the capstone on the hierarchy there are the needs for self-fulfillment. These are the needs for realizing one's potential, for continued self-development, for being creative in the broadest sense.

Drawing upon Maslow's notion of a need hierarchy provides one possible explanation why the vast majority of people who are now participating in volunteer work is drawn from the middle and upper classes. It would seem that these people, having satisfied their physiological and safety needs, now experience the emergence of social, egoistic, and self-fulfillment needs and seek and gain satisfaction and expression through voluntarism. By contrast, a group of people who are preoccupied with the day-to-day necessity of meeting physiological and safety needs would have a lower potential for motivation to do volunteer work.

Clients who fall into the general category of those whose basic needs are not being met, should most certainly be afforded the opportunity to become volunteers, but additionally they should have the opportunity for special job training and work experiences which could lead toward paid employment. Certainly, as a minimum, there should be money allowances to cover expenses and some expectation that the volunteer experiences will lead to job qualifications.

Another well-recognized motivational factor, and one noted many years ago by Alexis de Tocqueville in his *Democracy in America*, is the proclivity of Americans to induce their fellow men into organizations that espouse causes. This tendency for people to band together for the purpose of acting on some common need or self-interest is the basis for many of our national organizations as well as for the increasing number of self-help groups which characterizes American life today. I view this as an extremely important generating force in approaching the question of the client as a volunteer in any human service system, such as welfare, rehabilitation, or health. Any effort to engage the client as a volunteer should always encompass some viable plan whereby client-volunteer representation is included in the program-planning and

policy decision-making process of the agency. Such a feature not only stimulates client interest, identification, and involvement, but becomes an essential input to the appropriateness and acceptability of services provided by any agency.

Traditional voluntarism has tended to parrot institutionalized helping systems in that the status of the volunteer, like that of professional staff member, is of a higher level than that of the recipient of the service. That is, one has something to give, in the old tradition of "noblesse oblige"; the other has a need to receive. The inclusion of client-volunteers in the service function and decision-making process can add new vitality of purpose and direction to any agency and, in turn, help further the American dream of participatory democracy. The challenge to engage the client as a volunteer in our welfare and rehabilitative agencies policies and planning is indeed a formidable one but one that holds great promise.

Long ago, St. Francis of Assisi, in his Prayer for Peace, said: "It is in the giving that we receive." More comtemporary students of human behavior have discovered the "helper therapy principle" which suggests that the person who provides assistance to another with a similar problem frequently improves his own condition.[4] Thus, the helper principle calls attention to the therapeutic aid accruing to the volunteer who puts himself in a helper role to another person with a similar problem. Undoubtedly, this principle has accounted for the phenomenal success of Alcoholics Anonymous, Recovery, Inc., National Association of Patients on Hemodialysis, Paraplegic Veterans Association, Blind Veterans Association, and many other self-help organizations.

Established agencies in health, welfare, and rehabilitation have not capitalized on this potential use of volunteers. The reasons are not clearly evident but very likely are related to our earlier discussions about professional distance from clients. But for whatever reasons, the question remains as to whether or not agencies indeed have readily available to them a rich source of volunteer potential in those clients who have benefited from the services of the agency. Unlike the clientele group who are in a day-to-day struggle to meet their basic physiological needs, these clients are on the road to coping successfully with their problems and have achieved a degree of independence, social functioning, and self-sufficiency.

Whether or not these clients can be brought into present agency structures as volunteers or must function only in autonomous self-help organizations is another question which remains unanswered.[5] My own hope would be that both forms of self-help voluntarism can prosper and that established agencies will foster and promote further developments

in the self-help autonomous groupings as well as agency-based voluntarism utilizing the helper therapy principle. With regard to the latter, I am encouraged by developments within my own agency, the Veterans Administration.

For example, at the VA Hospital in Brooklyn, emphysema patients with only minimal supportive help from Social Work Service have organized for the purpose of mutual help and are mobilizing resources to meet a common problem. They have undertaken self-and family-educational projects and are actively involved in developing an emergency outpatient inhalation therapy clinic which will allow many of their members to leave their hospital beds and pursue a life in the community.

At our VA Domiciliary in Dayton, Ohio, older veterans of World War I and World War II have organized themselves into a group responsible for making contact with veterans returning from Vietnam, particularly the educationally disadvantaged, and encouraging them to use their VA benefits to further education and vocational skills.

A rather ambitious community mental health pilot project sponsored by the VA Hospital in Tuscaloosa, Alabama, provides for a professional team to go into the community when a veteran is experiencing a mental health problem. Instead of recommending a quick entry into the hospital, this team works with the veteran's family and other available resources to administer needed help in the community. Since the area covered by the hospital team is largely rural, most of the resources brought to bear on the individual and his problem are provided by local volunteers interested in the welfare of one of their neighbors.

As a final example, I would site the experience of a number of VA Hospitals in operating self-help wards and communal homes. Groups of veterans are brought together, and with a mutual self-help concept they assist one another in making the transition from the hospital to the community and, later, in sustaining a successful readjustmant to community life. Only minimal professional help is offered or needed.

Is the client as a volunteer a viable concept or just "pie in the sky"? If we approach the question with the simplistic solution that we need merely match the gaps in human services gaps with available client groups, we are doomed to failure. But if agency and staff perceptions of clients can change and if the agencies' practices and structures can be transformed into more imaginative, innovative approaches, I see great promise for the client as a volunteer.

I suggest the following guidelines and principles:

1. For those who are clients primarily because of their physiological need for food, shelter, clothing, and so forth, I would see a volunteer program which: (a) offers training, counseling, and assigned activities which carry the liklihood of future job placement; (b) provides compensation for any out-of-pocket expenses involved in training and in carrying out the volunteer assignment; and (c) gives representation in the policy and program decision-making process of the agency.
2. For clients who have benefited from health and rehabilitative programs, I would see a volunteer program based on the helping therapy principle using both individual (one-to-one) and group approaches. The volunteer assignments should be geared toward rehabilitation or health maintenance goals and coupled with the professional effort. Professionals should perceive such volunteers as enablers and not usurpers of professional prerogatives. The valuable insight these volunteers have into the agency's service program should be utilized as feed-back into the agency's decision-making authority and program design.
3. Agencies should actively encourage and support the development of autonomous self-help organizations. These efforts should be seen as supportive of rehabilitation goals rather than as competitive with established agency practices. Agencies should make every attempt to link the programs of self-help groups to their own programs.

And finally, I would offer a set of rights and expectations for voluntarism by clients:

- While a client should have the opportunity to volunteer, voluntarism should never be made a condition for receiving service.
- A client-volunteer should be afforded a peer relationship with others who serve in that role.
- The volunteer's assignment must be a purposeful one in keeping with his talents and abilities.
- The client-volunteer's life experience should be recognized for its unique value in the therapeutic process.
- The client-volunteer should be allowed to stipulate that his volunteer assignment encompass duties that will enhance his opportunity for paid employment.
- Client-volunteers should have representation in the program and policy decision-making processes of the agency.
- Client-volunteers who join or start to organize self-help groups within or outside the agency structure should be afforded professional help and support as needed and when requested.

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