Volunteering in health and care in England

A summary of key literature

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Executive summary

At least 3 million people in England regularly volunteer within the health and social care sector, but little attempt has been made to calculate a global assessment of the value of their work.

Volunteers work broadly and diversely within a range of settings in health and social care. Individual volunteers may work in a single institution or across a number of services. Different forms of volunteering attract a very different constituency of volunteers, with innovative approaches such as time-banking challenging the traditional conception of volunteering and successfully reaching out to new groups in the population.

This literature review is the first component of an ongoing study of volunteering in health and social care which seeks to gain a greater understanding of the role, size, scope and value of volunteering, and to explore how the government's programme of health reform might impact on volunteering.

Research shows that individuals have a range of motivations for volunteering, both philanthropic and self-orientated, and several theoretical frameworks have been developed for understanding these motivations more deeply. The various decisions that a volunteer makes along their volunteering 'pathway' (including, ultimately, the decision to stop volunteering) are influenced by many factors, some of which are very personal, while others concern how their volunteering experience is structured by the professionals they work alongside.

We indentified evidence that a number of difficulties can lead to volunteers becoming de-motivated, including not being able to meet patient expectations, poor quality volunteering opportunities, and burnout. In some cases, there is evidence of tensions between health professionals and volunteers, for example, where there is a lack of clarity and understanding among professionals about the role of volunteers. Such factors may prevent the volunteer workforce from meeting its full potential.

A significant volume of research exists assessing the health and social benefits of volunteering. There is good evidence that volunteering can have a positive impact on

both the recipient and the volunteer themselves in terms of improved self-esteem, wellbeing and social engagement. The benefits for older volunteers have been particularly well researched – older volunteers appear to experience less depression, better cognitive functioning and improved mental wellbeing relative to those who do not volunteer.

What is harder to demonstrate definitively is that volunteers succeed in creating lasting improvements in the health status and clinical outcomes of those who receive their support. This question is complicated by the issue of whether volunteers substitute for, or complement, professionally-led care. The evidence suggests that in practice they do both, depending on the circumstances. The relative balance of the two – and the relative appropriateness – is a crucial debate.

From the perspective of health and social care organisations – and from a broader societal perspective – volunteering has the potential to play a number of important roles. These include creating services that are more responsive to local needs; engaging hard-to-reach communities more effectively; filling gaps in provision; helping service users to navigate the system; and even reducing the need for formal services. Though the exact scale of the potential benefits is unclear, these represent significant opportunities, particularly in the current economic climate.

National data sources indicate that volunteering is considerably less common in for-profit health and social care providers than in the public or voluntary sectors. This has important implications at a time of proposed market diversification in health care – something which will be the subject of further study in the subsequent stages of this research project.

A number of important questions remain to be answered as to how volunteers can work most effectively in health and social care, and also how better to quantify the value that they have. The subsequent stages of our research will help to add to the evidence by exploring several of the questions raised by this literature review, including through qualitative work with groups of volunteers, professionals and service users. Importantly, the research will set volunteering in the context of the Health and Social Care Act 2012 and related reforms, and explore what effect these might have on volunteering in future.

Introduction

This document presents a summary of findings from a literature review conducted as part of a wider research project funded by the Department of Health. The literature review will be refreshed throughout the project and therefore this should be treated as a live document, and its findings as interim conclusions only.

The literature review aimed to establish what is already known about volunteering. In particular, we are interested in evidence about:

- the **size and scope** of volunteering in the health and social care sector (including the **roles and settings** in which they operate) **[Part 1]**
- the **motivations** of people who volunteer, either for health and social care organisations or in other sectors (and the factors that support them to continue/ encourage them to stop volunteering) **[Part 2]**
- the **value** of volunteering – including value to volunteers themselves, patients or clients, providers and commissioners, and to the sector as a whole **[Part 3].**

The wider research project has two over-arching objectives:

- to gain a greater understanding of the role, size, scope and value of volunteering in the health and social care sector
- to understand how health reform, particularly the potential changes in the types of organisations involved in providing health and social care, will impact on volunteering.

Literature search methods

Search protocol

The following bibliographic databases were searched:

- Social care online
- PubMed
- The King's Fund library database.

These searches were supplemented with web searching, examining key reference lists and input from the advisory group for the project.

Paper inclusion criteria and paper selection

Search results covered research from 2007 onwards. Approximately 50 articles were selected for review, out of a list of more than 500 articles initially identified. These included:

- policy documents
- empirical studies
- evidence reviews
- think tank reports.

We excluded short journalistic articles and descriptions of case studies with no evaluative/analytical component from the initial search (but have supplemented our review with recommended descriptive pieces as suggested by the advisory group). We also excluded studies based in low-income countries on the basis of limited transferability.

Papers were then selected by title and abstract, based on relevance to our research questions.

Data extraction

Each paper was reviewed via completion of the following template:

- profile of the volunteer
- motivations for volunteering
- value:
  - to the individual/ patient
  - *to the organisation*
  - wider benefits
- volunteering role
- volunteering setting
- other information.

What do we mean by volunteering?

Defining 'volunteering' in health and social care is not without its challenges. People play active roles in other's health and social care in a number of ways, both paid and unpaid. For the purpose of this literature review, we consider only formal volunteering, which we take to mean **unpaid work that benefits others to whom one owes no obligation** (Gottlieb and Gillespie 2008) **via an organisation that supports volunteering in health and social care** (Egerton and Mullen 2008). This is therefore distinct from the informal volunteering activities like unpaid caring for those who are not relatives, but which takes place as private interactions in society (Egerton and Mullen 2008).

By excluding informal volunteering activities, however, we must recognise that there is a significant economic and social contribution that informal volunteering makes, which has been found to far exceed the economic contribution of formal volunteering activities (Egerton and Mullen 2008). Further, the social value that informal and formal volunteering brings might be different. One research study posits that informal volunteering 'bonds' social capital (ie, creates social groups within society), whereas formal volunteering tends to 'bridge' social capital (ie, creating societal social capital) (Egerton and Mullen 2008).

There are also a number of related concepts which describe new kinds of relationships between people/communities and local public services. We have focused our review on voluntary activities which are directed towards augmenting or improving other people's care rather than initiatives which are primarily about engaging people in shaping their own care. For example, on this basis we have not included the **Expert Patient's Programme** as an example of volunteering, whereas we have included **Community Health Champions**, and **time-banking**, in which members of a community contribute in various ways towards the health and wellbeing of their community according to their skills and abilities, and trade these services with those offered by others.

We do not focus on **health trainers** in this review on the basis that most health trainers are paid for their services rather than working on a voluntary basis.

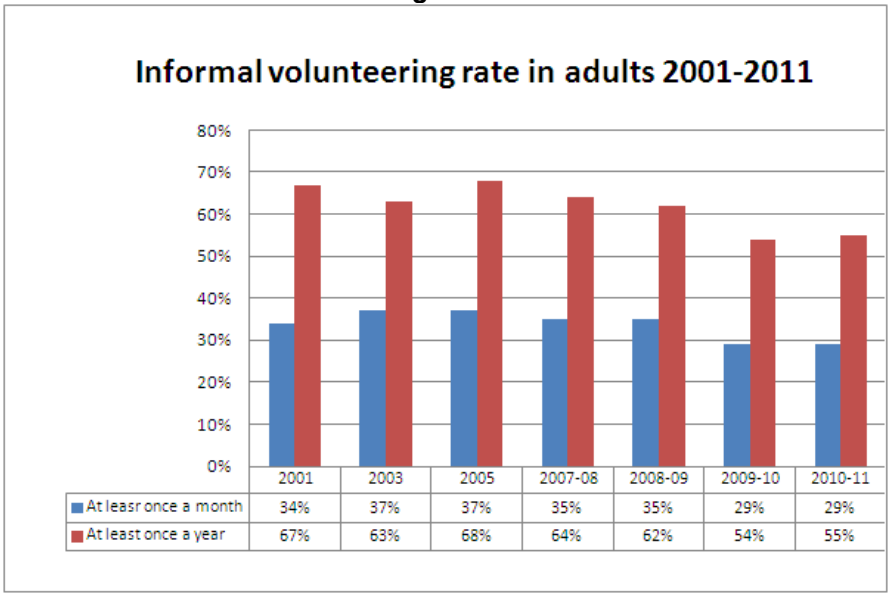
Part 1: The size and scope of volunteering

Who volunteers in health and social care?

There are unfortunately few reliable sources of long-term trends on volunteering in health and social care. The best available are the national citizenship surveys formerly undertaken every two years, but no longer done, by the Department for Communities and Local Government. These provide some information about health and social care volunteering in the broader context of volunteering trends.

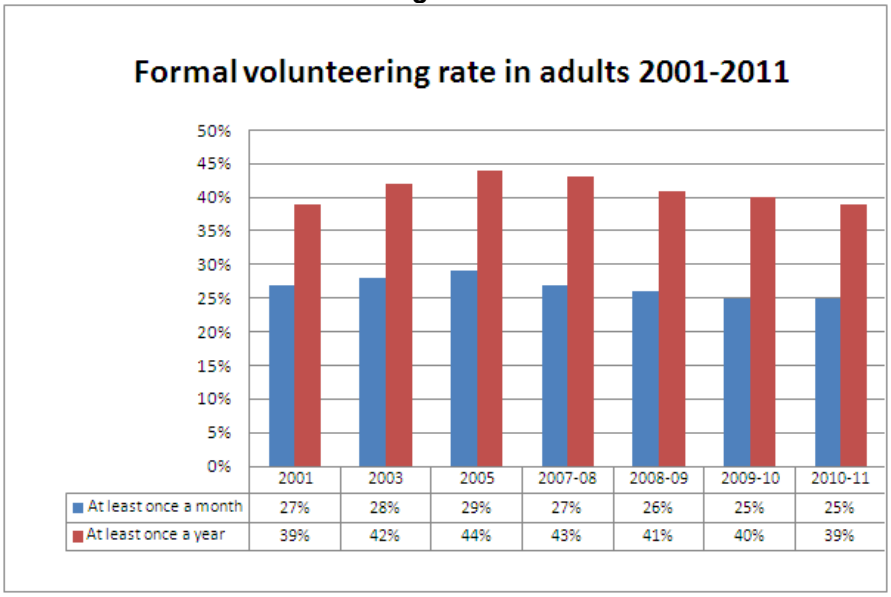
Volunteering can be broadly categorised into formal and informal volunteering, the former through the agency of organisations, the latter on an individual basis (see box above). The figures below show the best trend data there is on this overall level of volunteering in England from the National Citizenship Survey.

Figure 1



	2001	2003	2005	2007-08	2008-09	2009-10	2010-11
At leasr once a month	34%	37%	37%	35%	35%	29%	29%
At least once a year	67%	63%	68%	64%	62%	54%	55%

Figure 2



	2001	2003	2005	2007-08	2008-09	2009-10	2010-11
At least once a month	27%	28%	29%	27%	26%	25%	25%
At least once a year	39%	42%	44%	43%	41%	40%	39%

Source: Department for Communities and Local Government (2011)

This data shows that around one in four of the adult population are engaged in formal volunteering on a regular basis, with three in ten being informal regular volunteers. A further four in ten formally volunteer irregularly and 55 per cent informally do so. These trends are relatively stable over the last 10 years, although possibly suffering a slight decline.

The 2008/09 survey (Drever 2010) shows that there are differences by age, gender, ethnicity and socio-economic characteristics within these overall participation trends. Broadly, women were more likely to engage in all forms of volunteering compared with men; participation was higher for white groups compared to minority ethnic groups; younger people were less likely than older people to participate in regular volunteering but more likely to engage in irregular volunteering; those educated to degree level were more likely to be formal volunteers; volunteering was more common in the south of the country, with the exception of London which has the lowest rate of volunteering.

The health component of the Citizenship Surveys relates to the types of organisation helped by regular volunteers. In 2008/09, 27 per cent of regular formal volunteers were engaged in helping 'health, disability and social welfare organisations', 16 per cent were also engaged in helping 'the elderly'. The former includes those volunteering for the NHS or other health providers directly, through other organisations, or for health charities but not engaged directly with providers.

Given an English adult (16+) population of 43.2 million, of whom one in four are regular volunteers, around 27 per cent of them engage with 'health'. This equates to around 2.9 million regular volunteers in the sector as a whole, and around 1.9 million with 'the elderly', some of which is likely to be with social care providers. These are not mutually exclusive categories, so this does not imply there are as many as 4.8 million regular volunteers across health care and the elderly.

However, it is not possible to break these figures down further and distinguish just how and where volunteers interact with the health system from national sources. Greater specificity is available in the social care sector than in health, on the basis of a recent study analysing the 2010 National Minimum Dataset for Social Care (NMDSSC). However, the use of this dataset may need to be treated with some caution (see box below).

Volunteering in social care

A recent study (Hussein 2011) analyses the use that social care providers make of volunteers based on the 2010 National Minimum Dataset for Social Care. This provides information on more than 22,000 establishments – private, local authority-owned and voluntary – that provide social care services to adults and older people with social care needs, including information on use of volunteers. Hussein finds that:

Numbers and presence

- Volunteers represented approximately 1 per cent of the workforce.
- Just over 700 organisations indicated they had volunteers. They were more likely to be present in the voluntary sector (3.9 per cent) than either the private (0.2 per cent) or local authority (0.1 per cent) sectors.
- 87 per cent of volunteers were in the voluntary sector, which accounts for 22 per cent of the workforce as a whole. Medium sized organisations had higher numbers of volunteers than either small or large organisations.
- In organisations that have more than one volunteer, volunteers constitute nearly a quarter of the workforce.

Personal profiles of volunteers

- Almost nine in ten volunteers were of white ethnicity. They were more likely than

average to have a disability (13 per cent); one-third were male compared with a predominantly female social care workforce; median age was 48, with around a quarter over 65, and similar numbers under 30.

Setting, services and roles

- Almost half of the volunteers were in community care settings, followed by day care, residential care and finally domiciliary care. In terms of intensity, it is highest in day care, where they account for 6 per cent of the total workforce.
- More than half the volunteers focus on clients with needs that exclude dementia, learning disabilities and mental health needs. A third were involved with people with dementia and mental health needs.
- Volunteers had a wide variety of roles, the most common being care workers (22 per cent), other non-care providing job roles (18 per cent), community support and outreach (17 per cent) and administrative (9 per cent).
- Although fewer in absolute terms, volunteers provided a large proportion of the overall workforce on advice guidance and advocacy (24 per cent) and counselling (30 per cent).

Locations

- Volunteering was more common in the North-West, West Midlands, North-East and London, and least common in the South-East and East Midlands.
- It is more common in predominantly rural and predominantly urban areas, compared with mixed rural/urban areas.
- There is no clear relationship between deprivation levels and volunteering in social care. Neither is there a clear relationship with employment levels or local income levels.

In summary, Hussein's study suggests that volunteering is low in the social care sector as a whole, although it can be very important in the organisations in which it is present, particularly in relative terms in areas such as counselling and advice and support. It also seems that volunteers are much more likely to be present in voluntary providers compared with private sector or statutory providers.

While these estimates are certainly the most comprehensive to date they may be artificially low for several reasons. As Hussein states, this provides information on some but not all volunteers working in the long-term care sector. Completion of the NMDSSC is not compulsory, though there are incentives to take part; some organisations may not recognise volunteers as part of the workforce and therefore not report them as such; and almost 2,000 organisations did not return any information on volunteers.

However, the estimates also raise questions about the practical and philosophical barriers to greater uptake of volunteering in the social care sector. For instance, sometimes people are dissuaded from using volunteers because of some of the requirements of Criminal Records Bureau (CRB, now known as Disclosure and Barring Service (DBS)) and other checks and processes that have to be gone through in care settings. The low figure for private providers seems very low, but some volunteer organisations are known to have philosophical objections to working with organisations which make a profit.

While national data sources provide a limited picture of the profile of volunteers in health and social care, research studies provide some further detail. A number of studies confirm the typical profile described above, with several noting the significant volunteering contributions of older people in particular (Morrow-Howell 2010; Konrath *et al* 2012; Morrow-Howell *et al* 2009; Hussein 2011; Cook 2011; Egerton and Mullen 2008; Piliavin and Siegl 2007; Gottlieb and Gillespie 2008). Some studies have found a

correlation between age and the number of hours spent volunteering (Morrow-Howell 2010; Egerton and Mullen 2008).

However, other studies have shown that in some less traditional forms of volunteering, there is much greater diversity (Department of Health 2011). In a review of the impact of volunteering in health, it was found that the volunteers engaging in time-banking included people from highly marginalised communities, both young and old people, single parents, disabled people, people with learning disabilities or a history of mental health problems, and people from ethnic minority groups (Paylor 2011).

A number of studies considered the volunteering activities of those who may also be active service users themselves. These included people with mild to moderate dementia (George and Singer 2011), and mental health problems (Farrell and Bryant 2009). Other research has indicated that overall, disabled people are slightly less likely than the general population to volunteer (McMillan 2010).

There is some research that explores the positive personal attributes of volunteers in health and social care (MacPherson 2010). For example, one study suggested that those engaged in formal volunteering tend to have high human capital, meaning they possess strong social skills, self-confidence and reasonable level of educational attainment (Gottlieb and Gillespie 2008).

In short, the profile of the volunteer depends on the range of tasks and settings included in the term 'volunteering'. Different forms of volunteering attract a very different constituency of volunteers, with non-traditional forms of volunteering such as time-banking successfully reaching out to new groups in the population.

What are volunteers doing and where?

Volunteering roles

The literature review gave an indication of the variety and breadth of roles volunteers hold:

- participation in planning, consultation, advice and research in health (Paylor 2011)
- service delivery eg, delivery of a theoretically derived, structured behaviour change intervention (Buman *et al* 2011; Paylor 2011)
- signposting to existing services/ 'navigators' of the health system (Paylor 2011; Kennedy *et al* 2007; Cook 2011)
- supporting clients through lifestyle changes – giving people the skills to set their own behavioural goals; acting as a lifestyle coach, motivator, knowledge giver, practical demonstrator (Paylor 2011; Kennedy *et al* 2007; Cook 2011)
- counselling, (peer) support, advocacy and advice (including to families) (Akister *et al* 2011; Paylor 2011; Hussein 2011)
- respite care and support (Paylor 2011; Casiday *et al* 2008)
- accompaniment and befriending (Sevigny *et al* 2010; Paylor 2011)
- supporting families (Sevigny *et al* 2010)
- fundraising and administration (Sevigny *et al* 2010; Casiday *et al* 2008)

The most commonly cited volunteering activities included counselling, support, advocacy and advice. A number of papers bring to life the roles that volunteers in health and social care are filling, for example the recent report from Think Local Act Personal, *Volunteering: Unlocking the real wealth of people and communities* (Wilton 2012) provides a number of innovative examples of services working effectively with volunteers to deliver high quality care.

While it is useful to define volunteering by role and setting in order to understand the breadth and diversity of activities that volunteers are undertaking, it is important not to forget that within a volunteer's career or pathway, the role and setting in which they operate might change. For example, a volunteer who begins in a service delivery role may move into governance or service design, which adds a value that cannot be adequately captured unless a perspective is taken which acknowledges the dynamics of volunteering.

What settings are volunteers working in?

The most commonly cited settings for volunteer support were:

- hospices (mainly not-for-profit but also some for-profit) (Block *et al* 2010; Brodie *et al* 2011)
- community settings (Buman *et al* 2011; Paylor 2011; Department of Health 2011; Hussein 2011; Cook 2011)
- hospitals (Brodie *et al* 2011; Paylor 2011).

However, studies also mentioned the following arenas in which volunteers operate in health and social care roles:

- kindergartens/ primary schools (George and Singer 2011)
- home care – but occupy a 'fluctuating space' between formal and formal/ private and public settings (Sevigny *et al* 2010; Barnes *et al* 2009)
- children's services (Akister *et al* 2011)
- older people centres (Brodie *et al* 2011; Paylor 2011)
- mental health trusts (Paylor 2011)
- primary care (Paylor 2011)
- non-NHS premises (Kennedy *et al* 2007)
- online volunteering.

A useful distinction can be drawn between issue-based volunteering (eg, volunteering to increase lay understanding of cancer symptoms) versus institution-based volunteering (attached to a particular health/social care organisation) (Brodie *et al* 2011). Over the course of a volunteer's career, it is very possible that they will move between the two forms of volunteering.

In summary, volunteers work broadly and diversely within health and social care. Individual volunteers may work in a single setting or across a number of services in one particular role.

Part 2: What motivates, and demotivates, people to volunteer in health and social care?

Motivations for volunteering

Some research has distinguished between two distinct categories of motivation: self-orientated motivations such as learning, self-enhancement and self-protection; and other-orientated motivations eg, building social connectedness, altruistic values (Konrath *et al* 2011). Other research has suggested that volunteers with higher levels of educational attainment were likely to volunteer for self-orientated reasons, namely progressing into 'professional' public health roles, while those with lower levels of educational attainment were more likely to remain 'deep-rooted' in their communities. Older people were found to be more likely to volunteer for other-orientated reasons, whereas younger people and middle aged volunteers had more instrumental reasons for volunteering eg, getting work experience (Morrow-Howell 2010; Teasdale 2008). However, a comprehensive review of the literature into the impact of volunteering in health found that older people seek to remain active and socially engaged, which by the definition employed above would be classified as a self-orientated motivation (Casiday *et al* 2008). The reality is that the motivations for volunteering are likely to often combine elements of self-interest and altruism (Hardill and Baines 2007).

Role theory, social integration theory and activity theory are among the theoretical frameworks used to explain why people volunteer.

- **Role theory**: people volunteer to maintain a role as a productive individual in society.

- **Social integration theory**: people volunteer because multiple social roles provide meaning and purpose in life, promote social support and interactions and therefore contribute to feelings of wellbeing (Casiday *et al* 2008).

- **Activity theory**: assumes that activities provide a sense of purpose and control, higher personal energy, and an active stance in society (Ayalon 2008).

These theories can be applied most easily to the motivations for volunteering of older people. The literature that looked at the volunteering activities of older people suggested that because people are living longer, and are healthy into their retirement, there is an increasing amount of time for older people to engage in volunteering (Gottlieb and Gillespie 2008). Indeed, there is a body of literature that suggests it is in their interests to do so (see Part 3).

The volunteering pathway/career

The concept of the volunteer 'career' or 'pathway' is used in some literature. For example, there is research which examines the factors that influence the decision to start volunteering, the pathways taken through different volunteering activities, and exit from volunteering. One study suggested a number of factors that affect a person's choice to volunteer or not (Brodie *et al* 2011), including:

- personal preferences and qualities
- capacity to take action
- upbringing
- family and social connections
- the extent of opportunities to volunteer in a local area
- whether local groups and organisations have a culture and facilities that support and encourage participation

- perceptions of both participation (eg, politically driven), and participants (eg, are they 'do-gooders'?).

Some of these factors relate very much to the person themselves, while others are about the supply side ie, the organisations offering the volunteering, which is a distinction that runs throughout the course of a 'volunteer pathway'.

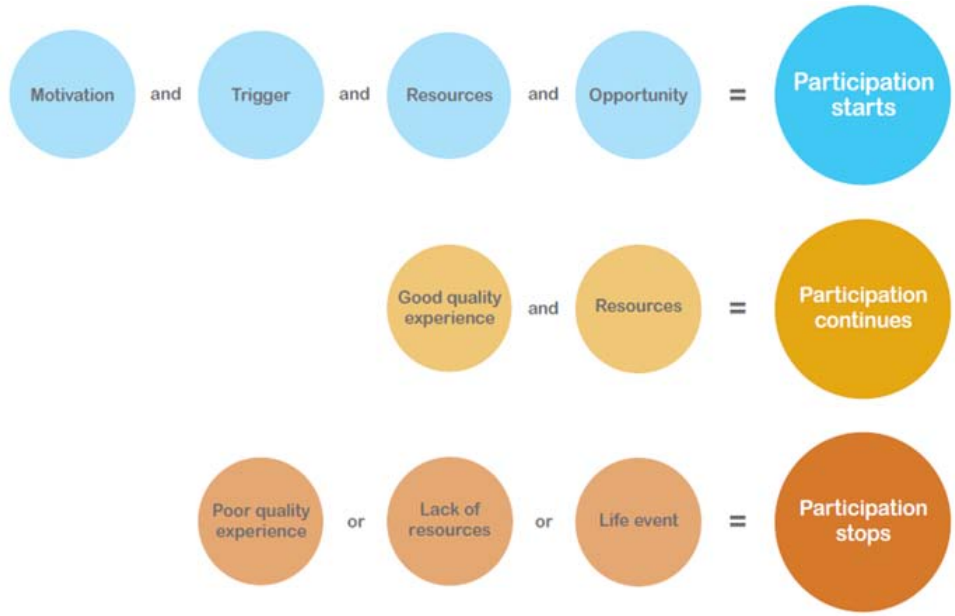
Research also considered the motivations keeping volunteers going, including the quality of the volunteering experience; whether the volunteer feels like they are making a difference and having impact; if the volunteer feels valued; if the volunteer is enjoying their experience; and the quality of their relationships with others while volunteering (Brodie *et al* 2011). These are likely to be affected by both individual and organisational factors (Morrow-Howell *et al* 2009).

A small number of studies describe factors that can discourage a volunteer from continuing with their volunteering activities, such as volunteers not being able to meet patient expectations; and organisations not being able to offer a quality volunteering experience (MacPherson 2010; McMillan 2010). Research has also pointed to the potential negative impacts on wellbeing when people are involved in multiple roles (creating so-called 'role strain' and impacting on their ability to cope), which may cause volunteers to burn out and stop volunteering (eg, Nazroo and Matthews 2012).

For some groups of volunteers, particular factors may be important. Research into why disabled people are less likely to volunteer suggested that lack of special equipment, inappropriate premises, the extra cost of travel and the need for support workers to provide assistance all inhibit disabled people from volunteering (McMillan 2010). Similarly, research into volunteering and social inclusion found that there are many practical and attitudinal barriers that exist for disabled volunteers, including negative attitudes. Unless these barriers are addressed, volunteering opportunities may fail to be socially inclusive for some marginalised groups (Farrell and Bryant 2009).

One paper (Brodie *et al* 2011) proposed the volunteering lifecycle could be conceptualised by the 'participation equation' below that outlines why participation starts, continues or stops (see Figure 3).

Figure 3 The 'participation equation'



Source: Brodie *et al* 2011.

Professional relationships and attitudinal barriers to volunteering

The literature reviewed contained only limited evidence about the level of professional engagement with volunteers. One study, in a mental health setting, found that not all paid staff were positive about volunteering programmes – some felt volunteers got in the way and even provided a poor service. Support for volunteering from paid staff was greatest when volunteers were current or former service users, but concerns emerged when volunteers were placed in administrative roles (in Teasdale 2008). Another research study noted that in long-term care, opportunities to benefit from volunteering may be constrained by regulations, if these stipulate that certain tasks are the responsibility of professional/paid staff (Hussein 2011).

Some research describes issues arising in relationships between volunteers, patients and staff. Issues with continuity and accessibility can exist where volunteers provide direct support to patients or service users on a one-to-one basis. For example, problems were identified with the administration of volunteers working on a longer term basis in patient's homes where patients and volunteers did not feel they could keep in touch with each other adequately because messages had to be passed through a third (professional) party (MacPherson 2010).

Research also noted that while volunteers traditionally play an essential role in palliative care, the nature and scope of their role can be unclear to patients and staff. Blurred boundaries between volunteers' and professionals' responsibilities can create tensions between professionals, families and volunteers (Sevigny *et al* 2010).

There appear to be both push and pull factors influencing an individual's decision to start, continue and stop volunteering. While some appear to be very personal factors, the literature reviewed also suggests that organisations can have a big part to play in recruiting and maintaining volunteers. They can also trigger an individual's exit from volunteering.

Some literature discusses the tensions that can exist in some cases between health professionals and volunteers, and suggests that there can be a lack of clarity and understanding among professionals about the purpose and role of volunteers in health and social care. This can have a significant impact on the volunteering 'pathway'.

Part 3: What value does volunteering have in health and social care?

In this section we distinguish between value accruing to the recipients of volunteering, to volunteers themselves, to health and social care organisations and to the wider community.

Value to recipients

Benefits to the recipients of volunteering (for example, patients or service users) include the following:

- increased self-esteem, improved disease management and acceptance, increased breastfeeding and better parenting skills, improved mental health, improved survival times for hospice patients, adoption of healthy behaviours, concordance with medical treatments, and improved relationships with health care professionals (Casiday *et al* 2008; Department of Health 2011)
- improved wellbeing (eg, Akister *et al* 2011)
- reduced social isolation, exclusion and loneliness (Sevigny *et al* 2010; Farrell and Bryant 2009; Ryan-Collins *et al* 2009)
- more effective changes to health-related behaviours via the use of lay volunteers, whose 'social affinity and unique ability' are of particular benefit, enhanced further when they are indigenous to the served communities (Kennedy 2010)
- higher quality of end of life care in hospices with more volunteer hours per patients (association remained after controlling for organisational/ programme characteristics) (Block *et al* 2010)
- service users reported a host of added values in volunteer services: expertise through experience, being seen as independent and outside the formal service structures, emotional support, availability, a sustained relationship, provision of respite care, and acting as a mediator between different family members (Weeks *et al* 2008)
- preventive support may also be better received, and achieve better outcomes for the patient, if it is from an informal source than a professional (in Barnes *et al* 2009)

There is some evidence that those with fewer personal and social resources may benefit the most from volunteers (Morrow-Howell 2010). However, a number of studies indicate that findings into whether some groups benefit more than others remain inconclusive (Morrow-Howell *et al* 2009).

Although the studies cited above provide evidence that volunteering activities are correlated with positive outcomes for recipients, attributing causality in these studies is not always straightforward due to the complex nature of the interventions studied. A further complicating factor in research of this kind is the difficulty of defining the counterfactual – ie, what service would be provided if volunteers were not present? The important issue here is the question of whether volunteers substitute for or complement professional support. This significant debate is discussed more in the box below.

Assessing the value of volunteering by asking recipients directly is not always possible as patients do not necessarily know they are seeing a volunteer as opposed to a professional. Some organisations also deem it inappropriate to survey patients about the value of volunteering (Teasdale 2008).

Do volunteers substitute for or complement professionals?

Volunteers can both substitute for and complement the work of health and social care professionals. Below we set out examples for both as suggested by the literature.

Examples of evidence for substitution

- A minority of service user volunteers interviewed in another study felt that they were being used as cheap labour, or providing services that paid staff should be doing to keep costs down (Teasdale 2008).

- Other research suggested that volunteers fill a gap left by the limited provision of formal support from local professionals on child rearing practice (MacPherson 2010).

Examples of evidence for complementing

- Another suggested that volunteers provide a valuable complement to professional support when families have few local family members, and the need for engaged social support is stronger (Barnes *et al* 2009).
- The literature in long-term care suggests that when volunteering takes place in organisational settings where professional staff are present, the voluntary role often augments the professional one, especially in providing companionship and information (Hussein 2011).

There are inconsistent definitions and uses of the terms 'complement' and 'substitute' across the literature and no clear consensus on whether the work of volunteers is mainly a substitute or a complement for paid labour. The first example provided for substitution provides a good example of the confusion between concepts. From one perspective, extending the reach of existing services could be seen as a complement to professional activities, since the volunteers are not doing the same thing as paid staff, but are instead completing similar roles with added value. On the other hand, 'extending the reach' implies that a professional could have fulfilled the function, and therefore represents substituting.

Value to the volunteer

There were a number of studies reviewed that concluded that volunteering had very positive health and wellbeing outcomes for those who undertook it, including a number that have attempted to control for confounding variables in order to assign causality.

- Older people who volunteer or still work, versus non-volunteering retirees, were found in a number of studies to experience less depression, better cognitive functioning, higher mental wellbeing and life satisfaction (Morrow-Howell 2010; Schwingel *et al* 2009; von Bonsdorff and Rantanen 2011; Morrow-Howell *et al* 2009; McMunn 2009; Nazroo and Matthews 2012).

- Volunteering, but not paid work or childcare, was also associated with less development of frailty in later life in cohort study after adjusting for age, disability and cognitive function (Jung *et al* 2010).

- In one study, volunteering was associated with halved mortality risk by more than four years, with effect strongest for those who volunteered most regularly (Konrath *et al* 2012).

- Volunteering was also seen to provide roles and social ties which lead to improved social integration and wellbeing, and improved self-esteem, life skills and social engagement (Farrell and Bryant 2009).

- Volunteering was also cited as helping to develop skills, connections and networks, avoid boredom, keep fit and healthy, make new friendships, have a more positive sense of self-worth, and an improved sense of community (Brodie *et al* 2011; Paylor 2011; Casiday *et al* 2008).

- Similarly, there are benefits of progression into paid roles or professional qualifications that stem from volunteering, particularly when training is offered as part of the volunteering package (ie, volunteering forms part of a career pathway) (eg, Prasad and Muraleedharan 2007).

- Further, it was found to reduce health service costs for treating those service users who are engaged in volunteering (Teasdale 2008).

Some evidence suggests that the scale of the personal health benefits obtained by a volunteer depends on how many hours of volunteering they complete (Morrow-Howell 2010). Older retirees were also found to benefit more than younger retirees in a number of research studies (Schwingel *et al* 2009). However, generalisations could not be made from these research findings.

There were many cautions drawn in the literature as to how strongly associations between positive health and wellbeing outcomes and volunteering could be drawn. For example, one study found that volunteering may help keep healthy volunteers healthy rather than improving health, with benefits being experienced differently across the lifecycle (Farrell and Bryant 2009). In another, volunteering did not predict risk of development of chronic diseases or being admitted to nursing homes among older people (von Bonsdorff *et al* 2010). Volunteering was also found to reduce stress levels but had no significant effective on cognitive functioning, depression or sense of purpose for people with mild to moderate dementia (George and Singer 2011).

Further limitations with the evidence in this area were highlighted by previous literature reviews. One review of the literature into the relationship between volunteering and health found that studies looking at the health impacts of volunteering on volunteers related to volunteering in general rather than in any particular setting or role (Casiday *et al* 2008). This makes it difficult to know precisely which aspects of volunteering are responsible for the protective effect observed in some studies. Another literature review on the benefits of volunteering for people with mental health acknowledged that much of the evidence was conflicting and that findings were inconclusive (Farrell and Bryant 2009).

Volunteering is shown to have a positive impact on both the patient (and in some cases the wider social network of family and friends around the patient), and the volunteer themselves. Improved self-esteem, wellbeing, and social engagement for both the recipient and volunteer were widely cited.

However, a number of research studies, and reviews of the literature, stressed the limitations and inconsistencies of the findings (much more so around health outcomes than general wellbeing outcomes) and appealed for further evidence to support conclusions. In particular, it is not always clear what mechanisms lead to these effects, with a range of possibilities being discussed in the literature.

Value to the organisation/system

Of particular relevance to this research study is the value gained to the organisation, and wider system, in health and social care. Many research studies considered the various benefits that volunteering can bring.

- **Adding capacity/improving coverage, thereby increasing quality in services/ the system:** eg, stakeholders including social workers welcomed the extra resource offered to families and the different approach that volunteers bring (Akister *et al* 2011; Paylor 2011); volunteers are often seen to 'fill gaps' within services but also improve the quality of existing services, including by freeing up

professionals to spend more time with patients who are most in need. This allows for improvement in skill mix, 'matching' and service/system efficiency (Hussein 2011; Kennedy *et al* 2007).

- **Improving value for money / reducing health care costs:** eg, for an investment of £140,000 per annum, 64 families were matched with a volunteer and the outcomes delivered saved the authority a minimum of £283,644 (Buman *et al* 2011; Akister *et al* 2011; Paylor 2011; Rogers *et al* 2006). NB the Expert Patient Programme was found to increase patient out-of-pocket costs ie, cost shifting out of NHS (although some studies found no difference in routine health service utilisation where voluntary interventions had been in place) (Rogers *et al* 2006; Kennedy *et al* 2007).

- **Reducing the need for health care services:** via a number of means, such as supporting people to manage their own health (Jones 2004). Volunteers were also found to delay entry into residential care (Paylor 2011), and reduce delayed transfers of care and re-admissions (Jones 2004).

- **Creating services that are more responsive to local needs** (Paylor 2011) eg, by providing volunteering support in community spaces currently not served by health professionals, such as community exercise classes taught by a volunteer leader who is culturally and socially acceptable to the community served.

- **Contacting and engaging the 'hard to reach':** eg, public health interventions using lay volunteers who had cultural and social proximity to the communities they were working in served to help break down social and cultural barriers between formal services and marginalised local people (Kennedy 2010) (also see below).

- **Bridging the current gap between services and patients / communities** (Paylor 2011; Casiday *et al* 2008); opens up channels so that community knowledge can be fed back to inform strategic planning and service delivery (Paylor 2011) and facilitates greater patient engagement in local health services and issues (Jones 2004).

- **Diversifying the health and social care workforce:** The benefits of an 'age diverse' workforce include: improved rates of staff retention, higher staff morale, fewer short-term absences, higher productivity and contribution of a wide range of skills and experiences (Cook 2011).

- **Mechanism for building strong partnerships across different sectors** (Jones 2004): supporting the proposals in the Wanless report (Wanless 2002) for more collaborative working in order to improve performance and outcomes in health.

- **Innovation and fresh perspectives** (Casiday *et al* 2008): eg, community health champions who share social and cultural norms with local populations are able to tap into information about local preferences etc that might support the development of more effective local services.

- **Adding a personal human touch** to health and social care (Casiday *et al* 2008), eg, volunteers may be able to offer more time with patients than professionals can, and may be less likely to use professional medical language that does not resonate with patients and families.

A number of studies explore what health and social care organisations need to do in order to maximise their use of volunteers, and gain the most value. One study suggested that the value gained from volunteers depends on:

- the number of volunteer hours made available by organisations

- the level of professionalism of volunteer programmes
- the effectiveness of volunteer programme management
- budgets for the volunteer programmes
- the size of the volunteer programme (Hotchkiss *et al* 2009).

The review suggests that there is great variability across organisations with regard to all of the factors listed above, meaning that the value to be gained from volunteers is not currently being maximised.

With regard to adequately supporting elderly volunteers, another research study suggested that organisations must provide 'clear roles, offer the opportunity to use skills beyond retirement and develop new ones; offer training and be supportive... and be flexible, if necessary the same roles can often be carried out by different people on different days' (Cook 2011).

Hotchkiss *et al* (2009) makes the following suggestions for maximising the use of volunteers by organisations (these will be explored further at later stages of this research project to understand the nuances underlying these issues):

- regulation on reporting the financial value of volunteers (including standardisation of the estimates used)
- standards for volunteer programmes in health and social care that may enable quality improvement within volunteer programmes
- monitoring the number of hours volunteers are offered/ commit to (the study found that patient satisfaction with hospitals increased relative to the number of hours volunteers committed to, so they suggest a minimum time commitment in order to maximise the value of volunteers to patient experience).

Is volunteer labour being misconstrued as free labour? Third Sector Research Centre report

Recent research completed by the Third Sector Research Centre has highlighted some of the issues with viewing volunteering as 'free'. These have been set out in the report as follows:

'Involvement in volunteering not only involves the cost of lost income for hours that might have been spent doing paid work, but it can also involve sacrificing time that might have been used to care for or interact with family members, or for (other) leisure activities, for example. Paid work commitments may prevent individuals from participating generously in formal volunteering, and wider socio-economic conditions affecting housing and labour markets can have a significant impact on people's availability for this.

'This raises questions about who will shoulder the cost of the responsibilities being devolved to communities, families and individuals, and about whether these costs – and the varying abilities of different local communities to meet them – have been factored into decisions to increase the delivery of services by third sector organisations in order (at least in part) to reduce costs. Furthermore, involving volunteers is not free to the organisations that do so and the costs entailed in supporting and training volunteers also needs to be considered by those promoting volunteering as part of the Big Society agenda."

(Buckingham 2012)

Wider benefits

Volunteering can also support the development of healthy communities, in a number of ways:

- **building community networks/creation and maintenance of social capital** (Ryan-Collins *et al* 2009; Paylor 2011), making people more powerful, preventing needs rising and engaging sustainable resources (Ryan-Collins *et al* 2009)
- **increasing community resilience** (via public participation in shaping and delivering services) (Paylor 2011)
- **breaking down stigma**, and increasing understanding of mental health in society (Ryan-Collins *et al* 2009; Teasdale 2008)
- **increasing community access to health resources and activities** (Paylor 2011)
- **supporting the joining up of services** (Department of Health 2011)
- volunteers have also been found to **expose flaws in the system** that can create barriers to volunteering eg, slow CRB (now DBS) checks, that cause volunteers to give up (Department of Health 2011)
- inter-generational projects can **improve relations between young and old** in society (Department of Health 2011)
- volunteers attempt to **resocialise the end-of-life process** by reintroducing death into the social experience, and also contribute to the creation of social bonds that foster more humane and cohesive community around terminally ill patients (Sevigny *et al* 2010)
- some research suggests **social participation is cumulative** – formal volunteering can encourage people to get involved in informal things too (and vice versa) (Morrow-Howell 2010; Department of Health 2011).

Evidence for a number of impressive benefits for organisations within health and social care, and for wider society, were found in the research. Particularly in a time of austerity, the notion that volunteers represent value for money, fill gaps in services, effectively navigate patients around the system, and could even reduce the need for statutory provision, are significant assertions.

Part 4: Research limitations identified by the literature review

The current literature only takes us so far in understanding the full contribution of volunteering in health and social care. From the literature reviewed, there were some commonly noted limitations to the studies completed to date:

- much of the research cited has taken place in non-UK settings, so may have limited transferability
- many studies are small scale and the findings are applicable only to the particular context in which the research took place, so commenting generally on value becomes harder to do
- establishing causal relationships between volunteering and health and wellbeing is difficult, and much research relies more heavily on associations/ correlations.

The limited information on volunteering available from national data sources is a particular concern. There is far too little information on the prevalence and roles of volunteering in the health and social care sector. Although we know that large numbers of people are involved in volunteering in the sector – at least 3 million in England – it is impossible to know from current surveys the details of what volunteers do, and where.

Particular underexplored areas that the research recommended for further work include:

- under what conditions does volunteering enhance volunteers' wellbeing, and what are the mechanisms by which this happens? (Morrow-Howell 2010)
- does volunteering have a different effect on health than other forms of social participation? (Morrow-Howell 2010)
- what strategies should organisations use to attract and retain volunteers? (Morrow-Howell 2010)
- what are the commonly held perceptions of volunteers among volunteer recruiters? (Farrell and Bryant 2009)

A number of important questions remain to be answered as to how volunteers can work most effectively in health and social care, and also how better to measure and quantify the value that they have. The subsequent stages of our research will help to add to the evidence base by exploring several of the questions raised by this literature review, including through qualitative work with groups of volunteers, professionals and service users.

Part 5: Conclusions

The literature review has provided critical insights into the breadth and depth of volunteering in health and social care. Not only in terms of scoping the scale of volunteering activities that take place, but also in understanding why people volunteer, what is likely to encourage them to continue, and what might make them stop. Herein lies an area that will be important to explore further in the next stage of the research project, as it offers an important opportunity for providers interested in working with volunteers to improve the quality of the programmes they offer, and thus increase the value they gain from their services. It became clear from the review that volunteers do not operate equally in all parts of the health and social care system, and again it will be useful in future stages of this work to better understand why particular types of organisation, and particular areas of health and social care, attract and/or work more closely and effectively with volunteers.

There remains a dominant stereotype of the volunteer in health and social care, but this is being challenged by new forms of volunteering emerging as part of community-based public health programmes. For example, there is emerging literature discussing the value gained from working with community health champions in order to deliver programmes to marginalised communities. Our qualitative work will examine both traditional and newer forms of volunteering in the health and social care sector to explore motivations for engaging in both of these, and the benefits obtained.

The review identified a range of benefits that can be gained from working with volunteers, from individual-level benefits through to the system-wide level. Ensuring that organisations of all kinds are able to fully harness the value that volunteers can deliver will be essential. In doing so it will be important to develop a better understanding of volunteering in health and social care and the organisational conditions required to support it effectively. Our ongoing work intends to contribute to developing this understanding, in order to support the most effective use of volunteers within health and social care.

References

Akister J, O'Brien N, Cleary T (2011). *CSV Volunteers in Child Protection (ViCP): An assessment of its impact and effectiveness: Executive summary.* London: CSV.

Ayalon L (2008). 'Volunteering as a predictor of all-cause mortality: what aspects of volunteering really matter?' *International Psychogeriatrics*, vol 20, no 5, pp 1000–13.

Barnes J, Senior R, Macpherson K (2009). 'The utility of volunteer home-visiting support to prevent maternal depression in the first year of life'. *Child: Care, Health and Development*, vol 35, no 6, pp 807–16.

Block E, Casarett D, Spence C, Gozalo P, Connor S, Teno J (2010). 'Got volunteers? Association of hospice use of volunteers with bereaved family members' overall rating of the quality of end-of-life care'. *Journal of Pain and Symptom Management*, vol 39, no 3, pp 502–6.

Brodie E, Hughes T, Jochum V, Miller C, Ockenden N, Warburton D (2011). *Pathways Through Participation: What creates and sustains active citizenship? Summary report.* London: Pathways through Participation.

Buckingham H (2012). *No longer a 'voluntary' sector?* Third Sector Future Dialogues: Big Picture Paper 2. London: Third Sector Research Centre.

Buman M, Giacobbi P, Dzierzewski J, Aiken M, McCrae C, Roberts B, Marsiske M (2011). 'Peer volunteers improve long-term maintenance of physical activity with older adults: a randomized controlled trial'. *Journal of Physical Activity & Health*, vol 8 suppl 2, pp S257–S266.

Casiday R, Kinsman E, Fisher C, Bambra C (2008). *Volunteering and Health: What impact does it really have?* Report to Volunteering England. London: Volunteering England.

Cook J (2011). 'The socio-economic contribution of older people in the UK'. *Working with Older People*, vol 15, no 4, pp 141–6.

Department for Communities and Local Government (2011). *Citizenship Survey 2010-11 (April 2010-March 2011), England*. London: Department for Communities and Local Government.

Department of Health (2011). *Opportunities for Volunteering: Legacy report: 30 years of funding volunteering in health and social care.* London: Department of Health.

Drever E (2010). *2008–09 Citizenship Survey: Volunteering and charitable giving topic report*. London: Department for Communities and Local Government.

Egerton M, Mullan K (2008). 'Being a pretty good citizen: an analysis and monetary valuation of formal and informal voluntary work by gender and educational attainment'. *British Journal of Sociology*, vol 59, no 1, pp 145–4.

Farrell C, Bryant W (2009). 'Voluntary work for adults with mental health problems: a route to inclusion? A review of the literature'. B*ritish Journal of Occupational Therapy*, vol 72, no 4, pp 163–73.

George D, Singer M (2011). 'Intergenerational volunteering and quality of life for persons with mild to moderate dementia: results from a 5-month intervention study in the United States'. *American Journal of Geriatric Psychiatry,* vol 19, no 4, pp 392–6.

Gottlieb B, Gillespie A (2008). 'Volunteerism, health, and civic engagement among older adults'. *Canadian Journal on Aging*, vol 27, no 4, pp 399–406.

Hardill I, Baines S (2007). 'Volunteering for all? Explaining patterns of volunteering and identifying strategies to promote it'. *Policy & Politics*, vol 35, pp 395–412.

Hotchkiss R, Fottler M, Unruh L (2009). 'Valuing volunteers: the impact of volunteerism on hospital performance'. *Health Care Management Review*, vol 34, no 2, pp 119–28.

Hussein S (2011). 'Volunteers in the formal long-term care workforce in England'. *Social Care Workforce Periodical, issue 13*.

Jones H (2004). *Volunteering for Health: A research report produced for the Welsh Assembly Government*. Cardiff: Wales Council for Voluntary Action.

Jung Y, Gruenewald T, Seeman T, Sarkisian C (2010). 'Productive activities and development of frailty in older adults'. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, vol 65B, no 2, pp 256–61.

Kennedy A, Reeves D, Bower P, Lee V, Middleton E, Richardson G, Gardner C, Gately S, Rogers A(2007). 'The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial'. J*ournal of Epidemiology and Community Health,* vol 61, no 3, pp 254–61.

Kennedy L (2010). 'Benefits arising from lay involvement in community-based public health initiatives: the experience from community nutrition'. *Perspectives in Public Health*, vol 130, no 4, pp 165–72.

Konrath S, Fuhrel-Forbis A, Lou A, Brown S (2012). 'Motives for volunteering are associated with mortality risk in older adults'. *Health Psychology*, vol 31, no 1, pp 87–96.

MacPherson K (2010). 'Volunteer support for mothers with new babies: perceptions of need and support received'. *Children and Society,* vol 24, no 3, pp 175–87.

McMillan I (2010). 'A voluntary effort'. *Learning Disability Today*, vol 10, no 3, pp 28–30.

McMunn A (2009). 'Participation in socially-productive activities, reciprocity and wellbeing in later life: baseline results in England'. *Ageing and Society*, vol 29, no 5, pp 765–82.

Morrow-Howell N (2010). 'Volunteering in later life: research frontiers'. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, vol 65, no 4, pp 461–9.

Morrow-Howell N, Hong S, Tang F (2009). 'Who benefits from volunteering? Variations in perceived benefits'. *Gerontologist,* vol 49, no 1, pp 91–102.

Nazroo J, Matthews K (2012). *The Impact of Volunteering on Wellbeing in Later Life: A report to WRVS.* London: WRVS.

Paylor J (2011). *Volunteering and Health: Evidence of impact and implications for policy and practice*. London: Institute for Volunteering Research.

Piliavin J, Siegl E (2007). 'Health benefits of volunteering in the Wisconsin longitudinal study'. *Journal of Health and Social Behaviour*, vol 48, no 4, pp 450–64.

Prasad B, Muraleedharan V (2007). *Community Health Workers: A review of concepts, practice and policy concerns.* Working paper. London: Consortium for Research on Equitable Health Systems.

Rogers A, Bower P, Gardner C, Gateley C, Kennedy A, Lee V, Middleton P, Reeves D, Richardson G (2006). *The National Evaluation of the Pilot Phase of the Expert Patients Programme. Final report.* Manchester: National Primary Care Research and Development Centre.

Ryan-Collins J, Stephens L, Coote A (2009). *The New Wealth of Time: How timebanking helps people build better public services.* London: New Economics Foundation.

Schwingel A, Niti M, Tang C, Ng T (2009). 'Continued work employment and volunteerism and mental wellbeing of older adults: Singapore longitudinal ageing studies'. *Age and Ageing*, vol 38, no 5, pp 531–7.

Sevigny A, Dumont S, Robin Cohen S, Frappier A (2010). 'Helping them live until they die: volunteer practices in palliative home care'. *Nonprofit and Voluntary Sector Quarterly*, vol 39, pp 734–52.

Teasdale S (2008). *In Good Health. Assessing the impact of volunteering in the NHS*. London: Volunteering England.

von Bonsdorff M, Rantanen T (2011). 'Benefits of formal voluntary work among older people. A review'. *Aging Clinical & Experiential Research*, vol 23, no 3, pp 162–9.

Wanless D (2002). *Securing our Future Health: Taking a long-term view.* London: HM Treasury.

Weeks L, MacQuarrie C, Bryanton O (2008). 'Hospice palliative care volunteers: a unique care link'. *Journal of Palliative Care*, vol 24, no 2, pp 85–93.

Wilton H (2012). *Volunteering: Unlocking the real wealth of people and communities. A report on behalf of Think Local Act Personal, In Control, CSV, ADASS and SCIE*. London: Think Local Act Personal.