A VOLUNTEER PROGRAMME
FOR PATIENTS IN A PROVINCIAL MENTAL HOSPITAL

A Review of Organization and Services
Contributed, Based on some Current

by

ROBERT MacGREGOR ROSS

Thesis Submitted in Partial Fulfilment
of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard
required for the degree of
Master of Social Work

School of Social Work

1958

The University of British Columbia
Abstract

The goal of hospital treatment is the return of its patients to their community in a healthy, happy condition. This can be a particularly difficult objective to achieve in the case of mental illness because of traditional hospital isolation, and fear and misconceptions about on the part of the public. More and more it is being realized that if there is to be effective rehabilitation of the mentally ill, there must be greater understanding and acceptance of mental illness by their communities. This study examines the recently-developed volunteer programme at the Provincial Mental Hospital, (Essondale, B.C.,) sponsored by the Canadian Mental Health Association. It describes the programme's organization, and its activities aimed at bringing the community to the patient, as well as interpreting hospital and patient needs to the community.

The method used in the study began with a review of professional and other literature in order to learn what volunteer services were being offered in mental hospital settings elsewhere. A questionnaire was then completed and interviews with key people in the volunteer movement conducted, in order to compile details of its development, organization and acceptance by hospital management and staff as a "treatment extra". In order to illustrate volunteer activities and potentials in detail, the focus was then narrowed to the study of one particular ward (Chapter 3.)

Types of patients were described experimentally as belonging to behavior groups observed on the ward, such as "attention seekers" and "rescue seekers." (The possibility of a ward classification according to the various categories of mental illness such as chronic brain syndromes, psychotic disorders, etc., was considered but discarded because the required information was not available.) Ways in which volunteers can help the patients in the various behavior groups when visiting and assisting in occupational therapy are discussed, using two case examples for illustration.

The study confirmed the general thinking that the volunteer programme is contributing a very useful service to the hospital treatment programme. In the concluding chapter some suggestions are offered towards increasing the effectiveness of this growing volunteer service. These are related to a problem common to all volunteer work, namely, sustaining the interest of volunteers. In addition, suggestions are made as to some ways in which the volunteers could work with the Social Service Department in this hospital setting.
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the Head of my Department or by his representative. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of Social Work

The University of British Columbia, Vancouver 8, Canada.

Date May 15, 1958.
TABLE OF CONTENTS

Chapter 1. **Mental Hospitals and Changing Attitudes**

The past two hundred years. Volunteer programmes in mental hospitals: scope and function. Two examples of volunteer programmes: (a) Boston; (b) Saskatchewan. Scope and method of present study. .................. 1

Chapter 2. **The Volunteer Programme at Essondale**

The hospital setting. Starting the volunteer programme. Volunteer visits begin. Types of volunteer services. Transportation. Recruiting and training. Hospital and volunteer programme relationship. ........ 17

Chapter 3. **Volunteer Activity on One Ward**

East Lawn building. A closed ward (H3). Patient categories, and volunteers' activities related to them. Volunteers and occupational therapy. Case examples: (a) Individual aid; (b) A "team approach". .............. 42

Chapter 4. **Summary and Findings**


Appendices:

A. Canadian Mental Health Association Questionnaire on Hospital Volunteer Training.

B. Questionnaire for purpose of gathering information about the Volunteer Programme.

C. Bibliography.

**TABLES FOUND IN THE TEXT**

Table 1. Relationship between the Volunteer and the Hospital. ........................................... 39

Table 2. Floor plan of Closed Ward (H3). ............... 50
Acknowledgements

I wish to express my thanks and appreciation to all those whose interest and active help have made this study possible. I particularly acknowledge with gratitude the direction, criticisms and counsel of the following persons: Dr. L.C. Marsh, Miss Muriel Cunliffe and Mr. A. Marriage, of the School of Social Work, University of British Columbia; Mr. G. Dodsworth, Coordinator of Volunteers, Miss O. Curtis, Department of Occupational Therapy, and the members of the Social Service Department at Essondale, British Columbia.
A Volunteer Programme
for Patients in a Provincial Mental Hospital
Chapter 1

Mental Hospitals - Changing Attitudes

The Past Two Hundred Years

Centuries of beatings, straitjackets, barred windows, locked doors and ostracism of emotionally disturbed persons have not solved the mystery of mental illness. Nor was man's fear of insanity lessened, his troubled conscience soothed. Even in our own times we fluctuate between an out of sight, out of mind attitude toward mental illness and a yielding to a humanistic desire to help those "sick souls". ¹

More than a hundred years ago there was a determined and enlightened effort made to combat mental illness which was called "moral treatment". It flourished for a time in the United States, reaching its height of effectiveness between 1830 and 1840. The idea of moral treatment stemmed from the philosophical and political movements of the nineteenth century, and from the teachings of the great French physician, Philippe Pinel. It was Pinel who "struck the chains" from the insane at Salpetriere. Along with Pinel, the early leaders of moral treatment believed that insanity was not necessarily the result of a permanent lesion of the brain. They were convinced that in many cases the indiv-

¹Greenblatt, Milton, Mental Hospitals; From Custodial to Therapeutic Patient Care. Russell Sage Foundation; New York; 1955. p. 37.
idual's sanity could be restored if proper attention was paid to "psychological, experiential, or emotional factors". ¹ Moral treatment did not entail any specific routine: it was more a "way of life" offered to the patient. Briefly stated, the philosophy of moral treatment placed high valuation on the individual as a fellow human being and on his potential recuperative powers. A favourable environment was considered essential and efforts were made to organize group living in order to integrate work, play, and social activities. Every aspect of hospital life was utilised for its therapeutic effect.²

However, this highly enlightened approach to mental illness was soon to be decisively discarded. From 1850 on there was a rapid increase in population in the United States and an ever-growing demand for beds as mental institutions were doubled and re-doubled in size. Founders of moral treatment made plea after plea for smaller hospitals as a basis for more effective treatment of the mentally ill. They were largely ignored and moral treatment experienced its decline and fall. It was not an effective method of treatment in the overcrowded institutions and statistics showed a steady fall in improvement rates.³

Reinforcing the statistics were reports from pathologic laboratories stating that, through new microscopic techniques, it had been discovered that mental patients suffered lesions in their central nervous systems. There followed a period when

¹ Greenblatt, op. cit., p. 407.
² Ibid., p. 408.
³ Ibid., p. 414.
psychiatry preferred to wait for clearance from the pathologic laboratory rather than to regard mental illness as a challenging problem to be attacked with every means at hand. Treatment emphasis became custodial.¹

Then, towards the close of the century, Sigmund Freud's dynamic conception of personality was becoming known and provided a new orientation to the mind and personality. Along with this was the work of mental health volunteer Dorothea Dix who crusaded across the United States and into Canada for better conditions in mental hospitals. Moreover she carried her crusade across the British Isles and over to the Continent. By the sheer force of her personality, she awakened the public to the plight of the mentally ill, in a manner never equalled by any person before nor for many years to come. At the end of her long career she had made tremendous gains for her cause. Deutsch states that "Twenty States had responded directly to her appeals by establishing or enlarging mental hospitals. In several States more than one institution was credited to her personal efforts....In all she was directly responsible for the founding or enlarging of thirty-two mental hospitals in the United States and abroad."² In almost every case improvements followed in housing and physical care of the patient.

It was a former mentally ill person, Clifford Beers, who sparked the next significant move toward professional and lay enlightenment of mental illness. Shortly after the turn of the century (1908) his book "A Mind That Found Itself" was published

¹Ibid., p. 414.
with an introduction by William James, the outstanding American Psychologist and philosopher of his generation. Of Beers he says:

You have handled a difficult theme with great skill and produced a narrative of absorbing interest to scientist as well as layman. It reads like fiction, but it is not fiction; and this I state emphatically, knowing how prone the uninitiated are to doubt the truthfulness of descriptions of abnormal mental processes.¹

The mental hygiene movement arose out of this and out of Beers' organizing abilities and dedicated drive. When Beers recovered from his illness and was discharged from hospital in 1903 he made a successful return to his business career, but his consuming desire to do something about the painful experiences he had suffered, and had seen others suffer, never lessened. He obtained a leave of absence from his work and wrote his book "A Mind That Found Itself". Through telling the story of his own hospitalization Beers drew attention to the condition of the mentally ill and capitalized on this by including in his book a concrete programme to rectify these conditions. He then formed the National Committee for Mental Hygiene which was formally organized in 1908. His movement was to be followed later in other countries.

In 1917, following a conference between Clifford Beers and Dr. Clarence M. Hincks of Toronto, the Canadian National Committee for Mental Hygiene was organized. This is now known as the Canadian Mental Health Association, and its present day development is largely the result of the intensity and zeal with

¹Beers, Clifford, A Mind That Found Itself; Doubleday; New York; 1948. p. iii.
which Hincks threw himself into his work. It is of interest to note that Dr. Hincks story is somewhat similar to Beers' in that he is a neurotic. In spite of this handicap, he has used the persuasive power of his personality to raise "at least $500 millions for mental health in the United States and Canada from ordinary citizens, millionaires, charitable foundations and governments."¹ For several years, like Dix, Hincks went "storming through" mental hospitals from coast to coast in an effort to obtain more humane treatment for the patients by "educating, pleading, flattering and sometimes threatening government officials and hospital authorities." Whichever approach he took his basic sincerity seemed to come through and people realised that his prime interest was in helping other people.²

The road back was in sight. Improvement of institutional care; emphasis on dynamics of personality development (rather than categories of disease); recognition of importance of prevention; re-educating the public on the matter, and emphasis on the positive of mental health as against mental illness - these five areas were and are being developed.

There are encouraging signs that we are on the road back to more enlightened treatment of the mentally ill. Certain general principles of social treatment are emerging. In many respects we are seeing a reinterpretation of the moral treatment idea of the 1830's in the light of present day knowledge.

²Ibid., p. 38.
of mental illness - specifically, the team approach. The role of the volunteer would seem to be closely allied to this in the socialization of mental hospital patients.

Volunteer Programmes in Mental Hospitals

During the last decade both mental hospital personnel and the community at large have been taking another look at their ideas on care and treatment of the mentally ill. The emphasis on "asylum", "isolation" and custodial care is giving way to that of active treatment and getting as many patients as possible well enough to return to the community. A very important goal of the treatment programme is to encourage patient interest and participation in social living as we know it in the community. Few patients in mental hospitals are bed-ridden. There are many activities in which they can participate that may help them regain their confidence and interest in everyday life. Much thoughtful leadership, guidance and companionship are required if this type of programme is to succeed. The volunteer programmes in mental hospitals are considered by many to be an essential part of the new treatment approach.¹ The volunteers are representative of the community. It has been said that they act as a bridge between the hospital and the community and that travel on this bridge is in two directions: to and from the hospital. Through the volunteers the patients begin to regain contact with the community and the community with their fellow citizens who are ill in hospital.

Generally speaking there are three types of volunteer services used in mental hospitals. First, those where volunteers

¹Greenblatt, op. cit., p. 89.
come for a specific affair such as a dance, an entertainment, or to play games. Often they come as groups, perhaps representing some club or organization. This type of volunteer service has been going on for many years and is generally considered helpful to patients not only in the entertainment line but in gathering materials such as clothes, books, gifts and special equipment. The second type of volunteer might be called the "expert" volunteer because he is a specialist in such things as music, art or lecturing on a particular subject. Again, this type of volunteer has been serving in mental hospitals for many years. Because of his specific use of some particular skill he usually comes independently and is not interested in the training programme for volunteer services. A third type of volunteer is the person who expresses a wish to be of service in the mental health setting but who may have no particular specialty. The volunteer programme under discussion in this thesis is made up of volunteers in this category. The aim in this programme is that of individual contact with patients by volunteers. Group projects of various kinds are in operation but these are a means to an end, namely, the individual friendly visiting with the patient to help him regain a healthful contact with the community. This type of volunteer (in British Columbia) is recruited by the B.C. Division of the Canadian Mental Health Association and following an orientation course, may be selected for active volunteer work. It is usual and desirable that training be given by the hospital in order to fit the volunteer for work in various hospital departments. They are carefully
selected for their work with such things in mind as "humanitarian sympathy", earnestness and willingness to work. As indicated, their aim is to try to bring the community to the patient on an individual basis, characterized by a sincere and friendly interest in him.

It is important to understand that the use of volunteers does not mean that "a shortage programme" is in operation. That is, volunteer service is not meant to fill the gaps in professional programme and cannot, because, ideally the role of the volunteer is well thought out to fit in with the jobs of the paid personnel in a harmonious manner. Volunteer services are sometimes described as "plus services" or "treatment extras".

If paid staff is not adequately prepared in advance for inauguration of volunteer services there will probably be a problem of "staff acceptance" of volunteers. Staff tend to take a sceptical view of volunteers if they (staff) are not taken into the planning of a proposed volunteer programme for their hospital. However, "nothing so quickly kills prejudice, replacing it by a spirit of helpfulness and cooperation, as personal acquaintance." Those words, spoken by Mary Richmond, are very appropriate because if paid staff are to believe in the volunteers' contribution they must understand what it means in relation to their own job and they should be given a chance to help in the planning. The job of easing the volunteer into programme activity

2 Ibid., p. 22.
3 Richmond, Mary, The Long View; Russell Sage Foundation; New York; 1930. p. 96.
falls in large part on staff and in the beginning will probably be time consuming for them rather than permit more time for their own specialized jobs. If they are convinced in themselves of volunteer service possibilities they are then able to accept this "breaking-in" period with the conviction that in the long run the patient and the treatment team's effectiveness will be enhanced.

Selection and training of volunteers, then, is of vital importance. The National Committee for Mental Hygiene has devoted considerable thought to this in their manual on Volunteer Participation in Psychiatric Hospital Services. A volunteer who is to be of real assistance to the hospital must be carefully selected not only because of hospital needs but personal and patients' needs as well. For example, the desire of the volunteer to work in a psychiatric setting should be carefully assessed. A person who has had experience with mental illness in their own family may be well suited to work in a volunteer capacity because of his or her increased understanding of the needs of the patient. On the other hand the prospective volunteer may have developed guilt or anxiety about the relative concerned which is perhaps accompanied by a sense of shame. It is possible that he is repressing his guilt and volunteer work may be his attempt to compensate for it. If such is the case it will probably not be long before such attitudes begin to express themselves to the detriment of the patient(s) - to say nothing of the volunteer. Careful selection is a very necessary step in the use of

volunteers in hospital programme.

What are some of the qualities necessary in a volunteer? Dr. Daniel Blain, formerly medical director of the American Psychiatric Association, has stressed certain personality traits. "Generally speaking, one thinks of stability, and ruling out too great insecurity, frustration hostility, aggressiveness, neurotic and paranoid, erratic trends." He also suggests that one should try to evaluate such things as cooperativeness, honesty, productivity, speech, mood, tone of voice, posture, gait, and neatness. Most important points, he states are "warmth and empathy."¹

An orientation period is absolutely essential for volunteers because few have had experience with mentally ill people. As well as the orientation course given by the community agency or association there is usually provision for periodic courses of instruction because continuous growth of knowledge is essential to worthwhile volunteer participation. An introductory course, for example, might include the following areas: basic needs and drives of people; facts and misconceptions about the mentally ill and their care, and community aspects. Appropriate reading is suggested and films shown as supplements to the course. Examples of further training are hospital sessions to discuss rudiments of hospital administration, the psychiatric patient, hospital etiquette and ethics and the volunteer programme. The sessions usually include a tour of the hospital and small group discussions with department heads and may include an oral or written examination. It is hoped that through this type of

¹ McBee, Marian, and Frank, Marjorie, op. cit., p. 72.
course the new volunteer will be able to gain an understanding of the various services of the hospital and get a picture of how the patient is admitted, treated and rehabilitated - including the volunteer's role in this.

Following completion of the course of training comes assignment to a ward or special job. The volunteer is under the general supervision of the hospital supervisor of volunteers. Supervision on the job is given by paid personnel of the department concerned.

Dr. Agnes Sharp, in her study of volunteer work in state hospitals, has stated a very simple truth: "Volunteers are people."¹ This simple truth is related to the matter of staff acceptance of volunteers and bears re-emphasis because cooperation and consideration are so important to the team approach of to-day. Nevertheless, there has been a tendency on the part of staff members to doubt the staying power of the volunteer, or to be overly demanding in their expectations of him. When pointing out that volunteers deserve the same consideration as staff members under all circumstances, Dr. Sharp gives a good example to illustrate her point.² A staff person had asked "how can you count on volunteers? When you have just finished training one and, because her sister breaks her leg she thinks she has to stay home and take care of her "my answer to this person was a question: 'what does a staff member do when her sister breaks her leg and she has to take care of her?'" The staff person

¹Sharp, Agnes A., op. cit., p. 25.
²Loc. cit.
arranges for time off in a manner recognised in every employment contract. Staff are people; volunteers are people.

Examples of Specific Programmes.

The Boston Psychopathic Hospital (recently renamed: Massachusetts Mental Health Center) is considered to be representative of one of today's advanced teaching and research institutions concerned with mental illness. Dr. Milton Greenblatt, psychiatrist in charge of the research laboratories at Boston Psychopathic, has remarked on his "deepened" respect for the possibilities inherent in the social sciences for making hospitals into more truly therapeutic communities.\(^1\) When discussing the history of the hospital he notes that in spite of impressive advances the ward care of patients (even in the early 1940's) lagged and the deeply personal significance of hospitalizations to the mentally ill was largely glossed over. There were relatively few attempts to use the physical and social environment of the hospital for the patients benefit. However, many changes in treatment, attitude and practice were being effected.

Not the least of these concerned the formation of the Boston Psychopathic Hospital Auxiliary in 1945. At first it was composed mainly of wives of professional hospital staff and their close friends but to-day there are some 400 volunteers bringing community to patients. Dr. Greenblatt states that it is now difficult to imagine how the hospital could "thrive" without their assistance and observes "that without such warm ties with the community any psychiatric hospital is almost certain to be

\(^{1}\)Greenblatt, op. cit., p. 38.
bereft of dignity and respectability.¹

Their auxiliary is well organized and the programme includes recruiting, selecting, orienting, and placing volunteers in various parts of the hospital. Some are former patients and it is interesting to note that the auxiliary considers that selected former patients often show greater sensitivity and understanding than non-patients as a result of their own suffering. A review of some of the volunteer programme achievement at Boston Psychopathic during the 10 years since 1945 is impressive. They have conducted regular pottery classes; assisted patient government in planning of large social events; conducted and supervised cooking classes; home nursing classes, book discussion groups, art classes, textile painting, dancing, drama, sports, and tournaments. They have also acted as shoppers, research assistants and in various other capacities. The assistance of volunteers is felt to be almost indispensable in bringing patient care to its present level.

The Saskatchewan Division of The Canadian Mental Health Association has had its volunteer programme in operation since May 1952 when groups of volunteers began visiting the Saskatchewan Hospital at Weyburn. This progressive volunteer programme tends to place its emphasis more on group activity than does the Essondale programme although friendly individual visiting takes place as well. The activities which take place are essentially the same as those of the Boston volunteer programme and will not be repeated here.

¹Ibid., p. 89.
Mention of the Saskatchewan programme is made here because it is an interesting example of volunteers carrying their work directly into the community as well. They are actively participating in a social group project aimed at rehabilitating discharged mental hospital patients. Under the auspices of the Canadian Mental Health Association suitable premises were obtained in the city of Regina which has a population of about 90,000 and is situated some 75 miles north of the Saskatchewan Hospital at Weyburn. The "Centre", as it is known, has an active evening programme and both hospital staff members and volunteers are present. Activities include a Social Club, Dancing Class, Craft Clubs and Bowling Clubs.

Volunteers give freely of their time and talents in giving leadership to the various groups. It is the job of the social worker to interpret to the Association and to the leaders, the need of both the technical and psychological know-how in conducting the various activities.

It has been observed that a particular group of over forty former patients is doing extremely well. Only one of this group had to return to hospital at the time this report was published. It is interesting to note that most of these members have been treated for the various conditions which come under the general psychiatric diagnostic classification of schizophrenia. In order to get more conclusive evidence of this almost no return to mental hospital the group plans to keep accurate statistics of up to five years.¹

¹Mayotte, A.S., "A Social Group Project in the Rehabilitation of Discharged Mental Hospital Patients", A study made for the Canadian Mental Health Association, Saskatchewan Division; The Social Worker, January Issue, 1957.
The Saskatchewan "Centre" idea is something that the British Columbia division of the Canadian Mental Health Association is planning also.

Scope and Method

This thesis is a review of volunteer services to the Provincial Mental Hospital at Essondale, British Columbia. In this first chapter the changing attitude towards mental illness has been discussed and this was followed by some introductory remarks on the growth of the volunteer idea in the mental hospital setting citing two brief examples of other volunteer programmes.

The second chapter describes the organization and growth of the Canadian Mental Health Association volunteer programme at Essondale. In order to get this information, the writer interviewed the Executive Secretary of the British Columbia Division of the Canadian Mental Health Association and the Hospital Coordinator of volunteers at the Provincial Mental Hospital. With the generous help of the Coordinator details of recruitment were compiled and questionnaire material completed by volunteers as to age-grouping, skills, and where they had first heard about the programme. Minutes of both Volunteer Policy Committee and Volunteer Services Committee meetings were made available also.

The third chapter describes the East Lawn building at Essondale with specific attention being paid to description of one ward and volunteer activity on it. For the purposes of this study, the patients are described as belonging to various
groups which were decided upon with the help of the Clinical Director and Social Service Supervisor of East Lawn. Valuable assistance in this connection was received also from the Charge Nurse of the ward concerned.

The writer thought it might be possible to group the patients according to the various categories of mental illness such as chronic brain syndromes, psychotic disorders, and so on, but was advised that this was not feasible because an accurate breakdown of that kind of information was not available at this time. The alternative suggestion was to classify patients into groups according to their ward behavior. There follows some comments on volunteers working with patients in these groups and some suggestions as to how they could assist in the Occupational Therapy programme on the ward. Two brief case studies are included which illustrate a volunteer's work with a patient and the worth of apparently small gains. One case is in collaboration with a Social Worker indicating the help the volunteer can be.

The final chapter restates the focus of the thesis and makes some suggestions regarding ways of directing and sustaining interest of volunteers. Finally, there are some suggestions as to how volunteers might be used in the Social Service Departments at Provincial Mental Hospital and Crease Clinic of Psychological Medicine.
The Hospital Setting

The Provincial Mental Hospital of British Columbia is situated at Essondale, a particularly lovely part of the countryside, about 17 miles south of the City of Vancouver. At present, the hospital, in its wooded setting with views of the Fraser on the horizon, is considered to be in a rather out of the way spot but present day building is reaching towards it and before long will be encircling it.

The hospital, with its capacity total of about 4,000 patients, is made up of several units - East Lawn, West Lawn, Centre Lawn, North Lawn, Colony Farm, Home for the Aged and the Crease Clinic of Psychological Medicine.

The East Lawn building is for women. It consists of 10 wards and is for long-term patients. Until 1954 all the wards in East Lawn were "closed", i.e. locked, but in February of that year, after a great deal of preparation, the first ward was opened. This has proved to be the first of several and since this time other wards have been opened not only in this building but in others as well.
West Lawn is the long-term unit for men. It has 7 wards. There are two open wards here.

Centre Lawn is the admitting centre for the mental hospital. It has 8 wards for both men and women patients, the majority of whom are acutely ill and have not been long in the hospital.

Another main unit is the Home for the Aged. It has 9 wards and is for both men and women.

Colony Farm caters specifically to certain categories of armed service veterans. Both dairy and agricultural farming are carried on here in a successful and highly organized way.

Crease Clinic is the newest treatment unit at Essondale. It has its own admitting centre to its 7 wards where both men and women are treated. It is a short-term treatment centre with a maximum time of four months. One male and one female ward is open. It has excellent occupational and recreational therapy accommodation. The operating room for the entire Essondale patient population is located on the top floor at Crease Clinic and all surgery is performed there.

Treatment offered at Essondale is highly enlightened in approach and varies widely according to the needs of the patient. The treatment team, consisting of all the various disciplines within the hospital tries to formulate a plan for each patient even though it may be a tentative one and even though there may be no immediate opportunity to carry it out. This is because, in actual practice, it is the number of staff available which, of necessity, decides the amount of individual care a patient can be given. The staff are ever mindful of the security and
protection of the patient and adequate supervision is given at all times, care being taken to keep accident hazards away from the wards. Should a patient develop a physical illness he goes to the Infirmary; if he is tubercular, a T.B. ward is available (North Lawn); if he is to undergo insulin treatments, he is placed in the insulin ward, and so on.

Occupational therapy is well utilized at Essondale and is found to be quite effective. The aim is to substitute some real and useful piece of work in order to stimulate the patient towards more normal and constructive mental processes. Farm work, cooking, laundry work, industrial work, handicrafts of various kinds seem to be especially effective towards this end.

In addition to the occupational therapy there is highly organized recreational therapy as well. Professionally trained recreational therapists conduct dances, walks, indoor parties, indoor sports, outdoor sports, physical exercises, swimming, motion pictures, music, cards, etc. The emphasis again is to stimulate more productive thinking and attitudes of oneself and one's community.

Physiotherapy and hydrotherapy are in wide use throughout the hospital and are a far cry from the water cures and "baths of surprise" of a century ago.

In 1951 the Provincial Mental Hospital and Crease Clinic were awarded the American Psychiatric Association's efficiency award. However, in spite of the comparative excellence of programme, it is more than ever recognised that much that needs to be done and could be done, cannot be done because of the
lack of enough trained staff to give the individualized treatment so necessary for mentally ill patients. It should also be noted that the one reservation stated in the award was that one problem common to so many state hospitals, namely, overcrowding.

Starting the Volunteer Programme

In the late 1940's Mrs. William Irwin began some serious thinking about the use of volunteers in mental hospitals. The matter came to her attention through learning about volunteers doing this type of work in mental hospitals in the United States. In order to get such a programme started here she had three groups of people to convince, namely, the hospital authorities, the Board and Scientific Planning Committee of the Canadian Mental Health Association in British Columbia, and the community. Mrs. Irwin had first-hand information of the volunteer programme at Topeka, Kansas and the emphasis there appeared to be occupational and recreational work. Her interest in the possibility of volunteers in mental hospitals had reached quite a height just prior to the organizational meeting of the British Columbia division of the Canadian Mental Health Association in 1951. At this meeting were lay people who were connected with various community groups and who had considerable knowledge regarding the organization of community sponsored programmes concerning Health and Welfare. Dr. A. Gee, the Director of Mental Health Services in British Columbia, and other members of the medical and psychiatric professions were also present. Mrs. Irwin

1 Selman, Laura, "Volunteers in a Mental Hospital; Canadian Welfare; December 15, 1956. p. 223.

2 Hereafter referred to as C.M.H.A.
brought up the possibility of volunteer work being done at Essondale but the suggestion was not picked up at that time. The suggestion was presented in terms of the volunteer work being done in Kansas which was in the occupational and recreational work already mentioned. But as the Essondale programme was already highly organized along these lines, and also because the whole idea of a citizen working in this setting was so new, Mrs. Irwin's suggestion was not picked up.

At any rate, the British Columbia division of C.M.H.A. was set up. The Director of Mental Health Services and the Deputy Director were individual members on the Board. Mrs. Irwin again suggested the possibility of volunteers and this time there was a partial response to the idea by the Deputy Director. He suggested that he would like to see a programme of volunteer work begun on the psychiatric ward of Vancouver General Hospital. It is interesting to note that the Social Services staff at Essondale expressed interest in Mrs. Irwin's suggestion and that they arranged a luncheon to discuss the matter. Nothing concrete came of this but it showed an awakening interest on the part of hospital staff and was encouraging to Mrs. Irwin in her efforts.

Another factor which stimulated interest in volunteer work in mental hospitals was the visit by Lady Hamilton who was familiar with volunteer programmes in England. The C.M.H.A. arranged a tour of Essondale for her at which time she spoke to staff on the use of volunteers in the mental health setting in England. While Lady Hamilton's visit did not convince admin-
istration when one of Manitoba's mental health service officials visited the hospital and discussed the need for community participation and the value of volunteer work in mental hospital programmes. It happened that this renewal of interest took place just at the time when the present Director of C.M.H.A., Mr. J. Ward, took office. He is a man whose training and previous experience had been in health and adult education in Saskatchewan and in the State of Maine. His deep conviction of the value of community interest and participation went a long way in helping to interpret the potential value of a volunteer programme for the Provincial Mental Hospital.

The Director of the mental health services now offered to set up a staff committee at Crease Clinic and the Mental Hospital to study the possibility and desirability of using volunteers in those institutions. Members of this committee represented medicine, nursing, social work, occupational and recreational therapy, music therapy and rehabilitation.

At the same time a group of eight women were called together in Vancouver. These were women active in, and with a knowledge of, community affairs. They discussed the volunteer programme from the community point of view. The two committees worked separately for some months before getting together to compare their findings. Both committees decided favourably on the idea of volunteers working in mental hospitals and the programme was enthusiastically endorsed.

In May 1954 a volunteer committee was formed under the Association. It's Chairman, Mrs. L. Selman, gathered together
some key women from such groups as Junior League, Local Council of Women, Parent Teacher Association and similar groups who had resources for volunteers and in some cases volunteer experience. It was out of this policy committee that the appointment of a Chairman of Volunteers resulted. The structure and organization of committees will be discussed more fully below, but suffice it to say here that the first team of ten volunteers under a captain were chosen as a result of this committee's work.¹

Volunteer Visits Begin

The volunteers started their work in Crease Clinic and on their arrival there on the first day were met by Mr. F. McNair, the Clinical Director, who gave them a short talk on the Clinic and gave them a choice of areas of work. To begin with, this first team, captained by Mrs. G. Creighton,² worked every Thursday morning. Before beginning their work they had been given a two day training course sponsored by the C.M.H.A. who worked in cooperation with the hospital staff. They saw films and had discussions to acquaint them with types of mental illness, their treatments, the purpose of their visiting and some ethics for them to observe. In addition they were given individual interviews to assess their suitability for work in a mental health setting and upon acceptance took out membership in the C.M.H.A. They were then assigned to the volunteer team. The date of the first visit was set for June 29th, 1954 and transportation was arranged for team members. Some volunteers used their own cars

¹Exner, Helen, "Development of a Programme for Volunteers in Mental Health in British Columbia." (Unpublished Manuscript.)
²Personal Interview with Mrs. G. Creighton.
but bus fares were paid by C.M.H.A. if desired. Mrs. Creighton describes the feelings of the volunteers about going out to the Clinic on this first day. "We were wondering just what mental patients would be like to work with, how it would feel to be locked in, would it be depressing, and numerous other questions." The reaction of the team at the end of the day was very favourable. "I can say that we found the work so interesting, the patients so easy to talk with, that we never noticed the locked doors, were not depressed and wondered where the time had gone."

Adjustment to work in the mental hospital was considerably more difficult but this will be discussed in some detail later.

On that first day at Crease Clinic they spent most of their time in the occupational therapy department under the skilled supervision of trained therapists. Two team members worked in the women's occupational therapy, two in the men's occupational therapy and two in the Clinic library taking library service to the Home for the Aged. The reaction of the women who had been placed in men's occupational therapy was that the patients responded to their presence and were friendly. They noted that the staff was friendly toward them as well but had no specific jobs set up for them to do. On this first day they felt their way slowly and were content to walk amongst the patients, commenting and showing an interest in their work. The reaction of the volunteers in the women's section was essentially the same. In a short time the volunteers felt that a half day was not enough and on October 7th, 1954 the first all-day visiting started.
As time went on, and as more volunteers were recruited, it was felt that there was a greater need for volunteer work in the Mental Hospital buildings and also on October 7th the first visit was made to one of the more disturbed wards in East Lawn women's building. On this first occasion the volunteers did not take any work up but instead talked to patients and walked around among them. It was noted that the atmosphere was quite different from Crease Clinic. Here many of the patients were quite hostile, suspicious and unaccepting of the volunteers presence. This contrasted sharply with the generally positive response noted in Crease Clinic.

Recruiting was going on all this time, new volunteers were being trained, new teams formed until to-day, (March 1958) the total number of volunteers at Essondale is 130. This number is composed almost entirely of women, there being only six male volunteers. Their areas of work have increased too, covering more wards.

The two main areas from which volunteers come are Vancouver and New Westminster and while they are generally referred to as the Vancouver group and the New Westminster group, C.M.H.A. prefers to regard them simply as C.M.H.A. volunteers. There is also a breakdown into day volunteers and night volunteers. The Thursday visiting day as such is now a thing of the past, and volunteer visiting is spread over the entire week. Each volunteer decides which particular day or evening is most suitable for him. The average time spent per volunteer is about twenty hours per month. A formal record of the volunteer's time is kept by the Co-ordinator of Volunteer Services.
A few words from Dr. Gee's message to the volunteers would seem appropriate.

The hospital welcomes you as a volunteer and invites you to participate with us in the most satisfying work of all, helping people back to normal mental health. It may be a new idea to you, and frankly it was a new idea to us, but it does work. In fact it works in many ways. It assists the patient individually — yet you are not going to be asked to do things that normally would be considered duties of the staff. You are going to be doing the things that people just cannot be paid to do. You are going to bring a spirit of friendliness and hope to those who have these needs. You are going to bring some of the graciousness of good healthy living with you. You are going to initiate and assist in some of the social and diversional activities which are so wanting in an institutional type of living, no matter how good it may be.

You too, I am sure, are going to derive many benefits by participating in the Volunteer Programme. You are going to get a lot of personal satisfaction out of assisting where assistance is so badly needed. You cannot help learning many interesting things which will, I am sure, assist you towards better understanding. Then, too, you are going to learn a good deal about the problems of maintaining and restoring good mental health, which you are going to take back home with you and share with others.

There are many misconceptions and misunderstandings about mental illness and mental hospitals. You will be in a much better position to understand these things and to help us in our program of public education. Remember that you are a representative of the British Columbia Division of the Canadian Mental Health Association, a group of public-spirited citizens and scientists who dedicate part of their time, voluntarily, to further good mental health in our province.

I am sure that you will enjoy your work with us. We need your help.

This type of acceptance and enthusiasm for the work of the volunteers has with few exceptions permeated the entire staff of the hospital in the areas where the volunteer is serving. Without this the effectiveness of the volunteer programme would be seriously undermined. Perhaps a concrete example of the

---

1Selman, Laura, op. cit., p. 224.
administration's acceptance and enthusiasm for the volunteer's role is the fact that a volunteers' room has been built in a centrally located position on the hospital grounds. It is comfortably furnished and serves as a comfortable headquarters where the volunteers can simply relax or have discussions or training talks. It is from this base that the volunteers move out to the various hospital units to offer their services.

Types of Volunteer Services

These services are many and varied. The following list covers most of them: Home for the Aged mobile book service, foreign language service, bridge scoring and playing card games generally, assistance in letter writing, friendly chats with patients, reading to patients, sing-songs, dancing, record playing, walks, shopping service, games, flower making, birthday parties and special day parties, beauty culture and grooming, bowling, swimming, drives, town visits, sewing groups, Christmas gifts, Apparel Shop, Coffee Shop. Recently, some post-discharge friendly home visiting has been done. A lot of work is done in the occupational therapy sections assisting the therapists in getting material ready for the patients as well as working with the patients. They assist the patients in doing such things as untangling the warp and setting up the loom, tracing outlines for toys - a task too complicated for some patients, or perhaps helping a patient work on a cotton table mat or a rug or slippers, or maybe a staffed animal and generally mingling in a quiet way among the patients in harmony with the

---

1Personal Interviews with G. Dodsworth, Coordinator of Volunteers.
therapists' planned patient activities.

Volunteers learned early in their experience that the closest cooperation was necessary between therapist and volunteer. One instance recalled by a volunteer was when she, over-anxious to help, unwittingly reversed the therapist's plan and helped a patient who should have been allowed to help herself. Staff interest and guidance is of the utmost importance to the volunteers if they are to function harmoniously in this setting.

Two very important developments of the volunteer programme are the Apparel Shop and the Pennington Hall Coffee Shop. Actually there are two apparel shops, one for men and one for women. The women's shop was opened on November 3rd, 1955 and marked a milestone in the growth of the volunteer programme. A fashion show featuring professional models was a high-light of the opening and gowns modelled were from the stock of the shop. All clothing was and is donated by various individuals, groups, and organizations in the community. Only good clothing is accepted and people are asked to give clothes which they would wear themselves. All dry-cleaning of clothing for the apparel shops is looked after by the hospital through its own laundry service which is largely patient staffed. The Apparel Shop was made possible through the hard work of the volunteers and through the excellent support and cooperation of the hospital administration who saw to it that space was made available for the enterprise. The women's shop is located in the East Lawn building and the service is designed to meet the clothing needs of patients who are on the road to recovery whether they are actually ready to go home or not. The hospital
of course, does supply good quality clothing to patients who need it but, of necessity, the styling is unimaginative and utilitarian. The women's shop resembles any suburban dress and accessory shop, and the patient is able to look for what she wishes with the volunteer playing the role of sales clerk. The men's shop, which was opened in the West Lawn building some time after the opening of the women's shop, is much more rough and ready but the articles of clothing are of good cut and quality. There is a clothing depot in Vancouver, staffed by volunteers, which acts as a clearing house. The volunteers have since staged further fashion shows in connection with the Apparel Shop and patients are becoming much more clothes conscious. Patients are used as models. The commentary is done by a patient and piano music is provided by another patient. Many more patients form a large and interested audience, and usually have quite a few family members in attendance as quests. That the Apparel Shop and the service it provides is truly appreciated by patients and ex-patients is shown by the numbers of letters of thanks received at the volunteer office. One of these letters is quoted in which the patient writes as follows:

Dear Saleslady,

The work of the Apparel Shop deserves a great deal of credit, I think. May I thank you again for the courteous service you gave me. Your shop as I remarked that day is set up like an exclusive small ladies department store and is very pleasing. I can assure you it was a great pleasure to be served by you and to see your lovely little shop.

Sincerely,

Even after a patient has left the hospital the service provided by the Apparel Shop is still available to him should he need it. On being discharged from the hospital the patient is given the
We know that when you have reestablished yourself, you will prefer to choose and buy your own clothes, but if in the meantime you need additional apparel, we would like to help.

PHONE US!

THE CANADIAN MENTAL HEALTH ASSOCIATION
5 East Broadway
Dickens 5330

The Coffee Shop at Pennington Hall is the most recent venture undertaken by the volunteers. Pennington Hall is a recreation centre at the hospital where movies are shown, dances are held and sports activities are conducted, and there is a good sized canteen connected with it. It is a place where both staff and patients may congregate for coffee or a snack. Observations of experienced volunteers indicated that while the canteen was serving a functional purpose, a little imaginative planning would probably make it more therapeutic for patients and their relatives. The Canadian Mental Health Association volunteers thought that they could undertake to bring this about. They felt that while the canteen operation on the hospital grounds was a concession of the Institute for the Blind it nevertheless could come within the sphere of volunteer activities. Moreover, it was felt that although the Canadian National Institute for the Blind was a worthwhile cause, that the cause of mental health was not being served as it could be by this resource. The matter was discussed at a meeting of the Policy Committee \(^1\) and a sub-committee was set up to look into the matter. The report came back from this committee at the October 29th 1957 meeting recommending that

\(^1\)Dodsworth, G., *op. cit.*
the Canadian Mental Health Association volunteers take over the Coffee Shop operation. Dr. Gee submitted the plan to Mr. Pennington, Deputy Provincial Secretary, (after whom the hall had been named) and events transpired more rapidly than had been expected. A special executive meeting was called a week prior to the regular Policy Committee meeting and the Canadian Mental Health Association committed itself to the hospital to assume responsibility for the Pennington Hall Coffee Shop. Preliminary planning was done at that point in terms of staff coverage, paid and volunteer, financing, recruiting of extra volunteers and formation of an interim chairmanship of the project. The project went into operation on February 4th, 1958 and as presently constituted has one full-time and one part-time paid staff. They are looking after book auditing, purchasing, etc. As far as the volunteers are concerned the project is a means toward an end, namely, a point of contact between the volunteer and the patient and relative. It is planned that a refresher cooking school for patients will be established so as to utilize to the utmost the kitchen facilities that are available. This would provide patients returning to a home situation after a long absence with an opportunity to become familiar with a kitchen again. It is also planned that waitress training will be provided for girls who may plan, or have to take, employment of that kind. Volunteers are conducting the training programme and will serve primarily as hostesses. The Coffee Shop is open from 10:00 a.m. to 10:00 p.m. seven days a week so that shift arrangements have been worked out to take care of it. It is hoped that this project will help the volunteers establish a pleasant atmosphere where
patients and relatives of patients may visit. Staff will continue to patronize the Coffee Shop as it is felt that this four-way mixing of patients, relatives, staff and volunteers will add rather than detract from the operation. This project will also provide an opening for contact with the men patients at the hospital which, up until now, has been quite limited. Any profits which may be realized from the operation will go back to the patients through the various Canadian Mental Health Association activities.

Transportation

Transportation is a very important consideration in the effectiveness of the volunteer programme. The majority of volunteers come from the city of Vancouver, some twenty miles from the hospital. In the past, transportation has been a matter which caused a fair amount of difficulty and to some extent affects the recruiting of further volunteers. It is a fairly expensive proposition for volunteers to take care of themselves. The Canadian Mental Health Association decided that transportation costs of volunteers should be met by the Association. In the beginning there was a trial period when volunteers were given 10 cents per mile for the use of their own cars provided they brought another volunteer as a passenger. The cost of this eventually became prohibitive as numbers increased and a bus was chartered at a cost of $22.50 per trip. The transportation chairman has since been able to arrange for the substantially cheaper rate of $17.50 for the bus. The route has been extended now to include New Westminster at a cost of $21.50 per trip.
This bus runs on Thursdays and Tuesdays. The Hospital provides a bus on Wednesdays for near-by New Westminster and area volunteers.

Recruiting and Training

Recruiting, of course, is a very important part of the volunteer programme and is a continuing process from one year's end to the next in order to replace volunteer workers who have dropped out for one reason or another and in order to expand the volunteer force gradually as the programme develops. Publicity for volunteer recruitment is through television, radio, newspapers, magazines, speeches to groups and the recruiting efforts of present volunteers. For example during Canadian Mental Health Week in May 1957 radio stations C.K.W.X. and C-FUN made available their recording facilities and discs of talks by prominent authorities were made. These talks were then broadcast on every radio station in the Province. In addition, there were one minute "Plug" discs for mental health which were logged on programme schedules throughout the Province. While most of the publicity given during Mental Health Week was devoted to mental health generally, there nevertheless was some direct mention of the volunteer programme and a general heightening of community awareness of the problem.

Once people have heard about the volunteer programme and have become interested, they respond in several ways. They may phone the Canadian Mental Health Association office to ask about the programme or may make a personal visit to the office. On the other hand, one of the regular volunteers may phone in a
name or the Volunteer Bureau of the Community Chest may refer potential volunteers. Whatever the case, the Canadian Mental Health Association staff gives the interested person a cordial welcome and an orientation session is arranged. The volunteer is usually notified by letter of the date of the orientation meeting and this is followed up by a phone call two days before the date of the meeting. On the day of the meeting the volunteers are received individually as they arrive, and introduced to each other and to the Coordinator of Volunteers and the Chairman of Volunteers. This is usually followed by a talk on the purposes of the Canadian Mental Health Association and the volunteer programme. There is then a section of the talk devoted to volunteer hospital visiting, pointing up that volunteers are the newest addition to the treatment team and defining the purposes. These are, under the supervision of the hospital administration, as follows: First, to assist the treatment team and the hospital to accomplish their purposes; second, to assist the patient to overcome his need to be ill and to be in hospital; third, to assist the patient to look forward to his discharge and to see the community as being concerned about him and desirous of his return to normal life; fourth, more recently to assist the patient in the immediate post-discharge period, sometimes in conjunction with the follow-up by the Social Worker. (This follow-up usually takes the form of moral support and occasionally has to do with helping the patient find suitable accommodation or employment); fifth, to offer friendship to the patients, and sixth, to provide a source of public education in the community designed to counteract misconceptions about mental illness and
promote positive public support of the mental health programmes. In addition, the prospective volunteers are given instructions on attitudes and ethics for volunteers. Volunteers are instructed about rules of patients entering and leaving the ward, the use of keys, the approach to patients on the ward, keeping matches, scissors and other dangerous articles away from patients and the censoring of mail, which for obvious reasons has to be done, between patients and the outside world.

Volunteers are also made aware of certain basic, common human needs such as the need for people to express their feelings, both negative and positive; the need for understanding response to the feelings expressed; the need to be recognized as a person of worth and innate dignity, despite dependency, weaknesses or faults; the need to be dealt with as a person rather than a case, a type, or a category; the need not to be judged as a failure or a weakling or the cause for the difficulty in which the person finds himself; the need to make one's own choices and decisions regarding one's own life. (People want to be helped not bossed or commanded); and the need to have personal information respected and kept confidential.

Volunteers, particularly on their first few visits wonder how they should conduct themselves, and in addition to the above, they are given helpful hints such as the need to encourage the patients interests in things outside themselves; the need to avoid comments which may be interpreted as rejection and the need to avoid conversation on topics which seem to excite or disturb the patients. The volunteer is also cautioned to expect personal or uninhibited remarks by the patients ans is asked to try to control reaction to these as much as possible. A final and
very important ethic is to make sure the volunteer realizes that outside discussion of patients and problems cannot be condoned.

Following the orientation talk a very complete questionnaire is given to the prospective volunteer to fill out. This questionnaire\(^1\) is designed to assess the applicant's motivations for volunteer work and to bring to light any tendency on the applicant's part to be over-identified in one way or another with mental illness. Care is taken in this regard not only with the patients in mind but also the well-being of the volunteer. The completed questionnaire is used as the basis for a personal interview and from this interview comes the decision for or against accepting the application. The volunteer understands that he or she is volunteering for work in any part of the programme and on that basis, if accepted, is soon assigned to one of the volunteer teams.

The following figures give an idea of the number of volunteers recruited, the number of resignations and the percentage resignations of current year recruits.

<table>
<thead>
<tr>
<th>Year</th>
<th>Joined</th>
<th>Resigned</th>
<th>Active December 31st</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>25</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>or 20%</td>
</tr>
<tr>
<td>1955</td>
<td>103</td>
<td>23</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>or 18.7%</td>
</tr>
<tr>
<td>1956</td>
<td>156</td>
<td>82</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>or 52.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>44 1955 members</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>33 1956 members or 59.1%</td>
</tr>
</tbody>
</table>

\(^1\)Appendix B.
1957  74  carried forward  
from Dec. 31, 1956
112  joined  
74  resigned (39.74%)  -  2  1954 members
112  active December 13  1955 members
31st, 1957  8  1956 members
51  1957 members or 45.5%

These figures are not absolutely accurate because statistics of this nature have not been kept by the Canadian Mental Health Association to date. However, they are approximately correct, having been compiled from the Coordinator's card record system. It was not possible to ascertain the reasons behind each resignation because this type of information had not been recorded. Certain general observations may be made. It is fair to say that a good many of these resignations took place in the summer time, which seems to be a common phenomenon with most volunteer programmes. The percentage of current year resignations is decreasing and this may be attributed to energetic recruiting and gradual development of what might be termed "team spirit" on the part of more and more volunteers. The general feeling remains, however, that sustaining the interest of the volunteer in the programme is the main problem and some suggestions in that regard are made in the final chapter.

Hospital and Volunteer Programme Relationship

It is important to understand the relationship between the volunteers and the hospital if one is to get a clear picture of how the programme operates. A great deal of planning was done before the idea of volunteers was accepted and before the actual
volunteer visits got under way. A chart (p. 39) is included which shows the organizational set-up of the volunteer programme. The following material will indicate the representation on these committees and discuss their function. Dr. A.M. Gee is the head of the Provincial Mental Health Services and it was he who gave the go-ahead on the volunteer programme. He was very active in the initial planning and is now on the Board of Directors of the British Columbia Division of the Canadian Mental Health Association, the Scientific Planning Committee and the Volunteer Policy Committee. The Hospital Committee on Volunteers still exists but meets only rarely. The various disciplines in the hospital are represented on this committee (doctors, charge nurses, psychologists, social workers, etc.) The purpose of this committee is to discuss the progress of the volunteer programme, possible new areas of service, and any problems which may arise affecting the hospital policy. In practice, such discussion now takes place between Dr. I. Kenning, Clinical Director in charge of treatment, and Mr. G. Dodsworth, Coordinator of Volunteers, or it may be discussed by the Volunteer Policy Committee. Dr. Kenning sits on this committee as does Dr. Gee. Mr. Dodsworth, as Coordinator, sits on both the Volunteer Policy Committee and the Volunteer Services Committee. The Chairman of the Volunteer Services Committee sits on the Policy Committee as well. The Chairman of the Policy Committee is elected to her office and is also an active volunteer worker at the hospital. She is also a member of the Board's Executive Committee. The representative of other parts of the volunteer programme have
Relationship Between the Volunteers and the Hospital

PROVINCIAL MENTAL HEALTH SERVICES

HOSPITAL COMMITTEE ON VOLUNTEERS

COORDINATOR

VOLUNTEERS POLICY COMMITTEE

VOLUNTEERS SERVICE COMMITTEE

RECRUITING

TRANSPORTATION

EAST LAWN

CENTRE LAWN

WEST LAWN

CREASE CLINIC

HOMES FOR AGED

APPAREL SHOP

EVENING
representation on the Volunteer Services Committee. They are the Chairman of Recruiting (Vancouver and New Westminster), the Chairman of Transportation, and the various area representatives listed at the bottom of the chart. Now that the programme is well established, most matters are discussed and settled at the Service Committee level. If a question of policy enters about which they are not sure and the Coordinator feels a discussion on policy is indicated, the matter will be referred to the Policy Committee for decision. An example of such a question is "what happens to patients who have been in hospital a long time, have lost contact with family and friends, ...where do they get clothes to wear?" The answer and end result of this question was the planning and establishing of the Apparel Shop. It is evident that there is fully adequate opportunity for hospital volunteer communication.

The key person upon whom effective communication depends is the Coordinator of Volunteers. The duties of the Coordinator are many and the increasing number of volunteers is making his job more important than ever to the success of the volunteer programme. His duties include the following: assist at orientation meetings, compile list of interests and talents of volunteers, utilize list in discussing assignments with Chairman of Volunteers, contact ward charge nurses as to starting date for new volunteers, personally contact new volunteers as to when and where to come, visit volunteers on the job, devise ways to maintain volunteers interest, and keep both hospital and Canadian Mental Health Association up to date on programme activities.
The Coordinator is a psychiatric nurse by training and is also president of the British Columbia Psychiatric Nurses' Association. These qualifications are extremely helpful because they combine an understanding of hospital and ward routines plus a prestige position in the Nurses' Association. As such, the Coordinator is in an excellent position to help the nursing staff come to accept, and take an active interest in, the work of the volunteer. This in itself is not enough, and some suggestions are made in the final chapter which will hopefully be of some value in that respect.

In the next chapter the focus narrows to a discussion of volunteer activity on a particular ward (H.3) in East Lawn. Other wards are described briefly to set the frame of reference. Ward H.3 was chosen simply because several volunteers have been active on it for some time and because it is a ward where the majority of patients have been hospitalized for a good many years. In many cases the hospital community will be their community for most, if not the rest, of their lives.

The volunteers on this ward are experienced and have a sincere desire to give of self as well as of time. They combine friendliness and warmth with flexibility and a certain aggressiveness, which is often necessary to encourage patients. This aggressiveness is based on understanding the patients needs as mentioned earlier.
Chapter 3

Volunteer Work in East Lawn (Ward H3)

East Lawn Building

Since the start of the volunteer programme at the Provincial Mental Hospital a good deal of volunteer activity has been centred at the East Lawn Building. This unit has been described briefly in Chapter 2, but because the focus of the present chapter is on the specific volunteer activity in one ward of this building, a more complete description of East Lawn is warranted.

East Lawn is one large building and is the long term treatment unit for female patients. Its bed state is about 1,450 beds which are all occupied well over 90% of the time. There are 10 wards, the smallest having a bed count of about 37 and the largest 192. The average bed count per ward is about 150. The patients who eventually come to East Lawn have all previously had the benefit of the investigative and therapeutic techniques that were available either in the Centre Lawn admission centre or at the Crease Clinic. These patients have a common problem in that they failed to respond quickly enough to be retained in those areas, or to be discharged to the community. As a result, they have been transferred to East Lawn for continued
treatment and care. Many have been patients in East Lawn for many years, and their prognosis for rehabilitation to the community is very poor, although some long term patients have had gratifying remissions of their illness and been able to return home. Others who make partial recovery may be given ground privileges, not only with freedom to engage in walks in the grounds unattended and to go to various recreational activities provided, but also to participate in the various occupations on or off the wards.

A brief description of the ten wards in East Lawn as presently constituted is as follows:

Ward F2: this ward has the most home-like appearance of any in East Lawn and the patients are active in all phases of hospital programme and also in the government of their own ward. There is some volunteer activity on the ward but more during the evening than during the day because patients have full ground privileges and many are active in jobs around the hospital. The ward is comfortably furnished, having carpets, pictures, curtains, rock maple furniture, smoking room, piano, television and other conveniences. There are approximately 173 patients on this open ward. It is hoped that a good many of them will be rehabilitated to their community.

Ward F3: this is an open ward with a patient population of about 160. These are mostly long-term patients who have progressed far enough to make use of ground privileges but who need quite a lot of supervision because there is a fair amount of deterioration and a number of retarded and epileptic patients
among them. They participate fairly well in supervised occupational and recreational activities provided and enjoy movies and the occasional ward party. Volunteer work is being done on this ward consisting of individual visiting and conducting simple projects such as flower-making and slipper making.

Ward F4: this is a closed ward with a patient population of about 160. These patients are long term consisting of many pre-senile and mentally defective persons characterized by a fair degree of deterioration. They require a lot of nursing care and supervision. Only a few have ground privileges. There is not much movement on this ward and most will be hospitalized for the remainder of their lives. There are no volunteers on this ward at present although there have been and will be again when volunteers are available.

Ward H1: this is a closed ward with a patient population of 115 and many of the patients are mental defectives requiring a great deal of assistance with personal hygiene. At the present time volunteers are not active on this ward because the patients do not seem able to benefit by their services. Possibly with more volunteers available, and working in conjunction with trained recreational therapy personnel, they could be quite helpful in conducting simple sing-songs, playing the piano and helping in musical games and children's type games.

Ward H2: this is an open ward with a population of 170 and the patients are between sixty and seventy years of age. The occupational therapy potential is considered to be good on this ward as is the recreational potential in the sense of music and movies. There is some interest in grooming.
Volunteers can be helpful in all these areas.

Ward H4: this is a closed ward with a patient population of about 120. There is also provision for keeping disturbed patients on this ward. Volunteer potential is good and there has been a request for more volunteers when available. There is a case for foreign language service on this ward. The patients include a Doukhobour lady, a Chinese lady and Jewish lady all of whom do not speak English and are, therefore, forced to spend most of their time unable to converse with anyone. Arrangements are being made by the volunteer Coordinator to have volunteers visit these patients and talk with them in their own language.

Ward H5: this is a closed ward with a population of 100 patients some of whom have ground privileges. The average age of patients on this ward is about sixty years of age and there is some deterioration. There is quite good scope for simple occupational and recreational therapy programmes and volunteers are active as well. This ward has language problems also and volunteers could be very helpful in individual visiting with such patients. Many patients to to bed around eight o'clock so that evening volunteers are not too practical, although there is some volunteer activity.

Ward J3: this is one of the smaller wards with a patient population consisting of 63. It is an infirmary ward made up of bed or wheel chair patients. Entertainment consists mainly of record player and shows with some reading.

Ward J4: this is the other small ward in East Lawn and has between 38 and 40 patients. a "total push" therapy programme
has just been started on this ward, that is, all disciplines are active with this selected group of patients in a total rehabilitation effort. There is a place for volunteers to help with language difficulties, individual companionship, dance classes, and so on.

Ward H3

Ward H3 is described in considerable detail for a number of reasons. First, it seems necessary in order to give the unfamiliar reader a better idea of what a ward in a mental hospital can be like. Second, it sets the frame of reference for the reader, of the volunteer in the ward setting. Third, it points up material for ward surveys which the coordinator might compile with a view to appropriate volunteer assignments and programme planning.

This is a closed ward for long-term mentally ill patients. It has a bed count of about 170 beds, and it is nearly always full. The age range of patients at present is from 19 to 74 years with most of the patients being middle-aged or over. For example, a statistical count in September, 1957 showed 8 patients under 30 years of age, 121 patients between 30 and 59, while 26 patients were 60 and over. About 64 patients on the ward have been in hospital more than 15 years; about 40 have been in 5 years or less, and the remaining 60 or so fall in between. There were 163 patients on the ward when this count was taken and 121 of these were classed as "Ladies of Leisure". The remainder were active in some form of work. In this case 10 worked at the laundry, 1 at the nurses home, 12 in the industrial sections,
12 at ward work, 6 at the occupational therapy shop and 1 did "other work." Of the 52 patients who had ground privileges, 49 made use of them.

There is a slow, steady movement of patients usually because of improvement in condition and therefore to a more suitable ward. The ward function is probably best described as that of habit training.

Ward H3 in 1955 was a far cry from the H3 of today. Then it had a strong smelly odor and was dull and depressing. There was a general untidiness about it. Today it is a clean, bright ward with no offensive odors although it lacks the warmth of a ward such as F2. When the present charge nurse took over in 1955 she immediately made a request that the floors be waxed and was told by the waxer that that was the first request for this service on that ward for a year. The present staff shortage was acute at that time also, and staff morale was low and there was a lack of inspired ward leaders. Security was carried to quite an extreme; not only were all the doors locked but even almost empty cupboards were locked as well.

Ward behavior was considerably different then. It was very noisy and a type of seclusion was in quite frequent use—that is, patients who were upsetting to the ward were taken out of the day room and put into their dormitory. Patients were commonly seen lying here and there on the floor, huddled in a corner, sitting listlessly in one spot or pacing or running back and forth in the day room or in the corridor. While it was noisy, there were many who were either completely silent or made only
grunting sounds. Many of the patients showed little or no interest in food and their physical condition was not the best, necessitating quite a bit of medical attention.

The above perhaps implies that the hospital had a rather unenlightened approach towards treatment and care of the mentally ill. It must be clearly understood that this was not the case. The impetus for change to more enlightened patient care did exist as demonstrated in the Crease Clinic treatment programme. It had also been demonstrated right in East Lawn as seen in the preparation for and opening of ward F2. The hospital administration was keenly aware of the needs for improvement in treatment and care of the patients, and were effecting such changes as rapidly as was possible, taking into consideration the limited budget and staff shortages. In considering improvement in conditions in H3 the Clinical Director saw to it that a top notch charge nurse was transferred to the ward. With his full backing she would have to give inspired leadership to motivate her staff to be enthusiastic about their task and to give them a sense of purpose. It was also very necessary to gain their complete cooperation in following her firm and consistent policy making. These patients were badly in need of habit training and long months of persistent effort would be required on the part of both staff and patients.

When this ward began its present habit training programme in 1955 the patients were very disorganized in their routines. The charge nurse reported that on her first day on duty 75 women got up and shuffled to breakfast without their shoes or stockings. Some were in their nightgowns, some in petticoats and some were
wearing the plain denim dress which was institutional issue. After two weeks this number was down to 4 patients without shoes and these wore slippers. Part of the problem was getting a proper and comfortable fit in shoes for patients. Another big step that the charge nurse initiated with the Clinical Director's backing was to get attractive dresses for the patients through the volunteer's Apparel Shop. This had the immediate effect of pleasing the patients and encouraging them to take more interest in their grooming. One striking result was the decrease in the number of ladies who sat or lay on the floor. They did not want to dirty their dresses.

The charge nurse who was chosen had twelve years experience at that time and is a steady, reliable person with a strong sense of duty. She is flexible but not permissive. She is consistent in her follow through, shows no favouritism and is firm with the staff regarding their duties. She gives credit where credit is due. The welfare of her patients is uppermost in her mind. She saw habit training as for their good and therefore was firm but kind in her requirement of it. Above all, she had patience which was so necessary for the months ahead and acceptance of the slowness and smallness of gains.

A diagram showing the floor plan of ward H3 is shown (p.50) in order to give the reader a better idea of the ward. The numbers noted on the diagram indicate the number of beds per dormitory. The numbers in themselves do not let us know whether beds were comfortably spaced or not. Actually, the dormitories are crowded, and generally speaking, the neatly made beds with their white spreads, have only enough room between them to per-
mit limited movement. It is worth noting that when the hospital administration shifted its focus to concentrate on this ward one of the first changes was to replace a good deal of the bedding with properly fitting sheets and blankets. The day rooms are now characterized by clean floors and clean walls. The windows do not have curtains but there is a pleasantly bright cloth valance above each window. Several more comfortable chairs have been provided although there are still quite a few of the long, straight-backed wooden benches. There are a few tables here and there throughout the two day rooms and there are some framed pictures on the walls. Some of these were donated by volunteers. At one time there were a few rugs in this ward but they were in such bad condition that they had to be discarded. It is also to be noted that there is no grouping of furniture which would make for a homier atmosphere. One reason for this is the over-crowding of the ward. The long wooden benches seat six patients in much less space than would six individual comfortable chairs.

The lavatories are spotlessly clean. The one main drawback is that the patients have absolutely no privacy because the toilets have no partitions whatsoever between them. A request was made by the Clinical Director for the minor structural changes necessary to rectify this but to date there has been no action on the matter.

Patients rise at six a.m. and are ready for breakfast by eight a.m. A good deal of time is required because of the large number of patients and the shortage of staff. There are 17 staff members assigned to this ward. This does not represent
the number per shift but the number for the entire twenty four hours. It can be readily seen that the amount of individual work with patients is extremely limited.

Following breakfast, there are various activities such as ward housekeeping, occupational therapy and grounds privileges. Some of the patients go off the ward to work in hospital industries such as the laundry. All patients are back in the ward by eleven o'clock for lunch which lasts until one o'clock. After lunch, occupational therapy programmes resume, various ward duties continue, and there are supervised walks and visiting. At four o'clock everyone is back on the ward again for the beginning of the supper period. After supper many of the patients are bathed and then all are put to bed with the day ending between eight and nine o'clock.

Patient Categories

When discussing the types of patients on this ward with the Clinical Director, the Social Service Supervisor and the charge nurse, the writer asked if it was feasible to group them according to categories of mental illness, such as chronic brain syndromes, psychotic disorders, personality disorders, and so on. The Clinical Director replied that on a small ward where a thorough psychiatric examination had been made, it would be possible to give an accurate answer to this question but not on this ward. The writer suggested an alternate way of classifying patients which might be called a type of social classification according to the behavior that the individual patient manifested. The following broad groupings were suggested by the Clinical Director and the Charge nurse. The first group was termed "Tranquillized
Long-term Apathetic Schizophrenics. The second group was termed "Long-term Apathetic Schizophrenic." The term schizophrenic is defined by the American Psychiatric Association as follows:

A severe emotional disorder of psychotic depth characteristically marked by a retreat from reality with delusion formations, hallucinations, emotional disharmony and regressive behavior. Formerly called dementia praecox.\(^1\)

The main difference between these two types, for our purpose, is that one is on medication, sometimes very heavily, and the other is either little or no medication. A possible difference that was not considered here is that the tranquillized patient, while appearing very similar to the apathetic patient on little or no medication, may have greater potential. This is, she may be on heavy doses of tranquillizer in order to contain considerable activity displayed within her psychosis as against the apathy of the patient not on medication. These two groups can be picked out very easily on the ward because they are usually just standing or sitting, or squatting or lying, or perhaps pacing slowly back and forth. Their faces are usually void of expression. They may talk only rarely or not at all. The majority of patients fall into these two categories and number about 120. A third grouping has been called the "Attention Seekers" who are very demanding of staff people whenever they appear on the ward. These patients are not generally troublemakers in the sense that they have violent outbursts but their

---

\(^1\)A Psychiatric Glossary, Committee on Public Information, American Psychiatric Association, 1957. p. 25.
seemingly insatiable attention needs consume a lot of staff time. There are about 15 people in this group. There is another group which has been termed "Acting-out Psychopaths." The term psychopath is described by the American Psychiatric Association as follows:

A person whose behavior is predominantly amoral or antisocial and characterized by impulsive, irresponsible actions satisfying only immediate and narcissistic interests without concern for obvious and implicit social consequences accompanied by minimal outward evidence of anxiety or guilt." (They also note: Increasingly considered a poor and inexact term.)

This group numbers about three patients only, and while they too crave attention, it is more because they like to be the centre of attraction. If this type of attention is not gained they are apt to act out by breaking windows, attacking other patients and so on. A fourth group suggested was termed "Occasionally Violent." It was felt that this group's occasional disturbance was usually the result of their delusions and hallucinations. There are only about three patients in this category. The fifth group was termed the "Rescue Seekers." There are about 20 in this group and they are said to be confused psychotics, who do not realize that they are ill and are apparently indignant and surprised that they are "in this place." A final type seen occasionally on this ward was termed "The Manipulating Epileptic." There is none on the ward at the present time.

Volunteers and Patient Categories

Volunteers first came to work on ward H3 in September, 1956.  

1Ibid., p. 23.
2Dodsworth, op. cit.
The Coordinator discussed the plan with the charge nurse and later introduced the volunteers to ward staff. There were three volunteers at first and then, after a few months, a fourth joined the H3 group. Staff reaction to the volunteers was polite but the volunteers sensed a certain reserve. If this actually was so, it seemed to disappear quickly once H3's staff and volunteers got to know each other. Certainly, to-day, this group feels entirely welcome on the ward and, in fact, are most welcome according to ward staff comments. This small group has come regularly and have proved their mettle, so to speak. In October 1956 they gave a Hallow'een party for the patients and have followed this practice ever since whenever any special time of year comes along. At Christmas 1956 they arranged for a big Christmas party with decorations and presents. This was the occasion of the first Christmas tree on ward H3. One of the volunteers visited the Manager of Woodward's display department and after telling him of the purpose of her visit received a large donation of Christmas decorations which the store delivered to the Hospital. The store repeated their donation last Christmas and sent along two of their display men to help set up the decorations. It is interesting to note here that the volunteer told them a little bit about the ward and of what to expect before they arrived which proved helpful later. The presence of the two men on the ward did excite both positive and negative reactions on the part of some patients but the men took it in their stride and everything turned out satisfactorily. Other examples of parties put on by the volunteers are Valentine's, St. Patrick's and Easter parties.
The patients' reaction to both the volunteers and their activities, on the whole, has always been positive, and they are quick to express their appreciation. All of the volunteers now feel perfectly at home during their visits on this ward but all admit to feeling apprehensive when they first started. With some it was simply because they were viewing, for the first time that they were aware, fellow human beings in a far from normal state. With another volunteer there was the shock of taking her first steps into the day room of the ward, having the door locked behind her, and having a patient dive at her legs and hold on. Actually, all the patient wanted to do was find out if the volunteer was wearing stockings, and as the stockings were seamless she could not tell, she did what seemed logical to her to find out. This volunteer with the moral support of a fellow volunteer was able to turn the situation into a brief, friendly conversation. Another volunteer underwent a much more frightening experience when a suddenly upset woman attempted to choke her by slipping a stocking around her neck. An incident such as this is certainly the exception rather than the rule. The interesting point is that the other patients in her group rescued her in a matter of seconds before a staff member could help out. The patient then attempted to do the same thing with another patient. The volunteer, while very definitely shaken by the experience at the time, returned the next week as usual, made no mention of what had happened and continues to come on a regular basis.

From discussions with the charge nurse and volunteers it
would appear that most of the volunteer visiting on the ward takes place with the two largest patient groups, namely, the tranquillized long-term apathetic schizophrenic and the long-term apathetic schizophrenic. This is partly because they are the majority in the ward but also because they are quieter and less demanding, and therefore less threatening to the volunteer. This is not to say that the other groups are ignored because the volunteers try to move around the ward so that they can have at least a brief contact with most, if not all the patients who can be interested. There seems to be a natural tendency on the part of the volunteers to regard these two major groups as the "less fortunate and forgotten ones." The volunteers work in several ways with these two groups. First, they visit with them and encourage them to talk if they seem inclined to do so and listen in an understanding manner. The volunteers seem to have a very good appreciation of the helpfulness to the patient of "just listening." Quite often, if a patient seems interested, but has difficulty in talking herself, the volunteer may simply talk about her own family, perhaps giving the patient a snapshot or two to try to give them a sense of belonging. Many of these patients are now without living relatives, or the relatives perhaps have preferred to forget them. It is surprising to the volunteers at first the way in which the patient responds and remembers what may seem commonplace to the volunteer. Once this has been experienced by the volunteer the old question, which seems to plague most new volunteers, namely, "what will I say, what will I talk about" answers itself. A second way in which
the volunteers help is by supplementing the staff's habit training efforts. For example, they help motivate patients by going on brisk walks with them, dancing with them, conducting flower making classes and so on. This helps arouse them out of their apathy and sluggishness which is manifested in their sitting, lying, crouching and standing doing nothing. It is surprising to find that so much interest can be shown by these groups when sparked by the enthusiasm of the volunteer. A third way in which the volunteers help is by focusing the attention of the patient on her grooming. This is done in a tactful manner and quite often is a result of the patient's pleasure in the volunteer's good appearance. There are often requests made of the volunteers for a repeat performance of one particular outfit which a volunteer has worn. The charge nurse and volunteers have remarked on the renewed interest in clothes and even concern about their hair, face and figure on the part of patients.

The volunteers perform a very useful service with that group which has been called "the attention seekers." One particular aspect of the service which is appreciated very much on this hard-pressed, short-staffed ward is that while the volunteers are visiting, the patients are much less demanding of staff. That is, the continual knocking on the door to ask trivial questions and make inconsequential requests, is narrowed down to more legitimate demands. It is recognized that these interruptions by patients are expressions of their unmet needs, but nevertheless, they do take up staff time which also is being devoted to the over-all running of the ward and well-being of all the pat-
ients. The volunteers are able to meet, or at least alleviate this almost insatiable need for attention through their willing attention. They are able to help this type of patient to help themselves more and attend to their own needs. One of ten finds that this type of patient will eagerly report to the volunteer on her next visiting day on what has happened during the week and what she may or may not have done about it. When this type of patient finds that they have someone who will be coming, and who will listen to them, it seems to help them a great deal in containing themselves. The volunteer can also assist this type of patient to get along with others better and therefore be more considerate of others. In one or two cases the volunteer has been able to enlist the cooperation of the attention seeker in becoming a "patient helper". A patient helper is a patient who will take an interest in a fellow patient and help her to take a greater interest in herself and in her surroundings. For example, the volunteer may start out by getting acquainted with the attention seeker through talking with her and listening understandingly so that the patient gradually feels the volunteer's interest in her as a person is real. Then the volunteer may use their conversation to test the attention seeker's awareness of other patients. If the attention seeker is able to mention or point to some particular patient in, say, the "apathetic" group, then the volunteer may be able to pick up on this by tentatively suggesting that the two of them take the apathetic patient for a walk, or try to talk with her. The attention seeker may not be ready to pick up such a suggestion and if there is hesitation
the matter is dropped for the time being. Volunteers, because of the nature of their service, and because of their warmth, sincerity, and desire to help, are often able to devote the time and patience necessary to achieve their end.

Volunteers and Occupational Therapy

The volunteers' role in assisting in the occupational therapy programme in East Lawn is not yet clearly defined. Perhaps because of this it has not been understood and made use of most constructively. In this connection, the writer interviewed the recently appointed head of the Department of Occupational Therapy, Miss O. Curtis, to get her opinion on how volunteers might best be able to work on a ward such as H3, and in the patient categories under discussion. Miss Curtis is entirely in favour of selected volunteers assisting in the occupational therapy department and in the therapist acting as a consultant to volunteers who are working on the ward.

When discussing the two major groupings of patients on H3 Miss Curtis pointed up their need to be "activated and stimulated" to take an interest in things and the need to maintain this function at the highest possible level. She stated that the general difficulties encountered by the therapist (and by the volunteers) were in "making contact" and getting the patients' response because of the latter's lack of interest, deterioration, and/or physical difficulty resulting from heavy medication, such as drowsiness, poor eyesight, and swelling of the hands. A combination of one or all of these factors may limit what the patient
is able to accomplish even in what may seem very simple to the inexperienced volunteer. Another very important aspect, often not realized, is that when working with this type of patient, the volunteer will have to do more than just get the patient started; she may have to get the patient started on each new step of the work no matter how obvious it may seem to her. On a habit training ward such as H3 this applies in most cases.

The trained occupational therapist, acting as consultant on ward, can be very helpful to volunteers explaining the needs of patients and, at the same time, receiving valuable assistance in carrying out her therapy. Particularly with new volunteers, she can help them to understand and deal with the patients' lack of initiative. Then the volunteer will be on the look-out for difficulties which the patient is encountering and be able to help the patient help herself. By recognizing the patient's innate dignity and worth; by sincerity of approach; by not pushing her beyond her capacity and by carefully watching for, and commenting on, the smallest bits of progress, the volunteer will be doing her part in the long slow process of nursing a patient back to a healthier state of mind.

When discussing the attention seeker group, Miss Curtis stressed the need to get and keep this person interested in doing something. For example, where there is a group project under the guidance of a therapist, with volunteers assisting, the latter could encourage the attention seeker to collect the tools. This may seem a trivial task to some but may be the first link in a chain of little tasks and things the attention seeker may do in
order to develop her capacity to think of others. By helping in occupational therapy she may be able to see ways she can help nursing staff around the ward, rather than having to get their attention by other means. The praise that will be forthcoming will stimulate her to sustain small gains and move toward larger ones. The volunteers' potential in this area has already been mentioned but cannot be too strongly emphasized. The unsuspecting volunteer may fall into the pitfall of letting the attention seeker play her off against staff and should be on the lookout for this tactic. For example, the hypochondriacal complaint is commonly used by the attention seeker. A specific example in occupational therapy would be a tool scratch, magnified out of proportion by the patient. When reasonable attention and kindness has been given by the volunteer, Miss Curtis advises an understanding firmness and directing of the patient to some constructive work as planned by the therapist. In other words, it is not a case of being harsh and strict, but rather firm and consistant; the idea of rejecting the attention seeker's devices but not the attention seeker herself. Praise following the attention seeker's first efforts at carrying out the volunteer's re-direction usually brings positive results. It is important that the volunteer realizes that while praise may be enthusiastic, care must be taken to avoid sounding "gushy" which the patient senses as being insincere.

Another group mentioned above was that termed the acting-out psychopath. Miss Curtis felt that this would be a difficult group for the volunteer to work with because in her experience they are persuasive, manipulative and inclined to be aggressive.
In addition, they are easily frustrated, quick to sense failure, and, if things are too easy, quick to become bored. Miss Curtis felt that volunteer work with this group would be limited unless, under close supervision of an experienced occupational therapist or other staff person, depending on the situation.

The final group discussed was the confused psychotics or rescue seekers. It was felt here that within the occupational therapy programme the volunteer could assist by helping the patient get a sense of purpose. That is, the patient should be given work having purpose and be helped by the volunteer to see work as a means of progression towards reality. By helping them achieve a sense of purpose, the volunteer is helping the patient to allay her agitation. As with all patients the need to be tactful but truthful should always be kept in mind.

The volunteer can also be most helpful in preparing materials and work for patients. For example, there is a period between the volunteers' arrival time, 10:45 a.m., and 1:00 p.m., when patients and staff are at lunch, which could be utilized by them, if they wished, to make these preparations. Also, there is quite a bit of trimming and touching up work that is needed on patients' handiwork before it is saleable. (Under the present system, a patient who is unable to buy the material for her project agrees to make two items, keeping one and donating the other for hospital sale.) Some volunteers could be kept quite busy on that, according to Miss Curtis, and on collecting material for occupational therapy. Examples are special materials such as oddments of silk and fur, too expensive to be provided for out
Case Examples

Case I - Mary M.

This case is a brief illustration of a volunteer-patient relationship which has developed as a result of simple friendly visiting.

Mary is 52 years old now and has been in hospital for 20 years. Her own family and relatives have either died or moved away. Mary's "Visitors' Sheet" in the Visitors' Book, like that of many other patients, has had no entry for a long time. Mary falls within the "Apathetic schizophrenic" group and until recently just sat or stood or looked out the window most of the day. She apparently took no interest in anything, except that she sometimes tried to write poetry. She has a high school education and was once a music teacher, having studied for, and been awarded, her A.C.T.M.

One of the volunteers, who at that time had just started on the ward, spoke to Mary and introduced herself using her first name. Mary was unable to respond, but the volunteer chatted for a few moments before moving on, saying that she would see her next time she was out. The volunteer's next time out was a week away but, while unable to respond at the time, those few words meant a lot to Mary. Every afternoon for the next week she waited near the door of her closed ward watching for the volunteer to come and visit. One week later when the volunteer came Mary was able to mumble "Hello" in response to the volunteer's greeting.

Mary will probably never be well enough to leave hospital.
but her hospital community is much enriched by this volunteer and those who visit with her. She is now taking more interest in her appearance, enjoys walks with the volunteer and particularly appreciates the occasional car drive around the local countryside. When the volunteer was away on vacation she and Mary corresponded regularly. A simple little poem written by Mary about her "Friend" expresses very clearly the happy change in her life.

My Friend Norah is a girl
Of Happiness and social whirl
Of gaieties and merry ways
Grand services brought by trays.

One of the most important things a volunteer can offer is Friendship.

Case 2 - Dorothy D.

This case is an illustration of a way in which a social worker may enlist the aid of a volunteer to help a patient take more interest in herself and, hopefully, become more accessible to casework services. It also illustrates how a social worker can be helpful to a volunteer by briefing her on the patient's behavior and possible sensitive areas.

Dorothy is a 41 year old single woman with a university degree in education. Following graduation she taught school but, while her academic ability was excellent, she could not make a success of teaching. As a child she had been seclusive, sensitive, and suspicious. A relative described her as "over-conscientious". In her teaching capacity she was not successful in handling her class; nor was she able to get along with her fellow teachers. She started going from one school to another, had frequent crying spells in front of the class, periods of staring out the window,
and her personal appearance became very untidy. A psychotic break resulted.

Immediately prior to her hospitalization 11 years ago, Dorothy was as described above and generally withdrawn for about 3 years. Following admission she received extensive electro-convulsive therapy and some insulin coma, but did not improve to any great extent. Dorothy has remained fairly apathetic throughout her hospitalization although there have been active periods when she was quite grandiose. She has been on tranquillizers for some time and would fall within the "tranquillized apathetic schizophrenic" group.

Recently she started to show a greater awareness in things and began thinking about resuming her teaching career. She is gradually improving to the point where she may be discharged if a suitable rehabilitation plan can be worked out with her. Her present idea of teaching is not realistic at this time and possibly never will be. However, Dorothy found it was difficult to accept this idea and would have nothing to do with her doctor in this regard, nor with the social worker who was assigned to the case. For one thing, they were "paid" to be interested and for another, the idea of social worker smacked of "charity" which was a blow to Dorothy's "pride". (Her family had once been very well to do.) Her refusal to participate in discharge planning is blocking her successful rehabilitation to her community.

The social worker felt that a volunteer might be able to make friends with Dorothy and patiently help her to understand the type of service the social worker had to offer and be more
accepting of it and of more modest rehabilitation plans. The result was a planning conference between the Coordinator of Volunteers, the volunteer selected for the assignment, and the social worker. The social worker gave the volunteer a brief picture of Dorothy's background and how she behaved as a rule. Then, the volunteer (herself a former teacher) was introduced to Dorothy. Dorothy was unresponsive the first time or two saying "Yes" or "No" to the volunteers remarks or perhaps just staring at her. But she soon warmed to the sincerity and friendliness of her "visitor" and it was not long before she began to take more interest in her clothing and personal grooming generally. The improvement in her appearance has been quite remarkable. In addition, she is becoming more accepting of the idea that teaching would be a big step to take right away, having been away from it for so long.

Dorothy still has quite a way to go before she will be able to participate in realistic discharge planning, and in her ability to accept, and benefit from, the social worker and her knowledge of human behaviour and community resources. The volunteer continues to visit with Dorothy, go for walks with her, take her to town, all of which is gradually orienting her to the community again and giving her a feeling of acceptance in it.
Chapter 4

Summary and Findings

Restatement of Focus

In the past half century the mental hygiene movement inspired by mental health crusaders such as Dix, Beers and Hincks has created widespread and sustained public interest in mental hospitals. This public awareness has been sharpened even more in the last two decades in Canada through the educational efforts of the Canadian Mental Health Association. C.M.H.A. has made wide and constructive use of the press, the radio, television, movies and public speaking, to reach more and more Canadians. The once discarded idea of moral treatment is making its return in a more enlightened form. There is a blending of "laboratory" knowledge with that of psychology and the social sciences. There has been a change in the approach to mental hospitals and mentally ill patients from straight custodial care often characterized by thoughtlessness and physical abuse to one where the well-being of the patient is uppermost in the minds of the treatment team. The day has not yet come when the enlightened treatment team approach can be effected for each patient but determined efforts are being made and gradual gains are being realized in the successful remotivation and rehabilitation of patients back to
their community. The focus and attention of this thesis has been on the development of a volunteer programme consisting of the services of fellow citizens who have volunteered their time and talent as a "treatment extra" to bring the community to the patient on a gradual non-threatening basis, thus assisting in bridging the gap between mental hospital and community.

It is the writer's hope that this last chapter may provide material for thought out of which will come new ideas that will increase and give depth to an already effective volunteer programme.

Direction and Interest of Volunteers

A main problem in volunteer programmes is that of sustaining the volunteers' interest in the programme and giving the volunteers "direction" and appropriate recognition for their efforts. This is basic to successful community organization in any area. A group or individual responsible for continuing action in a community programme, such as the volunteer programme should not have the responsibility for direction of the operation taken away from them by professional personnel. The importance of this relates to "morale, feelings of responsibility, motivation for action." That is, if the group does not have, or relinquishes, major responsibility for direction of the operation then some of their sense of responsibility, some of their enthusiasm, creativity, and, very important, some of their sense of status and achievement is not forthcoming. This, of course, leads to discouragement, disinterest and dropping out of the programme.

---

Coordinator as Guide

While in general the volunteers express satisfaction with the organization of this programme and feel accepted by most staff, they do express a wish for more direction. At first this may seem out of keeping with the above remarks on taking care that responsibility for direction of programme is not taken away from them by professional personnel, but such is not the case. The volunteers do not want to be directed in the most obvious sense of the word but they do want to be guided or enabled. This difference may be hard for some volunteers to accept because, particularly when new and unsure, they probably believe they want more direction than they actually would be willing to accept. That is, they would soon realize that they were relinquishing a sense of responsibility, achievement and status. For example, the Coordinator in the role of guide must exercise considerable discipline of self in order to play this role successfully. It is very tempting for him to pass judgment on such questions as "what would be the best project for us to start?" or "what is the most important thing for me to do to-day?". The Coordinator, in giving a direct "do this" answer is not only stepping out of his role but is not permitting the volunteer's involvement in programme to develop in the healthiest manner. Unless volunteers feel they are in on the planning, not merely carrying out planning, their involvement will be of a fringe nature only. Real satisfaction will not be forthcoming and this, plus legitimate recognition of services rendered, is the volunteers' pay check.
What can the co-ordinator do when asked such direct questions? His ability to handle such questions most constructively will depend on the data he has on hand about patient needs. For example, surveys of individual wards are essential to learn the number of patients, the general groupings of patients on ward (such as H3), the time they go to lunch, that staff goes to lunch, that ward duties are going on, the numbers involved, the number of ground privileges (and those who do not make use of them), the time patients are at Occupational Therapy, at Recreational Therapy (and when these activities are on the ward) and so on. With this type of information the co-ordinator may, at a Volunteer Services Committee meeting or at an informal gathering of that day's volunteers, guide the volunteers via their questions to provide their own direction. If the Co-ordinator does not give direct answers to "direction" questions how does he handle them? In his role of guide he may provide data upon which a judgment can be made by the volunteers or he may summarize and clarify various arguments and points of view. In addition he may point out the implications of different courses of action and perhaps suggest courses not previously considered.¹ The whole point of this guiding role is to help the volunteers grow in capacity, which they will, as they strive to achieve what they have decided upon themselves. If the Co-ordinator provides the solution per se then the purpose is defeated.

The interpretation of this role to the volunteers may not be easy, and possibly at first it may seem to them as unsatisfactory handling of their questions. However, those who may not

¹Ross, Murray, Ibid p.210
at first see the logic of this approach will eventually understand, accept, and appreciate this type of guidance because, in fact, it is recognition of the volunteer's capacity as a person and as a valued helper on the treatment team.

**Value of Fact-Finding**

The acceptance of this approach by volunteers will be possible only if the Co-ordinator has the data at his finger-tips; otherwise it will be impossible to handle the requests for direction in a truly constructive manner.

Fact-finding should have value from three points of view. First and obvious, the Co-ordinator will be fully conversant with, and have a knowledge of, the entire hospital programme as this relates to use of volunteers. Second, one proven method for unanimous staff participation in the volunteer programme of a mental hospital is to have the members of each department and the employees of each ward discuss and list specific needs of the patients and the departments as to how volunteers may meet or help provide for these needs. The third way is to get "patient-minded" volunteers (who have had some experience in volunteer work at the hospital) together for discussion group meetings with the Co-ordinator. They will have skills, abilities, and ideas to relate and if guided, will do so in a specific and detailed manner. The Co-ordinator will then be able to study both lists and attempt to organise the material according to feasibility, timing, and implementation. However, the already

---

hard-pressed staff cannot be expected to take the time to tabulate this information without guidance and Administration encouragement. For example, if the Clinical Director makes it known in official terms that he wishes this information compiled this could well supply the needed push. Timing is all-important if such a request for information gathering is to be implemented. Here the Co-ordinator can offer guidance by preparing in advance a mimeographed questionnaire anticipating ward needs which can be simply ticked off where applicable and which will stimulate ideas and thought as well. It would seem that volunteers could be of considerable help to the Co-ordinator here by suggesting possible volunteer activities. Department representatives should be brought into planning also by advising on organization and content of early drafts.

Co-ordinator's Council

In this connection, there would seem to be a good case for a Co-ordinator's council to be formed, perhaps based on the existing Hospital Committee on Volunteers which is not too active at present. The Volunteer Manual on Psychiatric Hospital Services ¹ mentioned earlier discusses the hospital co-ordinating council idea. It suggests that the Superintendent usually appoints a committee of two or three interested medical staff members, the Co-ordinator, and when advisable the Heads of Social Service and Nursing Departments. Representatives from other departments were not mentioned but it would certainly seem

¹McBee, Marion, and Frank, Marjorie, op cit p. 11
advisable for Occupational and Recreational Therapy departments to be represented. The function of such a committee as stated in the manual would be to ascertain and evaluate volunteer needs of all hospital departments, formulate plans and act on the broad aspects of the programme in an advisory capacity. The Co-ordinator is given responsibility for effecting these plans and for handling the everyday details of co-ordination, assignments and supervision. It is also recommended that the committee meet at least once a month.

As it stands now, the Co-ordinator makes his departmental contacts mainly on an individual basis for which there is certainly a case. However, from the point of view of the combined understanding of all concerned there would seem to be a definite need for the council idea; otherwise the Co-ordinator's efforts will be less effective in this growing volunteer programme. Out of such discussions based on information of actual patient and departmental needs can come the kind of planning which is backed by understanding and interest and therefore has a chance of timely and efficient implementation.

Supervision of Volunteers

The term supervision as applied to a volunteer service programme is used here for lack of a more appropriate one. It is not meant to imply the highly developed worker-supervisor relationship used in social work. The Latin root of the word "supervision" means literally "looking over". This seems to come closer to describing the type of supervision for volunteers
which is indicated. That is, the responsible staff person should "look over" what they do. The social worker's role, for example, would be that of a helper, advisor, and friend. There is a training function implied in that the worker concerned should familiarize the volunteer with the social service setting. The volunteer should be introduced to staff and be given some idea of how the work of the department is conducted. The general philosophy of the volunteer-worker contact should be that of developing in the volunteer a sense of participation and involvement in the treatment team.

In each case, when the decision of assignment of volunteers is made, the volunteers concerned should be put under the supervision of a designated staff person in the department concerned. This procedure is followed to some extent at present but in a rather loose manner which contributes to some volunteers feeling a lack of direction and perhaps frustration.

Continuous supervision based on the volunteer's job requirements should be worked out. The possibility of supervision being provided in group sessions may be indicated considering the limited supervision time available. One Social Service Department\(^1\) has found the group method satisfactory. It was found that the sharing of ideas and experience plus praise and constructive criticism were particularly meaningful in the group setting. The social worker concerned would be responsible for preparation and orientation of the patient to volunteer services as well as preparation and orientation of the volunteer to the particular patient's needs.

\(^1\)McGriff, Dorothy. "A Volunteer Program in a Neuropsychiatric Hospital". Social Casework, Feb.'54.
The Volunteer Services Manual recommends that a confidential and brief record of the volunteer in relation to the job should be kept. The volunteer should know of the record which might include amount of time given, punctuality, reliability, competence and suitability to the work.

When discussing the volunteer programme with various staff members the writer noticed a tendency to consider supervision of volunteers a nice idea but time-consuming and with staff shortage, not really feasible. Certainly there is an acute staff shortage, but one wonders if we are not using the term a little too conveniently these days to the extent that we are losing out on invaluable community interest and participation in the hospital programme. If the purpose of the volunteer programme is clearly understood, and accepted, there should be no hesitancy to accept supervisory responsibility any more than there would be to supervise a paid staff member while on the job. Granted the volunteer may require a little more time at first but on the average, this is because of coming one day a week and consequently taking that much longer to get the feel of the surroundings. It is not because the volunteer is unreliable or incapable of giving helpful assistance. Social workers, with their family-oriented casework services and keen appreciation of the individual's need for community acceptance, can be of great help here. We can engage in continuing interpretation in regard to what the volunteer programme is trying to accomplish. Its success depends on staff understanding and true acceptance. Assuming conscious supervision of volunteers working on wards or in departments is an example of such acceptance.

1McBee, Marion, and Frank, Marjorie, op cit p.37
The assistance of an advisory council and assumption of more conscious supervision of volunteers by staff concerned should permit the Co-ordinator to concentrate more effectively on assignments, performance evaluation, and perhaps re-assignment of volunteers. It should also give him greater opportunity to keep his ward and departmental data up-to-date and to plan for present and future hospital volunteer needs.

**In-Service Training**

In the opinion of the writer the main factor in sustaining the interest of the volunteer is that of proper direction which has already been discussed.

However, proper direction needs to be supplemented by an appropriate in-service training programme given to the volunteers at regular intervals. Professional literature based on experience with volunteer programmes in mental hospital settings points up the need for regular in-service training sessions for volunteers. Many mental hospitals hold in-service training throughout one week of each month so as to include all volunteers most of whom are out only one day a week. It is felt that if volunteers are to be effective and intelligent interpreters to the community they must get the guidance of the hospital staff at all levels as to hospital aims, needs, programme of treatment for patients, and hospital activities generally. The writer discussed this possibility with the Heads of the Occupational Therapy, Recreational Therapy, and Social Service Departments, and they all agreed that the idea had merit. The Head of the Recreational Therapy Department strongly recommended that such

a course be not merely an unrelated series of talks by representatives of the different departments but rather a carefully structured course which would emphasize the treatment team idea. This could be carefully planned with the assistance of the Co-ordinator's Council.

Volunteer's Reading Shelf

At the present time there is no volunteer literature easily available to the volunteers at their hospital headquarters. It is suggested that the Co-ordinator take steps to acquire certain suitable books on mental health which would help the volunteer increase his or her understanding of work in a mental health setting. In addition a few interested volunteers could be selected to check monthly publications for material on volunteer work. Possibly the librarian at Crease Clinic could advise the volunteers of the most efficient way to check for source material. The bibliography at the end of this study contains numerous suitable references. By scanning various articles the library project volunteers could prepare helpful summaries of their content and obtain some useful ideas. All volunteers could be asked to cut out material from magazines and newspapers which they feel is appropriate in one way or another to their work. For example, one volunteer group started what they called a grab bag. This was simply a bag or box into which the library volunteers (and any other interested volunteers) put clippings from newspapers and magazines which had to do with mental health. It could be an editorial, a statistic, a letter to the editor or something else. It proved popular with volunteers who liked to reach in and pull out a brief clipping to read
while at their headquarters. The library project should be the responsibility of the volunteers, not the Co-ordinator.

The Co-ordinator could take responsibility however, for compiling a policy manual including minutes of Volunteer Service Committee meetings which would be available at the volunteer's room for reference and study. The programme is increasing rapidly and a proper policy manual along with individual records is essential to its smooth functioning.

Volunteers and Social Service

To date the services of volunteers have not been utilized by Social Service to any great extent, although the department's administration does recognize the value of their services to the Hospital. Supervisory staff see certain areas where volunteers could be of real assistance to social workers.

One area of service would be to act as an escort, or chaperone. The Mental Hospitals Act of British Columbia states that patients if required to go off the hospital grounds with a staff person may do so only if that person is of the same sex. The problem this brings up is that a male social worker, for example, is definitely hampered when working with a female patient. This may be particularly true if the patient has been hospitalized for some time, and the matter of facing the community is quite frightening. Planned outings and ego supportive casework may be indicated at the same time. A female volunteer acting as escort would meet the requirements of the Act.

A second area would seem to be that of friendly visiting with patients on the ward. This of course is being done at present but with selected volunteers attached to the Social
Service Department more purposeful use could be made of this visiting. That is, where a social worker is working with a patient the volunteer's visiting experience can be used to keep the worker in closer touch with the patient's moods, and to utilize conversation content to therapeutic ends.

A third and related area of help might be termed a "discharge holding contact." For example, a social worker may work out a discharge plan with the patient which is approved but which cannot be effected for perhaps a month's time. This may have to do with a job that will not be available until then, an accommodation problem, or some other matter. The social worker's main purpose may have been accomplished and in terms of work priority he or she should be moving to another case. Through utilizing the services of the volunteer to maintain contact with the patient during this waiting period, the worker is free to concentrate on another case, knowing that regularly scheduled, brief discussions with the volunteer will keep him up to date as to whether the patient has questions to discuss, is expressing concern, and so on.

A fourth area where the volunteer could assist is at the admitting section. Social Service endeavours to interview a relative or person accompanying the patient at admission in order to begin their study of the patient in his home situation. Quite often the intake social worker will be interviewing when a new patient arrives. The natural desire of a new patient and relative is to be told about the hospital, and in general what happens. The selected and experienced volunteer, who should be given some specific training in this area, will be able to provide this information and allay some of the patient's and relative's fears
which may be due to misconceptions of one kind or another. The Third Report of the World Health Organization's Expert Committee on Mental Health describes a similar type of role. They are speaking of a staff person who is chosen to receive a new patient into the hospital group, but the situation is similar enough to warrant comparison. "Such a role should be undertaken by a woman with a capacity for social contacts, and with the personal qualities of sensitivity, intelligence, and an attractive personality. These qualities are more important than any theoretical training she may have had."

There has been only brief volunteer-social service collaboration on cases to date but it seems entirely feasible that this be much more extensive. However, it should be on a gradual basis to ensure optimum working arrangements between volunteers and social workers. In addition, it would seem desirable that those volunteers selected to work with social service be attached to that department.

**Implication for Further Study**

There would seem to be a case for further study of this volunteer programme in relation to categories of illness. For example, there are no volunteers on the word for mental defectives. One reason given for this is that there is a lack of volunteers to meet total programme needs. A second, and supporting reason given, is that nothing can be done for the defectives, so that time is better spend elsewhere. Other reasons may be that volunteers are discouraged at the lack of results, or they may feel personal discomfort over the type of patient, or they may feel a lack of direction.
It would be interesting to try and set out the criteria for one ward being chosen over another because that is what is happening. There may be a case for a survey to be done of the defectives' ward, following which a volunteer team would work on the ward once a week for, say, six months to see what patient and staff response there might be.

Volunteers and Community Enlightenment

The contribution of services by the volunteers to the hospital is very helpful and valuable as revealed in their daily activities with the patients on the wards and other areas. Possibly their greatest contribution however, is in helping their family, their friends, their neighbours, their communities, to gain a better understanding of mental illness and what the personnel of the Mental Health Services are trying to do for the mentally ill person.

Only through greater understanding of mental illness will fear of it be overcome. The mentally ill man, woman, or child quite often behaves strangely, reacts unpredictably, and often inspires fear in the bystander, neighbour, or even loved one. In some cases, certainly, there is fear resulting from real danger of physical violence, but probably in most cases it is the fear of the unknown.

Through the centuries the mentally ill person has been regarded in various ways. He has been considered as being of a divine nature and as such was respected but the respect was born out of fear. On the other hand, he has been regarded as a demon, possessed by an evil power, and either driven away
or killed. While this may seem (and was) drastic it did mark the beginning of a therapeutic attitude because the aim of the ill-treatment was to expel the evil spirit rather than to cause suffering to the person unfortunate enough to be possess by it. Still later, although feared, the mentally ill person became an object of pity but nevertheless different in nature from other human beings, requiring that he be locked up. This was to protect him from himself but also to rid society of his presence.

To-day, thanks to the work of the mental health crusaders of the last hundred years and to such organizations as our own Canadian Mental Health Association, not only is the battle for proper psychiatric treatment for mentally ill citizens being won, but real inroads are being made towards getting community cooperation as well. These advances have led to the mentally ill being considered as sick people capable of being treated and cured. However gratifying this may be the feeling still persists in our minds that only those who are not dangerous and who have a good prognosis are sick; the others are insane.

It is in helping to overcome this distinction, this remaining fear of the insane, that the volunteer can contribute what may be his or her most worthwhile service to the cause of mental health, namely, interpretation to the public.

Effective as highly organized public relations efforts may may be they can be made even more so by the person-to-person contacts of the volunteers.

---

Many articles have been published in recent years about the mentally ill, but very few about what to those of us in hospitals is the most important change for the better in our own case - our friends, the volunteers.

The private world of the mentally sick is only a part-time thing, except with the old style "backwards." What troubles us more than this, which medicines and treatment can remove, is the superstitions ... only with us, we aren't afraid of unusual behavior - we are afraid of other peoples fears of us!

The volunteer has been to the mental hospital, has seen and visited with "insane" people and, presumably, has dispelled his or her own fears about the mentally ill person. In their own way volunteers can interpret clearly and frankly to their neighbour or fellow worker (or whatever the case may be), the facts of the situation as they see it. Perhaps a smoother job of interpretation could be done by a professional person, but there is a real case for the frank, down-to-earth interpretation which the volunteer can give. We are living in a propaganda age, an advertising age, the key note of which is persuasion. In this writer's opinion we have had so much of this that we now tend to look at any "professional" sales "pitch" with reservations which restrict our objectivity. Generally speaking, the volunteer has no axe to grind and is much easier to identify with - being a friend, neighbour, or work-mate - than is a voice on the radio, a stranger on the television screen, or a lecturer on a platform. The volunteer's interpretation of mental illness will go a long way toward substantiating large scale public relations efforts and toward dispelling the remaining fears of the public about mental illness.

---

1 Letter to Editor by a former mentally ill person, Redbook; August, 1957.
In his 1957 annual report, Dr. Arthur Gee, Director of Mental Health Services in British Columbia had this to say about community awareness:

The years following World War II have seen a tremendous development in the psychiatric services of our Province ... probably the greatest single development which has occurred has been the awakening of public interest in matters pertaining to mental health and an increasing awareness of the part which the community can play in maintaining good mental health for its citizens.¹

This "awakening of public interest" has resulted in the formation of the Canadian Mental Health Association's volunteer services to the Provincial Mental Hospital and Crease Clinic. The staff of C.M.H.A.'s British Columbia Division and the volunteers deserve high praise for the excellent programme they are developing. This community volunteer programme has tremendous potential and every effort should be made by management and staff not only to continue its present support and encouragement but to increase activity in this regard. The more effective we are in interpreting the hospital's needs to the volunteers, the more effective they will be as interpreters to the community.

¹British Columbia, Annual Report of the Mental Health Services; Queen's Printers; Victoria, British Columbia; 1957. p. 15.
Appendix A

Canadian Mental Health Association Questionnaire on Hospital Volunteer Training.
HOSPITAL VOLUNTEER TRAINING - PRELIMINARY QUESTIONNAIRE

1. Miss, Mrs., Mr. ____________________________

2. Address ____________________________ Telephone (Home) ____________________________
   ____________________________ ZONE ____ (Business) ____________________________

3. (a) Occupation ____________________________
    (b) Place of employment ____________________________

4. (a) What languages do you speak? ____________________________
    (b) What languages do you read? ____________________________

5. (a) Can you provide your own transportation to and from the hospital? ______
    (b) How many others can you accommodate? ______

6. (a) Have you ever done hospital volunteer work before? ______
    (b) What type? ____________________________ Length of time ____________________________

7. (a) Do you like to read aloud? ____________________________
    (b) With what types of handwork or craftwork are you experienced? ____________________________
    (c) What types of discussion groups, if any, have you conducted? ____________________________
    (d) Have you any library experience? ____________________________
    (e) Have you any teaching experience? ____________________________
    (f) Have you any special hobbies? ____________________________

8. Availability:
   (a) Can you participate throughout the year? ____________________________
   (b) Will you be out of town a certain amount? ____________________________
   (c) Can you serve any day during the week? ____________________________

   Preferences ____________________________
   (d) Can you serve during the - daytime? ____________________________
   - evenings? ____________________________
   (e) How much time can you give - weekly? ____________________________
   - monthly? ____________________________

9. Do you have any preference for working in any one hospital activity? ______
   If so, which? ____________________________

10. Do you know others in this volunteer program with whom you would like to work?
    If so, give their names. ____________________________
### QUESTIONNAIRE

The following Questionnaire is composed of a number of statements - some true and some false. Each statement is followed by the letters "T" and "F". Read each statement carefully. If the statement is true, circle the "T". If the statement is false, circle the "F". Please answer all questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>T</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unusual behaviour and peculiar ideas are always present in all mental patients.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>2. People who like to work around mental patients are usually somewhat mentally queer themselves.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>3. Mental disease is not contagious.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>4. It is very difficult to insult or offend a mental patient.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>5. I have had a nervous disorder.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>6. People who work around mental patients often become ill themselves.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>7. All mental patients are very much alike.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>8. In order to work successfully with mental patients, you should first win their confidence.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>9. Many people feign insanity to receive government support.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>10. Knowledge of mental disease is not harmful to well-adjusted normal people.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>11. I have been under treatment for a nervous condition.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>12. There is much that can be done for mental patients aside from administering to their physical wants and hoping they will get well.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>13. Insults and obscene language are invariably found with mental patients.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>14. Mental patients should be sterilized before being allowed to leave the hospital.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>15. One should pay no attention to requests from mental patients since they do not know what is best for them.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>16. Some mental patients have a real sense of humour.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>17. When dealing with patients in a mental hospital, one should remember that they are different from normal people in their thinking and feeling.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>18. Mental disease is hereditary.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>19. I have been a patient in a mental hospital.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>20. Mental disease is not more definitely prevalent in one race than another.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>21. It is unnecessary to win a mental patient's confidence as he mistrusts everyone anyway.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>22. Most mental patients are curable.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>23. In working with mental patients, a sympathetic attitude is more important than an understanding of their disease.</td>
<td>T</td>
<td>F</td>
</tr>
</tbody>
</table>
24. Most mental patients are homicidal. T F
25. Punishment often convinces a patient that he should behave more normally. T F
26. I have changed jobs frequently because of physical or mental ailments. T F
27. Wealthy people very seldom have mental illness. T F
28. "Everybody is a little crazy" at times, and all of us have had serious doubts about our sanity at one time or another. T F
29. Most mental patients appreciate favours that you do for them. T F
30. All mental patients like to be by themselves and resent interruptions and intrusions from outsiders. T F
31. I am subject to frequent blue spells or sick headaches. T F
32. You can usually tell whether a man is insane by the look in his eyes? T F
33. Mental patients are really sick like other patients in other hospitals. T F
34. The actions and speech of most mental patients are revolting and disgusting to a person of fine breeding. T F
35. Once a person has been mentally ill, he can never lead a completely normal existence again. T F
36. I consider myself a rather high-strung person. T F
37. Some mental patients do not require kindness and consideration. T F
38. Most mental patients come from the slums. T F
39. Mental patients need more punishment and criticism than normal people because they do not understand what they are doing. T F
40. I often complain of various physical ailments. T F
41. Demanding mental patients should be ignored. T F
42. People who lead immoral lives often go insane as a result. T F
43. Mental patients have feelings and emotions like other people do. T F
44. Many insane people are really criminals and are not sick. T F
45. People consider me a healthy, well-rounded person. T F

Thank you for your good will in answering this questionnaire. It is our desire to protect potential volunteers from assignments which may prove detrimental to them. Without the volunteer's co-operation in answering all of the above items truthfully, that would be impossible.
Appendix B

Questionnaire for purpose of gathering information about the Volunteer Programme.
The purpose of this Questionnaire is to assist in the gathering of information about a Volunteer Programme.

Special Skills and Education of Volunteer:

<table>
<thead>
<tr>
<th>Skill</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology Course</td>
<td>11</td>
</tr>
<tr>
<td>Sociology Course</td>
<td>4</td>
</tr>
<tr>
<td>Arts &amp; Crafts</td>
<td>15</td>
</tr>
<tr>
<td>Physical Education</td>
<td>5</td>
</tr>
<tr>
<td>Music</td>
<td>13</td>
</tr>
<tr>
<td>Drama</td>
<td>3</td>
</tr>
<tr>
<td>Language (specify)</td>
<td>5</td>
</tr>
<tr>
<td>Other Specialties</td>
<td>15</td>
</tr>
<tr>
<td>No Specialty</td>
<td>46</td>
</tr>
</tbody>
</table>

AGE range of Volunteers:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 years and under</td>
<td>5</td>
</tr>
<tr>
<td>21 - 30 years</td>
<td>1</td>
</tr>
<tr>
<td>31 - 40 years</td>
<td>20</td>
</tr>
<tr>
<td>41 - 50 years</td>
<td>35</td>
</tr>
<tr>
<td>51 - 60 years</td>
<td>20</td>
</tr>
<tr>
<td>Over 60 years</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>89</td>
</tr>
</tbody>
</table>

HOW did you hear of the Volunteer Programme?

<table>
<thead>
<tr>
<th>Source</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>10</td>
</tr>
<tr>
<td>Television</td>
<td>3</td>
</tr>
<tr>
<td>Newspaper</td>
<td>15</td>
</tr>
<tr>
<td>Hospital staff</td>
<td>2</td>
</tr>
<tr>
<td>Other Volunteer</td>
<td>37</td>
</tr>
<tr>
<td>Volunteer Bureau</td>
<td>5</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
</tr>
<tr>
<td>Ex-patients</td>
<td>1</td>
</tr>
<tr>
<td>Community Groups (specify)</td>
<td>16</td>
</tr>
<tr>
<td>Other source (specify)</td>
<td>6</td>
</tr>
</tbody>
</table>

DISTANCE travelled from Home to Hospital: average 17 miles approx.

TIME spent in travelling from Home to Hospital: average 40 minutes

NAME
Appendix C.

Bibliography

General References

Beers, Clifford, A Mind That Found Itself; Doubleday; New York; 1948.


British Columbia, Annual Report of the Mental Health Services; Queen's Printers; Victoria, B.C. 1957.


Canadian Mental Health Association, British Columbia Division, Annual Report. 1957.


Greenblatt, Milton, Mental Hospitals; From Custodial to Therapeutic Care; Russell Sage Foundation; New York; 1955.


Richmond, Mary, The Long View; Russell Sage Foundation; New York; 1930.


von Mering, Otto, and King, Stanley, Remotivating the Mental Patient; Russell Sage Foundation; New York; 1957.

Specific References

Collins, Marjorie A. "The Volunteers Role in Rendering Service to Individuals", Casework Papers 1957, Family Service Association of America; New York; 1957.

Evans, Ruth L., "Volunteers in Mental Hospitals" Mental Hygiene, volume 39, 1955.


Frank, Marjorie, "Volunteers in Mental Hospitals", Mental Hygiene, volume 32, 1948.


Handbook for Volunteers, Canadian Mental Health Association, British Columbia Division.


Kimball, Joy, Guide for Organization of Volunteer Service in Mental Hospitals; Massachusetts Association for Mental Health, Inc.


Notes on Volunteer Work in Mental Hospitals, Canadian Mental Health Association, Toronto, Ontario, 1956.

Ridgeway, Elizabeth, "The Volunteer Program at Delaware State Mental Hospital", Journal of Occupational Therapy, volume 5, 1951.

Selman, Laura, "Volunteers in a Mental Hospital", Canadian Welfare, December 15, 1956.

Sharp, Agnes A., How Volunteers Work in State Hospitals; Department of Public Welfare; 1953.

