

School of Occupational Therapy

**A Pilot Investigation of the Volunteer Work Participation of
Mental Health Consumers**

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DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

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ABSTRACT

Mental illness is often associated with social isolation, unemployment and limited community participation. Mental health rehabilitation services aim to decrease these psychosocial effects of illness and encourage better community integration for mental health consumers. Volunteer work is one avenue in which consumers can become actively involved with their local communities. However whilst often supported clinically, limited empirical evidence exists which supports the use of volunteer work as a potential mode of rehabilitation for consumers.

The overall aim of this study was to document consumer perceptions and experiences with volunteer work and to identify if participation in volunteer work has a positive impact on their mental health.

Phase one of this study involved in-depth interviews with nine consumers currently volunteering. Themes identified from these interviews supported the notion that volunteer work is a meaningful occupation for consumers and one which promotes community integration and supports consumer recovery. Findings from the interviews also guided the development of a volunteer scale for later use within the study.

Phase two involved the development and pilot testing of a volunteering questionnaire which measured consumer attitudes and experiences with volunteer work. This scale was combined with other standardised tests which measured the mental health variables of personal empowerment and quality of life.

Phase three involved the administration of the questionnaire battery developed in phase two. The battery was distributed and completed by thirty consumers, including both those who were and were not volunteering. Analysis conducted identified that overall consumers held a positive view of volunteer work, believing it was a way of developing work skills, friendships and promoting positive mental health. Analysis comparing the volunteering to the non-

volunteering group indicated that those volunteering experienced better quality of life, specifically within the psychological health, social relationships and personal environment domains. This provides support for the hypothesis that participation in volunteer work promotes consumer recovery. However, age was identified as a potential confounding variable and so the significant results should be viewed with caution.

Cost, stigma and becoming unwell during volunteering were identified as barriers to consumer participation. It is argued that mental health services are in a good position to support consumers not only to access but also to maintain ongoing volunteer participation. To date minimal evidence has existed that supported this intervention. This study has begun to fill this research void, however, small study numbers and the cross-sectional, descriptive design make establishing a cause and effect relationship impossible. It would thus be beneficial to conduct a larger study investigating the impact further, including measuring the influence of any interventions that promote consumer participation in volunteer work, such as supported volunteering.

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ABBREVIATIONS AND ACRONYMS

ICF – International Classification of Functioning

K10+ - Kessler Psychological Distress Scale

LIDO – Longitudinal Investigation of Depression Outcomes

The Australian WHOQOL-BREF – The Australian World Health Organization
Quality of Life Brief Assessment

VVS – Victorian Validation Study

WHO – World Health Organization

1. INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Volunteering in Australia is growing. From 1995 to 2002, the percentage of adult Australians volunteering increased from 24% to 34% and the service hours they provided increased from 512 million in 1995 to 704 million in 2000 (Australian Government Department of Family and Community Services, 2005). However, despite the growing number of adult volunteers, international data show that individuals from minority groups, such as disability groups and people of different ethnic origins are volunteering at lesser rates (Davis Smith, Ellis, Howlett, & O'Brien, 2004).

Peter Costello, the Australian National Treasurer spoke of volunteers being needed to build the spirit of the Australian community (Costello, 2001). In this speech he encouraged individuals to volunteer one hour per week of their time to community service. Costello spoke of volunteering being a way for community members to meet, get to know each other and help each other out. In the scientific literature this concept is referred to as social capital. The current volunteering literature has investigated the impact volunteering has on the volunteer. This information has demonstrated that volunteering is indeed good for the volunteer and good for developing social capital.

The statistics demonstrate that Australians are meeting the volunteering challenge. The number of community volunteers is growing. However, not everyone is involved in this process. Some minority groups are missing out on the opportunities and experiences. If volunteering is good for building social capital and community linkages, it seems logical that minority and socially disadvantaged groups may benefit the most from the opportunity.

This research project has attempted to address two main factors that current volunteering research has yet to answer. Firstly, to document the volunteering experiences of mental health consumers, including where they volunteer, how they become volunteers, and their perceptions of the benefits and limitations of volunteering and secondly to investigate the impact volunteering has on the mental health of mental health consumers.

1.2 SIGNIFICANCE OF THE STUDY

Consumer participation in volunteering is often encouraged clinically, but scientific enquiry into this process has been lacking. This research project is thus important to formally document the benefits and limitations of consumer participation in volunteer work. One in five Australians experience mental health problems and a proportion of these experience resultant functional impairment. Volunteering is associated with positive mental health benefits in the general population and therefore may be an avenue to promote recovery for mental health consumers. However, to date no empirical enquiry has investigated this prospect and it is required. This study will commence this scientific process and provide initial empirical evidence either for or against the inclusion of volunteer work programs within mental health rehabilitation services.

1.3 OBJECTIVES AND PHASES OF THE STUDY

The overall purpose of this study is to investigate the volunteer work participation in a mental health consumer population. Specifically, it aims to:

1. Explore consumer perceptions about volunteering
2. Develop an assessment battery to measure consumer participation in volunteer work, their attitudes about volunteering, quality of life and personal empowerment.
3. Identify if any differences exist between the empowerment and quality of life of two consumer groups; volunteers and non-volunteers.

1.4 OVERVIEW OF STUDY DESIGN

1.4.1 Background of the research question

The motivation for conducting this study is grounded in clinical experience. Whilst working for a community mental health rehabilitation service, the primary researcher began conducting a small volunteer work group in the community with consumers. When researching this topic in search of evidence for such a group's efficacy, very minimal tailored research was found. Thus, the researcher started on the pathway to developing this research project, attempting to answer

the question “Does participating in volunteer work positively impact upon the mental health of consumers?”

1.4.2 Study Design – Mixed Methods

This research project employed a mixed methods design. Mixed methods research involves the integration of both quantitative and qualitative data within a single study conducted in multiple phases (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). The research process applied has been described by Morgan (1998) in his Priority-Sequence Model. This model states that to successfully integrate the qualitative and quantitative methodologies, a systematic approach must be adhered to through both research design and implementation. This involves firstly deciding which method of data collection will be the principal and which will act as a complement to this. Then secondly, deciding on the sequence in which the research phases will take place (Morgan, 1998). The diagram below outlines Morgan’s Priority-Sequence Model (1998), with the area highlighted identifying the research design employed in this study.

Figure 1.1 The Priority-Sequence Model

		Priority Decision	
		Principle Method: Qualitative	Principle Method: Quantitative
Complementary Method: Preliminary	1. Qualitative Preliminary QUAL à quant	2. Quantitative Preliminary QUANT à qual	
	<u>Purposes:</u> Smaller qualitative study helps guide the data collection in a principally quantitative study. Can generate hypothesis, develop content for questionnaires and interventions etc.	<u>Purposes:</u> Smaller quantitative study helps guide the data collection in a principally qualitative study. Can guide purposive sampling, establish preliminary results to pursue in-depth etc.	
Complementary Method: Follow-Up	3. Qualitative Follow-up Quant à QUAL	4. Quantitative Follow-up Qual à QUANT	
	<u>Purposes:</u> Smaller qualitative study helps evaluate and interpret results from a principally quantitative study. Can provide interpretations for poorly understood results, help explain outliers etc.	<u>Purposes:</u> Smaller quantitative study helps evaluate and interpret results from a principally qualitative study. Can generalize results to different samples, test elements of emergent theories etc.	

Source: Morgan, D.L. (1998). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research*, 8(3), 362-376.

This research project was sequenced with the qualitative phase conducted first so the research findings could inform the development of the measurement tool for use in the quantitative phase. This was required because of the limited information available in the literature on which to build. This study design is quite common and often used for this purpose (Morgan, 1998).

Pope and Mays (1995) argue that rather than dichotomise the two methodological paradigms, qualitative and quantitative methodologies should be used to complement each other. They believe that this can be achieved in two major ways. Firstly, qualitative investigation can provide preliminary information such as description, terminology and theory regarding the phenomenon being studied from which quantitative investigation can be launched. And secondly, through a process of triangulation a clearer and more complete picture of the results can be developed. In this way, the different findings can provide deeper layers of understanding about the phenomenon in question.

Qualitative and quantitative purists however, argue that the philosophical underpinnings of the two research paradigms are so inherently different, that they cannot be used in unison (Hanson et al., 2005). Yet despite this, mixed methods research is becoming an increasingly popular research culture. Countering the purist view, it is frequently argued that “multiple methods may be used within a single research study to take advantage of the representativeness and generalisability of quantitative findings and the in-depth, contextual nature of qualitative findings” (Hanson et al., 2005, p. 225). Mixed methods researchers believe that research should be underpinned by a philosophy of pragmatism. This school of thought states that the researcher should employ those methods that work, regardless of any pre-existing and potentially opposing theoretical foundations (Hanson et al., 2005). The philosophy of pragmatism has been applied within this research project. However, whilst applying the pragmatic approach, the researcher has also ensured that rigorous methods have been adhered to within both the inductive and deductive frameworks applied (Speziale & Rinaldi Carpenter, 2003).

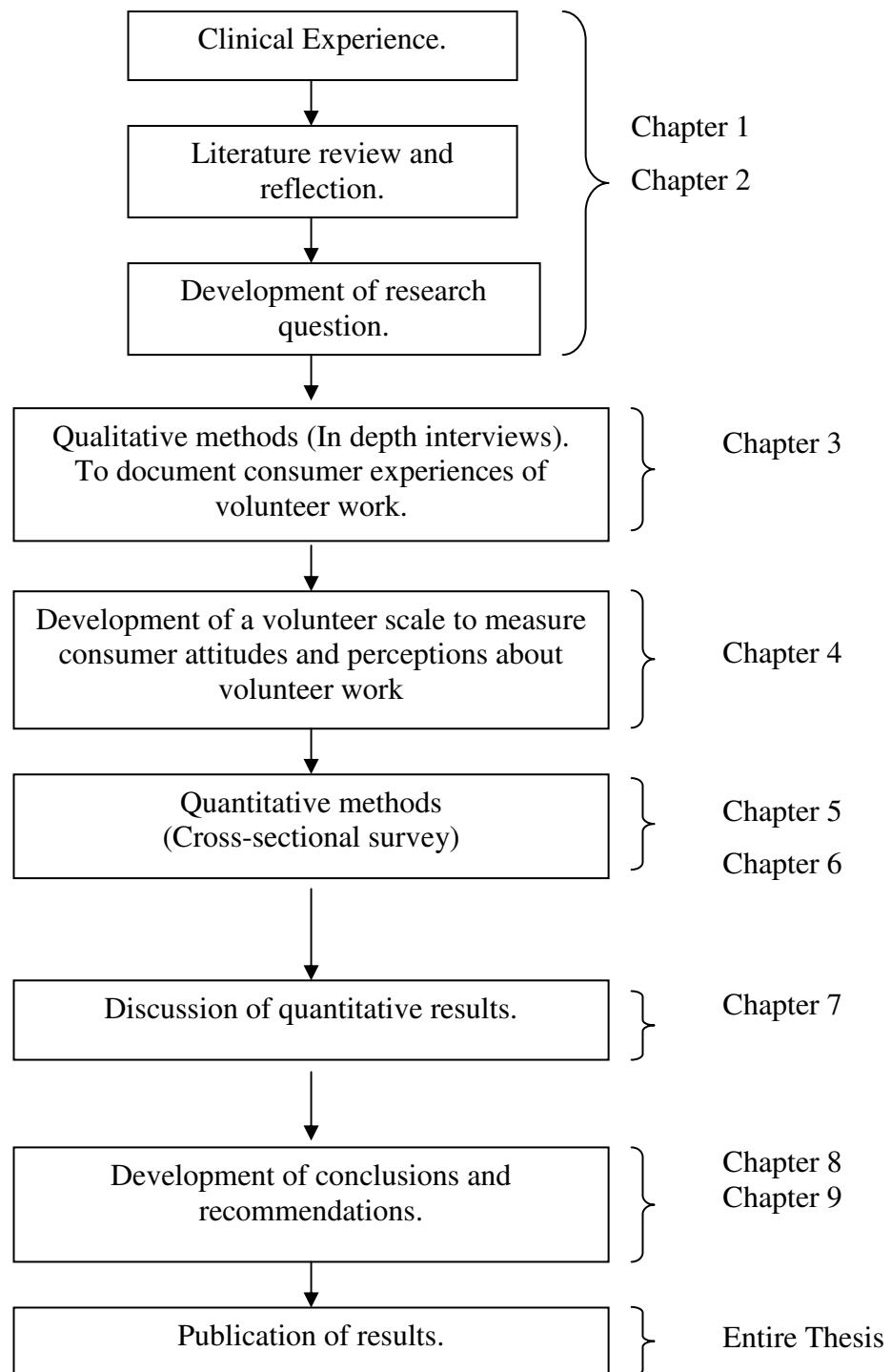
A phenomenological approach to qualitative enquiry was employed with in-depth interviews chosen as the research method. The quantitative phase of the study involved the use of a cross-sectional survey to investigate mental health consumer participation in volunteer work. The in-depth interviews were conducted first, because consumer participation in volunteer work is a new phenomenon of which very little information is known. Qualitative methods are often recommended as a first step in exploring a new phenomenon (Langhout, 2003) and the researcher conducted interviews with consumers who currently volunteer as a way of developing understanding about the topic before commencing the quantitative phase. Quantitative methods are considered most appropriate where the researcher wishes to demonstrate generalisability, cause and effect relationships, or complete structured research (Langhout, 2003). This method was chosen as the second phase of the project, to enable the research findings to be generalised to the broader population of mental health consumers at the completion of the project.

The final process within any mixed methods research design is the integration of the data (Hanson et al., 2005). To complete a truly mixed methods research study, the two forms of data need to be blended at some stage within the research process. Data integration has occurred at two major time points within this investigation. Firstly, data blending occurred when the themes emergent from the interviews were transformed into measurable questionnaire items. Secondly, the development of the conclusions and recommendations occurred following reflection and triangulation of information obtained from both forms of enquiry. Through the integration of both the qualitative and quantitative research findings, the researcher hoped to develop a comprehensive understanding of consumer participation in volunteer work and the impact it has on their mental health.

The specific processes applied within each of the research phases, are outlined in future chapters of this thesis. However, it was believed important to provide an overview as to the reason the mixed methods research design was chosen. To further the understanding of the reader, the following diagram provides an outline of the overall research process. This presents the structure of the research project. Each of the stages in the research design correspond to chapters within

the thesis, therefore, this diagram can be used as a guide to the overall thesis structure.

Figure 1.2 Overview of Study Design and Thesis Structure



2. LITERATURE REVIEW

2.1 INTRODUCTION

This literature review commences by discussing the current mental health issues affecting Australia, including the prevalence of disorders, current treatment frameworks and shortfalls within current treatment systems.

The clinical and social issues impacting on consumers are highlighted, such as high levels of unemployment and limited participation in meaningful activity. Current intervention models of management are outlined, however volunteer work is also proposed as one strategy for promoting consumer recovery from mental illness.

The review thus concludes with an overview of the literature surrounding volunteer work from Australia and overseas, focusing on the participation of consumers and other disability groups. Specifically, the impact participating in volunteer work has on consumer mental health status will be discussed.

2.2 OVERVIEW OF MENTAL ILLNESS WITHIN AUSTRALIA

2.2.1 Prevalence and Burden of Mental Illness

The prevalence of mental illness in Australia is high with one in five Australians having a mental illness. The specific overall prevalence has been estimated at between 20.3 and 22.7% of the population. This equates to approximately 15% of the burden of disease in Australia being surpassed only by heart disease and cancer (Andrews, Henderson, & Hall, 2001). Mental illness is also the leading cause of years lost due to disability with depression being the primary cause of non-fatal disease burden in Australia (Mathers, Vos, Stevenson, & Begg, 2000). This large burden of mental illness within Australia has stimulated the government to include mental health as one of Australia's seven national health priorities.

The national health priority areas focus on chronic diseases of significant burden to the Australian health and welfare system. The health priorities initiative

recognises that in order to decrease the burden of chronic diseases such as mental illness, a seamless continuum of care is required from acute hospitalisation services through to community treatment and prevention strategies (Australian Institute of Health and Welfare & Commonwealth Department of Health and Family Services, 1997).

Mental health services have traditionally not been favoured by government funding. The national mental health report of 2004 documented national spending on mental health at 6.4% of the total expenditure on health care despite the burden of mental health care being previously outlined at 15% (Mental Health Council of Australia, 2005). However, recent recognition of the burden mental illness is having on the community has resulted in an additional allocation of \$1.9 billion over five years dedicated to the improvement of mental health services (Australian Government Department of Health and Ageing, 2006).

2.2.2 Functional Issues of Individuals with Severe Mental Illness

As a group mental health consumers tend to experience lower rates of marriage, less education and high rates of unemployment (Andrews et al., 2001). Furthermore, individuals with schizophrenia and related illnesses experience alarming rates of social isolation and loneliness. They are also more likely to live in group housing lodges and experience problems with managing their home and self-care (Jablensky et al., 2000).

Studies that have examined how their time is used, the activities they participate in and the roles they hold indicate an overall lack of productive activity. Shimitras, Fossey and Harvey (2003) analysed how 229 individuals with schizophrenia living in London allocated their time. The majority of occupations this group participated in included sleeping, eating and personal care with limited time dedicated to active leisure or productive activity such as paid or unpaid work or study (Shimitras et al., 2003). Kelly, McKenna and Parahoo (2001) also investigated consumer participation in activity and its relationship to their perceived quality of life. Through surveying 92 respondents with severe mental illness, they found that the overall participation in activity was very low, with

half of the respondents indicating no form of structured activity within their life. This is further highlighted by both Boyer, Hachey and Mercier (1998) and Eklund (2001) who investigated the roles individuals with major mental illness held in the past, currently and expected to hold in the future. The majority of roles currently held were generally non-productive such as friend, family member, religious participant and hobbyist. In both studies only a small number indicated current participation in the worker role, however the majority expected to fulfill this role in the future (Boyer et al., 1998; Eklund, 2001). These social issues affecting consumers continue to gain recognition through mounting consumer voice. A model emphasising consumer recovery is lobbied to address the problems.

2.2.3 Mental Health Reform in Australia

Mental health reform in Australia is guided by the National Mental Health Strategy and its associated National Mental Health Plans. The mental health strategy has four broad objectives. The strategy aims to promote positive mental health within Australia, focus on prevention of mental health problems, reduce the burden of disorders, and advocate for the human rights of people with mental illness. The current National Mental Health Plan states that mental health service delivery should have a recovery orientation (Australian Health Ministers, 2003). This highlights a major change within service delivery from a medical model to a recovery oriented model of service provision. In accordance with this strategy, the recovery model has also been used as an overarching framework throughout this thesis.

2.3 THE RECOVERY MODEL

2.3.1 Medical Model to a Recovery Model

Mental health services have traditionally been based upon a medical model of care. A medical model of health views disability as a problem within the person which requires treatment by a medical professional (World Health Organization, 2001). Critics of the medical model state that it focuses on illness and limitation, rather than health, personal strength and opportunity (Deegan, 1992; Munetz & Frese, 2001). In accordance with mental health reform, the National Mental

Health Standards indicate that mental health services must provide consumers access to treatment services appropriate for their stage of recovery (Commonwealth Department of Health and Family Services, 1996). This highlights a change in typical service provided within Australian mental health care from a traditional medical model to a model of recovery.

2.3.2 Definition of Recovery

The recovery concept has been defined as a personal journey through which consumers learn to acknowledge and accept their mental illness and are able to live happy and fulfilling lives despite any boundaries it places upon them (Anthony, 1993). Recovery is therefore considered both a process and an outcome. The process of recovery for mental health consumers is compared to that in which people with physical disability or trauma injuries are able to move on and accomplish life goals following rehabilitation assistance (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). The recovery model was first described in the early 1990's by Anthony (1993). However despite more than a decade having lapsed the literature still largely refers to recovery as an emerging concept. The recovery model is a model through which rehabilitation programs can be framed. It is not a specific treatment strategy, rather it is a framework on which treatment and service provision can be based. Despite the National Mental Health Action Plan specifying that services should be driven by this framework, to date specific recovery based approaches and service implementation guidelines are lacking (Oades et al., 2005). This has implications not only in Australia but internationally where the recovery framework is the guiding force of current mental health care. Therefore recent attempts have been made to accurately describe and also to operationalise recovery concepts into measurable outcomes (Lieberman, Kopelowicz, Ventura, & Gutkind, 2002; Noordsy et al., 2002). This has been done in an attempt to better understand and explain the concepts of recovery and also to enable more meaningful measurement of consumer recovery.

Throughout this process, differences between researcher, clinician and consumer descriptions of recovery have emerged. For example, researchers define recovery as the absence of symptoms, clinicians as an improvement in

functioning and consumers as an ability to fully join the community (Lieberman et al., 2002). The propensity of researchers to continually measure recovery based solely on the presence or absence of psychiatric symptoms does not provide accurate documentation of the complete clinical picture. Many consumers are able to function independently in the community, despite continuing experience of persistent psychiatric symptoms. Overwhelmingly the research focus on recovery and recovery related processes demand the adoption of new measures for recovery which incorporate not only symptom management but also factors such as community and social integration, and independence.

2.3.3 Limitations of the Recovery Model

Debate has occurred in the literature over the limitations of the use of the recovery model. Some clinicians have voiced concern over the recovery model being taken too far, and focusing services too heavily on consumer driven priorities (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). The argument for this is that the recovery framework is not suitable for consumers who experience debilitating illnesses which severely impair their ability to make decisions and problem solve. Advocates for the recovery model however, believe that in these cases treatment should be focused on improving the consumer's ability to make decisions in order to enable future opportunities for guiding their treatment (Munetz & Frese, 2001). Some authors also believe that the recovery model demands that consumers have succeeded at managing their illness symptoms before services are provided to help them reconstruct meaning in their lives, such as building social networks and participating in meaningful activity (Davidson et al., 2001). However, generally the recovery literature believes these factors are embedded within the recovery process. Despite some debate within the literature regarding the usage and limitations of the recovery model, most articles identify similar characteristics of the recovery process. Thus a consistent image of recovery is emerging from within the literature.

2.3.4 The Process of Recovery

The recovery definition and stages of recovery as outlined by Andresen, Oades, and Caputi (2003) will be used as the guiding definition of recovery throughout this thesis. The reason this model has been chosen is because it has been

developed based on extensive review of the literature regarding recovery. The majority of recovery literature is qualitative-based providing definition and description of the consumer experience of recovery. Andresen and colleagues (2003) systematically reviewed 36 articles about consumer recovery, including 28 experiential accounts of recovery, 14 recovery articles authored by consumers and eight qualitative studies investigating the recovery process. Based on this systematic review, they have defined the recovery concepts and have developed a model of the recovery process. They identified four important processes of recovery including, finding hope, redefining identity, finding meaning in life and finally taking responsibility for recovery (Andresen et al., 2003). Each of these factors is discussed below, along with suggestions for how mental health services can incorporate them within their protocols.

Finding Hope

The concept of finding hope and having a hope for the future is most pervasive throughout the recovery literature (Kotake Smith, 2000; Mead & Copeland, 2000; Torrey & Wyzik, 2000; S. Young & Ensing, 1999). This stems from many consumer reports that their recovery was facilitated by having people who believed in them despite at times not believing in themselves (Torrey & Wyzik, 2000). Developing hope can often be the catalyst for making changes. Clinicians can foster hope by supporting the development of a collaborative therapeutic relationship through which united treatment planning can be conducted with the consumer. Within this relationship clinicians should provide messages of hope through appropriate use of optimistic language. For example clinicians should frame questions and statements positively thereby encouraging the consumer to consider the future, when they are indeed recovered (Corrigan, 2002; Torrey & Wyzik, 2000).

Redefining Identity

The second recovery theme involves redefining one's identity. This task can be difficult and involves individuals questioning "Why me?" and "What now?" Why have they developed a mental illness and what will happen to them now (Pettie & Triolo, 1999). They are required to develop a new sense of personal

identity, one that is not dependent upon the illness, but does, however, integrate the illness as part of their life that requires management.

Finding Meaning in Life

Finding meaning in life refers to seeking out and developing roles, responsibilities, relationships and participating in meaningful activities within the community (Kotake Smith, 2000; Noordsy et al., 2002). Torrey and Wyzik (2000) refer to this as broadening one's life, to include activities such as work and parenting responsibilities. Clinicians should be providing opportunities for consumers to become actively involved in their community. This involves providing support to overcome barriers to community participation. For this to occur, mental health professionals need to consider the community environments as barriers to participation and attempt to break these down to support successful consumer participation (Corrigan, 2002; Rebeiro, 1999).

Taking Responsibility for Recovery

The final theme involves taking responsibility. Nobody but the consumer can take responsibility for their recovery. It is not the job of the health professional to recover rather it is the task of the consumer. Once the consumer identifies that they are responsible for their recovery, the recovery process can be sped up (Mead & Copeland, 2000). Taking responsibility can include things such as learning about one's illness, appropriate medications and treatment strategies as well as paying closer attention to one's self-care (Kotake Smith, 2000; S. Young & Ensing, 1999). Clinicians can foster this process by providing consumers with education and resources and empowering them to learn about their illness and how they can best manage it (Torrey & Wyzik, 2000). A critical element of this process involves the provision of consumers with relevant treatment choices and a willingness to accept these choices even if they are not recommended by the clinician (Finfgeld, 2004).

The recovery model was chosen to guide this research project for two main reasons. Firstly, because it is the model endorsed by the National Mental Health Action Plan and secondly because the concepts are applicable to those of volunteer work. An overall aim of this research project is to identify if

participation in volunteering can support the recovery process for mental health consumers. It is hypothesised that volunteer work will be an avenue for consumers to develop roles and relationships in the community and build their self-esteem and confidence. These are factors that are clearly outlined within the recovery model.

2.4 PROVIDING REHABILITATION UNDER A RECOVERY FRAMEWORK

If mental health services are to provide care in accordance with the recovery model, it is argued that a number of criteria must be satisfied. These include firstly, a commitment to collaborative treatment planning conducted with the consumer, secondly a chance to develop skills that will enable consumers to function better within their community, thirdly, opportunity to develop life roles and participate in activities which bring a sense of meaning to consumers, and finally dedication to providing all services within the community in an attempt to better integrate consumers with their local neighbourhoods.

Each of these factors is critically discussed below and the challenges to their implementation are described.

2.4.1 Collaborative Treatment Planning

Recovery based mental health services should be client-centered. In order for clients' needs to be met they need to be documented and understood by service providers. This is done through a process of collaborative, rather than unilateral treatment planning, where the clinician and consumer together identify priorities for treatment and develop plans for meeting the consumer's personal goals (Corrigan, 2002). Collaborative treatment planning is now a requirement under the national mental health standards which state that every consumer must have an individual care plan which is not only created with consumers but also regularly reviewed with them (Commonwealth Department of Health and Family Services, 1996). Whilst theoretically this should promote recovery orientated practice, literature suggests that consumer and clinician opinions conflict regarding the use of collaborative treatment planning.

This has been demonstrated by Chinman and colleagues (1999) who surveyed 113 service providers and 106 consumers about perceived barriers to joint treatment planning. Service providers identified limited consumer participation due to consumer disability and lack of compliance or interest. On the contrary, consumers identified the main barriers as being lack of time, not knowing how to do the planning and being unsure of the benefits (Chinman et al., 1999). Furthermore, clinicians and consumers also often disagree on treatment priorities. Crane-Ross, Roth and Lauber (2000) surveyed 385 consumer and case manager pairs regarding the perceived needs of the consumer and their beliefs about whether their needs were being met. Overall, case managers identified a greater number of consumer needs, however, they were within a restricted range and tended to focus on traditional mental health care such as medication management. Consumers on the other hand identified less needs spread over a wider range of areas and included things such as community support (Crane-Ross et al., 2000).

For collaborative treatment planning to be an effective and empowering experience for consumers, clinician prejudices regarding the process will need to change. The above studies emphasise the need for clinicians to remember that under the recovery framework consumers guide the treatment process and therefore their participation in treatment planning should be encouraged despite any clinician preconceptions about their ability to do so. Conversely, when services do not provide opportunities for consumers to be actively involved, a cycle of disempowerment and despair can result. This occurs when consumers have their decision making power stripped from them and handed to the system. The result of this is simply that consumers become more dependent on the service (Deegan, 1992).

2.4.2 Empowerment

Segal, Silverman and Temkin (1995) define empowerment as “a process by which individuals with lesser power gain control over their lives and influence the organizational and societal structures within which they live” (p. 215). The recovery model endorses the empowerment of consumers via promoting the use of collaborative treatment planning and thus the relinquishing of power on behalf

of clinicians and the provision of power to consumers. Empowerment is therefore a significant concept within the recovery model, and one can hypothesise that those consumers who more readily use this power will achieve better recovery outcomes. The construct of empowerment was chosen as a variable to be measured within this study in order to identify if consumers participating in volunteer work had higher levels of personal empowerment than those consumers not volunteering.

2.4.3 Quality of Life

In line with these criteria for recovery, quality of life was also chosen as a variable to be measured within this study. Quality of life encompasses a range of factors associated with recovery including not only psychological and physical well-being but also being able to connect with others in the community, manage one's personal time, and exert personal choices and control (Laliberte-Rudman, Yu, Scott, & Pajouhandeh, 2000). Quality of life will be measured to identify whether participation in volunteer work is associated with improvements in quality of life.

2.4.4 Psychosocial Rehabilitation

Psychosocial interventions are those interventions that are related to improving a consumer's functional capacity to live and participate in community life (Rossler & Haker, 2003). Psychiatric rehabilitation approaches typically involve two main aims, firstly to assist the consumer to develop skills and secondly, to acquire supports within their environment to foster successful integration (Garske & McReynolds, 2001). Traditional mental health approaches such as medication and counselling have limited effectiveness in improving the social and vocational skills of individuals with severe mental illness. It is argued that in these cases a skills development approach is required, as used within a psychiatric or psychosocial rehabilitation framework (Garske & McReynolds, 2001). Skills development programs focus on building consumer capacities required for independent and community living. This can include things such as the teaching of home management skills, stress and illness management skills and social skills. These competencies are typically taught through modular programs.

Unfortunately at present Australian mental health expenditure centers on hospital, medical, pharmaceutical and high level residential care costs. These areas account for 71.6% of the overall expenditure. Limited funding is spent on allied health and rehabilitation services, with allied health accounting for only 3.6% of the overall expenditure, and community and public health accounting for 21.9% of the expenditure (Australian Government Department of Health and Ageing, 2006). The result of this expenditure bias is that immense disparity exists between the need for rehabilitation services and the capacity for mental health teams to deliver them.

Jablensky et al. (2000) interviewed 980 individuals with psychotic disorders in Australia and found that whilst the levels of social isolation, unemployment, lack of occupation and problems with self and home care were highly evident, only 6.3% of those interviewed had received any type of rehabilitation within the last six to twelve months. Respondents reported high rates of service usage however this predominantly involved medication and counselling.

If consumers do not believe that mental health services are going to meet their needs they are deterred from accessing care. Andrews et al. (2001) conducted a national epidemiological study investigating the prevalence of anxiety, affective and substance use disorders in Australia. Only 55% of individuals who met the diagnostic criteria and who were classified as either moderately to severely disabled accessed any type of care. This means that 44% of these individuals clearly in need of care, did not access any treatment, namely medication or counselling. The major reason provided by this group for not accessing these treatments was that they did not need such treatment (Andrews et al., 2001). This comment is interesting because it may indicate a lack of insight on the part of these individuals, however it also may indicate, that indeed they did not require counselling or medication, but wanted practical help in other areas of their lives. For example, they may have wanted practical help to obtain a job, or access the community, however did not believe this could be achieved through medication and counselling. This provides further evidence for the need for mental health services to improve the broader rehabilitation services that they offer mental health consumers.

A review conducted at both the national and state level of current mental health service provision identified the lack of workplace-based rehabilitation and recovery programs as priority areas to be developed (Mental Health Council of Australia, 2005).

2.4.5 Promoting Opportunity for Participation in Meaningful Activity

The recovery model stresses the need for consumers to develop roles and relationships within the community that provide a source of meaning for them. Mental health services should thus provide opportunities for consumers to participate in community activities, in attempts to expand their social networks and allow them to experiment with roles and hobbies. A positive relationship exists between the involvement of consumers in meaningful activity and their overall perceived quality of life (Goldberg, Brintnell, & Goldberg, 2002; Kelly et al., 2001; Laliberte-Rudman et al, 2000).

Rebeiro and Cook (1999) describe a process of occupational spin-off which occurs for individuals who engage in meaningful activity. Through participation consumers became motivated to engage in more activity. The therapist's role within this process is to provide opportunities for engagement and appropriate choices for the consumer (Rebeiro & Cook, 1999). Fostering opportunities for individuals with mental illness to engage in meaningful activity will therefore provide opportunity to positively influence their overall perceived quality of life, increase their levels of motivation and finally allow them to practice and master skills (Mee & Sumsion, 2001).

2.4.6 Ensuring a Community Focus

However, for psychiatric rehabilitation programs that encourage participation in activity to be truly meaningful and productive for consumers, the opportunities they provide need to be realistic, age appropriate and challenging. As one consumer reported "he had been hospitalized time and time again, but he never got well, because the only expectation was that he would paint ceramic elephants" (Henry & Lucca, 2002, p. 174). Rehabilitation services that focus on facility based activities may certainly occupy consumer time through the

prescription of diversional activity, however they also foster dependence and lack the realism of community based activities (Noordsy et al., 2002). Consumers live in communities and as such therapeutic activities should be based within these communities and encourage greater integration between community and consumer. Consumers learn skills best when they are in their actual environments. Therefore, rehabilitation services need to take place in real life environments and provide real life opportunities.

Far too often, however, mental health professionals are concerned with identifying problems within the consumer as a reason for their lack of participation in activity as opposed to identifying opportunities for their participation. This has resulted in a tendency for programs to centre solely on skills development. Whilst it has been previously discussed that skills development is an important part of the psychiatric rehabilitation process (Garske & McReynolds, 2001), emphasis also needs to be placed on developing opportunities for consumers to actually participate in community activities.

Mental health consumers identify the negative effects of a myriad of mental health and social security systems that are set up to help them, however only hinder them in their search to engage with the community in meaningful activity. This has been described as the labyrinth of community mental health (Rebeiro, 1999) and fosters the development of a sick role in which much time and energy is wasted in negotiating the system. In this system focus is on consumer symptoms and deficits, rather than on creating opportunities for engagement. It is thus argued that mental health rehabilitation services need to consider the environment in an attempt to diminish barriers to consumer participation rather than focusing on the personal problems of the consumer when designing intervention programs (Rebeiro, 1999). This is supported by the World Health Organization (2001) which classifies the environment both social and physical as a causal factor restricting individuals with disabilities from participating in their communities.

2.5 WORK AS A CONTRIBUTOR TO RECOVERY

2.5.1 Benefits of Participation in Work

One of the big issues identified in the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 is work (Commonwealth Department of Health and Aged Care, 2000). This action plan recognises the importance of work, whether paid or unpaid to the mental health of individuals and indeed the recovery process. The action plan appreciates that some members of the community who are unable to work for payment due to levels of disability need to be supported to have meaningful work participation in other ways.

Participation in work is associated with social status in Western society. It not only provides financial benefits for individuals but also can promote increased self-esteem and confidence, provide purpose and reason in one's life and assist in developing motivation (Bryson, Lysaker, & Bell, 2002; Provencher, Gregg, Mead, & Meuser, 2002; Strong, 1997; Van Dongen, 1996). Furthermore, consumers who participate actively in work indicate higher levels of satisfaction with their daily activities than other consumers, including those that attend structured day programs (Eklund, Hansson, & Ahlquist, 2004). However the reasons for this higher level of satisfaction are largely unknown. For example, are working consumers more satisfied with life because of the extra income they receive or does the social contact they have with workmates play a more important role. Regardless of the reasons for the benefits it is clear that being a worker advances recovery.

2.5.2 Unemployment and Mental Health Consumers

Whilst the benefits of participation in work are obvious, the rates of unemployment for consumers are extremely high and indeed higher than any other disability group. In Australia, 75% percent of householders with psychotic illness are unemployed, 21% are employed and 3.7% are looking for work (Waghorn, Chant, White, & Whiteford, 2004). This is in line with unemployment estimates from elsewhere including between 75 and 85 per cent

in the United States of America and between 61 and 73 per cent in the United Kingdom (Crowther, Marshall, Bond, & Huxley, 2004).

2.5.3 Supported Employment Versus Prevocational Training

Much research has been conducted in the mental health field investigating practices encouraging consumer participation and retention in the workforce. This research definitely favours the supported employment approach. Supported employment is paid work that takes place in normal work settings with support being provided by a mentor (Crowther et al., 2004). The emphasis for supported employment programs is on assisting consumers to locate employment, providing direct job placement in competitive settings and supporting the consumer once the employment has commenced (Ackerman & McReynolds, 2005). In the Cochrane review conducted by Crowther et al. (2004) supported employment was shown to be significantly more effective than prevocational training in organising consumer work participation. Prevocational training focuses on developing consumer work competencies such as stamina, routine and punctuality before assisting consumers to look for available employment. This differs to the supported employment approach which assists consumers to search for competitive employment from the outset and then provides support once they have commenced the job. The supported employment approach was more successful at 18 months with 34% of the supported employment group in competitive employment compared to only 12% in the prevocational training group (Crowther et al., 2004).

2.5.4 Common Problems Experienced by Consumers in the Workplace

Supported employment programs recognise that consumers often experience difficulties within workplace environments, and so provide supports to overcome these. The types of functional problems that are most commonly encountered by consumers include those of both a social and cognitive nature. MacDonald-Wilson and colleagues (2002) investigated the functional difficulties as well as the workplace accommodations provided to 191 consumers participating in supported employment programs. The three major functional limitations

identified were firstly, interacting and conversing with others, secondly remembering the job tasks and developing successful job routines, and thirdly, maintaining a suitable work pace. The functional limitations identified are congruent with the types of workplace accommodations used, generally involving human resources such as a job coach, or changes in work scheduling (MacDonald-Wilson, Rogers, Massaro, Lyass, & Crean, 2002). Job coaches can help to assist the consumer not only to become familiar with and learn the job task, but also help to promote a positive work environment by facilitating interaction with other staff and identifying support systems for the consumer in the workplace (Ackerman & McReynolds, 2005).

2.5.5 Importance of the Work Environment

The importance of the work environment in facilitating successful consumer employment has been further highlighted by Kirsh (2000a). She surveyed 36 consumers in two groups, those in competitive employment and those who had recently left their employment. Her study identified that the two groups were demographically similar in terms of personal and mental health characteristics. There were also no statistical differences between the two groups relating to their level of personal empowerment and perceived level of social support, however statistical differences did exist regarding the work climate and the person/work environment fit (Kirsh, 2000a). This suggests that the work environment was more important in determining the success of the consumers' work role than any personal characteristics within the consumer.

Qualitative analysis was also conducted with these two consumer groups regarding their working experiences. Participants in successful work environments were typically working in services that were flexible regarding their work and provided open and honest communication with their coworkers and supervisors. Consumers also spoke of the difficulty surrounding disclosure of their illness. Despite the many potential benefits associated with disclosure such as the development of workplace accommodations, many of the consumers were wary of disclosing for fear of being ridiculed or punished as a result (Kirsh, 2000b).

The importance of considering the work environment as either a barrier or facilitator of consumer employment has been noted by both consumers and vocational service providers. A qualitative study conducted by Henry and Lucca (2004) showed that despite both groups indicating that mental health symptoms impacted on a consumers' ability to work to some extent, more important were personal characteristics beyond the illness and environmental factors. These environmental factors included the stigma held by service providers and potential employers, the labyrinth of mental health, vocational and social security systems, and peripheral skills development programs. Conversely, finding jobs which provided the right challenge and were well-suited to the individual were considered major facilitators (Henry & Lucca, 2004). Again, this study highlights the importance of considering the environment not only within the job itself, but also within the services that are attempting to support consumers to find employment. There is a need for clear intersectorial linkages to be forged between vocational and mental health services to provide relevant assistance with minimal duplication of services. Currently in Australia mental health services and vocational rehabilitation operate separately (Waghorn & Lloyd, 2005).

These findings provide support for the need to look beyond individual consumer capacities and limitations and to further consider the workplace environment as the site for intervention when attempting to promote consumer participation in work. The final evidence for the importance for this comes from a comparison of two models of supported employment, one based on clinical readiness of consumers and one focusing on building social supports within the workplace. The program which was more successful in both finding and sustaining work for consumers was the social model that provided ongoing support to both the consumer and workplace throughout the work placement (Secker, Membrey, Grove, & Seebohm, 2002).

Generally the literature regarding consumer participation in work supports the following notions. Firstly, that meaningful work fosters consumer recovery from mental illness. Secondly, consumer unemployment rates are high. And thirdly, supported employment programs are best practice at encouraging consumer participation in work. However, also highlighted is the fact that many positive

benefits are developed through work separate to income provision. It has been discussed that work can promote the building of daily structure and routine, meaning, motivation and socially integrate consumers into the community. These factors are identified in practice and a number of papers which discuss the implementation of supported employment programs include not only outcomes of engagement in paid work, but also engagement in community volunteer work or study as positive outcomes (Davis & Rinaldi, 2004; McGilloway & Donnelly, 2000).

This project specifically looks at the volunteer work in which mental health consumers participate. The hypothesis behind this is that, volunteer work will provide many of the benefits associated with paid work, such as a meaningful role and responsibility, social networks and routine. It is also important to consider the group of consumers who would like access to meaningful work in the community but who do not have the personal resources or inclination for paid work.

2.6 VOLUNTEER WORK

2.6.1 Definition of Volunteering

Volunteering can take the form of formal volunteering, where an individual is officially aligned with an organization, or informal volunteering where there is no available record of the volunteering effort made. This research project is specifically interested in formal volunteering. It is defined by Volunteering Australia as

an activity which takes place through not-for-profit organisations or projects and is undertaken to be of benefit to the community, of the volunteers own free will and without coercion, for no financial payment and in designated volunteer positions only.

(Volunteering Australia, 2001, p. 1).

2.6.2 Volunteer Work in Australia

There are a growing number of Australian volunteers. Statistics show that between the years of 1995, 2000 and 2002 volunteer rates in Australia have increased from 24%, to 31% and finally 34% of the population. In addition to this the total number of volunteer hours increased from 512 million to 704 million between 1995 and 2000 (Australian Government Department of Family and Community Services, 2005). Bringing the microscope closer to focus on Western Australia, approximately one third of the population volunteered in the year 2000 (Forte & Paull, 2001). Australian volunteers are predominantly participating in the activities of administration or clerical work, working with children or youth, fundraising, emergency response, education or tutoring, and community and sports events (Volunteering Australia, 2006).

2.7 VOLUNTEERING ACROSS THE LIFESPAN

2.7.1 Volunteer Demographics

Wilson (2000) completed a comprehensive literature review regarding the demographics of volunteers and theories surrounding volunteer participation. His review highlights that education is the most consistent predictor of becoming a volunteer, namely because the educated have an increased awareness of social issues. The review also indicates that those who are working and have access to extensive social networks are more likely to be volunteers, than non-workers with few social contacts (Wilson, 2000). These demographic criteria are consistent with statistics from both Australia and the United States of America regarding who is a typical volunteer (Australian Bureau of Statistics, 2000b; Boraas, 2003). In Australia the volunteer prototype tends to be a middle aged white collar worker in paid employment who volunteers in an area closely matched to their professional expertise (Australian Bureau of Statistics, 2000b; Warburton, Oppenheimer, & Zappala, 2004). Other studies indicate further that individuals who are married and have children volunteer at greater rates than those without (Boraas, 2003; Thoits & Hewitt, 2001). However, demographics also suggest that whilst some groups as a whole volunteer less in the community, when they do volunteer they actually volunteer more hours and over a longer

period of commitment. These groups of individuals would thus be very beneficial for organisations to recruit (Boraas, 2003; Warburton et al., 2004).

Thoits and Hewitt (2001) investigated the selection effects that led to individuals becoming volunteers. They developed multiple regression models based on data from two waves of the Americans' Changing Lives study, in 1986 and 1989. This study looked at participants involvement in volunteer work, including the number of hours worked. It also included measures of life satisfaction, happiness, self-esteem, mastery, physical health and depression. Their study demonstrated that volunteers tended to have access to social and psychological resources prior to volunteering. They concluded that healthy individuals volunteered at greater rates than unhealthy individuals. Other authors have posited similar hypotheses namely that individuals who are healthy and socially connected to the community have a greater chance of being selected into volunteer work (Rietschlin, 1998; Wilson & Musick, 1999).

2.8 VOLUNTEERISM AND HEALTH

In the above study conducted by Thoits and Hewitt (2001) they also tested for the impact volunteering had on six domains of psychological health including happiness, life satisfaction, self-esteem, sense of control over life, physical health and depression. They concluded that despite adjusting for pre-existing psychological health levels, volunteering still had a positive impact on adult happiness and well-being (Thoits & Hewitt, 2001).

The Americans' Changing Lives data set has been further studied by a number of research groups investigating the impact of volunteer work on psychological and physical health variables. Harlow and Cantor (1996) analysed data from 1977 but used baseline data from 1950 and 1972 to control for variables such as life satisfaction. Their study demonstrated that participation in community service was a predictor of life satisfaction in older adults, the median age of their sample being 65 years (Harlow & Cantor, 1996).

Wilson and Musick (1999) analysed data from 1986, 1989 and 1994 to identify the impact participation in volunteer work had on personal well-being. The rate of depression was measured in 1994 using the Center for Epidemiological Studies Depression Scale and the analyses were adjusted for controls measured at the baseline including self-rated health and demographic and social characteristics. Congruent with the findings of Harlow and Cantor (1996) they concluded that volunteering lowered the rates of depression for adults over 65 years with their analyses not demonstrating significant effects for adults under the age of 65 (Wilson & Musick, 1999). These measures showed changes as a result of prior volunteering and account for demographic characteristics of the sample. The authors therefore argue that volunteering is the cause of this lowered rate of depression (Wilson & Musick, 1999).

Young and Glasgow (1998) used secondary analysis on data obtained from a survey investigating the community participation of older adults conducted in 1993. The study attempted to identify the impact of 'instrumental' community based voluntary service, such as volunteering at a recreational club versus 'expressive' activities which benefited only the participant, such as using the services of a recreational club. Regression analysis of the data showed that participating in instrumental activities was related to better perceived health within the elderly (F. Young & Glasgow, 1998).

A number of other studies confirm the health promoting benefits of volunteer work participation. Oman, Thoresan and McMahon (1999) conducted a prospective study of 1972 elderly residents in California and measured variables of: physical health and functioning, health habits, social functioning and support networks, psychological and finally sociodemographic variables. They developed multivariate models relating the amount of volunteering individuals participated in to various measures of mortality. Following adjustments made for levels of social support and involvement in religious organisations, they concluded that individuals who volunteer for two or more organisations had a 44% lower rate of mortality than did those that did not participate in any volunteer work (Oman et al., 1999). This demonstrates the protective nature of volunteering.

Van Willigen (2000) investigated the impact of volunteering on the psychological and physical well-being of adults. He also questioned whether elderly volunteers experience benefits differently to younger adult volunteers. He was able to show that older volunteers perceived greater changes in their perceived health and life satisfaction than did younger volunteers. Therefore this study demonstrated that older adults appear to benefit more from volunteer participation than do younger adults (Van Willigen, 2000).

A similar finding was made by Musick and Wilson (2003). They demonstrated that participation in volunteer work lowers depression among those over 65 years. This has tended to be a theme within the literature that the positive health and well-being effects of volunteer work are more potent within the elderly (Musick & Wilson, 2003; Van Willigen, 2000). It is proposed that participation in volunteer work for the elderly has more of an impact on their perceived mental and physical health because they have experienced role loss and this is a way in which they can positively contribute and be involved in their community again (Van Willigen, 2000).

One study investigating volunteering in the elderly reported conflicting results to the above mentioned studies. Oakley and Pratt (1997) surveyed 40 older adults. They compared the scores from 20 volunteers to the scores obtained from 20 non-volunteers. Independent samples t-tests were used to identify if any differences between the two groups regarding the variable of life satisfaction were apparent. There were no significant differences found. The results from this study differ to the previous results discussed which overwhelmingly found that participation in volunteer work had a significant impact on the perceived level of life satisfaction and health outcomes amongst the elderly. Furthermore these studies namely, Harlow and Cantor (1996), Wilson and Musick (1999), Van Willigan (2000) Young and Glasgow (1998) and Oman et al. (1999) all employed larger sample sizes and some included longitudinal data. Therefore the outcome of these studies is considered more rigorous. Also, their findings have remained stable and been consistently demonstrated at various time points by different groups of researchers, increasing their credibility.

Whilst the extra benefits of volunteering for the elderly have been discussed, the benefits for younger adults can also be shown. Firstly, the study discussed above conducted by Thoits and Hewitt (2001) was conducted in the general adult population and demonstrated positive benefits for adult psychological health. This has been further supported by Reitschlin (1998) who examined data from a sample of 850 community subjects in order to test for associations between the variables of distress, stress, voluntary association membership and psychological and social resources. Through multi-variate regression analysis of the data he concluded that voluntary association has a statistically significant effect on decreasing psychological distress, independent of social status and personal psychological resources. The study was able to demonstrate that participating in volunteer work may reduce and even buffer against psychological distress in the general adult population (Reitschlin, 1998).

Further to this, Black and Living (2004) surveyed 109 adult volunteers requesting qualitative information about their personal motivations to volunteer as well as the perceived outcomes of their voluntary participation. The participants identified volunteer work as a positive experience in which they gained confidence, and a sense of achievement, felt appreciated for their work, were able to meet new social contacts and develop a meaningful social role (Black & Living, 2004). These qualitative findings are similar to those identified by Primavera (1999), who described the impact volunteering had on college students who conducted volunteer hours as part of their coursework. The college students identified that the volunteer work was a meaningful experience for them upon which they thought about and reflected after the completion of their volunteer hours. Their satisfaction with the volunteering process stemmed from their belief they were making a difference and the positive acknowledgement they received from those they were assisting. All of the college students indicated that they would participate in volunteering again in the future (Primavera, 1999).

The benefits of volunteering have also been demonstrated with adolescent populations participating in volunteer programs with school based support. Moore and Allen (1996) conducted a critical analysis of the literature

surrounding such programs and were able to conclude that participating in volunteer work for adolescents was associated with lower rates of school subject failure, suspension, dropout, teen pregnancy and improved reading abilities and self-concept (Moore & Allen, 1996). The studies that were reviewed were of good quality including randomised control trials and longitudinal studies. Furthermore, due to the randomised nature of some of the studies it can be concluded that the benefits attributed to the volunteering programs were independent of any sociodemographic variables such as family income or personal motivation on the part of the student.

In summary, the current research effort regarding the impact of volunteer work on the health and well-being of individuals supports the following. Firstly, volunteering is associated with a positive cycle of health in which healthy people tend to volunteer more but volunteering in turn keeps them healthy. Secondly, participating in volunteer work promotes positive mental and physical health for all groups across the lifespan including adolescents, adults and the elderly, regardless of an individuals' health status prior to commencing volunteer work. Thirdly, elderly volunteers appear to experience more potent benefits from volunteer work than younger adults potentially because it is a way for them to redevelop life roles following the experience of role loss.

This research project focuses on the impact of volunteer work on the mental health of consumers. It will be interesting to identify if the heightened benefits of volunteering within the older adult population can be related to individuals with mental illness. Similar to the elderly, mental health consumers often experience role loss and occupational deprivation (Boyer et al., 1998; Shimitras et al., 2003). Therefore, it may be likely that this population also experiences more powerful benefits of volunteering because of their limited social and community contact elsewhere.

2.9 VOLUNTEERING AND SOCIAL CAPITAL

Wilson and Musick (1999) propose that one reason volunteering is beneficial for mental health is because it encourages social integration. This is consistent with

the argument for volunteer work being an agent for developing social capital. Social capital refers to personal social networks which are established within groups of individuals who share common beliefs and values. It is considered a form of capital because individuals can invest in the development of such networks in order to reap rewards such as friendship, caring and community favours (Organisation For Economic Co-Operation and Development, 2001). Social capital therefore describes an individual's involvement and connection with their community, such as through work, family, friendships, sporting or cultural pursuits. Participation in volunteer work is one way in which governments can measure these social fabrics and draw conclusions about the interconnectedness of their communities. As discussed within the Introduction Peter Costello, the Australian National Treasurer spoke of volunteers being needed to build the spirit of the Australian community and by this he was referring to the building of social capital (Costello, 2001). However, whilst volunteering is suggested as a means of building social capital, it also appears to be a system burdened with social exclusions and prejudices.

2.9.1 Volunteering and Social Exclusion

The processes of social exclusion evident within the voluntary sector are described below with a specific emphasis on the exclusion of individuals with disabilities. At the end of this literature review, the volunteering of mental health consumers will be specifically discussed.

In a research report for the Institute for Volunteering Research, Davis Smith et al. (2004) investigated the relationship between volunteering and social exclusion. The large multiphase study involved consultation with volunteering stakeholders, questionnaires completed by 98 voluntary organisations, 203 volunteers, and 40 non-volunteers, qualitative case studies of voluntary organisations and finally focus groups held with the minority groups including ex-offenders, ethnic minority groups and disability groups (Davis Smith et al., 2004). This research project identified a number of barriers that impacted upon the involvement of these groups within volunteering. These barriers included the psychological barriers, of not believing they fitted the public image of a typical volunteer, fear of becoming overcommitted and not having enough time for

volunteering, lacking in confidence that they have the skills and ability to volunteer, concern that they will lose their social security payments and concerns about the attitudes of others. Environmental barriers also acted to prevent these groups from volunteering. These included not being able to find out about volunteering opportunities, difficult recruitment processes, limited follow up of new volunteers, physical inaccessibility and the cost of volunteering (Davis Smith et al., 2004).

Further reasons that individuals with disabilities are excluded from the volunteering movement have been discussed by Balandin and colleagues (2005). They conducted focus groups with volunteer coordinators within Australia and discovered that whilst volunteer managers identified volunteering as an avenue for disabled individuals to socialise, learn skills and contribute to their community they believed that resource constraints within the voluntary sector would make this task difficult for voluntary organisations to manage. They felt that limitations inherent within disability, such as decreased stamina and skills, lack of resources to provide extra supports and disablist attitudes amongst volunteers would act as barriers to volunteering opportunities for individuals with developmental disabilities. However, the group were able to identify strategies to attempt to overcome these barriers believing that increasing physical accessibility, providing supported volunteering opportunities and educating the voluntary sector on inclusive volunteering practices would be positive first steps (Balandin, Llewellyn, Dew, & Ballin, 2006).

A study with very similar objectives was conducted within the United States of America. This study conducted by Miller, Schleien and Bedini (2003) utilised quantitative methodology and supports the above qualitative findings from Australia. The Miller et al. (2003) study sent a mail out questionnaire to 500 volunteer services across America in an attempt to quantify how many services involved people with disabilities, and the issues surrounding this. Volunteers with disabilities were under represented accounting for only 5.7% of the overall volunteers, compared to a national disability rate of 19% within the United States. Volunteer coordinators perceived the barriers to their involvement to be lack of staff, the cost of extra resources required to support individuals with

special needs, transport limitations, being unaware of how to recruit them, having tasks that they do not have the skills to complete, attitudinal barriers and finally physical access.

Furthermore, previous research has shown that individuals with access to psychosocial resources and networks volunteer at higher rates (Thoits & Hewitt, 2001; Wilson & Musick, 1999). By virtue of their social status and connections they have more chance of being recruited for volunteer work. This is especially important since Australian data show that word of mouth or simply being asked to volunteer is by far the most common way individuals become involved in volunteering (Volunteering Australia, 2006). This works against marginalised individuals who are often subjected to stigmatising attitudes and prejudice resulting in social exclusion. In addition to this age old process of discrimination, the changing face of volunteer work may also be acting as a barrier to their inclusion.

Volunteer work is undergoing a transformation from being an informal activity that was traditionally associated with middle aged women to an age of insurance, liability, orientation, training and formal job description. This has been referred to as the professionalisation of the volunteer (Warburton et al., 2004). These processes have been instigated for the protection and support of volunteers, however they could potentially act conversely to this unless diversity within volunteer work is openly encouraged (Warburton et al., 2004).

2.10 DIVERSITY IN VOLUNTEERING

The study conducted by Davis Smith et al. (2004) clearly demonstrated that a number of barriers prevent minority groups from becoming involved in volunteering. However, it also found that volunteering acted to reduce social exclusion in a number of ways. If people from these groups were provided the opportunity to participate in volunteer work, they became more included in society through meeting others and having a regular purposeful activity. The opportunity also enabled individuals to learn skills and build their personal confidence (Davis Smith et al., 2004). This demonstrates the powerful tool

volunteer work can be for promoting inclusive communities and developing the potentials of individuals. The importance of encouraging volunteering within minority groups to achieve these positive outcomes has been endorsed internationally throughout the volunteering community.

Following the International Year of the Volunteer in 2001, a number of agendas were identified to promote the ongoing development of volunteer work internationally. Globally the International Association for Volunteer Effort (2001) developed a Global Agenda to Strengthen Volunteering. This global agenda recognises that various cross-sections within the community, including voluntary organisations, government departments, educational and media sectors have a role to play in the development and promotion of volunteer work. Specifically relating to diversification, they identify that voluntary organisations should be removing barriers which are excluding marginalised groups from participation, providing opportunities to not only engage these groups but also to develop their leadership skills and thus their sustainability within volunteer environments (International Association for Volunteer Effort, 2001).

The national agenda on volunteering developed by Australia also documents the need to promote diversity in volunteering. They recognise that volunteer work is still plagued by stereotypes of middle aged women volunteering, which may act as a deterrent for potential volunteers. They identify that the voluntary sector needs to encourage individuals from indigenous and culturally diverse backgrounds, people with disabilities and young people (Volunteering Australia, 2001).

Suggestions for volunteer agencies attempting to diversify their volunteer base have been proposed in the literature. These include, providing reimbursement for expenses such as travel or uniform requirements, being flexible regarding scheduling, being willing to provide extra training and more intensive support, ensuring advertisement is distributed widely and uses welcoming and sensitive language, and finally formally documenting the progress of and acknowledging volunteer efforts (Hostad, 1993). These ideas were proposed in 1993 arguing that organisations that adopt inclusive practices will have future success. As

identified within the international agendas regarding the diversification of volunteering, these practices are still very relevant today. The Davis Smith et al (2004) study highlighted that some organisations within the United Kingdom were using these principles to guide their recruitment and support of volunteers with special needs. In addition to those listed above, services also mentioned developing user-friendly recruitment interviews and processes, matching the individual to the volunteer role and organising diversity training (Davis Smith et al., 2004).

2.10.1 Managing the Resource of volunteers

Fostering the inclusion of individuals from marginalised groups within the community represents a true challenge for the volunteer sector. In order to succeed with the task, appropriate human resource management procedures need to be developed and adhered to. For volunteers to be effective, time and effort needs to be invested by organisations to train and support them (Henderson & Silverberg, 2002). Nearly all voluntary organisations state that they can always use more volunteer manpower (Volunteering Australia, 2006). However, the issue does not rest with the recruitment of volunteers it is their retention that is important. For volunteers to remain volunteering at their chosen organisation they need to be satisfied with their volunteer role. The level of volunteer satisfaction in fact is a predictor of their ongoing volunteer participation (Davis, Hall, & Meyer, 2003). The need to provide ongoing support and commitment to volunteers was highlighted for the “Caring Hearts Service” which provides bereavement support for families within an American military hospital. The service experienced a very large attrition rate within their volunteer pool. Interviews conducted with 42 volunteers from their service indicated that the volunteers felt isolated in their work and believed that greater commitment was required from the organisation to training, professional development and fostering peer support within the volunteer group (Skoglund, 2006).

In order to survive not for profit organisations are generally dependent upon two factors, building a resilient volunteer team and having ongoing access to funding opportunities. A case study of the Robert Wood Johnson Foundation Faith in Action Program which used community volunteers to provide support to

individuals with disabilities in America demonstrated these two principles. Surveys were conducted with 787 of these programs to identify factors which promoted success. Aspects associated with the successful programs regarding their management of volunteers included, allowing volunteers to work in teams, providing volunteer training, providing an assortment of tasks, ongoing formal supervision with volunteers and finally having leadership within the program provided by an individual with experience in supervising caregivers (Leviton, Herrera, Pepper, Fishman, & Racine, 2006).

This highlights that volunteers are the lifeblood of many non-government organisations and are thus an essential resource that requires nurturing in order to support their ongoing commitment to service. This can be in the form of ensuring that volunteers are linked in with each other to build informal support networks but also ensuring that formal measures are introduced that manage volunteer issues. It is further proposed that individuals from marginalised groups such as individuals with disabilities will most probably require more intensive support and training in order to become effective volunteers.

2.10.2 Benefits to Individuals with Disabilities

The benefits of volunteering for the general population have been discussed in sections 2.8 and 2.9. The benefits that individuals with developmental disabilities can obtain from volunteer work participation are expected to mirror those of the general population. These proposed benefits are increased self-confidence, development of empowerment, personal and social skills, social networks, work skills and finally increased purpose and structure (Roker, Player, & Coleman, 1998). These descriptors were identified through a national survey within the United Kingdom investigating the participation of young adults with disabilities in volunteer work. However, very limited methodology of this study was provided and so the results are described here as propositional.

Similarly the benefits of volunteering and a description of a volunteer project involving high school students with disabilities were provided by Miller et al. (2002). They described a volunteering project in which high school students with developmental disabilities were paired with college students and participated as a group building a walking trail. The benefits described within

the students with disabilities are limited to reports made by special education teachers. However, they reported that these students were very eager to participate and discussed the upcoming volunteer day each week with enthusiasm. They also reported decreased self-stimulatory behaviours amongst some of the students with autism and an increase in motivation and participation from others. The college students involved also believed the project was a positive experience for them personally (Miller et al., 2002).

2.11 SUPPORTED VOLUNTEERING

The project discussed above used one approach to supportive volunteering, namely a collective approach where a larger group participated in an ongoing activity. The other type of supported volunteering and the one referred to throughout the remainder of this thesis is one on one volunteering in a community setting. Supported volunteering commences through identifying the individuals' strengths and limitations and searching for an appropriate volunteer role in the community that is suited to their needs. Support for as long as required is then provided within the organisation from a volunteer mentor (Miller, Schleien, Brooke, Frisoli, & Brooks, 2005). Supported volunteering in this way mirrors the ideas of supported employment reviewed earlier. Yet, unlike supported employment, supported volunteering has not undergone empirical investigation.

Despite volunteer coordinators identifying barriers to the participation of individuals with special needs, most also indicated an interest in involving them in the future, but felt they needed training if they were to be successful at forging integration. The volunteer coordinators believed they required skills to be able to complete a comprehensive assessment of the individual with disability, identify the barriers to their participation and strategies to overcome these barriers, disability awareness, how to pair up mentors with individuals with disabilities, how to recruit participants and finally how to break up tasks into smaller steps (Miller et al., 2003). All of these processes would formulate part of a successful supported volunteering program.

Roker and colleagues (1998) provide further suggestions for developing successful supported volunteering programs. They described two case studies of volunteering projects successfully involving young adults with disabilities within the United Kingdom and included a synopsis of factors that promoted their success. These factors included, having extensive consultation with the young adults involved, matching the individual to a volunteer activity of interest, building projects gradually, providing support such as transport or a volunteer mentor, providing appropriate training for staff and finally focusing on the strengths of the individual (Roker et al., 1998).

These approaches have been developed within the physical and developmental disability fields. This study is specifically concerned with the volunteer participation of individuals with experience of mental illness and it is yet to be understood whether these approaches will be appropriate within this sector. As discussed by Deegan (1992) whilst inspiration for changes within services can be taken from other disability fields, mental health services and consumer movements need to be built from the ground up so that approaches specific to their needs can be developed. However, the many benefits of supported employment within the mental health sector have already been discussed (Crowther et al., 2004) and therefore it is proposed that applying similar principles for consumers in the volunteering field will be beneficial.

2.12 VOLUNTEERING AND MENTAL HEALTH CONSUMERS

2.12.1 Benefits of Volunteering for Mental Health Consumers

The mental health literature relating to the impact of volunteering on the mental health of consumers is even sparser than within the disability field. Information specifically referring to consumer volunteering is limited to descriptive surveys, case studies and reports based on non-representative samples. No rigorous empirical investigation has been conducted to date. However, the existing information primarily indicates a valid role for volunteering in the recovery process. These preliminary reports identify volunteer work as a positive

experience through which consumers can learn skills, meet new people, attain a sense of purpose and contribute to their community. They document volunteer work as an avenue for consumers to build confidence and self-esteem, keep active, better manage their time, and socialise (Institute for Volunteering Research, 2003; Kayloe, 1985; Rebeiro & Allen, 1998; Risbey, 2004). As discussed above however, there is no high level evidence to date and this information can only be considered preliminary in nature. It does however provide a springboard from which to launch empirical investigation.

The best information currently available comes from within the United Kingdom where they surveyed consumers regarding their experiences with volunteer work (Institute for Volunteering Research, 2003). This survey involved 120 participants, 100 of whom were mental health consumers. Descriptive data concerning consumer participation in volunteer work including roles held, organisations volunteered for, motivations for volunteering, and beliefs about the impact volunteering had on their lives were provided. The results indicate that mental health consumers overwhelmingly volunteer in the area of mental health; this included 58% of their survey sample. Respondents also indicated that volunteering was a positive experience for them that encouraged personal development and facilitated the learning of vocational and personal skills (Institute for Volunteering Research, 2003).

One quantitative research project that also provides support to the benefits of unpaid work was a study conducted by Bryson, Lysaker & Bell (2002). They randomised mental health consumers to either a pay or no pay work condition to investigate the resultant effects on quality of life. The randomisation of 97 participants with schizophrenia or schizoaffective disorder to either a paid work or unpaid work condition showed that the level of participation in work, regardless of whether performed for payment or not is strongly related to increased quality of life (Bryson et al., 2002). Although this provides evidence for the quality of life benefits of unpaid work, this is not synonymous with volunteering. Volunteering has been defined as an intrinsically motivated activity that is undertaken of an individuals' own free will (Volunteering

Australia, 2004). In this study subjects did not exercise free will and therefore cannot be called volunteers.

Currently minimal evidence supports consumer participation in volunteer work, however even less exists to contraindicate it. Through qualitative investigation Van Dongen (1996) documented consumer volunteering as stressful, lacking preparation for paid employment, and as an avenue for potential exploitation. This information however was obtained from only one study and via only two questions on an interview. As such, it cannot be considered fully representative of consumer views and experiences.

2.12.2 The role of mental health services in supporting consumer participation in volunteer work

Consumers indicate that the place they would prefer to be informed about volunteering opportunities is through mental health services (Institute for Volunteering Research, 2003). In order for mental health services to be able to do this, they need to have knowledge about opportunities available but also a willingness to address these issues with consumers. It is believed that mental health service staff, especially those involved in rehabilitation, are well-placed to encourage and support mental health consumers to become active community volunteers. Furthermore, supporting consumers to become involved in real life volunteering opportunities is one example of a community focused rehabilitation strategy. Almost half of the participants involved in the Institute for Volunteering Research (2003) survey indicated concerns that they would lack the skills required of them to adequately perform the volunteer work tasks (Institute for Volunteering Research, 2003). This highlights the need for opportunities to not only be provided by mental health services but for consumers to be supported throughout the process to ensure solid outcomes.

It has been argued, however, that current mental health services attempting to encourage consumer participation in volunteer work are not providing adequate service. Interventions appear to either be too shallow and involve merely referral with no support, or focus too heavily on skills development or group projects

with no options for actually moving into independent and sustainable volunteer work opportunities in the longer term (J. Young & Passmore, 2006).

2.12.3 Volunteer Management Strategies for Mental Health Consumers

It is proposed that by matching consumers to appropriate volunteering opportunities in the community and supporting them to commence and learn the role, as outlined in the supported volunteering approach positive, volunteering outcomes for consumers will be achieved. The importance of having volunteer management structures in place has already been discussed. Managing the volunteer roles of individuals with mental illness does not require significantly different processes to these. However for their volunteer experience to be successful, knowledge of the functional capacity of individuals and a willingness to challenge both consumers and volunteer organisations regarding these so as to ensure the best volunteer role fit for the consumer is required (May, 2003). Providing flexible and accommodating working environments which do not overly pressure individual consumers is also an important consideration within the volunteer environment (Clark, 2002). Within supported employment programs consumers identified having a good fit between the consumer, work task and environment as a major facilitator to successful work placements (Henry & Lucca, 2004). The same concept essentially applies to the volunteering sector. However, overall for the process to be successful, being committed to the integrative process is perhaps the most important.

2.13 CONCLUSION

The prevalence of mental illness is on the rise within Australia with approximately one in five individuals experiencing it. The statistics are particularly alarming because as a group, individuals with mental illness experience many social injustices including limited opportunity to participate and contribute to their local communities. The recovery model is the current model of choice internationally for addressing these issues of social exclusion and injustice for mental health consumers. Rehabilitation services however, need to ensure they are promoting opportunities for real, rather than tokenistic consumer participation. To allow this, clinicians need to consider the environment as more

of a facilitator or barrier to participation rather than focusing on the personal problems of consumers as the issue of concern.

The recovery model encourages mental health services to address issues of developing meaning and fostering community integration for consumers rather than merely focusing on stabilising symptoms. Volunteer work is one community opportunity that can be promoted more within services. Volunteer work fosters good physical and mental health in the general population and is a way individuals can meet others in the community. However, volunteer work is less accessible for individuals with disabilities and support from mental health services is required to promote pathways for consumer participation.

Furthermore, whilst volunteer work is proposed as a rehabilitative option, consumer participation in volunteer work has been scarcely investigated in the mental health literature. Some evidence for the benefits of volunteering and its potential within the recovery process has been shown, however the mechanisms for this are not understood. Consumer participation in volunteer work requires further investigation. This research project attempts to begin the documentation of the volunteering process by investigating if volunteering positively influences the mental health in a population of consumers, as well as documenting the barriers and enablers to consumer participation in volunteering.

3. EXPLORATION OF CONSUMER PERCEPTIONS OF VOLUNTEER WORK

3.1 INTRODUCTION

This chapter discusses the first stage of the study and addresses objective number one, to explore consumer perceptions about volunteer work.

3.2 OBJECTIVE

To explore mental health consumer perceptions of volunteer work through naturalistic inquiry, using phenomenological methods.

3.3 METHODS

3.3.1 Qualitative Methodology

As has been previously demonstrated in the literature review, at present very little is known about consumer participation in volunteer work. The methods consumers use to access volunteer work, their motivations for participation, the impact it has upon their health and the role it plays in their lives are unknowns. Naturalistic inquiry was thus chosen as a method of first exploring and describing the phenomenon before applying a structured scientific method of measurement. It is widely acknowledged that qualitative research is extremely useful for developing theory and describing processes and phenomena that are largely unfamiliar (Meadows, 2003a; Morgan, 1998; Pope & Mays, 1995). Qualitative inquiry was thus considered an important step to develop an understanding of the issues inductively, from within consumers actual real life experiences with volunteer work.

3.3.2 Phenomenology

Phenomenology is a science concerned with identifying and describing phenomena as they are experienced by individuals (Speziale & Rinaldi Carpenter, 2003). There are two competing schools of thought that exist within phenomenological enquiry, those attributed to Husserl and Heidegger. The qualitative approach used within this phase of the study, was Husserlian transcendental phenomenology (Koch, 1995). The study thus aimed to describe the lived experience of consumer participation in volunteer work. Through the process of exploring and describing the consumer experiences the researcher

hoped to uncover the essence of these experiences. Essences are considered the core building blocks that construct the true meaning of a phenomenon, occurring both individually and interconnected with others (Speziale & Rinaldi Carpenter, 2003). In-depth interviews were chosen as the method of capturing these personal accounts and experiences.

3.3.3 In-depth Interview

The purpose of the in-depth interview is for the researcher to develop an understanding about experiences which they are unable to observe directly. Instead the researcher is able to develop knowledge about the phenomenon through actively listening to the accounts and experiences of those who have participated in or lived through the event (Minichiello, Aroni, Timewell, & Alexander, 1995). In-depth interviewing is thus defined as “a conversation between researcher and informant focusing on the informant’s perception of self, life and experience, and expressed in his or her own words” (Minichello et al., 1995, p. 61). Participants in this project were interviewed using an in-depth semi-structured interview format, concentrating on the participants’ personal experiences being a volunteer.

3.3.4 Interview Development

The content for this interview was developed following a review of the literature, reflections on clinical experience and liaison with a senior researcher. Phenomenology generally advocates for the literature review to be completed at the end of the data analysis process in order to limit the number of researcher held preconceived ideas impacting upon the inductive analytical process (Speziale & Rinaldi Carpenter, 2003). However, for this study a cursory review of the literature was conducted prior to data collection and analysis. This was completed to focus the research question and ensure that the study was not merely duplicating work but instead adding new information to the existing body of knowledge. A more rigorous literature review was then completed following data analysis.

Prior to and throughout the development of the interview guide and interview process the researcher participated in the process of bracketing where conceived

biases, assumptions and experiences were reflected on and made explicit (Creswell, 1998). This was completed through regular discussion with the project supervisor, peer debriefing, and personal reflection. This process was undertaken to enable the researcher to focus on the information provided by the participants in order to develop a comprehensive and reliable description of their experience and minimise the impact of the researcher's personal viewpoints (Creswell, 1998).

During development of the topic questions initial reflections resulted in the development of 35 questions. However, through a process of discussion, review and contemplation these were able to be limited. Limiting the number of prompt questions was deemed necessary in order to enable the participant time to reflect and tell their story in their own words, and to follow the participant within the interview, rather than follow a structured interview schedule. The questions developed explored the meaning of the consumers participation in volunteering and sort descriptions from respondents about their everyday volunteering experiences (Creswell, 1998).

The interviews followed a focused semi-structured format. The content of each interview was centered around their personal experiences with volunteer work and were conducted in a flexible manner (Minichiello et al., 1995). From the initial list, 15 questions were deleted to decrease the overall question list. A further 11 questions were reworded to suit the audiences needs. For example, the question "Were there any barriers for you becoming a volunteer?" was reworded to "What things made it difficult for you to become a volunteer?" This was done to ensure the questions were truly focused on the issue and clear for the respondents to understand (Patton, 1990). This process was completed through ongoing discussion with the project supervisor.

The final result was a list of 20 questions that were used to guide the interview process (Appendix D). It is important to emphasise that these prompts were used as a guide only, because often valuable information was elicited through other probing, or the information was already obtained from participants deeming it unnecessary to ask certain questions. Participants were encouraged to tell their

story in their own manner and the topic questions were used merely to guide this process.

3.3.5 Sample Participants

A purposive sample of individuals diagnosed with mental illness who currently volunteer in the community were interviewed. Participants were recruited through advertisement at local mental health services, consumer consultant contacts and non-government organisations. Nine participants responded to the advertisements and volunteered to participate in the study. All participants were females, which is identified as a limitation of this phase of the study. Six lived in a metropolitan area, two lived in regional areas and one lived in a rural area. The participants ranged in age from 28 to 60 years. They volunteered in a range of areas including, consumer representation, group facilitation in a mental health service, teaching in a hospital, and volunteering in an art gallery. The following table provides some demographic information about the participants. The demographic information was obtained through completion of a one page questionnaire prior to the interview commencing.

Table 3.1 *Respondent Demographic Information*

Participant	Age	Sex	Volunteer Role	Volunteer hrs per week	Education Level
1	56	F	Consumer Advocacy	3 – 15	TAFE certificate
2	50	F	Group facilitation at mental health service	2	Primary school
3	52	F	Consumer Advocacy	2 – 5	Completing TAFE certificate
4	60	F	Consumer Advocacy	25	Primary school
5	60	F	Consumer Advocacy and Creative Arts	N/A	TAFE certificate
6	50 estimate	F	Consumer Advocacy	4 – 10	University degree
7	44	F	Children's hospital	4	University degree
8	28	F	Consumer Advocacy	15 – 20	Secondary school
9	55 Estimate	F	Mental health sector	8	Higher education

3.3.6 Data Collection

Interview process

Interview data was collected from August through to December 2005. In-depth semi-structured interviews of between 60 and 90 minutes duration were conducted. Interview participants were contacted by telephone, in order to set up

an appropriate time and mutually agreeable location in which to conduct the interview. During the telephone discussion, participants were provided with an outline as to what the interview would focus on, and permission was obtained in advance to audiorecord the interview. Therefore, on the day of the interview, participants were prepared for both the topic of the discussion, and for the audio recording equipment to be used. The interviews occurred in a variety of locations as negotiated with each participant, these included, participant homes, a mental health service and an art gallery.

Interviews were conducted until data saturation was reached. Therefore, whilst it was envisaged that approximately eight to ten interviews would be required to obtain the necessary information, this was not decided until the interviews were actually conducted. Participants were recruited until each new interview provided confirmation of previous results as opposed to eliciting any new information. Therefore, sampling occurred until the results from the interviews were repeated and confirmed in the subsequent interviews (Speziale & Rinaldi Carpenter, 2003). The result was the engagement of nine participants.

Each interview began with the researcher introducing herself and providing a broad statement outlining the purpose of the interview and the research project. At this stage, each participant was provided a copy of the information sheet regarding the study, encouraged to read it, and asked to sign the accompanying consent form. In addition to having it in the written form on the information sheet, the researcher verbally provided participants with information regarding what type of questions would be asked, how the information would be used, and how the participants' confidentiality would be ensured (Patton, 1990). A demographic information sheet was also completed at the beginning of the interview. During this stage, whilst the participant was reading and signing the forms, the researcher set up the tape recording equipment and engaged the participant in light conversation in an attempt to develop some rapport, prior to the interview commencing. This strategy worked well in comforting the participant before the interview actually progressed. This was also the opportunity for participants to ask any questions of the researcher. The researcher made certain that at least sometime was dedicated to the development

of rapport before the interview commenced. The aim of this was to increase the participants' level of comfort and make the informant at ease so as to obtain a higher quality of information (Baum, 1998).

Throughout the interviews the researcher was observant of the non-verbal behaviour of the participants and made every attempt to ensure the participants felt comfortable throughout. The researcher actively listened to the participants' comments and stories, and used non-verbal cues such as gentle head nodding, and quiet "uh-huhs" to encourage the participant to keep talking. This was done to provide the participant with recognition and feedback that what they were saying was valid and important to the researcher (Patton, 1990).

Recording of the data

Each interview was audio recorded and later transcribed verbatim by the researcher. Interviews were transcribed as close as possible to the interviews' conduct so that any reflections and thoughts were still fresh in the researcher's mind. This process also helped to confirm when saturation of information was reached.

3.3.7 Data Analysis

Thematic analysis was conducted as outlined in a number of qualitative research texts (Boyatzis, 1998; Creswell, 1998; Speziale & Rinaldi Carpenter, 2003). The aim of the data analysis was to develop a comprehensive description of what it is like to be a volunteer for a mental health consumer.

In order to do this the researcher immersed herself in the data for a number of weeks. The processes of intuiting, analysing and describing the data were applied. Firstly, the researcher conducted a naïve reading of the data, by immersing herself in the data and reading and rereading the transcripts a number of times to obtain a comprehensive overall picture. The data was then analysed with an interpretive reading. This interpretive reading allowed for significant statements to be highlighted, extracted and labelled. The labels identified used the words the consumers used themselves to describe the phenomena in the interviews. In this way the themes identified were driven from within the data

inductively as opposed to fitting the data within previously identified themes (Boyatzis, 1998). These labels were written next to each paragraph that involved an important word or phrase. Table 3.2 below provides two examples of how the researcher highlighted text, and developed suitable labels for emergent themes.

The words and phrases were then typed into a separate computer document so that the data could be easier managed. In order to complete the final phase of describing the data, the labels needed to be grouped into connected themes. This final phase of describing the phenomenon, occurred by considering each of the labels identified during the analysis. The labels were carefully considered within each individual transcription and also compared across transcriptions. The aim of this process was to cluster and connect similar themes together and where possible develop an umbrella theme that covered each topic. This process resulted in the emergence of five key themes from within the interview data. Complete descriptions of each of the five key themes were then developed in order to provide a comprehensive description of the experience of volunteering from the consumers' perspective.

Table 3.2 *Process of Identifying Key Interview Themes*

Significant statement	Derived meaning	Overarching Theme
<p>Occasionally all of a sudden I look at my life and I go, wow, overcommitted here in seven different places. Then I do a little bit of a reality check. ...</p> <p>But, sometimes I am in it, before <u>I recognise it.</u> All of a sudden I am starting to crash and burn a bit and so <u>I have my strategies for looking after myself. So, the first thing I do, is come home and sit in the bath and various other things that I do to reduce my anxiety.</u></p>	<p>Strategies for taking care of self</p>	<p>Self-Management of Illness</p>
<p>I think it's by <u>trusting me to have a key,</u> to open the building. Just those, symbolic things they are. On the surface they may not look much. But, when someone gives you a key and trusts you to look after the place and they are not there. That is very very ...</p> <p>It's an honour. <u>They know that you are capable and trustworthy.</u> And, I think that, that really you know, that <u>really makes me feel appreciated.</u></p>	<p>Trust</p> <p>Importance of appreciation</p> <p>Ways of showing appreciation</p>	<p>Enablers to and continuation of volunteering</p>

3.3.8 Trustworthiness

Trustworthiness refers to the demonstration of rigour within qualitative research. Trustworthiness is achieved through the demonstration of four criteria, these being credibility, dependability, confirmability and transferability/fittingness (Speziale & Rinaldi Carpenter, 2003).

Credibility

Credibility refers to the extent to which the findings obtained are believable. Sandelowski (1986) states that qualitative research findings are credible if descriptions of the phenomenon are read and can be immediately recognised by someone who has experienced that phenomenon and if other researchers or practitioners could recognise the phenomenon if they were presented with it (Sandelowski, 1986).

Any activity undertaken by the researcher to improve the chance that real and plausible findings will be obtained from the interviews enhance credibility (Speziale & Rinaldi Carpenter, 2003). Credibility within this study was achieved through the processes of bracketing and checking. In order to answer the research question of “what is it like to be a consumer volunteer?” the researcher first engaged in a process of eliminating preconceived ideas. Bracketing out personal perceptions and ideas was conducted, and all preconceived ideas were made explicit prior to the interviews being conducted (Koch, 1995). This was done through discussion with the research supervisor, peer review, and personal reflection. For example, much discussion with the project supervisor was held about my previous experience as a mental health clinician. I had previously organised a community volunteering group for consumers and had seen some of my clients benefit greatly from this group. My supervisor and I engaged in much discussion about this prior to confirming the final interview questions and conducting the interviews. I needed to bracket out my bias that volunteer work was beneficial for consumers, before the interviews were conducted to ensure I didn't ask leading questions and bias the results. My preconceived ideas about consumer volunteering were therefore separated as much as possible, to ensure I could focus on the consumers first hand accounts.

Member checks of the full interview transcripts were conducted with two interview participants (Appendix E). Excerpts of transcripts were also given to other researchers for checking to ensure congruence between the labels the primary researcher identified and those others identified. This process identified overall agreement between the researcher and checkers. In addition to this, the project supervisor read through all of the transcripts and the final themes developed were confirmed with the project supervisor. Every participant was then sent a letter describing each of the interview themes (Appendix F). They were requested to provide feedback from this, should they wish to update or comment on the emergent themes. Therefore overall agreement of the research themes was obtained from outside researchers, the project supervisor, the primary researcher, and all of the interview participants.

Confirmability

Confirmability or auditability refers to the extent to which another researcher is able to follow the studies progress and understand the logic behind the research being presented. This has been achieved in this study through the documentation of a clear audit trail, held by the researcher, from the beginning of the research process through to the end (Sandelowski, 1986). This has taken the form of a research notebook in which the researcher has documented information such as memos to herself about her thoughts and ideas regarding the research, communications with the project supervisor, and recruitment information. Important decisions made throughout the research process are documented within this research notebook to promote reflection and ensure the researcher remembered the reasoning behind such decisions. The following excerpt from the researcher's notebook dated 08/03/06 provides an example of how the researcher reflected upon the data and made decisions throughout the research project.

“The consumers who participated in the interviews didn't really mention 'symptoms' per se as a barrier to volunteering. Symptoms were mentioned but more in the way of needing to manage the volunteer work so as to not get too stressed, because this would have an impact upon them.”

Transferability

Transferability refers to the ability of the research findings to be applied to other environments. The decision of transferability rests with other researchers or practitioners who need to decide whether the research is applicable to their field or particular setting. Thus to enhance transferability of findings reports should provide detail about the research setting, participants, and methods to enable others to make such judgments (Baum, 1998). Transferability has been optimised in this investigation through the honest and logical detailing of the research project and the methods used in obtaining the research findings. All attempts have been made to provide a clear description of the project so that others will be able to decide if the results are applicable to their clinical area.

3.3.9 Data Storage

The interview transcripts and tape recordings are stored in locked facilities at the Centre for Research into Disability and Society at Curtin University of Technology. The tapes will be destroyed following completion of the research project. Copies of the written transcripts will be kept for a minimum of 5 years at the research centre. Copies of the interview transcripts are also kept on the primary researcher's computer that is password protected.

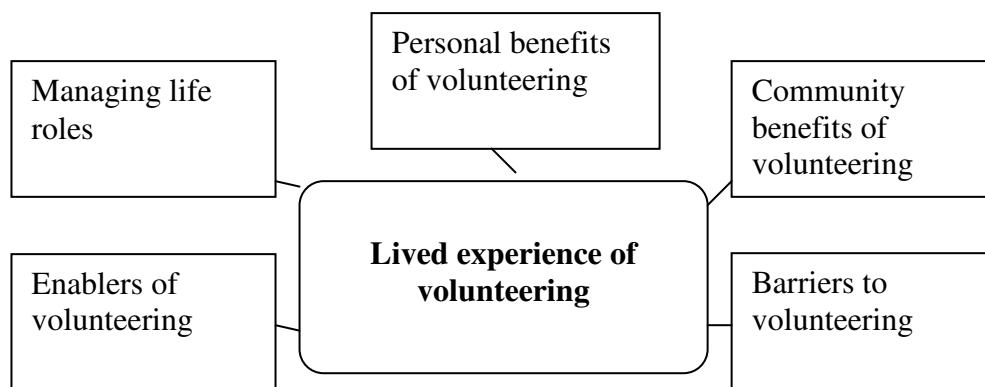
3.3.10 Ethics

Written informed consent was obtained from all participants. Therefore all participants were informed about the overall purpose of the research project and any potential risks or benefits from participation (Kvale, 1996). Ethical approval was obtained from both the South Metropolitan Area Health Service and Curtin University of Technology Human Research Ethics Committees. Prior to the commencement of the interview, participants were also provided with verbal information regarding the interview purpose, and how the information will be used and confidentiality ensured. Participants were informed about the opportunity to cease the interview at any stage, and that they were able to refuse to answer any questions that they did not wish to answer. None of the participants became upset or disturbed during the interviews, however should this have been the case, appropriate referral would have been made on the participants' behalf.

3.4 FINDINGS

Five themes were identified from within the data. Descriptions of these themes are included below. Quotes have been used throughout to provide concrete illustrations and enhance the reader's understanding of the themes being described (Sandelowski, 1994).

Figure 3.1 Five Major Interview Themes



3.4.1 Personal Benefits of Volunteering

Overall the interview participants described volunteering as a positive experience. This first theme titled the personal benefits of volunteering was constructed from four main personal benefits which emerged from the interview data. These benefits included a sense of purpose, improvements in self-esteem and confidence, development of social connections, and opportunities to cultivate work skills.

Firstly, volunteering provided participants with a sense of meaning and purpose. Helping others provided them with a great sense of satisfaction and an opportunity to participate in their community. The following quote from one of the interviewees clearly demonstrates the energy and inspiration she drew from her volunteer work.

"...you feel important, you feel like, wow, I'm doing something, I'm helping out. I'm helping people that are not as fortunate as me. And you have got a purpose, you get up in the morning and it's good."

Secondly, by experiencing success within their volunteer roles, participants experienced increases in their self-confidence. Volunteer work was thus an avenue for the participants to accomplish and gain recognition for their achievements. These successes, no matter how small were important building blocks for their self-esteem and self-efficacy. For example, one participant explained how being assigned a specific task and managing it well was the catalyst for her becoming more involved in other community activities and roles.

“I had burnt out. And I hadn’t worked. And just doing something again and knowing I could do it and could do it well was huge for me. Great strides. ... So since then I have not hesitated to take on stuff.”

Thirdly, volunteering enabled the participants to learn practical work skills, participate in training opportunities and develop employment networks. Six of the nine participants obtained periods of paid work as a direct result of their volunteer work. The following quote outlines how one interview participant learnt work skills within her volunteering and was then offered a job.

“... that’s where I learnt all my bookwork skills, my administration skills. ... I actually got taught on the job to do things. ... and then the position came up – part time administration, and I got the job. ... you can gain some wonderful skills, without the pressure of having to perform like when you are getting paid.”

The final personal benefit identified, was the development of social connections. Volunteer work provided opportunities for the interview participants to build personal relationships and friendships. The interview extract below demonstrates how one participant became close friends with people she had met through volunteering.

“ ... there is a couple of girls. Well there is three actually, that we have all become very close. We have this three way conversation on the phone. ... They have been terrific and we have got strong friendships out of that.”

Although sparse, the literature dedicated to consumer volunteering has previously identified each of these personal benefits which emerged from the interview data (Davis Smith et al., 2004; Institute for Volunteering Research, 2003; Rebeiro & Allen, 1998). The sense of purpose respondents obtained from volunteer work has been documented as a benefit of participating in meaningful activity, and more particularly work based activity (Bryson et al., 2002; Provencher et al., 2002; Strong, 1997; Van Dongen, 1996). Mental health consumers as a group experience occupational deprivation. They have limited participation in meaningful activity, and a tendency to partake in passive leisure based activities as opposed to engaging in productive roles (Shimitras et al., 2003). Volunteer work provided a niche for these consumers to actively participate in a productive role within their community, which has previously been shown to have a positive relationship with consumer quality of life (Goldberg et al., 2002; Kelly et al., 2001; Laliberte-Rudman et al., 2000).

Furthermore, the benefits of purposeful activity have also been associated with recovery, as defined in the model proposed by Andresen et al. (2003). They report that 'finding meaning in life' is an ingredient in consumer recovery. Volunteering provided a source of meaning for the participants through a socially acceptable and recognised role in the community, true responsibility and a channel for developing relationships. It also enabled them to 'find hope' a second recovery theme from the model (Andresen et al., 2003). Informants identified that when they experienced success in their volunteer work they became inspired to try new challenges and were awakened to future possibilities. Thus, hope was instilled within them and they began to believe that if they can accomplish within volunteer work they can also achieve within other areas of their lives. Hope was further infused in the consumers through being entrusted with responsibilities. Despite at times informants questioning their personal capacity to complete assigned tasks, having another person believe in their capabilities and supporting them to achieve aroused hope within the consumers themselves.

Volunteering also provided the consumers with social connections and an opportunity to develop friendships. This is of great consequence for consumers

who experience high rates of social isolation and loneliness (Jablensky et al., 2000) yet indicate that having access to friendships and relationships is a crucial element to their quality of life (Laliberte-Rudman et al., 2000). The social benefits of volunteering documented throughout these interviews supports previous research that volunteer work can be a powerful instrument for promoting social integration and inclusion for marginalised groups (Davis Smith et al., 2004).

Finally, volunteering offered the consumers a real-life situation that demanded and advanced the development of their work skills. High rates of unemployment and underemployment exist for consumers (Waghorn & Lloyd, 2005). Thus having access to genuine work in which one can gain experience, develop a resume, obtain possible work references, and generally build their work stamina and readiness will improve their employability. Previous research has documented that many consumers do participate in volunteer work as a way of improving their work skills and employment prospects and thus this finding is of importance (Institute for Volunteering Research, 2003).

3.4.2 Community benefits of volunteering

The second theme emergent from the interview data included the community benefits of volunteering. All participants believed that volunteering was an opportunity to give back to society and positively contribute to their community. This concept was expressed in different ways by each participant and covered issues such as, teaching people skills, providing a voice for those who may not have been able to speak up, helping organisations and freeing up the time of paid staff. The following two quotes provide examples of how the participants expressed the importance of giving back to their community.

“I’m never going to cure cancer or build the Taj Mahal. But hopefully ... I’m making the world a better place. That’s what feels good.”

“It’s given me a chance to help others, where I can see that they need help. And there are people out there that need help that just don’t have help. And if I can get a chance to do that, it’s a big deal for me.”

Participants felt that they were making a difference and improving things for those that were to follow behind them. Whilst the respondents identified volunteer work as more flexible than paid work, they also believed it was a real responsibility and important work that demanded true commitment. The quotes below describe how the participants obtained a sense of satisfaction from the belief that they were helping others and making changes for the future.

“Participating in changing things that perhaps haven’t been that crash hot for you can give you a real sense of achievement. Knowing that you are making a difference for somebody that comes after you. Particularly in mental health services, a lot of people get a lot of joy out of that.”

“Well the fact that we can make change. And we can make it for the better. So, that everyone’s life is made easier.”

The benefits of volunteering to the community cannot be denied. In 2004, 836 million hours of volunteer time were donated by the Australian public (Volunteering Australia, 2001). However, the reasons individuals volunteer are still largely unknown. Support is provided to a number of theories ranging from the personal motivations and prosocial attitudes held by volunteers through to behavioural theories of social selection and socialisation processes (Wilson, 2000). This interview theme highlights the reciprocal benefit obtained from helping others as a motivating factor for the consumers to continue their volunteer work. The interview participants felt good because of the contribution they were making to society and the belief that they were making a difference and improving services for those to come after them. Wilson and Musick (1999) propose that this is one of the reasons that volunteer work is beneficial to the mental health of individuals. They suggest that volunteer work inspires a sense that individuals can make a difference and thus have control over their life and actions. This internal locus of control is associated with decreased feelings of depression (Wilson & Musick, 1999) and increased personal empowerment (Segal et al., 1995).

3.4.3 Managing life roles

The third theme identified from within the interview data was managing life roles. Participants thought that volunteering positively impacted on their mental illness in a number of ways. These included, providing a positive focus, structure and routine, demanding self-care and hygiene, and learning self-management strategies. The quote below describes the benefit of having another focus very well.

“And I have found it [volunteering] really good to do it. Because I have been able to throw my illness off onto doing something positive. So, I have become better as a result of doing this volunteer work. I don’t sit at home dwelling on my illness. I’m actively involved in doing something, which improves my illness.”

Some participants also spoke of the motivation that volunteer work provided, and how being committed to a volunteering project would mean they would force themselves to get up and get there. This provision of routine and structure within their volunteer work resulted in other improvements such as increased personal self-care and hygiene.

“ with my particular illness, you sometimes can’t even get out of bed in the morning. So, you actually force yourself to do that. You force yourself to have a shower and look after yourself. Because you have to not smell when you go to one of these meetings. So, that improves your self-esteem by knowing that you have actually done something and you have sort of set yourself a goal, when you attend these meetings.”

The interview respondents highlighted the importance of looking after themselves within the volunteering process. This meant taking responsibility for the amount of volunteer work and projects they took on, and managing their commitments. They also wanted this responsibility to be their own, rather than needing to submit to others telling them what they should and should not do. The two quotes below demonstrate these two processes. The first demonstrates the process of self-management that the consumers undertook to enable the management of their commitments, and the second demonstrates the desire on

the consumer's part to have control of her own decisions. Both of these themes are important within the recovery process.

“Occasionally all of a sudden I look at my life and I go, wow, overcommitted here in seven different places. Then I do a little bit of a reality check. ... But, sometimes I am in it, before I recognise it. All of a sudden I am starting to crash and burn a bit and so I have my strategies for looking after myself. So, the first thing I do is come home and sit in the bath and various other things that I do to reduce my anxiety.”

“... I had it happen recently, you are doing your work ... you are busy... And you get the psychiatrist or the mental health professionals saying ‘now you better watch out that you don’t do too much or overdo it’. And I hate that patronising way, because look I know how much I need to do. And if I ... do too much and I crash, so what. It’s my fault. It’s my responsibility. But don’t protect me. I need to protect myself. I need to learn those things for myself by experiencing them.”

Volunteering provided the respondents with a means of managing their time, through the provision of structure and routine. The volunteer work offered a positive focus for the consumers enabling them to take their mind off their illness and problems. Having access to activity which provides routine and structure has been identified as an essential element to consumer quality of life. Laliberte-Rudman et al. (2000) documented that having activity to structure their time provided consumers with the benefits of “increased motivation, diversion from present problems and avoidance of negative moods” (p. 140).

The responsibilities and commitment demands of volunteering also encouraged the participants to learn skills in the self-management of their illness. As the above quotes have demonstrated the participants needed to manage their lifestyles, including the potential stresses and demands associated with their volunteer work in order to maintain wellness. This is referred to within the Andresen et al. (2003) recovery model as ‘taking responsibility for illness’. The previous literature has documented volunteer work as a means of providing

consumers with structure, social relationships, skills development and sense of purpose (Institute for Volunteering Research, 2003; Kayloe, 1985; Rebeiro & Allen, 1998; Risbey, 2004). However, this specific theme of volunteer work encouraging the development of self-management strategies has not previously been documented. This is thus a significant finding from within this study and important because of its relationship with supporting consumer recovery from illness (Andresen et al., 2003). Consumers have identified the inability to control their illness as a detractor from their quality of life, and attributed this to a lack of knowledge on management strategies (Laliberte-Rudman et al., 2000). Thus, participating in an activity which can actually support consumers to learn personal and symptom management strategies may have a positive impact upon their quality of life. The informants also emphasised the need to make these decisions independently and take personal risks. The process of empowerment involves individuals taking control over their lives and the social systems which influence them (Segal et al., 1995). The dedication expressed by the participants to be personally responsible for these decisions is an example of this process.

3.4.4 Enablers to Volunteering and Retention of Volunteers

The fourth theme emergent from the data was the enablers to volunteering and the retention of consumer volunteers. A number of factors emerged which encouraged consumers to both enter into but also to continue volunteer work. First and foremost this included having an avenue into volunteering. Only two people of the nine interviewed actively sort their volunteering opportunity, the rest of the participants spoke of “falling” into volunteering. Therefore, having an entry point to volunteering was an important concept. Most people chose their volunteer organisation because of a personal interest or experience in the area, with a number of participants having volunteered in the mental health area. However, it may be the case that if consumers were in positions to hear about other volunteering opportunities, the mental health field may not have been as common. The quote below outlines how one respondent came to volunteer in the area mainly because it was what was available to her at the time.

“ ... its what I had access to at that stage in terms of community and things. ... I didn't really have any other contact with any other community

organisations and so it was just because it was at the clinic where I had heard about it.”

Another factor that encouraged ongoing volunteering was the fact that it offered more flexibility than paid work. Informants felt that they got many of the same benefits as paid work but had more flexibility and less stress within their roles. The participant below describes how she felt less pressure to perform within her volunteer work than when she had a paid job.

“Also, my health with bipolar you could be really well for days, weeks, and sometimes if your lucky enough you go months and then you can be in a heap. ... and in a paid position, the fact that you’re in a paid job, a 9 – 5 type job, automatically puts pressure on you. Worrying, what if this, what if that. ... so it takes some of the pressure away, if you do it on a voluntary capacity.”

Receiving positive recognition for their volunteer efforts also emerged as a factor important to the retention of volunteers. The participants believed that recognition for their contribution was essential, no matter how small the recognition appeared to be.

“...I got a certificate. ... I loved that. That was great. I love getting certificates for things. Its nice. Just people acknowledge your contribution.”

“I think it’s by trusting me to have a key, to open the building. Just those, symbolic things they are. On the surface they may not look much. But, when someone gives you a key and trusts you to look after the place and they are not there. ... it’s an honour. They know that you are capable and trustworthy. ... that really makes me feel appreciated. That I am capable. I can take responsibility.”

The provision of appropriate support and resources within their volunteer roles were also important factors for the volunteers. This included organisations

having an understanding about mental illness. One participant spoke of how she felt more secure volunteering for an organisation with an appreciation of mental illness because she knew she would be both supported and respected.

“ ... I would be comfortable to volunteer anywhere now, but that safety aspect that sense that there would be support here, there would be understanding was very important.”

A clear enabler to consumer participation in volunteering that emerged was having an entry point to volunteer work. Previous authors have proposed that individuals who already have social networks and resources will be more likely to volunteer because their social connections open up volunteering opportunities for them (Rietschlin, 1998; Thoits & Hewitt, 2001; Wilson & Musick, 1999). This has been supported by Volunteering Australia's national survey of volunteering issues 2006 which surveyed 373 Australian volunteers and 341 volunteering organisations on a range of volunteer issues. They reported that 32% of the volunteers found their volunteer work through a friend or relative, with very few using a volunteer centre (4%) or responding to an advertisement (13%) (Volunteering Australia, 2006). The interview findings match these reports, in that it was generally the consumers' social connections that established their volunteer involvement rather than a formal application process.

The interviewees volunteered in a range of areas however the mental health field was the most common. This mirrors previous research conducted which identified mental health as the area of choice for consumers to volunteer in (Institute for Volunteering Research, 2003). However, one participant noted that this was what she knew of and what was available to her at the time. Perhaps the propensity for consumers to volunteer in the mental health field is a function of both a passion for improving mental health care but also a pragmatic issue of what is presented to them as a volunteering option. This has important implications for mental health practitioners, who may need to simply provide an entry point to various volunteer work roles in order to facilitate involvement of their clients.

Other enablers to volunteer work participation included the recognition of volunteers and a volunteer support system. Again, these enablers have also been identified as important within the general volunteering population. Volunteering Australia's national survey showed that 26% of respondents felt that their volunteering was insufficiently recognised by their organisations. Respondents felt that volunteer retention was encouraged if volunteers were appropriately recognised for their service. This was mainly through opportunities for training, volunteer social events and suitable recommendations made to employers (Volunteering Australia, 2006).

3.4.5 Barriers to Volunteering

The final theme that emerged from the interview data was the barriers to volunteer work. In many instances these were the opposite factors to the enablers of volunteering. The main barriers identified were the cost of volunteering and lack of structure and support within some volunteering roles. Consumers felt that not being reimbursed for their personal costs, such as travel, parking and printing, was difficult to manage, especially because the majority of respondents already had limited funds and were reliant on the disability support pension. Cost emerged as the biggest barrier to their participation with many of the respondents indicating that they had at times provided their own resources in order to complete tasks.

“Oh the worry over how much it is costing and the money you know. ... its very stressful, when you have got like three dollars in the bank and you have got to look at your petrol tank and you have got two meetings to go until pay day and you got three dollars and you have to really monitor that petrol ...”

Some participants who volunteered within the consumer representation field also spoke of the politics within the consumer movement as a barrier to their involvement. This included issues such as conflict within the consumer group and limited guidance and support to complete projects. The participants felt that there was very little structure provided from government departments to support the consumer movement. For example, suitable procedures were not developed

to manage any difficult situations or conflicts that arose and the consumers were left as a group to try and manage the issues as they presented. They felt that as a group they lacked the skills to do this properly. The two quotes below highlight the negative impact this had upon two of the participants, including one ceasing previous volunteer work because of the lack of support and structure available.

“That was in situations that weren’t held by an organisation. And so there was a lack of skills within the group, in terms of managing the whole process, of ... organising an association and getting on with it. And it spilled over into other things. But it was ... a situation where everybody was a volunteer ... and we didn’t have the skills between us to keep it clean and healthy.”

“I was effectively doing a 30 hour a week job and not getting paid any money. So, then I decided to pull back. And I have had a number of stages, I have gone through stages of doing nothing, then going back, then taking on too much, then doing nothing, then trying to find a boundary. But because it’s not organised the way they do the volunteering, at all. It’s completely unstructured. So you end up just doing ... so much work.”

The major barriers to consumer participation in volunteer work were identified as cost and lack of structure and support in some volunteering roles. One particular cost that was mentioned consistently in the interviews was the cost of travel and especially petrol. Once more, this issue has also been identified as affecting the general population of Australian volunteers. Volunteering Australia surveyed 841 volunteers seeking clarification as to whether the cost of petrol was impacting on their volunteer work. 80% of the survey respondents indicated that reimbursement for their travelling costs was unavailable to them. The survey also identified that the cost of petrol was causing volunteers to reconsider their volunteering duties and limit some due to the rising costs (Volunteering Australia, 2005). This information was certainly discussed in the interview data as adversely affecting the consumer volunteers. Furthermore, Volunteering Australia’s national survey highlighted that 28% of the volunteers reported that it had cost them money to volunteer and were not reimbursed for the costs. And a

further 14% indicated that they were unsure whether they were eligible to be reimbursed for costs. The interview data also supported this finding. The volunteer work conducted by the interview participants resulted in a number of personal costs, for which limited or no reimbursement was provided. This was considered a definite barrier for the interview participants, especially as most were dependent upon the limited funds of a disability support pension.

Lack of structure was also identified by some participants as a barrier and even a deterrent to their ongoing volunteer participation. This was especially the case for those volunteering in the mental health field where participants felt there were no management procedures for the volunteers and they had to fend for themselves in many ways. Previous research has identified that successful volunteer organisations have established leadership within their programs provided by an individual with experience in supervision (Leviton et al., 2006). Such leadership appears to be lacking within the mental health field, and is required to both encourage the retention of these volunteers and build better working conditions for them.

3.5 CONCLUSION

This qualitative phase of the study provides support to previous research efforts which have documented the benefits of volunteering for mental health consumers and discussed the barriers and enablers to their involvement (Davis Smith et al., 2004; Institute for Volunteering Research, 2003; Kayloe, 1985; Rebeiro & Allen, 1998; Risbey, 2004). However, the in-depth analysis of the interview themes have also highlighted a new finding as well as clarified a number of important relationships. These interviews have uncovered a new benefit provided by volunteer work for mental health consumers. Namely that volunteer work can assist consumers to develop personal skills in the self-management of their illness. The consumers were required to learn self-management strategies in order to manage their volunteering roles and responsibilities whilst maintaining their personal health and well-being. This has not been previously discussed within the literature and is thus an important finding of this study.

The in-depth analysis has also clarified a number of significant relationships. These include, firstly, the relationship between volunteer work and recovery from mental illness. Volunteer work appears to support a number of processes within the recovery model including finding hope, finding meaning in life and taking responsibility for illness (Andresen et al., 2003). Secondly, participation in meaningful activity, such as volunteer work, has a positive association with consumer quality of life. These interviews emphasised the deep sense of purpose and meaning obtained by the respondents through their volunteer work, and thus it is hypothesised that participating in volunteer work will have a positive effect on consumer quality of life. Thirdly, volunteer work provided consumers with an outlet to provide help and support to others. This promoted a feeling of control and a sense that they could make a difference in the world. These feelings are associated with personal empowerment, and thus it is also proposed that volunteering may foster personal empowerment within consumers. These relationships between personal empowerment, quality of life and volunteering are further investigated in phase three of this research project.

4. DEVELOPMENT OF THE VOLUNTEER SCALE

4.1 INTRODUCTION

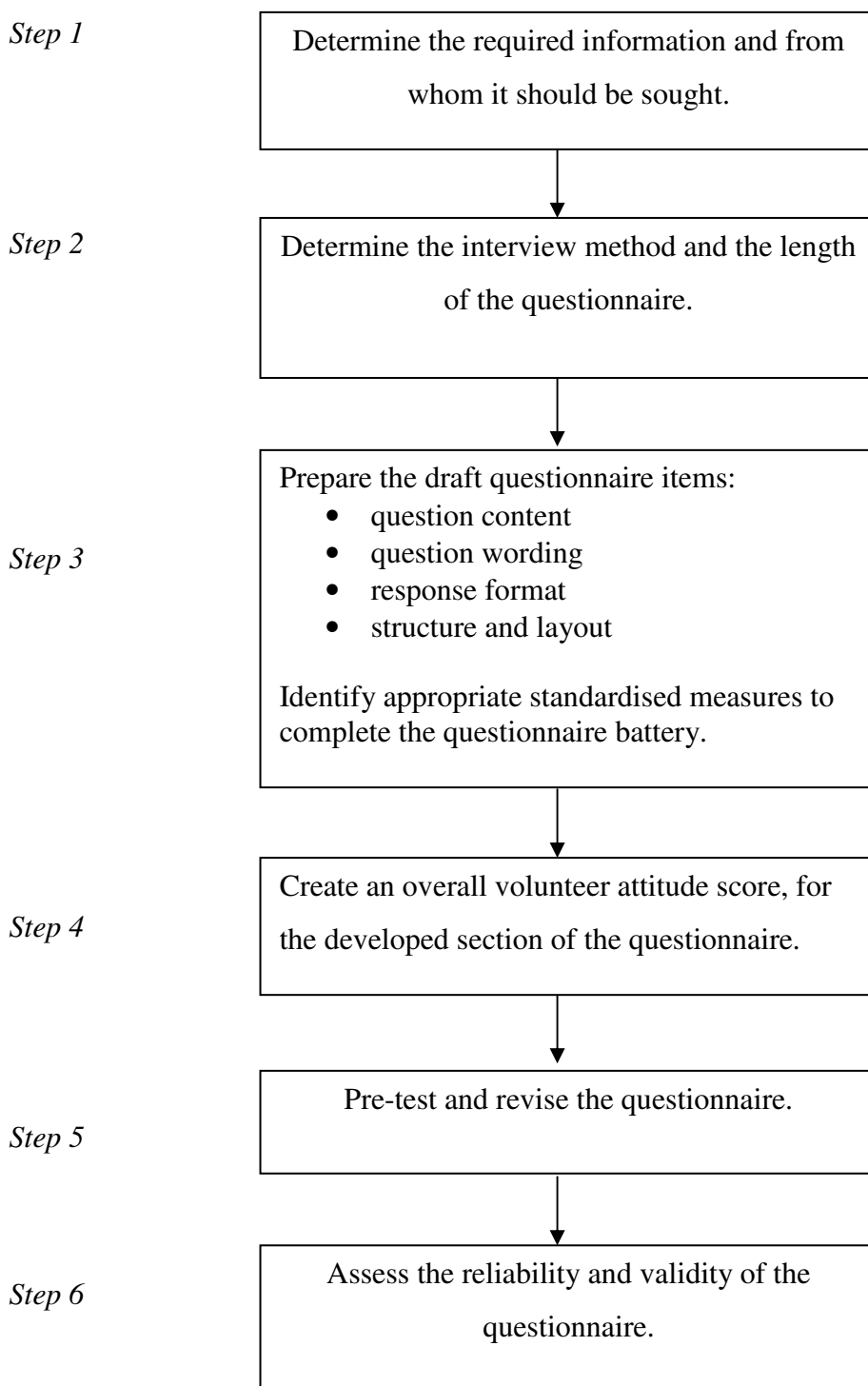
This chapter outlines the process undertaken to develop The Volunteer Scale used later in the study. The aim was to measure consumer volunteer work participation, attitudes about volunteer work, quality of life and personal empowerment.

4.2 OBJECTIVES

1. To develop a draft volunteering questionnaire by transforming themes obtained from in depth interviews, literature review and clinical experience into scale items.
2. To combine the volunteering questionnaire with additional standardised measures identified that meet the study aims in order to develop an overall battery.
3. To have the battery reviewed by a panel of three experts in questionnaire design for inclusions, exclusions, and layout advice.
4. To pilot test the battery with a convenience sample.
5. To modify and finalise a copy of the battery ready for distribution to study participants.

4.3 METHODS

The questionnaire design process as outlined by Frazer and Lawley (2000) was followed during construction of the volunteering questionnaire. Steps relevant to the development of this questionnaire were added or altered in order to meet the research objectives. The diagram below illustrates the process of development and is largely based on the work of Frazer and Lawley (2000), however it also includes the appropriate modifications.

Figure 4.1 The Questionnaire Design Process

Based on: Frazer, L. & Lawley, M. (2000). Questionnaire design and administration: a practical guide. Brisbane: John Wiley & Sons Australia, Ltd.

4.3.1 Step 1 – Determine the required information

Information was required from mental health consumers about their personal experiences, viewpoints and attitudes about volunteer work. The researcher was also interested in measuring personal empowerment and quality of life variables.

4.3.2 Step 2 – Determine the method and questionnaire length

It was deemed appropriate to use a written, self-report questionnaire format to obtain the above information. The self-report method was chosen because the topic of volunteer work is not overly complex. It was believed that the questions could be easily answered without assistance, and mainly closed ended questions could be used (Meadows, 2003b).

To ensure minimal participant burden, it was deemed inappropriate to have the entire questionnaire battery take longer than approximately 20 minutes. In order to accommodate this desired questionnaire length however, the researcher was forced to revisit the original study objectives, and discard one of the variables originally planned to be measured. The Kessler Psychological Distress Scale (K10+) was initially planned as a measure of symptom severity (Furukawa, Kessler, Slade, & Andrews, 2003; Kessler et al., 2002). The K10+ was withdrawn during this stage of battery development for three reasons. Firstly, the themes obtained from the interviews centred around the importance of managing one's illness opposed to the impact of specific symptoms, secondly the added length to the overall battery was considered too burdensome and thirdly because there was a psychological health subscale within the Australian World Health Organization Quality of Life Brief Assessment (Australian WHOQOL- BREF) which could measure this variable.

4.3.3 Step 3 – Prepare the draft questionnaire

The third step was completed by incorporating themes obtained from the in-depth interviews with the volunteer work literature review, and reflections on clinical practice into both likert scale and multiple choice question items. This process of tailoring questionnaire content through literature review and previous qualitative investigation is advocated by Meadows (2003b).

The content of the questionnaire items developed included information about the consumer's current volunteer status, their volunteer history, and their attitudes towards volunteering.

Throughout this phase of the questionnaire development, the researcher reviewed numerous scales and surveys for both inspiration and guidance. For example, the demographic questions were written based on review of previous questionnaires, including the Australian census form (Australian Bureau of Statistics, 2000a) and questionnaires used by the researcher's peers. The questions relating to the consumers specific participation within volunteer work were based on those used by The Institute for Volunteering Research (2003) in their survey on volunteering for mental health. The author would like to formally acknowledge this source:

Institute for Volunteering Research. (2003). *Volunteering for Mental Health: A survey of volunteering by people with experience of mental ill health*. London: National Centre for Volunteering.

Item wording

Throughout the development of the volunteering questionnaire particular attention was paid to the wording of the items. This was important to guarantee that respondents clearly understood the questions and how they were meant to respond. To this end the principles outlined by Moser and Kalton (1986) were adhered to during construction of the questions. These included the use of specific tailored questions with simple everyday language and avoidance of 'why' and leading questions. The questions were also continuously reviewed and revised to ensure that no presumptions were being made (Moser & Kalton, 1986).

Item order

Due consideration was also given to the order of the developed questions. Three main rules were followed at this stage. Firstly, easily answered, factual based questions were ordered at the beginning of the questionnaire and the more difficult or personal questions were placed at the end. Secondly, questions were

grouped into sections to promote a logical order and flow. And finally, within the likert section of the scale, a mixture of both positive and negative questions were posed to avoid an acquiescent set of responses (de Vaus, 1995).

Questionnaire layout

The quality of questionnaire design including attention to layout and format can impact upon the quality of the information obtained from survey respondents (Sanchez, 1992). The overall layout of the questionnaire was developed drawing from design aspects of other questionnaires. The main aim of the layout was to ensure consistency, flow and ease of understanding (Meadows, 2003b). Graphics, headings, and italics were used to guide the respondent through the questionnaire.

The design of the front cover was eye catching and interesting. It included a statement attempting to motivate interest and participation and a graphic to attract attention. The cover also included a brief explanation about the survey's purpose (Frazer & Lawley, 2000). Inside the front cover, space was provided for respondents to leave their contact details in order to receive a copy of the research report. This was included on the inside cover, so this page could be removed to ensure anonymity during the process of data entry.

Identification of Standardised Measures

The variables of empowerment and quality of life were targeted for measurement within the research question. The relevance of these variables to the study was discussed within the literature review however the themes obtained from the qualitative phase have also supported their inclusion. Empowerment was defined in the literature review as a process by which individuals with limited power gain control and influence over their lives and the political and social structures that impact upon them (Segal et al., 1995). Themes of empowerment were recurrently addressed in the interview data. Examples include, firstly, the desire of participants to make decisions regarding their volunteer workload and stress levels independently without conforming to clinician recommendations. Secondly, the willingness of informants to either change or work around the limited funding and government support for the consumer movement through the

autonomous acquisition of funding and personal development of support networks. And finally the clear motivation of respondents to make a difference and improve the future forecast for their chosen volunteer agency.

The construct of personal empowerment was highlighted within the literature review as being essential to the recovery process for consumers. Factors related to empowerment were also further emphasised throughout the interview data. Therefore obtaining a measurement of personal empowerment and attempting to identify if participating in volunteer work had an impact on personal empowerment was considered highly relevant for this study. The Empowerment Scale was chosen because it was the only measure identified that specifically addressed the construct of empowerment for mental health consumers. Furthermore, it was constructed with extensive consumer input and had undergone rigorous testing within America (Rogers, Chamberlin, Langer Ellison, & Crean, 1997; Wowra & McCarter, 1999). Information regarding the reliability and validity of this measure can be obtained from section 5.5.1 of this thesis.

Parallel with the recovery concepts discussed throughout the literature review, the aim of this study was not to measure merely the absence of symptoms but to obtain a sense of whether participation in volunteer work positively impacted upon other areas of a consumers' life. The interview themes endorsed that volunteering improves consumer quality of life through the development of friendships, meaningful community roles and by encouraging better self management of their illness. To date however, no research has specifically quantified the impact volunteering has on the quality of life of consumers. To enable this to be completed within this study a standardised quality of life measure was chosen. The Australian WHOQOL-BREF (Murphy, Herrman, Hawthorne, Pinzone, & Evert, 2000) was used as the quality of life measure for a number of reasons. Firstly, it was developed through international collaboration under the auspices of the World Health Organisation and is thus well-recognised. Secondly, an Australian version has been rigorously tested for reliability and validity. And finally, the brief version was chosen as a means of keeping the overall questionnaire to a reasonable length. Information relating to the

reliability, validity and clinical utility of this measure are documented in Section 5.5.2 of this thesis.

Permission to use both of these measures was obtained from their respective agencies (Appendix H).

4.3.4 Step 4 – Pre-test and revise the questionnaire

This step occurred in two phases. The first phase involved providing a copy of the developed questionnaire to a panel of three experts in questionnaire design, for their feedback and critique. The aim of this review process was to incorporate expert opinion into the design layout and receive consultative advice regarding question wording, inclusion and exclusion. Interviews were conducted between the researcher and each expert reviewer, throughout which copious notes were taken regarding recommendations and changes. Appropriate changes were made to the questionnaire following this review process. These processes ensured the development of face validity for the questionnaire.

The second phase involved providing a copy of the questionnaire to a convenience sample of four colleagues for pilot testing. The pilot test involved testing the entire questionnaire administration process. Thus, each pilot participant was provided with the information and instruction sheet, questionnaire and return envelope, as if they were participating in the actual study. The aim of this was to ensure that each of the items was easily understood, and the process would work when applied to the real study group. In addition to completing the questionnaire, pilot participants were asked to note any queries or concerns they had about the questionnaire and to time themselves from start to finish. The pilot testing confirmed that the questionnaire was an appropriate length with pilot participants taking approximately 15 minutes to complete the questionnaire. The pilot testing resulted in a small number of extra changes and editing to be completed before the questionnaire was ready for distribution.

Pilot testing provides best results when sample participants are representative of the target study population (Meadows, 2003b). Therefore, it would have been ideal to pilot test the questionnaire with a sample of mental health consumers.

However, this was deemed unrealistic for this research project. The author envisaged problems recruiting enough consumers to participate within the actual study, and thus did not wish to use consumers for pilot purposes only. This is duly acknowledged as a limitation in the study design.

4.3.5 Step 5 – Create an Overall Volunteer Attitude Score

It was considered important to gain an overall score as an outcome for the section of the volunteering questionnaire designed to measure consumer attitudes regarding volunteer work. This overall score could then be used as an outcome which could be compared across consumers. The aim was to enable differentiation between those consumers with positive attitudes about volunteering and those with negative attitudes about volunteer work.

An overall volunteer attitude score was calculated from the volunteering questionnaire in the following way. Firstly, negatively worded items were identified. Secondly, the scoring for the positively worded items was reversed. In this way, all of the items were calculated with a score of four being the most positive response and a score of one being the most negative response. The positive items were reversed, rather than the negatively worded items because the scale was originally developed with a score of one indicating the most positive response. After ensuring that all the items were reversed or retained appropriately, the overall score was obtained by adding the individual item scores together. This resulted in a possible score for participants ranging from 17 through to 68. The higher score indicated a more optimistic perception of volunteer work. This included that volunteer work was beneficial to one's mental health, easy to access and well-supported within the community. This scale was thus developed upon the assumption that each of the items was equally weighted. The current study sample was small and therefore further testing of the psychometric properties would be the aim of future research with a larger sample.

4.3.6 Step 5 – Assess the reliability and validity of the questionnaire

The reliability and validity of the developed volunteering questionnaire was established in two ways. Firstly, prior to questionnaire administration the above outlined processes of having the questionnaire reviewed by an expert panel and pilot tested with a convenience sample ensured face validity was established. Face validity refers to the overall relevance of the questionnaire (Bowling, 1997). The survey items were judged by both the review team and pilot participants to be applicable and clear, thus confirming face validity.

Secondly, post administration, internal consistency was tested through the calculation of Cronbach's alpha. This yielded a Cronbach's alpha of 0.72. This indicates that 72% of the variance is related to volunteer attitudes and 28% of the variance can be explained by random chance. A level of 0.7 is often indicated by researchers as an acceptable standard for Cronbach's alpha (Bowling, 1997).

4.4 RESULTS

This extensive process of development, consultation, reflection, and literature review resulted in the development of a 95 item battery titled "The Volunteer Scale".

The make-up of the 95 items within the battery included:

1. The Empowerment Scale (28 items)
2. The Australian WHOQOL-BREF (26 items)
3. The volunteering questionnaire constructed for this study. Measuring:
 - a.) Volunteer work participation and history (16 items)
 - b.) Volunteer attitudes (17 items)
4. Demographic questions (eight items)

This questionnaire was used during phase three of this research project. A copy of the questionnaire is filed in Appendix G.

5. ADMINISTRATION OF THE VOLUNTEER SCALE

5.1 INTRODUCTION

This chapter discusses the administration of The Volunteer Scale to a sample of mental health consumers. It addresses research objective three, to identify if any differences exist between the empowerment and quality of life of consumer volunteers and consumer non-volunteers.

5.2 STUDY DESIGN AND METHOD

A cross-sectional study design was employed for this phase of the study. Cross-sectional studies provide a snapshot of a population at a specific time point (Cohen, Manion, & Morrison, 2000). Cross-sectional designs are descriptive in nature. This particular study aimed to provide a snapshot of a population of mental health consumers, and to identify if any differences existed between the empowerment and quality of life variables between consumer volunteers and non-volunteers. It was acknowledged during study planning that a cause and effect relationship could not be established through the use of a cross-sectional study. However, this method was still chosen because of the extreme paucity of research specifically investigating this issue in the literature. The lack of available empirical evidence supporting the benefits of volunteer work for consumers meant that developing and testing an intervention that encouraged consumer participation in volunteer work was not appropriate, because as yet the benefits of volunteer work had not been established.

5.3 OBJECTIVES

5.3.1 Research Objectives

1. To describe the volunteer work participation and attitudes to volunteering of mental health consumers.
2. To describe the level of empowerment and quality of life of mental health consumers and compare these results to available Australian norms or mean data obtained from previous research.
3. To identify any differences between empowerment and quality of life variables between two consumer groups, specifically volunteers and non-volunteers.

5.4 PARTICIPANTS

5.4.1 Sample

Individuals between 18 and 65 years of age with a diagnosed mental illness were recruited to complete the questionnaire battery for this phase of the study. No inclusion criteria were set regarding specific diagnosis or experience with volunteer work. The required sample size was calculated through the use of Cohen's tables (Cohen, 1987, as cited in Munro, 2001). Due to the limited theoretical knowledge regarding the phenomenon in question, two-tailed tests were chosen for the analysis. Sample sizes were calculated based on a power level of 0.8 which is often used by researchers (Munro, 2001) and an effect size of 0.7. This large effect size was chosen because it was the documented effect size calculated between a group of employed and unemployed consumers as measured by the empowerment scale (Rogers et al., 1997). Thus it was based on prior studies measuring similar variables within the literature. Reference to Cohen's tables identified that 33 subjects were required in each of the research groups.

After many months of attempting to recruit participants the sample size obtained fell well below the expectations of 33 participants in each group. Such a sample size would have provided a power of 0.8, and thus a reliable chance to avoid type II errors and document any differences that were inherent within the data. The obtained sample size was 30 participants, including two groups of 15 respondents. Post-hoc power calculations were conducted and have been reported throughout Chapter Six. The hypothesised reasons for the small sample size obtained are discussed in more depth below (Section 5.4.3).

5.4.2 Recruitment Strategy

Participants of this study were individuals who self-identified that they experienced mental illness. Consumers were voluntarily recruited through widely distributed advertisements at mental health services, non-government mental health organisations, consumer consultant contacts, and employment agencies. No documentation confirming diagnosis was attained by the researcher and thus this was based on self-report. Recruitment was completed in three ways. Firstly, a number of questionnaires were provided to mental health organisations for their direct distribution to mental health consumers via case managers and group facilitators. Secondly, the primary researcher visited mental health organisations, distributed the surveys and then collected the completed sealed questionnaires to ensure anonymity. And finally, the study was advertised through mental health organisation newsletters and contact details were provided for the primary researcher. Consumers interested in participating were then requested to contact the researcher directly. A true response rate cannot be calculated because case managers sought their clients' interest before providing them with the questionnaire. Thus, only those consumers who were interested in the project completed the questionnaire, and the numbers who declined to participate were not documented.

It is here highlighted that mental health organisations and services were targeted as opposed to volunteering organisations. The reason for this was twofold, one to protect the confidentiality of any consumers who were volunteering and secondly to avoid an influx of volunteers who were not mental health consumers completing the questionnaire.

In total 17 services were contacted and requested to distribute the questionnaire. This included ten non-government organisations and seven government mental health services. Nine of the organisations agreed to circulate the questionnaire to consumers. A total of 140 questionnaires were disseminated to these organisations for their support in further distributing them to mental health consumers.

5.4.3 Survey Response

Thirty questionnaires were deemed appropriate for analysis within this study. Thirty-two questionnaires were returned, however two were not used. One was discarded because the participant identified themselves within the two mutually exclusive groups of “I currently volunteer” and “I don’t volunteer right now but I have done in the past”. The second was not used because the participant identified a diagnosis of intellectual disability, opposed to mental illness. One questionnaire was returned without an indication of their mental health status, however, this was included in the analysis because recruitment took place only within mental health services and the questionnaire clearly outlined its relationship to mental health consumers.

As discussed in Section 5.4.1 above, the response rate did not reach the desired level of questionnaires. This was believed to be due to a number of reasons. Firstly, clinical and demographic characteristics of mental health consumers make accessing them for completing questionnaires difficult. The consumers needed to independently volunteer for the study and were not coerced or provided with any means of incentive for completing the questionnaire. Common clinical presentations of mental illness such as amotivation, depressed mood, poor concentration, hallucinatory experiences and suspiciousness, coupled with social characteristics such as social isolation, lower education levels and high unemployment (Jablensky et al., 2000) make accessing this group and enlisting their cooperation difficult. Further compounding this issue was the parallel conduction of other mental health surveys within the Perth region during the data collection period. Other studies being conducted at the same time as this project provided participants with honorarium payments. In meetings conducted between the researcher and mental health organisations regarding recruitment it

was suggested that similar honorary payments for consumer participation would be beneficial. However, no funding was obtained for this study and so payment of participants was not made. Funding considerations will thus be important for future mental health investigations if payment for participation becomes the norm in the area.

5.5 MEASURES

5.5.1 Introduction

The complete questionnaire battery was titled “The Volunteer Scale”. This scale included items relating to demographic information, The Empowerment Scale, The Australian WHO-QOL BREF, and volunteering questionnaire items specifically measuring volunteering attitudes and volunteer participation and history. Each of these sections is discussed below.

5.5.2 Demographic Information

Demographic information was collected. This included information relating to the consumers’ age, gender, mental health diagnosis, employment and income status, living situation and education level.

5.5.3 The Empowerment Scale

The Empowerment Scale is a consumer-constructed scale developed to measure empowerment amongst a mental health consumer population. The scale consists of 28 items, which are rated on a four-point likert scale ranging from strongly agree to strongly disagree. Following testing on 271 consumers in America, the scale has been shown to have a high degree of internal consistency (Cronbach’s $\alpha = 0.86$, $N=261$) (Rogers et al., 1997). This level of internal consistency was confirmed within a second validation study involving 283 participants. The Cronbach’s α for this second study was 0.85 (Wowra & McCarter, 1999). Reliability analysis was also conducted on the Empowerment Scale for this current volunteer work study and yielded a Cronbach’s α of 0.86, consistent with these previous results.

Factor analyses identified five underlying principles of empowerment including: “self-efficacy-self-esteem, power-powerlessness, community activism, righteous anger, and optimism-control over the future” (Rogers et al., 1997, p. 1042). The Empowerment Scale has shown statistically significant positive correlations with income, amount of time spent engaging in activity and social supports. Positive correlations were also found between empowerment and quality of life and self-esteem, though unknown tools developed by the authors were used to measure these factors (Rogers et al., 1997). The correlation coefficients for these factors ranged from 0.17 for social support through to 0.51 for self-esteem. The authors suggest that the large effect with self-esteem is partly due to a number of items within the empowerment scale itself specifically measuring self-esteem. They also recommend that further testing is required to establish discriminant validity and sensitivity (Rogers et al., 1997; Wowra & McCarter, 1999).

Agreement to use The Empowerment Scale was obtained in writing from the Boston University Center for Psychiatric Rehabilitation (Appendix H).

5.5.4 The Australian WHOQOL-BREF

Quality of life was measured using the Australian WHOQOL-BREF. This assessment contains 26 items measured on a five-point likert scale. The scale contains two items measuring overall quality of life and general health, as well as 24 questions measuring four domains including physical health, psychological health, social relationships and environment. The subscale of physical health measures perceived levels of pain, sleep, energy, mobility, ability to complete activities of daily living and work capacity. The psychological health subscale measures positive and negative feelings, perceived cognitive capacities, self-esteem and body image. The social relationships subscale measures personal and sexual relationships as well as social supports. And finally the environment subscale measures safety, physical environment such as traffic and noise, finances and access to information, health and transportation (The WHOQOL Group, 1998).

Field testing of the Australian WHO-QOL-BREF has included two major studies, the first being the Victorian Validation Study (VVS) (N=996), in which

participants completed six health-related quality of life assessments. Participants in this study included community members, outpatients and inpatients. The healthy community members from this study have provided Australian normative data. The second study involving field testing was the Longitudinal Investigation of Depression Outcomes (LIDO) study (N=552). This study measured depressed and non-depressed individuals on a number of variables. Internal consistency for each of the domains was measured in both studies (Table 5.1). Cronbach's alpha ranged from 0.58 through to 0.87 with only one factor falling below 0.6 for the two studies. The factor which achieved the lowest Cronbach's alpha of 0.58 was the social relationships subscale, but only for the inpatient study participants with depression.

The Cronbach's alpha coefficients obtained from this volunteer work study have also been listed in Table 5.1. It is generally accepted that scales obtaining a Cronbach's alpha of greater than 0.7 demonstrate satisfactory internal consistency (Bowling, 1997). The Cronbach's alpha scores obtained for the Australian WHOQOL-BREF both within this study and previous studies thus demonstrate an acceptable level of internal consistency. The scores also indicate congruence between the previously reported coefficients and those obtained from this research project.

Table 5.1 *The Australian WHOQOL-BREF Internal Consistency*

Domain	Victorian Validation Study Total Group n=996	LIDO Study Total Group n=518	Volunteer Study Total Group n=30
Physical Health	$\alpha = 0.87$	$\alpha = 0.86$	$\alpha = 0.755$
Psychological Health	$\alpha = 0.81$	$\alpha = 0.83$	$\alpha = 0.810$
Social Relationships	$\alpha = 0.68$	$\alpha = 0.65$	$\alpha = 0.760$
Environment	$\alpha = 0.81$	$\alpha = 0.81$	$\alpha = 0.793$

α = Cronbach's alpha

Test-retest reliability was investigated in the LIDO study following a two-week period. Pearson's r on this data ranged from 0.571 through to 0.858 indicating good test-retest reliability (Murphy et al., 2000).

Agreement to use the Australian WHOQOL-BREF was obtained from the Australian WHOQOL Field Centre. This research project has been registered with this Centre, with the registration number of 2005/90 (Appendix H).

5.5.5 The Volunteer Items

The volunteer items within the questionnaire battery were developed specifically for this study aiming to measure current consumer volunteer participation, their volunteer history, and their attitudes about volunteer work. Chapter Four of this thesis provides in-depth explanation of the development of these items and Appendix G contains the final questionnaire.

5.6 DATA COLLECTION

Questionnaires were given to consumers accompanied with an information sheet about the study and a reply paid envelope for the consumer to seal and post the

questionnaire back to the researcher. Questionnaires were collated by the researcher upon their receipt and raw data entered into SPSS version 13 (SPSS Inc., 2004).

5.7 DATA MANAGEMENT

SPSS version 13 was used to manage and analyse the data (SPSS Inc., 2004). All questionnaires were de-identified, provided with an identification number and entered into SPSS by the researcher. The raw data were checked for any mistakes in entry. The relevant journal articles and user manuals for The Empowerment Scale and the WHOQOL-BREF did not address how to manage missing data. Therefore, the researcher managed all missing data using the mean replacement approach. The mean value for the required variable was calculated and entered as a substitute for the missing data (Munro, 2001). This was completed manually and the SPSS database was checked to ensure that a data set as complete as possible was entered for all participants.

Instructions from the appropriate journal articles and user guide manuals were followed regarding the grouping together of items and calculating of total and domain scores. The researcher also kept a running index chart which documented the labels and reference information to ensure integrity within the data management process.

5.8 STATISTICAL ANALYSIS

5.8.1 Demographic Characteristics

Descriptive statistics were used to chart the demographic characteristics of the research participants in terms of age, gender, employment status, living situation and socioeconomic status.

5.8.2 Research Objectives

1. The first research objective was to describe the volunteer work participation and attitudes to volunteering of mental health consumers. This was answered using descriptive statistics. To describe their participation in volunteer work, frequency distributions of the activities

and organisations they volunteered for, along with their reasons for commencing and ceasing volunteer work were developed.

To describe their attitudes to volunteer work, frequency distribution, mean and standard deviation were calculated for their overall volunteer attitude score. These results were tested for normality using the Shapiro-Wilks statistic. Frequency distributions of the individual volunteer attitude items were also developed.

2. The second research objective involved describing the level of empowerment and quality of life of mental health consumers and comparing these results with available Australian norms or mean data obtained from previous research. This was answered using both descriptive statistics and one sample two-tailed t-tests. Means, standard deviations and frequency distributions were obtained for the level of empowerment and quality of life of the entire research group. The empowerment scores were then compared to the mean empowerment scores obtained from previous studies (Rogers et al., 1997; Wowra & McCarter, 1999) using one sample t-tests. The quality of life results were compared to both Australian norms and mean mental health consumer scores available from previous research (Murphy et al., 2000) using one sample t-tests.
3. In order to identify if any differences for empowerment or quality of life existed between the volunteering and non-volunteering groups independent t-tests or the non-parametric equivalent, Mann-Whitney U test were used. To enable this analysis, the volunteering group was defined as those individuals currently participating in volunteer work and the non-volunteering group was defined as those individuals not volunteering at the present time. Consumers who were currently employed were included in the analysis, and were also divided according to their current participation in volunteer work.

The statistical test chosen was dependent upon the assumptions being met. Normality tests were conducted on the data and a value obtained for the Shapiro-Wilks statistic. The Shapiro-Wilks statistic was used because of the small sample size. If the significance level for the Shapiro-Wilks test was greater than 0.05 then normality was assumed (Coakes & Steed, 2003) and the independent groups t-test was applied to the data. This parametric test was used when possible because of its greater power for detecting differences within the participant groups (Howell, 1997). However, if the Shapiro-Wilks significance level was lower than 0.05 and normality was not assumed, the non-parametric Mann-Whitney U test was conducted instead. Data transformations to make any non-normally distributed data more normal were not used because of potential problems in interpreting the transformed data. For example, Munro (2001) suggests transformations be used with caution due to the changes in scale causing changes in the measures of central tendency and dispersion.

When reporting on the results of the independent groups t-test, the data were first checked to ensure homogeneity of variance, by referring to Levene's test for equality of variances. If the significance level for Levene's test was below 0.05, then unequal variances were assumed between the two groups. The t statistic and significance level were then reported from the "equal variances not assumed" data. If the significance was greater than 0.05, the results were reported from the "equal variances assumed" data (Munro, 2001).

Post-hoc power calculations were completed manually for every independent groups t-tests according to the following process.

Step 1: Calculate effect size (d)

$$d = \frac{\text{mean 1} - \text{mean 2}}{\text{SD}}$$

Step 2: Calculate delta (δ)

$$\delta = d\sqrt{N/2}$$

(NB: For uneven sample sizes the harmonic mean was calculated according to the equation)

$$N = \frac{2N_1N_2}{N_1 + N_2}$$

Step 3: Consult tables: “Power as a Function of δ and Significance Level α ”

5.9 REPORTING OF STATISTICAL SIGNIFICANCE

It is acknowledged that this study is small and exploratory in nature. Thus, despite the large number of statistical comparisons that have been conducted the results have been reported based on a statistical significance level of 0.05 without any mechanism applied to control for type I errors. Should a larger sample have been obtained, more stringent measures to control for type I errors would have been applied. For example, the use of Bonferroni’s correction to control for the inflation of the probability of type I errors due to the sizeable number of statistical analyses conducted (Feise, 2002). However, because of the small sample size and the already existing substantial chance of making type II errors this was decided against. The findings of this study will thus need to be replicated through future research using a larger sample to provide confirmation of the results.

5.10 ETHICS

Ethical approval to conduct this phase of the study was attained from both the Curtin University of Technology and South Metropolitan Area Health Service Human Research Ethics Committees. All questionnaires were distributed with an approved information sheet outlining the rights of participants involved in the study. The information sheet also included contact details for the Research Centre, ethics committee and primary researcher should consumers have had any questions or complaints. Consent was assumed through completion and returning of the questionnaire. Questionnaires were provided with an option for consumers to include their personal contact details in order to receive future correspondence about the research project. If consumers completed this page of the questionnaire, this was removed to ensure anonymity before the

questionnaires were collated for data entry. These contact details were stored in locked facilities at Curtin University of Technology to be destroyed following the posting of final research reports to these consumers. The questionnaires will be archived and stored in the Research Centre for five years.

6. SURVEY RESULTS

6.1 INTRODUCTION

This chapter details the results obtained from administering The Volunteer Scale to 30 mental health consumers. It addresses project objective three which was to identify if any differences exist between the empowerment and quality of life of two consumer groups including volunteers and non-volunteers. Specifically, the objectives for this quantitative phase of the research were:

1. To describe the volunteer work participation and attitudes to volunteering of mental health consumers.
2. To describe the level of empowerment and quality of life of mental health consumers and compare these results to available Australian norms or mean data obtained from previous research.
3. To identify any differences for empowerment and quality of life variables between two consumer groups, specifically volunteers and non-volunteers.

6.2 DEMOGRAPHIC CHARACTERISTICS

The research participants ranged in age from 24 to 58 years and included 13 males and 17 females. A range of mental health diagnoses were reported including depression, anxiety, bipolar affective disorder, schizophrenia and related disorders, and personality disorders. The majority of respondents received a disability support pension as their main income source and most either lived alone (n=15) or with family (n=9). These demographic characteristics are summarised in Table 6.1 below.

Table 6.1 *Demographic Characteristics of Respondents*

Variable	Participant Information (n=30)
Gender	Male n=13 Female n=17
Age	Ranged from 24 to 58 years Mean age 42.6 years Standard Deviation 9.86
Self-Reported Mental Health Diagnoses	Depression and Anxiety n= 9 Bipolar Affective Disorder n= 7 Schizophrenia and related n= 6 Borderline Personality Disorder n= 2 Not Reported n= 6
Main Source of Income	Disability or other Pension n=22 Wages n= 5 Newstart n= 3
Living Situation	Alone n= 15 With family n=9 With friends / flatmate n=2 Supported Accommodation n=1 Other n=3
Employment Status	Employed >8 hrs per week n=8 Employed <8 hrs per week n=1 Unemployed n=21
Education Level	Primary School Education n=1 Secondary School Education n=11 Tertiary Education n=13 Other n=5

6.3 RESEARCH OBJECTIVE ONE

This objective was to describe the volunteer work participation and attitudes to volunteering of mental health consumers.

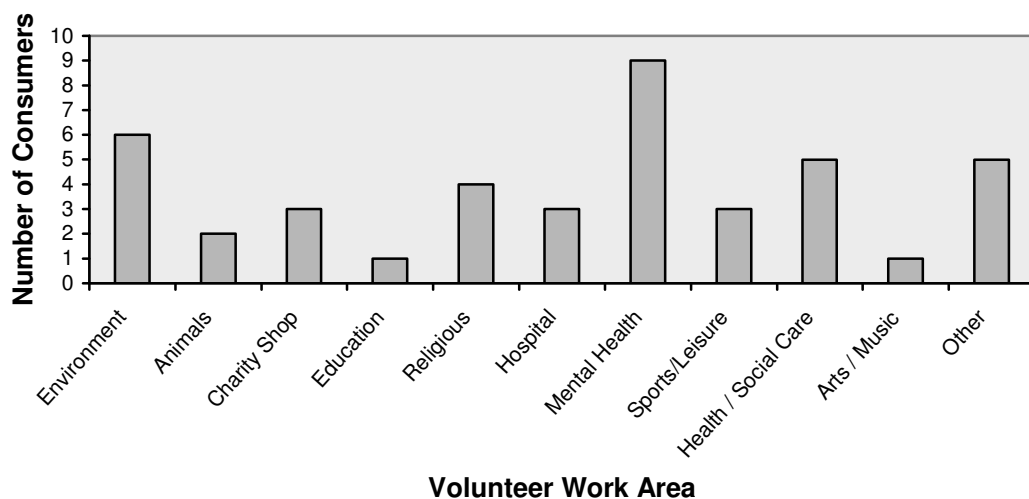
6.3.1 Volunteer Work Participation

Half of the respondents (n=15) indicated that they were currently volunteering. Respondents indicated an assortment of volunteer activities undertaken and

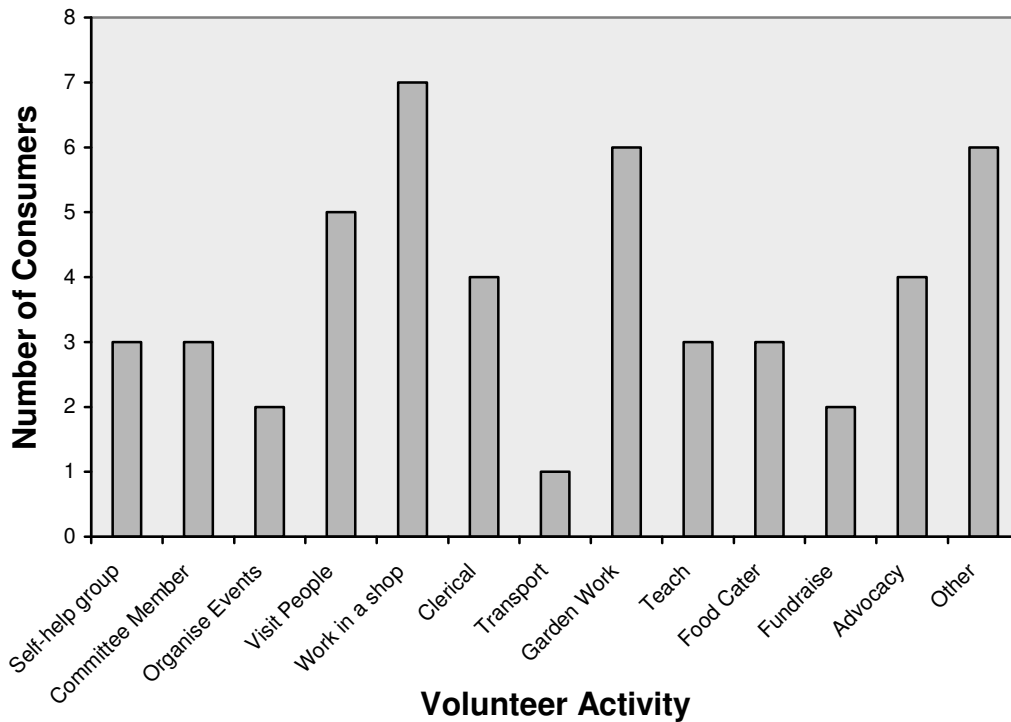
services provided, as well as a range of reasons for commencing their volunteer work. The majority of participants volunteered in the mental health area (n=9) with the second most popular area being volunteering for the environment (n=6). Most participants were aware of the volunteering opportunity through either word of mouth (n=10) or by contacting the organisation directly (n=9). The main reasons for volunteering were because participants thought it would help them to feel better (n=15) and to support organisations (n=11). The reason for stopping volunteer work that was cited most frequently was that participants became mentally unwell (n=5).

The bar graphs below provide more detail about the particular activities the participants undertook.

Figure 6.1 Services For Which Consumers Volunteered

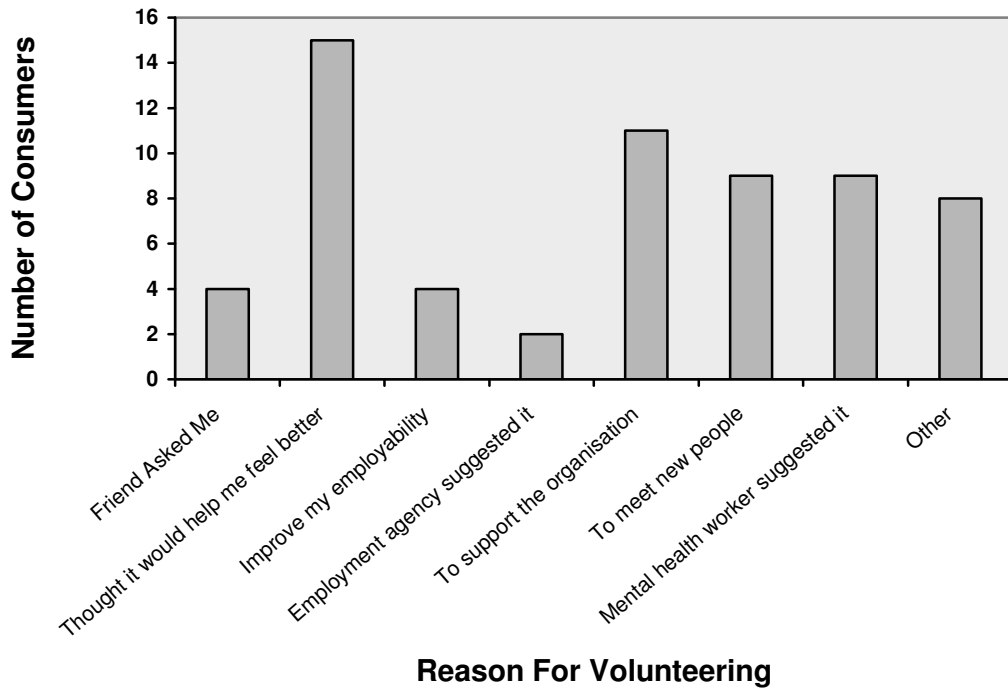


The most frequently cited area for the consumers to volunteer was within mental health (Figure 6.1). The organisations reported as “other” included “volunteering for a park”, “the state emergency service” and “outreach and community building”. The graph indicates the number of times each service area was identified by participants. Respondents were provided with the option of choosing more than one service if they required and so the numbers may add up to greater than 27.

Figure 6.2 Volunteer Duties Performed By Consumers

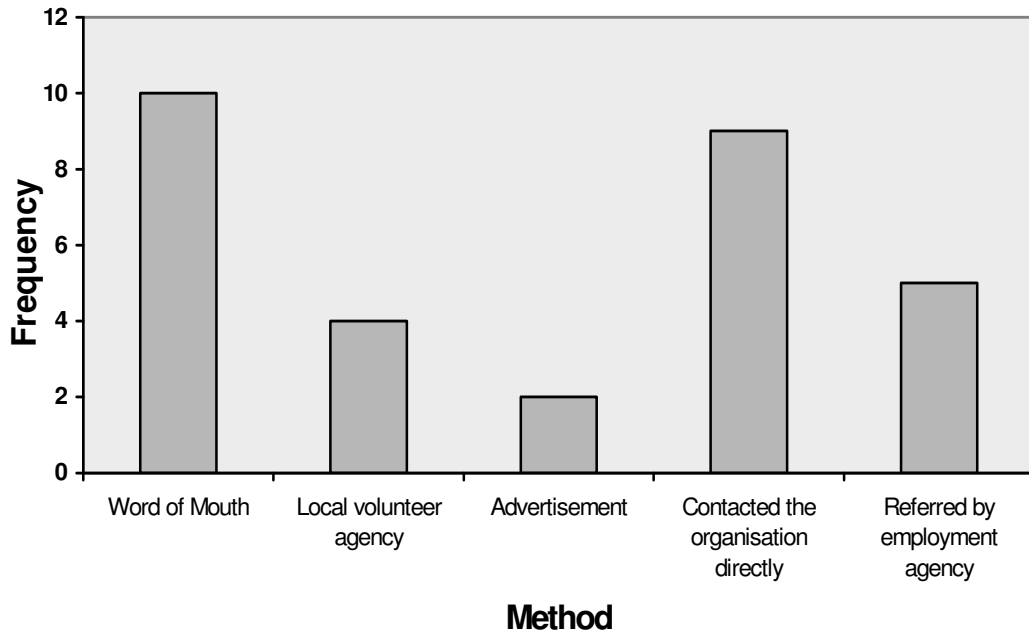
There was great variation in volunteer activities undertaken ranging from assisting with transport to advocacy work (Figure 6.2). The most common activities were working in a shop and gardening. Activities reported as “other” included, “caring”, “restoration”, “searches and storm damage clean-up”, “guiding/counseling” and “visual arts”.

Figure 6.3 Reasons Consumers Volunteered



The most commonly cited reason for volunteering was “to help me to feel better” (Figure 6.3). This was further highlighted by two individuals who identified “other” but stated it was because they “felt lost” and “needed something to do”, which are very similar. The reasons identified as “other” included, “felt lost”, “needed something”, “to help those in need”, “fell into it”, “something to do”, “a mental health worker forced me to”, and “a passion to make a difference”.

Figure 6.4 How Consumers Found Out About Their Volunteer Role



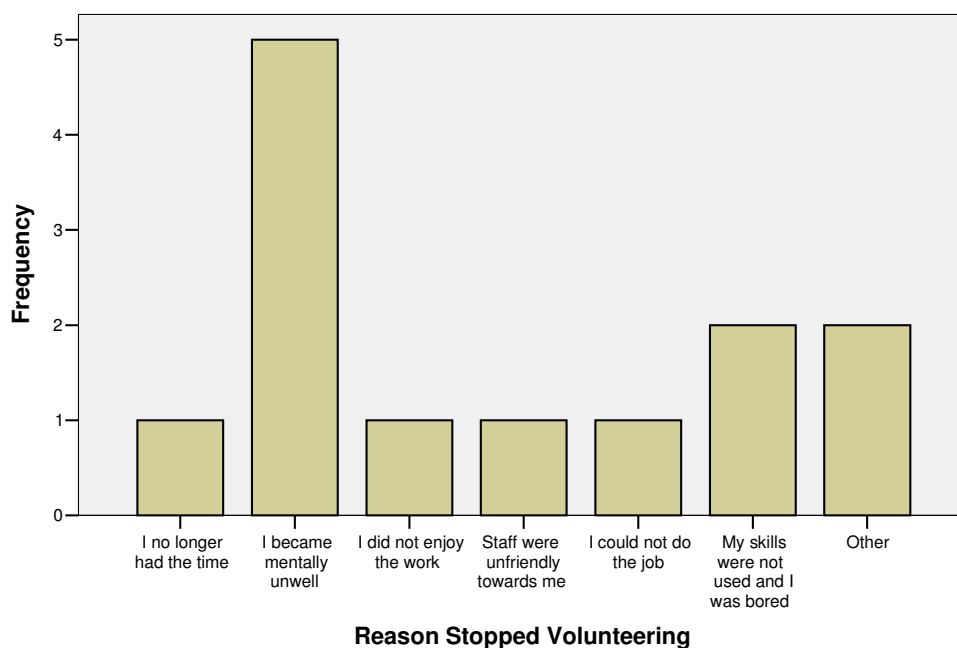
Hearing about the volunteer opportunity through word of mouth or social connections was the most common method respondents learnt about their volunteering opportunity (Figure 6.4). This was closely followed by directly contacting the organisation.

The majority of respondents volunteered on a weekly basis, with weekly volunteering accounting for 60% of the sample. The number of hours that they dedicated to the task ranged from one through to 38 hours per week. However, the majority volunteered between two and ten hours per week (66.7%). The length of time they had participated in volunteer work was spread evenly from less than six months through to more than five years.

Most of the participants who had or were volunteering reported that they did so in a role that was clearly defined (70%) and generally well supported (60%). Most also indicated that they had good relationships with the other volunteers and staff at their relevant organisations (70%).

The respondents who had previously volunteered but no longer participated in the activity had ceased volunteering from one year previously through to more than ten years ago. Of the 13 responses for ceasing their volunteer work, five indicated that this was due to becoming mentally unwell which was the most common reason (Figure 6.5).

Figure 6.5 Reasons Consumers' Stopped Their Volunteer Work



6.3.2 Volunteer Attitude

The participants' attitudes toward volunteer work were examined using the volunteering questionnaire items developed specifically for this study. The scores for consumer attitudes about volunteer work could range from 17 through to 68, with a higher score indicating both a more positive view of volunteer work but also a belief that it is easy to access. Refer to section 4.4.5 of this thesis for specific information regarding the development of the overall volunteer attitude

score. Descriptive statistics for volunteer attitude including the mean and standard deviation are outlined in Table 6.2 below.

Table 6.2 *Descriptive Statistics of Volunteer Attitude*

	N	Min.	Max.	Mean	Std. Deviation
Volunteer Score	30	41.00	62.00	52.524	5.214

6.3.2.1 Positive Attitude Toward Volunteer Work

Overall, the responses obtained from the volunteer attitudes items indicated that most participants believed volunteer work to be a meaningful and positive experience. Between 93.3 and 100% of the sample indicated they believed volunteering to be a positive, enjoyable activity, through which individuals could attain a sense of purpose and contribute to their community. Also, between 80 and 90% of the respondents believed that volunteer work could eventually lead to paid employment and was a way of developing individual work skills. Seventy to 83.3% indicated that volunteers were adequately supported in the workplace and their efforts recognised within the community. The majority (between 83.4% and 90%) also believed themselves capable of being volunteers and knowledgeable of the process of how to become a volunteer. Yet, regardless of this knowledge 79.9% indicated that mental health services should provide support to assist consumers to become volunteers in the community.

6.3.2.2 Barriers To Consumer Volunteer Work Participation

These statistics demonstrate that the majority of participants believed that volunteer work was a positive experience through which one could develop work skills. However, some factors also emerged which were considered barriers to consumer engagement in volunteer work. These included, 43.3% of the sample believing that volunteers did not receive appropriate training and orientation within their volunteer work sites. Half of the respondents indicated that volunteers could be taken for granted, and 63.3% of the participants identified that it cost money to be a volunteer. Finally, 47.7% of the sample did not believe

that individuals with mental illness were accepted as volunteers within the community.

6.4 RESEARCH OBJECTIVE TWO

This objective was to describe the level of empowerment and quality of life of mental health consumers and compare these results to Australian norms or mean data obtained from previous research.

6.4.1 Quality of Life

Quality of life was measured using the Australian version of the WHOQOL-BREF (Murphy et al., 2000). The Australian WHOQOL-BREF provides information about an individuals' perceived quality of life, across a range of subscales including physical health, psychological health, social relationships, and their environment. Each of the scores for these subscales range from zero to 100, with a higher score indicating a higher level of perceived quality of life. The scale also includes one item about the respondents' overall quality of life and their overall health status. Each of these two items is measured on a scale from one to five, with a higher score indicating a greater level of perceived health or quality of life. More detailed information about what is measured within each of the subscales can be found in Section 5.5.2 of this thesis. Table 6.3 below indicates the range, means and standard deviations for each of these quality of life variables for the entire study group (N=30).

Table 6.3 *Quality of Life Descriptive Statistics for All Respondents*

	N	Min.	Max.	Mean	Std. Deviation
Overall QOL	30	1.00	5.00	3.367	1.033
Overall Health	30	1.00	4.00	2.483	1.004
Physical Health	30	25.00	82.14	51.158	16.464
Psychological Health	30	0.00	67.49	44.274	16.427
Social Relationships	30	0.00	83.33	40.518	22.321
Environment	30	18.75	68.75	44.630	14.024

One sample t-tests were used to compare the mean quality of life scores obtained from this consumer population to both the Australian normative data and the means obtained from participants with depression in the LIDO study (Murphy et al., 2000). These comparisons demonstrated that the perceived quality of life of the current study respondents were substantially lower than both the Australian population norms and the LIDO study group. Current study participants experienced significantly lower scores on all subscales compared to the Australian data and lower overall health, social relationship, and environment scores compared to participants in the LIDO study (Table 6.4).

Table 6.4 *Differences in Mean Quality of Life Scores between Current Study Participants, Australian Norms and the LIDO Study*

QOL Subscale	Volunteer Work Study	Depressed Group (LIDO Study) N= b/w 429 and 437		Australian Norm N= 396	
Overall QOL	Mean 3.367	Mean 3.29	t = 0.41 df = 29 p = 0.687	Mean 4.27	t = -4.79 df = 29 p = 0.000***
Overall Health	Mean 2.483	Mean 2.87	t = -2.11 df = 29 p = 0.044*	Mean 3.66	t = -6.42 df = 29 p = 0.000***
Physical Health	Mean 51.158	Mean 53.58	t = -0.806 df = 29 p = 0.427	Mean 74.25	t = -7.68 df = 29 p = 0.000***
Psychological Health	Mean 44.274	Mean 50.34	t = -2.02 df = 29 p = 0.052	Mean 69.83	t = -8.52 df = 29 p = 0.000***
Social Relationships	Mean 40.518	Mean 50.29	t = -2.398 df = 29 p = 0.023*	Mean 67.58	t = -6.64 df = 29 p = 0.000***
Environment	Mean 44.631	Mean 55.75	t = -4.34 df = 29 p=0.000***	Mean 73.6	t = -11.31 df = 29 p = 0.000***

t = one sample t-test, * = p < 0.05, ** = p < 0.01, *** = p < 0.001

6.4.2 Empowerment

Level of personal empowerment was measured using the Empowerment Scale (Rogers et al., 1997). This is a consumer constructed scale designed to measure levels of personal empowerment within a mental health consumer population. Scores can range from one through to four, where a higher score indicates a higher level of empowerment. A number of subscales are also obtained from within the empowerment scale, including, esteem, activism, control, righteous

anger, and power. Table 6.5 below indicates the range, mean and standard deviation for both overall empowerment and each of these empowerment subscales for the entire study group (N=30).

Table 6.5 *Empowerment Descriptive Statistics for All Respondents*

	N	Min.	Max.	Mean	Std. Deviation
Overall Empowerment	30	1.85	3.07	2.443	0.319
Activism	30	1.33	3.67	2.787	0.612
Anger	30	1.5	3.00	2.219	0.425
Control	30	1.50	3.25	2.445	0.447
Esteem	30	1.00	4.00	2.492	0.662
Power	30	1.50	3.25	2.498	0.421

One sample t-tests were conducted on the overall empowerment score data comparing the mean scores obtained from this study to those previously documented by Wowra and McCarter (1999) and Rogers et al. (1997). These tests demonstrate that the scores obtained from this study sample are significantly lower than those obtained from the previous studies (Table 6.6).

Table 6.6 *Differences in Empowerment Means Between This Study and Previous Studies*

	Volunteer Study (n=30)	Wowra & McCarter Study (n= 283)		Rogers et al Study (n= 271)
Overall Score	Mean 2.443	Mean 2.74	t = -5.1 df = 29 p=0.000***	Mean 2.94 t =-8.54 df = 29 p=0.000***
Activism	Mean 2.787	Mean 3.12	t = -2.98 df = 29 p= 0.006**	Not Available
Anger	Mean 2.219	Mean 2.34	t = -1.56 df = 29 p = 0.130	Not Available
Control	Mean 2.445	Mean 2.72	t = -3.37 df = 29 p = 0.002**	Not Available
Esteem	Mean 2.492	Mean 2.82	t= -2.71 df = 29 p = 0.011*	Not Available
Power	Mean 2.498	Mean 2.51	t = -0.15 df = 29 p = 0.881	Not Available

t= One sample t-test, *= p<0.05, **=p<0.01, ***=p<0.001

6.5 RESEARCH OBJECTIVE THREE

This objective was to identify if any differences existed on the empowerment and quality of life variables between consumer volunteers and consumer non-volunteers. Independent group t-tests and Mann-Whitney U tests were used to

achieve this objective. Demographic variables were also compared where possible to identify any differences and potential confounding variables.

6.5.1 Demographic Characteristics of the Volunteering and Non-volunteering Groups

The volunteering and non-volunteering groups contained 15 participants in each. The volunteering group included six males and nine females and the non-volunteering group contained seven males and eight females. The majority of participants in each group received the Disability Support Pension as their main source of income, this included 13 of the volunteers and nine of the non-volunteers. Four of the non-volunteers reported wages as their main income source compared to only one within the volunteering group. The five people who reported wages as their main source of income, included two working full-time, two working part-time and one who did not indicate the number of hours worked.

The volunteer group was significantly older than the non-volunteering group. The mean age of the volunteers was 48 years compared to 38 years for the non-volunteers, which was a statistically significant difference ($p=0.003$) (Table 6.7). Age was thus identified as a potential confounding variable.

In an attempt to identify other potential confounding variables chi-squared analysis comparing the demographic categorical variables of education, living situation and diagnosis for the volunteering and non-volunteering groups was considered. However, the assumptions for conducting chi-square analysis were not met due to the high number of categories and the small sample size. Chi-square analyses need to have a minimum expected frequency of five in every cell to be reliable and this was not achieved (Coakes & Steed, 2003). Thus no statistical analysis could be conducted searching for demographic differences between the two groups. However, graphs were constructed comparing the frequencies for the two groups regarding these demographic variables to provide a visual comparison of the data. These figures are included on the following pages and illustrate minimal differences between the two groups for these variables.

The diagnoses identified in each of the two groups were very similar. However, the volunteering group had more respondents identify bipolar affective disorder and the non-volunteering group had more respondents with depression or anxiety. The level of education for the two groups were also alike, with the majority of participants in both groups having completed secondary or some tertiary education. There was one exception to this with one of the volunteers having only attended primary schooling. Both groups showed very similar living situations to each other, with the majority in both groups living alone.

Figure 6.6 Graph Depicting the Living Situation of Volunteers and Non-Volunteers

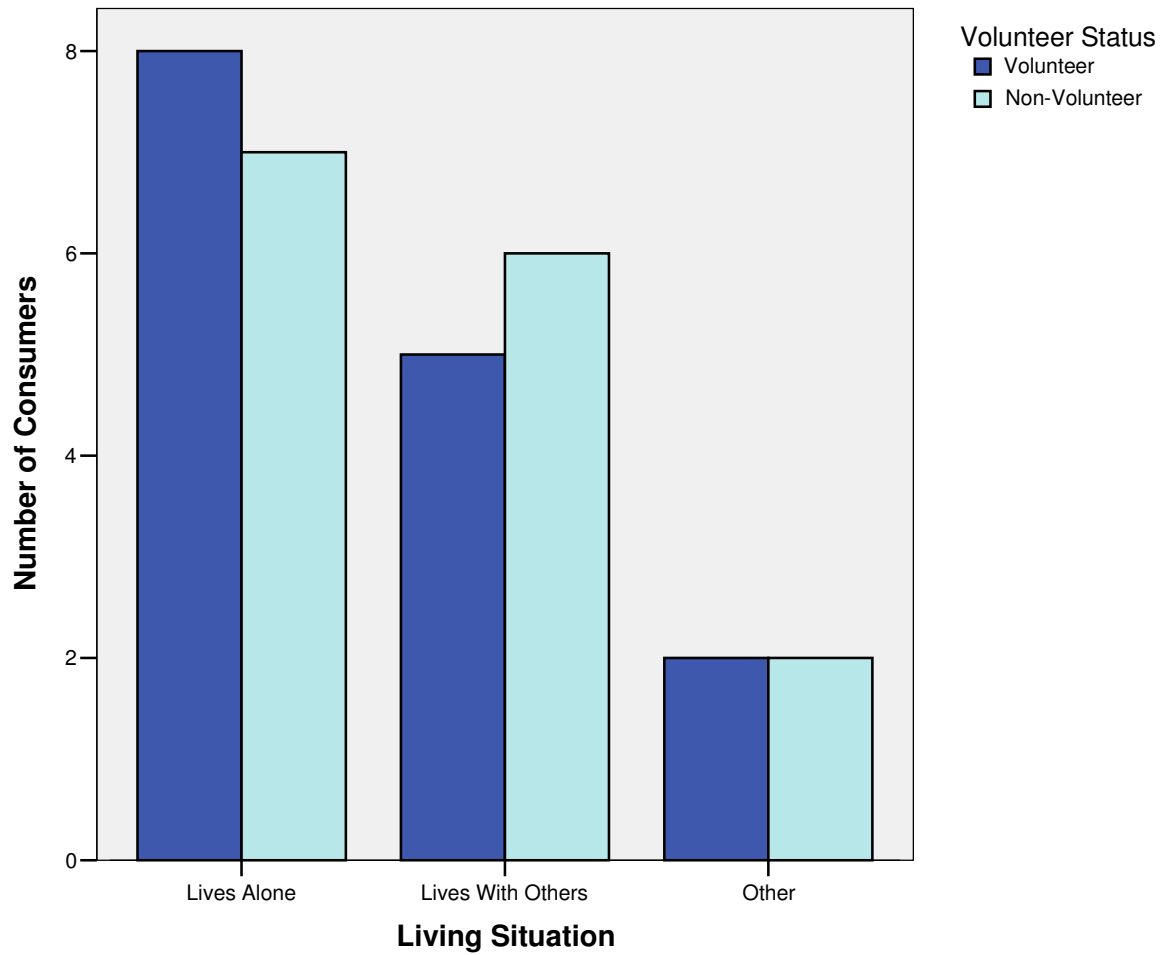


Figure 6.7 Graph Depicting the Education Level of Volunteers and Non-Volunteers

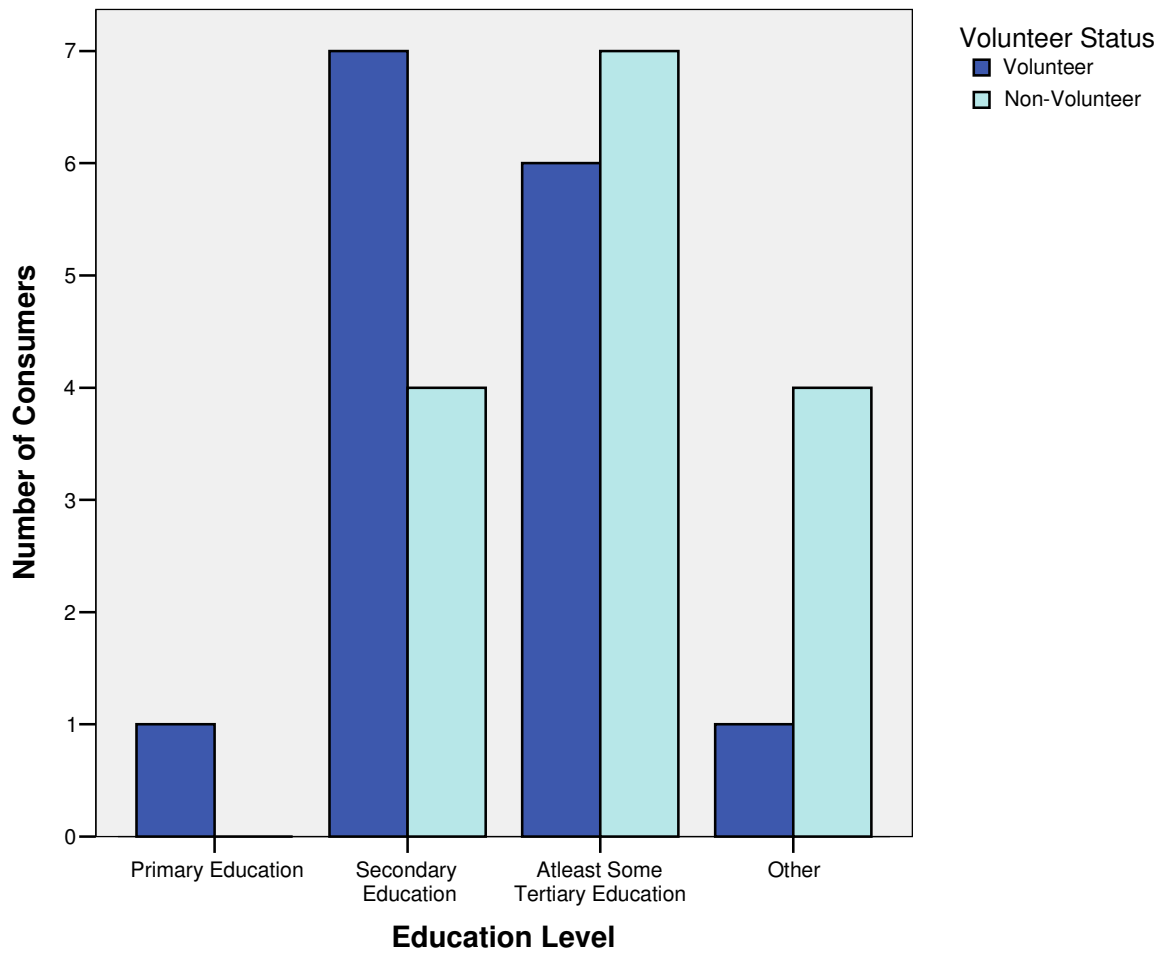
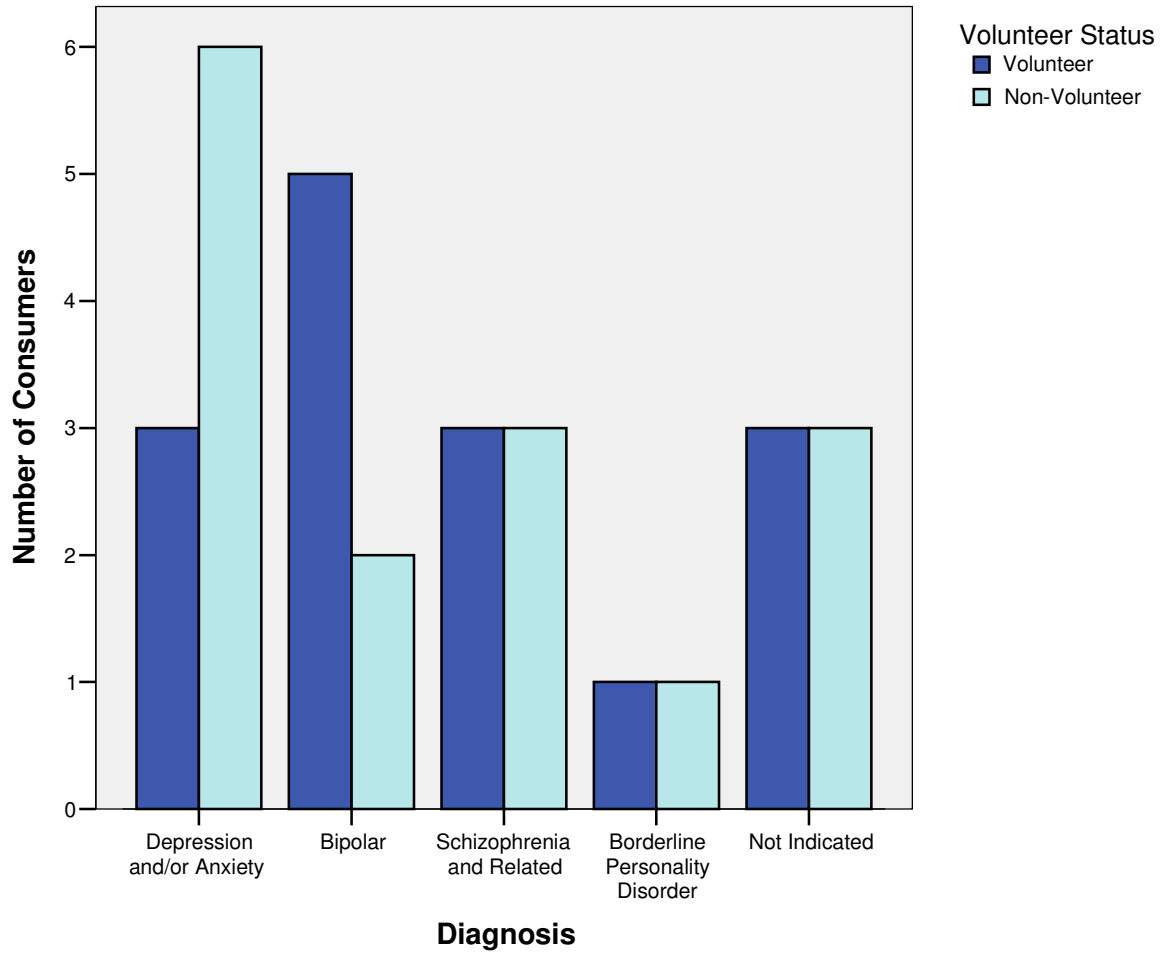


Figure 6.8 Graph Depicting the Diagnoses of Volunteers and Non-Volunteers



6.5.2 Quality of Life and Empowerment Differences between the Volunteering and Non-Volunteering Groups

Volunteers and non-volunteers were significantly different on three of the four quality of life subscales measured by the Australian WHOQOL-BREF. Specifically, the volunteer group scored better on the subscales of psychological health ($p=0.018$), social relationships ($p=0.021$) and environment ($p=0.038$) (Table 6.7). No differences were found between the two groups regarding the subscale of physical health, nor the two single items measuring perceived overall quality of life and perceived overall health.

No differences were also found within any of The Empowerment Scale domain scales, nor the overall empowerment score.

Table 6.7 Normality and Statistical Tests for the Volunteering Group and the Non-Volunteering Group

Group	Variables	Shapiro-Wilks		Statistical Test	Mean	Mean	Result		
		Vol.	Non-Vol.		Volunteers	Non-volunteers			
Vol. (n= 15)	Empowerment	0.029	0.474	Mann W. U	2.48	2.41	M-Whit. U = 107		p= 0.819
	Activism	0.249	0.133	Ind. Gr. t-test	2.62	2.96	t= -1.544	df= 23.7	p= 0.136
	Control	0.055	0.247	Ind. Gr. t-test	2.46	2.43	t= 0.140	df= 28	p= 0.889
	Anger	0.132	0.273	Ind. Gr. t-test	2.26	2.18	t= 0.467	df= 28	p= 0.644
	Power	0.261	0.792	Ind. Gr. t-test	2.60	2.39	t= 1.401	df= 28	p= 0.172
Non-Vol. (n= 15)	Esteem	0.186	0.726	Ind. Gr. t-test	2.58	2.40	t= 0.728	df= 28	p= 0.473
	Overall QoL	0.000	0.086	Mann W U	3.67	3.07	M-Whit U = 82.5		p= 0.18
	Overall Health	0.066	0.038	Mann W U	2.77	2.20	M-Whit U = 76		p= 0.116
	Physical H.	0.087	0.245	Ind. Gr. t-test	54.74	47.57	t= 1.202	df= 28	p= 0.239
	Psychological H.	0.239	0.880	Ind. Gr. t-test	51.22	37.33	t= 2.521	df= 28	p= 0.018*
	Soc. R'hips	0.333	0.179	Ind. Gr. t-test	49.72	31.32	t= 2.443	df= 28	p= 0.021*
	Environment	0.457	0.781	Ind. Gr. t-test	49.89	39.38	t= 2.182	df= 28	p= 0.038*
	Vol. Attitude	0.514	0.899	Ind. Gr. t-test	53.17	51.88	t= 0.671	df= 28	p= 0.508
Age	0.221	0.560	Ind. Gr. t-test	47.67	37.53	t= 3.247	df= 28	p= 0.003**	

Vol. = Volunteer, Non-Vol. = Non-volunteer, Ind. Gr. t-test = Independent Groups t-test; *= $p < 0.05$, **= $p < 0.01$, ***= $p < 0.001$

6.5.3 Post-Hoc Power Analyses

Post-hoc power analysis revealed extremely low power within the Empowerment Scale. The power for the empowerment subscales specifically ranged from less than 0.17 through to 0.32. A power level of 0.8 is generally recommended to enable the researcher adequate opportunity to reject false null hypotheses (Munro, 2001). The power demonstrated by the empowerment subscales fell well short of this recommended level.

The power level for the quality of life domains ranged from 0.22 through to 0.63 (Appendix J). Whilst this was an improvement upon the power provided from the empowerment scale it still did not meet the recommended 0.8 level. The low power of these tests means that the risk of making type II errors and not identifying real differences within the data is high.

6.5.4 Effect Sizes

The ability to demonstrate the significant differences between the psychological health, social relationships and environmental quality of life domains is attributable to the large effect sizes within the data. Effect size refers to the difference between groups and is generally a measure of the strength of the relationship. A small effect size is valued at 0.2, a moderate effect at 0.5, and a large effect at 0.8 (Munro, 2001). The effect sizes for the statistically significant results were large including 0.85 for psychological health, 0.82 for social relationships and 0.75 for environment (Appendix J). This indicates large differences between the two groups on these variables. The remaining quality of life subscale, physical health, attained an effect size of 0.44.

The Empowerment Scale domains achieved small to moderate effect sizes, ranging from 0.17 for the subscale of anger, through to 0.55 for activism.

6.5.5 Analysis of Environment Subscale Individual Items

One of the quality of life subscales that demonstrated a significant difference between the consumer volunteers and non-volunteers was environment. This subscale included the individual items of safety, physical environment, finances,

opportunities for obtaining information, opportunities for leisure, and access to health care and transportation. The consumer volunteers experienced significantly better personal environments than the consumers not volunteering. To further explore this difference each of the individual items within the environment subscale were compared using a Mann Whitney U test. This non-parametric test was chosen because each of the items was non-normally distributed. Whilst, the entire subscale of environment was significantly different between the volunteering and non-volunteering groups, the only individual item which demonstrated statistical significance was having access to leisure opportunities ($p=0.029$). Specifically, the volunteering group reported better access to leisure and recreation opportunities than the non-volunteering group (Table 6.8).

This analysis was not an original objective however was included post-hoc because of the variety of constructs measured in the environment subscale. In order to understand the difference between the volunteering and non-volunteering groups for the diverse environment domain individual item analysis was considered important. Despite the item analysis involving multiple comparisons, no statistical method of controlling for type I errors was applied to the data. A rationale for this decision has been discussed in detail in Section 5.9. Item analysis was not conducted on the significant subscales of psychological health and social relationships because their constructs were less varied.

Table 6.8 *Normality and Mann-Whitney U Tests Comparing the Environmental Subscale Items Between the Volunteering and Non-Volunteering Groups*

Group	Variable	Shapiro-Wilks		Mean	Mean	Result	
		Vol	Non-Vol	Volunteer	Non-Volunteer	Mann W. U	p-value
Vol = Volunteering (n = 15)	Safety	0.000	0.062	3.064	2.933	107.5	0.838
	Physical environment	0.000	0.165	3.420	3.200	101.5	0.653
	Finances	0.022	0.031	3.116	2.400	78.0	0.161
Non-Vol = Non- volunteering (n = 15)	Information access	0.040	0.050	3.579	3.200	85.0	0.267
	Leisure access	0.038	0.001	3.118	2.400	60.0	0.029*
	Living situation	0.006	0.000	3.667	3.298	87.0	0.305
	Health service access	0.025	0.025	3.867	3.096	68.0	0.067
	Transportation	0.010	0.017	3.800	3.371	96.0	0.512

Mann W. U = Mann Whitney U Test, *=p<0.05

7. DISCUSSION OF SURVEY RESULTS

7.1 INTRODUCTION

A cross-sectional descriptive survey was employed for phase three of this research project. Thirty consumers including fifteen volunteers and fifteen non-volunteers completed a questionnaire investigating their volunteer work history and current participation, their attitudes about volunteer work, and finally their level of personal empowerment and quality of life.

7.2 VOLUNTEERING AND CONSUMER QUALITY OF LIFE

The chief finding of this phase of the study was that the research participants who volunteered experienced greater quality of life than the research participants who did not volunteer. Specifically, the group of consumer volunteers scored significantly higher than the consumer non-volunteers on three of the four subscales within the Australian WHO-QOL BREF. These subscales included psychological health, social relationships and environment. The psychological health domain measured positive and negative feelings, perceived cognitive capacity, self-esteem and body image. The social relationships subscale investigated personal relationships, social support and sexual activity and the environment domain measured safety, physical environment, finances, and access to leisure, health and transport (The WHOQOL Group, 1998). The measured effect sizes for each of these subscales indicated that there were substantial differences between the volunteering and non-volunteering groups on these variables.

This finding provides support to the hypothesis that volunteering is beneficial for mental health consumers. Previous research has demonstrated a connection between consumer involvement in purposeful activity and their quality of life (Kelly et al., 2001; Laliberte-Rudman et al., 2000). This research project has demonstrated that participation in the specific activity of volunteer work is beneficial for consumers.

The positive impact of volunteering in promoting the health and well-being within the general population has been clearly argued throughout the literature

review. It has been shown that despite any pre-established level of social and psychological health, volunteering still leads to increased levels of happiness and well-being in adults (Thoits & Hewitt, 2001). This study cannot argue for a cause and effect relationship because of the cross-sectional study design. However, evidence is presented that consumer volunteers experience significantly greater psychological and social health than non-volunteers.

Previous investigations have documented the social advantages of volunteering for consumers (Institute for Volunteering Research, 2003; Rebeiro & Allen, 1998; Risbey, 2004). These findings were further confirmed within the qualitative stage of this study, where participants identified the development of friendships as one of the major positives of their volunteer work roles. This quantitative phase has been able to provide further evidence to the social advantages for consumers by demonstrating that those volunteering scored better on the social relationships subscale of the Australian WHO-QOL BREF than those not volunteering. Volunteer work is often difficult for minority groups, such as those experiencing mental illness to access, however if they do become engaged, volunteering can be a powerful tool for promoting social inclusion (Davis Smith et al., 2004). As a group mental health consumers experience high levels of social isolation and loneliness (Jablensky et al., 2000), and thus the identification of any activity which can improve their social circumstances is of great importance.

A significant difference was also found between the volunteering and non-volunteering groups within the subscale of environment. Analysis of the individual items within the environment subscale was conducted to explore which specific environmental factors were more positive within the volunteering group than the non-volunteering group. The only item of significance included having access to leisure and recreation activities. Volunteer work is generally referred to as a productive or work based activity. However, previous authors have also documented it as a serious leisure occupation (Miller et al., 2005). It may be the case that consumers label their volunteer work as both a productive activity but also one of leisure, accounting for the significant difference between the two groups regarding access to recreation activities. Further research into the

meaning consumers attach to their volunteer work is needed to clarify this issue. For instance, some consumers may view their volunteering as a substitute for paid work, some may be using volunteer work as a stepping stone to employment and others may see volunteer work as purely a leisure based activity. Volunteer work has benefits because of its inherent flexibility and potential to be adapted to the needs of the individual consumer. This further supports its utility as an intervention strategy because one activity may satisfy the needs of a variety of consumer populations.

7.3 VOLUNTEERING AND AGE

The potential confounding variable noted within all of these significant analyses was age. The group of volunteers were significantly older than the non-volunteers, with a mean age of 48 years as compared to 38 years. The mean ages obtained from this study indicate that older individuals volunteer more frequently, however this is not typically the case. Despite commonly held beliefs, older individuals do not volunteer more than younger people. In Australia volunteer participation peaks with the 35 to 44 year age group volunteering the most frequently (Australian Bureau of Statistics, 2000b).

Age has been reported in the literature to have no impact on the variable of empowerment (Rogers et al., 1997), however the issue is not so clear cut with regards to quality of life. Conflicting results have been reported within the literature regarding the influence of age upon consumer quality of life. In a study surveying 165 consumers aged between 21 and 64 on quality of life, the older consumers were more satisfied with their lives and experienced fewer concerns. However, they also expressed less desire for life change and the authors proposed that although they reported higher quality of life this may have been a direct result of lowered personal expectations (Mercier, Peladeau, & Tempier, 1998). A second study conducted involving 495 consumers aged between 21 and 50 years showed that age was negatively correlated with the quality of life variables of personal relationships, social support, sexual activity, and physical health (Masthoff, Trompenaars, Van Heck, Hodiament, & De Vries, 2006). Thus, while the impact of age on consumer quality of life remains unclear within

the literature, it cannot be ruled out as a confounding variable within this study. That is, the significant results reported above, namely that the research participants who did volunteer work experienced greater psychological health and better social relationships than those participants who did not volunteer should be viewed with caution. The cross-sectional study design is unable to determine the extent to which the variable of age as opposed to the variable of volunteer participation is responsible for these benefits.

7.4 VOLUNTEERING AND CONSUMER EMPOWERMENT

The interview themes highlighted that helping others increased the feelings of personal control within the consumer, which is a factor associated with empowerment (Wilson & Musick, 1999). As a consequence it was hypothesised that the group of consumer volunteers would experience higher levels of personal empowerment than the non-volunteering research group. However, this was not confirmed within the data. No significant differences between the volunteering and non-volunteering groups for overall empowerment or any of the empowerment subscales were identified. Previous studies testing the empowerment scale identified that a relationship existed between participation in meaningful activities and empowerment (Rogers et al., 1997). However this was not demonstrated within the current study. The prior studies however had much larger sample sizes which perhaps demonstrates this scale is more effective for use with larger groups opposed to smaller samples, such as was used within this research project.

7.5 EMPOWERMENT AND QUALITY OF LIFE SCORES OF THIS SAMPLE

The empowerment scores obtained from the current study participants were significantly lower than those previously obtained from American consumers on whom the empowerment scale was developed and tested (Rogers et al., 1997; Wowra & McCarter, 1999). The reason for these apparent differences between the current study and the American studies are unclear. Participants of the current volunteer work study were recruited from public mental health services,

and non-government mental health services which matched the recruitment strategies used in the American studies. In fact, in the Wowra and McCarter (1999) study, participants needed at least five contacts with a public mental health service in the previous four month period to be eligible for the study. It can be assumed from these strict criteria that these participants experienced major mental illness causing significant impact within their lives. Other demographic variables also appeared similar to the current research group, including high rates of unemployment and the majority ranging in age from 36 to 55. Demographic variables can thus be ruled out as causing these different scores. The differences could potentially be accounted for by cultural differences between American and Australian consumer groups, differences in services received between the two countries or perhaps the cohort of consumers who participated in this volunteer work study experienced particularly severe social impairment due to their illness.

A comparable finding also emerged within the quality of life variables. The current study participants had substantially lower quality of life scores than the Australian population norms. However, they also scored lower than individuals with depression from within the LIDO study. Whilst it could be hypothesised that the lower quality of life scores relative to the general population could be accounted for by the impact of mental illness, the same hypothesis would not account for the differences between the participants with depression in the LIDO study and the current research participants. These differences could not be explained by mental health status, because stringent inclusion criteria were imposed upon the LIDO study. Participants with depression were only included in the LIDO study after having met the criteria based on the Composite International Diagnostic Interview. Thus both groups would be considered to be experiencing significant mental illness. This volunteer work study, however, included a broader range of illnesses, incorporating affective, psychotic and personality disorders as opposed to the LIDO study which focused on individuals with depression. Diagnosis could therefore be a contributing factor accounting for these differences in quality of life and empowerment between the volunteer study group and the LIDO study group, however, a larger sample size is required to clarify these relationships.

7.6 VOLUNTEERING AND THE RECOVERY PROCESS

The recovery model referred to throughout this thesis is that developed by Andresen et al. (2003). They document the recovery process as having four factors; finding hope for the future, finding meaning in life, taking responsibility for illness and redefining identity. The interview data clearly demonstrated the contribution volunteer work has to the first three themes. This quantitative phase then measured attitudes consumers held about volunteer work which further endorse its recovery promoting capacities. For example the majority of respondents identified volunteering as a way of joining in the community, making friends, fostering a sense of purpose and potentially leading to paid employment. Furthermore, half of the respondents specifically commenced volunteer work as a way of making them feel better thereby anticipating its recovery oriented qualities.

7.7 BARRIERS TO CONSUMER VOLUNTEERING

A number of barriers to consumer volunteering were identified throughout the survey data. Inadequate training of volunteers, volunteers potentially being taken for granted, the stigma associated with volunteers with mental illness, cost and ceasing volunteer work due to becoming unwell were the issues identified.

Consumers have previously identified mental health services as a preferred place to be informed of volunteer work opportunities (Institute for Volunteering Research, 2003). It is thus important for mental health professionals to have a clear understanding of the barriers to consumer volunteering, in order to advocate and support consumers to overcome them. Whilst two of these barriers are specific to the mental health area namely stigma and ceasing volunteer work due to becoming unwell, the other concerns have also been identified within the general population of Australian volunteers. Volunteering Australia surveyed 373 volunteers through their national survey of volunteering issues in 2006. This survey demonstrated that 21% of the volunteers were not satisfied with the orientation and training they had received, 32% felt that their volunteering contribution was insufficiently recognised within their organisation, 28%

reported it cost them money to volunteer for which they were not reimbursed, and a further 14% were unsure of their eligibility to be reimbursed for volunteering costs (Volunteering Australia, 2006). These results mirror the concerns identified by consumers throughout this study and because they are the same it seems reasonable that as they are addressed within the wider volunteering sector the effects should be also felt within consumer volunteering.

However, the issues of stigma and ceasing volunteer work due to becoming unwell are specifically related to mental health consumers and will require support from the mental health field in order to be overcome.

7.8 CONSUMER VOLUNTEER ACTIVITIES

The mental health field was the most commonly cited area in which the survey participants did their volunteer work. This finding is consistent with both the interview data and previous research in the area which identified mental health as the most popular area for consumers to volunteer in (Institute for Volunteering Research, 2003). Also consistent with the interview data, the majority of survey participants found out about their volunteering opportunity either through word of mouth or by contacting the organisation directly. Thus many of the research participants, both within the qualitative and quantitative phases of this study, became volunteers within the mental health field, through their contact with mental health services. It could therefore be argued that being provided with a direct opportunity or information about volunteering through mental health services was the catalyst for these individuals to commence volunteer work. Approximately 80 per cent of the survey respondents believed that mental health services should provide support to assist consumers to become volunteers. This mirrors previous research which has found that consumers identify mental health services as the preferred place to be informed about volunteering opportunities (Institute for Volunteering Research, 2003). The results from this study indicate that mental health consumers volunteer most frequently within the area of mental health, an area that is easily accessible and advertised to them. It is argued that mental health services should be providing information to consumers about not only the mental health field of volunteer work, but also other volunteer areas in

the broader community. The approach of supported volunteering is advocated for this.

7.9 SUPPORTED VOLUNTEERING

Efforts to improve the inclusivity of volunteering for individuals with disabilities have included supported volunteering approaches involving matching the task to the volunteer and then providing ongoing support (Miller et al., 2003; Miller et al., 2005). Supported volunteering is based on the philosophies of supported employment which is considered best practice for encouraging consumer participation in paid work (Crowther et al., 2004). It is believed that similar approaches could be used to foster the integration of consumer volunteers by assisting them to overcome the barriers to volunteering and encourage the development of supportive volunteering environments. The provision of such support should decrease the frequency of consumers needing to cease their volunteer work when they become unwell, and subdue any negative attitudes or fears organisations hold about utilising volunteers with mental illness. A supported volunteering approach would also assist consumers to broaden the areas they would consider volunteering in, by minimising their fears of being taken for granted or not accepted. Supported volunteering would involve mental health service staff acting as mentors, ensuring consumers are placed in suitable volunteer work roles, appropriately orientated and monitored to foster successful role placements.

7.10 CONCLUSION

The results obtained from this study provide preliminary support for the inclusion of volunteer work programs within mental health rehabilitation services. The consumer volunteers within this study experienced significantly better psychological health, social relationships and personal environments than the consumer non-volunteers. Thus, this research project provides support to the hypothesis that volunteering benefits the mental health of consumers. Mental health professionals are in ideal positions to be supporting consumer participation in volunteer work and this appears necessary to assist them to overcome barriers such as stigma, preventing their participation. Supported

volunteering approaches are advocated as the best method of providing this support.

8. LIMITATIONS

8.1 INTRODUCTION

A number of methodological limitations arose throughout the conduction of this research project. These limitations are outlined below.

8.2 SMALL SAMPLE SIZE AND LIMITED POWER

By far the biggest limitation within this study was the small sample size resulting in limited power to demonstrate statistically significant differences. Due to the low power the chance of the researcher making type II errors and not reporting on real differences within the data was very high. The significant differences that have been reported on were due to the large effect sizes within the data. The previous research investigating consumer participation in volunteer work was descriptive in nature. This study was also descriptive but extends on from existing research through the provision of in-depth qualitative data and the demonstration of significant differences between consumer volunteers and non-volunteers on a range of quality of life variables. However, due to the cross-sectional nature of the study a cause and effect relationship cannot be inferred from the results. Furthermore, the small sample sizes used within the study also means that the results should be generalised with caution. The ability of small scale research to be generalised to real populations is often slight (Cohen et al., 2000).

The small sample size also limited the analyses that could be conducted. One of the consumers within the volunteering group and four within the non-volunteering group indicated paid employment as their main source of income. There are similarities between paid work and volunteer work and thus having more individuals in the non-volunteering group who were paid workers could have caused some bias in the results. However, no subgroup analysis could be conducted with a separate employment group because of the small sample size.

8.3 INABILITY TO DEMONSTRATE A CAUSE AND EFFECT RELATIONSHIP

The cross-sectional design allows for the demonstration of significant differences between the groups to be highlighted, however the cause of these differences remains unclear. The only way a true cause and effect relationship can be demonstrated is the application of more controlled data collection methods, such as longitudinal studies or controlled studies.

8.4 LIMITED DIAGNOSTIC INFORMATION

Individuals with mental illness are considered a vulnerable population by Human Research Ethics Committees. Thus, special consideration needs to be paid to issues regarding confidentiality and consent. This study obtained no confirmatory information regarding diagnosis from hospital or clinic medical records. Information regarding length of illness, number of previous hospital admissions, participation in rehabilitation, and level of functional independence, would have been useful measures for the conducting of the statistical analysis. Access to this information would have enabled further identification of potential confounding variables. The current study was based solely on self-report and did not obtain any of this information. However, this would be recommended for future studies.

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 CONCLUSIONS

Previous research has documented the benefits of volunteering within the general adult population, the elderly and adolescents. Specifically, volunteering has been found to increase health and happiness and buffer against stress in adults (Rietschlin, 1998; Thoits & Hewitt, 2001), improve life satisfaction and decrease mortality in the elderly (Harlow & Cantor, 1996; Oman et al., 1999; Wilson & Musick, 1999) and decrease delinquency behaviours in adolescents (Moore & Allen, 1996). All of this research has highlighted the benefits within psychological domains for each of these groups. Following this research effort some authors proposed that volunteering may be beneficial for improving the mental health of consumers (Black & Living, 2004). However to date the research endeavours investigating the impact of volunteering on mental health consumers has been scarce and generally considered preliminary in nature. Investigations have involved case studies, descriptive surveys and qualitative investigations (Birch, 2005; Institute for Volunteering Research, 2003; Kayloe, 1985; Rebeiro & Allen, 1998; Risbey, 2004). At present no rigorous quantitative studies have been conducted investigating the impact volunteering has on the mental health of consumers. This study thus provides the next level in empirical evidence supporting consumer participation in volunteer work. This investigation has been able to add three new findings to the current knowledge base.

9.1.1 Mental health consumers who volunteer experience significantly greater quality of life than consumers who do not volunteer.

This was demonstrated through the cross-sectional survey results which identified that the consumers participating in volunteer work performed better on various quality of life domains than the non-volunteering consumers. Specifically, the benefits were identified within the areas of psychological health, social relationships and personal environments.

9.1.2 Volunteer work is an agent for promoting the recovery of the consumers.

Volunteering supports the recovery process for consumers by affording them a social connection, a meaningful role and responsibility within their community, and by encouraging them to learn skills in managing their life roles. Each of these factors has been identified by Andresen et al. (2003) in their model of recovery. These elements were highlighted throughout the interviews conducted and also through the positive volunteer attitude survey results obtained from the quantitative phase of this research project.

9.1.3 Substantial barriers exist to consumer participation in volunteering.

Barriers emerged to consumer participation in volunteer work. A number of these were prevalent within the broader Australian volunteering sector such as cost, and lack of training and recognition (Volunteering Australia, 2006). However, others were unique to the mental health area and included stigma and quitting volunteer work during periods of ill mental health. These particular barriers are mental health related and it is argued that they require the support of mental health services in order to be overcome.

9.2 RECOMMENDATIONS

This research project has demonstrated through qualitative investigation that volunteering can promote consumer recovery. Quantitative enquiry demonstrated that the consumers who volunteered experienced significantly greater quality of life than the consumers who did not volunteer. An argument can thus be created supporting the inclusion of monitored volunteer work programs within mental health rehabilitation services. Specifically, a supported volunteering approach is endorsed.

9.2.1 Supported Volunteering

This study has shown volunteer work to be one approach that is community based and as highlighted within the interview data, not only encourages the development of skills and confidence but also integration with the community. It is recommended that mental health services invest time in developing relationships with volunteer organisations so as to establish suitable volunteering opportunities for consumers. The adoption of a supported volunteering approach

is recommended, where consumers are supported to not only find appropriate volunteer work but also to learn and maintain the volunteering role (Miller et al., 2005). Mental health professionals working through a rehabilitation framework are in a good position to develop such collaborative partnerships with the volunteer sector and through these provide the required support to both the consumer and the volunteering organisation involved.

9.3 RECOMMENDATIONS FOR FUTURE RESEARCH

This study has explored consumer participation in volunteer work and thus identified areas worthy of further investigation. Four main areas for future research are recommended. Firstly, this study was a small, descriptive study and thus it is recommended that a larger study be conducted further investigating the impact of volunteering on consumer mental health in order to confirm the results. Further psychometric testing of the volunteer questionnaire developed for this study could be conducted at this stage. Secondly, supplementary investigation into the meanings attached to volunteer work by various consumer groups is suggested to enable specific tailoring of programs to suit consumer needs. And finally, the development and empirical investigation of supported volunteering programs to identify their clinical effectiveness within rehabilitation services is recommended.

9.4 CLOSING SUMMARY

This research project provides support that volunteer work is a beneficial activity for mental health consumers. Volunteer work has been acknowledged as a purposeful activity that encourages community integration, the development of friendships, the learning of valuable work skills, and promotes the self-management of mental illness. Furthermore, the consumer research participants who volunteered experienced significantly greater quality of life than their non-volunteering counterparts. Participants identified that volunteer work was a positive experience for them, and one that should be encouraged by mental health services. It is argued that mental health services should be supporting consumer participation in volunteer work through the provision of supported

volunteering programs. The benefits of volunteer work have been clearly endorsed by the participants of this study. I would like to close by quoting the words of one interview respondent which highlights the personal meaning of her volunteering role.

“I’m never going to cure cancer or build the Taj Mahal. But hopefully ... I’m making the world a better place. That’s what feels good.”



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APPENDICES

Appendix A: Consent and Information Forms (Phase One)

CONSUMER INFORMATION SHEET – PHASE ONE

AN INVESTIGATION OF VOLUNTEER PARTICIPATION BY MENTAL HEALTH CONSUMERS

We invite you to participate in a research study gathering information about the impact participating in volunteer work has on the mental health of mental health consumers. The researcher is conducting this study as part of a Masters By Research Postgraduate Degree through Curtin University of Technology. This study has been approved by the South Metropolitan Area Health Service Human Research Ethics Committee.

If you decide to take part in this research study, it is important that you understand the purpose of the study and the procedures you will be asked to undergo. Please read the following pages, which will provide you with information about what is involved, and also the potential benefits and precautions of the study. If you are currently involved in a research study you will be ineligible to participate in this one.

Nature and Purpose of the Study

We have asked you to participate in phase one of this study because you are a mental health consumer and are currently participating in volunteer work.

At present very little is known about the volunteering that mental health consumers do, how they organise it and the impact it has on their mental health. The information that is provided from this study will help us to start answering some of these questions. In turn, reports from this study may help to influence the inclusion of volunteer work programs for consumers in mental health services.

The aim of phase one of this study is to document consumer experiences of volunteering, including how they accessed volunteering, and their thoughts about the benefits and limitations of volunteering.

What the Study Will Involve

This is the first phase of the study. This phase involves the completion of interviews to gather information about consumer experiences with volunteering. If you decide to participate in this study, you will be interviewed by the researcher. The interview will be for approximately one hours' duration, and will be tape recorded. You are able to stop the interview at any stage, and refuse any questions you do not wish to answer.

Confidentiality

All the information you give in this questionnaire is confidential. The taped information you provide will be typed out word for word and then entered into a computer system using a coded ID number not your name. You will not be identified in any reports generated from this study. The tape from this interview will be destroyed. Your medical record will not be consulted for this study.

Benefits

There will be no direct benefit to you from participation in this study. However, the knowledge gained from your participation may help others in the future.

Discomforts and Risks

The interview will ask specifically about your participation with volunteering. If however, at any stage you experience discomfort or embarrassment from the questions asked you can refuse to answer. Should the interview cause you distress in any way, the researcher will provide appropriate service referral.

Voluntary Participation and Withdrawal from Study

Your participation in this study is entirely voluntary and if you decide not to participate in this study, your treatment will not be affected in anyway.

You may withdraw from this study at any time, for whatever reason. Such withdrawal will not in any way influence decisions regarding future treatment.

Complaints or Concerns

If you have any complaints or concerns regarding this study, please contact the Chairman of the South Metropolitan Area Health Service Human Research Ethics Committee on 9431 2929.

Janelle Young
Primary Researcher
Ph: (08) 9266 3611
e-m: janelle.young@curtin.edu.au

Assoc. Professor Anne Passmore
Research Supervisor
Ph: (08) 9266 3600
e-m: A.Passmore@curtin.edu.au

Linda Whitby
Secretary
Ph: (08) 9266 4651
e-m: L.Whitby@curtin.edu.au

This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth 6845 or by telephone 9266 2784.

CONSUMER INFORMATION SHEET – PHASE TWO

AN INVESTIGATION OF VOLUNTEER PARTICIPATION BY MENTAL HEALTH CONSUMERS

We invite you to participate in a research study gathering information about the impact participating in volunteer work has on the mental health of mental health consumers. The researcher is conducting this study as part of a Masters by Research Postgraduate degree through Curtin University of Technology. This has been approved by the South Metropolitan Area Health Service Human Research Ethics Committee.

If you decide to take part in this research study, it is important that you understand the purpose of the study and the procedures you will be asked to undergo. Please read the following pages, which will provide you with information about what is involved, and also the potential benefits and precautions of the study. If you are currently involved in a research study you will be ineligible to participate in this one.

Nature and Purpose of the Study

We have asked you to participate in phase two of this study because you are a mental health consumer.

At present very little is known about volunteering that mental health consumers do, how they organise it and the impact it has on their mental health. The information that is provided from this study will help us to start answering some of these questions. In turn, reports from this study may help to influence the inclusion of volunteer work programs for consumers in mental health services.

This is the second part of this study. The first part involved interviewing consumers who have volunteered to find out about their volunteering experiences. This second part of the study involves the completion of a questionnaire. You do not need to have done volunteer work to participate in this second part of the study.

The aim of this phase of the study is to measure the impact participating in volunteering has on the mental health of consumers.

What the Study Will Involve

You are requested to complete the questionnaire. The questionnaire we would like you to complete for this phase will take a total of about 30 minutes of your time. The questionnaire will ask about different areas including your quality of life, symptoms, satisfaction, as well as specific questions about your experiences with work, volunteer work or unemployment.

Confidentiality

All the information you give in this questionnaire is confidential. The information provided by you will be coded and entered into our computer system. You will not be identified in any reports generated from this study. Your medical record will not be consulted for this study.

Benefits

There will be no direct benefit to you from participation in this study. However, the knowledge gained from your participation may help others in the future.

Discomforts and Risks

Should completing these questionnaires cause you distress in any way, the researcher will provide appropriate service referral.

Voluntary Participation and Withdrawal from Study

Your participation in this study is entirely voluntary and if you decide not to participate in this study, your treatment will not be affected in anyway.

You may withdraw from this study at any time, for whatever reason. Such withdrawal will not in any way influence decisions regarding future treatment.

Complaints or Concerns

If you have any complaints or concerns regarding this study, please contact the Chairman of the South Metropolitan Area Health Service Human Research Ethics Committee on 9431 2929.

Janelle Young
Primary Researcher
Ph: (08) 9266 3611
e-m: janelle.young@curtin.edu.au

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This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth 6845 or by telephone 9266 2784.

CONSENT FORM –PHASE ONE
An Investigation of Volunteer Work Participation by Mental Health Consumers

Patient's Name:

1. I agree entirely voluntarily to take part in this Investigation of Volunteer Work Participation by Mental Health Consumers. I am over 18 years of age.
2. I have been given a full explanation of the purpose of this study, of the procedures involved and of what will be expected of me.
3. I understand that I am entirely free to withdraw from the study at any time and that this withdrawal will not in any way affect my future standard or conventional treatment or medical management.
4. I understand that information in my medical records will not be accessed for this study.
5. I understand that I will not be referred to by name in any report concerning this study. In turn, I cannot restrict in any way the use of the results that arise from this study.
6. I have been given and read a copy of this Consent Form and Information Sheet.

Signature of Consumer

Signature of Researcher

Signed:.....

Signed:.....

Date:.....

Date:.....

If you have any questions, please contact:-

Janelle Young
Primary Researcher
Curtin University of Technology
Ph: 9266 3611
e-m: janelle.young@curtin.edu.au

Assc. Prof. Anne Passmore
Project Supervisor
Curtin University of Technology
Ph: 9266 3637
e-m: A.Passmore@curtin.edu.au

Appendix B: Recruitment Letter (Phase One)

Dear Sir / Madam,

I am writing regarding research that I am conducting through Curtin University of Technology. I am investigating the impact participating in volunteer work has on the mental health of mental health consumers. At present very little is known about the volunteering that mental health consumers do, how they organise it and the impact it has on their mental health. This study being conducted through the Centre for Research into Disability and Society at Curtin University of Technology aims to address some of these issues.

The study is being conducted in two phases. The first phase involves the completion of interviews with consumers who are currently participating in volunteer work, to document their stories, experiences and perceptions about volunteering. The second phase of this study involves questionnaire completion.

At present, I am completing phase one of the study. I am writing to request assistance with recruiting consumers to participate in an interview discussing their volunteering experiences. If there are any consumers who volunteer for your service or if you are in a position to advertise this study to consumers – it would be appreciated if you could pass on the information. I have enclosed some study information sheets for this purpose. If any consumers are interested in participating in an interview, they can contact me via telephone, mail or email – so we can organise a time and place.

This study has been approved by the Curtin University Human Research Ethics Committee. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth 6845 or by telephone 9266 2784.

I am very appreciative of any assistance and am happy to answer any queries. Please contact me on 9266 3611 if you wish to discuss this further. Thank you for your support and assistance.

Yours Sincerely,

Janelle Young
Occupational Therapist
Research Masters Candidate
School of Occupational Therapy
Curtin University of Technology
GPO Box U1987
Perth Western Australia 6845
janelle.young@curtin.edu.au

Ph: 9266 3611

Appendix C: Demographic Information Sheet (Phase One)

VOLUNTEERING AND MENTAL HEALTH STUDY

DEMOGRAPHIC INFORMATION FORM

What is your age? _____

What is your gender?

Male Female

What is your level of education?

Completed Primary School only

Completed to Grade 10

Completed High School

Partially completed university degree

Completed university degree/s

Where do you volunteer? _____

What tasks do you do as volunteer? _____

How many hours per week do you volunteer? _____

How did you find out about the volunteering opportunity?

Do you do the volunteer work by yourself or with a group of people?

By self

With a group

Have you had to spend any money to volunteer?

Yes

No

Have you participated in paid employment?

Yes

No

Appendix D: Volunteer Interview Guide

Volunteer Interview

This is a list of questions which will be used to guide the semi-structured interviews to be conducted with consumers in phase one of the study. These questions will serve as a guide during the interview and therefore, some may be omitted or explained further to elicit relevant information.

Why did you decide to become a volunteer?

Why did you choose that particular volunteer work?

What people or things made it difficult for you to become a volunteer?

What people or things helped you become a volunteer?

Did you have any concerns about volunteering before you began?

What do you like about volunteering?

What do you dislike about volunteering?

How do you find the challenge of volunteer work? Is there enough of challenge, too much challenge or just the right amount?

Do you feel there is someone that can help you if you need help?

How well do you feel you are managing in your volunteer work?

Have you made any friends through volunteering?

Do you have any special responsibilities in your volunteer work?

Do you feel your work is recognised by the organization?

Has volunteering helped in any other areas of your life?

Has volunteering had a bad effect on other areas of your life in anyway?

What do you think volunteering can offer mental health consumers in general?

What would you change about your volunteer work?

Would you like to get paid employment? (If yes, do you see volunteer work as helping you getting back to paid work?)

How do you feel your health effects your volunteer work?

Do you think volunteering is a worthwhile experience for you?

Do you have anything extra to add?

Appendix E: Letter Requesting Participants to Check Full Interview Transcript

Dear ,

Thank you for participating in an interview with me, discussing your experiences as a volunteer. The support is greatly appreciated. I have now completed all the interviews and typed up the transcripts. I have enclosed a copy of the transcript from your interview with this letter.

Part of the research process involves sending the transcript to a selection of participants for their feedback, to ensure the research is reliable. It would therefore be appreciated if you could peruse the transcript enclosed and contact me if you have any problems with it, or points that you would like to discuss further. If I do not hear from you I will assume that you have no concerns.

The next part of my research will be analysing the interviews for themes. Once I have completed this process I will send you a copy of the results to keep you informed of the research outcomes. Thank you again for your participation, it is most appreciated.

Yours sincerely,

Janelle Young
Centre for Research into Disability and Society.
Ph: 9266 3611
janelle.young@curtin.edu.au

Appendix F: Letter Advising Participants of Interview Themes

12th July, 2006

Dear ,

I am writing to thank you for participating in an interview with me last year, which asked about your experiences with volunteer work. During the later half of last year (2005), I conducted a total of nine interviews with consumers who currently volunteer, in order to document their experiences with volunteer work. From these nine interviews a number of themes emerged, which I would like to share with you. I would also like any feedback you have about these themes.

Five major themes emerged from the information provided. These included:-

1. The benefits volunteering has for the individual

People thought being a volunteer provided many benefits for the individual. These included improvements in self-esteem and confidence, learning job skills and developing networks that could lead to getting paid work, meeting peers and making friendships and having a sense of purpose and personal meaning.

2. The benefits volunteering has for others and the community

Participants felt that volunteering enabled them to help others and the community. This included things such as helping those less fortunate than themselves, teaching others skills, being a voice for those that may not be able to speak out in situations, and making positive changes for the future.

3. Self-management

Overall, people felt that volunteering had a positive effect on their mental health. This was in terms of the improvements in self-esteem and confidence, but also in terms of increasing their motivation, and personal self-care. People spoke of the need to monitor the amount of volunteer work they were doing, to ensure it was manageable. This was because people needed to look out for their personal health as a priority. Participants did not speak of their mental illness being a barrier to the volunteer work, rather the need to acknowledge it, monitor and manage it.

4. Barriers to volunteering

Two main factors were identified as barriers to volunteering. These included cost and lack of structure in some areas. The cost of volunteering ranged from petrol, parking and transport costs, to clothing and printing costs. Another barrier identified was a lack of structure in some areas. People felt that if the role lacked structure and support it was difficult for the volunteer.

5. Enablers to volunteering and the retention of volunteers

This theme included both factors that encouraged people to firstly become a volunteer, but also factors that encouraged people to

continue on volunteering. These factors included, having an interest or experience in the area volunteered in, training and support, recognition and acknowledgement, personal motivation to volunteer, and finally having an entry point to volunteer work including being asked by someone to help out.

Where to now with this research project?

This phase of interviews, was the first phase of this research study. I am now moving into the second phase of the study. This second phase involves consumers completing a questionnaire. The questionnaire includes questions about their thoughts and experiences with volunteering, their opinions on making life decisions and their quality of life.

I have enclosed with this letter an information sheet about the second phase of this study. If you are interested in participating in this phase, please contact me on the details below.

What is being done with this information?

I am presenting this information at the World Federation of Occupational Therapy conference, to be held in Sydney in July 2006. I also plan on publishing this information in the form of journal articles and my completed thesis.

Thank you for your help

I would like to sincerely thank you for your support with this research project. I am hoping that the results overall will be useful for mental health services in deciding whether programs that support consumer volunteering are worthwhile.

Yours sincerely,

Janelle Young
Ph: (08) 9266 3611 (work)
Ph: 0421 089 078
e-mail: Janelle.Young@curtin.edu.au

Appendix G: The Volunteer Scale

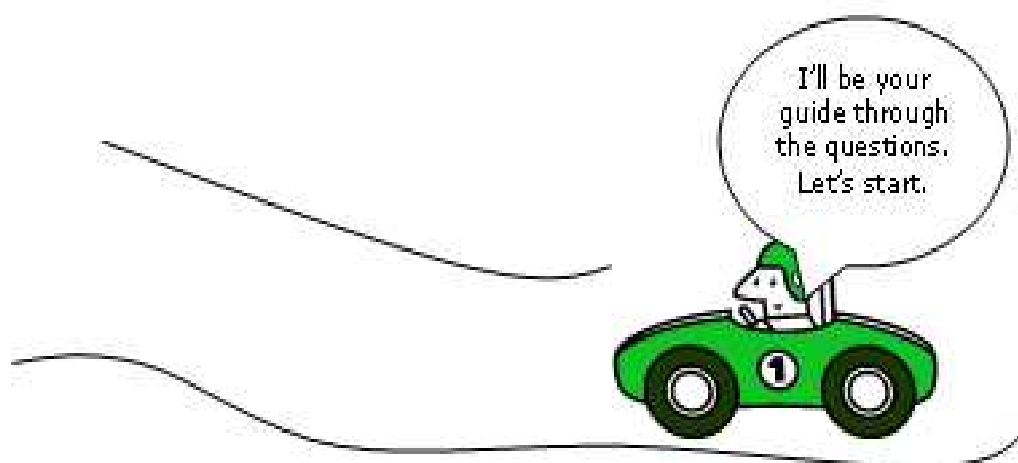
*Mental health consumers, make
your voice heard.....*

The Volunteer Scale

This questionnaire asks about your thoughts and experiences with volunteer work. It does not matter if you have not been a volunteer, it is your opinions that we are seeking.

The information obtained from this questionnaire will be used to guide mental health services in deciding on the importance of programs that support consumers to volunteer in the community. Therefore your opinions on the topic matter greatly.

The survey also includes some questions about your quality of life and living circumstances. Please be aware that this information will be confidential and no names or contact details are required. It would be greatly appreciated if you could offer 15 minutes of your time to provide your much needed input.



Thank you for agreeing to complete this survey. Can you please hand this survey back to the researcher or alternatively mail it to:

Mrs Janelle Young
Curtin University of Technology
School of Occupational Therapy
PO Box U1987
Perth, Western Australia, 6845.

If you have any questions or comments, please contact:

Mrs Janelle Young
Janelle.Young@osstomd.curtin.edu.au
Ph: 9266 4651

This project is being supervised by
Associate Professor Anne Passmore
Phone: 9266 3637
A.Passmore@curtin.edu.au

A report will be generated from this research project. If you would like to be sent a copy of this report, please write your name and address you would like this sent to below. This information will be separated from your responses on the questionnaire and will remain confidential.



1. Volunteering and You

1. Are you or have you ever been a volunteer?

(a) Yes, I volunteer at the moment.
└───────────┘ (Go to q. 5)

(b) I don't volunteer right now but I have done in the past.
└───────────┘ (Go to q. 3)

(c) No, I have never been a volunteer.
└───────────┘ (Go to q. 2)

2. If you have never been a volunteer, please tick the most appropriate response and then go to q. 15.

(a) I have no interest in volunteering

(b) I'd like to find out about volunteering but don't know how to get the information

(c) I've never thought about volunteering

(d) I don't have time to volunteer

(e) Other _____

└───────────┘ (Go to q. 15)

3. When did you stop volunteer work?

(a) less than 12 months ago

(b) More than 12 months ago

4. What was the main reason you stopped volunteer work?

(Tick only one option)

(a) I obtained paid employment

(b) I no longer had the time available

(c) I became mentally unwell

(d) I did not enjoy the work

(e) The organisation did not appreciate my efforts

(f) Staff were unfriendly towards me.

(g) I could not do the job

(h) My skills were not used and I was bored

(i) The organisation no longer needed me

(j) Other _____

5. On average how often do you or did you volunteer?

(a) Daily

(b) Weekly

(c) Monthly

(d) One-off Event

(e) Other _____

6. On average how many hours per week do you or did you volunteer?

_____ hours

7. How long have you been or were you a volunteer?

(a) Less than 6 months

(b) 6 months to 1 year

(c) 1 to 3 years

(d) 3 to 5 years

(e) 5 to 10 years

(f) Over 10 years

8. What organisation do you or did you volunteer for?

(Tick all that apply)

- | | |
|-------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> (a) environmental | <input type="checkbox"/> (g) mental health |
| <input type="checkbox"/> (b) animals/pets | <input type="checkbox"/> (h) sport/leisure |
| <input type="checkbox"/> (c) charity shop | <input type="checkbox"/> (i) health/social care |
| <input type="checkbox"/> (d) education/training | <input type="checkbox"/> (j) arts/music |
| <input type="checkbox"/> (e) Religious | <input type="checkbox"/> (k) human rights |
| <input type="checkbox"/> (f) hospital | <input type="checkbox"/> (m) Other _____ |

9. What volunteer activities do you or did you do?

(Tick all that apply)

- | | |
|----------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> (a) run a self-help group | <input type="checkbox"/> (i) gardening |
| <input type="checkbox"/> (b) committee member | <input type="checkbox"/> (j) teaching |
| <input type="checkbox"/> (c) organising events | <input type="checkbox"/> (k) catering |
| <input type="checkbox"/> (d) visiting people | <input type="checkbox"/> (l) coaching |
| <input type="checkbox"/> (e) working in a shop | <input type="checkbox"/> (m) fundraising |
| <input type="checkbox"/> (f) clerical/admin. | <input type="checkbox"/> (n) advocacy |
| <input type="checkbox"/> (g) transportation | <input type="checkbox"/> (o) other _____ |

10. What was the reason you volunteered?

(Tick all that apply)

- (a) A friend asked me
- (b) I thought it might help me to feel better
- (c) To improve my chances of getting a job
- (d) An employment agency suggested it
- (e) To support the organisation
- (f) To meet new people and make friends
- (g) A mental health worker suggested it
- (h) Other _____

11. How did you find out about your voluntary work?

- (a) Word of mouth
- (b) Through the local volunteer agency
- (c) Advertisement (poster / newspaper etc)
- (d) Contacted the organisation directly
- (e) Library or community centre
- (f) Referred by mental health worker
- (g) Referred by employment agency
- (h) Other _____

12. How is or was your relationship with other volunteers?

- (a) Very good
- (b) Good
- (c) Difficult
- (d) Very Difficult
- (e) Undecided

13. How clear is or was your volunteer role?

- (a) Always Clear
- (b) Clear Most of the Time
- (c) Clear Sometimes
- (d) Rarely Clear
- (e) Never Clear

14. Support from staff for your volunteering is or was available?

- (a) Always
- (b) Often
- (c) Sometimes
- (d) Seldom
- (e) Never

15. What is your current employment status?

- (a) Currently employed more than 8 hours per week
 └──────────────────┬──────────────────▶ (Go to q. 16)
- (b) Currently employed less than 8 hours per week
 └──────────────────┬──────────────────▶ (Go to q. 16)
- (c) Currently unemployed
 └──────────────────┬──────────────────▶ (Go to q. 17)

16. On average how many hours per week are you employed?

_____ Hours



2. Your opinions on volunteering

Below is a list of comments about volunteer work. Please circle the number that is closest to how you feel about the statement.

		Strongly Agree	Disagree	Agree	Strongly Disagree
17.	Volunteering is a way to help others and positively contribute to society.	1	2	3	4
18.	Volunteering can lead to paid employment.	1	2	3	4
19.	Volunteering provides people with a sense of purpose.	1	2	3	4
20.	Volunteering is bad for one's mental health.	1	2	3	4
21.	The contribution of volunteers is recognized in the community.	1	2	3	4
22.	Volunteers are supported in the workplace.	1	2	3	4
23.	Volunteering is a way of being involved in the community.	1	2	3	4
24.	I am unsure how to become a volunteer.	1	2	3	4
25.	Mental health services should help consumers become volunteers.	1	2	3	4
26.	Volunteers are taken for granted.	1	2	3	4
27.	I am capable of volunteer work.	1	2	3	4
28.	It costs money to be a volunteer.	1	2	3	4
29.	People with mental illness are accepted as volunteers in the community.	1	2	3	4
30.	Volunteering is a way to develop work skills.	1	2	3	4
31.	Volunteering is a way of meeting people and making friendships.	1	2	3	4
32.	Volunteers do not receive appropriate training and orientation.	1	2	3	4
33.	Volunteering is an enjoyable activity.	1	2	3	4



3. Your thoughts on making decisions

Instructions: Below are several statements relating to one's perspective on life and with having to make decisions. Please circle the number that is closest to how you feel about the statement.

		Strongly Agree	Agree	Disagree	Strongly Disagree
34.	I can pretty much determine what will happen in my life.	1	2	3	4
35.	People are only limited by what they think is possible.	1	2	3	4
36.	People have more power if they join together as a group.	1	2	3	4
37.	Getting angry about something never helps.	1	2	3	4
38.	I have a positive attitude toward myself.	1	2	3	4
39.	I am usually confident about the decisions I make.	1	2	3	4
40.	People have no right to get angry just because they don't like something.	1	2	3	4
41.	Most of the misfortunes in my life were due to bad luck.	1	2	3	4
42.	I see myself as a capable person.	1	2	3	4
43.	Making waves never gets you anywhere.	1	2	3	4
44.	People working together can have an effect on their community.	1	2	3	4
45.	I am often able to overcome barriers.	1	2	3	4
46.	I am generally optimistic about the future.	1	2	3	4
47.	When I make plans, I am almost certain to make them work.	1	2	3	4
48.	Getting angry about something is often the first step toward changing it.	1	2	3	4
49.	Usually I feel alone.	1	2	3	4
50.	Experts are in the best position to decide what people should do or learn.	1	2	3	4
51.	I am able to do things as well as most other people.	1	2	3	4
52.	I generally accomplish what I set out to do.	1	2	3	4
53.	People should try to live their lives the way they want to.	1	2	3	4
54.	You can't fight the local government.	1	2	3	4
55.	I feel powerless most of the time.	1	2	3	4
56.	When I am unsure about something, I usually go along with the rest of the group.	1	2	3	4
57.	I feel I am a person of worth, at least on an equal basis with others.	1	2	3	4
58.	People have the right to make their own decisions, even if they are bad ones.	1	2	3	4
59.	I feel I have a number of good qualities.	1	2	3	4
60.	Very often a problem can be solved by taking action.	1	2	3	4
61.	Working with others in my community can help to change things for the better.	1	2	3	4

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4. Your quality of life

This section has been included to identify if volunteering has any impact on a persons quality of life. To measure quality of life The World Health Organisation Quality of Life Measure is being used. It asks how you feel about your quality of life, health, & other areas of your life. Some of the questions are of a personal nature. Therefore I would like to remind you that your answers will be anonymous, strictly confidential and used only for the purpose of this study.

Please read each question and assess your feelings, for the last two weeks, and tick the box for each question that gives the best answer for you.

62. How would you rate your quality of life?

- (a) Very Poor
 (b) Poor
 (c) Neither Poor Nor Good
 (d) Good
 (e) Very Good

63. How satisfied are you with your health?

- (a) Very Dissatisfied
 (b) Fairly Dissatisfied
 (c) Neither Satisfied nor dissatisfied
 (d) Satisfied
 (e) Very Satisfied

The following questions ask about how much you have experienced certain things in the last two weeks. Please circle the number on the scale for each question that gives the best answer for you.

		Not At All	A Small Amount	A Moderate Amount	A Great Deal	An Extreme amount
64.	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
65.	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
66.	How much do you enjoy life?	1	2	3	4	5
67.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not At All	Slightly	Moderately	Very	Extremely
68.	How well are you able to concentrate?	1	2	3	4	5
69.	How safe do you feel in your daily life?	1	2	3	4	5
70.	How healthy is your physical environment?	1	2	3	4	5

		Not At All	Slightly	Somewhat	To A Great Extent	Completely
71.	Do you have enough energy for every day life?	1	2	3	4	5
72.	Are you able to accept your bodily appearance?	1	2	3	4	5
73.	Have you enough money to meet your needs?	1	2	3	4	5
74.	How available to you is the information you need in your daily life?	1	2	3	4	5
75.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Not At All	Slightly	Moderately	Very	Extremely
76.	How well are you able to get around physically?	1	2	3	4	5

The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks.

		Very Dissatisfied	Fairly Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
77.	How satisfied are you with your sleep?	1	2	3	4	5
78.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
79.	How satisfied are you with your capacity for work?	1	2	3	4	5
80.	How satisfied are you with yourself?	1	2	3	4	5
81.	How satisfied are you with your personal relationships?	1	2	3	4	5
82.	How satisfied are you with your sex life?	1	2	3	4	5
83.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
84.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
85.	How satisfied are you with your access to health services?	1	2	3	4	5
86.	How satisfied are you with your transport?	1	2	3	4	5

		Never	Infrequently	Sometimes	Frequently	Always
87.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Source: WORLD HEALTH ORGANISATION (WHOQoL-BREF Australian Version: May 2000).





88. Are you

- (a) Male (b) Female

89. How old were you on your last birthday?

_____ years

90. What is your current living situation?

- (a) Alone
 (b) With family (e.g. parents, siblings)
 (c) With relatives (e.g. uncles, cousins etc)
 (d) With spouse / partner
 (e) With spouse / partner and children
 (f) With friends / flatmate
 (g) Supported Accommodation
 (h) Other _____

91. Have you been diagnosed with a mental illness?

- (a) Yes
 └───────────────────> (Go to q. 21)
 (b) No
 └───────────────────> (Go to q. 22)

92. What is this illness? (optional)

93. What is the highest education level you have completed?

- (a) Primary School
 (b) Year 10
 (c) Year 12
 (d) Certificate / Diploma
 (e) Degree or above
 (f) Other _____

94. What is the gross income that you usually receive each fortnight from all sources?

- (a) No income
 (b) \$1 - \$199 (\$1 - \$5199 per yr)
 (c) \$200 - \$399 (\$5200 - \$10399 per yr)
 (d) \$400 - \$599 (\$10400 - \$15599 per yr)
 (e) \$600 - \$1000 (\$15600 - \$25999 per yr)
 (f) \$1000 - \$1499 (\$26000 - \$39000 per yr)
 (g) \$1500 or more (\$39000 per yr or more)

95. What is the main source of this income? (e.g. wages, disability support pension)



Thank you for taking the time to complete this survey. Your help has been most appreciated.

**Appendix H: Permission to use The
Empowerment Scale and The Australian
WHOQOL-BREF**

Boston University
Center for Psychiatric Rehabilitation

Sargent College of Health and Rehabilitation Sciences
940 Commonwealth Avenue West
Boston, Massachusetts 02215
617-353-3549
Fax: 617-353-7700
TDD: 617-353-7701
www.bu.edu/cpr



March 22, 2005

Janelle Young
School of Occupational Therapy
Curtin University of Technology
GPO Box U1987
Perth, Western Australia 6845


Dear Ms. Young:

Enclosed you will find a copy of the Empowerment Scale, directions for use, the article that appeared in *Psychiatric Services*, and a summary of information obtained on the Empowerment Scale from the Crisis Hostel Project in New York State (this study provided additional information about the measure's stability over time and its ability to discriminate between the treatment and control groups). You have permission to use the scale, but I would like to ask that, if you administer it to a large number of people, you share the data (computer-entered) with us, so that we may do further psychometric testing.

Please be aware that the Empowerment Scale is a newly developed research instrument. Its most appropriate use at this time is to assess empowerment among groups of individuals, as opposed to an individual-level clinical tool. In addition, this scale was developed and normed on adults and may not be appropriate for children.

Please contact me if you have further questions.

Thank you.


E. Sally Rogers, Sc.D.
Director of Research

From	▶ Graeme Hawthorne <graemeeh@unimelb.edu.au>
Sent	Thursday, March 10, 2005 11:34 pm
To	Janelle Young <janelle.lauga@student.curtin.edu.au>
Cc	
Bcc	
Subject	Re: Registration for Australian WHOQOL-Bref

Hi Janelle -

Please accept my apologies for the delay in responding to your email, but I have been workin interstate and am now playing catchup with my emails.

Thank you for the registration for your project for the WHOQOL-Bref. This project has now been registered with the Australian WHOQOL Field Centre; your registration number is 2005/90.

You can find more details about the WHOQOL family of instruments at the Australian WHOQOL Field Centre website

(<http://www.acpmh.unimelb.edu.au/whoqol/default.html>).

Registration also entitles you to additional WHOQOL technical support; including access to the WHOQOL manual; advice on data entry and maintenance; imputing missing data; the WHOQOL scoring algorithms; and assistance with interpretation of WHOQOL data including population norms.

Should you require any further assistance please feel free to email at your convenience.

Cheers -

Graeme

At 01:00 PM 26/01/2005, you wrote:

Hi,

Attached is my registration to gain permission to use this assessment for a research project that I am organising. The project is investigating volunteer work participation by mental health consumers. Thank you for your assistance with this assessment tool.

Janelle Young

Ph: (08) 9266 3611 (Monday to Thursday office hours)
or 0421 089 078.

A/Professor Graeme Hawthorne

Principal Research Fellow

Australian Centre for Posttraumatic Mental Health

Department of Psychiatry

The University of Melbourne

Email: graemeeh@unimelb.edu.au

Appendix I: Post-Hoc Power Calculations Related to Primary Research Objective 3

Post-Hoc Power Calculations for the Independent Groups T-tests conducted between the Volunteering Group and the Non-Volunteering Group

Variable	Effect Size	Power Level
Empowerment	0.24	<0.17
Activism	0.55	0.32
Anger	0.17	<0.17
Power	0.50	0.29
Esteem	0.27	<0.17
Control	0.05	<0.17
Psychological Health	0.85	0.63
Physical Health	0.44	0.22
Social Relationships	0.82	0.60
Environment	0.75	0.54
Age	1.01	0.77

**Appendix J: Letter Sent to Phase Three
Participants Advising them of the Research
Outcomes**

1st October, 2007

Dear

Thank you for participating in this research project investigating mental health consumer involvement in volunteer work. The study has now been completed and I would like to share the major results and recommendations with you.

This study has shown that volunteering is beneficial to the quality of life and recovery process for consumers. Volunteering was shown to be an activity considered meaningful by consumers, a way for them to become involved in their local communities, meet friends, and learn work skills.

This research project is therefore recommending the inclusion of programs that support consumers to become volunteers within mental health services. Participants of this research project identified a number of barriers to consumers becoming volunteers. These included stigma, cost, having to quit volunteering due to periods of ill mental health, and lack of structure within some volunteering roles. This project is therefore recommending that mental health services adopt procedures for supporting consumer volunteering, such as assisting them to find suitable volunteer work, but also maintaining contact with them to ensure they receive proper orientation and are able to settle in and enjoy the volunteering role.

If you would like to discuss the findings of this research project further or receive more information, please contact the Centre for Research into Disability and Society on (08) 9266 4651 or email janelle.young@postgrad.curtin.edu.au .

Yours sincerely,

Janelle Young (Primary Researcher)