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

Judy A. Pickard
University of Wollongong

Frank P. Deane
University of Wollongong, fdeane@uow.edu.au

Publication Details
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

Publication Details

This journal article is available at Research Online: http://ro.uow.edu.au/hbspapers/2581
Evaluation of the "Helping Hands" Volunteer Program for People with Mental Illness

Judy A. Pickard and Frank P. Deane
Department of Psychology and Illawarra Institute for Mental Health, University of Wollongong

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).

Thanks go to Belinda Mehl and Pip Whyte for their assistance in facilitating the data collection and to David Corby for his assistance in trying to set up a control group.

Address for correspondence: Dr Frank Deane, Illawarra Institute for Mental Health and Department of Psychology, University of Wollongong NSW 2522, Australia. E-mail: Frank_Deane@woll.edu.au
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 “Amistad 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) focused on volunteers only and did not evaluate the effects of the program on consumers. Pre-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-
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 (Sedman, Younglee, Mellish, 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 VMI, 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 VMI 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 VMI 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 VMI 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 relationships, 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 (Nieuwenhuieten, 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. (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**

<table>
<thead>
<tr>
<th></th>
<th>After 4 hours of training (n = 14)</th>
<th>After 18 hours of training (n = 14)</th>
<th>6 months after training (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Knowledge</td>
<td>21.67</td>
<td>1.88</td>
<td>21.13</td>
</tr>
<tr>
<td>OMI</td>
<td>2.41</td>
<td>0.33</td>
<td>2.32</td>
</tr>
<tr>
<td>CI</td>
<td>2.80</td>
<td>0.77</td>
<td>2.54</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>—</td>
<td>—</td>
<td>3.87</td>
</tr>
</tbody>
</table>

Notes: 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**

<table>
<thead>
<tr>
<th>Problem Domains</th>
<th>Trauer et al., 1999</th>
<th>Helping Hands Before Program</th>
<th>Helping Hands After 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Schizophrenia (N = 1119)</td>
<td>Depressive Disorder (N = 179)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggression</td>
<td>.75</td>
<td>.76</td>
<td>.10</td>
</tr>
<tr>
<td>Self Harm</td>
<td>.20</td>
<td>.75</td>
<td>.64</td>
</tr>
<tr>
<td>Alcohol/drug</td>
<td>.53</td>
<td>.41</td>
<td>.82</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>.69</td>
<td>.70</td>
<td>1.45</td>
</tr>
<tr>
<td>Physical Impairment</td>
<td>.68</td>
<td>1.03</td>
<td>2.00</td>
</tr>
<tr>
<td>Hallucinations — Delusions</td>
<td>1.44</td>
<td>.42</td>
<td>1.45</td>
</tr>
<tr>
<td>Depression</td>
<td>0.78</td>
<td>1.89</td>
<td>1.55</td>
</tr>
<tr>
<td>Other Behaviour</td>
<td>1.23</td>
<td>1.89</td>
<td>1.91</td>
</tr>
<tr>
<td>Relationships</td>
<td>1.65</td>
<td>1.34</td>
<td>2.73</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>1.26</td>
<td>.96</td>
<td>2.18</td>
</tr>
<tr>
<td>Total</td>
<td>9.19</td>
<td>10.15</td>
<td>15.73</td>
</tr>
<tr>
<td>Accommodation</td>
<td>0.63</td>
<td>0.41</td>
<td>—</td>
</tr>
<tr>
<td>Occupational</td>
<td>0.81</td>
<td>0.50</td>
<td>—</td>
</tr>
<tr>
<td>Medication Adherence</td>
<td>—</td>
<td>—</td>
<td>1.00</td>
</tr>
<tr>
<td>Social Skills</td>
<td>—</td>
<td>—</td>
<td>2.29</td>
</tr>
</tbody>
</table>

---

### TABLE 3

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

<table>
<thead>
<tr>
<th></th>
<th>Before Program (n = 5)</th>
<th>After Program (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Objective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of Daily living</td>
<td>3.10</td>
<td>0.55</td>
</tr>
<tr>
<td>Family</td>
<td>3.10</td>
<td>1.56</td>
</tr>
<tr>
<td>Social</td>
<td>2.20</td>
<td>0.82</td>
</tr>
<tr>
<td>Financial</td>
<td>0.72</td>
<td>0.27</td>
</tr>
<tr>
<td>Legal</td>
<td>0.13</td>
<td>0.18</td>
</tr>
<tr>
<td>Subjective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of Daily living</td>
<td>3.94</td>
<td>1.24</td>
</tr>
<tr>
<td>Family</td>
<td>3.30</td>
<td>1.20</td>
</tr>
<tr>
<td>Social</td>
<td>4.00</td>
<td>0.95</td>
</tr>
<tr>
<td>Financial</td>
<td>4.45</td>
<td>0.97</td>
</tr>
<tr>
<td>Legal</td>
<td>5.73</td>
<td>0.98</td>
</tr>
<tr>
<td>Health</td>
<td>3.07</td>
<td>0.86</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>3.20</td>
<td>1.57</td>
</tr>
</tbody>
</table>
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 HbNOS (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 (HbNOS 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 HbNOS and QLI is similar to that found by O’Loughlin et al. (1989). Until the present study, the Amrre’ 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

The Australian Journal of Rehabilitation Counselling

Guidelines for Authors

The Australian Journal of Rehabilitation Counselling is a refereed, international journal which is published twice a year. It contains original contributions dealing with a broad range of topics in the rehabilitation and disability fields. Topics include rehabilitation counselling, case management, rehabilitation education, rehabilitation administration, job placement, vocational assessment, psychosocial rehabilitation, independent living, transition planning, supported employment, industrial rehabilitation and disability management. Authors from Australia, New Zealand, Oceania and South-East Asia are particularly encouraged to submit manuscripts.

Guidelines for preparation and submission of manuscripts are given below. Intending contributors should submit an original plus four copies of their manuscript to:

The Editor, Herbert C. BiggsPh.D
Global Education Designs
PO Box 5014
West End QLD 4101
Australia

A cover letter should accompany the manuscript which includes a return mail address and email address if possible.

Manuscript Preparation

1. Manuscripts should follow the format, style and typing guidelines detailed in the Publication Manual of the American Psychological Association (4th edition), except that spelling should conform to The Macquarie Dictionary. Manuscripts must be clear and legible.

2. Manuscripts should not exceed 20 double-spaced A4 typed pages inclusive of abstract, text, references, appendices, tables, and figures.

3. Manuscripts should include a cover sheet which shows the title of the article, authors names, organisational affiliation, and a running head.

4. The first page of the manuscript must include only the title.

5. An abstract should follow the title page and contain between 50–100 words.

6. A biographical description (not exceeding 75 words) of the author(s) must be submitted on a separate page that includes highest degree earned, job title, and organisational affiliation.

7. References are given at the end of the text. All references cited in the text must appear in the reference list.

8. Tables and figures should be presented on separate sheets and their approximate location in the text indicated.

9. Manuscripts should not be previously published material or currently submitted to another journal.

Manuscript Review

1. The Journal uses a blind review process in which the author's identity is anonymous to referees.

2. It is expected that most manuscripts will undergo revision before final acceptance.

3. Unless otherwise indicated in the cover letter, the first author will be responsible for communication with the Editor and editorial revisions of manuscripts.

4. Although feedback will usually be provided to authors, the editor reserves the right to reject a manuscript for publication without providing a rationale for his decision.

5. Final decision regarding acceptance of a manuscript will be made by the Editor.

Manuscripts Accepted for Publication

1. Upon acceptance for publication, authors must provide the Journal with a computer disk copy (3.5" disk) of their manuscript in addition to a final print-ed copy. Acceptable word processing formats are Microsoft Word (For Macintosh, Windows, or DOS up to Version 6) and Word Perfect (Up to Version 5.1). The word processing program used and version number should be specified on the disk or on an accompanying letter.

2. When illustrations are used, one camera-ready sheet (of at least 1000 dpi resolution) should be submitted. Diagrams and lettering must have a professional finish.

3. Proofs will be sent to the first author who is expected to return them to the Editor by Express Post or Air Mail within five working days of receipt.

4. Accepted manuscripts become the sole property of the Journal for copyright purposes. However, the author(s) remain responsible for any views expressed in a manuscript that is published.