VOLUNTEER ADMINISTRATION

VOLUME VIII, NUMBERS 3-4, JANUARY-APRIL, 1975

ASSOCIATION OF VOLUNTARY ACTION SCHOLARS

THE JOURNAL OF VOLUNTARY ACTION RESEARCH, JVAR MONOGRAPHS, and VOLUNTEER ADMINISTRATION are official publications of the Association of Voluntary Action Scholars (AVAS).

The Association of Voluntary Action Scholars (AVAS) is an autonomous interdisciplinary and interprofessional association of scholars and professionals interested in and/or engaged in research, scholarship, or programs related to voluntary action in any of its many forms. By voluntary action is meant all kinds of non-coerced human behavior, collective or individual, that is engaged in because of commitment to values other than direct, immediate remuneration. Thus, voluntary action includes and emphasizes a focus on voluntary associations, social movements, cause groups, voluntarism, interest groups, pluralism, citizen participation, consumer groups, participatory democracy, volunteering, altruism, helping behavior, philanthropy, social clubs, leisure behavior, political participation, religious sects, etc.

The Association seeks not only to stimulate and aid the efforts of those engaged in voluntary action research, scholarship, and professional activity, but also to make the results of that research, scholarship, and action more readily available both to fellow professionals and scholars and to leaders of and participants in voluntary associations and voluntary action agencies. Thus, AVAS attempts to foster the dissemination and application of social science knowledge about voluntary action in order to enhance the quality of life and the general welfare of mankind through effective and appropriate voluntary action.

AVAS attempts to be self-supporting on the basis of dues, subscriptions and gifts. Support for the creation and initial organizational expenses of AVAS was provided by the Center for a Voluntary Society (CVS), a non-profit organization located in Washington, D. C.

For information write:

Association of Voluntary Action Scholars
Box G-55
Boston College
Chestnut Hill, Massachusetts 02167
617 969-0100 Ex. 2494, 2371

VOLUNTEER ADMINISTRATION

Volume VIII January-April Numbers 3-4
1975

VOLUNTEER COORDINATORS IN BOSTON AREA HOSPITALS

Fred Arnstein
Department of Sociology
Boston University

Reasons for The Study: Developments in Voluntarism

This report is the first step in exploring a group of related occupations which, for convenience, I am calling a Volunteer Establishment in the human services. The establishment consists of paid occupations which have as their main goals the recruitment, placement, coordination, etc. of volunteers; or which try to create policy for the use of volunteers; or which are supposed to advocate and advertise voluntary activity.

This Volunteer Establishment is of particular interest at present. Since 1969 voluntary activity has been undergoing some amount of expansion and reorganization, with an emphasis on the positive role of voluntarism in American life. The most recent upsurge in the promotion of voluntary activity came in the late 1960's from the Nixon administration and some wealthy private patrons, but a new departure was made at that time: voluntarism was given a nationally centralized and government controlled organizational base through the creation of two agencies, one public (Action), the other private (NCVA).

These new developments continue a tendency toward consolidation and rationalization in human service voluntary organizations which became vigorous early in the twentieth century with the consolidation of fundraising and centralization of allocative procedures in the Community Chest.

Nor is it entirely new for government to be involved in 'voluntary activity'. Some of the programs now included under the ACTION umbrella were begun before ACTION was created (although the most well-known of these, Peace Corps and VISTA have a dubious status as 'voluntary' activities, since the 'volunteers' in them are paid). The difference between past and present is the emphasis which the federal government has put upon centralization and rationalization of voluntary activity. Standard advertisements are now used across the country to encourage voluntary activity. Voluntary Action Centers, long a feature of local urban life (under the rubric of "Volunteer Bureaus"), have been established anew by ACTION, or integrated into ACTION programs where possible. The allocation of volunteers is monitored, and can be controlled to some extent by the types of programs which ACTION establishes, and by ACTION's selection of particular projects in a program.

Attempts to change the scope and structure of voluntarism are bound to be met with resistance from those who feel that the new forms are threatening to them. Three main sources of resistance at this time are (1) certain labor unions, (2) some parts of the feminist movement, and (3) individuals long active as volunteers or paid members of the volunteer establishment who see their autonomy and status threatened.

It is not at all certain that the government effort is the beginning of any long-lasting change. The fact that the emphasis on voluntarism has been so strong, and so consistent for the last six years does, however, make the issue seem worth exploring. We might ask about the volunteer establishment:

- Who are the members of this occupational group, and what are their relations to one another?
- To what extent have the conditions mentioned above become salient in their thinking?
- Do they buy into the new effort toward national integration?
- What are their goals as voluntarists, and where have these goals come from?
- What forces in their settings help or hinder them in attaining those goals?
- In what direction are they really going?

These are the sorts of questions to be explored. The present study is a preliminary step: the assessment of one area of the Establishment, studied in a single metropolitan area.

Method

The main criterion in choosing a sample was to study a relatively homogeneous population, at least in terms of the organizations for which the respondents worked. Coordinators of hospital volunteer services seemed best suited for this purpose since (a) the necessities and realities of hospital organization are likely to impose similar role demands on hospital coordinators; (b) the use of volunteers in hospitals has a sufficiently long history that we could expect many hospital coordinators there to have been in the field for a long time and to be well versed in it; (c) health care has changed considerably in recent years and is still changing, so that we would hope to see some recognition of and reaction to these changes by the coordinators; (d) there are a large number of hospitals in the Boston area which we could reach in an hour's drive or less, and the names of most, if not all, of the volunteer coordinators are listed by the New England Association of Directors of Hospital Volunteer Services (NEADHVS).

Our sample was taken from the current NEADHVS list (with three updates). We selected from this list all hospitals within about a 15 mile radius of Boston, 46 entries in all. (There were fewer than 46 hospitals represented because a few hospitals listed more than one coordinator.) Letters soliciting participation were sent to all 46 coordinators, and soon were followed by phone calls requesting an interview. The two interviewers (Charles McCarthy and Fred Arnstein) did not contact all 46 because there was not enough time to interview each one of them. In total, 31 were contacted and two of these were so evasive as to be counted refusals (both were at the same hospital). Otherwise, the population was extremely receptive to the study. Thus the response rate, for those who were telephoned, was near perfect, and the sample represents 63% of all the coordinators listed in the greater Boston sample which we defined. We would therefore vouch for the representativeness of these results for the Boston area population. Of course, results might be different elsewhere.

Fifteen of the interviews were conducted by McCarthy, fourteen by Arnstein. They ranged in length from about one hour to over three hours, in most cases taking close to two hours. Many of the coordinators took time not just for the interview but to show the interviewers around their hospitals and to have coffee or lunch with them.

The two interviewers felt, by the end of their appointments, that they had gained a fair sense of which issues are generally pressing, and a sense of the personalities and concerns of a variety of respondents. As we proceeded from one interview to the next, we got the sense of how much there was to be said, of what statements would sound absurd, and we also got comments from many respondents about other coordinators -- whom we had already interviewed in some cases. Of course those comments are not a part of this report, but they were important to us in confirming that the ideas which many coordinators expressed in the interviews were the same ideas they expressed to other coordinators. Therefore, we feel fairly certain about stating that our respondents falsified very little, if at all. We also feel that, although some of our respondents may have been reluctant to talk about a few issues, on the whole they answered us truthfully -- each as she saw the truth.

It was clear at times that a respondent did not want to go into detail about an issue, but even in those cases we got a sense that the issue was there. Therefore, what follows is a blend of data and interpretations. We feel that the 'hard' data in themselves are inadequate and sometimes misleading because of the tendency of respondents to avoid difficult issues and because some respondents were better able than others to articulate issues. This report is a blend of quantitative data and our interpretations based on comments from the various respondents.

Types of Coordinators

On the whole we found that our respondents were highly concerned about the running of their individual programs, but very little concerned about, or even aware of, issues and trends which occupy the attention of those who are active in the 'field' of voluntarism on the national level. We learned this from the first question of the interview which asked:

> "What do you perceive to be the most significant issues in the voluntary sector of the human welfare services?"

and retained this impression through the remainder of the bulk of interviews.

Many respondents had to think awhile before beginning to answer the first question, and sometimes carried facial expressions that indicated to us that they were trying hard to think of some issue, not merely sorting through the issues that were already on their minds. In a few cases, co-ordinators simply could not identify any issues or trends. We probed and explained after asking question one, but sometimes got little in return beyond the local hospital program. For example, some coordinators stressed the benefit of volunteering to the volunteers; some talked about the details of running their programs.

On the other hand, a number of the coordinators did respond in terms of broader issues, such as labor unionism and its impact, or the concept of the paid volunteer. But we want to emphasize that in general the coordinators were locally oriented in comparison to any of the Volunteer Establishment personnel that one encounters in general placement agencies or in the larger national organizations.

As we interviewed a number of coordinators we began to notice that many of them seemed to

be one of two contrasting types. One type was the woman who is fairly well educated, and active in her field both inside and outside the hospital. This type of woman was more likely to be rather poised and self-confident, with clear and relatively broad ideas about the field. A second group seemed generally less well educated, only peripherally active in the professional associations or other voluntary agencies, and tended to be less selfconfident and, in fact, sometimes humble about their own programs or abilities. A few seemed to be so different from these two types that they were relatively 'lone wolves' in the sample. Nevertheless, the descriptive types do seem to say something important about the coordinators and the relations among them.

In order to see whether this distinction meant a great deal about the behavior of the co-ordinators, we constructed a new classification based on objective indicators.

The first two indices chosen were (1) awareness of broad social issues as indicated in the first question of the interview, and (2) amount of education. We find that the two characteristics are indeed related, as Table 1 indicates:

TABLE 1

Awareness of broad social issues

	Little	Some	Much
High School	5 (Local)	1 (Local)	0
Some College	2 (Local)	3 (?)	3 (?)
Education			
B.A. or B.S.	0	4 (?)	1 (Cosmopolitan)
Graduate Work	0	2 (Cosmopolitan)	3 (Cosmopolitan)

The cells of that table were then classified as Local or Cosmopolitan in orientation (Merton, 1957, 387-420).

In order to classify all respondents in to one of the two groups, we placed all those in the middle (?) who had organizational or volunteer affiliations outside the hospital in the Cosmopolitan camp, and those without such affiliations among the Locals. Organizational affiliation was used because it was central in our conception of the Cosmopolitan-Local distinction and because all but one of the Locals in Table 1 were lacking such affiliations, while four of the six Cosmopolitans in Table 1 for whom we have the information did have extra-hospital affiliations.

Thus, all the respondents except one (for whom educational data were lacking) could be classified as either Cosmopolitans or Locals on objective grounds. These categories corresponded rather closely to our initial impressions, as shown in Table 2.

TABLE 2

Comparison of Objective & Subjective Ratings

		Categories based on objective criteria: Cosmopolitan	Local
Categories based on general interviewer impressions	Cosmopolitan	6	3
	Local	2	11
	Other	3	4

It is clear from the interviews that there is a hierarchy and structure of sorts in the field. We have only some vague impressions, which could be followed up later. Certain Cosmopolitan coordinators are considered excellent by many of the Locals; however, not all Cosmopolitans seem equally trusted. For the Locals, who tend to be more traditional in their outlook and perhaps less self-confident about running their programs in ways the hospital administration will like, the more traditional among the Cosmopolitans are the more praised. These traditional Cosmopolitans are held up as models of excellence and helpfulness. At the same time, at least one non-traditional Cosmopolitan coordinator told us that some Local colleagues come to her for advice 'on the sly.' Certainly one interesting study that might be undertaken would examine the network of affiliations and advising that occurs among the various coordinators. Such a study was not part of this work.

The coordinator's setting

To understand our respondents, one must have some sense of the conditions in which they work and the demands placed on them. While there is wide variation in many aspects of the work, there are some important common themes also, and we discuss these first.

Most hospitals are large organizations where status distinctions are well-understood by staff and play an important part in their behavior. Within such a setting the concept of the volunteer is hard to accept. The volunteer is not specialist at anything, has no clear work or reference group, and is not governed by a definable set of sanctions. The volunteer can cause trouble without fear of losing her livelihood, or just as bad, can threaten to become so useful that a paid employee is in danger of being no longer needed by the hospital. Volunteers, like paid employees, come to the hospital for a variety of reasons, but unlike paid employees, the motivations of volunteers are not automatically channeled along lines of money and status rewards. (These problems tend to be somewhat different in the case of auxilliants, who will be discussed shortly.).

The role of the volunteer coordinator is equally problematic within the structure of the hospital. The coordinator is a sort of personnel manager who allocates unpaid labor in the hospital. Unlike the regular personnel manager, however, the coordinator must keep track of the doings and progress of each volunteer throughout the time the volunteer is active, which may be many years. The coordinator is constantly re-allocating her volunteers to new positions, partly because of the turnover in volunteers and partly because new positions for volunteers open up as paid staff sees a need for them. The coordinator also needs to create opportunities for volunteer service by convincing staff that the volunteers will be useful to them, unlike the regular personnel officer who merely allocates applicants to predefined positions.

Therefore the volunteer coordinator is in contact with many parts of the hospital on a daily basis. She, like the volunteers, has no formally defined reference group even when she is called a department head. She is free to give help or make trouble for any of the regular status groups within the institution, and so tends to be mistrusted until she proves herself in action over a long period of time. Even then, she faces the conflict between her need to keep the volunteers happy and her need to satisfy the departments where volunteers are placed. This conflict can occur, for example, when a volunteer arrives on her appointed day but there is no work which is really appropriate for her. Shall the coordinator take the chance of putting the volunteer in an assignment where she may not perform well in order to keep her allegiance for the future?

Although the volunteers' status in the hospital is ambiguous, it is also very low. This fact was expressed to us by enough coordinators that we feel it must be fairly pervasive in hospitals, although there are surely exceptions as well. As one coordinator said, "They think of us like they think of the toilet. You don't think about it at all until you need it." Or as several others put it, "We are at the bottom of the totem pole !"

The volunteer coordinator is therefore in the position of having to try to appear to like and want to please all parties, including her volunteers. She has very little power over anybody, so she must rely on the traditional techniques of isolated low status individuals who attempt to influence others: ingratiation, flattery, loyalty, working hard to be useful, and subtle, friendly manipulation. Most coordinators see themselves as running programs which the hospital administration will insist represent administration needs and policy. The coordinator, for all her involvement in 'professional' associations, has only very weak independent professional standards which can be invoked in fighting the hospital.

Volunteer programs at most hospitals have, in the abstract, considerable potential for expansion and change simply because there are no very clear guides as to what a volunteer program should be. However, when the hospital administration is traditional and clear in its demands, the chance for innovation is small. The coordinator must then either go along unwillingly with administration policy (because she is so easily replaced if she causes trouble) or else she must identify sufficiently with administration policy that she can operate comfortably within her constraints.

Many hospitals, on the other hand, are not so rigid about the co-ordinator's role. In such cases, coordinators can expand and upgrade the quality of volunteer services by getting to know the various other hospital staff, suggesting new programs, and slowly proving that their volunteers are capable and reliable.

Auxiliary, Coordinator and Hospital

A deeper understanding of the coordinators' role and status require a look at the women's auxiliary, or its equivalents. Several of our respondents explained to us that the auxiliaries at many hospitals were in the past, and sometimes still are, composed of doctors' wives and other fairly wealthy women who served their own interests through auxilliant activity by advancing their husbands' careers or satisfying their own needs for involvement in activity outside the home, while they kept the hospital in touch with a wealthy segment of the population who were able to donate or raise money for gifts to the hospital. Until recently (perhaps the last twenty years and less), the auxilliary actually was the volunteer corps, or at least had control over it. The activities of these auxilliary volunteers, however, were usually closely circumscribed both by what they were willing to do and by the fears of hospital staff that they might be troublesome if they attempted to do more.

The auxilliants were both tolerated and pampered by hospital administrators, who saw them as sometimes meddling and troublesome, but also as sources of money and other support. In time, as hospitals grew larger and more complex, and as volunteers from outside the auxilliary have become both willing and anxious to take on more responsibilities, it became necessary to find regular coordinators for auxilliary/volunteer services. The first volunteer coordinators were thus auxilliary members, and the first coordinators from outside the hospitals were considered, in many cases, only administrative assistants for auxilliary activities.

However, just as volunteers are not subject to the same standard sanctions as paid workers, so coordinators drawn from the auxilliary were not as useful or tractable to hospital administrators as paid coordinators whose primary loyalty did not lie with the auxilliary. Besides, as the scope of voluntary service expanded and began to include some tasks which were distasteful to higher status ladies, the auxilliants themselves often did not want to be full time coordinators. For these reasons, it has become widespread practice for volunteer coordinators to be recruited from outside the ranks of the auxilliary.

Now the 'typical' coordinator (in hospitals with an affluent auxilliary) plays something of a liaison role between the auxilliary and the hospital. From the point of view of administration, the role of the coordinator seems to be to keep auxilliants feeling that they have an important role in the hospital so that they will continue to give money and support, but at the same time to keep them under control and out of the administrator's hair by fielding some of their complaints and educating them as to what the hospital really is all about. The coordinator also allocates auxilliants to assignments where they will do no harm (like the hospital giftshop), though in this she is supported by the auxilliants themselves, who have traditionally run such services. The 'typical' coordinator in the hospital with a less powerful auxilliary plays these roles with less feeling of tension or conflict. She is more oten very much in tune with the auxilliary, and sees it as her ally.

Our data, unfortunately, do not deal systematically with many of these issues, but we do have some information worth noting. Of the twenty-eight hospitals we saw, only three did not have an auxilliary or its equivalent. (In some cases, community organizations which are not called auxilliaries serve essentially the same function. We were conservative in making this judgement in our counting). The auxilliary is therefore a very pervasive institution. The auxilliaries generally were restricted to particular areas of voluntary activity, notably running gift shops and coffee shops and raising money, with a variety of other activities depending on the hospital. In some hospitals where the auxilliaries were officially volunteer organizations, they did very little in the way of regular hospital volunteering. In a smaller number of hospitals this was not true, and auxilliants did account for a sizable proportion of the volunteer staff. We saw many cases where a small number of auxilliants had given thousands of hours of volunteer time over the course of many years, but in the course of that time had developed their own baliwicks, particularly gift shops, in which they spent all their volunteer time, leaving other volunteer tasks to non-auxilliants.

In most hospitals, the auxilliary and volunteer office work very closely together, and all auxilliary volunteers are channeled through the paid coordinator. On the other hand, six hospitals had the auxilliary and paid coordinator entirely separated. In some of the latter cases we heard comments like, "I was told to stay strictly away from the auxilliary." In two other hospitals, the coordinators said they served an explicitly liaison role between auxilliary and the hospital.

We did not ask people about their feelings toward the auxilliary, but feelings often came out in the conversation. Most often, the feelings expressed were positive (13), and somewhat less often we heard about conflict, tension or trouble either presently or in the past (8). One coordinator, in a hospital without an auxilliary, said that she had been warned full well that it would be a great mistake for her to try to create an auxilliary. It would only cause her trouble.

In some cases coordinators had mixed feelings about the auxilliary. One respondent, who for the most part had negative comments to make about her own and other auxilliaries, nevertheless said that auxilliaries were necessary as a way for the hospital to maintain relations with the community. In fact, she said, if they had not already been there, it would be necessary to create them.

Thus there appears to be a spectrum of coordinator/auxilliary relations, including cases where the auxilliary does not exist, cases where it is on cordial terms with the coordinator, and cases where there is tension. It does seem that the trend is toward more power in the hands of the coordinator and a more specialized and weaker role for the auxilliary. Some of the coordinators in our sample have experienced aspects of this transition during their years on the job.

Where a volunteer coordinator finds herself at odds with the auxilliary, she must maintain a facade of friendliness. Otherwise, with very few exceptions, she could not keep her job. Again and again we encountered statements like "The main thing is not to rock the boat." Or-- again in the nautical metaphor-- "The first thing they told me when I came here was Don't Make Waves."

The Coordinator as Public Relations Officer

Even where there is no auxilliary, there are generally other groups in the community on whom the hospital relies for support, such as religious organizations for religious hospitals, or veterans groups for veterans hospitals. The hospital also finds itself needing often to address the entire surrounding community in order to secure support for its programs, and for expansion. In all these cases, the volunteer coordinator functions as a liaison between hospital administration and community groups, just as she did with the auxilliary.

The coordinator's role as general public relations and public education staff was elaborated to us by many respondents in some detail for their particular hospital. Some systematic data are also available which indicate that the issue is important, and shows that coordinators often have different priorities for their jobs than they think their administrations have.

We gave each coordinator a list of possible goals of her volunteer program and asked her to rank these goals, first as she perceived them to be held by the hospital administration, and then as she herself felt about them. The goals listed were:

a. Helping the sick by providing voluntary services.
b. Recruiting health professionals by involving people in volunteer experiences which may influence their career choice.
c. Helping the volunteers find meaning and satisfaction through their volunteer experience.
d. Achieving social change or reform.
e. Maintaining good relations with the community.
f. Other goals.

Table 3 summarizes the rankings.

Table 3 shows that the first three goals, which have to do with patient care, volunteer satisfaction and health personnel, are relatively highly ranked by the coordinators, and the coordinators feel that administration agrees with them for the most part.

The goal which shows the most interesting difference is (e.) 'Maintaining Good Relations with the Community.' Six respondents thought administration would give this goal highest priority, but no coordinators gave it such a high ranking themselves. Eight respondents thought administration would give it second highest priority, but only four would give it such a high ranking themselves. On the other extreme, eight of our coordinators put community relations in fourth place as a goal for themselves, but only two felt that administration would rank it so low.

The table reflects the feeling of many coordinators that the hospital is primarily or largely interested in the volunteer program for its usefulness in keeping good relations with various constituencies in the community, while they are only peripherally interested in the actual functioning of volunteers in the hospital. On the other hand the coordinators themselves are concerned with precisely that which administration does not care so much about: the day to day tasks performed by volunteers and their impact on patient and volunteer alike.

Success in this setting is measured by the degree to which the coordinator can create a program which is attractive to both volunteers and hospital. In hospitals where volunteers are allowed a wide choice of tasks and where many of these tasks are intrinsically rewarding, success is most likely. In a few hospitals we visited we had the impression that the entire organization was run by

TABLE 3

Goals for the volunteer programs as volunteer coordinators rank them and as they believe their hospital administrations rank them.

Perceived Rankings of Administrators							Coordinators' own rankings					
High 1	2	3	4	Low 5	Mean		Mean	High 1	2	3	4	Low 5
18	4	1	1		1.4	a. Helping sick	1.3	20	7	1		
1	2	10	7		3.2	b. Recruiting	2.7	4	2	9	3	1
1	10	6	4	2	2.8	c. Helping vols.	2.2	6	11	3	2	1
	1	1	3	6	4.3	d. Social Change	3.6		3	2	2	4
6	8	7	2		2.2	e. Community Rel.	3.2		4	8	8	
	2					f. Other				1	2	1
	N = 26						N = 27					

volunteers, who seemed to be everywhere, doing everything, in their coral-colored smocks. In such hospitals, volunteers have become so accepted and important a part of hospital operations that they would not likely be dispensed with, and the volunteer coordinator can count on support from the hospital for at least some new programs.

In other hospitals one sees few volunteers. The problem is not always just in administration policies and coordinator ingenuity, however. In hospitals for the chronically ill and the aged, volunteers are more difficult to recruit because the conditions are more depressing and the range of opportunities is smaller. Yet even in some such hospitals, it appeared to us that volunteers were doing a considerable amount for the institution.

Some personal characteristics of the respondents

During the course of the interviews we several times encountered women who told us that "we are all pretty similar in this field" and others who told us just the opposite, "you won't find two of us alike". We began the study thinking that co-ordinators would be similar-- as indeed they are in some ways-- but found that the differences among them are as striking as the similarities.

There is no common training or socialization for the volunteer coordinator. She may be recruited from virtually any background. We did not collect systematic data on the previous occupations of our coordinators, but we learned enough to know that they come through a diverse collection of former pursuits and motivations. Some worked at the hospitals where they now coordinate, but in other capacities, and many of these women did not seek the volunteer position but were asked to take it when the job opened up. Some women said they frankly were not sure they wanted the job, but after some hesitation decided to try it. Of course, for most of the women we interviewed, the job has worked out fairly well for them or they would no longer be there. We did not try to interview any former volunteer coordinators.

Some women did actively seek employment in volunteer or related fields, and happened upon jobs as they opened. Others were not really looking for volunteer-related jobs, or any job, but knew a hospital administrator or were recommended to an administrator. Again, these women were sought out. Many of our respondents had long and wide experience with various aspects of voluntary activity, while others had none before their present jobs. If one could draw a picture of the 'average' volunteer coordinator, she would be a woman who had been more sought after by the hospital than she was seeking the job, and who had not considered taking such a job before although she did have some experience in voluntary activity. But many coordinators deviated from this 'average'.

Educational backgrounds are similarly diverse. The twenty-eight women who gave us information about their education were distributed this way:

Amount of education

High school diploma or less	6
Some college	10
Undergraduate college degree	6
Graduate Work	6

In their ages, however, the women are much more similar to one another. Of the respondents we interviewed, only two were under forty years of age. All the rest ranged between 40 and 65 years old, with a mean age of 52 years. We are not sure why there are so few younger women in the occupation. One possibility is that the age structure of the occupation reflects life-cycle situations and hiring practices. Mature but not elderly women are perhaps most likely to have the time to do full time coordinating, have the experience and contacts that often help get these jobs, and know a good deal about interacting with people. But there appears to be a bias against hiring women over the age of fifty. A scatter plot of age against years at the job (not reproduced here) shows that all coordinators over 50 in our sample have been at their present jobs at least four years. All those over 55 have been there at least 7 years. No coordinators over 50 were hired recently.

We asked the women whether they had any future career plans. The majority (20) of them replied that they did not. Among those who did were a few who saw definite goals for themselves after retirement. This suggests that for most of the women, being a coordinator is not part of a career pattern which is planned in advance. Certainly there are no clear directions to go after being a volunteer coordinator except perhaps personnel work.

Professional Self-Images

One question asked each respondent whether she considered herself to be a professional. More (18) of our respondents did consider themselves professional in their jobs than did not (11). A few of those who didn't consider themselves professional in the jobs said that their non-job activities, like membership or officership in professional associations, was a more professional activity. Although Cosmopolitan respondents tended to call themselves professional more often than did Locals, the difference was not significant.

However, even among those who claimed to be professional there was a range of conclusiveness about the matter. Some were very definite: they would say 'Absolutely' or

'Definitely' when asked if they were a professional. Others hesitated, or said 'Yes, I guess so' and similar less clear things. Furthermore, among those who claimed not to be professionals, there were a range of attitudes. Some claimed that they themselves were not professionals but that other people in the field were. (These were Local respondents referring to Cosmopolitans.) Others said that nobody in the occupation was a real professional. And some expressed that interesting idea that being a non-professional was an important part of the job because "Being a non-professional, I don't intimidate my volunteers" as one women put it. Evidently there is a feeling in the hospital that professionals do have power and are intimidating to others of lower status. Most of the volunteer coordinators we saw found themselves often taking an interest in the personal affairs of the volunteers, out of necessity in order to keep the volunteers working well, and out of interest and compassion to help them over their personal difficulties.

Hospital volunteer coordinating is not a profession by the usual criteria. Coordinators do not possess a body of common skills and training which renders them expert in well-defined procedures and enables them to claim that they are the best judges of each other. They have no equivalent of 'private practice' through which they can maintain autonomy; instead, they are bureaucratic functionaries whose special job is the maintainance of relations between the hospital and its clients (patients) on the one hand, and its patrons (the auxilliary and other community forces) on the other. As soon as she ceases to be supported by her employing hospital, the coordinator is no longer a coordinator. Her status has very little autonomous component. And because she is so constrained, she has little independent say about who may volunteer and what these volunteers may and must do. In this last respect, however, some coordinators have tried most successfully to make their jobs 'professional' -- control can exist to some degree over the volunteer program depending on the availability of alternative volunteer options within a hospital, the attitude of administration, and the ability of the particular coordinator to create and impose standards.

When asked what qualities about them or their job make them feel they were professionals, most respondents answered in terms of personal qualities like outgoingness, compassion, sensitivity, or organizational ability. The qualities listed were not always the same, probably because different coordinators see their jobs in somewhat different terms. For some, the person contact is extremely important. These coordinators are extremely interested in watching, helping and even supervising the development of their volunteers. For others, patient care is most important, and the coordinators who feel this way voiced concern throughout the interviews that hospital care, and medical care generally, must be improved, and that it is imperative to have good volunteer programs to fill the gaps. For still other coordinators, the running of the program and the education of staff and community seem the most important priorities. These different types, and other, emerge from the interviews.

A volunteer coordinator must be able to handle masses of detail at the same time being warm to the various people she contacts. For the running of a successful program, there is no doubt that considerable personal ability is required, but this in itself does not make one a professional. It seems quite clear that many co-ordinators are using the word about themselves in hopes that the claim will make it so. In fact, judging from their status at most hospitals, the claim does not help very much.

Hospital Coordinators and other Placement Agencies

We asked whether volunteer placement agencies or other organizations outside the hospitals were helpful in providing volunteers. Only three hospitals seemed to rely heavily on outside agencies, and two of these were hospital of a special nature, one located in the center of the metropolitan area, accessible to university students and other potential volunteers who came through outside programs. A second hospital was for chronic patients and relied heavily on RSVP.

Most coordinators said they got no help (9) or almost none (11) from outside agencies. Many of these said that the Voluntary Action Center in Boston was not helpful in providing volunteers even though the hospitals were there. The same was said, with less frequency, for other agencies, including ACTION and the Civic Center and Clearinghouse. For the most part, these comments implied that the outside agencies simply were not geared to attracting appropriate volunteers for the hospitals, and that the main avenue for recruiting new volunteers was through word-of-mouth enthusiasm shown by current volunteers or patients. Most (21) of the coordinators did very little or no active recruiting; four said they did recruit. However, there is a hazy line between recruitment and public education, and many of the coordinators who do not explicitly recruit nevertheless speak to various civic and community groups when they can.

Relations with hospital staff and other problems

We have emphasized that the coordinator's job entails a great deal of interaction with many different staff in the hospital, and this interaction succeeds or fails largely on the basis of the coordinator's personal qualities of friendliness, persuasiveness and helpfulness to other staff. Several sections of our

questionnaire asked respondents how they felt about aspects of the hospital and its staff in relation to the volunteer program.

One series of items asked respondents first to rate their own attitudes toward voluntary activity in the hospital, according to the scale:

1. Extremely valuable
2. Definitely valuable
3. Somewhat valuable
4. Of small value
5. Of approximately no value
6. Of negative value.

Then they rated the feelings of other groups in the hospital toward voluntary activity. Of course these ratings were the coordinators' perceptions and so may not reflect how the other groups really feel, but they do reflect the coordinators' feelings of trust and ease in working at their hospitals. The mean scores are presented in Table 4 in declining rank order of favorable attitude.

TABLE 4

Group	Attitude toward Volunteers (Mean Score)
Volunteer coordinators	1.46
Patients	1.65
Patients' families	2.04
Hospital Administrators	2.19
Nurses	2.30
Therapists	2.71
M.D.'s	2.85

Another set of questions asked respondents whether they had any conflicts with other hospital staff. The majority of coordinators (17/29) claimed there were no conflicts. Perhaps this question deserves to be treated as cautiously as any, since it touched on sensitive ground for the respondents. We can therefore take the positive replies (12) as a minimum estimate of the number who actually experienced conflict. A second question asked whether there were any other main problems which the coordinator faced in carrying out her program. Here, the responses indicated that more (19/29) respondents did have important problems.

A listing of the different 'problems' and 'conflicts' mentioned shows that sometimes there is overlap between these categories. The most commonly mentioned (9) conflict or problem is lack of acceptance of volunteers by other hospital staff. This was phrased sometimes as staff feeling threatened, sometimes as staff being uneducated about the use of volunteers, sometimes as a complaint that the staff had a non-accepting attitude.

Along similar lines, four respondents complained that the hospital administrations were indifferent to volunteer programs and would not provide the recognition and other support that a program needs to be entirely successful. One respondent complained that her hospital would not accept a particular program which was threatening to the status-quo there. And three respondents complained about problems with the auxilliary when asked these questions (several other complained elsewhere in the interview).

Three respondents complained about their low pay. And several other problems also had to do with money: lack of money for new programs, for more paid staff in the volunteer office, and for transportation for volunteers. The related problem of office space was mentioned by three respondents. And two respondents said they had difficulty because their hospitals are located in dangerous city neighborhoods where volunteers rightly fear to travel.

The quality of the volunteers was mentioned as a problem by six respondents. The particular qualities the respondents were seeking differed among them: one needed more minority people, but a more common problem was finding volunteers who were reliable and committed to helpful interaction with patients. This seemed to be a problem particularly in chronic hospitals, and among younger volunteers.

Volunteers and Unions

In addition to the importance of educating hospital staff to the potential uses of volunteers, particularly now that volunteers are willing to do a larger variety of tasks than they once were, respondents also were keenly aware of the threat to job security posed by a volunteer corps. Many of our respondents mentioned this issue in the first question, where we asked them to define whatever issues they saw as important. There, and elsewhere, they mentioned unions and trouble with unions, either in the past, presently, or anticipated. Often, coordinators claimed that in fact volunteers do not take the place of paid employees but only supplement them. This does appear to be true in the sense that a coordinator would not risk offending paid staff by proposing that a volunteer do a job which was already done by an employee. One gets the impression that the coordinators have been through some difficult times on the issue and are treading carefully at this time.

On the other hand, it is clear that volunteers perform a great many tasks which might be paid if there were money available, or if the hospital decided to allocate its budget that way. Table 5 summarizes the activities of volunteers in the hospitals we saw. Let us consider first those activities which are least likely to be paid.

TABLE 5

Activities of volunteers as reported by coordinators

Below are listed various areas of responsibility which volunteers may have.

a. Which of these services are performed by volunteers in your institution? (check all those applicable).

b. Which two of these services consume the most volunteer time? (Write 1 for the most time consuming and 2 for second most.)

c. Are there any areas where you feel that the volunteer provides a unique or significantly important service to this institution? (Check all those applicable.)

a	b	c	
27	22	21	One-to-one interaction with patients (reading or talking to patients, playing cards, etc.)
13	6	6	Organizing and facilitating group activities for patients (recreation, drama, etc.)
13	4	8	Taking an advocate role (calling the attention of hospital staff to patient problems, etc.)
21	11	9	Providing shopkeeping services
27	7	7	Bookkeeping and other office functions
8	0	4	Policy-making and advisory functions
11	7	8	Other...

Table presented here is same format as original question sheet. Numbers indicate how many coordinators responded positively in each cell.

The table shows that most of the hospitals use volunteers in one-to-one interaction with patients. This is said (by the coordinators) to be the most essential function of volunteers as far as they are concerned: the direct care of patients, the humanizing of the hospital. Not only did our respondents mostly claim that their volunteers interacted directly with patients, but most of those also said that this activity took up a large proportion of the total volunteer time, and also felt that it was a significantly important service to the hospital. This is the kind of service for which the most compelling arguments can be made that payment is not appropriate or necessary.

Interacting with groups of patients was listed in only about half the hospitals, and was considered very important in only half of those. Another activity happens with a similar frequency: the volunteer taking an advocate role vis-a-vis the patient. A still smaller number of hospitals listed policy-making and advisory functions as part of their volunteer operation.

So much for the activities which are least likely to be paid. Three other types of activity are also listed with some frequency which would ordinarily be paid. Bookkeeping and other office functions is listed at nearly all the hospitals, and shopkeeping at two thirds. 'Other' activities, which are listed at eleven hospitals, usually mean non-interactive chores like running errands and rolling bandages. All these potentially paid activities consume a large proportion of volunteer time at seven or more of the hospitals.

Therefore even though the coordinators are careful to stress that they do not threaten paid workers, it is also clear that they provide services to the hospital which would otherwise have to be paid for or foregone. A number of coordinators emphasized to us that they are really saving their hospitals thousands of dollars each year by providing volunteer services. Logically, the two issues are separable: the services provided save money but without threatening existing jobs. However, the reality of the situation at some hospitals seems to be that the coordinator is actually on the side of the administration against organized labor. Not all coordinators wish to be in that place, but it is our impression that most of them tend to see the unions as troublesome.

Furthermore, in a pinch, administrators would call on volunteers to be scabs, and to this we do not think most coordinators would object. The potential for conflict in this area is certainly present.

Conclusions and Implications

This study began with the postulation of a Volunteer Establishment, defined in terms of certain occupational roles. We proceeded to explore the details of this 'Establishment' by studying one of its parts: hospital volunteer coordinators.

Certainly one conclusion we can draw here is that hospital coordinators do not have many links to members of the Establishment, aside from their own hospital peers. For models they look to the more conspicuously successful among themselves. For concrete help they rely mainly on the public constituencies who support their hospitals, not on volunteer placement agencies, with very few exceptions. Although some of them do have opinions about ACTION, most find it and other national volunteer-promotion organizations pretty much irrelevant to their work. The vigorous debates and speculations which are part of NCVA, or which one may find at conventions of the American Association of Directors of Volunteer Services, or the Association of Voluntary Action Scholars, concerning the meaning, philosophy and direction of voluntarism as a whole are conspicuously absent from the personal agendas of the bulk of the coordinators, except as these issues become salient through the hospital work experience itself.

Let us suppose for a moment that the same insularity was typical of other major institutional areas as well -- areas such as education, welfare, and mental health. If such were the case, then we would be dealing not so much with an 'Establishment' as with an occupational category stratified into two parts. One of these, the larger part, would be doing the work of coordinating volunteers in their everyday activities. The second part, more visible to the public, would be typified most by those who staff the organizations which deal at a secondary level with volunteers, organizations which in fact can abstract themselves more easily from the everyday requirements of specific volunteer situations, and deal instead with the general phenomenon of voluntarism.

There is no doubt that neither model -- the well-integrated 'Establishment' or the two-part occupational group -- represents the reality, which is somewhere between. Further study of the nature of the links within this structure ought to be worthwhile because in fact there is little known about the degree of penetration which the national organizations have upon attitudes and programs in the nation as a whole, the types and sources of resistance to national influence, or, to put the whole matter a different way, the sources of the various philosophies and practices which together make voluntarism what it is.

All this is suggested by way of a worthwhile topic for study. What I am certainly not suggesting here is that one or another volunteer approach is superior and that we need to figure out how to sell this approach to the heathen.

From a practical point of view, at any rate, one should not expect very rapid change among hospital volunteer coordinators. Given the network of associations which we have found and the pressures of hospital coordinators' jobs, the most effective source of training and innovation at this point would seem to be from within the ranks of the coordinators themselves. Certainly, training which suggested grandiose or startling innovations would be unacceptable for most hospital coordinators, because most hospitals would not be ready to accept them.

Finally, the question remains to what extent the present state of affairs is satisfactory. The answers will depend to some extent on the interests of the party who asks. Our study suggests that, from the patient's point of view, volunteers are both useful and wasted. If we assume that a patient gets the most benefit from direct contact with volunteers (and to judge from coordinators' comments, this is a fair assumption), then a good deal of volunteer time is wasted. Volunteers, as we have seen, are used in a variety of positions for which direct patient contact is not present or is routinized. Ideally, a hospital would pay to have these jobs done, leaving volunteers free to associate with patients on a primary level. However, there is an important exception: some volunteers are not able or willing to interact effectively with patients. To what extent does this factor account for the proportion of volunteer time spent away from patients? We would like to know, but we did not set out to examine the problem and have no data that bear on it.

From the point of view of hospital administrations, our data suggests that the volunteer services are running smoothly and satisfactorally. The length of tenure of our respondents tends to support this conclusion, as does the general tone of their responses. They are loyal and dedicated to their hospitals, in spite of any frictions or problems that may occur. The data, however, cannot fully support this view, because there are some hospitals in which volunteers services are present very little or at all. We made no attempt in this study to discover how many such hospitals there were or to explore their experiences with volunteers. Our data are also less than satisfactory because we did not interview the administrators themselves. It is possible that they would like to see better trained coordinators in some cases. Nonetheless we strongly suspect that, by and large, administrators are happy with the coordinators.

There is no way from these data of determining the adequacy of the coordinators from the point of view of the volunteers themselves. During the course of our visits to hospitals, we encountered volunteers and spoke with them briefly. They sometimes praised and sometimes condemned their coordinators. Because the coordinator's role involves a high degree of personal discretion at the level of interaction with volunteers, the personal qualities of the coordinator will be of tremendous importance in creating a satisfactory situation for the volunteer.

From the point of view of the coordinators themselves, we have the impression of general satisfaction with their jobs and relatively little felt need to pursue extra training or expand horizons beyond that which is already offered in the context of the hospital coordinator associations.

VOLUNTARISM AS AN ORGANIZATIONAL DEVELOPMENT PRIORITY: A CASE STUDY

Eva Schindler-Rainman and Ronald Lippitt
Hilltop Seminars, Los Angeles, California

In many communities, agencies, and organizations, one of the key determinants of productivity and quality of operation is the scope and effectiveness of releasing and utilizing volunteer time and energy. But very few managements have focused on this area of productivity as an O.D. ("Organizational Development") priority.

We are reporting here a case study of a national voluntary organization, the YMCA, which has become involved in the improvement of voluntarism as an intervention for stimulating organizational improvement.

Like many other national, state, and local organizations, the YMCA is concerned about maintaining a basic corps of direct service and policy making volunteers as collaborators with the professional program staff and administration.

Sensitive to the need to improve productivity in this area, the National Board in 1972 adopted a set of national goals which included the goal of "mobilizing and utilizing a far greater number of volunteers",..." within five years doubling the number of volunteers active in the YMCA".

Concern about achieving this goal was an important source of readiness to become involved in the activities which are reported below.

We believe the design, and learnings, and methods of this case example are very relevant and applicable to the functioning of many agencies, organizations and communities.

Evolvement of concern

There were many ways in which the organization became sensitized to action around its volunteers. These included the following events:

1. The Black and other non-white staff requested that the organization critically look at the number, kind and positions of its non-white volunteers.
2. A national youth-serving inter-agency consultation, suggested by the authors, was initiated by the YMCA. The original consultation of 17 agencies led to an on-going national inter-agency group that continues to meet. Collaboration on the training of volunteers has been one of their concerns.
3. The Research and Development Committee of the National YMCA sponsored the development, publication and dissemination of a new major resource, The Handbook for Training Volunteers. This was a direct outgrowth of a study "Issues of the 70's" which identified the lack of volunteer trainer and recruiter resources.
4. The National Board chairman wrote a letter in which he stated his concern about the high budget appropriations for support of expenses of participation by policy-making volunteers. Concern was also expressed about the amount of staff time spent to support these volunteers as contrasted to the efficiency and lower cost of direct staff service.

   The authors of this article responded to this letter with a rationale and plea for expanding, rather than constricting, voluntarism and for real thinking as to how this might be done and the positive consequences for the organization of better utilization of volunteer resources.
5. Increasing concern in the total society about better, more rewarding ways for volunteers to serve also influenced the YMCA. These included statements by volunteers themselves, and by the women's movement and some unions who worried about volunteers replacing paid workers.

Steps taken in light of these concerns

1. The Research and Development Committee held an evening seminar with the national Executive Director and some key board members to focus concerns and plan action.

2. A national retrieval and derivation seminar was decided upon to involve local, regional and national people and experiences.
3. Drs. Clifford Carey[1] and James Hardy[2] were asked to prepare a paper tracing the role of laymen-volunteers in the YMCA and analyzing volunteer-professional relationship patterns.
4. Drs. Ronald Lippitt and Eva Schindler-Rainman were requested to do a working paper reviewing present-future trends affecting voluntarism and the specific implications of these trends for the YMCA.
5. Dr. Helga Roth[3] was willing to review and analyze innovative approaches to volunteer work in light of the future trends -- with specific appropriateness for the YMCA.
6. The R & D Committee got commitment from the above named persons to do the working papers, and a recruitment plan for participants was developed to meet a variety of criteria.
7. The date for the seminar was set: January - 1975, 1:30 to 9:30 p.m. in New York City.

Design of the Seminar

Criteria for the invitation of national, regional, local and outside persons were developed. These included:

- That Regional Directors and their chairpersons come as a team.
- That R & D committee members would act as convenors and resource persons.
- That National Board persons represent men and women, a variety of groups, backgrounds, ages, and local as well as national involvements in the YMCA.
- That National Staff related to the National Board be invited.
- Some key persons outside the YMCA, leaders in the Volunteer World.
- That the group be kept to about 50 persons.

All persons were recruited via a personal letter from the staff and the chairperson of the R & D Committee. The timing was designed to coincide with the regular quarterly meeting of the R & D Committee so that the committee could take followup action.

The purposes of the Seminar were:

- to analyze the dynamics of voluntarism in the society - now and future.
- to derive implications for the YMCA from these trends.
- to look at the history of the YMCA to help with the understanding of where the YMCA has been and needs now to go.

Consultants for the seminar were an inside-outside team consisting of Drs. Carey and Hardy from the YMCA and Drs. Lippitt, Roth, and Schindler-Rainman. This team was responsible for designing all activities related to the seminar before, during and after.

There were three kinds of retrievals before the seminar. A historical paper on voluntarism in the YMCA was sent to all participants one month before the seminar. The present and future trends paper was developed and reproduced for use at the seminar and appropriate innovative volunteer practices were retrieved through the clearing house at NCVA. The design encouraged maximum participation during the day. The flow was as follows:

1. Welcome to participants seated at round tables of 8 persons each.
2. Opening session: Dialogue between national director and seminar consultants on the seminar's origin, purpose and hoped-for outcomes.
3. Highlights of the historical perspectives paper presented by the authors. The seminar group participated with questions, comments and additions.
4. Table group members then discussed, identified, and recorded on large sheets of paper current confrontations in relation to the YMCA as they saw them.
5. Confrontations were posted on the wall, read by everyone, and summarized in writing by one of the consultants.
6. Selected Images of the Future potentially affecting the YMCA were presented by the authors of this article. Copies were made available to each seminar participant. Therefore the authors gave only one image verbally. They asked table groups to each take one of the other 6 images, discuss it and add to the implications of each for the YMCA.
7. During the social and dinner break which followed, the seminar consultants read the implication reports and developed 4 interest groups for after dinner. These were: volunteer training, volunteers in program, inter-agency relationships, and board-staff relationships. Participants picked the group of their first choice. This meant that some topics had more than one work group.
8. Interest groups met and developed specific recommendations for action. One spokesperson for each group reported these out verbally to the larger group and on large sheets.
9. The total group then looked at the recommendations and called out their suggestions of how the recommendations for action should be implemented.
10. The Research and Development Committee met the next morning to begin work on the action recommendations. The ad hoc work was over and use of this work now required effort from an ongoing group in the organization.

The Voluntarism Seminar-Consultation: Content and Process

As a warmup for the seminar, all the participants received ahead of time the historical paper, "Perspective on Lay-Staff Relations and Voluntarism in the YMCA", by Drs. Cliff Carey and James Hardy, retrieving for the seminar the perspective on past policies and practices about staff-volunteer relationships and the utilization of volunteers by the YMCA.

Abstract of Retrieval of the Past

Organization began in London in 1844 and Boston in 1851 as a fellowship of laymen to provide spiritual leadership and needed services to young men in urban areas. There was no paid staff, only elected officers to conduct the affairs of the Association. All were members, and "town meetings" of members made decisions and conducted business.

As size of membership of local associations grew, a division of function and label among volunteers developed. "Laymen" were the members of committees and policy making boards, as contrasted to "members" who were participants in the program of activities. The headquarters of the Confederation of YMCA's, and its records, moved from place to place with the election of new officers.

The opening of rooms with libraries and social facilities required employed staff, called "secretaries", very subordinate to lay leadership.

Then the term "volunteer" emerged to denote unpaid persons providing direct services to "members" under the direction of "staff" guided by "layman" policy makers.

The different terms used to describe staff-lay relationships have been: employer-employee, amateur-professional, volunteer-paid, corporate board and manager, joint partnership.

From 1963 to 1973 the number of consumers of service increased 48% to 8 million men, women, youths and children. During this period the number of policy level laymen volunteers increased 32% to 367,220, while the number of direct service volunteers decreased 1% to 187,034, and the number of paid direct service staff increased 110% to 79,062.

Active lay volunteers have become more heterogeneous, there have been significant increases in the number of women, in racial minority leaders, and in youth under 25.

From this review we can discern 4 trends:

1. Increasing emphasis on more paid workers to provide more varied and more sophisticated services, with relative decrease in unpaid volunteers.
2. Increased emphasis on paid professionals to take on functions of "top management" and to take initiative in relationship to lay Boards of volunteers.
3. Great expansion of programs to serve a wider circle of constituents than young men -- e.g., families, couples, women, co-ed youth groups, retirees, urban neighborhoods, etc.
4. Recruiting of more heterogeneous groups of volunteers to provide policy-making and program leadership.

The seminar participants reviewed their reading of the paper with Drs. Carey and Hardy, probing with questions of clarification and adding interpretations of historical trends. This discussion moved the seminar ahead to the next diagnostic focus on the here-and-now of voluntarism in the organization.

Current Issues and Confrontations about Voluntarism

Drs. Carey and Hardy started the inventory of issues and problems by identifying 6 current issues of effectively utilizing volunteers:

1. Increasing impact of "big business" managerial models that tend to decrease the depth and breadth of involvement of volunteers in decision-making, planning and evaluation.
2. Increasing demand for technically competent paid staff work on complex problems and for rapid response to changes in the environment -- making involvement of laymen more difficult.
3. Increasing pressure on top lay leaders from the demands of their own occupational roles.
4. Outdated structures for doing work -- traditional agendas of "trivial" work, lack of use of ad hoc task forces, unclear functional relations between Boards, Executive Committees, and professional directors.
5. Less continuity of paid leadership (more cross-agency mobility) so more lay responsibility for continuity.
6. Increased complexity of program methods and quality of service demands increases hesitation and resistance of professionals to recruit and train volunteers.

The discussion of these issues stimulated the remaining participants to identify the following additional current issues/needs:

7. Provide growth-producing opportunities for volunteers.
8. Redefine role of volunteers in the Y -- provide more significant roles for volunteers.
9. Decrease emphasis on fund raising as main volunteer role.
10. Improve training for volunteers.
11. Develop total plan for utilization of volunteers.
12. Increase clarification of staff-volunteer role in decision-making.
13. Be aware of external pressures for program quality accountability.
14. Develop better forms of recognition of volunteers.

15. Develop more staff skill in utilizing volunteers.
16. Clarify that non-Christians can be Y volunteers.
17. Create volunteer talent banks.
18. There is a confrontation between those who really believe in voluntarism and those who push it only for economic reasons.
19. Competition between agencies for volunteers, need to collaborate.
20. Lack of priority given by local leadership to their goal of developing voluntarism.

As the participants shared their diagnoses of issues they also identified several trends of current experimentation to cope with some of these issues. The innovative efforts identified included:

1. Increased use of laymen with professional and technical training as consultants and special helpers.
2. Development of meetings of clusters of Associations where lay leaders can exchange know-how and get insights to strengthen their leadership.
3. Development of new materials for the training of volunteers to provide competent services.
4. Moves toward decentralization of decision-making with more involvement of volunteers.
5. Increased use of short term commitment ad hoc task forces, commissions and subcommittees.
6. Increased use of phone conferences and other communication technologies to involve busy laymen more fully.
7. Small beginnings of inservice training of professionals to work more effectively with and through volunteers.

The seminar was now ready to move from the perplexities of here-and-now problems to the freeing-up mindstretching of looking into the future -- assessing trends and projecting desired "images of potential" for the future of voluntarism in the organization.

Utilizing Images of the Future

Seven major future images affecting voluntarism in a post-industrial society were presented. They were:

1. Changes in value emphases and life styles: mobility and short term commitments; 2 family breadwinners; active, involved consumers of services; etc.
2. More emphases on humane human services in all people-helping areas: emphasis on development of individual human potential, guaranteed annual income; guaranteed regular health care, human service teams (professional, volunteer, and paraprofessional); etc.
3. Organizations and institutions reorganize to involve staff, volunteers and consumers in decision-making and problem-solving: flatter structures instead in hierarchial; more temporary groups; long range planning; etc.
4. Interdependence and collaboration between organizations, agencies and institutions flourishes at National, State, Regional and local levels: interagency human resources banks; collaborative use of agency buildings and camps; etc.
5. Greater priority is given to quality control and accountability of service delivery: semi-annual reviews of agency services by teams of staff, constituents, volunteers and outsiders; funding bodies require action research on quality of services; etc.
6. More volunteers are available---male, female, all ages, diverse religious, racial and ethnic backgrounds and life styles: new person-to-person recruitment methods; multi-media collaborative portable training; volunteer enabling funds (expense reimbursement).
7. More confrontation of voluntarism by many sectors of society: development of skillful negotiators; union members help make policy re volunteers; more demands by new volunteers to help make decisions; volunteers active in many new places and spaces.

Some of the derived implications of these images for the YMCA were:

1. There will need to be active recruitment of the older citizen and persons from all minority and majority groups.
2. New creative volunteer jobs need to be developed.
3. Renewal training is needed for staff to work with volunteers.
4. Decision making volunteers need to be more varied as to age, race, sex, background and length of experience.
5. Volunteers and staff need to participate in a variety of meetings together including staff meetings.
6. The YMCA needs to develop a Volunteer Human Resources Bank available to all Ys throughout the country (also available to other agencies).
7. Joint staff-volunteer evaluation and research teams need to do much of the needed YMCA research, etc.

Some Priority Ideas for Action

These action recommendations were made by seminar members at the end of the day. They fall into 4 categories.

1. Training
   - That there be developed a team training program for staff-volunteer teams to work as trainers and/or recruiters.

- That an overall new training program be developed for new and experienced staff in relation to working with volunteers.
- That the professional schools now training youth agency workers be contacted re including work with volunteers in their curricula.

2. Interagency relationships and collaboration
   - That there be a retrieval and dissemination of extant interagency collaboration practices.
   - That information be gathered re funding sources for collaborative activities.
3. Program
   - That volunteers be much more involved at all levels in program planning and delivery of services.
   - That an appropriate orientation and personal growth training plan be developed specifically for program volunteers.
4. Boards
   - That a task force be appointed to work on new guidelines for volunteer-staff relationships within the National Board, its related committees and the regional boards.
   - That another task force develop a policy statement on Voluntarism in the YMCA including these elements:
     - The belief in the nurturance of pluralism
     - The nurturance of voluntarism in all YMCA association programs and leadership
     - Relation to funding sources
     - The volunteer and staff resources of the organization

Post Seminar - Translation into Action

There is a multi-thrust plan for action derived from the R & D Committee review of the recommendations. There will be the following foci of efforts, with both staff and volunteers participating at every step.

1. Involvement of National Board.
   a. A mini experience at the March Board Meeting to briefly go through the seminar process.
   b. Recommendation that the Board appoint a task force on voluntarism beliefs, policies, guidelines.
2. Preparation and wide dissemination of the Seminar Report.
3. Development and design of materials on voluntarism, to be used at Regional Assembly and cluster meetings.
4. Asking the National Director of Training to make sure that all in-service professional training include a module on working with volunteers.
5. Asking the Training Committee to develop an overall new volunteer training plan and to disseminate examples of successful board training.

Ensuring Momentum and Continuity of Effort

The seminar-consultation was a limited event of an ad hoc group, convened because of its resources and representativeness of all sectors of the organization. But the seminar was convened by a continuing part of the organization, the Research and Development Committee appointed by the National Board. This unit, and the professional staff related to them, had a commitment to use the seminar, and the findings from it, as the source and legitimization of a continuing intervention effort toward organizational improvement through enhanced voluntarism. The transition from a consultation event to an implementation thrust occurred the day after when the R & D Committee and staff had on their agenda review of the recommendations of the seminar-consultation, development of committee plans and decisions about next steps of implementation, and assignment of responsibilities for action. A review of the success of these steps was put on the agenda for the next meeting, three months later, and a series of interim assignments were accepted to complete the seminar report, confer with the National Director, design a session at the National Board, adopt materials for regional and local workshops, etc.

Summary of Organizational Development Principles for Organizations Utilizing Volunteers

1. The formation and utilization of an inside-outside consultant team lends objectivity, perspective and built-in continuity to such an effort.
2. Multiple entry of an O.D. effort insures that many parts of the system are involved from the beginning and are more likely to continue to stay involved and involve others.
3. Multi-focal diagnosis -- past, present and future, makes all of these sources of data important in developing an action plan.
4. Development of criteria for who should be involved in the process and at what points in time is important for the success of the intervention.
5. Involvement of the relevant decision makers (staff and volunteers) in diagnosis, planning, recommending and implementing the plans spreads "ownership", personal investment and responsibility among the appropriate persons. It also decreases the dependence on consultants and technical experts.

6. Documentation of the process, for purposes of history, retrieval, evaluation and dissemination is crucial.
7. Preparation of materials and of persons participating is always necessary, though the methods for so doing may vary with the intervention.
8. Followup demonstration efforts should have a plan for ripple effects, so that the effort does not stand isolated and unconnected to the organization.
9. If ad hoc or temporary structures are used, it is helpful if they overlap with a continuing structure (e.g., the Seminar with the R & D Committee).

Using This Case Experience in Other Settings

In every community, school system, and in most public and private agencies, increasing the productivity of the involvement and utilization of volunteers is an important goal.

We believe the principles underlying and guiding the efforts reported here are applicable to this variety of situations.

This report, or the more complete report available from the YMCA, might serve as a stimulus to activate such a process in your organization.

The diagnostic review paper about the past might serve as a model for a similar trip into the past of voluntarism in your organization.

The full paper on the future (available in the seminar report) might be used as the basis for an "implications brainstorm" of your staff or board or a special group.

The design of the seminar and its flow of activities might serve as a model for you to adapt to your situation.

You might find some of the resources listed below under References to be helpful for your efforts to increase the quality of voluntarism and through it the strength and vitality of most human enterprises.

Footnotes:

1. Dr. C. Carey is former Director of Research, National Council of YMCA, now volunteer member of R & D Committee.
2. Dr. J. Hardy is Director of Organization-Development, National Council of YMCA.
3. Dr. H. Roth is director of the Clearinghouse of the National Center for Voluntary Action.

REFERENCES

Batchelder, Richard L.
1968 The 1970's and Beyond, Research and Development Series, YMCA.

Cleveland, Harlan
1973 "The Decision Makers". Center Magazine. The Center for the Study of Democratic Institutions, Santa Barbara, Calif., October.

Fox, Robert, Ronald Lippitt, and Eva Schindler-Rainman
1973 Towards a Humane Society - Images of Potentiality, NTL Learning Resources Corporation, Fairfax, Va.

The Futurist (something of interest in most issues) e.g.,
1974 "The World of 1974," Vol. 8, No. 3. June, 1974. World Future Society, P. O. Box 30369, Bethesda, Washington, D.C. 20014.

Hardy, James
1973 Corporate Planning for Non-Profit Organizations, Association Press.

Lippitt, Godon
1973 "Hospital Organization in the Post Industrial Society". Hospital Progress, St. Louis, Missouri, June.

Lippitt, Ronald and Eva Schindler-Rainman
1974 The Human Energy Crisis, Research and Development Division, National Council of YMCAs, New York.

Loeser, Herta
1974 Women, Work and Volunteering, Beacon Press, Boston.

Schindler-Rainman, Eva
1975 "Trends, Societal Forces Affecting School Volunteers", The School Volunteer, January-February.

Schindler-Rainman, Eva and Ron Lippitt
"Hope and Prospects in Adult Education: Working with People Whom We Forgot", Interpersonal Development, Vol. 4, No. 2, S. Karger, Basel, Switzerland.

Schindler-Rainman, Eva and Ron Lippitt
1973 The Volunteer Community: Creative Use of Human Resources. NTL Learning Resources Corp., Fairfax, Va., (see extensive bibliography).

Schindler-Rainman, Eva, Ronald Lippitt, Richard Olson and Irvine Millgate
1974 Developing Your Volunteer Community, a Multi-Media Package: XICOM, N. Y., or LRC, Fairfax, Va.

Vickery, Florence
"Creative Programming for Older Adults: A Leadership Guide", YMCA.

Voluntary Action Center Clearinghouse and Newsletter
(Dr. Helga Roth, NCVA, 1785 Mass. Ave. N.W., Washington, D.C. 20036)

YMCA (these items may be ordered from the YMCA, 291 Broadway, New York, N. Y., 10007)
#3106 Perspectives for Social Relevance in Long Range Planning.
#3151 YMCA Boards and Committees of Management in 1973.
#3152 Today's Changing YMCA Boards and Committees.
#3150 Training Volunteer Leaders, 1974.

Training Series:

#3502 Development of the Human Resources of the Organization.
#3504 Assessing Training Needs.
#3503 Conditions for Learning.
#3505 Designing Training.
#3506 Sensitivity Training.
#3106 Perspectives for Social Relevance in Long Range Planning.

MANAGING THE VOLUNTEER WORKER

Howard R. Smith
Professor of Management
University of Georgia

Managing the volunteer worker!

To begin with, I'll bet you can guess how awkward I feel telling a bunch of pro's like you how to run your business. And because I do feel awkward, let me begin with a few further words about my qualifications.

For example, I am a professor. And everyone knows what a professor is -- the guy who tells you how to solve problems he avoided by becoming a professor.

As a professor, moreover, I have behind me all of the resources of a great university. And let me tell you what that means! I expect you have wondered why there is so much knowledge in our colleges. It is because the freshmen always bring in a little -- and the seniors almost never take any away.

But then, very seriously, for some years now I have been working closely with Chamber of Commerce executives. And I have learned some things from them about volunteers in organizations that I will risk passing on to you.

For one, I really can understand why you need help -- being in such a "backward" business. No, maybe "backward" isn't the best way to say it; "upside-down" would get at it better. Out on a factory floor, they pay people money to come work. In your situation -- if people will come to work, you let them.

I know you probably get a little tired having that thrown up to you. Nevertheless, I do sometimes wonder if this "upside-downness" doesn't sometimes get in our way. More specifically, I suggest that the biggest mistake that can be made in dealing with volunteers is to assume that people who say they want to help really do.

Your Friendly Volunteer

I realize how strange that may sound when you say it fast. But let me tell you some of what I think I understand about this from Chamber of Commerce operations.

To be sure, my Chamber friends started out putting it the other way. "Very often," they said, "these people are your friends -- and of course you don't treat friends like you do other folks. And these people are also volunteers, and that is another big difference."

Well, sure enough, I wasn't going to quarrel with that -- at least not before I knew a lot more. So I said, "O.K., for openers, tell me how friends are different from other people in you kind of operation."

And they did! "You don't hassle your friends," they said, "and of course with friends you don't have to."

"Fine," I said, "I've got that; now tell me how volunteers are different from, say, shop-floor workers." And they did that, too! "Volunteers," they said, "are there because they want to be; workers are there because they have to be."

Of course there was one more thing I needed to know. So I asked, "Does that mean, then, that you don't have motivation/performance problems with these friends of yours who are also volunteers?" "Oh no," they said, "there are problems, alright. They're just different problems." And anxious to help me all they could, they went on to explain the difference. "You see," they said, "these people are also busy with their other lives and it is therefore often difficult for them to get at and stay with their volunteer work."

And there, I submit, you have it! That's exactly the trouble we have with factory workers -- who also often have more important things (to them) on their minds than the boss' business. Put a little differently, the factory worker doesn't do as well as would be appreciated because he doesn't want to badly enough; and that's frequently the problem with volunteers. Oh, sure, they do often have "better" excuses. But your work isn't getting done just the same.

Thus, because friends and volunteers, even when they are your workers, are people just like everybody else, you don't really start all that far ahead just because they volunteered.

Keep Some Of Them Far Away

And let's be very concrete about this. For example, the fact that people help because they want to quickly becomes a "little man who isn't there," as those who "are there because they want to be" too easily come to believe they should "do what, and when, they want to do."

And if you then hesitate to hassle a friend who must help you get out the work, you make it that much easier for him to take advantage of your friendship -- by, as only one possibility, "snowing" you with his "good excuses."

Yet there they are, holding down slots in your operation you can't put better people in as long as they are in them. And there you are -- "stuck."

The moral of this part of our story is almost obvious. If we can't take it for granted that people who say they want to be helpful really do, the first big job is careful recruiting. And as you well know, that is not as paradoxical as it might sound to others -- though it does say more about how "upside-down" this kind of operation is. For isn't it interesting that we must work to get more out of volunteers by keeping some of them as far away from our organizations as we can?

Now I know this runs afoul of one of the "magic" words of our day -- "participation." From all directions they are pushing at us the great virtue of "letting everybody help." But may I say to you, very confidentially because professors aren't supposed to say this, that that is not necessarily so. The fact is that "participation" is by no means all it promises; a square peg in a round hole, by any other name, is still a square peg in a round hole.

"Red-Eye Rule Number Five"

From recruiting, thinking naturally moves to rewarding -- for of course these two things are the other side of one another. Surely, too, nowhere is the volunteer business more "upside-down" than in the reward realm. And here also some of these relationships reach more deeply into the way we live together than is often supposed.

To begin with, we tend/want to think about volunteers as working for nothing -- or nearly so. But that is another mistake it is all too easy to make. Nobody knows better than managers of volunteers that they are not costless. The fact is they have come to you for something they want -- and if you are not doing much for them with money, it must follow that they are after something else. And suppose what they want and what you can give them do not come out even.

As a point of departure [illegible] saying more about this, let me give an illustration that I am sure will not sound foreign to your world.

I was once told that in Chamber of Commerce work one of the choice assignments was being Chairman of the Industrial Location Committee. The group telling me this then agreed that that was because this job carried with it highly desired rewards -- such as pictures in the papers, and going "out on the town" with visiting dignitaries. But, they were quick to add, there is no necessary connection between those who most want these rewards and those who will do well as Chairman of the Industrial Location Committee.

What we are first and foremost up against here, in other words, is "Red-Eye Rule of Motivation Number Five." We are all the time running into workers, indeed, sometimes having great difficulty steering clear of them, who want jobs but do not really want to do what they require -- who are more interested in receiving rewards (whatever it is they are after) than in earning them. And therewith our "Red-Eye Rule," which says that if people can get what they want without giving the performance we want in exchange, they are very likely to do that.

Now I wonder if some of you are beginning to bristle -- as I say things that are not quite "nice" about some of your volunteers. Of course I know that many of these people are dedicated, competent -- and eager to do exactly what, when, and how you want. I shall therefore not be disturbed if you bristle a bit -- for I also know you have problems with your volunteers because everyone has some.

Getting Along Without Money

And so -- let's move quickly past defensiveness and get to cases. Perhaps, moreover, that can best be done by looking closely at the problem of rewards -- and noting how much easier the factory boss' task is than yours.

To be sure, money does have limitations as a payment for work. But at the very least, it gives us two quite useful kinds of flexibility. On the one hand, what we give people can then pretty easily be increased or decreased -- depending on how well they do. On the other hand, we can in effect say to workers, "O.K. so we don't have just what you want -- but here's some money that will let you get for yourself the next best things on your list."

Without money, we have much less of both of these flexibilities. Where people find what they are looking for in intangibles in and around their jobs, very often we cannot increase or decrease these in response to better or poorer performance. Our people are then, to that extent, out of control.

Moreover, money as a "second-best" may be even more fundamental than this. We know, of course, that job enrichment is a widely acclaimed way of "buying" better help. Unfortunately, however, it has turned out that enriching many jobs is not easy. Failing in that, or at least until we succeed, it is really essential to have a money "second best" option. But where, as in our volunteer operations, job enrichment must succeed now "or else" -- this lack of flexibility can be painfully crippling.

The Preacher Has It Easier

Furthermore, speaking of job enrichment, there are some other complications which also cut across the siamese-twin difficulties of recruiting and rewarding. And these might best be looked at by noting how much better off than you ministers are.

After all, the church is also a "helping" organization. And most of the assistance the minister has available as he manages that helping work must come from volunteers. But if he does not get confused about some quite basic things, he has some real advantages.

Thus, as every minister quickly learns, people do their helping in their way -- and very often that means the easy way. Furthermore (and there really is little confusion about this among ministers), recognizing that giving of oneself is typically so much more costly to givers than giving money, most of his people much prefer to help by giving money rather than giving of themselves. Again, in the absence of all of the just-right job enrichment opportunities, a money "second-best" option can do a lot.

By the way, you can readily see where that puts the minister from the standpoint of the "magic" idea of "participation." Given the facts of life he must deal with, trying to get more help from more and more people at some point becomes turning his organization over to "friendly enemies."

And you can see, too, how much better off he is than you are. His success does not depend on his getting work out of all of his "volunteers." Because, in other words, he can be quite comfortable with members who want mostly to be left alone, one of his treasured assets in a sizable group around him who are content to pay their money and "leave the driving" to someone else.

But you, you're just like the shop-floor supervisor from this standpoint. With the people we're thinking about here, you -- like the factory boss -- usually don't have the option of deciding whether you will take their money or get help from them. Your success depends, as the minister's does not, on getting effective work out of as nearly as possible every member of your volunteer force if you run a volunteer program. And that is why a key dimension of that job probably has to be keeping many volunteers away from your organization. In short, participation really works only when it is a genuine two-way street -- when those who want to help and those who want help find each other. And note again here that the matter of whether those who say they want to help really do comes quickly to front and center.

The Blind Leading The Blind?

Now on occasion when I talk about some of these things, I get pointed backtalk. And so -- let's be sure what ground we are standing on as we move forward.

To be sure, this backtalk asserts, giving of oneself is more difficult than giving money. But people who come to us as volunteers are already one long step past that; they are ready to give of themselves as we want.

Now if any reader believes that, may I earnestly urge upon you second thoughts! Here again you are at a large disadvantage by comparison with the minister. And may I tell you a church-related story to illustrate.

The plates were being passed by the ushers -- gathering offerings, a significant fraction of which would go for missionary support. One parishioner, when offered a plate, whispered to the usher: "I never give to missions." The usher promptly whispered back: "Then please take something out of the plate, sir, it's for the heathen."

Precisely that is what you are often up against out in the world of managing volunteers. The helping organization must position itself to be helpful to the needy. It is then more uncomfortable than strange that many of those who offer themselves as helpers of the needy are themselves too much in need to be as helpful, as even they no doubt would prefer. This is not to suggest that the needy helping the needy is the same thing as the blind leading the blind. But there are parallels.

Refugees From Discipline

Two cases in point to illustrate. First, one of the key difficulties we have with our volunteers is the problem of disciplining. Not, of course, disciplining in any sense of punishing. But they do need to do what they do so it will help with what the organization is all about -- and that is a very important discipline.

Interestingly enough, however, many people who seek opportunities as volunteers are already refugees from discipline. Thus, they may be escaping from housework, the job of maintaining a home -- which can be, as we all well understand, quite disciplining. Or they may be refugees from "paid" employment, because the expectations of salary-paying employers are too demanding.

Is this not, in both of these instances, much like the blind leading the blind? For one of the things volunteers most need to be helpful, a willingness to be disciplined in the interest of being useful, is precisely what they often do not have. And observe how difficult this irony really is. Refugees from discipline often offer themselves as volunteers because they do not have one of the resources most needed in that work.

Our Deenriched Work World

There is another kind of situation in which the needy are in need of precisely what is not there for them. We do do a lot of thinking these days about job enrichment. Probably, too, people are doing much more deciding about their lives than ever before on the basis of quests for enrichment. In other words, they come into our organizations to escape deenrichment in other realms of their living. And what if they thus come to us wanting much more of something than is there for them?

When, for example, complaints are registered about too little job enrichment, we are already talking about some parts of your organization. Which is to say that even apart from the enrichment needs of volunteers, there is not enough enrichment for our "regulars." Furthermore, "regulars" are much better situated to scramble for the too-little enrichment that is already there than are volunteers. Partly on the basis of the skills required, but also in part on account of having more organizational leverage, paid people can ordinarily outmaneuver unpaid ones.

Please note that I am neither scolding nor complaining. The fact is that we live in a world in which people's feelings about the kind of work they would like to do is significantly out of balance with the kind of work that is out there to be done. And it is not at all surprising that the task of managing volunteers gets painfully caught up in that imbalance.

Love Is Not Enough

This circle of often-uncomfortable relationships can then be completed by two kinds of summary observations. Why do people say they want to help when that is really not quite so? And why do they try to team up with organizations that may not have very much of what they want?

Some things here are explained by the fact that people often do not understand very clearly what they do want -- and we may be living in a world which makes that an especially large problem. Moreover, the complexities of that world surely make it difficult to know what might be available to a volunteer "out there somewhere."

More crucial to these interactions, however, is a very hard fact of life. People say they want to be helpful when they really may not, because when the chips are down, it is the boss, the organization, that must define what "being helpful" means. And is that not, after all, another way of describing what we all think of as "do-gooders" -- people who earnestly, if naively, want to be useful in ways which likely will not be very useful! How often, in this connection, we remind ourselves of Goethe's turn of phrase: "The road to Hell is paved with good intentions" -- and of Theodor Reik's classic book Love Is Not Enough.

In short, it is easy enough to understand why a large gap could develop between what organizations need and what volunteers want to give them. (Remember the young Navy lad who wrote in his first letter to his mother after going to sea: "Dear Mom! One of the reasons I so wanted to get in the Navy was because in the pictures I saw the ships were always so clean and shiny. Now I know why that is.") And it is then no play on words to emphasize that when that gap gets quite wide, volunteer wishes really do move off toward taking rather than giving. And remember, that is what "Red-Eye Rule of Motivation Number Five" is all about -- people who are more interested in receiving rewards than earning them.

You, As A Con Artist

And now -- counting down toward a conclusion -- let me get much more positive about some things. What kind of business are you in from the standpoint of getting more out of volunteers? And I think I know exactly how that should be said. When you find out what the other fellow wants, you must "con" him into joining forces with you.

Now I know it would be easy for you to let the word "con" turn you off. But let's not let words get in our way.

What, after all, are the skills of the "con" man? There are two of these. He must get victims to see the future in a particular way; and victims must take on the contagion of his enthusiasm for that future.

Now, really, don't you do precisely the same thing?

Many people have a very limited capacity to see clearly what might be. But just as an antique dealer must be able to "see in the rough" how a piece of furniture will "finish out," so must you see clearly the future your efforts are pointing toward. Therefore you, just as the "con" man, are in the business of showing people a future they want to be a part of.

There are also people who, though they can see what might be, nevertheless cannot get up a head of steam behind it because success seems so doubtful. That is where enthusiasm comes in. Just as "con" victims must absorb

enthusiasm from the "con" artist, so must you give your volunteers a shot of yours. And by the way, that is the beautiful thing about enthusiasm; it grows when and only when it is shared, and the more it is shared the larger it becomes.

And so -- aren't you, quite literally, in the "con" business? Remember, leadership is defined as letting the other fellow have your way -- for his reasons. In this world in which everybody and his brother has to be more and more in the "volunteer" business, aren't we really in competition with one another to see who can do the better "con" job?

Of course I am teasing you a little about that. There is one difference -- though not, repeat not, in the skills that are needed. Whereas the "con" man is "selling" a future he knows will not happen, you are "selling" one that just might come to be -- if you get the help you need.

In short, what you are doing is manipulating perceptions. And you need have no fear of that word "manipulation." For the fact is that no work of man can be accomplished unless it is "seen" and believed before it is even begun. It follows that what you can achieve by "adjusting" the way people "see" things is perhaps limited only by your imagination. And that says that the key to what you can accomplish in this realm is creative thinking.

And two things more -- very briefly!

First, helping people move more surely toward the future they prefer turns out to be, in large part, helping them "find" their "better selves." Indeed, that is one of the principal joys of working with volunteers -- it is so often a "better self" that is trying to put in an appearance by way of a "helping"/volunteer activity. And isn't it interesting to reflect that, really, "finding" a "better self" is what job enrichment is mostly all about.

Second, I do suggest that you think of your "con" skills as a "secret" weapon. For most of us are funny folks. Though we want very much to be a part of a future we need others to help us see, we nevertheless often resent being "pushed"/"hard sold." Is that not a fancy "Catch-22?" We want to be "conned" as we work to realize our "better selves" -- but we don't want to "see" it happening.

THE MENTAL HEALTH VOLUNTEER

Armando R. Favazza
Associate Professor of Psychiatry
University of Missouri--Columbia

It is no great secret that state mental hospitals, with few exceptions, are not particularly pleasant places. Originally built as retreats where the mentally ill might recuperate, they frequently have become isolated and antiquated institutions of ill repute. Like prisons, they have cultural characteristics which may be antithetical to therapy and rehabilitation (cf. Giffman 1961). Indeed, "institutional neurosis" is a psychiatric term to indicate a type of pathology which may be superimposed on a patient's more basic psychopathology.

One of the great obstacles to recovery for a patient residing in a large mental hospital is the relative lack of contacts with "normal" individuals. The staff of mental hospitals are not "normal" because they have certain roles to fulfill and their interactions with patients are often quite different from the interactions of everday life that go on between people outside of the institution. Volunteers, because of their lack of professional training, have proven to be highly therapeutic in hospitals. Greenblatt has referred to the volunteer efforts of Harvard and Radcliff students in this regard as "an historic milestone." He noted that "College students popularized the challenge of working with the chronically ill, working with them not only in groups but individually in case aide arrangements and other personal relationships. They evolved innovations in rehabilitation such as the student-patient cooperative halfway house (Wellmet); developed conceptual frameworks for their so-called "friendship therapy"; and finally, proved that student attention could make patients well, even where long hospitalization and failure of previous staff efforts had sometimes labelled them as hopeless" (Evoalt 1967 pp. XI).

The state hospitals are gradually being phased out of existence, largely as a result of the community mental health movement. Community mental health centers serving limited areas have been established throughout the nation. These centers are best understood as a complex of programs within a community rather than as a complex of buildings (although financial grants for construction have usually been more liberal than staffing grants).

One of the great hopes for these centers has been that they would offer services to individuals who were often out of the mainstream of the existing system (e.g., the poor). One method which was devised to assist in this goal was the development of the paraprofessional concept. In practice, most paraprofessionals are potential consumers of community mental health services (e.g., the poor and the black) as well as consumers who have successfully utilized services and who are employed as service givers in an agency (e.g., ex-addicts). In the rush to develop the paraprofessional concept, the role of volunteers has frequently been neglected.

Psychiatry has been accused of being a middle class creation. Much of psychiatric theory was founded on observations of middle class patients; most psychiatrists come from middle and upper class patients. With this heritage it is apparent that psychiatrists might relate quite well with middle class volunteers. In my own experience this, indeed, has been the case. Just as mental health professionals have had problems with understanding and relating to patients from the lower socioeconomic classes, so too they may have some difficulty with "indigenous" paraprofessionals. I do not mean to imply that such relationships are always tumultuous or dissatisfying. It seems reasonable, however, that a mental health professional who is used to middle class conventions and methods of assessment might have difficulty in comprehending individuals with different orientations (and vice versa). It is my contention that, with the assistance of middle class volunteers, both paraprofessionals and professionals can work more effectively (cf. Favazza 1974).

Community mental health centers typically offer a wide variety of services with an emphasis on the prevention of hospitalization. The assistance offered frequently is in the realm of crisis intervention and environmental manipulation. Many of the clients also need the assistance of other agencies (such as welfare and legal aid) and in these cases the community mental health center "therapist" may act as the spokesman for a client.

It is my contention that when an indigenous paraprofessional works as a member of a team with a middle class volunteer, a client may be better served. The indigenous worker may possess skills in obtaining information and establishing a relationship with a client. The middle class volunteer may possess skills in relating to other agencies (which are almost always headed by middle class bureaucrats). An illustrative case is that of a poor client who was justifiably distraught because of difficulties over living accomodations in a municipal housing project. Her own attempts to resolve the conflicts had stirred the animosity of the lower eschelon housing staff. She went to a community mental health center and shared her plight with an understanding paraprofessional. The paraprofessional was unable to make any headway with the housing staff, who made it almost impossible for her to contact an upper level bureaucrat. The volunteer member of the team, the wife of a physician, was able to reach the bureaucrat successfully. The method she used was to contact a friend whose husband was a relatively high official in local government. Through this contact she spoke with the official very briefly on the telephone and he readily agreed that she should contact the bureaucrat. Needless to say, the bureaucrat was responsive when told that a higher ranking official had suggested he be apprised of the situation. A volunteer may at times be in a better position to raise some turmoil than a paraprofessional, because her livelihood cannot be jeopardized.

Clearly there are injustices in the systems which influence people's lives. Change may be affected through pressure. When the pressure is applied harshly, as through confrontation, a short term victory may eventuate into a long term loss. The middle class volunteer is not infrequently naive about social injustices because her life has not been obviously affected. Through her contact with paraprofessionals and with people in distress, she may come to appreciate the insidious as well as the blatant harmful effects of oppression and injustice. Armed with this education she may be in a position to act as a system change-agent (e.g., through personal contacts with influential persons in the community). I am not implying that every volunteer who is exposed to injustice should be expected to use what influence he or she possesses to champion a cause. I am saying, however, that the right person in the right situation may be in a position to make a real difference in how a system functions.

My strong personal belief in that a helping agency will function more effectively when it is the recipient of multiple inputs. For too long the major input has come only from the professional staff. With the rise of consumerism and paraprofessionalism, other major inputs have been heard. By enlisting the assistance of volunteers in a meaningful way, a significant input offering new perspectives and presenting wider ranges of options may enhance the effectiveness of an agency which is sometimes ineffectual, and may lend new hope to the resolution of seemingly hopeless situations.

REFERENCES

Ewalt, P. (editor)
1967 Mental Health Volunteers, C. Thomas, Springfield, Illinois.

Favazza, A.
1974 "Mental Health Paraprofessionals: Indigenous and Middle Class," Amer. J. Public Health 64:907-908.

Favazza, A., B. Favazza and P. Margolis
1970 Guide for Mental Health Workers, University of Michigan Press, Ann Arbor.

Goffman, E.
1961 Asylums: Essays in the Social Situation of Mental Patients and Other Inmates, Anchor Books, New York.

DECISION-MAKING AND VOLUNTARISM IN THE COMMUNITY: UNITED FUND AGENCIES IN TWO COMMUNITIES

William H. Gulley
Wake Forest University

THE PROBLEM

In one city a few years ago, the United Fund was asked for extra support by the Y.M.C.A. They had proceeded with plans to build a new "Y" to the point of accepting bids for construction. In the neighborhood, near the proposed site, there was an extremely active boy's club which served about 300 young men. It was a member agency of the Fund. The Fund declined the request by the Y. M. C. A. and also fought the new development.

A social worker discovered that one of her families on public welfare was receiving some additional services from two private agencies.

Public school teachers in a nearby city were instructed in a workshop in spotting children with hurtful emotional problems, but there was no machinery through which they could refer children for treatment or evaluation.

If you multiply this lack of communication and coordination by a hundred, it would approximate the situation in which many cities find themselves. There has been significant development of services, and departments of city planning have been created, but little or no efforts have been made to coordinate efforts.

Part of the problem might be explained in terms of rapid growth, or the increasingly complex and impersonal character of cities. At least part of it can be explained in terms of the necessity of cities to make use of volunteers and their agencies, and the absence of any means for communication and planning. Each agency pursues its own programs, and there is frequently no time or money left for developing channels of communication. There is also vested and personal interest at all levels.

SINCE WWII

There have been several developments in cities in the U. S. since WWII which have encouraged us to look at the problem, and at the same time provided some help. The first was the emergence and rapid development of city planning departments in cities. Planning, even in terms of land use, needs coordination. The second development was the wide spread acceptance of United Fund types of financing for private agencies. A third development was the trend in professional social work to create a specialty in, and establish programs of, community social work. In this specialty, the social worker is concerned with the planning, creating, and sustaining of community resources, rather than working directly with families and individuals. Federal programs such as Model Cities, E.S.R., etc. have played a role in bringing us to where we are. And finally, new problems but new thinking in terms of the boundaries of our communities.

ALTERNATIVES

Cities around the country have responded to the problems of lack of coordination, planning, and communication by forming agencies or committees. Some have been temporary or one-shot efforts. Others have been permanently established. A few of the more successful ones are in Fort Worth, Boston, and Richmond. Because of both tradition and formal necessity, it is almost impossible for a municipal government to provide the kind of coordination and planning which is needed. Even though many cities have large and effective city planning departments, they are not representative of the community, and are frequently restricted in the scope of their mandate, specifically dealing primarily with land use.

Increasingly, the modern complex community has to deal with organizations rather than

with people. These organizations are in the private sector, the industrial, business, religious, and voluntary organizations. Because of this, the way a community involves its volunteers has much to do with its effectiveness.

The goal of this paper is limited. It deals with the way communities involve their volunteers. More specifically, it deals with only the way communities involve volunteers and voluntary agencies associated with the United Fund. When the study of two communities was done, the present United Way was the United Fund. It happens, not necessarily by chance, that in the case of the two communities selected for analysis, the United Fund seemed to play a key role.

TWO CASE HISTORIES

These two case histories are presented to highlight a few of the issues and problems related to the way a community involves its voluntary agencies. The real names are not used to protect the communities, or individuals who might be identifiable through their offices. One community does look much better than the other. They are compared at points. The facts occasionally speak so loud that analysis in not necessary but will be done at the end. The first community looked at, Newtown, differs in some basic ways from Oldtown. The selection was made not to bias the case but to reveal the issues.

NEWTOWN

Newtown was formed through legal incorporation of two smaller communities in 1913, both of which were old towns. It is called Newtown only because it is new relative to the other case. By the turn of the century, the community had become an industrial one. It was the center of a hustling tobacco industry. Between WWI and WWII, the knitting industry also grew. After WWII, there was expanding industrial and commercial growth. At that time it was the most rapidly expanding city in the state. It could be characterized as a rather typical, middle size, Southern, industrial/commercial non-union community. There was, and is, a small power elite who both managed and constituted the upper class. The mass of the population were working class and "hangers ons" until quite recently. The middle class is still emerging.

Two important additions were made in Newtown following the Korean War. A well established college moved its entire operation to the community to join two other colleges already there. The second addition was the arrival of a large electronics firm, with both research and production plants. At the same time, major highways enabled the growth of an extensive trucking industry. These developments, plus an ever-expanding commercial/industrial scene contributed to the gradual growth of the "new" middle class.

The civic center in Newtown is in the central business district and contains both city and county offices, since the city is the county seat. The Federal offices are also found in the central business district. The business and commercial centers are adjacent to the civic center. The county and city governments are separate; however, the larger Newtown community extends well beyond the city limits in the typical arrangement of contemporary cities.

The 1963 population, when this community was first studied, was 117,000 for the city and 204,000 for the entire county. Of this number, approximately 30 percent were remote from, and independent from larger Newtown. This left about 143,000 who were a part of the Newtown community. By 1973, the community had grown to include 174,000 persons. More will be said about the definition of the community later in the paper.[1]

The United Fund in 1963 was active, and still very much in the traditional Community Chest pattern. It had 40 agency members, and responded directly to their interests and needs. It was year of transition. In 1962, The Citizens Planning Council of Newtown County was incorporated, with a professional director, and secretary. Its first annual budget was $45,000 which came from the Newtown Foundation (a private foundation), the Public Health Service, and contributions from 23 businesses or industries. In addition, both the county and the city gave a small donation. Sixty-three percent of this amount came from the private business/industrial donations. In the first year of operation, only $28,000 was used. The Citizens Planning Council was requested by the U. G. F. to review agency programs and to make recommendations; in short to become the advisory body to the Fund.[2]

The Citizens Planning Council Board consisted of eighteen members, one of them being the person employed to serve as executive director of the Council. The membership of the Board was what Floyd Hunter referred to as "the front men," and came from the industries and businesses supporting the effort.[3] This board remained with the Council almost completely intact until the Council was phased out in 1969, still operating on an annual budget of less than $45,000.

In 1968, the Urban Coalition was formed. It was facilitated by the mayor, who was a member of the Citizens Planning Council Board, and also president of one of the larger operating corporations in the community. The Urban Coalition was formed from the momentum

generated by E.S.R., C.E.P., and the mayor's Committees on Housing, Employment, and School Dropouts. A young and dynamic man was asked to move from directing the local E.S.R. to head the Urban Coalition. At the same time, the Model Cities Program and several progressive smaller community programs were making significant strides in meeting some of the needs of the poor blacks and youth population.

In 1969, the Urban Coalition, a quasi-public organization with membership reviewed by the mayor, took over the function of advising the United Fund. This was accomplished by combining the Citizens Planning Council with the newly formed Urban Coalition, to form the Citizens Coalition. The director of the Citizens Planning Council retired, and the director of the Urban Coalition resigned. The Citizens Coalition was headed by a younger person, brought in to do the job. The mayor was to serve as president of the new organization. Several other more "active" leaders of organizations resigned, and several small but effective programs were phased out.

By 1972, the time of ferment and change had cooled, and apparently a new structure had been molded. A new mayor had been elected in 1970, and the old mayor continued to serve as President of the Citizens Coalition. By this time, the city had experienced a significant loss in progressive leadership. It was experiencing the loss in membership and commitment to the United Fund. In both the years 1972 and 1973, the Fund was not able to make its annual budget, and received funding from what was referred to as a local foundation. The agency membership had dropped from an all-time high of over 40 to a low of 32. Though the number of agencies had dropped, the budget, and thus the goal, maintained a steady level, being $173,000 in 1973.

In addition to noting that the Fund was relying to an extent on foundation help, of more importance was its reliance on local business and industry. The old coalition of "front men" were still in these businesses, and employees were expected to contribute. As a result, the Fund was able to maintain its budget level, even with the loss of member agencies. The director of the Fund resigned in 1973, but a new director has not been employed as of September 1974.

The second community aspect which might be noted is that the agency base, and consequently the community base, for the Fund had been reduced.

OLDTOWN

Oldtown was incorporated many years before the Civil War, and for many years was the largest community in its state. It was the seat of the state government, and had the good fortune of having an old and well established economic base. The base, since the turn of the century, had been quite broad, with both industry and commerce well represented. Further, the presence of a Federal Reserve Bank had been a long-standing benefit to the community.

The state in which it is located has a system whereby cities are independent governmental units within the county, as opposed to Newtown where the city is part of the county. Oldtown metropolitan community reaches out into three adjacent counties. There were approximately 65,000 people who were residents of these counties and employed in the central city in the 1973 census.

The community has an old and well established middle class, which is very large and influential. The upper class is larger proportionately than Newtown, and is also influential. The proportion of dependent population, in the 1973 census, though slightly smaller than Newtown, had a higher economic base. The Oldtown community could be characterized as a large, old, Southern, metropolitan, commercial/industrial, semi-union community. By semi-union, it is meant that there is more extensive union organization, and it is not fought by management to the extent found in Newtown.

It is an educational center, like Newtown, with a major university, and a smaller university. It has four smaller institutions of higher education. It has evidenced a sustained growth pattern since WWII.

The civic center in Oldtown is adjacent to the central business district. The civic center has deliberately been brought together from other spots scattered in and around the central business district. The civic center contains city offices, and an extensive development of Federal Offices.

The population of the Oldtown S.M.S.A. in 1963 was 460,000. The actual population areas served by the U.G.F. and the Community Council contained 399,000 persons. By 1973, the population served had grown to 480,000. In this larger community, as with Newtown, a proportion of the total population of 549,000 was remote and socially independent from the Oldtown community.

Oldtown had a well established Community Chest/United Fund organization over the years. It was larger than that in Newtown, and felt the need for an advisory agency several years prior to the 1962 move in Newtown. By 1963, the Oldtown Community Council had been formed. The United Fund, as in Oldtown, was primarily concerned with the collection and disbursement of funds. In both cases, advisory bodies were formed with the explicit understanding that these organizations would advise in terms of planning and thus in terms of needs in the community.

In 1963, the Oldtown Area Community Council

had an agency representation of 128 community agencies. Each member agency had one professional and one volunteer member representative on the Council. Since the Council was an advisory body to the United Fund, it could have participants from both the private and public sector, and it did.

The Council was an agency member of the U. G. F. and thus had reciprocal representation. It was funded through the Fund. Its budget in 1963 was $65,000, and in 1973 had increased to $98,000. It should be noted that a part of the 1973 budget was used to maintain the Volunteer Service Bureau with a full time director and secretary. This had been an independent agency which needed the support, and which in many communities was brought into, or started by, community planning agencies.

The goals, and thus the budgets, of the U.G.F. were high in Oldtown due to the large number of member agencies and a local tradition of community-wide support. The 1973 budget was approximately $4,500,000. A relatively large proportion of giving was from the public at large as opposed to large blocks of "expected" giving within the corporate structures. This is to say that in both communities funds were sought through the institutional structures. This is seemingly the only practical way in contemporary urban society.

A last minute report published by the Oldtown Community Council was sent to the author. It is noted here, because of its implications. The report was completed in the Spring of 1974. It recommended a significant reorganization in line with the new United Way concept. Two points; the Volunteer Service Bureau would become the Voluntary Action Center, and operate indepentely of the Council and as a member agency of the Fund and Council. The total organization nexus would conform to new expectations in terms of the United Way, with the U.G.F. maintained as a strictly fund raising agency. The arrangement is geared toward taking advantage of revenue sharing as it develops in importance for local communities.

ANALYSIS OF THE TWO COMMUNITIES

The two communities, considered alone or in comparison, suggest many dimensions of concern and interest in terms of volunteer involvement. In the following analysis, they are looked at from the perspective of contemporary views in urban community sociology. It is impossible to separate these several facets which will be discussed below, as they are within each community part of one interrelated system. At the same time, looking at the "parts" seems to help to understand the whole. The format will be to label and treat each dimension separately.

THE ECOLOGY OF THE TWO COMMUNITIES

Both communities are a part of a larger SMSA. Both have maintained a steady growth rate relative to other SMSAs. Both rank fairly close to each other in the nation. This is deceiving, so first we will look at the metropolitan patterns.

Newtown SMSA had a population of 604,000 in the 1970 census, and ranked 56th in the nation. Oldtown had a population of 518,000 at the same time, and ranked 65th in the nation. As a SMSA, Newtown is larger than Oldtown. The census definition of a SMSA imposes a set of criteria. Each of these communities fall within their respective areas in terms of these criteria.

Newtown is in a SMSA which is composed of three counties. Each county has a sizable city which is the county seat, and the leading city in their respective counties. They are the economic, political, and social centers. None of the counties with their cities would qualify as an SMSA alone.

Because of the peculiarities of state governments, Newtown is a real and functional legal part of the county. The three cities operate independently of each other, each being the central city of what is commonly called an urban community. They are each central cities, dominating a suburban area and the surrounding rural-urban fringe. Each city has an evidenced ambition to "out-grow" the others. They are also in the position of having formal obligations to serve their respective counties. The only formal relationship between them is a loosely organized and poorly supported Triad Council of Governments.

The Triad Council, already unable to develop significant triad programs, finds itself in competition with an eleven county body, known as the Northwest Development Association. The three counties are a part of this association, and it is the agency responsible for piping Federal funds into the area from the Regional Development Act. The relative strength and influence of the Development Assn. further weakens the influence of the Triad Council.

Each city and county in the Triad finds itself in a competitive relationship. All three have separate Boards of County Commissioners and City Boards of Aldermen. Both governing groups have tradition, competition, and vested interest which tends to distract the communities from cooperative efforts. At the same time, each of the three communities is caught up in the urbanization process, and locked in struggles of jurisdiction, responsibility, and local competition. Consolidation is seen as "far off," and annexation is fought bitterly.

The conclusion for the Newtown community is that the technical identification as part of a SMSA has little if any practical meaning. It is a well defined modern urban community, confined within its county.

Oldtown is located at the juncture of three counties. According to the census, the city and the three counties compose a SMSA with a 1970 census of 518,000 persons. The city as a political unit is independent of the three counties. As in the case of Newtown, the SMSA and the functional Oldtown community are not exactly the same. They do come closer to composing a community than in the case of Newtown. The metropolitan character of the SMSA is much more pronounced, and the influence of the central city is much more pervasive. There are no other cities within the SMSA to compete with.

While about 30% of the population of the county in the case of Newtown is considered independent of the city, only 20% is so considered in the Oldtown situation. Of this 20%, almost exactly two thirds is located in one county, which is a large, sprawling county, with a large portion still rural farm land. The Southern portion of one of the other two is under the influence of an adjacent SMSA. The third is completely dominated by the city. This pattern follows what has become a truism in urban ecology; the larger the central city, the more extensive its influence.

While there is "competition" between political units within the Oldtown community, it is of a very different sort. Each of the units does maintain its political integrity. There is only one city involved. The competition reflects a more prevalent pattern. The population of the central city is moving out into all three counties, leaving the city with a relatively less well off population and continued, if not heightened, public responsibilities. When problems arise, such as integration of the schools, services, utilities, etc., they have to be negotiated between four politically independent units.

PROBLEMS RELATED TO FINANCE

The U.G.F. is a community wide program. This is true because the actual areas served are well defined and extensive, and because the suburban population consider themselves part of the larger metropolitan community. One might deduce that one reason for the relative success of the Fund lies in the necessity to have some kind of a mechanism which cuts accross political boundaries. This is at least partly true. When this need, accomplished at some level, is coupled with the tradition and strength of the Fund programs, it explains a great deal.

In all fairness, when one considers the relative size of the two communities in this study, and the relative per capita income, one might expect some difference between their respective abilities to solicit funds. A statistic which helps to clarify the picture might be the ratio of population served to the amount raised, or the per capita giving. This figure in 1973 was almost exactly $1.00 per person for Newtown, and $9.40 for Oldtown. It is doubtful if this amount of difference could be explained only in terms of size and per capita income. Additional explanations might lie in the broad and expanding community agency involvement in Oldtown as opposed to the narrow and declining involvement in Newtown. The Oldtown Community Council and the Fund represent almost five times as many agencies as are represented in Newtown. The budget for research and planning through the Oldtown Council, a member agency of the Fund, is two thirds that of the entire budget for the Fund in Newtown.

The "locals" in Newtown place the blame on poor economic times.[4] They also cite the fact that a few agencies, nationally and locally, have pulled out of the Fund since they felt they could do better with independent fund raising drives. In a check on this, it was learned that only two, and possibly three agencies have withdrawn for that reason. The reason cited by agency representatives is that they felt that they were not getting their share of the funds, but further, their negative feelings were heightened by the fact that the Fund itself did not make the decisions directly, but on the advise of another agency. They realized that their agencies were not represented in the decision-making process.

The picture in Newtown is further clarified by the attitude of the Fund, and the Coalition. They saw the complaining agencies as "trouble makers" and since they did not have a large budget to raise, they could raise it without the discontented agencies. The chairman of the Coalition saw the broadening of the base of decision-making and planning as seeing "our planning work fragmented."

One final point before moving to a different focus. In considering size and per capita giving, it should be noted that the middle class is not only smaller in Newtown, but it is "newer." Many of Newtown's middle class are really new, coming from the poor and working class. The locals in this category feel a strong sense of debt and loyalty to the local upper class. Others in the new middle class are new in the sense that they have come to the community from other places and are not "in."

In contrast, Oldtown has a much broader base of population to tap in their campaigns for funds. There is a more extensive middle class. They are proportionately more old middle class. They occupy positions both within the institutional structures and the voluntary associations. Perhaps of more importance, they are the people who set in the Council and vote on the distribution of funds to the member agencies of U.G.F. They are not the front men for a highly centralized

elite, and they are much more likely to be professionals directly involved with the programs of the agencies. They know, in a positive and direct way, that local business and political interests did not "put them there."

When Oldtown was ready to move toward a broad base of decision-making, they created a Community Council with representation from the Fund agencies, and other public and private sources. This not only allowed the members to vote on the allocation of Fund money, indirectly, but also involved them in a community wide perspective which was quite healthy. The word "indirectly" in the preceeding sentence was inserted, because the U.G.F. is the final deciding body, but is consistently faithful to the guidance of the Council.

SOME POLITICAL QUESTIONS

From the beginning of the human ecology "school" in sociology just prior to WWII, a continuing interest has been both in observing communities extend beyond city boundaries, and establishing sound methods to locate the "true" boundaries of a community. Because of the nature of this paper, no effort is made to document those developments. Suffice it to say that it has become truistic that the political boundaries of a city never coincide with the true boundaries of the community. Further, procedures to locate the true boundaries have been refined to the point that such efforts are highly reliable.

In both of the cases under consideration, there are the problems surrounding the relationships between county and city political units. It is ironical that in the case of Oldtown, where the units are clearly separated legally, there is less resistance to cooperative efforts. There is formally established liaison between the city and the three counties surrounding it. The very overlap in Newtown, the city being within the part of the county, seems to contribute to disputes of jurisdiction and responsibility. There is continuing bickering and conflict between the County Commissioners and the Board of Aldermen. An example would be the question of which should be responsible for one of the community's hospitals. It is within the county, but it is also within the city limits.

This situation should be objectively viewed against the general pattern of contemporary urban growth. At the present time, almost exactly two thirds of our entire urban population is located outside of the central cities. These people work in the city, and are dependent on it in almost every dimension of their lives. They do not vote in the city, nor do they pay taxes. Though there is some "people level" resistance to annexation, because of the thought of higher taxes, these people still want all the services that go with being in the city. The counties, in these cases at least, are not capable at this time of providing the public services at a reasonable level. As a result, the suburban population is generally supportive of annexation, while the county units generally oppose annexation.

One rather common solution other than annexation has been for county and city governments to work out selective service agreements such as water/sewage, street maintenance, garbage collection, etc. It is the private sector which has generally pushed for these, and other more extensive cooperative arrangements. What is becoming increasingly clear is that community interest is overcoming political interest.

THE PUBLIC AND PRIVATE SECTORS

Politicians and persons in public office are key decision-makers in both communities. The private sector does have influence. In a particular way, we can get at our interest in terms of volunteerism by looking at this division. The private sector can exercise its influence in two broad ways. It can have "representatives" in the public offices. You can think of this as "the National Bank's man on the Board of Aldermen." This works two ways, as you can have "the Board's man at the National Bank." Putting value judgements aside, this is a most common pattern, and does work in terms of liaison and communication.

The second general means, operating apart from the political and economic institutions, is the voluntary agency sector. There are voluntary associations with quite specific representation functions such as the Chamber of Commerce or the Better Business Bureau. Something that deToqueville wrote about in the early 19th century and which we tend to forget is that the political parties are in fact voluntary agencies. They work to get people into the formal positions of government. The political parties are subject to both the voting and non-voting public at large, and to the manipulation of political affairs on the part of the economic interest. Since the voluntary associations do play such an important role in the contemporary urban community, they vary in effectiveness according to the way they are involved in the decision-making process.

In Newtown, there are more voluntary agencies of various sorts outside of the U.G.F. than there are in it. Recognizing that we are dealing with only a portion of the agency picture is important. The agencies within the Fund see membership as an advantage

because of both the funding they receive and because there is some liaison with the political and economic structure through the Citizens Coalition.

The boards of directors of the Fund agencies evidence a heavy overlapping of membership. The people are mostly from the higher level of management in the industrial/commercial world. They are also in positions of power in the political parties. More recently, there have been some interesting exceptions to this pattern, but the extent of it does not enable any change in the decision-making process. A local younger man started, and got support for, a fair housing association. He was subsequently invited into the system. A militant Black lady, very aggressive in personality, came out of the Model Cities committee structure to serve on several boards and committees. The over-all picture is one of highly centralized control through the institutional offices, the political party organizations, and the volunteer sector. When one combines this with the fact that even the agencies within the Fund do not have representation, professional or volunteer, in the decision making process, one can understand better why some things do not get done, and why the public is apathetic to the Fund.

It should be noted that in the past five years in Newtown, five key agencies have brought in progressive younger men who proceeded to feel pressured and leave, or were summarily discharged. This includes both agencies within and outside of the United Fund. The dilemma is that if the agencies take initiative, they lose support, and if they are benign, they survive. As a result, private interests most frequently wins out over community interest. It would be practically impossible to establish an alternative arrangement to the Fund, and there has been no one to publicly propose such a move.

Occasionally, crises are precipitated by the leaving of a person, or a situation developing within the community. When this happens, a professional from outside the community is brought in to do a study. The funds expended in the ten year period under observation have been horrendous. The studies are filed, or the results condones the status quo. This situation is apparently related to a real reluctance to involve the professionals in the community. They are screened carefully at employment, but watched carefully in their local careers. The failure to involve the professionals in the agencies, and in the institutional structures, as professionals, has been a costly thing. The additional disadvantage is that in the long pull, the more creative professionals move on.

The way the Fund is managed, the relationship between the public and private sector and the Fund, is not the cause of failure in Newtown, but reflective of the presence of a conservative power structure.

The position of the Fund in Oldtown is quite different. The Community Council is a member of the Fund, and vice versa. The president of the Fund sits in on the Executive Committee of the Community Council. The Council members are members of the voluntary agencies operating in the community. By policy, each agency is required to have one professional, and one volunteer representative to the Council. These people not only vote on planning issues, but on recommendations to the Fund on the allocation of funds for their agency budgets.

Since the members of the Council are chosen by the agencies, this at least reduces the possibility of direct political appointments. Of far greater importance, it is a means to insure the involvement of professionals in the decision-making process. At the same time, it does allow both the public and the political interests to be represented through board members.

The latent consequences of this arrangement have been beneficial. The professionals are able to contribute much to the planning process, thus reducing expenses for having studies done. Many Council members have expressed the notion that it is like getting extra, and free, professional guidance. There is a regular means for communications between agencies in the council proceedings. Further, the professional and volunteer members are exposed to the broader spectrum of community agency work, getting an opportunity to see the function of their respective agencies in the community context.

One of the unique and useful arrangements has to do with the involvement of public agencies, such as the Oldtown Department of Recreation. In the case of public agencies, by policy each is represented by two professional workers, since they do not have boards. The Council has even gone beyond this to ensure a wide community involvement. Individuals who do not represent a particular agency, but who are active in community affairs, may be voted into membership by the Council.

Some final benefit might be derived from looking at the stated goals of the Council as they appear in the Certificate of Incorporation.

1. To serve as a continuing conference of community agencies.
2. To further cooperation.
3. To facilitate coordination.
4. To improve levels of effectiveness in the endeavors of the agencies.
5. To formulate more extensive plans for the community welfare.
6. To provide a facility for the mediation of conflict.
7. To accept and distribute bequests and endowments for community welfare.
8. To improve the economy of planning and coordinating.

CONCLUSION

The human ecology view of a community enables us to see the many common patterns which are characteristic of contemporary urban communities. This in turn tends to spotlight the variations in how particular communities respond to the challenges of growth and change. The view reenforces what used to be considered an idealistic stance; this is just one big community, and we are all dependent on one another. This is now a functional reality.

All urban communities are to some degree concerned about the problems of boundaries. They are all concerned about the relationships between the public, the private, and the volunteer sectors. Some sustained and representative means to include the volunteer sector is a must in all of these communities. The United Way move on the part of the Fund, and those outside of it, allows broader organizational choice for local units. This move is sensitive to the prospect of revenue sharing, which might be the wave and the hope of the future.

Footnotes:

1. These figures are obtained from estimates made by the Planning Board of the community.
2. Annual Report: Citizens Planning Council, 1967.
3. Hunter, Floyd, Community Power Structure. Doubleday, 1963. p. 34.
4. An useful analysis can be made of local situations using Robt. K. Merton's local - cosmopolitan typology.

FLEXIBILITY AND STRUCTURE IN A VOLUNTEER CASE AIDE PROGRAM

Margaret F. Goldberg
Boston State Hospital

The Program

The Case Aide Program at the Boston State Hospital, Boston, Massachusetts, has been in existence since 1963 when it was funded for a three year demonstration project by the Permanent Charities Fund.[1] In 1967 a Manpower and Training Grant from NIMH was awarded and in 1970, the Program became permanently financed by the State.

In the past ten years, the Volunteer Case Aide has offered "community citizens an opportunity to develop a one-to-one relationship with a mentally ill and/or emotionally disturbed patient who has been referred by the hospital or one of its mental health centers. The volunteer is asked to give four hours per week, for one year (an academic year for students.) He visits with his assigned patient and participates in a group meeting with other volunteers under the direction of an experienced, trained supervisor. The program is staffed by professional psychiatric social workers" (Evans et al. 1973).

The Program is structured, yet increasingly flexible, due to the changing times, different motivations and a broadening of ideas and goals. Structure and flexibility are especially evident in the selection of volunteers, patients and site of work.

Selection of Volunteers

Our volunteers come from all walks of life and they range in age from seventeen to eighty-four. The average age of the volunteers is 33.5 years and the median age is 25. Of the total volunteer population of 118 people, 66% are women and 34% are men. At present, 40% of our volunteers are students, 34% are employed and 26% are at home.

In the selection of volunteers we depend upon the intuitive and learned skills of our interviewers rather than utilizing a checklist of requirements. The philosophy behind this approach is that, taken at face value, an individual coming in to volunteer can be encouraged to bring his own talents and style to the patient and group, thereby demonstrating the freshness of his original, creative point of view.

With few exceptions, most people are accepted as volunteers because usually a person's desire to be of service can be utilized effectively. In view of the permissive attitudes displayed in the acceptance of applicants, a strong effort is made to match a volunteer to a particular patient, taking into consideration the outstanding strengths, weaknesses and needs of both. The matching process has proved to be an effective and necessary technique, and has demanded a skilled use of interviewing and diagnostic insights by the interviewing supervisor. Our efforts to match a specific patient with what appears to be an appropriate volunteer seem productive. For instance, a shrewd, manipulative, defensive young female patient is given a warm, vital volunteer who feels comfortable in setting limits. Because we feel cultural and racial elements play an important role in maintaining relationships, we would try to assign, for example, a black male volunteer to a black male patient. If a black volunteer were not available, a white male would be more suitable from the patient's point of view, than a female of any color. A further illustration of this principle is an actual situation we encountered some time ago when a young, white male was assigned as a volunteer to an older Chinese man. The relationship between the two men never really developed and the volunteer was always keenly aware of a language and cultural gap.

Patient Referrals

Referrals from the units and services throughout the hospital and all its expanding out-

reach services form the pool from which we select patients. We accept patients regardless of their age, sex, race or severity of illness. It is also common practice to go directly to a ward staff member and request help in finding a patient for a new case aide. As a result of our open policy of accepting all referrals, we see geriatric, alcoholic and adolescent patients and those from the hospital's out-patient clinics, home-care and co-operative apartment services, as well as patients from the chronic and acute wards.

Many of our recent patient referrals are acutely disturbed, deprived young people, from the age of fifteen and up, with severe family, social and drug problems. At present, our volunteers are seeing 126 patients.

Community Groups

Our newest venture is in the formation of community case aide church groups serving catchment area people on secondary and tertiary preventive bases (cf. Caplan 1964,Chaps. 4 and 5). Secondary prevention involves early diagnosis followed by effective treatment, as well as alteration of the factors which led to the problem. Secondary prevention also includes primary prevention which tries to counteract damaging circumstances before they have the opportunity to produce illness. Tertiary prevention takes into consideration primary and secondary prevention and focuses on the rehabilitation of the individual with an emotional or mental problem, and his relationship with the community.

We are making strong, renewed efforts at establishing working relationships with members of the black community in the areas served by the hospital. We now have on our volunteer associate leader staff a young black man who is so concerned over the poor rapport between blacks and whites that he has committed himself to bring in black volunteers from the community to work with patients here and to help bridge the gap. As we stated earlier, we feel that it is much easier for a black patient to relate to a black volunteer. The potentials in this kind of a program are both exciting and far reaching.

Aftercare and Follow-up

According to our aftercare policy, when a patient is discharged from the hospital into a nursing home, a co-op apartment, or into the community, it is understood from the beginning that the case aide will follow him, whenever possible, into the new surroundings. A new and troubling problem is the decision as to whether volunteers should visit their patients in communities which have had an upsurge in the incidence of violence. We meet this on an individual basis and are often able to arrange for the volunteer and patient to meet in a selected, less hazardous environment.

Timing

Timing is an essential element in the use and training of volunteers. Traditionally, we have had a minimum requirement for volunteers of commitment to at least one year's service to the program. This expectation is basic to our structure. Volunteers tend to come and go quickly in many programs, but not so here, because right from the beginning we clarify with each volunteer what his commitment to the mentally ill person means to him. However, we have been flexible in certain areas. Since a little over one-third of our volunteer population has been composed of college students, varying in age from 18 to 25, our requirement for some students was modified to encompass their academic year, if, for example, they planned to leave the city at the close of school. We came to realize that a sincere, meaningful relationship of a somewhat shorter duration would indeed be productive and helpful for many patients. This has worked out well. When the student, or any volunteer, leaves, every effort is made to find another volunteer for his patient so that there may be a continuity of the caring relationship.

As a further example of flexibility of the time expectation, an outgrowth of the above-mentioned student experience is shown in the expansion of our program to include those volunteers who are only able to give time during the three to four summer months. In special instances, we hope to develop a service encompassing the six-week college summer semester. We are finding that this briefer involvement also can be invaluable for some patients. For example, what is felt by the patient who is about to move from the hospital into the community and who needs help in getting used to the daily routine of shopping, riding the bus, looking for a job, and just having someone with whom to talk things over? He can be benefitted enormously by a warm, short-term, helping relationship, as well as the regular relationship of a longer duration. Also gaining from this kind of a shortened relationship, among others, are the patients who have terminated with their case aides, either temporarily for the summer or permanently, and who need the continuity of a relationship to tide them over until the return of the original case aide or arrival of a new long-term volunteer.

Supervision

The structure of our program involves the assignment of each volunteer to a supervisor

and a group. Weekly supervision is under the direction of trained and experienced psychiatric social workers and is an inherent part of our program. Supervision, both group and individual, is an ongoing process.

"Our volunteers, after an initial naiveté and subsequent disillusionment with the limitations of professional knowledge and technical skill, have come to a realistic engagement with severe mental illness and have demonstrated dedication and persistence in grappling with the problems. Our people have accrued experience of over a year of working with patients, during which time they learn many things. They learn, for instance, what is pathology in the patients they work with, and what is health (or strengths) that can be fostered. They learn to cope with paranoia, withdrawal and zero motivation---and do not lose their humanity in the process. They learn also what a complicated sociological microcosm the mental hospital is, and they learn how to deal with it, including when to fight it, and when to realize that it is City Hall. Along with this, they also come to know and understand various echelons and individuals on the hospital staff, and to develop an effective, if at times turbulent, modus vivendi" (Progress Report 1965).

"Another tremendously important function, at which Case Aide Volunteers become adept with the help of supervision, is that of tapping community resources on behalf of their patients. These volunteers are people who have extensive roots in the community, and they use them to provide nourishment for the patients whom they rightly feel have been radically pruned from the community garden.

"In addition to his efforts on behalf of his patient, the Case Aide Volunteer inevitably profits, through supervision, from the process of having to examine himself or herself in the context of a group of peers, all engaged in a common effort to help others. The increase in insight and the ability to work with others in a group setting is notable in our volunteers. As a result of all of these experiences, we have seen previously directionless altruistic impulses crystallize into a firm and serious intent to work more effectively with others. This may have been through acquiring professional training or taking advantage of some of the new avenues for meaningful service created by our expanding Case Aide Program" (Goldberg et al. 1973, p. 59).

A flexible, innovative outgrowth of the program, was to offer training to a group of selected volunteers, thereby creating a new category of worker, the Associate Leader. The rationale of this new type of leader, taking into consideration the principle of accountability, is that "the volunteer, as a non-professional, but experienced and sophisticated worker, is capable of supervising case aide volunteers in their work with patients. Associate Leaders in the Program are trained by professional psychiatric social workers. The Associate Leaders are an enrichment to the program and are a big step in helping to alleviate the manpower shortages.

Every now and then we encounter the problem of the volunteer who continues to see his patient but, for one reason or another, resists coming in for supervision. If the patient is on the ward, this situation can be stopped by not permitting the volunteer to enter the ward. If the patient is in the community, it is usually not possible to exercise this type of control and one must decide whether or not steps can be, or need be, taken. An example of our flexibility in these situations is a student volunteer who formed a close, personal relationship with a patient, now back in the community, working and going to college. The patient expressed her feelings toward her volunteer in a long, touching poem, a small portion of which says:

"When leaves fell and flowers went to sleep, You came to me.
On a September day one year ago, a friendship was born.
Your gladness abated the pain that was all around and your smile warmed the October breezes that
Soon swept over us .....
You knew my inner thoughts and shared secrets
That only good friends understand ....."

This was an atypical relationship in that it developed into a true friendship. Because of these feelings, the volunteer was reluctant to discuss her relationship with "her friend" in the group or in detail with the supervisor. Therefore, supervision was purposely rather permissive.

When the volunteer has been with the Case Aide Program for several years (some have been with us for ten years, since the program's inception), we find that he may or may not continue attending supervisory meetings. We can be quite flexible in this regard as there is a good deal of variety in the needs of long time volunteers. Some of the volunteers seem to gain satisfaction and security from attending the group meetings, year after year. Coming to group has become an important routine for them and the group relationships and interaction appear to meet various needs they have, in addition to those of supervision. Other long time volunteers are "too busy" to come, but they keep in touch by telephone or pop into the office every now and then. One gentleman who has been with the program and the same patient for nine years, rarely contacts his supervisor in a regular fashion, but invariably does when a crisis occurs or he feels the need of help.

Membership in each group has a consistent nucleus but new members are always welcome, sought after and absorbed into the groups. We presently have sixteen groups, each containing four to fifteen members.

Staff Expectations of Volunteers

We expect a lot from our volunteers. We expect them to be productive, supportive, and helpful; and we believe it is their responsibility to be here. We feel that they will grow and develop within themselves, to varying degrees, and they do. We have confidence in them and boundless faith in what they can and do achieve. The staff perceives that the volunteer case aide has an important role to play in relation to the patient, the community, the hospital staff and the Program.

The volunteer is given status in the Case Aide Program, regardless of his age, education or employment. He is treated as a unique person and a strong effort is made by staff to fit his special qualities into the structure as expeditiously as possible. We find that there is an individualistic, maternalistic or paternalistic atmosphere in the program, a backing up of the volunteer by the supervisor. The volunteer is made to feel that someone in a supervisory capacity is always available if needed, either in person or by telephone, in the hospital or at home.

Program Philosophy

An important part of our philosophy is that the case aide, an unpaid person who is coming to visit the patient because he wants to have this relationship, is definitely not a staff member. The patient is very much aware of the difference and responds to it favorably. Countless patients ask, "You mean you are coming to see me every week and you are not getting paid?" For example: an older female patient on the ward has established a relationship with her young volunteer. She has been able to tell her volunteer on several occasions how much she likes her and that her weekly visits mean a great deal to her. At this point, the patient is talking to her volunteer about the possibility of being discharged from the hospital. She has demonstrated her feeling for the case aide by confiding in her, giving her an affectionate hug and a squeeze of the hand upon leaving. While the patient has maintained friendly relations with the ward staff, she has been much more restrained in her show of affection. Her actions clearly indicate that her feelings toward the volunteer and staff are quite different. With the Case Aide's help, she is coming down strongly on the side of health!

We believe that the volunteer case aide relationship is special and that the patient can, to varying degrees, identify with the volunteer as a role model. On the other hand, the volunteer gains an understanding of the strengths and pathology of the patient, and through flexible but constant supervision becomes more effective in utilizing himself as a therapeutic agent.

SUMMARY

In summary, the Case Aide Program at the Boston State Hospital, Boston, Massachusetts, is a structured but flexible unit, with a defined clarity of purpose. It utilizes a wide variety of volunteers from the community who work with catchment area patients (chronic and acute, in and out) on a one-to-one basis. The goals of the volunteer are both therapeutic and preventive. The usual minimum time commitment is a year, but in some cases, shorter periods are acceptable.

Weekly group meetings and some individual supervision, under the direction of trained and experienced psychiatric social workers, are inherent to the structure of the program. Supervision is supportive and educational for the volunteers, and fulfills the case aide staff's responsibility to the patient, the hospital staff, and the community.

Patient referrals are from the units and services throughout the hospital, including all its expanding outreach services.

We see the volunteer case aide as a valuable mental health worker who is relieving the manpower shortage and fulfilling a vital need in the field of human services.

Footnote:

1. Proposal to the Permanent Charity Fund, Boston, Mass., August, 1963, developed through the efforts of Dr. Milton Greenblatt, formerly Superintendent of Boston State Hospital and formerly Commissioner of Mental Health in the Commonwealth of Massachusetts; Mrs. Maida H. Solomon, Professor Emeritus of Social Economy, Simmons College School of Social Work and Consultant in Psychiatric Social Work Research at Boston State Hospital; and Dr. Victor A. Gelineau, then Co-Director of the Wellmet Half-Way House Studies.

References

Boston State Hospital Case Aide Program
1965 Progress Report to Committee of the Permanent Charity Fund, March.

Caplan, Gerald
1964 Principles of Preventive Psychiatry, Basic Books, Inc.

Evans, Anne S., Katharine H. Cole, Margaret F. Goldberg, and Maida H. Solomon
1973 Statement of Policy, Boston State Hospital Volunteer Case Aide Program. December.

Goldberg, Margaret F., Anne S. Evans, and Katharine H. Cole
1973 The Utilization and Training of Volunteers in a Psychiatric Setting, British Journal of Social Work, Vol. 3, No. 1, April.

THE VOLUNTEER CASE AIDE PROGRAM: AN ADVENTURE IN COMMUNITY OUTREACH

Anne S. Evans
Boston State Hospital

In the past year, the Boston State Hospital Volunteer Case Aide Program has become increasingly involved in a new departure from that of its traditional hospital based services. Since its inception in 1963, "the Volunteer Case Aide Program has offered community citizens an opportunity to develop a one-to-one relationship with a mentally ill and/or emotionally disturbed patient who has been referred by the Hospital or one of its Mental Health Centers. The volunteer is asked to give four hours per week, for one year (an academic year for students). He visits with his assigned patient and participates in a group meeting with other volunteers under the direction of an experienced, trained supervisor" (Goldberg 1975). Administration and supervision of the overall program are the responsibilities of trained and experienced psychiatric social workers.

The program has developed and implemented a community outreach plan in the hospital's catchment areas. It utilizes the services and resources of several different groups of people as suppliers of volunteers to consumers of volunteer services. The following describes the background, philosophy and implications of three community based groups:

Group A: The Jewish Family & Children's Service (J.F.C.S.) Agency Program (Boston)

In July, 1973, the Director of the Case Aide Program received a telephone call from a former Case Aide Volunteer, who, since graduating from the Simmons College School of Social Work, had found employment at a large family-service agency. In discussion with her casework supervisor, the subject of her prior volunteer experience with Case Aide came up. The program aroused the curiosity of the supervisor to the point of suggesting that we three meet to discuss in greater detail the philosophy and structure of the Boston State Hospital Volunteer Case Aide Program.

As a result of our meeting, the supervisor discussed with the women's committee of the Jewish Family & Children's Service the possibility of developing a Case Aide Program within the Agency. The plan which eventuated was the following:

1. Volunteers from the Women's Committee would be asked to join in a pioneer program.
2. Clients served would be those in the J.F.C.S. caseload from the Walk-Hill District Office.
3. Supervision of the Volunteers would be given by a member of the Associate Leader Staff of the Boston State Hospital Volunteer Case Aide Program.

As a result, a flyer was sent out by the President of the Women's Committee to the board members of that organization. A meeting was held with the board members, the Supervisor of the agency, an Associate Leader of the Case Aide Program and the Case Aide Director. Three women (2 from the Board and 1 non-board member) initially decided to join in our effort to introduce the Case Aide Model into the community. Since its inception in October, several other volunteers have been added to the group.

Selection of clients has come primarily from the caseload of the Walk-Hill Branch of the Agency. The rationale in choosing cases primarily from this particular district was to offer case aide volunteer services to those JFCS clients residing in the Boston State Hospital catchment area, thereby justifying the Associate Leader's supervisory time spent away from the hospital. Referrals have come from other districts, as well, however, since the caseload of the Walk Hill Branch Office has shifted with the population shift of the area. Many predominately Jewish Agencies have moved their bases of operations in order to be closer to the population they

serve. We,therefore, have included clients from other communities that the Jewish Family & Children's Service Agency serve.

While in the negotiation period, we assumed that we would be offering services to clients primarily in the area of "secondary prevention" (cf. Caplan 1964, Chaps. 4 and 5). The supervisory and administrative staffs of both agencies discussed some of the clientele which came to the J.F.C.S. for services. It soon became apparent that we were really dealing with some acute situations where active planning and treatment would be required.

One situation included a middle aged Jewish lady who had a congenital leg problem. As a child she was pampered by guilt ridden parents with the expectation the she would be cared for by the family throughout her life. The original reason for referral (made by the client's married sister) to the agency was a need for housekeeping services for the client and her aged father, after the mother's death. It soon became apparent to the caseworker, however, that the family has considerable work to do to deal with the emotional problems of grief and loss of their mother who was the pivotal person in the family, as well as working through the anger felt towards the "useless" 53 year old sister.

After a long term relationship with the caseworker, it was felt that the client would greatly benefit from the relationship that a case aide volunteer could offer. This woman needed another adult woman, outside of the family trauma, who could befriend her and offer her support. As a result, perhaps the client could begin to learn and hopefully enjoy making herself useful around the house, making simple meals, swapping recipes, shopping for clothes, etc.

While the agency caseworker still maintains contact with the client's father and sister, the introduction of a case aide volunteer into the situation has been of considerable help to the client and has taken some of the "sting" out of the existing situation within the family constellation.

As already alluded to, supervision of this group of volunteers has been given weekly by a skilled Associate Leader of the Boston State Hospital Volunteer Case Aide Program. The supervisor herself, initially a volunteer in the hospital-based program for several years, went on into the Associate Leader Supervisory Training Program and ran a group of novice Case Aide Volunteers for two years (cf. Goldberg et al, 1973). After this experience, the leader continued to develop her skills in the out-patient department of the hospital as a member of a screening and evaluation team. She was an excellent choice to supervise the new community based program, utilizing the model upon which the hospital program is built (i.e., weekly group supervision with the requirement that each volunteer make a year's commitment to the program and submit an individual weekly written report of her activity with the assigned client). The supervisor is also responsible for individual supervision when advisable. In this specific instance,the Associate Leader supervisor discusses the relationship between the volunteer and the specific agency caseworker and is administratively responsible to the J.F.C.S. supervisor-coordinator of the program as well as to the Director of the Case Aide Program.

What are the implications of this new program? The responses from the agency and the Boston State Hospital Volunteer Case Aide Program have been enthusiastic and encouraging. There appears to be more interchange and less mistrust among the casework staff of Jewish Family & Children's Service Agency and Case Aide Program. The J.F.C.S. volunteers are most enthusiastic about the greater degree of responsibility and sharing amongst themselves, the agency caseworkers and supervisors. The supervision given is excellent and well received. The agency sees that volunteers can be very effective partners of the professional casework staff.

The traditional case aide model developed at the Boston State Hospital in 1963 has been integrated well into the structure of a family agency in 1973. The model, which provides for group supervision, offers the volunteer the opportunity of becoming familiar and knowledgeable with a variety of client-volunteer relationships. Group supervision, in turn, enables the volunteer to command a greater knowledge and expertise in handling a variety of human needs.

Furthermore, the volunteers of the J.F.C.S. have been able to develop a unique working relationship with members of the agency's case work staff, who are the referring agents of clientele served by the volunteer. As a result of her own intervention, the volunteer is learning something about the clarification of her role and the role of the social caseworker. What is becoming clearer is that the volunteer offers herself as a role model, an expeditor, an ombudsman, a support and an enabler, in behalf of her client.

Group B: St. Theresa's Church (West Roxbury)
The inception and development of a church-sponsored Community Case Aide Program came about in a different way from the Jewish Family & Children's Service Agency, previously reported. A considerable part of the Assistant Catholic Chaplain's responsibility at the hospital has been to develop community based case aide programs, recruiting volunteers and, once again, utilizing the case aide model as a means of providing a structure to the program. His training as a Jesuit Priest and experience, both as a teacher and as a supervisor in the Clinical Pastoral Education

Program at Boston State Hospital and at the Case Aide Program, enabled him to relate to both clergy and laity in a very positive and dynamic manner. As the catchment area is a heavily Catholic one, it was quite appropriate to try to interest the clergy and their parishioners in our community efforts.

We explained our program to a number of priests and ministers in the area. Several expressed varying degrees of interest in our proposal of engaging their parishioners as volunteers. One priest, whom we approached, is currently supervising a deacon assigned to his parish for the academic year. As a part of his commitment to his deacon, he is currently matriculating in the St. John's deacon supervisory training program, which the Chaplain and Case Aide Director supervise. The parish priest offered to discuss the program with a group of parishioners and nuns. As a result of his interest and the enthusiasm of his parishioners (some of whom, as it turned out, already were involved in other community-based mental health programs), a group of 15 women, including housewives, secretaries, lay-teachers, nuns, etc., met in January, 1974, with the parish priest, the assistant chaplain and the social worker, Director of Case Aide Program. The chaplain brought to their attention the issue of Christian commitment to their neighbor in need. The social worker discussed the success of a 10 year old hospital-based program, utilizing volunteers in individual relationships with the mentally ill. Together, the team articulated the needs of the socially and/or emotionally disenfranchised members of the community who need the concerned, supportive relationship that volunteers could offer.

At that initial meeting, four women offered to engage in the new parish-based community out-reach Case Aide Program. Several others expressed a desire to participate in the weekly supervisory meetings without a specially assigned client. While these interested people had other commitments to families, jobs or school, they offered to do public relations for the program. Since that January meeting, several new men and women have been recruited into the program by these very able public relations people. We also spoke to a group of 250 women in the parish Sodality, in March. This promotional effort gained four or five more volunteers for our ranks. As of this writing, we now have 12 men and women engaged in the group. There is a good possibility that another case aide group will be formed in this parish.

Referrals of clients to the church group have come from several sources. The primary referral agent has been the West-Ros Park Out-Patient Clinic, which has referred a number of "clinic patients" to the Case Aide Program.

One such referral is a 47 year old woman, whose husband is an alcoholic. The couple has three teen-aged children who are experiencing varying degrees of difficulty in school or jobs. The woman was seen for several months and treated for her depression with psychotherapy and medication. Referral to case aide was made as the clinic staff felt that a long-term relationship would be most supportive and beneficial to this isolated and lonely woman. The volunteer could relate to the woman as a friend. They could "compare notes" on a variety of topics such as child rearing and shopping; in other words, the volunteer could relate herself through the mutual roles of wife and mother as well as being a friend to the client.

Another referral is that of a 26 year old young man who is a single child. As a youngster the boy was very withdrawn, had no friends, and his parents over-indulged his every whim, this being their only child. As the child became more isolated and autistic, he was shuttled from one psychiatric clinic to another, finally being placed under the care of the Adolescent Service of the Boston State Hospital for many months. While he was very intelligent, having passed the high school equivalency program with flying colors, his hostility and belligerence towards his parents and peers kept potentially meaningful relationships at a distance. While he was in the hospital, the Adolescent Service, and upon his discharge, the West-Ros Park Clinic as well as the young man's father, all made direct appeals to the Case Aide Program for volunteer intervention. For two years, no volunteer assignment could be made as no man was available to see the patient at his home at the times he had free from work; no one, that is, until a vigorous 70 year old man in the church group volunteered. While he has only met with "his young friend" two or three times, the rapport that has been established is truly unbelievable. Each takes turns in going to the other's home. Common interests in the relationship include swapping stories of baseball and sports personalities. The volunteer has lent "his friend" a copy of The Jimmy Piersall Story with the idea that Piersall's biography offers a great deal of hope to those beleaguered by mental illness. Thus far the relationship has been most exciting and gratifying to the patient, his volunteer, his peers in the group, and especially to the supervisors and parish priest.

In other instances, the priest who has acted as the coordinator of the Case Aide Program in his parish has suggested people whom he feels could profit from the intensive and extended individual relationship that the program offers. His awareness of some of his parishioners' needs has come out of his monthly communion calls to homes of the elderly or infirm who are unable to come to church. He has become increasingly aware of several isolated people in the parish who could benefit from the relationship that our volunteers offer.

While the group has only recently begun, there are some interesting implications which have captured our attention. In our initial discussions with the parishioners and in a question period that followed our presentation to the Ladies' Sodality, it became increasingly clear that there was tremendous anxiety on the part of the audience about "mental health." The parish community tended to view "mental health" issues in terms of mental illness. We tried to make it clear that we were asking people to join in a community effort and were not asking people to come into the hospital Case Aide Program. There were several people who were traumatized by the prospect of having to relate to a "crazy person - running around loose."

One question asked was to describe the client referrals in terms of their psychiatric diagnoses. In this instance, it seemed appropriate to respond with discussion of life crises, the traumas of normal life such as birth, child-rearing, marriage, death of a loved one, as customary problems that we all, in one way or another, experience during our life time. Additionally, we suggested that often an extended hand and listening ear can make an enormous difference to people in times of stress....that many serious emotional illnesses might be prevented if someone cares. The issue of isolation and loneliness as destructive forces in our fragmented society was stressed. The significant issue in this instance was to alleviate the audience's anxiety about mental illness by focusing on life situations rather than diagnostic categories.

Another significant by-product of this particular community based program has been the general curiosity and interest aroused in other community mental health programs. Several groups in the West-Ros Park Catchment Area have asked for meetings to discuss the focus and rationale for our "out-reach" programs. In one instance we have been approached by a representative of a Housing Project for the Elderly, to come and speak to some of their "club members" with the aim of recruiting a group of senior citizens as volunteers to relate to their socially isolated peers.

Group C: St. Patrick's Church Program (Roxbury)

A third group with which the Program has most recently become involved is located at St. Patrick's Church in Roxbury. The Church serves a tri-cultural neighborhood of the inner-city, its population made up of blacks, Spanish speaking Portuguese, and whites. It is one of the most economically and socially deprived neighborhoods in the city. We were told by the priest that the highest incidence of fires is in this area, and by way of a further half-hearted joke, he indicated that the neighborhood was so bad that the police had moved out of the station across the street several months ago. The neighborhood is a very transient one; for many families it is their first place of residence upon arrival to this country. As soon as they become economically able, they move.

As a result of the chaplain and social worker supervising priests at St. John's Seminary in Brighton, the priest from St. Patrick's inquired as to our availability and interest in supervising a group at his church. We learned that 18 nuns connected with the parish school and 3 parish priests had undertaken an effort in "making themselves known to their parishioners." After a recent parish census, the clergy decided to divide the census up into streets and each assigned him/herself the task of developing an on-going relationship with 8 to 10 families.

In this particular instance, recruiting volunteers and selecting "cases" was already accomplished. The group of religious professionals were "set to go" -- each of them having a clientele already assigned. The chaplain and social worker were asked to supervise the group in terms of thinking about issues of relationship building, establishing a climate for trust, appropriate goals in the relationship, etc. The most immediate concern of the group has been developing ways of "getting in the front door."

As of this writing, we have met with the whole group twice. We are planning to meet for 1 1/2 hours once every three weeks, rather than the weekly supervisory model already described for other groups. We see our role more as supervisors-consultants, that is, meeting less frequently with this group, and, as a result, having less responsibility in working through individual relationships. More importantly perhaps, we will be dealing in the area of "primary prevention." It will be most interesting to see how this new exciting departure for the Case Aide Program develops.

Summary

In the past year, the Boston State Hospital Volunteer Case Aide Program has become increasingly involved in a new departure from that of its traditional hospital-based services. The program has developed and implemented a community outreach plan in the hospital's catchment areas. It utilizes the services and resources of several different groups of people as suppliers of volunteers to consumers of volunteer services.

Three different groups have been formed:

1. The Jewish Family and Children's Service, which utilizes volunteers from the agency's Women's Committee and is referred cases by the agency's social service staff.

2. The St. Theresa's Church Community Case Aide Program, which recruits volunteers from the parish and is referred cases from both the catchment area out-patient clinic and the parish priest.
3. The St. Patrick's Program which utilizes nuns in the parish school and priests in the parish in an effort to make themselves known and available to the parishioners they serve.

We have found that the Volunteer Case Aide model developed at the Boston State Hospital in 1963 has been replicated, transplanted and integrated into various community settings today. The model which provides for group supervision offers the volunteer the opportunity of becoming familiar and knowledgeable with a variety of client-volunteer relationships. Group supervision, in turn, enables the volunteer to command a greater knowledge and expertise in handling a variety of human needs.

Further, we have found that interpretation to the community of mental health needs should focus on life situations rather than diagnostic categories. The focus on health rather than pathology alleviates a great deal of anxiety on the part of the public.

Our model of supervision has been expanded to include consultation to an already formed group, with a new emphasis on primary prevention.

Interest has been aroused in other community programs resulting in invitations to speak to potentially interested groups. The small ripple made in three settings has begun to make waves in the larger community!

REFERENCES

Caplan, Gerald
1964 Principles of Preventive Psychiatry, Basic Books, Inc.

Goldberg, Margaret, Evans, Anne S., & Cole, Katharine
1973 "The Utilization and Training of Volunteers in a Psychiatric Setting," British Journal of Social Work (April), 3,1., pp. 55-63.

Goldberg, Margaret F.
1975 "Flexibility and Structure in a Volunteer Case Aide Program," Volunteer Administration, VIII, no. 3-4.