THE VOLUNTEER AS A NEW RESOURCE IN THE COMMUNITY PSYCHIATRIC TEAM

ROYAL COLLEGE OF PSYCHIATRISTS
KING'S FUND CENTRE
AND THE VOLUNTEER CENTRE

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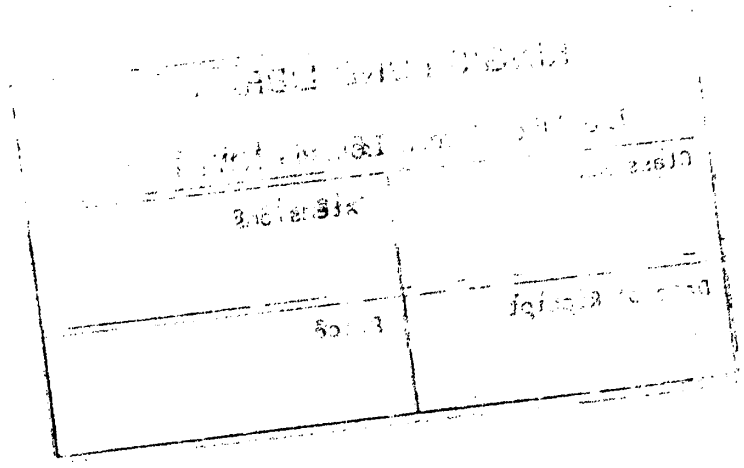
The King's Fund Centre
126 Albert Street
London NW1 7NF

QADT (Roy)



This conference report has been produced as an edited version of a draft prepared by Julia Birley, Voluntary Help Organiser at the Bethlem Royal and Maudsley Hospitals to whom the conference organisers are very grateful.

INTRODUCTION

The publication of the report of the Wolfenden Committee entitled 'The future of voluntary organisations' has focussed attention on the pluralism which is a significant feature of our system of caring. One of its chief recommendations is that there should be an increase in the funding and assistance given by the statutory services to the voluntary sector, coupled with a growth of co-operation in the planning of provision, whilst resisting the temptation to bring the voluntary sector under too close statutory control.

Psychiatrists too are looking at groups and invididuals among the lay public to improve or even supply community support networks. As one of the background documents for this Conference points out, this initiative has been slow in coming. One of the reasons adduced may be historical: as long as psychiatric care was largely confined to mental hospitals a great distance from their catchment areas, there could be little hope of successful collaboration with community workers - and a fortiori with volunteers. Another may be the reliance which psychiatry naturally places on informal support of spouses, relatives and friends. The growth of community care, which has underlined, sometimes in a shocking fashion, the enormous problems of isolation in mental illness, especially where informal support is absent or impracticable, may be expected to hasten a change of attitude. A Conference at which psychiatrists and volunteers, along with others concerned, both speak from the platform and work together in groups to discuss strategic problems must surely be evidence of that change.

BACKGROUND

The Conference was sponsored jointly by the Social and Community Psychiatry Group of the Royal College of Psychiatrists, The Volunteer Centre and the King's Fund Centre. It was planned on the premise that 'at a time when community services are developing rapidly, despite the effect of cuts in public expenditure and ever-growing case-loads, there is a need for re-thinking some of our traditional ways of working. - It is reasonable to examine how volunteers might more effectively contribute to this aspect of our work.' Key persons were invited who had already initiated, or were taking part in schemes involving collaboration between psychiatric staff and volunteers working in the community. These included psychiatrists, community psychiatric nurses, social workers, voluntary service co-ordinators (VSCs) and volunteers from nine community psychiatric teams. Participation was also invited from health-care planners, community physicians, and others from the Department of Health, the Health Advisory Service, the Scottish Health Service Centre and elsewhere. In addition to individual volunteers serving the psychiatric teams, the voluntary arm was represented by a general secretary of a Council of Social Service and officers of MIND and of the Mental Health Association of Ireland.

Two reports were circulated to all participants before the Conference. Each contained thought-provoking and perhaps controversial material.

I The Report of a Working Party on the Organisation of Preventive Services in Mental Illness, set up by the Public Health Committee of the Council of Europe, Strasbourg 1974-5.

The introduction to this wide-ranging document explains that its originators 'addressed themselves mainly towards mental health techniques. They did not concentrate on mental illness in its strict sense, but considered it more broadly as a form of maladjustment which interfered with the capacity of individuals to perform their daily tasks.' An equally broad view of techniques and responsibilities for prevention is taken, that will involve society as a whole, as well as the professional mental health services, alike in primary prevention (identification of high risk situations) secondary prevention (early treatment) and tertiary prevention (rehabilitation). The concept of total care will be community based; in the section on personnel, members of support groups such as teachers, police, clergy and neighbours are described as key figures.

A specific message for this conference occurred in the section on Techniques of Prevention, which states that a role for the professional is to foster the development of support systems, initiating processes that can be continued by others; but that he should recognise the skills of lay helpers, and not try to impose a professional pattern on them.

In the appendix a useful check list is given of high-risk groups within the community together with the agencies which are in a position to identify people at risk and those which are able to help to reduce that risk.

This Council of Europe report is staggering in the number and range of services which it recommends - only an organisation of organisations could hope to co-ordinate these. The second paper tries to introduce a possible solution to this problem, the deployment of a Voluntary Service Co-ordinator (VSC).

II Report on the Use of Psychiatric Resources for Indirect Services (1975) by a multidisciplinary working party set up by the Social and Community Psychiatry Group of the Royal College of Psychiatrists.

This Report considers 'the extent to which psychiatric resources should be devoted to collaboration and consultation with other care givers rather than the provision of direct clinical service', and looks at 'the implications of this for the planning of services and training of psychiatrists.'

In the second section, volunteers are named as an underused source of help for the psychiatric team. The responsibility for improving this resource is placed specifically with the Voluntary Service Co-ordinator, whose remit should be extended beyond the hospital environment. It is recommended that one or more VSCs be appointed in each Health District, that they should be members of the Health Care Planning Team (Psychiatry), should review services and identify

the areas in which needs are not met, in addition to drawing up and effecting a programme for voluntary service. This would be to revolutionise the role of the VSC as seen at present, and to create another field of administration ancillary to the psychiatric team. Psychiatrists and their colleagues should thus acquire a much closer working relationship with volunteers and voluntary organisations, which would include offers of consultation at various levels, and participation for instance in the selection and training of those who are to counsel the emotionally distressed.

THE PROGRAMME

The conference was held at the King's Fund Centre on March 22 1978, with over 80 participants. The morning was devoted to a plenary session. Two speakers on the general implications of the subject were followed by members of the Multiprofessional Psychiatric Team in Central Lewisham, which is beginning to involve volunteers in a much expanded service. In the afternoon, participants divided into 5 groups to discuss in more detail the many problems of using volunteers. A further plenary session received the statements of a rapporteur from each group.

PLENARY SESSION

Dr Rudolph Freudenberg, as Chairman, had been a member of both the Working Parties which had produced the background documents, and reminded his audience that they had been convened, in accordance with the aims of the conference, 'in the hope of promoting new services as well as helping to improve those already in existence.' He felt that the contribution of volunteers could be of value in all three fields of prevention.

Speaking of Report I, he underlined the approach by defining high risk groups, people who, for one reason or another, are at special risk of mental illness and suggesting measures for identifying and supporting them as useful starting points for planning a service according to local needs and available resources. It was hoped that the conference would stimulate interest and explore broad strategies rather than concern itself with working out detailed programmes for specific groups.

The Chairman introduced Dr Parkes and Mr Duncan as speakers, to be followed by Dr Brough, who would introduce members of the Lewisham team and present the project.

Dr Parkes, who had been chairman of the Working Party which produced Report II, opened on a firmly optimistic note. He felt that the contents of both background documents were relatively uncontroversial: that preventive and community psychiatry are already widely recognised as practical possibilities. However, as the services are now organised, psychiatrists can treat only a small proportion of people with mental illness, while those who take an interest in the wider field of the vast numbers 'at risk' are often accused of 'empire building'. In fact people whose work, whether paid or voluntary, confronts them with the problems of prevention, are all aware that they cannot hope to meet more than a small part of the total need. Thus preventive service has so far developed in a haphazard fashion, dependent on individual whims and interests.

Some guidelines for a better approach to planning, which could lead to a lasting improvement in mental health care already exist in the White Paper 'Better Services for the Mentally Ill'. This recommends that multidisciplinary teams, responsible for and responding to the needs of limited sectors of the Health District, should be linked with community agencies, and operate services within the district, rather than from a distant mental hospital. Far greater mobilisation of community resources is needed, however, to give effect to the ideas proposed in the Reports I and II. The establishment of hospital VSCs, though an encouraging development, may not realise its potential, if their activities remain confined to the hospital. Now that the psychiatric team is beginning to leave the hospital in order to improve community service it is time for the VSC to do the same.

For members of the psychiatric team, Dr Parkes' advice was to 'know their patch'. The Community Psychiatrist should inform himself about the range of voluntary services provided in his district, and should work to fill gaps.

Mr Sandy Duncan presented the perspective of a long experience of volunteer organisation in the community, in hospitals and as an officer of The Volunteer Centre, in a discussion of the identities of the volunteer and the VSC. He had felt in watching the growth of multidisciplinary teams that members needed to be sure about their identities as a pre-requisite to blurring roles and sharing skills. To regard the volunteer for instance as a 'mini professional' would be counterproductive, as a very natural antagonism to the blurring of roles would arise. His great advantage, which does not challenge the professional, is that he is a 'generalist' and a man among men, who may be perceived by the client more as one of Us than one of Them. Thus he should be a new resource in, rather than to, the community psychiatric team, provided his identity is maintained. An example of successful befriending of a self-destructive patient was quoted in support of this.

In the case of the VSC, Dr Parkes had referred to the emergence of a new profession, but this profession was probably not too sure of its identity, judging by the adoption of at least 15 different titles for it in the Health Service. He felt this was partly due to quick development, partly to the curious role of bridge between volunteers and staff, hospital and community.

Dr Brough began by explaining the evolution of the Lewisham community-based multiprofessional team. Though well served by both DMT and Social Services, Lewisham, like other boroughs, was still waiting for its District Psychiatric Services. At present there were no inpatient or day patient facilities. In 1974, discussions began among interested professionals concerned with assessment and treatment of adult patients from central Lewisham (newly sectorised, with a population of 37,000) to find alternatives to inpatient treatment at Bexley Hospital, 12 miles away, or outpatient treatment at a local general hospital. This resulted in setting up a multiprofessional community-based team meeting weekly in a room provided in a local health centre. The DMT had funded a manager for the project.

The team was now on the point of moving to a house in the same district, where it was intended to provide a Mental Health and Advice Centre, which would greatly enlarge their scope. Referrals would come from various sources. A pool of volunteer counsellors would be recruited and trained, so that they could act alongside the team to cope with each day's referrals.

The scope of the work would expand as resources became available. The ultimate aim was a 24 hour crisis intervention service, for which at present both professional staff and trained volunteers were lacking. Meanwhile, self-help groups, and evening and weekend activities run by voluntary organisations could find a place at the Centre.

Mrs Mair Wynn Griffiths stated that her particular title was Voluntary Help Organiser, that she was a member of her District Psychiatric Health Care Planning Team, and enjoyed the support of the consultant at Bexley Hospital where she was in post.

She had always been convinced of the potential of volunteers for Dr Brough's team, and now, owing to well developed co-operation between statutory and voluntary services in Lewisham, other local agencies were interested in the Mental Health and Advice Centre, and the training of volunteers to assist the professionals there. Those selected for counselling and befriending would have to be briefed very thoroughly during a six months' training period. (She reminded the conference of the Wolfenden Report's recommendation that professionals in the statutory field should learn the art of working with volunteers as part of their own training.) Unsuitable candidates would be weeded out by the end of this period, or might be used in less testing situations. In addition to counselling in group sessions or one-to-one, and establishing an aftercare guild, she listed nine ways of involving volunteers in preventive care. Just as it had been said that their presence in a psychiatric hospital provided an extra 'star' for the service, so their flexibility should be a great resource to the community team. Through co-visiting with professionals, a code of practice should evolve, as both develop their understanding of the needs of patients outside hospital.

Volunteers should be recruited from every source; the retired, part-timers, shift workers, clergy, students, business and organisation men. Their work should be monitored, so as to earn a worth while place in the research aspect of the project.

A point she hoped would receive more notice than hitherto was that the success of a volunteer project often depends on the calibre of its co-ordinator. VSCs need a career structure which will tempt young, able people to enter this emergent profession. The expansion of responsibility to the community as envisaged at the conference must be accompanied by appropriate improvement in salary and career prospects. She looked forward to the day when graduate training for this post, perhaps a voluntary service co-ordination option in Social Science or Social Administration courses, would be available.

GROUP SESSIONS REPORT BACK

Group I Priority areas of service. How to assess service needs. How to select from among the various 'high risk' groups, those members of the population who are most vulnerable and open to help.

The group felt daunted initially by the scope of the question. An approach by looking at needs at different stages of life was adopted. Discussion broughtout suggestions: that volunteers might organise ante-natal (eg National Childbirth Trust) and post-natal support schemes for mothers at risk - the unmarried, mentally handicapped, psychiatrically vulnerable or very young; that teenagers can often be helped by learning to help other people: that housing departments could have volunteers attached to help those who are not good at making out their own case. Certain threads running through the discussion were felt applicable to voluntary services for all problems and age groups.

These were:

1 Counselling - without losing sight of practical needs.

2 Help given by those who had experienced a similar problem. There were of course dangers in this, but there was at present too much rigidity on the part of professionals - for instance in the refusal of some hospitals to use volunteers who had ever been mentally ill.

3 The right of someone with a problem to choose professional rather than voluntary help must be recognised, as also his right to reject all kinds of help.

It is important to learn how to discern needs, but it must be accepted that people have to be open to help as well as 'at risk'.

Group II Selection of volunteers for tasks and tasks for volunteers.

What are the main potentialities of volunteers, and what tasks should they not be expected to perform? Who should decide?

Some in the group felt that tasks should be found to suit volunteers wishes and aptitudes rather than volunteers found for pre-arranged tasks. The element of self-selection is strong and can be exploited by working for trial periods without undue theoretical briefing. Constant evaluation is necessary. The VSC takes responsibility for selction and placement, but in practice volunteers elect themselves.

Good matching of volunteer and client is crucial, and clients should have the ultimate decision as to who should help them.

The main potentialities of volunteers arise from their various motives and skills. They may be wanting useful employment (eg young mothers), to test the ground before a change of career, to use legal and financial knowledge outside their everyday jobs, or to act as a pressure group for improvement of services. Work which extends that of the professional includes befriending, family support and counselling, with the 'extra dimension' of the personal, non-clinical approach. Unsuitable tasks would be the prescribing, administering or supervision of medication.

Group III Priorities in the use of professional staff time in relation to volunteers. How can volunteers be adequately supported? What financial backing is, or should be made available?

It was felt that professionals need to be involved at all stages of the employment of volunteers, with inputs from all the team members concentrated at the outset of any project, in order to reap maximum benefit later. Support will remain an ongoing need, and the professional will have to invest time to acquire new skills to provide it. The role of the VSC is central, but management support must not consist merely of tacit approval. The work of volunteers may eventually release the time of professionals, or it might be that their support will take as much total time as was originally spent with clients. This may be the price of raising the threshold of care and providing more and better services in the community.

Financial backing should include adequate provision for the costs and expenses of volunteers, and recognition of their work (over and above the necessary courtesies). In the case of large-scale projects, capital costs will need to be met. For this, all available statutory and charitable sources should be exploited, including joint-funding from Health and Social Services, though the fate of the project after the first five years will then be uncertain. Volunteers in community psychiatric projects should not be required to raise their own funds, as this lessens their effectiveness. More explicit government backing is required.

Funds will also be needed for evaluation, but the largest investments are seen as the promotion of VSCs (which in fact has suffered from Health Service cut-backs) and the time of other professionals.

Group IV For what tasks do volunteers require training? How and by whom should this be provided?

This group distinguished between positive and negative aspects in any form of training. Valuable spontaneity can easily be replaced by self-conscious anxieties and hierarchical ambitions. It must be asked whether volunteers need any particular piece of induction, or whether it is making the professionals happy. The tasks to be performed are multifarious, and each needs its own form of contract between volunteer and VSC or other key worker. On the other hand, preparatory courses give important information, a sense of security in the definition of responsibilities, and establish mutual trust and good relations. Training may thus be a 'rite of passage' into the team.

It should take the form of broad-based induction or orientation courses by professionals or experienced volunteers, followed by inservice training as necessary. In all cases, training should be geared to the volunteer's own expectations.

Group V What difficulties prevent volunteers and professionals from working together? Can these be overcome?

A fundamental difficulty was felt to be the lack of opportunity for each to learn about the other. Stereotyped views about roles

had given volunteers a negative image, in which they were seen as cheap labour, rather than positive contributors of complementary skills and enthusiasm.

Volunteers on their side may be uncertain about their role and rights, and suffer from isolation and underuse.

Professionals may feel threatened by the intrusion of a 'critical eye', especially in working with long-established groups of volunteers. They may resent the time diverted from more important tasks, especially for building up trust and a workable partnership in the early stages on an unproven scheme.

Good liaison and communication must be built into the scheme. Continuous monitoring and supervision will be necessary, and the volunteers must take their own part in evaluating their own function. They should never be expected to work in isolation.

CONCLUSION

Most of the real improvement in world health which has occurred in the last 100 years has resulted from improvements in Preventive rather than Curative Medicine. Prevention is both better and cheaper than cure in the long run. In the short run it is necessary to spend money in order to save money. Government must invest more funds in the creation of a proper support system to volunteers. More VSC posts must be created and adequate backing for the costs and expenses of volunteers fully met.

Because projects using volunteers are cost-effective they are very popular with funding bodies who like to see their money bringing in a good return. For this reason sometimes it is not difficult to raise funds and professionals should make full use of the resources which are already available from statutory and charitable sources.

Many of the community projects discussed at the conference are eligible for Joint Health and Social Services funding. The government budget for this is increasing annually and money is relatively easy to obtain. The only snag is the uncertainty of continued funding after the initial 5 year period has expired.

Whilst volunteer agencies can be set up to raise funds volunteers working on specific community psychiatric projects should not be distracted by the need to raise their own funds.

The involvement of volunteers as a new resource in the community psychiatric team is no longer just an idea but, as this conference showed, is becoming a reality. This resource is now available and whilst it it not 'for free' it is certainly cost effective. Those attending this conference were mainly people who had begun to tap this resource and it is to be hoped that an outcome of this exercise will be the encouragement of other community psychiatric teams to follow with the development of their own schemes for volunteer involvement.