
# Working with Volunteers who are Mentally Ill

by John D. Weaver,
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*AN UNTAPPED RESOURCE:*

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# PREFACE

What do these famous individuals have in common?

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|---|---|
| Sir Winston Churchill | Abraham Lincoln |
| Gustav Mahler | Sylvia Plath |
| Anne Sexton | Mark Twain |
| Jackson Pollock | Virginia Woolf |
| Ernest Hemingway | Peter Ilyich Tchaikovsky |
| Michelangelo | Ezra Pound |
| George Frideric Handel | |

Creativity, intelligence, productivity, and a history of mental illness; all suffered problems with depression and mood disorders. In fact, 1 in every 6-7 Americans (15% of our Nation's population) has a diagnosable form of mental illness at any given time. It does not matter whether the people are rich or poor, Black or White, young or old; 15% of the population is mentally ill.

Why is mental illness an issue of concern for volunteer coordinators? There are two main reasons:

1. Given the high percentage noted above, many of the persons you are currently serving are mentally ill (you just may not always realize it); and, more importantly,
2. Persons with mental illness represent a vast, untapped resource of quality volunteer talent.

Mental health professionals see much therapeutic value in volunteerism. Constructive activity plays a key role in the rehabilitation process for persons with many types of mental illness. For some, volunteer work is a step toward gainful employment, allowing people to come off welfare and/or disability rolls and become tax payers rather than tax funded assistance recipients. For others who may never be able to hold regular jobs, the chance to do volunteer assignments simply is a way to improve their overall quality of life. Either way, the trend is for more mentally ill persons to be seeking placements.

As a result of this trend, and somewhat fearful of the individuals that were being referred for volunteer placements (due to the stigma associated with mental illness), volunteer coordinators sought help in understanding the motivation and needs of this special target population. A brief training session, providing both **general information** and **specific interviewing techniques** ( the "**Controlled Interview Process**"), lessened their initial fears and improved their ability to serve this client group, thus allowing mentally ill persons greater access to volunteer opportunities. This book will review the various elements of this highly successful program.

# BACKGROUND

Mental health professionals are increasingly looking toward volunteerism as a way to increase socialization and offer vocational rehabilitation opportunities for their patients. Kees (1982) gives one example of a program which served 385 individuals over a five year period. The clients stayed in their volunteer placements an average of nine months, working an average of 15 hours per week. Although twelve percent dropped out after their initial placement interview, ten percent went on to obtain competitive employment.

While treatment professionals, rehabilitation counsellors, advocates, and the patients themselves support this trend toward volunteerism as rehabilitation, it seems to be less well received by volunteer directors. Unfamiliar with mental illness or its treatment, local volunteer coordinators reported serious misgivings and were reacting with fear when having to deal with this population. Unfortunately, part of the stigma of mental illness is the errant belief that mentally ill persons are more prone to violence than the rest of the general population.

The Volunteer Center of the United Way (VCUW) and the Society of Volunteer Administrators jointly sought mental health consultation to address the special needs of the mentally ill. While concerned about their own safety, other risk management issues needed to be addressed (e.g. liability issues should the volunteers jeopardize the welfare of staff and fellow volunteers at the agencies where they would be placed). Also, volunteer administrators feared their overall mission to provide agencies with responsible,

hardworking, and dedicated individuals might be somehow compromised if they placed individuals who, because of their illnesses, could not handle their assignments.

Key elements of the resulting training program were:

A Brief Overview of Warning Signs of Mental Illness, with general information to help identify persons who may be functioning poorly as a result of their conditions;

A Review of Potentially Fear Inducing Situations, with hints on how to handle any exceptionally disturbed persons they might encounter, with a look toward an office-wide approach to quality assurance and risk management for any crisis situation; and,

A "Controlled Interview" Process, designed to help the coordinators gather the kind of information that would maximize the potential for successful volunteer placements. At the same time, the process allows the potential volunteers to learn more about the nature of the work they are seeking and remove themselves from consideration for placement, should they judge themselves not to be able to handle their assignments.

The following pages will describe all of this information in detail. Included are several checklists designed to aid readers' efforts to replicate this successful program in their own communities.

# WARNING SIGNS OF MENTAL ILLNESS

Current estimates are that one person in every six to seven (15 percent of the population) in America is suffering with a diagnosable form of mental illness at any given time. The problems touch persons of both sexes, and persons of all ages, races, and levels of income. Some folks will readily talk about their illness, but others will try to keep it a closely guarded secret.

These are the most common warning signs:

1. prolonged feelings of anxiety and/or despair;
2. inability to concentrate and/or to make decisions;
3. changes in habits (e.g. eating, sleeping, or sexual activity);
4. changes in personality (e.g. a quiet, shy, cautious person begins to live dangerously);
5. loss of self-esteem (e.g. feelings of extreme guilt after an arrest or the loss of one's job);
6. withdrawal from others/social isolation;
7. symptoms of disordered thought processes:
   - -- undo suspiciousness of others;
   - -- believe people are talking about, laughing at, or trying to somehow control him/her;
   - -- hears voices and/or sees things;
   - -- believes TV, radio and/or print media are addressing him/her;

-- e.s.p. or telepathy;
-- grandiosity;
-- religious preoccupation;

8. misdirected anger and/or desire for revenge;
9. extreme dependency;
10. exaggerated fears;
11. physical problems without any organic cause;
12. mood swings;
13. performance is not up to par;
14. compulsions/rituals (e.g. too frequent hand washing);
15. thoughts of harming self or others (includes overt acts and/or statements as well as covert moves, e.g. getting one's affairs in order as though preparing for death).

While reading this list, some may think "I do that!" or "I have this!" Do not worry. It is normal to experience some of these things from time to time. Problems arise when you have several, serious ones and/or when the ones you have are interfering with activities of daily living (e.g. cannot handle responsibilities at home or at work). In addition to these general warning signs, a number of other, more specific clues to aid in screening persons with mental illness are covered in the next section.

**SPECIAL NOTE**: These **Warning Signs of Mental Illness** also appear as **Checklist 1**, in the **Quick Reference** section at the end of the book.

# CLUES
## (To aid recognition of mentally ill persons)

1. body language/initial observations - persons may:
   - -- be anxious;
   - -- laugh inappropriately;
   - -- give little eye contact;
   - -- speak too rapidly or too slowly;
   - -- be sloppy and/or dirty (or appearance may vary greatly from visit to visit);
   - -- not respect personal space/distance;
   - -- display strange movements (tics or stereotypic motions), some of which are secondary to prescribed medications;
   - -- experience mood swings (or mood may stay up/down); and/or
   - -- show mood not matching verbal messages (e.g. denies anger but appears very agitated).

   A Note of Caution: Body language clues may be deceptive, especially in dealing with persons from a different cultural, racial, or ethnic background than your own. This is especially true for factors such as eye contact, speech pattern, and personal space/distance.
2. thought processes - persons may:
   - -- be confused and/or seem to ask too many questions;
   - -- be disoriented to time, place, and/or persons;
   - -- report hearing/seeing things which are not perceived by others;

-- be overly suspicious;
-- talk a lot but say little that makes sense;
-- make very loose associations from one thought to another;
-- brag a lot and exhibit grandiosity;
-- be preoccupied with religion or with themes of good vs. evil (e.g. some will believe they are biblical characters); and/or
-- display magical thinking.

3. educational history - may have been interrupted (e.g. dropped out of school/college or frequently transferred) or names and/or types of school will indicate that it was some type of special education facility.
4. employment history - may be unemployed, underemployed, "self employed" ( and the nature of the business is itself a clue), too frequently unemployed, or on disability.
5. life stresses - has often experienced many stressful events and may want to tell you all about it in great detail, often pouring out an entire life history (including mental health treatment) with little or no prompting from the interviewer; family history is often chaotic.
6. aspirations - often wants to be in a counsellor/therapist role or serve as a hotline worker.
7. motivations - may be:
   -- "other-directed" - referred by a counsellor, case manager, or the court system for therapeutic reasons; or
   -- "inner-directed" - desiring chance to help others and, in the process, improve self-esteem and/or resolve own issues (e.g. rape or substance abuse).

8. prejudices - may offer negative comments about prior treatment or more general gripes about psychiatrists, hospitals, etc. or may make outspokenly negative comments about family, former employers, etc. (responses which are too easily triggered by routine conversation and which most people would normally suppress).

9. identifications - may make comments indicating a desire to be just like "_____" (someone who's name or position will yield information indicating things may be amiss).

10. medications - asking what medications a person takes, has ever taken, and/or to which one may be allergic, triggers all kinds of valuable information and often yields a good idea as to the person's diagnosis (see Table 1). Also, be alert for common side effects of some medications (e.g. stiffness, tongue movements, pill rolling motions with the hands, dry mouth, etc.) which patients often refer to as "allergic reactions".

A Note of Caution: many of the medications used in psychiatry have other medical uses. Be careful not to draw too many conclusions from a person's medication(s) without other supporting evidence.

**SPECIAL NOTE:** These **Clues to Aid Recognition. . .** also appear as **Checklist 2** in the **Quick Reference** section at the end of the book.

## Table 1
## COMMONLY PRESCRIBED PSYCHIATRIC MEDICATIONS

ANTIANXIETY AGENTS
atarax (hydroxyzine)
ativan (lorazepam)
buspar (buspirone)
centrax (prazepam)
equanil (meprobamate)
librium (chlordiazepoxide)
miltown (meprobamate)
paxipam (halazepam)
serax (oxazepam)
tranxene (clorazepate)
valium (diazepam)
vistaril (hydroxyzine)
xanax (alprazolam)

ANTIMANIC AGENTS
cibalith-s (lithium)
eskalith (lithium)
lithane (lithium)
lithium
lithobid

ANTIPSYCHOTICS
clozaril (clozapine)
compazine (prochlorperazine)
haldol (haloperidol) *
loxitane (loxapine)
mellaril (thioridazine)
moban (molindone hcl)
navane (thiothixene)
orap (pimozide)
permitial (fluphenazine)
prolixin (fluphenazine) *
serentil (mesoridazine)
stelazine (trifluoperazine)
taractan (chlorporthixene)

ANTIPSYCHOTICS continued
thorazine (chlorpromazine)
trilafon (perphenazine)
verprin (thiflouprornazine)

ANTISPASMODICS/
ANTICHOLINERGICS
akineton (biperiden)
artane (trihexypenidyl)
benadryl (diphenhydramine) ***
cogentin (benztropine)
inderal (propranolol)
symmetrel (amantadine)

ANTIDEPRESSANTS
adapin (doxepin)
ascendin (amoxapine)
aventyl (nortriptyline)
desyrel (trazodone)
elavil (amitriptyline)
endep (amitriptyline)
etrafon ( perphenazine&
amitriptyline)
limbitrol (chlordiazepoxide & amitriptyline)
ludiomil (maprotiline hcl)
marplan (isocarboxazid)
nardil (phenelzine)
norpramin (desipramine)
pamelor (nortriptyline)
parnate (tranylcypromine)
prozac (fluoxetine hcl)
sinequan (doxepin)
surmontil (trimipramine)
tofranil (imipramine)
triavil (perphenazine & amitriptyline)

ANTIDEPRESSANTS continued
vivactil (protriptyline)
wellbutrin (bupropion hcl)
zoloft (sertraline)

SEDATIVES/HYPNOTICS
butisol (butabarbital)
dalmane (flurazepam)
doral (quazepam)
halcion (triazolam)
mebaral (mephobarbital)
klonopin (clonazepam) **
nembutal (pentobarbital)
noludar (methyprylon)
phenobarbital
placidyl (ethchlorvynol)
prosom (estazolam)
restoril (temazepam)
tegretol (carbamazepine)
valmid (ethinamate)

C.N.S. STIMULANTS
cylert (pemoline)
dexedrine (dextroamphetamine sulfate)
ritalin (methylphenidate hcl)

MISCELLANEOUS
antabuse--a drug which helps alcholics avoid drinking alcohol
methadone-- a drug which replaces heroin for heroin addicts
anafranil (clomipramine hcl) antiobsessional drug of the antidepressant class.

* haldol and prolixin are available as long-acting, injectable medications as well as tablets
** also used to treat thought and affective disorders
*** also used as a sedative (and misc. other uses)

# WHAT ABOUT DIAGNOSTIC LABELS?

Sometimes you will learn patients' diagnoses, either from the clients themselves or from the professionals who are treating them. Other times you will not know what they have been diagnosed. Not knowing the label is just as well because professionals often disagree on diagnosis and, even when it is known, it will not be of much help to you unless you have had formal mental health training or experience. Also, people with relatively minor illnesses can sometimes be harder to work with than folks with major disorders such as schizophrenia.

The main things you need to know are any "functional limitations" the person may have. These are things such as:

-- should not work around machinery, because of sedating medication;

-- has had trouble holding jobs and needs to be placed in a low stress environment; and/or,

-- is fearful in group settings and would perform best where he/she can perform simple tasks (e.g. stuff envelopes) alone or with only one or two other persons.

Getting a clear picture of the client from this perspective is of far more practical use than knowing the diagnosis. Generally, it is also easier to get information about functional limitations from treating professionals than it is to get the diagnostic labels and/or other types of more specific social history or background information.

# FEAR INDUCING BEHAVIORS

**The vast majority of persons with mental illness are not at all dangerous in any way!** At most, 1 in 1000 patients cause the problems which yield bad press and fuel the stigma of mental illness. In cases where there is a violent act, the aggressive behavior is usually directed inward (acts of self mutilation and suicide). If anyone else is threatened or harmed, it is often someone seen as a controlling, authority figure (e.g. a parent).

Because of the stigma and the frequent sensationalistic press accounts of incidents which are attributed to persons diagnosed as being mentally ill, people generally react with considerable fear when confronted with an obviously mentally ill individual, known or unknown, especially if he or she seems to be in a state of decompensation. If any of these elements are present in an interview, they may trigger and/or heighten a fear response:

1. a surprise walk-in by an unknown person (or by a known person who does not seem to be himself/herself);
2. loud, rapid, and/or pressured speech, glassy eyes, and indications the individual is under the influence of drugs/alcohol;
3. unkempt appearance/strange mode of dress;
4. confused thinking (either the client's or your own, as you begin fumbling for an appropriate next move);
5. impatience - the intruder may want immediate action and/or gratification;
6. violations of personal space (someone gets too close for

comfort);

7. learning the client you are interviewing has a history of incarceration in prison or involuntary psychiatric care;
8. discovering someone who needs treatment is no longer taking medication and/or keeping appointments;
9. knowing you are alone in the office (or knowing the only persons nearby are the kinds of folks who will panic and/or probably could not help very much if this client becomes violent); and,
10. somehow, at moments like this, memories of prior, similarly traumatic experiences are likely to be triggered and they will flash through your mind.

**INTERRUPTION OF ROUTINE + FEAR OF THE UNKNOWN = DISTRESS**
**DISTRESS → PANIC**

Whether or not these fear inducing factors lead to panic, they are usually so disruptive that they cause a loss of structure in the interview. Immobilized by his/her fear, the interviewer unwittingly yields control of the session to the client.

The interviewer's task is to recognize and break the cycle of fear before things get out of control. The "**Controlled Interview Process**" outlined next will help.

# CONTROLLED INTERVIEW PROCESS

1. Take your time and make all of your actions and comments somewhat slow and very deliberate (remember, violations of this first, simple concept will raise the client's level of anxiety and worsen the interview climate):
   -- be a **calm** role model;
   -- do not allow the client to make you blow your cool;
   -- and try not to raise your voice.
2. Be sure the client is attentive - you may need to repeat things several times, as the person may be having trouble focusing his/her attention and/or processing your information.
3. Before doing anything else, gather some basic demographic information (e.g. name, address, phone number, etc.). This simple task usually has a calming effect on everyone.
4. If you are blessed with a quick wit and a low-key, non-threatening sense of humor, use it to help break the tension of the moment. Be careful never to make a comment that might cause the client to think you are making fun of (or belittling) him/her. Instead, poke a little fun at yourself for something you said (or did, or need to do), etc. This will show your gentle, human frailty and will lessen any threat the client may feel from you. Yes, believe it or not, he/she is probably more anxious about this than you are - many times you're just too scared to notice it.

5. Unless you are very comfortable with the person and the overall situation, do not accept pushy, demanding walk-ins. Instead, firmly tell him/her you will schedule an appointment to return at a later time (when you will be more mentally prepared and/or security will be better).

6. Explore motivation by doing a history interview - it takes time but it really gives you a feel for the client's wants, needs and tolerances. It also allows ventilation, which will lower tension in the client.

   Special Note: This interview may result in discovering that the client would prefer immediate, paid employment and/or training over volunteer work. If so, referral to the Office of Vocational Rehabilitation, the Private Industry Council or back to the case manager, therapist, probation officer, etc., who sent the person to you in the first place, might be the best possible outcome.

7. Further test motivation by assigning one or two small tasks:
   -- having the person return for a scheduled appointment is one exceptionally good way to do this;
   -- others might include bringing in a resume, one or two written references, a therapist referral and/or functional limitations form (see Table 2 for an example), or making a list of the types of volunteer work he/she is interested in trying and why.

8. Get consent and release forms signed and gather background information from all of these: referral source; therapists; physicians; references; and any past or present employers.

If possible, and in addition to written information, try to phone some of these folks to get additional, "off-the-record" impressions.

9. Praise the desire to help others and work to find the most appropriate setting for the individual - the better you tailor the volunteer assignment, the more optimal the end result.
10. Explore the person's support system, uncover strengths, and use both to your advantage - this may include involving family members (e.g. get the whole family to share a volunteer assignment), friends, social workers, probation officers, treatment professionals, and/or representatives of various self-help and advocacy groups (e.g. Alliance for the Mentally Ill). Cooperation lessens confrontations with these folks.
11. When the position requested by an individual exceeds his/her grasp (e.g. someone who appears quite unstable wants to work on a suicide hotline), focus upon the needed education, skills and abilities, and then begin to work toward a small piece of that goal (e.g. suggest the person try being a peer counselor at a support group, drop-in-center, or shelter, where other staff and/or volunteers can observe and supervise the activity). Developing written job descriptions will make this easier.
12. Try not to say "**NO**" and never deceive the clients. Instead, take time to openly and honestly explain the rigorous nature of the work they are seeking; few people understand how difficult many volunteer assignments can be. Allow clients to remove themselves from the program

as they begin to realize the great commitment of time and degree of responsibility volunteering will require.

13. Never make statements you cannot substantiate or promises you cannot keep. "I don't know, but I'll try to find out" is a better response than one which will later turn out to be incorrect. Everyone can rather easily recall the statements made to us by others which caused us to experience feelings of disappointment and hurt.

14. Write reminder notes regarding these interviews. People tend to hear and remember what they like to (or want to) hear and disregard the rest. The best ways to avoid communication problems are to:

    -- have the client keep written reminders of all assigned tasks, and of all important names, dates, and times relating to his/her volunteer assignment or pre-screening process; and,

    -- keep summary notes of each visit in the client's file, so you can keep track of what was said by all parties, what tasks were assigned, client behavior, and what (if any) commitments you made to the individual; this way, should he/she drop out, you will be able to easily pick up the process if the person returns.

    -- notes in the client record should simply and factually describe the events which occurred. Be careful not to use words which document negative value judgements or opinions. A good rule of thumb is: **"Do not write anything you would not want to**

see in court."

15. If a placement plan fails but the client wants to try again, then try again, doing so with a structure in place to handle whatever rough spots occurred on the previous attempt.

Keep in mind that folks with mental illness (or any disability) want to be viewed first as people. They prefer not to have their primary identification be their illness (or their handicap). Also, be careful to treat others as you would like them to treat you--with courtesy and respect. Protecting the dignity of others is extremely important. By doing so, you will greatly enhance the quality of your interactions.

**SPECIAL NOTE:** A summary of the **Controlled Interview Process** also appears as **Checklist 3**, in the **Quick Reference** section at the end of the book.

## Table 2

United Way of the Greater Lehigh Valley
PO BOX 6478, Lehigh, PA 18001-6478

Client Name_____Birthdate_____

Would you consider this person appropriate for a volunteer position in the community at this time?

_____ Highly Appropriate
_____ Appropriate with limitations
_____ Not Appropriate

If you recommend with limitations, what are those limitations?

_____
_____
_____

Do you have any suggestions regarding appropriate volunteer work?

_____
_____
_____
_____

If necessary may this background information be shared with the agency to whom we refer?

_____ Yes
_____ No

Signature_____

Agency_____Date_____

# PLACEMENT OPTIONS

Ideally, a wide spectrum of placement agencies needs to be identified for special needs clients. These must range from simple, highly structured settings with lots of support and few, if any, deadlines (almost a sheltered employment model), to complex sites with routine levels of expectation and little supervision/support. Consumer and family run self-help groups, programs such as "Compeer" (adopt-a-patient), drop-in centers, soup kitchens, food pantries, and homeless shelters are usually relaxed settings where staff and other volunteers are already comfortable working with mentally ill persons.

The Community Support Program (CSP) model is catching on in the mental health field. This model calls for the establishment of a wide range of programs and services in every community, to support the seriously and persistently mentally ill individuals who reside there. Along with the CSP movement came a growing interest in consumer involvement in the design and ongoing management of both new and existing programs. Because of a growing need for consumers to serve on boards and committees, volunteer opportunities for mental health consumers are on the rise and this too will generate placement opportunities.

Generate a list of all the sites in which you have placed volunteers with special problems or needs. Also, keep in contact with volunteer coordinators who have worked well with this target group. As more and more sites have experienced success with this population, more and more opportunities will open up for others.

# CASE EXAMPLES

These brief case studies will help illustrate some of the possible outcomes when working with volunteers and using the various techniques which are outlined in this book.

* * *

The Director of Volunteers at a local hospital first encountered a man who wanted to volunteer at her facility. Something about him scared her so she referred him to VCUW. There, a VCUW staff member and this author interviewed him (together). He expressed interest in learning about medical technology as he volunteered. His preference was to work with an ambulance squad or hospital. We suggested two squads to try. He made those contacts and was turned down because he did not live in their areas (he lived in a large city with a paid emergency squad). By now, we'd gotten to know him pretty well.

With the passage of time he'd both proven his motivation to us and lowered his expectations. We referred him back to the original hospital and, at their request, he became a patient transporter. Follow-up calls indicate he successfully served in that capacity for several months before leaving the hospital on his own; we are unsure why he left. High turnover in that position is very common and the hospital was pleased with his performance for the time he was with them.

* * *

A VCUW staff member interviewed a woman seen as a walk-in. She did not give any history of mental health treatment but she

seemed rather strange in that she could not offer any eye contact whatsoever and showed other "clues" that she was mentally ill. Nevertheless, she seemed to be highly motivated.

After a routine interview and screening process, she was placed in a large nursing home in the role of patient transporter. The first follow-up call revealed that she'd "been promoted" to friendly visitor. After several months of follow-up, staff learned she had been working in positions which involved increased responsibility. She eventually left her volunteer assignment, on her own, for full time employment.

* * *

The psychiatric ward of a local hospital arranged a pass for one of its residents so he could begin to do volunteer work before they discharged him. He was placed in an assignment at a food bank, loading and unloading, sorting and packing food orders. He took to the work immediately and fit right in with others who volunteered there.

With that activity in place he was released from the hospital. He did quite well for about one year in an assignment that may have bored many other volunteers to death. Then his illness became worse and he again required inpatient treatment. Due to the cyclical nature of some forms of mental illness, even people who strictly follow their treatment regimen will sometimes experience a relapse.

Afterwards, his family reported that he had done better during that year of his adult life than he did during any other period. They also reported that he was most grateful for the positive volunteer experience he enjoyed during that time. He hopes to become well

enough to return to that job someday.

* * *

A female client, active with the local mental health clinic, came in with her boyfriend seeking to volunteer. With her consent, her caseworker shared background information and she was placed at Head Start. She did well there for six months but then became paranoid. She believed the children there were talking about her and mocking her about some facial hair. After talking with the volunteer director, she decided to leave the agency.

She calls VCUW occasionally about selecting another site in which to volunteer but, to date, she has not followed through with simple tasks to move toward that goal. Staff sense that she, herself, knows she is not yet at the point in her recovery to be able to tackle a new assignment; staff believe she is "checking in" to be sure she can return when she is ready.

* * *

As you can see in these examples, mentally ill persons can easily be productive volunteers. They (and the folks in their support system) will know their own strengths and weaknesses and be able to help tailor a successful assignment.

# A FEW WORDS ABOUT MENTAL HEALTH PROFESSIONALS

Mental health professionals (MHPs) come from many different disciplines including psychiatry, psychology, social work, nursing, vocational rehabilitation, education, and pastoral counselling. As with any profession, there are good MHPs to know and then there are the others.

The good ones to know are open and honest, both with their clients and with other community helpers (like volunteer coordinators) who are working in the client's interest. With proper consent, these MHPs will fill out functional limitation forms and/or talk with you in easily understood terms about the things which will help resolve screening and placement issues.

The others tend to see themselves as "experts" who must closely guard their secret work from those who are not similarly trained. No matter how hard you try, you will not get much help from these MHPs. Neither do their clients, because while the mainstream of the mental health field is moving to better educate all patients about their illnesses and treatments, and have them take an active role in decision making, these people still want the clients they treat to just blindly follow orders.

Things are changing for the better with this aspect of the mental health field. The majority of MHPs will understand your need for appropriate information about the prospective volunteer's functional limitations and will supply it to you as soon as they have their client's written consent. If you encounter resistance, make it

a task for the individual seeking placement (or for someone from his/her support system) to get after the MHP for whatever is needed.

There is one other bit of information about MHPs that will be of comfort to those who are still wary of mentally ill persons. MHPs must break confidentiality and notify anyone who is in imminent danger of being harmed by someone they are treating. They also must take all other appropriate steps to avoid having anyone be harmed. This stems from several famous court decisions and means police can be involved, mental health commitments can be sought, and so on, to further insure safety in those extremely rare cases when someone they are treating does represent a threat to self or others. Thus, most MHPs will very carefully consider any matter of dangerousness (in addition to the more routine matter of functional limitations) whenever they communicate with you.

# WHAT ELSE CAN BE DONE?

Those who want to do more, in order to further address quality assurance and risk management concerns, should consider taking these steps:

1. Review your process for handling all special needs clients--this may mean developing one from scratch. See **Checklist 4** on **Risk Management** for some help in getting started.
2. Reexamine (or develop) forms used for release of information and determination of functional limitations. See **Table 2** for a sample functional limitations form.
3. Rethink the safety of the office environment. Be sure others are nearby (and have been alerted) when any potentially troublesome interviews are scheduled. Try to place yourself in a seat near an exit from the office/interview room which you commonly use. Have emergency phone numbers handy.
4. Evaluate interview techniques to see what worked and what needs work. Were you scared? Effective? Caring? When possible, get feedback from colleagues by using group supervision for this review. Ask the clients how you are doing.
5. Track volunteers who have been placed at set intervals following placement (e.g. one week, one month, three months, etc.). The volunteers and the agencies will enjoy the attention and support and it will generate new contacts.

6. Consider using peer supports for special needs clients. Sponsor a buddy system or offer them a mentor at the same volunteer work site.
7. Work with those who are referral sources for volunteer resources to cultivate personal, trusting linkages. This may include hospitals, clinics, private practitioners, social service and vocational rehabilitation agencies, clergy, etc.
8. Be honest with yourself about your own strengths and needs and the limitations of your agency. If things are tough, involve others with mental health expertise. Consider hiring a consultant or, better yet, get one to volunteer.

**SPECIAL NOTE: Checklist 4** in the **Quick Reference** section at the end of the book summarizes several issues which relate to **Risk Management**.

# Summary

Given the high incidence of mental illness, there is an excellent chance that every volunteer coordinator is already handling mentally ill volunteers, even though he/she may not realize it or have procedures to formally address their needs. The controlled interview process was developed to address several issues, including:

- staff concerns about risk management (personal safety, as well as the welfare of other staff, clients, and volunteers);
- client's desires to expand their horizons by volunteering (persons suffering with mental illnesses need to have positive, success oriented experiences such as those which will occur in the context of a well planned volunteer assignment-one geared to individual needs, strengths, desires, and abilities);
- treating professionals' therapeutic goal of seeing their clients succeed at volunteer work because this activity will enhance self-esteem (and may even lead to regular employment); and,
- agency needs for capable volunteers, who are responsible, motivated, hard working, and dedicated individuals, who will add to their settings rather than become an additional burden.

With the stigma that surrounds the mentally ill, agencies may fear all types of disruption and irresponsibility. While it is true that if persons are poorly screened and/or improperly placed, there is an increased likelihood that problems will occur, rejection of mentally ill volunteers is not the answer.

Instead, volunteer coordinators must learn to do careful screening

to examine the qualifications, skills, and abilities needed to perform existing volunteer assignments. For those having goals which seem to exceed their current capabilities, sppropriate alternative placements need to be developed. This process will help strike a balance among all of the potentially competing interests, so that there can be a positive outcome from everyone's point of view.

* * *

This material was originally presented on June 18, 1991, in Nashville, at "Addressing Tomorrow's Problems Today," the 1991 Annual Conference of The National VOLUNTEER Center.

# Quick Reference Checklist 1
# WARNING SIGNS OF MENTAL ILLNESS

These are the most common warning signs:

_____ 1. prolonged feelings of anxiety and/or despair;
_____ 2. inability to concentrate and/or to make decisions;
_____ 3. changes in habits (e.g. eating, sleeping, or sexual activity);
_____ 4. changes in personality (e.g. a quiet, shy, cautious person begins to live dangerously);
_____ 5. loss of self-esteem (e.g. feelings of extreme guilt after an arrest or the loss of one's job);
_____ 6. withdrawal from others/social isolation;
_____ 7. symptoms of disordered thought processes:
  _____ undo suspiciousness of others;
  _____ believes people are talking about, laughing at, or trying to somehow control him/her;
  _____ hears voices and/or sees things;
  _____ believes TV, radio, and/or print media are addressing him/her;
  _____ e.s.p. or telepathy;
  _____ grandiosity;
  _____ religious preoccupation;
_____ 8. misdirected anger and/or desire for revenge;
_____ 9. extreme dependency;
_____ 10. exaggerated fears;
_____ 11. physical problems without any organic cause;
_____ 12. mood swings;
_____ 13. performance is not up to par;
_____ 14. compulsions/rituals (e.g. too frequent hand washing);
_____ 15. thoughts of harming self or others (includes overt acts and/or statements as well as covert moves, e.g. getting one's affairs in order as though preparing for death).

While reading this list, some may think "I do that!" or "I have this!" Do not worry. It is normal to experience some of these things from time to time. Problems arise when you have several, serious ones and/or when the ones you have are interfering with activities of daily living (e.g. cannot handle responsibilities at home or at work.)

# Quick Reference Checklist 2
# CLUES: To Aid Recognition of Mentally Ill Persons

_____1. body language/initial observations--persons may:

- _____ be anxious;
- _____ laugh inappropriately;
- _____ give little eye contact;
- _____ speak too rapidly or too slowly;
- _____ be sloppy and/or dirty ( or appearance may vary greatly from visit to visit);
- _____ not respect personal space/distance;
- _____ display strange movements (tics or stereotypic motions), some of which are secondary to prescribed medications;
- _____ experience mood swings (or mood may stay up/down); and /or
- _____ show mood not matching verbal messages (e.g. denies anger but appears very agitated).

**A note of caution**: Body language clues may be deceptive, especially in dealing with persons from a different cultural, racial, or ethnic background than your own. This is especially true for factors such as eye contact, speech pattern, and personal space/distance.

_____2. thought processes--persons may:

- _____ be confused and/or seem to ask too many questions;
- _____ be disoriented to time, place, and/or person;
- _____ be overly suspicious;
- _____ talk a lot but say little that makes sense;
- _____ make very loose associations from one thought to another;
- _____ brag a lot and exhibit grandiosity;
- _____ be preoccupied with religion or with themes of good vs. evil (e.g. some will believe they are biblical characters); and/or
- _____ display magical thinking.

_____3. educational history--may have been interrupted (e.g. dropped out of school/college or frequently transferred) or names and/or types of school will indicate that it was some type of special education facility.

_____4. employment history--may be unemployed, underemployed, "self-employed" (and the nature of the business is itself a clue), too frequently employed, or on disability.

_____5. life stresses--has often experienced many stressful events and may want to tell you all about it in great detail, often pouring out an entire life history (including mental health treatment) with little or no prompting from the interviewer; family history is often chaotic.

_____6. aspirations--often wants to be in a counsellor or therapist role or serve as a hotline worker.

_____7. motivations--may be:

_____ "other directed"--referred by a counselor, case manager or the court system for therapeutic reasons; or

_____ "inner directed"--desiring chance to help others and in the process, improve self-esteem and/or further resolve own issues (e.g. rape or substance abuse).

_____8. prejudices--may offer negative comments about prior treatment or more general gripes about psychiatrists, hospitals, etc., or may make outspokenly negative comments about family, former employers, etc. (Responses which are too easily triggered by routine conversation and which most people would normally suppress).

_____9. identifications--may make comments indicating a desire to be just like "_____" (someone whose name or position will yield information indicating things may be amiss.)

_____10. medications--asking what medications a person takes, has ever taken, and/or to which one may be allergic, triggers all kinds of valuable information and often yields a good idea as to the person's diagnosis (see Table 1). Also, be alert for common side effects of some medications (e.g. stiffness, tongue movements, pill rolling motions with the hands, dry mouth, etc.) which patients often refer to as "allergic reactions."

# Quick Reference Checklist 3
# CONTROLLED INTERVIEW PROCESS

_____ 1. Take your time and make all of your actions and comments somewhat slow and very deliberate.

_____ 2. Be sure the client is attentive.

_____ 3. Gather some basic demographic information.

_____ 4. Use a bit of light humor.

_____ 5. Move the meeting to a scheduled appointment time.

_____ 6. Explore motivation by doing a history interview.

_____ 7. Test motivation by assigning one or two small tasks.

_____ 8. Get consent and release forms signed and gather background information (stressing functional limitations).

_____ 9. Praise the desire to help; tailor the assignment.

_____ 10. Explore and use the person's support system.

_____ 11. Help clients work toward lofty goals in small, realistic steps.

_____ 12. Try not to say "No" and never deceive the clients.

_____ 13. Never make statements you cannot substantiate or promises you cannot keep.

_____ 14. Write reminder notes regarding all interviews and keep a client file.

_____ Have the client keep notes too.

_____ Notes should simply and factually describe the events which occurred. Be careful-**Do not write anything you would not want to see in court.**

_____ 15. If a placement plan fails, try again, doing so with a structure in place to handle whatever rough spots occurred on the previous attempt.

# Quick Reference Checklist 4
# RISK MANAGEMENT

_____ 1. Periodically review the **Warning Signs, Clues, Fear Inducing Behaviors, and the Controlled Interview Process.**

_____ 2. Reexamine (or develop) forms used for release of information and determination of functional limitations.

_____ 3. Rethink the safety of the office environment.
- _____ Are others nearby (and alerted)?
- _____ Are you in a seat near an exit?
- _____ Are emergency phone numbers handy?

_____ 4. Evaluate interview techniques to see what worked and what needs work.
- _____ Were you scared?
- _____ Effective?
- _____ Caring?
- _____ One thing I need to improve is-_____
  _____.

_____ 5. Track volunteers who have been placed at set intervals following placement (e.g. one week, one month, three months, etc.)

_____ 6. Use peer supports for special needs clients.

_____ 7. Work with those who are referral sources for volunteer resources to cultivate personal, trusting linkages.

_____ 8. Be honest with yourself about your own strengths and needs (and the limitations of your agency). Consider hiring a consultant or, better yet, get one to volunteer.

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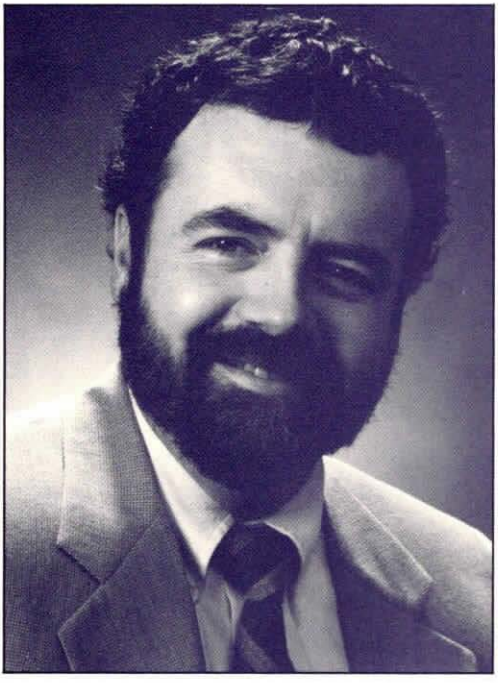

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