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TODAY'S VOLUNTEER

by

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Today's volunteer does not act out of a sense of condescension felt by the do-gooders of the past, rather he moves from a more profound concern for his fellow man and in his actions he relates directly and personally to the individual who needs his help. He does not perform with the sense that his conscience is relieved and he is exonerated for the enjoyment of his privileges; rather he performs with the sense of a man who sees the world as too small for racism or bigotry or class hierarchies, who sees the world as an island in space whose precious resources we must all cherish and share together. He does not act out of a sense of duty and the puritanical repression of his ego; rather he acts with the full sense that he too will benefit from the service rendered, that his humanity will be enlarged and he will be richer for the gift he gives. He does not act with the hope that his influence by itself represents salvation; rather he acts with the knowledge that social change is an arduous and frustrating task, and that no permanent benefits will accrue until we've found ways to alter or vastly improve our system.

CHARACTERISTICS OF VOLUNTEERS IN A STATE MENTAL HOSPITAL

by

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Increasing attention is given to the significance of volunteers. However, few attempts have been made to examine the characteristics of particular volunteer populations and to relate these to the problems of recruiting, placing, supervising and rewarding volunteers in order to meet patient (client) need most effectively.

The Veterans Administration maintains records of the numbers of volunteers and the amount of time they contribute to hospitals.[1] The Bureau of Labor Statistics, in 1965, surveyed the amount of time given by volunteers, but the characteristics of the volunteers were not examined.[2] Paul Pretzel, 1970, has described the homogeneous profile of a small, volunteer group in a suicide prevention center.[3] *Editorial Research Reports* for March 5, 1969, pointed to the sparseness of data on volunteers and concluded that with such limited information it is very difficult to assess the real extent of volunteer work and its worth.[4]

A current study, "Volunteers in Rehabilitation" sponsored by Goodwill Industries surveys the duties performed by volunteers and the attitudes of agency staff toward volunteer by personnel.[5]

The paucity of assessment suggests ambivalence of agencies toward the utilization of volunteers. Volunteers are sought and praised, but the small amount of published data suggests that often they are not taken seriously as members of the agency team. The purpose of this paper will be served if staff members are sensitized to examine characteristics of their volunteers toward more effective utilization. Increased awareness of the kinds of people already serving as volunteers may encourage better definition of future recruitment efforts.

Characteristics of an agency's volunteers will be influenced by the nature of the agency and its clients, by its status, the popularity of its cause, staff attitudes, roles allowed to volunteers, recruitment techniques, and the nature of the community. Generalizing about all volunteers from the data of one agency is not warranted, but a particular agency's data may have implications for many kinds of volunteer administration problems in many kinds of agencies.

Lincoln Regional Center, (State Hospital), in the process of a current study dealing with the attitudes of volunteers toward mental illness, has obtained data identifying characteristics of 288 volunteers enrolled in active service in March, April, and May of 1969. At that time the Center was in the process of shifting from providing custodial to more intensive care. Some of the volunteers in the study worked with chronic patients, and others were involved with the acutely ill. Patient population was about 700, a sharp decline from a daily census of 1150 in 1966. The hospital included Adult, Security, Children's, and Medical-Surgical Units.

Volunteers have been involved in the hospital program since the early 1950's. Their primary function has been to supplement social, recreational and educational activities.

Lincoln, with a population of 160,000 people, two small colleges and one large state university, provides considerable resources for volunteer recruitment. However, the presence of a number of social agencies, a veteran's hospital, institutions for children, and three general hospitals makes for keen competition. The Center's location, several miles from the city, demands that its volunteers have their own transportation. Lincoln, a largely white-collar community, is strongly church-orientated with 66% of its citizens expressing a formal religious affiliation.[6] These factors are all reflected in the Lincoln Regional Center volunteer population. What follows is a profile of this group and a discussion of its implications.

Implications for Recruitment

Fifty-one per cent of the volunteers were under the age of 30. However, only 17% were age 30 to 50. This skewing in the direction of the young reflects the fact that Lincoln is a university community. However, with the need for middle-aged volunteers as companions for middle-aged patients, it is important to consider other reasons why LRC recruited such a comparatively small number in the middle age group. Very possibly the demands on this age group that keep them from volunteering are the same family, community and work interests which could be most helpfully shared with patients. Other explanations may be the lesser tolerance of the older volunteer for deviant behavior, their greater reluctance to become involved in close relationships

TABLE I

Identifying Characteristics of Lincoln Regional Center Volunteers

Topic	Profile of Average Volunteer	General Characteristics	%	Specific Characteristics	%	N-288 No. Ans.
Age	33 years	Under age 30	51	Under age 20	20	49
				Age 20 to 29	31	
				Age 30 to 39	05	
		Age 30 and over	49	Age 40 to 49	12	
				Age 50 to 59	14	
				Over age 60	18	
Sex	Female	Female	83			38
		Male	17			
Marital Status	Married or has been married	Married	49			14
		Single	44			
		Divorced or Widowed	07			
Amount of Education	High School Graduate	High School or less	33			43
				Under 4 years	41	
		Post High School	67	4 years	17	
				Beyond 4 years	09	
College Major	Humanistic	Humanistic	77			119
		Non-Humanistic	23			
Present Occupation	Not Employed outside of home	Housewife	34			46
		Student	34			
		Employed	25			
		Retired	6			
		None	1			
Past Occupation	Non-Humanistic	Non-Humanistic	61			119
		Humanistic	34			
		None	5			
Religion	Protestant	Protestant	90			23
		Other	10			
Assignment	Group Socializing	Group Socializing	70			88
		Individual	11			
		Other	19			

Topic	Average	General Characteristics	%	Specific Characteristics	%	No. Ans.
Organizational Affiliation	Church	Church School Other	55 34 11			87
Length of Service	Between 2 - 2½ years	Under 2½ years Over 2½ years	77 23	(ranges from less than 1 month to 29 years)		48
Previous Work as Volunteer	None	No Yes	96 4			41
Hours per Month	6 hours	4 hours or less 5 hours or more	68 32	(ranges from 1 to 80 hours)		75
Reason for Volunteering	Diverse	Help Others By Referral Gain Experience Personal Satisfaction Other	36 27 16 12 9			128
Help from Staff	Quite helpful	Very Helpful Quite Helpful Adequate Poor or Inadequate	54 33 12 1			33
Number of Volunteer Workshops Attended	3 Workshops	None 1 2 3 or More	34 30 16 20			69
Influence of Previous contact with Mental Illness	No Influence	No Yes	78 22			104
Reason for Terminating	Voluntary	Voluntary Termination	67	Too Busy Family Duties Taking a job Not Suited No satisfaction Try another agency Depressing	22 13 11 05 03 03 00	246
		Involuntary termination	33	Project ended Moving away	30 03	

with patients, or that their social-psychological needs are being met elsewhere. Whatever the cause, the profile reveals a need to discover a more successful way of attracting middle-aged volunteers. The 18% over age 60 demonstrates the important role retirees have as mental health volunteers.

The fact that about one-fifth of LRC volunteers are males suggests a greater potential for the recruitment of males than is generally realized. A concentrated effort to reach additional males, and the use of present male volunteers in this effort is indicated.

Volunteering offers opportunities for fulfilling educational and professional interests as well as social-psychological needs. That this may be a motivational factor is indicated by the fact that 77% of the volunteers had received some academic training in the humanities or social sciences. That 25% are employed people demonstrates the falsity of the stereotype of the volunteer as a middle aged housewife. With 90% of LRC volunteers declaring a formal religious affiliation, as compared to 66% of Lincoln's citizens, it is apparent that religion plays a significant role in volunteer motivation. Recruitment through church groups constitutes a major source of supply. That religion and group affiliation are intertwined as motivational factors is evidenced by the fact that 55% of LRC volunteers were participating as members of church projects and another 34% were involved in student organization programs. While recruitment through groups is relatively easy, a disadvantage may be the enrollment of volunteers more interested in their organization than in personal, meaningful involvement with patients. Also, the volunteer population shifts as the memberships of the groups change. While organization affiliation provides many supports for the volunteer within the agency setting, a question arises as to whether these volunteers are functioning with the degree of autonomy necessary to form meaningful relationship with patients. The average length of service of the Lincoln Regional Center volunteer is two and a half years. Seventy-six percent have worked less than two and a half years, while 24% have service records ranging from two and a half to twenty-nine years. Since no record was kept of the number of volunteers working at any one time prior to 1966, this data does not reveal whether we have a large group of volunteers constantly changing plus a small group of sustained volunteers, or whether there has been a greatly expanded number of new recruits since 1967. A study of volunteer retention over a five year period might well be in order along with an evaluation of why the volunteers come and why they terminate. With the many changes in the contemporary volunteer scene a determination of reasonable length of service to be expected would be useful. Turnover may be partly explained by the high percentage of volunteers who are students. While there is little

published data with which to make comparisons, LRC would seem not to have the rapid replacement of volunteers seen at Peninsula Children's Center which also uses many student volunteers.[7]

Volunteer retention is related to help given by staff. This is indicated in a study concerned with factors influencing students to stick with their volunteer assignments and even to pursue mental health careers. The most important motivator was the help they received from agency personnel.[8] Eighty-seven per cent of Lincoln Regional Center volunteers reported that staff had been either "very" or "quite" helpful. Some may find it hard to reconcile this endorsement of help received from staff with the large number of relatively short-term volunteers. The seeming inconsistency may relate to the absence of standards for determining what is a reasonable time for volunteers to remain with one agency. The Peninsula Study reported that 72% of their volunteers remained three months or less.

Implications

For Orientation and Supervision

The great diversity of age, education, length of service and motivation, revealed in the profile necessitates highly individualized programs of orientation, supervision, and on-the-job training. The traditional type of daytime orientation programs, described in the literature of so many hospitals, which caters to the interests, enjoyments, and motivation of middle-class housewives, will not fill the bill for the 65% of LRC volunteers who are either students, or full-time employees, or retirees.

Educational techniques, staff instructors, and supervisors need to be selected so as to accommodate the variations within the population. With a large number of the volunteers enrolled in college or having college degrees, serious attention must be paid to the level of presentation of both initial orientation and continuing education. A high degree of psychiatric sophistication cannot be assumed from available data, but many volunteers do have the educational backgrounds which permit a more than superficial presentation of information about treatment programs and philosophy. Such volunteers can be expected to assume competency on the part of staff, and staff can expect such young and educated volunteers to raise many questions about programs and procedures. Danger exists that an insecure staff member may be uncomfortable supervising a volunteer with more education and experience. The staff member, so threatened, could consciously or unconsciously let the volunteer feel rejected or unneeded. On the other hand such a staff member might over-estimate the real knowledge and understanding of such a volunteer and withhold-sufficient aid and support.

Age relationships between volunteers and staff working together should also be considered. Young staff may feel less at ease in interpreting treatment programs and in offering constructive criticism and support to the middle-aged and senior citizen volunteers. Uncomfortable relationships between volunteer and staff supervisor could easily result in dissatisfaction for all - staff, volunteer, and patient. Good supervisory practice requires that adequate concern be given to matching volunteers and staff so that they can work harmoniously together.

It is evident that the majority of LRC volunteers are busy people and the agency must use their limited volunteer time efficiently. Goals for orientation of new volunteers and goals for the continuing education of the longer-term volunteer must be set so that volunteers will not be asked to participate in time-wasting programs. With many volunteers serving as part of group projects, much training could, with the cooperation of the organization, be accomplished through regular meetings of the group. The kind, intensity, and extent of training should be a function of the roles volunteers play. Volunteers providing, for example, normalizing social experiences, need not be given a great deal of training about mental illness, nor should volunteers whose primary function is to provide the "kinship touch". These volunteers need a clear orientation to the agency, some understanding of the kinds of problems patients face, an awareness of treatment goals, and what is expected of them. On the other hand, volunteers, who may be taking more staff-like roles, such as tutoring, would need more intensive training. Whatever their roles, volunteers need continuous staff support and availability in the event of problems.

The constant influx of volunteers demands that an almost continuous orientation program be immediately available for the newcomer, as well as continuing education programs for the long term volunteer. The volunteer of several years might well be integrated into more advanced training programs and be included in any inservice education or special staff development programs that may be offered. As with long-term staff it is important to recognize the need for keeping the "old timers" up to date as treatment programs and philosophy of care changes. Without such continuing education long-time volunteers may exhibit the same inability to adjust to change as is sometimes seen in staff who have spent many years with the agency.

Implications for Utilization and Recognition

Preliminary analysis of our data on attitudes held by volunteers toward the mentally ill shows that authoritarianism and social restrictiveness are positively correlated with age. Therefore, age may be significant in placement of volunteers. Utilization of older volunteers in experimental programs which demand flexibility and permissiveness may

be questionable. With the expansion of the federally funded Senior Citizens Volunteer Program, RSVP, it would behoove agencies to examine the kinds of placement held by older volunteers in terms of service to the patients and satisfaction to the volunteers. Staff-volunteer age relationships may influence the effective utilization of volunteers. Situations where staff are supervising volunteers at least twice their age may be a problem for both staff and volunteer.

Also important in placement is the relationship of patient-volunteer age. In many cases the college-student volunteer is serving as a companion to a middle-aged or older patient whereas close friendship usually involves people of approximately the same age. If we see the volunteer companion in terms of helping to normalize the institutional environment, such mis-matching of ages may negate the most important value gained from such "one-to-one" placements. Our statistics on the age of volunteers indicated a dearth in the age group 30 to 50. This is the age group that would be most helpful in reintegrating the middle-aged patient back into the community and serving as role models for appropriate family and community behaviors. Although only one fifth of LRC volunteers are male, staff are currently requesting four times more male volunteers than female. This requires a careful evaluation of placement priorities in regard to sex and demands that more effort be expended on the recruitment of males.

Since the education level of LRC volunteers is high, consideration must be given to the possibility that educational and cultural distance between patients and volunteers may create barriers to a genuine friendship relationship and make identification and modeling more difficult. As the importance of the volunteer in one-to-one companionship relationships becomes more widely recognized, placement criteria may demand re-thinking. Many patients are aware that the achievements of the assured, well-educated middle class volunteers are beyond them. Volunteer coordinators and agencies will have to be more adventuresome in seeking out volunteers with whom patients can be more comfortable when the primary reason for the utilization of the volunteer is to meet friendship needs. The more educated volunteer may be more useful in the quasi-professional roles traditional for volunteers such as tutors, assistants in occupational, recreational and music therapies and as case aides, but placement in a "friendship" relationship may not always be appropriate. The need for research on qualities necessary for this kind of volunteering is increased as programs with one-to-one relationships expand.

The length of tenure of volunteers should also influence their utilization. Long term volunteers can be used to fill various roles relating to the teaching of new volunteers and the management of the program.

Volunteering at LRC is not prestige or power-giving. The majority of its volunteers are likely to be seeking meaning and understanding through personal involvement. As volunteers' motivation changes, new ways of providing recognition must be defined. The very large under-thirty volunteer group at LRC does not respond positively to the kind of certificate-giving, public-meeting-system of recognition so often used. The volunteer often resents giving time to participate in a recognition program. Today's volunteer finds his value through the quality of his inter-personal relationship with patients (clients) as well as through feedback from staff. Both are more powerful re-inforcers for volunteers than the institutionalized forms of recognition. The significant role for the coordinator of volunteer services is facilitating meaningful relationships between patients and volunteers and between staff and volunteers.

FOOTNOTES

1. *Editorial Research Reports* Vol. 1, No. 9. Mar. 5, 1969. P. 171.

2. *Editorial Research Reports* Vol. 1, No. 9. Mar. 5, 1969. P. 171.

3. Pretzel, Paul W. "The Volunteer Worker at the Suicide Prevention Center" *Volunteer Administration*, Fall 1970.

4. *Editorial Research Reports* Vol. 1, No. 9, Mar. 5, 1969. P. 171.

5. Speech - Levin, Stanley, Director, Volunteers in Rehabilitation Project, Annual Meeting of the American Association of Volunteer Services Coordinators. September 13, 1971.

6. *Lincoln Journal and Starr, P.* 7, Section G, July 25, 1971.

7. Burk, E. David and Switzer, Gail, "A Successful Program for the Constructive Use of Volunteers in a Community Agency," American Orthopsychiatric Association Meeting, March 21-24, 1971, Washington, D.C.

8. Reinherz, Helen, Sc.D. "Professional Supervision as a Means of Achieving Volunteer Program Goals," *Mental Health Volunteers* by Ewalt, Patricia and Greenblatt, Milton, Charles C. Thomas, 1967.

VOLUNTEERS IN THE AFTERCARE PROGRAM OF A COMMUNITY MENTAL HEALTH CENTER

by

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"Although the needs for manpower and the number of ways that volunteers can be used in expanding programs seems overwhelming, this very trend may actually provide the solution to some of our 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. . . 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".[1]

We are all aware of the difficulty of restoring the discharged mental hospital patient to the community and to an independent life. Discharge from the hospital and the ability to function independently are rarely synonymous, and various mechanisms such as the halfway house, day hospital, and aftercare programs have evolved to ease the transition from hospital to home.

The policy of The Northeast Community Mental Health Center has been to give the patient a continuity of care which at its best would enable him to develop his own strength and highest potential. Such continuity, it is felt, can best be assured by the use of supervised, empathetic volunteers who can be trained on the job and able to work closely with aftercare patients in a non-threatening way.

The Northeast Community Mental Health Center operates as a free-standing agency, with its own Board of Directors. Strong administrative support permits a degree of flexibility in the development of a broad volunteer program which began with the opening of the Center in the spring of 1970. The Coordinator of Volunteer Resources, her

Administrative Volunteer and the Coordinator for the Aftercare Program collaborated on plans for the use of volunteers at the very inception of the Aftercare Program during the first summer. Within two weeks, six volunteers from the Center's community were recruited. A newspaper article about the Center, written by the Staff Development Director, brought in two applicants (one a retired history teacher with a background of volunteer experience in a prison); a memo about the volunteer program to the Center's small grassroots auxiliary accounted for four other responses.

The Center set up a clinic schedule of eight sessions per week to accommodate over 100 aftercare patients on a monthly basis, to be seen in staggered units. Each clinic was staffed with a team: a psychiatrist who sees each patient alone in his office, and a psychologist, social worker and volunteer see the patients in a group. Depending upon staff background (state hospital experience) or special interest in the aftercare patient, each team has developed its own treatment pattern. The patients, now living in the catchment area, had previously been traveling over nine miles to the state hospital four times a year for medication and psychiatric follow up. Early difficulties in the Aftercare Program included the patient's reluctance to alter old habit patterns and the staff's struggle to keep up with constantly changing government regulations, guidelines and forms. With everyone else, the volunteers were swept into the "organized chaos" of the first two months of organizing the Aftercare Program. Frequently, the volunteers were the first contact the apprehensive aftercare patient would have on entering the Center's main building.

Staff attitudes toward the volunteer have been varied. Some psychiatrists tended to be concerned with the details of medication and directives relating to Aftercare follow-up as dictated by government mental health/mental retardation legislation. They are also concerned with laboratory tests and physical (including eye) examinations, to determine any untoward effects of long-term drug therapy. Their early training and work in general at state hospitals had familiarized them with the traditional hospital volunteer; but there were those who also saw the volunteer as an important component of the new kind of therapeutic milieu in a community mental health center. The psychologists and social workers also had varying attitudes: several were enthusiastic about using volunteers, particularly social workers who had worked in halfway house agencies or community mental health centers where, without volunteers, aftercare had to be limited to little more than "pill clinics" and brief visits; others were wary and ill at ease about how to relate to the volunteer on a working or personal level. Weekly Aftercare staff meetings, attended by the Coordinator of the Volunteer Program and at times by the Administrative Volunteer, became a forum. Discussion of the volunteers' work frequently

led to a reexamination of the concepts and goals of community mental health. How far dare one come out from behind the desk; what about home visits; what kind of therapy do you use on these people if your experience has been limited mainly to the treatment of the neurotic, usually middle-class, patient? At times, a note of wishful thinking appeared to underlie statements such as "Well, they don't really *want* to come in — why should we force them!".

One of the early difficulties was abstracting vital statistics of over 100 patients from the voluminous state hospital records. In this task of such magnitude and urgency at the beginning of the program, the effectiveness of the clerical unit was expanded by the work of volunteers.

As staff attitudes, personalities and methods varied, so did the volunteers. Mrs. J., one of the first of the Aftercare volunteers, has no difficulty making personal contact with the patient. Her approach is intuitive, stationing herself near the entrance to greet the patient warmly, saying a few words to the family who brought him, she senses the patient's apprehension and recognizes to what degree each might need support through the clinic procedures; coming into the group room, answering questions, going down the hall for the visit to the psychiatrist's office, back again to the group to rejoin whatever activity is taking place. On through the morning, until she says goodbye to each patient, expressing pleasure about their mutual contact and a word about looking forward to their next visit. She is concerned about continuity of care, suggesting ways of maintaining contact between visits, following up a "no show", and for one patient who speaks no English, making a half-dozen calls to find an organization concerned with Spanish-speaking people and arranging a meeting between the patient and a member. In a word — casework!

Mr. N., on the other hand, is a dyed-in-the-wool authority figure. Drawing upon a tremendous background knowledge of history, politics, current events, people, etc., he has devised a number of programs to meet the different levels of understanding for the Aftercare patients. Using audio-visual aids, he conducts discussions, quizzes and lectures for several Aftercare groups. Asked what he got out of it, he replied, "After a lifetime of teaching junior high school students, it's a pleasure to have people *listen* to you!".

Mrs. T., another early volunteer, conveys a sense of great strength with a dynamic approach. From the beginning, the psychologists and psychiatrists staffing the two clinics she works in used her as a member of the therapeutic team in their group work. The whole group process absorbs and excites her: the interaction among patients and between patients and therapists, body language, symbolic references,

hallucinations, obsessional behavior — what is going on at the time and what evolves from sesssion to session.

These are three of the contrasting kinds of personalities — subjective and intuitive, factual and didactic, insightful and analytic — who, with their varied approaches and personality differences, are samples of the twelve volunteers in the Aftercare Clinics who have become an integral part of the Aftercare Program. It is pertinent to note, however, that our placements are not always successful. Some volunteers function more successfully in a structured routine setting, quite different from our community mental health center Aftercare setting. Where a staff member or a volunteer have expressed discomfort in their working relationships, we have not hesitated to move the volunteers to more compatible assignments.

Supervision and training of the volunteers proceeded in steps. After the initial in-depth screening interview in the Volunteer Office, the Aftercare Coordinator (with the Administrative Volunteer attending for liaison), held an orientation meeting for the volunteers. Each Aftercare Clinic staff team was responsible for on the job supervision, and an attempt was made to set aside a few minutes after clinic to discuss and evaluate the session. Staff and volunteers recognized early that this was not adequate, but it was the volunteers who actually demanded more intensive training. Finding themselves in a group of particularly difficult or strangely acting patients, volunteers stated on a number of occasions, "I'm not a professional — how can I trust my judgment?".

We scheduled two-hour training sessions at monthly intervals running from 11 A.M. to 1 P.M., including a lunch hour, to allow many Aftercare staff to participate who might otherwise have had scheduling difficulties. The Volunteer Office planned, hosted, and chaired these early meetings. The volunteers had very definite ideas about what they wanted to know; what did the behavior, appearance, and speech of the people they were seeing signify; what were the names of their disorders; what kinds of treatment — chemical and psychological — had proved to be effective? They had many questions and some anxiety about their own roles; what could they safely talk about and do with the patients?

At the Aftercare staff meetings, a psychiatrist, psychologist or social worker would volunteer to be responsible for presenting a subject for the following volunteer training lunch session. A discussion and question-and-answer period was planned to follow the prepared talk.

From the beginning of the program, relationships between several of the staff and volunteers had been warm, sharing, and reinforcing,

setting the tone for the informal atmosphere of the training sessions. We sat in a loose circle; other Aftercare staff would drift in if they had a free hour, as well as did staff of the children's unit, intrigued by the din, or possibly the free lunch. From 12 to 1 P.M., staff and volunteers of the different clinics would group together and get deeply involved in exchanging thoughts and ideas about their mutual patients and program problems. Many times, people forgot to help themselves to the buffet lunch, became so interested we had to remind them to eat, of what time it was, and that some had clinics or patients waiting. The new Aftercare Coordinator, a psychiatric social worker, appointed from the Center's Outpatient Service, brought further innovation and tremendous enthusiasm about the value of the volunteer corps. By this time, with the program four months along and the patient load up to more than 150, it became evident that more meaningful groupings within the clinic had to be worked out. The staff, with volunteers peripherally helping, made up new patient groupings based upon a more realistic appraisal of needs.

As various levels of ability and ego strength of the patients were assessed, one group of patients began to stand out what seemed to call for a climate not provided by the clinics alone. These were people who had had many years of hospitalization, and little, if any, familial or social resources. They were unable to work or even to become engaged in any kind of structured treatment setting. Based on the great success of holiday parties spontaneously planned by staff and volunteers, the Aftercare Coordinator and some staff, with the Administration's approval, conceived of a weekly leisure-time drop-in lounge. One of the Center's outpatient branch clinics, housed in a small row house in the community, seemed a more comfortable, friendly place than the main building. Experienced volunteers would provide the manpower, with professional staff in the building available when needed and for supervision. The goal was to provide socialization in the least threatening, least institutional atmosphere. The clinic patients were informed and invited to drop in; some were offered transportation. Response by the patients and excitement on the part of the volunteers was immensely gratifying; for example, amazement at the seventeen patients who poured in on a cold, rainy day of the fourth week. The true interest and concern of the volunteers triggered creative ideas for activities and compensated for early lack of supplies. Homemade craft work, sewing, games, and sometimes just chatting together took place. Two young Center staff of the clerical unit had run a crafts bazaar in the main building for the Aftercare Program, and this provided funds for refreshments and some equipment for the early parties and then for the leisure-time lounge. The auxiliary raised a thousand dollars for furniture and equipment. Deceptively, this seemed an easier situation for the volunteers than the clinics: to welcome with warmth, nurture, entertain, encourage simple skills in a relaxed, easy-going at-

mosphere. At the now weekly and more intensive training sessions, (alternating didactic with case discussion), the dynamic volunteers of the leisure-time lounge discussed what they were doing. There was thoughtful comment and criticism by the clinic staff and volunteers: "Sounds like you're doing too much *for* them"; "Do they help themselves, or do you serve them?"; "Shouldn't they take some responsibility for the running of the lounge — even contribute?" Professional staff raised the question of what actions might foster dependency. What were the goals of the lounge: to create a totally accepting, ultimately static climate, or try to raise the levels of performance and think in terms of helping some patients to move into other community agency programs such as those offered by the YWCA or neighborhood clubs?

It became apparent that staff did not agree among themselves abou. handling this program. There were intense exchanges revealing philosophical differences. What indeed was within the province and responsibility of a community mental health center to help these most disabled people? An individual coming in from outside upon a meeting such as this might well have difficulty distinguishing the professional from the volunteer. For the Volunteer Coordinator and the Administrative Volunteer, looking at the total Aftercare Program and participating on a different level, the greatest fascination has been to observe the gradual welding together of volunteers and professionals into a coordinated team. We notice attitudes shifting. Some staff speak constantly to the strengths of the volunteers; "You aren't hung up with a professional image - you are the reality link to the world our patients must adjust to." Others of the staff are becoming more and more won over to the value of trained volunteers to the program. The Aftercare Coordinator relates to her volunteer on a matter-of-fact level, her expectations enabling the volunteers to continually develop and grow.

The Aftercare volunteer force is now a year old and consists of 12 carefully selected people. Plans to run the leisure lounge another day, and possibly an evening, creates a need for more volunteers. Men from the business and religious community of the catchment area are applying to the volunteer office, and the potential for developing our own rehabilitation program and consulting with community agencies on the problem of housing for discharged patients, excites us all. A good working relationship established by the Aftercare between the Center and Philadelphia State Hospital, has permitted trips of all the Aftercare volunteers to visit the Hospital's sheltered workshop and the unit housing patients who will be discharged to our catchment area. Future plans include offering to Aftercare volunteers a 40-week credit course to be approved by a local university with the view toward developing a corps of para-professionals.

There is no doubt that change creates problems and makes many people uncomfortable. It is appropriate to point out that without change, flexibility, innovation, and creative thinking, community mental health, the "Bold New Approach", is in danger of becoming just another rigid bureaucratic institution. Fortunately, there do exist idealistic, sometimes impractical, deeply caring people who will aways challenge the status quo. It is this kind of constructive professional, working along side of, and training the untrained, who recognize the boundless limits for the creative use of human resources.

(1) From address by Dr. Joseph Adelstein - Deputy Secretary for MH/MR of Pennsylvania Department of Public Welfare, Annual American Association of Volunteer Service Coordinators Conference, Norristown, Pennsylvania, August 1970.

UNHAPPY EXPERIENCES WITH COURT VOLUNTEERS: A SOURCE OF LEARNING

by

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It is well known by those who manage volunteer programs that *things do not always work out well.* Conflict between volunteers and paid agency staff is not uncommon. When volunteers work directly with agency clients, conflict and misunderstandings can also develop between the volunteer and the client. Such conflicts are unpleasant to deal with and can make the coordinators job rather stressful. These unhappy experiences can, however, be a source of learning. By paying attention to what goes wrong we can discover ways of improving the procedures we use for the selection, training and supervision of volunteers.

This article reports selected findings derived from a larger study of volunteer activity in juvenile court probation.[1] In particular, this article focuses on the complaints and criticisms expressed by some parents whose children were involved with court volunteers. The volunteers were expected to meet with the probationers once a week and serve as a friend and an adult model. Each volunteer had been carefully screened and each had participated in nine hours of training.

In order to find out how the parents of probationers perceived the volunteer, forty-five parents were interviewed. Each parent was asked thirty-seven precoded questions designed to measure their assessment of the volunteer's impact on the probationer. The final interview question was open-ended. This question was the following: "Can you think of any other way that the volunteer has been either helpful or harmful to ———(probationer's name)———, to you or to your family." The parents took from about two to ten minutes to answer this question. Most of the parents gave answers which indicated that they were generally positive toward the volunteers and the volunteer program. Quite a few, however, expressed a mixture of satisfaction and dissatisfaction with the volunteer. A few parents registered only complaints and criticisms. The exclusive focus of this article is on dissatisfactions, complaints and criticisms.

[1] Charles R. Horejsi, "Parents' Perceptions of the Effect of Volunteers on Juvenile Probationers" (Doctoral Dissertation, University of Denver, 1971).

Presented below are the paraphrased statements of parents who were less than satisfied with how the volunteer had performed. Needless to say, these are subjective statements. They do, however, draw our attention to the complexity of volunteer-probationer relationship and the fact the program manager must be alert to what can "go wrong."

A Mother's Statement About Her Fourteen Year Old Son and An Eighteen Year Old Volunteer

I felt positive toward the volunteer until I learned the volunteer had made it easy for my son to lie to me. The volunteer found out that my son had stolen some money. The volunteer tried to cover-up for my son. He didn't want me to find out about the theft. As his mother I had a right to know. I was very angry with the volunteer. Maybe the volunteer was too young to be a volunteer. Whatever the reason, he used poor judgement.

A Mother's Statement About Her Fourteen Year Old Son and a Forty-One Year Old Volunteer

The volunteer was too old. He was as old as my son's father. The volunteer came on too strong—he acted as if he were a teenager. Also, the volunteer was a divorced man. People who have personal problems should not try to help others. Also, my other children didn't think it was fair for their brother to have a volunteer and be able to participate in enjoyable activities just because he had gotten into trouble with the law.

A Mother's Statement About Her Sixteen Year Old Daughter and A Twenty-one Year Old Volunteer

The volunteer dressed like a Hippie. I didn't like the idea of my daughter associating with her. Once when they were together the volunteer was stopped by a policeman for speeding. I don't think the volunteer did much harm but she didn't help either. Sometimes she was a poor example.

A Mother's Statement About Her Fourteen Year Old Son and A Thirty-One Year Old Volunteer

I was unhappy because the volunteer didn't follow through. The volunteer only met with my son six times during the past six months. The volunteer would make promises to meet with my son but then broke

the promises. The volunteer had a job that involved a lot of out-of-town travel. Since he didn't have the time, he should not have been selected as a volunteer.

A Mother's Statement About Her Sixteen Year Old Son and An Eighteen Year Old Volunteer

The volunteer did not spend enough time with my son. Also, he was just too young to be able to deal with my son's behavior. He bit off more than he could chew. My husband and I cannot handle our son either. Maybe an older, more mature volunteer would have succeeded.

A Father's Statement About His Fifteen Year Old Son and A Twenty-Seven Year Old Volunteer

It seems like our son was rewarded for getting into trouble. After breaking the law he was assigned a volunteer. As a result of getting into trouble he got a lot of attention and got to go a lot of places that were enjoyable and fun. Instead of the volunteer taking our boy places, it would have been better if we could have been given the money to take him places ourselves.

A Mother's Statement About Her Fourteen Year Old Daughter and A Nineteen Year Old Volunteer

The volunteer was helpful in some ways but I didn't like it when the volunteer tried to push religion down my daughter's throat. The volunteer didn't pay much attention to the kinds of things my daughter liked to do. Instead they went places and did things that the volunteer selected.

A Mother's Statement About Her Sixteen Year Old Daughter and A Thirty Year Old Volunteer

The volunteer was helpful to me. She probably helped me more than my daughter. Because the volunteer spent time with me, my daughter was jealous. She resented me being involved with her volunteer.

A Mother's Statement About Her Sixteen Year Old Son and A Twenty-One Year Old Volunteer

I never had much control over my son. In some ways the volunteer made things worse. When I tried to keep my son at home as punishment the volunteer would come along and take him out to have fun somewhere else. My son was manipulating the situation and I couldn't do much about it.

A Mother's Statement About Her Fifteen Year Old Son and A Twenty-One Year Old Volunteer

At times my husband has felt replaced by the volunteer. He feels he

is the father and should be the one who takes our boy to ballgames and places like that. Also, my other children think it is unfair that they do not have a volunteer. They have never been in trouble. Their brother has been rewarded for getting into trouble. The other children ask why they can't have a volunteer.

A Mother's Statement About Her Fifteen Year Old Son and A Thirty Year Old Volunteer

I hate to say it but the volunteer was terribly naive. My son really manipulated the volunteer and the volunteer didn't even know what was going on. The volunteer believed everything my son told him.

A Mother's Statement About Her Thirteen Year Old Daughter and A Twenty-Three Year Old Volunteer

My biggest complaint is that sometimes the volunteer would not show up when my daughter expected her. Once I was very upset when the volunteer asked my daughter to babysit. My daughter expected to be paid for babysitting with the volunteer's child but she was never paid. My daughter never said anything to the volunteer but she was very hurt.

Conclusions

What do these "unhappy experiences" teach us? First, they tell us that volunteers and volunteer programs, like any other human effort, can create problems, misunderstandings and conflicts. We should expect problems to occur. It is unrealistic to expect that every volunteer will work out well and that every volunteer assignment will be a "success." By knowing what can go wrong, we can develop better methods of selection, training and supervision. Being alert to potential problems, we can prevent many from occurring.

These experiences make us aware that volunteer activity is complex. When, for example, a volunteer works with one member of a family he also has an effect on other family members. Different family members may perceive the volunteer differently. Volunteers need to be aware that the various family members may have different expectations. By meeting the expectations of one family member, the volunteer may disappoint others.

Programs of court volunteer training and orientation should include a discussion of the volunteer's relationship with the probationer's family. The typical training program gives little attention to the volunteer's interaction with the probationer's family or with other

signficant persons in the probationer's life. It is apparent that the volunteer cannot avoid being involved at least to some extent with the probationer's family.

Volunteer supervisors or coordinators must keep in touch with the volunteer's work. This is especially important when the volunteer assignment involves a family. The coordinator should inquire about the volunteer's relationship with other members of the probationer's family and help the volunteer assess his impact on all concerned. The coordinator should be alert to any developing problems and attempt to deal with them before they grow too large.

Lastly, these unhappy experiences tell us that we must be open to both positive and negative "feedback" from the probationer, from the probationer's family and from anyone else whose opinion can assist us in evaluating a volunteer's performance and the impact of our volunteer program. Such an openness is a prerequisite to advancing our understanding of how to utilize volunteers effectively.

A VOLUNTEER RECREATION PROGRAM IN A GENERAL HOSPITAL

by
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Voluntarism is a way of life in our society. It affords the opportunity to realize one's potentialities by giving time, energy, comfort to another human being - bringing the meaning of purpose to another's life.

The volunteer of the 70's is a non-paid person who gives time to furthering the objectives of the organization. In a hospital setting, the volunteer enhances the quality of care, provides complimentary proficiency, and helps to sublimate depersonalization.

In the 20th century, voluntarism means housewives, retirees, factory workers, clerks, professional people, students, office workers, people from all walks of life - the microcosm of America.

An excellent example applicable to the importance and effect of non-paid staff in a medical setting is cited accordingly:

"Terrific program, we really enjoyed ourselves." "I forgot my aches for awhile." "We will come again." "I just couldn't believe someone would do this for us." "Who is responsible for this - who do we thank?"

The above comments were made by patients who had participated in our informal education recreation program. Beginning on December 3, 1970, and as a demonstration project, it presented recreational opportunities for all patients able and interested in participating. The project was a joint undertaking between the departments of Occupational Therapy and Volunteer Services.

A 503 bed general hospital with many critically ill patients is an unexpected place to find an informal education recreation program. It was not surprising to experience negative reactions when the director of Social Service recommended it for consideration. The basic questions centered around the recipients - did the patients feel the

need for such an event? To obtain an answer, a two day survey was completed by members of the chaplain's class and volunteers. A total of 233 out of a possible 402 indicated they would participate if physically able. There seemed to be no doubt; the machinery was put in motion, plans were formulated.

Operational volunteers and a group of supportive volunteers were recruited. The first evening the participants varied in ages from fourteen years to eighty, and rehabilitation, psychiatric, surgical and medical patients and their immediate families came. Bingo was chosen as the activity; 89 attended. Resulting from the taping of an analytic discussion immediately after the session, some of the difficulties encountered by the volunteers and therapists were transportation of wheelchair and cart patients, timing, communications between day and night staff, too few experienced and too many inexperienced volunteers, and some overcrowding. To the volunteer director, the most apparent improvement necessary to make the project successful was giving the volunteers training in the area of informal group leadership. Basic concepts would have to be taught; therefore, the social recreation program had two extremely important objectives - (1) alleviation of pain and discomfort for the patient, and (2) concentration on development of each volunteer as informal education and recreation group leader. Through verbal instruction and written resource materials, group work concepts were introduced. Throughout the following months particular group work techniques were applied. Each volunteer proceeded to his own level of competence; each reached a plateau of development which perpetuated sensitiveness, confidence and rapport with patients' varied personalities.

The informal recreation program is envisioned as one mechansim which has great potential for the patient, for the volunteer, for their future growth. Singers, a magician, a one act play, slides, etc. were some of the programs presented. All of these were resources gleaned from the community. A questionnaire given out during one of the programs specified a number of possible events that could be scheduled. To the amazement of the volunteer director, requests for speakers, current events, discussion groups, and hobbies were listed as units of interest. What great possibilities could be explored and certainly great potential for community involvement!

St. Luke's Hospital embraces the philosophy of "total patient care" and certainly this is perpetuated. Fears, anxieties, concerns may often delay recovery; yet, these feelings can be subdued for a time. Wheelchairs, canes, portable oxygen tanks slip into the background and are forgotten as volunteers assemble the patients for an activity.

KEEPING CURRENT

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ANNOUNCEMENTS

THE OLDER VOLUNTEER

A portfolio on *The Older Person as a Volunteer* has recently been published by and is available through the Clearinghouse, National Center for Voluntary Action, 1735 Eye Street, N. W., Washington, D.C. 20006. The cost is $1.00.

This portfolio of materials selected by the Clearinghouse includes:

—Over 20 one-page program descriptions which illustrate the diverse volunteer activities of older persons, such as:

business and employment counseling	assisting with taxes
caring for "latchkey" children	informing consumers
serving as friendly visitors	helping veterans
providing telephone reassurance	aiding in crime prevention
	assisting teachers

—The name and address for a source to contact for additional information are listed for each program.

—"Green Sheet" annotated listing of relevant resource groups, general publications on older volunteers and materials related to training older volunteers - prices and source information provided.

—Sample brochures, a reprint, information sheet on the RSVP program, film information . . .

GRANTS ANNOUNCED TO DEMONSTRATE

VOLUNTEER POWER

Twenty-three communities nationwide are part of a demonstration to show how a minor investment of public funds, coupled with citizen energy, can create a major public benefit.

Edwin D. Etherington, president of the National Center for Voluntary Action, announced that approximately $400,000 of federal money is being channeled through the National Center, a non-governmental organization, to help create more effective ways to put volunteers to work in community service. The funds have been provided by the federal ACTION agency.

Seven grants will help communities get Voluntary Action Centers into place. Sixteen others will help existing centers develop model volunteer programs for duplication nationwide.

Henry Ford II, chairman of the National Center, this past September announced the formation of 32 Voluntary Action Centers. Nineteen more have since joined the network.

Focusing on the alleviation of critical social problems through citizen-to-citizen assistance, the funded programs range from New York City's plan to situate volunteer recruitment stations in disadvantaged communities, to San Mateo County, California, where former mental patients will be trained for and placed into community service roles, to assist their transition back to full employment.

In Boston, where the Volunteer Office of United Community Services of Metropolitan Boston has been designated the Voluntary Action Center of Metropolitan Boston, a $28,223 grant has been awarded to inventory and develop new roles for groups of volunteers.

Funds will also reach such rural communities as Billings, Mont., McAlester, Okla., and York County, Me., where pilot Voluntary Action Centers are being developed.

Grant-supported projects in other localities will aim at training volunteers, providing out-of-pocket expenses for low-income volunteers, establishing neighborhood service centers, conducting volunteer recruitment campaigns and organizing student community-service activities for academic credit.

Edwin D. Etherington, president of the National Center, said, "These grants demonstrate how small amounts of money can seed vast public benefits through volunteer service — such as in day care centers, food cooperatives, prisoner rehabilitation programs and countless other areas of community needs."

Erthington continued, "In the state of Washington, for example, in two years time a volunteer program has been developed where more than 11,000 citizens provide services —not otherwise available—in the welfare and criminal justice systems and in facilities for the mentally ill and retarded. Supported by minimal staff, budget and taxpayer dollars, the dollar return is in the millons."

Nine grants range from $10,000 to $40,000, which must be matched locally, and fourteen from $2,000 to $10,000.

The National Center for Voluntary Action was opened in February 1970 as the private-sector component of the National Program for Voluntary Action initiated by President Nixon. Supported by private contributions, including a major grant from the Ford Foundation, it operates the nation's largest clearinghouse on volunteer programs and the annual National Volunteer Awards to recognize volunteer achievement.

The announced grants will support voluntary action efforts in Birmingham, Ala.; San Mateo, Calif.; Los Angeles, Calif.; the Monterey Peninsula, Calif.; Riverside, Calif.; Palm Beach County, Fla.; Atlanta, Ga.; Gordon County, Ga.; Evansville, Ind.; York County, Me.; Boston, Mass.; Detroit, Mich.; Saginaw, Mich.; Kansas City, Mo.; St. Louis, Mo.; Billings, Mont.; New York City, N.Y.; Niagara Falls, N.Y.; Toledo, Ohio; McAlester, Okla.; Philadelphia, Pa.; Providence, R.I.; and Seattle, Wash.

VOLUNTEER PROBATION ORGANIZATION

BECOMES PART OF

NATIONAL COUNCIL ON CRIME AND DELINQUENCY

The National Council On Crime and Delinquency, the country's largest volunteer agency in the criminal justice field, and Volunteers In Probation, Inc., the largest volunteer probation program will merge operations this month. VIP will become a major part of NCCD's citizen action program.

According to Carl M. Loeb, Jr., President of NCCD, the addition of VIP will strengthen the agency's efforts to involve citizens in practical programs to help combat crime and delinquency.

VIP was established, in 1959, by Judge Keith J. Leenhouts of Royal Oak, Michigan. He pioneered in the development of the volunteer probation aide concept and helped establish programs in more than 2000 courts and correctional institutions. An estimated 150,000 volunteers now provide probation assistance to juveniles and adults, augmenting the efforts of professional probation officers primarily as friends serving on a one-to-one basis to offenders.

Judge Leenhouts, who will continue as director of the program, contends that virtually every court can use volunteers — mature men and women who are willing to devote some time to rehabilitation efforts. Said Leenhouts: "NCCD will now begin to promote volunteer probation and other volunteer programs in the criminal justice field through its state councils. The recruitment of citizens who are willing to assist the courts and other agencies will be a major step forward in helping rehabilitate offenders."

National VIP Board Chairman, Joel E. Nystrom and Mrs. Potter Stewart have been nominated to the NCCD Board of Trustees as a result of the merger. Mr. Nystrom, of Skillman, New Jersey, is the retired International YMCA Executive Director. Mrs. Stewart is the wife of the Supreme Court Justice.

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