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## Evaluation of the helping hands volunteer program for people with mental illness

### Abstract

Volunteer programs have been used to alter attitudes, provide long-term knowledge towards mental illness and increase the quality of life of consumers receiving volunteer services. Sixteen volunteers completed an 18-hour training program and in pairs worked with 11 consumers over 4 months. Sixteen volunteers completed training measures of knowledge and attitudes scales. Pre and post program quality of life and behavioural functioning measures were taken on 5 consumers. Volunteers maintained their knowledge of mental illness over 6 months and had significant increases in their comfort in interactions with people who have mental illness. Case managers, consumers and volunteers all reported high levels of satisfaction with the program but there were no significant changes in behavioural functioning or quality of life for consumers over 4 months of receiving volunteer support. High levels of client disability and the need for longer term follow-up were identified as factors needing to be addressed in future studies.

### Keywords

evaluation, hands, volunteer, people, helping, illness, mental, program

### Disciplines

Arts and Humanities | Life Sciences | Medicine and Health Sciences | Social and Behavioral Sciences

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# Evaluation of the "Helping Hands" Volunteer Program for People with Mental Illness

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Volunteer programs have been used to alter attitudes, provide long-term knowledge towards mental illness and increase the quality of life of consumers receiving volunteer services. Sixteen volunteers completed an 18-hour training program and in pairs worked with 11 consumers over 4 months. Sixteen volunteers completed training measures of knowledge and attitudes scales. Pre and post program quality of life and behavioural functioning measures were taken on 5 consumers. Volunteers maintained their knowledge of mental illness over 6 months and had significant increases in their comfort in interactions with people who have mental illness. Case managers, consumers and volunteers all reported high levels of satisfaction with the program but there were no significant changes in behavioural functioning or quality of life for consumers over 4 months of receiving volunteer support. High levels of client disability and the need for longer term follow-up were identified as factors needing to be addressed in future studies.

The ability of publicly funded psychosocial rehabilitation programs or case managers to meet the needs of people with chronic mental illness is constantly under pressure. Consumers have been frequently found to require additional assistance in the areas of social support, financial matters, housing maintenance, medical and mental health care plus legal and safety issues (Lehman, 1988).

Volunteer support programs aim to supplement other programs and address some of these needs by way of assistance with practical life skills (eg: shopping, budgeting and cooking), social skills and activities. It has been suggested that the use of community-based volunteer programs provide greater community integration and the added benefit of promoting community awareness regarding the realities of mental illness (Brook, Fantopolous, Johnston & Goering, 1989).

However, we could locate only six published studies that evaluated the effectiveness of volunteer programs for people with mental illness (Armstrong, Korba & Emard, 1995; Brook et al., 1989; Lieberman, Gowdy & Knutson, 1991; Mowbray, Wellwood & Chamberlain, 1988; O'Loughlin, Laurendeau & Gangnon, 1989; Skirboll, 1994).

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These studies whilst reporting largely favourable findings, also varied in their program goals, volunteer training, evaluation strategies and methodological rigor. All programs had social or emotional support and the reduction of social isolation as primary goals. For example, the "Partners for Progress" program (Armstrong et al., 1995) aimed to "...provide companionship, emotional support and opportunity to participate in social and recreational activities (p. 45). "Project Stay" (Mowbray et al., 1988) aimed "...to provide a support network and to teach life maintenance skills to individuals with severe emotional problems...to maintain an independent lifestyle in the community" (p. 35). The "Amitre Friendship Program" (O'Loughlin et al., 1989) encouraged "...the clients to develop social and other life skills, which will progressively enable them to better integrate into their social environment and to increase their degree of socialisation" (p. 48). Three of the six studies reported the number of hours training provided to volunteers and this ranged from 12 (O'Loughlin et al., 1989) to 30 hours (Mowbray et al., 1988). Training structure and methods generally involved lecture formats supplemented with various teaching resources, small group discussion, community visits and ongoing supervision. Four of the six studies assessed changes in volunteers as a result of training and the number of volunteers included in each study ranged from 11 (Lieberman et al., 1991) to 37 (Mowbray et al., 1988). The study by Brook et al., (1989) focussed on volunteers only and did not evaluate the effects of the program on consumers. Pre-post training changes in 30 volunteers revealed an increase in knowledge, 90% of volunteers pre-program goals were met and that 86% of volunteers had decreases in their fear of mental illness.

The remaining studies all made some attempt to assess the effects of volunteer services on consumers. Sample sizes ranged from 11 (Lieberman et al., 1991) using focus group methodology to 163 (Skirboll, 1994) using mail out surveys to consumers and their therapists. The "Project Stay" study (Mowbray, et al., 1988) only reported consumer-volunteer service activity data (e.g. 25.3% received help with housing, 18.6% assistance with transportation etc). Two studies used interviews as the source of their data and reported predominantly qualitative data for relatively small numbers of recipients ( $n = 11$ , Lieberman et al., 1991;  $n = 16$ , Armstrong et al., 1995). In the only study (O'Loughlin et al., 1989) to use a standardised measure with established psychometric data the Satisfaction with Life Domains Scale (Andrews & Withey, 1976) was used in addition to service activity data. This was also the only study to include a control group and no significant differences were found on any measures between the experimental and control groups. However, this study also had one of the least intensive training programs (12 hours) and there was irregular consumer contact by volunteers. Thus, whilst there have been generally positive findings reported for volunteer programs there are also significant limitations to the available research. To summarise, the majority of this research has confirmed positive pre-post training effects on volunteer's knowledge and satisfaction with various components of the volunteer experience. One study provided survey data indicating that most consumers (67%) and their therapists (86%) were satisfied with volunteer services (Skirboll, 1994). In the same study, 79% of consumers indicated that they felt less alone, 67% reported increased self-esteem and 47% increased social skills, all findings which were generally consistent with smaller interview based studies (Armstrong et al., 1995; Lieberman et al., 1991).

Most studies tended to only address a limited number of variables in the program and used non-standardised tools to identify what consumers and volunteers consid-

ered the most important and beneficial aspects of the programs. This raises serious concerns regarding reliability and validity of the measures and limits the ability to compare across studies. Four studies were descriptive and did not provide pre-post measures, and most studies lacked data about the chronicity, severity or levels of disability amongst program recipients.

These limitations in evaluation methodology are likely a function of limited financial resources amongst volunteer organisations, their focus on service delivery and the very real difficulties in obtaining sound measurement from an often difficult to assess target group. Similarly, some of the benefits of volunteer programs, whilst not measurable in quantitative terms are self-evident to many observers (e.g. human contact for isolated individuals). Despite these concerns there is a need to continue to evaluate the effects of various volunteer programs on consumer functioning and quality of life in an effort to improve their potential effects.

The present study aims to address some of the limitations of previous studies and extend prior findings by evaluating the effects of the "Helping Hands" Volunteer Program at several levels. These include volunteers knowledge retention and attitudes following a structured training program, and then again subsequent to working with consumers. To assess consumer functioning and life satisfaction, standardised measures completed by both case managers and consumers will be used to provide a comprehensive picture of program outcome.

It was predicted that volunteer training and work would have a positive impact upon volunteer attitudes towards and comfort with mental illness. Whilst it could be reasonably assumed that volunteer training would lead to an increase in volunteer knowledge the emphasis of the present study was on how well volunteers retained their knowledge over time. This would provide an indication as to the necessity of ongoing education and support following the initial training program. Finally, it was predicted that volunteer contact and assistance would be associated with improvements in consumer functioning and life satisfaction.

## Method

### Participants

**Volunteers.** Fifty-four responses were received in response to a local newspaper advertisement calling for volunteers to help people with a mental illness. The advertisement called for people willing to "...help people living with a mental illness to become more independent...with practical tasks such as shopping, budgeting, cooking and cleaning; visiting people at home; providing transport to appointments; providing companionship for people interested in pursuing leisure activities and/or being part of a working bee to help with lawn mowing and minor house maintenance." The advertisement also offered an intensive training program and ongoing support from the mental health service as part of the volunteer role.

All respondents were sent an application form and 24 applications were returned. Twenty applicants were interviewed and 16 volunteers were accepted and completed the 18 hour structured training program. Volunteers also received ongoing support through monthly meetings with the volunteer coordinator and fellow volunteers.

The age of the volunteers ranged from 28 to 65 years with a mean age of 44.8 years ( $SD = 2.8$  years). Two of the volunteers were in full time paid employment, 8 were in

part time paid employment and 3 were consumers of mental health services. Twelve (75%) of the volunteers were female and 4 (25%) were male. All volunteers were based in the Shoalhaven Area, which is comprised of 49 coastal towns and villages, rural farming land, state and national parks. The total population of the area is 82,000 people with towns ranging from approximately 20,000 people to 500 people. The largest town of 20,000 was the location of the local mental health centre.

**Training Program.** The volunteer training program aimed to increase knowledge of mental illness, increase volunteers' confidence and skills in working with people with mental illness and provide community education and professional development. The volunteers training program involved nine, two-hour sessions conducted over a five-week period. The training sessions covered the following content; Introduction to volunteering, Mental Illness — The Facts, Impact of living with a Mental Illness, Psychosocial Rehabilitation, Effective Communication, Aggression Management, Suicide Prevention, Occupational Health and Safety and Where to from here?

Subsequent to the training program, all consumers were matched with two volunteers who worked in pairs to assist in addressing individual consumer needs. The pairing of volunteers was a Mental Health Occupational Health and Safety directive. In addition, pairing of volunteers was considered desirable to increase consumer-volunteer contact, reduce consumer dependence on one volunteer and provide support amongst the volunteers. The volunteer network met on a monthly basis to discuss areas of difficulty plus provide ongoing support and education for volunteers.

**Volunteers Program.** In addition to completing the training program all volunteers were required to: establish a support agreement with the consumer and volunteer coordinator, undergo a standard criminal record check, receive ongoing supervision and regular performance appraisal (three – six monthly), maintain confidentiality of consumers and the mental health team, and provide only support services stated in the support agreement.

The volunteer coordinator matched each consumer with two volunteers according to education, hobbies, interests and skills identified in the volunteer application form. A support agreement was developed between the three parties to identify activities and times of contact. Specific tasks identified in the support agreement included such things as shopping, walking and financial management activities. Volunteers and consumers met on average once a week for one to two hours and generally had one phone conversation per week to organise their activity. Activities most commonly identified were "going for coffee", shopping and walking. Volunteers were required to complete an activity report following each period of contact with the consumer. Volunteers attended a monthly meeting that provided support and ongoing education.

**Consumers.** All consumers were receiving services from the local Mental Health Service and all were on psychotropic medication. The participant group was comprised of 11 consumers. Most ( $n = 7$ ) had a diagnosis of schizophrenia, ( $n = 2$ ) depression and ( $n = 2$ ) generalised anxiety and depression. The mean age of consumers was 52 years ( $SD = 3$ ) and mean duration of diagnosis was 18.3 years ( $SD = 7.9$ ). Six consumers were living in housing department accommodation, two in group housing, and one each in private rental and living with a carer. Program recipients were identified by their case manager as requiring additional assistance to satisfy activities of daily living beyond that provided by their residential worker and

families. Eleven consumers were originally referred to the volunteer service. Nine of these consumers were interviewed at Time 1 regarding their quality of life using Lehman's Quality of Life Interview (Lehman, 1988). One participant was later excluded from the program following three unsuccessful attempts to establish a support agreement with the volunteer and case manager. The client was agitated and confused and subsequently hospitalised. Unsuccessful attempts were made to interview the final two consumers. One participant was unable to participate in the interview due to extreme anxiety at meeting new people. The final participant did not complete the interview due to high levels of fatigue and the inability to concentrate on the task at hand in order to complete the protocol. Both agreed to permit access to referral data completed by their case managers.

Of the 9 consumers interviewed in the initial phase only 5 could be re-interviewed at follow up. One consumer who had begun receiving volunteer services died during the program from a pre-existing heart condition. Two consumers refused to be re-interviewed at follow up. (One of these consumers was no longer receiving volunteer services).

#### *Procedure and Measures*

All volunteers completed a Volunteer Attitudes Scale and Volunteer Knowledge assessment one week after receiving 4 hours of training on knowledge of mental illness and volunteering. This assessment was repeated in the final session of the volunteer training program and again six months later. Demographic data regarding the volunteers was gathered from the volunteer application form.

The form used by clinicians to refer consumers to the volunteer program was comprised mainly of the Health of the Nations Outcome Scale (Stedman, Yellowlees, Mellsoy, Clarke & Drake, 1997). This was completed prior to involvement with the volunteer program and again six months later.

All consumers were approached to complete the Quality of Life Interview (Lehman, 1988) before receiving volunteer services and again four months later.

Volunteer attitudes were measured utilising selected items from two measures, the Comfort in Interaction Scale (CI) (Beckwith & Matthews, 1994) and the Opinions of Mental Illness (OMI) Scale (Struening & Cohen, 1962).

**Comfort in Interaction Scale** (CI, Beckwith & Matthews, 1994). The CI has 43 items each rated on a 7-point Likert-type scale and aims to identify attitudes toward dealing with unfamiliar person characteristics and situations and measures the level of comfort that individuals have in interacting with people with disabilities. The scale was originally developed with people with intellectual disabilities as the identified target, but in the present study the identified target was "people with mental illness". The CI has a coefficient alpha of  $r = .88$ , test-retest reliability of  $r = .91$ , and a low and insignificant relationship with social desirability measures (Beckwith & Matthews, 1994).

**Opinions of Mental Illness Scale** (OMI, Cohen & Struening, 1962). The OMI was originally developed to "identify and develop measures of important dimensions underlying opinions about mental illness" (p. 350) and is one of the most extensively used measures of attitudes towards mental illness.

The original form identified five dimensions underlying opinions about mental illness (e.g. authoritarianism, benevolence) and additional dimensions were later

incorporated (e.g. community resistance/stigma, Keane, 1991). The full scale consists of 100 items scored on a 5-point Likert-type scale. Reliability and validity coefficients are considered within acceptable limits for most of the factors, ( $r$ 's range from .82-.89) (Cohen & Struening, 1962; Keane, 1991).

Unfortunately the demands of training meant that it was impractical to administer all 143 items of both the CI and OMI, thus items deemed most appropriate to the context of volunteer training were retained in the final form. Sixteen items from the CI were used and 27 items from the OMI were retained. These were rated on a 6-point Likert-scale ranging from 1 — "Strongly agree" to 6 = "Strongly disagree". This rating scale was originally used in the development of the CI (Gething & Wheeler, 1992) and was retained because it does not have a neutral point and thus requires respondents to indicate level of preference. When selecting items for inclusion repetition was avoided. For example; "If I was with people with mental illness I would feel OK about my lack of illness" was retained and "I feel overwhelmed with discomfort about my lack of illness" was removed. Items were also eliminated where they were considered not applicable to the population being assessed and therefore unnecessary. A number of items on the OMI referred to hospitalised patients and those were not included because all recipients of the service were living in the community. For example; "The best way to handle patients in mental hospitals is to keep them behind locked doors". In addition, several items were reworded in accordance with more acceptable current terminology, for example; the OMI items used the term "mental patients" and this was altered to "people with mental illness".

**Volunteer Knowledge (VK).** Retention of knowledge from the training program was assessed using a 29 item True/False scale developed specifically for the purpose of this evaluation. The scale was based on the content and outline of the training manual. The VK was administered following the initial 4 hours of training that addressed knowledge of mental illness. This was re-administered 4 weeks later at the completion of the training program and then again 6 months later in order to assess knowledge retention. This was aimed at determining the amount of knowledge learnt in the program and retained over time.

**The Quality of Life Interview.** (QLI, Lehman, 1988) was developed to evaluate the quality of life of people with chronic mental illness (and ultimately assist in the planning of services). It addresses eight influential life domains on both an objective and subjective level. These include; living situation, daily activities, family and social relations, finances, work, training and study, legal and safety issues, and health. A ninth domain, "religion" is optional and was not included in the present study. In addition clients are asked to give a rating of general life satisfaction.

An interview format was selected by Lehman (1988) to limit the problem of client misunderstanding of questions and to increase client cooperation. The interview first identifies objective data regarding the specific life domain and then asks the client to subjectively appraise their degree of satisfaction in that domain. The subjective rating scale asks the consumer to nominate a rating on a 7 point Likert scale (1 = terrible, 7 = delighted). The interview takes approximately 30-45 minutes to complete.

Internal consistency reliability coefficients were similar across the development sample populations and ranged between  $r = .78$  and  $r = .88$  for the subjective scale and  $r = .44$  and  $r = .87$  for the objective scale. Test-retest reliability correlations exhibited significant stability in most scales, (ranging between  $r = .29$  and  $r = .98$ ).

In a review of instruments assessing quality of life reliability and validity the QLI was within acceptable limits and it was identified as the tool of choice where psychometric properties and appropriateness of use for people with mental illness is a major consideration (Nieuwenhuizen, Schene, Boevink & Wolf, 1997).

**Health of Nations Outcome Scale.** (HoNOS, Wing, Curtis & Beevor, 1998). The referral form incorporated an adapted HoNOS. This form had the dual purpose, as a referral form to identify levels of consumer functioning and client goals of the volunteer program and secondly, for use as a tool to evaluate changes in functioning over time. Selection and development of this tool was conducted in conjunction with the Volunteer Program Coordinator. Case managers completed the form initially for referral purposes and again three months later in order to assess any change over the period of volunteer service provision.

The HoNOS has been recommended for use as one of the standard national mental health outcome measures in Australia (Stedman et al., 1997). The tool contains twelve scales (see Table 2 for all scale domains). Two scales were excluded from the referral form because they were not considered targets of the volunteer program (Problems with Living Conditions, Occupation & Activities). All other items were retained and two additional items were developed: Problems associated with Medication Adherence and Problems associated with Social Skills. Medication Adherence was considered a concern when matching volunteers and consumers and social skills was an identified objective of the program that was not sufficiently covered in the existing HoNOS.

Stedman et al's (1997) comprehensive review of the HoNOS in Australian conditions indicated internal consistency was generally low mostly due to the diverse domains tapped, and sensitivity to change was considered only "reasonable". However, given the dual roles of the instrument (referral and evaluation) and the measurement of diverse domains with a small number of items it was considered appropriate to the present study.

**Client Satisfaction Questionnaire-8.** (CSQ-8, Attkisson & Zwick, 1982). Evaluation of satisfaction with the training and volunteer program was assessed in volunteers, consumers and case managers. Volunteers rated satisfaction with the training program at the final training session. Consumers, volunteers and case managers rated satisfaction with the volunteer program four months after initiation.

The CSQ-8 (Atkinson & Zwick, 1982) is an 8-item version of the full Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, Nguyen, 1979) and provides a measure of general service satisfaction. Each item is rated on a 4-point Likert-type scale ranging from "1" indicating the lowest degree of satisfaction and "4" the highest. The CSQ-8 has high internal consistency, with alpha coefficients ranging from .87 (Nguyen, Attkisson, Stegner, 1983) to .93 (Attkisson & Zwick, 1982) in a variety of mental health facilities.

## Results

Paired  $t$ -tests were conducted to evaluate the effect of training and consumer involvement on knowledge retention and attitudes towards people with mental illness. Paired  $t$ -tests were chosen over repeated measures ANOVA to minimise the loss of data (due to a reduced sample size at the final evaluation). Table 1 indicates that knowledge was maintained over the course of the training program and at a

descriptive level increased at the 6-month follow-up, but this increase did not reach statistical significance.

There were no significant differences in volunteers' attitudes toward people with mental illness (OMI) over the 6-month period. Volunteers did show a significant increase in their level of comfort in interaction (CI) with people with a mental illness,  $t(13) = 1.95, p < .05$ , at the completion of the training program. There was no significant change in this level from immediately at the end of the training program to 6 months later.

Volunteers expressed high levels of satisfaction regarding the training program and at the 6-month follow-up. The highest possible mean score on the CSQ-8 is 4 and the mean satisfaction ratings were 3.72 (post-training) and 3.84 (6-month follow-up). The 6-month follow-up asked about satisfaction with volunteer experience and ongoing support and education provided by the program. Volunteers reported a sense of fulfillment, increased awareness of mental illness and improved communication skills as the most valuable benefits to them from the program. Future recommendations and suggestions made by volunteers included reimbursement for out of pocket expenses, access to additional readings and increased support.

In order to supplement the description of consumers referred to the "Helping Hands" Volunteer Program they were compared to samples with similar diagnoses on the HoNOS scores. Table 2 indicates that on average the study sample were experiencing more severe problems in most domains when compared with other client samples on the HoNOS. Descriptively, 8 out of 10 domains of functioning improved over the 4 month period but these changes did not reach statistical significance ( $p > .05$ ). The small sample size may well have contributed to low power and difficulty in detecting significant change.

High levels of satisfaction with the volunteer program were expressed by consumers ( $M = 3.38, SD = .42$ ) and case managers ( $M = 3.55, SD = .31$ ). When case managers were asked to comment on the effects of the program most reported improvements in client self esteem and socialisation levels as the most beneficial aspects of the program. Future recommendations and perceived problems included a need for more stringent screening of volunteers, volunteer drop out and a need for more volunteers. Consumers reported the socialising aspect of the program most

**TABLE 1**  
Pre and Post Training Volunteer Attitude and Knowledge Scores

	After 4 hours of training (n = 14)		After 18 hours of training (n = 14)		6 months after training (n = 8)	
	M	SD	M	SD	M	SD
Knowledge	21.67	1.88	21.13	2.64	23.00	2.93
OMI	2.41	0.33	2.32	0.28	2.03	0.35
CI	2.80 <sub>a</sub>	0.77	2.54 <sub>a</sub>	0.58	2.54	0.46
Satisfaction	—	—	3.87	0.24	3.72	0.45

Note: a = means sharing this subscript differ at  $p < .05$   
OMI — Opinions of Mental Illness  
CI — Comfort with Interaction

**TABLE 2**  
Comparison of Consumers Receiving Volunteer Assistance With Other Client Groups on the HoNOS

Problem Domains	Trauer et al., 1999		Helping Hands	
	Schizophrenia (N = 1119)	Depressive Disorder (N = 179)	Before Program (N = 11)	After 6 months (N = 7)
Aggression	.75	.76	1.0	.43
Self Harm	.20	.75	.64	.43
Alcohol/drug	.53	.41	.82	.71
Cognitive Impairment	.69	.70	1.45	1.29
Physical Impairment	.68	1.03	2.00	2.14
Hallucinations — Delusions	1.44	.42	1.45	.71
Depression	0.78	1.89	1.55	1.29
Other Behaviour	1.23	1.89	1.91	2.86
Relationships	1.65	1.34	2.73	2.14
Activities of Daily Living	1.26	.96	2.18	1.86
Total	9.19	10.15	15.73	13.86
Accommodation	0.63	0.41	—	—
Occupational	0.81	0.50	—	—
Medication Adherence	—	—	1.00	1.43
Social Skills	—	—	2.29	2.43

**TABLE 3**  
Pre and Post-program Objective and Subjective Quality of Life Ratings by Consumers

	Before Program (n = 5)		After Program (n = 5)	
	M	SD	M	SD
<b>Objective</b>				
Activities of Daily living	3.10	0.55	2.90	0.89
Family	3.10	1.56	3.60	1.14
Social	2.20	0.82	1.75	0.47
Financial	0.72	0.27	0.76	0.26
Legal	0.13	0.18	0.20	0.30
<b>Subjective</b>				
Activities of Daily Living	3.94	1.24	3.72	1.60
Family	3.30	1.20	3.60	1.14
Social	4.00	0.95	3.70	0.89
Financial	4.45	0.97	3.65	1.63
Legal	5.73	0.98	4.87	1.15
Health	3.07	0.86	3.50	1.10
Life Satisfaction	3.20	1.57	3.30	1.60

beneficial to them with the majority of volunteer contact involving "going for coffee" or shopping.

Table 3 provides means and standard deviations for objective and subjective domains from the QLI. There were no significant differences between pre and 4-month post-program ratings on any scales.

## Discussion

The main findings of this study were that volunteers' knowledge of mental illness during the training course was retained over the 6-month follow-up period and their comfort in interacting with people who have mental illness increased. This supports previous research which indicated alterations in attitudes and comfort with mental illness following volunteer training (Brook et al., 1989). There were no significant changes in volunteer attitudes toward mental illness over the course of the training program. However, it is likely this was in part due to the relatively positive attitudes in a group who were self selected to work as volunteers with people with mental illness. That is, they were highly likely to be positively predisposed to working with people with mental illness before training and hence they had only a small margin for improvement.

The retention of knowledge noted in the study is encouraging since it demonstrates not only that the training program provided short-term improvement in knowledge (Brook et al., 1989) but that these benefits were maintained over time. All parties involved in the Helping Hands Program at all levels reported high levels of satisfaction. This finding failed to convert to measurable improvements in consumer functioning and quality of life. In general, the results suggest no significant changes in client functioning or quality of life over the period that they were actively receiving volunteer services. There are several potential reasons for this finding.

A major limitation of this study was the small sample size. Unfortunately this was unavoidable due to the program evaluation taking place in the first 6 months of inception and hence having a small number of participants. In addition, the sample referred for volunteer services was seriously affected by mental illness which resulted in barriers to some being assessed, (e.g. high levels of distress). The high level of disability in the study sample was confirmed by comparisons with other samples on the HoNOS (Trauer et al., 1999, see Table 2).

Secondly, the Quality of Life Interview whilst reported as suitable for people with mental illness (Lehman, 1988) was found to be limited in its application. In particular, respondents had difficulty in providing subjective ratings of satisfaction on the 7-point Likert-scale. It may be more fruitful for future research to use more refined measures of the socialisation components of clients functioning since these are typically the most frequently cited aims of volunteer programs.

Demographic data indicated that the Helping Hands consumers had been receiving treatment for their mental illness for a long period of time ( $M = 18.3$  years  $SD = 7.9$ ). Given the chronic nature of their illness and the relatively high levels of disability (HoNOS ratings) it would be unlikely that a volunteer program would be sufficiently potent to impact significantly on recipients quality of life or behavioural functioning over a 4-month period. In situations where recipients of volunteer services have access to other sources of social support such as family carers, it may be that over the short-term (ie. 4 months), the volunteer service provides some

respite to these carers. It is unclear what effects volunteer services have on other carers and whether there are more or less frequent visits to family or others with the advent of additional social contacts with volunteers. If such a short-term effect did arise from other carers taking the opportunity for some respite, then this could have an impact on other global outcome measures. These are research questions requiring future research.

However, the high level of satisfaction reported by all parties in the present study provides positive data consistent with previous studies that identified other favourable program outcomes. The lack of significance on standardised scales such as the HoNOS and QLI is similar to that found by O'Loughlin et al. (1989). Until the present study, the Amitre' Friendship program stood alone in the use of a standardised scale assessing life satisfaction and also failed to show a significant impact on consumers' lives.

These findings further reinforce the need to evaluate volunteer programs in their entirety, to identify the positive effects they represent and also their limitations. Existing evidence suggests that volunteer programs represent a well-received addition to treatment by mental health services and consumers by providing a form of social contact. However, preliminary data suggests this does not appear to convert to measurable improvements in behavioural functioning or quality of life in severely disabled groups.

The continued establishment of volunteer programs with similarly identified goals of friendship and companionship (eg: Compeer Program), prompts the need for more comprehensive evaluations of their effectiveness. This includes establishing clearer guidelines for referring consumers, targeting groups of recipients and identifying more sensitive measures that might better detect impacts on consumers' quality of life. In general, there were many gaps in even the descriptive data from prior studies. In particular, there is a need to clearly describe the level of disability in research evaluating the effects of volunteer programs.

Our experience in attempting to provide a comprehensive evaluation of program effects met with many difficulties. The use of a matched control group would provide an ideal comparison to identify program effects, but the logistical challenges of recruiting participants for a suitable control group are substantial. The resources required for such evaluations are considerable and this is clearly one reason we, and other researchers, have struggled to provide more rigorous designs. The levels of disability of some groups make assessment time consuming. Participants in our study often had difficulty with transportation and there were costs of both time and money in arranging interviews. Coordinating input from volunteers, consumers and therapists or case managers also added complexity to data collection. There may be a need to consider not only funding to support direct service delivery in the future, but also to support research into methods to better develop and target volunteer services as well as increase the effectiveness of such innovative programs.

## References

- Andrews, F. & Withey, S. (1976). *Social Indicators of Well being*. New York: Plenum Press.
- Armstrong, M. L., Korba, A. M. & Emand, R. (1995). Of mutual benefit: The reciprocal relationship between consumer volunteers and the clients they serve. *Psychiatric Rehabilitation Journal*, 19, 45-49.



- Atkisson, C. C. & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilisation and psychotherapy outcome, *Evaluation and Program Planning*, 5, 233–237.
- Beckwith, J.B. & Mathews, J.M. (1994). Measuring comfort in interacting with people with intellectual disabilities, *Australian Journal of Psychology*, 1, 53–57.
- Brook, S., Fantapolous, I., Johnson, F. & Goering, P. (1989). Training volunteers to work with the chronically mentally ill in the community. *Hospital and Community Psychiatry*, 40, 853–855.
- Cohen, J. & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. *Journal of Abnormal and Social Psychology*, 64, 349–360.
- Gething, L. & Wheeler, B. (1992). The interactions with disabled persons scale: a new Australian instrument to measure attitudes towards people with disabilities, *Australian Journal of Psychology*, 2, 75–82.
- Keane, M. (1991). Acceptance vs rejection: nursing students' attitudes about mental illness, *Perspectives in Psychiatric Care*, 27(3), 13–19.
- Larsen, D.L., Atkisson, C.C., Hargreaves, W.A. & Nguyen, T.D. (1979) Assessment of client patient satisfaction: Development of a general scale, *Evaluation and Program Planning*, 2, 197–207.
- Lehman, A. F. (1988). A quality of life interview for the chronically mentally ill. *Evaluation and Program Planning*, 11, 51–62.
- Lieberman, A. A. Gowdy, E. A. & Knutson, L. C. (1991). The Mental Health Outreach Project: A case study in self help, *Psychosocial Rehabilitation Journal*, 14, 100–104.
- Mowbray, C. T., Wellwood, R & Chamberlain, P. (1988). Project Stay: A consumer run support service, *Psychosocial Rehabilitation Journal*, 12, 33–42.
- Mehl, B. (1999). *Volunteer Policy Manual for Shoalhaven Mental Health Service*, Nowra, NSW, Illawarra Area Health Service.
- Nguyen, T.D., Atkisson, C.C. & Stegner, B.L. (1983). Assessment of patient satisfaction: Development and refinement of a service evaluation questionnaire. *Evaluation and Program Planning*, 6, 299–314.
- Nieuwenhuizen, C. V., Schene, A. H., Boevink, W. A. & Wolf, J. R. L. M. (1997). Measuring the quality of life of clients with severe mental illness: A review of instruments. *Psychiatric Rehabilitation Journal*, 20, 33–41.
- O'Loughlin, J., Laurendeau, M.-C., & Gagnon, G. (1989). An evaluation of a volunteers visitor program for socially isolated adults with chronic mental health problems, *Canadian Journal of Community Mental Health*, 8, 48–52.
- Skirboll, B. (1994). The Compeer model: client rehabilitation and economic benefits, *Psychosocial Rehabilitation Journal*, 18, 87–94.
- Stedman, T., Yellowlees, P., Mellsop, G., Clarke, R. & Drake, S (1997). *Measuring consumer outcomes in mental health*, Canberra, ACT: Department of Health and Family Services.
- Trauer, T., Callaly, T., Hantz, J. Little, R., Shields, R. & Smith, J. (1999). Health of Nations Outcome Scales – results of the Victorian field trial. *British Journal of Psychiatry*, 174, 380–388.
- Wing, J.K., Beevor, A.S. & Curtis, R.H. (1998) Health of the Nation Outcome Scales (HoNOS): Research and development, *British Journal of Psychiatry*, 172, 11–18.
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