Formal Volunteering and health in the 50+age group in Northern Ireland: (First interim Report)

2011

Contents

Page

Acknowledgements

1.0 Executive summary of main findings 4

2.0 Introduction

2.1 The Unlocking Potential Project 8

2.2 Background

2.2.1 Population changes 9

2.2.2 Volunteering in Northern Ireland 10

2.2.3 Mental Health 11

2.2.4 Physical Health 12

2.2.5 Quality of Life & attitudes to ageing 14

2.3 Summary and rationale for study 14

2.4 Aims of project 15

2.5 Methodology

2.5.1 Sampling frame 15

2.5.2 Measures 16

3.0 Main Findings

3.1 Description of baseline sample 19

3.2 Main activities carried out within volunteer organisations 22

3.3 Reasons for volunteering 22

3.4 Reported Health & Wellbeing at baseline

3.4.1 General diagnosed medical conditions 23

3.4.2 The number of diagnosed medical conditions 24

Contents

			Page
	3.4.3	Satisfaction with health	25
	3.4.4	Functional status	25
	3.4.5	Rates of reported disability	27
	3.4.6	Activity levels at baseline	29
3.5	Response rates and health		30
3.6	Comparing reported health at baseline and 6 months		
	3.6.1	General medical conditions	33
	3.6.2	WHOQUAL-BREF Physical health Scale	34
	3.6.3	WHOQUAL-BREF Psychological health Scale	35
	3.6.4	AAQ Physical Change Scale	35
	3.6.5	AAQ Psychological Growth Scale	35
	3.6.6	AAQ Psychological Loss Scale	35

Acknowledgements

Volunteer Now would like to thank all those individuals who took the time to complete the survey. Thanks also to the members of the project advisory group and research reference group who provide ongoing advice on the work of the project.

Thanks to the Atlantic Philanthropies for funding this project. The aim of this organisation is to bring positive change to the lives of disadvantaged and vulnerable people around the world through funding projects whose aims fit with their vision. Further information can be found at www.atlanticphilanthropies.org

September 2011

Volunteer Now works to promote, enhance and support volunteering across Northern Ireland. Volunteer Now is about connecting with individuals and organisations to build healthy communities and create positive change.

Volunteer Now enhances recognition for the contribution volunteers make, provides access to opportunities and encourages people to volunteer.

We provide training, information, guidance and support to volunteer-involving organisations on issues of good practice and policy regarding volunteering, volunteer management, child protection, safeguarding vulnerable adults and governance.

The Unlocking Potential Project can provide information and support on how to successfully attract, support and retain older volunteers. To find out more, including names, role and contact details of the project staff, go to http://www.volunteernow.co.uk/supporting-organisations/developing-volunteering and clicking on Volunteering for Over 50s.

Additional copies of the report can be downloaded from www.volunteernow.co.uk.

Volunteer Now Contacts

Denise Hayward
Director of Outreach & Engagement
34 Shaftesbury Square
Belfast BT2 7DB
T: 028 9020 0863, F:028 90237570
E: Denise.Hayward@volunteernow.co.uk W: www.volunteernow.co.uk

Billy Eagleson
Manager, Unlocking Potential Project
34 Shaftesbury Square
Belfast BT2 7DB
T: 028 9020 0863, F:028 90237570
E: Billy.Eagleson@volunteernow.co.uk W: www.volunteernow.co.uk

Christine Irvine
Senior Policy & Information officer
129 Ormeau Road, Belfast, BT7 1SH
T: 028 9023 6100, F: 028 9023 7570
E: Christine.Irvine@volunteernow.co.uk W: www.volunteernow.co.uk

University of Ulster Research Team

Professor Maurice Stringer
Director Psychology Research Institute
School of Psychology
T: 028 70124656
E: m.stringer@ulster.ac.uk
W: http://www.science.ulster.ac.uk/psyri/Professor-MauriceStringer,17.html#page=background

Dr. John Mallett
Psychology Research institute
School of Psychology
University of Ulster
T: 028 71674234
E: j.mallett@ulster.ac.uk
W: http://www.science.ulster.ac.uk/psyri/Dr-John-Mallett.html#page=background

1.0 Executive Summary

Work is currently ongoing on a longitudinal research study commissioned by Volunteer Now and funded by The Atlantic Philanthropies examining the relationship between formal volunteering and health in the 50+ age group in Northern Ireland (2010-12).

Since March 2010 people aged 50+ engaged in formal volunteering activities in Northern Ireland have been involved in providing data for this study over four consecutive 6-month time periods. Data collection will be completed in June 2012 with a final report of the findings published early in 2013. When data for all time points have been collated and analysed, it is hoped that the study will provide new insights into our understanding of natural age related change trajectories in health, quality of life and activity levels in this target group.

Results are still preliminary at this point but the key findings to date are as follows:

- The majority of older volunteers in the sample (91%) expressed satisfaction with their volunteering experiences in the six months since baseline.

- Given the age profile of this cohort at baseline (50-89 years) the participant sample is a relatively healthy one.

- There were some health differences in reported health and activity levels between volunteers who completed the survey at 6 months compared to those who did not respond at 6 months. Those who completed questionnaires at both time points were more likely than those who did not complete at time 2 to report better physical health, satisfaction with their quality of life and their ability to perform daily activities. Those completing questionnaires on both time occasions were also less likely to report being limited by pain than those who did not complete at the six month time point.

- The most commonly reported medical conditions at baseline were hypertension (33%), Arthritis/Rheumatism (29%) and heart problems (11.7%) with smaller numbers reporting serious medical conditions such as diabetes, stroke, cancer and chronic lung disease.

- Over half of those who responded at baseline (55%) reported having at least one diagnosed medical condition and 48.1% indicated that physical pain prevented them from doing what they needed to do. Paradoxically, 79%, 86.3% and 90.8% respectively expressed satisfaction with their overall health, their ability to perform daily activities and their ability to 'get around'.

- With little exception (<1%), the majority of volunteers have reported being involved in mild, moderate and vigorous activities for at least 1-2 days in the week prior to completing the baseline questionnaire. In addition, attitudes to

ageing were generally positive at baseline and remained stable over the time period from baseline to six months.

- 6 months after baseline there were some reported physical health improvements and significant increases in the reporting of all levels of physical activity (mild, moderate and vigorous).

- The sample included both experienced volunteers (64.7%) and those new to volunteering at baseline (33.7). There were no significant differences in the reported health status of new and experienced volunteers at baseline.

2.0 Introduction

This report was prepared by the University of Ulster's School of Psychology as the first of two quantitative interim reports in advance of the full report due in January 2013. The full report will also include and complement the findings of a parallel qualitative study based on focus group interviews with volunteers and non-volunteers carried out by the same team at the University of Ulster examining aspects of volunteering and health.

All reports have a focus on the 50+ age group in Northern Ireland in terms of increasing our understanding of how their volunteering experiences relate to their self-reported health and quality of life in general. These reports are providing an up to date picture of the volunteering and health patterns of this age group. This age group is one which is growing as a proportion of the overall population of Northern Ireland and one that is therefore gaining increasing influence over the shape of the political, economic, social, cultural and general civic landscape here.

The 'Unlocking Potential Project' is a five year initiative which began in 2008. It is funded by The Atlantic Philanthropies and managed by Volunteer Now. The overall aim of the project is to encourage and support healthier ageing and civic engagement in Northern Ireland, by enabling and empowering older people to take part in volunteering. It is planned that over the course of the 5 years, the project will be informed by ongoing pieces of primary and secondary research, which will be used to inform the shape and direction it takes. This research report is one of a number of pieces of work that have been completed and work is ongoing in relation to collecting complementary quantitative and qualitative data on this issue. The full range of research reports that the project has carried out can be found by going to http://www.volunteernow.co.uk/publications and searching under 'Older People Volunteering'.

2.1 The Unlocking Potential Project

The project has a number of specific objectives which are listed below:-

- To challenge attitudes and raise awareness of the contribution and benefits of volunteering;
- To increase the number of older volunteers over the next five years *(50-64 year olds by 5% and the number of 65+ years olds by 10%).* In numeric terms this equates to an expected increase of 7,650 volunteers;
- To improve access to and develop volunteer opportunities for older people that meet their expectations and positively impact on communities; and
- To enhance, older people's quality of life in relation to equality, social inclusion, support and health issues.

Volunteer Now commissioned the University of Ulster's School of Psychology to help carry out a questionnaire survey among the over 50s in Northern Ireland engaged in formal volunteering activities across a range of volunteer involving organisations. There is currently a lack of detailed empirical evidence based research in Northern Ireland examining the relationship between volunteering and health. The focus of the questions in the 2009 survey was on different themes and the methodology included 6 focus groups. In 2009, the key themes included 50+ year olds lifestyle and availability of free time, caring responsibilities, volunteering imagery, marketing and advertising and volunteer activity and participation. The 'Making the Connection' Report (2009) is available to download from the Volunteer Now organisation website at http://www.volunteernow.co.uk/publications . The aim of this second survey was to explore some of the issues raised in the 'Making the Connection' report, but also to investigate some new areas.

2.2. Background

2.2.1 Population changes

In 2008 the proportion of people aged 65+ in Northern Ireland was 14% (249, 000 people) compared to 16% in the UK and 11.1% in the Republic of Ireland. The steady growth in the numbers of older people in the past 4 decades means that there were approx. 717, 000 people aged 65+ and a million aged 60+ living on the island of Ireland (McGill, 2010). This report also states that in Northern Ireland between 2010 and 2041 the 65+ population is projected to make up nearly one quarter of the total population (24%). One of the effects of this demographic change is that the risk of becoming socially excluded is rising, particularly among older people who have left the labour market. For this reason social inclusion of the elderly and strategies to promote voluntary work among older people are of growing importance.

Volunteering is a powerful tool in encouraging active citizenship and engagement and plays a key role in addressing key government priorities which are focused on older people which include active ageing, healthy living, social inclusion, equality, citizenship and community safety. Maintaining the health of the population is a key policy concern. 'A Healthier Future' is the regional strategy which provides a vision for how health and social services will develop and function over the next 20 year (DHSSPSNI, 2004). In March 2005 the Government launched "Ageing in an Inclusive Society: a strategy for promoting the social inclusion of older people". The strategy aimed to "to ensure that age related policies and practices create an enabling environment, which offers everyone the opportunity to make informed choices so that they may pursue healthy, active and positive ageing". This strategy is due out for consultation again as the age sector in N. Ireland and other groups interested in ageing issues felt it was in need of updating. Other government policies such as 'Ageing in an Inclusive Society' (OFMDFM, 2005) and 'Lifetime Opportunities Strategy' (OFMDFM, 2006) demonstrate the importance of supporting and

encouraging active ageing, healthy eating, social inclusion, promoting equality, promoting citizenship and regenerating neighbourhoods.

In May 2011, the Department for Social Development published the current 'Volunteering Strategy for Northern Ireland' following an extensive consultation period and this strategy was subsequently agreed by the Northern Ireland Executive at its meeting in June 2011 (see the full consultation response document at http://www.dsdni.gov.uk/index/voluntary_and_community.htm. Both of these strategies reinforce the importance of older people and volunteering as key public policy priorities in Northern Ireland. It is timely therefore that this interim report ha been produced in 2011 (the designated European Year of Volunteering) and the EC has also declared 2012 as the European year of active ageing.

2.2.2 Volunteering in N. Ireland.

Northern Ireland has a vibrant volunteering base. Figures from the 2007, 'It's All About Time' survey show that there are 282,067 people over the age of 16 involved in formal volunteering, these are people who are carrying out unpaid work with or under the auspices of an organisation. In percentage terms it has been estimated that 21% of the Northern Ireland population are involved in 'Formal Volunteering'. It has also been estimated that in 2007 the economic value of 'Formal Volunteering' was £433 million. There is substantial evidence which demonstrates the important role that volunteers have in the sustainability and capacity building of many organisations[1]. Almost 8 out of 10 organisations questioned in 'Its All About Time' stated that they could not operate without the support of volunteers (Volunteer Development Agency, 2007).

A comparison of this survey in 2007 with more recent figures produced by Volunteer Now's "Making the Connection' report (2009) and 'Making the Connection 2" report (2011) shows an increasing trend in volunteering participation rates among the 50+ age group. In 2011 approximately 36% and 59% respectively of this age group indicated involvement in formal and informal volunteering activities. Furthermore, older volunteers are more likely to give more time than any other age group (Volunteer Development Agency, 2007).

All volunteers bring their own value to the voluntary work they carry out. Older volunteers, in particular, have been recognised for their particular set of skills (Volunteer Development Agency, 2009; Hoffman, 2008; Hill, 2006; Rochester & Thomas, 2006; Gill, 2006). As a consequence of the demographic shift, older people are becoming an increasingly untapped resource for volunteering (Volunteer Development Agency, 2009). Volunteering is a two-way process in which people give time and energy to a charitable cause with no expectation of financial gain or other material benefit (Volunteer Development Agency, 2001). Older people can also be a

[1] The majority (37%) of all volunteering occurs in the voluntary and community sector (75,000 volunteers).

particular resource in complementing the health and social care system through assisting organisations in a voluntary capacity.

2.2.3 Mental Health

Anxiety and depression in later life are both strongly linked to personality, cognitive and physical function, disability and state of health (Gale et al., 2011). In Northern Ireland the heaviest use of health services and poorest mental health is found in people aged 75+ years (Evason et al., 2005). A recent report from Help the Aged (2008) indicated that social isolation and depression are the biggest issues for older people living here. The report also found that 21% of those aged 65+ stated that they are 'always or often lonely', 1 in 4 people aged 65 years and over spend more than 15 hours home alone per day and 53% stated that television was their main form of company (Help the Aged, 2008). Also a recent study carried out in the UK reported on an epidemic of late onset drinking amongst the over 60s (Foundation66, 2009). Herbert (2008) investigated the possible effect of volunteering across differing age groups in the Northern Ireland context and produced evidence for the impact of volunteering on the physical health and mental health of older people. This report suggested that voluntary work had positive effects on the depression scores of those people who were 65+ years.

A recent study of older people and volunteering found an interesting contrast in the attitude and life satisfaction of the volunteers and non-volunteers who were over 65 (Volunteer Development Agency, 2009). The volunteers described feeling like they were making a useful contribution to society, having great satisfaction and a sense of self-worth whereas the non-volunteers described feeling under-valued and stuck in a routine of day to day life. The health and social benefits of volunteering were highlighted by respondents in this research. The benefits were more likely to be mentioned by the volunteers than the non-volunteers. The non-volunteers, particularly the older respondents (65+), were more likely to use health concerns as a reason for not volunteering, a finding that has been supported in other research (Mellor et al., 2008). Furthermore, research by Greenfield & Marks (2008) showed that formal volunteering was associated with more positive affect and moderated the negative effects of losing major role identities due to events such as retirement, widowhood, children leaving home etc.). Linked to this idea, Lum & Lightfoot (2005) and others (e.g. Moen et al., 1992) have suggested that some of the positive benefits from volunteering stem from role enhancement.

> *"…Older people who volunteer enhance their role, which then amplifies their opportunities to increase social networks, power, prestige, resources, and emotional gratification, which can have a positive effect on their health…" (p33).*

However, role theory also suggests that there may be a limit to the size of the role a volunteer takes on and those who volunteer too much may experience role strain and thus may not experience physical and mental health benefits of volunteering

(Moen et al. 1992; Morrow-Howell et al. 2003; Musick et al. 1999; Van Willigen, 2000). Windsor et al., (2008) examined the relationship between the frequency of volunteering and wellbeing among a sample of Australian survey of people aged 64-68 years. The found that non-volunteers and those volunteering at high levels produced lower well-being scores relative to those who volunteered at moderate levels. Their results suggest that there might be an optimal frequency of engagement in volunteering activity in terms of psychological wellbeing gains.

Role theory also suggests that role strain will depend on the resources available to the volunteer such as social and organisational support mechanisms (Morrow-Howell et al., 2003; Musick et al., 1999). A recent study by Tang et al., (2010) examined the link between organisational support and volunteering benefits for older adults across ten volunteer programmes. Organisational support (measured by choice of volunteer activity, training, and on-going support) had significant direct associations with volunteers' perceived contribution and personal benefits and perceived contribution was significantly related to mental health. For this reason the current study will examine the amount of time spent on volunteering activities and the degree to which volunteers feel supported and satisfied in their activities.

2.2.4 Physical Health

Retirement can be a particularly stressful life event. Moving out of the workforce and into retirement also brings with it a change in lifestyle. A recent study from the English Longitudinal Study of Ageing (ELSA) found that retirement significantly increases the risk of being diagnosed with a chronic condition such as cardiovascular disease and cancer. Lupton et al., (2009) has reported a significant effect of later retirement age in delaying the age of onset of Alzheimer's disease for men. It also suggested that maintaining cognitive activity helped to reduce the risk of dementia. Greater involvement in social and leisure activities and fewer television viewing hours were also reported as reducing the risk as there is a strong association between increasing age, reduced social activity and increased television viewing (Help the Aged, 2011). TV viewing was also the most regular hobby for 81% of the 50+ year olds in Northern Ireland (Volunteer Development Agency, 2009). It is important that initiatives are put into place which helps to promote and encourage healthy activities as a lifestyle choice.

In addition, the benefits of getting involved in volunteering can also be multiple and varied and cross physical, mental, social and economic boundaries (Volunteer Development Agency, 2001). Some of reported health impacts which have been associated with volunteering include lower blood pressure, stronger immune system, the ability to cope with one's own illness, improvements in self-rated health, improved self-esteem, reduced social isolation, increased social support and interaction, improved life satisfaction, healthy behaviours and enhanced community links and connectedness (Graff 1991; Musick & Herzog, 1999; Volunteering England, 2008; Volunteer Development Agency, 2007; Herbert, 2008; Rochester and Thomas, 2006; Price, 2007 and Hill, 2006). Thoits & Hewitt (2001) have suggested a bi-

directionality in the relationship between volunteering and health and argue that that people with greater personal wellbeing (i.e. greater psychosocial resources and better mental and physical health) may volunteer more often, and people who are involved in community service may have greater life satisfaction, self-esteem, sense of purpose in life, physical and mental health. Their longitudinal study of provided evidence of social selection as well as social causation effects of volunteering. For this reason, this study will also acknowledge the possibility of selection effects when examining the health of volunteers.

In the UK, the Institute of Volunteer Research (2008) has also provided support for the beneficial effects of volunteering on older people's physical and mental health. They found that people who had retired from work were particularly likely to receive a sense of purpose, role identity, self-respect and reduced isolation from volunteering. There is a clear argument that maintaining civic engagement and community activity is important for maintaining the physical and mental health of older people. There is continuing debate regarding the causal relationship between health and volunteering. The University of Wales Lampeter carried out a systematic review of existing research to ascertain the health impacts of volunteering on individual volunteers and on health service users. The report showed very clear links between volunteering and positive health impacts. In particular, the review highlighted that older volunteers appeared to derive greater health benefits than younger volunteers (Volunteering England, 2008). The Corporation for National Community Service in the US suggests strongly that people who engage in volunteer activities were less likely to suffer ill health later in life and that volunteer activities introduced people into a positive 'reinforcing cycle' of good health and future volunteering (2007).

Lum and Lightfoot (2005) have provided valuable insights to our understanding of the connections between volunteerism and health. They make the point that most research to date supports the notion that volunteering can help people to maintain their self-reported physical and mental health or slow down age related health declines. In their longitudinal study of people aged 70+ in the US they found that those who had volunteered (at least 100 hours in the year) showed slower declines in self-reported health and physical functioning, slower increases in depression levels and lower mortality rates than non-volunteers. Importantly, volunteering was not shown to be linked to the rate of accumulation of the physician diagnosed medical conditions over time. It would appear therefore that volunteering does not impact on the likelihood of developing a general medical condition but may impact on a person's ability to cope and on attitudes to ageing in general through enhanced social support networks and reciprocity. The findings of this study can be tied to a previous study by Sabin (1993) who concluded that the positive effect of volunteering was stronger for those who reported being in good health. This suggests that volunteering could help maintain good health but may not improve the condition of those whose health is poor (p150).

Sabin's study was an example of research demonstrating that the effects of volunteering on health are moderated by actual health status of the volunteer.

Another study by Musick et al., (1999) using longitudinal data to estimate the effect of volunteering on mortality rates found that volunteering was most beneficial for those who had initially reported low levels of social interaction and social engagement. Harris & Thoresen's (2005) longitudinal study of health and social functioning among a representative sample of people aged 70+ living in the USA found that frequent volunteering was associated with reduced mortality (after adjusting for covariates such as demographics, medical status, physical activity and social integration.) Frequent volunteers fared better than non-volunteers and the association between frequency of volunteering and mortality was strongest for those who visited with friends or attended religious services. This latter finding is somewhat at odds with Musik (1999). For this reason, the possible moderating role of social support and health status will be investigated further in this study.

2.2.5 Quality of life and attitudes to ageing

Most studies of life at older ages that found that a person's health is strongly associated with heir perceived quality of life (Bowling et al, 2004; Netuveli et al., 2005; Wiggins et al., 2004). Some studies have also shown that ageing is perceived to decrease self-perceived quality of life (William, 1977; Wiggins et al., 2004; Von dem Kneseback, 2007). Other studies have demonstrated that when other factors are taken into account the negative effects of ageing might disappear (Stock et al., 1983; Netuveli et al., 2006; Zaninotto et al., 2009). For this reason the study will assess attitudes to ageing as well as aspects of perceived quality of life. Demakakos et al., (2007) add an interesting dimension to the debate by describing the potential psychosocial pathways to health. They have claimed that that a younger age identity and positive age perceptions serve to "…catalyse an increase in psychosocial resources that can benefit later life and extend health…" (p78).

2.3 Summary of research and rationale for study

A systematic review by Casiday et al., (2008) concluded that the majority of research papers in this area were from the US, including all of the large scale longitudinal studies of health impacts on volunteers, thus pointing to a need for a UK based longitudinal study of the health of volunteers.

Also, the majority of studies examining the health impacts of volunteering have been related to volunteering in general rather than any particular setting or role. This research will examine contextual factors such as setting and focus specifically on older adults (50+) since older volunteers appear to derive greater benefit from volunteering than younger ones (Van Willigen, 2000; Li & Ferraro, 2006). In addition, the potential age range of the sample (50+) will enable comparisons between the middle and older age groups. The uniqueness of this research therefore lies in the cultural context, the target age group and the design of the study. The use of a longitudinal designs allow for the measurement of continuous change over time. Rather than simply comparing a person's 'before' and 'after' status, longitudinal growth modelling is a more subtle and effective way of revealing the features of

individual change trajectories over time (Singer & Willet, 2003). In addition, the collection of data at 4 time points will allow for the assessment of linear as well as curvi-linear health trajectories across differing volunteering experiences.

2.4 Aims of the project

Main Research Question

Are there health and well being benefits for the over 50's, in Northern Ireland, who engage in formal volunteering?

The main objectives of the current study are to:

1) Assess whether involvement in various formal volunteering activities are related to differences in older people's reported health and well-being status.

2) Assess whether the experiences of formal volunteering among older people (50+) predict changes in health over an 18 month time period. Specifically, the study aims to determine the extent to which formal volunteering activities moderate the relationship between ageing and health and whether the volunteering experience has an impact on natural trajectories of health improvement, maintenance or decline.

3) In addition, the study will examine whether demographic variables (e.g. age, sex, living alone, retirement), attitudes to ageing and levels of reported social support mediate the relationship between volunteering experiences and health and whether such variables predict variations in individual health and wellbeing trajectories over time.

2.5 Methodology

2.5.1 The sampling frame

Fiedwork for the study began in March 2010. The investigation employed a mixed methods approach comprising a longitudinal questionnaire survey of older adult volunteers in N. Ireland over a period of 18 months, complemented by the strategic use of focus group interviews with a cross-section of older volunteers and non-volunteers.

The design of the study provided a useful longitudinal framework for the evaluation of change in reported health status with baseline data collected from both older participants undertaking formal volunteering activities for the first time and existing older volunteers with some previous volunteering experience. Data collection 6 months after baseline was completed in July 2011 and the data has now been collated and analysed for this report. Data collection for two further time points (12

and 18 months post-baseline) will be completed by May 2012 with a final report on the findings available in early 2013.

In addition to the quantitatve study, focus group interviews are being conducted among distinct older groups (older volunteers with a range of volunteering experiences and older non-volunteers). It is intended that the findings of the initial focus groups will be reported in January 2012 and the findings from the stage 2 focus groups reported along with the quantitative findings early in 2013.

2.5.2 Measures

The quantitative questionnaires at each time point contained common questions relating to the following themes:

The number of physician-diagnosed health conditions.
An adaptation of Lum & Lightfoot's (2005) classification was presented as a series of YES/NO questions to 7 general medical conditions (High blood pressure, diabetes or high blood sugar, Cancer or a malignant tumour of any kind, Chronic lung disease, heart attack or other heart problems, Stroke, Arthritis/rheumatism.

Self-reported height and weight.
Responses to these questions were used to calculate each respondent's Body Mass Index (BMI).

Social contact and support.
The Lubben Social Network Scale-6 (LSNS-6) is a six item abbreviated version of the Lubben Social Network Scale (Lubben et al., 2006). The LSNS-6 has two sub-scales (friends and family) with each subscale containing three questions relating to the number of friends or relatives the respondent has been in contact with/ feels at ease with or feels close to on at least a monthly basis. Responses to all scale questions ranged from none to nine or more friends/relatives placed on a 6-point Likert scale. The LSNS-6 total score is an equally weighted sum of these six items. Scores range from 0 to 30 with higher scores indicating more social contact and support.

Quality of life and mental health.
The World Health Organisation's Quality of Life- Brief Instrument (WHOQOL-BREF) consists of 26 items assessing four domains of quality of life (Physical Health, Psychological, Environment and Social relationships). The three questions relating to the social relationships domain were dropped and replaced by six questions from the LSNS-6. To reduce the questionnaire length only the Physical and Psychological domains were employed. The Physical domain contained six questions each measured on a 5-point Likert scale relating to activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest and work capacity. The Psychological domain also contained six similarly scored Likert type items relating to bodily image and appearance, negative feelings, positive feelings, self-esteem, spirituality / religion / personal beliefs, thinking and concentration. In addition to the physical and psychological domain scores and the WHOQOL-BREF also contains two separate

items asking about an individual's overall perception of their quality of life and their health. Both items were presented on a 5- point Likert scale from 'very poor' to 'very good'. Domain scores are scaled in a positive direction (i.e. higher scores denote higher quality of life). The mean score of items within each domain is used to calculate the domain score. Mean scores were then multiplied by 4 in order to make domain scores comparable with the scores used in the larger WHOQOL-100.

Activity levels/ functional status.
Three questions were included relating to activity levels during the previous seven days. Respondents were asked how many days in the previous week they had been engaged in vigorous, moderate and mild exercise for at least 10 minutes. Examples of vigorous exercise offered were running, aerobics, heavy gardening with examples of moderate exercise given as cycling, vacuuming, gardening and mild exercise defined as walking at a brisk pace. Three other Likert type questions on 5-point Likert scales assessed respondents' satisfaction with their ability to 'perform daily acts', ability to 'get around' and the the extent to which physical pain prevents them from doing what they need to do.

Attitudes to Ageing.
The attitudes to Ageing Questionnaire (AAQ) devised by Laidlaw et al., (2007) is a self-report measure with which older people can express their attitudes to the process of ageing. It contains 24 items aimed at assessing three attitudinal sub-scales (attitudes to physical change, psychological growth and psychosocial loss,). Each subscale contained 8 items assessed on a 5-point Likert scale. The physical change subscale focuses on physical functioning with items related primarily to health, exercise and the experience of ageing itself. Scale 2 is explicitly positive in focus and can be summarised as a 'Wisdom' or 'Growth' scale; with items reflecting both positive (and possible surprising) gains from ageing in relation to the self and to others. Scale 3 examines psychosocial losses relevant to older adults in which old age is seen primarily as a negative experience involving psychological and social loss. Scores on each subscale are derived by equally summating all 8 items and each subscale scores ranged from (0-32) with higher scores indicating greater more positive attitudes to physical ageing, greater personal growth and greater psychosocial loss respectively.

Nature of the volunteering organisation.
Respondents were asked to provide the name of the host organisation they mainly volunteer with and these were subsequently classified by Volunteer Now in terms of the nature of the organisation (i.e. Voluntary/community, statutory, church/faith-based or other), the sub-sector to which the organisation can best be placed (older people, community development, disability, advice/information, arts/culture/heritage, Young people/children, disability, education/training, health and wellbeing, other) and the estimated annual income of the organisation (less than £1000, £1K-£10K, £10K-£100K, £100K, £100-£250K, £250K-£500K, more than £500K).

Demographic questions
Questions were also included on sex of respondent, age, marital status, retirement status, living alone or with others, nature of the volunteering experience.

In addition to the commonly assessed questions over the four time points some variations in the content of the four time point questionnaires are worthy of note. The baseline questionnaire contained questions on individual motivations for volunteering, whereas the time point 2 questionnaire replaced these questions with items relating the volunteering experience (i.e. the perceived personal benefits of volunteering) and also included questions on volunteering quantity (amount of hours per annum) and quality (nature of the role). The time point 3 questionnaire subsequently replaced the volunteering experience items with somewhat different questions on the perceived positive and negative aspects of volunteering and these questions were again asked at time point. Table 1 summarises the four timeframes for fieldwork in the quantitative study as wells as the key themes assessed at each stage of the data collection.

Table 1.
Summary of quantitative study time frame and measures used.

Quantitative Questionnaire content and fieldwork timings			
Baseline Questionnaire 1	***6 months Questionnaire 2***	***12 months Questionnaire 3***	***18 months Questionnaire 4***
Stage 1 Fieldwork March-November 2010	Stage 2 Fieldwork October '10 - June 2011.	Stage 3 Fieldwork March '11-December 2012	Stage 4 Fieldwork September '11 -June 2012
Common health/ and quality of life questions (see section ? for full descriptions) Questions on the types of volunteering activities Questions motivations / reasons for choosing formal volunteering	**Common health/ and quality of life questions** *PLUS* *Questions on…* The volunteering experience (perceived personal benefits of volunteering) Changes in circumstances in previous 6 months	**Common health/ and quality of life questions** *PLUS* *Questions on…* The volunteering experience (positive and negative aspects of volunteering) Changes in circumstances in previous 6 months	**Common health/ and quality of life questions** PLUS *Questions on…* The volunteering experience (positive and negative aspects of volunteering) Changes in circumstances in previous 6 months
Sample Response (N= 344)	**Sample Response (N=287)**	**Sample response not yet known**	**Sample response not yet known**

Note: Text in bold highlights common questions presented at each time point.

3.0 Main Findings

3.1 Description of baseline sample.

Demographic composition (figure 1)
The baseline sample consisted of 344 participants (60% female and 40% male) whose ages ranged from 50 to 90 years (M=64.9, SD=7.6). The majority of respondents were aged 60-69 (51.2%) with smaller numbers in the older 80-89 category (n=14). The sample also comprised a mix of new (33.7%) and experienced volunteers (64.8%). The majority reported living with a spouse or partner (56.4%) with sizeable proportions indicating living alone (27.6%), having caring responsibilities (25.9%) and living with some form of disability (22.7%).

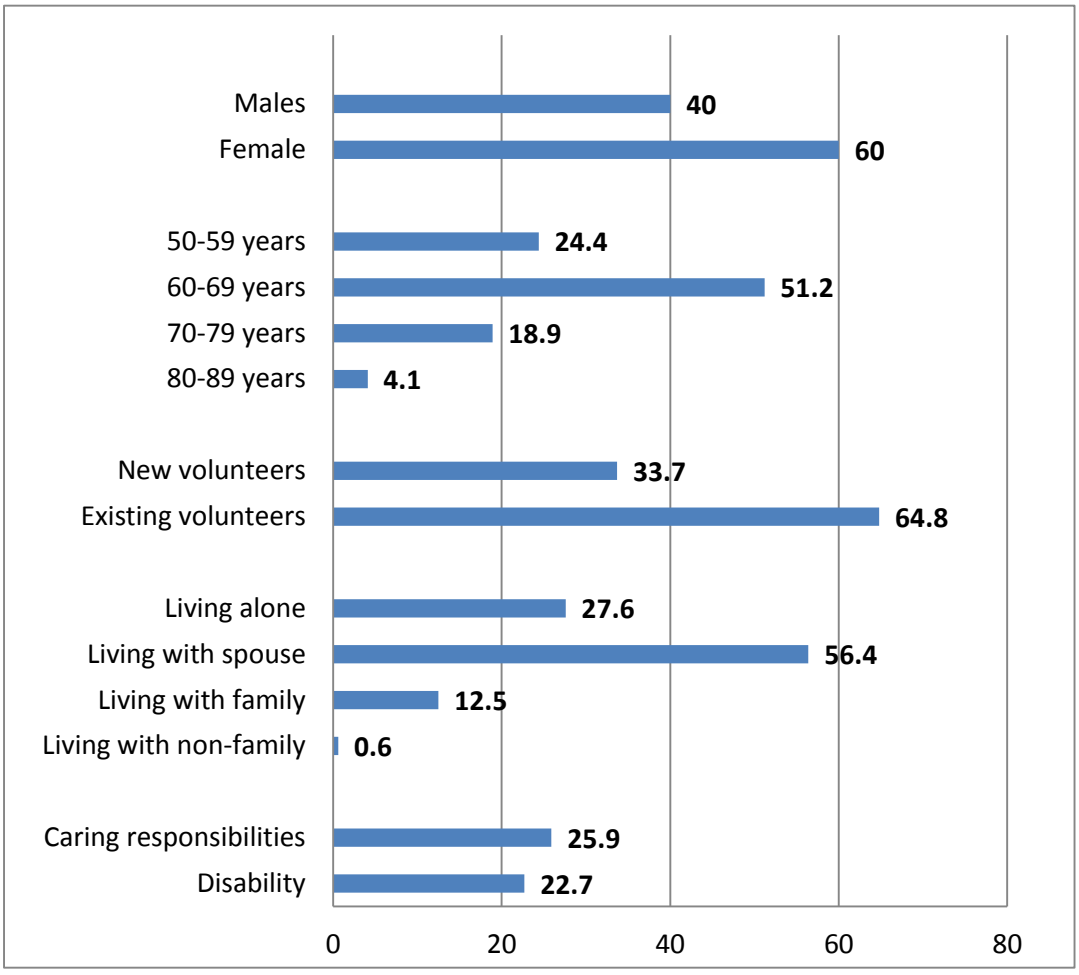

Figure 1. Demographic composition of sample at baseline (% of sample, N=344).

Socio-economic status (figure 2)

The majority of respondents were retired (69.8%) with smaller numbers in full-time or part-time work (18%) and unemployed (8.7%). The sample also reflected a wide range of weekly household incomes with a small proportion of very low household incomes (i.e. 1.7% on £99 or less per week). There were approximately equal

numbers (10.2-11.9%) across the low to middle income bands and few in the higher income bands (19.7% reporting more than £650 per week). Approximately one quarter of volunteers preferred not to answer the income question.

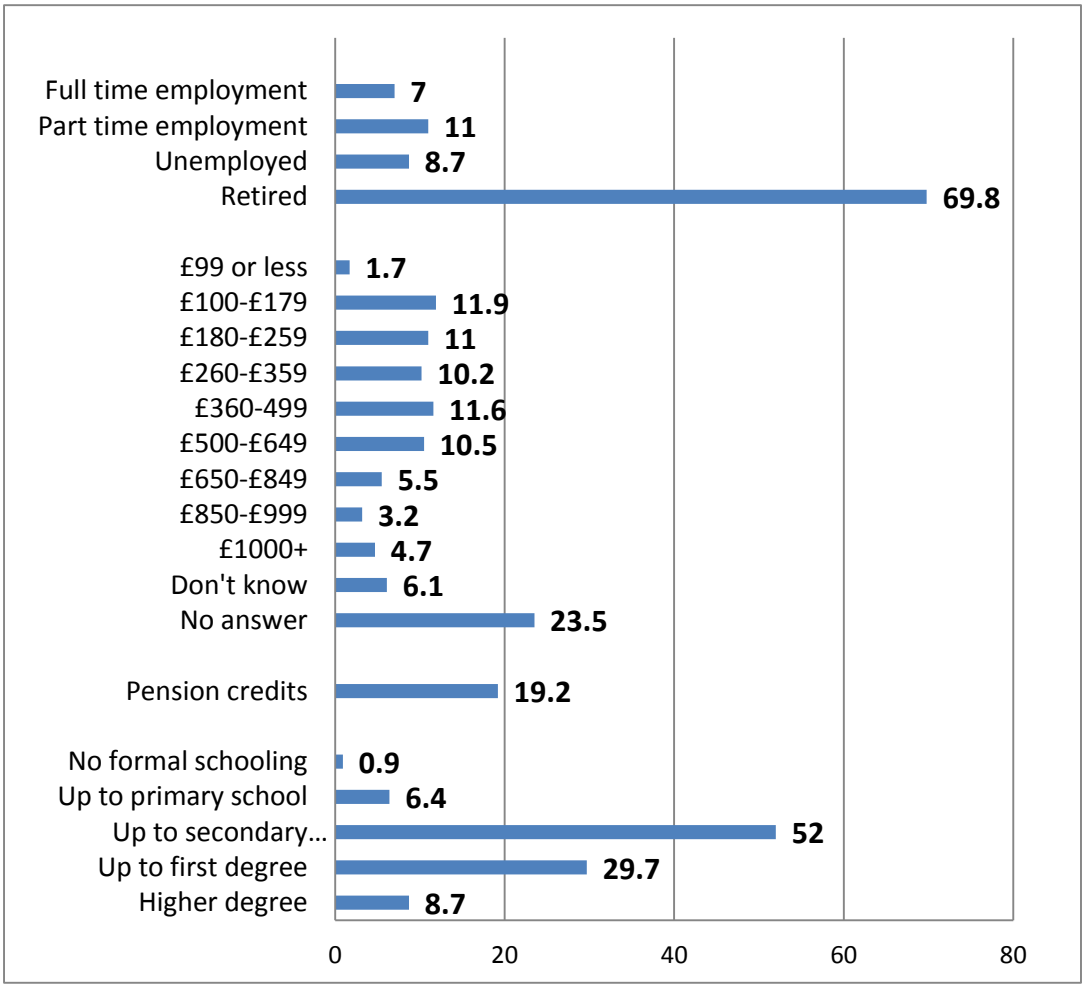

Figure 2. Socio-economic and educational composition of sample at baseline (% of sample, N=344)

Geographical distribution (table1, figures 3-4,)

All local Government districts were represented in the baseline sample with urban areas accounting for proportionately higher numbers (e.g. Belfast, 21.8% and Derry-Londonderry, 10.5%). Table 1 shows that Belfast and the greater Belfast areas accounted for 38.1% of respondents with other regions represented approximately in line with regional variations in the population.

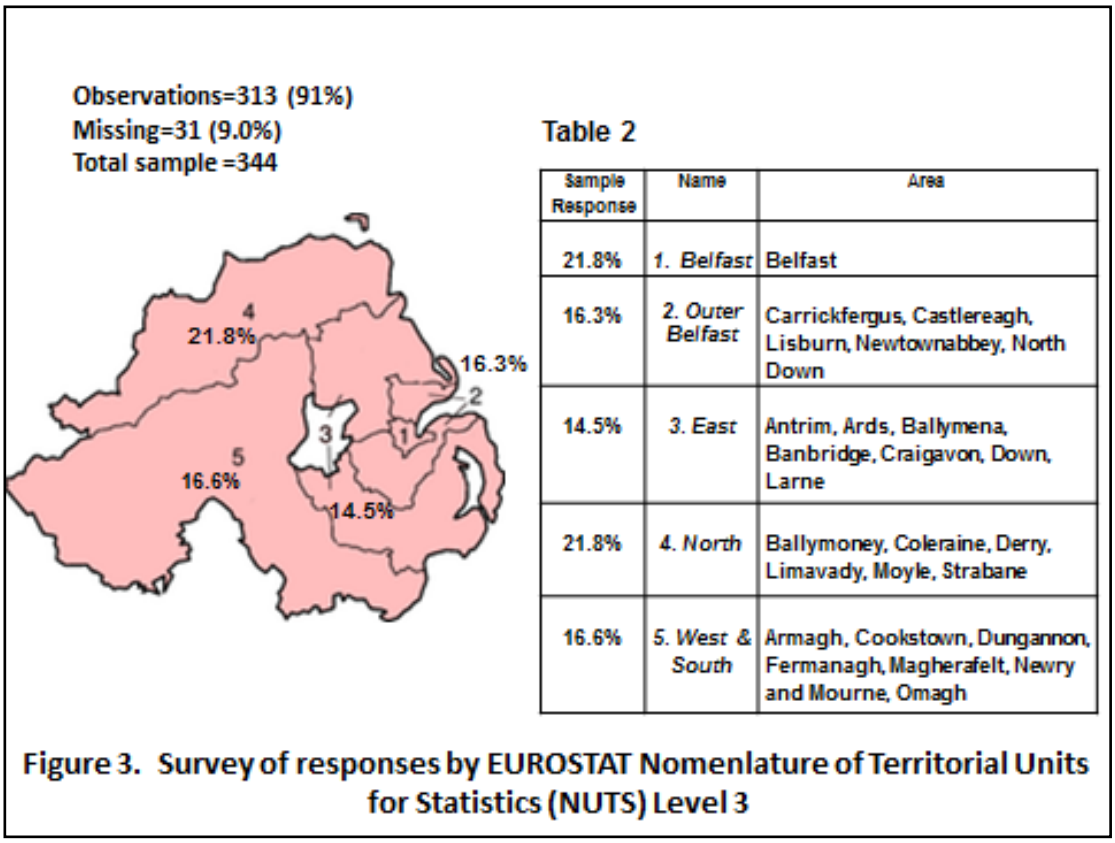

Table 2

Sample Response	Name	Area
21.8%	*1. Belfast*	Belfast
16.3%	*2. Outer Belfast*	Carrickfergus, Castlereagh, Lisburn, Newtownabbey, North Down
14.5%	*3. East*	Antrim, Ards, Ballymena, Banbridge, Craigavon, Down, Larne
21.8%	*4. North*	Ballymoney, Coleraine, Derry, Limavady, Moyle, Strabane
16.6%	*5. West & South*	Armagh, Cookstown, Dungannon, Fermanagh, Magherafelt, Newry and Mourne, Omagh

Figure 3. Survey of responses by EUROSTAT Nomenlature of Territorial Units for Statistics (NUTS) Level 3

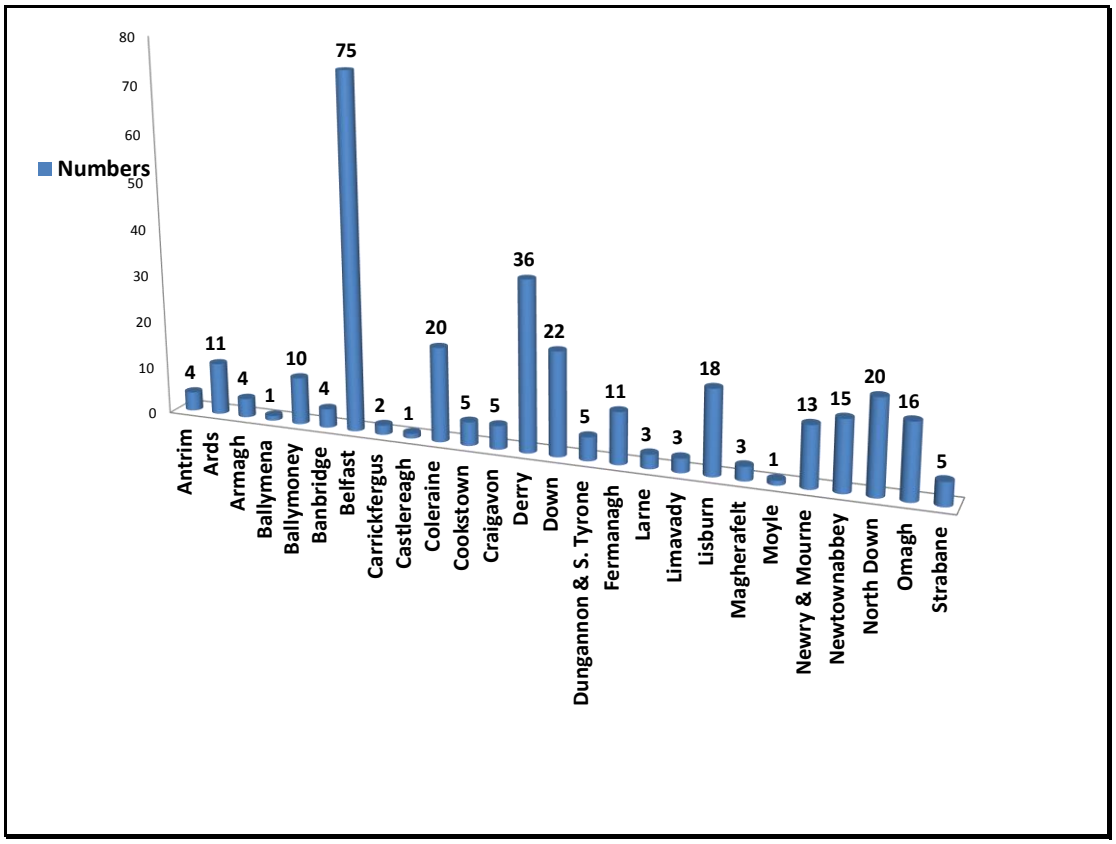

Figure 4. Survey responses by Local Government District (LGN)

3.2 Main activities carried out within volunteering organisations (figure 5)

Respondents reported involvement in a wide variety of activities, the most popular of which were organising/ running events (38.4%), giving advice (30.5%), befriending/mentoring (29.7%) and raising/handling money (29.1%). Volunteers were involved in various combinations of activities and so the percentages in figure 5 do not tally to 100%. Results here indicate diversity in terms of the range of formal volunteering activities being pursued by older people across the sector.

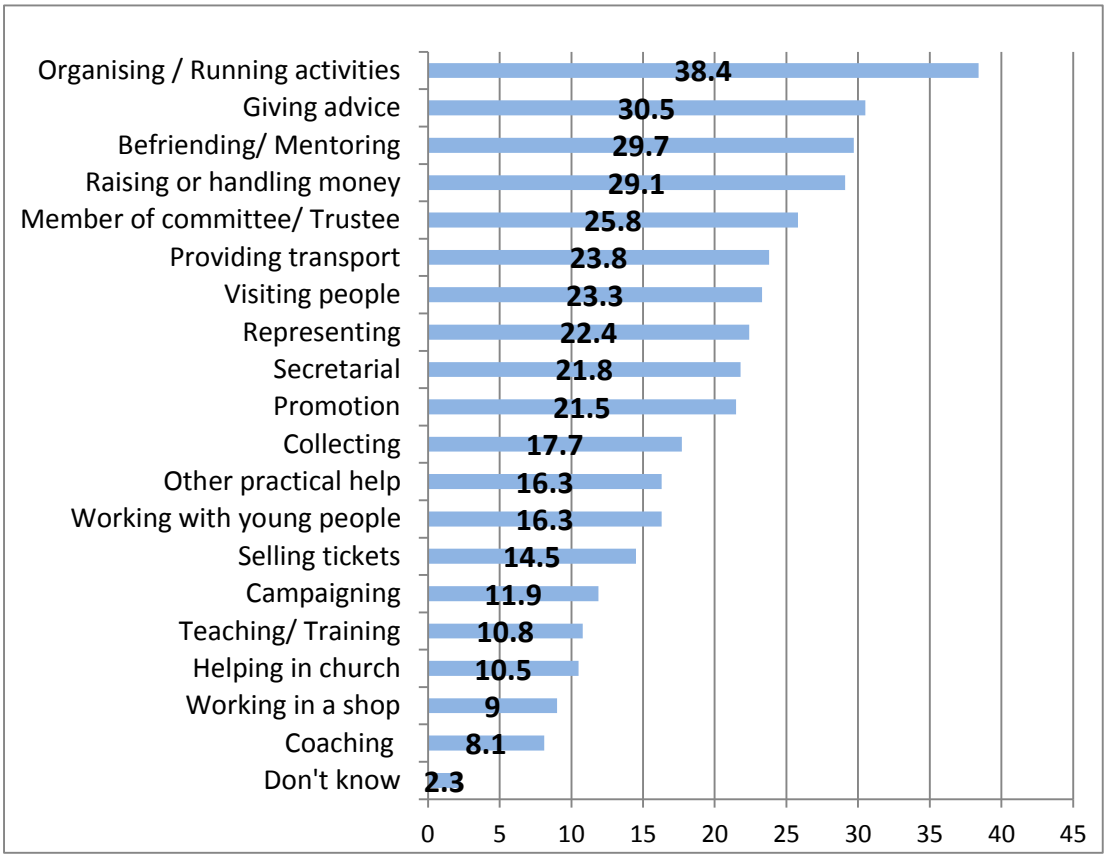

Figure 5. Main activities carried out by respondents in volunteering organisations at baseline (% of sample)

3.3 Reasons for volunteering (figure 6)

The reasons given for volunteering illustrate that many active volunteers in this age group have time to spare, skills to offer and the motivation to become involved in worthwhile activities they perceive as benefiting others in their community whilst enhancing their own learning and enabling more social contact. Altruism featured highly with 65% of respondents wanting to 'improve things' through volunteering and 46.5% stating that the 'cause was important'. The self-enhancing role of volunteering is also emphasised with 54.7% motivated by the prospect of using their existing skills and 35.8% wishing to learn new skills. The desire to learn and acquire new skills does not appear to be related to improving their own career prospects with only 3.5% stating this as a motivating factor and only 4.7% interested in gaining

formal educational qualifications. These findings concur with the reasons for volunteering cited in previous research with the 50+ age group in N. Ireland (Making the Connection report , 2009, page 26).

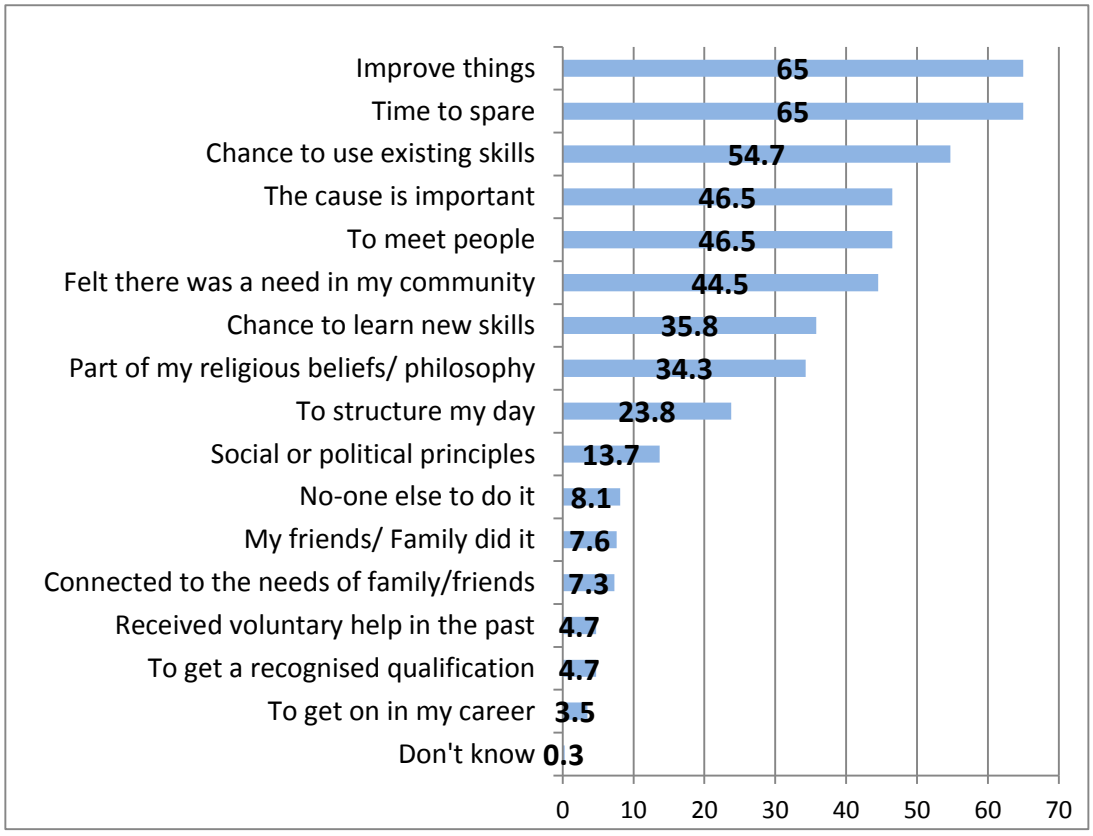

Figure 6. Reasons given for becoming involved in volunteering (% of sample)

3.4 Reported Health & Wellbeing

3.4.1 *Diagnosed medical conditions (figure 7)*

At baseline, just over half of the respondents (54.5%) reported that they had been diagnosed by a doctor as having at least one of the seven general medical conditions depicted in figure 7. Gender differences emerged in the reporting of medical conditions. Although proportionately more males (34.8%) than females (31.9%) reported having high blood pressure, this difference was not statistically significant [$\chi^2(1) = .317$, $p = .573$]. A statistically significant gender difference was evident in relation to the reporting of heart conditions with 18.8% of males and 6.9% of females reporting having heart related problems [$\chi^2(1) = .317$, $p = .573$]. Females on the other hand were more likely to report having arthritis/rheumatism (37.3%) compared to 18.8% of males [$\chi^2(1) = .317$, $p = .573$]. The reporting of diabetes was lower for both males (10.1%) and females (6.4%), with the reporting of stroke, cancers and chronic lung disease lower still (range 2.3% - 3.5%). No gender differences emerged in the reporting of these conditions.

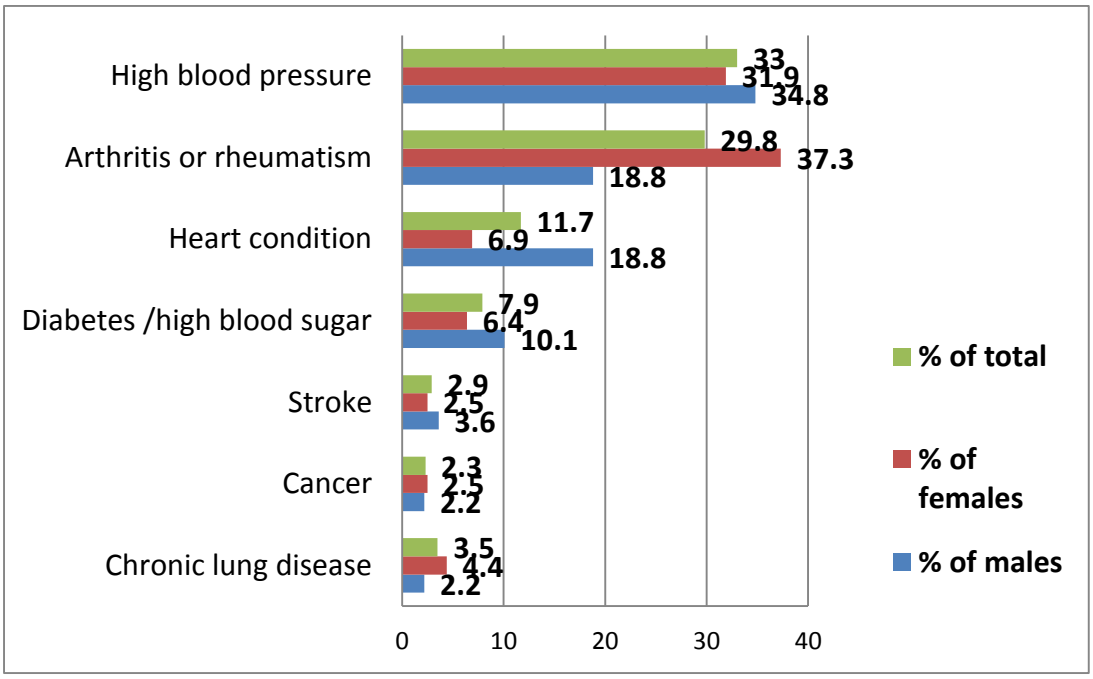

Figure 7. Percentage at baseline reporting various diagnosed medical conditions.

3.4.2 The number of diagnosed medical conditions (figure 8)

The percentage of the sample reporting being condition free was 45.4% and variation in this percentage by sex of respondent and their amount of volunteering experience was not statistically significant (p >.05). Figure 8 shows some age-related variations in condition free reporting but the overall test of this trend was not statistically significant [$\chi^2(3) = 5.29$, $p = .152$]. Although those in the oldest categories were much less likely to report being condition free (21.4%), the lack of statistical significance in the overall age trend is likely due to less pronounced reporting differences between the remaining age categories, particularly between the 60-69 year olds (45.5%) and the 70-79 year olds (41.5%).

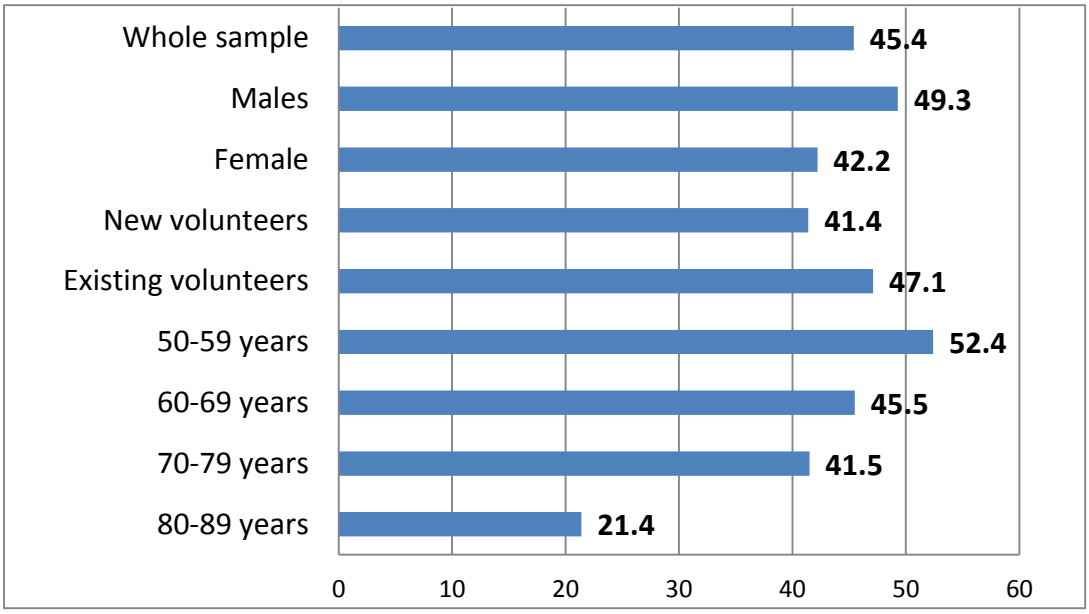

Figure 8. Percentage of sample reporting having NO diagnosed medical conditions by gender, volunteering experience and age.

3.4.3 Satisfaction with own health (figure 9).

On the whole, the majority of volunteers were satisfied with their overall health (78.6%). There were no statistically significant differences in the reporting of health satisfaction by gender or volunteering experience (p >.05). The age differences in reported satisfaction showed that proportionately fewer 50-59 year olds (69%) expressed satisfaction with their health compared to the 60-69 year olds (79.8%) and the 70-79 year olds (89.2%). This finding is somewhat counter-intuitive and is worthy of further exploration and explanation in the final report. Overall, the results on health satisfaction concur with figures cited in the 'Making the Connection 2' report (2011) from the Continuous Household Survey (CHS, 2009-10) which showed that 77% of the 50+ age group reported their health to be 'good' or 'fairly good'.

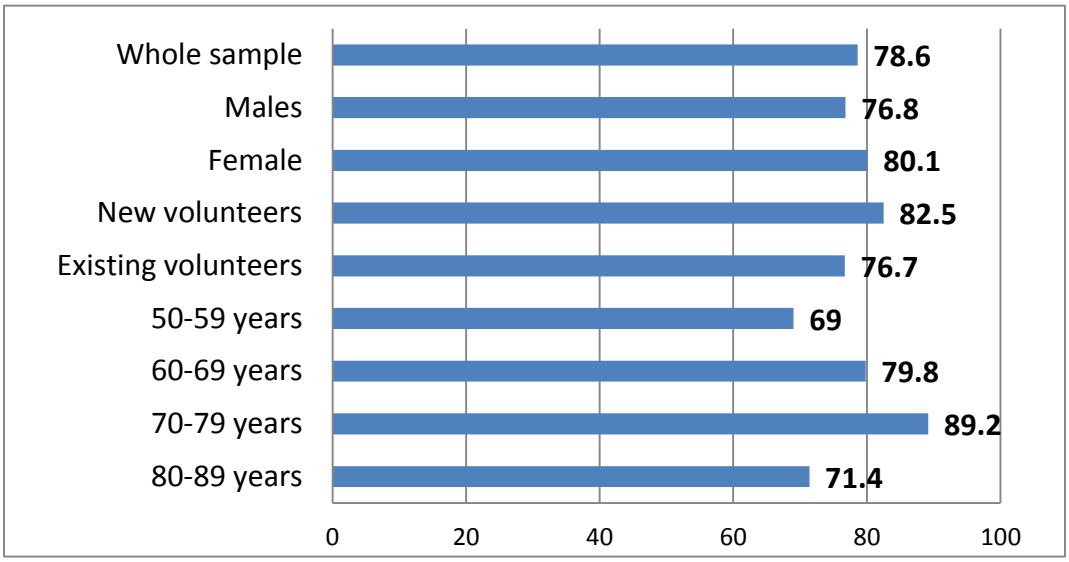

Figure 9. Percentage of sample reporting being 'satisfied' or 'very satisfied' with their own health by gender, volunteering experience and age.

3.4.4 Functional Status (at baseline)

Satisfaction with ability to perform daily activities (figure 10) and ability to get around (figure 11).

In terms of volunteers' perceived ability to perform general daily activities, a large proportion indicated high self-efficacy in this regard. Although higher percentages of new volunteers and those in the oldest two age groups responded positively to this question, these differences were not statistically significant (p >.05).

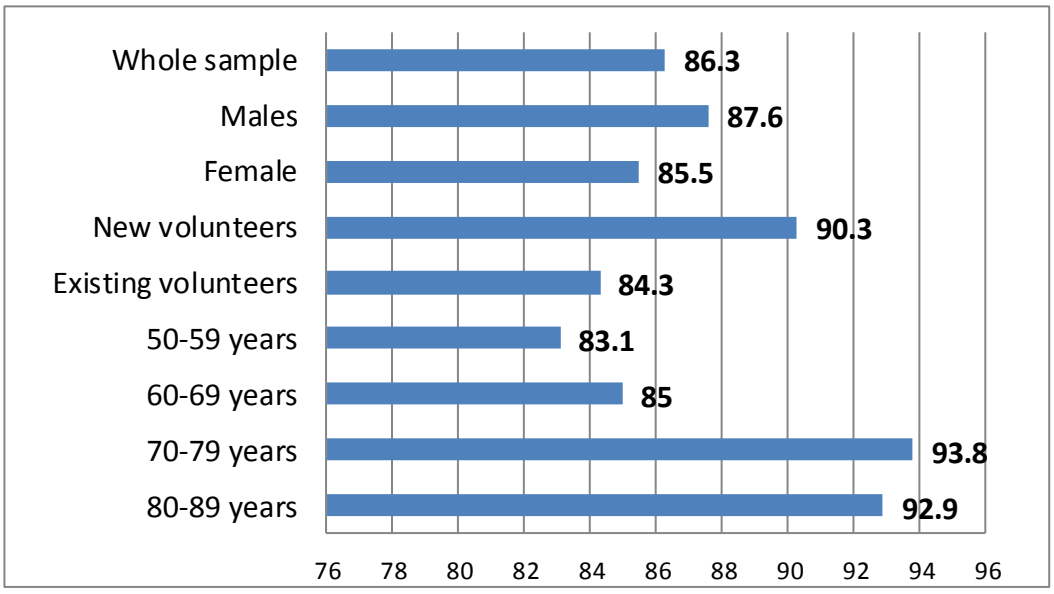

Figure 10. Percentage of sample reporting satisfaction with their own ability to perform daily acts (by gender, volunteering experience and age).

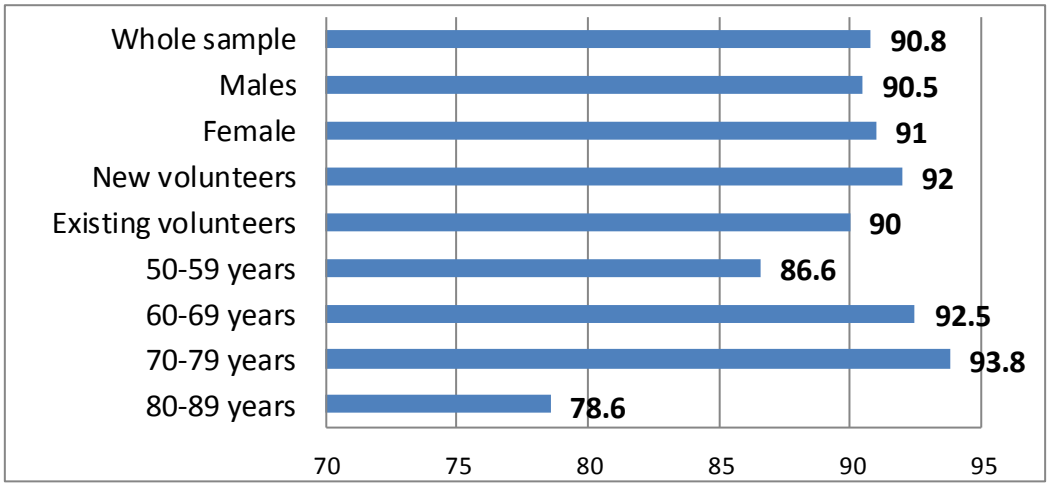

Figure 11. Percentage of sample reporting ability to get around by gender, volunteering experience and age.

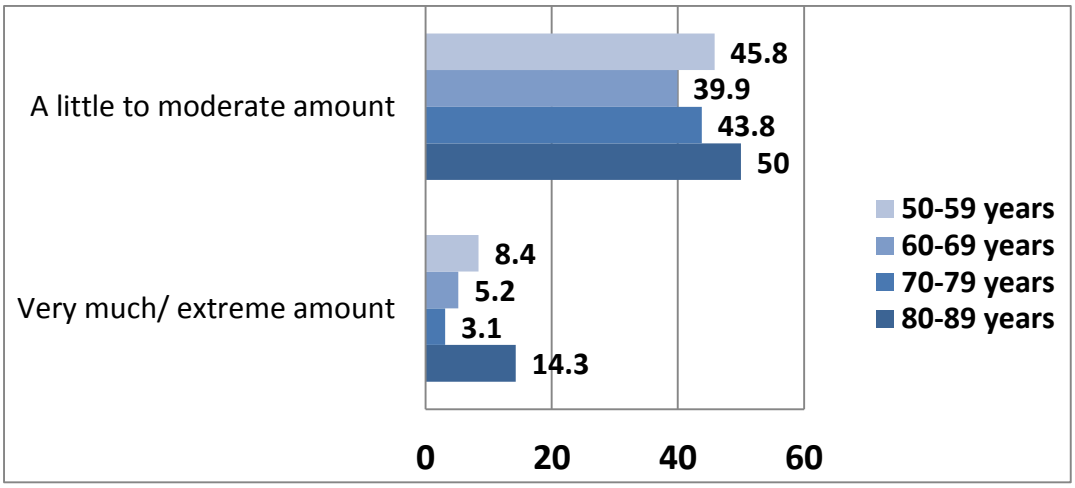

Figure 12. Percentage of sample reporting the extent to which physical pain prevents them from doing what they need to do (by age).

In addition, 90.8% of the baseline sample indicated that they were 'well' or 'very well able to get around'. There were no differences in this regard by gender or volunteering experience (p >.05). However, proportionately fewer volunteers in the oldest age category (80-89 years) responded positively to this question (78.6%). Somewhat surprisingly, fewer of those in the youngest age category (50-59 years) responded favourably (86.6%) compared to the middle two age groups (92.5% and 93.8% respectively).

It should be noted that the rate of positive responding to this question was generally high with the slightly lower positive rates expressed by those in the oldest age category explained partly by the nature of the age group and the finding (figure 12) that approximately 14.3% of this older group also reported experiencing extreme amounts of pain in their daily lives which could impair their mobility somewhat.

3.4.5 Rates of reported disability.

There is no universally accepted definition of disability (NISALD, 2007) and for this reason the question on disability was deliberately general, i.e. "*Do you consider yourself to have a disability?*" The percentage of volunteers reporting 'yes' to this question was (22.9%) with the prevalence rates higher in the oldest age category (80-89 years - 35.7%) and also somewhat surprisingly in the youngest age category 50-59 years - 31.3%). The first report from the Northern Ireland Survey of people with Activity Limitations (NISALD, 2007) offers a more precise definition as 'any longstanding disability, illness or infirmity that limits the respondent's activities in any way' (p.10). According to this definition 21% of all people living in Northern Ireland living in private households report some degree of disability and this percentage increases with age for both men and women. Disability rates for older people in the volunteer sample cannot be directly compared to those in the

population and are somewhat at variance with these population estimates. Table 3 shows that 31.3% of the 50-59 year olds in the sample reported having a disability compared to 23% of the population aged 45-59. The higher rate in the volunteer sample may be explained partially by the higher average age of the group since no one aged under 50 was included. However, in the 60-74 age category the volunteer sample showed a markedly lower rate of disability (19.6% compared to 41% in the population. This contrast was also evident in the oldest age group (75+). Table 3 highlights these differences. The contrast in the figures suggests that many older volunteers do not consider themselves as being 'limited' or 'disabled' despite having more medical and health problems.

Table 3.
Comparison of reported rates of disability by age category in current volunteer sample and in the Northern Ireland population, 2007.

Age Category	Volunteer Sample at baseline (N=344) %	Northern Ireland average (NISALD, 2007) %
45-59	-	23
50-59	31.3	-
60-74	19.6	41
75+	23.1	60

These sample figures on disability among volunteers mirror similar age trends in reported health satisfaction (figure 9) and mobility (figure 11).

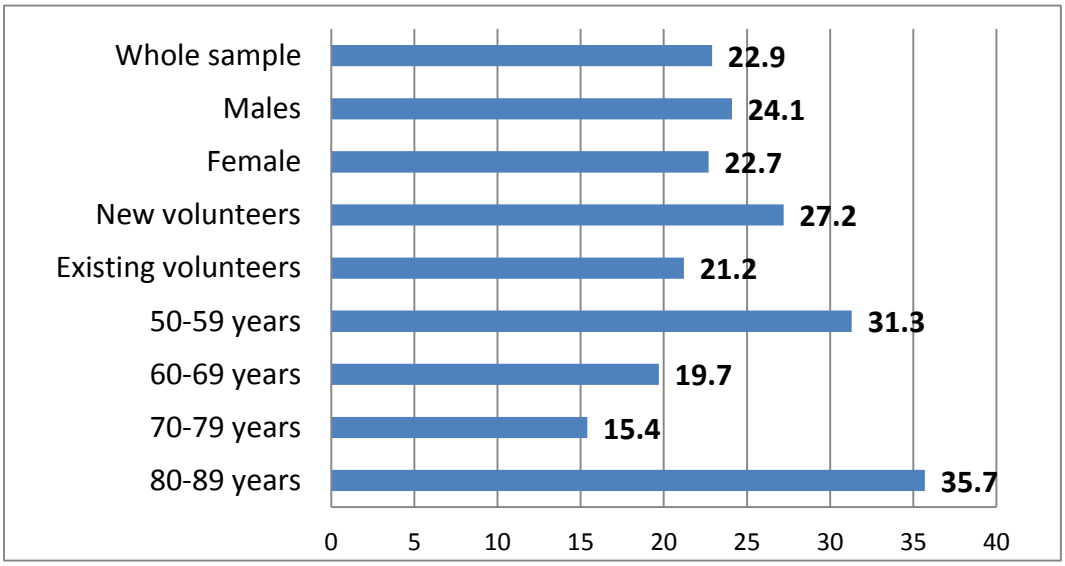

Figure 13. Percentage of sample who consider themselves to have a disability.

3.4.6 Activity levels (at baseline)

The overall picture emerging in relation to activity levels is that with little exception, the volunteers sampled have reported being active for at least 1-2 days in the week prior to completing the questionnaire. Notably, this finding applies to vigorous activities as well as moderate and mild activities with less than 1% of those who answered these questions reporting no active days. It should be noted however, that 12.8% of respondents did not answer the question on vigorous activity with approximately 5.2% and 10.2% respectively failing to respond to the questions on moderate and mild activities. Reasons for this are unknown but perhaps these respondents were relatively inactive or did not fully understand the nature of the questions.

The first continuous Household Health Survey for Northern Ireland (2010-11) has been completed and the questionnaire for this includes some of the same activity/exercise questions that were asked in the volunteer survey. The results of this survey are due for release in November 2011 which will allow the data in this study to be benchmarked against the Northern Ireland older adult population. When the results are made available these comparisons will be added to the final volunteering and health report.

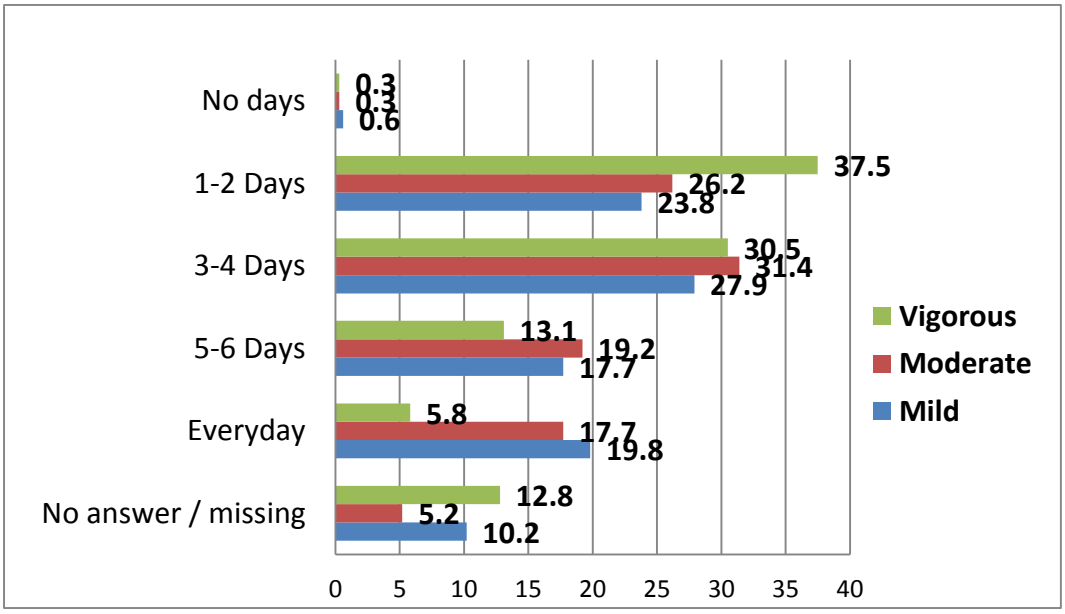

Figure 14. Percentage of sample reporting number of days in past week engaged in vigorous, moderate or mild physical activity for at least 10 minutes.

3.5 Response rates and health

Given the possibility that health status may be a factor in the response rates to the survey over time (i.e. that healthier people are more likely to volunteer, remain in volunteering and complete the survey questionnaires over the period of the study), it was necessary to compare the overall reported health outcomes of those in the baseline sample who remained in the study at 6 months with those who completed baseline questionnaires but did not subsequently respond at 6 months.

The baseline sample consisted of 344 respondents of whom 287 (83.4%) responded again at 6 months. A total of 57 respondents (16.6%) who completed the baseline questionnaire did not respond at time point 2. Figures 15-19 compare reported health outcomes of this group with the respondents who completed questionnaires at both time points.

Figure 15 shows that those who completed the baseline survey only were more likely to report having at least one general medical condition (68.4%) compared to those who completed both baseline and time point 2 questionnaires (52.1%) [$\chi^2(1)=5.11$, p=.024]. A statistically significant reporting difference between the groups was also evident in relation to arthritis/rheumatism [$\chi^2(1)=10.17$, p=.001]. The percentage of the matched sample reporting this condition at baseline (26.2%) was significantly lower than the percentage who responded at baseline only (47.4%). Reporting differences for the other general medical conditions were not statistically significant.

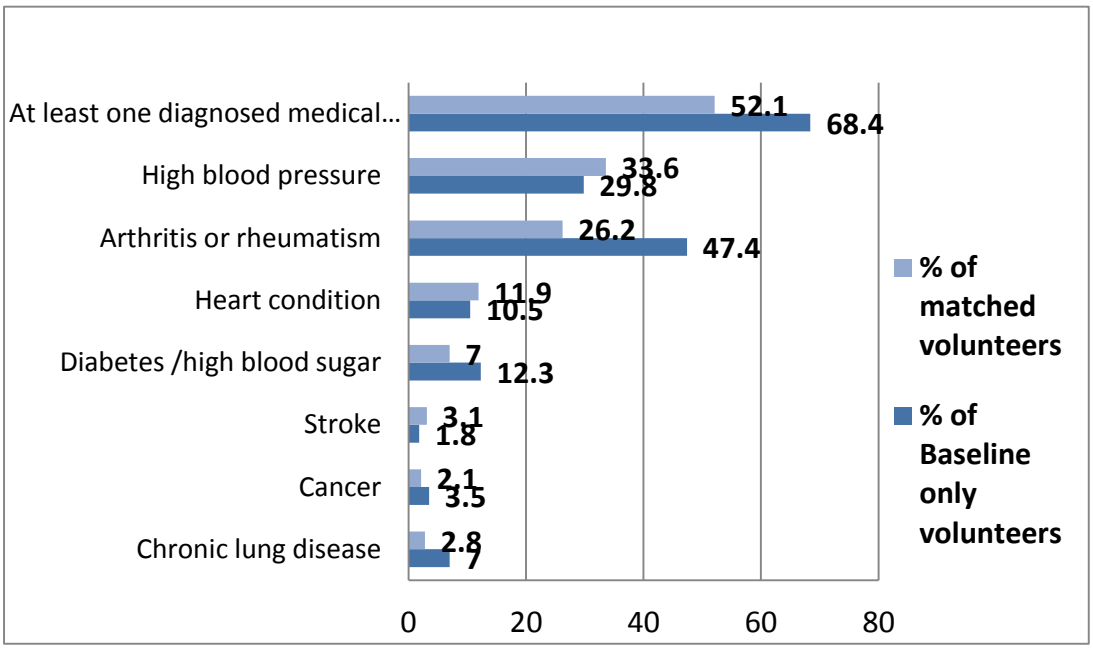

Figure 15. Percentage of sample reporting various general medical conditions.

In relation to group differences in reported levels of satisfaction with health, functional status and mobility, some interesting trends emerged (figure 16). Those who completed questionnaires at both time points were more likely to report satisfaction with their quality of life [$\chi^2(2)=7.34$, p=.025] and their ability to perform daily activities [$\chi^2(2)=11.25$, p=.003] than those who did not complete at time 2. Those completing questionnaires on both time occasions were also less likely (45.7%) to report being limited by pain [$\chi^2(2)=7.49$, p=.024] than those who did not complete at time point 2 (60.7%).

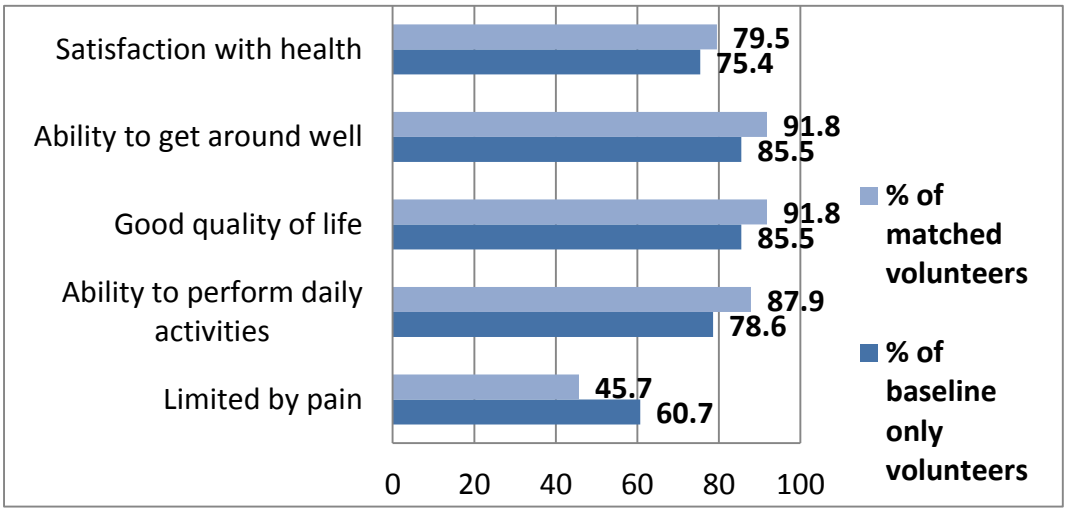

Figure 16. Percentage of sample reporting satisfaction with health, mobility and quality of life.

Table 3 shows no significant differences between matched and baseline only samples in terms of psychological health nor any of the Attitudes to Ageing Questionnaire scales. However, some differences were evident. Those who completed the baseline questionnaire scored significantly lower on the WHOQUAL-BREF Physical Health Scale than those in the matched sample [t(335)=2.347, p=.020] and those who did not respond at 6 months reported being less physically active with fewer days in the previous week engaged in 'vigorous' [t(298)=1.97, p=.049] and 'moderate' activities [t(324)=2.57, p=.011].

Table 4.

Mean scores on reported health, attitudes to ageing and activity levels for respondents completing at baseline and 6 months and baseline only responders.

	Matched Volunteers (N=287)	Baseline only (N=57)	P-value for difference
Number of reported medical conditions	.84 (.99)	1.05 (.95).	.136
WHOQUAL-BREF Physical health	14.89 (2.17)	14.12 (2.63)	.020
WHOQUAL-BREF Psychological health	15.83 (2.14)	15.63 (2.40)	.528
AAQ Physical Change	3.45 (.72)	3.35 (.69)	.361
AAQ Psychological Growth	3.53 (.55)	3.61 (.50)	.321
AAQ Psychological Loss	1.91 (.59)	1.93 (.67)	.799
Mild Physical Activities (No. of days in last week)	4.10 (2.06)	4.08 (2.35)	.954
Moderate Physical Activities (No. of days in last week)	4.12 (1.96)	3.35 (2.23)	.011
Vigorous Physical Activities (No. of days in last week)	3.15 (1.82)	2.60 (1.76)	.049

Note : figures in brackets represent standard deviations.

3.6 Comparing reported health at baseline and 6 months

3.6.1 General Medical conditions

The previous section confirmed some significant differences between those completing questionnaires at baseline and 6 months and those completing baseline only. This suggest that volunteer health may be a factor in response attrition with those remaining in the study at 6 months less likely to report having any medical conditions, particularly arthritis/rheumatism and more likely to report satisfaction with the quality of their life and functional status.

Given the relatively healthy nature of this group at baseline, this section examines the extent to which respondents reported health improved, maintained or declined in the time between baseline and 6 months. Given the small numbers reporting some of the general medical conditions at baseline and 6 months (diabetes, stroke, cancer and chronic lung disease), statistical tests of the difference in reporting rates over time were not feasible.

Table 5 shows the numbers reporting each of the general medical conditions. High Blood pressure and arthritis were the two most commonly reported conditions. Approximately 33.8% of the matched sample reported having high blood pressure at baseline with a further 2.8% a reporting having acquired the condition in the 6 month period after baseline. The acquisition rates in column 3 of table 5 are generally low over this 6 month period. Work is ongoing exploring the possibility of comparing these acquisition rates to incidence of newly acquired conditions in the 50+ age group in the Northern Ireland population during the period of data collection for the volunteer study (March-November 2010). If these figures can be obtained, further details will be included in the second interim and final reports in this series.

Table 5.
The numbers of volunteers who reported having various general medical conditions at baseline and 6 months (Matched sample ONLY N=287).

	At Baseline	At 6 months	Newly acquired in previous 6 months
High Blood pressure	97 (33.8)	105 (36.6)	8 (2.8)
Arthritis	74 (25.8)	82 (28.6)	8 (2.8)
Heart	34 (11.8)	38 (13.2)	4 (1.4)
Diabetes	20 (7.0)	24 (8.4)	4 (1.4)
Stroke	10 (3.5)	15 (5.2)	5 (1.7)
Cancer	6 (2.1)	12 (4.1)	5 (2.1)

Note: Figures in brackets represent percentages of the matched sample (N=287).

Table 6 compares changes in health well-being related scales over the two time points. Small but statistically significant differences emerged on a number of these scales.

3.6.2 WHOQUAL-BREF Physical health Scale

A similar pattern of results emerged in relation to the WHOQUAL-BREF Physical Health Scale. Higher scores on this scale indicate better perceived physical health on a range of health related issues (activities of daily living, dependence on medicines or treatments, energy, mobility, pain, sleep and work capacity). Mean scores on this scale significantly increased from 14.9 at baseline to 16.19 after 6 months [$p<.005$].

3.6.3 WHOQUAL-BREF Psychological health Scale

Scores on the Psychological Health scale reduced slightly over time from a mean of 15.84 at baseline to 15.58 after 6 months (p=.019). Although this difference was statistically significant, **psychological health scores on average were not substantively different across the two time points.** The difference in the two means over time was of the magnitude of -.26). This difference should be viewed in the context of the potential range of scores on this scale (5-20) with higher scores indicative of better physical health. At both time points mean scores were in the upper range (14.9 -16.18).

3.6.4 AAQ Physical Change Scale

The Attitudes to Ageing Questionnaire (AAQ) is a self-report measure that allows older people themselves to express their attitudes to the process of ageing. **The Higher scores indicating more positive attitudes to physical change at baseline (M=3.46) compared to 6 months (M=3.29)**. This mean difference (-.17) although small was statistically significant (p<.005) and this difference should also be viewed in the context of the range of potential scores on this scale (1-5).

3.6.5 AAQ Psychological Growth Scale

Psychological growth scores have remained stable over time and the difference in the scale means (-.03) was not statistically significant (p>.005). This may be due to the relatively short time frame (6 months) and the possibility that attitudinal beliefs held by older people may become relatively fixed or take longer periods of time to change as a function of the processes of ageing.

3.6.6 AAQ Psychological Loss Scale

Psychological loss scores show a similar pattern of results over time to those for AAQ Growth and Physical Change. Psychological loss scores have remained stable, albeit declined marginally and this difference (-.06) was not statistically significant (p=.054). It is notable however, that the mean scores for 'Loss' are lower at both time points (1.91 and 1.85) than those reported for Growth and Physical Change (both > 3) despite being scaled on the same number of items (range 1-5). This again reflects the generally positive attitudes expressed by the cohort in relation to ageing.

Table 6.
A comparison of the mean scores on reported physical health, psychological health, attitudes to ageing and activity levels at baseline and 6 months.

	Means Scores			
	Baseline (Time 1)	6 Months (Time 2)	Difference (Time 2-Time 1)	
WHOQUAL-BREF Physical health	14.90 (2.20)	16.18 (2.92)	+1.28 (2.04)	*
WHOQUAL-BREF Psychological health	15.82 (2.14)	15.51 (2.39)	-.30 (1.89)	*
AAQ Physical Change	3.45 (.72)	3.28 (.73)	-.16 (.69)	*
AAQ Psychological Growth	3.51 (.54)	3.47 (.53)	-.040 (.54)	NS
AAQ Psychological Loss	1.91 (.60)	1.85 (.58)	-.06 (.51)	NS
Mild Physical Activities (No. of days in last week)	4.07 (2.06)	4.61 (2.29)	+.54 (2.33)	*
Moderate Physical Activities (No. of days in last week)	4.12 (1.96)	4.73 (2.23)	+.61 (2.39)	*
Vigorous Physical Activities (No. of days in last week)	3.14 (1.81)	3.55 (2.18)	+.41 2.34	*

Note : figures in brackets represent standard deviations. * denotes statistically significant change over time. NS denotes no statistically significant change.

Conclusions – Work in progress.

This first interim report presents preliminary findings emerging from the responses of older volunteers at baseline and at six months follow-up only. The results at this stage have been largely descriptive and some of the analyses have been exploratory in nature in order to gain a better understanding of the demographic, health and attitudinal characteristics of this sample of older people engaged in formal volunteering activities throughout Northern Ireland.

Work is currently in progress to collate and analyse the questionnaire data at 12 months and 18 months after baseline. In addition, Volunteer Now have recently been involved in collating additional information on the nature of the volunteering organisations (sector, size etc.) whose members have contributed to this study. This information will be added to the questionnaire data currently being collected on the respondents' own experiences of their volunteering and used to assist in assessing the factors relating to natural age related trajectories of health improvement, maintenance or decline in this target group.

The study will also examine whether demographic variables (e.g. age, sex, living alone, retirement, socioeconomic status), attitudes to ageing and levels of reported social support mediate the relationship between volunteering experiences and health and whether such variables relate to observed variations in individual health and wellbeing over time. The final report will therefore necessarily involve more complex multivariate statistical modelling techniques which are more appropriate given the nature of the available data.

References

Bowling, A. (2004). A taxonomy and overview of quality of life. In J. Brown, A. Bowling, & T. Flynn (Eds.), *Models of Quality of Life*. FORUM project, European forum on population ageing research, department of sociological studies (pp. 6–77). University of Sheffield: Sheffield.

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

Corporation of National Community Service (2007). *The Health Benefits of Volunteering - A Review of Recent Research*, Office of Research and Policy Development, Washington, DC.

DHSSPSNI (2004). *A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005 – 2025*, available from http://www.dhsspsni.gov.uk/healthyfuture-main.pdf

DSDNI (2010). Your Response to 'Join In, Get Involved: Build a Better Future - A Consultation Paper on a Volunteering Strategy for Northern Ireland'. (December). (Available at http://www.dsdni.gov.uk/index/voluntary_and_community.htm).

Gale, C.R., Sayer, A. A., Cooper, C., Dennison, E. M., Starr, J. M., et. al., (2011). Factors associated with symptoms of anxiety and depression in five cohorts of community-based older people: the HALCyon (Healthy Ageing across the Life Course) Programme. *Psychological Medicine, 41 (10)*, 2057-2073 DOI: 10.1017/S0033291711000195 .

Gill, Z. (2006). *Older People and Volunteering*. Office for Volunteers, Government of South Australia.

Graff, L. (1991). *'Volunteer for the Health of it'.* Volunteer Ontario.

Harris, A. H. & Thoresen, C. E. (2005). Volunteering is associated with delayed mortality in older People: analysis of the Longitudinal Study of Aging. *Journal of Health Psychology, 10(6)*, 739–752. DOI: 10.1177/1359105305057310

Help the Aged (2008) *'Northern Ireland Spotlight Report: Spotlight on Older People in Northern Ireland',* Help the Aged NI.

Herbert, D. (2008). *Volunteering and its Unintended Consequences, Economic Social Research Series, Mapping the Public Policy Landsc*ape, Economic and Social Research Council.

Hill, K. (2006). Older Volunteering: Literature Review. Volunteering in the Third Age.

Hoffman, L. (2008) *Increasing Volunteerism among Older Adults: Benefits and Strategies for States*. NGA Center for Best Practice. Washington DC.

Institute of Volunteering Research (IVR) (2008). *'Who gives time now? Patterns of Participation in Volunteering'*, Research Bulletin, available from http://www.ivr.org.uk/NR/rdonlyres/1225B8F0-57AD-4830-89D6-AF6448D7AAF7/0/Final_Giving_Time.pdf

Li. Y. & Ferraro, K. F. (2006). Volunteering in Middle and Late Life: Is Health a Benefit, Barrier or both? *Social Forces*, Vol.85, (1) pp.497-519.

Lubben, J., Blozik, E., Gillmann, G., Iliffe, S., von Renteln, Kruse, W., Beck, J.C., et al., (2006). Performance of an abbreviated version of the Lubben social network scale among three European community-dwelling older adult populations. *Gerontologist*, *46*: 503–513.

Lum, T. Y. & Lightfoot, E. (2005). The Effects of Volunteering on the Physical and Mental Health of Older People. *Research on Aging*, Vol. 27 (1), 31-55.

Lupton, M., Stahl, D., Archer, N., Foy, N. (2009). Education, Occupation and Retirement Age Effects on the Age of Onset of Alzheimer's Disease, *International Journal of Geriatric Psychiatry*.

McGill, P. (2010). Illustrating ageing in Ireland North & South. Centre for Ageing Research & Development in Ireland. ISSN: 2041-6997.

Mellor, D., Hayashi, Y., Stokes, M., Firth, L., Staples, M., Chambers, S., Cummins, R. (2008). *Volunteering and Its Relationship with Personal and Neighbourhood Well-Being*, Non-Profit and Voluntary Sector Quarterly available from http://nvs.sagepub.com/cgi/content/abstract/38/1/144

Moen, P., D. Dempster-Mclain, and R.Williams. (1992). Successful Aging: A Life-Course Perspective on Women's Multiple Roles and Health. *American Journal of Sociology, 97 (6)*: 1612-38.

Musick, M., A., Herzog, R. & J. House, J.S. (1999). Volunteering and Mortality Among Older Adults: Findings From a National Sample." *Journals of Gerontology, Series B: Psychological Sciences and Social Science 54B (3)*: S173-S180.

Musick, M. and J.Wilson. (2003). Volunteering and Depression: The Role of Psychological and Social Resources in Different Age Groups." *Social Science and Medicine 56*, 259-69.

Netuveli, G., Wiggins, R. D., Hildon, Z., Montgomery, S. M., & Blane, D. B. (2005). Functional limitation in longstanding illness and quality of life: Evidence from a national survey. *British Medical Journal, 331*, 1382–1383.

Netuveli, G., Wiggins, R. D., Hildon, Z., Montgomery, S. M., & Blane, D. B. (2006). Quality of life at older ages: evidence from the English longitudinal study of aging (wave 1). *Journal of Epidemiology and Community Health, 60*, 357–363.

NISRA (2006). *Statistics Press Notice- 2006- Based Population Projections*.

OFMDFM (2006). Older People's strategy: Ageing **in an inclusive Society.** 2005/06 Annual Report *at March 2006.* Office of the First Minister & Deputy First Minister (available at http://www.ofmdfm.gov.uk).

OFMDFM (2005). *Ageing in an Inclusive Society: Promoting the Social Inclusion of Older People.* Promoting Social Inclusion Initiative, available at www.OFMDFMni.gov.uk/age-ageing-in-an-inclusive-society.htm

OFMDFM (2006). *Lifetime Opportunities-Governments Anti-Poverty and Social Inclusion Strategy for Northern Ireland*, Central Anti-Poverty Unit, available at www.communityni.org/uploads/docs/antipovertynov06.pdf

Oman, D., C. E. Thoresen, and K. McMahon. (1999). Volunteerism and Mortality Among the Community-Dwelling Elderly. *Journal of Health Psychology 4 (3)*: 301-16.

Price, S. (2007). *Volunteering in the Third Age: Findings and Conclusions from the VITA programme and Looking to the Future of Older Volunteering*. Volunteering England & Volunteering in the Third Age.

Sabin, E. P. (1993). Social relationships and mortality among the elderly. *Journal of Applied Gerontology*, *12(1)*, 44–60.

Singer, J. D., & Willett, J. B. (2003). *Applied longitudinal data analysis: Modeling change and event occurrence*. London: Oxford University Press.

Thoits, P. and L. Hewitt. (2001). Volunteer Work and Well-Being. *Journal of Health and Social Behavior, 42*: 115-31.

Rochester, C. & Thomas, B. (2006) *The Indispensible Backbone of Voluntary Action: Measuring and Valuing the Contribution of Older Volunteers*. Volunteering England & Volunteering in the Third Age.

Stock, W. A., Okun, M. A., Haring, M. J., et al. (1983). Age and subjective well-being: A meta analysis. *Evaluation Studies Review Annual, 8*, 279–302.

Van Willigen, M. (2000). Differential benefits of volunteering across the life course." *Journals of Gerontology, Series B: Psychological Sciences and Social Science 55*: S308-S318.

Volunteer Development Agency (2001). *As Good as they Give: Attracting and Selecting Volunteers, workbook 2*, available from http://www.volunteering-ni.org/what_we__do/publications/#Volunteer%20Management

Volunteer Development Agency (2007) *'It's All About Time'* Volunteer Development Agency available from http://www.volunteernow.co.uk/publications

Volunteer Development Agency (2009). *Organisational Involvement of Volunteer who are 60+ Years Old: A Snapshot of the Opinions and Practices of Organisations within the Belfast / Castlereagh and Londonderry / Strabane Area* available from http://www.volunteering-ni.org/what_we__do/publications/#Research

Volunteer Development Agency (2009) '*Making the Connection: Volunteering by the over 50's in Northern Ireland'*. Volunteer Development Agency available from http://www.volunteernow.co.uk/publications

Volunteering England (2008). *Volunteering and Health: What Impact does it really have?* University of Wales, Lampeter.

Volunteer Now (2011) '*Making the Connection 2:* A Further Exploration of the Attitudes, Lifestyle and Volunteering Activity of the 50+ Age Group in Northern Ireland*.* Volunteer Development Agency available from http://www.volunteernow.co.uk/publications

Von dem Knesebeck, O., Wahrendorf, M., Hyde, M., & Siegrist, J. (2007). Socioeconomic Position and quality of life among older people in 10 European countries: Results of the SHARE study. *Ageing & Society, 27(2)*, 269–284.

Wiggins, R. D., Higgs, P., Hyde, M., & Blane, D. B. (2004). Quality of life in the third age: key predictors of the CASP-19 measure. *Ageing and Society, 24*, 693–708.

William, A. (1977). Measuring the quality of life of the elderly. In A. Evans & L. Wingo (Eds.), *Public Economics and the Quality of Life* (pp. 13–27). Baltimore: Johns Hopkins University Press.

Zaninotto, P., Falaschetti, E. & Sacker, A. (2009). Age trajectories of quality of life among older adults: results from the English Longitudinal Study of Ageing *Quality of Life Research, 18*: 1301–1309.