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Evolution and sustainability of the Helping Hands volunteer program: Consumer recovery and mental health comparisoins six years on

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Abstract

The Helping Hands program commenced in 1999 and partners volunteers with mental health consumers for support and to increase social contact, recreational and friendship opportunities. The aim of the present study is to describe the evolution and sustainability of the program over the first 6 years. A description of consumers accessing the program using recovery-oriented measures and traditional measures of behavioural functioning is also provided. Service data was collected on the development of the program, service utilisation, volunteer participation and funding patterns. Cross-sectional measures of recovery and baseline and follow-up Health of the Nation Outcome Scales (HoNOS) were collected on 27 participants. Results showed that the Helping Hands program has evolved significantly since start-up with the development of numerous recreational, health and support groups and 48 active volunteers and 62 active clients. Consumer feedback indicates that the service increases the quality of life of participants considerably. Current clients showed less severe disability at referral than did the original group. There were improvements in the area of relationships on the HoNOS for those who had baseline and follow-up measures. The high volunteer participation rates and positive consumer outcomes represent significant value in return for the modest level of funding.

Keywords

consumer, mental, health, six, years, evolution, helping, hands, volunteer, program, recovery, comparisoins, sustainability

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Evolution and Sustainability of the Helping Hands Volunteer Program: Consumer Recovery and Mental Health Comparisons Six Years On

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The Helping Hands program commenced in 1999 and partners volunteers with mental health consumers for support and to increase social contact, recreational and friendship opportunities. The aim of the present study is to describe the evolution and sustainability of the program over the first 6 years. A description of consumers accessing the program using recovery-oriented measures and traditional measures of behavioural functioning is also provided. Service data was collected on the development of the program, service utilisation, volunteer participation and funding patterns. Cross-sectional measures of recovery and baseline and follow-up Health of the Nation Outcome Scales (HoNOS) were collected on 27 participants. Results showed that the Helping Hands program has evolved significantly since start-up with the development of numerous recreational, health and support groups and 48 active volunteers and 62 active clients. Consumer feedback indicates that the service increases the quality of life of participants considerably. Current clients showed less severe disability at referral than did the original group. There were improvements in the area of relationships on the HoNOS for those who had baseline and follow-up measures. The high volunteer participation rates and positive consumer outcomes represent significant value in return for the modest level of funding.

The Helping Hands volunteer program partners volunteers with consumers to increase social contact, practical support, recreational opportunities and friendship. Programs such as this also have the potential to reduce stigma and to foster greater community awareness and more positive attitudes towards those with mental illness.

The Helping Hands program trains community volunteers to provide one-on-one support for consumers, and to facilitate support and recreational activities groups. Volunteers may assist consumers with practical living skills and encourage social interaction by providing transport and access to community resources. The close relationship fostered by matching consumers to volunteers places the volunteer in a unique position to understand the consumer's individual needs. Helping Hands assists consumers to achieve levels of life skills to maintain independence, improve quality of life and enhance social mobility. The program provides opportunities for participation in recreational, social, vocational and therapeutic activities.

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An initial evaluation of the Helping Hands program was provided by Pickard and Deane (2000). The limited research base on volunteer programs providing friendship, recreation and social contact was noted and this continues to be an under-researched area with only two studies being reported since the 2000 review. The first of these two studies was descriptive and reported the number of participating student volunteers and service hours provided through a university-based Compeer program (Sousa & Frizzell, 2005). The second was also conducted using participants from a Compeer program and assessed the impact of contact with people who have severe mental illness (SMI) on stigmatising attitudes (Couture & Penn, 2006). Compeer volunteers were compared to community controls, who had no contact with people who had SMI. It was found that over 6 months the Compeer volunteers had a significant decrease in negative affective attitudes (e.g., empathic versus angry) compared to the community controls (Couture & Penn, 2006). This finding extends those of Pickard and Deane (2000) who found volunteers had significant increases in their comfort in interactions with people who have mental illness. However, the Pickard and Deane study did not have a control comparison group.

There is little data regarding the sustainability of volunteer friendship programs. A recent United States (US) study reviewed 787 faith-based volunteer programs that provided a wide range services to people with chronic physical and mental disabilities. The programs were initially funded under the same granting scheme from 1988 to 1992 and by 2001 it was found that a 'conservative estimate of program sustainability is 62.0%' (Leviton, Herrera, Pepper, Fishman & Racine, 2006, p. 202). It was also found that of the surviving programs 70% increased the number of clients and volunteers, almost doubling the median number of volunteers from a median of 22 (at 6 months) to 40 at the time of the survey. The number of clients increased from a median of 22, 6 months after receiving the grant, to 60 clients. The factors found to be associated with program sustainability included provision of services prior to receiving the grant, and building a strong volunteer pool with a solid funding base. Volunteer recruitment and retention was associated with matching clients with a team of volunteers (versus exclusively one-to-one), provision of volunteer pretraining, provision of diverse services, volunteer supervision and leadership by a program director with experience in training and supervision of caregivers (Leviton et al., 2006).

Clearly, sustainability of volunteer organisations is a critical issue with almost 38% of those initially funded not surviving some 10 years later. In the context of volunteer programs such as Compeer and Helping Hands, little is reported about the long-term viability of these programs, nor how their profiles may change or adapt in order to maintain their sustainability in the community. This is particularly important in the context of changes to other mental health services in communities and the new national priority on 'recovery-oriented services' in Australia.

The National Mental Health Plan 2003–2008 (NMHP; Australian Health Ministers, 2003) emphasises the need for the promotion of recovery from mental illness, which must extend into all sectors of service provision and into the community. The plan stresses the need for accessibility to a wide range services, including community services, which should 'provide continuity of care, adopt a recovery orientation and promote wellness' (p. 4).

The NMHP emphasises the importance of collaboration with non-government sectors, consumers and carers to deliver programs that promote mental health,

prevent mental illness and support rehabilitation and recovery. A priority is to increase access to recovery and rehabilitation by providing a range of community-based care alternatives. This can be achieved by fostering recovery and rehabilitation programs outside clinical frameworks, including in nongovernment sectors, and may involve 'psychosocial, recreational and vocational programs' (p. 21). The role of nongovernment organisations in support, advocacy and psychosocial rehabilitation is recognised and supported. The focus of recovery-oriented programs is on promoting hope, wellbeing, self-determination and development of meaning and purpose in the lives of consumers (Andresen, Oades, & Caputi, 2003). Less emphasis is placed on more traditional outcomes such as symptom reduction or changes in behavioural functioning. This shift also means that alternative measures of recovery should now be considered for assessing improvements in the lives of consumers as a consequence of mental health services or programs.

The aim of the present study is threefold. First, we wanted to describe how the Helping Hands program has evolved and sustained itself over the 6 years since the initial evaluation conducted by Pickard and Deane (2000). A description of the funding arrangements, organisational changes, number of volunteers, clients and activities will be provided. Second, we aim to describe the characteristics of the current cohort of clients that are currently accessing services through Helping Hands, but with an emphasis on more recovery-oriented measures. Finally, using the Health of the Nations Outcome Scales (HoNOS) we aimed to compare the mental health functioning of those currently in the program with the sample described by Pickard and Deane (2000) 6 years earlier.

Service Evolution and Sustainability

Helping Hands was initiated with transitional project funding from the Commonwealth in 1999. This funding allowed a coordinator to be employed who developed the program and the various training and program protocols. The program went unfunded from 2000 to 2001, but the volunteers continued to work without a coordinator. From 2001 to 2003 the program was supported by funding from the Illawarra Mental Health Integration Project (Posner & Abello, 2003). This project was one of three national mental health integration projects funded by the Australian Department of Health and Aged Care, which had the aim of improving linkages between private psychiatrist services and public sector mental health services. The Illawarra program aimed to provide a more integrated, comprehensive and coordinated system of mental health care by developing partnerships between private psychiatrists, general practitioners, nongovernment organisations (NGOs) and the public mental health system (Eagar et al., 2005). At the end of this period of funding, expressions of interest for the coordination of the program were taken and the NGO, Schizophrenia Fellowship, was successful in taking on the project for further development in 2003. From July 2004 to July 2007 a funding and performance agreement has been provided between the local public area mental health service and Schizophrenia Fellowship. Total funding provided to the Helping Hands service by the area health service averages $56,000 per annum for the 3-year period. The Helping Hands program is run out of The Junction, a rehabilitation facility that is part of the public sector mental health service based in a coastal regional city of approximately 25,000 people.

Staffing and Volunteer Workers

The Helping Hands program has only two part-time paid positions: a volunteer coordinator (20 hours per week), and an administration assistant (8 hours per week). The coordinator is responsible for interviewing, assessing, training and matching voluntary workers with consumers, ensuring compliance with volunteer support agreements and administrative support.

Volunteer Recruitment

Volunteers are recruited from all sectors of the community. Recruitment campaigns are conducted by media release, press and poster advertising, and presentations to students and health bodies. The volunteer coordinator is responsible for objectively selecting volunteers based on the capacity of the individual to comply with the obligations, rights and responsibilities of the volunteer program as defined in the *Volunteer Policy Manual* and in accordance with the philosophy and mission statement of Helping Hands. Sustaining volunteer recruitment is ensured by networking with tertiary educational and employment agencies. Helping Hands makes available workplace training positions for students, conducts class presentations and provides mental health educational materials to educational institutions such as Illawarra Institute of TAFE. Employment agencies such as Mission Australia and Centrelink assist in the on-going recruitment of volunteers.

Volunteer Training

Volunteers undertake a Helping Hands training course that is comprised of modules on: Introduction to volunteering, Psychosocial rehabilitation, Effective communication, Suicide awareness, Mental illness education, and the Impact of mental illness, Confidentiality, and Occupational health and safety. This training is facilitated by the staff of The Junction and the Nowra Mental Health team. In addition, volunteers undertake training in mental health first aid and drug and alcohol abuse management. Volunteer training is also provided by Volunteering Illawarra. Voluntary workers are recognised as members of the rehabilitation team and receive due appreciation and respect from professional staff.

Referral to the Service

The original referring agency was the Illawarra Area Mental Health Service. After coming under the auspices of the Schizophrenia Fellowship in 2003, the service has been able to accept referrals from the entire health and welfare agency spectrum. As well as the mental health service, referrers include general practitioners, psychologists, Centrelink, St Vincent de Paul and other NGOs. Anyone may make a referral, provided the person being referred has a diagnosed mental illness, has a formal case manager and is in the rehabilitative phase of the illness. People may also self-refer to the service.

Activities Offered by Helping Hands

One-On-One Linkage

The core service of Helping Hands is the provision of one-on-one linking of volunteers with clients. These volunteers assist clients with practical living skills such as cooking, shopping and budgeting; encourage social interaction; provide transport

and facilitate access to community resources. Through this service, consumers are assisted in achieving the level of life skills required to maintain independence, improve quality of life and enhance social mobility.

Call Outreach

A more recent innovation of the Helping Hands service is the Call Outreach Service for remote clients, or those who do not or cannot go out in public. This service commenced in January 2006, and response by clients and volunteers has been very positive. Volunteers are linked with a client whom they call each week from The Junction and talk to for 10 to 15 minutes. Volunteers undergo additional training for this service. There are currently 7 Call Outreach volunteers, and 15 Call Outreach clients.

Support Groups and Activities

The Helping Hands service also makes available opportunities for participation in recreational, social, vocational and therapeutic activities to which consumers may not otherwise have access. Activities offered by Helping Hands include:

- art and craft group
- guitar group
- writing group — consumer run and volunteer supported
- care and share support group
- swimming group in warm weather
- weight management program
- walking program
- ten pin bowling group
- St Vincent de Paul garden farm project
- Call Outreach — a regular phone call service for remote or isolated consumers
- the Helping Hands newsletter — a combined effort of staff, consumers and volunteers, which provides information and facilitates continued communication with more isolated consumers
- West Street Sport and Recreation Club — run by the Helping Hands volunteers each Monday 9.30 am–12.30 pm, with a cooked lunch and Thursday 12.30 pm–3.30 pm with a BBQ
- the Helping Hands monthly outings — the lack of public transport available in the local area makes these outings important to consumers, who often lack private transport
- holidays away, with funding support from local organisations.

The groups are only open to people who have been referred to Helping Hands. However, the West Street Sport and Recreation Club, the monthly outings and the holidays away are open to all people with a mental illness in the local area. It can be seen that there is much emphasis in the program on physical health as well as creative outlets.

The support groups are held at The Junction in Nowra. At the time of the Illawarra Mental Health Integration Report (Posner & Abello, 2003), groups were also held in a small coastal town approximately one hour away (Ulladulla). However, in 2004, there was no longer sufficient funding to maintain the consumer rehabilitation assistants, who had been coordinating the groups.

Service Utilisation and Activity

Volunteer and Client Numbers

There are 60 trained volunteers registered with Helping Hands, 48 of whom are currently active. Two of the trained volunteers were mental health consumers, and 11 were carers of a person with a mental illness. During the period of data collection there were 62 active clients in the Helping Hands program. These include clients referred for one-to-one volunteer services and/or group activities.

Service Utilisation

Service utilisation and activity data was obtained from the Helping Hands records over a 7-month period from August 2005 to February 2006. Table 1 provides a summary of the service utilisation data. Over the 7 months there was an average of 399 separate individual attendances at groups each month, averaging 140 hours of group contact per month. There was an average of 37 individual one-on-one contacts between a consumer and volunteer each month, averaging 40 hours of contact each month. In addition, some volunteers provided support in the service office, which averaged 30 hours a month. Preliminary data was also available for the new Call Outreach service, which commenced in January 2006 and provided 24 call links constituting 4.2 hours of contact up to the end of February 2006. Using the direct client contact data, the combined mean client contact hours (including Call Outreach) is 184 hours per month. At a rate of $4667 per month to run the service, this equates to $25.36 per client contact hour. If the mean frequency of client contacts per month is used (M = 448) then the rate is $10.42 for each episode that a client attends or accesses an activity.

Method

Participants and Procedure

Current and recent clients of the Helping Hands project were approached by a research assistant for consent for access to their records, or to complete the recovery measures or feedback forms. The recovery measures and consumer feedback forms were completed only once. For those who gave permission and had an

TABLE 1

Service Utilisation of Helping Hands Over 7 Months

	Aug 2005	Sept 2005	Oct 2005	Nov 2005	Dec 2005	Jan 2006	Feb 2006	Total
Numbers attending groups	466	472	412	277	456	301	408	2792
Group hours	121	114.5	150	102.5	221	86.5	150.8	981.8
Number of 1-to-1 contacts	55	38	45	41	15	27	38	259
1-to-1 contact hours	130	85	108.5	81	23	48	70	277.5
Volunteer office hours	32	40	32	32	24	18.5	32	210.5

initial HoNOS as part of the referral process, a repeat HoNOS was requested and completed by their case manager in the mental health service. Although 36 Helping Hands clients agreed to participate in the research, not all completed every aspect of the evaluation. Thus, 58% of all active clients in the program ($N = 62$) participated in some component of the evaluation. Twenty-seven consumers completed the Recovery measures and feedback forms. Referral Forms were accessed for 27 participants and provided HoNOS data. Recent HoNOS information (completed during the data collection period) was collected for 26 participants. Descriptive information for the 27 participants who completed the recovery measures is provided in Table 2.

Measures

Recovery Measures

Stages of Recovery Instrument (STORI; Andresen et al., 2006). A consumer-oriented self-report measure consisting of 50 items. Items represent *hope*, *responsibility for wellness*, *positive identity* and *meaning in life* over five stages of recovery, rated on a 0 to 5 scale. The measure yields 5 subscale scores representing each stage of recovery. Stage of recovery is determined by the highest subscale score, yielding possible scores of stage 1 through to stage 5. An example item is for Responsibility in stage 3: 'I am ***beginning*** to learn about mental illness and how I can help myself'.

Mental Health Inventory — 5-item version (MHI-5; Berwick et al., 1991). A short mental health screening test, utilizing those five items from the original Mental Health Inventory, which best reproduce the results of the longer version. The MHI-5 items assess depression and anxiety. For example, 'How much of the time during the past four weeks have you been a very nervous person?' Items are scored on a scale of 1 to 6, and total scores are converted to a 0 to 100 scale according to a standard procedure (Ware et al., 2000).

Recovery Assessment Scale (RAS; Corrigan et al., 1999). A continuous measure of recovery, consisting of 40-items rated on a scale of 1 to 5. A factor analysis (Corrigan, Salzer et al., 2004) resulted in the creation of five subscales: *personal confidence and hope*, *willingness to ask for help*, *goal and success orientation*, *reliance on others*, and *no domination by symptoms*. Only total scores are reported in the current study. An example item is 'I have my own plan for how to stay or become well'.

Psychological Well-Being Scales (PWB; Ryff & Keyes, 1995). Consists of six 7-item subscales measuring: Autonomy, Environmental Mastery, Self Acceptance, Positive Relationships, Personal Growth and Purpose in Life. The PWB Scale yields a total score, and six subscale scores. Items are scored on a scale of 1 to 6. An example of an Autonomy item is 'My decisions are not usually influenced by what everyone else is doing'.

Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003). This is a 25-item measure of resilience, or the ability to cope with stress. Items are scored on a scale of 1 to 5. An example item is 'Past successes give me confidence in dealing with new challenges and difficulties'.

Adult State Hope Scale (Snyder et al., 1996). A 6-item measure of Hope, consisting of Agency and Pathways towards goals subscales. Items are scored on a scale of 1 to 8. An example of a Pathways item is 'There are lots of ways around any problem I am facing now'.

Demographic information. Age, diagnosis, age at first diagnosis, time since last hospitalisation, length of stay, level of education, occupation and accommodation circumstances.

Health of the Nation Outcome Scales

The HoNOS (Wing et al., 1998) is a12-item instrument designed to monitor severity of mental health disorder. The HoNOS measures four outcome domains: Behavioural, Impairment, Symptoms and Social. It is a mandatory mental health outcome measure in New South Wales. While the full 12-item version of the HoNOS was used in the study, only the results from 10 of the items are reported since in the original Pickard and Deane (2000) study two items were removed by program developers because at the time they were not relevant to the program (Item 11 Occupation and Activities and Item 12 Living Conditions removed).

Consumer Feedback Forms

These client-completed evaluation forms specific to the service were mainly open-ended questions as outlined below:

1. How long have you been linked with your volunteer?
2. What activities have you been involved in as part of the Helping Hands program?
3. What is the best thing about being linked with your volunteer?
4. What is the worst thing about being linked with your volunteer?
5. What would you be doing right now if The Junction and the Helping Hands program didn't exist?
6. How is your relationship with your volunteer different to your relationship with staff members?
7. Have you ever felt that life without your volunteer would be different? Has your volunteer made any difference in your life?
8. If yes, can you explain this difference?

Results

Consumer Data

Of those who participated in the evaluation, 19 (53%) were linked to a volunteer on a one-to-one basis. Thirteen of these also attended groups run by volunteers. Twelve were involved in group activities only, and two were Call Outreach clients who received contact from volunteers through the telephone.

Demographic Information

Twenty-seven Helping Hands clients completed demographic information, which was included in the booklet. The results are shown in Table 2. Fifty-two per cent had a diagnosis of schizophrenia, 22% had a diagnosis of bipolar disorder and 22% had other diagnoses. Twenty participants indicated their current occupation using tick

TABLE 2
Demographic Information for Participants Who Completed the Recovery Measures

	N = 27
Age — Mean (*SD*)	46.25 (10.43)
Gender	
Male	13
Female	14
Nationality	
Australian	26
Other	1
Language	
English	27
Diagnosis	
Schizophrenia	14
Bipolar disorder	6
Other	6
Years since last hospitalisation — Mean (*SD*)	3.96 (5.39)
Years Unemployed — Mean (*SD*)	6.38 (8.98)
Education level	
1. < Yr 10	5
2. <Yr 12	10
3. Higher School Certificate	3
4. TAFE	4
5. Associate Diploma	1
6. Some university	1
7. Degree	1
8. Higher degree	0
Living situation	
Independent (whether alone or with others)	19
With carer family	6
Supported accommodation	2

boxes. More than one occupation could be selected. Six people ticked 3 or 4 boxes. The results are shown in Table 3.

Recovery-Related Measures

Recovery-related measures were completed at only one time point. However, the availability of a data set from another study provided us with an opportunity to compare scores with another sample. As part of the Andresen et al. (2006) study, consumers from a wide area of New South Wales, who were on the Neuroscience Institute of Schizophrenia and Allied Disorders research volunteer register (Loughland, Carr, & Lewin, 2001) completed the same set of recovery-related measures. The Andresen et al. study reported results from 94 participants and an additional 25 responses were added subsequent to publication of this study. These are presented for comparison with those attending Helping Hands.

TABLE 3

Current Occupation of Participants Who Completed the Recovery Measures

Occupation	Frequency (*n* = 20)
Formal education	2
Part-time paid work	2
Voluntary work	5
Unemployed and wanting work	4
Rehabilitation program	4
Creative work	4
Caring for others	6
Personal development courses	2
Age pension	1

Twenty-four current service users completed all items in the booklet of recovery measures. Mean time with the service for these participants was 2 years (*SD* = 1.23). Table 4 provides the total scores on each of the recovery measures compared to those found by Andresen et al., (2006).

It can be seen from Table 4 that those attending the Helping Hands program scored lower on recovery measures compared to the Andresen et al. sample on all measures although none of these differences reached statistical significance. Stage of recovery as determined by the STORI were: Three in stage 1 (Moratorium); one in stage 2 (Awareness); four in stage 3 (Preparation); ten in stage 4 (Rebuilding), and six in stage 5 (Growth; Andresen et al., 2003; 2006). These participants were placed into two broader groups to indicate Early Stages (stages 1–3, *n* = 8) and Late stages (Stages 4 and 5, n = 16) of recovery. A 2 x 2 Chi-square was conducted to compare proportions allocated to the various stages with the Andresen study (Early *n* = 16, Late *n* = 102). There was a significantly greater proportion of people in the Late stages of recovery in the Andresen sample (86%) compared to the Helping Hands sample (67%), $\chi^2 = 5.54$ ($df = 1$, $p < .05$).

TABLE 4

Total Scores on the Recovery-Related Measures

	Present study *n* = 24		Andresen et al. *n* = 119	
	Mean	*SD*	Mean	*SD*
STORI stage	3.63	1.28	4.16	1.19
MHI-5	56.50	19.43	63.86	18.75
Recovery Assessment Scale	154.53	21.49	159.62	24.96
PWB total	162.62	35.78	172.32	36.64
CD-RISC (resilience)	84.98	19.36	88.39	17.84
Adult State Hope Scale	30.42	9.78	34.56	9.61

In comparison to other studies, the participants scored generally lower on mental health than a general population sample, with two-thirds of the participants below the cut-off point of 67 for poor mental health on the MHI-5 proposed by Ehrle and Anderson Moore (1997).

The mean score on the RAS was 154 out of a possible total of 205. Although no norms have been established for the RAS, Corrigan and Phelan (2004) conducted research with 176 clients with a serious mental illness and functional disability who were using consumer-operated services. RAS scores of the Helping Hands group were very similar to those found by Corrigan and Phelan.

Scores on the CD-RISC resilience measure were higher than those found by Connor and Davidson (2003) in a sample of 43 psychiatric outpatients (M = 68.0, SD = 15.3) and in 577 subjects from the general population (M = 80.4, SD = 12.8).

On the Adult State Hope Scale, Helping Hands clients' scores appear higher than those in a group of 98 mental health outpatients *after* psychotherapeutic intervention (Irving et al., 2004). Those subjects had a mean age of 32 years and mean scores on the Adult State Hope Scale of 23.3 (SD = 9.8) at baseline, and 29.1 (SD = 11.4) after 11 sessions of psychotherapy.

Consumer Feedback Forms

Twenty-seven participants completed the Consumer Feedback Form. Activities undertaken as part of the Helping Hands program were categorised as shown in Table 5. Participants listed from 1 to 6 categories of activities in which they were involved, though some categories contained several activities, in particular, Games, Sport/Outdoor/Health and Creative Pursuits/Hobbies.

Benefits of service. For 22 (82%) of participants, the friendship of the volunteer was the most important aspect for them. 'Meeting people', 'support', 'enables me to do the things I enjoy', 'something to look forward to' and 'practical help' were also listed as important.

Worst thing about being linked with volunteer. Twenty-five (93%) participants could not identify a negative aspect of having a volunteer. Two indicated that the only negative thing was the need for them to be organised.

Life without the service. Twenty-three participants (85%) said that without the service they would stay at home or hang around town, and 11 (41%) said they

TABLE 5
Activities Undertaken With the Service

Category	Frequency	%
Games (sedentary)	18	67%
Sport/ outdoor/ health activities	14	52%
Lunch at West Street/socialising/outings	25	93%
Creative pursuits/ hobbies	12	44%
Holidays	7	26%
Support groups	4	15%
Practical/moral support	4	15%

would be isolated and depressed without the service. Only two mentioned looking for a job, one mentioned activities he or she might undertake and only one mentioned visiting family or friends.

How the volunteer has changed my life. Seventeen participants (63%) mentioned having someone who cares about them and who will help and support them, in response to this question. Being more outgoing and making friends was mentioned by 11 (41%) participants, as was leading a fuller, happier life. Having a more positive outlook, increased hope, and enhanced psychological and physical wellbeing were also noted. All participants stated that the volunteer service had changed their life for the better.

Relationship with volunteer. Thirteen participants (48%) stated that there was no difference between their relationship with staff at The Junction and their volunteer. Some qualified this by adding that they had a very good relationship with staff. Fifteen (56%) said their relationship with the volunteer was more friendly and informal than with staff. Two mentioned that the volunteer was non-judgemental and treated them with respect.

Health of the Nation Outcome Scales (HoNOS)

HoNOS data was collected as part of the referral process. Initial referral information was available for 27 people. This information is completed by the referring service, and, as well as the modified HoNOS, includes tick-boxes indicating reasons for referring the client to volunteer services. Most noted several reasons for referral. Reasons given for referral were: Increase quality of life (n = 24, 89%), decrease isolation and withdrawal (n = 23, 85%), increase independence (n = 17, 63%), prevention of relapse (n = 13, 48%), improve life skills (n = 8, 30%) and for one person it was for help to maintain their housing.

Time 1 (T1; referral) and Time 2 (T2) HoNOS data were available for 24 current service users. The length of time with Helping Hands from the date of referral to T2 follow-up ranged from approximately 4.5 months to 4 years (M = 2.18 yrs, SD = 1.33). Thus, the intervals between T1 and T2 HoNOS varied between participants with 29% less than one year, 38% between 1 and 3 years and approximately 33% between 3 to 4 years.

Table 6 provides the mean scores for the 10 HoNOS items along with comparisons with Pickard and Deane's (2000) data. The present sample had substantially lower scores than the earlier sample at the point of referral suggesting better mental health functioning at baseline.

For the present sample most individual items were scored lower on the T2 HoNOS indicating improvements in functioning. The exceptions were *Drug and Alcohol Problems*, *Cognitive Impairment* and *Physical Impairment*. However, the only significant difference in individual items was for *Relationships* which showed significant improvement, $t(21) = 2.87$, $p < .01$.

Discussion

The service activity and utilisation data shows that Helping Hands is a vital part of the local mental health delivery system. Groups providing a wide range of activities promoting social interaction, physical health, emotional wellbeing and creative

TABLE 6

Mean HoNOS Scores of Present Sample Compared to Pickard and Deane (2000)

	Pickard and Deane (n = 11)		Present sample (n = 24)	
	Before	After	Referral	Latest
Item	Mean	Mean	Mean (*SD*)	Mean (*SD*)
Aggression/overactivity	1.00	0.43	0.59 (.80)	0.52 (.77)
Self-harm	0.64	0.43	0.29 (.53)	0.08 (.28)
Alcohol/drug problems	0.82	0.71	0.46 (.80)	0.58 (1.02)
Cognitive impairment	1.45	1.29	0.68 (.72)	0.68 (.80)
Physical impairment	2.00	2.14	0.91 (.92)	1.20 (1.22)
Hallucinations/delusions	1.45	0.71	1.02 (1.22)	0.68 (.90)
Depression	1.55	1.29	1.39 (1.05)	1.04 (1.02)
Other behaviour	1.91	2.86	1.69 (1.54)	1.21 (.98)
Relationships	2.73	2.14	1.93 (1.20)	1.04 (.79)
Daily living	2.18	1.86	1.23 (1.15)	0.76 (1.05)
Total (10 items)	15.73	13.86	10.11 (5.84)	7.72 (5.37)

expression are well attended. Although the service has only 28 paid worker-hours per week, it is serving the needs of 62 active clients with a mental illness. The sustainability of the service is evidenced by the 48 currently active trained volunteers, an increase of 71.5% from 28 active volunteers in May 2003 (Posner & Abello, 2003). There are a further 12 trained volunteers who are not currently active. The fact that volunteers continued to work during a break in funding demonstrates how highly the service is valued, not only by clients, but also by the volunteers. The inclusion of mental health consumers and carers as volunteers further reflects the maturity of the service and its collaborative and empowering approach. These characteristics are highly consistent with the principles outlined in the National Mental Health Plan (NMHP, 2003) which state that 'Consumers, and their families and carers, should be empowered to fully and meaningfully participate at all levels, including in individual treatment plans, service delivery, planning and policy', (p. 10).

Compared to the Pickard and Deane (2000) report, the range of activities offered by the service and undertaken by participants has increased greatly under the auspices of the Schizophrenia Fellowship and as a result of support through the Mental Health Integration Project (Posner & Abello, 2003). Most frequent activities in 2000 were 'going for coffee', 'shopping' and 'walking' and the service has evolved to provide a much wider range of activities and group work. Over the past 6 years there are more volunteers, more clients accessing the service and a wider range of services on offer. However, another change relates to the mental health functioning of the clients who are currently accessing the service. On average, HoNOS data suggest that the level of impairment and disability due to mental illness is somewhat lower than the original cohort of clients who first attended the service in 1999–2000. It was noted by Pickard and Deane (2000) that the original group referred to the service had an average of 18 years of mental health

treatment and particularly high levels of disability when compared to other normative samples. Despite these changes in client problem severity, the current cohort had levels of disability on the HoNOS that were similar or higher than the large Australian sample of people diagnosed with schizophrenia described by Trauer and colleagues (Trauer et al., 1999). In the Trauer sample of 1119 patients the total score for the 10 items used on the HoNOS was 9.19 (Table 2 in Pickard & Deane, 2000, p. 53), whereas for the Helping Hands sample in the present study it was 10.11 at time of referral.

Given increasing calls for assessment of recovery-oriented outcomes, we also aimed to describe those attending Helping Hands using recovery measures. The recovery-related measures indicate that the group is characteristic of people with a serious mental illness in the community. Using allocation of people to recovery stages based on scores on the STORI, there was a greater proportion of people in the earlier stages stage of recovery in comparison to the NISAD research register group. Participants generally had scores on the recovery-related measures that indicated lower levels of recovery compared to the NISAD comparison group, but these differences did not reach significance. Those participants on the NISAD register of research volunteers might be expected to be at a later stage of recovery: the desire to make a contribution to science through participating in the register may correlate with a number of characteristics that reflect further progress toward recovery. It is likely that such volunteers have greater clarity and acceptance of their illness, are able to see past their own immediate needs to manage the illness and make an altruistic gesture to help others. That the measures of recovery were lower, but not significantly so, to the NISAD comparison group, suggests overall that the Helping Hands group were progressing relatively well on average. There was a mix of participants who completed these measures and the fact that they had been involved with Helping Hands for about 2 years would suggest they had access to a range of activities that are theorised to support recovery processes. The assessment of recovery was cross-sectional, so we were unable to determine what, if any changes on these recovery measures had occurred. Helping Hands participants tended to score higher on resilience and hope than comparable mental health outpatient groups. Future research should obtain entry-level measures of recovery and assess changes in recovery measures over the course of participation in Helping Hands.

Changes in behavioural and psychiatric functioning over time tended toward improvement, but were not significant, with the exception of the item for Relationships. HoNOS scores were lower, both at time 1 and time 2, than those in the earlier evaluation (Pickard & Deane, 2000). This could be due to the fact that clients in the current study had been attending The Junction (rehabilitation program) for a period of time before referral to the Helping Hands service. As the service has grown and become more widely publicised, referrals have come from a broader range of sources, including self-referral. The current time 1 referral HoNOS scores appear to be in keeping with the broader population of people with psychotic illnesses in community care. Eagar, Burgess and Buckingham (2003) have cautioned that a ceiling effect can occur when people have a relatively 'good' score on a measure, leaving insufficient room for change. In addition, the sensitivity of the HoNOS to change in community mental health settings has been questioned (Rees et al., 2004). Rees et al. found that scores on the HoNOS did not decrease over a 6-month period for patients with psychosis who were attending a community mental health team. So the lack of significant change in HoNOS scores may in part be related to a lack of measurement sensitivity.

The current study has reported on the evolution and sustainability of the Helping Hands volunteer program over a 6-year period. Despite periods of unstable funding the program has been able to adapt and develop to offer a wider range of services to a larger group of mental health consumers. The opportunities offered by Mental Health Integration funding to further consolidate and expand service offerings along with the support of the Schizophrenia Fellowship have all contributed to sustainability of the program. However, integration into existing public sector mental health rehabilitation programs and co-location with these services may also have further strengthened the program. It is notable that Helping Hands also has many of the characteristics associated with volunteer program sustainability (i.e., Leviton et al., 2006). Specifically, there is volunteer pretraining prior to contact with consumers, provision of diverse services, involvement of coalition members (e.g., educational, employment and public mental health services), volunteer supervision (from program coordinator), and good leadership from the coordinator and administering organisation. Sustainability factors associated with maintaining funding base thresholds have been met to date, but will require ongoing attention. Prior research suggests diverse service provision (at least 3 services), fundraising by the board and coalition, frequent board meetings, larger coalitions and program director leadership were all associated with the capacity of volunteer organisations to maintain their funding threshold, and that this was critical to survival of the service (Leviton et al., 2006). The relatively modest continued funding likely constitutes excellent value given the high rates of participation by consumers and volunteers alike.

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