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Title

Pandemic policy making: The health and wellbeing effects of the cessation of volunteering because of restrictions during the COVID-19 pandemic on older adults.

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The materials that support the findings of this study are publicly available. We have included citations in the reference section.

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volunteering, health and social care, wellbeing, pandemic, NHS, policy

Abstract

On 29th June 2020 the President of the UK's Academy of Medical Sciences, Professor Sir Robert Lechler stated that: "Pandemic policy making needs science". This commentary reflects on this statement exploring two distinct questions relating to the health and wellbeing effects of the cessation of volunteering 1) older adults who volunteer and 2) older adults who receive volunteer support.

COVID-19 is a disease that disproportionately affects mortality of older adults around the globe. The policy responses to the pandemic, in particular, halting social interaction without preparation to address the adverse effects of this, are likely to affect public and voluntary sector services and subsequently to disproportionately affect the health and wellbeing of older adults.

Purpose

This policy-orientated commentary aims to provide a perspective on the effects of policy changes designed to reduce risk of infection as a result of COVID-19. The example of the abrupt cessation of volunteering activities is used to consider the policy and practice implication that need to be acknowledged in new public service research to deal with the on-going implications of the COVID-19 pandemic and for future preparedness.

Design

The paper will provide a critical challenge to English pandemic health policy making, in particular the national instruction '*to stop non-essential contact with others*' without a strategy on how to remedy the serious side effects of this instruction, in particular on older adults.

Findings

The abrupt cessation of volunteering activities of and for older people because of the COVID-19 crisis is highly likely to have negative health and wellbeing effects on older adults with long-term and far-reaching policy implications.

Originality

The paper combines existing knowledge volunteering of and for older adults with early pandemic practice evidence to situate an emerging health and wellbeing crisis for older adults. It emphasises the importance of immediate further detailed research to provide evidence for policy and practice following the lifting of COVID-19 related restrictions and in preparation for future crises.

Title

Pandemic policy making for remedial practice and preparedness: The health and wellbeing effects of the cessation of volunteering because of restrictions during the COVID-19 pandemic on older adults in England.

Introduction

The health and wellbeing effects of volunteering by and for older adults have been described in studies around the globe (Smith et al 2016). These effects can be described within two specific dimensions: the effects on the older volunteer and the effects associated with programmes delivered by volunteers for older adults and their carers. In the UK nearly three quarters of adults have volunteered at some time in their lives. It is estimated that around five million older adults regularly volunteer, experiencing associated health and wellbeing benefits. It is likely that a similar or larger number might benefit from volunteer programmes for older adults and their carers, albeit the numbers who benefit currently remain mostly speculative, extrapolated from available partial data, such as the number of volunteers and their beneficiaries in some hospitals, hospices, care homes and other volunteer involving public, voluntary sector and private organisations. (Naylor 2013; Age UK no date)

In England the onset of the pandemic led to a clear unequivocal policy direction delivered in television addresses and an undated letter to all households by the UK Prime Minister. On 16th March 2020 he called for dramatic reductions in social contact:

“now is the time for everyone to stop non-essential contact with others”

This was followed on 23 March 2020, by his televised request asking people to “*stay at home*” to “*protect our NHS and save lives*”. This was followed in an undated letter

to all households containing the unequivocal instruction “*you **must** stay at home*” [bold as in the original quote].

This led to the immediate and almost total temporary cessation of all volunteering by older people outside the home and almost all, non-emergency response related, volunteering with direct contact for older people. The four reasons for which people were at the time officially permitted to leave their home, ‘shopping, exercise, medical need and work’, did not include volunteering. Any remaining activities involving volunteers, for example, in the emergency response or food provision, explicitly excluded people who are considered clinically vulnerable including people who are 70 and older.

While government called for and promoted the wider beneficial effects of volunteer mobilisation in the UK in April 2020 with regard to the emergency response, this does not appear to have been well-coordinated nor aligned to public concerns to support older people by and through volunteering. (Booth 2020)

Some initial data, for example from sports volunteering (Savanta ComRes 2020) and social networking feedback from individual volunteer involving organisations, suggest that volunteering from home, for example, by phone and online or to produce Personal Protective Equipment (Scrub Hub 2020) continued but no detailed or comprehensive data about this is available (Lachance 2020).

On the available evidence it seems that COVID-19 not only affects mortality of older people, but that pandemic policy making in response to it is also likely to affect the health and wellbeing of older adults disproportionately, which has the potential to deepen an emerging social care crisis and exacerbate existing inequalities for older peoples health and wellbeing in England.

The two questions at the core of this policy commentary are therefore;

Firstly, what are the unintended consequences of pandemic policy? In particular, can we expect the cessation of volunteer involvement of older people to lead to dissipating health and wellbeing exacerbated by the suddenness and unpreparedness.

Secondly, are current plans for public service reform and public health interventions involving volunteering viable within current pandemic policy planning. This is particularly relevant the NHS and others are planning to increasingly rely on volunteers in public service reform, and that public health interventions such as social prescribing are essentially a form of volunteer involvement.

Method

The paper will summarise knowledge about the health and wellbeing effects of volunteering on older people in two aspects, health and wellbeing effects on the older volunteer and the effects associated with volunteering programmes directed at older people. It will then review emerging evidence received by the Institute for Volunteering Research through professional networks about how the effects of restrictions imposed because of COVID-19 affect older adults. Finally, the paper will critically consider this in the context of available policy and practice guidance, with a view to identify foci for developing appropriate guidance to support the volunteering-related health and wellbeing in the near future when COVID-19 related restrictions will be lifted.

Health and wellbeing effects of volunteering on older people

The older volunteer

The conversation about the role of volunteering in keeping older people physically fit and mentally active has been on-going for at least two decades. In that time volunteering for older people has been generally promoted in the UK and volunteer-involving organisations have also targeted this group more in their recruitment (Davis-Smith and Gay 2005). As a result since the late 90s, the rate of regular volunteers over the age of 65 has increased and overtaken those of younger age groups, while overall volunteering rates have remained steady (NCVO 2020). In the late 90's the 50+ age groups were the least likely to volunteer (Davis-Smith, 1998) and in 2007, still, the proportion of formal volunteers was highest among people in the 35–44 and 55–64 age brackets and was lowest in the 65 or over age group (Low 2007). This shifted dramatically to the over 65s being proportionally the highest in 2019 (McGarvey 2019) suggesting a current estimate of approximately five million over 65s regularly volunteering.

While the complexities of defining volunteering continue to be actively debated in terms of purpose and scope, here we will use the definition adopted by the UK Volunteering Forum in 1998 as quoted in Kearny (2001/2007):

“It is the commitment of time and energy for the benefit of society and the community and can take many forms. It is undertaken freely and by choice, without concern for financial gain.”(page 6)

Examples of the values underpinning the choice to volunteer, the purposes of the volunteers, are summarised by Rochester (2010) as altruism, solidarity, reciprocity, equity and social justice. Examples of the many forms volunteering takes, its scope, are described in a typology of formal volunteering activities as ‘community activity;

emergency response^[L]_[SEP]; community peacekeeping; social assistance; personal assistance; children and youth; human rights, advocacy, and politics; economic justice; religious volunteering; education; health care; environment; data collection^[L]_[SEP]; promotion of knowledge; promotion of commerce; law and legal services; culture; and recreation' (Dingle 2001). Some of these have remarkably high numbers of older volunteers. For example, in 2011 52% of all volunteers at the National Trust were over 65, and 84% over 55. (Harflett 2014:97)

The research evidence over the last two decades clearly suggests positive effects of volunteering on mental health, physical health and longevity (Smith et al 2016). For example, with regard to mental health volunteering might alleviate the negative effects of stress (Greenfield and Marks 2004), offer a sense of belonging (Thoits and Hewitt 2001) and of personal identity (Gottlieb and Gillespie 2008). In particular there is evidence suggesting that volunteering can alleviate symptoms of depression symptoms (Choi and Bohman 2007; Schwingel et al. 2009; van Willigen 2000)

Therefore volunteering and associated social contact may be especially beneficial during challenging personal episodes such as retirement or bereavement. Studies also suggest that volunteering improves physical health overall (Adams et al 2011; Lum and Lightfoot 2005; Piliavin and Siegl 2007; Poulin and Holman 2013; Shmotkin, Blumstein and Modan 2003). Indeed some evidence suggests that volunteering has beneficial effects regarding specific health conditions such as hypertension (Burr, Tavares and Mutchler 2011; Sneed and Cohen 2013), albeit those effects can vary amongst age groups (Burr, Han and Tavares 2016). With regard to longevity the evidence is less conclusive as some studies have not found effects of volunteering on mortality, for example, among Americans aged 70–79 (Gruenewald et al 2007), with others finding that volunteering can prolong life (Kim et al 2020; Okun, Yeung, and

Brown 2013). In particular the evidence suggests that older people benefit from volunteering more than those of other aged groups (Musick and Wilson 2003; Kim and Pai 2010). Of direct relevance to the pandemic policy of stopping social contact, losing social connections, which are a key feature of volunteering, is associated with reduced life expectancy (Holt-Lunstad et al 2010).

Volunteering programmes

The role of volunteer programmes in support of older adults is an on-going research and policy concern in England. For example, a three year evaluation of volunteering in care homes, funded by the Department of Health, found “*profound positive impacts for residents, backing up findings from the wider literature*” (Hill 2016:4). Similarly the supportive role of volunteers in non residential social care is recognised, for example, through British Red Cross volunteers complementing statutory services by providing health and social care support to people discharged from hospital (British Red Cross 2018). Furthermore, while older people volunteering often supports other older people it is important to acknowledge that older people volunteering also supports intergenerational relationships with schemes such as Home Start and reading in schools.

The exact number of volunteers in social care is not known but based on Citizenship Survey, a face-to-face household survey carried out by the Department for Communities and Local Government, the King’s Fund in 2013 has estimated the number at approximately three million volunteers in health and social care. It states, for example, that the Yorkshire and Humber Community Health Champions programme had trained 17,000 volunteers reaching around 100,000 members of the community and also references the approximately 70,000 volunteers in hospices

around the UK. (Naylor 2013:5) The NHS has recently stated its plan to double that number over the coming years. (NHS 2019)

Volunteering is also reciprocal by its very nature with effects on the volunteer and the beneficiaries, for example, as reported in Cameron et al 2020 where for the retired volunteer the activity gave structure and purpose to the day and for the older person having someone who could really take the time to talk and listen was important. A study by Lilburn et al. explores the experiences of six adults aged 68-90 who volunteer for home visiting. Volunteers positioned the activity as ‘work and a responsibilities’ but there were also narratives of shifting obligations into mutual connections that benefit both the volunteer and those they visit (Lilburn, Breheny Pond 2018). These examples highlight that the ceasing of volunteering activities is likely to have had a detrimental impact on both.

How the restrictions imposed because of COVID -19 are affecting volunteering

Even before the UK Prime Minister’s announcement 23 March 2020 triggered the ‘lock down’, organisations had started to reduce volunteer involvement which relied on social contact, especially after 16th March 2020, when the Prime Minister called for dramatic reductions in social contact. By the end of March this led to an almost complete temporary cessation of regular volunteering activities outside the home, for examples, in hospitals, heritage and charity retail.

“We have made the decision to stand down our 700 hospital volunteers for this month following the lock down advice from the PM and we won’t be looking at them or any new volunteers coming back into the system until the risks are much lower... So for now we are collating a list of our own volunteers who are willing to take on alternative roles at home (telephone support, welfare checks, advice

lines etc) away from any public facing areas and a list of new applicants who are interested in volunteering longer term.”

Volunteer Manager, anonymous

It is unclear how many volunteer managers, staff who are employed to recruit, deploy and retain volunteers for voluntary and public sector organisations, were put on furlough at that time, but it seems very likely that it became difficult to continue to provide support for volunteers who struggled with the sudden loss of all social contact, including that they had through volunteering. Volunteer managers speak of it as one of their biggest challenges.

“One of the biggest challenges during lock down has been how we support our volunteers who are struggling with isolation and lack of purpose... We are emailing, phoning and producing regular newsletters but it's still been really tough on some of them... Quite worryingly so in some cases.”

Volunteer Manager

Examples of adapted activities

While face-to-face volunteering activities largely ceased during March 2020 the commitment of many volunteer organisations mean that several have tried to adapt their support activities to continue to meet the needs of older people.

“During lockdown the needs of those living with dementia have become more pressing. As a singing group we're busy remodelling 23 music/singing groups: telephone befriending (and sometimes singing!) services, but more specifically an interactive newsletter where people can share their thoughts on singing and music in words, pictures and poems. There's been wonderful

uptake and creativity - clearly it's helping those isolated at home to feel connected, valued and not forgotten."

(Coordinator of music groups)

National organisations such as Age UK have also increased telephone befriending schemes. While a telephone call is welcome it is unlikely to provide the same social stimulation as attending a luncheon group or Men's Shed project, or a memory café.

This coordinator of a dementia group noted:

"We arranged a programme of support with twice weekly phone calls and offers to do shopping, collect medicines etc but we couldn't provide the one thing everyone craved, that is company and respite time. Hopefully we are going to be able to start some activities in the near future but all our clients are vulnerable and many of our volunteers are over seventy, which is not a good combination in a pandemic."

(Coordinator of Dementia support group)

Furthermore, virtual volunteering offered through digital means is unlikely to be accessible to all volunteers or receivers of the support due to the inequalities related to age in access to IT. As we move forward from the acute pandemic crisis, there seems an urgent need to identify and report those groups who were most marginalised by the drive to digitalism the majority of social support.

In summary, in the UK older adults are the largest group of regular volunteers to be affected by pandemic policies causing a cessation of their volunteering. This is not an experience unique to the UK as for example data from other parts of the world, like

Australia, also suggest that female and older adults were most likely to have stopped volunteering as a result of the pandemic (Biddle and Grey 2020). The cessation of most volunteering activities in the UK from 16 March 2020 means that around five million older people might currently not be experiencing the health and wellbeing benefits they derived from volunteering and that potentially further millions of older people and their carers who had been supported by volunteers are currently not receiving that support.

What do we know about how this might play out when restrictions ease

Alan Hopley, Chief Executive of Voluntary Norfolk, said:

“...Going forward, the role of the volunteer is not only integral to the recovery of the current crisis but is also instrumental in providing early help and support for communities longer term.”

(Norfolk County Council 2020)

However, conversations with volunteer involving organisations suggest three immediate areas of on-going concern: fear of liability, sustainable safeguarding and anxiety about returning to volunteering and the organisation of volunteering. Establishing ways to return volunteers over 70 requires volunteer involving organisations to identify ways to manage sustainable supervision and safeguarding for them. Any return will most likely be volunteering in unfamiliar roles and required to adhere to new restrictions and practices all of which need to be trained and maintained at all times. As a result the role of the volunteer service managers and volunteer coordinators will possibly become far more operational than before the pandemic. This will also require effective and efficient collaboration with their Human Resources,

Occupational Health and Health and Safety Teams to create policy and to design risk assessment tools to initiate recovery plans post lock down.

It is expected that informed decisions have to be made balancing of a number of factors, such as the benefits of the volunteering role to the organisation, the effects on beneficiaries such as older people and their carers but the benefit or danger to the volunteers themselves. In short, this is extremely complex. The responses from practitioners suggest that pandemic policy making in this context requires detailed experiential knowledge of volunteers and those who organise volunteering to be combined with the substantial evidence gathered from pre pandemic volunteering research.

Discussion

The evidence overwhelmingly points to potentially negative health and wellbeing effects from the sudden cessation of volunteering both of and for older adults. The national English pandemic policy does not appear to have included any remedial actions, for example, resources for volunteer managers to help them support volunteers that had been stood down. The same applies regarding the lack of resources for and consideration of volunteer involving organisations delivering programmes for older adults and their carers. This is linked to what appears to be a lack of preparedness, with pandemic policy planning either not being available or not being used to consider societal impact beyond the immediate medical emergency response.

The anxieties now expressed by volunteers and volunteer involving organisations, dealing with a return to volunteering in changed circumstances are exacerbated by the absence of consistent and clear policies and associated practice guidance, which

indicates return to ‘volunteering as normal’ may be some time in coming. Therefore it is likely that the negative health and wellbeing impacts on older adults will be on-going. Finally, it is currently unclear how the learning about the reduction in social connectedness on older people’s health and wellbeing from the COVID-19 pandemic policy response will be systematically gathered or how it may be to be used in future pandemic policy, especially regarding preparedness.

Conclusion

To answer the two questions at the core of this policy-orientated commentary we considered materials concerned with the immediate and on-going consequences of pandemic policy making using the example of volunteering. Firstly, from the materials reviewed a picture emerges that suggests insufficient pandemic preparation, with regard to the requirement to stop non essential contact with others, resulting in negative impacts on older adults’ health and wellbeing with these impacts likely to be on-going. Secondly, in pandemic policy planning there appears to be a lack of evidence and systematic use of experiential knowledge of volunteers and practitioners about how the return of and for volunteering for clinically vulnerable people might be achieved safely and consistently and what the long term effects for the plans of the NHS and others with regard to the role of volunteers in public service reform are. This commentary therefore agrees whole-heartedly with the President of the UK’s Academy of Medical Sciences, that ‘pandemic policy making needs science’, because the emerging evidence about the effects of pandemic policy making, indicates very poor use of existing knowledge to prepare for the pandemic, with calamitous results. Given the nature of the crisis there is now a particularly strong argument for involving volunteers and those working to involve volunteers. Volunteers have experiential

knowledge to bring to making practice relevant pandemic remedial and preparedness policy. Nearly three quarters of adults in the UK having volunteered at some time in their lives. Considering the example of volunteering enables us to learn important lessons for policy and practice, to better support the health and wellbeing of older adults and pandemic planning.

We therefore suggest that further to Academy President Lechler's request 'pandemic policy making needs social science and systematic approaches to democratic participation in research' to address the need for much improved remedial practice and preparedness regarding the health and wellbeing effects related to the COVID-19 pandemic.

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