Only available to a selected few? Is it feasible to rely on a volunteer workforce for complex intervention delivery?

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Abstract

This paper recounts the process of undertaking a randomised controlled trial which was designed to examine the effectiveness of an intervention for socially isolated older people aged 75 years and over. It describes the reasons for early cessation of the study and raises the implications of this outcome for policy, practice and research. The intervention under investigation was designed to alleviate loneliness and foster companionship. It involves participants being linked with a small group of others through a teleconferencing system with each group being facilitated by trained volunteers. There was a requirement to recruit and train a minimum of 30 and maximum of 60 volunteers over one year to facilitate 20 friendship groups to meet the numbers of older people required to be recruited to the study. Problems with recruiting and retaining the volunteer workforce by the voluntary sector organisation, who were commissioned to do so, led to the study closing even though older people were recruited in sufficient numbers. The paper draws upon analysis of various data sources from the study to identify the potential reasons. The discussion raises considerations regarding the extent of infrastructure required to deliver community services to vulnerable user groups at scale, identifies some of the issues that need to be addressed if such volunteer initiated services are to be successful and informs future research programmes in this area.

What is known about this topic

- Volunteering is a key element within a mixed economy of service provision
- The demands placed upon volunteers can be significant
- Who volunteers is influenced by a range of societal factors and individual motivations

What this paper adds

- Scaled up services are challenging to deliver through a volunteer workforce
- Volunteer provided services require infrastructure and skilled support for sustainability
- Evidence of effectiveness of voluntary sector led services is required but evaluation is fraught with challenges

Introduction

Contrary to popular belief, only a minority (about 15%) of older people are in contact with care services (Audit Commission, 2004) and many play an active role in society. For example, 65% of volunteers in the UK are 50 or older (Janjua & Goss, 2012).

However changes in family and societal structures combined with longer life spans have increased the likelihood of single person households and consequent isolation; a phenomenon that crosses different populations, countries and cultures with varying prevalence (Yang & Victor, 2011). Older people are socially excluded when they experience economic and material deprivation and/or lack access to social networks, services and activities (Office of the Deputy Prime Minister, 2006). Being lonely is associated with poorer self related quality of life and has an impact on morbidity and mortality (Hawkley & Cacioppo, (2010) and while living alone does not necessarily equate with social isolation and loneliness, self reported loneliness is less likely among those who live with others (Bowling, 2005). UK national guidance on interventions to promote mental wellbeing in older people (National Institute for Health and Social Care Excellence (NICE) 2008) concluded that further research into home-based interventions that might improve or maintain the mental wellbeing of vulnerable, older people living in the community was a priority, particularly for those who are housebound or find it challenging to leave the house and are therefore likely to be lonely. The significance of this is reflected in the inclusion of a self reported measure of social isolation within the Public Health Outcomes Framework 2013/2014. However funding limitations combined with a continuing statutory service focus upon treating and managing population morbidity means that a volunteer workforce is likely to be involved in delivering interventions to allay isolation and loneliness rather than the statutory sector. Moreover, these volunteers are likely to be active older people if supported in their involvement (Hatamian et al, 2012).

The value of volunteering is expressed variously, particularly with regard to which sectors of society might benefit from engaging in volunteering activity. The European year of Volunteering in 2011 aimed to reduce obstacles to volunteering and raise awareness of its value at micro (individual), meso and macro levels. The continuing drive to involve society in volunteering is also exemplified through country specific policies and initiatives (Hardill et al, 2007) as well as international actions (Davis Smith, 2000). In 2010 the UK Government launched its Big Society programme. This placed emphasis on the role of the third

(voluntary) sector in delivering services and upon a civil society where communities are empowered to develop and deliver services (Alcock, 2010). More recently the UK Cabinet office launched a two year, £36 million pound programme to promote volunteering initiatives through a newly formed Centre for Social Action. Evaluation of the charitable venture 'Silverline' in the UK, which provides a free helpline to older people 24 hours a day is illustrative of the need that exists amongst those who experience loneliness in later life and how this can be met through a simply delivered intervention by a volunteer workforce (Centre for Social Justice, 2013).

Despite continued policy push and the benefits that can be derived for the volunteer as well as recipient, recent reviews confirm the paucity of evidence that exists to demonstrate the efficacy of volunteer delivered services (Jenkinson et al, 2013; Smith & Cordery, 2010; Cattan et al, 2011).

The study discussed in this paper was in response to a commissioned call for research identified out of the 2008 NICE guidance. The brief specified research into interventions to allay isolation and loneliness in older people, to be delivered to people aged 75 years and over in their own homes. It would require intervention identification (or development) followed by implementation and robust evaluation of population effectiveness through a randomised controlled trial.

Telephone befriending was identified as an intervention which met the brief. Qualitative research reported since the publication of the NICE guidance has suggested that telephone befriending services can be beneficial in helping older people to improve in confidence and enabled engagement and socialisation" (Cattan et al, 2011). The concept of befriending or the use of tele conferencing in these ways were not new; the Royal National Institute for Blind People (RNIB) have an established tele-befriending service and the Community Network has been in existence for over 20 years, providing facilitated teleconferenced friendship to groups with a common need.

To demonstrate future sustainability intervention costs had to be borne by a service provider. Accordingly a partnership was brokered with the national organisation of a charity for older people who agreed to fund a local franchise to deliver the intervention. The additional funding to support the intervention was provided due to the specific interest and relevance of the intervention to the national organisation. The Community Network was

also engaged with the specific remit of providing the technology infrastructure and access to training in group facilitation skills.

Methods

The methods described here refer solely to the processes involved in engaging volunteers for this study. Other aspects of the study are reported elsewhere (Mountain et al. 2014; Hind et al, 2014).

Ethical approvals

The study was approved by South Yorkshire NHS Research Ethics Committee for the recruitment of study participants through GP mailing lists and for the application of pre and post intervention research instruments.

Three committees were convened to govern the conduct of the study: a Trial Steering Committee, a Data Monitoring and Ethics Committee and a Trial Management Group, all of which operated in accordance with the Clinical Trials standard operating procedures.

Volunteer recruitment and induction

Volunteer recruitment and retention were important criteria for study feasibility and service sustainability and involved matching service demand (participant recruitment) with capacity of the service provider to recruit and maintain volunteers. The study timeline afforded a window of one year to recruit 248 older people. To meet this target it was estimated that a minimum of 30 and maximum of 60 volunteers were required to facilitate approximately 20 groups.

An experienced worker from the service provider (henceforth referred to as the volunteer coordinator) was responsible for recruiting volunteers, supported by one other worker. The opportunity was promoted on the organisation's website and other relevant websites and through the local press. Employment agencies were not approached as this strategy was reportedly unlikely to be successful. Additional sources for recruitment were suggested over time by the study team.

Intervention design and training for delivery

The befriending intervention incorporated up to six initial weekly one to one phone calls between a participant and volunteer facilitator followed by a weekly phone based group with the same facilitator and up to five others for twelve successive weeks. Intervention design was informed by previous research (Cattan et al, 2011; Heller 1991). Training and delivery protocols were designed and manualised by researchers in partnership with partner organisations. Delivery was limited to office hours to meet the safeguarding requirements of the service provider.

Prospective volunteers were given an induction to the service provider organisation and to volunteering with older people in line with established practice. Those deemed to be appropriate for telephone befriending were offered the role and if they accepted, trained by the volunteer coordinator in conducting the one-to-one calls before progressing to group training. Cohorts of 4-5 volunteers were then organised to receive four one hour sessions of phone based training in group facilitation skills from a trainer recommended by the Community Network. This included how to run groups in a style conducive to creating group cohesion and promoting a safe environment for participants. Volunteers were told that assisting the group to be self-sustaining if possible was an important goal. The coordinator also committed to offer volunteers on-going mentoring. The contract with the service provider subsequently included this but did not specify the type and frequency of mentoring.

Data sources available to examine the success of recruitment, training and intervention delivery

Content analysis of the following was undertaken;

- Documented records of meetings with the service provider; namely Chief Executive, volunteer coordinator and second member of staff involved in the study
- Minutes of the Trial Management Group which included provider representatives

Semi structured Interviews were conducted with all available volunteers upon study cessation and are reported elsewhere.

Results

Volunteer recruitment and intervention delivery

Figure 1 shows the flow of volunteers through the study. Ten out of 42 volunteers completed training and three of these 10 delivered the intervention. The number of volunteers trained in group facilitation during a five month period was 11 compared with the 20 estimated as being necessary to meet study demands. Three volunteers facilitated four groups (n=24) to completion between September 2012 and May 2013. Members of one further group all received one-to-one befriending from a fourth volunteer who then dropped out prior to facilitating the group. An existing volunteer took over for the group calls stage. The number of days volunteers 'survived' in the project between point of completing group training and the day they dropped out ranged from 12 days to 118 days (mean 62).

Identified reasons for volunteer attrition

A first cohort of six potential volunteers was identified early in the project. These were all already known to the charity rather than being new recruits and were inducted into the project and received training in delivering one to one calls by the service provider ahead of the agreed timeline. The subsequent delay in being allocated a group of older people led to volunteers losing interest, with some consequently being lost to the study. Other contributory factors which subsequently emerged included;

1. Identifying suitable volunteers; two of those recruited and trained were not able to accept a group due to organisational issues; one was a student who found their availability to be too limited and the second had not understood that it would not be possible to make evening calls.
2. Matching volunteer availability to group training; three training sessions had to be cancelled over a six month period due to lack of take up.
3. Matching volunteer recruitment to participants for the purposes of the study.
4. Trained volunteers not delivering the intervention; identified reasons included ill health and lack of confidence illustrated by ongoing requests for reassurance with procedures for intervention delivery.

5. Volunteer disenfranchisement with the intervention; for example not being able to contact participants being attributed to the older people being socially active and therefore not the target group for telephone befriending.

Records also suggest that the initial delay in participant recruitment led to the volunteer coordinator expressing doubts about pursuing active recruitment. Sustained difficulties with identifying volunteers occurred from that time onwards despite the accelerated participant recruitment. The volunteer coordinator left the provider organisation for another post in the charitable sector a month before the study ceased. The study was not able to continue as the provider could not identify alternative staff due to ever decreasing resources and it was not possible to transfer the contract.

Discussion

The issues that resulted in study cessation were complex and varied. They include lack of engagement of older people in intervention design, using a volunteer workforce for intervention delivery, relying on a volunteer workforce for research, delivering a trial design which is not necessarily compatible with the voluntary sector culture and finally the overarching realities of undertaking research with the voluntary sector. Each of these points is discussed below.

User engagement in intervention design

Our interpretation of 'users' includes the charitable organisation that had agreed to deliver the intervention and its staff, the volunteers as well as older people for whom the intervention was intended.

The engagement of older people in this study was highly acceptable from a research perspective; older people were represented on each of the Governance committees. The patient and public representative on the Trial Management Group was particularly active in the design of information for study participants. Recruitment of participants to the study was also successful; sufficient older people were identified to take part, demonstrating that the notion of the intervention was acceptable. However some of those who did receive the intervention expressed disappointment at the manner in which the volunteers ended the group after the 12 week intervention period (Hind et al, 2014).

As previously described, intervention design was located in existing evidence (Cattan et al, 2011). The format of additional initial one to one calls prior to group engagement was informed by an expert trainer recommended by the Community Network. However there was not the time within the study timeline to involve the charitable organisation in intervention design. This omission did not enable 'buy in' to the intervention from the outset from those commissioned to deliver it. Also it would have been ideal to involve potential volunteers and end users in intervention design and then pilot the intended intervention to ensure acceptability before embarking on a pilot trial as described by the MRC complex interventions evaluation framework (MRC, 2008).

The fragilities of the volunteer workforce

Recent initiatives indicate that volunteering capacity can exist within communities (Hatamian, 2012) but sustaining such activity is challenging as volunteers balance the demands stemming from this altruistic contribution with other aspects of their lives. Thus the volunteering contract is a fragile arrangement based on shared understanding and reciprocity. Agreements between organisation and individual are recommended but cannot be mandated even though the recruiting organisation is responsible for volunteer health and safety. Furthermore the main beneficiary of the activity, volunteer or recipient, can be unclear. It therefore follows that the volunteer workforce cannot be expected to perform in the same manner as paid employees. Findings from this study illustrate funnelling of numbers of potential volunteers to a small cohort who were committed but needed on-going support; a common pattern in volunteer recruitment. The intervention designed to be delivered during this study necessitated volunteer participation in mandatory group based training to prepare them for the facilitation role. However the timing of this training did not necessarily match either volunteer availability or that of older people recruited to participate. This level of demand and complexity can negatively impact upon volunteer turnover, with retention demanding a higher level of resources from the host organisation (Tang et al, 2010). Delivering services which are evidence-based are arguably more likely to involve structured and possibly specialised training. This offers greater opportunities for a volunteer workforce who may be looking to improve skills and gain valuable experience for paid work but also places greater resource demands on the host particularly where a high turnover of volunteers exists. Therefore the sustainability of such a workforce and what it

might deliver can be fragile, emphasising the need for further research to determine the true resource implications of using volunteers to deliver services. The importance of this is raised recently published report volunteering for health and social care (Naylor et al, 2013). One of the recommendations out of this work (which did largely focus on volunteers in formal health settings) is the need to use volunteers to extend and improve service quality rather than a means of reducing service costs. Additionally providers bidding for commissioned services should consider the costs of supporting a volunteer workforce. Hanlon et al (2011) described the concept of 'stealth voluntarism' in Canada whereby health professionals provide extra services as volunteers. The findings of this study give rise to the alternative concept of 'stealth service provision', provision of services to older vulnerable people at minimal cost. In common with previous findings, this study exposed the idiosyncrasies and complexities of research into the use of volunteers in third sector contexts. For example the study of access to a befriending facilitator for carers of people with dementia by Charlesworth et al (2008) evaluated the effect of access to a befriending facilitator rather than the direct effect of the intervention. The results were equivocal in that the facilitator role was not found to be effective. However those carers who had been matched to a trained lay befriender for at least six months benefited in terms of their mental health, raising questions regarding whether it is realistic to provide and sustain services to increasing numbers of older people using a largely transient unpaid workforce.

Undertaking research that relies upon a volunteer workforce

Quite early in the study it became clear that the demands of the research eroded the already limited capacity of the service provider to organise intervention delivery. Additional constraints were placed upon intervention delivery such as the need to retain office hours for safeguarding purposes and to accommodate the limitations of the few paid staff that were involved.

After the study closed it emerged that the number of volunteers required for this study equated to the existing total volunteer workforce of the service provider. The requirements of the trial meant that the provider charity were trying to manage targets that were unpredictable and out of their control; for example available volunteers were dependent upon a number of factors such as those presenting for voluntary work independently and

referrals from agencies such as Job Centre Plus. Available recruits were then filtered due to the need to identify those most suited to the facilitation role.

The consequences of the research design

Randomised controlled trials are, by necessity highly prescriptive research designs so that they are both replicable and reliable. Protocolisation and randomisation can be counter to the philosophy of reduced bureaucracy and creation of community capital that can exist within charitable organisations (Kime et al, 2012). For this study stringent requirements were identified for intervention training, supervision and delivery so that fidelity to the original intervention might be maintained (Bellg et al, 2004). This did not necessarily place extra requirements upon volunteers and providers but did raise questions about maintenance of intervention fidelity which then proved challenging to address given the limited resources of the charity and the perceptions of some volunteers. Additionally study resources meant that recruitment and intervention delivery was limited to a 12 month timeframe.

While the value of obtaining trial evidence for an intervention delivered through the third sector was recognised by the National organisation and the charity's Chief Executive, the process of trying to achieve this within a voluntary sector environment compromised all concerned; paid staff, volunteers and researchers, resulting in eventual withdrawal by the provider service. It was also evident that the idiosyncrasies of the delivery site challenged study progression; a phenomenon that has been previously observed (Wells et al, 2012).

Finally this study was a single site randomised controlled trial. This is a precarious strategy as has been previously observed (Bentley et al, 2014).

The realities of research with the third sector

Was it realistic to expect a franchised third sector provider to introduce a new intervention and support individuals to deliver it at scale in the manner attempted through this study? Our results would indicate not in the short to medium term. Two other UK voluntary sector organisations are successful in achieving larger scale delivery of telephone befriending but they have been able to build this capacity over many years and both have paid staff dedicated to running the service and supporting the volunteer workforce. In contrast this

study was expected to achieve successful intervention development, delivery and evaluation within a three year timescale with no extra staffing resources for the charity involved. The findings described in this paper suggest that reduced ambition is necessary to match the capabilities of the programmes under evaluation and there might be benefit in including research to determine the service models which can lead to successful delivery of community based interventions within constrained finances.

Conclusions

UK policy is focussed upon supporting society to establish and deliver services at grass roots level using a largely volunteer workforce. Heightened awareness of the extent of social isolation among older people has led to consideration of how volunteers and the community can be harnessed to reduce loneliness. This paper on a study of telephone befriending for older people has critiqued the premise of this policy and questioned the reliable delivery of interventions through workforce that is not paid and therefore not subject to rigorous regulation. Volunteering is important for a civil society. It should be encouraged and evaluated to inform future endeavours (Rochester, 2006). Randomised controlled trials remain the study design of choice for health services research. However this study challenges the realism of applying rigorous randomised controlled methodology to studies within charitable organisations which may not be equipped or amenable to the demands that this also creates. We therefore recommend methods of evaluation that fully engage all stakeholders from the outset and enable the identification and addressing of issues that need resolving as the study progresses rather than imposing a prescriptive design in the manner described in this paper.

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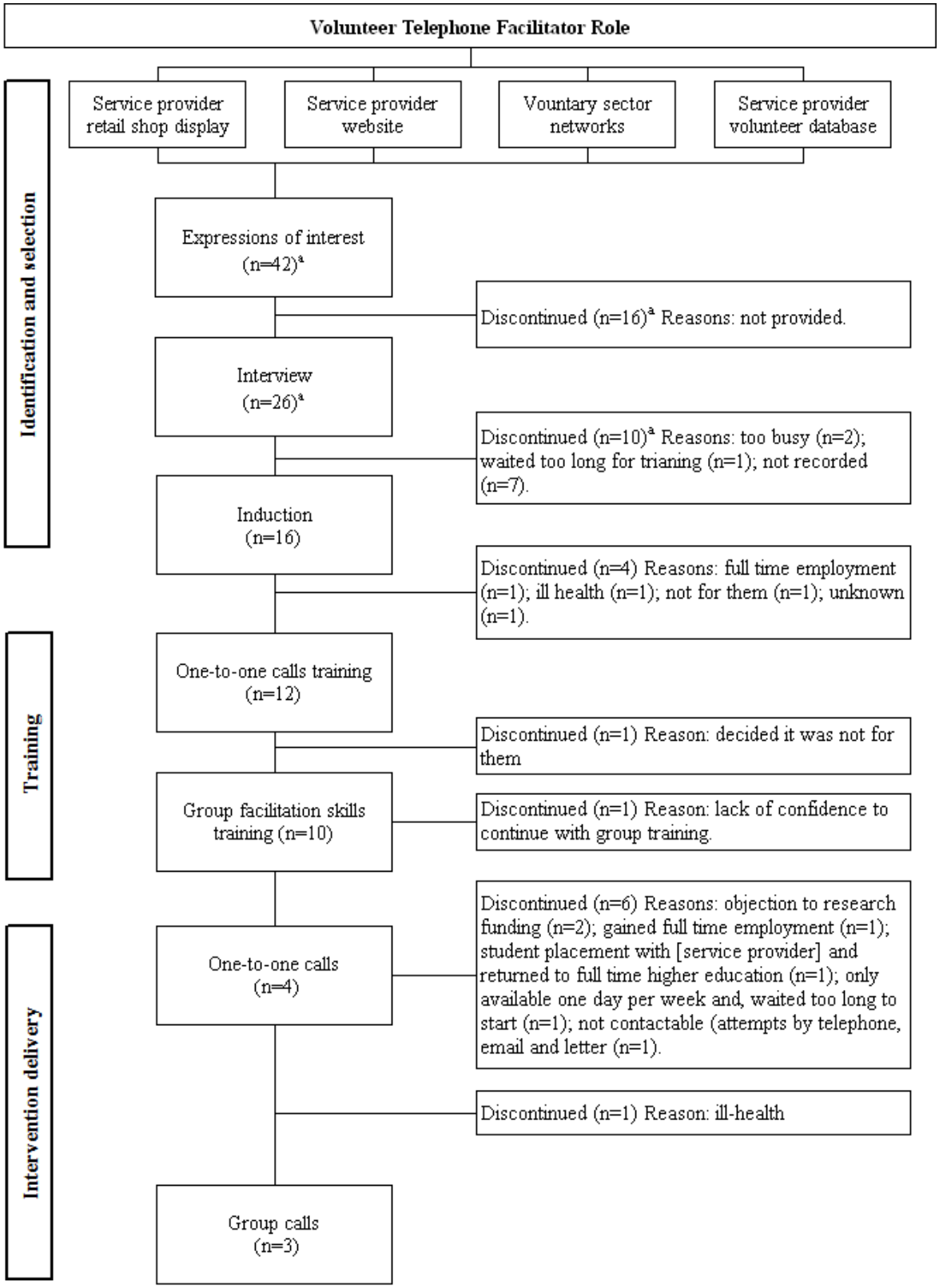

[a] Information supplied by service provider (Field note; 13 November 2012). Detailed information was not captured for all expressions of interest/referrals to the service provider (including agencies e.g. job centre). The service proider reported that all candidates were screened for suitability for a number of volunteer opportunities including the telephone group faciliator role.