VOLUNTEER ADMINISTRATION

Volume V Number I

MARCH 1971

8094

VOLUNTEER ADMINISTRATION

A quarterly journal devoted to the promotion of research, theory, and creative programming of volunteer services.

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SUBSCRIPTIONS: Subscriptions are $6.00 per year. Checks should be made payable to VOLUNTEER ADMINISTRATION.

Published in cooperation with the Center for Continuing Education, Northeastern University, Boston, Massachusetts.

ADVERTISING SPACE available. Write the Editor for further information.
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Volume V Number 1 March 25, 1971

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EDITORIAL NOTE

This issue is devoted to papers presented at the 10th Annual Meeting of the American Association of Volunteer Service Coordinators, held in Philadelphia, Pennsylvania, September 1970. We dedicate them to the memory of James H. Parke, former Director of the Veterans Administration Voluntary Service.

"JAMES H. PARKE, C. V. C."
Keynote Address

by
SIDNEY ZWEIG, C. V. C.
Director, Voluntary Service
Veteran's Administration Hospital
Montrose, New York

I hope you will all understand my hesitation, my reticence at this moment, because I never dreamed that I would be talking to you in this keynote role. I have in my hand the biography of James H. Parke, Director of the Veterans Administration Voluntary Service. I was to have introduced Jim, my boss, my personal friend, with whom I had been so closely associated for nearly a quarter of a century. Jim Parke was to have been your keynote speaker today.

Jim Parke was suddenly taken from us just two short weeks ago. If I do anything at all today by way of inculcating something of the nature of what it has meant to me to be a Director—a Coordinator—of Volunteers, I must reflect the spirit, the philosophy, the knowledge and understanding which Jim instilled in everything I have stood for in this profession.

I came to the VA in 1946, the same year that Jim had laid the groundwork, the foundation, the formula for the VA Voluntary Service, which today, in 166 VA Hospitals throughout our land, is responsible for over nine million hours a year of citizen volunteer participation for about 100,000 veteran patients each and every day.

My first exposure to the volunteer program came at the VA Center in Bath, New York, where I dabbled in many phases of a social and recreational program, and which brought me into contact with hundreds of dedicated volunteers. It was during that early period that I began to see how much positive effect the volunteers really had on our patients, and how selfless and devoted their services were.

Just about that time I had an occasion to meet Jim Parke for the first time, and I became completely wrapped up in his enthusiasm, his all-encompassing philosophy of an effective, viable volunteer movement.

My valuable apprenticeship in upstate New York lasted until 1950, when I had the rare opportunity to be offered a transfer to the brand new VA Hospital, soon to open at Montrose, New York, just 45 miles north of Times Square, to head up the Volunteer Service there. Soon after my arrival there, I had another chance to meet with Jim, and to discuss this new and very involved program. I remember he gave me a copy of the "Bible," which to us in the VA was our Voluntary Service Manual. That "bible," as early as two decades or more ago, was all set up, through Jim's foresight, for every contingency which our program might encounter.

Quite significantly, our manual spelled out where we were in the institution's scheme of things—and I think you'll agree with me that quite often we Coordinators of Volunteers have not known just where we stood, or to whom we were responsible, or to whom we went for supervision and advice.

But just having this Manual wasn't enough. Here I was, at a brand new psychiatric hospital, with what seemed to be about a thousand new volunteers just clamoring to get into this place. Curiosity seekers, persons who had never been in or even seen a psychiatric hospital. We had all kinds of "Kooks," and good people, thoughtful people who wanted to help.

We were not prepared for this onslaught. Management was not prepared. Our staff was not prepared. I was not prepared. All I had was my "bible" and some idea of what I was hoping to accomplish. The volunteers were storming our non-existing gates. I knew I had to keep statistics, to count hours, to interview, to screen, to orient, to help train.

But I didn't really know what was going to happen. I didn't know the extent of volunteer participation in our services. But I found out soon enough, when some of our volunteers were kicked off the wards for getting in the way. The Social Workers said they couldn't be bothered. The Recreation staff hadn't had time to work out their own program patterns. And so it went. Throughout the hospital.

Through all of this floated hundreds of volunteers, most of whom had never done this work before. And as Director of Voluntary Service, I floundered and groped and hoped.

My meetings with Jim Parke became more frequent, and Jim began to create for me something of an aura of the philosophy of Voluntary Service which I did not find in our Manual and which went beyond the instructions in fine print. And regardless of whatever initial resistance and reticence we were encountering from the nurses, the therapists, the social workers, the psychologists, the physicians—and yes—even Management, the volunteers began to show something of the nature and intrinsic value of what they could perform. The volunteers taught the staff, taught <u>me</u>, and most of all, Management, that there was indeed a deep relationship which existed between the community, the patient and the staff.

Little by little we began to see that the patients <u>responded</u> to the volunteers. There were "Lady Bountifuls," and volunteers often getting in the way, but the patients began to relate to the community. This, in a large psychiatric hospital. A difficult hospital to get under way at the outset. Much resistance from community areas which resented the presence of a psychiatric hospital.

Through all this, something unique kept happening when volunteer and patient came in contact with each other. The members of the staff saw things which they had not often encountered before—which I had not encountered. And something of what Jim Parke had tried to show me,

how to read between the lines in that "bible," began to take effect and have deeper meaning for me.

Out of this—out of the relationship and the response between the patient and the volunteer, I began to feel the first stirrings of professionalism in my job. Up to then I had not known what I was. A Civil Service worker. Underpaid. (I still am.) But when this started happening, it happened all over again.

And so the staff began to find more meaningful assignments for volunteers, and their belief in the value of the volunteer took root. The support of staff, and the support of Management became of vital importance to my job as Coordinator.

Once this was accomplished, Voluntary Service began to find its place in the sun. But it was not enough. A close and meaningful relationship with staff had to be maintained if the quality and value of the volunteer services in the institution were to be enhanced and augmented.

And so we began to work more closely with a vitally important aspect of our program—the Staff Advisory Committee. Oh—it was in our "bible" all along—but we had never been able to get it off the ground, until many of our Services were convinced that volunteers could be of value. And this concept of staff members, sitting together, discussing uses of volunteers, brought our Voluntary Service closer to its goal of true professionalism. Through the collective thinking of the Staff Advisory Committee, volunteers' assignments were upgraded and integrated, and the volunteers became an integral part of the treatment team. And it took them out of the Lady Bountiful and Ditty Bag category once and for all.

We began to see a relationship between the quality of assignment and the volunteers' longevity. And our statistical reports were much better, because we paid attention to the quality of assignment. Yet we know that in many areas, even yet, volunteers are not given their due, and are not given the kinds of jobs which they are equipped to perform, or are not taken seriously enough.

With such Staff and Management support, the position of Coordinator became more meaningful and significant in terms of what we were, what we thought of ourselves—which we hadn't had before. And this, too, added to our sense of professionalism. We began to find specific meaning to our jobs.

Now we had it made. Now we could take it easy. We had arrived. With our membership in AAVCS we became preoccupied with status, with Certification, with prestige. Did we have it made? I think not.

You don't reach a plateau and feel that you've become a professional. It's not that easy. We must keep pace with any changing concepts of treatment. We must know what is going on in the institution, and in the community. As Harriet Naylor has so aptly stated, 'we must continue to be patient oriented.' In many of our VA Hospitals now, patients

are being given the opportunity to suggest ways for volunteers to assist.

We must keep pace with the changing facades of our mission. And we must continue to recognize and truly believe in the fundamental value of the volunteer, as a catalyst of social community comment and action. We must continue to believe in volunteer maturity. We must have a stake in the policies of the institution, because no one is quite in the unique position that we as Coordinators are in, reflecting both the Community and the Institution. To paraphrase Harriet Naylor again—Attitude Creation is the responsibility of the Coordinator. What this has said to me is that we must reflect community attitudes to the staff. We must constantly re-evaluate our volunteer's performance and patients' reaction. And we must indeed be a true liaison between the volunteer, the using service, the patient and the community.

Know your volunteer. Only the Coordinator can have this unique relationship, and it is vital to the responsibilities of our profession to keep pace with the new and changing situations around us, and to adapt these to the full potentials your volunteers can bring to your programs.

It is at this point that we can then begin to feel the professional qualities of our jobs. Because in a very real sense, we have the power, through the volunteer, to mold and strengthen the social attitudes of our communities.

The use of the volunteer as the liaison with the community—for social support, as an education tool, as a public relations asset, in legislative areas, for budgetary support—is an increasingly significant role of the Coordinator, if the Coordinator is to fully utilize his professional power.

It is easy to become bogged down in bureaucratic red tape, regulations, paper work, statistics, records, reports—

But Jim Parke taught me that to be truly a professional part of the Voluntary Service profession, our certification as professionals must not be based on us, but on the true value of the volunteer and the volunteer concept of Service Above Self.

Why do we use volunteers?

Why do we need volunteers?

When we have these answers, with objectivity and from the heart, we will achieve professional status.

Almost six months from now, at the 25th Anniversary of the National VA Voluntary Service Program in Washington, Jim Parke would have had his finest hour.

The whole range of this VA program—its concept, philosophy, operation, expansion, acceptance and respect—became a reality through Jim Parke's spirit, dedication and foresight.

Our 25th Anniversary of VA Voluntary Service will be a profound suc-

cess, I am sure, because, above everything, all of us who knew Jim Parke continue to be imbued with his values.

We have found those values through the volunteer, and we have discovered that to live at all is to live in a community of man for the betterment of its citizens and our world.

Then we, as Coordinators of Volunteers, can become truly professional.

VOLUNTEER SERVICES IN THE DECADE OF THE SEVENTIES

by

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At the very beginning of my remarks, I feel I must say that I found the suggested title of my remarks, "Volunteer Services in the Decade of the Seventies," quite beyond me. The whole human services field is changing so rapidly that I find it extremely difficult to think of projecting what anyone will be doing in this field ten years from now. It is almost like being asked to predict what the role of the State mental hospital will be in the seventies. I think the only safe prediction is that it is not going to be what it is today. However, just as it is clear that change is upon us, like it or not, it is even more clear that our opportunities for bringing about change in a desired direction and at an accelerated pace are greater than they have ever been before. Consequently, most of my remarks will concern themselves with the climate of this change and its implications.

As I started to think about the various developing trends in mental health and mental retardation programs and their implications for volunteer services, I became increasingly bothered by the term "volunteer services." The term implies a worker performing a service without pay of a type for which ordinarily he would be paid, i.e., he is volunteering his services for free. Although this will undoubtedly always remain a source of much needed help in all of our services and programs, i.e., the extension of manpower resources in direct service programs through the integration of non-paid workers with paid workers, as our programs change rapidly, increasingly we see an ever more critical role for the citizen to participate in these programs, not as an extension of the manpower of the service agency, but rather fulfilling a unique and different role that can only be filled by a non-employee of the program. I would like to suggest that perhaps in some of our programs in the not too distant future we might be thinking of Citizen Participation Programs, rather than Volunteer Services Programs, to borrow from a model that NIMH is apparently already following. This may seem to be nit-picking, but I believe the implications of the differences between these two terms will become more apparent as I attempt to explore very briefly with you only a few of the developing changes and trends that have

implications for the services for which you are responsible. I trust you will pardon me if many of my remarks are couched in terms of what we see here in Pennsylvania, since I am sure this is not too much different from that going on elsewhere.

In Pennsylvania, as elsewhere, there is a strong commitment to increased active citizen participation in the shaping and development of programs. As we have moved to develop local responsibility for services to the mentally ill and mentally retarded, we have built into these organizational patterns the requirements for as much citizen participation as we can anticipate. The nature of this participation is quite different from the past role of the citizen in voluntary agency affairs.

Just as we now say freely that the mental health of a community is too important to leave to the professional "mental healthers," we are also saying that participation on citizen boards can no longer be left to the so called "professional board member."

One of our commitments to the changing times is that programs must be responsive to the needs of those whom they purport to serve; the people being served must become equal partners with those providing the service. If this commitment is tied to another commitment of the changing times, i.e., services should be developed to serve a limited population base to make possible a service that is attuned to the needs of that population and reflective of the ways of life of that population, it becomes apparent that we must find ways of involving a whole new body of citizens in policy formation, one which has never been involved before. This is a role for most of these citizens that is a completely new one to them. As many of our programs have already found out, this increased participation from a body of citizens, never before able to participate in any meaningful way, is fraught with many difficulties and dangers.

It is going to call for the best of our efforts in leadership, training, and knowledge of community to insure that this participation becomes a productive one rather than a destructive one. The potential for destruction has developed in many instances already. However, we have no choice. If our mental health programs of the future are to live up to their much touted promises, they must find ways of achieving this kind of citizen participation. I believe the evidence is already in. Just as we could not leave the development of volunteer services in our institutions to happenstance—or to the interests of staff to bring in volunteers—or to outside voluntary agencies to develop such programs—but rather had to come to look on volunteer services as needing the deliberate, planned, program development and administration as any other service in the institution, so can we not leave to happenstance the kind of citizen participation that is so critical to our developing community programs—the interests of voluntary agencies—or what have you—but rather we must move rapidly and vigorously to develop this service as we would any other service. That is to say, citizen participation is as critical to the functioning of a program as psychiatric services, social services, or any other service.

Even greater implications are present for the direct service rendering role of the volunteer. Throughout the country there is almost an explosive nature to the development of services at the local community level. The success of these programs will mean not only fewer of the mentally ill or mentally retarded being treated in institutions, but also that large numbers of those chronically disabled from mental illness or mental retardation will be maintained in the community rather than in institutions. This trend will be compounded especially by certain concepts that are strongly influencing program development throughout the country. Among these is the strong civil liberties movement with the increasing emphasis on the right of everyone to maintaining his freedom within the community as long as he is not a threat to the community.

A parallel development is the firm conviction of many who are responsible for program development that the need for residential care does not of necessity require institutional care. A residence can often be provided within the community, with the other elements needed for a comprehensive program coming from the extra-residential resources of the community. In other words, the total community becomes, in a sense, the institution.

The promise is tremendous. We are going to make sure that the mentally disabled are able to live and function as members of the community—not excluded from it and shuttled off to some isolated institution.

But the promise is filled with dangers. We can already see the worst influences of the back wards of our institutions being transferred to the community, in sub-standard rooming houses housing the mentally disabled in a way of life not much above the vegetative. Patients become as easily lost, forgotten, and isolated in the community as they did in the institution. The name of the game may change, community living rather than institutional living, but the game and its results may still be the same as far as the patient is concerned. It is apparent that, if we are not just to transplant the mistakes of institutional care to community care, vigorous action is necessary. Have no doubt about it: care of the mentally disabled in the community in many ways is much more difficult than in an institution. Greater care is needed that the patient or client does not get lost and forgotten. Considerably more effort is required to insure that all elements needed for comprehensive care are present and coordinated since they may come from a variety of disparate resources under different auspices. The manpower needs are even greater in this type of program than institutional programs. All this is but to say that the need for volunteers becomes ever greater and their role ever more critical.

From our very limited experience in Pennsylvania in the past three years or so, I am becoming rapidly convinced that one of the most important roles anyone can fulfill in insuring the success of our community programs, and this role remains yet to be developed, is that of the client or patient advocate, to insure that the patient does not get lost, to insure

that the patient is integrated into the community, and to insure that the system responds to the needs of the patients. For a variety of reasons I believe this role can only be fulfilled by a non-employee of the system, and can only be fulfilled by one whose primacy of interest is not how good is the mental health center, or clinic, or program that he is identified with, but rather his primacy of interest is how well are those services meeting the needs of the person he is interested in. I suspect if every one of our patients in our institutions had had this type of advocate, our institutions could never have drifted into the kinds of practices which circumstances forced us into.

Although the needs for manpower and the number of ways that volunteers can be used in expanding programs seem overwhelming, this very trend may actually provide the solution to some of our many manpower needs.

As programming for the disabled moves out of institutions into the community and closer to those who need services, we may suddenly have available sources of manpower of a size we never dreamed possible if only we have the brains to use it. Let me give you just one example. Here in Philadelphia just two weeks ago I had the exhilarating experience of visiting what to many would be considered a small insignificant program. Small, it was; insignificant, no!

A few years ago, a handful of mothers of severely multiple-handicapped children just finally refused to accept what was happening to them and their children. The children were excluded from programs for the physically handicapped because they were too retarded; they were excluded from programs for the retarded because they were too physically handicapped. There seemed to be only one recourse—institutionalization. Those of you who are familiar with this type of child know how much individualized care is necessary to help these children progress even a little, and also know, I am sure, the chances of getting such care in our understaffed facilities. To make a long story short, these mothers by dint of their own persistence, and I do mean persistence, have developed a special class for these children. They provide the one to one attention the child needs. They bring the child to school, they provide the teaching, the social experiences, the remedial training under the direction and supervision of an expert teacher on a four to five hour a day basis. It is impressive to hear of the progress these children have made and of how the involvement of the mother in the formal classroom carries over into a well trained person being with the child 24 hours a day, and thus the four hours of training become parlayed into 24 hours.

There are many other examples of a similar nature, I am sure, to which we could all point. Just stop and think for a moment of what possibilities such children would have for a one to one relationship in either our institutions or community programs staffed entirely by employees. Such a program developed State-wide, depending only on paid staff, would be impossible in terms of critically short resources of both money and manpower; however. such a program, utilizing mostly mothers as

the manpower, immediately has the potential for being developed even in our smallest communities of the State.

One of the mothers, in parting, summed up their program and experiences in a way that at least for me is going to require some rethinking about volunteer programs:

"All we asked, all we wanted, was not for some agency, or for the government to take over for us. All we wanted was some help, some guidance, some direction, so that we could continue to care for our own."

To me this is a most profound thought, and may be the only answer to the impossible needs for manpower we have in so many of the human service areas. As more and more of our programs move into the community we have a chance to build on such a concept in a way we never have had in institutional programs, where we separated the patient from his family and community, and found substitutes for them. In fact, as I recall, in most of our volunteer programs we go to great lengths to insure that volunteers do not work with their own. Perhaps in the communities, we need to think of how paid staff can help the "volunteers," including the family, which we never before had so readily available, care for their own. Perhaps, if we could think that way, our manpower needs would not be so overwhelming.

I know we are not thinking that way now. I know we are mostly thinking of how we can expand programs with staff, and very little, if at all, in most community programs of how volunteers could be used. I know we are not thinking of volunteers, families, citizens, as our primary resource and of how staff can be developed and used to help the family and the community care for its own. I do know that the way we are thinking and planning now will never overcome the shortages in manpower and resources we need to overcome if we are to come even close to coming to grips with our problems in the magnitude they exist.

To think and plan this way is not easy, though it may seem to be so on the surface. It requires the professionals to think first not of what they can do and then what the volunteers can do to help them, but rather what the non-staff can do and what the staff can do to help them. It requires the volunteer coordinator not to analyze institutional programs, the roles of staff, and the kinds of jobs volunteers can do, but rather to analyze the needs of patients, the kinds of needs volunteers can meet, and how staff can help them meet those needs. It requires the volunteer coordinator to think of an entirely different type of volunteer, no longer just the citizen who has time and wishes to give of himself to help others, but rather of the individual who is already involved with some one needing care, who is willing and able, with help, to extend himself to provide large elements of the care, not just as a member of the family in the family situation, but as an active equal member of the treatment team.

Perhaps the most sophisticated example of this that I can think of at the

moment is one that exists in what I am sure we would refer to as a very primitive community in Africa with a dearth of mental health resources.

A rather comprehensive psychiatric treatment program has developed there that in many ways takes the place of our institutional programs. Patients come from the surrounding villages from many miles away. Although many need to be under treatment a long time, there is no hospital as such. Members of the family accompany the patient and set up housekeeping in the community where the treatment is being provided. The family provides the residential aspects of care; they in turn are welcomed and integrated into the total community by the other residents. This indeed seems like a dream program, adequate manpower to provide dedicated 24 hour a day care on a highly individualized basis by those who really know the patient, have always been involved with him, and will continue to be closely involved after he leaves the program.

This, of course, is a model that is not readily translatable to our own culture, but nevertheless there are aspects that could probably be well developed if we set ourselves to it. There are programs for older people, where the disabled one has not been separated from his or her mate, but rather where they have been admitted as a couple so the one who is not disabled can help care for the disabled. How much more humanitarian to help couples who have been devoted a lifetime to the care of each other, to continue to provide that care, rather than by separating them from each other and making each one's life a little more empty, a little more meaningless just when they need each other the most. We have experimented, all but on a very limited basis, with moving an entire family into one of our institutions for a period of time to care for their very disturbed child. I can attest not only did it help the child, but it provided us with a source of manpower needed to help a very disturbed child 24 hours a day that we would not produce from staff or the other more traditional use of volunteers.

I bring these up not for the sake of illustrations of programs for volunteers, but rather as a means of urging all of us to start thinking differently about volunteers—who they might be and how they might fit into a program, or even of how a program might be built around them. I have dwelt considerably on community programs, but the need for new and different approaches in our institutions is just as apparent. Our institutions are becoming less and less hospitals and more and more like communities in which a variety of people with specialized needs are living. Increased participation in all aspects of that community by citizens, who are not similarly disabled and who are not employed, to take care of the disabled is critical if that community is to avoid the dehumanizing aspects in our institutions of the past as well as to ensure the concept of normalization, that we hear so much about currently, underlies all of our programming. I do not see our institutions disappearing. Rather, I see them changing and changing rapidly.

In our own instance we are coming to view our hospitals as a collection

of resources, human in terms of staff, physical plants, budgets and programs which can be used to meet the changing needs of the communities they serve. We see their horizons broadening rather than constricting, even though their role may be quite different. We suspect programs will become more intensive and rehabilitative rather than less so. We suspect our need for citizen participation in those programs will increase and not decrease.

As I conclude, I feel I must apologize for rambling more than I intended and for being more abstract than I wanted to be. You asked me to talk about "Volunteer Services in the Decade of the Seventies." What they will be like, I'm sure I don't know. But of this I am sure, we are entering a decade in which volunteer services as a matter of the more fortunate, giving of their time and efforts to help the less fortunate will rapidly change. We will see less of doing for and more of being involved with; we will see less of a limited involvement of only a narrow strata of society to involvement of all the socia-economic levels; we will see less of volunteers serving as auxiliary to staff, and more of citizens participating in their own right and in their own unique roles as equals with staff in policy making, program development and direct service. In fact, this latter level of participation is critical to the success or failure of this whole new mental health revolution, as some are wont to refer to the changes we are now going through. And, as part of this revolution, I suspect we will hear less and less of mental health services, but more and more of human services in which mental health/mental retardation services will become thoroughly integrated health and welfare services, and we will hear less and less of mental hospitals and mental health centers and more and more of human service institutions and centers.

Of this we can be sure—the decade ahead can be the most frustrating and disillusioning one of many of our professional careers, or it can be the most exciting of all, if we allow ourselves to have new visions and to find new ways. Those of you who are directly involved with responsibility for volunteers' services and citizen participation should be most excited. This is the decade you must come into your own, or we all fail and slip back again.

VOLUNTEER SERVICES COORDINATORS IN THE SEVENTIES

by

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Not only the Volunteer Services Coordinators, but every person is going to have to learn new attitudes, skills and knowledge to live successfully in the rapidly changing world of the 70's.

Most of us who are over thirty grew up in a fairly homogeneous society. We lived and associated through our early years with people much like ourselves. Communities and neighborhoods were fairly stable. Our neighbors and friends were usually of our own racial, social, economic and religious background. If we were black, we probably knew few, if any, white people. If we were white, we probably did not have black friends. Even protestants and catholics mingled chiefly with their own religious groups. There wasn't much overt hostility, because there was so little contact.

Today we are seeing great hostility between racial, economic and ethnic groups. (I like to think that the ecumenical movement of recent decades has lessened religious antagonisms—although they still appear in unexpected places.) The tensions arise because we are in the period of transition to a pluralistic society. We will gradually begin to discover that differences between people are enriching. They make life far more interesting. Groups of men and women are more stimulating than women's groups or men's groups. A few young people in a traditionally adult activity can add great dimensions of creativity, realism and excitement to any activity.

As we learn to appreciate diversity, hopefully we will stop putting people in pigeon-holes or stereotypes. We may begin to realize that every individual is unique and important. This will have an effect on our attitudes toward—and our handling of—both volunteers and those they serve—in your case the mentally handicapped. With the volunteers—we will not limit ourselves to one group of people. If we have had mainly middle-aged, middle-class housewives as volunteers, we may find the supply drying up. But volunteers cannot be stereotyped as "middle-aged, middle-class housewives." Increasingly, retired people, businessmen and women, young people, poor people are volunteering. Are you finding your share of such people?

Very often these "non-typical" volunteers can make better contact with patients—many of whom relate to them more readily than to the "typical" volunteer (if there is any such animal!)

It is largely <u>your</u> attitude toward and about volunteers which will determine whether or not you recruit and welcome those who are different. How do you feel about differences? Do you see them as enriching, or as potential sources of conflict and trouble? How comfortable are you in working with people very different from yourself?

Another difference in the volunteers of the 70's may well be their motivations. We used to assume that people volunteered for purely altruistic reasons—simply to help the less fortunate. This is, of course, a part of the motivation of most volunteers. But today, where such things as mental handicaps are openly acknowledged, you may get volunteers who have a mentally handicapped family member, and who volunteer in order to learn more about the mentally disabled. Or you may get volunteers who are testing a possible career. Or you may find students looking for data or research possibilities. We are increasingly realistic about motivations today, and need to admit that most volunteers expect and receive some satisfaction from their volunteer work. You and I need to be careful about possible "judgmental" attitudes toward motivation.

And our attitudes toward the patients or clients can have a great influence on the volunteers. Do we lump all the mentally handicapped together and treat them as "things"? Or do we recognize the fact that they differ as much as so-called "normal" people—and so treat each one as an individual? Especially in a hospital or institutional setting, this individual concern can be a powerful therapy.

If attitudes are so important, what can we do about them? We must not assume that attitudes cannot be changed, because they can! Human relations training has developed effective change. It cannot be accomplished by telling people what their attitudes should be. But involvement techniques—role playing, case studies, well designed audio-visual aids—can do it. Have you had such training? Do you include it in your training of volunteers? There are skilled human relations trainers in every area of the country. Use them.

As we all acquire new attitudes which are appropriate to the 1970's, we will begin to want new skills. This great new vocation of "Coordinator of Volunteers" which you are pioneering can make use of a wide range of skills. Don't feel that one course, or even one series of courses, will teach you all you need to know. One of the best features of our modern society is the growing emphasis on continuing education. Just as teachers, doctors, lawyers and other professionals go back to school every few years, you and I need to plan this into our careers. I'll list a few skills that you need now. By 1975, the list may be very different.

1. As I have already suggested, you need human relations skills above all else, because your job is human relations. The NTL Institute, for which I work, is the pioneer in modern human relations training and runs a nationwide program of basic human relations laboratories every year. But many colleges and universities and a wide range of other organizations and institutes also offer such training. I only urge you to be careful in checking the training and credentials of those who offer it, because—like any field—this one has its "quacks."

2. You need some good management skills—ability to plan, to delegate responsibility, to make decisions, to evaluate your own and others' performance. Management training is offered in many settings. Check with

some of your local business firms, as well as colleges and universities. Our Center for a Voluntary Society is planning management training for executives of voluntary organizations and for coordinators of volunteers and will be glad to keep you informed of such opportunities.

3. Your own association, through the American Psychiatric Association, should be planning seminars and workshops to keep you up to date on the latest developments in the field of mental illness and its treatment. New discoveries are being made every day, and you can do your job far better if you have a current knowledge of the field.

4. You need skill in designing and conducting training courses. Here again, the NTL Institute, our Center, many universities offer "Training of Trainers" programs which will teach you how to design and conduct effective training. Too many of us tend to repeat the patterns of training which we received, when there are endless innovations which could help us enormously.

5. You need skills as a consultant, because this is a role which you probably play more often than you realize. You often act as a consultant to a volunteer who comes for a first interview, or an experienced volunteer with a problem. If you improve your consulting skills, you may be helpful to staff members who have problems with volunteers, or to organizations who supply volunteers.

The new knowledge which you are going to need as we move through the decade of the 1970's is implied in many of the things I have already suggested. Among the changes of our day, the knowledge explosion is one of the greatest. None of us dare be satisfied with what we knew five years ago, or even last year. How to keep up with all the new discoveries and ideas in the field of mental health and the exploding world of volunteering is a real problem. But if we are to do our jobs, we must find a way. Within a hospital or institution, or in a community where there are several Volunteer Service Coordinators, you could very well establish an informal seminar, meeting perhaps once a month. At each meeting one participant could do some special reading, or interview a psychiatrist or researcher, and report on new developments. If you are like me, this is the only way I can make myself keep up with the fields in which I need to be informed.

Back of all this—which may seem formidable—lies the simple question—"What do you think of yourself and of the job you are doing?" If you feel inadequate, frightened and defensive—or if you wish you were doing something else—maybe you should!

But if you recognize that you are pioneering a new vocation—as a Volunteer Service Coordinator—which by the end of the 1970's may well be recognized as on a par with Social work, medicine and other established fields; and if you recognize that in working in the field of mental health you are in what is probably the most important area of human life today—your pride and joy in what you are doing will impel you to keep learning and growing and changing.

More power to you!

SOCIAL INTERVENTION IN THE SEVENTIES

by

MADOLIN E. CANNON

Today—with acceleration of everything, we tend to categorize TIME in terms of DECADES. I call attention to the theme of your Conference—Social Intervention in the Seventies.

Before we discuss that, let us turn back, for a few moments, to the end of the Fifties—1959 to be exact.

This is not the first time that a gathering of volunteer resources coordinators from states throughout the country have been welcomed here in Philadelphia. In April, 1959, during the APA Annual Meeting, about seven individuals who were responsible for volunteer coordination at state levels met for two days. The states represented were Illinois, Indiana, Maryland, New Jersey, New York, Ohio, and Pennsylvania. Representatives from Texas and Minnesota could not attend. The Commissioners or their representatives met with us for one session.

The agenda had a dual focus:

1. Discussion on Communications: Horizontal (Between state level community organizations, other disciplines in programs, institution directors/superintendents, and other state coordinators); Upward (To Commissioners); and Downward (To institution volunteer supervisors).
2. Suggested agenda for the Buffalo Meeting—October 1959 APA Mental Hospital Institute.

A firm recommendation was made that the agenda be geared for both state level and institution volunteer coordinators.
Topics included: Philosophy, administrative principles, professional qualifications, state training of volunteer coordinators, interpretation to staff and community, and relationships with community organizations.

The agenda was institution focused, and the base was being laid for this Annual Conference structure.

Now, let us take a look at that fleeting decade, the 60's.

We always point out that the first step in volunteer administration is the identification of volunteer jobs. Was it not in this past decade that real strides were made in Identifying the Volunteer? Did we not and are we not still finding that many individuals, of all ages, sex and backgrounds met the criteria of volunteer commitment, but had not been recognized as volunteers? They were happily functioning under titles like Members, Leaders, Board of Trustees, Assistants, etc. This identification has been of more value primarily in staff education than to the volunteers themselves. Staff found there had been those who would not be caught dead working with anyone labelled VOLUNTEER! The base of volunteer participation has been broadened through recognition of the extensiveness of existing volunteer endeavors.

The base has also been broadened through the recognition that it is an individual right to be of service to one's fellowman. The doors are be-

coming wide open for anyone to accept responsibility for volunteer service.

I doubt if the concept of volunteerism has changed. I think the identification of all persons who volunteer has appeared to be a concept change.

Have we also not seen increased identification of the need for direct service manpower? This has led to identification of Volunteer Administration as an essential staff element for the economic integration of volunteer resources into programs of human services.

Has not the patient, in this past decade, become or is he not becoming identified as a person by both the community and mental health/mental retardation staff?

All of these progressive changes in identification give us our clues for the 70's—along with recognition and consideration of all the identifications which have been and are developing in our socio-economic environment.

In Pennsylvania, there has been awareness for many years that the administrative structure which had been initiated for the State mental health/mental retardation programs for volunteer community participation should also serve other programs in the Department of Public Welfare. As you know from your associations with each other, few states meet their human services needs in quite the same organizational structure. One or two state structures are similar to Pennsylvania, but in many states mental disability programs are either separate or aligned differently.

Briefly, the Pennsylvania Department of Public Welfare has three major programs:

1. Office of Family Services
2. Office of Medical Services & Facilities
3. Office of Mental Health/Mental Retardation

With emphasis on mental institutions becoming an integral part of the community; with patients being looked at as individual persons with individual capabilities; with increased financial resources for some patients, the mental health/mental retardation institutions are becoming more closely related to both the private sector of the community and to other State operated and funded programs.

Considering both interest and need in relation to other Department of Public Welfare programs and the changing mental health/mental retardation programs, the transfer of the Division of Volunteer Resources to the Office of the Secretary of Public Welfare is timely.

The concept of volunteer resources; the types of services which are needed and can be provided; the administrative principles which must be utilized are essentially the same. The resources in the community for both individual and group volunteers are identical. Mutual education of all employed and volunteer staff is similar.

We feel that this is an exciting period of our experience. Federally, the programs we work with involve many Federal departments. Standards and methods which are being developed must consider all clients/patients being served as well as involvement of all types of volunteers. We also must be aware and utilize all the resources, state, federal, and local which will provide the best service to clients/patients with sound integration of the volunteer community.

To enable us to find out where we are and what volunteer services exist in the State Department of Public Welfare programs, the Secretary approved a Survey of Existing Volunteer Resources in all of the programs. This was the first time that a Survey on this subject had ever been done. There have been many by-products already, even though we are just in the process of analyzing the material we have received. We have received 100% response from State operated programs.

The Secretary has also appointed a Staff Planning Committee for Volunteer Resources at the State level, with representatives from both program and administration. We hope to work with this Committee on a variety of aspects of volunteer administration.

The Pennsylvania Department of Public Welfare is also in the process of an organizational change into six Regions. Our projected staffing pattern is based on the premise that regional coordinators for volunteer resources will be the focal point for volunteer development within regions.

Several major administrative procedures are currently in the mill, which include:

1. A revision of the Volunteer Resources Coordinator job description geared to work with all Department of Public Welfare programs, and
2. A Staff Guide for Department of Public Welfare programs including a review of existing and/or development of appropriate administrative tools.

To top it off, legislation is again circulating to establish a Department of Human Services which will merge, if passed, the Department of Public Welfare and the Department of Health.

So, you see our work for the 70's is cut out for us.

THE VALUES OF VOLUNTEERISM: I

by
HOBART C. JACKSON
Administrator
Stephen Smith Home for the Aged

It is a pleasure to be with you on the occasion of your conference focusing on Social Intervention in the 70's as you move to a more complete professionalism.

As an administrator of a home for the aged I am well aware of the significance and value of the volunteer, and in our own experience have watched the growth of the volunteer system bring about the creation or establishment of the position on our staff of the coordinator of volunteer services.

Philosophically volunteerism grew out of need: the need of one person to be needed—the need of another to be served. This is ideally a two way street with the served also needing to give of himself and the giver or the volunteer also needing to be ministered to.

The voluntary social agency is a natural for the development of a system of volunteerism; beginning with the Board of Directors, moving through the women's auxiliaries, to various program aides, and then on to the friendly visitor. Perhaps we can share some thoughts with you this morning regarding our own experiences.

May I say first of all that our Home is more like a geriatric center development than a traditional home for the aged, with a multipurpose range of services from an apartment building for the elderly, facilities for intermediate care, and approved extended care facility with round the clock registered nursing supervision.

Traditionally the Board represented the vested interests of families, frequently passing that interest from parent to child. More precious than the making of policy was the opportunity afforded for personal involvement in the lives of the residents. This was frequently reflected in a "lady bountiful" or "beneficent prince" attitude. In such a volunteer relationship the needs of the benefactor most often superseded those of the resident and sometimes, although well meaning, interfered with the orderly administration of the facility.

Boards have undergone change. Still manned by persons desiring to contribute time and talent to the elderly, the concern is primarily with the development of a facility or complex designed to meet the immediate needs of the residents and the broader needs reflected in the community. Embracing the philosophy of the consumer's right to participate in planning and decisions affecting him, the Board includes in its membership, representatives from the Residents and Tenants Councils and from the auxiliaries so vitally involved in services to the institution, as well as a relatively new Family and Friends Council composed obviously of the families and friends of residents. We especially commend

this approach as a viable representative of consumers for agencies in the mental health field.

So necessary to the life blood of the voluntary agency or institution is the group primarily concerned with raising funds necessary for the day to day operation but more importantly for the growth and development of both the physical plant and expanded programs. The members of first auxiliaries are hardy souls and willing workers, raising funds and attracting friends and finding countless ways to be of service. We were fortunate in that our Senior Auxiliary remained the bellwether of money raising groups while attracting other clubs and groups to pool their interests and resources in behalf of the Home. It soon became evident that someone should and must coordinate the efforts of these organizations so as to bring order and harmony to bear and insure maximum return to the beneficiaries. Thus was born for us the Council of Auxiliaries and the Coordinator of Volunteers. Public relations was a natural added responsibility to this position. As the corps of individual volunteers increased, some structure had to be set up which would allow for the maximum use of time and talents.

In our Home each volunteer becomes a service aide in a department of the facility and is directly supervised by the director or supervisor of the particular service; i.e., recreation, social service, nursing, physical and occupational therapy, and so on. If it is felt that some of the spontaneity and individual choice is sacrificed in this type of planning, it is offset by the positive use the various departments can make of volunteers to effectively supplement the work of regular employees. This is not to say that particular skills and talents are not extended in special ways to augment regular services or even to bring an extra dimension.

Returning to our philosophical premise that volunteers need to be needed, what other characteristics should we note? We might extend "need" to include a sense of usefulness, a feeling of importance, a feeling of acceptance and an avenue of social acceptance. The volunteer brings a variety of skills, talents, interests and abilities and frequently wants to serve as she wants to serve, when she wants and whom she wants. This selfish element in the volunteer is one of the problems faced by the coordinator who has the unique responsibility of keeping the volunteer, the resident and the employee happy or at least compatible.

The coordinator must have patience, tact, energy, and good humor. In addition, a kind of complete knowledge of the agency function and operation, administrative ability, and a sense of satisfaction, securing good will for the agency, and above all helping the residents achieve a more fulfilling life experience, regardless of the level at which they may be functioning.

The volunteers for specific services must be carefully screened for the nature of their service rests on a personal relationship where attitudes, expressions, even postures can not only defeat the purpose of the

service but also damage the adjustment of an individual to his surroundings, thereby negating in effect our entire reason for being.

I'm sure you're asking what we would like to see in a volunteer and when we think of all the things we hope they will do, it seems somewhat presumptuous on our part to give our profile but this is one way we can develop a corps of volunteers worthy of the name. We ask the volunteer to be ready to submerge his need in the larger need of the one served—and do primarily the job we want done.

Although I wholeheartedly endorse volunteerism as a right, not a privilege, I hasten to say that the volunteer must recognize a responsibility to represent the agency when he serves in any capacity—he becomes for that time a part of the organization. He must accept the reality of less than perfect conditions under which to work. These frequently reflect low operating budgets and poor physical facilities. He must either accept these or join in social action efforts to change them. (Hopefully the latter.) Another interesting hazard is the non-cooperative, perhaps even hostile, regular employee of the agency. (This phenomenon of the reluctant employee may be due to some feelings of insecurity or jealousy—some discomfort that someone from the outside has an opportunity to evaluate his service or augment his skills.)

Most difficult of all, the volunteer must be prepared to forego the tangible expression of gratitude from the direct recipient of his services. This becomes a part of our responsibility to recognize the magnitude of sacrifice entailed in volunteers and attract new ones.

It becomes our responsibility, too, to suggest new vistas for volunteers—new ways to serve—new challenges for their abilities. Today's word is relevant involvement and supporting that is awareness. There is re-recognition that many of the individual problems the volunteer meets are rooted in the larger problems of society. There is recognition that unless we all begin to attack the ills in social welfare, physical and mental health, education, racism, poverty we will make little headway in solving or alleviating the problems of individuals in our homes, or institutions, or agencies. The volunteer must reach out and join hands with the consumers of services and help them to join the ranks of the politically aware and socially active.

All segments must become volunteers to broaden the base, strengthen the bonds, sweeten the rewards of involvement. For instance in our own Home to repeat an earlier reference, relatives and friends of residents have organized as volunteers. This has brought them into the Home, relieved them of anxiety and guilt feelings, kept them abreast of Home problems and aims, reassured loved ones of continued interest and concern with their welfare and happiness, and serve to reconcile expectations with performance.

Aged men and women have joined Vista or become substitute grandparents, giving of themselves and their substance. Volunteers are everywhere! Young people are candy stripers or tutors, or readers, or friend-

ly visitors, or hosts at parties or what ever! Middle agers raise funds, drive cars, run errands, bake and sew and pour tea. Meetings and conferences are everywhere!

Active recruiting should be where the people are and around specific projects. Schools, school groups, churches, church groups, clubs, sororities, fraternities and the like are ready resources. A happy volunteer is a happy recruiter.

Value the person—value the service. The agency should regularly publicly and privately express its appreciation to volunteers. Tangible expression in plaques, citations or the like should be used where possible. The natural desire for praise should be recognized.

Share your dreams, your plans, your future; for your success is in the hands of the many volunteers who serve in so many ways. That these efforts should be supervised and directed by a coordinator is right. That you should seek to strengthen the professional stature of this position is right. Since the coordinator frequently began as a volunteer, care should be taken not to breed out those qualities of difference. Perhaps those qualities are epitomized in that famous answer "he isn't heavy, Father—he's my brother"; for truly the volunteer is his brother's keeper and this in turn is our mutual responsibility.

One final note—these are serious times in which we live. Our country is in real trouble, internationally and domestically. The problems of peace, racism, poverty, and repression beset us on all sides. The hopes of black people and other minorities are continually frustrated as their calls for freedom, social justice, equity, and dignity continually go unanswered.

We should not deceive ourselves into believing that things are changing for the better. They're not! In my opinion, things have seldom looked worse.

It is part of the overall responsibility to heed these calls and help reorder our priorities to bring about needed changes—to make a better world in which to live.

THE VALUES OF VOLUNTEERISM: II

by
HAROLD KNUDSEN
Psychological Service Associate
(Team Coordinator)
Philadelphia State Hospital

I speak to you today as a representative of a treatment team at Philadelphia State Hospital. This team is becoming increasingly aware of the present value and future potential of volunteers in the treatment and rehabilitation of its patient population. I would like to report to you some of the developments we are now experiencing, especially with regard to the expanding role of volunteers in our own setting.

To maintain a proper perspective, a brief look at our hospital in the past is helpful. Byberry, as it is commonly known, is the largest mental institution in Pennsylvania. In 1948 and 1952, *Life Magazine* featured Byberry as one of the most deplorable mental institutions in the country. This article enhanced a stigma already placed on every person granted an admission number at Philadelphia State Hospital, the stigma of being a "mental case." Obviously the *Snake Pit* stereotype is no longer accurate, thanks to the extraordinary advancement of psychopharmacology. The volunteer has also been the victim of stereotyping. Until recent years, the volunteer at Byberry was envisioned by staff and patient alike as a bearer of gifts. There was a perpetuation of the "Lady Bountiful" image. Fortunately, attitudes are changing and we are moving ahead to the 70's anticipating more community awareness regarding mental illness as well as more efficient and productive use of volunteers.

Today, the scene has changed. In three years, the patient population has decreased from over 6,000 to approximately 2,400. The team concept is becoming more prevalent and will probably be the major treatment modality in state institutions during the coming years. There is a staff to augment the treatment possibilities. Volunteers play a vital role by providing the needed manpower to increase our services to our patients. Various treatment disciplines are represented on our team; they include volunteers, psychology, social service, chaplaincy, nursing and therapeutic activities. The patients we work with are older women whose average age is sixty-two years and who have been hospitalized, on the average, more than twenty years. As a result, we are primarily concerned with rehabilitating an individual whose foremost problem is institutionalization. These people are the "remnants" of the mass exodus of patients into the community during the past few years. Presently, we are directing our efforts on two fronts. Our primary goal is to enable the patient to return to the community. A secondary goal is to educate the community so that it will be better able to help its new or returning citizen. The concerted team effort of staff and volunteers is the first step in achieving these goals.

The roles that volunteers can assume in the treatment setting are ex-

tremely diverse. The following are a few ways in which we now use volunteers. One gentleman, a retired high school teacher, gives about three full days a week to the hospital. After receiving some information regarding the needs of our patients, he began working with one of our groups exploring their knowledge of present day food and clothing prices. One of our ladies, who had been hospitalized more than twenty years, wrote up a food shopping list and then totaled the amount she thought it would cost her; her total was $5.10. Were she to have actually purchased the items in the market, her bill would have been close to $30.00. This prompted the volunteer to ask the team to bring empty food cartons which he used to construct a market situation in which patients could select desired grocery items and then get a more realistic appraisal of current price trends. Another volunteer, who teaches music privately, spends one day each week leading a music appreciation group with interested patients. Others are involved in arts and crafts, personal hygiene, community trips, discussion groups . . . all of which are programs designed for the resocialization of our patients, There are still a large number of individuals and groups in the community who make their annual pilgrimage at Christmas time to show kindness to those less fortunate than themselves. We are trying, however, to spread the joy throughout the year. Many of these people are becoming atune to the fact that they can do more than entertain; they can help patients leave the hospital and return to the community.

An extremely important facet of working with volunteers is enabling or training them to work with patients. Some people who volunteer are professionals who need little or no training. Others are people who are offering their willingness to work with people, but probably need some academic information about mental illness, and more particularly, information about our type of patient. Training has been primarily on a one-to-one basis—staff supervisor-to-volunteer. Our program is now in the process of planning two other methods of training which will improve quality and quantity of help given to volunteers. We are attempting to draw as many of the volunteer team members together to form a regular seminar or problem solving group. A major benefit of this type of group will be to increase cohesiveness among volunteers working with a particular team. (Propagating the feeling: "We are volunteers.") It would expedite the educational and counseling process. Various discipline representatives could have sessions with the volunteers in which they could clarify their role in the treatment of patients. In this training seminar the participants could canvass each other for ideas in developing their various programs, thus enhancing the creativity so necessary in working with our type of patient. This group meeting might serve as a communication meeting for the volunteer coordinator during which time he could simultaneously contact all volunteers connected with a particular team. Another training process to be used by our treatment team will be the structuring of the age-old technique—to learn from experience. We hope as a team to groom two or three volunteers, who have been working with us for an extended period of time, to begin

training volunteers who are having their first experiences in a state institution. This also implies that one volunteer who may have a certain skill, would, if possible, share his expertise with other volunteers. Both of these training methods will give staff more time to work with patients or expand the existing program.

Volunteers are not only an integral part of our present operations but are a major factor in our plans for the future. There will be numerous opportunities for the community to be socially involved in the 70's. The team has drawn up and is now presenting to the community an expanded program we have called "Focus on People." We are asking individuals and groups in the community to join with us at the hospital in helping to rehabilitate our patients by volunteering their manpower and resources. We are requesting more than one hundred volunteers to come into our building and be a friend to a patient. As a treatment team we become increasingly aware of the need to establish relationships on an individual basis. This has been a void for most patients during their stay at the hospital. As we have brought in more volunteers to be a friend, we have seen more interaction and better social adjustment. Relationships established in the hospital could be continued when the patient returns to the community. A federally-funded, experimental program at the hospital has shown that individuals who return to the community and are aided in their adjustment by "enablers" have a better chance of succeeding in the community. Volunteers can be "enablers." Pennsylvania has made a step in this direction with its various conferences on "Transitional or Alternate Planning."

Finally, where do we see the volunteer coordinator in this operation? We see him right in the middle of it. Ideally, every team should have its own volunteer coordinator. Practically, the state can't afford it. I suppose the next step is to develop volunteer volunteer coordinators. I'm sure that this is currently planned in many places. With the ever-increasing volunteer force, we need careful recruitment. The volunteer coordinator is usually the first screening device. Consequently, most overt problems are avoided prior to the placement interview. The coordinator is our liaison with the community. In our case the coordinator, on occasion, has made the initial contact in the community. Then the team is contacted, and a representative delegation including the coordinator presents its needs personally to the individuals or groups involved. Our treatment team could not have developed or continued to develop without the ambitious efforts of two excellent volunteer coordinators.

It seems that we are in a continuing state of "transition for progress." If the present trend of volunteerism can be sustained, then we can anticipate great progress in the field of mental health.

A VOLUNTEER OF THE SEVENTIES

by

JEANNETTE M. VITKIN

Of course, I am honored to be here and to be the voice of the volunteer—representing perhaps thousands of in-service and potential volunteers in your agencies.

Now this is a tall order . . . truly no man or woman, under these circumstances, can honestly speak for others. But from my experience of twenty years as an active in-service volunteer and five years as a volunteer coordinator of volunteers, I will tell you what I have learned and observed.

In the first place, as we know, the whole concept of volunteerism has changed from the days of Lady Bountiful.

We now have a very sophisticated, disciplined function. Volunteerism has become a way of life, and members of the community feel that they have a right to the experience of being a volunteer.

In addition to the school child, the teen-ager, the college student to the adult business man and woman, housewife and—most recent addition—the disadvantaged person and the ever-larger growing group of retired people, we also have today the patient as a volunteer.

With a glow of satisfaction, I remember, sixteen years ago when I cooperated with the medical director of the Westchester Division of the New York Hospital, and at his request, instigated the first program in White Plains to allow patients at the New York Hospital to become volunteers at a rehabilitation center, which is also in White Plains—a hospital treating muscular, physical and cardio-vascular disorders. From this start, the patient volunteer program from the New York Hospital has continued successfully and expanded to many other agencies in the area.

We know, therefore, that volunteerism is in action everywhere. It has expanded from the field of health, education and welfare to government, law enforcement, business, and industry, to mention some. Necessarily, then, these volunteers must be professionally coordinated.

Now let us come back to us—right here—today. Let us view the volunteer seeking fulfillment and guidance from the coordinator working in the field of mental health and rehabilitation. To do this, I am going to Role-Play.

I will be that volunteer. Call me Jane Q. Volunteer. I have perhaps gone to a volunteer service bureau to seek counsel in finding a suitable agency and I am sent to your agency for an interview.

The first thing that confronts me is the intake interview form. For the average person, this is routine. We are a form-oriented nation, anyway. But let us assume I am a person from a disadvantaged neighborhood who is not too happy filling out forms. Please help me—without making me feel inadequate. Many wonderful volunteers have been "turned

off" by some of our bureaucratic ways.

Now, I want to choose where I am going to work, if possible. I have capabilities and would like to utilize them. I feel that if I am happy and I am enriched by my volunteer experience, the patients and staff will benefit immeasurably. They will be receiving the best that I have to give and will not be confronted by a square peg in a round hole—which would make me an irritant to staff and a bad reflection on your ability to place a competent volunteer.

To accomplish all of this, we must have a good rapport. I must have confidence in you as a coordinator. You must give me the opportunity to tell you what my preferences are. I must let you know my potential; you must give me the opportunity to speak to you about myself. And then you must have the acumen to place me wisely. This, I believe, is one of the requisites of a qualified, trained coordinator—to Jane Q. Volunteer. Countless times, a volunteer's special abilities have started whole new ancillary services, because the coordinator was able to recognize talent and put it into action.

Perhaps my orientation spells the difference between success and failure. To know and understand what is expected of me and what I must expect to encounter, I must be guided. If I am an average person and have enjoyed or accepted classroom teaching, your scheduled program of lectures and reading material will be received as prescribed. I must be encouraged to refer to the orientation rules and regulations of the agency from time to time. In our enthusiasm, we all seem to become lax and tend to forget them. But, as my medical director, Dr. Francis Hamilton, says, "Let us run a tight ship."

However, if—as a new volunteer—I resent or avoid the orthodox methods of orientation because of bad or unhappy school experience, please use new methods of communicating with me. Perhaps we can do this in an informal group setting.

Now, I—Jane Q. Volunteer—start on my assignment. There will be times—especially in the beginning—when I will have misgivings . . . feelings of frustration and inadequacy. New volunteers, working with patients, do become very confused and fearful at times, and it takes a time to begin to understand the patients, the treatment, the staff, and yourself in this new setting. I may be reluctant at first to speak to the staff of my confusion and uncertainty. And so I will come to you, the coordinator. You are my sounding board. I need your reassurance, support and guidance.

Do I detect waves of exasperation from coordinators who have hundreds of volunteers to deal with?

I am sure it is impossible for you to be all of these things to all people. But please supply the volunteer with a competent surrogate. One of the most important needs of the volunteer is continuity in supportive advice and counsel from the supervisor.

Let me get back to Jane Q. Volunteer. After working successfully for a while, I want the privilege of growing at my work. I may become bored with the sameness of the work, or I may envision new concepts and want the opportunity to try them out. Again, I must speak to the coordinator. Perhaps the coordinator will approach me with ideas of diversified experience.

We speak of ways of recruiting and keeping volunteers. A successful, grateful and fulfilled volunteer will not leave a post, but will bring others to the agency. As Jane Q. Volunteer, my experiences have been so gratifying that I want to share my joy with everyone, as I bask in the sunshine of the smiles of the patients and staff. So I become a public relations department of one. I elicit the ear and the imagination of everyone who will listen to me. This is very important for the agency and for the patients who will ultimately be going out into the community. It helps to involve the community and prepare it for the recently discharged patient.

As I have said before, each volunteer is an individual. We each have different life experiences so that our responses and ideals and objectives vary. The student, perhaps, is testing a career in the field of health or welfare. The adult may be satisfying a long-desired affiliation with nursing or medicine. Many of us just need to be needed. We strive for a good self image, and by volunteering our service we see an appropriate way of finding it or proving it.

We must satisfy the urgent pressure of obligation to society and our fellow man. What better way than to serve, help, support and be a member of the team that tries to alleviate the pain and frustration that human beings impose upon each other?

As volunteers, we look for a coordinator who is a warm human being and sensitive to our needs, who has the knowledge and ability to build an enriched service program that we can serve—and who has the far-sightedness to allow us to help expand that program.

Now, in true schizophrenic fashion—so that you will all feel at home—we will leave Jane Q. Volunteer.

I, Jeannette Vitkin, will take her place and will speak to you from my personal experience. Perhaps you would like to know what I have been doing at the New York Hospital for nearly three years: as a volunteer three days a week, practically everything within reason. From selling candy and notions from the buymobile to acting as receptionist at the front desk or escorting families of potential patients to view the hospital. But my duties are now as part of the team on a hall of male patients. I play an active role at the patient staff and staff meetings. I am in a unique position. The staff considers me staff. But the patients consider me—as they have said—"A friend . . . one of us."

My other service, which is most unusual for our hospital, started over a year ago with me as the first volunteer in the EST Department. Here

my coordinator allowed me the privilege of trying to bring something to EST that had never existed before. Understandably the atmosphere was tense. I felt there was a need for change and it has worked miraculously. We now have soft music and the atmosphere is lighter. The charge nurse, anesthetist, doctor, and aide all accept this new atmosphere and like it. We are a team. We work in perfect harmony. I bring in the patient with smiles and conversation. The patient feels the absence of tension and is not as apprehensive as formerly. My presence is respected and has become a vital part of the procedure. I do not look for gratitude but it is wonderful to hear a member of the staff say, "Thank you. I do not know what I would have done without you today."

A time limit of fifteen minutes is a cruel blow to a woman who has a captive audience. But I must tell you one story that will explain why, I think, I was asked to speak to you today. After all, why me?

I have not worked as a volunteer for forty years as some volunteers have, and so it must be my courage. I have proved my courage by coming here today and daring to speak to you in the manner I have.

Mrs. Phillips, my coordinator, who is my constant support knows that I am courageous. Because she heard tell that the first week of my volunteer service at the New York Hospital nearly three years ago, I was walking along the ground floor corridor when I came face to face with a live squirrel. He was sitting on the carpet. Believe me, we were both surprised. I had to make a very quick decision—catch him, I must. So, I went into an office filled with psychiatrists at a meeting. "Excuse me," I said. "Would you help me? There is a squirrel in the corridor." This took courage—believe me—and it has ever since. Because there was no squirrel there when they followed me out. I get the strangest looks from these doctors whenever we meet. A sort of—Is she? or Isn't she?—look.

Only her coordinator knows for sure.

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