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In This Issue: “Volunteerism and Health Care”

*From Headstart to Revenue Sharing – from mental health to senior programs –
from comprehensive health programs to the Community Development Act –
community and citizen input is not only requested, but required.*

Marlene Wilson, 1976, p. 21

Thirty years ago, a pioneer in the organized management of volunteers and in the volunteer administration profession wrote these timeless words in her groundbreaking book, *The Effective Management of Volunteer Programs*. Yet the words still echo true today regarding the critical role that volunteers and volunteerism play in health care programs, organizations, agencies, and institutions. Consequently, this second issue (Number 2) of Volume XXIV of *The International Journal of Volunteer Administration* explores these critical roles in greater detail, and in more contemporary contexts.

On behalf of the entire editorial staff and review Board of *The International Journal of Volunteer Administration (IJOVA)*, I want to express our appreciation to each of you who has contacted one of us regarding this new generation of the former *Journal of Volunteer Administration*. In many ways, we are still building a new bridge as we walk upon it, seeking to connect practitioners, academicians, and consultants in greater service to the global volunteer community. We appreciate and welcome your continued comments, advice, and manuscript contributions to *The IJOVA* as we seek to continue the tradition of excellence established by the former Association for Volunteer Administration, transitioning *The Journal* into its new web-based design and international focus.

The response to the new publication has been overwhelmingly positive! Since *The Journal's* on-line premier in July of this year, *The IJOVA* web site has experienced 23,112 "hits" (i.e., someone accessed *The IJOVA* home page) and 815 extended "visits" (i.e., someone linked from the home page to at least one additional page in *The Journal*). Thank you for accessing *The IJOVA*, and please continue to share this resource with organizational colleagues, professional peers, students and clients.

The issue opens with three excellent *Feature Articles*. Ramirez-Valles provides an excellent overview of volunteers in public health causes, describing both public health areas and activities to which individuals volunteer as well as characteristics of the volunteers themselves. Allen discusses roles and participation of volunteers in a long-term care ombudsman program, and assesses potential differences between nursing homes with and without volunteer ombudsmen. Swinson focuses upon using potential health benefits of volunteering as a strategy in recruiting volunteer generational cohorts, concluding that “Identifying and understanding the potential volunteer market and the motivational strategies needed to attract those volunteers will be key issues for the future of volunteerism.”

The former *Research In Brief* section has been transformed into the more extensive (yet still very applied) *Research Into Practice* section. This issue highlights a qualitative study by Blanchard that explores sources of personal motivation among hospital volunteers as well as possible

differences in motivation based upon age or gender. The exploratory research reported by Edwards, Safrit, Gliem, and Rudd highlights positive affects upon teen volunteers themselves regarding obesity and overweight while serving as volunteer teachers of younger youth in an obesity and overweight prevention program.

Tools of the Trade includes a review of two companion publications by the American Society of Directors of Volunteer Services (ASDVS), a professional membership group of the American Hospital Association (AHA). Both publications address serious issues surrounding legal, risk management, and accreditation issues in volunteer-based health services organizations and agencies. The reviewer, Hood, appropriately concludes that “following the recommendations outlined throughout these manuals . . . should pose no threat to the volunteer director who focuses on good business practices for volunteer programs in healthcare organizations,” and I would add, any volunteer-based organization.

Ideas That Work includes an excellent description by Loh of how a Singapore hospice organization has successfully guided its student volunteers to focus their volunteer experiences upon the larger development of the island-nation’s communities. This Community Involvement Programme (CIP) approach within the health care agency has, according to the author, “[instilled] in student volunteers a sense of social responsibility, better preparing them for active citizenship.”

Sue Wood’s *Commentary* provides the reader with serious thought-provoking questions that are especially relevant in light of the upcoming influenza season, last season’s appearance of the avian flu strain, and ongoing concerns regarding a potential influenza pandemic.

Beginning with this issue, *From The JOVA Annals* will feature articles focused upon the volume’s theme, yet published previously in *The Journal of Volunteer Administration (The JOVA)*. We hope this new feature will allow for easier online access and retrieval of quality articles that still have relevance in today’s global volunteer community. Thus, we are pleased to reprint three such works: “Psychosocial Support: A Crucial Component for the Successful Management of AIDS Volunteers,” by Tommy J. Breau (originally published in 1993/1994); “Partners in Caring: Administration of a Hospital-based Volunteer Program for the Education of Cancer Patients,” by Joyce Nyhof-Young, Ph.D. and Jennifer M. Jones, Ph.D. (first published in 2003); and “Volunteering for the Future: The Impact on Young Volunteers of Volunteering in Paediatric Palliative Care,” by Rosalind C. Scott and Denise Burgin (first published in 2004).

We hope this issue of *The International Journal of Volunteer Administration* will provide each reader with information, inspiration, and renewal as we nurture, support and sustain the critical roles that volunteers and volunteerism play in providing for the mental, emotional, and physical well-being of individuals around the world.

R. Dale Safrit, Ed.D.
Editor-In-Chief

**Dedication of Volume XXIV
to**

Mary V. Merrill, LSW



If I have seen further, it is by standing on the shoulders of giants.

(Sir Isaac Newton, 1675)

Volume XXIV of *The International Journal of Volunteer Administration* is lovingly dedicated to the memory of Mary V. Merrill, LSW, a dear friend to any volunteer, a colleague to all managers of volunteers, a mentor to me personally, and the former editor of *The Journal of Volunteer Administration*. Mary left this world suddenly and unexpectedly on February 19, 2006, yet her legacy will remain with us forever.

Mary Merrill dedicated her career and her life as an international speaker and author to providing consultation and training in volunteer administration, board development, and strategic planning to strengthen the leadership and structures that support volunteerism. She was adjunct faculty at The Ohio State University and Editor of the *Journal of Volunteer Administration* from 2002 until her death. Mary taught and consulted internationally in 15 countries, and nationally in 37 of the 50 United States. Working with the Points of Light Foundation she helped establish the first volunteer center in Russia and worked for two years with developing Non Government Organizations (NGOs) in Armenia.

More recently, Mary worked with the Volunteer Development Committee of the United Nations, and presented at the European Volunteerism Conference in Croatia. Mary was an invited speaker

for the Asian Pacific Conferences for Volunteer Administration in Korea (2002) and Hong Kong (2005), the IAVE Latin American Conference on Volunteerism (Venezuela, 1998), and the 1st International Conference of Museum Volunteers (Mexico City, 2002). She was an annual star trainer for the Points of Light National Community Service Conference and recipient of a 2004 Distinguished Service Award from AVA.

Mary's innovative ideas and models have been published in *The Journal of Volunteer Administration*, *Voluntary Action: The International Journal of the Institute for Volunteering Research* and the *Not-For-Profit CEO Monthly Letter*. She authored a book for the Paradigm Project, Points of Light Foundation, wrote the Volunteer Literacy Manual for Reading Recovery International, and co-authored and produced teleconferences/training videos on risk management, ethical decision making, and, non-profit board development.

Mary was an invited speaker at the 1998, 2001, 2002 and 2004 Biennial World Volunteerism Conferences in Canada, The Netherlands, Korea, and Barcelona (resp.), and presented joint and individual volunteer-related research at the 1998, 1999, 2000, and 2001 annual conferences of the Association for Research on Nonprofit Organizations and Voluntary Action (ARNOVA). She was past-president of Volunteer Ohio, and a past recipient of the Award for Excellence presented by the Volunteer Administrators' Network of Central Ohio. She helped create and co-taught the Institute for Community Leadership through the Leadership Center of The Ohio State University, and developed pioneering work in the area of impact evaluation for volunteer programs.

So, Mary, if we have been able to see further into the future of volunteerism and volunteer administration, it is because we as your peers benefited from your individual dedication to humanity, your professional passion for volunteerism, and your personal unconditional love for your family, friends and colleagues. You were a giant in our profession, and we miss you dearly.

R. Dale Safrit, Ed.D.
Editor

**Long Term Care Ombudsman Volunteers:
Making a Measurable Difference for Nursing Home Residents**

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Abstract

This study investigates the roles and participation of volunteers in a Long Term Care Ombudsman Program (LTCOP) and assesses if differences exist between nursing homes with and without volunteer ombudsmen. Volunteers are found to favorably influence the environment in nursing homes by encouraging a supportive climate in which residents and their representatives can voice complaints. Furthermore, the working relationships between unpaid advocates and regulators are viewed as beneficial in illuminating and addressing problems. The study evaluates Connecticut's operating facilities (N=261) with 180 volunteers, and finds those with increased volunteer presence also have significant higher sanctioning activity. The study promotes volunteer advocacy and serves as a step toward improving the status of nursing home care through volunteer presence. The power of the volunteer in the LTCOP in enhancing both the program and mission may provide insight to other volunteer organizations, particularly those serving members of our aging society.

Key Words:

volunteer ombudsmen, nursing homes, advocacy, long-term care

Introduction

Volunteerism is a critical ingredient in the effectiveness of the Long Term Care Ombudsman Program (LTCOP), a nursing home advocacy/watchdog agency that has been widely credited as advancing pro-resident efforts in nursing homes and other long-stay settings since the late 1970s (Estes, Zulman, Goldberg, & Ogawa, 2004). Unpaid workers provide the great majority of ombudsman advocacy nationwide. In 2000, there were more than 12,000 volunteers in contrast to the 1,000 paid staff. Paid and unpaid workers combined handled 231,889 concerns by 137,165 individual complainants of ombudsman personnel

nationwide (NORS, 2006). This study views one state's operating nursing facilities, comparing those with and without volunteer presence to deficiencies issued by the Department of Public Health. It also looks into the role and relationship between volunteer and surveyor in terms of strengthening the efficacy of the program in identifying real problems, and remedying poor care and deficient quality in the nursing home setting. Implications to utilize effective volunteers in other venues are explored.

Do Volunteers Increase or Decrease Complaints?

Discussion as to whether ombudsman program volunteers raise complaints or ward off problems has been debated from the program's beginning. There are at least two schools of thought as to whether volunteers increase or decrease complaints and deficiencies. Earlier research indicated that grass roots ombudsmen provided a "sentinel effect" (Litwin & Monk, 1987, p. 102) warding off problems by their regular advocacy presence (Arcus, 1993; Cherry, 1991). But the power of the role exceeds mere presence, and realities such as volunteers conferring with regulators ahead of the survey add teeth to the volunteer's role. Recent literature speaks to volunteers increasing deficiencies, through education, empowerment, and whistle-blowing, given that they tip off the surveyors prior to inspections (Nelson, Huber & Walter, 1995). Those facilities with volunteer presence raise official investigation of concerns, which may allow facilities to be more accountable to citing deficiencies. Therefore, the roles may be synergistic. Others have attributed the presence of ombudsmen to higher complaint reporting in general, and to more vigorous regulatory activity in particular (Nelson, Huber et al., 1995) both believed to provide short and long-term benefits to nursing home care (Cherry, 1991).

Nelson, Huber and Walter (1995) found that nursing homes with assigned volunteers had more substantiated abuse complaints; a finding also confirmed by Allen, Gruman and Kellet (2003). Allen, Klein and Gruman measured volunteer presence against complaint types and found the longer an ombudsman volunteer was in a facility, the more likely care and resident rights complaints surfaced, while administration and quality of life complaints diminished.

Nelson, Huber and Walter (1995) expanded on Litwin and Monk's original question posed in 1987: Do ombudsmen make a difference? Overall, volunteer ombudsmen felt they were making a difference in the lives of their residents, but often voiced ambivalence about the extent of their contribution. Consistent with this study, Nelson, Huber and Walter found that volunteers' presence increased overall complaints and deficiencies. This paper suggests that the presence is not necessarily an "either or" situation, but rather both. Volunteers ward off problems through their presence with heightened accountability of workers, and illuminate problems needing sanctioning activity for those issues that require a higher level of intervention, each favorable to the health of the residents occupying nursing facilities.

Managing Volunteers

The volunteer's working relationship with the paid ombudsman manager is essential in promoting change in nursing facilities. Overall, ombudsman managers see the volunteer role aiding their efficiency. There is no question that an investment of a manager's time and energy pays off with a skillful volunteer advocate. Given the huge numbers of nursing home residents paid ombudsmen are expected to advocate for, having an in-house, ongoing presence fulfills the original intent of the ombudsman program. Overseeing volunteers is an added level of managerial responsibility, and the difference between a good and bad working relationship might make all the difference between retention and resignation. Managers can favorably influence quality in the volunteer's role, from providing guidance on documentation, to the level of advocacy embraced. Perhaps most important, paid workers can illuminate and recognize the volunteers' efforts. Managers also conduct monthly meetings to allow for regular

contact with the site office, and for ongoing education and troubleshooting. Meetings also provide socialization and connection to other advocates, both of which have been found to be beneficial to volunteers' morale (Nelson, Hooker, DeHart, Edwards, & Lanning, 2004).

Volunteer Ombudsman Role Orientation

Ombudsman volunteers have been categorized in a variety of roles, including mediators, educators, collaborators, advocates, friendly visitors, counselors and watchdogs (Harris-Wehling, Feasley & Estes, 1995; Keith, 2001a; Monk, Kaye & Litwin, 1984). Pioneering LTCOP researchers, Monk, Kaye and Litwin (1984) set the trend in exploring ombudsmen role orientations. Three primary roles have persisted in the literature (Nelson, Pratt, Carpenter & Walter 1995): advocate, collaborator, and counselor. Advocates are identified as watchdogs who use a contest-oriented "win-lose" approach, forcing change by arguing the resident's cause from getting a warm meal to changing policies at the macro political level. Collaborators use a "win-win" approach to problem-solving, while the counselor orientation is a non-conflict patient support model sometimes linked to the ombudsman's education and resource brokering roles (Monk & Kaye, 1982; Nelson, 1995). The majority of ombudsman volunteers in Monk and Kaye's study self-identified as counselors (Monk & Kaye, 1982, p. 198), while those in Nelson's study a decade later (1995), found that those using the contest strategies were more numerous and generally, more effective. It may be that we are advancing to more of an advocacy-based model of training due to the increased recognition that nursing home residents require a strong presence of fearless advocates.

Volunteer Presence

The Department of Health and Human Services (DHHS) in 1991 assessed the national LTCOP. One defining characteristic of effective programs was the use of volunteers (Nelson, 1995). Regular presence and consistency, as well as timely follow-up to concerns, distinguish successful ombudsman programs from unsuccessful programs (Nelson, 1995). Volunteers were not always well received by the nursing home industry and are occasionally strong-armed out of facilities. However, legislation under the 1987 Older Americans Act (OAA) bolstered the strength of volunteers, giving them parallel power to paid ombudsstaff. The Act secured volunteers the right to make unannounced visits, to access any appropriate party relevant to the concern, to proceed on complaint investigation with the permission of the resident or the legal responsible party when the resident is deemed legally/medically incapacitated, and to communicate concerns to the regulating agency prior to an inspection. The OAA specifies that facilities interfering or not cooperating with ombudsman program personnel, including volunteers, can be sanctioned. Given the heft of the role, the position undoubtedly has its challenges.

Role Perceptions

Keith (2005) studied perceptions of ombudsman volunteers before and after they spent time in their assigned volunteer role and noted that the majority changed perceptions of what nursing homes were like. Largely, perceptions were changed for the better. Volunteers felt more of a sympathetic stance toward primary workers and found that facilities were not always as bad as they originally feared. Authors in the area of volunteer practices highlight the favorable exchange between volunteer role and agency/provider. For example, Nagel,

Cimbalic and Newlin (1988) suggest the positive return volunteers have on the provider. Pillemer (1988) likewise describes volunteerism as mutually beneficial to those who participate and to those served (Estes, Zulman, Goldberg, & Ogawa, 2004).

Communication with Officials

As noted, some of the ombudsman program's power lies in the ability to report wrongdoings to government officials (Kahana, 1994). A requirement of LTCOP is that ombudsmen are kept apprised of times and dates of health department inspections. If a volunteer is assigned to a facility, that volunteer has the responsibility to communicate any concerns to inspectors prior to the time of inspection or upon the survey team's entrance. The ombudsman raising a concern for official investigation, therefore, may add accountability to the survey team to investigate issues. Ombudsmen personnel are also invited to attend the exit conference where findings are presented. Inspectors reviewing facilities without volunteers rely on regional or local ombudsmen to communicate concerns. Hence, the better the worker's ability to align with other agencies, the more effective they will be in producing positive change within the nursing home, and in ensuring that residents' complaints are carried to the powerful regulators (Zischka & Jones, 1984).

Program Implementation

Connecticut meets the OAA mandate to provide advocacy for some 30,000 nursing home residents by training and placing ombudsmen volunteers in its 261 nursing homes. Volunteer ombudsmen are trained by regional (local) staff managers and appointed by the state ombudsman. Measures are taken to screen and appropriately match ombudsmen volunteers with nursing homes. Given the reality that

volunteers work with vulnerable populations with close access to resources and information related to residents' lives, prospective ombudsmen are required to disclose any criminal history. Motivations for entering the volunteering role are reviewed, such as whether there is a past history with the facility, if there is an ax to grind of sorts, or if there is a more general willingness to volunteer where the advocate is needed. Furthermore, current work placement and other demographic information are identified. Efforts are made to assure that no conflict of interest exists under the OAA. For example, volunteer ombudsmen may not receive any remuneration from the nursing home industry while serving as a volunteer.

In addition to thirty hours of classroom training, ombudsmen volunteers visit a minimum of two nursing facilities with an experienced volunteer or paid staff member. Placement is prioritized for facilities lacking ombudsman representation. Other considerations are made, such as proximity to the volunteer's home. Once certified, volunteers provide a minimum of five hours per week to their assigned facility. Many work far beyond the minimum requirement. Barriers to

Barriers to Volunteering and Retention

Volunteers handle resident concerns spanning the gamut from cold food to rape in a conflict-riddled environment, deeming ombudsman volunteerism one of the most difficult in the entire volunteer arena (Keith, 2001b; Monk, Kaye & Litwin, 1984; Nelson, 1995). Furthermore, nursing homes are plagued with bad press and are places people would rather avoid (Keith, 2005). LTCOP volunteers, facing daunting realities, take on challenges in these stigmatized places. The role of nursing home advocate, important as it is, does not boast a long waiting list. The work requires a serious

investment of time and energy in a venue many wish to avoid.

Contrary to her study expectations, Keith (2005) did not find time constraints a major barrier to effective advocacy. The majority of the unpaid staff had simultaneous roles as caregivers, paid employees, and volunteers in other capacities. It seems to echo the old adage: To get something done, you've got to ask a busy person. Volunteers are largely busy, productive people who wish to improve society through the effort of advocacy (Keith, 2005). In terms of retention, those who stay in the program longer feel they are making more of a difference, receive regular feedback from the paid staff, and have a favorable working relationship with the facility and manager. Alternatively, those who drop out feel that supervision is lacking, their work is unappreciated, and/or they are met with resistance from nursing facilities and paid workers in the ombudsman program (Nelson, Netting, Huber, & Borders, 2004). Educating volunteers on effective strategies of problem-solving may prove beneficial in breaking through barriers that may undermine the capacity of the workers' efforts (Nelson, et al).

Motivation

Most often, volunteers enter the arena of volunteer resident advocacy after personal experiences with family members or friends in the long-term care system. Scholars investigating motivations behind volunteerism find that older volunteers have longer tenure rates and higher alignment to the ombudsman program's mission than their younger counterparts (Nelson, 1995). The majority of LTCOP volunteers are at or above retirement age, yet variations of ages exist, as do motivations. Younger volunteer advocates are found to have more selfish motives than altruistic ones, such as resume-

building (Nelson, Hooker, DeHart, Edwards, & Lanning, 2004). Nelson et al. also reported that male volunteers feel less effective than female volunteers. In Keith's article (2005), males were found to be more likely to volunteer to put their professional and technical skills to work, whereas women were more likely to feel motivated to help others with more personal problems.

It is becoming known that volunteers are needed in nursing homes and volunteers themselves find the work rewarding. In short, the power of the volunteer role is gaining momentum as a high impact, necessary effort. With an aging society, there may be more interest in working to promote advocacy in areas that baby boomers and their older cohorts might have to utilize in the future. With this added buy-in and recognition that the work done by today's volunteers may influence the future conditions for the volunteers themselves, a synergy of increased numbers and increased dedication seems to exist. Volunteers lacking a so-called professional role may be a strength rather than a weakness. Using indigenous/volunteer workers can prove successful in human service delivery as it reduces stigma of clients seeking assistance on a more formal level (Gilbert & Terrell, 2005).

Methods

The exploratory nature of the study posed whether facilities with and without volunteers would vary in deficiencies imposed by the health department. There was an expectation that the longer tenure of a volunteer's presence, the more the deficiencies received. The findings speak to the level of investment of volunteers in bringing serious issues to the forefront of regulatory reviews. The sample included a retrospective account of deficiencies from the 261 operating facilities received over a two-year period in the Connecticut LTCOP.

The study reports whether the facility had volunteer ombudsman presence during the reporting period. To evaluate whether these differences existed, chi-square tests were used.

Health Department Deficiencies

All Medicaid and Medicare certified nursing facilities must undergo yearly inspections and meet basic federal requirements (USDHHS, 2005). Each state has a designated unit charged with providing unannounced surveys to long-term care providers who monitor such issues as decubitus ulcers, weight loss, restraints, end of life care, and proper staffing levels. Typically, inspection teams choose a core sample of residents with various “triggered” or high-risk conditions. Ombudsmen personnel receive survey schedules in advance to inspections to facilitate communication between the advocates and the inspectors. Volunteer advocates, partnering with the licensing agencies, favorably change the nursing home environment through advocates dialoguing with inspectors, instead of the historic cold war between the two factions (Nelson, Huber & Walter, 1995; Sadden, Deaton & Gonzales, 2004).

The deficiency variable reflects the number of deficiencies over the two-year time period. In order to collect data covering the National Ombudsman Reporting System (NORS) time period, the researcher entered data from the reports of 1998 - 1999 and 1999 - 2000 into SPSS (Statistical Package for the Social Sciences)12.0, adding the number of deficiencies each facility received over the reporting years. The variable refers to the total number of deficiencies (A & B) received from the Department of Public Health. As stated in the Public Health and Well-Being section of the Connecticut General Statutes (1999), deficiencies are classified Class A or B:

1. Class A violations are conditions which the Commissioner of Public Health and Addiction Services determines present an immediate danger of death or serious harm to any patient in the nursing facility. The penalty for Class A violations cannot exceed \$5,000.
2. Class B violations are conditions which the Commissioner of Public Health and Addiction Services determines present a probability of death or serious harm in the reasonably foreseeable future to any patient in the nursing home facility, but which does not find constitute a Class A violation. Fines for Class B violations do not exceed \$3,000.

Findings

There were 180 volunteers trained and placed by the Ombudsman Program in Connecticut during the reporting period. In terms of facility coverage, 30% of the facilities had a volunteer placed only one of the two years, and 66% had a VRA formally assigned to them during both reporting years, which showed an increase in volunteer presence in Connecticut’s facilities.

Facilities with volunteers at least one of the reporting years were significantly more likely to have one or more survey deficiencies than those without volunteer coverage ($\chi^2 = 4.42, 1 df, p = .035$). In terms of increased deficiencies in relation to increased volunteer presence, 39 facilities with no volunteer coverage received one or more deficiencies, but the number of facilities with at least one or more deficiencies jumped to 99 with a volunteer placed for at least one year. As advocacy presence increased, deficiencies followed. Nineteen percent of all facilities received zero deficiencies. Deficiencies (Type A & B) ranged from zero to three in the reporting period almost three quarters receiving one or

more. Taken separately, Type A deficiencies are the less common, and reflect the more injurious of the types. Twenty-four facilities (9.2%) had one Type A deficiency in the reporting period, with only one facility receiving two Type A deficiencies. Fifty-two percent of the facilities had one Type B in the reporting period, 23 had two Type B deficiencies, and five facilities received three Type B deficiencies. Connecticut is a low ranking state in regard to receiving deficiencies. A related study revealed that Connecticut ranks fourth nationally in the lowest deficiencies received (IOM, 2001).

Conclusions and Implications

Fewer, if any, avenues exist in providing such an intimate exposure to nursing facilities from a resident's perspective as ombudsman volunteers (Nelson, Huber & Walter, 1995). Huber, Borders, Netting and Nelson (2001) suggest that ombudsman data give a clearer picture than lone survey reports from health departments about actual problems seen on a daily basis by nursing home residents. Using both in tandem may illuminate what is really happening inside of the facility. Such findings are suggested by the increased numbers of substantiated deficient practices sanctioned by the health department in facilities with volunteers. It appears that the dual-arm approach of volunteer advocate and surveyor stands as a stronger ally to the resident. The power of an advocate lies in the ability to empower the client and to suggest change. That power is enhanced when regulators heed advocates' input regarding problems within nursing homes, which is implied in this study.

There are several areas of volunteerism worthy of exploring. Why is it that volunteerism in general is declining, but volunteerism within the LTCOP is increasing? Might it be that people investing in human capital wish to do meaningful

work despite the challenges? How can states with lower volunteer rates and shorter retention increase the participation of the valuable workers? And who are these workers? Are they representative of the general public? What are the most salient reasons for keeping them volunteering? Further, studies on the surveyor's reaction to the volunteer may reveal interesting findings. Only through continued research and investigation can we discover more valuable information pertaining to the precious, unpaid workers' roles. Given the increased numbers of baby boomers soon to retire, issues of volunteerism may prove more and more important to the health of our society. These workers may prove the most robust given their historical inclination to advocate for change.

The volunteer represents a true change agent toward the vision of social change and reduction of problems within the nursing home. The partnership between volunteers, ombudsmen, residents, families, nursing home staff, and inspectors is a favorable one. It is critical for the ombudsman program to recognize the contribution of these members on a regional, state, and national level. Proper resources targeted to effective running of the ombudsman program, such as training resources and recognition remain a top priority of advocates and researchers (Huber, Borders et al., 2001; Keith, 2005; Nelson, Hooker et al., 2004). By encouraging nursing home residents and their representatives to voice concerns, the fundamental right of dignified care -- free from abuse, maltreatment, corporal punishment, retaliation, and fear of expressing the speech that belongs to them -- is upheld. The potential to encourage unpaid workers to do such important work as to strengthen quality of care within the nation's facilities is hopeful and has implications in other areas.

There are countless opportunities in other venues for unpaid workers to add strength in numbers and power to the service delivery system. With proper training and identifying passionate individuals, volunteers may be champions to provide other levels of work, breathing energy and participation in the profit and nonprofit sectors. Nonprofit organizations taking a proactive approach in recruiting, training, and utilizing volunteers in advocacy roles would support a win-win situation for both the organization, the workers, and the clients/consumers served. Volunteerism is a powerful bridge to effective advocacy and investment in quality of life (IOM, 1995). We often hear of broken systems in our educational, political, and health care arenas, and volunteers, invested in making a difference, may be a key to address the enormity of problems that seem intractable. They certainly have made a difference in our nation's nursing homes.

Given the timing with so many vital social services being cut, human service organizations may profit from recruiting and training volunteers. Of course challenges exist, and some may fear that a volunteer's role may undermine a professional's. However, there is more than enough room for paid and unpaid workers to fulfill common missions in working to improve the conditions of humanity, particularly where social injustices are involved. Also, with a growing retired force, several trained professionals may find a logical, rewarding role in programs such as the LTCOP. It may be time for society to recognize the true spirit of people who willingly work for benefits other than pay.

The relationship found between unpaid workers and regulatory officials in a time of human service contraction gives hope to protecting resident rights. Rather than succumbing to the reality of the power of the nursing home industry, pairing unpaid

workers in the profit and nonprofit health care sector bridges an arena that often as viewed as impossible. The ombudsman program provides a model for upholding the rights of historically vulnerable people and may indeed be a model necessary for the overall health and well being of our aging society.

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Volunteering in Public Health: An Analysis of Volunteers' Characteristics and Activities

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Abstract

Despite current interest in social capital and health, little is known about volunteers in public health causes. This study describes public health areas and activities in which individuals volunteer, and assesses the volunteers' characteristics. Data were collected from a cross-sectional sample of Illinois residents (N = 605) through a random-digit-dialing telephone survey in 1999. Ninety-nine (16.3%) individuals volunteered for a health organization. The most common areas for volunteering included cancer and the elderly. The most frequent activities were fundraising and support to the sick. Higher income was the only significant predictor of volunteering after controlling for age, gender, race, marital status, and education. Public health-related organizations and volunteer administrators need to promote volunteerism among the disadvantaged.

Key Words:

volunteering, public health, volunteering, participation, community involvement

Introduction

Volunteering, as a form of social capital, has a two-fold critical role in public health (Putnam, 2000). First, via such organized action, individuals create change in their communities and make health interventions both culturally appropriate and sustainable (Kelly, 1999; Omoto, Snyder, & Berghois, 1993; Zimmerman, Ramirez-Valles, Suarez, De la Rosa, & Castro, 1997). Second, through their volunteer work in health-related organizations and efforts, individuals become educated about risk and preventive behaviors, develop and maintain a positive sense of themselves and their community, and mobilize their social networks to cope with stressors (Arno, 1986; Bellah, Madsen, Sullivan, Swidler, &

Tipton, 1996; Chambre, 1991; Kobasa, 1991; Moen & Fields, 1999; Perrow & Guillen, 1990; Snyder & Omoto, 1999; Thoits and Hewitt, 2001; Weitzman & Kawachi, 2000; Wolfe, 1994; Youniss & Yates, 1997). Yet, little is known about volunteering in health-related endeavors, especially among ethnic minority communities.

The purpose of this study is to describe the public health areas and activities in which individuals volunteer, and assess the sociodemographic characteristics of volunteering. This study is especially significant for volunteer administrators and public health professionals because of their interest in both community mobilization and

social capital. The study may assist them in understanding who participates in community mobilization. In particular, this research informs the recruitment and involvement of communities by documenting what groups are likely to get involved and in what types of public health activities.

For the purpose of this study, volunteering refers to individuals' unpaid work on behalf of others or a collective good and in the context of a formal or semiformal organization, that is, outside the home and the family (Schondel, Shields, & Orel, 1992; Smith, 1997; Wilson & Musick, 1997). The term volunteer emerged in the 19th century in Britain and in a social class system (Taylor, 2005). At the height of industrialization, middle classes, mostly women, engaged in volunteer work as a charity, to "help those less fortunate," and fulfill their own class and gender roles. The working class and the poor, however, did not engage in that type of work. Their unpaid work was in the form of mutual aid, solidarity, and as a means of survival (Taylor, 2005).

The most recent national data, collected by the Independent Sector (2001) indicate that 44% of adults (i.e., 21 years and older) volunteered in 2000. Of those who volunteer, only about 7% do so in health and 10% in human services areas (Independent Sector, 1999). The most commonly reported volunteer activities were direct service (e.g., serving food), fundraising, and informal volunteering (e.g., helping neighbors). Regarding socio-demographic characteristics, volunteering is higher among older cohorts (e.g., >35 years), women, Caucasians, and those with higher education (e.g., college degree) and income (e.g., > \$40,000) (ibid). African-American and Latino groups seem to volunteer less than White groups (Smith, 1997). Unfortunately,

little is known about volunteering and civic involvement among non-White and low-income populations, and the available evidence is inconclusive. In some studies, racial differences disappear when social class is taken into account (Wilson & Musick, 1997). Other studies indicate that racial minorities do not participate less than White populations, but they participate in different types of organizations such as neighborhood-level organizations (Portney & Berry, 1997; Schondel et al., 1992).

In the area of HIV/AIDS, for example, Ferrer, Ramirez-Valles, Kegeles, and Rebehook, (2002) found that young white gay men in the southwest (i.e., Austin, Phoenix, and Albuquerque), volunteered at higher rates (26%) than their Latino peers (20%) in HIV/AIDS and gay issues. In another study based on a probabilistic sample of Latino gay men in Los Angeles, Miami, and New York City, the rates were higher, ranging from 37% in the first, to 63% in third city (Ramirez-Valles & Diaz, 2005). These differences could be attributed to measurement, besides the evident geographic variation. The study in the southwest assessed only volunteer work (e.g., *yes, no*) on HIV/AIDS and gay issues during the last 12 months. The study in the metropolitan areas included current level of involvement (e.g., *definitely yes to definitely no*) in gay and Latino organizations. In the latter study, being involved was associated with being bilingual (i.e., Spanish and English) and with experiences of homophobia and experiences with HIV/AIDS (e.g., people who are HIV-positive in one's social network). Education and income were not related to involvement. Furthermore, the involvement of those who are HIV-positive also seems to be higher than expected. About 60% of Latino gay men, who are HIV-positive, report participating in AIDS organizations in New

York City, while 40% report in Washington DC (Ramirez-Valles & Diaz , 2005).

Methods

Sample. Data for this study come from a random-digit-dialing telephone survey of households in the state of Illinois (Survey Research Laboratory, 1999). A dual frame design was used by which a reverse directory provided addresses of households with listed telephone numbers. Then, a letter was sent to these households to inform about the survey and solicit their cooperation. Telephone interviews were conducted during the spring of 1999. The final sample included 605 respondents for a response rate of 45.3%. Post-stratification weights were applied to adjust for biases in response. Data were weighted by gender, education, age, and race, following estimates in the 1998 Current Population Survey.

Measures. Data were collected on respondents' age, gender, race, marital status, education, income, and volunteer work. Education was measured with a 4-point scale (e.g., 1 = *Less than high school*; 4 = *College or higher*). Similarly, income was assessed as the total 1998 household income from all sources using a 6-point scale (e.g., 1 = *Less than \$10,000*, 6 = *More than \$70,000*). For our outcome variable, volunteering, we asked participants: "During the past 12 months, did you do volunteer work for any health-related organization or event, not including donating money?" Those who answered "yes" were then asked for the health-related issue addressed by the organization in which they volunteered (e.g., cancer, HIV/AIDS, violence). In addition, we asked for the types of volunteer work done (e.g., counseling, outreach, fundraising). In the latter two questions, respondents had the option to report up to three volunteer areas and activities.

Analysis. In descriptive analyses, volunteers were compared to nonvolunteers on study variables of interest using *t*-tests for continuous variables, Mann-Whitney tests for ordered categorical variables, and chi-square tests for unordered categorical variables. A series of three logistic multiple regressions was conducted to evaluate the additive effects of the study variables (e.g., education and income) on the outcome variable, volunteering (yes/no). Logistic regression is the most appropriate statistic modeling for these data given the dichotomous nature of the outcome variable. Model 1 consisted of age, gender, race, and marital status. Models 2 and 3 added the variables of education and income, respectively. Interaction effects were assessed for each model (e.g., race and income) as well as nonlinear associations. All analyses were conducted on weighted data and then verified on non-weighted data. No significant differences were found on those analyses, hence I only present those based on weighted data.

Findings

Table 1 shows the socio-demographic characteristics of the sample by volunteering. Ninety-nine (16.3%) participants reported volunteering in the previous year. The volunteer areas most commonly cited include cancer ($n = 18$), elderly ($n = 18$), disabilities ($n = 12$), hospitals ($n = 11$), heart conditions ($n = 9$), diabetes ($n = 8$), homelessness ($n = 7$), and HIV/AIDS and blood drives ($n = 6$, respectively). The activities most frequently reported are fundraising ($n = 39$), support services to the sick or the elderly ($n = 19$), office help and health fairs ($n = 12$, respectively), organizing meetings and events ($n = 11$), housekeeping tasks ($n = 8$), and health education and outreach/recruitment ($n = 5$, respectively).

In bivariate analyses, no significant correlations were found between volunteering and age, gender, race, and marital status. Education and income were positively correlated with volunteering.

The results of the logistic multiple regressions are presented in Table 2. In Model 1, which included four demographic variables, race (e.g., White) was the only statistically significant predictor of volunteering (OR = 1.81; $p < .05$). In Model 2, education was added to the equation and no variable was found to be statistically associated with volunteering. Notably, the effect of race on volunteering became non-significant. Finally, in Model 3, the addition of income was significant. Individuals with higher incomes were more likely to volunteer (OR = 1.22; $p < .05$). This final model also fitted the data well, as indicated by the significant chi-square value. No interactions or nonlinear (e.g., inverted u-shapes) effects were found.

Conclusions

The intent of this study was to assess which public health areas and activities attract volunteers, and the socio-demographic characteristics of volunteers. Compared to national data (Independent Sector, 1999), I found a larger percentage of volunteers in health-related areas (i.e., 16%). This discrepancy may be due to a couple of factors. First, the Independent Sector survey (which collects national data on volunteering), does not ask directly about volunteering in health-related organizations, as it was done in this study. Furthermore, in this study, respondents were not asked about their volunteer work in general, as the Independent Sector does. This could have increased reporting of volunteering in health-related areas in this study. Second, the difference could reflect actual regional variations.

In regard to the socio-demographic attributes of volunteering, the findings from this study are consistent with previous research. Education and income were found positively correlated with volunteering in bivariate analyses. National surveys and small community studies have consistently found that individuals with higher education and income are more likely to be recruited for volunteer work than those with lower levels of formal education and income (Hodgkinson, 1995; Smith, 1994; Wilson & Musick, 1997). As noted previously, ethnic minorities seem to volunteer at lower rates than White populations (Smith, 1997). Here it was found that race differences disappear when education is controlled for statistically. Further, the only significant predictor in the final model was income. These results suggest that race difference may be explained by the overall higher income levels among the White population. Individuals with higher incomes may be more likely to volunteer in health-related organizations because (a) they may have technical and professional skills that organizations need, and (b) they may be more socially connected, therefore, more exposed to opportunities to volunteer. It is plausible, however, that individuals with lower income levels and who are members of racial minorities, channel their collective action through informal groups, nonissue-oriented organizations, or neighborhood groups (Portney & Berry, 1997). Moreover, and perhaps of most importance, their leisure time is very limited as to get involved in unpaid work with formal or semiformal organizations.

Consistent with the relationship between income and volunteer work, fundraising was among the most frequently reported activity, followed by the areas of cancer and the elderly. Notably missing are substance use and maternal and child health, among others.

Also, activities such as organizing groups and health education are rarely reported. These types of activities, while requiring more time and involvement than fundraising, are central to public health and to reach the working class and the poor.

A significant limitation of this study is the single dichotomous measure of volunteering. A more comprehensive measure should include length and frequency of involvement, and types of activities performed (Ramirez-Valles, 2002). In addition, the concept of volunteering, as measured in this study, may fall short in capturing the ways and extent to which minority and low income individuals work (unpaid) for others in health issues. For working class individuals, for instance, volunteering may be irrelevant because it denotes the upper and middle class notion of “giving back” (Abrahams, 1996; Boehmer, 2000).

The low percentage of volunteers in the sample precluded the analysis of differences in the kinds of volunteers who work for different types of organizations. In addition, the telephone interview used to collect data could have introduced social desirability bias in reporting volunteering (Acree, Ekstrand, Coates, & Stall, 1999). A data collection method that does not require participants to be identified (e.g., mail surveys and computer assisted-interviewing) may help avoid this bias in future research. In addition, the random digit sampling method could have systematically excluded those in the low-income categories. Our findings, however, are consistent with previous studies, suggesting that such biases were limited. A final shortcoming of this study is the fact that the data were collected in 1999. Yet, the data are unique and rarely collected, particularly at the state level, and changes in

volunteering trends might take longer than six years to take place.

Implications for Practice

This study corroborates traditional tendencies in volunteering. The current pool of volunteers in public health endeavors is comprised of individuals with higher incomes, working in cancer and elderly-related organizations, and fundraising. Public health initiatives may need to promote collective mobilization, such as volunteering, and in the context of organizations (as opposed to informal helping behaviors), among disadvantaged groups to increase their social capital (Arno, 1998). This may be accomplished in several ways. First, organizations and volunteer administrators may need to get closer to the communities they serve, which tend to be low income. By getting closer, they can listen to those communities’ concerns and incorporate them into the organizations’ agendas and recruitment strategies. That is, the goal to attract low-income communities to volunteer may be to create a better fit between the organizations’ agenda and needs and those of low-income communities.

Second, the concept of volunteer may not resonate among some low-income communities. Informal helping behaviors (which are common among poor communities) may provide a more meaningful experience than volunteering. Thus, administrators and their organizations may need to show the significance and meaningfulness (at both personal and societal levels) of volunteering so that it closely resembles informal helping behaviors. Third, and final, recruitment efforts may have to emphasize the social spaces in which that informal help takes place, such as social networks, churches, and neighborhood groups.

Those efforts, however, need to be broadened to include youth. Volunteerism, as a form of civic participation, is a cultural and social practice learned from childhood, in homes, neighborhoods, and schools (Independent Sector, 2001). There is an opportunity, thus, for local and federal governments and not-for-profit organizations to promote forms of volunteering and their importance to society in schools and neighborhoods among youth.

One last implication is the need to diversify the types of organizations and activities in which the current volunteer pool participates. Public health areas, other than cancer and the elderly, such as the environment, substance use, and HIV/AIDS seem to be in need of volunteers and are unable to attract significant numbers of them. Likewise, tasks, other than fundraising, need to be promoted by organizations and volunteer administrators. Although fundraising may be one of the most important activities for not-for-profit public health organizations, too much emphasis on it may be hampering opportunities to attract more volunteers to other activities such as organizing groups and meetings, advocacy, and organizing health promotion campaigns.

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Table 1.

*Sample Characteristics (Means and Percentages) by Volunteering,
Illinois 999 (N= 609).^a*

	Volunteers (n= 99; 16.3%)	Non-volunteers (n= 510; 87.7%)
Age	46.5	44.5
Gender		
Female	60%	52%
Male	40%	48%
Race		
White	81%	74%
Non-White	19%	26%
Marital Status		
Married	54%	55%
Single	46%	45%
Education ^b		
1. Less than High School	10%	16%
2. High School	23%	33%
3. Some College	37%	27%
4. College or More	30%	24%
Income ^c		
1. < \$10, 000	4%	9%
2. \$10,000-\$19,000	12%	10%
3. \$20,000-\$29,000	17%	19%
4. \$30,000-\$49,000	21%	29%
5. \$50,000-\$70,000	13%	13%
6. > \$70,000	33%	20%

a. Weighted data.

b. Mann-Whitney= 20290; Z= -3.157; p< .05.

c. Mann-Whitney= 16950; Z= -2.33; p< .05.

Table 2.

Logistic Regression Odd Ratios (and Confident Intervals) for Volunteering.^a

Independent Variables	Model 1		Model 2		Model 3	
Age	1.00	(0.99-1.02)	1.00	(0.99-1.02)	1.00	(0.99-1.02)
Gender (Women)	1.46	(0.91-2.35)	1.46	(0.91-2.34)	1.54	(0.95-2.50)
Race (White)	1.81 ^b	(1.00-3.29)	1.69	(0.93-3.09)	1.56	(0.85-2.86)
Marital Status (Married)	0.90	(0.57-1.44)	0.88	(0.56-1.42)	0.69	(0.41-1.16)
Education			1.04	(0.99-1.08)	1.02	(0.97-1.07)
Income					1.22 ^b	(1.01-1.49)
X ²	7.04; p > .05		9.78; p > .05		14.39; p < .05	

a. n = 605 due to missing data.

b. Beta p < .05

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**Focusing on the Health Benefits of Volunteering
as a Recruitment Strategy**

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Abstract

There has been an upward trend in volunteering since 1998, with the most significant increase after the tragedies of September 11, 2001. Identifying and understanding the potential volunteer market and the motivational strategies needed to attract those volunteers will be key issues for the future of volunteerism. Fortunately, there is more evidence today than ever before that helping others has real health benefits. This paper will share the findings of a number of studies as well as insight into the generation most likely to be interested and influenced by this information.

Key Words:

volunteerism, seniors, health benefits, recruitment, motivation, baby boomers

The days of the long-term volunteer are gone. Today's volunteers are more reluctant to commit to a scheduled, weekly block of time. They are looking for flexibility, special projects of limited duration, and short-term commitments. Administrators of volunteer programs will be challenged to look at current recruitment methods and think outside the box. Organizations may need to offer options for flexible shifts, possibilities for both short- and long-term time commitments, and opportunities for family and couple volunteering. According to Merrill (2006), "Understanding and recognizing the wide variations of available time require structuring work to maximize opportunities for broad participation without placing undue burdens or expectations on individuals." This strategy, however, may be only one of the keys for successful recruitment.

Another key to successful recruitment is to attract the baby boomer generation. According to a research initiative

commissioned by AARP (2004), baby boomers, those born between 1946 and 1964, comprise 77.5 million people—the largest generation in United States history. Europe's boomer population consists of nearly 160 million people ("The strongest market in Europe is growing," para. 1).

As the baby boomer generation begins to retire, it will make up a large resource base that could provide ample volunteers for many years to come. In order to effectively recruit the baby boomers, volunteer administrators must adapt to our changing culture and find creative ways to communicate the benefits of volunteerism. The results of a United States survey just released by *SecureHorizon* show that seniors' most important concerns include maintaining their health and mobility (62%) and maintaining an active lifestyle (55%) ("US: Health and well-being tops seniors' biggest concerns over finances," 2006). From a recruitment perspective, using data from studies that validate the health benefits

of volunteering may be the single most important key to recruitment success.

In researching the correlation between volunteering and good health, it was surprising to find a number of studies and research projects on this topic over the past decade, not only in the United States but in a number of countries around the world.

According to Michael Callow, Assistant Professor of Marketing at Morgan State University, Maryland, "when developing a recruitment campaign, nonprofits can highlight the various appeal of volunteering by examining both the motives for, and the benefits of, volunteering" (Callow, 2004, p.263). Callow explains that an individual may choose to volunteer for altruistic reasons, but find further satisfaction in the experience because it meets social needs as well. From a recruitment perspective, using data from studies that validate the health benefits of volunteering may indeed spark interest in this soon-retiring group of adults.

In Canada, an Ontario study of volunteering linked to health benefits found that volunteering not only improves self-esteem, but helps to reduce social isolation, lower blood pressure, and enhance the immune system. Furthermore, a study on volunteerism and mortality revealed that older adults who volunteer actually experience a lower mortality rate (Jenkins, 2005).

A study performed at the University of Michigan Research Center supports this finding. The study tracked volunteers who had histories of heart conditions and found they experienced a reduction in chest pain and lower cholesterol levels. Furthermore, men who volunteered at least once a week lived longer than men who did not volunteer. The study concluded that volunteering is a positive way of connecting with others, regardless of race or income. Results demonstrated that those participants

with many social contacts tend to live longer than those who are isolated. In essence, people need people. ("Volunteering is good for your health," para. 1).

According to Yaffee (2005), Canadians who volunteer are reaping health benefits such as reduced anxiety and depression. Yaffee goes on to comment that other potential benefits for seniors include: enhanced images of older adults in society, improved personal self-regard, increased mental functioning, and reduced self-concern. Yaffee observes that "society benefits and the person volunteering may personally benefit. What a perfect prescription for health promotion and maintenance" (p.1).

The Nottingham Council for Voluntary Services newsletter shared that medical and scientific research in the UK supports the health benefits of volunteering: a sense of well-being, a decrease in insomnia, a stronger immune system, and a speedier recovery from surgery ("Improve your well-being," 2005, para. 1).

In the *Healing Power of Doing Good*, Luks and Payne (1992) share a number of benefits that volunteers experienced as a result of volunteering: a more optimistic outlook, increased energy, better perceived health, less depression, less pain, more ease in relaxing and sleeping, an improved immune system, better weight control, a healthier cardiovascular system, and a speedier recovery time from surgery.

The web site for The Centers for Disease Control and Prevention (2006) recently published a study on the importance of physical activity, stating that volunteer programs play an important role in promoting physical activity and that those benefits can help to control weight and high blood pressure ("Physical activity resources," para. 1).

Musick and Wilson (1999) utilized data from three waves (1986, 1989 & 1994) from the Americans' Changing Lives data set and revealed that volunteering did lower depression levels for those over age 65. Like other studies noted above, their findings revealed that individuals who volunteer have a lower mortality rate than nonvolunteers. Musick and Wilson (2003, abstract section, para. 1) noted, "There are a number of reasons why volunteering might yield mental health benefits, especially to older people. Volunteer work improves access to social and psychological resources, which is known to counter negative moods such as depression and anxiety."

Van Willigen (2000) conducted a study assessing the long-term impact of volunteering on the life satisfaction and perceived health of persons aged 60 and older. He found that older volunteers experienced greater increases in life satisfaction over time as a result of volunteer hours than did younger adult volunteers. The study also concluded that older volunteers experienced greater positive change in their perceived health than did the younger volunteers.

OASIS, a nonprofit agency in the United States dedicated to promoting volunteerism among the elderly, commissioned Nancy Morrow-Howell (1999) to discover what kinds of benefits volunteers receive from their volunteer activities. She found that 80% of those she spoke to reported an increase in well being attributed to volunteering, a larger circle of friends as a result of volunteer activities, and a perception that their lives were more productive.

In Scotland, a two-year project is currently under way to improve mental health and well being. The study has identified these benefits to volunteerism: escaping from dependency, enhancing strong links within the community, getting people involved, and helping individuals to

understand the importance of healthy lifestyles. ("Volunteering in health is good for volunteers," n.d.).

Haddon (2001) shares a study published in the British Medical Journal in which doctors followed 2,761 people over the age of 65 for 13 years. The study compared individuals that were active in volunteer work to those who did not volunteer but who exercised regularly. The researchers stated the results were impressive, and noted that participants who had forged active lifestyles through volunteerism were just as physically healthy as the participants who exercised faithfully.

At the Canadian Forum on Volunteering in Montreal, Chappell (1999) presented information concerning 37 independent studies, 34 of which were conducted in the United States and three in Canada. Chappell stated, "These studies demonstrate that 70 percent of older volunteers claim to enjoy greater quality of life than the average nonvolunteer; those involved in direct helping seem to derive greater rewards from volunteering than elders engaged in more indirect or less formal helping roles" (p.12).

In summation of the thirteen studies mentioned, seven studies identified an overall reduction in anxiety and depression, six studies noted improved self-esteem, five studies identified lower mortality rates, three studies identified improved immune systems, and two studies recognized better weight control, reduced blood pressure, and a speedier recovery time from surgery. Only one study identified increased mental functions as a health benefit of volunteering.

Although research has been conducted over the last 15 years on the health benefits of volunteering, there is no information to indicate that any focus has been placed on using this information in recruitment efforts. With the baby boomer generation on the cusp of retirement, this is the time to seize the

moment and put the results of these studies to work for the future of volunteerism. The engagement of the boomer will bring a level of unprecedented skills, energy, and experience to volunteerism that we have not seen in the past.

In order to effectively use this strategy, a marketing campaign to attract volunteers interested in health benefits would be developed. A starting point would be to redesign your volunteer web page. Ask an intriguing question on the page; *Do you have high blood pressure?* Find out how volunteering can help. Promise a benefit; *feeling blue, not quite yourself?* Click here to find out how volunteering can help change your outlook on life. Develop branding; *Volunteering is good for your health* and use it on all of your printed materials; brochures, advertising, stationary, and business cards. Develop brochures specifically for recruitment focusing on the health benefits and provide to physician

offices, senior service agencies, and retirement communities. On your voice mail, end your message with a statistic about health benefits of volunteering. Offer to be a guest on your local radio or television station to share information on the health benefits associated with volunteering. Put your name on the speakers bureau to speak on this topic and take a volunteer with you that could conclude your talk with a few comments about how volunteering has personally enhanced their health. Contact your local newspapers and offer to write an article on volunteering and health benefits. If they are not interested, offer to write an article on baby boomers and add the health benefits as part of the baby boomer approach. Finally, engage your volunteers in activities in the healthcare community, be visible. And always have an ample supply of handouts that provide information on studies that validate the health benefits of volunteering.

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Hospital Volunteers: A Qualitative Study of Motivation

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Abstract

This exploratory qualitative study was conducted using in-depth individual interviews of hospital volunteers to determine motivations operative in their choice to volunteer in a hospital and to explore whether any significant differences in motivation could be ascertained on the basis of age or gender. The study further probed the satisfaction and needs of these volunteers relative to their choice and motivation. No clear differences in motivation were found on the basis of gender. Volunteer job satisfaction was favorable, and positive interactions with patients and staff were significant to that satisfaction. This study demonstrated that motivations to volunteer in a hospital are complex and often specific to the role adopted by the volunteer.

Key Words:

motivation, hospital volunteer, gender differences, generational differences

Introduction

While substantial research has addressed questions about what motivates individuals to volunteer, less is known about why volunteers choose a specific industry, environment, or role. This study was conducted to identify the needs, intentions and interests of individuals who chose to devote their time, absent any professional investment or benefit, to hospital volunteerism. In light of the continuing higher ratio of females involved in this form of volunteer work, the study further looked at whether a discernible difference in motivations existed between genders or among age groups.

According to the Bureau of Labor Statistics (2005), from September 2004 to September 2005, 65.4 million people in the United States volunteered through or for an organization, representing 28.8% of the civilian, non-institutional population age 16 and over. This total unpaid workforce comprised 27.4 million male and 38.0 million female volunteers, representing 25%

and 32.4%, respectively, of the total male and female populations. Of the eight types of main organizations for which volunteer activities were performed, hospital or health organizations accounted for 7.7 % of the total unpaid labor force. This category included 9.2% of the total female volunteer workforce and 5.5% of the total male volunteer workforce, representing a wider gap between genders than those of all other categories except public safety. The percentage distribution among categories also demonstrated the significance of other types of community service to the volunteer population at large. In the interest of attracting individuals from demographic groups underrepresented in the field of hospital volunteerism and in light of the competitive market for committed volunteers, it might benefit managers of volunteers to have an increased understanding of what influences a person's volunteering decisions.

In exploring motivations of hospital volunteers, consideration must be given to

the expectations of time and affiliation, which are implicit in the form of service they have chosen. The model of volunteerism appropriate to hospital volunteers includes uncompensated and uncompelled, beneficial actions characterized by proactive commitment and performed in the context of formal association. Penner (2002) defined volunteer activity as “long-term, planned prosocial behaviors that benefit strangers and occur within an organizational setting.... Volunteerism has four salient attributes: longevity, planfulness [sic], nonobligatory helping and an organizational context” (p.448).

Motivational Theory

Various disciplines and fields of research have contributed theories regarding volunteer motivation. The functionalist approach suggests that volunteers can be recruited and sustained by appealing to and satisfying their psychological functions. Applying this theory, Clary et al. (1998) identified six motives served by volunteerism: values, understanding, social, career, protective and enhancement. Schram and Dunsing (1981) determined that human capital returns (e.g., improved skills) had an influence on married women’s decisions to volunteer. From an economist perspective, Govekar and Govekar (2002) summarized several theories of motivation including the “private goods” and “job skills” models which assume volunteers accrue some compensation from their actions by satisfying a private (non-altruistic) motive or by developing skills. Freeman (1997) proposed that many people volunteered because they had been asked to, resulting in “conscience goods” (i.e., public goods supported because a particular cause is

valued by the volunteer and because the volunteer experiences social pressure).

Hospital Volunteers

In their study of volunteer motives, Zweigenhaft, Armstrong, Quintis, and Riddick (1996) compared a group of hospital volunteers’ responses to R.T. Fitch’s Community Service Involvement Survey with those provided by Fitch’s 1987 college student group. The results indicated that, in general, the hospital group more highly endorsed items that Fitch classified under “social obligation” when compared to the students, who more highly rated items indicating career or personal enhancement. Although the findings of this study were significant with regard to differences in volunteer motivation among age groups, the questions were generally not specific to hospital volunteerism.

In his study to determine whether hospital volunteers could be differentiated from volunteers in other organizations, Wymer (1999) concluded that hospital volunteers were “older and more committed and dedicated to their organizations.” They tended to be “more religious” and had “a healthy sense of self-worth” (p. 70). Qualitative results indicated that adjusting to a life stage transition (e.g., retirement or widowhood) was the most prevalent factor leading to volunteering. Ibrahim and Brannen’s (1997) study of the relationship between hospital volunteers’ gender and volunteer motivation indicated males were more responsive to items regarding volunteering that appeared to be occupationally or externally focused. Females were found to be more responsive to questions on volunteering that the researchers identified as more personal or internal, such as continuing a family tradition or gaining educational experience. The study found little significant difference

between genders with regard to items related to altruism or personal satisfaction.

Zweigenhaft et al. (1996) concluded that women were more dependable than men, and older volunteers more dependable than young ones. Women with strong religious ties were determined to have had the most positive impact on the volunteer program. In light of these findings the authors noted, "Perhaps, given the nature of different socialization patterns for men and women in this society, the women had more experience caring for sick people" (p.33).

Some literature suggests that associating gender with nurturing and expressive roles may be more complex than is commonly indicated. Karniol, Grosz and Schorr (2003) found no difference between male and female volunteers regarding caring scores, and concluded that "volunteering is better predicted by one's adoption of the ethic of care than by one's gender" (p.18). Eisenberg and Okun's (1996) study of older hospital volunteers found little difference in men and women's empathic dispositions, and suggested that men and women may become more similar in later years, or that only more emotional men volunteer in hospitals. Skoe, Matthews, Pratt and Curror (1996) noted the disparity in socialization among generations and suggest that there may be fewer differences between younger men and women because their social experiences are more similar than those of older men and women.

Methodology

This exploratory study sought to achieve a better understanding of individuals who volunteer in hospitals, particularly those who had some interaction with patients or the families of patients; what accumulation of motivations and issues were operative in their decision to spend their time in that

particular arena; how their volunteer experience related to those factors; and whether any significant differences could be identified on the basis of gender or age. This qualitative cross-sectional study was conducted utilizing separate, in-depth interviews of individual hospital volunteers. Interviewing allowed the subjects more latitude in explaining feelings and experiences too complex to be responsive to formatted questioning (Babbie, 2004; Patton, 1997).

The sample. The researcher developed a purposeful sample of 21 volunteers assigned to two hospital campuses of a major northern California medical center drawn from a group of current hospital volunteers who responded to a request to participate in the research. The study group comprised eight male and 13 female participants whose ages ranged from the early 20's to over 80 (Table 1). Eight of the study participants were retirees over the age of 70 (four females and four males). With lengths of service ranging from five months to over 18 years, each participant was engaged in a volunteer activity which was regularly scheduled and required some degree of personal interaction with patients or the loved ones of patients. The latter requirement was intended to strengthen the representative sample with regard to the significance of hospital volunteering experience by excluding volunteers whose experiences may be similar to those in other environments. None of the participants were volunteering because it was a mandatory requirement for school or employment. (See Table 1 for further detail on age distribution and years of service).

The research instrument. The researcher developed an interview schedule to collect data during face-to-face interviews with research participants (Babbie, 2004). Topics and questions were structured to elicit

information regarding each participant's prior volunteer history, current hospital volunteer activity, and attitudes toward their current hospital volunteerism. In order to provide a basis for comparison and analysis, specific probes and prompts were included to explore general themes proposed by the literature on motivational theory and to identify unique circumstances which may have contributed to a participant's volunteering decisions. Although the interview schedule provided a structured and consistent framework for the interviews, the nature of the study was such that some flexibility was warranted in order to facilitate reasonable and meaningful responses from the research participants.

Data collection and analysis. Individual interviews ranged from approximately 40 to 75 minutes and were conducted with the volunteers at the hospital campus at which they worked. At the time of the interview, interested parties were apprised of the purpose of the research study, advised that they should decline to answer any questions which made them uncomfortable, and requested to sign an "Informed Consent" form. The participants were asked various questions regarding volunteering in general and with regard to their reasons for choosing to volunteer in a hospital setting. Questions were designed to allow respondents to explain their feelings about this type of volunteer work as well as to facilitate the identification of factors (separate from generalized altruism or sympathy) relevant to their motivation and socialization issues or experiences that might be pertinent to their hospital volunteerism. Respondents were screened for any indication of circumstances which may have impacted or restricted their volunteering choice or commitment, such as mandatory community service or professional field work.

Relative to motivations and needs, subjects were asked to discuss satisfactions, disappointments, and difficulties that characterized their hospital volunteer experience and whether, having had the experience, they intended to continue their hospital volunteer work and would recommend it to others. Subjects were queried as to how much authority and autonomy they desired in carrying out their volunteer functions as well as how much they currently had, and whether having a "sense of belonging" was important to them.

All but one of the 21 interviews was tape recorded. The researcher assigned a confidential alpha code to each set of notes and tapes representing a unique research participant. Sample data, including years of experience, gender, age category and "yes" or "no" indicators for responses to questions regarding volunteer experience, religion, etc., were linked confidentially with the specific participant on a spreadsheet and used for data analysis. The narrative text for each transcribed taped interview and interview outline was coded in accordance with themes found in the literature review and addressed by the interview questions.

The researcher examined all of the formulated data (i.e., coded from narrative text with related demographics) for identifiable patterns and meaningful inferences. To facilitate final analysis, the researcher compiled and organized the data by types of motivation as well as other research study categories, cross referenced with specific demographic information (Babbie, 2004).

Findings

Study results suggest that both generosity and personal fulfillment were influential in the volunteering decisions of study participants. The research also indicated that

a combination of design and circumstance brought the participants into the hospital environment, and that a combination of choice and adaptation were significant to their fulfillment as volunteers in a hospital.

Volunteer experience. Each participant reported having engaged in at least some form of volunteering either prior to or concurrent with (or both) their current hospital volunteer engagement. The amount of volunteer work engaged in over time, per individual, ranged from minimal to extensive. Of those who reported more significant volunteer histories, seven of the volunteers indicated they had volunteered in other hospitals, with two of the seven still doing so. Other types of volunteer experiences varied considerably.

Motivation to volunteer. Participants rarely cited a single motivator for engaging in volunteer work, especially when their assignment required a formal commitment and the potential for stress. Some combination of altruistic (other-oriented), egoistic (self-oriented) and practical reasons was generally indicated as reasons for volunteering, both in general and at the hospital. Common responses included “paying back” or contributing to society, although the contexts in which this motive was expressed varied. For example, some individuals were grateful for some aspect, or the whole, of their life while others recognized the need to help people faced with difficulties that they, too, had experienced. Another participant did not want to emulate the selfishness he perceived in his own environment. “Making a difference in people’s lives” was another common expression, although participants often provided unique perspectives on what this meant to them. In addition to their feelings of communal responsibility and concern for individuals in need, participants readily admitted that receiving personal

satisfaction from performing their volunteer work, or being engaged in a role that they felt was personally meaningful or reflected their unique interests, was significant to their volunteering decisions. Practical considerations were also reported, including the health benefits of using one’s leisure time productively.

Hospital volunteering. Roles assumed and tasks performed by the volunteers at the hospital varied, as did the nature of the contact with patients and the families of patients. Very few of the participants had prior experience in a hospital environment as patients, visitors, or caregivers. Only one of the volunteers had prior paid experience working in a hospital directly with patients’ physical needs. Three others had previously been employed by hospitals in professional capacities unrelated to patient care. Two other respondents were current hospital employees with no direct patient contact.

When asked why they chose to work in a hospital, some participants indicated wanting to volunteer in a medical institution but being unsure as to what capacity, while others had a specific position or patient population in mind. For personal reasons, being able to work with cancer patients, sick children, or newborn infants was important to many participants. Others wanted simply to help people and felt those in the hospital were among the neediest. Other participants, without initially choosing to volunteer in a hospital, found they were able to share their interest in literacy or education in programs with hospital patients. Two male retirees found themselves volunteering at the hospital when it was suggested to them that the hospital would have opportunities for them to use their time effectively.

When asked why they chose a particular hospital, participants’ responses included a combination of factors, including location or

convenience, familiarity, opportunity, and the availability of specific programs. Because of size, services, and historical presence in the community, most knew the specific hospital by general reputation. However, reputation was not a reason stated often, and never the sole reason, for choosing that particular institution.

Personal interests and experiences, practical needs, and the desire to help each combined to motivate the study participants. Some motivating sentiments and circumstances were shared by genders and generations, while other reasons for volunteering in a hospital were unique to each individual. Perception of need and availability of meaningful opportunities were significant broadly for hospital volunteerism.

With regard to the influence of religion and social factors on decisions to work in a hospital, responses were generally negative. With the exception of one volunteer, none of the participants directly attributed their choice to become a hospital volunteer to religion or current involvement with a church, although some felt religious principles to which they had been exposed in their early family life might have influenced their general sense of charity or community. In addition, neither social engagement, social obligation, nor social recognition was strongly indicated by participants as reasons for volunteering. Although some of the volunteers were informed, influenced, impressed, or inspired by the volunteer spirit of family members or others, none chose to volunteer in the hospital because of pressure from parents or peers. That the volunteers were self-directed in their reasons and choices was a common theme.

Skill development and gaining experience toward paid employment were not significant factors in the motivations

reported by participants. For the most part, skills brought by the participants to their respective volunteer roles (and developed as a result of them) were more social and abstract than tangible (e.g., sensitivity, openness, and the ability to communicate effectively in difficult circumstances).

Satisfaction and difficulties. With few exceptions, participants' responses to some or all of the questions regarding the most satisfying and difficult aspects of their hospital volunteer work had to do with relating to other people. Many participants felt satisfied when they were able to provide comfort to a patient, while others with less patient contact noted that pleasing a staff member or making a positive connection with a hospital visitor brought them satisfaction. Difficulties expressed were matters of experiencing the uncomfortable realities of life (e.g. the death of a child, the loneliness of long term patients, or the strain on patients' loved ones). Other difficulties cited had to do with feelings of failure, frustration or ambiguity with regard to being able to perform a volunteer role effectively.

Conclusions, Implications, and Recommendations

Participants of both genders and all generations expressed similar altruistic motives for volunteering (e.g., giving back to the community and making a difference in the life of someone in need). As would be expected, indications of sensitivity varied on an individual basis. For many participants, having direct patient contact and doing work that was personally meaningful or of personal interest were strong factors in their choice and commitment. Participants had varied views on autonomy and somewhat more varied views on "sense of belonging," but there were no clear differences in attitudes along gender lines. Despite the

skewed ratio of female to male hospital volunteers, this research failed to indicate that females have more time or significantly different interests or predilections than do males. The most significant difference suggested by the study findings was that of possible generational differences: Retired males reported no significant adult volunteer histories, whereas younger males suggested that they were creating volunteerism histories well before retirement.

The findings do not identify many of the motivators proposed commonly by the literature. For the most part, participants did not volunteer for social reasons or because of social expectations, nor did they volunteer on the basis of religious convictions or as representatives of a specific religious congregation. Implications for human capital development were not notable when career or educational goals are considered. Retirement as a life stage transition was a contributory factor in the decision to volunteer for several participants, although not necessarily to hospital volunteerism in particular. Participants were satisfied with their hospital work, although many indicated having to resolve specific difficulties at one time or another.

For the most part, participants expressed satisfaction with their treatment by paid hospital staff and were very appreciative of both the help and expressions of gratitude they received from them. In addition, regardless of their attitude towards having a sense of belonging, several participants expressed surprise and respect for volunteer administration staff who knew each of them individually, thanked them on a regular basis for their time, and/or gave them the opportunity to pursue positions which fit their needs and interests. Having that single recognition was significant.

Several practical implications for volunteer recruitment and retention are suggested by the study findings. The research indicated that the study participants' volunteer programs were appropriately relevant in considering an individual volunteer's interests and needs in identifying appropriate matches for new volunteer recruits. Participants were not full of expectations but did desire to be in areas where they felt useful and effective. Many needs and interests disclosed by study participants, however, may well have been indulged via other volunteer environments. The findings imply that volunteer recruitment efforts would benefit from an analysis of what volunteers are looking for in any volunteer position, and a determination as to whether current marketing materials are sufficiently informative with regard to the scope and potential for hospital volunteer opportunities that might complement a volunteer's unique and complex motivations. In addition to personal agendas, perception of need was instrumental in the choice to be a hospital volunteer for many study participants. Mindful of that perception, highlighting the variety of areas where a volunteer may be useful to the hospital, its patients and staff would be a credible outreach program strategy.

The study results further suggest that recruiters and managers of volunteers should note satisfactions and recognize difficulties experienced by hospital volunteers. Some hospital volunteers must develop coping strategies for dealing with the stresses and sadness associated with individual patient circumstances and learn how to maintain distance without becoming dismissive or lapsing into denial. Others must adjust to changes or demands that challenge their ability to work effectively. They must also learn to cope and adjust in a limited amount

of time and without some of the peer support and resources appreciated by paid employees. Restricted hours and lack of complete integration into the hospital team, though desired, may also be isolating. New recruits may feel somewhat ambiguous about their commitment if they are not able to work through an uncomfortable situation that might arise. Managers should be conscious of these factors and be able to provide both assurances of worth and resources for empathy when needed.

In light of the study findings regarding participants' attitudes toward their hospital work, there is some indication that professional coordinators and recruiters of volunteers might derive advantage from viewing the volunteers themselves as a valuable marketing resource. Persons often learn of volunteer opportunities through friends who volunteer for an organization. Managers should understand why a volunteer would or would not recommend their work to another individual, and factor that information into volunteer recruitment plans. Consideration might be given to designing opportunities for volunteers to be ambassadors for a hospital's volunteer program. The findings also suggest that recruiters should seek out the assistance of male volunteers, or those of underrepresented demographic populations, to ascertain whether such volunteers might provide insights that would help to attract and retain an appropriately diverse and committed volunteer pool.

The author suggests that volunteer motivations are complex, and will vary with the choice of industry where an individual decides to volunteer and even with the role one adopts within that industry. The findings of this study suggest no outstanding differences between genders or among generations in terms of motivations or attitudes towards volunteer work. This

research suggests positive indications for the approach and attitude of volunteer staff, and also demonstrates the importance of developing a more comprehensive understanding of how and why individuals are attracted to certain volunteer positions. Based on location, services, and a variety of other considerations, a hospital's volunteer needs will vary. In this instance and presumably in other areas, the volunteer pool does not reflect the gender or ethnic realities of the holistic patient population or the geographic area that the hospital serves. This research suggests there may be inadequately tapped volunteers whose recruitment would better benefit both hospitals and the patients they serve.

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Table 1.

Sample Population Distribution by Gender, Age, Years Volunteered and Education

Category	Number (n = 21)
Gender:	
Female	13
Male	8
Age:	
18-25	2
26-40	6
41-55	3
56-65	2
66-75	5
76-90	3
Years Volunteering at Hospital:	
Under 1 year	3
1 - 5	11
6 -10	1
11-15	4
16-20	2

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Judith Blanchard holds a Master of Nonprofit Administration from the University of San Francisco. She is active in community service as a board and committee member for local nonprofits as well as a direct service volunteer for several organizations. Judith also serves as an officer on the Advisory Council to the Retired & Senior Volunteer Program of San Francisco.

**Knowledge and Attitudinal Impacts Upon Teen Volunteers
Teaching Younger Youth
in a Community-Based Obesity and Overweight Prevention Education Program**

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Abstract

Researchers have documented positive effects of volunteering upon adult volunteers' personal health, yet no similar research has focused upon youth volunteers. The researchers developed a mixed-methodology to investigate knowledge and attitudinal changes among 43 teen volunteers teaching in a cross-peer, cross-generational program designed to educate 5-to-12-year-old youth about obesity, fitness, and nutrition. The quantitative data showed an average gain of approximately .11 points between the pretest and the posttest, resulting in a small effect size of .2. Two overarching themes resulted from qualitative data analysis: (1) teen volunteer teachers increased knowledge regarding fitness and nutrition; and (2) teen volunteers learned more about themselves as teachers of younger youth. The researchers suggest that beyond the teaching activity success of the teen volunteers, the program also was successful in impacting positively the teen volunteers themselves regarding obesity, fitness, and nutrition.

Key Words

teen volunteers, evaluation, impact, obesity, health education

Introduction

For decades, managers of volunteers, medical researchers, and nonprofit organizations have espoused the positive effects of volunteering upon a volunteer's mental, emotional, and/or physical health. As early as 1991, Graff reported on a project funded by the Ontario Ministry of Health that explored relationships between volunteering and health. She concluded that "Volunteering can generate a heightened sense of self-esteem, . . . reduce heart rates and blood pressure, increase endorphin production . . . boost immune system and nervous system functioning, reduce life's stresses, and overcome social isolation" (p. ii). Luks and Payne (1992) synthesized medical and scientific documentation supporting the health benefits of volunteering upon volunteers, including a heightened sense of well-being; improved insomnia; a stronger immune system; and speedier recovery from surgery.

Among medical clinicians and researchers, Kawachi and Kennedy (1997), Gillies (1998), and Lomas (1998) all concluded that an individuals' voluntary involvement in social, civic, and/or volunteer organizations was correlated positively with both improved personal and public health. More recently, Li (2004) explored relationships between volunteering and health at different stages of adulthood. She concluded that formal volunteering exerted a beneficial effect on adult volunteers' depressive symptoms in later life stages, especially among older widows.

However, at least one contemporary study has concluded that volunteering may actually be detrimental to a volunteer's health (Ziersch et al., as cited in the British

Broadcasting Corporation, 2004). Based upon a survey of more than 500 Australian adults involved in voluntary groups and volunteer efforts, researchers from Flinders University in Australia found that respondents who did volunteer work linked it with negative effects on their health. According to the lead researcher, "[Volunteer] involvement may not be beneficial for individual health, and that for the individuals involved [in the study] there is some evidence that this involvement may in fact be detrimental for their own health" (Ziersch, 2004, para. 11). The researchers did recognize, however, that the relationship between individuals' volunteer activities and organizations is ". . . complex, and . . . there may be hidden differences between types of civil society groups" (para. 12).

While limited, the published literature supports overwhelmingly the positive relationships between an individual's volunteer activities and her/his personal health. However, that majority of data reported in the literature are either purely anecdotal or collected in clinical contexts. Valid and reliable empirical social science research is needed to investigate such possible connections between volunteers' activities and their health, for both adult and youth volunteers.

Youth Obesity in North Carolina

In North Carolina (N.C.), five of the 10 leading causes of death and disability are linked to dietary factors (North Carolina Prevention Partners, 2005). The epidemic of obesity (and the chronic diseases that often accompany it) will lead to more hospitalizations, require more medications,

and underlie the premature maiming and killing of more people than any other condition currently known. The state's increase in overweight and obese youth has far exceeded that of other states. Mohad, Serdula, Dietz, Bowman, Marks, and Koplan (1991) indicated that North Carolina's children ranked 11th in the nation in the rate of overweight and obesity at the beginning of the 21st century, with 25% of youth ages 12 to 18, and 20% ages 5 to 8, being overweight.

In addition to obesity, poor dietary quality among North Carolina's children and youth is a concern. The 2002 and 2005 N.C. Prevention Partners Report Cards (North Carolina Prevention Partners, 2002, 2005) show that North Carolina earned "F's" in nutrition both years. The reports suggested that this failing grade was the result of a statewide diet high in foods that are high in fat, sugar, and calories and low in consumption of fruits and vegetables and the protective nutrients contained therein.

The problem of poor dietary quality is compounded by the lack of physical activity among youth. North Carolina has one of the most sedentary populations in the nation. According to the United States Centers for Disease Control and Prevention (2001), nearly 40% of the state's youth are not getting the recommended amount of physical activity needed for good health. As a result, North Carolina youth scored 12 – 15 % below the national average in heart-lung fitness tests. The high level of physical inactivity, coupled with poor dietary quality, translates into a troubling statistic for the state as a whole: North Carolina's children and youth are two to three times more likely to be obese and poorly nourished than children nationally.

Teens as Volunteers

Teens need to be engaged actively and meaningfully in their communities through volunteerism and service. One such opportunity would be engaging teens as volunteer teachers of younger youth in community-based non-formal educational settings. Such a cross-peer volunteer program delivery model has proven successful both historically (Smith, Havercamp, & Waters, 1990) and more contemporarily with various content foci and delivery settings. In Nevada, high-risk teens served successfully as volunteer teachers of younger latchkey youth (Smith & Havercamp, 1991). Groff (1992) developed the NC 4-H Teens Reaching Youth (TRY) program to, among other goals, empower teens to make a difference in the lives of others (especially younger youth) through teaching opportunities.

Safrit, Scheer and King (2001) noted that "Teens are more willing to . . . seek greater responsibility in deciding what volunteer projects to conduct. Volunteer opportunities can enhance the teen's career exploration, provide an opportunity to learn about themselves, and be included as a part of building a strong college application or job resume" (p. 19). Subsequently, Safrit (2002) described the need for managers and administrators of teen volunteer programs to recognize and practice the "Four E's" of working with teens: empathy, engagement, enrichment, and empowerment. Lee, Murdock, and Paterson (2002) concluded:

Teenagers can be extremely effective teachers of young children. Children respond well to teen teachers. Teenagers can be positive role models for young children. Using teenagers as teachers is efficient. A team of eight teenagers can teach 60 or more children organized in small groups. (p. 2)

The authors also noted, "Teenagers themselves benefit from being teachers. Attitudes toward teachers and school can improve. Self-confidence and a sense of accomplishment can increase" (p. 2).

Regarding critical aspects of successful youth service learning programs, Junck (2004) encouraged such volunteer programs to focus upon true community problems rather than issues of the sponsoring volunteer organization, while making adult mentors available to support the youths' service initiatives. Safrit, Gliem and Gliem (2004) described the importance of cross-generational volunteerism, stating that "the most effective infrastructure for youth volunteerism and community service may be through youth-adult partnerships, i.e., youth and adults working together as equal peers to address through volunteerism the serious challenges facing their communities" (p. 39).

The Cross-Peer, Cross-Generation Teen Volunteer Program

North Carolina (N.C.) 4-H Youth Development is the youth-focused program of the Cooperative Extension Service. In 4-H, community-based youth development professionals manage adult and youth volunteers who guide experientially based educational programs for youth ages 5-18. The N.C. 4-H program is administered by the Department of 4-H Youth Development and Family and Consumer Sciences at North Carolina State University, and North

Carolina A&T State University, and seeks to create helping relationships to enable youths to become responsible, productive citizens.

In 2002, in direct collaboration with National 4-H Council, Safrit, Edwards, and Flood (2005) developed "Teens Reaching Youth through Innovative Teams" (TRY-IT!) as the next generation of an original cross-peer, cross-generational teen volunteer program (Groff, 1992). TRY-IT! utilizes innovative Web-based learning modules to strengthen and expand community-based teen volunteerism and service through effective teen-adult partnerships. In TRY-IT!, teens (ages 13-18) work with adult volunteer coaches to teach curricula to younger youth (ages 5-12). County 4-H TRY-IT! Teams are organized by county 4-H Youth Development professionals, and attend two, three-day state level face-to-face training retreats. The first retreat empowers teen and adult Team members as leaders, challenges them to work as an effective teen-adult partnership, and prepares them to be effective and safe teachers of younger youth. The second retreat trains Team members in the specific curricula to be taught.

In February 2005, the authors received a \$7,500 competitive grant for the six-month period April through October, 2005 to nurture successful and positive teen and adult partnerships through active teen leadership and citizen involvement in N.C. counties, targeted toward educating youth about serious issues of youth obesity and overweight. Specific objectives included: 1) to establish and train County 4-H TRY-IT! Teams (each consisting of an average of 3-4 teen and 1-2 adult volunteers) to teach health, nutrition and fitness curricula; and 2) for the teen and adult volunteers to collaborate to teach obesity, fitness, and

nutrition curricula to a minimum of 500 youth ages 5-12. The overall program goal was to strengthen both the teen volunteers' and youth participants' knowledge and attitudes toward relationships between obesity, proper nutrition and fitness so as to address the issue of youth overweight. Thirteen county 4-H TRY-IT! Teams were trained, comprised of 43 teen volunteers (ages 13-18) and 17 adult volunteer leader coaches. As of October 7, 2005, the 13 county 4-H TRY-IT! Teams had taught 70 individual educational sessions (consisting of 278 instructional hours) to 1,579 youth between the ages of 5-12.

While the program's true societal impact would have been best documented by assessing resulting knowledge and attitudinal changes upon the 1,579 youth taught (Safrit & Merrill, 1998) such an impact evaluation model was not possible. The N.C. State University research Institutional Review Board expressed serious concerns about subject (i.e., youth/minors) protection and test administration considering the project's widespread outreach. With parental consent requirements and expressed concerns about minors (teen volunteer teachers) administering the surveys to other minors (session participants), logistical and protective realities made this level of data collection impossible for this short-term project.

Subsequently, the researchers collected quantitative data describing program inputs (Safrit & Merrill, 1998) focused upon program activities (e.g., number sessions taught, total hours taught, etc.) and program participation (e.g., number youth ages 5-12 taught, numbers of teen and adult volunteers teaching, etc.). They also collected qualitative data describing

program participants' (e.g., youth ages 5-12, teen volunteer teachers, etc.) initial reactions to the teaching sessions. These data satisfied the program funder's basic stipulations for required formative and summative project reports.

However, the researchers also sought to develop an outcome-focused impact evaluation model largely on knowledge and attitude changes affected by the program upon the program's teen volunteer teachers rather than the 5to-12-year-old youth they taught. While not the ideal impact evaluation focus, such impact data would be extremely useful in documenting valid and reliable outcomes of the program upon a targeted stakeholder group (i.e., the teens actively engaged in the cross-peer cross-generational program).

Purpose and Methodology

The purpose of this exploratory study was to assess the impact of teens' participation as volunteer teachers of youth ages 5-12 in a community-based obesity and overweight education program upon the teen volunteers' knowledge and attitudes regarding obesity, fitness, and nutrition. The researchers developed an exploratory mixed-method design (Creswell, 2003) using a written questionnaire to collect quantitative data (de Vaus, 1996), and an interview schedule to collect qualitative data (Marshall & Rossman, 1999).

The researchers developed a written questionnaire based upon guidelines described by Fowler (1988) and Dillman (1999). The questionnaire was constructed based upon the four constructs identified as the program's major goals and included three sections. Section I included 10 items investigating teen volunteers' knowledge of obesity prevention and physical fitness, and

proper nutrition. Section II included 10 items investigating teen volunteers' attitudes toward both obesity prevention and physical fitness, and proper nutrition. Section III included five items investigating teen volunteers' selected personal and 4-H program traits and characteristics. Items in both Sections I and II used a five point Likert-type scale (categorized as 1 = Totally Disagree; 2 = Disagree; 3 = Undecided; 4 = Agree; and 5 = Strongly Agree) to measure respondents' knowledge and attitudes toward obesity, fitness, and nutrition.

The researchers established the instrument's face validity using a panel of obesity, nutrition, fitness, and volunteer experts in Cooperative Extension, and modified the instrument based upon input from the panel. The researchers calculated Cronbach's alpha ex-post facto for the instrument ($\alpha = .78$) as an indicator of reliability. Nunally (1976) stated that for purposes of exploratory research, a Cronbach alpha of .60 or greater as a measure of internal consistency is permissible.

The interview schedule was developed by the authors based upon Marshall and Rossman (1999); Safrit, Schmiesing, King, Villard, and Wells (2003); and an initial set of open-ended questions required by the program funder. The schedule consisted of five open-ended questions that investigated participating county 4-H Youth Development agents' perceptions of the program's successes, challenges, and impacts upon the teen volunteer teachers, 5-to-12-year-old youth taught, organizational partners and collaborators, and the county 4-H program. In October 2005, the authors collected qualitative data using the interview schedule. Due to the resulting small volume of qualitative data collected (i.e., 26 double-

spaced pages), the authors analyzed the data using the methods described by Creswell (2003).

The researchers used a convenience sample ($n = 43$) and the written questionnaire to collect data using Campbell and Stanley's (1963) Separate-Sample Pretest-Posttest Design (Design 12). The pretest was administered at the beginning of a Friday-Sunday content training retreat conducted in April 2005. The posttest was administered at the end of the six-month grant funding period in October 2005, where 4-H staff members administered the written questionnaire at final county Obesity TRY-IT! Team meetings for the program. Quantitative data collection followed procedures suggested by Kraut (1996), McNabb (2002), and Rea and Parker (1997). The researchers entered all quantitative data into a personal computer and calculated descriptive statistics for central tendency, variability, and effect size (Cohen, 1988; Gall, Gall, & Borg, 2003) and inferential statistics for comparing group means.

Quantitative Findings

The findings from the study were summarized and are presented in Table 1. The data showed an average gain of approximately .11 point ($C.I. [-.19 \leq \mu \leq .41] = .95$) between the pretest and the posttest but was not statistically significant. The lack of statistical significance was likely the result of low statistical power (approximately 10%) due to the small sample size. Cohen's d (1988) was calculated and resulted in an effect size of .2, which would be classified as small.

Qualitative Findings

The researchers suggest two overall themes resulting from analysis of the

qualitative data. First, the teen volunteer teachers learned new basic knowledge regarding fitness and nutrition. One participating county 4-H agent quoted one of her teen volunteers as stating, "I learned how to read labels. The kids [we taught] loved making low-fat ice cream sandwiches. They learned how to move more and eat healthier." Another responded, "They [the teen volunteer teachers] also learned about the new [U.S.D.A.] 'My Pyramid' and how it can be tailored to meet individuals' needs based on age and gender." Another 4-H agent responded that while one of her teens admitted, "I need to change my own eating habits!", that overall her teen volunteers "reported that the youth they taught really enjoyed the snack ideas that they got to try out." Still another county 4-H agent reported that her Team "learned nutrition, how to teach, the new food pyramid, and exercises." A sixth county 4-H professional shared that her "TRY-IT! members and the youth [they taught] shared what they had learned with others; many would ask their own parents to make the healthy snacks at home for them."

The second overarching theme is that the teen volunteers learned more about themselves as volunteer teachers of younger youth. A 4-H agent reported that her TRY-IT! Team's teen members learned that "different age groups require different techniques to keep them interested in what they are trying to teach them." She reported that several of her teen volunteers commented that it took "more effort and energy to work with the youngest youth, but was still fun." Another county 4-H agent reported that, "My TRY-IT! Team discovered they could teach and reach other youth." Finally, a third county 4-H agent

reported that her TRY-IT! Team members "all indicated that they developed leadership skills".

Conclusions and Implications for Volunteer Administrators

The reader is cautioned about generalizations of the study findings beyond the N.C. teen volunteer participants due to the study's exploratory nature.

The research findings suggest that beyond the teaching activity success of the NC 4-H TRY-IT! obesity and overweight education program as measured by number of youth ages 5-12 taught (i.e., 278 instructional hours for 1,579 youth), the program also was successful in impacting positively the program's teen volunteer teachers regarding the program's targeted knowledge and attitudes regarding obesity and fitness, and proper nutrition. This finding is supported by both the quantitative and qualitative data.

The researchers suggest that although the data showed an average gain of approximately .11 point between the pretest and the posttest that was not statistically significant, the lack of statistical significance was likely the result of low statistical power due to the small sample size. The resulting effect size of .2, while considered small, does indicate that the teen volunteers' participation as peer teachers in the program did have some effect upon their knowledge and attitudes regarding obesity, fitness, and nutrition. While the purpose of this research was not to investigate possible cause-and-effect relationships, subsequent research using a true experimental design with a larger sample could further clarify such possible causality.

Educators of adults (Bloom, 1976; Heck & Williams, 1984) have commented

about the role of the teacher of adults as part of the “hidden curriculum,” or messages that are conveyed by the teacher passively or even subliminally beyond formal content to both students and teacher alike during the learning experience. This phenomenon may be described by the often-used cliché, “the best way to learn something is to teach it to others.” Thus, while knowledge and attitudinal changes were not assessed in the younger youth being taught, they were documented with methodological rigor in the older youth doing the teaching.

While the reader may well argue that the initial goals of the TRY-IT! obesity and overweight educational program were not to affect knowledge and attitude in 43 teen volunteer teachers, but rather to do so in a minimum of 500 5-to-12-year-old youth taught by the teen teachers, one narrowly-focused yet well-documented impact of the program was the positive effects it had upon the teen volunteer teachers regarding the program’s initial objectives for the younger youth.

The study findings support the practice of engaging teens as volunteer teachers of younger youth identified by Lee, Murdock, and Paterson (2002). By the actual design of the N.C. 4-H TRY-IT! Program, county 4-H TRY-IT! Teams trained through the obesity and overweight education program have continued to teach obesity, fitness, and nutrition curricula to 5-to-12-year-old youth after the grant period formally ended in October, 2005. The teen volunteer teachers will also be involved in training new county 4-H TRY-IT! Teams in the areas of obesity, fitness, and nutrition. All 13 participating counties’ respective 4-H agents indicated that the TRY-IT! Teams will continue to teach the curricula in the

next six months (at a minimum), and the State 4-H Office will continue to collect and compile longitudinal outcome and impact data describing the TRY-IT! Teams’ teaching activities. During the next 12 to 24 months, the ultimate impact of the program upon the knowledge and attitudes of the 43 teen volunteer teachers involved could be documented by investigating actual changes in personal fitness or diet habits based upon the knowledge gained and attitudes formed through the program. The researchers look forward to contributing to a healthier citizenry in a state with young people who are physically active, nutritionally savvy, and ready to share their expertise with others.

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Table 1
Summary Statistics and Independent Samples t Test

Group	n	Mean	S. D.	S.E.	t	df	p	Mean Difference
Control	22	3.58	.37	.08	.718	41	.48	.106
Experimental	21	3.68	.58	.13				

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**Instilling Social Responsibility Among Student Volunteers:
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Abstract

The author discusses how a Singapore hospice, in working with student volunteers, successfully diverted its volunteer efforts towards building society. The program has proven to be a successful tool in inculcating social responsibility among students who opt to do their community work at the hospice as part of a Community Involvement Programme (CIP). While some not-for-profit organisations (NPOs) and volunteer hosting organisations (VHOs) do not appear to recognize the value of CIP hours and student volunteers, others have leveraged such efforts to benefit both the organisation and its clients. The hospice has gone one step beyond by turning the described program into an effective tool to instill in student volunteers a sense of social responsibility, better preparing them for active citizenship.

Key Words:

hospice, social responsibility, community-involvement-programme, student volunteers

Introduction

Not-for-profit organisations (NPOs) and volunteer hosting organisations (VHOs) have as primary goals helping build or rebuild society in specific areas that are unique or of special interest to the organisations. For example, hospices are built with the primary goal of improving the quality of life of patients and their families facing problems associated with life-threatening illnesses. Hospices around the world direct efforts and resources towards achieving these goals may it be in the area of fund management, resource allocation, or volunteer/staff deployment.

However, there are occasions when such NPOs or VHOs successfully redirect volunteer energy towards benefiting society

by venturing outside of the organisations' primary goals. This paper will discuss the experience of a hospice operating in the island-nation of Singapore in order to illustrate how this can be achievable.

The Community Involvement Programme (CIP) in Singapore

The national CIP in Singapore was launched in October 1997 to provide equal opportunities for all students in Singapore to play an active part in the life of the community in which they live, and to be active citizens who contribute towards nation-building. The objectives of CIP are to nurture students to be socially responsible and develop a sense of belonging and commitment to the community and country.

By participating in community work, students also learn the value of service and of developing enduring friendships with one another, and become more conscious of individual personal responsibilities to family, community, and country.

Beginning in January of 1998, every Singapore student from primary school to junior college must volunteer a minimum of six hours of service each year under this programme. On a long-term basis, a pupil with 10 years of schooling would have completed at least 60 hours of community service under this programme by the time s/he graduates from school.

The programme can be conducted through activities within the school such as peer group tutoring, taking care of an eco-garden, maintaining the school environment, or making handicrafts to raise funds for the needy. Other activities may extend to the wider community whereby students may perform duties in public libraries or welfare homes such as homes for delinquents, orphanages, shelters for abused children and so forth, teach computer skills to senior citizens, or enhance the environment through adopting a beach or a park which they will maintain and beautify.

However, there have been complaints from some participating students that their CIP experience, particularly at welfare homes, had been reduced to performing meaningless menial tasks. Such perceptions may result from a multitude of factors. Insufficient work being available for student volunteers, minimal supervision by paid staff, lack of creativity in the ways of working with volunteers, or simply the absence of real interest in working with volunteers are some of the most common reasons for the lack-lustre way welfare homes are organising CIP for students.

Structure of the Hospice CIP Programme

Recognising these pitfalls, the Singapore hospice embarked on a structured CIP for student volunteers, applying the primary principles of service learning. Students who opt to do their CIP at the hospice are asked to develop specific program objectives and state the intent of their visits. The hospice manager of volunteers will, at a preliminary meeting, discuss with the student volunteer ways to achieve their objectives and methods of measuring their desired outcomes. This is normally conducted on-site at the hospice to give the student volunteer the opportunity to become familiar with the hospice and its environment.

Thereafter, a minimum of three visits comprising at least nine CIP hours is required, although many student groups have voluntarily opted to do more than the minimum. The first visit establishes the CIP experience for the student. S/he is given an orientation that highlights the work of the hospice and the holistic approach it adopts in caring for patients. Students are then given practical tips on how to go about doing the task they have identified. The second half of the first visit is a walk through the hospice wards with the assigned volunteer adult host (VAHs) who also guides them through their task.

Students receive hands-on experience during their subsequent visits, with VAHs present to give guidance and assistance when required. The VAHs are also available to provide a "listening ear" for those who have problems managing personal emotions, such as feelings of separation and loss, pain and suffering, and coping with the imminence of death which is prevalent at the hospice. These are very real issues that are faced not only by student volunteers but also by paid staff and caregivers. Students who are traumatized by the hospice experience are referred to their

school counselors for follow-up consultations.

Between visits, students plan the “end-of-programme” client project, which is the pinnacle experience for CIP students at the hospice. Some of the novel projects that students have developed include celebrating a patient’s birthday by decorating his bed-station with balloons, ribbons and bows, and photographs and family memorabilia; throwing a “mother’s favourite recipe” tea party during a festive celebration whereby every dish was personally cooked by the students under a mother’s watchful eyes; and an *ice-kachang* party using the traditional techniques of ice shaving. (*Ice kachang* is a popular local dessert consisting of sweet condiments embedded under a mountain of shaved ice.)

At the last visit, time is set aside for reflection, which represents the closure of the student’s hospice experience. VAHs encourage students to share personal experiences using “feeling” words to describe emotions. They are also asked to share how they coped with these emotions. Coloured papers are then distributed for them to list the following: (a) changes they wish to see in their lives; (b) take-away lessons to share with others; and (c) resolutions.

Desired Changes in their Lives

A vast majority of the hospice’s CIP students have stated emphatically that they wish to take better care of themselves so that they could continue to enjoy life to the fullest with their families and friends, and to treasure life, family and friends more than they already were doing. Similarly, a large number of students also resolved to be less self-centred and to be more sensitive of the feelings and needs of people around them; to be more giving by leading lives that will be of service to others especially those who are more in need than themselves; to be more

responsible in their actions and words and bear the consequences; and to be more caring toward the elderly and the infirmed. A significant number of students also said they want to be more active in community work and be able to contribute towards building society.

Lessons to Share with Others

The following rank the highest of all the lessons that students want to share with others including family, friends, and fellow students: (a) importance of treasuring life and relationships; (b) the meaning of living life to the fullest; (c) the meaning of living and sharing; (d) the need to be of service to others; (e) the need to be more resilient and to be able to face challenges ahead of them such as suffering, failure, death, separation, and pain of loss; and (f) benefits of being socially responsible.

Resolutions

The most commonly cited resolutions are: (a) I want to offer my time as a volunteer; (b) I want to study hard so that I can hold a good job and be able to give more generously to the needy; (c) I want to do more good deeds; (d) I am very fortunate and want to share what I have with those who have less; and (e) I want to be a good son/daughter.

Observations Regarding Students’ Reflections

From students’ responses during the reflections, it may be deduced that they have learned some very valuable lessons that have been catalytic in their decisions to make certain changes to their lives and to resolve to take actions that can benefit or matter to others. Conversations with hospice patients often give rise to personal sharing. Oftentimes, patients voice their regrets for not taking better care of their health and for not spending sufficient quality time with

their loved ones due to work and other pursuits. Poignant statements that patients make, such as “it is too late for regrets now that I am dying”, strike and tug at the heartstrings of the CIP students and spur them on to think about their own lives and to take stock of what lies ahead of them. As a result, students realize the importance of family and relationships.

Some CIP students have not seen pain and suffering in their lives. Coming to the hospice for CIP opens up a new dimension in their world and makes them see that there are indeed people in this world who are suffering and dying of diseases that have no cure. It makes them more aware of the mortality of men. Therefore, they learn to treasure life and appreciate their purpose in life even more. In other words, they have become more socially responsible.

The resolutions they make suggest that they recognize there are needs, other than their own, that need to be addressed in society. They have also come to realize that they, as individuals or groups, can provide assistance or make contributions to society to make it more livable for others who are less fortunate than they are. From sharing at reflection sessions, one may observe how the CIP students have matured after being exposed to hardships and suffering.

Making the CIP Programme Work

The hospice CIP works for the student volunteers because it has been structured specifically to meet objectives and measure outcomes. It does not merely ‘use’ student volunteers to complete tasks that paid staff are unable or unwilling to do. The hospice values people who supervise the programme, namely paid staff and volunteer adult hosts. As a result, they are highly motivated and do the best they can to ensure the success of the programme. The following factors have also contributed to the success of the hospice CIP:

1. Appropriate preparation of student volunteers for the hospice experience:

During preliminary discussions, student volunteers are given information about the kind of work and types of patients they can expect to meet during the course of their CIP. They are also invited to visit the hospice for on-site reconnaissance and watch paid and volunteer staff at work so that they are familiar with the environment and can judge for themselves whether they are ready for such an emotionally charged experience. This introduction prepares them mentally and aids in preventing possible emotional traumatisation.

2. Programme structure: Any programme that requires participants to establish learning objectives and measures outcomes generally yields better results. Students undergoing CIP at the hospice establish their own objectives and target goals. In other words, they are entrusted with ownership of the programme which, in turn, motivates them to work hard and ensure its success.

3. Guidance for students to achieve learning objectives: Throughout the hospice CIP experience, VAHs are on hand to provide student volunteers with guidance and assistance. They teach students skills that are required to care for hospice patients, such as listening skills and communication styles; show students how to deal with patients who are demanding; and help students through difficult situations. At the end of each session, the VAHs conduct a short debriefing with the student volunteers to monitor their progress. This is useful since the students can bring up problems that they faced, and potential solutions and preventive measures can be discussed. A good indication and gauge of the success of the programme is when the actual outcome at the end meets the demands of the learning objectives set by the student volunteers at the outset of the programme.

4. *Time for reflection*: VAHs facilitate reflection sessions, which are normally conducted at the end of the entire programme and mark closure of the CIP experience for the students. Good closure is imperative considering the nature of the work carried out at the hospice and the effects it may have on paid staff, volunteers and care-givers, and particularly the student volunteers, who are exposed to such an environment for the first time. Besides facilitating the reflection sessions, VAHs also stimulate student volunteers to think about what more they can do after the end of the programme. Do they wish to do more and go beyond CIP?

5. *Beyond CIP*: Many of the student volunteers make a conscious decision to do more for the community and the hospice after their CIP has ended. There have been groups of students who continued to volunteer their time and efforts to the hospice. For example, a group of student volunteers produced a film based on their CIP experience and all proceeds from the *film's premiere* were donated to the hospice. Another student volunteer group organised an art and poetry competition depicting lessons they learned from their short experience at the hospice. Again, proceeds from the art exhibition were given to the hospice to support its charitable causes.

6. *Proper selection of VAHs*: The pool of dedicated VAHs is specially handpicked from the hospice's existing volunteer base. Applications for the position are stringently screened to ensure they meet predetermined criteria. Aptitude for youth work, love for sharing knowledge with youth, patience in guiding and teaching youth new ideas and concepts, and creativity and innovation in organising projects for clients' benefits are some of the prerequisites for the job.

7. *Training*: VAHs are given on-the-job training to acquaint them with the CIP's structure, procedures, and processes in order

to enable student volunteers to have an enjoyable and meaningful experience at the hospice. They are trained to conduct tours of the hospice, which comprises part of the orientation programme for student volunteers, and to facilitate brainstorming sessions with students to come up with brilliant and original ideas for their end-of-programme client projects. They are also given training to equip them with the ability to conduct the reflection sessions at the closure of the programme.

Conclusions

The structured CIP introduced at the hospice has given students the rare opportunity of experiencing real-life volunteerism in its true spirit. This experience has planted in these students the "seeds of volunteerism" which will yield long-term results that can benefit the community in the long run.

Judging from the sharing and resolutions of the students, it is safe to conclude that the student volunteers have learned valuable lessons from their CIP experience at the hospice. It can also be concluded that the hospice has succeeded in instilling in these students a deep sense of social responsibility towards family, community, and country.

How well the hospice programme has succeeded in instilling social responsibility in student volunteers is best encapsulated in the words of one student volunteer who testified that, "The Hospice has taught me that only a life lived for others is worth living and when we stop contributing to the community we live in, we begin to die spiritually." At another session, a student shared, "I really want to help make life better for people, especially those who are less fortunate. I am saying this now because I have time to reflect. Very soon I will be busy with examinations, then building my career and starting my own family. I hope

when the time comes, I will not forget this. The day in my life when I have to make the choice of the kind of life I want to lead, I want to remember to be of service to others.” Testimonies such as these clearly indicate the effectiveness of the hospice CIP in instilling social responsibility in student volunteers.

Author’s Note: This article was adapted from a paper entitled “Building Social Responsibility Among Student Volunteers” presented originally at the 10th IAVE Asia-Pacific Volunteer Conference held in November 2005 in Hong Kong.

About the Author

Michael Loh is General Manager of Heartware Network, a Singapore-based charitable youth organisation, where he directs and leads a dedicated team that engages youth to be more proactive in service and champion social causes within the community. A former manager of volunteers at Dover Park Hospice in Singapore, he is also a trainer in volunteer management with the National Volunteer and Philanthropy Centre and the Social Service Training Institute, an Academy of the National Council of Social Service. During his tenure as manager of volunteers, the Hospice received two major national awards including the Inaugural National Volunteer Award for Best Volunteer Management System (2001) and the President’s Social Service Award for Volunteers (2002). Mr Loh is also Founding Chairman of MOVE (Managing & Organising Volunteer Efforts), which is the official professional association for practitioners of volunteer management in Singapore.

Legal, Risk Management and JCAHO Issues for Healthcare Organizations

American Society of Directors of Volunteer Services. (2000). Washington, D.C.: American Hospital Association. (117 pp.; paperback)

**Legal, Risk Management and JCAHO Issues for Healthcare Organizations:
Addendum I**

American Society of Directors of Volunteer Services. (2004). Washington, D.C.: American Hospital Association. (96 pp.; paperback)

Reviewed by: Mary Kay Hood, Hendricks Regional Health, Danville, IN, USA.

The American Society of Directors of Volunteer Services (ASDVS), a professional membership group of the American Hospital Association (AHA), has as its primary mission to: Strengthen the profession of volunteer services administration; provide opportunities for professional development; promote volunteerism as a resource in serving the healthcare needs of the nation; support healthcare volunteerism; and forge alliances to build healthy communities. To this end, ASDVS works to provide materials that will be beneficial to those in volunteer management/coordination roles for healthcare organizations. Healthcare organizations, as defined by ASDVS, represent all hospitals, medical centers, healthcare networks, long-term care facilities, clinics, and other facilities providing healthcare.

One useful publication, authored by a coalition of volunteer directors throughout the country in a collaborative effort, is *Legal, Risk Management and JCAHO Issues for Healthcare Organizations*. Originally published in 2000, there is an *Addendum I*, published in 2004, reflecting updated information regarding laws and best practices for the volunteer field in healthcare organizations.

The primary purpose of the 2000 publication is to “encourage quality performance for healthcare organizations.”

While “many laws do not directly indicate volunteers,” it is smart business sense to understand the legality regarding employment and follow those same guidelines when dealing with volunteers. With a caveat to verify local laws, this guide takes a manager of volunteers through all aspects of legal and risk management issues.

With an eye on all aspects of volunteer management, this manual focuses attention on legal entities that fall under scrutiny when managing/directing a volunteer program. Beginning with legal definitions of a volunteer, the first chapter also discusses the National Volunteer Protection Act of 1997 with some explanation of liability as it pertains to a volunteer or volunteer department. The next chapters discuss various laws having implications for volunteer programs: e.g., the Fair Labor Standards Act (FLSA), child labor laws, the American with Disabilities Act (ADA), Occupational Safety and Health Act (OSHA) and the Health Insurance Portability and Accountability Act (HIPAA). Not only are these laws explained, but there are also recommendations included on how these laws affect a volunteer program and what steps the program manager should take to ensure compliance with legal entities.

There are sections on best practices when it comes to harassment, background checks, ergonomics, workplace violence,

confidentiality, and disciplinary action including definitions, sample forms, and policy statements that can easily be formatted to each healthcare organization. Additional resources are cited at the end of each chapter to provide more depth and validity to the content.

Because of the accreditation of healthcare organizations as a process to “maximize service excellence, productivity, and safety,” there is a small section in the original 2000 publication about the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), with an expanded section of ASDVS’ interpretation of JCAHO standards in 2004. While this information is good, anything in writing regarding JCAHO standards is only good for the year that it is published because the JCAHO standards are changed and updated annually. Although the

Addendum I makes mention of additional up-to-date resources available to volunteer directors for JCAHO standards, JCAHO is not the only accreditation body. While the majority of healthcare organizations may follow the JCAHO standards, the books fall short of discussing other accreditation entities.

However, in following the recommendations outlined throughout these manuals with regard to legal matters, risk management and the law, any accreditation standard by JCAHO, Healthcare Facilities Accreditation Program (HFAP), or some other accreditation body should pose no threat to the volunteer director who focuses on good business practices for volunteer programs in healthcare organizations.

About the Reviewer

Mary Kay Hood is the Director of Volunteer Services at Hendricks Regional Health. She is a national speaker on all aspects of volunteer management and author of *The One Minute Answer to Volunteer Management Questions*. Mary Kay has an M.S. degree and serves currently as president of the Indiana ASDVS affiliate, the Indiana Society of Director of Volunteer Services (ISDVS).

Volunteer Involvement in a Pandemic Influenza Disaster

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Abstract

The engagement of volunteers during a disaster involves precise planning taking into consideration ethical issues, risk management, and the appropriateness of when and how volunteers should be utilized. During a pandemic influenza disaster, it is predicted that the first workers to become infected by the pandemic will be professional healthcare workers. Healthcare facilities must then plan for a depletion of professional workers at a time when patient numbers will escalate. This plan discussed how professional hospital workers can be supported through volunteer involvement.

Key Words:

disaster, pandemic, healthcare, risk management

The World Health Organization (WHO) has suggested that an influenza pandemic is both inevitable and imminent. We have all read the news coming out of Asia about the increasing number of cases of A/N5N1, or Avian Flu. The world is not only watching, but is preparing itself for an outbreak that is speculated to kill as many as two million to 50 million people worldwide.

A pandemic occurs when a new influenza virus, which differs from existing strains, appears. Because it is new, few (if any) people have immunity allowing it to spread widely and rapidly. Due to the expansion of global travel and tourism, it is felt that the transmission will be unprecedented.

An Integrated Approach

Pandemic Influenza Disaster Plans are not created in isolation, but rather are designed from a global to a local perspective. The WHO initiated a global plan establishing international standards. This was adapted, in this case by Canada,

outlining Canadian standards designed to meet Canadian needs in a plan called "The Canadian Pandemic Influenza Plan". This national plan provided the framework for plans to be developed at a provincial and local level.

In Calgary, Alberta, the Calgary Health Region began its work with Alberta Health and Wellness as far back as 2000. The Calgary Health Region is the governing arm of community health delivery for Calgary and surrounding areas. It includes acute care, community care, and long-term care.

In 2002, a steering committee was formed to draft the first plan addressing a pandemic disaster. An expanded plan was completed in 2005. The steering committee was comprised of a diverse and broad representation of healthcare in Calgary including such areas as medical, operations, public health, acute care, long-term care, logistics, risk management, communications, and human resources. Volunteer Resources sat on the initial steering committee and was later

represented by Human Resources, so was integral to the planning from the start.

Work Force Impact

The projection for Calgarians affected in the event of a pandemic is that there will be 5,400 to 12,600 hospitalizations and 180 to 420 deaths. These numbers far outweigh the resources in place for day-to-day health care. Clearly, very careful and strategic planning is necessary to assist those people who fall ill and to help reduce the number of people who contract the flu.

In the initial planning, a key assumption was that healthcare workers will be one of the first impacted by the pandemic either directly (by getting ill) or indirectly (by caring for family members at home). Based on this premise, the volunteer component of the plan was critical ensuring that sound and ethical volunteer management principles were employed.

Considerations in Planning for the Utilization of Volunteers

During the initial planning process, a number of questions arose regarding the utilization of volunteers in an influenza pandemic. The answers to many of these questions formed the essence of the volunteer management strategy. Some of the issues faced were:

- What are the ethical concerns regarding asking volunteers to participate in a high-risk environment?
- How do we deal with large numbers of people coming to a site to volunteer with no training or experience?
- What ages should we consider as appropriate for a volunteer?
- How do we get volunteers trained and “on the ground” in an expedient manner?
- What roles are appropriate for volunteers to perform?
- What is the risk for volunteers serving in a hospital or patient care setting?
- How do we accomplish appropriate screening levels in the midst of a disaster?

The Essence of the Volunteer Management Plan

Recruitment. The primary volunteers to be deployed in a pandemic flu disaster will be the currently registered volunteers in the Calgary Health Region over the age of 18. These volunteers are already screened, orientated, and trained. Volunteers will be asked if they wish to participate. Each potential volunteer will be made aware of the risk factors involved in exposure to the pandemic so each will be able to make an informed decision. Most regular programs will be discontinued for the duration of the disaster in order to free up volunteers willing to assist in the disaster.

A secondary call for volunteers will be made to affiliated organizations of the Region as there is confidence in the volunteer management programs to which these volunteers have been exposed. There may be a call to volunteers from other organizations within the Region where it is known that diligent volunteer management systems are in place. There will be no volunteers recruited from “off the street”.

Screening. The screening process will be considered complete based on the recruitment strategy. All volunteers not currently registered with the Region will fill out an application. This ensures that they are covered by liability insurance.

Placement. Volunteers will be assigned to the following roles: Emergency Department Assistance, Media Centre, Family Relations Centre, Discharge Centre, Personnel Pool, and Acute Care Unit Friend.

Other assignments may occur depending on the number of patients and severity of the disaster.

Orientation and Training. Every volunteer will receive an orientation to the pandemic flu and as necessary, to the site to which they are assigned. Training will occur within each program area.

Supervision. Volunteers will be supervised by an assigned staff member within each program area.

Recognition. The Pandemic Flu Disaster Plan includes a recognition component that applies to both paid staff and volunteers.

Evaluation. Volunteer resources will be part of the overall Pandemic Disaster Plan evaluation as this plan is designed as a prototype for all disaster plan implementation.

In Conclusion

The state of readiness for the implementation of the Pandemic Influenza Disaster Plan is impressive. Time will be the judge and experience will help in creating new and better iterations. It is encouraging to see that the role of volunteers is once again integral to the success of the plan.

Reference

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About the Author

Sue Wood has spent her career in the nonprofit sector primarily in volunteer resources management. Her 13 years leading 500 volunteers on two acute-care hospital sites gave her the experience and knowledge to become a consultant in volunteer resources development. Passionate about the integral role that volunteer administrators play in the nonprofit sector, she has worked to promote the profession through her involvement with the now-dissolved Association for Volunteer Administration, in particular regarding the integration of the Certified Volunteer Administrator credentialing program as a means of professionalization. She volunteers on a number of boards, both locally and internationally.

Editor's Note: The following article is reprinted exactly as it appeared originally in the JOVA, 1993-1994, Fall/Winter, pp. 61-68.

**Psychosocial Support: A Crucial Component for the Successful
Management of AIDS Volunteers**

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(Note: no current contact information available)

Abstract

A multidisciplinary approach in the support of AIDS volunteers is discussed employing three dimensions: educational, social and psychological. This approach was developed by the Foundation for Interfaith Research and Ministry (FIRM) in Houston, Texas, to combat volunteer burnout and attrition often exhibited by volunteers when serving clients with AIDS and other chronic, debilitating diseases. An examination of the specific goals and tasks required of volunteer managers/coordinators to utilize this approach are outlined. Although these three components of support were implemented for AIDS volunteers, they can easily be modified to suit virtually any type of volunteer environment and are appropriate tools to enhance a variety of volunteer settings. Ideas and suggestions as to how this psychosocial model of support can be adapted for an organization's use are included.

Key Words:

HIV, AIDS, management, volunteers

Introduction

We are well into the second decade of AIDS. As with the first decade, the second persists in its unrelenting depletion of resources, finances and lives. As of Sept. 1993, the cumulative total of all people diagnosed with AIDS in the United States was 339,250 (Center for Disease Control, 1993). Of these men, women and children, 60% (204,390) have already died. Unfortunately, the current rate of AIDS diagnoses appears to be rapidly accelerating. The first 100,000 cases of AIDS were diagnosed eight years into the epidemic (CDC, 1989). The second 100,000 cases followed only 26 months later (CDC, 1991). The third 100,000 were documented 18 months later when the Centers for Disease Control (CDC) expanded the definition for the diagnosis of AIDS (Chang, Katz, and Hernandez, 1992). Indisputably,

AIDS will remain a major public health challenge for decades to come.

Along with this challenge comes the significant task of maintaining an active involvement of volunteers in the provision of services to people affected by HIV/AIDS. The professional role of the volunteer coordinator/administrator is critical to the ultimate success of those organizations which rely predominately upon volunteers for service delivery. This article presents the efforts of one such organization, the Foundation for Interfaith Research & Ministry (FIRM) in Houston, Texas. Described are the specific psychosocial support mechanisms instituted to surmount the challenge of maintaining long-term, compassionate and experienced volunteers. Although these mechanisms are discussed within the framework of FIRM's organizational structure, they can easily be adapted to accommodate virtually all types of volunteer environments.

Program Summary

The Foundation for Interfaith Research & Ministry (FIRM) was created as a nonprofit organization in 1986 by clergy and lay people to provide educational and service programs in response to the expanding AIDS epidemic and to initiate other programs in the future. The underlying factors which led to the inception of the AIDS care team program, accompanied by the obstacles overcome in its implementation, are discussed elsewhere (Shelp, DuBose, and Sunderland, 1990). FIRM is responsible for recruiting, training and supervising volunteers organized into congregation based care teams. The goal of the care teams is to offer friendship and support in the form of nonjudgmental care and companionship. In effect, the care teams become surrogate and extended families to those they serve. Examples of the types of services provided by the volunteers are social and emotional support, light housekeeping, limited transportation, shopping assistance, meal preparation and hospice care. In addition, case management and the Challenge/FIRM Co-op (a food pantry) are offered to clients who are in need of these services. All programs and services are provided free of charge.

Immediately following the recruitment of a new care team from the membership of a sponsoring congregation, volunteers are trained in several major areas. These areas include information on topics such as introduction to AIDS, infection control, psychosocial issues affecting clients and their loved ones, the provision of social and emotional support, care team organization and volunteer responsibilities. Applicable skills regarding basic nursing and hospice care for adults and pediatrics are later taught by a registered nurse.

Clients are referred to the agency by

physicians, nurses, social workers, healthcare providers, agencies, volunteers, family and loved ones, or are self-referrals. The service coordinator completes an intake and assigns a care team to each client. The volunteer coordinator then conducts an initial home visit to determine the appropriateness of the referral, to explain the role and function of a care team, and to assess any ancillary needs which may require supplementary referrals. The volunteers meet with their new client and create a schedule of visitation and assistance based upon a needs assessment. This schedule is consistently renegotiated as the disease progresses and the amount of assistance intensifies.

Unlike the traditional "Buddy" program where one volunteer is assigned to one client, the client is introduced to as many as six to eight volunteers who will be providing assistance. This team approach allows for a wider range of services available to clients. In addition, no one volunteer is overwhelmed by the expectation that he/she is the sole person responsible for providing the social, emotional and physical support of the duration of the client's life. Rather, volunteers are comforted knowing that they are part of a collective effort in the provision of services to their client.

Care teams typically consist of 15-20 volunteers and either one team leader or two co-leaders. A paid staff person is assigned to each team and functions in a variety of roles. Primarily, this volunteer coordinator is responsible for volunteer recruitment, continuing education, team supervision, volunteer support, assessment of client satisfaction and other administrative duties. Each volunteer coordinator is responsible for the supervision of 10-12 care teams and meets with each team monthly. The coordinator must also maintain an "open door" policy and be available daily to

respond to both volunteer and client needs as they arise. For an in-depth program description accompanied by training outlines and job requirements, refer to Sunderland and Shelp (1990).

Agency Statistics

Presently, there are 60 AIDS care teams representing 70 churches and synagogues in the Houston metropolitan statistical area (HMSA). Serving on these care teams are 1,200 active volunteers. These volunteers provide care and support services to an average daily census of approximately 215 clients. This census is roughly 6% of the 3,732 documented number of people living with AIDS in the HMSA (Houston AIDS Surveillance Update, 1993).

As of December, 1993, the Care Team program had provided non-judgmental care and support services to 1,310 men, women, and children affected by HIV/AIDS since January, 1986. The Houston AIDS Surveillance Update (1993) reports that a total of 9,567 people have been diagnosed with AIDS in the HMSA. The 1,310 clients served by care teams represent 14% of the total number of AIDS patients diagnosed in Houston.

In 1988, FIRM began documenting the number of hours donated by volunteers. To date, volunteers have provided over 350,000 hours of service. Darling and Stavole (1992) report that the average hourly value assessed for time donated by volunteers to nonprofit organizations is \$10.91 per hour. Based upon this figure, care team volunteers have documented services valued in excess of \$3.81 million. In 1992 alone, the number of volunteer hours exceeded 110,000, representing a value greater than \$1.2 million. In order to continue providing this level of client care, the program must maintain a rigorous approach in its

commitment to the support and well-being of each of the 1,200 volunteers.

Volunteer Support

It is during the monthly care-team meetings that the preponderance of volunteer support is provided. Though staff-labor intensive, the psychosocial support of all volunteers is regarded as an administrative priority crucial to the integrity and survival of the program.

Over the past several years, the range and content of the volunteer support component has gradually evolved to incorporate the changing demographics of people infected with HIV and those who volunteer their services to assist them.

One illustration of the modification of the care team model occurred when there was a rise in the number of women and children requesting services. These women and children were predominantly black or Hispanic, a contrast from the white, homosexual male population volunteers traditionally served. Instead of providing support to only one person in the household, volunteers were now faced with the challenge of working within the complex dynamics of an entire family unit. Often times, these families were suffering from poverty, lack of adequate health care, or drug addiction. Add to this burden the emotional impact of the impending death of an infant and perhaps one, if not both, parents, and the situation has the potential to become overwhelming for volunteers. Consequently, the care team model was augmented in its structure, volunteer support, and minority volunteer recruitment in order to account for these difficulties (DuBose and Shelp, 1990).

What has been achieved by program efforts over the years is simply one approach toward combating burnout and the volunteer attrition which typically ensues. The

psychosocial approach utilizes the following three elements of volunteer support: education, social and psychological. An examination of the specific goals and tasks required to accomplish these goals is presented below.

Educational Support

The goal of the first component, educational support, is to provide a comprehensive foundation of the knowledge and skills necessary to allow volunteers the opportunity to be successful and effective in their role as care givers. The educational tasks of the volunteer coordinator begin with the introductory orientation and continue throughout the volunteer experience. Volunteer coordinators are required to keep abreast of all pertinent issues within the study of HIV/AIDS. Another task of the coordinator is providing continuing education and training as new information is learned regarding such topics as medical discoveries, therapy innovations, disease symptomology, etiology and epidemiology, infection control procedures, etc.

As an adjunct to continuing education, specific skill modules are provided by consulting medical and mental health professionals. These modules include, but are not limited to, nursing and hospice care for pediatric and adults, boundary setting and other drug related issues for working with the chemically dependent personality. The Volunteer Coordinator facilitates monthly meetings for all Team Leaders which consist of seminars on suicide, case management, grief, cultural diversity and client advocacy. Finally, Connections, a quarterly agency publication, is mailed to everyone which affords another opportunity to disseminate information about important events, agency news, AIDS information, and special recognition.

Cross cultural or minority issues must also be addressed. Volunteers and clients may come from very different religious and ethnic backgrounds. The coordinator must be knowledgeable about and sensitive to these issues so that volunteers have every advantage for providing the best possible care in a manner acceptable to the client. Sometimes this may require a special educational session which helps to illuminate potential differences such as family structure, socio-economics, cultural values and an occasional reticence in the acceptance of help. Hopefully, this conversation enlightens volunteers toward a better understanding of the living arrangements and conditions of their clients. What may at first seem like an unwillingness to accept a volunteer's offer of assistance may in fact be simply a matter of ethnic or cultural difference. These differences may require an interim period of trust building before services can be accepted.

Because of the diverse scope of material presented over the course of the volunteer experience, a variety of learning modes have been utilized. This varied approach to teaching is much more conducive to reaching a broader range of volunteers who may not always acclimate to the standard lecture style of learning.

Social Support

The goal of the second component, social support, is to foster a safe volunteer environment where team building, fellowship and nurturance can transpire. The tasks of the coordinator consist of regular team meeting attendance, facilitation of team building, team and volunteer recognition through anniversary parties and social events, assisting the team in its visibility within the congregation through bulletin articles and recruitment and setting

an example of open, safe communication skills that can be learned by all members.

Many teams choose to meet in individual homes rather than at the church or synagogue. This grants the occasion to share meals or refreshments with one another. This meeting environment serves a dual purpose; first, as a primarily social event for fun and fellowship and, second, as a tool for team building and mutual nurturance.

Team leaders facilitate the team meetings. However the volunteer coordinators must maintain an objective, resourceful presence should they need to intervene with comments and suggestions, guidance, or conflict resolution. By using effective communication techniques, volunteers swiftly learn how to interact and discuss topics and situations that are sometimes volatile. Two such examples are learning to react appropriately as a team to the behavior of active drug users, and reaching consensus about team guidelines to be upheld by everyone. Due to the concept of team care, it is extremely important that the team acts as a cohesive unit. Independent volunteers who undermine the decisions of the team by keeping secrets or not respecting team boundaries must be confronted, so that these types of issues are resolved.

A second type of social event, the anniversary party/ is subsidized by FIRM. Parties are given annually to each care team to celebrate a year of service. This event permits teams to reflect and celebrate the many things that they have accomplished as well as plan for the upcoming year. The party is also a chance for the agency to publicly recognize the individual and collective achievements of the team. A third type of social support is spiritual support through the annual Service of Hope and Remembrance. This interfaith worship service is conducted by volunteer clergy of

many denominations and permits care teams, staff, clients, and the general public an opportunity to come together and pray for hope and healing, reaffirm a commitment to serve those affected by HIV/AIDS and to grieve as we remember clients, friends and family who have died.

Also, care teams plan many different outings and social events with their clients. These entertaining events include birthday parties, dinner, movies, picnics, walks, theater and concerts. If the clients are not physically able to participate, then appropriate events are planned that allow volunteers and clients a chance to socialize in a way that is sensitive to the clients' limitations.

Psychological Support

The final and perhaps most important component is psychological support. The goal of this component is to empower volunteers to confront and process their emotions, fears, concerns, frustrations, and grief so that stress, burnout and attrition can be minimized. The major task for the volunteer coordinator consists of paying careful attention when volunteers process their personal concerns or feelings during the team meetings. These personal disclosures are intimate windows into how effectively a particular volunteer is coping with his/her experience. This type of emotional sharing should always be encouraged, unless it becomes dysfunctional for the team. Should this occur, it is appropriate to suggest counseling to the individual.

It is also critical to spend time discussing the current health and condition of each client assigned to the team as well as how the volunteers assigned to that client are handling their duties and emotions. Other tasks of the coordinator include supervision and input, personal recognition of

volunteers, and suggesting "time-out" when a volunteer is overwhelmed by grief or fatigue.

The manner in which the psychological stressors are addressed is essential to the successful amelioration of their symptoms. Volunteers must be given the chance to reveal their honest and sometimes very personal feelings about a particular issue or problem. This must be done in an environment which is both safe and welcomed by all members. Coordinators can help assure this safe environment by respecting the feelings of everyone, regardless of personal agreement or disagreement. By constantly stressing the importance of sharing emotions and then respectfully exploring those emotions, the coordinator sets an example which can be quickly emulated by others.

Pre-existing beliefs, attitudes, or moral judgments about the behaviors which transmit HIV must be confronted candidly from the very beginning. FIRM's philosophy of care is compassionate, nonproselytizing, and nonjudgmental. If pre-existing attitudes are addressed at the initial training, or during the first team meeting, it may weed out those volunteers who cannot accept this philosophy of care. Since volunteers are recruited from the religious community, it is meaningful to remind those who want to volunteer that they have a religiously grounded moral obligation to care for the sick and dependent regardless of the affliction or the means by which the illness developed (Shelp and Sunderland, 1992).

It is imperative to not only challenge the prior beliefs or myths about AIDS, but the volunteer coordinator must also be sensitive to the individual religious beliefs and traditions of each denominational care team. Volunteer coordinators must be flexible and willing to learn from and accept the

uniqueness of each team and the manner in which it operates. This may not always be easy. It is essential to view the relationship with volunteers as a reciprocal learning experience.

Volunteers are confronted by countless issues which arise over the course of working with someone with AIDS or other chronic diseases. Some of these issues include fear of contagion, personal confrontation with death and dying, over identification with clients, assuming control of things outside of their control, unrealistic expectations of accomplishments, prejudice or lack of familial support caused by the stigma of working with someone with AIDS, learning how to set and respect boundaries and placing proper emphasis on self-care to avoid burnout. Inevitably, many, if not all, of these issues will surface. It takes skillful coordinators working closely with their volunteers to manage each problem as it arises. One approach to volunteer management is knowing that not every problem can be effectively resolved, but the stress underlying the problem can be alleviated through proper processing of emotions.

Perhaps the most stressful part of the AIDS volunteer experience is coping with the grief and loss of all those served and loved. Some type of team ritual or memorial service after a client dies seems to be very cathartic. This ritual can simply be an evening of sharing memories by candlelight, a formal memorial service given by the team's pastor or rabbi, the making of an AIDS quilt, or the planting of a tree. Attention to grief during regular team meetings is vital. It may also be meaningful to remember a team's many losses over the course of its work, for example, sharing memories about deceased clients on the anniversary of their deaths, or on other special holidays. If a volunteer's

grief goes unresolved, the volunteer will probably soon become overwhelmed by his/her anguish or depression and be unable to continue volunteering productively. The loss of volunteers must be averted to assure the successful continuity of the program.

Discussion

Macks and Abrams (1992) assert that burnout is not only costly to the individual, but also to the organization and the population served. The first step in implementing appropriate and effective mechanisms of volunteer support is acknowledging the crucial role of self-care for both staff and volunteers. Further, each agency must be committed to offering psychosocial support that is acceptable and welcomed by its volunteers. The stress of working with AIDS or other chronic, debilitating diseases will always be present. However, the effects of these stressors can be reduced.

The author believes that a multidisciplinary approach to volunteer support is crucial to maintaining a healthy pool of active volunteers. A seven-year analysis of the volunteer roster, beginning in 1986 when the agency first began recruiting volunteers, has shown that the average duration of volunteers in active service is approximately two years (643 days). A significant factor in the longevity of volunteers' commitment is the intensive support extended to everyone; however, there are some limitations. Findings are based on volunteer records, anecdotal evidence learned at team meetings and through personal conversations and other data available during the seven-year history of the care team project. There is a need for a scientific investigation with an *a priori* hypothesis. Unfortunately, this type of investigation is extremely costly, both in dollars and in staff time. To help overcome

this obstacle, a demographic survey of volunteers will be implemented and is expected to be followed by an annual volunteer satisfaction assessment. These evaluation tools will allow a determination of what changes may be needed in order to enhance volunteer support. Until then, the data will continue to rely on correlational findings based upon the trends in volunteer data.

The three components of psychosocial support described above can be modified to suit virtually any type of volunteer environment and are appropriate tools to enhance a variety of settings. In fact, FIRM's care team approach has proven so successful that in 1993 the model was adapted to include the care of people suffering from additional diseases, such as Alzheimer's and other dementia-related disorders.

To adapt the illustrated psychosocial model of volunteer support for author organization's use, here are several suggestions which may help in facilitating this process.

- Encourage collaboration dialogue between staff and volunteers to determine the types of volunteer support that is most beneficial.
- Institute an "open door" policy for volunteers with the volunteer coordinator.
- Incorporate a strong education and training program that utilizes varied modes of learning throughout the volunteer experience.
- Offer *safe* support meetings that 1) foster the processing of volunteer emotions (especially grief and burnout), 2) provide problem resolution, 3) create a forum for suggestions or improvements that can be conveyed to the staff, and 4) provide socialization and nurturance. It may be useful to conduct special meetings of volunteers related by job responsibility or

geographic location in order to promote team building.

- Provide volunteer recognition in a manner that is acceptable to the volunteers. Ask them what is important or appreciated.
- Periodically evaluate volunteer support using all data at disposal. Do not hesitate to revise or discontinue what does not work and retain or enhance what does.

These are only a few ways to get started toward developing an individualized approach to volunteer support. Exactly how a psychosocial approach can accommodate a program depends upon creativity, organizational structure and a commitment to healthy, satisfied volunteers.

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Editor's Note: The following article is reprinted exactly as it appeared originally in the JOVA, 2003, 21(4), pp. 24-31.

Partners in Caring: Administration of a Hospital-based Volunteer Program for the Education and Support of Cancer Patients

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Key Words:

volunteer administration, cancer, patient education

Introduction

Volunteerism is a fertile field for research (Ellis, 1985; Independent Sector, 2002; Institute for Volunteering Research, 1997; Hall et al., 2001), and investigating relevant issues is not only of academic interest, it is also immediately useful to practitioners in volunteer programs. The purpose of this paper is to highlight significant administrative issues within the volunteer program of the Patient Education Program in Princess Margaret Hospital (PMH), a comprehensive care oncology hospital within the University Health Network (UHN) located in Toronto, Canada. PMH has created a highly useful and successful volunteer system for patient education (PE), in which volunteers can make an effective and personally fulfilling contribution to the education and support of patients and their families. Such volunteer activities can be crucial in empowering those dealing with cancer (see also Fusco-Karman and Tamburini, 1994; Fusco-Karmann et al., 1996; Edgar et al., 1996; Halmay et al. 1995; Hoare and Peters, 1996; Jimenez and Jimenez, 1990; Chevrier, et al., 1994). Administrative support is an essential component of any program development effort (Diamond, 1989), and volunteer administration is a crucial and continually evolving component of our PE program. A variety of volunteer administration models exist (Culp, et al., 1998), and our

administrative model of volunteer recruitment, training and support is presented here, with the understanding that the strategies and principles that we have developed are transferable to other situations, including those beyond healthcare. While we recognize that no one formula exists for a volunteer program, we describe our model for the management and use of volunteers for PE in our context in the hope that others will benefit from our understandings and programs.

What follows is a discussion of the key points we identified as important in our developing PE program. We describe the PE program at PMH and the role of volunteers in its success. We then detail the formalized volunteer management systems and procedures in our program. Specifically, we consider the role of the Director of Patient Education, the necessity of collaboration in the development, and design of our volunteer curriculum, and finally issues around volunteer motivation, satisfaction, support and recognition.

The PMH Patient Education Program

PMH has initiated a volunteer supported, computer-based PE program (Jones et al., 2001) that aims to empower those dealing with cancer by providing consistent, comprehensive and evidence-based medical information and support. This is done via an interactive Intranet Web Site containing

information about cancer (the Oncology Interactive TM Education Series), library resources, Internet links, information about PMH services, and a hospital calendar of events.

In total, 17 Patient and Family Resource Centers have been established within cancer site-based waiting areas throughout PMH to provide appealing and easy access to the Website. Each Resource Center is clearly visible and easily accessible to patients and families waiting for healthcare appointments. Trained PMH Resource Center volunteers provide computer assistance, manage resources, and support patients and their families in a manner that demonstrates compassion, respect and empathy.

To date, 45 volunteers have been recruited and trained from the hospital pool of volunteers to assist users of each Patient and Family Resource Center. The majority are women (79%). Their average age is 44 years, and 79% are presently attending or have completed university. PMH serves a large multicultural community (close to half of Toronto residents speak a mother tongue other than English) and our volunteers reflect the diverse cultural and linguistic backgrounds of our surroundings; 47% were born in a country other than Canada, and 50% speak a language other than English in their household. We assume that personal assistance by volunteers increases the likelihood that a learning experience will be both memorable and supportive for patients and their families. The primary goals of our volunteer support program are to: (1) empower patients and families dealing with cancer, (2) improve patient and family education at PMH, (3) exert a positive effect on the hospital environment, and (4) better

the hospital experience for patients and their families.

Administration of Patient Education Volunteers

The formalized structure of the volunteer program is exemplary of a wave of professionalization of volunteer administration that began in the latter part of the 20th century (Ellis and Noyes, 1990; Institute for Volunteering Research, 1997) in response to the demands of both volunteers and organizations. Formalized management systems and procedures in our program include:

- A designated Director of Patient Education to identify needs and develop the volunteer training program and management strategies
- A hospital-wide Department of Volunteer Resources that assists in volunteer orientation and management.
- A formalized agreement with the Departments of Volunteer Resources and Psychosocial Oncology and Wellspring (a community organization) for volunteer training.
- Written volunteer policy/practice and procedures handbook for the hospital and patient education programs.
- Systems for ongoing support and supervision of volunteers that include moving volunteers to new tasks and counseling volunteers.
- Procedures for evaluating volunteer work, managing staff/volunteer relationships and recognizing volunteer contributions.

Many difficulties in creating, managing and costing a volunteer-driven program in PE can be circumvented by giving a single individual overall responsibility for the program (Goodlad and McIvor, 1998; Ellis, 1985). Part of the administrative role of Director of Patient Education at PMH

encompasses the design, implementation, management, and evaluation of the volunteer program to achieve organizational goals. Administrative volunteer program functions of this position in PMH include (see also Ross and Brudney, 1998):

- Establishing a rationale for volunteer participation
- Integrating the patient education volunteer program into the Department of Volunteer Resources and the hospital infrastructure
- Preparing job descriptions for volunteer positions
- Developing volunteer training curriculum
- Applicant interviewing and screening for volunteer positions
- Meeting the needs of volunteers by placing them in productive and satisfying jobs
- Training volunteers
- Monitoring, evaluating, and recognizing volunteer performance
- Acting as an advocate for volunteer needs and interests
- Recruiting and training staff to work with volunteers (e.g., Resource Center Coordinator and Administrative Staff)
- Responding to problems, mediating conflicts among volunteers, and handling release of volunteers.

The Director of Patient Education takes personal responsibility for day-to-day decision making, maintaining program momentum and encouraging effective communication among stakeholders in the hospital.

In order to be successful, a volunteer program must be compatible with the hospital's organizational culture, and an integral part of that culture (Silver, 1988). Therefore, an important initial task for the Director of Patient Education has been to understand the organizational culture at PMH, and integrate the PE program within it. Necessary skills for the position include a good understanding of

our patient audience, strong interpersonal skills, and the ability to inspire and motivate others and defuse conflict. Establishing and maintaining the conditions in which communication can occur are important facets of the role.

As a liaison between the organizational, volunteer and patient groups, the director functions to bring the different cultures together in as effective a way as possible to meet the educational needs of patients and their families, and to enhance hospital performance.

For example, hospital departments in our large organization tend to operate independently, often resulting in a sense of isolation for educators, duplication of service and inefficient use of resources. The Patient Education Director identified common objectives within various clinical programs; established hospital-wide programs, such as a centralized pamphlet development and distribution system; formed a Patient Education Advisory Committee to foster networking and collaboration among our stakeholders; and articulated how skilled volunteers could provide a supportive response to patient education needs.

Clearly, this is in great part a political role that requires familiarity with and networking within all hospital departments involved with patients in order to make the various groups aware of shared objectives, values and problems. Organizing a hospital-wide program for the education of patients and their families requires tremendous commitment, energy, and enthusiasm from all levels of hospital administration.

Volunteer Training: A Collaborative Effort

In a strong collaborative effort, the PMH departments of Psychosocial Oncology, Volunteer Resources, and Patient Education, and Wellspring (a community organization with an expertise in peer support training) all

partnered in the development of this volunteer-assisted initiative. Given that volunteer "good will" must be integrated with competence (Fusco-Karmann et al., 1996), a comprehensive volunteer training program has been designed to provide volunteers with the technical and psychosocial skills necessary to support users in each Resource Center. Specialized training allows the volunteers to work at their highest levels of expertise, and is also a form of acknowledgement of the importance the hospital places on volunteers. Their input is worthy of the investment of substantial time, energy and resources on the part of staff at PMH.

Department of Volunteer Resources

An understanding of the overall focus and concerns of the hospital is an essential starting point of the training process (see also Fusco-Karmann et al., 1996). Therefore, prospective volunteers must attend an information session hosted by the Department of Volunteer Resources in order to be considered by programs/services in support of PMH patients, families and staff. The UHN Volunteer Opinion Survey (VOS, 2002) indicates that what volunteers value most is information to help them perform their volunteering duties. Orientation sessions allow questions to be posed and answered and for provision of background information about the hospital.

Newly recruited volunteers are provided with a Volunteer Resources Handbook welcoming them and outlining the hospital's goals, guiding principles and values. The handbook also explains the volunteer code of ethics, as well as infection control, safety and security and emergency procedures. Through the written materials, volunteers learn about communication, confidentiality and dealing effectively with the public. Administrative guidelines clearly lay out performance

expectations, and the benefits of volunteering. For example, expectations about scheduling, absences, vacations, volunteer sign in/out, dress codes and resignation procedures are clearly explained. All volunteers are bound by a code of ethics and a signed confidentiality agreement.

Motivation and Satisfaction

What motivates volunteers, and why they find satisfaction in their efforts, have implications for recruitment, selection and administration of a volunteer program (Chevrier, et al., 1994). According to a recent Canadian survey (Hall et al., 2001), the top four reasons Canadians gave for volunteering were: (1) believing in cause supported by the organization (95%); (2) using skills and experience (81%); (3) being personally affected by the cause the organization supports (69%); and (4) exploring one's own strengths (57%). Similarly, a UK survey (Institute for Volunteering Research, 1997) found that people volunteered for a mix of altruistic and self-interested reasons, including meeting one's own needs and those of family and friends, responding to a community need and learning new skills. Key personal benefits were: enjoyment of the activity; satisfaction at seeing results; meeting people; and a sense of personal achievement. The UHN Volunteer Opinion Survey (VOS, 2002) indicates that the most important things contributing to volunteer satisfaction are helping patients, families and employees; recognition, respect and appreciation; growth in role, skill development; making a difference; and other, namely "giving back", working with a good team, and communications.

Volunteers potentially receive many intangible benefits in exchange for their gifts of time and effort. Understanding what

inspires and hinders people's contributions can provide volunteer supported programs with valuable insights (Hall, et al., 2001) and promote structures that assure that those benefits are attained (Manninen, 1991). In other words, from a programmatic perspective, "reciprocity is required—efficient and effective service in exchange for some form of benefit" (Goodlad and McIvor, 1998). Measuring the subjective dimensions of volunteering (e.g., through informal conversations, targeted interviews and focus groups) is an important part of our continuing program evaluation efforts.

Job Description and Volunteer Satisfaction

A critical part of early program development has been the development of a clear profile of the patient education volunteer who will be compatible with the tasks to be done (Silver, 1988). Persons who express interest in volunteering for the Patient and Family Resource Centers are provided with position descriptions (Appendix 1) that identify: the general and specific program objectives; the desirable skill-set; program training components; commitment expectations; duties and related tasks; and the rewards of becoming a Resource Center Volunteer. The posted job announcements and descriptions contain a clear description of the tasks to be accomplished as well as the personality styles, attributes, and beliefs necessary to succeed in our setting.

Having volunteer expectations match the responsibilities of the position is an important component of volunteer satisfaction. Our UHN Volunteer Opinion Survey (VOS, 2002) concludes that volunteers consider role definition to be a key issue. The survey indicated that:

- It was most important for volunteers to have a clearly defined role.

- Volunteers are most concerned about the degree to which they are utilized within their placement area.
- Volunteers are very concerned about having meaningful activities and tasks to perform.

In the United Kingdom, 7 out of 10 volunteers report dissatisfaction with the way their volunteer work is organized (Institute for Volunteering Research, 1997), citing the top four drawbacks of volunteering as follows: things could be much better organized; you sometimes get bored or lose interest; you cannot always cope with the things you are asked to do; you do not get asked to do the things you would like to do. Clear job descriptions can minimize these types of concerns.

In our setting, the written job description has proved to be a good foundation for successful selection and placement of our volunteers (see also Gale, 1997). Similarly, the policies and procedures developed earlier by Volunteer Resources have also established the standards for knowledge and behaviour for the volunteers, and ensured that staff and volunteers alike understand their responsibilities. Together, the patient education job description, and the broader hospital policies, and procedures for volunteers serve a useful role as early orientation and training tools for volunteers.

Volunteer Training: Curriculum Design Issues

During the pilot phase of the PMH Computer-based Education Program, 25 volunteers were recruited by the Department of Volunteer Resources. Following an interview and orientation by volunteer resources, interested candidates were screened by the Education Department. As candidates advanced through the screening process they were

invited to participate in the computer-based PE Volunteer Training Program. Volunteers not selected were redirected to Volunteer Resources for other assignments. A comprehensive volunteer training curriculum was designed to provide volunteers with the technical and psychosocial skills necessary to support cancer patients and their families in each Resource Center. Since volunteers do not work as many hours as regular staff, training is especially important to facilitate their integration into the hospital system. The specific goals of the training program were to impart knowledge, and develop skills and positive attitudes for the provision of information and support to patients and their families. The curriculum was developed in collaboration with Wellspring, a community agency, and experienced facilitators implemented the program.

Volunteers receive a comprehensive, easy-to-read, training manual, a full day of psychosocial training, a half-day of resource management instruction, a half-day of computer training and nine hours of self-directed computer practice. Strong emphasis is placed on each volunteer's individual learning efforts and motivation to learn, and ample time is provided for self-directed learning with the multimedia material. Written self-test exercises are given to volunteers, enabling them to assess their progress through the computer training. Volunteers are instructed on how to provide computer assistance to users, manage resources, and support patients in a manner that demonstrates respect, compassion and empathy. All forms of training strive to emphasize the importance of relating the hospital experience to the everyday life of both the patient and the volunteer. To date 45 volunteers have been trained.

The formal PE training and accompanying manual/materials clarify what we expect of volunteers, and orient them to their immediate work situation. We are currently developing ongoing training initiatives (continuing education) in order to retain and challenge our outstanding volunteers. Such "maintenance-of-effort training" is an investment to build volunteer satisfaction, morale, and commitment (Bolon, 1995). Several "senior" volunteers have also become managers, sitting on administrative bodies such as the Patient Education Advisory Committee and adding their expertise to hospital deliberations.

Training provides volunteers with the information, skills, and practice they need to carry out their work with oncology patients. It promotes an understanding and appreciation of the important subtleties of working with specific kinds of cancer patients. For example, an important component of the volunteer role is to support hopefulness and positive energy in patients (Jimenez, and Jimenez, 1990). "Hands-on" psychosocial training through role-play enhances that ability, while simultaneously screening out those individuals who, for a variety of reasons may not be suitable to carry out this role. Former cancer patients who are still too close to their own illness experiences to deal objectively with those of others, and those who exhibit difficulties during small group experiences may be reassigned to other duties in the hospital. Training is, in effect, part of our screening process.

Clearly, this PE program is very labour intensive and volunteers play a key role in supplementing and complementing the work of our paid staff. Although volunteering can be cost-effective, our training program illustrates that it is not cost free (see also Dingle et al., 2001). Volunteers need the same investment as

paid staff (Manninen, 1991). Determining the extent of this investment has involved calculating the number of volunteers and hours that are needed, reassessing this as the program evolves, calculating overhead costs for staff, supplies, and training, and deciding from where funding is to come.

Support and Recognition for Volunteers

In our experience the impact of the volunteers on the quality of life of patients and their families can be profound, and that positive impact should be rewarded and celebrated. UHN volunteers (VOS, 2002) have indicated that on average, they prefer regular recognition, rather than formal recognition events, and that they wish to receive regular feedback on their performance from their placement area. Volunteers also need opportunities to network with each other, and to share their challenges, excitement, and feelings of helplessness or anxiety. They need opportunities to support each other, reflect on their experiences, and establish connections between themselves (Katz, 1998). This may take the form of regular meetings and buddy systems (Jimenez & Jimenez, 1990).

We have chosen the administrative route of individual supervision on an as needed basis, group supervision sessions, debriefing meetings, and celebrations to recognize the accomplishments and time commitments of volunteers. For example, in 2001, a day-long celebration of volunteer participation was held in the newly launched Patient and Family Library and satellite Resources Centers. The Patient Education Volunteers themselves facilitated an open house to orient hospital staff and other volunteers to the patient education program. Informal recognition is also a priority, and volunteers receive regular feedback about their important

roles in the patient education team. Last year books in the library were dedicated and inscribed with a commemorative certificate in the name of each volunteer.

In addition, the hospital's Department of Volunteer Resources plays a central role in recognizing the contribution of volunteers. Among other UHN events, they host a summer youth recognition event; the annual fall recognition event for all volunteers; and an educational symposium for all volunteers. Recognition lunches, celebrations, etc. recognize the contribution of volunteers, and promote a sense of belonging and accomplishment that motivates people to continue volunteering their time and energy.

Summary

We have found volunteers to be key to effective and efficient technology and resource utilization by many of our patients and their families. Effective professional development of volunteers is essential to help improve patient learning, and raises the question of what hospitals and other organizations can do to better prepare and maintain a high quality and technologically literate volunteer service. In this paper we have examined the principles of good practice and administrative procedures that we have found necessary for the task of selecting, managing and training PE volunteers in an oncology hospital setting. We identified key issues that will likely need to be addressed by other practitioners and policy makers in similar programs, such as those dealing with another chronic disease. For example, new programs need to be aware of the key role of the program director in collaborating with diverse groups within and beyond the hospital to develop an effective program, train and

manage volunteers, and maintain volunteer motivation and satisfaction.

Our program development efforts indicate that volunteers involved in any computer-based learning program must receive the administrative support and training they need to integrate technology-based tools into their patient support efforts or they will ignore the technology we are implementing or simply view it as a source of ongoing frustration. In addition to a well-designed training program, such support involves continuing opportunities for professional development, practice/learning time, ample feedback about performance, staff assistance for problems and concerns, and peer communication (i.e., conversations and debriefings) to promote best practices and content skills. Our ongoing program evaluation efforts are examining how volunteers increase the depth and breadth of information and support available to patients and their families. A future paper will share how volunteer assistance is augmenting the services of paid hospital staff.

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Editor's Note: The following article is reprinted exactly as it appeared originally in the JOVA, 2004, 22(2), pp. 21-25.

**Volunteering for the Future:
The Impact on Young Volunteers of Volunteering in Paediatric Palliative Care**

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Key Words:

hospice, palliative care, youth volunteers

Background

The children's hospice movement in the UK is still relatively young with the first children's hospice, Helen House, being established in Oxford in 1982. Children's hospices are purpose built buildings offering respite and palliative care to children and young people suffering from life-threatening conditions and support to their families. Palliative care for young people with life-limiting conditions is described as "an active and total approach to care, embracing physical, emotional, social and spiritual elements. It focuses on the enhancement of quality of life for the young person and support for family and friends and includes the management of distressing symptoms, provision of respite and care through death and bereavement" (ACT ; R.C.P.C.H. 1997). The aim is to help the children and young people to live life as fully as possible and achieve hopes and dreams in the time they have left.

Less than 11 percent of children using hospices have cancer. Many have a range of other complex, life threatening conditions such as, duchenne muscular dystrophy, cystic fibrosis; Batten's disease, mucopolysaccharidosis and neurological conditions such as severe cerebral palsy (ACT et al. 1997). The period of time that children and families stay varies from hospice to hospice, and is dependent on the child's specific needs, condition and the circumstances of each family. On average it is for periods of 3 - 5 nights on several occasions throughout the year, up to approximately 21 nights. The demand for hospice/respite care has increased considerably in recent years and consequently there are now more than 27 children's hospices with many more in the planning stages. The maintenance and continuing development of all hospices rely heavily on voluntary income as only a small proportion of their funding comes from statutory sources such as the National Health Service and Social Services. It is of great concern therefore that the "National Survey of

Volunteering in UK" (1997) identified a "sharp reduction" in levels of participation by young people aged 18-24 years and more negative views of volunteering among the younger generation than older age groups. Further research was funded by the Institute of Volunteering Research (Gaskin 1998) to explore young people's understanding of voluntary work and their view of its relevance to them. Attention was focused on the conditions and incentives which would attract them to voluntary work and the best ways of publicising and marketing volunteering opportunities. Some of the key findings were a need for flexibility and ease of access to volunteering opportunities, which is still considered to be a barrier. Young people also stated that volunteering should be "enjoyable, satisfying and fun."

Culbertson (2003) speaking about youth volunteering in America, argues that the greatest hurdle to supporting youth volunteering over the next decade is the generally disapproving perception of adults about youth. He believes that adults have a "misperception" about young people and underestimate their capacity to deliver meaningful and effective [voluntary] service. Most importantly Culbertson cites research sponsored by the "Independent Sector" and "Youth Service America" (2002) which indicated that adults who engaged in volunteering in their childhood give more money and volunteer more time than those who began in later life.

The Study

Rachel House, currently Scotland's only children's hospice, opened in March 1996. It is well supported by 140 volunteers of all ages including young volunteers aged between 16 and 21 years. Initially there was concern that young volunteers might experience difficulty working alongside

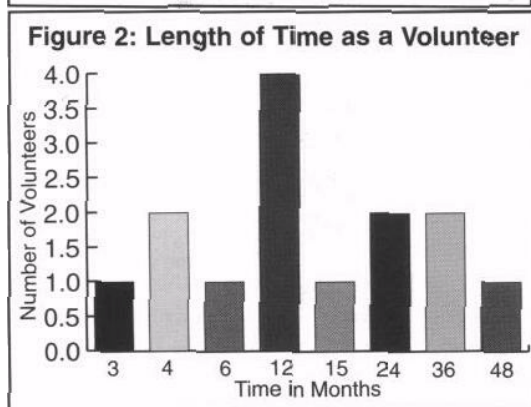
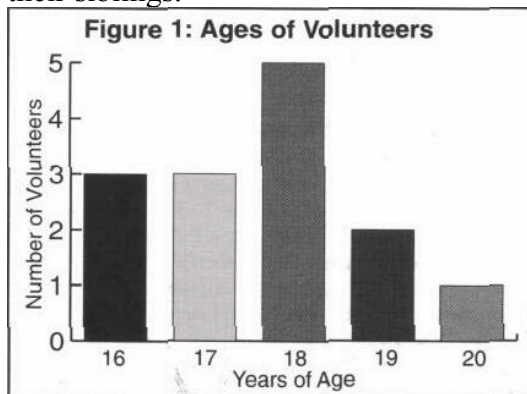
people of a similar age, who were not expected to live until adulthood. Particular concerns were expressed about their vulnerability when a death occurred in the hospice. It was decided therefore to undertake a study to explore the impact on young people of volunteering in a paediatric palliative care environment. The purpose of the study was to explore the experience on young volunteers (age 16-21 years) of working in a children's hospice environment; to identify the extent of involvement of young volunteers in children's hospices throughout the U.K. and to determine the attitudes of children's hospice professionals towards their involvement. The sample comprised the total population, at the time of the investigation, of two distinct groups: Group A: young volunteers aged 16—21 years, who were or had been involved within Rachel House children's hospice at the time of the study or within two years of the time of the study (n=16); Group B: other children's hospices in the U.K. listed in the "Association of Children's Hospices Directory" (n=18).

Two questionnaires were developed and used to gather information from the two groups. Postal questionnaires were sent to Rachel House young volunteers. The hospice questionnaires were sent to the member of staff with responsibility for/interest in volunteers. A subsequent follow up telephone interview was conducted with a small selected sample (n=3, 27%) of young volunteers. The purpose was to explore in more depth some of the responses made within the questionnaire.

Informed consent was obtained from all participants initially and throughout the process. They were also informed of their ability to "opt out" at any time. Confidentiality and anonymity were assured

to all participants. There was an awareness throughout the study of the sensitivity required when discussing issues of loss, death and bereavement.

Fourteen completed questionnaires were received representing an 88% response rate. The data obtained from the questionnaires were analyzed both qualitatively and quantitatively. The findings were grouped under headings related to the questions asked. The age of the volunteers ranged from 16 to 20, with the mean age being 17.6. (Figure 1 demonstrates the age range of volunteers). The period of time that volunteers had been with the hospice varied from 3-36 months (Figure 2). The roles that volunteers undertook included helping in the kitchen, helping with meals, helping with housekeeping and working with the activities team with affected children and their siblings.



In relation to their experience of the environment, 86% (12) of young volunteers had not found the paediatric palliative care environment a difficult area in which to work. This was attributed to the reassurance and support of experienced staff and volunteers; opportunities to talk about their experiences; and the friendly atmosphere and openness of the hospice staff. Fourteen percent (2) had initially found the environment difficult because of the similar ages of the children and also found it difficult to accept that the children would die. However these respondents indicated that although it had taken time, they had settled into the environment. The majority 72% (10) felt that the introductory period of the induction training had adequately prepared them for the impact of volunteering in a paediatric palliative care environment. Attendance at the quarterly support meetings had been difficult for young volunteers with only 14% (2) making use of these sessions. Those who had not attended these meetings cited other commitments and lack of time as the main reasons. One respondent did not feel the need to attend, whilst another feared s/he would be the only young person there. They suggested meetings be held at evenings and weekends; sessions which were specifically for young people and a young volunteers' social evening. At the times when there were deaths in the hospice, 79% (11) of the young volunteers felt that they received the support needed. Young people reported that opportunities to talk; the caring, reassurance and support of experienced staff and volunteers; the family spirit; the friendly atmosphere, and the openness of the environment were important at these times. One respondent (7%) had not found adequate support and indicated that knowing that they could talk to someone would have helped. Subsequent contact with the Chaplain had been very helpful to this

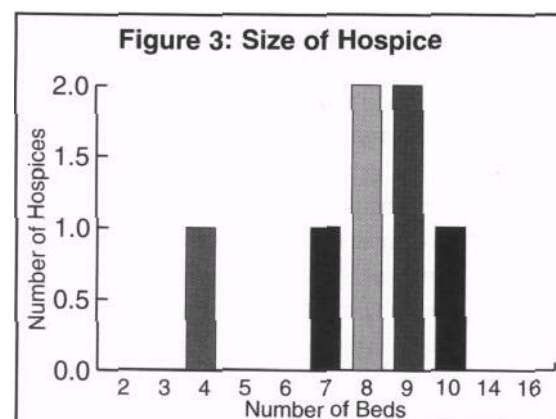
volunteer. All (100%) respondents indicated that their experiences had been very rewarding. A few put forward suggestions for improvement, which included more contact with children; more appreciation from staff; and a certificate of achievement.

Findings From Telephone Interviews With Young Volunteers

Seventy-nine percent (11) of respondents indicated in the initial questionnaire that they would be willing to take part in a further telephone interview. Information obtained by telephone supported the above findings. These interviews, however, highlighted that working with an experienced volunteer partner was very important. This they felt gave confidence and one to one support. Also, the practical aspect of the induction period was identified as being of most value. They felt that this was the only way to find out what volunteering would really be like. The role of the volunteer coordinator was specifically identified as a key role in the support of young volunteers. It was suggested however that more emphasis be given to support in the recruitment and introductory stages of volunteering. Young people reported that they had learned a great deal and had overcome their fears about interacting with the hospice children and their families. Key learning included the fact that there were many misconceptions about children's hospices and that it was "OK" to be happy in such an environment. Young people indicated that through their volunteering experience in a children's hospice, they had gained valuable insight into an area of life of which they had no previous experience.

Findings From Questionnaires to Hospices. Group B

Of the questionnaires sent to other hospices (19), 10 were returned, a 53% response rate. Figure 3 demonstrates the number of beds within each of these establishments. Only 3 hospices involved young volunteers. They identified a range of roles involving young volunteers which included pool aides, housekeeping, befriending, helping with mealtimes, helping with activities with children, and office duties. No specific support needs for young volunteers were identified. They were found to cope well in an environment of loss and bereavement. All identified the value of young people working with an older, more experienced, mentor as a key factor. It was felt also that most young people had thought through their wish to volunteer carefully before application and that careful selection and training helped to ensure success. Specific issues identified included the failure of young volunteers to notify hospices of their lack of availability and also the fact that they would like to keep the young people involved as volunteers for a longer period of time.



Children's hospices reported that the involvement of young volunteers ensured that the hospice community reflected the range of ages within the community as a

whole, and broadened the diversity of skills within the volunteer team. They reflected that young volunteers were usually mature, motivated, bright, cheerful and an asset to the hospice. The hospices that did not include young volunteers in their organisation cited a number of reasons for their non-involvement. These included: concern about the similarity in age to the young hospice users resulting in greater support needs, and a lack of a coordinator to supervise volunteer input. Hospice policy was given as another reason. Figure 4 represents the number of young volunteers as a percentage of the total number of volunteers in children's hospices. This figure demonstrates the low level of involvement of young volunteers.

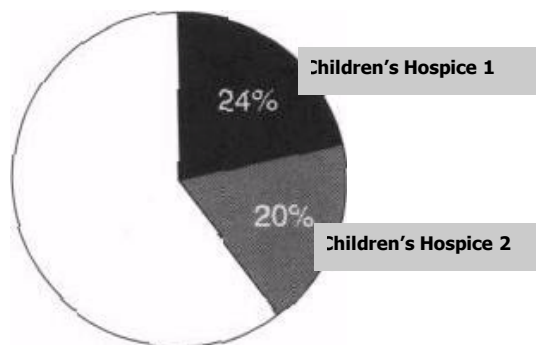


Figure 4: Young Volunteers as Percentage of Total

Discussion and Conclusion

This study involved a very small sample which affects the statistical significance and generalisability of the findings. It is, however, reflective of the small number of children's hospices and the number of young volunteers participating at the time of the study. It is clear that children's hospices and young volunteers derive significant mutual benefit from each other. It appears that concerns about the difficulties which may

arise because of the similarity in age between young volunteers and children using hospices is totally unfounded. The range of roles undertaken varied considerably and highlights the fact that young volunteers do not necessarily have to have close contact with hospice clients in order to offer a valuable contribution. The variety and flexibility of roles available means that young volunteers can adjust the amount and intensity of involvement according to their developing confidence and experience.

Contrary to previously held beliefs by many hospice professionals/personnel, the majority of young volunteers did not find the paediatric palliative care environment a difficult place to work. Factors associated with this positive finding were supportive staff and a friendly, open environment. Two respondents, however, did find their experience difficult because of the similarities in age of the client group and difficulties around the time of death. Although these respondents reported that they did eventually settle into the environment, it would be interesting to explore if these could have been identified at the selection stage and more support offered. The majority of respondents felt that their introductory induction training had prepared them for their role. Other commitments and a lack of time, the reasons given by those unable to attend support meetings verify the findings of Gaskin (1998) who identified flexibility and ease of access as some of the key factors affecting young people's willingness to participate in volunteering. The suggestion made by respondents of holding these meetings at weekends or in the evenings should be explored. Reassuringly everyone indicated that their experiences had been very rewarding and the ideas for improvement such as more appreciation from staff and certificates of achievement

could be implemented with relatively little effort or expenditure. The findings in relation to the involvement of young volunteers in other hospices, demonstrate that they are being excluded or only involved at a peripheral level. This is a very important finding as it may support Culbertson's (2000) contention that adults have disapproving perceptions of youth.

Those children's hospices that did involve young volunteers identified that they had coped well and were very positive about their experiences. Key factors to success appear to be, careful selection, flexibility of training opportunities and meetings, ongoing support and working alongside older more experienced volunteers. The young people of today are the volunteers of the future and failure to capture their interest and involve them at an early age could pose significant challenges to all organisations that rely on voluntary support in the future.

Implications for Future Practice

It is clear that if organisations are to succeed in developing effective volunteer programmes involving young people, negative attitudes to young volunteers must be identified and challenged. Positive attitudes should be encouraged by education, the sharing of good experiences and successful strategies.

Organisations should assess their volunteer programmes to identify areas where young people could make effective contributions or contribute in a more meaningful way. There is a need for adults/professionals to have confidence in the abilities of young people and to recognise their capacity to cope in challenging environments. Effective management includes: active recruitment, selection, matching, training and support strategies to aid their introduction and development is vital.

Criteria for the selection of young volunteers should be developed and used in all recruitment situations. A support strategy specific to the needs of individual young volunteers should be identified, documented and monitored by the volunteer co-ordinator during the introductory training period. The availability of ongoing support which is flexible and that young people know how to access, should be reinforced at each meeting. Organisations need to think imaginatively about methods of the delivery of training. These might include: one-to-one mentoring or coaching by experienced volunteers and innovations such as web-designed training.

Young volunteers need a voice, both individually and collectively within organizations and their views need to be heard. This could be achieved through representation within organizations and on committees locally and nationally. Young volunteers are the future. They must feel valued and appreciated or we risk losing them to volunteering forever.

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