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THE DEVELOPMENT OF VOLUNTEER SERVICES IN A COMMUNITY MENTAL HEALTH CENTER

by

Dorothea Smith, C. S. W., Coordinator of Volunteer Services
Maimonides Medical Center
Community Mental Health Center
Brooklyn, New York

Maimonides Community Mental Health Center—an integral part of Maimonides Medical Center, a large general hospital—is a newly developed facility with its own building which serves a population of 112,000 in its "catchment area" in the Boro-Park; Sunset-Park Communities of Brooklyn, New York.

The Center receives matching funds from the Federal, State and City government and offers not only five mandated services (Emergency, Outpatient, Inpatient, Partial Hospitalization, Community Consultation and Education) but also referral services, vocational rehabilitation, learning disability therapy, research, etc. Its Hospitalization Services include a receiving and short-term hospital for the population in its "catchment area" and has 41 beds with an average census of 24 full-time inpatients with 15 day hospital patients and 2 night patients.

Since the focus of the Center is to render its services easily accessible, a large part of its treatment and prevention programs are located in the community: in homes, schools, churches and synagogues, two Neighborhood Service Centers, etc.

During a given year, the Center provides direct clinical services to over 2,000 patients (including 350 inpatients), clinical consultation to 2,500, and outreach community services to over 10,000 individuals.

VOLUNTEERS AND THE COMMUNITY MENTAL HEALTH CENTER CONCEPT

The concept of a Community Mental Health Center implies three concerns: the treatment of mental illness, the prevention of mental illness, and the maintenance of mental health. The latter two goals, especially, require a sensitive exploration of new ways in which the community may be informed of the nature of mental illness and the resources available to meet it. In addition, methods must be developed by which the community's own organizations and relationships can be determined, approached, studied, and improved in terms of mental health. The use of local volunteers is one vital way in which the Community Mental Health Center can begin to get to know its community.

In the Community Mental Health Center setting, patient care can become a unified process. The outpatient who comes in from the neighborhood for weekly therapy can, during a crisis period, be fully hospitalized in our Inpatient Service, can return later to the community as a Day Hospital patient, and ultimately can resume weekly Outpatient treatment—all without a break in time or place. Or a person unknown to us can arrive at the Center in an emergency and be immediately hospitalized—to be followed, when later released, as an outpatient living in the community. Since the community thus tends to be a continuing part of our patients' experience, its volunteers (recruited locally and representing all segments) become a natural resource to the Center.

The benefit is not only to the Center in terms of manpower but also to the community. As the experienced volunteers inevitably become more knowledgeable about mental illness and the Center's resources, they are seen by their neighbors as "experts" on what the Center has to offer. More important than facts about the Center, the volunteers' changing attitude around mental illness can communicate itself also to the community. Volunteers can, in addition, bring feedback from their neighborhoods on local needs and problems, as well as keeping the Center alert to how it is being experienced by the community. Volunteers—outside the professional "system"—can offer a critical appraisal of how the Center operates (often as seen through the eyes of a patient) and they should be encouraged to do so.

Since it seemed important at the outset of our Volunteer Program to help the volunteers see themselves as concerned community people offering personal relationships to other community people who happen to be patients, volunteers have been used only in direct service to patients: not for clerical, messenger, or similar indirect services. Volunteer assignments are made around a certain ongoing task (visiting one patient, leading a group) rather than in terms of "clocking in" each time to perform different kinds of assignments.

PROTOCOL FOR VOLUNTEER SERVICES

At the outset of the Volunteer Program, and in order to explore the various needs for volunteers in the Center, many individual conferences with staff members were held. Out of this dialogue and thinking, a written *Protocol for Volunteer Services* was prepared, tentatively outlining philosophy, plans, and procedures; this was circulated to all staff in the Center.

RECRUITMENT

Recruitment was expected to be most difficult, but so far, has not been necessary. Interested applicants still, after two years, telephone almost every day: housewives, college and high school students, pro-

fessional people—boys and girls, men and women. At such time as recruitment becomes necessary, or the need for a broader representation of volunteers apparent, visits to the various organizations in the community (schools, churches and synagogues, block associations, social and political clubs, etc.) will interpret both the Center and its needs for volunteers. A forty minute "picture story" on the Community Mental Health Center for this purpose has been used by the Coordinator of Volunteer Services about ten times in the community with favorable response. A network of volunteers throughout our entire Center community should be the ultimate goal.

MOTIVATION

Motives for volunteering are mixed: some applicants come as concerned local community people, some are intrigued by the mystery of mental illness, some seek adventure and identity outside of home and children, some want to test themselves out for possible work in the mental health field.

It sometimes becomes evident that volunteers have come unconsciously seeking help for their own problems. An effort is then made to work with them around their volunteer assignments (through training, on-the-job supervision, crisis conferences) until they have either become more successful in dealing with their "hang-ups" or have realized themselves that they are not equipped at this time for volunteer work in this setting. Applicants are seldom rejected at the outset; it is important to keep in mind that each volunteer has something unique to offer, and conformity to a certain "model" may well deprive the Center of just that variety needed to stimulate its growth.

INITIAL INTERVIEW

Each applicant is seen initially by the Coordinator of Volunteer Services in an hour-long interview which involves an exploration into the applicant's reasons for volunteering, background, affiliations, abilities and interests. This information is entered on a Volunteer Application Form and is later cross-indexed for future reference. It is important to know how much time the volunteer plans to give; in this low-middle-income community time is precious and limited. Available job assignments are explained and also a brief interpretation of the Center's philosophy, goals, services, and structure is given (often the only overview the volunteer receives).

For example, volunteers preparing to work in our Hospitalization Services need to know that we consider all elements in a patient's environment to be important and are trying to create a "therapeutic community" which will embody this concept. No uniforms or name tags are worn by staff, volunteers, or patients; patients are expected to

take as much responsibility for themselves as possible; crises on the Unit are handled on the spur of the moment by patients and staff, meeting in open confrontation. A volunteer going to one of our Outpatient Services is oriented as to the specific nature of that service.

At the end of the initial interview, the volunteer and the Coordinator of Volunteer Services usually reach a tentative agreement on a possible job assignment, generally made in response to a special or standing request from a staff member which has been previously submitted on a Request Form for Volunteer Services devised for that purpose. Should a volunteer turn out to have some special talent (such as hair-styling) this possibility would be brought to the appropriate staff member (the Director of Inservice Program) who would then discuss it not only with other staff but with the patients on the Unit as well.

ROLES OF VOLUNTEERS

Roles which volunteers have assumed in our Center seem to divide into four categories, that of:

1. volunteers who work with one patient (in the Center or at the patient's home), filling a request by the therapist of the patient and usually supervised by that therapist (In our setting, the therapist may be a psychiatrist, psychologist, psychiatric nurse, or social worker.),
2. volunteers who work with a group of patients in terms of an activity (sewing, etc.),
3. volunteers who supplement the activities of staff (helping the dance therapist, etc.),
4. volunteers (with considerable time to give) who function as members of a staff team and respond to the needs of patients as determined by that team. This use of volunteers was suggested by the Director of our Hospitalization Services and has proved so satisfactory that it has become the regular procedure.

TYPES OF VOLUNTEER ASSIGNMENT

During 1968, the first year of our Community Mental Health Center Volunteer Services, 131 volunteers (men and women of all creeds, ranging in age from 16 to 75), contributed the following services on a weekly or more frequent basis:

* tutoring children in our Remedial Reading Clinic
* acting as "big brothers and sisters" for emotionally disturbed children

* helping a Senior Citizens' Club plan trips and programs
* assisting in our Children's Waiting Room
* acting as language interpreters (Spanish and Hebrew)
* visiting patients in our Hospitalization Services both to share interests and skills and to provide social stimulation
* serving as escorts for patients (to and from the Center, to Welfare, to find apartments and jobs, to shop, etc.)
* visiting the housebound (the aged, the physically and emotionally handicapped, the socially isolated)
* collecting clothing and furniture

Since the first of the year 1969, volunteers who were involved in our Training Course for Volunteers have taken greater responsibility, focused especially around helping discharged inpatients to get back into the mainstream of life: following up on their home situations, trying to help them structure their lives in terms of home-making and care of their children. Some volunteers have worked with relatives of patients, relatives who will not come to the Center for guidance but will trust someone from the community. Several volunteers have also been involved this year in working with a group of school dropouts in an experimental program—alongside of staff. Another volunteer, trained in group process through one of our Community Education programs, worked with a small committee of our Senior Citizens' Club which contacts absent members.

PLACEMENT INTERVIEW

After the initial interview, and on the basis of our choice of assignment, an interview is arranged for the volunteer with the staff member who requested the service and who will be supervising the volunteer. The Coordinator of Volunteer Services is not usually present at this interview and sometimes does not see the volunteer again unless problems arise on either side which necessitate a three-way conference (with volunteer, supervisor, and Coordinator). If the volunteer does not have a fixed supervisor (as in the case of those working weekends on our Inpatient Service—due to staff rotation) the Coordinator then assumes more of a supervisory role and acts as liaison between the volunteer and the Program Director of the Unit.

TRAINING AND SUPERVISION

For the sake of the patients, volunteers need to be able to respond sensitively and therapeutically to situations as they arise; for their own sake volunteers need to feel comfortable in so responding. If volunteers

have been made aware of the goals of treatment to which they are contributing (either in terms of an individual or a group) it will help prevent their being side-tracked or overwhelmed in their work. If volunteers can see the importance of encouraging the patient toward independence, they will not undermine this in their eagerness to be "helpful." It has helped our volunteers to understand that they are expected to relate to patients in the here and now as human beings to human beings—not as "therapists" (though the result may be therapeutic).

To help the volunteers feel secure in their work, training can be done individually or in groups. Where individual training and supervision are concerned, staff members seem to accept volunteers more readily if given the responsibility for on-the-job training of these volunteers. There is less anxiety for both parties: staff has less fear the volunteer will go off on a tangent; the volunteer has someone to turn to immediately in a crisis, an essential for those working in our Hospitalization Services, but appropriate also for volunteers in our Remedial Reading Clinic, for example, where a carefully structured tutoring method is employed. The patient's therapist can give immeasurable help to the volunteer in terms of long range goals for the patient.

When the volunteers' assignments take them alone into the community, however, on-the-spot supervision is impossible, and some foundation must have been laid to help volunteers meet situations on the basis of their own judgement.

TRAINING COURSE

In an effort to provide this foundation, our first formal Training Course for a group of volunteers was instituted in the beginning of this year, running for 14 weeks and involving six local housewives who were also mothers (their children ranging from elementary to graduate school age). These volunteers had all previously been interviewed by the Coordinator of Volunteer Services and had expressed eagerness to take the Training Course.

The course really opened with a weekend (two and one half days) of Sensitivity Training—though this had been preceded by one session involving introductions of the volunteers to each other, explanations of the format of the course, and an explanation of Sensitivity Training by the staff member who was to lead it. At this preliminary session, the group was told that this course was the first attempted in this setting, was of necessity a bit of an experiment; and the volunteers were invited to examine its effectiveness—was it meeting their needs as they began their volunteer assignments?

Outstanding among the reasons for choosing Sensitivity Training were the following:

1. to acquaint the volunteers with the kind of open climate that can exist in the "therapeutic community,"
2. to encourage them to recognize and accept the strong feelings that exist within all of us (both positive and negative feelings),
3. to give them feedback from the members of the group which would help them:
   a) learn how they were being seen by others,
   b) to become aware of their own "hang-ups" as a way toward understanding patients' deeper problems,
4. to initiate them into some understanding of group process in a setting where the use of groups is a frequent modality.

At the end of the Sensitivity Training, the above goals seemed to be largely realized. It had been a moving experience for everyone, even upsetting for some; later, when these volunteers were assigned to the Inpatient Service, each reported that the experience had provided a helpful basis for functioning in this difficult setting. Staff found these volunteers to be more insightful than those who had not participated in the training. Obviously it is not possible to require Sensitivity Training for all volunteers on all levels of service, but it has proved a useful training tool for those preparing to take fuller responsibility with patients.

One caution: while the Coordinator of Volunteer Services participated in this first Sensitivity Training ostensibly as "just another member" of the group, it was impossible for these new volunteers to see her as anything but an authority figure who was there to give information, to test, and to judge them. This not only occupied much precious time, but blurred the role of the actual leader of the group. It is better for the Coordinator not to participate.

After the Sensitivity Training, these volunteers met as a group twice a week: one day for Seminars, another day for Group Supervision. They also began giving a third block of time around their volunteer assignments.

The two-hour, weekly Seminars (with discussion time included) featured our staff members who spoke on a variety of subjects: the Community Mental Health Center itself, the Inpatient Service, the community we serve, ways in which the community organizers reach out to the community, and four sessions on human behavior. Frankly, the volunteers never felt that these theoretical Seminars had quite filled their needs. The two Seminars they found most satisfactory were those in which the speaker was willing to abandon his agenda in order to discuss with them their questions around their own immediate con-

cerns: their role with patients ("what is therapy and what do we do instead?"), their relationship to staff ("we are afraid they'll look down on us because we haven't their education"), how to deal with unexpected situations ("will we harm a patient if we respond in the wrong way?")—they were asking for guidelines and reassurance that they did have something to offer.

The open, exploratory climate of the Sensitivity Training was continued in the two-hour, weekly Group Supervision, led by the Coordinator of Volunteer Services. These sessions were held with the full consent of the volunteers' individual supervisors, as they were geared more to dealing with the volunteers' feelings around their assignments than to supervision in the assignments. The volunteers were encouraged to help each other as they discussed their various problems, with some working principles drawn out of whatever had been discussed. Since the volunteers' job assignments included work with individuals and groups both inside and outside the Center, this allowed them a larger range of experience, helped them discover some common guidelines, and also build a sort of group morale during the first difficult weeks of their work.

The volunteers said they found these sessions more helpful than the Seminars (probably because they dealt with concrete problems and allowed for ventilation of feelings around these). Attendance for the 14 weeks at both sessions was high, broken only by an occasional crisis at home. At the end of the course, the volunteers indicated a desire to continue after the summer with some kind of group training related to actual situations in which they found themselves.

VOLUNTEER COMMITTEE

This group of volunteers has become the core of a Volunteer Committee which has begun to take responsibility for planning the entire Volunteer Program in terms of policy, training, use of volunteers, recruitment, etc.; as active, "working" volunteers they make an enormous contribution at each monthly meeting. New volunteers have been invited to join this group and all areas of volunteer service will ultimately be represented.

EVALUATION OF VOLUNTEERS

No formal system of evaluation has been worked out for volunteers as yet, partly because the program is still small enough for each volunteer's particular contribution to be known by the Coordinator. It would be advisable to set up some method of evaluating each volunteer at regular intervals: perhaps initially after three months, in a session shared by the volunteer, the supervisor and the Coordinator of Volunteer Services at longer intervals thereafter.

RECOGNITION

While our volunteers hopefully derive their satisfactions from the work they do with patients, from their association with staff members who respect their contribution, from their feeling of testing out new roles in a pioneer program, it is unrealistic to think that they will not be warmed by some formal recognition of their work—either through a party given by staff and patients or some other acknowledgement of their efforts, perhaps a certificate or pin. This has not yet been achieved at our Center, but it is a "must" for the coming year.

RECORD KEEPING

It is important to work out a system of record keeping from the beginning of the Volunteer Program, as it is much harder to institute at a later date. Every service in our Center that uses a volunteer keeps a record of that volunteer's days and hours on a Weekly Schedule Form designed for the purpose. Returned to the Coordinator of Volunteer Services, this goes on file (by month) and serves as a basis for statistical information.

A volunteer working individually with a patient has an Individual Monthly Schedule Form to fill out and return; this form is also used by staff for volunteers in the Inpatient Unit.

PROBLEMS IN DEVELOPING A CMHC VOLUNTEER SERVICE

VOLUNTEER-STAFF RELATIONSHIPS

Volunteer-staff relationships should probably head this list. Staff attitudes toward volunteers can range from an enthusiastic acceptance to an unyielding mistrust. Some staff members see volunteers as a threat to their jobs; others see them as a threat to their professionalism. Staff resistance to volunteers may be based on the fear that confidentiality will be violated by them. Staff should be encouraged to air its misgivings to the Coordinator of Volunteer Services, who should respond to them seriously. In the final analysis, a competent and creative volunteer is the best selling point for the use of volunteers.

In our setting, staff antagonism to volunteers has been minimal. A greater handicap to the Volunteer Program has been staff preoccupation. In a new Center, where the structure is evolving, where reorganization is frequent, where staff itself is struggling with its own roles and relationships, volunteers often get lost in the shuffle. It has been tragic to witness on the one hand the need for volunteers in our Center and on the other to be bombarded by applicants—yet not be able to find a way to install volunteers so that they can function securely under staff supervision in this setting. Much patience and determination is required in the face of continuous frustration.

OUR SETTING CREATES ITS OWN PROBLEMS

Sometimes our scheduling creates problems for volunteers. Due to a rotating, skeleton staff on week-ends in our Hospitalization Services (owing to a smaller patient population at those times) there is less opportunity for volunteers to relate to staff or program. As a result, in spite of efforts by the Coordinator of Volunteer Services to give regular supervision and support on a "remote-control" basis to week-end volunteers, frequent drop-outs occur. This kind of after-the-fact supervision does not take the place of on-the-spot coaching by the actual staff on duty and probably is not even appropriate to the role of Coordinator.

Too, some Hospitalization Services volunteers experience disappointment around the fact that ours is a short-term hospital (three months maximum stay); no sooner do they see progress in the patients they are working with than these may be discharged to go home. Two factors help to ameliorate this problem. First, it is important to help the volunteer to focus on the therapeutic process in which everyone is involved, rather than on the volunteer's personal "success" with an individual patient. Secondly, since ours is a Community Mental Health Center, some volunteers are able to continue with the same patients after they are discharged through our Mobile Treatment Team, furnishing supportive services such as help in job and apartment hunting, home management, or just companionship.

COMMUNITY RELATIONSHIPS

Adding to the complexity of the many problems is the fact that there are community people involved with our Center who are not service volunteers to the Center but who represent the concern of the community, helping Center staff in its planning and decision making. They must be allowed to develop their own roles in the Center and not be co-opted thoughtlessly as volunteers.

Another tricky question: should our community organizers and the Coordinator of Volunteer Services reach out together into the community to serve their separate purposes or should each make overtures and develop relationships on their own—which way will best promote the growth of the Center while preserving its unity?

STUDENTS

To make the volunteer situation more complex: a Community Mental Health Center is a desirable field work setting for college and university students who need assignments which will provide good learning experiences. Should these assignments differ from those of the volunteer? And if there are not enough well-supervised placements to

go around, who should be sacrificed: the student who plans to go into the field as a professional or the community volunteer who needs to be a part of his own Community Mental Health Center? These questions are not easily answered; it can only be hoped that all parties can remain open-minded as they explore the possibilities.

CMHC-GENERAL HOSPITAL RELATIONSHIPS

If the Community Mental Health Center is an adjunct of a General Hospital, as is ours, questions may arise in connection with overall policies. Our General Hospital has its own large, active, and well-run Volunteer Department with its own Director of Volunteers. Its traditions differ from what we have developed at the Center (uniforms for volunteers, pins for hours of service, volunteer assignments which include indirect service but not yet visiting the house-bound). By regarding our two departments as completely separate entities (as are our buildings) with different needs and requirements, and by maintaining open and frequent communication about any overlappings that arise, we two Volunteer Directors have achieved a relationship of trust and cooperation instead of rivalry.

INSURANCE FOR VOLUNTEERS

Insurance for volunteers who are escorting patients or visiting them in the community can be a problem. Each Community Mental Health Center can be governed by different rules or laws regarding this, so there is little point in discussing it here. The Volunteer Departments of the hospital funding agencies (such as United Hospital Fund, Federation of Jewish Philanthropies, etc.) and the government funding agencies (city, state and federal) are an excellent resource for the latest information and good advice. The trend is toward a freer interpretation of existing policies, and no progress will be made if our Centers are not willing to push ahead.

CONCLUSION

This *Report* was written in response to several requests made of this Coordinator for guidelines for the development of Volunteer Services in a Community Mental Health Center. It does not pretend to be definitive or to offer global solutions. It represents just one person's attempt to deal with some of the problems of volunteer administration in this new setting.