Volunteers in Hospitals

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Volunteers in Hospitals

– a guide for organisers

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Introduction

These papers are offered as a companion volume to *Organisers of Voluntary Services in Hospitals* by Jan Rocha, published by King Edward's Hospital Fund for London in 1968.[47] They were written in an attempt to help people appointed to the comparatively new post of organiser of voluntary help in the hospital service, and are directed particularly to those with little or no experience of the hospital world. It is also hoped that all staff, particularly nurses and administrators in hospitals which have or are planning to have a voluntary help organiser, will find the papers helpful.

It is important to get voluntary help into perspective. It is nothing new. In one form or another voluntary help has been with us for years and there is now a nation-wide growth in voluntary help in all areas of community life. Apart from the long-standing and immensely valuable work done by organisations such as the British Red Cross Society, St John Ambulance Brigade, Women's Royal Voluntary Service, women's institutes, rotary clubs, leagues of hospital friends, townswomen's guilds and so on, volunteers are being used to an increasing extent by local authorities to help a wide range of people, young and old, mentally sick or physically sick. Examples include the involvement of volunteers in caring for the elderly in Birmingham and Glasgow, the widespread use of volunteers in Croydon[43], the Social Responsibility Centre in Walthamstow[42], which has coordinated the efforts of all religious congregations in the area, and the increasing involvement of schoolchildren and young volunteers throughout the country.

In the past, all voluntary organisations in hospital worked through the matron or another senior hospital officer. These officers came to realise that they had neither the time nor skills needed to make full use of volunteers, that they really needed help to organise voluntary work. And it is as a direct result of this recognition by the professionals in hospitals that the appointment of so many organisers has come about.

This growth is taking place against a background of official recognition that people in the community must play a fuller part if the statutory services are to cope at all. The time has gone when people believed that the State could provide all. What is needed now and in the future is increasing voluntary effort.

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1 Basic Considerations

Some Implications in Appointing an Organiser

Jan Rocha

Chapter One

OTHER CHAPTERS DEAL VERY THOROUGHLY WITH THE PRACTICAL ASPECTS of the organiser's work. The move to appoint organisers has gathered momentum and, like a rolling snowball, there is danger that its direction can be lost. It might be a good idea first to pause for a moment and consider some of the implications of such an appointment.

To begin with, there are widely different interpretations of the organiser's role.

'The four most frequent ways of regarding a voluntary help scheme are:

> the provision of workers to fill gaps in the hospital's services with a minimum outlay of time and effort on the part of the staff;
>
> as a fashionable means of enhancing a hospital's public relations image for the benefit of the public;
>
> as a means of providing the "personal touch", a more satisfactory service to patients by people with time to spare;
>
> as a deliberate means of drawing the hospital into the community and the community into the hospital, breaking down still further the hospital's isolation and aloofness from the community, particularly in the case of mental hospitals.

'The first two can provide a service which in the short term does a lot of very useful work and will achieve their objectives. But long-term problems will be created and the scheme might then become the means of creating bad relationships in many other sectors, inside and outside the hospital. The third way will provide a service beneficial to hospital, patients and staff, as long as no problems arise and the volunteers are content to do undemanding work with little or no responsibility. The fourth way involves replacing the professional mystique of knowledge, and the layman's uncertainty and apprehension, with a working partnership as an expression of real community care.'[47]

But what does 'real community care' mean? It is participation, knowledge and responsibility.

The appointment of an organiser is not in itself a solution. It should not be a grudging admittance by the hospital of the community's *desire* to participate, but a welcome recognition of its *right*. Ultimately,

the hospital belongs to the community, its patients are members of the community and so are its staff. The division of 'us' and 'them' is superfluous and unreal.

This recognition must mean that the era of splendid isolation is over. Why should a hospital be able to refuse access to the local community? How can community care flourish, or even exist, if the community is not allowed to care or to know about what goes on inside the hospital? This is particularly true of psychiatric hospitals and hospitals for the mentally handicapped. Why do we criticise the residents of quiet streets who refuse to allow half-way houses and hostels, but not the hospital which refuses to allow volunteers? The hospital's isolation and its rejection of the community feed public ignorance, apathy and fear. The 'open door' policy has been successful with patients. Now it must surely be extended to the rest of the community. Community care, to be effective, must be allowed to begin before the patient gets into hospital and must continue in the ward and on his return home.

From participation comes knowledge. Knowledge of mental illness and mental handicap can mean an end to the prejudice caused by ignorance, and the beginning of support and understanding for the staff and their problems. Mental illness will affect at least one out of every dozen of us during our lives. It is something which concerns all of us, not just an isolated few.

With knowledge there must be responsibility. No longer will it be enough to express shock and indignation when brutality and neglect are revealed. When there is community participation, ignorance of conditions cannot be pleaded. All will be responsible, not just the individuals directly concerned. 'They' can no longer be blamed. Acceptance of responsibility must mean pressure for greater priority for the neglected areas of the health service, mental handicap and mental illness. It could mean a much better hospital service. Why are so many hospitals afraid to try real community cooperation?

The appointment of the organiser to resolve the practical problems of a voluntary help scheme should ideally come when the right mental climate already exists. That is, when the hospital has decided it wants the community to participate, to know and to be responsible and that it is not merely seeking a cheap way of doing the hospital's work, developing a better public relations image, or mobilising a brigade of flower-vase fillers.

The organiser is the small but visible sign of a massive tangled web of

hospital-community relations. Appointed in the right climate he becomes the interpreter between the hospital and the community, two groups who do not always speak the same language, but who have a common objective – mutual aid in improving the well-being of those members of the community who are temporarily or permanently members of the hospital. Hospitals need to have a wider view of their place in and involvement with the community in order to be able to select the right person for the job. In the few years that voluntary help schemes have already been operating, experience has shown that they work well in hospitals which have this wider view. Without it, unsuitable organisers are appointed and the scheme becomes a disaster not only for that hospital, but for the whole voluntary movement. The rise and fall of ill-thought-out schemes can produce a reaction spreading disillusionment to other hospitals. And the community is deprived of its chance – its right – to participate, to know and to be responsible.

Perhaps it would be a good idea for hospitals thinking of appointing organisers to ask themselves a few good questions. Not 'Where will he have his office?' and 'What colour shall we make the uniforms?' but 'Do we think the community has a right to participate?', 'Do we have a right to deprive patients of community involvement?', 'Are we prepared to go into partnership?'.

Not 'Can we afford to have an organiser?' but 'Can we afford *not* to have an organiser?'.

People and Their Needs

David H Clark

Chapter Two

WHY ARE VOLUNTARY HELP SCHEMES DEVELOPING IN BRITAIN IN THE 1970s? Why do hospitals want volunteers? Why do people want to volunteer? Why do many patients welcome volunteers? Why do some staff *not* welcome them?

As soon as we begin to think about these questions we realise that we are entering the field of needs – not the rational, practical ones but the irrational and emotional. Britain's hospitals have never been better equipped to deal with people's manifest, rational needs than they are now. The hospitals are bigger than they have ever been and there are more doctors and nurses working in them, all more highly trained than ever before. Hospitals have more of everything – more staff, more machines, more laundries, kitchens, boiler-houses, computers. They prescribe more drugs, carry out more operations, admit and discharge more patients. The apparent needs of the patients are being met more efficiently than ever they were. So why do we have a rapid increase in voluntary service? It is surely because people's emotional needs are being less well met than they used to be.

First let us clarify what a few of the needs may be. These are tentative formulations because no one knows for certain what needs *are* being met by the rising flood of volunteers. But we can see a few of them. Social scientists have begun to teach us something of the human emotional needs that can be lost among the gleaming metal and plastic tubes of the modern hospital.

The volunteer movement in Britain in the 1960s can be seen as one of a number of movements which sprang up as a human response to, and often as a protest against, the increasing bureaucracy and complexity of modern life. Examples of such movements are the consumer associations, conservation trusts, civic societies, ratepayers' associations, arts laboratories and so on, which emphasise the personal involvement of people in the arrangement of at least part of their lives. People feel lost in a vast, impersonal world. They seem to have lost individual choice and personal contact. They meet functionaries – shopkeepers, porters, officials, traffic wardens – who all say, 'I'm sorry, there's nothing I can do about it, the rules insist'. Most of the time people accept this – and withdraw a little further into themselves. Sometimes they protest, sign petitions, take part in demonstrations. Sometimes they give service, or join a volunteer group.

The volunteer movement seeks to meet two human needs – the need of patients in hospitals for human contact and the need of community members to give altruistic service. This need has always been present

in civilised societies. The extrusion of voluntary help from hospitals in 1948 was an error of judgment based on political preconceptions. Only in the 1960s did we again begin to see how much was being lost. If we try to spell this out we may be able to see why some kinds of voluntary service are more satisfactory than others.

The patient's basic needs

What are the needs of a sick person in hospital? First, there are certain immediate and basic needs which come before everything else. The patient must be fed, kept warm, kept clean and must receive efficient medical care. In Britain today we take these things for granted but we must remember that it takes a lot of effort, a lot of medical and nursing skill, a great deal of money and complex organisation just to ensure that these basic needs are met. If you gather sick people in a place that does not have food, beds, sanitation, nurses, doctors, drugs and operating facilities, their condition rapidly becomes appallingly worse. Organisation of these numerous resources is needed. Conditions of squalor, neglect, death from starvation and infectious diseases are still to be found in so-called 'hospitals' in many parts of the world today – due, largely, to lack of organisation of resources.

We avoid such problems in Britain by spending large amounts of public money on health services. We can now guarantee that no one in hospital suffers from lack of food, bedding, or clothing, that all people get minimal nursing care and that many get a very high level of care indeed. We are immediately indignant when this service fails even in quite a small degree. As we have successfully met the physical needs of the patients, however, we have become more aware of their emotional needs which, at the moment, we do not meet very well. To meet some of these needs is one of the functions of the volunteer.

Short-term and long-term patients

The emotional needs of short-term and long-term patients show certain differences. The majority of people who come into hospitals are short-term patients; they come in acutely ill, suffering, often frightened, sometimes in danger of death. They are often visited regularly by their relatives, friends and workmates and keep a lively contact with their homes to which they soon return. What they need from the institution is immediate response and effective action. What they need from the volunteer is informal, friendly support.

The blessings of regression

What *are* the psychological needs of short-term patients? A most useful key to appreciating such needs is an understanding of regression. As babies we were utterly helpless and dependent and our mothers looked after us. They fed us, gave us the breast and the milk, kept us warm, cleaned us, cared for us, loved us. As we grew older, became stronger and more competent, we walked away from mother. We became responsible adults and moved effectively in the world. But in times of difficulty and despair the warm soft comfort beckons. When we are sick, hurt, wounded or in pain it is good and necessary to slip back – to regress – to the state of dependent infancy. It is good to go into hospital, to lie in bed, to be fed milky good things by a kindly, maternal figure, to have every need met at once. At a time of sickness it is *right* to regress because both our hurt body and frightened mind need to slip back into the childish situation.

The effects of authority

As we grow up we come under the authority of many people – parents, then school teachers, employers and many others. We obey and respect these people, we model ourselves on them and cherish their judgments. We also criticise them and overturn their judgments. Whenever in later life we meet authority figures, women or men, we transfer to them many of our childish feelings of gratitude, rebelliousness or deference. Nurses and doctors are authority figures who arouse many primitive attitudes. The fact that they know the hidden secrets of our bodies makes them even more powerful. So when we become patients we put ourselves in their hands and see them as all-powerful. And they, being only human, respond to this. From our position as patients the nurses seem bountiful but imperious and busy, the doctors knowledgeable but aloof. We feel frightened to ask them questions and are certain that they will be too busy to answer.

We all have fantasies and feelings about nurses and doctors, these beneficient, mysterious, powerful, healing people. We are bitterly disappointed when they are not superhuman; shocked and resentful when they clamour for more pay. All these feelings surge up during a period in hospital. This is why it is so difficult for patients to be 'sensible' or 'reasonable'. This is why they fail to ask questions and then complain that no one told them any answers. This is why they thank the staff effusively and then complain bitterly to their relatives.

Volunteers can have a special part to play in this. They are part of the

hospital – and yet part of the outside world. They know some of the secrets – but they are not committed professionals. The volunteer can be a comrade – a person who will listen to the questions too silly to bother a nurse with. The volunteer can explain some of the rules – and even how to get round some of them. The volunteer can be a 'befriender'. The amateurishness of the volunteer may in itself sometimes be a reassurance to the patient that here is someone fallible and human.

Needs of long-term patients

These are people who are spending a substantial part of their lives – months and even years – in institutions dominated by health professionals. There are several groups of people in this situation. People suffering from severe mental disorder, notably schizophrenia, may spend many years in a psychiatric hospital which is often a vast, dreary Victorian institution marooned in the countryside, although, thanks to modern methods of rehabilitation, the number of these people is not so great as it was in the 1950s. Elderly people without homes, some confused and many physically enfeebled, are in geriatric hospitals, mostly old Victorian poorhouses, patchily renovated. The number of old people is increasing. The mentally handicapped are found in rather newer buildings but also isolated in the country. This group is changing; the sturdy feeble-minded are fewer but the number of crippled, helpless and severely subnormal children is rising while the staff numbers decrease. There is also a small, tragic group of young chronic sick – people in early adult life so severely crippled by disease that they cannot live outside hospital – people with multiple sclerosis, brain damage following road accidents and other miscellaneous relics of medical resuscitative zeal. All these people are too damaged to maintain independent life. They have to be in hospitals which, to be fair, do a brilliant job in keeping them alive. Unfortunately, keeping them alive often unwittingly cripples them socially. Doctors and nurses are so conditioned to remove others' independence that they do it to *everybody* – though they should do it only to the sick. For the acutely sick person racked with pain, intoxicated by fevers or fuddled by drugs, dependence on the staff is necessary and good. This training, however, is so ingrained in doctors and nurses that they go on doing it to anyone who remains in their care. Patients in long-stay institutions are treated as irresponsible children, constantly instructed what to do and when, hedged in by petty regulations and protected from innumerable common risks. As a result they gradually become like children – dependent, frightened, out of touch with the outside world. Many welcome this state of perpetual, irresponsible childhood; those

who do not conform come under much pressure. This process probably reached its climax in the TB sanatoria of the first half of this century – a bizarre world described by many writers but best of all by Thomas Mann in *The Magic Mountain*.[32]

These tendencies towards social crippling become worse if the institution is short of money or staff. Food is slop, furniture is massive, walls are dull brown, personal belongings are forbidden, everything is scrubbed and bare. In such institutions people lose what few social attributes they had and become dulled, withdrawn beings. Subnormal children become absorbed in repetitive rituals like head banging. The staff can only concentrate on cleanliness, getting food into the patients, changing beds, clearing away faeces and urine. They cannot do more. So clothes become communal – picked from a heap dumped on the floor. Days are empty, idle and pointless. Old people are left sitting in chairs or lying in beds because no one has time to move them.

How volunteers can help

Volunteers can meet some of the needs of long-term patients very well – often better than the institution's professionals – simply because they do not accept the dull, grey life as the only reality and because they are part of the greater world. Volunteers can give individual attention and personal contact. They can assist at different levels. They can help and relieve the staff with the jobs already being tackled – bed making, bathing, feeding, serving meals, clearing laundry and so on. They can help the staff to do the extra jobs for which there is seldom time – reading, writing letters, tidying and sorting personal belongings, playing, planning and organising outings and excursions. They may be able to supply specialist help or instruction – in Braille, in languages, in piano playing – all things which many of the staff could not do, even if they had the time. In all this, they are not so much helping with the necessary tasks of the institution as adding an extra and necessary dimension to the treatment programme and allowing the patients to retain and develop individuality and social skills that would otherwise wither away.

These are some of the needs of the people in institutions which volunteers can begin to meet. But it must be remembered that human needs are complex. All people wish, some of the time, to be dependent and irresponsible. Some patients will resist a change in their lives. Many people, certainly most health professionals – and some volunteers – enjoy making people dependent on them. There is a resistance to newcomers. Some staff may even take a perverse delight in their

continual battle against impoverishment and social ostracism and resent those who penetrate their little world. Jan de Hartog's *The Hospital*[8] describes how the staff of a grossly impoverished hospital in Houston, Texas, resented and thwarted the attempts of some Quakers to penetrate the hospital as volunteers.

Volunteers and their organisers will find people who welcome their advent and others who look at them askance. As their work develops some will delight in it and some will be hesitant and reserved. If they work with skill and sensitivity, however, volunteers will find that they get much joy from giving pleasure, that they may relieve some of the pains and terrors of being a short-term patient and may even help a few to break out of the grey hopelessness of the life of the long-term patient. These captives of the healing professions have many social needs. They need material things – personal belongings, delicacies, special goods, and they need human contact and personal interests. They need challenge and chance for initiative. Above all, they need contact with the changing outside world.

The Role of the Organiser

Chrystal King

Chapter Three

IT IS IMPORTANT THAT THOSE TAKING UP THE POST OF VOLUNTARY HELP organiser should appreciate the complexities of the service they are joining. It is rated high in the league of big employers in this country, and in annual turnover is almost the largest. It has to face all the problems of management inherent in an organisation of this size and in addition has the responsibility of providing services of an intensely personal and often frightening nature.

This responsibility introduces a special element into the management of the service. It leads to all kinds of pressures, emotional, technical, economic and political, which pose tremendous problems for all those charged with the duty of providing an efficient and adequate service for the sick and handicapped.

It is vital that voluntary help organisers should not only acquaint themselves with the structure of the health service, but that they should also be aware of the complex attitudes of the numerous professions involved. When the care of a patient was only the responsibility of his family, the physician and the nurse, all authority lay with the physician. Today, full patient care involves the skills of a seemingly endless number of different professionals, of which the physician and the nurse are only two.

Inevitably, jealousies and frictions arise and the organiser must not only be aware of their existence, but must try to understand their origins. The use of volunteers is seen very often as a threat to professionals whose whole training has been directed towards accepting entire responsibility for their patients. The report of the Aves Committee, *The Voluntary Worker in the Social Services* [38], emphasises the need for organisation, management and support if volunteers and professionals are to work usefully together. The voluntary organisations most closely connected with the hospital service have long recognised this and most now appoint a member of their staff to ease the contact between the hospital and their organisation.

With the increasing awareness of the value of more community involvement in the health service, hospitals themselves are appreciating the need for a member of the staff with interest in and specialist knowledge of voluntary help to initiate and coordinate the help of the local community. Voluntary help schemes with full-time organisers paid by the hospital are now to be found in general hospitals, hospitals for sick children, for the mentally ill, the mentally handicapped, long-stay patients and old people. Not so many voluntary help schemes run by paid organisers are found in the community, but it is likely that the

number will increase, as the social work services reorganise according to the recommendations of the Seebohm report.[17] The future will see a considerable increase in the number of voluntary help schemes both in hospitals and in the community, probably with interchange and joint appointments, as the unification of the health services proceeds. It is against this rapidly changing background that the role of the organiser must be studied. It is difficult to describe, even more difficult to put into practice.

The overriding aim of *any* voluntary help scheme was well summed up in the report of a weekend seminar in October 1968 of the Standing Conference of Voluntary Help Organisers, 'We aim as paid voluntary help organisers to assist in the healing of patients'.* But putting this simple aim into practice is not easy. Voluntary help schemes will vary from hospital to hospital and between hospitals and the community. Different approaches, different organisation, different plans will be needed. The use, training and support of volunteers in a large, busy teaching hospital will be very different from that needed in a hospital for the mentally handicapped or in a community based scheme.

There are, however, certain basic guide lines for the organiser which apply no matter where the service is based or whom it serves. It is from these that the role of the organiser emerges.

Defining a scheme

For a scheme to stand the first chance of success, the objectives must be defined and time must be spent on this. Furthermore, the objectives must be defined as they affect the three main groups of people; patients, volunteers and staff.

'To assist in the healing of patients' – this is the cardinal aim. From this premise, all else follows. Patients, all patients, need human contact. They also need challenge and chance for initiative. They need to be helped to overcome the effects of living in large institutions. 'Institutionalisation'[5] can affect patients in general hospitals just as much as those in hospitals for the mentally ill or handicapped.

Perhaps the simplest, most obvious way of assisting in the healing of patients is to provide human contact which is not professional: to be a person who can be unhurried, relaxed and personally friendly with patients who may feel strange in a situation which grows increasingly

* *See Appendix B.*

technical, efficient and seems impersonal despite the best efforts of the staff. Such personal contact can vary greatly. It may involve nothing more than a simple chat; it may mean reading or writing letters for patients, working as a friendly receptionist or guide in a busy out-patient department, regular visits to lonely old people at home, or caring for pets or possessions that otherwise would be neglected. Above all, to the patient these things mean that he still matters as an individual and that someone cares enough to give up time freely and regularly to offer help.

Volunteers

Volunteers need help to develop their caring skills and the role of the organiser in this respect is that of administration, of enabling. The organiser must ensure that volunteers 'are as efficient as possible in the work they do, work harmoniously with the paid staff, are happy and achieve job satisfaction in their work'.* This demands flexible managerial skills. It demands that the organiser takes into account the help already available to the hospital from the national and well-known voluntary organisations and long established local ones. It also demands the ability to place people where they will do the most good, to move them when they have outgrown certain jobs and to recognise, in time, when they need a change of scene or job.

Staff

More than anyone else the staff can make or break any scheme of volunteer help. For a scheme to be successful, the staff must be aware of what it is trying to do, shown that it can be effective, that it can enhance rather than diminish their own roles, that it really can improve patient care and that the patients can be better for it. It can help the staff to overcome some of the defects of working in a large institution. It can let light into the scene, bring fresh air into dusty corners and, inevitably, bring some frank criticism of long accepted practices. In the long term this can do nothing but good. But the organiser must also realise that a voluntary help scheme will affect the staff. In the short term it may prove deeply unsettling to staff and the organiser must develop relationships with the staff which are effective enough to cope with such problems. Above all, staff must be clear about the responsibilities of the organiser.

It is probably true to say that a successful scheme depends upon the

* *See Appendix B.*

staff's understanding and support of it, and upon the way the staff use voluntary help to meet their needs quickly and efficiently. To achieve this the organiser must be fully aware of the work carried out in the wards and departments of the hospital and of the structure of the organisation, particularly the nursing administration which is presently undergoing radical change since the implementation of proposals in the Salmon report.[22] It is also important to understand something of the personalities of those who work there, their purposes, interests, attitudes, needs and relationships with other wards and departments. Once this kind of understanding is achieved it is possible to discuss with the staff what potential roles they consider volunteers could usefully perform and to involve the staff in the planning and development of the voluntary help schemes. This is a selling exercise.

Like all selling exercises it will be wasted if the goods are not delivered. It is here that the organiser must use the management skills of personnel selection, of placing people in the jobs for which they are best suited, of ensuring that volunteers understand the need for reliability, of explaining to them the policy and needs of the hospital or organisation. The organiser must support the volunteers, study their work and their progress in order to make sure that they receive recognition for their services and increasing responsibilities, and promotion where appropriate.

In defining the needs of the hospital the organiser becomes identified with the staff; in meeting those needs he becomes identified with the volunteers. In maintaining the scheme the organiser becomes a mediator who interprets the staff's needs to the volunteers and the volunteers' needs to the staff. He must also be something of a troubleshooter. It is vital at all stages of the scheme, once the initial preparation and recruitment have been done, to ensure that the staff make appropriate use of the volunteers' services and treat them as members of the working team. This can only be achieved if staff are helped to identify and define their need for volunteers. And, in turn, staff will only feel able to do this if they are sure the voluntary workers are not a threat.

As well as regular contact with staff in the various wards and departments, one of the best ways to achieve understanding and mutual appreciation is for the organiser to hold regular feedback meetings for small groups of volunteers and staff, in which problems can be discussed. No matter what form the meetings take or who is involved, the organiser must ensure that all kinds and grades of staff are involved at some stage.

People outside

There is another relationship that the organiser must develop and maintain. That is with people outside the hospital. This has a twofold aim:

to recruit a steady flow of volunteers, whether through existing organisations or as individuals
to create a greater understanding between the hospital and the local community

Recruiting cannot succeed if understanding is lacking. Recruitment of volunteers involves talks to interested groups, write-ups in the local press, 'mail shots' through the letter-boxes. Recruitment must be continuous because, for many reasons, a constant flow of volunteers is needed to keep the service at optimum level and to allow for changes and expansion. If the hospital or the hospital group has its own public relations department (and few, unfortunately, have) the organiser can develop close working links with it.

The role of the organiser is one of communication and coordination. The organiser has to work with staff at all levels in the hospital and with the voluntary organisations already operating there. He has to recruit, select, prepare, place and follow up every individual volunteer taken into the scheme. Care in selecting and preparing volunteers is essential. Placement involves taking time to get to know the staff, and what they need, as well as the volunteers. Regular checks have to be made to see how every placement is going. Sometimes a task comes to an end or is changed and the staff may be too busy to let the organiser know. The volunteer may begin to find the job unsatisfactory or too demanding and may hesitate to approach the organiser, not wanting to seem to be complaining. If the organiser fails to keep a regular check on every placement, volunteers get disheartened and depressed and may even resign because of problems which could have been avoided. Equally, if the organiser does not keep in good touch with current hospital opinion, problems arise that could have been avoided.

The task of the organiser is complex. He has the responsibility of enabling all sections of the community to contribute to the care of its sick members. I am convinced that success lies in the depth of his appreciation of, and concern for, people's needs, whether in receiving or giving help.

2 Practice

Recruiting, Preparing and Supporting Volunteers

Hilary Webb

Chapter Four

WHEN THE ORGANISER ARRIVES TO TAKE UP HIS POST HE MAY FIND THAT a certain amount of reconnaissance has already been done by a member of the nursing or administrative staff as part of the hospital's preparation for the introduction of a voluntary help scheme. However, the organiser may feel it necessary to undertake his own researches. This will not only help him to get the feel of the place but will also give him an opportunity for getting to know the staff and their reactions to, and understanding of, his role. It will also be his first chance to explain the use of voluntary service to those who may never have thought about it before. Having made some assessment of the hospital's needs it will then be necessary to get to know the local community and its resources so that recruiting can begin. Much will depend upon the kind of district in which the hospital is situated, and it is useful to spend some time in taking a good look at the neighbourhood and seeing what it has to offer.

Sources of help and advice

The organisations which have been involved in voluntary work for many years have a great deal of experience, knowledge and skill to offer and the organiser should seek their advice and help at a very early stage. This is especially important if people from these organisations are already helping in the hospital. Obviously, it is important not to disturb an arrangement which is working well and the other organisations should be reassured on this point from the very beginning. At the same time, they should know the purpose of the appointment and that the organiser is the member of the hospital staff with responsibility for developing voluntary service. If the hospital already has a league of friends, it is important for the organiser to discover from them the kind of help which they are already giving, and to let them know the jobs which the other volunteers are being given to do. Leagues of friends sometimes confine their activities to fund-raising, but often undertake practical work – such as running a shop and taking trolleys round the wards, or making regular visits to lonely patients. The aim of the organiser should always be coordination, not competition.

The local authorities should be able to supply a list of local voluntary societies undertaking social welfare. The list might well include the Rotary Club, Inner Wheel, Women's Institute or Townswomen's Guild, Residents' Association, Mothers' Union and, of course, the churches and chapels. Personal contact with these groups is more effective than a letter. The clergy are almost always helpful and willing to insert a paragraph about the voluntary help scheme in their parish

magazines. Public libraries usually have space for a poster or a large handbill giving brief particulars of what is needed and where to apply.

There may be offices, factories, shops, schools and colleges in the area and these can often provide voluntary helpers. Many of them will not be free to come in the daytime, but they may be able to help in the evenings. An interview with the personnel manager or headmaster followed, if possible, by an article in the house or school magazine, and notices for display can bring useful results.

The editor of the local newspaper will probably want to publish an article about the scheme and it will be worth following up from time to time with further regular information. This will help to reach everyone in the community, including those who do not go out to work or who do not belong to any organisation – the housewives. Though most will have their hands full, there may be some whose children have grown up and who have some leisure to spend. Housewives who have brought up a family can be valuable members of a voluntary help scheme and it is worth making a special effort to recruit them. A handbill setting out what is required can be prepared and pushed through letter-boxes of local houses and flats (perhaps with help from Scouts, Guides or school children), and the results can be most rewarding.

The important point to make, whether one is addressing a society, writing to the press or writing handbills, is that people are wanted, not (for once) to give money, but to give their time, and that it is not necessary to have any specialised training. They are needed for what they are – people of goodwill to be good neighbours to the patients in their local hospital.

Selection

When the first volunteer arrives at the hospital to offer her services, the organiser must be prepared to interview her as an employer would interview a potential candidate for employment. The purpose of the interview is to assess the character and potential of the volunteer in order to determine which part she is best fitted to play, and also to inform her of the kind of help that is needed.

It stands to reason that the scheme will not be successful if the volunteers prove unreliable, so the first point to look for is evidence of dependability. If the volunteer is going to make a useful contribution she must be prepared not only to come punctually and regularly but

to continue for a stated period, at least six months or whatever period the organiser considers necessary. Some people may be carried away by enthusiasm and offer more time than they can reasonably afford. Experience has shown that it is best to start with a small commitment and increase it.

What about her abilities? Some people are good at practical tasks; some will be more at home sitting and chatting with anxious or restless patients. Some may possess special qualifications, the ability to play chess or speak foreign languages. It is as well to discover how squeamish she is, and whether she is likely to faint at the sight of blood. This is not necessarily a drawback, but it may influence her placement!

Motivation

Motivation is important, as this also has a bearing on the volunteer's placement. Loneliness often motivates the volunteer, possibly after the loss of a near relative. The choice of ward or department where she is to work needs to be made with care. Gratitude for personal good health and good fortune is often the motivating factor in young people. Boredom is another. Many people in well-paid jobs, working under good conditions, are bored and feel the need for balance by some form of personal service outside working hours. Such people usually respond well to a demanding situation.

But sometimes people volunteer for what may be unsuitable reasons. They may be overburdened with personal or psychological problems which they hope to forget by absorbing themselves in the lives of others. It may be obvious to the organiser that the benefit will be at the expense of the patient who, as a captive audience, may be unable to escape from a woeful monologue. An ex-patient may see voluntary work as an opportunity of keeping in touch with the medical staff for the next bout of illness. Some are clearly going to put self-interest before service.

The organiser would be well advised not to accept those whose motives appear dubious. It may be necessary to take up references. This is quite in order, but should be done only with the volunteer's consent. Anyone who feels affronted at the suggestion can be reminded that the volunteers play an important part in the life of the hospital, and one must be certain that they are suited to it.

The necessity to turn away a would-be helper is a difficulty which confronts all organisers from time to time. Sometimes there are

obvious practical reasons which the volunteers can understand. Sometimes the organiser has to harden her heart in the interests of the hospital. If at all possible attempts should be made to put the applicant in touch with some other form of voluntary activity which may be more suitable.

At some stage of the interview, the would-be volunteer asks what kind of work is involved and it is worth explaining in some detail what is required. When all the questions have been answered she may be offered an application form, either to take home or to fill in on the spot. It is helpful also to have a booklet or leaflet giving factual information about such matters as car-parking, smoking, meal arrangements, suitable clothes, the desirability of not bringing valuables to the hospital, and where to send messages if prevented from attending.

A pause for reflection on both sides may now be sensible. If the volunteer has doubts about joining the scheme, this is the moment to withdraw. It is obviously better to do so at this stage rather than after joining.

Reception and briefing

Having selected a voluntary helper, the organiser must now consider the list of requests from ward sisters and others and decide on the most suitable placement. It is worth taking time and thought over matching the volunteer to the task. Factors to be borne in mind include the day and time that help is needed, the kind of help required, the type of ward and, of course, the respective characters and temperaments of volunteer and ward sister. The volunteer must be given a clear idea of what she will be expected to do; the ward sister must be clear herself what help she needs and what can be provided.

Assuming that the placement is to be in a ward, it is desirable to arrange the volunteer's first day there when the sister is on duty. Particularly in the early days of a voluntary help scheme, before it becomes well-known in the hospital, the sister, with many cares on her shoulders, may go off duty without telling her deputy that a volunteer is coming. Such omissions are quite unintentional, but a blank expression will be chilling to the would-be helper, and the situation is not improved if she is then left standing in a busy ward while the nurses, not understanding why she is there, ignore her.

The volunteer must be carefully briefed before she starts work. She must be told what kind of ward she will find herself in, the sort of

patients she will meet, what sort of help she will be expected to give, and the significance of the different types of nurses' uniforms. She will need an explanation of ward etiquette, what to do when arriving in the ward, and the different situations that may arise, for example, a death in the ward.

The absolute necessity for discretion must be emphasised. No patient should be discussed outside the hospital. This is particularly important where a patient may be known to the volunteer. From time to time, a patient may confide in the voluntary helper who has had time to sit and chat, and may reveal, in confidence, something which the volunteer feels the sister-in-charge should know. Should she, the volunteer, break the patient's confidence? If some information is given which may have an important bearing on the patient's recovery, the sister should certainly know. If the problem is a social one, the sister will seek help from the medical social worker. But at no time should the volunteer pass on information given in confidence, without first having gained the patient's consent. It is also undesirable for a volunteer to become so involved in a patient's problems that she takes it upon herself to try to solve them without reference to the professional workers. This can lead to the most damaging results to all concerned, the patient, the voluntary helper, the social worker, the nursing staff and the voluntary help scheme.

It will greatly add to the volunteer's confidence if at an early stage in her career she can be given some introduction to ward procedures by a member of the nursing staff. But if this is impossible, it is always useful to place a new volunteer with an experienced one for the first few weeks. It begins things well if the sister can personally greet the new volunteer on her arrival, introduce her to the nurses and patients and show her round the ward, give her a list of what needs to be done and perhaps attach her to a nurse for the morning. The sister should have previously explained to the nurses what part the volunteer can play in the ward, and also have put the domestic staff in the picture.

It is important that the ward staff know that volunteers are not mini-nurses, quasi-domestics or puppet porters. Sufficient care must be taken to ensure that staff do not feel threatened by the presence of volunteers through misunderstanding their role.

Support

Once the volunteer is launched into the ward, it is up to the organiser to ensure that her progress is smooth and that she enjoys coming to

hospital. During the early weeks the organiser should, if possible, see every volunteer each time she comes to the hospital and be available for consultation and advice. Not only will the new volunteer need reassurance but situations can and do change. The ward sister may be away; a senior nurse who has never seen a volunteer before may be imported from another ward to take charge. There may be new nurses on duty. Nursing shifts can alter and result in too many nurses or too few being available. As a result the volunteer may find the jobs she has become accustomed to have already been done, or she may be asked to take on some duty which is beyond her capabilities. The number of patients may also fluctuate, and there may be nothing to do. The ward may be closed for cleaning. The volunteer may have been upset by death or worried by the severe illness of a patient. One of the staff may have been rude or offhand.

The organiser must be aware of all these situations in order to inform or advise the volunteer, smooth difficulties with the staff, or even arrange a transfer to another ward. If the organiser is not regularly available for consultation, the volunteer may become disheartened and, not wishing to come and make a complaint, may leave without saying why. Even when her position is established and she herself is used to the ward, it is desirable to check up from time to time to ensure that all is well. An occasional discussion away from the hospital can be very useful.

The ward sister may also want to consult the organiser. She may feel dissatisfied about her volunteer, or may not understand how much she can ask her to do, and perhaps need help in drawing up a list of duties. But if the selection has been good the volunteer should settle into the ward, and the sister, realising the special help that a lay person can give, will gradually work her into the ward team to the general satisfaction of all concerned.

The Volunteer in the Ward

Norna Jamieson

Chapter Five

A YOUNG NURSE SAID RECENTLY, 'BY THE TIME I HAD CRAWLED ROUND reading all the dials quarter-hourly, I was lucky to have one minute left to take a look at my patient'. Nurses have been known to resign from working in intensive care units because they felt that the patient's human needs were being left unattended and they could not tolerate the situation.

A consultant obstetrician told me he thought there was less successful breast feeding today than there was ten years ago. He attributed this to the fact that some women in the early days of motherhood require the help of a skilled and experienced midwife and, because today there were fewer of these people about, volunteers could help by meeting the simpler needs of patients, thus releasing the midwives to make maximum use of their skills. The volunteer helps to reduce the anxiety of the professional workers and enables them to undertake the more technical aspects of their jobs with greater efficiency.

Talking and listening

Only the most disciplined of professional workers manage to avoid the impression of haste when listening and talking to patients. A nurse who was recently a patient said that she found herself becoming the 'listener' to the other patients in the ward because 'they regarded the sister as being too busy and the nurses as too young'. Some patients are more approachable than others and it is very easy for people – volunteers *and* nurses – to congregate around the bed of a gay extrovert; but it is the withdrawn, the prickly and the disgruntled who are in the greatest need of attention and often the least appreciative of what it is that we have to offer. They are the ones who challenge the skill of nurses and volunteers and we must not neglect them. It is only by patient attentiveness, generosity and imagination that their hostility and isolation can be reduced. Many patients, like children, require time to become accustomed to those caring for them.

Relatives and friends often need encouragement and support as much as the patients. A friendly word with them is nearly always appreciated. These friendly contacts often give a fuller understanding of the patient's background and feelings which can help towards recovery. It is his life and we all have to be careful not to impose ideas from our own lives which have, after all, been quite differently conditioned.

Patients frequently direct the most difficult questions to the least qualified member of the ward team. Volunteers can always plead ignorance but this will seldom bring much comfort to the patients.

However, returning the question to the patient quite often helps him or her to bring out particular anxieties and this, in itself, brings some relief. Nothing, however, should be done to undermine a patient's confidence in the doctor. It is the doctor who has to decide what the patient is told about his condition. The patient must always be told the truth but it is for the doctor to decide how much and when. He takes his decision according to his understanding of the needs of the patient and not according to the principles of those looking after him. People caring for a patient must always bolster his faith in his doctor and if a patient makes a derogatory comment about his doctor (for example, about his failure to appear when expected) it is always more helpful to suggest what might have delayed him rather than to add fuel to the fires of indignation. Again, a mere readiness to listen will help to allay the hurt.

Questions of confidence

Talking or, better still, listening to patients are two of the volunteer's most valuable tasks. The ability can be cultivated and those who really find themselves able to get alongside the patient will know that they must hold all personal information entrusted to them in confidence. Some of the information, with the patient's permission, may have to be passed on to the doctor, social worker or the nurse-in-charge, but must never otherwise be discussed.*

A doctor owes it to a patient to treat all that has been confided to him in absolute secrecy. Volunteers, too, must remember that it is unethical to discuss patients outside hospital – or even in such places as the hospital dining-room. During their work they may have access to confidential reports and documents which, in the patient's interests, must be treated as such. Employers, relatives, friends, and even neighbours often think they have a right to know personal details about a patient. Such information must not be given without the patient's explicit consent. This does not mean, of course, answering a friend's urgent enquiry with a cold silence. Whenever possible the answer should be individual and reassuring. 'No change' and 'satisfactory' are cold comfort. The enquiry should be relayed to the patient or, if this is not possible at the time, to the nurse-in-charge. In any event, it would be wise to keep the nurse-in-charge fully informed.

* *See also pages 35 and 73.*

Working together

The division of work between volunteers and professionals will depend on those concerned in the situation. The ability and qualifications of volunteers vary as much as those of the trained staff. Some volunteers like to be kept busy the whole time, others are delighted if there is no specific task for them and if they are free to talk to the patients. Some sisters can use any quantity of help, others only require it for certain specific duties. These factors will emerge during the initial survey carried out before the scheme goes into operation. It is worth remembering that the junior and more insecure nurses may have more difficulty in directing the work of the volunteer. People are inclined to think that a young girl in uniform should know all the answers. One young nurse said, 'I was so worried about getting all my own jobs done correctly and on time that to have a volunteer coming and asking me what to do was the last straw'.

Unequal work flow is one of the problems facing all acute hospitals. Emergencies cannot be admitted on a rota basis, although hospitals can prepare for such regular events as Guy Fawkes night. This means that there is seldom exactly the right amount of work to fill the staff's time. The organiser should be aware of this so that questions of what to do during slack periods can be discussed and worked out with the staff.

Volunteers must also expect to have to work themselves into their jobs. Generally speaking, the longer they stay the more varied the tasks they will be given and the more rewarding they will find the work. It is normal to feel strange and useless in a new ward or department. The feeling is hard to bear, but it is shared, even by trained staff. Different areas and different people require a longer or shorter running in period but such a period is inevitable, should be expected, and volunteers will need support from the organiser and from the ward staff if they are not to become discouraged. Frequently, they will find, as many a young nurse has, that patients are their most sympathetic supporters. Once the volunteer has worked her way in, it may well be that she is the one who shows a new nurse around the ward and who is hailed by old patients delighted to see a face they know on returning to the ward.

There are many jobs in hospital which are better done by two people and it is usually quite sufficient if one of the pair has technical expertise. An extra pair of willing hands can make all the difference between a job which is well and comfortably done and one which is distressing to all concerned. A volunteer usually enjoys working with a nurse

because this gives her an opportunity to learn.

What to wear and how to behave

Successful cooperation between professionals and volunteers is easier if volunteers start with some understanding of hospital etiquette and ethics. Patients are a captive audience and it is important that the appearance of the volunteers should be reassuring.

Overalls, if worn, should be fresh, well fitting, well laundered and disinfected after contact with an infectious patient.

Hair should be suitably dressed; even clean hair can pick up germs and the volunteer should choose a neat style which keeps the hair close to the head rather than a style which is loose, flowing or bouffant.

Nails, unless kept level with the finger tips, can easily become offensive weapons.

Flat shoes are essential for comfort and should have rubber heels to reduce noise.

An interest in personal appearance is one of the first signs that a patient is on the road to recovery and volunteers can help by example as well as by more active encouragement.

And because example can be contagious, running in hospital is always avoided except in such emergencies as a patient's collapse, or fire, simply because it always causes alarm. Volunteers, like everyone else, must know exactly what to do in case of fire.

Reliability is a quality that will do much to ensure a volunteer's success. Only after a sister feels that she can fully depend on a volunteer will she be willing to include her in the ward team. In cases of absence, the sister *must* have sufficient warning so that a substitute may be found and so that the patients do not suffer. Trained staff usually report on and off duty and it is helpful if volunteers do the same and do all they can to be punctual. Hospital routine is, of necessity, dominated by the clock.

Emergencies and care of the dying

Most volunteers will very naturally be frightened of being faced with some emergency. In general, their most important role at such times is to comfort and calm other patients, leaving the nurses free to

concentrate on the emergency. The sister, however, will prepare the volunteer for any emergency she may have to cope with on her own. If, for example, a patient has a breathing tube it is usual to teach everyone in the ward what to do if it becomes blocked. This tends to allay everyone's apprehensions.

Many volunteers will never have been in the presence of death. The prospect of caring for the dying or seeing someone die can frequently give rise to anxiety.* Volunteers should be given the opportunity to question the trained staff and to receive the support and information they require. In such a situation, it is very helpful to have trained and untrained staff working together but any signs of stress among volunteers should be noted quickly and alternative employment found if necessary. Every effort should be made to anticipate and avoid such a situation. Volunteers must understand the importance of controlling their facial expression. Any sign of alarm on their part will increase the patient's distress.

As volunteers get to know the areas in which they work they will become familar with routines. Routine is essential in order to get the work done but it can make life deadly dull for all concerned. This is where young volunteers can be such a help. They see life with fresh eyes, act spontaneously and in doing so may quite often get a better response. A fresh approach to familiar situations is one of the most valuable contributions volunteers can make. They should feel free to ask questions but must realise that there are suitable times for this. Many older nurses were trained in a rather rigid and narrow school and their very dependability makes them somewhat resistant to change. They seldom welcome fresh ideas immediately, tending to drop them quietly, but such ideas may be brought up again until they are finally introduced by a triumphant sister who is blissfully unaware of the original author!

Give and take

Harmonious relations between professionals and volunteers are usually readily established and enthusiasm for their work is widespread. We, as nurses, can seldom supply all that we would like – imagination, ingenuity and inspiration are essential for the care of the very sick and the give and take of ideas and information can be very valuable. But as we are all human, volunteers, despite all their good intentions, may occasionally meet with hostility.

* *See also Chapter 11, pages 86–9.*

The reasons for this hostility, which may not be clear to the volunteer – who may feel hurt and rejected by it – are many and varied. 'The hospital is an organism characterised by anxiety', as Revans put it[45], and a great deal of this anxiety impinges directly on to the nurses. They are under pressure of time, pressure caused by suffering and death, pressure caused (according to the stage of training they have reached) by their own lack of knowledge. They are placed under pressure by medical advances, by the increasing number of powerful drugs they have to administer and by the increasing complexity and technicalities of their tasks.

Some nurses may resent the presence of the volunteers who appear to be removing some of the nurse's pleasanter tasks, such as talking to the patients, leaving only the more scientific, technical and impersonal ones. There may also be a feeling that volunteers are a threat to the jobs of the trained staff, that somehow the hospital is getting nursing on the cheap. In hospitals where the voluntary help scheme has been well planned and launched and is properly run, where there is ample scope for discussion and a mutual appraisal of problems, such anxieties can be overcome. But they must be borne in mind by all volunteers and treated with the understanding and sympathy they deserve. A clash of personalities cannot always be forecast and may occur anywhere. Sometimes the trouble can be resolved by the exercise of patience, tolerance and generosity; at other times a change of working area may be the best solution.

Creating conditions likely to promote harmonious relations among all contributing to the patient's welfare is one of the ward sister's most exacting tasks. There is no doubt that friendly give and take between volunteers and nurses can do nothing but good in promoting new ideas, avoiding monotony and giving a really personal service to the patients.

Ways of Using Volunteers in Hospitals

Jean Finzi

Chapter Six

IT IS ESSENTIAL THAT EVERYONE IS CLEAR AT THE OUTSET THAT VOLUNTEERS should never be regarded as cheap labour – available to cover up staff shortages or to do unpopular jobs. Volunteers are never taken on to replace staff. In fact, due to their own paid jobs or family commitments, they could not possibly undertake the full-time service, which is the province of the paid employee.

What voluntary activity provides is a range of important extra services, for which the hospital cannot afford to pay, and which are not strictly essential to its central medical function. To know that people from the community outside care enough to give up their free time and come in to help, can often significantly aid the recovery of patients who may be feeling isolated and alone in the unfamiliar, professional world of the hospital.

Introducing the voluntary help scheme to the hospital

At the very earliest stage in the development of the scheme, the organiser should hold discussions, not only with voluntary organisations already operating in the hospital, but also with trade union representatives and the heads of hospital departments so that the staff can fully understand what the volunteer's role in the hospital really is to be. The scheme's success will depend very largely on the cooperation of the senior hospital staff in getting the right ideas across. In a large hospital, where there is a constant change of personnel, it will help if the organiser can have frequent meetings, not only with senior staff, but also with all levels of nursing staff, either in the classrooms or on the wards.

Type of work done by volunteers

Much of the work for volunteers aged over 21 will be found in the wards. This ward work is mainly done by women, but patients and staff like men volunteers if they are willing to come. In the wards volunteers can concentrate on making the patient's stay in hospital happier. There are innumerable small jobs which can be done by unskilled people, so releasing the professional staff for skilled nursing duties.* Volunteers help to feed patients, they lend a sympathetic ear to the lonely ones who want someone to talk to, they introduce handicrafts to those who badly need diversion, play games with those who are bored, write or read letters for the handicapped, arrange the

* *See Appendix C.*

flowers and help with the manicuring, hairdressing and personal laundry or shopping for those who have no visitors. Ward work may be regarded as somewhat routine after a while, but patients change and the need is always there. However, a sympathetic follow-up by the organiser at the end of each day's work often helps a volunteer to see that what may have seemed to be a waste of time has really been an evening well spent from a patient's point of view.

Apart from ward work, adult volunteers help in many of the clinics and departments such as hæmatology, medical outpatient, pharmacy, central sterile supply and the diet kitchen. They also escort patients around the hospital and to and from their homes or for convalescent holidays. A small team of workers visits chronic sick outpatients or ex-patients in their own homes on a regular long-term basis. Many of these patients are immobile and lonely, and although the welfare services provide many facilities, the regular friendly visitor can often make a great difference to their lives. Medical social workers refer these cases to the organiser, who then takes great care to select the volunteers most suitable for these special tasks. For example, a 22-year-old patient who is a good chess player may prefer to have a game with someone his own age than with a far better player 20 years his senior.

One old man, who had become aggressive to the ward staff and who refused to eat, was, in fact, terribly worried about the welfare of his dog. A sympathetic volunteer, who also liked dogs, was able to make sure the animal was properly cared for, and put the old man's mind at rest. The volunteer then continued his visits after the man went home. A young man of 24, in the intensive care unit following a road accident, had lost all interest in ordinary life. The organiser found a young volunteer who was able to re-awaken his desire to get well and return to the world outside.

Young volunteers in hospital

The scope of work that boys and girls under 18 can be asked to do is inevitably more restricted. In acute general hospitals (except in special cases) people under 18 do not work in wards. There are, however, a great number of other jobs they can do. They can serve on clinics and evening refreshment trolleys, run a flower stall, and help with information and guiding services for patients and visitors. They can also carry out clerical and filing jobs of an occasional nature, help on surveys, escort patients and run errands. The errands include returning broken calipers, collecting and delivering wheelchairs to patients in their own homes, cashing pensions for people in hospital, delivery service to

wards, taking medicines to patients at home, and delivering blood samples to laboratories and other hospitals. They are often asked to go to a patient's home to feed the dog or the budgerigar for a patient who lives alone and is worried about his pet.

Many of the occasional jobs requested by the medical social worker or ward sisters can be tackled by young people, provided the organiser finds out exactly what is involved, and makes certain the young volunteer is not overwhelmed or overtaxed by the idea of the work in hand. Most young people welcome a challenge and can be most resourceful and useful if left to get on with the job with a reasonable briefing. One boy, for instance, was sent off to a patient's home to find his pension book and some personal belongings. On arrival he had to find the estate office and get the key to the old man's room. The volunteer had been informed that the patient had been an emergency admission, but he had no idea that he would find the room in such a bad state. He cleared up the food lying about (the rats had consumed most of it), made the bed, tidied up, found the necessary things, packed them up and brought them to the patient with a full and clear report for the medical social worker on the state of the room.

Another boy, who was a good carpenter, was asked to put up a gadget for a physically handicapped patient. He then thought of something else which would make the patient's life easier, and telephoned for permission to carry out his idea. Small points, but ones which illustrate the ingenuity and resourcefulness of some young people.

In many cases a young person can be a tremendous help visiting other young people in hospital, especially those in for a long time who are too old for the children's wards and too young for the adult wards, and who long to talk or play games with someone their own age. One overweight young man who had to walk to treatment at another unit of the group, far preferred being escorted by boys and girls who could talk football and pop groups to walking with a nurse or member of staff who, anyway, felt that escorting was a waste of professional time.

The best way of getting professional staff in hospitals to accept young volunteers is to introduce a few specially selected ones at first, and let people see what they can do. Although the young may have long hair and petunia pants, outward appearance is not always a true indication of the value of a volunteer.

Learning from the volunteers

Frequent group discussions can be a great help both to volunteers and to the organiser. Volunteers value the chance of talking over the problems they meet with other volunteers and with professional staff. Given the chance they can often present constructive and practical solutions. The organiser can learn a great deal from these discussions, about the atmosphere in the various wards and departments, any instances of friction with staff, or about jobs which have become boring or over-repetitive. It may not occur to an organiser, for instance, that it is difficult for volunteers to make good contact with a patient unless they can do something specifically with or for him. This sort of thing will emerge from a group meeting.

Why do people volunteer?

The desire to give voluntary service is growing, and it is the organiser's responsibility to assess whether each offer of service can be of real value to the hospital. Some people may not be suitable for hospital work, and it is well to discover this early!

The organiser should try to understand what leads people to volunteer. Older people often volunteer because they do not get much personal satisfaction from their daily jobs. Helping in a hospital for a few hours each week can give them a very real reward. Careful placement is important for volunteers of every age, but most of all for those who are in retirement. It means a great deal to them to feel they can still be of use, and their work has to be specially well planned and supervised. Older volunteers, whose pattern of life does not change much, may come to work in the hospital for years on end. They must not be so taken for granted that their needs, perhaps for change and variety, are overlooked.

The young volunteers, on the other hand, may come only for a matter of months, as part of their school curriculum. A minority see voluntary work as a 'soft option' for something they do not like doing, and this is a problem the organiser must deal with firmly. Many, however, come with a genuine desire to help, or else out of healthy curiosity. They may want to see how a hospital is run, or they may even be thinking of working in the health services later on. Yet, whatever benefits or sense of fulfilment the volunteers may gain from an opportunity to give their services, a voluntary help scheme in a hospital should always be run for the principal purpose of serving the hospital and helping to give better care to patients.

When a hospital or any specialised community is prepared to open its doors to volunteers of different age groups and talents, the effect is bound to be far-reaching. It is so often a good plan to let people come and see, and have experiences for themselves. The actual participation by volunteers in services for the sick and handicapped is a good method of enabling more of the community to learn and care about people in hospital.

Detailed Planning

Elizabeth Crawley

Chapter Seven

THIS CHAPTER ATTEMPTS TO LIST IN DETAIL HOW TO BEGIN ORGANISING a voluntary help scheme. When the new organiser arrives she may or may not find that the issues listed below have already been dealt with by the hospital's administrators. They are essential factors in the initiation of a successful scheme, and the organiser must deal with them on arrival if necessary.

1 Staff have been asked to determine whether or not they would welcome volunteers in their wards or departments.

2 Heads of wards and departments have been invited to make lists of work they consider suitable for volunteers.*

3 The league of hospital friends and other voluntary organisations already operating in the hospital have been consulted before the organiser was appointed. (They may be unclear about their future in relation to the organiser.)

4 Discussions with senior staff have been held, and possibly decisions made on practical implications such as office accommodation, secretarial assistance, meals, uniform and so on.

5 Consultations have taken place with trade union representatives. (In any case, it is important to establish quickly, and to maintain, good relations with them.)

The new organiser will need to know the administrative structure of the hospital and who are its senior officers. There will be many routine matters to discuss – for example, how to order stationery and obtain duplicating facilities, how to arrange a good message system ('bleep' and telephone), room for meetings, transport and hospitality amenities. Normally, the senior administrator is the first person to go to for guidance in these matters.

The organiser's office

A separate office is essential. Unfortunately, there is often no choice about where it should be, but the position is of importance to the character and viability of a scheme. The office needs to be geographically as central as possible, easily accessible and visible to staff and volunteers, so that the scheme becomes an integral part of hospital life.

* *See Appendix C.*

It is important that prospective volunteers coming for interview should not feel isolated in a backwater and that staff can call in to make requests for voluntary help, without having to go out of their way.

If the office cannot be central, it should at least be sited on a route used by hospital staff and easily found by newcomers. There should, of course, be adequate signposting. The office should be big enough for the organiser and an assistant, and for interviews and discussion with groups of volunteers.

Information for volunteers

Volunteers will need concise written information about the hospital and their role in it. The organiser should provide this in some form. It may be an addition to an existing hospital brochure or a separate publication and should include a map of the hospital. Some of the points that volunteers will need to know are listed below.

Overalls

It will be a matter of policy whether or not overalls are necessary and who should pay for them. Overalls, if worn, should be distinctive so that volunteers can be easily identified. Some arrangements must be made for laundering, especially for overalls used by volunteers who come into contact with patients. If hospital staff wear name badges, it is advisable for volunteers to have them also.

Cloakroom and lockers

Volunteers will need somewhere to leave their coats, handbags, and other personal things as it is often inconvenient and unwise to take possessions to the wards or departments.

Meals

Most hospitals allow volunteers to use the canteen on the pay-as-you-eat basis. Free meals are usually only provided for volunteers undertaking a whole day's work. Meals provide a useful opportunity for volunteers to meet staff and each other.

Expenses

Each hospital must make arrangements for paying travelling expenses in accordance with the volunteers' needs. There will be times when it

would be unreasonable to expect, for instance, old-age pensioners or young people to come to the hospital without some reimbursement of fares.

When a volunteer is asked to do any job which involves out-of-pocket expenses above the round fares to and from the hospital, the organiser should arrange reimbursement through the usual channels.

Insurance

The following extract from the companion volume[47] explains the procedure decided by the then Ministry of Health, and still in operation.

> 'The hospital authority is responsible for what goes on in its hospital and should be prepared to define and direct the work of the voluntary workers as necessary and therefore accept liability for the results of their actions within recognised spheres.
>
> 'The arrangements between hospital authorities and voluntary workers or organisations should be so worked out between those concerned, that the limits of their activities are clear and defined. The hospital authority would then, if satisfied that it should properly do so, stand with the voluntary worker in any legal action for loss or damage and reimburse damages that may be awarded as it would towards its own staff.
>
> 'This arrangement does not, of course, mean an automatic indemnity for voluntary helpers in all circumstances against legal action and it is for them, or their organisation, to take any action they think fit by way of insurance for their own protection. It does mean that the Minister (for his agents) carries his own insurance and, as he wishes his agents to do, stands by a voluntary helper in the same way as he would were the voluntary helper a paid member of the staff.'

Volunteers are, therefore, covered as are members of the staff so long as they are doing their appointed tasks which, in turn, means that their tasks must be clearly defined. So far, no case of a volunteer injuring a patient or being injured has been recorded.

Volunteers who use their own cars for bringing patients and relatives to and from the hospital must first inform their insurance companies.

Usually, the companies are prepared to include these passengers in the general cover provided, at no extra charge, but it is essential to make certain that they *are* covered.

Records and office equipment

The hospital administrator will require regular reports on the scheme, not only to know what progress is being made but also to assess whether or not the scheme justifies the salary of the organiser. In an expanding scheme, where extra help may be needed for another unit in the group, the administrator will need to take into consideration the progress records of the existing scheme.

The organiser may find it useful to consult the hospital's supplies officer and medical records officer on obtaining equipment and setting up a filing system. From the outset, a system of compiling detailed statistics should be built into the day-to-day record keeping. This will include:

1 an individual record card for each volunteer showing sources of recruitment, previous experience, present occupation, special skills, formal preparation (if any), placement and date of starting work, holidays, absences and other relevant information

2 ward and department cards or files showing requests received for voluntary help and number of volunteers supplied

3 list of volunteers available in emergencies or able to give help at short notice, together with their addresses and telephone numbers

4 index of volunteers with special skills

5 index of volunteers who have withdrawn from voluntary services, showing the reason for departure and whether a letter of thanks was sent (these need not be kept indefinitely)

6 records of overalls, keys and other hospital property issued to volunteers (if these are arranged by the organiser)

7 annual recruitment and wastage figures showing various sources of recruits and reasons for withdrawal – moving away, illness, leaving school, increased domestic commitments, taking paid work, and so on

8 coloured tags to classify special skills or other information on index cards

Other useful items to have in the office are:

1 wall chart showing daily deployment of volunteers by ward or department

2 notice board with information about hospital activities, social functions, new requests for help, and so on

3 list of current jobs to be filled

4 list of recent recruits showing placements as these are arranged

5 map of area showing public transport, and street index

6 newsletter to help volunteers to keep in touch with hospital affairs and the voluntary help scheme

7 notes on suggested work for volunteers for the use of ward staff

8 a large office diary and message pad

9 leaflets about the scheme and application forms

10 a small library or magazine basket of relevant journals or reprints*

* *See Guide to Reading, pages 90-94.*

3 Special Needs

Old People

Thomas N Rudd

Chapter Eight

THE EMPHASIS NOW BEING PLACED ON THE NEED FOR VOLUNTARY HELP in the community care of old people is the result of changing attitudes towards the whole subject of dependent old age. Twenty years ago, social planners at government level and below believed that the answer lay in institutional care and that the welfare state could provide the necessary services without help from the voluntary agencies. Experience has since taught us that the volume of support required is such that the welfare state cannot supply it and that the attitudes towards the total needs of old age can only with the greatest difficulty be provided within its framework. We have, in fact, come round full-circle to the view that the best place for the ailing dependent old person is his own home, surrounded and assisted by his family with help from neighbours and volunteers, and that the role of the State-run institution, whether hospital or residential home, is largely one of support. Apart from its duty of providing institutional care, and using it correctly, the primary role of the Government is now seen as the provision of good housing for old people, pensions of an adequate level and the efficient home care programme which is necessary to supplement the deficiencies of voluntary effort.

Those in need

In spite of the many and considerable achievements of the welfare state, many old people remain in urgent need of help of various kinds. They do not belong exclusively to any one social class or age group; hardship, unhappily, knows no frontiers. We can, however, recognise certain groups who are likely to be most at risk. These are:

people over 75 years of age

social isolates, including those living alone, whether by choice or compulsion, and who may either accept or reject offers of assistance

the recently bereaved

the physically unsteady who are, for this reason, either house-bound or accident-prone

the mentally confused and the forgetful

These people include not only the most needy, but also those whose needs are multiple. They are the people who are least in touch with their fellows, least able to help themselves, least able to use public transport and, therefore, unable to maintain outside contacts. They are

also the people most liable to malnutrition and to deficiency diseases.

The value of voluntary work among old people can be measured by assessing the proportion of time and effort devoted to people in the vulnerable groups. Unfortunately, there is the built-in difficulty that people whose needs are greatest and most urgent are also the hardest to discover and the most difficult to help. This must not allow us to seek the easy way out by diverting our attention away from the needs of the 'difficult' cases which most require our assistance.

Acceptance and compassion

Success in helping old people depends much on the kind of approach. The correct attitude of the helper, professional or voluntary, towards the client depends primarily on an acceptance of old age as an inevitable and, indeed, essential stage of life, with its own assets to counterbalance its obvious deficits. Old age has a valuable contribution to make to the common good. With this realisation must go a compassion for old people themselves. A feeling of identity between helper and helped is a corrective to the mental attitude which produces an artificial division into 'them' and 'us', an attitude which continues to bedevil human relations in old age. An understanding of our own psychological needs helps us to appreciate our common humanity and to realise that the needs of people of all ages, as well as those of minority groups, are basically the same. Indeed, in coming forward to help, the volunteer may even be declaring his own need for finding satisfactions in life and identity with the community: a feeling which, if recognised, does not necessarily lessen the value of the helper's contribution. The very old, just like ourselves, need respect for their personality, shown outwardly in our way of addressing them and inwardly by our appreciation of their past achievements and present needs. Like all other people, they have the right of security of tenure, so far as it can be applied to their state, and may justly resent attempts of others to arrange their lives for them without consultation. They have the right to choose their friends and not merely to accept or reject those whom their families or helpers wish to thrust on them. They have the right of privacy, so often denied to them in the overcrowded and sometimes inhumane conditions of institutional life. They have the right, too, to be retrained in independent living, whenever they have suffered disability either from illness or accident, so that in their future life they will be able to make the best of their restricted strength. Finally, they have the right, even when confined to home or hospital, of being kept closely in touch with the exciting world around them.

Pressures on staff

It is at this point that the philosophy of long-term institutional care, as held until recent years, breaks down. The full-time worker, whether professionally trained or not, is always in short supply, generally over-pressed and, like Martha in the Bible 'cumbered with much serving'. The time available is just not sufficient to provide all the personal approaches and attention to detail on which an old person's happiness may depend. This commonly results in physical needs such as food, cleanliness and toilet occupying the nurse's attention to the exclusion of the psychological ones, especially privacy, choice and the chance of self-expression. Of this matter, Margaret Hill[26] has written that pre-occupation with physical needs to the exclusion of human values can amount to actual cruelty. Some fortunate hospitals and residential homes have surmounted these difficulties, though they remain aware of the many necessary things they still have to leave undone. The integration of the volunteer into the organisation of care is one solution to this great problem of the hospital and welfare services. The volunteer gives, under professional leadership, the time necessary for the personal approaches which the paid worker cannot always give, and releases the professional from some of the chores, so that he can deploy his efforts more usefully.

Information and communication

Certain basic principles apply equally towards whatever is attempted to help old people. Failure to appreciate these principles leads to much well-intentioned effort being misapplied, both in an institutional environment and at home.

As in all social work, policy needs to be firmly founded on accurate knowledge of the social situation. Thus, the time and money spent on the repair and redecoration of an old person's home while the occupant is in hospital will be wasted if, in fact, the old person will never be fit to return to his home. The first principle, therefore, is the voluntary worker's need for information and communication with others involved in the situation. This is a very real difficulty which affects even professional medical social workers: patients are notorious in giving unreliable accounts of their own social situation while the families themselves may not always be fully informed. Case conferences, which should include the voluntary worker, are an obvious solution. But in some places it is wishful thinking to imagine that such conferences are a practical possibility in the immediate future. In any event, the volunteer who works as part of an official team will always be better placed than

the lone worker to obtain the knowledge he requires.

The second principle is that needs are seldom single and that what is seen is often only a small sign of concealed need. A worker who fails to realise this may spend much time shoring up a dangerous fabric which may collapse at any time, precipitating an even more dangerous situation. The multiplicity of need must always be remembered and any indication of its presence should lead the volunteer to refer the case to a trained social worker for a proper assessment to be made.

The role of the volunteer is thus, in part, one of communication between the client and the professionals who have at their command the resources which can help to solve his problems.

Arising out of this principle, is the third that regular help is preferable to the occasional one. This can be illustrated by the case of an old lady in a badly-heated house during excessively cold weather. An occasional bag of coal provided by the local charity will contribute far less to protecting her from such hazards of exposure to the cold as accidental hypothermia, than a regular supplementary grant from the Department of Health and Social Security for additional fuel, to which she may well be entitled.

Speed is important

Speed with which help is afforded is another factor of importance. 'He gives twice who gives quickly.' This, of course, applies equally to the local authorities' home care programmes as to voluntary effort. The old lady who needs protection against cold needs it today, before the coming night. A nutritional crisis needs an *immediate* solution, not one postponed to next week. Such situations provide urgent problems which the home care programme has no right to expect an overloaded hospital service to undertake when the needs are overwhelmingly domestic in nature. Some voluntary help fails because the worker is defeated by the simple needs of the situation. For instance, an old person forced to apply for a bedside commode is generally unable to arrange its collection from a central depot: she needs it delivered *to her bedside.*

'No one came'

Old people come to lean heavily on the visits of their new friends and helpers. They prepare for their coming and save up their questions and problems for the promised day: they are, in proportion, inconveni-

enced and disappointed if the visitor fails to appear. Regularity and dependability are the important factors. The visitor should realise the value of the moral support he provides for the lonely old person and for his family who are often enough unable to contribute anything themselves. Contrary to what is sometimes alleged, the solitary old person's problem is seldom that of answering the door to a host of visitors, statutory or voluntary, all of whom are pressing offers of help. Far more often do we hear the complaint, 'No one came'. As a result, morale falls, depression sets in, physical health deteriorates, because no one is at hand to warn doctor, nurse or social worker that urgent help is required.

Supporting the family

Families have had, generally speaking, a 'bad press' in regard to their support of dependent elders and have commonly been accused of neglect of their responsibilities. Perhaps the most striking fact about the families of old people is that, in many instances, they are non-existent; often the old person has no relations outside his own age group. When there are younger members, it often happens that the load of support they have had to bear has been so great and the amount of help received from the community so small, that they have broken down under the strain. The extent of these stresses is often quite unappreciated because no one in a position to help has even bothered to listen. As a consequence, prolonged strains are borne in silence, day and night, over the years, without any relief, producing such family situations as described by J H Sheldon in *The Social Medicine of Old Age*.[50] Short of offering permanent institutional care, hospitals and local authorities must contribute to the lightening of such burdens through the mosaic of medical and social provisions comprising conventional hospital facilities, day hospitals, day centres and all-day luncheon clubs. Attendance at these must be arranged in accordance with the patient's medico-social needs and the situational demands and, in all instances, full support by the home care programme. Voluntary organisations will be required. When the help available theoretically is seen by the family as available in reality, in appropriate amount and at the right time, the question of the family resuming responsibility frequently gets a favourable answer.

The key to success, however, lies in the amount of support which can be provided. This gives great opportunity to voluntary effort. Apart from the comfort and relief which such personal services afford, the voluntary visitor can become the link between the patient and the professional agencies which exist to support him. For example, after

discharge from hospital, old people often sink to a level of performance far below their capabilities. This can be avoided by proper communication between hospital personnel and those supervising home care, an area in which the official services often fail through lack of manpower. The link between hospital and home needs to be strong, but is one which perhaps can only be forged effectively if voluntary help is employed.

Help in hospitals

Voluntary help in hospitals is, in some ways, easier and less demanding than similar work in the community. There are, however, difficulties in integrating the volunteer unless he is working in a properly constituted team, whether he serves as an individual or as a member of an organisation. Patient and staff relationships can be a hazard for the unwary; for example, the sympathy-seeking old lady who will play off one staff member against another. It is easy for a superficial or new observer to misinterpret a hospital situation.

It is with simple and small jobs that voluntary work will often start and the volunteer should be prepared to accept these as an opening which may lead to later opportunities for more personalised and complex service to the patient, and which will give him the chance to be accepted as a member of the therapeutic team.

The difficulty and, indeed, danger of the 'lone wolf' volunteer have already been mentioned. Effort must be directed by a professional worker who can see the whole picture. There must be exchange of information between all concerned and an understanding of each other's role and the difficulties and limitations of each role, so that relationships are mutual between the employed and the voluntary workers. Extension of the volunteer's role is dependent entirely on his being accepted by the permanent staff as a team member with a specific and valid function, who can contribute not only to the patient's comfort, but also to the good of the team. How easily the volunteer will gain this acceptance will depend, not only on the professional staff and their ability to examine fresh ideas, but on the tact and wisdom of the volunteer.

The essential role of the volunteer

It must always be remembered that the idea of outsiders taking any part in the running of a hospital ward or institution is not one which will gain ready acceptance, especially from nurses who already work

under difficulties and may be afraid of the outcome. In wards where teamwork is an acknowledged thing and where it is routine to involve the medical social worker in the patient's affairs, the volunteer will be more readily welcomed, especially when he comes under the aegis of the social work department. The early days of this new form of collaboration are bound to be exploratory – and will remain so until the most satisfactory lines of procedure have been defined. But only such collaboration can meet the totality of need which every patient, irrespective of age, exhibits under conditions of prolonged stay in an institution. In hospital many contacts between people are necessarily superficial. There is just not the time nor the privacy for any other kind. Not until public responsibility has been aroused will sufficient resources be directed towards a remedy. The essential role of the volunteer in the hospital geriatric service is to be the personal link between the patient and the community from which he is temporarily isolated, so keeping the community aware of the needs of those of its members in hospitals.

Support at home

Home support of old people is likely to be of increasing importance in future. It is especially needed in the difficult days between the patient's discharge from hospital and the rallying of home services. A kind friend who has known the patient well in hospital and who carries her interest to the patient in her own home can do much to help maintain the degree of activity gained during rehabilitation and to help the family to understand what the needs are. The waste of the hospital's effort can then be avoided. But we shall never reach a time when ordinary good neighbours become superfluous. Informal help to meet immediate needs will always be required. Voluntary service is an extension of both good neighbourliness and professional aid. As Geraldine Aves points out in *The Voluntary Worker in the Social Services*[38], 'The object of making greater use of voluntary help should always be to extend and improve a service, by adding something to what is already being done, or by opening up new possibilities'. This sums up the role of the organiser.

Mental Illness

John Greene

Chapter Nine

NO GROUP OF SICK PEOPLE WAS, UNTIL RECENTLY, IN MORE DANGER OF losing contact with relatives than those admitted to mental hospitals. The blame for this did not rest entirely on the general public, it belonged almost as much to the people who administered the hospitals.

Changes over the years

Until the early 1930s, most mentally ill patients were in hospital because they were certified as insane – irrespective of the nature and degree of their illness. So labelled, whatever treatment and care they received was in a purely custodial atmosphere. The Mental Treatment Act of 1930[24], a major advance in medico-legal history, enabled some mentally ill patients to enter and leave hospital voluntarily. But even these patients had to submit to some extraordinary restrictions. They lived in locked wards. They were not allowed visitors during the first month in hospital. They had their letters opened by hospital staff. These restrictions must have contributed to the present plight of thousands of patients still in mental hospitals with no contact with relatives or friends. Another reason was the geographical isolation of so many large mental hospitals which made frequent visiting impossible for people who had no transport of their own or who could not afford the cost of the journey. The situation is now changed very much for the better, particularly since the Mental Health Act of 1959[23] which removed the unnecessary legal formalities and made it possible for all but a small number of patients to enter a mental hospital for treatment in the same way as patients go in and come out of general hospitals. There are usually no special hours for visiting. Most mental hospitals now encourage visiting at any reasonable hour. The benefits of the Act are enormous and the association of mental illness with the term 'legal insanity' has largely disappeared.

Nevertheless, the mentally ill are still at a disadvantage. Mental illness is still feared and surrounded by a great deal of ignorance and prejudice. But people are becoming more aware and more sensitive to the needs of these patients.

Only those who have been closely associated with mental hospitals for many years can really appreciate the great progress made; though, at the same time, they recognise how much more has to be done before mental illness can be equated with other types of illness.

While it may be useful for organisers of voluntary help in mental hospitals to know something of their background and history, it is much more important for them to have an understanding of the situ-

ation as it is today and to understand not only the needs of the patients but something about the people who care for them.

Voluntary work in mental hospitals is not new. There have always been some people ready to give their time to entertain the mentally ill, arranging concert parties and football and cricket matches. Some have extended their interest to visiting friendless patients. But contact tended to be limited, deep relationships were neither sought nor encouraged. Before 1948, mental hospitals had another disadvantage, they were semi-State institutions partly financed from the rates and partly by State grants. They lacked the public involvement which was so much a feature of the old voluntary general hospitals. After more than twenty years of the National Health Service, opportunities for voluntary service have greatly increased. Different opportunities in general and mental hospitals appeal to a wide section of society and a variety of skills can be used.

The basic needs of all mentally ill people are more or less the same, but there are more specific needs depending on the type of illness. Brief descriptions of the kinds of people the volunteer will find in a mental hospital may be helpful. The characteristics of each may be a deciding factor in the choice of voluntary worker and the way in which his or her skills may be used.

Nervous breakdown

People with nervous breakdown usually have symptoms such as extreme anxiety, loss of confidence in themselves, an inability to concentrate and cope with their everyday jobs. They may be mildly depressed, sleep badly and display apathy. Treatment is aimed at restoring their confidence by helping them to develop insight into their psychological and emotional problems. For example, a housewife in a new town finds she cannot cope with the family or the housekeeping. She is far away from her own relatives and friends and may lack the initiative to make new friends. If she has never belonged to a club or had an outside interest she finds it difficult to adjust to a new life. In hospital, the days seem long and dull with little more to do than talk about her illness with other patients. Yet with sufficient help there are boundless opportunities to develop fresh interests in her life.

Men under stress at work may not be able to relax in their leisure time and they, too, may benefit from learning new skills.

Facilities are usually available but what is lacking is sufficient people

to provide the variety of occupational, social and recreational activities to suit the individual needs of each patient.

Other forms of illness

People with a more severe mental breakdown, such as depression, schizophrenia or mania, are less likely to be helped by the voluntary worker while the illness is in the acute stage. But once convalescence has started there will be plenty to do in the way of social and occupational activities. Patients who have suffered a severe mental disturbance will welcome the help of people who do not regard them as social outcasts. Apart from helping them in hospital there may be opportunities of helping their families; looking after children while a parent visits the hospital, providing transport to or from hospital for patient or relative.

Long-stay patients

Every mental hospital has a number of long-stay elderly patients. Some were admitted years ago when treatment was less effective; others have not responded to present-day treatment. Many have found themselves unable to manage outside, and that hospital is the only security that life can offer. Many will almost certainly spend the rest of their lives in hospital, either because they are unfit to leave or because there is nowhere for them to go. Personal links with the outside world is the help most needed by all these patients. As their stay in hospital becomes longer their friends gradually stop visiting them. The sense of isolation which is already a feature of mental illness is increased by the reality. They *are* isolated and they feel unwanted. Familiar routines and repetitive programmes reduce the need to think or express feelings. Silence is all too familiar in long-stay mental hospital wards. A hospital well staffed with well trained people can do much to combat this state of 'institutional neurosis'[5], but nothing can compensate for the loss of friends, a forgotten birthday or a vainly-awaited letter from the outside world.

Visiting patients

Volunteers who are going to visit long-stay patients must be carefully chosen. They need to be stable and mature people who can visit at regular intervals. They must realise that conversation may be awkward, even impossible. Social relationships will be different and often difficult. Volunteers must not look for gratitude or immediate acceptance. In the early days it may be easier for two volunteers to visit

together and talk with a group of patients rather than to concentrate on an individual. The situation should gradually develop into one of *rapport* between visitor and patient and this can be most rewarding for the voluntary helper. It demonstrates to the patient that he has friends just like everybody else and he is less likely to feel that his illness is something of which he should be ashamed.

Old people

Old people can be tragic. They have probably been useful citizens, bringing up their own families or holding positions of responsibility. But now they are seen by the hospital staff as people in need of care. They are slow, inarticulate, forgetful and confused in unfamiliar surroundings. Overworked staff have little time to listen to them, so they gradually give up and lose the habit of conversation. They are clumsy and slow when they try to do things for themselves and in a busy and overcrowded ward they can easily lose their last shreds of independence. But most old people retain some early skills and some ability if they can do things in their own time and their own way. They like an audience to listen to their memories and they especially enjoy having young people or children around them so that they feel like grandparents again. A visit to the hospital shop or a walk in the gardens makes a welcome change and a visitor's supporting arm may be all that is needed.

Feeding, washing and dressing elderly people are things a lot of people do in their ordinary lives. In a geriatric ward they occupy most of a nurse's time. Volunteers could help so that the nurses are able to concentrate on those who need special nursing attention.

Attitudes of staff

The attitudes of hospital staff to volunteers vary from welcome and appreciation to hostility towards apparent 'do-gooders'. The slow development of leagues of friends in mental hospitals reflects the suspicion of hospital management committees and staff about the motives of those who show sudden interest in the mentally ill. They had become accustomed to the idea of a general public which either disdained mental hospitals or were morbidly curious. There were examples, too, of 'friends' who came to criticise rather than to give constructive help. Some hospital staff also felt that the working conditions and facilities for patients were poor, and they reacted defensively. These attitudes are now disappearing as friends and voluntary workers are proving that they are true friends of the patients

and staff.

Success is founded on careful preparation of the hospital staff, explanation of the role of voluntary workers, their aims and what they are prepared to do. But older staff still remember the meagre resources of mental hospitals in the past, their own low salaries and insecurity of employment. Even now, the amount of work to be done usually exceeds the number of people available to do it and the suspicion still lurks that voluntary workers may cause redundancies or a loss of earnings to the lower paid members of the hospital staff.

Attitudes of relatives and friends

Much guilt and shame are still felt about having mental illness in a family. It is necessary for relatives to know about voluntary helpers; the voluntary helpers must, in turn, understand the confidential aspect of the work they are doing. For example, the relative who is unable to face visiting a patient in hospital may be delighted to hear news of him through a chance meeting with a voluntary helper. But if the same news was learned as a result of indiscreet talk about the patient's condition, the reaction of the relative might be understandably different and the results damaging to the reputation of the hospital and the voluntary service.

The role of voluntary workers can extend beyond the hospital. With the emphasis on community care for the mentally ill and the aim of discharging more long-stay patients, there is a growing need to provide support for patients and their families. The patient may feel utterly lonely on leaving the safe atmosphere of hospital to return to a now unfamiliar world. People may be tactless in trying to be helpful, or create a worse situation by avoiding contact altogether. An understanding friend who has had some preparation for the task can do much to help re-establish a normal life for the patient and his family.

The organiser of voluntary help will not succeed without the co-operation of patients and staff. He or she should be seen, and well-known, as part of the hospital organisation.

The main group of staff with whom volunteers will come in contact will be nurses and occupational therapists.

Nurses

Nurses by tradition are protective towards their patients. They will

need convincing that the motives of voluntary helpers are genuine and in the interest of the patients. Any suggestion that only attractive tasks will be done by volunteers will cause suspicion and resentment. But once volunteers prove their worth the nurses will be their strongest allies.

It is important, too, that volunteers know something of hospital etiquette. The nurse in charge of a hospital ward is a key figure in the hospital organisation and has a special relationship with the patients as well as responsibility for their care. The ward sisters or charge nurses who occupy this position must be treated with the courtesy and respect given to the head of a household for this is what they are in a sense. They will want to know when a volunteer or the organiser is in the ward and, in order to be helpful, will expect to know the purpose of their visit.

Introduction to patients will usually be made by the ward sister or charge nurse. It should be routine for the volunteer to tell the nurses how the visit has gone, if any difficulties have arisen, and to ask for advice. The nurses will appreciate the problems of making conversation and may be able to suggest topics likely to succeed. The nurse who is sensitive to the situation will probably see that a cup of tea arrives at the right moment and quietly come to the rescue if there is an awkward silence or an embarrassing pressure of conversation.

It must be recognised that a relapse can occur. The visitor who has made friends with a patient may be distressed and disappointed to see a sudden change in behaviour, but these things must be expected at times. Proper preparation of volunteers is needed so that they can accept such things and know to whom they can turn for advice and support when needed.

Occupational therapists

Occupational therapists are specially trained in methods of interesting patients in the most appropriate occupation for their illness. The numbers of patients they have to deal with are usually far too great. They need help but it must be constant and dependable if it is to be effective. The variety of occupational activities in a mental hospital ranges from handicrafts to cultural pursuits, from packing sterile hospital supplies to gardening and other outdoor work. There really is a place here for any volunteer with a special skill. The occupational therapist and the nurses, with their combined knowledge of patients' needs and abilities, will be able to give valuable assistance to the

organiser and a great deal of support to the volunteers.

Doctors

The medical staff may not be much in evidence because a great deal of their work is outside the hospital. Their wishes in respect of the patients must be observed and, although they will be interested in all that goes on, the volunteers cannot expect to have frequent contact with them.

Social workers

Social workers and their assistants cannot give as much time as they would wish to individual patients and their families. Organised voluntary help could ease their difficulties, though it would be essential for the volunteers to have instruction and full approval for any task they undertook.

Apart from the professional workers so far mentioned everybody employed in a mental hospital has some part to play in the patients' treatment. Patients will be found working in the hospital laundry, kitchens, workshops, offices and many other places and all the staff have contact with them. This contributes to the atmosphere that makes a mental hospital so different from a general hospital. Everyone has something to contribute towards the making of a therapeutic community[31], which is what every mental hospital aims to be.

Mental Handicap

Diana Cortazzi

Chapter Ten

THE FIRST THING TO BE CLEAR ABOUT IN THIS TYPE OF VOLUNTARY WORK is that a hospital for the mentally handicapped, like any other, houses people – people with individual personalities, with good and bad points, with loves and hates and friendships, with hopes and needs like the rest of us. Where they differ is in lacking the intelligence (or the ability to use their intelligence efficiently) to deal with ordinary, everyday living without help – if at all. That is their handicap.

Linked with this is a further handicap, that of having spent years in an institution. At best, this means communal living, a perpetual boarding-school; at worst, it can be nearer to a displaced persons' camp. With anything from 500 to 2000 people living on one campus, sometimes in one vast building, there is bound to be a certain amount of regimentation and lack of initiative. There may also be the frustration of physical handicaps to cope with; spasticity, deafness, poor sight, inability to speak. And perhaps also the desolation of having no relatives or of being seldom visited.

But whether they are mongols or spastics or hydrocephalics, whether they are 'high-grade' or 'low-grade', whether they huddle apathetically in a corner, rocking to and fro, or wander restlessly from room to room, or jump up and down ceaselessly – they are first and foremost people. Friendly, affectionate, and easy to get on with for the most part.

The hospital is home. The patients themselves refer to 'visiting' their homes and 'coming home' to hospital. It is their world, the staff their family, and regular visitors become their extended family. No part of the lives of the staff and visitors is too small or obscure to be of interest: husband, children, garden, car, dog, cat, a holiday, a new hat – all are drawn into the patients' world. This makes for easy contact and the quick establishment of friendly relationships.

Nevertheless, home *is* a hospital. There are doctors and nurses in uniforms and white coats. There are teachers, occupational therapists, engineers and administrators, clerical, kitchen and wardrobe staff. There are hierarchies, heads of departments, areas of work and responsibility, and there are, therefore, conflicts and tensions.

Problems and needs of patients

Mentally handicapped patients have a good deal in common with patients in other types of hospitals plus some problems and needs which are specific. They can be listed.

Problems common to all hospitals

cut off from home

cut off from community

Problems common to mental hospitals

institutional living, regimentation, lack of independence

need for friendship, to belong to someone

need for active hobbies or development of wider fields of knowledge

need for a wide variety of entertainment

poor social skills (unfamiliarity with public transport, shopping, money, traffic)

poor work habits (unfamiliarity with time-keeping, care of tools, pride in work, respect for authority and rules)

Specific needs

Need for basic education (the ability to learn often develops in the mentally handicapped between the ages of 16 and 30)

need to be taught creative work (art, music, drama, hobbies)

need for regular, planned exercise

need to be taught how to play (because it does not come naturally and the mentally handicapped lack curiosity and the urge to explore)

need to be helped to communicate (to talk, to write home regularly)

need to be taught to wash, dress, eat (or, for those who are spastic or especially helpless, to be washed, dressed and fed)

need (for some) to be pushed out in wheelchairs for fresh air and a change of scene

Hospitals vary in policy, in allocation of funds, and in staff, and so priorities will differ. The organiser of voluntary work may be involved in satisfying any of these needs and there may well be others.

Problems and needs of staff

These are relatively less clear-cut than those of the patients and, since they can be a source of conflict or concern, it is important that the organiser is aware of the potential sources of tension.

Many basic staff difficulties arise because of two staff shortages – nurses and domestic staff. A ward sister may have to spend time cleaning the ward, or washing and dressing patients who could be taught to help themselves. Faced with some 40 patients to wash, dress and feed in one hour in the morning, there is little hope of the nurses concentrating on the few who might learn to be independent with regular instruction over a long period. Incontinence presents a perpetual and well-nigh insurmountable problem in such conditions. So often it leads to regimented clothing and the pervading smell of faeces and urine. Such things are hard to explain away to volunteers or visitors without causing ill-feeling in quarters where, in fact, the responsibility may not lie. Nurses are not always to blame. Many nurses are not only overworked but also frustrated because they have too little opportunity to do all they would like to do with their patients. Other departments which also contribute to the well-being of patients – such as the laundry, supplies department, catering department – may have their own problems which impinge on the nursing staff.

Unsuitable, old-fashioned buildings are another problem that faces many hospitals. Not only are they more difficult to keep clean, but ordinary facilities such as washbasins or lavatories may be in the basement or up two flights of stone stairs. The day-room may double as a dining-room, there may be lack of storage space and probably no privacy. Such conditions help to explain many a short temper, an apparent hopelessness, a lack of initiative and a sense of defeat on the part of the staff. The problems are very real and the staff have to cope with them every day and all day. The voluntary worker who visits for short periods cannot get a true appreciation of them, but can sense some of the tensions, conflicts and vague fears that these problems create for the staff.

It is vital for the organiser to realise that such feelings are uncomfortable, nagging and negative, and often become fastened on to some quite different situation or on to some person who can be comfortably

and positively hated – such as the outsider who comes in to do the interesting job.

One way of dealing with this is to communicate at every opportunity the firm principle that ordinary people of goodwill must be brought in from outside so that patients and staff feel less isolated and so that the public fear of subnormality can be slowly dispelled by knowledge and familiarity. This is an acceptable starting point for almost all staff.

Not only must the organiser understand and make allowances herself, she may also have to help the voluntary worker do the same. Volunteers, fresh, new and enthusiastic, judging the buildings, food and clothes by the standards of their own homes, and expecting the staff to be constantly bustling about all the time as in a general hospital, can create problems by their unwittingly critical attitude.

No policy can be laid down, it is up to the individual organiser. It is well to remember, however, that a nurse's day in these hospitals sometimes lasts from 7 am to 8 pm. Patients can be very trying. So can other staff.

Volunteers and their problems

Many of the problems that concern the volunteers themselves arise in these ways. Seemingly small happenings, arising from the total situation, can easily ruin a lot of the organiser's careful work and blow up into a major event.

There was, for instance, the 'lipstick trouble'. A Red Cross beautician had been giving lessons on make-up and several girls had arrived back in the ward with lipstick on for the first time – very proud of it. They were immediately sent to wash it off before tea. Tears and tantrums followed. No one outside the ward was told anything about it, and the beautician was bewildered on her next visit to find the girls refusing to have make-up on. Sorting out revealed that the ward sister had not been told about the make-up classes which took place in the occupational therapy period and away from the ward. She thought the girls had been blobbing stolen lipstick all over their faces, and anyway had not time to listen to their explanations. When she saw the object of the lessons and understood the girls could spend pocket money on make-up instead of the inevitable sweets, there was no difficulty. But it caused a lot of fuss for many people at the time and the repercussions were felt for some time afterwards.

Staff must know if and when volunteers will turn up. On one occasion, there were twelve grammar-school boys who kept turning up when they were not expected. Their social work scheme was in the charge of a rather elusive senior master. They worked to an eight-day timetable, we had a five-day week. They had a number of 'field' days when voluntary work was acceptable and sometimes used as an excuse to avoid exercises in military manoeuvres. Despite joint consultations and fixed dates, one was constantly finding this group of boys looking lost, without anything specific to do because they were not expected on that day. The answer seemed to be to give the school a task not involving patients, such as building an adventure playground.

Some volunteers agreed to help with the Saturday night dance. It so happened that two of the volunteers were parents of two of the patients. Unseen by anyone, the two volunteers wandered into the wards and enquired somewhat brusquely why their relatives were not at the dance. Nurses on both wards were quite reasonably annoyed at the unannounced presence of visitors at a time when patients were undressing and getting ready for bed, the more so because both the patients concerned happened to be too disturbed and uncooperative to join in the dancing. But the parents were too upset to listen, and the incident caused ill-feeling for a long time. This type of problem is perhaps specific to hospitals for the mentally handicapped where there are children resident. So many members of the league of friends tend to be parents and, therefore, emotionally involved.

Then there was the over-helpful committee member who, on hearing that voluntary workers were not wholly acceptable in every part of the hospital, issued orders about them without the organiser's knowledge. The repercussions from this also lasted a long time. These are some of the problems that organisers of voluntary help may meet. But hospitals vary and so do the senior staff who set the tone of the hospital and the emphasis will not be the same everywhere.

Some useful tips for organisers

The lesson to be learned from all these incidents is to tackle the problems of communication. This is not an easy art – perhaps because it seems elementary common-sense and because it is hard sometimes for those outside a situation to believe that people can get so upset over trivialities. Much of the trouble arises from the current delicate situation in some hospitals and the insecurity felt by the staff. The organiser will almost certainly have to accept philosophically that someone will be offended some of the time. But she can keep to a

framework of rules. One is to inform *everybody*. It might not seem necessary at the time, but it is – as subsequent events always show.

Also, she must go around thanking people. Even the most self-sufficient volunteer likes to know she is appreciated. So do the staff who have been concerned, such as the catering officer who provides coffee and sandwiches for meetings.

Medical officers must always be consulted if any physical activity is involved (some patients have weak hearts or other physical disabilities), and nursing staff should be asked about patients going on outings, especially if food is involved.

Constructive use of voluntary workers

Most volunteers prefer to work in the same place each time. Experience of voluntary work in hospitals for the mentally handicapped has shown that volunteers can be used in a variety of ways in the wards and departments.

Assistance can be given in feeding helpless patients, playing with the babies and children, bathing, dressing, bringing round the sweet trolley – or, in less structured ways, of simply chatting to elderly or infirm patients, playing records or looking through magazines with them, knitting or crayoning, or taking them out in wheelchairs. These less structured activities are, in fact, usually suggested by the nurses when they are asked how a new volunteer might best be employed. It is extremely difficult for most volunteers, who probably have no experience of, say, chatting to a mentally handicapped person or pushing a heavy spastic in a wheelchair. I am not keen on allocating new people to this type of work. It has no set goal and no measure of progress. It is work which sometimes suits a group of young people, however, since they can come on a rota basis, and include each other in the conversation. Patients with very little intelligence or speech seem quite happy to watch new faces and listen to voices and music.

In the hospital school, volunteers who can play the piano are always welcome. So are those young enough to play actively with a small group of children or take them out locally or in the grounds. A particular child may benefit from regular individual attention which cannot be given in school hours, or the volunteer may have a special skill. Students from schools or technical colleges may be brought in to devise and make large, sturdy apparatus, suited to the needs of older, heavier children.

Evening classes are held for those adult patients already out at work in the day-time who need extra coaching with reading or handling money, writing, telling the time, or with poor speaking habits. Although all these need the guidance of a teacher, a good deal is routine and regular practice which many volunteers can cope with. Adult education can include creative help. Educational film shows are surprisingly popular with all ranges of intelligence.

Social training is given to those who have left school and who may one day be considered for an outside job. It includes road drill and travelling on buses and trains, shopping, keeping an account of money spent, visiting places of local interest – in all of which the voluntary worker can usefully participate. Teaching of this kind is most effective with one or two patients at a time, and the hospital staff cannot be spared regularly to cover this adequately. Records of social training are kept and the volunteer can see progress and plan ahead.

The technical units, where simple repetitive factory work is done, need regular help in checking work before it goes out, or – as so often happens – in encouraging the work of individual patients. Occasionally, too, help may be needed with devising and making gadgets to overcome particular physical handicaps.

Help is always needed in the entertainment field – whist, bingo, concerts and shows, hobbies, painting and music groups – especially at weekends when teaching staff are off duty. Outings on the river or to the seaside, picnics, visits to a local play or a party are all enjoyed, and helpers are always needed. There are clubs and group activities to be developed, such as the deaf club, camping and rambling clubs, a patients' band.

Finally, there are a number of miscellaneous activities such as pulling down old buildings or clearing a shrubbery, running the hospital shop, helping with exhibitions, cataloguing, making costumes and scenery for drama productions. Many of these appeal to those who want to help, but don't wish to have direct contact with patients. The hospital league of friends is, of course, a voluntary organisation in itself. Its functions vary from hospital to hospital, but obviously the organiser will establish a good working relationship with it.

The qualities required in a voluntary worker are, first and above all, a great capacity for enjoyment and laughter; secondly, the capacity to adapt immediately to any unusual situation; and thirdly, patience. Age does not seem to matter. And the less stable people very quickly drop

out, if, indeed, they ever arrive on the doorstep of the hospital at all. Almost any skill or enthusiasm can be used in a community where ages range from birth to senility and mental capacity from six months to sixteen years.

In mental handicap, the patients – because they cannot speak for themselves – have, more than most, the right to life in a community. And because they are the most helpless of all, it is the duty of the community to give some of its time and talents. The voluntary organiser has a twin duty – to see that the patient is helped to lead the fullest life within his limitations, and to help the community to be less fearful and to accept its responsibilities. How this can best be done is ultimately up to the individual organiser in the particular situation. Those of us already working in this field can only point out the delicate problems and the attempted solutions.

Terminal Care

Cicely Saunders

Chapter Eleven

TERMINAL CARE IS PART OF ALL CARE AND IT IS NECESSARY FIRST TO emphasise how much in terminal care is exactly the same as everything that has been mentioned in other chapters. We are concerned not with 'the dying' – a de-personalised group to be thought of with fear or sentimentality – but with ordinary people who remain ordinary although they are mortally ill. Until recently, death was considered to be a taboo subject but although we seem no longer to suffer from that reticence, even so, much of what is written or said is often sensational or sentimental. There is a tendency to overlook the fact that death is part of life. Ordinary people have endured the death of their loved ones with dignity and come through bereavement to live afterwards greatly enriched by those they have known and loved.

The dying need time

Whatever their age, people are concerned, however limited their mental or physical sphere, that they should *live* up until the time they die. But the pace of their living may be greatly slowed down. So, above all, the dying need time. We all need to learn to go at their speed and never hurry them. We need also to learn to recognise the difference between someone who is confused and someone who takes longer than usual to find the right word. Volunteers, coming in from ordinary life outside, perhaps from an area that the patient knows, can be very important to this gift of time. They may feel inadequate at first, but so long as sufficient care is given to explanation, and so long as they are shown exactly how to do things, they quickly lose this natural apprehension and find out how much they can contribute.

Selecting the volunteer

We have to recognise the possibility that people volunteer from motives that may hinder their helpfulness. Certainly, those who are lonely after bereavement are often found to give a particularly valuable contribution. They understand parting all too well and are able to hand on the infection of a good courage. Their help is given more often in silence or in talking of other things rather than in a direct discussion of problems faced and comfort given. The strength that comes from going through desolation and finding a way to go on afterwards is passed on without any direct words. But those who have not come to terms with their own bereavement, or those who have other emotional problems, should probably not work in such wards. It may easily disturb them and they can then be disturbing to others.

Older volunteers are particularly good with patients and perhaps are

often able to give the support of a real and tried religious faith. The younger ones, also, seem surprisingly ready to accept and come to terms with the fact of death. A letter from a student who was with us at St Christopher's Hospice illustrates this. 'It really has been a wonderful experience for me, and I gained a tremendous amount from it – in fact I have got so much more than I've given. I suppose as far as I had ever thought about death before I had been frightened by it – a fear of the unknown, which has largely disappeared through coming face to face with it. I was sitting with Mrs C the night before she died and was absolutely terrified to begin with, sitting on the edge of the chair and thinking, "Please don't die while I'm on duty!" It turned out though, to be an extremely profitable couple of hours when the fact of death was brought home with a new reality and immediacy, and set me thinking in a new way about suffering, materialism, life after death and so on. I'm still thinking! But with much greater peace of mind – by the end I was ready and happy for her to go.'

This student visited the wards again at the end of her holiday, saying that she could not go back to Oxford without looking in at the Hospice. She wrote, 'It was good to be back, although some of the changes admittedly hit me pretty hard – harder than when I was there.' This underlines the importance of having something practical to do while one comes to terms with the situation.

Support

All volunteers, and indeed, all staff, need to talk about the work before they start. They must understand that everyone of us who works with the dying cares deeply about what goes on, that we all grieve when we see weakness and partings. They need to be told this when they first come and the organiser can try then to give them some idea of the confidence which grows as one sees the achievement of the patients and of their families and the comfort that is given. Volunteers will usually need to be able to talk again after they have been in this work for some time. Particularly, they need to be able to come and talk if they are suddenly overcome by their feelings. Above all, they must be helped to see that their own disturbed feelings are understood and shared by others. If they know that all of us have had to find a way through they are far more likely to do so themselves. We all know that in moments of family crisis such as this, one of the best ways is to persevere with the practical. So, with volunteers, it is important to begin with the dull jobs such as washing-up. It is from such tasks that people graduate to helping with meals and finally to what, with us, is a most important moment – the time when they are first allowed

to feed a patient. It is in these circumstances that the friendships begin. That part of the work which consists of just talking and listening to patients finds its place in due time. Not many people can just walk into a ward and immediately be a friend and confidante to those they find there. But some have this gift – and at the Hospice we are blessed with more than one.

Trained volunteers

There is a special place for volunteers who are trained nurses and who can usually offer only a few hours a week. In our experience, they very quickly find their old skills and rejoice in the fact that in this work they do not have the demands of keeping up with new techniques and drugs. It is particularly suitable work for nurses who have been away from nursing, raising a family or doing other work for some years.

'Never let them down'

This was the advice given to a volunteer going on her own to read to patients in the day-room of a long-stay hospital. After two months they said to her, 'We did not think that you would keep on coming; now we can trust you.' She then found herself writing letters, helping with teas, sitting with the dying and generally being a friend. One day she found herself comforting an old lady recently bereaved. She wrote to me, 'My great day was when Mrs X's husband died in another ward and I was able to use the fact that I was a widow too.' Reliability, emphasised in all the other papers in this book, cannot be emphasised too strongly to those who meet patients when they are unable to move any longer from one place. Their dependence is far less of a burden to them if they can be certain that the expected person will come to them as arranged.

The dying have a great need to be needed. Volunteers can often be those best able to show them how much they still have to give. The volunteer who can convey, 'I am glad to meet you just because you are you', has fulfilled a very important role. Perhaps this is one of the most important things any of us can learn to convey to the dying. We all, if we will let it happen, come to the point where a dying patient gives us far more than we can possibly give them. Once we have reached this point we are in a position to hand back to other patients something of what has been given to us.

Guide to Reading

Phyllis Willmott

THIS GUIDE CONCENTRATES MAINLY ON PUBLICATIONS AVAILABLE IN paperback or in most public libraries and includes those from the companion volume. Full details will be found in the list of references on pages 113-117.

1 Background to Hospital Services

An exhaustive historical account of the development of hospitals is given in Brian Abel-Smith's *The Hospitals 1800-1948*.[2] This is valuable not merely for its descriptions of hospitals as they were before the National Health Service, but also as an explanation of the forces which led to its creation and, thus, why our hospitals are what they are today. *A History of the Nursing Profession*[1], by the same author, covers the period 1800 to the 1950s. But the fight to create the professional nurse and improve hospital services comes most vividly to life in the biography, *Florence Nightingale 1820-1910*, by Cecil Woodham-Smith.[54]

The health service is now one of the major industries and *Trends in the National Health Service*[11], edited by James Farndale, provides an extensive look at problems and developments. Essays cover administrative, economic and social aspects of all three parts of the service, though the contribution of voluntary organisations is relatively neglected. This is a book to borrow and dip into, not to buy and try to read from cover to cover.

A book for the 'person whose work brings him into close and daily contact with the human problems of patients and staff in general hospitals' is *People in Hospital*, by Elizabeth Barnes.[4] Its usefulness lies in its recognition and exploration of the social climate of the hospital setting and of how this can serve – or not serve – the patient's general welfare.

2 Structure of the Health Services

The organiser should have a good general understanding of the structure of the health services and particularly of the hospital service and its relation to other services. *Health Services in Britain*[15], an HMSO pamphlet, gives a concise account of the administrative structure of present services. The Salmon report[22] describes the new structure of nursing administration now being introduced in all hospitals. The 'Cogwheel' report[19] proposes a new organisation of medical services. Plans are at present being discussed for the reorganisation of the whole administrative structure of the National Health Service. Reorganisation is expected to take place in 1974.

There is much interest in *Health and Welfare Services in Britain in 1975*, by D Paige and K Jones [41], erudite and academic though it may appear to the general reader. The wealth of statistical tables is leavened by the authors' keen awareness of the human needs behind their calculations.

3 Structure and Function of Other Statutory Services

A Social and Economic History of Britain, 1760-1965, by Pauline Gregg[25], *Penelope Hall's Social Services of England and Wales*, edited by Anthony Forder[12], and *A Reader in Social Administration*, edited by A V S Lochhead[30], will repay judicious browsing with a sharper understanding of just how and why our social services have developed. For the less ambitious – or the hard pressed – reader, the Central Office of Information reference pamphlet, *Social Services in Britain*[16], gives a comprehensive outline. A look at the Seebohm report[17], whose recommendations led to the recent reforms of local authority social services, would also be valuable.

4 Functions and Aims of Voluntary Organisations

The historical background to the growth of voluntary organisations and of their changing relationship with statutory services is to be found in *Voluntary Societies and Social Policy*, by Madeline Rooff.[48] Though published in 1957 and, therefore, in some respects outdated, most readers will find something of interest in this textbook study of voluntary organisations.

The Voluntary Worker in the Social Services, by Geraldine Aves[38] is an important publication. It is the report of a committee jointly set up by the National Council of Social Service and the National Institute for Social Work Training. It reflects the growing awareness of the need to clarify the contribution which can be made to the social services by the volunteer. The role of the voluntary workers, who they are, the jobs they do, how they are organised, recruited and trained are all examined. Attitudes and relationships with professional workers are also discussed. Another work of equal importance is *Voluntary Work in the Welfare State*, by Mary Morris.[33] Almost every kind of voluntary work is looked at in some detail, and the book is virtually a comprehensive review of the literature on voluntary work. Especially relevant are the final three chapters, comprising Part II of the book and entitled 'The Volunteer and the Community' and the second chapter on work in hospitals.

There is a growing literature, mostly to be found in professional journals, about voluntary work in hospitals. Some of particular interest are listed in the companion volume. The library of the King's Fund Hospital Centre has a collection of articles published from the 1950s onwards. The collection includes material on voluntary work in American hospitals. *The Volunteer in the Hospital*[3], for example, is a well-produced manual for the American equivalent of the organiser of voluntary services in hospitals.

5 Social Aspects of Physical and Mental Illness

Human Relations and Hospital Care by Ann Cartwright[7] reports on a large-scale sample survey of patients' reactions to hospital, often illustrated in the patients' own words. The King's Fund report, *Patients and Their Hospitals*[44], attractively covers some similar grounds but more briefly.

For some people hospital life may unfortunately be more than a brief experience and, therefore, present special problems. *Put Away*, by Pauline Morris[34], gives a depressing but scrupulously fair account of what life is like for long-term mentally handicapped patients. *Sans Everything*, edited by Barbara Robb[46], paints an alarming picture of what can happen to some old people in hospital. *Child Care and the Growth of Love*, by John Bowlby[6], documents the deleterious effect of prolonged institutional care on young children. *Stigma*, edited by Paul Hunt[28], a collection of essays by severely disabled people, vividly portrays what this means for those living both inside and outside hospitals.

All of these books help to enlarge understanding of the special needs of those involved and increase awareness of the particular contribution voluntary workers can make to help. For some of those with special problems, the skilled help of social workers is called for. *Introduction to a Social Worker*[39], published by the National Institute for Social Work Training, gives a brief account of those able to offer such help. Another small book, *Welfare in the Community*, by E M Goldberg[14], excels, with the aid of case histories of sick and disabled people, in giving an insight into how personal difficulties can be alleviated by social work skills allied with other community care services.

6 Society and Community

The understanding of special groups and of institutional life can be broadened by looking at the wider society. An interesting study of

modern family life is *Patterns of Infant Care in an Urban Community*, by John and Elizabeth Newson.[40] *The Family Life of Old People*, by Peter Townsend[52], is a classic study of old people living at home. *Communities in Britain*, by Ronald Frankenberg[13], draws on a wide range of earlier sociological studies to describe the way we live in town or village today. Professor Richard Titmuss's *Essays on 'The Welfare State'*[51] is essential reading for its breadth of vision on the relationship between society and social policy.

7 Practical and Reference

Leaflets obtainable from the King's Fund Hospital Centre give guidance on the kinds of work that can be done.* The booklet, *Interviewing in the Social Services*, by E and K de Schweinitz[9], is worth having for those who feel they might still have something to learn about this art. The National Council of Social Service publishes a number of handbooks and reference books.[35-38] Readers will also find much of interest in the Family Welfare Association's annual *Guide to the Social Services*[10], and in *Consumer's Guide to the British Social Services.*[53]

A Guide to Voluntary Service, by D Hobman[27], and *Community Work*, by R A B Leaper[29], can each claim a place as being of relevance and practical value. Three circulars have also been issued by the Department of Health and Social Security on voluntary help in hospitals.[18,20,21]

Finally, much useful reading matter, and advice to individual organisers, can be obtained from the Voluntary Services Information Officer at the King's Fund Hospital Centre, 24 Nutford Place, London WIH 6AN.

* *See also Appendix C.*

Appendices

Appendix A

Notes on the Standing Conference of Voluntary Help Organisers and the Voluntary Service Information Office

THE STANDING CONFERENCE OF VOLUNTARY HELP ORGANISERS WAS brought into being by the decision of the voluntary help organisers present at a meeting held at the King's Fund Hospital Centre in January 1968. The chief aim of the Standing Conference is to help in every way possible with the setting up of effective voluntary help schemes in hospitals, by enabling organisers to meet one another and discuss matters of common concern, and by making available information on current schemes to anyone who may be interested.

Membership is for paid and appointed organisers of voluntary help schemes in hospitals and is at the invitation of the Standing Conference. All members receive a newsletter and regular meetings are held.

The Standing Conference has produced the following written material, copies of which are available to members on request:

Guide lines for setting up voluntary help schemes in hospitals

Voluntary help organisers in hospitals: their responsibilities, terms of service

Address list of members

Newsletters

In June 1969, the Fund established a Voluntary Service Information Office at the King's Fund Hospital Centre, 24 Nutford Place, London W1H 6AN (01-262 2641), and appointed Mrs E M C King as

information officer.

The office has the following main objectives and functions:

1 to collate information on existing schemes of voluntary help

2 to provide information on the various methods of making effective use of voluntary help, whether in general or specialised units, or in joint hospital/local authority schemes

3 to prepare guide material on the various methods of recruiting, use and support of voluntary help in the health services

4 to arrange study days or courses for representatives from statutory and voluntary organisations wishing to develop schemes of voluntary help and also for members of individual professions (for example, doctors, nurses, occupational therapists and others) on the way a particular profession can utilise voluntary help and on how such resources can be mobilised.

The Standing Conference and the King's Fund have cooperated in arranging visits of observation for newly appointed organisers, and providing short induction courses at the King's Fund College of Hospital Management and weekend seminars under the guidance of Dr T R Batten, reader in community development studies, London University.

The members of the Standing Conference and the information officer at the Hospital Centre are ready to help in any way they can with information about the use of volunteers and the organisation of voluntary help in the health services.

Appendix B

Conclusions reached at a weekend seminar of the Standing Conference of Voluntary Help Organisers 4—6 October 1968, under the guidance of Dr T R Batten

Purpose I

We aim as paid voluntary help organisers **to assist in the healing of patients** by recruiting and organising volunteers

a to supplement the work of the paid staff

b to provide the homely touch

We aim to maximise the help thus provided by working **with volunteers** to ensure that they

a are as efficient as possible in the work they do

b work harmoniously with the paid staff

c are happy and achieve job satisfaction in their work

With staff

a to find out as much as possible about departments and individual personalities, the nature of the work they do, their purpose, attitudes, needs, and relationships within the department

b to discuss with them what potential roles volunteers might helpfully perform

c actively to involve the staff in the planning and development of the voluntary help scheme, **or if appropriate** (if the authority of the situation demands it) to explain the part that volunteers are expected to play

With the public

a to coordinate the work of voluntary organisations in the hospital and to recruit volunteers

b to create a sympathetic and supportive interest in the work of the hospital

Purpose II

We aim as paid voluntary help organisers

a to meet the needs of volunteers in ways that help them to develop as persons

b to develop in the hospital an overall sense of community

c to develop in the neighbourhood an overall sense of community – of *our* responsibility for *our* hospital which serves *our* people

Some suggestions, following group discussion, as to some of the main day-to-day aims of voluntary help organisers:

With volunteers

a skilled interviewing, to ensure that would-be volunteers are placed in jobs that they are really suited for

b to ensure the reliability of volunteers

c to define volunteers' work and to interpret the needs of the hospital to the volunteers

d to provide volunteers with the support they need

e to give volunteers continuing satisfaction in their work

f to arrange for due recognition and progression for volunteers

g to ensure the most effective preparation for volunteers in their role

With staff

a to ensure that volunteers are well and correctly treated, and made full use of, by staff, and accepted by them as members of the hospital team

b to help staff to identify and define their real needs for volunteers

c to prevent staff feeling threatened in any way by the presence of volunteers

d to encourage hospital staff actively to support the voluntary help scheme in the community

With public

a to use the most effective media for recruiting volunteers

b to promote in the community an active and favourable interest in the work of the hospital

Appendix C

Help volunteers have been asked to give

Please contact Mrs E M C King, voluntary services information officer, King's Fund Hospital Centre, 24 Nutford Place, London W1H 6AN (telephone: 01-262 2641) for latest lists of jobs done by voluntary helpers.

Direct services to patients

beauty treatment, including hairdressing, manicure and pedicure

escorting patients:

- on outings to shops, cinema, church services and other community activities
- to convalescent homes
- to various hospital departments
- to visit other patients in different wards

helping in radiography department by sitting with patients when photographs have to be taken

helping with lunches in day hospital

helping patients:

- at mealtimes, under supervision
- in use of launderette
- to bath

to dress and undress

to get in and out of bed

interpreting for foreign patients

buying, sorting, mending, marking, altering and washing clothes

collecting clothes from homes of patients before their discharge from hospital

peeling fruit and squeezing juice for disabled patients

putting foreign patients in touch with volunteers of the same nationality, or with befrienders

reading to patients from books, newspapers or magazines

reading, writing and posting letters

running errands

serving drinks

setting up books on page-turning machines

shopping

sitting with women in labour in maternity departments

taking library, shop or telephone trolley to wards

talking with patients

General services

In Wards and Departments

bandage rolling

changing cubicle curtains

clerical assistance in emergencies

decorating wards and outpatient departments at Christmas

distributing menu cards

emergency blood donors

filling water jugs

helping at nursing school during examinations

helping occupational therapists and physiotherapists

helping in nurses' reference library

helping with research projects in laboratory, pharmacy and other departments

laying tables and preparing tea

looking after birds, fish tanks, plants and flowers

maintaining lists of emergency accommodation for relatives

making beds

making charts for teaching purposes in dietitian's department

putting out clean paper towels

tidying lockers

In Outpatient Department

serving light refreshments in canteen, and making price lists and posters

being on call in reception area

giving change for prescriptions

running nursery creche for children of patients attending clinics

selling flowers

timing outpatient clinics as part of work study project

Other

assisting with despatch of house journals

collecting and sending abroad medical journals

fund raising

general assistance with routine work of nurses' league

helping in voluntary help organiser's office

looking after drink-vending machines

providing a choir for religious services in wards or chapel

running information services for visitors

showing visitors round the hospital

Specific services for children

escorting:

children and parents to and from hospital in special circumstances

convalescent children on picnics, trips to zoo

sick or disabled parents who are visiting their children in hospital

looking after brothers and sisters of patients while parents visit

looking after toys and play equipment

making scrapbooks

minding, playing with and reading to children

organising team games

providing adventure playgrounds

talking to older children who are lonely, depressed or isolated

tidying playrooms

running weekly Scout, Cub, Guide and Brownie meetings

Specific services for the elderly

helping patients' families to understand patients' disabilities

helping patients practice daily living activities

helping to prevent deterioration of patients discharged from hospital

helping workshop schemes in pre-discharge wards

indoor gardening

showing patients simple and gentle exercises, under supervision

taking patients out in wheelchairs

Recreational services

bingo sessions

birthday schemes

discotheque sessions

film shows

games in wards – draughts, chess, and so on

games outside – bowls, cricket, football, swimming

group discussions

hostess service

jazz clubs

jigsaw puzzles

playing records for patients

play reading

poetry evenings

providing facilities for art exhibitions for patients' work

quiz sessions

youth clubs

Classes to develop special skills

bee-keeping

care of pets

carpentry

child rearing

cookery

dancing

flower arrangement

fishing

handicrafts

home management

instrument playing

literacy

model making

painting

photography

physical education, under supervision

pottery

scriptwriting

shorthand and typing

stamp collecting

wine making

Services outside hospital

assisting staff with patients on holiday or during outings

entertainment at various day centres and homes for elderly people

helping in social clubs for discharged patients

inviting patients home

long-term volunteers living in hospital's halfway houses and providing help (domestic, home economics, social education)

making surveys of lodgings and finding lodgings for ex-patients

providing transport:

for patients' outings

for patients to participate in club and community activities

to bring volunteers to the hospital

redecorating and gardening, either at homes of ex-patients or at group homes

shopping for and settling in discharged patients

Appendix D

Example of an application form for volunteers

For Office Use Only

date started	ward/dept	session		total hours in dept	annual number of hours worked	
		hours	day		year	total

Issued with overall size

Key No

Followed up

Date of leaving

Letter of thanks

Overall returned

Key returned

Reason for leaving

Surname **Forename(s)** Mr/Mrs/Miss
(*Block letters, please*)

Address
(*Block letters*)

Telephone No at home at work

There are jobs all over the hospital and, in order to help with placing volunteers, we would be grateful if you would answer the following questions carefully

Age Group (*Please tick where applicable*)

17–20 21–25 26–30 31–35
36–40 41–45 46–50 51–60 Over 60

How much time would you be prepared to give?

Please state day of week, times during day, evening or weekend that you would be regularly available

Would you be able to come in an emergency, and if so, how and where could we contact you?

Can you type? sew? cook?

Can you play any musical instrument? If so, which?

Can you speak any foreign language?

If so, which?

Well or moderately?

Have you any nursing training? St John or Red Cross

If nursing training, please state where you were trained and dates

Have you ever worked with

children?

old people?

those suffering from mental disorders?

the physically handicapped?

any voluntary organisation?

Are you physically strong?

Do you mind a job which involves standing or moving about?

Are you good at arranging flowers?

Have you got a car that you would be prepared to use for voluntary work?

Would you like to visit old and lonely people who have been, or are, patients of the hospital?

What are your hobbies?

What is your job?

Where do you work?

How did you hear of this scheme?

(*Block letters, please*)

Address
(*Block letters*)

Telephone No at home at work

There are jobs all over the hospital and, in order to help with placing volunteers, we would be grateful if you would answer the following questions carefully

Age Group (*Please tick where applicable*)

17–20 21–25 26–30 31–35
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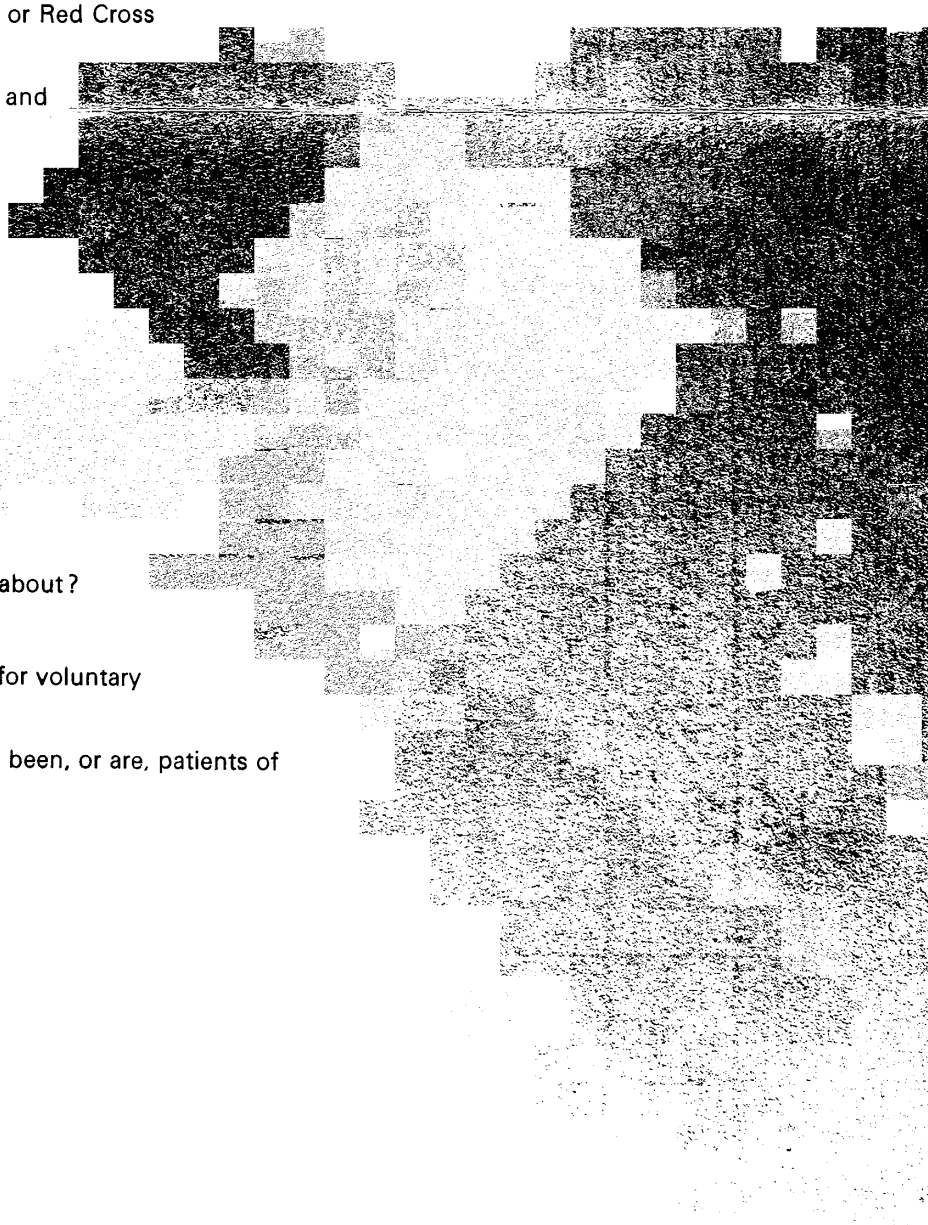
Where do you work?

How did you hear of this scheme?



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