



The Contribution of Volunteering to Scotland's Health and Wellbeing

Challenges, Opportunities and Priorities 2020 - 2040

Full Report, October 2019

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Executive Summary

1. Overview

This report highlights the major challenges facing our society in terms of demographic change, labour market and skills shortages, mental and physical ill-health, social isolation and loneliness, and poorly connected and engaged communities. However, it also presents wide-ranging evidence on the extraordinary contribution of volunteering in helping to address these challenges and in improving the health and wellbeing of Scotland's people. It achieves this through:

- Improving the health and wellbeing of volunteers
- Supporting activities and sectors which foster the health and wellbeing of the wider population such as physical activity and sport
- Supporting Scotland's health and social care sector.

Volunteering also fosters social connectedness and is embedded in communities for the benefit of those communities. It is inextricably linked to the health and wellbeing of engaged communities and resilient neighbourhoods. However, the greatest health and wellbeing impact from volunteering is for those who are most disadvantaged and excluded in society, and this applies both to the volunteers themselves and those who they are supporting.

This is a really 'good news' story for volunteering and for Scotland's health and wellbeing. It is also a strong foundation upon which to further develop the contribution of volunteering. There are big societal challenges facing Scotland and it is vitally important that volunteering is responsive, adaptable and focused in managing this change.

This report describes these challenges, identifies the opportunities and gives clear priorities for how volunteering can optimise its contribution to Scotland's health and wellbeing over the next 20 years. This includes a list of 10 key recommendations which support the implementation of Scotland's 'Volunteering for All: Our National Framework' and the attainment of health and wellbeing indicators in the 'National Performance Framework'.¹

2. Challenges

Demographic and labour market challenges – Scotland's population is ageing, and this is projected to continue. We are living longer but not healthier lives. It is projected that there will be an additional 428,000 people aged 65+ by 2041, comprising 25% of the population (up from 19% in 2017). In contrast, the working age population aged 16 – 64 is projected to decline by 144,000 in the same timeframe. These demographic trends will have major implications for:

¹[Volunteering for All: Our National Framework](#) – Scottish Government, April 2019 and [National Performance Framework](#) - Scottish Government

- *Our economy* – a vibrant economy depends on a growing and skilled workforce. Scotland is projected to have fewer people of working age, which may act as a constraint for our future growth. Furthermore, the increased proportion of retired people will act as a fiscal constraint on Government, due to lower tax revenues and increased costs.
- *Our health sector* – an ageing population which is living longer, combined with advances in medicine and science, will exacerbate the unrelenting upward trend of increasing demands on the very hard-pressed NHS.
- *Our society* – the change in age structure will have implications both for our older people and the challenges they face relating to their health and wellbeing, and for inter-generational engagement across our society.

Health and wellbeing factors – despite people living longer, we are not living healthier lives and there are worrying trends in mental health and the linked issue of social isolation and loneliness. Scotland is facing major health and wellbeing challenges, which are growing in significance over time. These health and wellbeing issues are particularly important for the most deprived communities in Scotland.

Community engagement - 'Community engagement' is a complex term to define let alone evidence. However, research suggests that we are becoming less neighbourly – many people don't know their neighbours or speak to them and this breakdown in neighbourliness has been getting worse over the last 20 years. We are also poorly engaged with our local community with many people having limited involvement. Contributory factors include more people living alone; the major growth in online communication at the expense of face-to-face communication; and problems of disadvantage and exclusion in society through, for example, mental ill-health and disability.

3. Opportunities

The omnipresent and inherent flexibility of volunteering is such that many of the challenges outlined in this report can be addressed by volunteering if we adopt an innovative and proactive approach. Volunteering cannot solve the health and wellbeing problems facing society, but it can certainly make an important contribution in reducing and/or mitigating many of them. It can best achieve this by integrating volunteering into wider social policy responses to societal change.

Demographic and labour market opportunities

Our ageing population is likely to result in a major shift in the age profile of our volunteers. It is projected that there will be 102,000 more volunteers aged 65+, but with a reduction of 41,000 volunteers aged 16 – 64 by 2041. This will result in a net additional 8 million volunteer hours per annum. It will also provide increased opportunities for volunteering in:

- Supporting our ageing population
- Inter-generational opportunities
- Improving the supply of skilled adults.

Improving physical and mental health

Volunteering already provides a major contribution to Scotland's health and wellbeing but, given the seriousness of the health challenges facing our society, it is essential that we optimise its contribution. There are three 'delivery channels' we need to focus on:

- **Capitalising on the health and wellbeing benefits for volunteers:**
 - *Physical health* – encouraging the adoption of healthy lifestyles and practices; increasing the level of physical activity through volunteering; helping older people to maintain their functional independence; and helping people to cope with personal illness.
 - *Mental health* – volunteering can improve the mental health of volunteers through increasing their social connectedness; providing them with a sense of purpose linked to task satisfaction and sense of fulfilment; enhancing their skills, building confidence and improving resilience and self-efficacy; increasing self-esteem and self-respect; and just by having fun and being happy – referred to as the 'Helper's High'.
- **Maximising the health and wellbeing benefits from physical activity and sport:** there are c. 280,000+ volunteers who help to deliver sport and physical activities across Scotland's 13,000 sports clubs and c. 900,000 members.^{2,3} They undertake a myriad of roles including administration, event organisation, coaching, refereeing and governance. They in turn are supporting the health and wellbeing of the 2.3 million adults in Scotland who are involved in physical activity or sport (51% of the population aged 16+ have participated in physical activity or sport in the last four weeks, excluding walking). If walking is included these figures rise to 3.5 million adults or 79% of the adult population.⁴
- **Supporting the NHS and health charities** – 200,000+ people volunteer in the health and social care sector in Scotland. Volunteers help to inform, educate, manage and support the population on a wide range of health conditions. They fulfil an invaluable role in helping to prevent illness, support early diagnosis, assist in the recovery of patients and provide an all-important aftercare support role.

² [Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, 2018; and [Young People Volunteering in Scotland](#) – Volunteer Scotland, 2016

³ [Sport 21 2003 - 2007: The National Strategy for Sport](#) – [sportscotland](#); March 2003

⁴ [Scottish Household Survey 2016: Chapter 8 - Physical Activity and Sport](#) – Scottish Government, Sept 2017

Tackling social isolation and loneliness

A lot of volunteering is by its very nature a social activity, which is often conducted in clubs, groups and societies. It is about engaging with others to support and help others. This is one of the key attributes of volunteering – it improves our social connectedness. This helps to address problems of social isolation and loneliness in three main ways through:

- The engagement of volunteers who are isolated and lonely and improving their social connections, allowing them to make friends and feel more integrated in society;
- The provision of services such as befriending which are targeted at those who are experiencing, or susceptible to, social isolation and loneliness; and
- The prevention of social isolation and loneliness for those who are already volunteering.

The strong bi-directional linkages between mental health and social isolation and loneliness must also be recognised. Preventing, alleviating or mitigating problems of social isolation and loneliness can have a direct beneficial effect on people's mental health and vice-versa – improving mental health can help people to become more integrated in society.

Community engagement

A key goal of the Scottish Government is to foster more engaged and sustainable communities where people feel they are part of their local neighbourhood and are contributing to it. Volunteering is central to the achievement of this goal due to its unique characteristics:⁵

- **Local delivery** – volunteering is usually embedded within a community for the benefit of that community. The local nature of volunteering is a key factor.
- **Social capital** – volunteering builds social relationships between volunteers, beneficiaries, staff and other voluntary bodies and organisations located in the community.
- **Reciprocity** – when a volunteer helps someone in the community the beneficiary is more likely to respond with another positive action. This leads to a virtuous circle of community members helping each other – this mutuality and sharing are important.
- **'Spillover' effects** – for people who live in a community with high levels of volunteering, even if they do not volunteer, their subjective wellbeing will still tend to be increased by the goodwill and social capital building around them.

⁵ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) – Volunteer Scotland, Dec 2018

- **Co-production and empowering individuals** – the involvement of people in shaping and delivering their local services fosters a sense of responsibility and community activism where people take control of their own lives and local services, create and develop social networks and galvanise resources for the local community.

Digital and online communication facilitates the contribution of volunteering not just to communities of place but also to communities of interest. This improves the 'reach' of volunteering especially where the 'community' is geographically dispersed. This enables volunteering to confer health and wellbeing benefits that would not otherwise be achievable. This is especially important for those who are housebound through for example a as it enables them to overcome the barriers to their engagement in volunteering.

Engaging those experiencing disadvantage

The strongest message which stands out from all this research is that the more disadvantaged a person is the more important the potential contribution of volunteering is likely to be. The evidence is compelling on two counts:

- Firstly, the much higher incidence of health and wellbeing problems for those who experience disadvantage. Using the Scottish Index of Multiple Deprivation (SIMD) as a proxy for 'disadvantage' it is clear that Scotland's physical and mental health problems are much more prevalent in quintile 1 (the most deprived 20% of areas in Scotland) compared to quintile 5 (the least deprived 20% of areas in Scotland); and
- Secondly, the higher positive impact of volunteering on people's health and wellbeing if they are living in deprived areas and/or are subject to aspects of disadvantage, including mental and physical ill-health, disability, refugee or asylum seeker status, loneliness, etc.

However, the irony is that those who can benefit most from volunteering are the people least likely to be volunteering. New evidence also points to a 'tipping point' issue whereby there is a step-change in the decline in volunteering participation once a health and wellbeing factor becomes acute. For example, in Greater Glasgow and Clyde the adult volunteering participation rate for those who feel lonely 'some of the time' is 21%, which declines to 9% for those who are lonely 'all the time or often'. Interestingly, volunteering participation for those who are 'rarely or never' lonely is 18%, which is lower than those who are lonely some of the time.⁶

Engaging the disadvantaged is not just a key challenge, but also a key opportunity. If we want to achieve a fairer and more equal society in Scotland, then volunteering has a crucially important role to play.

⁶ 'NHSGGC Health and Wellbeing Survey 2017/18' – Cross-sectional analysis by Volunteer Scotland – due for to be published January 2020

4. Priorities

To facilitate the prioritisation process the study has identified three pervading themes from the evidence which stand out as having a disproportionately significant impact on the nature and extent of people's health and wellbeing: age, sector and geography.

Demographic focus ⁷

- *Young (aged 16 – 24)* – young people have the worst General Health Questionnaire mental health score of any age group, the worst statistics for anxiety and self-harm, and the second highest attempted suicide rate. Although they are the most socially connected age group nearly one in four young people are likely to have experienced feelings of loneliness in the last week.
- *Early mid-life (26 – 44)*: some of the health and wellbeing issues affecting the young also flow through to the 26 – 44 year old age group, but to a less severe extent, particularly for mental ill-health and loneliness for those aged 35 – 44.
- *Later mid-life (45 – 64)*: there is a noticeable increase in physical ill-health and limiting long-term conditions in this age group. Early intervention is much better than cure, so there needs to be earlier engagement to encourage the adoption of healthy behaviours, and leverage other health and wellbeing benefits from volunteering, before the health conditions present themselves.
- *Younger old (aged 65 – 74)* – in contrast to the wide-ranging support for volunteering amongst the young in Scotland, older people have not received the same focus and encouragement. This is a missed opportunity, particularly for the 'younger old' given their characteristics:
 - Second highest volunteering participation rate
 - Highest volunteering hours of any age group
 - More available time for volunteering
 - Increasing physical ill-health
 - 15% increase in population to 650,000 by 2041
- *Older old (aged 75+)* – they have the worst health and wellbeing indicators of any age group:
 - 56% of this age group have limiting long-term health conditions, by far the highest of any age group
 - The highest proportion of people who experience loneliness and the second most socially isolated age group

⁷ The evidence for 'demographic' data sub-section is drawn from:

[Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

[Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report - Scottish Government, Sept 2018

[Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)

National Records of Scotland, Aug 2018

[Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, Jan 2019

- Absence of role identities such as not having a job, partner dying, no parental responsibilities in the household, etc.
- 76% increase in population to 790,000 by 2041, an additional 342,000 people.

Sector focus

All volunteering can, in principle, deliver important health and wellbeing benefits for volunteers. In that sense all volunteering sectors are equally important. However, if one examines not just the benefits to volunteers but to wider society, four characteristics of volunteering's contribution stand out as being central to the realisation of health and wellbeing benefits:

- **Age focus** – volunteering supporting the specific health and wellbeing needs of different age groups – from younger to older
- **Health and wellbeing focus** – volunteering directly supporting the health and wellbeing of Scotland's population through activities which impact on people's physical and mental health, and through support to health and social care services
- **Community focus** – volunteering fostering stronger local communities and neighbourhoods
- **Social capital focus** – volunteering facilitating social engagement and connectedness.

Each sector's contribution to Scotland's health and wellbeing varies according to its characteristics and focus. Some are particularly strong in community engagement; others have a direct impact on health and wellbeing through, for example, sport and physical activity; others are particularly good at facilitating social connectedness with mental health and social inclusion benefits; and for others it is due to their focus on specific age demographics. The report reviews each of the 'sectors' classified in the Scottish Household Survey, examining how they contribute to Scotland's health and wellbeing.

Volunteering sectors in Scotland (Total volunteer numbers in brackets)	
Children's activities within schools (311,000)	Environmental protection (95,000)
Children's/youth activities outside schools (310,000)	Education for adults (76,000)
Sport and exercise (287,000)	Safety, first aid (63,000)
Local community & neighbourhood groups (258,000)	Wildlife groups (58,000)
Hobbies, recreation, arts, social clubs (249,000)	Political groups (54,000)
Health, disability and social welfare (215,000)	Citizens groups (51,000)
Religious groups (200,000)	Domestic animal welfare (45,000)
Older people (155,000)	Justice and human rights (41,000)
Sources: Scottish Household Survey 2017 - Annual Report – Scottish Government; Sept 2018 Young People Volunteering in Scotland (YPiS) – Volunteer Scotland, 2016	

Geographic focus

Indicators of physical and mental ill-health are often much higher in the most deprived areas in Scotland as measured by the Scottish Index of Multiple Deprivation (SIMD). This is not unexpected given that health is one of the seven domains of deprivation in the SIMD. However, the SIMD encompasses a much wider scope of deprivation which is helpful when trying to encompass other aspects of disadvantage in society. We also know from our research that the contribution of volunteering is most significant for those experiencing disadvantage and exclusion, whatever the cause.

So, when considering the contribution of volunteering, geography does matter. SIMD data is helpful in providing a proxy for comparing between areas of high disadvantage and low disadvantage, identifying where volunteering can have a greater and lesser impact respectively. However, there are three caveats to this overarching assessment:

- Firstly, deprivation can be very location specific and hence it can be important to drill down to more precise geographic zones such as deciles (10% most deprived areas) and virgintiles (5% most deprived areas).
- Secondly, not everyone who is deprived lives in a deprived area; and vice-versa not everyone living in a deprived area is deprived. For example, there are no deprived data zones (representing the 15% most deprived areas of Scotland) in any of the Western Isles, Shetland or Orkney islands, but there are still people experiencing deprivation in these remote island communities.
- The final and most important caveat is that there are many aspects of disadvantage which are not linked to deprivation, such as disability, gender orientation, conditions of mental health, etc. which are prevalent across society irrespective of geography and deprivation areas. Yet volunteering has an equally important role to play in supporting the health and wellbeing of these people.

5. Recommendations

Those responsible for volunteering policy and practice in Scotland need to be aware of and act upon, where appropriate, the following recommendations to enhance the contribution of volunteering to Scotland's health and wellbeing:

1. **Manage demographic change** – consider what impacts the projected increase of c. 430,000 people aged 65+ and the projected contraction of c. 145,000 people aged 16 – 64 by 2041 will have on volunteering services and beneficiaries.
2. **Optimise volunteer engagement** – reflect on the implications for volunteer recruitment of the projected c. 100,000 additional volunteers aged 65+ (giving an additional 13 million hours p.a.) and the projected contraction of c. 40,000 volunteers aged 16 – 64 (giving 5 million fewer hours p.a.) by 2041.

3. **Understand health and wellbeing by age** – target and customise volunteering to address the health and wellbeing needs of different age groups.
4. **Develop volunteering roles which optimise health and wellbeing** – consider the types of volunteering roles and activities which are most likely to generate health and wellbeing benefits:
 - Socially engaged volunteering roles where volunteers are working in teams and where face-to-face engagement is the norm – this facilitates social connectedness, helping to minimise the risk of loneliness, and with potential spin-off benefits for mental health and wellbeing.
 - Volunteering involving sport and exercise and/or activities demanding physical activity which can result in physical and mental health benefits.
 - Volunteering roles which involve the outdoors and our engagement with the natural and historic environment – again providing physical and mental health benefits.
 - Volunteering roles which involve creativity, arts and culture – providing mental and physical health benefits through, for example, dance and music – and also social engagement.
 - Volunteering roles which give sufficient engagement (frequency and hours of volunteering) to enable the potential health and wellbeing benefits to flow through – referred to as the 'dose-response' effect.
5. **Ensure volunteering 'sectors' play to their strengths** – volunteering's sectoral contribution to Scotland's health and wellbeing varies according to the specific focus of each sector. Those with sectoral responsibilities should understand their sectoral strengths to optimise health and wellbeing benefits.
6. **Facilitate community engagement** – 81% of volunteering is locally based in Scotland and the evidence shows that volunteering is good for community wellbeing and communities are good for volunteers' wellbeing.⁸ It is important that people feel that they belong to their community, feel valued, and where they can influence decisions in their community. Volunteer engagers and community organisations have a key role to play in facilitating this community engagement process through social clubs, associations, religious groups and community groups.
7. **Support communities of interest** – in addition to communities of place, volunteering should support the health and wellbeing of people through communities of interest. Digital and online communication is important where the 'community' is geographically dispersed. Virtual volunteering is also good at facilitating volunteering engagement with those subject to exclusion and isolation: for example, those who are housebound through a health condition or are isolated.

⁸ 'Time Well Spent' – NCVO; January 2019 – analysis of the Scottish dataset by Volunteer Scotland; publication due early 2020

8. **Target support to the disadvantaged and excluded** - the strongest message which stands out from all this research is that the more disadvantaged a person is the more important the contribution of volunteering is likely to be to their health and wellbeing. However, the irony is that those who can benefit most from volunteering are the people least likely to be volunteering. This is not just a key challenge, but also a key opportunity. If we want to achieve a fairer and more equal society in Scotland, then volunteering has a crucially important role to play. Using volunteering as a means of reaching and supporting those experiencing disadvantage in Scotland should be a top strategic priority in the roll-out of the 'Volunteering for All: National Framework'.
9. **Adopt good practice in engaging and supporting volunteers** – it is important that volunteer involving organisations and those involved in Employer Supported Volunteering understand the contribution of volunteering to the health and wellbeing of volunteers and local communities and how best to optimise these benefits. Detailed practical guidance is presented in this accompanying resource: [Optimising health and wellbeing benefits from volunteering: Good practice for engaging and supporting volunteers](#).⁹
10. **'Influencers' to provide leadership in policy and practice** – this includes national and local government, national bodies (such as SCVO, Volunteer Scotland, Voluntary Health Scotland, etc.), NHS Boards and Health and Social Care Partnerships, Scottish Volunteering Forum members, Cross Party Group on Volunteering members, the Third Sector Interfaces (TSIs) and others with a vested interest in collaborating to maximise the contribution of volunteering for the benefit of Scotland. Guidance for these influencers is presented in this accompanying resource: [The contribution of volunteering to a healthier and happier Scotland: How organisations can help to influence policy and practice in Scotland](#).¹⁰

6. Research gaps

Finally, it is also important to make clear that these recommendations are 'work-in-progress'. The expectation is that they will be further developed and refined as more evidence and practical experience comes to light. This reflects the fact that there are still significant evidence gaps, which Volunteer Scotland and others will be working on to resolve over the coming years, including:

⁹ [Optimising health and wellbeing benefits from volunteering: Good practice for engaging and supporting volunteers](#) – Scottish Volunteering Forum and Volunteer Scotland, Nov 2019

¹⁰ [The contribution of volunteering to a healthier and happier Scotland: How organisations can help to influence policy and practice in Scotland](#) - Scottish Volunteering Forum and Volunteer Scotland, Nov 2019

- **The contribution of informal volunteering to health and wellbeing** – the informal volunteering dataset from the Scottish Household Survey 2018 has not been analysed as part of this study. However, it is interesting to note that the most common activity undertaken in the last 12 months was 'keeping in touch with someone who is at risk of being lonely', comprising 18% of informal volunteers.¹¹
- **Understanding loneliness and the relationship to social isolation** – notwithstanding the new questions in the Scottish Household Survey 2018, there are significant evidence gaps relating to the absence of time series data; the issue of the severity of loneliness versus the incidence of loneliness (the latter is the focus of data collection to date); and the inter-relationship between being isolated and being lonely.
- **Volunteering in mid-life** – there is a lot less evidence on the health and wellbeing benefits of those aged 35 – 64 than there is for younger and older age groups.
- **Community wellbeing** – understanding the relationship between volunteering and community engagement is complex and poorly researched. One of the key conclusions from the University of Stirling's literature review was the limited evidence base in this area. The current PhD research being supported by Volunteer Scotland is addressing this specific area.¹²
- **Causal mechanisms** – in Volunteer Scotland's literature review the causal relationship between volunteering participation and health and wellbeing outcomes was often uncertain.¹³ This evidence gap has persisted within the current research study, as interesting correlations between volunteering participation and health and wellbeing indicators have been revealed through the analysis of the Scottish Household Survey and the NHS Greater Glasgow and Clyde Health and Wellbeing Survey.¹⁴ However, until such time as Scotland has a longitudinal dataset relevant to this area of research, this is likely to remain an unresolved issue.

¹¹ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

¹² [What we do together: Associational life, volunteering and the benefits for health and wellbeing](#) – PhD research 2019 - 2022 led by the University of Strathclyde and supported by Volunteer Scotland

¹³ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) – Volunteer Scotland, Dec 2018

¹⁴ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019 and 'NHSGGC Health and Wellbeing Survey 2017/18' – Cross-sectional analysis by Volunteer Scotland – due for to be published January 2020

1. Rationale and scope

The genesis of this study was Volunteer Scotland's literature review on 'Volunteering, health and wellbeing: what does the evidence tell us?'.¹⁵ This research presented convincing evidence on the merits of volunteering for individuals (see Figure 1.1), but it also identified the variability of such impacts and the problem of evidence gaps:

- **Health and wellbeing benefits** – improved mental health and reduced social isolation and loneliness from volunteering were evidenced as particularly important contributors to improved wellbeing. Also important, but with less evidence, were physical health and life expectancy benefits. However, there was much less evidence in relation to employment and career outcomes, and community wellbeing.

Figure 1.1 – Health and wellbeing benefits from volunteering¹⁶



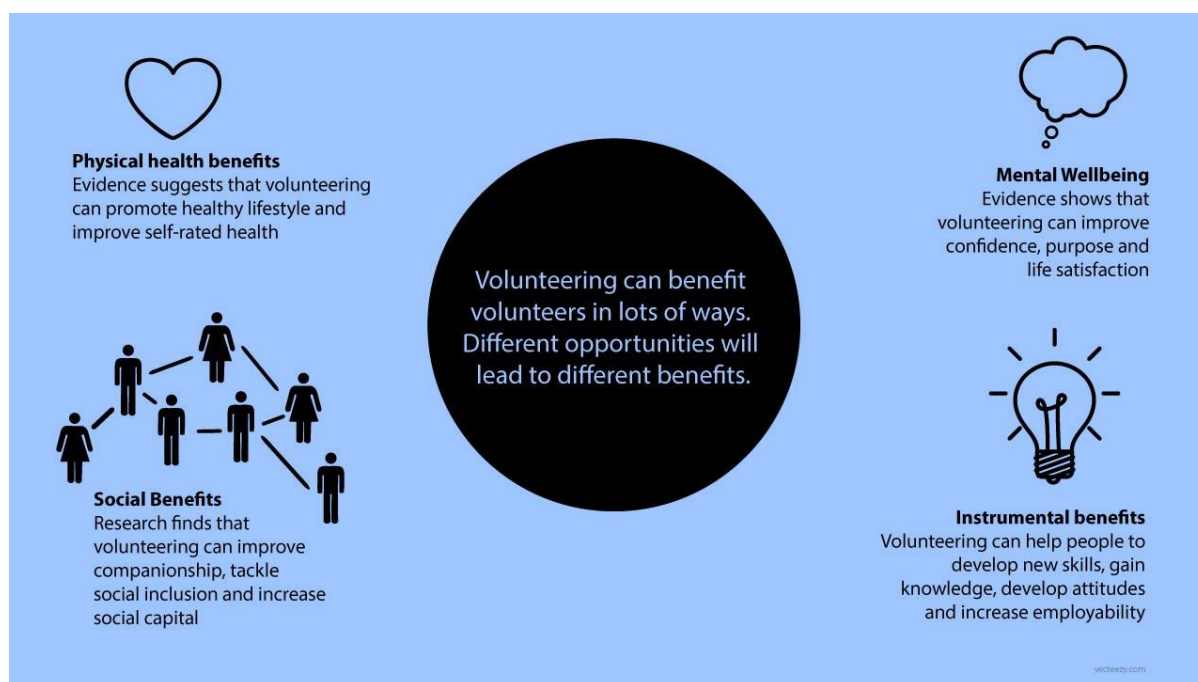
¹⁵ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) – Volunteer Scotland, Dec 2018

¹⁶ [The contribution of volunteering to a healthier and happier Scotland: How organisations can help to influence policy and practice in Scotland](#): Scottish Volunteering Forum, Volunteer Scotland, Nov 2019

- **Demographics** – the evidence has a very strong focus on the wellbeing effects of volunteering for older people and, to a lesser extent, young people. However, we identified very little evidence in relation to the impact of volunteering on those in their mid-life.
- **Excluded characteristics** – there is clear-cut evidence that those subject to exclusion from, and disadvantage in, society have the most to gain from volunteering. Although there are wellbeing benefits for those who are least excluded and least disadvantaged in society, they tend to be much more modest.

Since the publication of Volunteer Scotland's literature review, the University of Stirling completed its systematic review of the research literature on volunteering to help inform the development of the new National Volunteering Outcomes Framework.¹⁷ Their chapter on the 'Outcomes and benefits of volunteering' reinforced the evidence base developed by Volunteer Scotland, identifying physical health, mental wellbeing and social benefits in addition to instrumental benefits: see Figure 1.2.

Figure 1.2 – The benefits of volunteering¹⁸



However, these findings from the research of Volunteer Scotland and the University of Stirling were based on evidence drawn primarily from UK and international sources and were not Scotland-specific. Both studies also identified similar evidence gaps.

¹⁷ [Literature Review to Inform the Development of Scotland's Volunteering Outcomes Framework](#) – University of Stirling; April 2019

¹⁸ Ibid

These limitations were the trigger for this research study, which has attempted to supplement the evidence base, fill in some of the gaps where possible and contextualise the health and wellbeing findings for Scotland.

Volunteer Scotland has undertaken a comprehensive analysis of key indicators of the health and wellbeing of people in Scotland relating to mental and physical health, social isolation and loneliness and community engagement. For each health and wellbeing category it reviews the contribution of volunteering, identifying both the challenges and the opportunities. This information has also been supplemented by contextual data on demographic change and Scotland's labour market and skills.

The aim of this report is to answer four key questions:

- What is the current and projected state of people's health and wellbeing in Scotland?
- What are the challenges facing our health and wellbeing?
- What are the opportunities for volunteering to help address these challenges?
- What are the priorities for volunteering in helping to improve the health and wellbeing of people in Scotland?

Volunteer Scotland has given a 20-year time horizon of 2020 – 2040 for this report. Some may feel that this is unrealistically long given the difficulty of projecting change over two decades. This would be true if the objective of the report was to try and predict what 2040 will look like in detail.

However, this is not the objective. Volunteer Scotland is less interested in precise measurements twenty years hence than the overall direction of travel, what the nature of the health and wellbeing issues are likely to be and how volunteering can influence long term health and wellbeing outcomes.

Therefore, within the context of Scotland's health and wellbeing we believe this time horizon is appropriate given:

- The relative robustness of demographic projections over this period. The National Records of Scotland give their population projections up to 2041.
- The high quality historical trend data for many health and wellbeing indicators which can be used to help inform the future.
- The fact that the health and wellbeing challenges we face are serious and long-term in nature.
- There is no evidence that these challenges are going to be resolved in the near future.

In summary, if volunteering is to optimise its contribution to Scotland's health and wellbeing a long-term and sustained commitment will be required over at least two decades. This will also give sufficient time to monitor and evidence impact.

The report structure is as follows:

- Section 2 – Methodology
- Section 3 – Demographic projections
- Section 4 – Labour market and skills
- Section 5 – Physical health
- Section 6 – Mental health
- Section 7 – Social isolation and loneliness
- Section 8 – Community engagement
- Section 9 – Challenges, opportunities and priorities
- Section 10 – Conclusion and recommendations.

There is a strong connectivity between the Sections, particularly the very important inter-relationships between physical health, mental health and social isolation and loneliness. There is therefore cross-referencing between Sections where appropriate.

Each of the main evidence Sections on health and wellbeing (Sections 5 – 8) are structured as follows (Section 5 – Physical Health is used as an example):

- **Overview** of the topic – defining the scope and setting the scene
- **Evidence** of physical health – in Section 5 this has been structured into life expectancy, general health, long-term conditions, cardiovascular disease and diabetes
- **Summary** of Scotland's physical health
- **Contribution** of volunteering to physical health.

Section 9 gives an overarching summary of the evidence relating to the key challenges facing the health and wellbeing of people in Scotland, and the opportunities for volunteering to help address or mitigate these challenges. Section 10 presents the conclusion and a list of ten recommendations to help inform the implementation of Scotland's National Volunteering Outcomes Framework.¹⁹

Supporting publications

In addition to this Full Report there are the following supporting publications:

- [Summary Report](#)
- [The contribution of volunteering to a healthier and happier Scotland: How organisations can help to influence policy and practice in Scotland](#)
- [Optimising health and wellbeing benefits from volunteering: Good practice for engaging and supporting volunteers](#)

¹⁹ [Volunteering for All: Our National Framework](#) – Scottish Government, April 2019

2. Methodology

There were three main elements to the methodology: data collection, data analysis, and reporting. The work was conducted over the period December 2018 to October 2019.

2.1 Data collection

Quantitative data sources – to evidence Scotland's health and wellbeing and formal volunteering participation rates the report has drawn upon authoritative national data sources – see Table 2.1. Three of the major surveys are published annually in August or September each year and this has presented a timing problem for the study. Research work commenced in December 2018 and a lot of the evidence collected and analysed was based on 2018 published reports:

- Scotland's Population 2017 – The Registrar General's Annual Review of Demographic Trends (published August 2018)
- The Scottish Health Survey 2017: Volume 1, Main Report (published September 2018)
- The Scottish Household Survey 2017 (published September 2018)

Table 2.1 – Main quantitative data sources		
Source	Title and date	Key elements relevant to this research
National Records of Scotland (NRS)	"Scotland's Population 2017 - The Registrar General's Annual Review of Demographic Trends", Aug 2018 Link	<ul style="list-style-type: none"> • Population projections to 2041 • Trends in births, deaths and life expectancy • Migration • Number and occupancy of households
Scottish Health Survey (SHeS)	"The Scottish Health Survey 2017: Volume 1, Main Report", Sept 2018 Link	<ul style="list-style-type: none"> • General health, long-term conditions and cardiovascular diseases • Mental health and wellbeing • Community engagement
Scottish Household Survey (SHS)	The Scottish Household Survey: <ul style="list-style-type: none"> • 2016, Chapter 11 Link • 2017, Chapter 11 Link • 2018, Chapter 11 Link • Volunteer Scotland's time series analysis 2007 – 2017 Link • Volunteer Scotland's cross-sectional analysis of SHS 2016 Link 	<ul style="list-style-type: none"> • Adult volunteering participation statistics related to: <ul style="list-style-type: none"> ○ Health, sport/exercise, etc. ○ Demographic characteristics ○ Scottish Index of Multiple Deprivation Quintiles • Cross-sectional data on the relationship between volunteering participation and key fields in SHS such as physical activity and sport, culture and heritage, and neighbourhoods and communities

Table 2.1 – Main quantitative data sources

NHS Health Scotland	“Social isolation and loneliness in Scotland: a review of prevalence and trends” – Teuton, J. 2018 Link	<ul style="list-style-type: none"> • Prevalence of social isolation and loneliness in Scotland • Who is at risk? • Equality considerations and looking forward
Office for National Statistics (ONS)	“Loneliness: What characteristics and circumstances are associated with feeling lonely?” ONS, April 2018 Link	<ul style="list-style-type: none"> • Characteristics and circumstances associated with feeling lonely • This includes demographic factors, health, disability, loneliness and the unemployed. • Persona profiles

However, by the time Volunteer Scotland's report was going through final drafting in autumn 2019 the 2018 reports for the above data sources were available. The option of revising the whole report to reflect the latest annual data was rejected as it was not considered to be cost-effective and would introduce further delays to publication. The other factor is that, in general, the data fields do not tend to vary greatly from one year to the next.

The only exception to the adoption of the 2017 baseline relates to data from the Scottish Household Survey (SHS):

- The SHS 2016 report has been drawn upon for data not included in the SHS 2017 report. A number of questions are only asked every two years (on even numbered years).
- The SHS 2016 report has been used exclusively for Volunteer Scotland's cross-sectional analysis. At the time the research commenced the 2016 SHS dataset was the latest available (only becoming available to external researchers in the spring of 2018).
- The SHS 2018 report included new questions on informal volunteering and social isolation and loneliness. Given the relevance of this data to the study it has been drawn upon selectively, particularly in Section 7 – Social Isolation and Loneliness.

The quantitative evidence base was supplemented with other data sources, primarily relating to Scotland, but also supplemented with some statistics from England and the UK. The lack of national level data on social isolation and loneliness prior to 2018 was a particular challenge, as a consequence of which we have supplemented the evidence base from insightful analysis of the Community Life Survey 2016/17, undertaken by the Office for National Statistics.

Qualitative data sources – as explained in Section 1, Volunteer Scotland's literature review on 'Volunteering, Health and Wellbeing' was the catalyst for the examination of Scotland's own health and wellbeing.²⁰ The study provided wide-ranging evidence on the benefits from volunteering drawing upon UK and international evidence: see Figure 1.1. Its conclusions form the foundation for the analysis and interpretation of data relating to Scotland's health and wellbeing described in this sequel report.

However, the literature review also identified important evidence gaps which should be considered in assessing the potential contribution of volunteering:

- *Informal volunteering* – with a couple of exceptions the research evidence focused on formal nor informal volunteering.
- *Community wellbeing* – the vast majority of the evidence focused on individual rather than wider community wellbeing.
- *Youth and mid-life volunteering* – there was an extensive evidence base relating to volunteering and health and wellbeing impacts on older people, but much less on the young and particularly those in mid-life.
- *Volunteering roles* – the extent to which wellbeing impacts vary by the type of volunteering role being fulfilled was very limited.
- *Volunteer management* – the impact of volunteer management on the health and wellbeing of volunteers was completely ignored in the papers we reviewed.
- *Causal mechanisms* – it is not clear in a lot of the research we reviewed how the positive impacts of volunteering on final outcomes impacted on volunteers' wellbeing. This includes mental health, physical health, life expectancy, social isolation and loneliness, and employment and career outcomes.
- *Social isolation & loneliness* – a lot of the research on volunteering, health and wellbeing referenced important social capital and social connectedness benefits but failed to make overt linkages to potential beneficial impacts on social isolation and loneliness.

This sequel report has added to the evidence base and has shed further light on a complex area of study. It has also benefitted from the systematic review of volunteering undertaken by the University of Stirling published in the spring of 2019.²¹ Its research complemented the findings of Volunteer Scotland:

*"The review shows the focus in the volunteering literature on various benefits of volunteer activity. The outcomes and benefits of volunteering were wide and varied but generally positive. There are still assumptions in the literature regarding the positive foundations and impact of volunteering. However, it is worth noting that even in studies that offered critical analysis, there were always positive outcomes reported relating to volunteering."*²²

²⁰ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) – Volunteer Scotland, Dec 2018

²¹ [Literature Review to Inform the Development of Scotland's Volunteering Outcomes Framework](#) – University of Stirling; April 2019

²² Ibid

Their research also identified similar evidence gaps to those identified by Volunteer Scotland:²³

- *Informal volunteering* – “The relatively light coverage of informal volunteering in the literature – driven by a lack of data on this form of participation.....”
- *Community-level impacts* – “The research gaps that we identified include measurement of broader organisational and community-level impacts of volunteering.”
- *Demographic gaps* – “The existing evidence focuses primarily on volunteering amongst younger people and older people. There has been less study of volunteering patterns in between.”
- *Longitudinal data* – “There is relatively little longitudinal data on volunteering, which means that patterns of participation within the life-course are not that well studied at a population level.”

As indicated, a specific focus of this study was to identify measures of health and wellbeing and the contribution of volunteering to health and wellbeing which are Scotland-specific. This study has been successful in that regard. A wide range of evidence sources have been drawn upon which provide both quantitative and qualitative data to supplement the major quantitative data sources listed in Table 2.1.

However, the ‘known unknowns’ listed above still stand. In particular, the causal relationship between volunteering and health and wellbeing remains an intractable problem. As identified by the University of Stirling there is a dearth of longitudinal data on volunteering. Volunteer Scotland’s cross-sectional analysis described below has provided more detailed evidence on the correlation between volunteering and indicators of health and wellbeing, but the thorny issue of causation remains.

The reader should therefore recognise such limitations in the evidence base, particularly in a study of this breadth. However, hopefully it provides valuable insights and gives a balanced and objective interpretation of the evidence reviewed to help inform both policy and practice. Section 10 updates the evidence gaps as assessed at the conclusion of this study.

A full bibliography of the evidence used in this report is presented in the Appendix. Individual reports and data sources are also cited at the bottom of each page with hyperlinks used to facilitate access.

2.2 Quantitative data analysis

For each category of health and wellbeing examined (physical health, mental health, etc.) the most insightful indicators have been extracted, with the majority of the data presented in graphical format. For the Scottish Health Survey and the Registrar General’s Annual Review of Demographic Trends this was a straight extraction of the data with no further analysis.

²³ Ibid

However, for three other data sources Volunteer Scotland has undertaken its own quantitative analysis exploring the relationship between volunteering and relevant health and wellbeing indicators. This has provided a vitally important source of evidence to supplement the extensive evidence base on the health and wellbeing of Scotland's population. The data sources and analysis are explained below.

Scottish Household Survey (SHS), 2016

Volunteer Scotland has undertaken cross-sectional analysis of the volunteering data (Chapter 11) with other important fields such as the composition and characteristics of households in Scotland (Chapter 2); neighbourhoods and communities (Chapter 4); physical activity and sport (Chapter 8); and culture and heritage (Chapter 12).²⁴ This provides evidence on the relationship between volunteering and important variables linked to health and wellbeing such as sport, culture and demographic characteristics.

The SHS 2016 dataset was used because it was the latest available at the time the analysis was initiated in late 2018.²⁵ Even numbered years also provide the full dataset as a number of questions are omitted every other year. Volunteer Scotland is planning to repeat its cross-sectional analysis for SHS 2018 commencing spring 2020 when the data is made publicly available.

NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017-18

This is a major triennial survey of health and wellbeing conducted by NHS Greater Glasgow and Clyde (NHSGGC).²⁶ For the 2017/18 survey 7,834 face-to-face in-home interviews were conducted with adults (aged 16 or over) across Greater Glasgow and Clyde. The survey encompasses a wide range of questions relevant to the health and wellbeing research, and it also includes an identical question on formal volunteering participation to that used by the SHS.

One of the key advantages of this dataset is its sample size and the ability to produce statistically significant results for health and wellbeing indicators in defined geographies across Greater Glasgow and Clyde. Understanding how health and wellbeing and volunteering varies between the most deprived communities in Scotland and some of the least deprived is invaluable. Their research also gathers data on questions not covered by the SHS.

²⁴ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

²⁵ The SHS 2016 report was published in September 2017, but the data for statistical analysis is not made available till spring 2019.

²⁶ [NHS Greater Glasgow and Clyde 2017/18 adult health and wellbeing survey main report](#) – Traci Leven Research, Jan 2019

NHSGGC granted Volunteer Scotland access to their dataset to enable a similar cross-sectional analysis of data to that conducted for the SHS 2016 dataset. This work was completed during the course of this research and the data quality assured by the NHSGGC team. Unfortunately, publication is not scheduled till January 2020, but the NHSGGC team have kindly agreed that relevant evidence can be drawn upon for this report. When Volunteer Scotland's NHSGGC analysis is published a link will be provided on the webpage next to the link for this report.

NCVO – 'Time Well Spent' – A survey on the volunteer experience in Great Britain

'Time Well Spent' is a major report into the volunteering experience published by NCVO in January 2019.²⁷ It is the result of a national survey carried out through YouGov's panel (10,000+ respondents aged 18+). The survey focuses on volunteering through groups, clubs and organisations and includes data on recent volunteers, but also lapsed volunteers and non-volunteers. Their research provides important data on health and wellbeing indicators from the volunteer's perspective; data which is not available from other sources, but is complementary to the SHS and NHSGGC datasets.

NCVO granted Volunteer Scotland access to the Scottish dataset of 877 respondents out of the total GB sample size of 10,103. The Scottish sample size is sufficiently large to enable analysis of questions which are applicable to the total sample and for cross-tabulations which are binary. Analysis of sub-sets of the population and multiple response cross-tabulations can run into problems of statistical significance and have therefore had to be omitted from the results.

Volunteer Scotland's main analyses of the NCVO data were completed during the course of this research. Unfortunately, publication of the NCVO Scottish dataset is not scheduled till February 2020, but the NCVO team have kindly agreed that relevant evidence can be drawn upon in this report. When Volunteer Scotland's analysis of the 'Time Well Spent' data is published a link will be provided on the webpage next to the link for this report.

2.3 Reporting

Drawing upon the evidence assembled Volunteer Scotland produced a draft report based on the structure outlined in Section 1. The report was subject to peer review by a range of contributors who brought specialist knowledge on policy and practice relating to health and wellbeing. Based on this very helpful feedback the evidence base was enhanced, sections were developed more fully and edits relating to language and terminology were put through. In particular, the conclusions reached in Section 9 on 'Priorities' were revised and improved prior to the final report being published. Volunteer Scotland would like to express its thanks to all those who supported this work – please see our 'Acknowledgements' on page 1 of the report. As always, any errors, omissions or misinterpretations remain the sole responsibility of Volunteer Scotland.

²⁷ Time Well Spent - A national survey on the volunteer experience – NCVO; Jan 2019

3. Demographic projections

3.1 Demographic context

Volunteering is an activity delivered by people for people. By its very nature it is human resource dependent. Therefore, it is important to understand how Scotland's population is projected to change in the future and to assess the implications for volunteering.

The 'demographic time bomb' issue has been extensively publicised inside and outside Scotland, but what are the actual facts and figures? This Section provides answers to the following questions:

- How significant will the increase in the number of over 65s be?
- What are the population projections for those aged under 65?
- Are all age groups under 65 going to be subject to a declining population?
- What is the impact on Scotland's overall population and the number of projected volunteers?

The National Records of Scotland (NRS) annual publication 'Scotland's Population: The Registrar General's Annual Review of Demographic Trends – 2017' provides an invaluable data source to help us answer these questions.²⁸

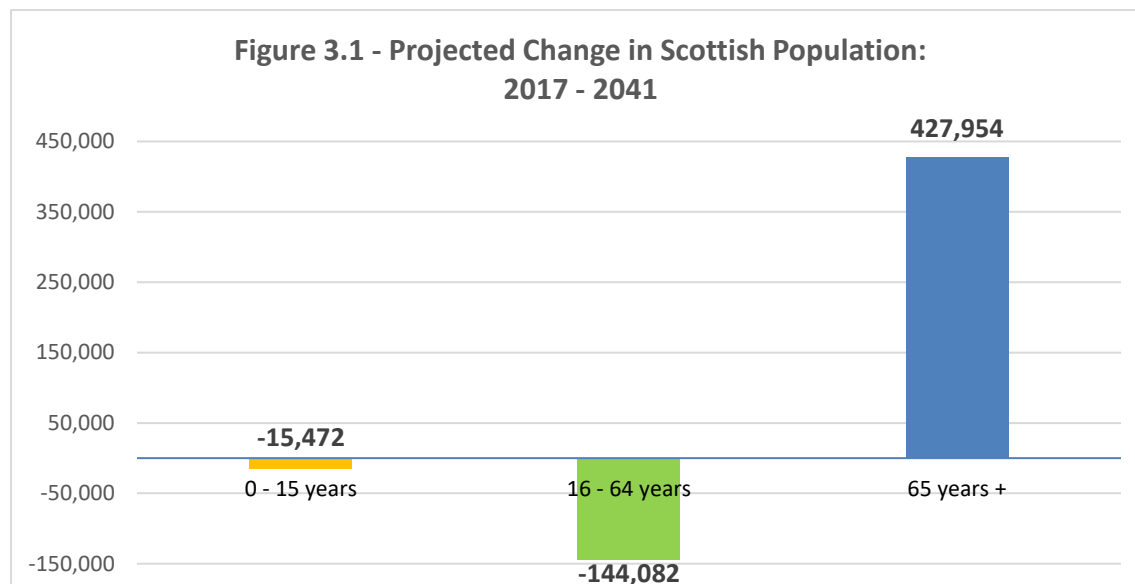
3.2 Key projections²⁹

- Scotland's population has grown for the last 15 years and it is projected to continue its growth for the 24-year period 2017 – 2041, increasing from 5,424,800 to 5,693,200.
- The projected increase in population over the next 24 years is due to net in-migration to Scotland, which is projected to be positive each year going forward. In 2041 it is projected that net in-migration will still account for an additional 14,600 people that year.
- In contrast, natural change (births minus deaths) is projected to be negative each year going forward. In 2041 it is projected that there will be 10,000 more deaths than births that year.
- Crucially, Scotland's population is ageing, with the proportion of those aged 65+ projected to increase from 19% in 2017 to 25% in 2041.
- In contrast, the proportion of the population aged 16 – 64 is projected to decrease from 64% to 59% of the population by 2041.
- Those aged 0 – 15 years will also decrease, but more modestly from 17% to 16% by 2041.

²⁸ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

²⁹ Ibid - All data has been drawn from this publication for sub-section 3.2

What are the implications of these demographic changes for the number of people in Scotland in the different age categories? Although there is a projected increase in the total population of 268,400 over the period 2017 - 2041, this masks a major shift in age structure. As illustrated in Figure 3.1, by 2041 there will be almost half a million more people aged 65+ in Scotland, but 160,000 fewer people aged under 65.



Source: NRS Population Projections, 2017

These demographic trends will have major implications for:

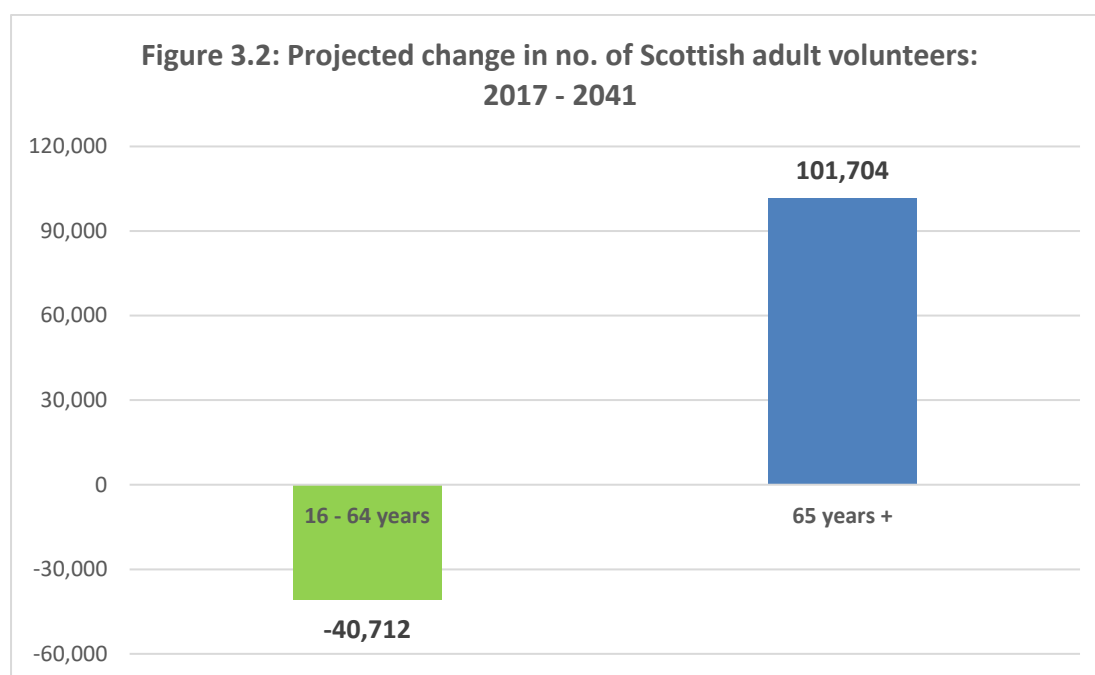
- **Our economy** – a vibrant economy depends on a growing and skilled workforce. Scotland is projected to have fewer people of working age, which could act as a constraint on our future growth, unless there is a significant shift in people retiring later in life or there is an increase in net in-migration. Furthermore, if, as projected, there is a significant increase in the proportion of retired people, then this will act as a fiscal constraint on Government due to lower tax revenues and increased costs.
- **Our health sector** – an ageing population which is living longer but with long-term health conditions, combined with advances in medicine and science, will exacerbate the unrelenting upward trend of increasing demands on our very hard-pressed NHS.
- **Our society** – the change in age structure will have implications both for our older people and the challenges they face (see the challenges outlined in Volunteer Scotland's "Volunteering, Health and Wellbeing" report) and for inter-generational engagement across our society.³⁰

³⁰ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) – Volunteer Scotland, Dec 2018

3.3 Implications for volunteering

Number of volunteers – we cannot predict the wide range of variables which could influence future volunteering participation. However, if we assume no change to these variables and apply the current Scottish Household Survey (SHS) volunteering participation rates in Scotland to the NRS population projections, this allows us to project volunteer numbers up to 2041: see Figure 3.2.³¹ Key projections:

- The number of adult volunteers is projected to increase by 61,000 over the next 24 years, which mirrors the projected increase in Scotland's population. This represents a relatively modest increase within the context of the 1,214,000 volunteers in 2016 – a 5% increase.
- However, the number of adult volunteers aged 65+ is projected to increase by 101,700, representing a 42% increase in volunteers in this age group.
- In contrast, the number of volunteers aged under 65 is due to decrease by 40,700, representing a 4% decline.



Source: NRS Population Projections (2017) and SHS volunteering participation rates (2016)

Number of volunteer hours – this change in volunteer numbers is mirrored in the change in volunteer hours: see Table 3.1. Assuming the average number of volunteer hours for each age group remains constant over the next 24 years, then it is projected that over 13 million extra hours will be contributed by those aged 65+ in 2041, but there will be nearly 5 million fewer hours by those aged 16 – 64.

³¹ 2016 has been used as the base year for the projection of volunteer numbers as NRS based its population projections for 2017 – 2041 on mid-2016 population estimates.

Table 3.1 – Projected change in volunteer hours in Scotland: 2017 - 2041			
Year	Age 16 – 64	Age 65+	Total
2017	116,726,000	30,983,000	147,709,000
2041	111,914,000	44,077,000	155,991,000
Change	-4,812,000	+13,094,000	+8,282,000
% Change	-4%	+44%	+6%
Source: NRS Population Projections 2017 and SHS volunteering participation rates (2016)			

This demographic restructuring may have implications not just for the age of our volunteers but also for the nature of the volunteering roles they are able to fulfil. For example, it is possible that older volunteers may not be as fit and able to undertake the more physically demanding roles currently undertaken by younger volunteers.

An uncertain future – the above projections are based purely on demographic change and current volunteering rates and hours and they make no allowance for a range of variables which may impact on both volunteer numbers and volunteer hours. For example, possible factors affecting different age groups include:

- **Those aged 16 – 64:** how will those in employment be affected by economic pressures? Working adults may become even more 'time poor' due to increasing demands on a shrinking workforce. For example, the recent growth in Scotland's economy has been achieved not through capital investment or job creation, but by employees working longer hours (see Section 4). Such pressures could result in reduced adult volunteering participation rates and fewer volunteering hours from those of working age.
- **Those aged 65+:** how will those in the 'retirement' age bracket be affected? Given a combination of factors such as improved life expectancy, constrained personal savings and pensions, and labour market pressures in the Scottish economy, it is possible that we will see a move of the 'retired' back into employment for those aged 65+. Indeed, it has been projected that in the near term up to 2023 there will be an increase in labour market participation by the 'economically inactive' – a high proportion of whom are from the retired population (see Section 4).
- If such a change was to occur this could impact on volunteering participation rates and volunteering hours for the 65+ age group; but not necessarily negatively. It is possible that there is a reinforcing employment and volunteering effect – a win-win outcome. Alternatively, there could be a displacement effect where employment displaces volunteering time for those who are 'retired'. Such impacts are impossible to predict.

Managing the demographic change – however, based purely on the demographic changes described above we should plan for the following:

- **Supporting our ageing population** – by 2041 one in four of Scotland's population will be aged 65+. It is inevitable that the increasing proportion of older people in society will place increasing demands on our health and social care provision and, when combined with problems of social isolation and loneliness, this will result in even greater pressures on the NHS, local authorities, charities and other support providers.

Volunteering already plays a key role in this area through its support for NHS frontline services, health charities, voluntary organisations, befriending services, etc. The upscaling of this vital contribution must be planned for over the coming years.

- **Upskilling our workforce** – volunteering has a key role to play in helping to mitigate the projected decline in our working age population. This includes helping to engage and upskill our workforce through supporting our young people in their transition from school to tertiary education and employment; through the upskilling and transitioning between jobs of adult workers (30+) to help meet the demand of the growth sectors in our economy; and through the engagement of the economically inactive – especially those in retirement.
- **Maximising people's health and wellbeing** - as evidenced by Volunteer Scotland, volunteering can help to mitigate the health and social isolation and loneliness challenges facing all age groups in Scottish society, but particularly those who are older, disadvantaged and subject to mental and physical health conditions.³² Given our ageing population, the increased evidence of mental and physical health challenges, and increased awareness of the problems of social isolation and loneliness, volunteering has a key role to play going forward.

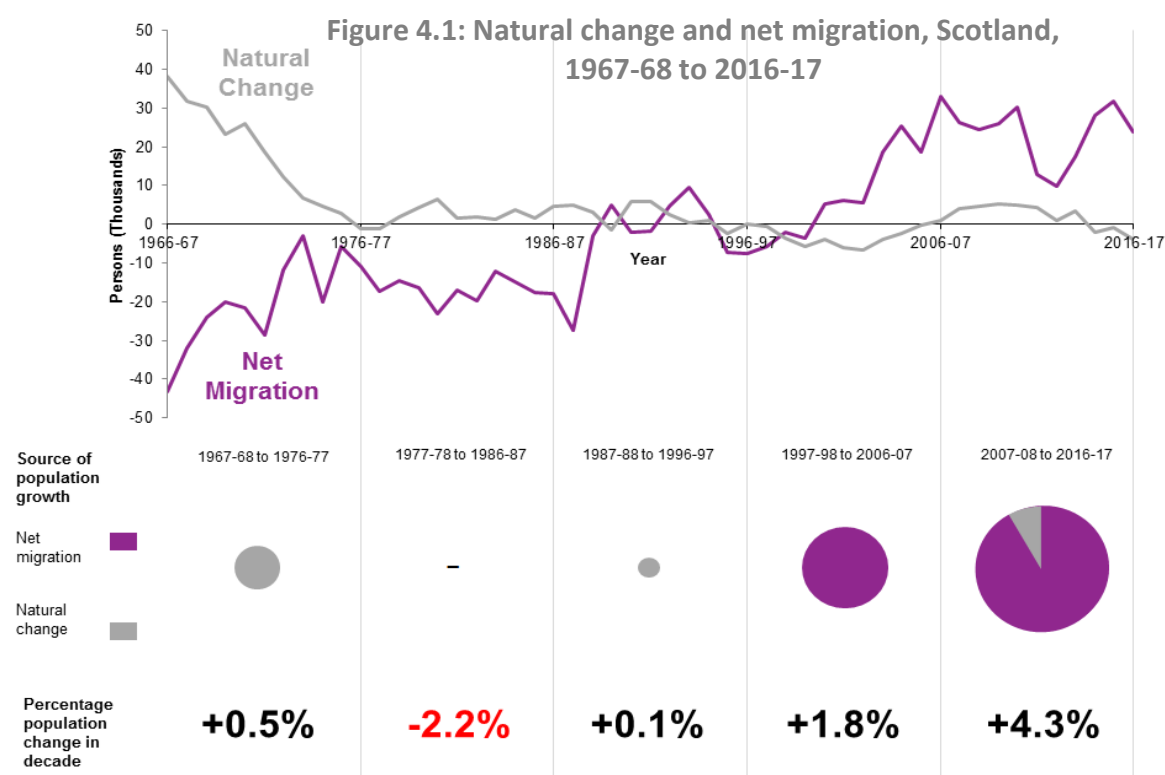
³² [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

4. Labour market and skills

4.1 Labour market and skills context

As discussed in Section 3 Scotland's working age population (aged 16 – 64) is due to decline by 144,000 by 2041. This presents a serious challenge to Scotland's economy which, for optimal performance, depends on a growing and highly skilled workforce.

There are two variables which impact on a country's population: natural change (births minus deaths) and net migration.³³ Since 2000 the growth in Scotland's population has been dependent on net in-migration, which in 2016/17 was 23,700 people: see Figure 4.1. Natural change over the same period has oscillated around zero in terms of the balance between births and deaths.



Source: NRS Population Projections (2017)

In-migration is particularly important for Scotland's labour market because most immigrants are of working age (81% were aged 16 – 64 in 2016/17) and their objective is to secure employment in Scotland.³⁴ They also tend to be well skilled.

³³ 'Net migration' is defined as difference between the number of long-term immigrants coming to Scotland and the number of long-term emigrants leaving Scotland.

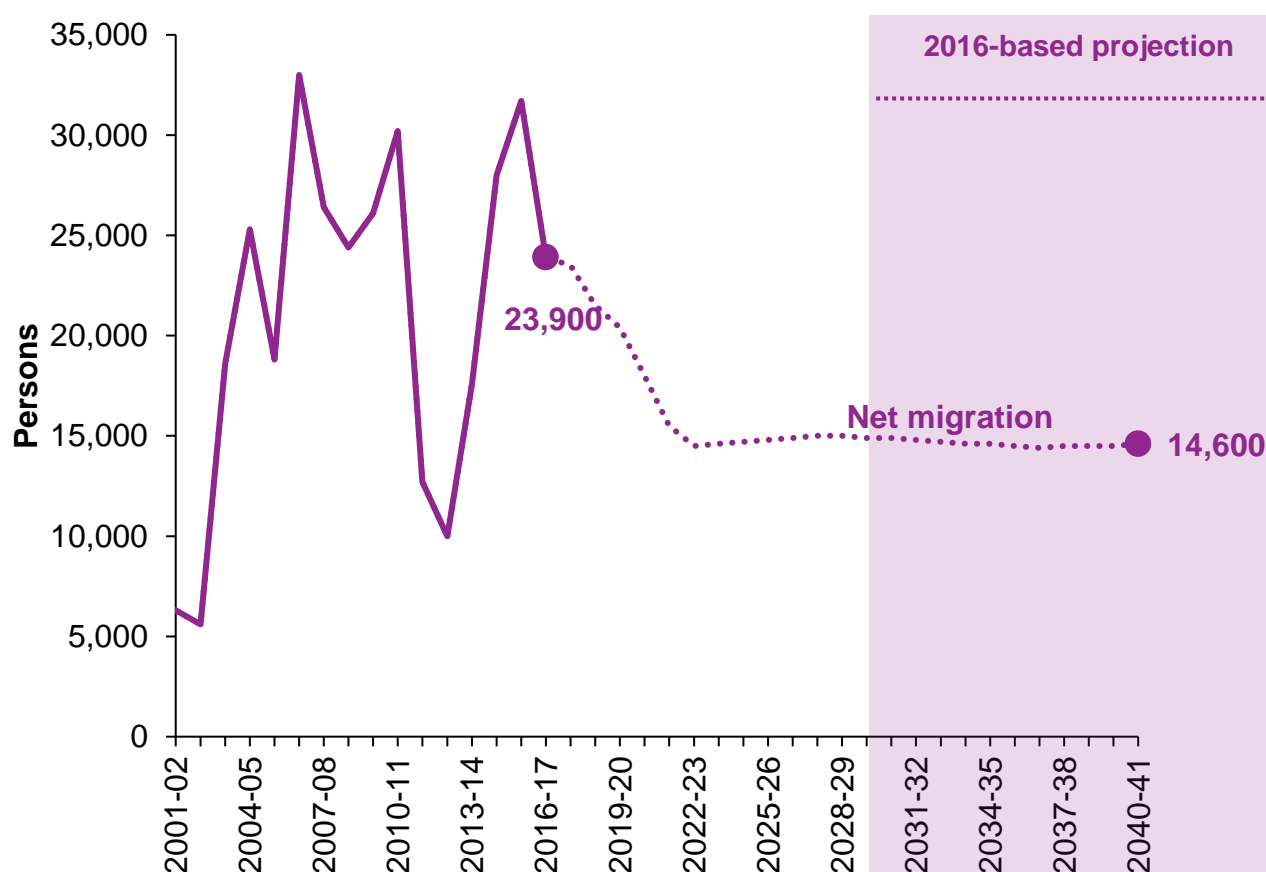
³⁴ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

4.2 Key projections

Starting with the National Records of Scotland (NRS) annual publication on demographic trends the impacts of their population projections are examined, with a specific focus on net migration.³⁵ Figure 4.2 presents the NRS projections for in-migration from 2016 to 2041. There is a steady decline in net migration from 2016-17 to 2022-23, after which it stabilises at around 15,000 p.a. Over this same period, natural change is projected to be negative throughout, meaning Scotland's future population growth is projected to be entirely reliant on migration. NRS explains the basis of its net migration projections as follows:

*"It is important to remember that the projections are trend-based; they are not forecasts and do not take into account changes in government policy and other social and economic factors, as it is very difficult in advance to know what impact these will have. **On that basis, the projections do not attempt to predict the impact of the UK leaving the EU.**"*

Figure 4.2: Net migration, Scotland, 2001-02 to 2040-41



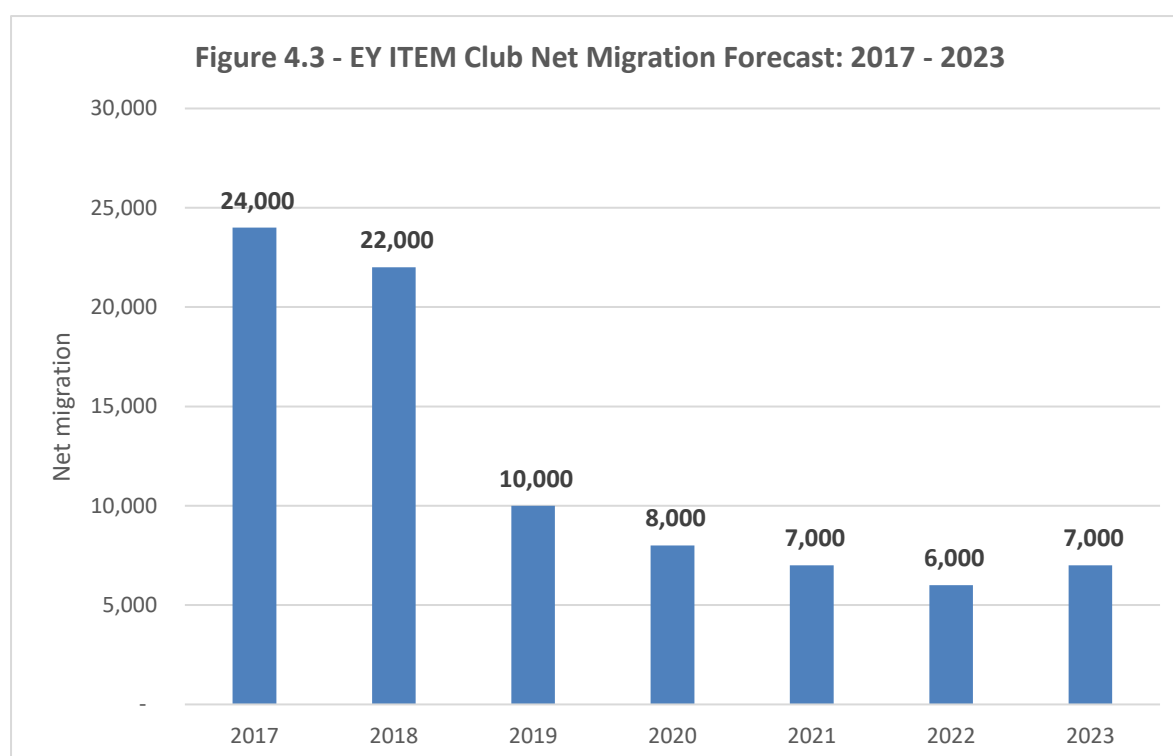
Source: NRS Population Projections (2017)

³⁵ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

Clearly, the impact of Brexit is highly uncertain, but the potential impact on net migration in Scotland may well be more pessimistic than projected in Figure 4.2. for all outcomes other than 'remain'. NRS has helpfully modelled different migration assumptions and this demonstrates that changes in net migration can have a significant effect on Scotland's population: see Table 4.1.

Table 4.1 – Scotland's projected population under variant migration assumptions		
Assumption	Projected population in 2041	% change: 2016 - 2041
High migration	5.96 million	10.3%
50% more EU migration	5.78 million	7.0%
Principal (baseline projection as per Fig. 4.2)	5.69 million	5.3%
50% less EU migration	5.60 million	3.7%
Zero EU migration	5.52 million	2.1%
Low migration	5.43 million	0.4%
Zero net migration	5.17 million	-4.4%
Source: NRS Population Projections 2017		

The EY ITEM Club Scottish Forecast also projects a declining net-migration figure for Scotland over the period 2017 – 2023, but its projected rate of decline is significantly greater to 7,000 p.a. net in-migration by 2023: see Figure 4.3.³⁶



Source: EY Scottish ITEM Club 2019 Forecast

³⁶ [EY Scottish ITEM Club 2019 Forecast: Challenges Ahead](#) – EY, Dec 2018. EY is the global accountancy firm which is the sole sponsor of the ITEM Club. The ITEM Club is the only non-governmental economic forecasting group to use the HM Treasury model of the UK economy.

The impact of the lower EY ITEM Club forecast net migration figures would be to lower the NRS population projection below the 'Principal' baseline in Table 4.1. The consequences are that Scotland's working age population would decline further than already projected. The EY 2019 forecast sums up succinctly the labour supply problems facing Scotland:

*"Furthermore, we expect the working-age population of Scotland to contract. A falling net inflow of workers suggests that migrants, typically of working age, will become increasingly less able to offset the natural ageing of the Scottish population. The working-age population is forecast to contract by an average of 0.4% per year to 2023, or 66,500 residents in total, compared with modest annual growth of 0.1% across the UK."*³⁷

4.3 Implications for volunteering

This analysis demonstrates that Scotland's economy is facing a major threat from the decline in its working age population over the 25-year period 2016 - 2041. The decline is attributable to two main factors: an ageing population and a contraction in net in-migration. Scotland's labour market strategy recognises these challenges in referencing the benefits of EU membership:

*"One such benefit is the free movement of labour – particularly important to Scotland, as a country that needs to grow its population to help address skills gaps and deal with an ageing population."*³⁸

Skills Development Scotland's report on jobs and skills highlights in more detail the key challenges facing Scotland's labour market:³⁹

- New jobs growth is forecast to be modest over the period 2017 – 2027: 56,000 in total – see 'expansion demand' in Table 4.2.
- Replacement demand is the dominant driver, which will amount to 944,000 jobs in total over the period 2017 – 2027. This much higher replacement demand reflects an ageing workforce and that workers leave the workforce for a number of reasons including retirement.
- This gives a total requirement of nearly 1 million jobs over this period, which is greatest for 'professional occupations' (254,900) and for 'elementary occupations' (197,000).⁴⁰

³⁷ Ibid

³⁸ [Scotland's Labour Market Strategy](#): Scottish Government, Aug 2016

³⁹ [Jobs and Skills in Scotland: The Evidence](#): Skills Development Scotland, Nov 2017

⁴⁰ 'Elementary occupations' is a standard occupation classification comprising cleaning jobs; manual jobs in agriculture, forestry and mining/quarrying; food preparation; and street vendors and refuse workers.

Table 4.2 – Expansion and replacement demand by occupation: 2017- 2027			
Standard Occupation ⁴¹	People ('000s)		
	Expansion demand	Replacement demand	Total requirement
1. Managers, directors and senior officials	4.3	50.1	54.3
2. Professional occupations	15.7	239.2	254.9
3. Associate professional and technical	7.4	83.1	90.5
4. Admin and secretarial occupations	-0.3	81.1	80.8
5. Skilled trades occupations	5.3	84.4	89.7
6. Catering, leisure and other service	10.1	65.1	75.2
7. Sales and customer service	6.2	114.9	121.1
8. Process, plant and machine operatives	-3.1	38.8	35.8
9. Elementary occupations	10.3	186.9	197.2
Total	56.0	943.6	999.6
Source: Jobs and Skills in Scotland: The Evidence : Skills Development Scotland, Nov 2017			

Volunteering can play an important role in the mitigation of these labour market challenges. However, there may also be negative impacts on the level and nature of volunteering in Scotland arising from the wider resolution of these challenges.

Opportunities to improve labour supply and market efficiency through volunteering

Volunteering can improve the operation of Scotland's labour market by facilitating the access of our young people to the labour market, through facilitating the access of older adults who are not currently in the labour market but who would like to have a job, and through engaging those who are economically inactive to consider employment.

Improving the supply of skilled young people - volunteering already plays a key role in developing both soft and hard skills, and providing work experience to assist the transition into employment, particularly for our young people entering employment from school, tertiary education, apprenticeships, training and those not in education, employment or training. This has been a key Government policy since the launch of the original volunteering strategy in 2004.⁴²

Given the pressures on Scotland's working age population, the importance of supporting our young people to get the best possible start in life and the wider wellbeing benefits volunteering confers on our young people, this policy focus should be maintained.⁴³ The emerging evidence on the effectiveness of this policy focus is also encouraging with the youth volunteering participation rate of 52%, almost double that of the adult rate (28%).⁴⁴

⁴¹ [Standard Occupational Classification \(SOC\) Hierarchy](#) – the ONS website gives descriptions for the standard occupations

⁴² [Volunteering Strategy](#) – Scottish Executive, Nov 2004

⁴³ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) – Volunteer Scotland, Dec 2018

⁴⁴ [Young People in Scotland - Analysis of Volunteering, 2016](#) – Volunteer Scotland, Jan 2017

Improving the supply of skilled adults – building on this successful youth work there is the scope to broaden the contribution of volunteering in improving labour market entry for those aged 30+. They can also benefit from volunteering in the development of their soft and hard skills and through important wellbeing benefits. This can relate to the long-term unemployed, women returners, those returning from long-term sickness, other disadvantaged groups such as ex-offenders and those in work who need to transition to new career paths requiring different skill sets and competencies. The example of refugees is described.

Meeting demand from refugees – the Scottish Government's Refugee Integration Strategy highlights the importance of volunteering for refugees, both in their integration to communities and in finding employment:

*“Refugees and asylum seekers have the right to volunteer. Volunteering can offer some of the same benefits that working provides including: opportunities to use and develop skills; a sense of purpose; and links to other people in the community. Volunteering can also be beneficial as a way of increasing employability, by gaining experience which could ultimately support a job application.”*⁴⁵

The Scottish Government's Programme for Scotland 2018-19 endorsed its commitment to supporting refugees through working with partners such as COSLA and the Scottish Refugee Council to:

*“....work to develop opportunities for refugees to build their skills and employment options, including through volunteering and work placements.”*⁴⁶

By quickly and effectively integrating refugees into society, the greater the chances are that they will be able to secure employment and contribute their skills and human resource for the benefit of both themselves, their communities and the wider Scottish economy.⁴⁷

Meeting demand from specific occupations – from the projected expansion and replacement demand projections in Table 4.2, it is clear that the level of labour market demand over the period 2017 – 2027 will vary considerably by occupational group. There would be merit in undertaking a more forensic analysis to identify those occupations subject to the greatest level of job turnover and to determine whether/how they could benefit from volunteering.

⁴⁵ [New Scots: Refugee Integration Strategy 2018 - 2022](#) – Scottish Government, Jan 2018

⁴⁶ ["Delivering for Today: Investing for Tomorrow" The Government's Programme for Scotland 2018-19](#) – Scottish Government, Sept 2018

⁴⁷ Note: asylum seekers can engage in volunteering, but they can't take up paid work while their case is being assessed.

It may be appropriate to develop volunteering 'task forces' in specific skill areas to help meet the labour and skill requirements of particular occupations. For example, there has been a concerted effort to maximise the contribution of volunteering to Scotland's historic environment sector in the last three years, as part of the implementation of the Our Place in Time strategy.⁴⁸

The work of the Historic Environment Volunteering Group has identified the need to diversify its volunteer profile away from the 60+ age group; and has a strategic objective to make its volunteering engagement more inclusive.⁴⁹ As part of this work there is the potential for wider labour market impacts to be considered to maximise the symbiotic relationship between volunteering and paid employment.

Engaging the 'economically inactive' – Scotland's labour supply can be increased through engaging those not currently part of the labour force.⁵⁰ This comprises those neither employed nor unemployed and includes students, housewives/househusbands and pensioners. In principle, it is possible for volunteering to 'open the eyes' of the economically inactive to the potential merits of employment. In particular, this may be relevant for those in retirement in the age group 60 – 75.

We know from analysis of the relationship between volunteering and employment that volunteering can play an important role in supporting the transition of unemployed people into work.⁵¹ Unfortunately, we are not aware of any evidence on the contribution of volunteering in the transition process from the economically inactive to the economically active.

However, given a combination of factors such as improved life expectancy, constrained personal savings and pensions, and the labour market pressures in the Scottish economy, it is possible that there will be a movement of the 'retired' back into employment for those aged 60+, are physically fit and who would benefit from improved social connectivity.

Interestingly, the EY ITEM Club Report forecasts an increase in labour market participation by the economically inactive in Scotland:

*"Although this (the decline in Scotland's working age population) will be coupled with growth in Scotland's overall employment over the same period, we forecast the unemployment to remain relatively stable at 4.4% in 2023. This implies there will be an increase in labour market participation by the (currently) economically inactive."*⁵²

It will therefore be important to research the potential contribution of volunteering to the economically inactive and to determine whether volunteering can play a positive role in the transitioning process into the economically active.

⁴⁸ [Our Place in Time: The Historic Environment Strategy for Scotland](#) – Scottish Government, Mar 2014

⁴⁹ [Volunteering and the Historic Environment](#) – Volunteer Scotland, June 2016

⁵⁰ [Definition of 'economically inactive'](#)

⁵¹ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

⁵² [EY Scottish ITEM Club 2019 Forecast: Challenges Ahead](#) – EY, Dec 2018

Possible negative impacts on volunteering

Working adults: how will those in employment be affected by the economic and labour market pressures discussed in this Section? A possible impact is that working adults may become even more 'time poor' due to increasing demands on a shrinking workforce. For example, the EY ITEM Club Report suggests that the recent growth in Scotland's economy has been achieved at the expense of hard-working employees:

*"It would also seem that the additional demand in the economy has been met not by capital investment or job creation, but by employees working longer hours. Again, this is not the most desirable formula for growth."*⁵³

The research evidence from "Volunteering, Health and Wellbeing" also demonstrates that the frequency and intensity of volunteering can have adverse impacts on the wellbeing of volunteers, especially those in mid-life in the age range 35 – 45.⁵⁴ These people are often the busiest and tend to have the most commitments. Evidence shows that for even fairly modest volunteering inputs of around 100 hours per annum, wellbeing may start to decline due to role strain and burnout issues (Van Willigen, M., 2000).⁵⁵ Those volunteering 140 hours or more experienced lower levels of wellbeing than those not volunteering at all, the implication being that volunteers' wellbeing would increase if they stopped volunteering!

To conclude, if there are increased pressures to work longer hours this could result in reduced volunteering participation rates and volunteering hours for those of working age. For those who do volunteer there is a potential risk of role strain and burnout.

The retired: how will those in the 'retirement' age bracket be affected? If there is a movement of the economically inactive to the economically active status for those of retirement age, then this could lead to:

- A reduction in the number of volunteers of 'retirement' age due to both a reduction of new 'retirees' taking up volunteering, and by a movement of existing volunteers moving back into paid employment and relinquishing their volunteering roles.
- A reduction in the frequency and intensity of volunteering by existing volunteers.

However, it is also possible that there is a reinforcing employment and volunteering effect – a win-win outcome – whereby volunteering encourages employment and vice-versa. The actual outcome is impossible to predict.

⁵³ Ibid

⁵⁴ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

⁵⁵ 'Differential benefits of volunteering across the life course': Van Willigen, M.; East Carolina University; 2000, Vol. 55B, No. 5, S308-S318

5. Physical health

5.1 Health and wellbeing context

Volunteer Scotland's report, which examined the evidence on the connections between volunteering, health and wellbeing, highlighted the critical role volunteering can play in helping to improve people's mental and physical health and their overall wellbeing.⁵⁶ It also revealed evidence that volunteering is associated with improved life expectancy. A key finding was the disproportionately important positive impact which volunteering can have on those who are disadvantaged in society – particularly the beneficial effects it can have on their mental health and social connectedness.

However, the literature review did not provide the health and wellbeing context for Scotland. In particular, it did not examine the specific health challenges facing Scotland's people. Therefore, one of the key objectives of this report is to review the state of Scotland's physical and mental health and to assess the nature and the scale of the potential contribution of volunteering to the improvement of our health.

There is a massive evidence base upon which to draw, so it is important to be very focused in the selection of the most insightful data. The Scottish Government's Scottish Health Survey - 2017 edition provides an excellent data source for the analysis of specific indicators of physical and mental health in Scotland.⁵⁷

However, unlike the National Records of Scotland Population Projections, the Scottish Health Survey (SHeS) does not project indicators of Scotland's health into the future. Instead, it provides an analysis of health trends over the last 20+ years and gives an up-to-date assessment of key indicators of Scotland's current health and wellbeing. This data source has been supplemented with publications from the Scottish Government and other health bodies such as Diabetes Scotland, which are referenced throughout the Section.

Section 5 focuses on physical health and Section 6 on mental health. The analysis of physical health is structured under the following headings:

- **Life expectancy** – what has been the trend in life expectancy for people in Scotland and, importantly, what has been their healthy life expectancy?
- **General health** – an overview of people's self-assessment of their own health, which sets the scene on health trends in Scotland.
- **Long-term conditions** – this encompasses any long-term physical and/or mental health conditions.
- **Cardio-vascular disease and diabetes** – this disease category was selected due to its prevalence, adverse impact and the fact that its incidence can be so effectively addressed through changes to exercise and diet.
- **Implications** – what the evidence tells us about volunteering and its contribution.

⁵⁶ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

⁵⁷ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report: Scottish Government, Sept 2018

5.2 Life expectancy

The 'Public Health Priorities for Scotland' report presents an analysis of life expectancy in Scotland which provides an interesting litmus test of the issues relating to the physical health of Scotland's population and the need for change:⁵⁸

- **Life Expectancy (LE)** – the average life expectancy at birth across Scotland was 81.2 years for females and 77.1 years for males for the period 2014 – 2016.⁵⁹ Since 1980 – 82 life expectancy increased by almost six years for women and eight years for men. However, the rate of increase has been slowing and in 2014 – 2016 it stalled, the first time this has happened for both men and women. It is unclear whether this is the start of a new trend or just a temporary variation.
- **EU comparison** – notwithstanding this improvement in life expectancy over the last 25 years, Scotland still has one of the lowest life expectancies in Western Europe (see Figure 5.1) and the lowest of all UK countries.⁶⁰
- **Variability within Scotland** – life expectancy varies dramatically between the most and least affluent areas in Scotland: see Figure 5.2.⁶¹ For males the variation can be as much as 28 years and for women 25 years. This is much greater than the variation by gender alone.
- **Healthy Life Expectancy (HLE)** – 'healthy life expectancy' is defined as the expected number of years during which we are healthy.⁶² What is important is not just longevity but also the quality of life. What is concerning is that HLE in 2016 was significantly lower than LE. For men HLE was 59.3 years compared to LE of 77.1 years (a difference of 17.8 years); for women HLE was 62.7 years compared to LE of 81.1 years (a difference of 18.4 years). Furthermore, over the period 2009 – 2016 the expected percentage of life in 'healthy health' has been deteriorating for men: from 79.0% to 77.0%. However, it has remained static for women at 77.3%.
- **Deprivation** – as for LE, there are marked differences in HLE between the most and least deprived areas in terms of how long people can expect to live in good health. There can be a difference of up to 28 years for men and 25 years for women – the same differential as for LE.⁶³

⁵⁸ [Public Health Priorities for Scotland](#) – COSLA and Scottish Government, June 2018

⁵⁹ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)

National Records of Scotland, Aug 2018 (see Chapter 4 – Life Expectancy)

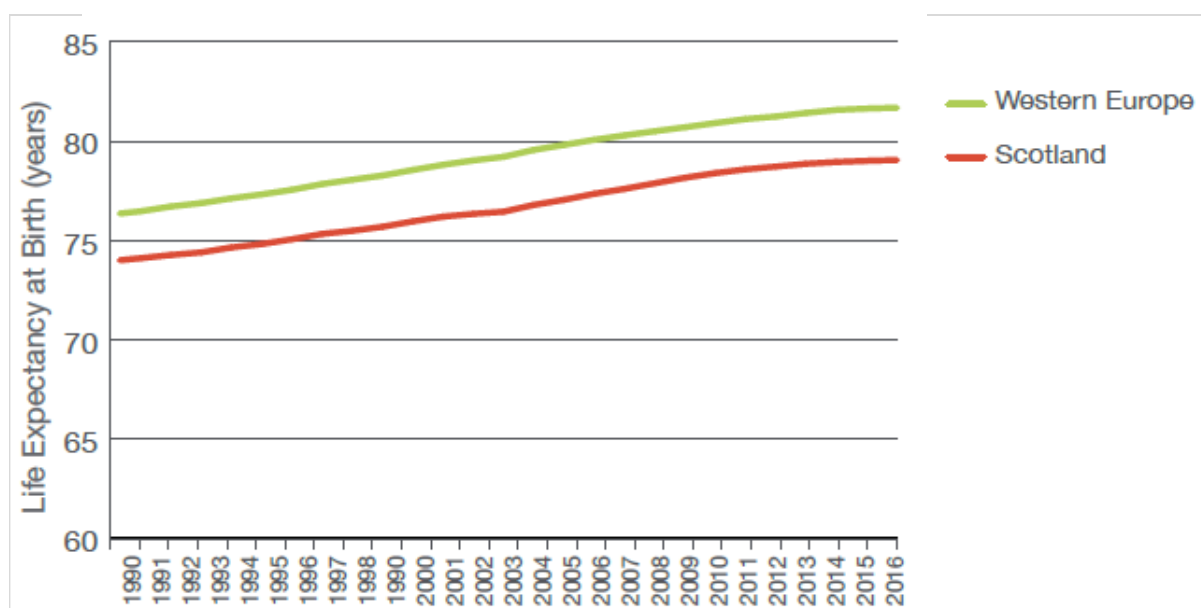
⁶⁰ [Public Health Priorities for Scotland](#) – COSLA and Scottish Government, June 2018

⁶¹ Ibid

⁶² Healthy life expectancy data has been analysed by [The Scottish Public Health Observatory](#) – Dec 2017. 'Healthy life' is based on 'self-assessed health' in the Scottish Household Survey – those who rate their health as 'good' or 'very good' on a five-point scale.

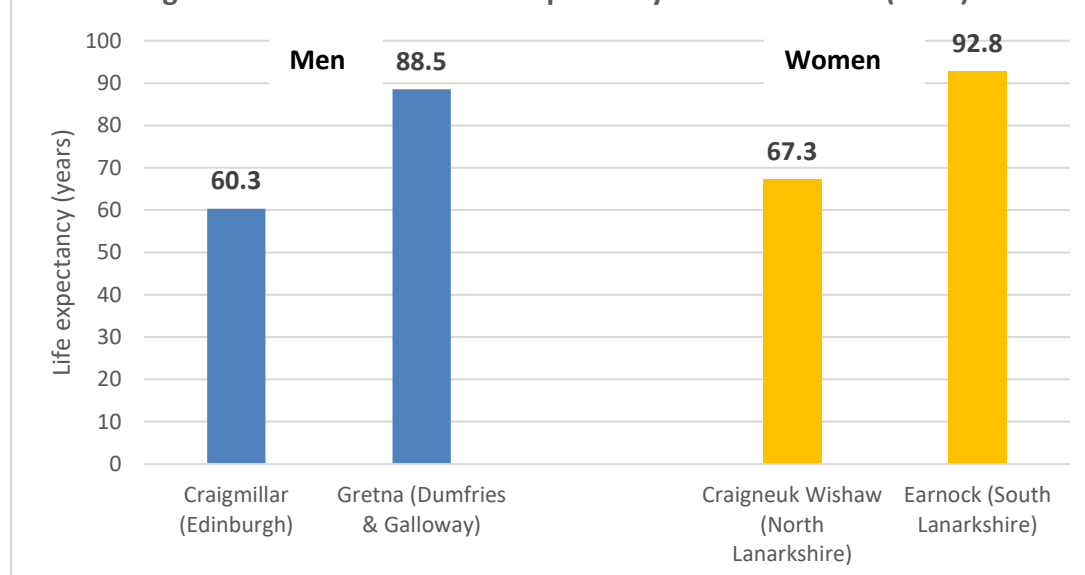
⁶³ [Public Health Priorities for Scotland](#) – COSLA and Scottish Government, June 2018

Figure 5.1 – Life expectancy in Scotland vs. Western Europe



Source: [Public Health Priorities for Scotland](#) – COSLA and Scottish Government, June 2018

Figure 5.2 - Variations in life expectancy across Scotland (2016)



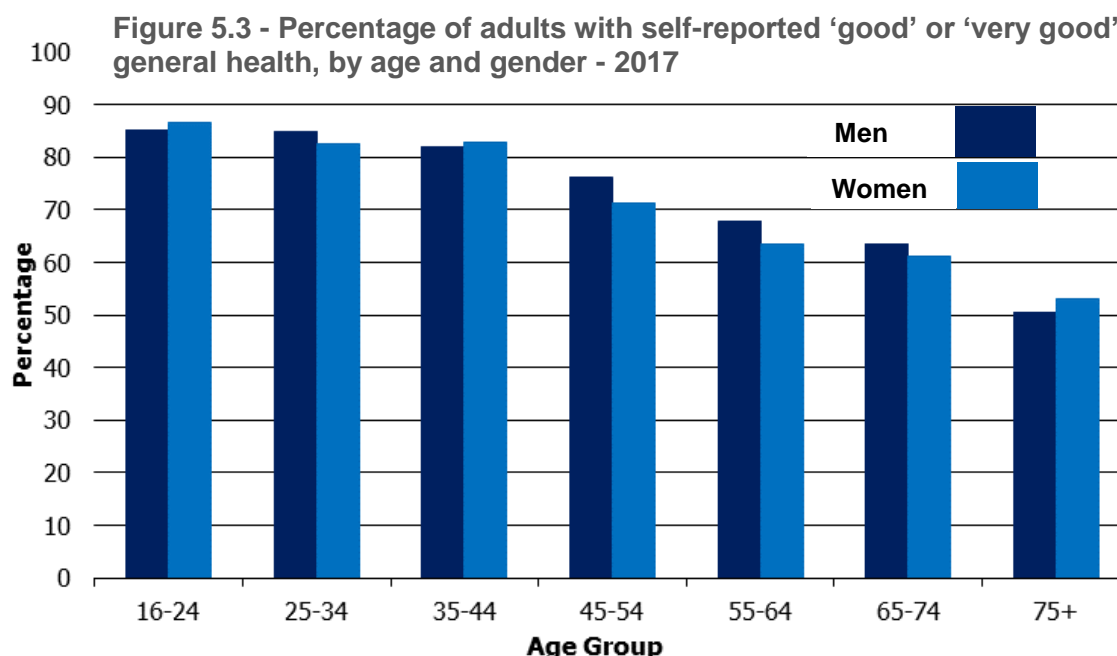
Source: [Public Health Priorities for Scotland](#) – COSLA and Scottish Government, June 2018

5.3 General health

From a peak of 77% in 2009, the level of self-assessed 'good' or 'very good' health for adults (aged 16+) has declined to 73% in 2017. As would be expected the proportion of children (aged 0 – 15) who self-assess their health to be 'good' or 'very good' is much higher at 94% in 2017, a figure which has remained relatively stable since 2008.⁶⁴

⁶⁴ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report - Scottish Government, Sept 2018

Examining the general health of adults by age group shows a marked decline as people age, which applies to both men and women: see Figure 5.3. However, it is also noticeable that the rate of decline becomes much more significant from age 45 onwards. The key implication is that the problems of ill-health are likely to have knock-on effects on those of working age, not just those who are approaching retirement or who have retired.



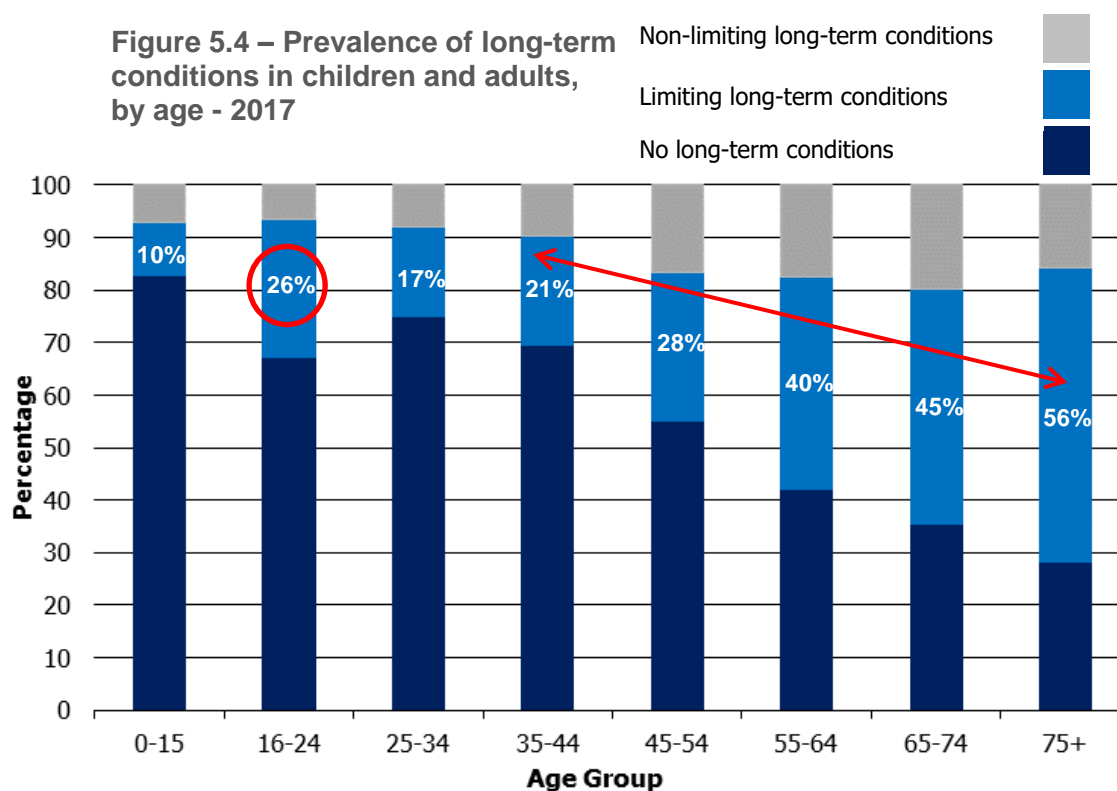
Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

5.4 Long-Term Conditions (LTCs)

In the SHes 'long-term conditions' are defined as any physical or mental health condition or illness lasting, or likely to last, for 12 months or more. The prevalence of long-term conditions in adults (both men and women) is increasing over time: see Table 5.1. Over the 10-year period 2008 – 2017 the proportion of adults in Scotland with an LTC increased from 41% to 45%.

Table 5.1 – Trend in Long-Term Conditions for adults in Scotland: 2008 - 2017			
	Proportion of adults with LTCs		
Adults (age 16+)	2008	2017	% Change
Men	38%	43%	+5%
Women	42%	47%	+5%
All adults	41%	45%	+4%
Source: Scottish Health Survey - 2017 edition – Volume 1, Main Report			

Furthermore, the proportion of adults with a 'limiting' LTC (defined as limiting their day-to-day living) increases very substantially beyond the age group 35 – 44: see Figure 5.4. In this age group 21% have a limiting LTC, but this increases to 28% for those aged 45 – 54, to 40% for those aged 55 – 64, to 45% for those aged 65 – 74 and 56% for those aged 75+.



Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

It is also interesting to note the spike in 'limiting' LTCs in the age group 16 – 24, which jumps from 10% for those under 16 to 26% for those aged 16 – 24. Given the generally positive physical health indicators for young people (compared to adults), the logical hypothesis is that this increase is attributable to mental health issues affecting young people. The evidence for this is discussed in detail in Section 6.

5.5 Cardiovascular disease and diabetes

Cardiovascular disease (CVD) – the Scottish Government has a National Performance Indicator for premature mortality (deaths from all causes for those aged under 75). CVD is recognised as one of the 'big killer' diseases around which action must be taken if this target is to be met. In 2017 over 15,000 people died in Scotland due to diseases of the circulatory system.⁶⁵

⁶⁵ [Vital Events Reference Tables 2017](#) (see Table 6.01) – National Records of Scotland

CVD is a general term describing diseases of the heart and blood vessels usually caused by a build-up of fatty deposits leading to restricted blood flow to the heart, brain or body and an increased risk of blood clots. It is one of the leading contributors to premature mortality. Its main components are ischaemic heart disease (IHD, or coronary heart disease, which includes heart attack, heart failure and angina) and stroke, both of which have been identified as clinical priorities for the NHS in Scotland. Diseases of the circulatory system are the second most common cause of death in Scotland after cancer, accounting for 26% of deaths in 2017 (compared with 29% for cancer). This includes 12% of deaths which are caused by IHD, with a further 7% caused by cerebrovascular disease (e.g. stroke).⁶⁶

Over the past 10 years the survival rate for CVD has been increasing and diagnosis of CVD has remained more common in older people, with incidence rising with age.^{67,68} Scotland's ageing population, coupled with the increasing survival rate, will mean that there will be more CVD survivors in the community in the future. Recent research has predicted significant and rapid increases in the number of people living with heart failure and hypertension, a major risk factor for CVD.⁶⁹

Diabetes – this is the most common metabolic disorder and is a major health issue for Scotland. Its prevalence has increased in recent years, due specifically to the increasing prevalence of Type 2 diabetes – linked to obesity, physical inactivity and ageing – which is driving the overall increase in the condition and causing concern.

The evidence on CVD and diabetes - from the SHeS analysis of CVD and diabetes two key findings emerge.⁷⁰ Firstly, the very dramatic increase in CVD and diabetes amongst adults from the age of 55 upwards. The proportion of the population affected increases from 13% at age 45 – 54 to 51% in the 75+ age category: see Figure 5.5.

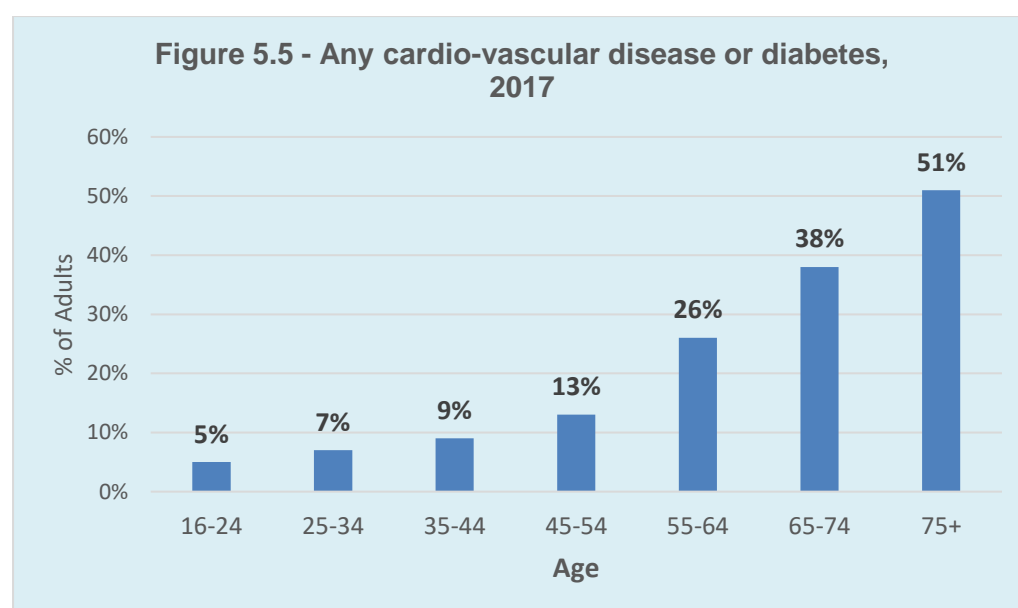
⁶⁶ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report - Scottish Government, Sept 2018

⁶⁷ [Scottish Heart Disease Statistics year ending 31st March 2018](#), Information Services Division Scotland

⁶⁸ [Scottish Stroke Statistics year ending 31st March 2018](#) , Information Services Division Scotland

⁶⁹ [Chronic Disease Intelligence to Optimise Service Planning in Scotland](#), Scottish Centre for Telehealth and Telecare

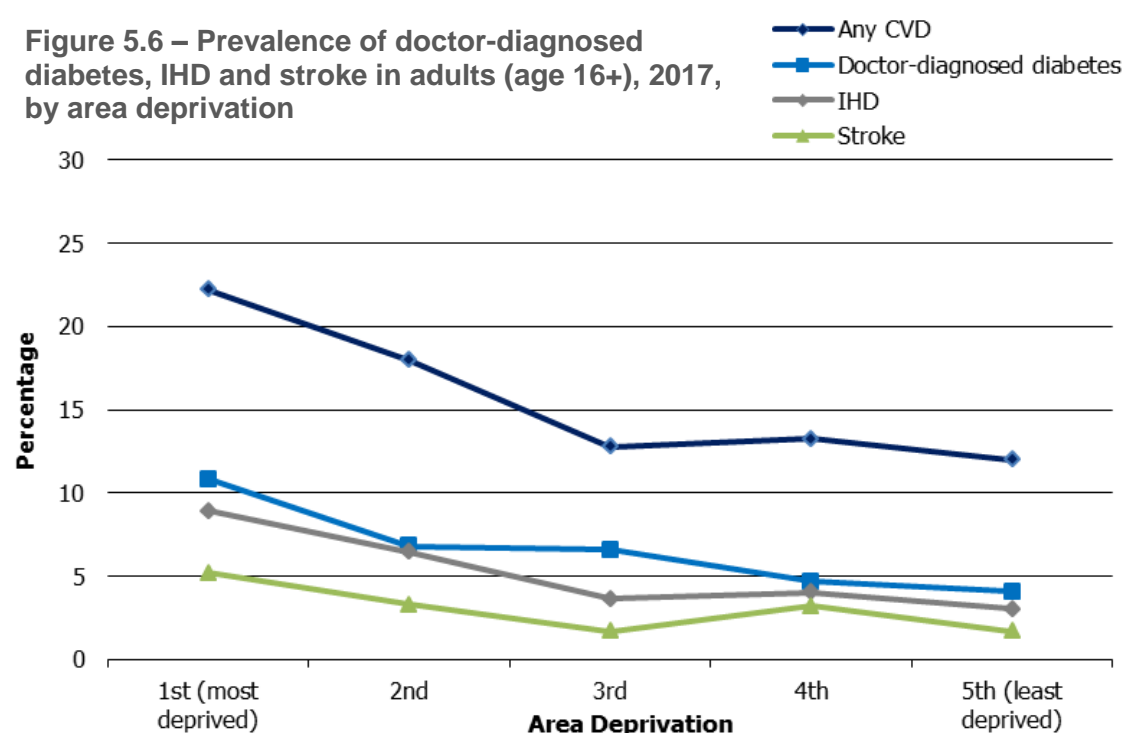
⁷⁰ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report - Scottish Government, Sept 2018



Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

The second key finding relates to the much higher incidence of CVD and diabetes in Scottish Index of Multiple Deprivation (SIMD) Quintiles 1 and 2 (where deprivation is greatest in Scotland): see Figure 5.6.⁷¹ For 'any CVD' doctor-diagnosed conditions, the incidence drops from 22% in Q1, to 18% in Q2 and is then stable at 12 -13% for Q3 – Q5.

Figure 5.6 – Prevalence of doctor-diagnosed diabetes, IHD and stroke in adults (age 16+), 2017, by area deprivation



Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

⁷¹ [Introducing the Scottish Index of Multiple Deprivation](#) – Scottish Government, 2016

Trend in diabetes – there has been a sustained increase in diabetes, driven by the increasing prevalence of Type 2 diabetes [which accounts for about 87% of diabetes in Scotland] the balance being Type 1 (12%) and a small proportion of other diabetes types (0.6%).⁷² Diabetes Scotland's 'State of the Nation' report highlights the key statistics as at 2015:

- 25% increase in the Scottish population with diabetes over the period 2008 – 2015
- > 276,000 people have diabetes
- 500,000 people are at 'high risk' of developing Type 2 diabetes
- 1,100,000 people are at 'increased risk' of developing Type 2 diabetes. That's one in five of Scotland's population
- By 2035 more than 480,000 people in Scotland will be living with diabetes.⁷³

Being overweight or obese is the most significant risk factor for developing Type 2 diabetes. Finally, across the UK the NHS spends approximately 9% of its total budget on treating diabetes.⁷⁴

5.6 Summary of Scotland's physical health

From this review of Scottish health data the following conclusions can be drawn:

- **We are living longer** - over the last three decades people in Scotland have been living longer. Women are living eight years longer than in 1980 – 82, and men six years longer.
- **But not healthier** – there are many indicators which show that our physical health is actually deteriorating in Scotland. People are often living with one or more health conditions (multi-morbidities) and this is an increasing problem:
 - Over the period 2009 – 2016 the expected percentage of life rated as 'healthy health' has been deteriorating for men: from 79.0% to 77.0%; but static for women at 77.3%.
 - From a peak of 77% in 2009, the level of self-assessed 'good' or 'very good' health for adults (aged 16+) has declined to 73% in 2017.
 - Over the 10-year period 2008 – 2017 the proportion of adults in Scotland with a Limiting Long-Term Condition (LTC) has increased from 41% to 45% (this includes both physical and mental health).
 - Although the percentage of the population affected by heart disease has been falling, the percentage affected by strokes has increased, and for diabetes there has been a 25% increase over the period 2008 – 2015. The number of people with diabetes in Scotland is projected to increase to 480,000 by the year 2035 (up from 276,000 in 2015).

⁷² [Diabetes in Scotland - diabetes.co.uk website](https://diabetes.co.uk)

⁷³ [State of the Nation 2015: The Age of Diabetes](#) – Diabetes Scotland

⁷⁴ [A Healthier Future: Type 2 Diabetes prevention, early detection and intervention: framework](#) – Scottish government; July 2018

- **Our lifestyles matter** – how we live our lives impacts dramatically on Scotland's health outcomes. In particular, the contribution of an active lifestyle combined with a healthy diet is critical. The majority of Scotland's population is too sedentary and is eating the wrong sort of food. Obesity is the single biggest health challenge facing society due to its adverse impact on health: particularly heart disease, stroke, diabetes and specific cancers such as bowel cancer.
- **Ill-health is linked to deprivation** – the health outcomes for those living in deprived areas of Scotland are much, much poorer. The variation in life expectancy between the least and most deprived areas is 28 years for men and 25 years for women. Not only do people have a shorter life, but they are likely to be living an unhealthier life. The proportion of the population living with 'any CVD' in SIMD Q1 is nearly double the rate for those living in Q5 (22% vs. 12%).
- **Early intervention is the key** – as expected, the data shows the problems of ill-health to be much greater for those aged 65+ and especially for those in the 75+ age category. Multi-morbidities are a significant problem for those who are older. However, what the evidence also demonstrates is that problems of ill-health start to present themselves when people are much younger. The age group 35 – 44 seems to be the 'tipping point':
 - The proportion of the population self-reporting their general health to be 'good' or 'very good' is 82% for those aged 35 – 44, and this decreases for each successive age band to 52% for those aged 75+.
 - The proportion of the population with limiting LTCs is 21% for those aged 35 – 44, and this increases for each successive age band to 56% for those aged 75+.
 - The proportion of the population with any CVD or diabetes is 9% for those aged 35 – 44, and this increases for each successive age band to 51% for those aged 75+.

Therefore, early intervention to change the behaviours of young people and early adults is a prerequisite for addressing the health problems in society. Prevention is better than cure.

Public policy implications - the Scottish Government's 'Public Health Priorities for Scotland' highlights the linked problems of demographic change, Scotland's deteriorating health and the adverse impacts this will have on its labour force and the NHS.⁷⁵ It concludes that the implications of these health inequalities are far-reaching within the context of an ageing population in Scotland:

- More people are now living with one or more complex health conditions.
- They require more health and social care and this requirement will increase as they age.

⁷⁵ [Public Health Priorities for Scotland](#) – COSLA and Scottish Government, June 2018

- Fewer people are able to work and remain in work as a result of health problems or because of the requirement to care for loved-ones who are unwell (the number giving up work to care in the UK has increased from 2.3 million in 2013 to 2.6 million in 2018 – a 12% increase).⁷⁶
- That these problems are more prevalent in the more deprived communities in Scotland.

Based on current trends, the health and social care burden on the NHS and local authorities will continue to grow and is likely to be unsustainable in the longer term based on the current funding model.

5.7 The contribution of volunteering to physical health

Volunteering plays a major role in improving and supporting the physical and mental health of Scotland's population. It achieves this in three main ways:

- By improving the health of those who volunteer.
- By supporting activities which foster health and wellbeing. This includes not just sport, but walking, using the outdoors for recreation and the use of green space.
- By supporting the NHS, health charities and voluntary organisations whose goals are to inform, educate, manage and treat Scotland's population in relation to a wide range of health conditions.

a) Physical health benefits for volunteers

Understanding the relationship between physical health and volunteering

Volunteer Scotland's report on 'Volunteering, Health and Wellbeing' found that eight out of the nine papers which examined the linkages between physical health and volunteering concluded that individuals' self-rated health had improved because of volunteering.⁷⁷

The report identified three main categories of physical health benefits that can be gained through volunteering:

- **Healthy behaviours** – this includes the adoption of healthy lifestyles and practices as a result of volunteering; also, an increase in the level of physical activity (for example, the number and intensity of physical activities which an individual engages in each week). This finding is relevant to all age categories.
- **Improved daily living** – for older people volunteering can help them maintain their functional independence; or reduce their level of functional dependency for longer than would otherwise be the case
- **Ability to cope with personal illness** – volunteering helping individuals to manage /alleviate their symptoms.

⁷⁶ [Juggling Work and Unpaid Care, 2019](#) – Carers UK, Jan 2019

⁷⁷ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

Examples of Healthy Behaviours

An older volunteer who had stopped volunteering, but who retained the positive lifestyle improvements post volunteering:

"My lifestyle is good. I don't sit and mope.....I go cycling every morning."

A desk research study which identified a range of healthy behaviours including the adoption of healthy lifestyles and practices such as HIV prevention behaviours, physical activity and healthy levels of drinking.

One study also identified improved cognitive and physical functioning, and one identified a potential benefit from 'health literacy' – through increased knowledge, awareness, skills and capabilities relating to living a healthy lifestyle.

Given the health problems facing Scotland's population and the importance of being active and adopting healthy behaviours to try and address these problems, the implications of this research are twofold:

- Firstly, we need to ensure that for those who currently volunteer, the physical health benefits are considered and optimised wherever possible.
- Secondly, if we can increase the volunteering participation rate there is the potential to reach a larger proportion of the Scottish population, which will share these physical health benefits more widely. The evidence also suggests that such benefits will be greatest for the most disadvantaged and those excluded from society. This includes disabled people, those subject to social isolation and loneliness, and those with mental and physical health issues, amongst many other aspects of disadvantage.

However, this finding is subject to the following caveats:

- **Type of volunteering role** – clearly, the nature and scale of any physical health benefits will be correlated to the type of volunteering role. So, if the role is active and /or in the outdoors such benefits are more likely, compared to an administrative role in an office. However, this is not a 'hard and fast rule'. For example, those in older age can generate health benefits just by getting out of the house. The increased activity that attending the site of volunteering involves can be a physical benefit in its own right.

- **Regularity and intensity of volunteering** – in a similar fashion to the attainment of mental health and wellbeing benefits from volunteering, we anticipate that people need to volunteer regularly and for a certain minimum amount of time for these physical health benefits to be realised. This is referred to as the 'dose-response effect'.⁷⁸
- **Age matters** – there is a tendency to focus on the health benefits for the elderly, as they are the group in society most adversely affected by ill-health. However, going forward we must give equal focus to prevention as well as cure. Therefore, early intervention and engagement through volunteering is key. In particular, the focus must move to young adults who have left school. The age range 20 – 44 is critical as we know that the engagement of young people in sport and outdoor activities declines after school and tertiary education. As does their engagement in formal volunteering – decreasing from 52% for 11 – 18 year olds to 23% for those aged 25 – 34.^{79, 80}
- **Volunteer coordination and support** – to maximise the physical health benefits from volunteering effective volunteer support processes need to be in place, which both recognises such benefits and actively coordinates volunteering to achieve them. In particular, that volunteering does not generate adverse health outcomes, particularly for those in older age.
- **Overcoming health barriers** – last but not least, one of the biggest challenges can be physical and mental ill-health which acts as a barrier to people volunteering. This is particularly problematic for those with long-term physical ill-health. 'The Chronic Illness Inclusion Project' is led by disabled people living with energy-limiting chronic illness.

The Chronic Illness Inclusion Project

People with chronic illness share common experiences of:

- A certain form of impairment
- A shared experience of disablism or social marginalisation based the nature of their impairments.

This Project's case study research has highlighted that people in the chronic illness community tend to be socially isolated because energy impairment renders them effectively housebound and unable to access work, leisure or social activities such as volunteering.⁸¹

⁷⁸ Ibid

⁷⁹ [Young People Volunteering in Scotland](#) – Volunteer Scotland, 2016

⁸⁰ [Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, 2018

⁸¹ [Stories of Our Lives](#) – Case studies from the Chronic Illness Inclusion Project's emancipatory research on benefits and work; Hale, C. (editor) – The Centre for Welfare Reform; May 2019

"A crucial question to explore ... is the extent to which society in general, including employers, civil society organisations and government policies, can, and should, make adjustments to enable participation for people who are wholly or largely housebound by energy impairment."

Correspondingly, what could inclusion and participation look like when one cannot be physically present in spaces of work, community or political action? ... In part, this may be because the internet and communication technologies that enable virtual connection and participation between people who are housebound are still too new and too rudimentary to be part of mainstream access provisions. ... It must also be explained by a lack of awareness of the impact of energy impairment in its severe form, that is, preventing people leaving their beds or homes. Our very absence from society is largely invisible."

Lived experience from the case studies

"Work is only possible because my job was carved out especially for a chronically ill person, I don't think I'd be able to work for someone else otherwise." Melissa

"I am a member of an arthritis charity and help them as much as possible. I am trying to help those who may feel that not working for someone else means you are 'of no use to society'." Bill

"A regular fear I have is when I post pictures of my paintings online, the thought that someone might be judging them in terms of sales value and report me to DWP. I don't sell them. I'm not well enough to go down that road." Ann

"I feel that I no longer participate in society as a whole, mostly my participation is online as I don't leave the house very often. I don't feel very loved anymore and that makes me feel incredibly sad. I feel invisible and pushed to one side and that my views and membership of society are no longer valid or wanted. I would love to have friends and family who really understood what my illness has taken away from me. The biggest improvement for me would be that there were places to go where I could be included in society and not judged as not valuable because of my limitations and that I could have friends that would include me. I would like to do something to feel useful to society as all my former positions revolved around helping people in NHS and advocacy charities. I'm often better in the evening so could maybe do something phone or online based." Karen

Evidence of health benefits from volunteering in Scotland

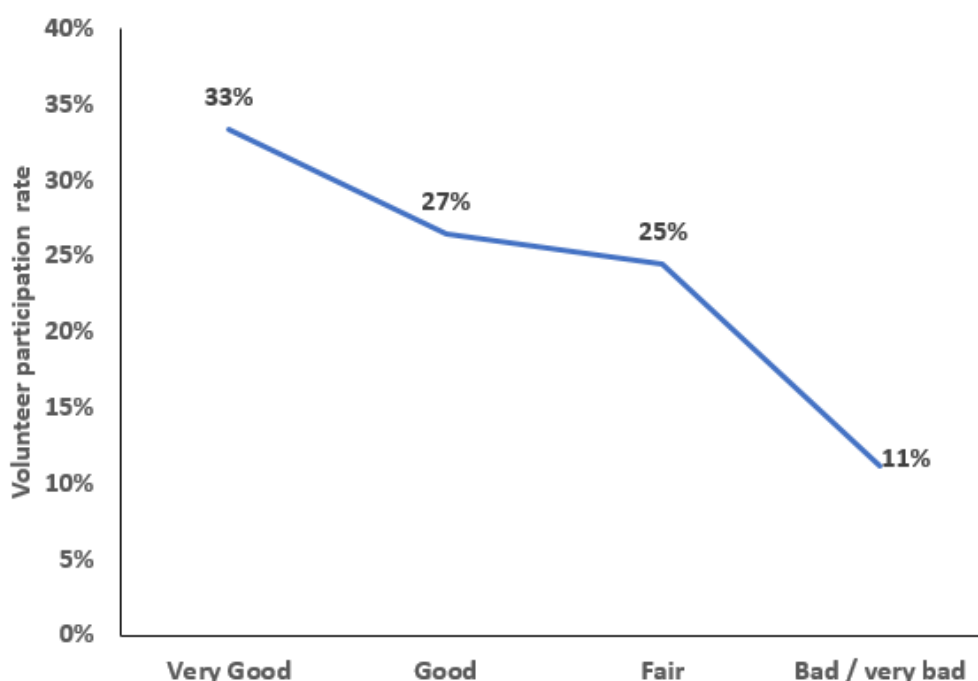
This sub-section focuses on two sources of evidence that provide insights into the health of those who volunteer and those who do not in Scotland:

- **Scottish Household Survey** – Volunteer Scotland has undertaken a cross-sectional analysis of the SHS 2016 dataset, and this forms the basis for the evidence presented in this sub-section;⁸²
- **NCVO 'Time Well Spent' Survey – A survey of the volunteer experience in Great Britain, Jan 2019** – Volunteer Scotland has undertaken an analysis of NCVO's Scottish dataset from which relevant evidence relating to health and wellbeing has been included. This report is due to be published in early 2020.

Volunteer Scotland has also undertaken a cross-sectional analysis of **NHS Greater Glasgow and Clyde (NHSGGC) Health and Wellbeing Survey 2017/18**, but it is not reported here because the focus is on Scottish level data. For those interested in the health and wellbeing data for Greater Glasgow and Clyde, this information will be published in early 2020. However, we can say that the same broad health trends identified in the SHS are mirrored in the NHSGGC survey.

General health - it is unfortunate that there is no question specifically on physical health in the Scottish Household Survey. The best proxy is 'How is your health in general?' Figure 5.7 shows that there is a positive linear relationship between people's general health and volunteering: the better one's health the more likely one is to be volunteering. It also shows that there is a 'tipping point' when people's health moves from 'fair' to 'bad/very bad'. Volunteering participation drops from 25% to only 11%.⁸³

Figure 5.7 – Volunteer participation by 'general health' – Scottish adults (age 16+), 2016



Source: [SHS 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland; N = 9,612

⁸² [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

⁸³ Ibid

Due to the causation conundrum it is impossible to provide a definitive explanation for this relationship between general health and volunteering.⁸⁴ All one can do is to put forward plausible hypotheses:

- **Healthier people are more likely to volunteer in the first place** – the implication is that volunteering engages healthier people, not that volunteering improves their health. Intuitively this seems a logical explanation, especially for those with 'bad/very bad' health, as there are likely to be significant barriers for such people to volunteer – see the evidence from 'The Chronic Illness Inclusion Project' discussed earlier in this Section.⁸⁵
- **Volunteering improves the health of those who volunteer** – again, this seems a logical explanation, especially for those whose health is not good and there is significant room for improvement. The extensive evidence base cited in this report and Volunteer Scotland's previous literature review shows that volunteering can confer really important health and wellbeing benefits, especially for those who have poor health, are disadvantaged and marginalised in society.⁸⁶

The reality is that both these factors may explain the positive health-volunteer correlation illustrated in Figure 5.7, but we just do not know the relative significance of each explanatory factor. However, what the graph does show is that those with the poorest general health have the lowest volunteering participation rate. If people can derive health and wellbeing benefits from volunteering, then this is a problem. Those who could benefit are not benefiting.

Long-Term Conditions (LTCs) – the Scottish Household Survey also asks the question 'Do you have a physical or mental health condition or illness lasting or expected to last 12 months or more?' Given the Scottish Government's policy priorities for a more inclusive society, understanding the relationship between LTCs and volunteering is important. Volunteer Scotland's cross-sectional analysis reveals that the volunteering participation rate for volunteers with LTCs is lower (24%) compared to those without LTCs (29%).⁸⁷

However, the evidence also shows that there is significant variation by age group. For those aged 16 – 34 the volunteering participation rate is higher for those with LTCs compared to those without LTCs: see Table 5.2. A similar anomaly is evidenced for mental health in sub-section 6.7, where the volunteering participation for those aged 16 - 24 with low mental wellbeing is double the rate for young people with high mental wellbeing (see Table 6.3).

⁸⁴ For a full explanation of the causation-correlation issue see 'The Causality Issue', Section 2.3 in [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

⁸⁵ [Stories of Our Lives](#) – Case studies from the Chronic Illness Inclusion Project's emancipatory research on benefits and work; Hale, C. (editor) – The Centre for Welfare Reform; May 2019

⁸⁶ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

⁸⁷ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

Table 5.2 - Volunteering participation rates by Age and LTCs - 2016		
	Long-term Health Condition	
Age	Yes	No
16-24	38%	31%
25-34	29%	26%
35-44	22%	31%
45-59	24%	28%
60-74	26%	30%
75+	15%	24%
Scottish Average	24%	29%
Source: Scottish Household Survey 2016 - Volunteering cross-sectional analysis – Volunteer Scotland, Oct 2019		

Why volunteering participation is more inclusive for younger age groups is not clear. Are younger people more interested in volunteering and determined to overcome barriers associated with their LTCs compared to older people? Or are education providers and volunteering involving organisations more receptive to accommodating the needs of young people with LTCs compared to older people? However, what we do know is that there has been a strong policy drive to support youth volunteering by both the Scottish Government and the voluntary sector and this may provide part of the explanation. The Third Sector Interfaces and youth groups provide considerable support and encouragement for young people to engage in volunteering.

This analysis has provided further evidence of the barriers to volunteering for those with serious health conditions. However, as evidenced throughout this report and in Volunteer Scotland's previous literature review, those who are most disadvantaged often have the most to gain from volunteering.⁸⁸ The challenge for society is how to overcome such barriers. For example, ensuring that people are 'able' to volunteer rather than being 'disabled' from volunteering. It is about changing the volunteering environment, not about trying to change the person – see 'The Social Model of Disability'.⁸⁹

NCVO evidence – the volunteer perspective - the final piece of evidence on the physical health benefits of volunteering comes from the NCVO 'Time Well Spent' study, where 51% of volunteers surveyed in Scotland stated 'It improves my physical health' as one of the benefits of volunteering.⁹⁰

⁸⁸ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

⁸⁹ [The Social Model of Disability](#) – Inclusion Scotland

⁹⁰ 'Time Well Spent' – NCVO; January 2019 – analysis of the Scottish dataset by Volunteer Scotland; publication due early 2020

Number of volunteers with the potential to derive physical health benefits

Working on the assumption that regular volunteering (defined as at least once a month) is important to generate health and wellbeing benefits, it is estimated that from Scotland's current volunteering population of c. 1.4 million, 851,000 have the potential to derive physical health benefits from volunteering: see Table 5.3. This is a significant proportion of Scotland's total population at c. 16%. In addition, there is the opportunity to engage the 3.3 million adults who do not currently volunteer and the c. 250,000 young people who do not volunteer.

Table 5.3 – No. of regular formal volunteers in Scotland in 2016 who have the potential to derive physical health benefits			
Adults (age 16+)	Young People (age 11 – 18)	Adults (16+)	Total²
Population	400,000	4,500,000	4,900,000
Total no. of volunteers	146,000	1,220,000	1,366,000
Estimated no. of regular volunteers	91,000 ¹	760,000	851,000
Sources: Volunteering in Scotland: Trends from the SHS 2007 - 2017 – Volunteer Scotland, 2018; Young People Volunteering in Scotland – Volunteer Scotland, 2016 Notes: ¹ The estimate of regular youth volunteers is based on the same ratio as for adults (17% volunteering at least monthly – versus the 27% adult volunteering participation rate in 2016) ² The youth and adult figures are not strictly additive, due to the age overlap. However, the youth volunteering figure is underestimated due to the exclusion of volunteering in private schools. The overall total should therefore be a good estimate of total formal volunteering in Scotland.			

b) Physical health benefits from physical activity and sport

This sub-section examines the contribution of volunteering to physical activities and sport. Volunteers help the people of Scotland be physically active, which forms an important focus within the Scottish Government's National Outcome 'We are healthy and active'.⁹¹ Two of the National Indicators are 'Physical activity' and 'Journeys by active travel'.

Definition of 'physical activity and sport'

In Section 8 of the Scottish Household Survey, the classification of 'Physical Activity and Sport' includes a wide range of physical activities over and above 'sports'. The full list includes:

- **Activities listed as response options in the survey** - walking (at least 30 minutes for recreational purposes), swimming, football, cycling (at least 30 minutes for recreational, health, training or competition purposes), keep fit / aerobics, multigym use / weight training, golf, running / jogging, snooker / billiards / pool, dancing and bowls.

⁹¹ [National Performance Framework: We are healthy and active](#) – Scottish Government

- **Activities provided by respondents to the 'other' response option** - angling, badminton, judo, horse-riding, skiing, sailing, yoga, angling, bird-watching, racket/ball sports, field sports – shooting and archery - water sports, winter sports – curling, skating, skiing - boxing, martial arts, riding, pilates, yoga, tai-chi, climbing and hillwalking.

The analysis of the Scottish Household Survey data in this sub-section is based on this wide definition of 'Physical Activity and Sport'. The breadth of this classification is both its strength and its weakness. The following factors should be considered in assessing the contribution of volunteering to people's physical health:

- The 'physical activities' listed vary in their contribution to the amount of exercise a person benefits from. Clearly, sports such as rugby and football involve considerably more exercise than snooker and pool.
- There are a range of other physical activities not included in the above list which can also provide important health benefits such as gardening, physically demanding DIY jobs and manual employment that people are involved in throughout the working week.

Contribution of volunteering to physical activity and sport

Volunteering is pivotal in the delivery of sport and physical activities across Scotland. Some 280,000+ volunteers help to administer, organise, coach, referee and govern a miscellany of activities which have direct physical health benefits: see Table 5.4.

Table 5.4 – Formal volunteering in sport and exercise across Scotland (2016)			
Age	Sectoral ranking (by no. of volunteers)	% of volunteers	No. of volunteers
Young people (age 11 – 18)	1 st	49%	74,000
Adult volunteers (age 16+)	5 th	17%	208,000
Estimated no. of formal volunteers in sport and exercise ¹	n/a		282,000
Sources: Volunteering in Scotland: Trends from the SHS 2007 - 2017 – Volunteer Scotland, 2018; Young People Volunteering in Scotland – Volunteer Scotland, 2016 Notes: ¹ The youth and adult figures are not strictly additive, due to the age overlap. However, the youth volunteering figure is underestimated due to the exclusion of volunteering in private schools. The overall total should therefore be a good estimate of total formal volunteering in Scotland.			

These volunteers help support Scotland's 13,000 sports clubs and their c. 900,000 members.⁹² Critically, they provide an invaluable contribution to the active participation of 51% of Scotland's adult population in physical activity and sport (excluding walking) in the last four weeks, equivalent to 2.3 million people: see Table 5.5. The equivalent figures for physical activity and sport participation including walking are 79% and 3.6 million adults.

⁹² [Sport 21 2003 - 2007: The National Strategy for Sport](#) – sportscotland; March 2003

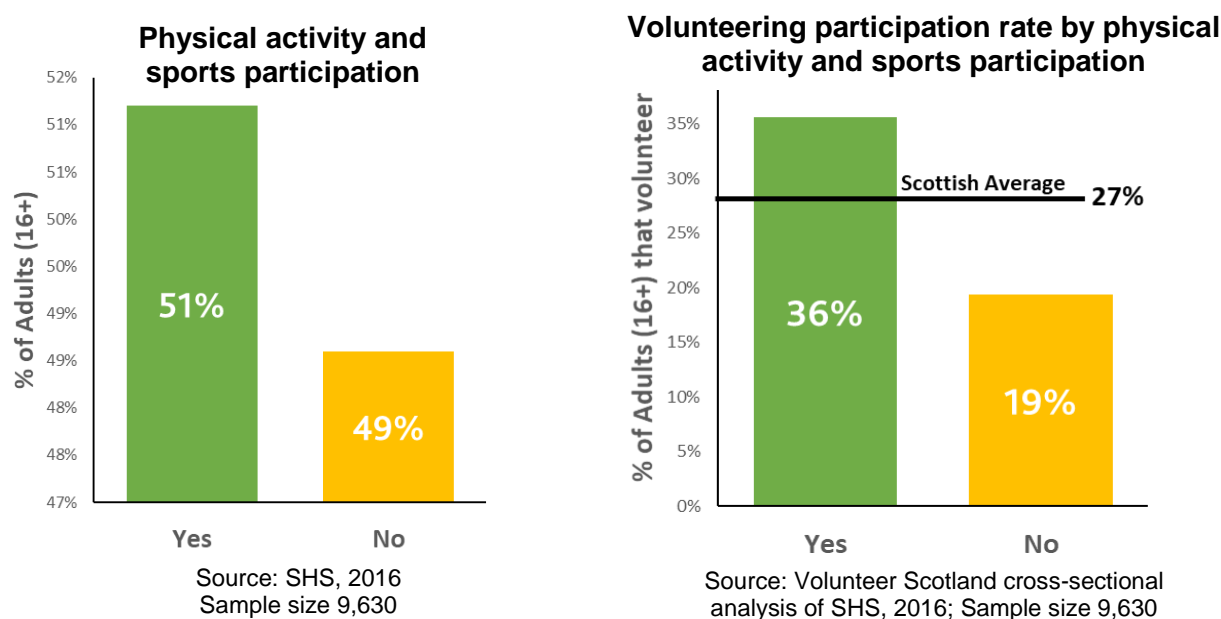
Table 5.5 – Scottish adults engaged in physical activity and sport (2016)			
Age	Adult population (age 16+)	% engaged in physical activity/ sport	No. of adults
Adult sport participation excluding walking	4,500,000	51%	2,295,000
Adult sport participation including walking	4,500,000	79%	3,555,000
Sources: Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017 Scottish Household Survey 2016: Chapter 8 - Physical Activity and Sport			

Given the nature and characteristics of walking, the role of formal volunteering for walking is likely to be different compared to many of the organised sports and physical activities listed in the Scottish Household Survey definition. Clearly, a large proportion of walking does not require volunteers, such as walking to work, taking the dog for a walk, etc. Although, again, one must be careful in such interpretations given the contribution of organisations such as 'Paths For All', who facilitate walking across Scotland and where formal volunteering plays a key role. They have 10,000 Volunteer Walk Leaders.⁹³

Contribution of physical activity and sport to volunteering

Figure 5.8 demonstrates (right hand graph) that volunteering participation is much higher for those who are involved in physical activity and sport (36%) than the Scottish average for volunteering (27%). The volunteering rate for those not involved in physical activity and sport is only 19%.⁹⁴

Figure 5.8 – Relationship between physical activity and sports participation and volunteering participation for adults in Scotland, excluding walking, 2016

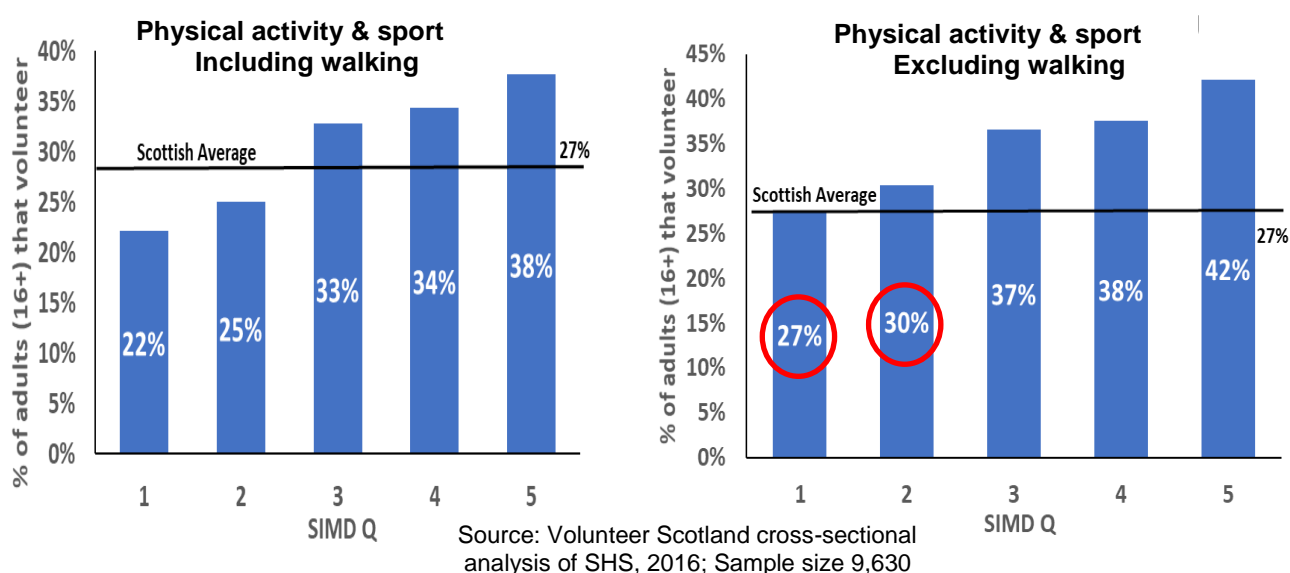


⁹³ [Paths For All - Volunteering section of website](#)

⁹⁴ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

This highlights the symbiotic relationship between 'physical activity and sport' and volunteering. This is good news given the spin-off benefits for Scotland's health and wellbeing discussed above. Furthermore, the 'reach' of volunteering for those who participate in physical activity and sport into the most deprived communities in Scotland is much better than many other types of volunteering: see Figure 5.9.⁹⁵

Figure 5.9 – Adult volunteering participation rates for those engaged in physical activity and sport by SIMD Quintile, Scotland, 2016



Those involved in physical activity and sport, excluding walking, (right hand graph in Figure 5.9) have a volunteering participation rate in Quintile 1 (the 20% most deprived areas in Scotland) of 27%, which is the same as the average volunteering rate across all activities in Scotland. Quintile 2 is higher than the national average at 30%.

This improved volunteering 'reach' into our most deprived communities for those engaged in physical activity and sport is highlighted when compared to Scotland's overall volunteering participation rates for Quintile 1 and Quintile 2:⁹⁶

- Quintile 1 – Scotland's volunteering participation rate across all activities is 18% in Q1, compared to 27% for those who are involved in physical activity and sport – nine percentage points higher;
- Quintile 2 – Scotland's volunteering participation rate across all activities is 22% in Q2, compared to 30% for those who are involved in physical activity and sport – eight percentage points higher.

The analysis in this sub-section has highlighted the important bi-directional relationship between 'physical activity and sport' and volunteering:

⁹⁵ Ibid

⁹⁶ [Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, 2018

- Volunteering helps Scotland's population to be physically active and engaged in sport;
- And those involved in physical activity and sport are more likely to volunteer, and their 'reach' into the most deprived communities in Scotland is significantly better.

This is a powerful conclusion. 'Physical activity and sport' and volunteering are helping to address the physical health challenges evidenced in this Section, which is particularly important in tackling the increased health problems facing those in Q1 and Q2 – see the evidence presented in sub-sections 5.2 and 5.5. This is a 'win-win' outcome and one which must be recognised, fostered and developed to its full potential.

c) Volunteering for the NHS, charities and voluntary organisations

Last, but not least, the contribution of volunteering in its support of the NHS and the voluntary sector must be recognised. Volunteers help to inform, educate, manage and treat Scotland's population in relation to a wide range of health conditions. It is estimated that just over 200,000 people volunteer in Scotland's health and social care sector: see Table 5.6.

Table 5.6 – Formal volunteering in the health sector across Scotland (2016)			
Age	Volunteering in the health and social care sector		Sectoral ranking by no. of volunteers
	No. of volunteers	% of volunteers	
Young volunteers (age 11 – 18) – supporting 'Health or disabilities'	13,000	9%	7th
Adult volunteers (age 16+) – supporting 'Health, disability and social welfare'	196,000	16%	6th
Estimated no. of formal volunteers in the health sector ¹	209,000		n/a
Sources: Volunteering in Scotland: Trends from the SHS 2007 - 2017 – Volunteer Scotland, 2018; Young People Volunteering in Scotland (YPiS) – Volunteer Scotland, 2016 Notes: ¹ The youth and adult figures are not strictly additive due to two factors: <ul style="list-style-type: none"> • Firstly, the age overlap which will tend to overstate the number of volunteers. However, the youth volunteering figure is underestimated due to the exclusion of volunteering in private schools. • Secondly, the different definitions used for volunteering in the 'health sector' between the YPiS survey and the SHS. However, the overall total is considered to be a reasonable estimate of total formal volunteering in health and wider social care in Scotland.			

These volunteers fulfil an invaluable role in helping to prevent illness, support early diagnosis, complement the treatment and recovery of patients and provide all-important aftercare support. If it was not for the contribution of volunteers the NHS would be even more hard-pressed than it currently is, and many of the charities and voluntary organisations supporting Scotland's health and care services would either not be able to function or their service offer would be severely constrained. The consequence would be a much poorer standard of health across Scotland's population as measured by the indicators discussed earlier in this section: life expectancy, healthy life expectancy, self-rated health, long-term health conditions and cardio-vascular disease and diabetes.

5.8 Integration to the National Performance Framework

The evidence presented in this Section provides a compelling case for volunteering as an integral element in Scotland's health and social care infrastructure and support services. In particular, it directly supports the Scottish Government's outcome '**We are healthy and active**' in the National Performance Framework.⁹⁷ The factors which will help to deliver this outcome are highlighted:

*"We implement a **whole system approach** to health and wellbeing which **targets harmful health behaviours** early on and from different angles. We have **revolutionised our food culture** and prioritise affordable, healthy food and local food production. We have addressed the availability of unhealthy food options and are combatting food and drink industry facilitation of ill-health. We have developed a **healthier, responsible attitude to smoking, alcohol and drug use**. We are **active** and have **widespread engagement with sport and exercise**. Our awareness of **mental health and suicide** has resulted in more immediate, comprehensive and successful support for those in need."*

Volunteering has a leading role to play in addressing each of the highlighted priority areas for intervention. As demonstrated by the evidence, volunteering provides a major contribution in helping Scotland to be healthy and active through the three channels discussed in sub-section 5.7:

- By improving the health of those who volunteer
- By supporting physical activities and sport which foster health and wellbeing
- By supporting the NHS, health charities and voluntary organisations.

The challenge is how to consolidate and build on this work during the next two decades, when Scotland will have an ageing population and when the evidence shows static or deteriorating performance across many of the key health indicators over the last decade. A serious consequence of this is that there will be fewer healthy volunteers to undertake current workload levels, let alone the expected growth in demand.

The next Section addresses the all-important issue of mental health, which has many complementary findings to those related to physical health.

⁹⁷ [Scottish Government's National Performance Framework - Health Outcome](#)

6. Mental health and wellbeing

6.1 Mental health and wellbeing context

Defining the scope - this is a complex subject and even defining the scope of what we mean by 'mental health' and 'wellbeing' is difficult. The World Health Organisation's (WHO) definition of health is helpful in giving a holistic description of what we mean by health: *"Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."*⁹⁸

The first key point is that mental health is more than the absence of clinically defined mental illness. As discussed by the WHO the absence of mental illness does not necessarily imply the presence of high levels of positive mental health and vice versa: people with mental health problems may also have positive mental health.⁹⁹ The potential independence of mental health and mental illness also suggests that some of the determinants of mental wellbeing are not the same as the determinants of mental illness.

The second key point is that there is ongoing debate as to what constitutes 'positive mental health'. The WHO defines the key parameters as follows:¹⁰⁰

"Concepts of mental health include subjective wellbeing, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of wellbeing whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities."

Setting the scene – the Scottish Health Survey highlights how important mental health and wellbeing are for both individuals and wider society:¹⁰¹

- Positive mental wellbeing encourages healthier lifestyles, better physical health and improved recovery from illness, better social relationships, and higher educational attainment.¹⁰²
- In contrast, poor mental health can have significant adverse impacts on individuals, their families and the wider community.¹⁰³ People with mental health conditions have disproportionately higher rates of disability and mortality than the general population; people with severe and enduring mental impairment can die 15-20 years earlier than they might otherwise do.¹⁰⁴
- Mental health conditions often co-exist with other diseases, including cancers and cardiovascular disease.

⁹⁸ [Constitution of the World Health Organisation: Principles](#) – July 1946

⁹⁹ [Mental Health, Resilience and Inequalities](#) – Friedli, L.; WHO, 2009

¹⁰⁰ [Investing in Mental Health](#) – WHO, 2003

¹⁰¹ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

¹⁰² [Mental Health, Resilience and Inequalities](#) – Friedli, L.; WHO, 2009

¹⁰³ [Investing in Mental Health](#) – WHO, 2003

¹⁰⁴ [Mental Health Strategy: 2017 - 2027](#) – Scottish Government, March 2017

- Many of the risk factors to general health such as obesity, excessive alcohol consumption, and low levels of physical activity, are common to both mental health conditions and other non-communicable diseases, with outcomes being critically interdependent
- Mental health is strongly associated with both poverty and social exclusion and as a result it is a key indicator of health inequalities in the population.¹⁰⁵

Structure of Section 6 – to review the evidence relating to the mental health and wellbeing of Scotland's population the key source we have drawn upon is the Scottish Government's [Scottish Health Survey - 2017 edition](#).¹⁰⁶ This provides an invaluable data source to help analyse specific indicators of mental health in Scotland. Other evidence is drawn upon to supplement the SHeS. We have structured the evidence and our analysis under the following headings:

- Mental wellbeing
- Mental ill-health
- Depression and anxiety
- Suicide and self-harm
- Summary of key findings
- Implications for volunteering.

6.2 Mental wellbeing

The **Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)** is used by the Scottish Government to assess mental wellbeing in Scotland and to track performance against the 'Mental wellbeing' Indicator in the National Performance Framework.¹⁰⁷ WEMWBS is based on 14 factors relating to mental wellbeing and for each there is a positive statement which respondents rate on a five-point scale (1 = 'none of the time' to 5 = 'all of the time'). So, the minimum score is 14 and the maximum score is 70.

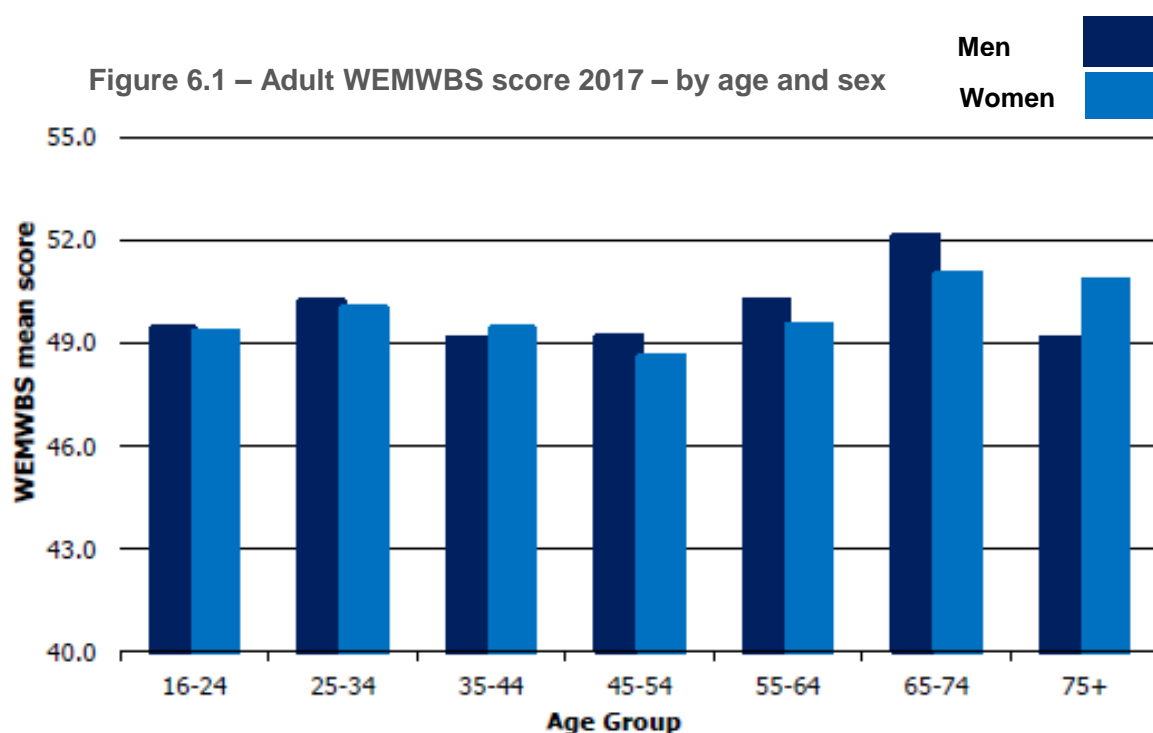
In 2017 the mean score was 49.8 and this has remained relatively constant over the period 2008 – 2017. However, when one examines the WEMWBS by age there are variations – see Figure 6.1:

- Those aged 65 – 74 had the highest mental wellbeing with a mean score of 51.5 (men 52.1 and women 51.0)
- The next highest scores were those aged 25 – 34 and those aged 75+, both with a mean score of 50.1
- Mental wellbeing was lower in the youngest age category, and again in middle age with those aged 16-24, 35-44 and 45-54 having the lowest mean wellbeing scores (49.4, 49.3 and 48.9 respectively).

¹⁰⁵ [Mental Health: Inequality Briefing](#) – NHS Health Scotland, 2017

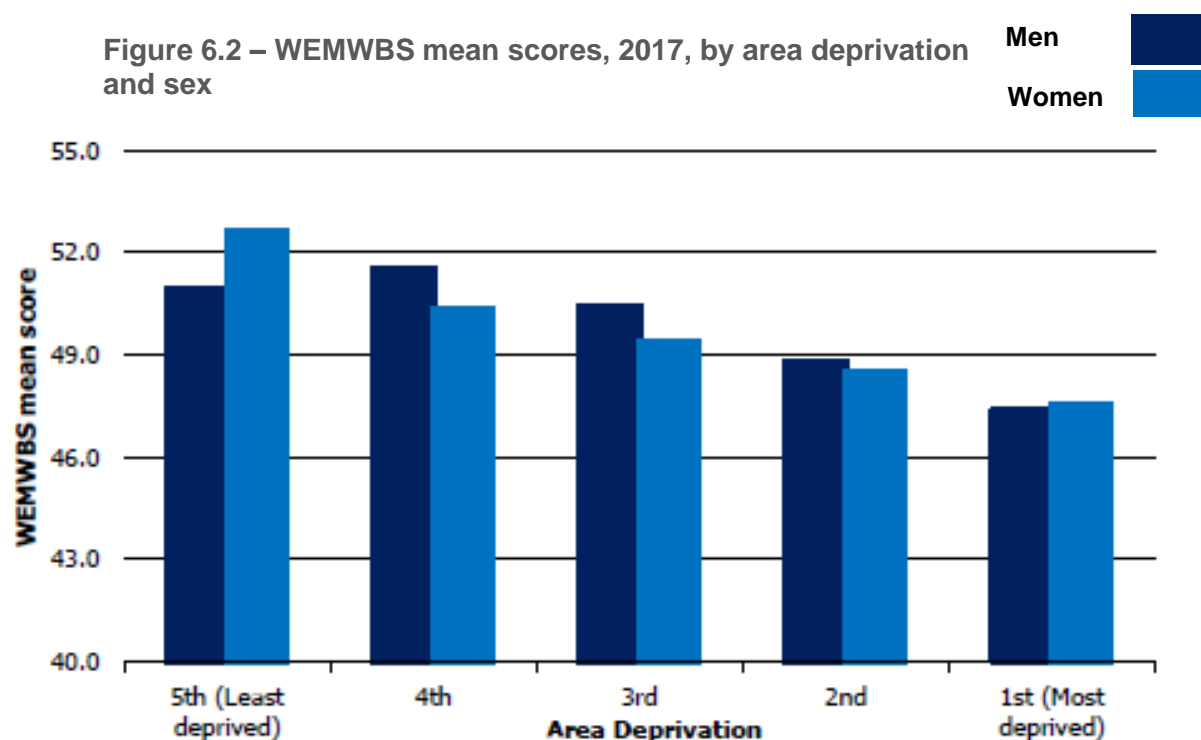
¹⁰⁶ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report: Scottish Government; Sept 2018

¹⁰⁷ [Mental wellbeing indicator in the National Performance Framework](#) – Scottish Government



Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

There variations in wellbeing are even greater when one examines mean WEMWBS scores by SIMD quintile – see Figure 6.2. The mean age-standardised WEMWBS score for the least deprived areas (51.8) was higher than the most deprived areas (47.5). A similar pattern was seen among both men (50.9 in the least deprived areas compared with 47.4 in the most deprived areas) and women (52.6 in the least deprived areas compared with 47.5 in the most deprived areas).



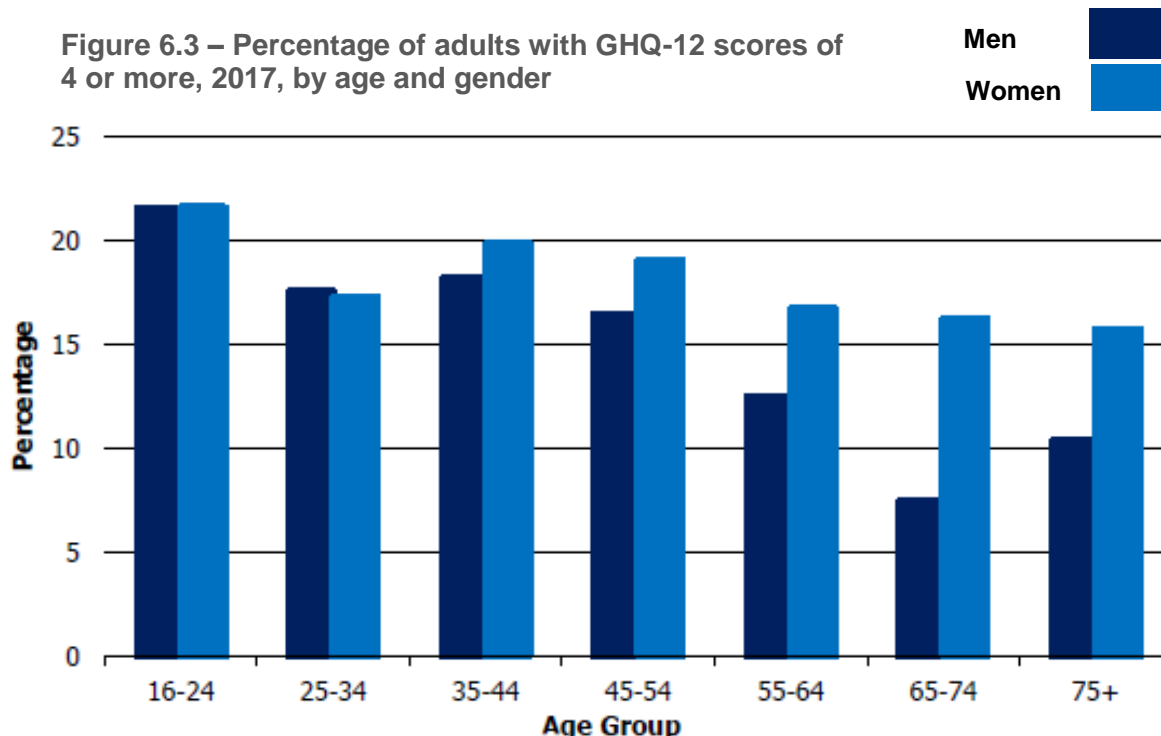
Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

6.3 Mental ill-health

The General Health Questionnaire 12 (GHQ-12) is a widely used standard measure of mental distress and mental ill-health and is used in the Scottish Health Survey. It consists of 12 questions on concentration abilities, sleeping patterns, self-esteem, stress, despair, depression, and confidence in the previous few weeks. For each question a point is scored if the respondent experiences this condition 'more than usual' or 'much more than usual' over the previous few weeks. Hence an individual's score can range from 0 – 12. In contrast to the WEMWBS where the higher the score the higher the wellbeing, for GHQ-12 the higher the score the worse one's mental health.

In 2017, 60% of adults had a GHQ-12 score of zero (indicating good psychological wellbeing with no symptoms of mental distress evident), 23% had a GHQ-12 score of one to three and 17% had a score of four or more (indicative of a possible psychiatric disorder).¹⁰⁸ Figure 6.3 analyses the GHQ-12 results for those scoring 4 or more. Two findings stand out:

- **By age** - young adults aged 16 – 24 have the highest proportion of the population (22%) scoring 4 or more. This age group also had the lowest percentage of the population with a GHQ-12 score of zero (46%).
- **By gender** – in adults aged 35 and over the percentage of women with a GHQ-12 score of 4 or more was higher than men, although this was only statistically significant for the 65 – 74 age group.



Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

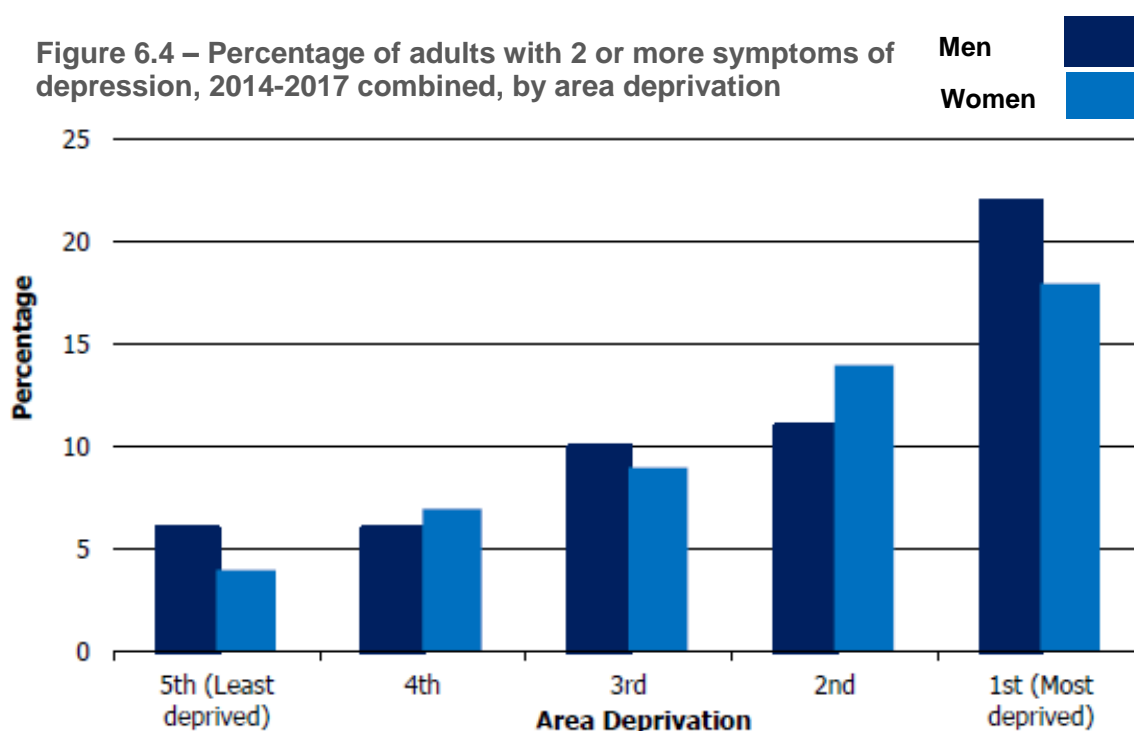
¹⁰⁸ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report: Scottish Government; Sept 2018

Like the WEMWBS data, there is a higher proportion of the adult population with GHQ-12 scores of four or more in areas of deprivation. In the most deprived areas, 24% of adults had a GHQ-12 score of four or more, compared to 14% in the least deprived areas.

6.4 Depression and anxiety

Depression - In 2016/2017, 11% of adults in Scotland reported two or more symptoms of depression, indicating moderate to high severity.¹⁰⁹ This represents a substantial increase since 2012/13 (9%), but no appreciable differences were identified by age.

The proportion of the adult population reporting two or more symptoms of depression varies from 5% in the least deprived SIMD quintile to 20% in the most deprived quintile: see Figure 6.4.



Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

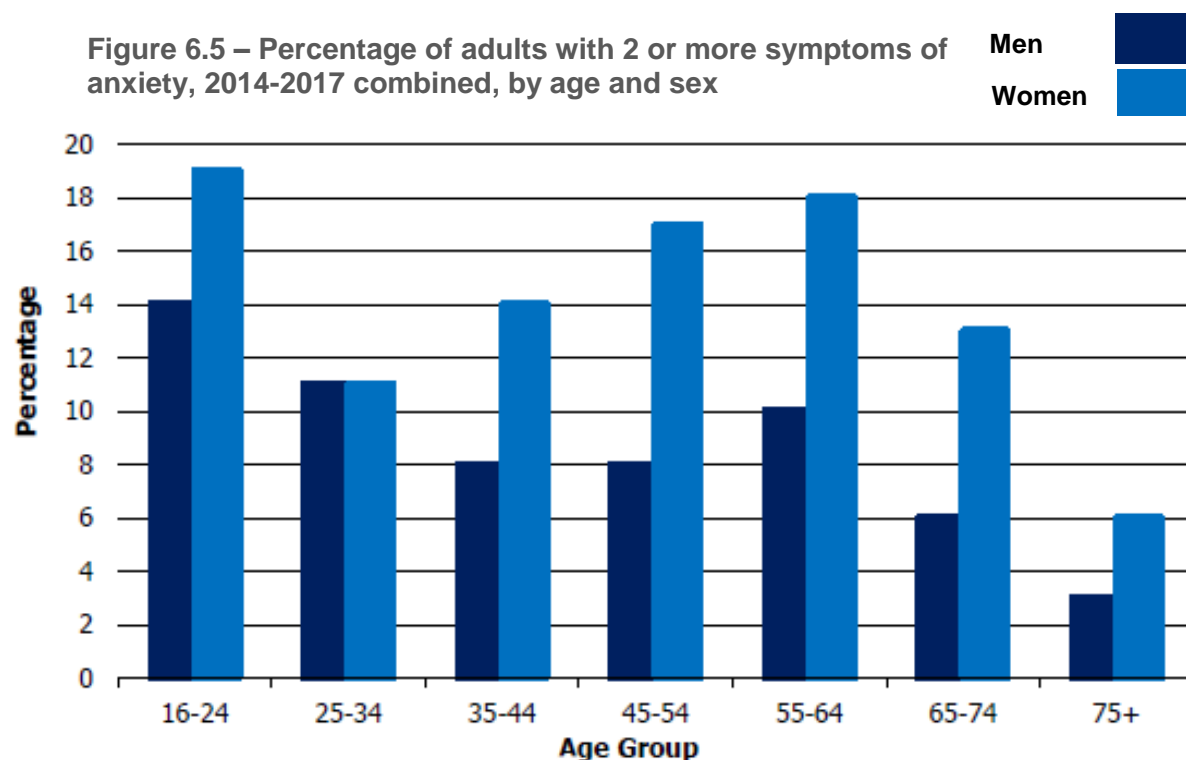
Anxiety – In 2016/2017, 11% of adults in Scotland reported two or more symptoms of anxiety. The prevalence of anxiety was greatest among young people aged 16 – 24, with 16% reporting two or more symptoms of anxiety: see Figure 6.5. Anxiety was lowest for those aged 75+ (5%).¹¹⁰

The other key finding is the higher incidence of anxiety amongst women, especially those aged 45 – 64. The proportion of women in this age group with two or more symptoms of anxiety was 17% - 18%, not much lower than the 19% for young women aged 16 – 24.¹¹¹

¹⁰⁹ Ibid

¹¹⁰ Ibid

¹¹¹ Ibid



Source: [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

Like the statistics on depression, the prevalence of 2 or more symptoms of anxiety among adults was much lower in the least deprived areas (7%) than in the most deprived areas (17%).¹¹²

6.5 Self-harm and suicide

Self-harm – 6% of adults reported self-harm in 2016/2017. However, reported self-harm is much higher for young people, especially those aged 16 – 24, with over one in five young people self-harming: see Figure 6.6. Also, the proportion of women self-harming in this age group is higher at 24%, compared to 19% of men.¹¹³ This evidence on the increased prevalence of self-harm amongst young people in Scotland is supported by the research of O'Connor, R.C. et. al. (2018), who reported a lifetime history of Non-Suicidal Self Harm (NSSH) of 16.2% amongst a representative sample of young people aged 18 – 34 in Scotland.¹¹⁴

Attempted suicide – 6% of adults reported attempted suicide at some point in their lives. However, this varied significantly by age but with no discernible pattern: see Figure 6.6. Among those aged 16-24 and 25-34, 8-9% reported that they had attempted suicide; this decreased to 6% among those aged 35-44 and increased to 8% again for those aged 45-54 before steadily declining to 1% among those aged 75 and over.¹¹⁵

¹¹² Ibid

¹¹³ Ibid

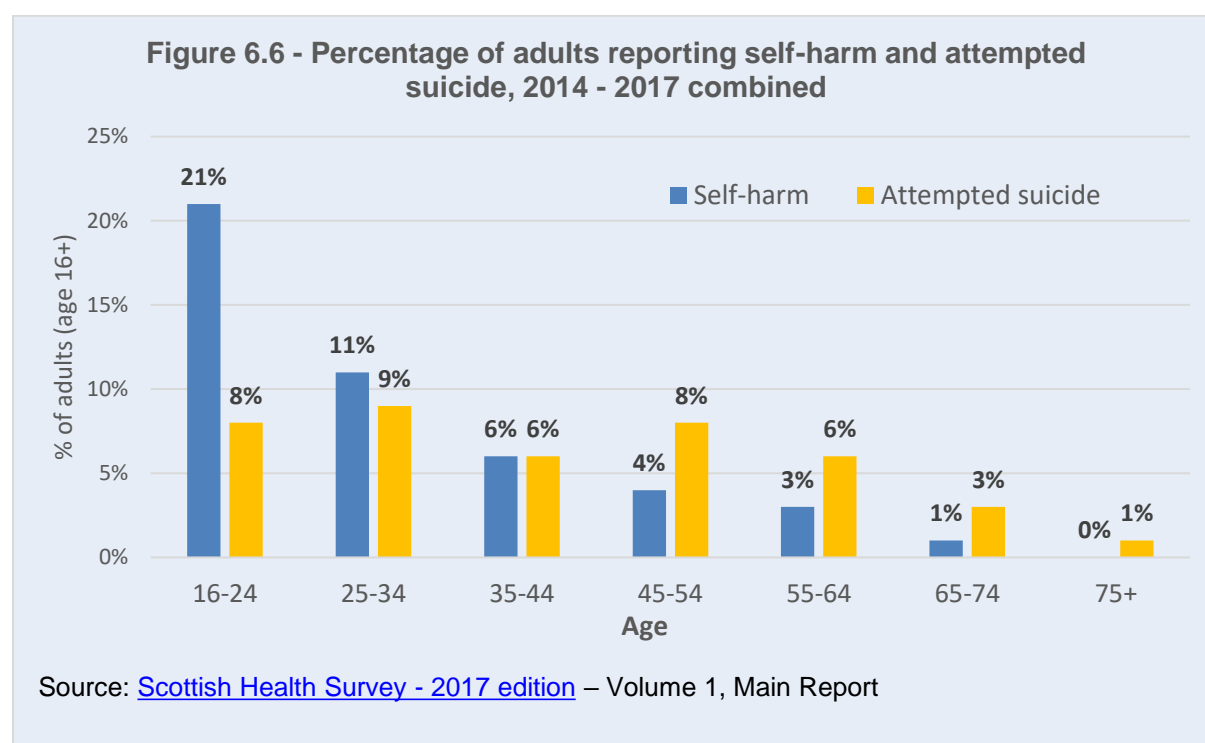
¹¹⁴ [Suicide attempts and non-suicidal self-harm: national prevalence study of young adults](#) –

O'Connor, R.C., et al – British Journal of Psychology (Vol 4 Issue 3), May 2018

¹¹⁵ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report: Scottish Government; Sept 2018

The proportion of adults that had attempted suicide was much higher among those living in the most deprived areas (12%), than in the least deprived areas (4%). This pattern was reflected for both men (11% to 4%) and women (14% to 4%).¹¹⁶

In the O'Connor study 11.3% of 18-34 year olds reported a lifetime history of suicide attempts, which is higher than the Scottish Health Survey figure of 8% and 9% for the equivalent age bands.¹¹⁷



Registered suicides – in 2018 there were 784 suicides registered in Scotland (581 males and 203 females), compared to 680 (522 males and 158 females) in 2017.¹¹⁸ This represents a 15% increase. However, there has been a decrease in the number of suicides in Scotland from 889 in 2011 to 784 in 2018.¹¹⁹

Deprivation and suicides – the incidence of suicide is three times higher in SIMD Decile 1 (the 10% most deprived areas of Scotland) compared to SIMD Decile 10 (the 10% least deprived areas of Scotland):

- SIMD Decile 1 (10% most deprived areas) – there was an average of 21.7 suicides p.a. during 2014 – 2018 per 100,000 resident population in Scotland

¹¹⁶ Ibid

¹¹⁷ [Suicide attempts and non-suicidal self-harm: national prevalence study of young adults](#) – O'Connor, R.C., et al – British Journal of Psychology (Vol 4 Issue 3), May 2018

¹¹⁸ [Suicide: Scottish Trends](#) – The Scottish Public Health Observatory; 2019

¹¹⁹ Ibid

- SIMD Decile 10 (10% least deprived areas) - there was an average of 7.0 suicides p.a. during 2014 – 2018 per 100,000 resident population in Scotland.¹²⁰

6.6 Summary of key findings on mental health

From this review of Scottish health data one can draw the following conclusions:

- **Mental ill-health is a significant problem** – the key indicators of mental health examined in the Scottish Health Survey 2017 show that a significant proportion of Scotland's population suffers from mental ill-health:
 - 17% of adults had a GHQ-12 score of four or more, which is indicative of a possible psychiatric disorder
 - 11% of adults reported two or more symptoms of depression, which is indicative of moderate to high severity depression
 - 11% of adults reported two or more symptoms of anxiety, which is indicative of moderate to high severity anxiety
 - 6% of adults reported self-harm and the same percentage for attempted suicide.

Also, the ultimate impact of poor mental health is evidenced by the 784 people who took their own lives in 2018.

- **It is also an increasing problem** – although there are issues relating to the analysis of some of the Scottish Health Survey time series data the evidence seems to suggest that the mental health of Scotland's population is deteriorating: see Table 6.1.¹²¹ There has also been a worrying 15% increase in the number of suicides in Scotland between 2017 and 2018.

Table 6.1 – Trend data on indicators of mental ill-health			
Indicators	2008/2009	2012/2013	2016/2017
	% of adults aged 16+		
Depression – reporting two or more symptoms	8%	9%	11%
Anxiety – reporting two or more symptoms	9%	9%	11%
Self-harm	3%	5%	6%
Attempted suicide	4%	5%	6%
Source: Scottish Health Survey - 2017 edition – Volume 1, Main Report			

- **Age matters** – young adults in the age range 16 – 24 are particularly susceptible to mental ill-health. For GHQ-12 scores, anxiety, self-harm and attempted suicide, young people ranked either worst or joint-worst. They were also one of the lowest scoring age groups in the WEMWBS.

¹²⁰ [Suicide: Deprivation](#) – The Scottish Public Health Observatory; 2019

¹²¹ In 2012 there was a change in the research methodology in the Scottish Health Survey which affected questions relating to depression, anxiety, self-harm and attempted suicide. One must therefore be cautious in comparing time series data before this date.

- **Gender matters** – women's mental health scored badly in the following indicators and age-brackets:
 - GHQ-12 – for adults aged 35 and over the percentage of women with a GHQ-12 score of 4 or more was higher than men, although this was only statistically significant for the 65 – 74 age group;
 - Anxiety – for all age groups except 25 – 34, the proportion of women reporting two or more symptoms of anxiety was higher than men;
 - Self-harm – the proportion of women reporting self-harm was much higher than men in the following age groups:
 - 16 – 24 (24% vs. 19%)
 - 25 – 34 (13% vs. 9%)

However, in terms of 'registered suicides' the proportion of males who take their own life is three times higher than females: 21 males per 100,000 population commit suicide compared to 7 females per 100,000.¹²²

- **Deprivation is the single biggest factor** – for the indicators of mental ill-health examined, deprivation has a major adverse impact on all except self-harm: see Table 6.2. However, even in the case of self-harm there was a 3% differential.

Table 6.2 – Impact of deprivation on indicators of mental ill-health			
Indicators	SIMD Quintile 1 (most deprived)	SIMD Quintile 5 (least deprived)	% difference
	% of adults aged 16+		
GHQ-12: scoring 4 or more	24%	14%	10%
Depression – reporting 2 or more symptoms	20%	5%	15%
Anxiety – reporting 2 or more symptoms	17%	7%	10%
Self-harm	10%	7%	3%
Attempted suicide	12%	4%	8%
Source: Scottish Health Survey - 2017 edition – Volume 1, Main Report			

6.7 The contribution of volunteering to mental health

Volunteering can play a major role in improving and supporting the mental health of Scotland's population in three main ways:

- By improving the mental health of those who volunteer;
- By reaching those volunteers who have the most to gain; and
- By supporting the NHS and health charities whose goals are to inform, educate, manage and treat mental ill-health in Scotland's population.

¹²² [Suicide: Scottish Trends](#) – The Scottish Public Health Observatory; 2019

The challenge is how best to optimise these contributions.

a) Mental health benefits for volunteers

Understanding the relationship between mental health and volunteering

In Volunteer Scotland's report on "Volunteering, Health and Wellbeing" 20 out of the 24 core papers examined the linkages between mental health and volunteering.¹²³ Notwithstanding the issue of causality, the overwhelming body of evidence concludes that volunteering has the potential to enhance individuals' mental health and wellbeing. Eighteen of the 20 papers cited evidence which supports this conclusion.

The benefits from volunteering which the authors cited as contributors to improved mental health include:

- *Increased social connectedness* – this relates to improving an individual's social capital. Examples include expanding social networks; meeting new people and making friends; feeling connected to wider society and developing a sense of belonging; and building networks, bonds, trust and common values with other people.
- *Sense of purpose* – through the volunteering role an individual benefits from task satisfaction; a sense of achievement and fulfilment; having control over one's life; and giving direction and meaning to one's life.
- *Enhanced skills and personal resources* – learning new skills; improved confidence; more personal resources such as the ability to handle stress and cope with life; resilience and self-efficacy.
- *Increased self-worth* – this includes self-esteem and self-respect
- *Having fun/ being happy* – laughing, enjoying oneself; feeling good about oneself; leading to improved life satisfaction. This is termed the '**helper's high**' by Luks, A. (1991).¹²⁴

If these outcomes can be facilitated through volunteering, then there is wide-ranging evidence that this will help to improve individuals' mental health and wellbeing. Of these factors, 'social connectedness' and 'having a purpose' were the most frequently cited.

¹²³ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

¹²⁴ Luks, A. and Payne, P. (1991) *The Healing Power of Doing Good. The Health and Spiritual Benefits of Helping Others*. Fawcett Columbine: New York

"There is good evidence that older people who make voluntary contributions report:

- *An increase in the quantity and quality of their social connections*
- *An enhanced sense of purpose and self-esteem*
- *Improved life satisfaction, happiness and wellbeing"* ¹²⁵

*"Getting out and being with other people made a big difference to life, as sitting in the house 24/7 would lead to 'going up the wall'. (Volunteer)"*¹²⁶

"This course and this place [Imperial War Museum North] have saved my life. I love working and connecting with the kids too and giving them a real-life experience as a real soldier, and overall this is helping me to move onwards and forwards." (Paul, volunteer, who suffers from Post-Traumatic Stress Disorder)¹²⁷

Also, academic research modelling suicidal behaviour by O'Connor, R.C. and Kirtley, O.J. (2018) suggests that 'motivational moderators' such as belongingness and social support are important in an individual's transitioning from the idea of suicide to attempting suicide.¹²⁸ Their model suggests that volunteering could play an active role in reducing 'thwarted belongingness' and increasing 'social support', with positive impacts on suicidal thinking and longer term mental health.

However, the consequence of mental ill-health is that it creates barriers which hinders people's engagement with society. So, an activity such as volunteering, which can assist in alleviating the symptoms of mental ill-health, can be very difficult for people to engage with. Research by 'Disability Research on Independent Living and Learning (DRILL) highlights the fact that people with mental ill-health, despite having a desire to engage in civic and public life, face significant barriers in volunteering. Interestingly, the most significant barriers are anxiety and stress and 'lacking confidence', which are indicators of mental health. However, there are also external barriers created by society through, for example, the stigma and discrimination linked to mental health.

Encouragingly, the DRILL research highlights a range of practical measures which can be taken to help address these barriers including information, peer support, mentoring and training: see the summary of their research study below.

¹²⁵ Jones, D. et al (2016) – "The benefits of making a contribution to your community in later life"; Centre for Ageing Better

¹²⁶ "The impact of volunteering on the health and wellbeing of the over 50s in Northern Ireland" – Volunteer Now and the University of Ulster

¹²⁷ Warby, A. – "Inspiring Futures: Volunteering for Wellbeing; Final Report 2013 – 2016, Social Return on Investment"

¹²⁸ [O'Connor, R.C., Kirtley, O.J. \(2018\). The Integrated Motivational-Volitional Model of Suicidal Behaviour. *Philosophical Transactions of the Royal Society B*. 373: 20170268.](#)

<http://dx.doi.org/10.1098/rstb.2017.0268>

Research evidence for those with mental ill-health**‘Untapped Potential: How people with lived experience of mental health issues engage in civic and public Life’¹²⁹**

Survey methodology – online survey of adults with lived experience of mental health issues in Scotland (249 responses) and follow-up focus groups.

Engagement in civic and public life:

- 55% of respondents were not involved in the public life of their communities; 44% are involved.
- 50% of respondents would either like to become involved in the public life of their communities or increase their level of involvement
- Volunteering was the most popular role aspired to by those who are or wished to be involved in public life (note: most of the other roles involve volunteering as well):
 - 49% - volunteering for a charity, charity shop or community organisation
 - 41% - activist in a campaigning/protest/lobby group
 - 26% - acting as advisor for a statutory or public body
 - 22% - trustee or director of a charity or community organisation
 - 10% - standing for election as local councillor, MSP or MP

Barriers to engagement in civic and public life: the barriers are listed in descending order of importance (average on a five point Likert scale):

- Stress and /or anxiety (3.4)
- Lack confidence (3.2)
- Work commitments (2.9)
- Stigma and discrimination (2.7)
- May affect social security benefits (2.2)
- Parental or caring responsibilities (2.1)

Support to become engaged in civic and public life: the following types of support were considered to be most important (% of respondents):

- 60% - more information and advice about the possibilities open to me
- 55% - peer support from other people with mental health problems who are active in civic and public life
- 50% - training for the roles I aspire to
- 37% - a mentor (personal adviser and supporter) in the organisation I work for
- 30% - counselling provided by my local health team
- 29% - financial help to cover transport, training costs and/or supplement or replace current income/benefits.

¹²⁹ **‘Untapped Potential: How people with lived experience of mental health issues engage in civic and public Life’**– Research commissioned by DRILL (Disability Research on Independent Living and Learning) Programme funded by the Big Lottery Fund – June 2018

Examples of the Benefits

"Being accepted. Being trusted. It keeps me well. It keeps me out of hospital. It gets me out of the house and keeps my brain busy."

"[It means] inclusion – the realisation that the stigma isn't there, that [the people you meet] are more aware of your problems and adapt to them."

"I've been part of so many different things and, honest to God, it is the best thing for my mental health problems in years."

"It's good for your neural pathways. They say, do something that is new and challenging."

Examples of the challenges and barriers

"I have an episodic illness. At times, I am capable of working, at times I am not. I am reluctant to step up because I am not sure I can provide the continuity."

"When I was unwell, I didn't want to meet people and the more interesting they were, the less I wanted to meet them because I thought I couldn't cope intellectually"

"People don't accept you. They look at you in strange ways when you say you've got a mental health problem."

"There is the issue of the time and energy it takes. If you have used up all your energy and your capacity to cope day to day, there is no room left for volunteering."

Recommendation (one example from a number listed):

All organisations engaging volunteers should offer those with lived experience of mental health conditions the same 'reasonable adjustments' as specified in the Equality Act 2010 that they offer to their paid employees.

Evidence of mental health benefits from volunteering in Scotland

This sub-section focuses on three sources of evidence that provide insights into the mental health of those who volunteer and those who do not in Scotland:

- **Scottish Household Survey** – Volunteer Scotland has undertaken a cross-sectional analysis of the SHS 2016 dataset focused on the evidence from the Scottish Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS). This forms the main evidence base for this sub-section;¹³⁰

¹³⁰ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

- **NHS Greater Glasgow and Clyde (NHSGGC) Health and Wellbeing Survey 2017/18** – Volunteer Scotland has also undertaken a cross-sectional analysis of the NHSGGC survey. Their research does not include data from the SWEMWBS, but we have drawn upon alternative mental health data from their survey to complement the SHS research. For those interested in exploring the volunteering, health and wellbeing data for Greater Glasgow and Clyde, the full dataset will be published by Volunteer Scotland in early 2020.
- **NCVO 'Time Well Spent' Survey – A survey of the volunteer experience in Great Britain, Jan 2019** – Volunteer Scotland has undertaken an analysis of NCVO's Scottish dataset from which relevant evidence relating to mental health has been included.

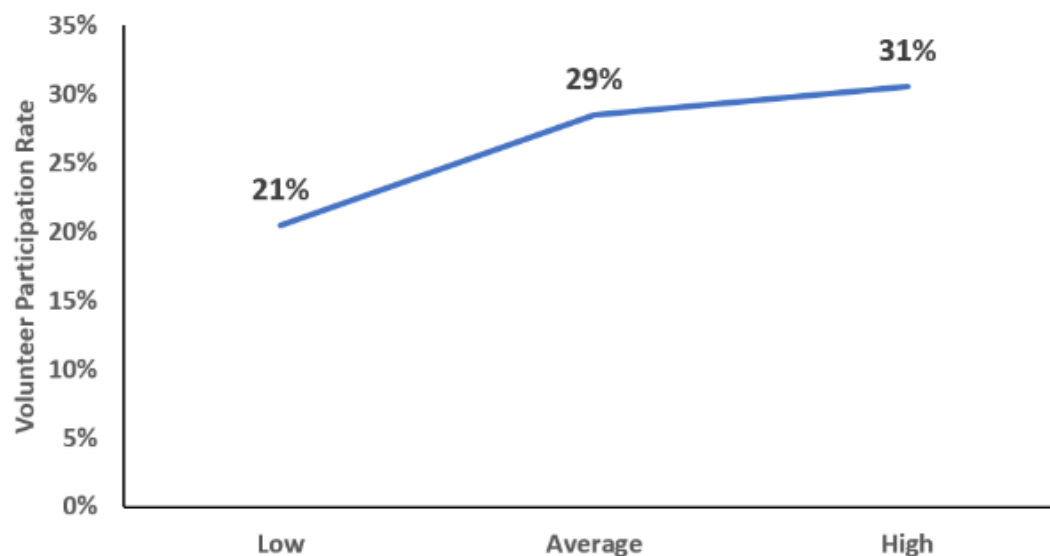
Mental wellbeing – the Scottish Household Survey uses the shortened version of the Warwick Edinburgh Mental Well-Being Scale, from which data has been included in sub-section 6.2 and where the wellbeing parameters are explained. As part of its SHS cross-sectional analysis Volunteer Scotland has banded the SWEMWBS scores into three categories: low (7- 20), average (20.01 - 28.99) and high (29-35). This method of splitting the SWEMWBS score follows the University of Warwick methodology.

Figure 6.7 shows that there is a relationship between volunteer participation and mental wellbeing. The higher one's wellbeing the more likely one is to volunteer. For those with 'low' mental wellbeing scores the volunteering participation rate is 21%, which increases to 31% for those with 'high' wellbeing scores.¹³¹ However, similar causation-correlation factors to those discussed in Section 5 for physical health apply here as well: see sub-section 5.7. Is this relationship explained by those with good mental health being more interested and willing to volunteer, or does volunteering improve the mental wellbeing of those who volunteer?

In the absence of longitudinal data, rather than the cross-sectional data drawn upon in this report (such as the SHS), there is insufficient evidence to resolve the causality-correlation issue. However, the reality is that both these factors may explain the positive mental health-volunteer correlation illustrated in Figure 6.7. However, we just do not know the relative significance of each explanatory factor.

¹³¹ Ibid

Figure 6.7 – Volunteer participation rate by mental wellbeing (SWEMWBS)



Source: [SHS 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019; n = 9,630

Mental wellbeing by age group – further analysis of the SWEMWBS data by age group reveals the young (aged 16 – 24) to have an inverse relationship between mental wellbeing and volunteering participation, the only age group to exhibit this. For young people with a low SWEMWBS score their volunteering participation rate is 41%, almost double the rate for young people with a high SWEMWBS score (21%): see Table 6.3.¹³² This finding is similar to evidence for ‘Long-Term Conditions’ and young people in sub-section 5.7 (Table 5.2).

Table 6.3 - Volunteering participation rates by age and SWEMWBS			
Age	SWEMWBS Scores		
	Low	Average	High
16-24	41%	33%	21%
25-34	22%	26%	32%
35-44	19%	30%	34%
45-59	18%	28%	34%
60-74	17%	30%	32%
75+	13%	20%	23%
Scottish Average	21%	29%	31%
Source: Supplementary cross-sectional analysis of SHS 2016 – Volunteer Scotland, not published			

Possible explanatory factors include:

- A social infrastructure and environment around young people at school, tertiary education and youth/social clubs which facilitates volunteering engagement by those with low mental wellbeing.

¹³² Supplementary cross-sectional analysis of SHS 2016 – Volunteer Scotland, not published

- More proactive and targeted support by schools, tertiary education providers and youth/social clubs to support young people with mental ill-health.

Further evidence of a 'tipping point' – drawing upon the NHS Greater Glasgow and Clyde (NHSGGC) data provides complementary evidence to the SHS SWEMWBS data. Their question is on 'mental or emotional wellbeing' the responses from which have been classified into three categories: 'positive', 'neutral' and 'negative': see Table 6.4. Volunteer Scotland's cross-sectional analysis with volunteering participation shows that volunteering is actually highest for those with 'neutral' mental or emotional wellbeing at 19%, but this drops to only 11% for those with 'negative' mental or emotional wellbeing.¹³³ This provides more evidence that a person's adverse health and wellbeing does not impact on volunteering participation rates until the issue becomes negative. See further corroborating evidence of a tipping point in sub-section 5.7 (Figure 5.7) relating to general health and sub-section 7.6 (Figure 7.12) relating to loneliness.

Table 6.4 – Greater Glasgow and Clyde	
Mental or emotional wellbeing category	Volunteering participation rate
Positive	18%
Neutral	19%
Negative	11%
Source: NHSGGC Health and Wellbeing Survey 2017/18 – Cross-sectional analysis by Volunteer Scotland – due for to be published January 2020	

Evidence from NCVO – the volunteer perspective – the final piece of evidence in this sub-section is volunteers' own perspective on the impact of volunteering on their mental health:

- 80% of recent volunteers (those who started volunteering in the last 12 months) acknowledged that 'It (volunteering) improves my mental health and wellbeing' as a benefit from volunteering.
- A higher proportion of older people over 55 (84%) identified improved mental health as a benefit of volunteering compared to those under 55 (77%).

b) Reaching those most in need

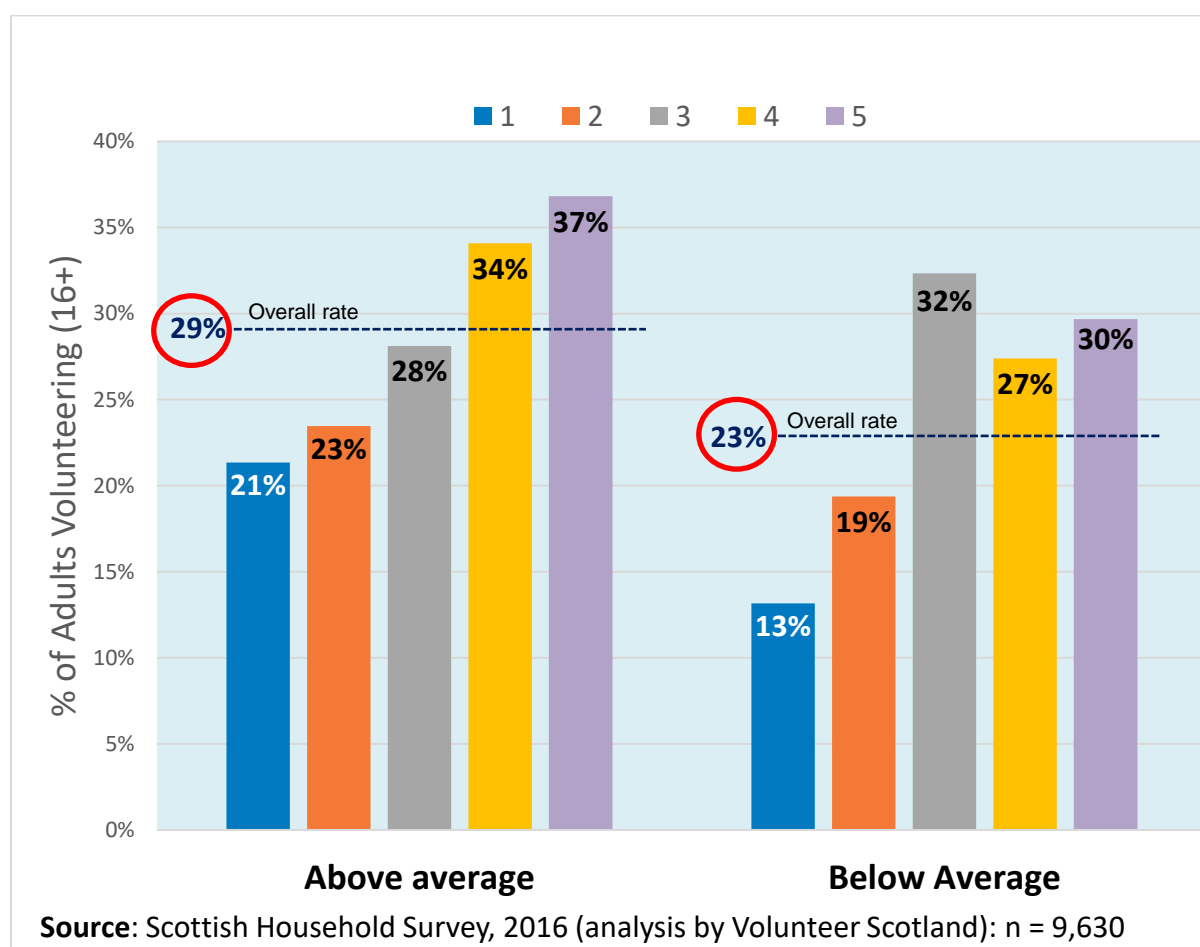
The wide-ranging evidence from Section 6 highlights the significant and potentially growing mental health problems facing Scotland's population. We also know that volunteering can fulfil an important role in helping to address mental health problems and that its impact is disproportionately important for those who are most disadvantaged. Hence, all the more reason why we need to try and optimise the contribution of volunteering in helping to address these problems.

¹³³ NHSGGC Health and Wellbeing Survey 2017/18 – Cross-sectional analysis by Volunteer Scotland – due for to be published January 2020

However, the irony is that those who can benefit the most from volunteering often have the lowest volunteering participation: see Figure 6.8. Based on the SWEMWBS results in the Scottish Household Survey, the volunteering participation rate for those with above average wellbeing scores was 29%, but this drops to 23% for those whose scores are below average.¹³⁴

Furthermore, the volunteering participation rates by deprivation are even more stark: see Figure 6.8. For Quintile 1 (the 20% most deprived areas in Scotland) the volunteering participation rate drops to 21% for those with above average SWEMWBS scores but is only 13% for those with below average scores. The challenge is how to engage those who have the most to gain.

Figure 6.8 – Adult volunteering participation rates by SWEMWBS scores and by SIMD Quintile

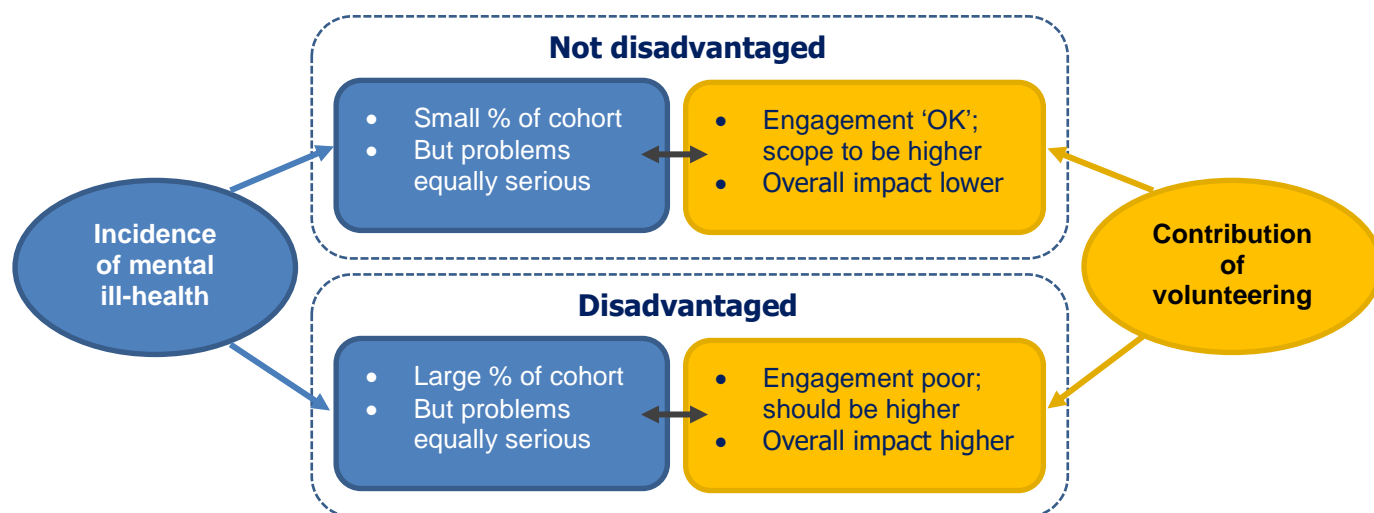


Finally, we also know from our analysis of the mental health indicators examined in Section 6 that mental ill-health is significantly more prevalent in the most deprived areas of Scotland. Deprivation has a major adverse impact on GHQ-12 scores of four or more, depression, anxiety and attempted suicide: see the results in Table 6.2 earlier in this Section.

¹³⁴ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

The analysis of this evidence reveals a complex set of inter-relationships between mental health, volunteering and deprivation and exclusion. To help explain this Volunteer Scotland has developed a simplified illustration of the factors at play.

Figure 6.8 – Contribution of volunteering to mental ill-health



Source: Volunteer Scotland, 2019

Those 'not disadvantaged' are not subject to major exclusion factors such as deprivation, poverty, disability, social isolation and loneliness, ex-offenders, those with alcohol and drug addiction problems, etc. The 'disadvantaged' includes individuals subject to one or more of these exclusion factors. Also, what is clear from the research is that intersectionality is a key issue. For example, those living in deprived areas are often subject to multiple and reinforcing problems which adversely affect their mental health.

For those not disadvantaged the proportion of this cohort subject to mental ill-health is smaller; but the mental health problems for those affected are equally serious to those who are disadvantaged. The reach of volunteering with the 'not disadvantaged' as measured by volunteering participation is 'OK' (it could and should be higher), but its impact on wider issues of disadvantage is likely to be more limited as evidenced by Volunteer Scotland.¹³⁵

For the disadvantaged the proportion of this cohort which is subject to mental ill-health is much higher. However, the reach of volunteering with the disadvantaged is much poorer, yet this is where the impact of volunteering has potentially the greatest contribution to make as evidenced by Volunteer Scotland.¹³⁶ This is the key challenge – the area where volunteering can generate the highest impact is also the most difficult to achieve due to the barriers to engagement.

¹³⁵ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

¹³⁶ Ibid

c) Contribution to the NHS and mental health charities

As explained in Section 5 on 'physical health', the contribution of volunteering to support the NHS and the third sector is very significant. Volunteers help to inform, educate, manage and treat Scotland's population on a wide range of health conditions. In the field of mental health and linked conditions such as social isolation and loneliness, volunteers play a crucial role as active listeners and supporters through befriending services and helplines such as the Samaritans. It is estimated that just over 200,000 people volunteer in Scotland's health and social care sector, a large but unknown proportion of whom will be focused on supporting mental health and social isolation and loneliness.

Peer volunteers play a particularly important role in that their lived experience of mental health conditions confers several advantages:

- **Engagement with beneficiaries** - volunteers who can relate directly to the mental health and wellbeing problems of those they are supporting are better able to engage with them;
- **Support for beneficiaries** – similarly, peer volunteers are more likely to have specialist knowledge of the conditions involved to provide practical support and/or signpost to relevant professional support; and
- **Reciprocal benefits** – being a peer volunteer can also aid their own continued recovery. They also benefit from volunteering and its contribution to their own mental and physical wellbeing.

7. Social isolation and loneliness

7.1 Social isolation and loneliness context

Background – the problems associated with social isolation and loneliness have been receiving much greater attention within Scotland in the last few years due to the emerging evidence base on these issues. In 2015 the Scottish Parliament Equal Opportunities Committee concluded that social isolation and loneliness were significant problems in Scotland and they recommended that further research be undertaken to:

- examine the prevalence of social isolation and loneliness in Scotland
- identify the typical profile of people who are most at risk of being socially isolated and lonely.¹³⁷

NHS Health Scotland was tasked with this research exercise and the evidence presented in their report has been drawn upon in this Section.¹³⁸ It was also used in the evidence section for the 'A Connected Scotland' strategy.¹³⁹

Filling the evidence gaps – prior to the inclusion of one question on social isolation and one question on loneliness in the Scottish Household Survey 2018, there has been no systematic, regular and authoritative research on social isolation and loneliness in Scotland.¹⁴⁰ In particular, there has been a lack of evidence on loneliness, not just its prevalence but also its severity. There has also been a lack of demographic information on possible variations by age, gender, health, deprivation, etc. The Our Voice Citizens' Panel surveyed the overall Scottish population.¹⁴¹ However, the sample size was modest at just over 500, as a consequence of which the results are not statistically significant for more detailed demographic breakdowns.

To address these evidence gaps and supplement the SHS 2018 data Volunteer Scotland has drawn upon the following sources:

- **NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18** – this survey includes a question on loneliness which has been cross-tabulated with the volunteering participation rate. It also includes questions relating to neighbourhood and community engagement.
- **NCVO 'Time Well Spent' Survey 2019** – this survey asks questions about the benefits of volunteering which includes meeting new friends and its impact on reducing isolation. It also provides new information on 'place' and the locality of volunteering. Scottish level data has been analysed by Volunteer Scotland.

¹³⁷ Equal Opportunities Committee. *Age and Social Isolation*. Edinburgh: Scotland Parliamentary Corporate Body; 2015.

¹³⁸ Teuton, J. [Social isolation and loneliness in Scotland: a review of prevalence and trends](#) – NHS Health Scotland, 2018

¹³⁹ [A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger connections](#) – Scottish Government, 18 Dec 2018

¹⁴⁰ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019. The full SHS dataset to allow more detailed cross-sectional analysis will not be available till 2020.

¹⁴¹ Our Voice Citizens Panel Survey: 2nd Survey Report, Scottish Health Council; Aug 2017

- **Scottish Household Survey 2016** – Volunteer Scotland has cross-tabulated neighbourhood and community engagement questions with volunteering participation rates.
- **Scottish Household Survey 2018** – for the first time there is data on informal volunteering and this evidence provides important insights on its contribution in combatting loneliness.
- **Other data sources** – a range of other data sources have been drawn upon including the Scottish Health Survey, Healthy Behaviours in School-Aged Children (HBSC) research and the Office for National Statistics analysis of the Communities Life Survey 2016/17.

This much more comprehensive evidence base provides the best insight we have ever had on the prevalence of social isolation and loneliness within Scotland and the potential contribution of volunteering in helping to address them.

Definition: “A Connected Scotland” strategy gives the following definition of social isolation and loneliness:

- **Social isolation** - “*when an individual has an objective lack of social relationships (in terms of quality and/or quantity) at individual group, community and societal levels*”.
- **Loneliness** - “*a subjective feeling experienced when there is a difference between the social relationships we would like to have and those we have*”.¹⁴²

It is important to highlight that these are two quite separate but linked issues. Social isolation and loneliness can be experienced independently from one another. It is possible for people who appear well connected socially to feel lonely – and for people who live in solitude or with few connections not to feel lonely. Too often these conditions are discussed as if they are always inextricably linked. This is often not the case. Nor does volunteering have the same curative effect if you are lonely as if you are socially isolated.

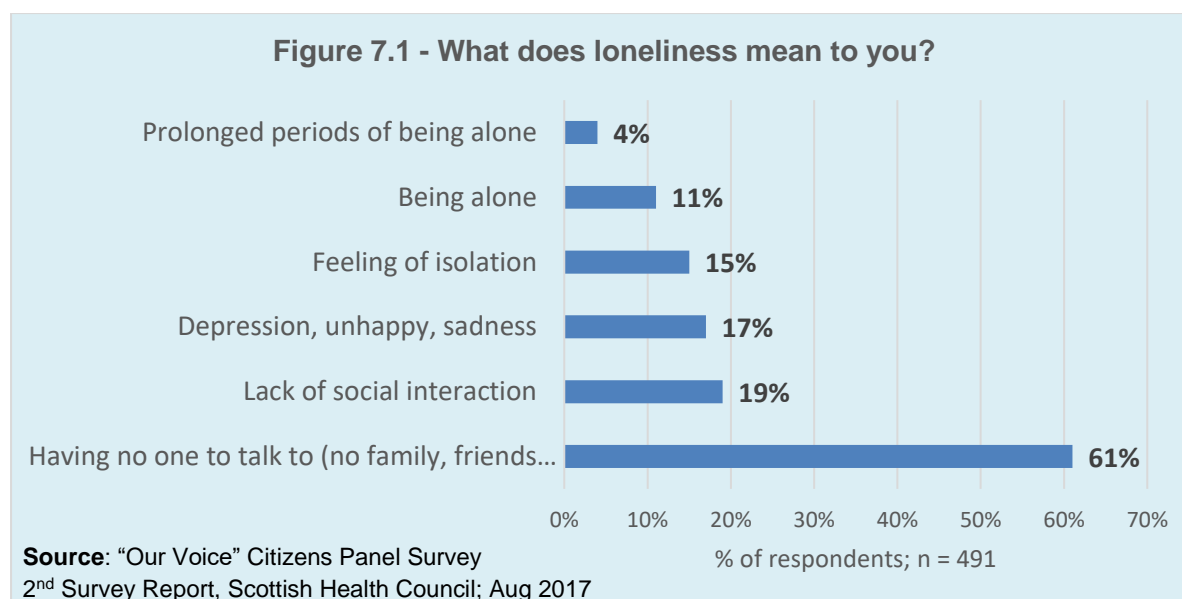
What does loneliness mean to people? Definitions are good for explaining the parameters of a condition, but what does it really mean in practice? The Our Voice Citizens' Panel Survey identified that for loneliness the single most important factor is not having anyone to talk to: see Figure 7.1.¹⁴³ Nearly two-thirds of respondents said that loneliness was defined as having no one to talk to – no family, friends or relationships. Qualitative research shows just how isolating people's lives can be: *‘Television was deemed to be the main form of company and the report showed that 21% of those aged 65+ were ‘always or often lonely’.*¹⁴⁴

Figure 7.1 also shows how loneliness is connected to mental ill-health, with 17% of respondents associating the condition with depression, unhappiness and sadness.

¹⁴² [A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger connections](#) – Scottish Government, 18 Dec 2018

¹⁴³ Our Voice Citizens Panel Survey: 2nd Survey Report, Scottish Health Council; Aug 2017

¹⁴⁴ “The impact of volunteering on the health and wellbeing of the over 50s in Northern Ireland” (Summary Report) - Volunteer Now and University of Ulster (undated)



7.2 Evidence on social isolation and loneliness

Social isolation evidence

Adults - A good indicator of social isolation is the frequency with which people contact others. The Scottish Household Survey 2018 questioned adults on the frequency with which they meet socially with friends, relatives, neighbours or work colleagues.¹⁴⁵ Over a quarter of adults in Scotland (27%) meet socially less frequently than weekly:

- At least once a month (but less frequently than weekly) 19%
- A few times a year or very rarely – 7%
- Never – 1%

The Scottish Health Survey asks the question: "*How often do you contact friends, relatives or neighbours?*", which is a stricter measure of social isolation and loneliness as this includes 'any contacts' not just 'social contacts'.¹⁴⁶ This reveals that 7% of Scotland's population have contact less frequently than weekly:

- Once or twice a month – 4%
- Less than once a month – 2%
- Never – 1%

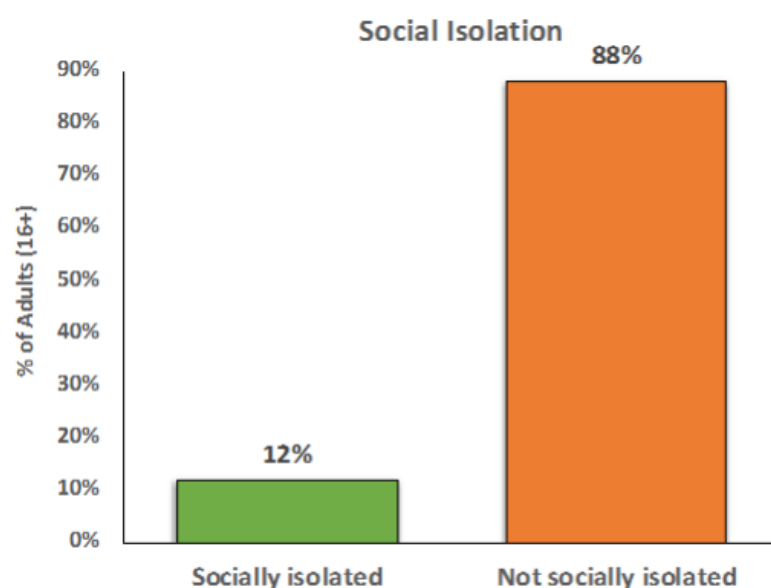
However, perhaps the most insightful evidence on social isolation is the direct question posed by the NHS Greater Glasgow and Clyde survey: 'Do you ever feel isolated from family and friends'? Twelve percent of people in Greater Glasgow and Clyde admit to feeling isolated at times (see Figure 7.2).¹⁴⁷

¹⁴⁵ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

¹⁴⁶ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report – Scottish Government; Sept 2018

¹⁴⁷ NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18 – analysis by Volunteer Scotland, publication in early 2020

**Figure 7.2 – Do you feel isolated from family and friends?
Greater Glasgow and Clyde Adults (age 16+)**



Source: NHSGGC 2017/18, n = 7,834

The Scottish Household Survey also tracks several indicators which provide proxy evidence on the extent to which people are socially isolated.¹⁴⁸ This includes people's involvement with other people in their neighbourhood: see Table 7.1. Although the percentages are relatively small, they do show that a proportion of Scotland's population is not closely involved with their neighbourhood. What is perhaps more worrying is that 8% would not offer to help their neighbours in an emergency!

Table 7.1 – Involvement with other people in the neighbourhood – SHS 2017	
Indicator of involvement	Either disagree or uncertain*
Could rely on friends/neighbours in neighbourhood for help	13%
Could rely on friends/neighbours in neighbourhood to look after home	13%
Could turn to friends/neighbours in neighbourhood for advice	18%
Would offer help to neighbours in an emergency	8%
Source: Scottish Household Survey 2017 - Annual Report – Scottish Government; Sept 2018 Note: * Respondents replying 'neither agree or disagree', 'tend to disagree' or 'strongly disagree' to the statements	N = 9,819

These findings are further supported by the fact that 21% of people do not feel a strong sense of belonging to their community, split 16% 'not very strongly' and 5% 'not at all'.¹⁴⁹

¹⁴⁸ [Scottish Household Survey 2017 - Annual Report](#) – Scottish Government; Sept 2018

¹⁴⁹ Ibid

Children – The Healthy Behaviours in School-Aged Children (HBSC) research is conducted every four years across 6,000 children in Scotland aged 11, 13 and 15.¹⁵⁰ The last reporting period was 2014. The report's introduction on 'peer relations' states:

“Adolescents who report having no friends use alcohol and illicit drugs more frequently, are more likely to smoke and perceive themselves as unhappy and lonely. Similarly, isolation from peer friendship groups can lead to depressive symptoms, low self-esteem and even suicide attempts.”

The key evidence from the HBSC research which is linked to indicators of social isolation and loneliness includes:

- **Number of close friends:** for 13 and 15 year olds 5% have fewer than three close friends:
 - 1% have no close friends
 - 1% have one close friend
 - 3% have two close friends
- **Ease of talking to best friend:** 12% of 13 and 15 year olds find it 'difficult' or 'very difficult' to talk to their best friend about things that really bother them.
- **Peer support:** 43% of children aged 11, 13 and 15 reported peer support to be low to medium (rated as scores from 1 – 5.5 on a 1 – 7 point scale. 'High' peer support was from 5.5 - 7)
- **Family support:** 38% of children aged 11, 13 and 15 reported family support to be low to medium (rated as scores from 1 – 5.5 on a 1 – 7 point scale. 'High' peer support was from 5.5 - 7). However, the level of support is perceived to worsen as the child gets older:
 - 28% of children aged 11 reported family support to be 'low to medium'
 - 49% of children aged 15 reported family support to be 'low to medium'

Loneliness evidence

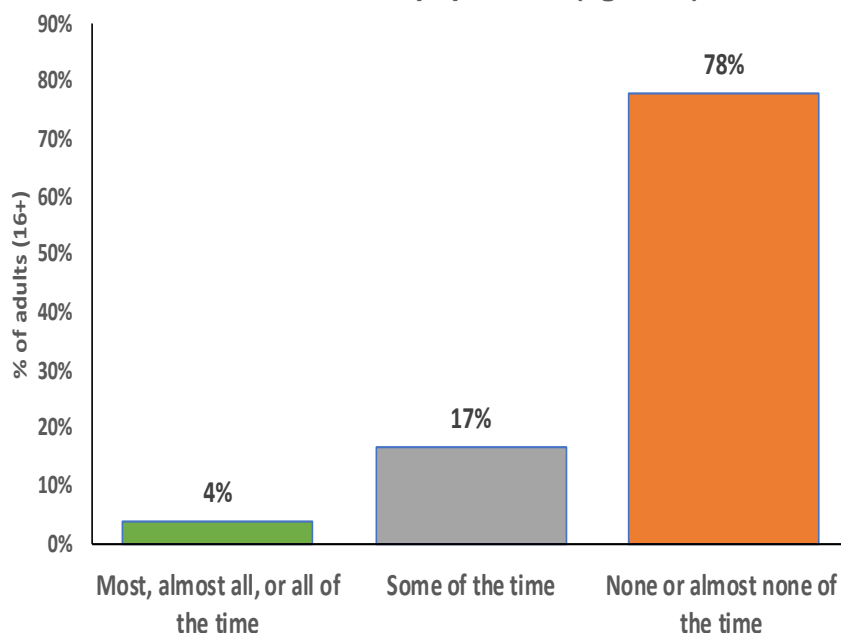
Adults – the Scottish Household Survey 2018 provides the first authoritative Scottish data on adult loneliness in Scotland. It shows that one in five adults (21%) have experienced loneliness from 'some' to 'all of the time' in the last week: see Figure 7.3.¹⁵¹ Key demographic variations include:

- **Age** – the 75+ age group have the highest proportion of lonely people (26%), followed by those aged 25 – 34 (24%) and those aged 16 – 24 (23%). The lowest proportion of lonely people are aged 60 – 74 (18%).
- **Deprivation** – the highest proportion of lonely people live in Quintile 1 (those living in the 20% most deprived areas in Scotland) at 28% falling to 16% in Quintile 5.

¹⁵⁰ [HBSC - 2014 Survey in Scotland](#) – World Health Organisation, collaborative cross-national study; Sept 2015

¹⁵¹ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

**Figure 7.3 – How often you have felt lonely in the last week?
Scottish adult population (age 16+)**



Source: SHS 2018, n = 9,700

Other evidence on loneliness includes:

- In Greater Glasgow and Clyde 17% of adults have felt lonely in the last two weeks:
 - 6% - all of the time or often
 - 11% - some of the time¹⁵²
- One in ten people in Scotland often feel lonely (Our Voice Citizens' Panel, 2017) – but a modest sample of 505.¹⁵³
- 11% of adults in Scotland often feel lonely, and 34% feel lonely sometimes (Mental Health Foundation, 2010) – very small sample size of 190.¹⁵⁴

Evidence from helpline services for key charities operating in Scotland also highlights the importance of social isolation and loneliness as one of the main causes for uptake of their services: see Table 7.2. Over 30% of calls to Silver Line Scotland and LGBT Health and Wellbeing related to social isolation and loneliness. Although the percentage figure for Childline is much lower, this data is likely to underestimate the significance of social isolation and loneliness because it will often be a contributory factor to other reasons for contacting Childline. For example, in 2017/18 106,000 out of 269,000 counselling sessions were related to mental health, emotional health and wellbeing.¹⁵⁵

¹⁵² NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18 – analysis by Volunteer Scotland, publication in early 2020

¹⁵³ Our Voice Citizens Panel Survey - 2nd Survey Report, Scottish Health Council; Aug 2017

¹⁵⁴ [The Lonely Society](#) - Griffin, J. (2010), Mental Health Foundation

¹⁵⁵ [The Courage to Talk: Childline Annual Review 2017/18](#)

Table 7.2 – National Helpline statistics linked to social isolation and loneliness			
Helpline services	No. of calls	No. of calls about loneliness/ isolation	% on loneliness/ isolation
Childline (2016-17 data) ¹	295,202	4,063	1.4%
Silver Line Scotland (first 6 months of 2016) ¹	16,000	4,960	31%
LGBT Health and Wellbeing (2017/18 data) ²	1,155	417	36%
Sources: <ol style="list-style-type: none"> 1. A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger connections – Scottish Government, 18 Dec 2018 2. LGBT Health and Wellbeing – statistics sourced from their Communications and Evaluation Team 			

The evidence submitted by Samaritans to the Scottish Government consultation on its social isolation and loneliness strategy also demonstrates the strong link between loneliness and suicidal ideation:

Evidence submitted by Samaritans to the Scottish Government consultation on social isolation and loneliness strategy

*“In 2017, in emotional support contacts in which people expressed suicidal thoughts loneliness and isolation were mentioned in 28% of contacts compared with 21% in contacts overall. Mentions of loneliness and isolation were also higher among contacts in which people expressed that they were planning to take their own life, mentioned in 26% of contacts”.*¹⁵⁶

Young people – there is limited information on loneliness in young people in Scotland. The last large-scale research was undertaken by the HBSC survey in 2010 and which was reported by NHS Health Scotland in 2013: see Table 7.3.¹⁵⁷ This data is the reciprocal of the question asked: “Never felt lonely in the last week”.

This evidence suggests that the majority of young people in Scotland feel some degree of loneliness on a regular basis – at least weekly – and that self-reporting is higher for girls than boys. Moreover, the incidence of loneliness increases as the young person ages. For example, 51% of boys in P7 felt lonely at least once in the last week, but this increases to 62% for boys in S4. The corresponding figures for girls are 60% in P7 increasing to 67% in S4.

¹⁵⁶ Baker, N. Isolation and Loneliness. Samaritans (2017) Contact systems data, UK and ROI (unpublished).

¹⁵⁷ [Scotland's mental health: Children and young people](#) – Briefing Paper - NHS Health Scotland; 2014

Table 7.3 – Children feeling lonely at least once in the last week in Scotland, 2010*			
	Boys	Girls	All
Pupils in P7	51%	60%	55%
Pupils in S2	58%	63%	60%
Pupils in S4	62%	67%	64%

Source: [Scotland's mental health: Children and young people](#) – Briefing Paper - NHS Health Scotland; 2014

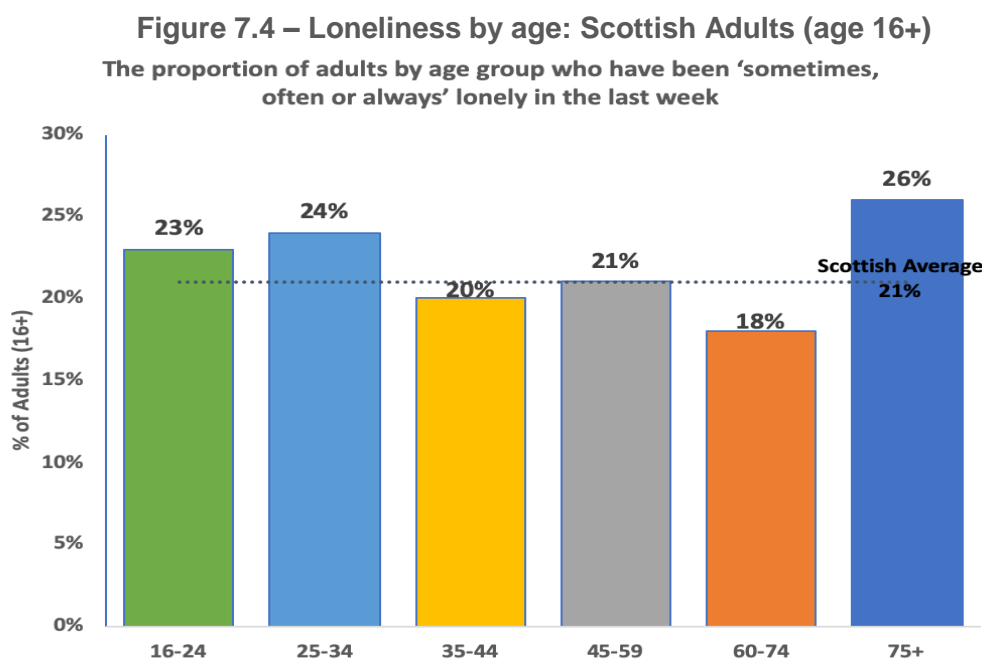
Note: * This table is based on reciprocal data for children's response to 'Never felt lonely in the last week'. It is possible that this data could be overstated due to the inclusion of a 'don't know' response category in the reciprocal figures above. Unfortunately, the spreadsheet disclosing the loneliness data does not give the 'yes' and possible 'don't know' response options.

However, the loneliness data for both adults and young people only tells us about the incidence of loneliness. It tells us nothing about how severe the loneliness is. There is likely to be a spectrum from one-off relatively minor incidences of loneliness at one end, to serious sustained loneliness which has very significant adverse impacts at the other end. This is a significant gap in the evidence base.

7.3 Characteristics and circumstances associated with feeling lonely

The Scottish Household Survey 2018 provides a robust analysis of key demographic characteristics and their relationship to the loneliness experienced by Scotland's adult population.¹⁵⁸ The key findings are:

- **Age** – the evidence shows that loneliness affects all age groups: see Figure 7.4. However, younger adults and those aged 75+ are likely to be the most susceptible to feelings of loneliness.

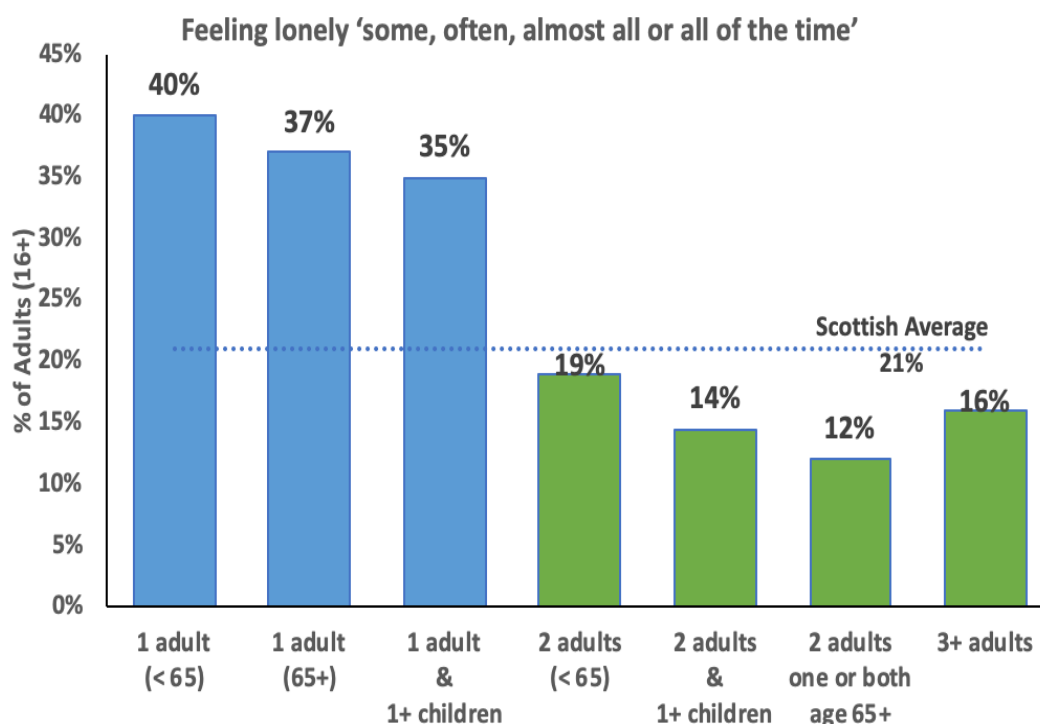


Source: SHS 2018, n = 9,700

¹⁵⁸ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

- **Health** – those with a long-term physical or mental health condition are much more susceptible to feelings of loneliness than those without long-term health conditions. The proportion of adults by health classification who have been sometimes, often or always lonely in the last week are:
 - Long-term health condition – 35%
 - No long-term health condition – 16%.¹⁵⁹
- **Deprivation** – those living in the most deprived areas of Scotland are almost twice as likely to experience feelings of loneliness compared to those living in the least deprived areas:
 - SIMD quintile 1 (the 20% most deprived areas) – 28%
 - SIMD quintile 5 (the 20% least deprived areas) – 16%.¹⁶⁰
- **Household composition** – there is a marked difference in feelings of loneliness for single adult households compared to multiple adult households: see Figure 7.5.
 - 35% to 40% of single adults and single parent households are 'sometimes, often or always' lonely
 - 12% to 19% of multiple adult households are 'sometimes, often or always' lonely.

Figure 7.5 – Loneliness of Scottish adults by household type



Source: SHS 2018, n = 9,700

¹⁵⁹ Ibid

¹⁶⁰ Ibid

This variance is even more extreme when one looks at the more acute classification of loneliness based on 'often, almost all or all of the time':

- 11% of single adults under 65
- 9% of single parent households
- 8% of single pensioner aged 65+
- 1% - 3% for multiple adult households.¹⁶¹

To supplement this evidence the Community Life Survey in England facilitates the examination of a wide range of key factors associated with feeling lonely. Not only does it provide some corroborating evidence to the SHS findings above, but it also provides insights into other variables such as gender, marital status and unemployment.¹⁶²

Basing their analysis on the 2016/17 Community Life Survey (CLS) data the Office for National Statistics completed an insightful analysis of loneliness, the key findings from which are presented below.¹⁶³ The CLS data are based on just over 10,000 valid responses to the loneliness question. The data was collected by an online/paper survey for those aged 16+ in England during the period August 2016 – March 2017. The key findings are:

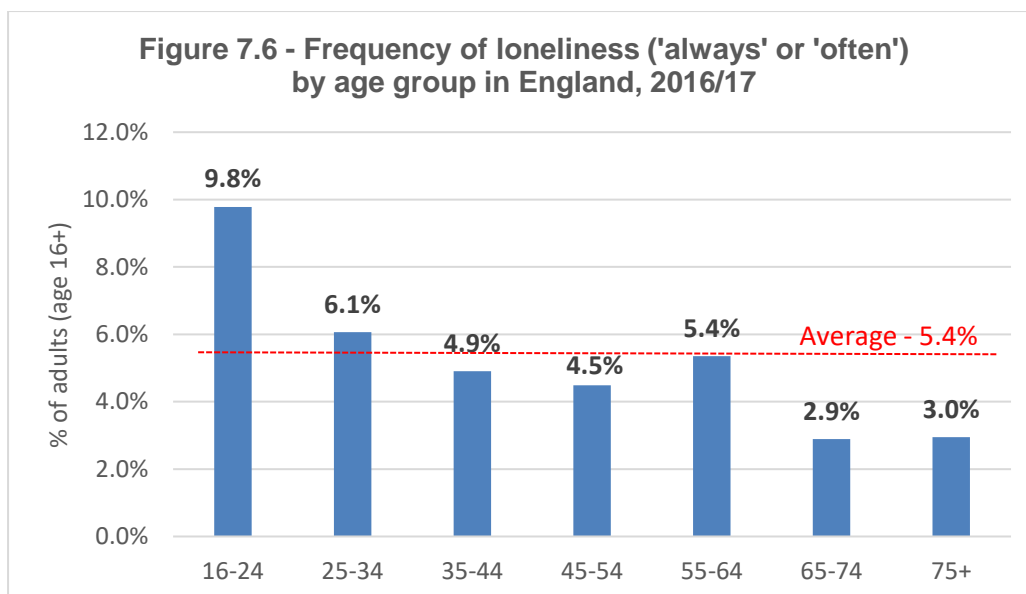
- **National rate** – 5.4% of adults in England feel lonely 'often' or 'always'. Although their classification of loneliness categories is not strictly comparable to the SHS, nor the timeframe over which the loneliness is being experienced, the results are broadly comparable to the 4% of adults in Scotland who feel lonely 'most, almost all or all of the time' (see Figure 7.3).
- **Age** - Younger adults aged 16 to 24 years reported feeling lonely more often than those in older age groups: see Figure 7.6. Compared with all other age groups, those aged 16 to 24 years were more likely to report feeling lonely 'often/always' (9.8%). The SHS shows higher loneliness statistics for those aged 16 - 34 when 'some' element of loneliness is experienced in the last week (see Figure 7.4). However, there is no appreciable difference between age categories for those who are lonely 'most, almost all, or all of the time'.¹⁶⁴

¹⁶¹ Ibid

¹⁶² When access to the SHS 2018 dataset is made publicly available from spring 2020, Volunteer Scotland will be able to run supplementary analysis on additional variables such as gender, etc.

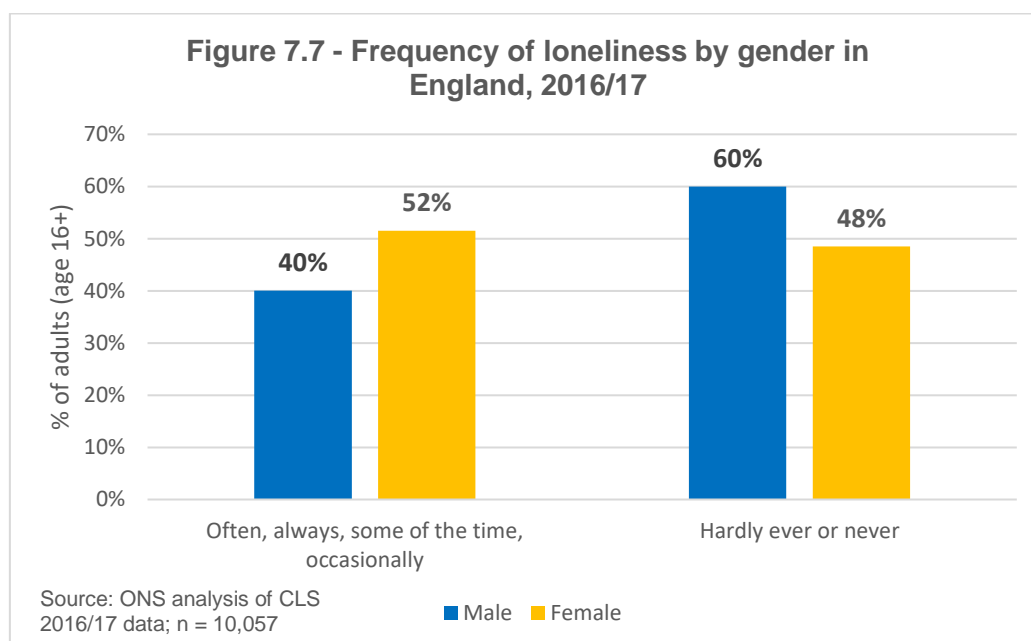
¹⁶³ [Loneliness: What characteristics and circumstances are associated with feeling lonely?](#) Office for National Statistics, April 2018

¹⁶⁴ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019



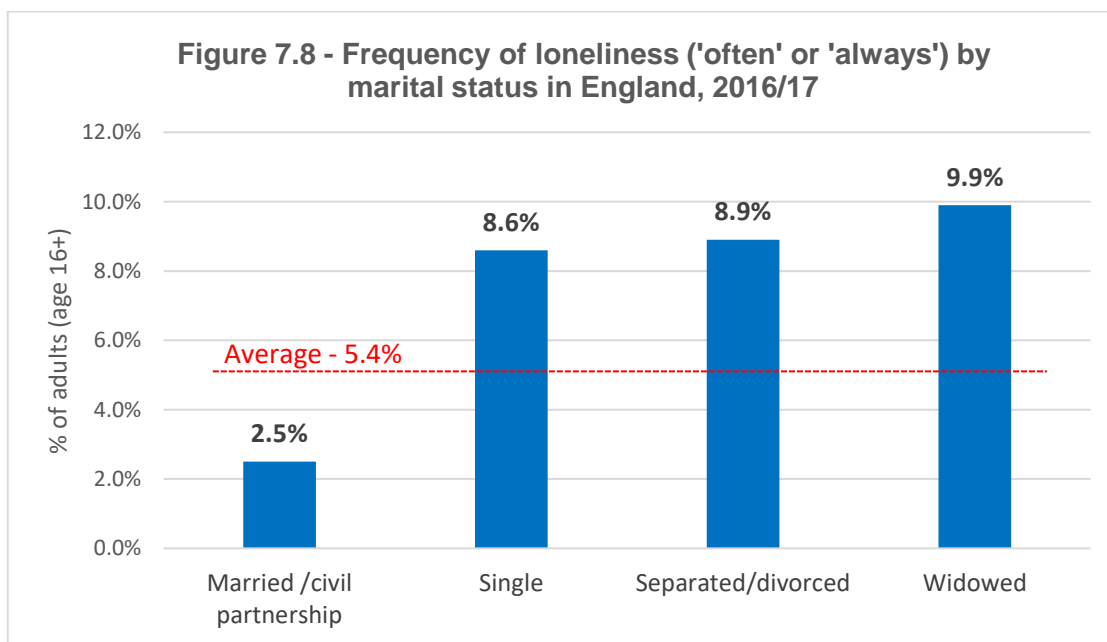
Source: ONS analysis of CLS 2016/17 data; n = 10,057

- Gender** - Women reported feeling lonely more frequently than men. They were more likely than men to report feeling lonely 'often/always', 'some of the time' and 'occasionally' and were much less likely than men to say they 'never' felt lonely: see Figure 7.7. However, one must be careful in the interpretation of this data, as there is some evidence which suggests that men may be less willing to report their loneliness as presented in a research paper on gender differences in loneliness: "*These results support the view that women are more apt to acknowledge their loneliness than men because the negative consequences of admitting loneliness are less for women*".¹⁶⁵



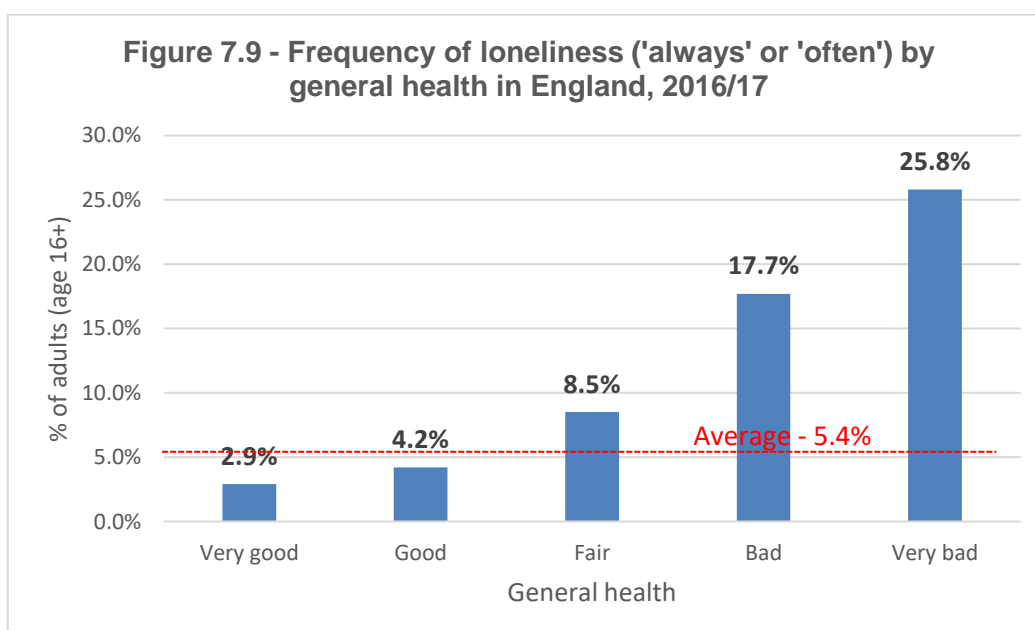
¹⁶⁵ [Gender differences in loneliness](#) – Boris, S.; Pearlman, D. (1985) – Personality and Social Psychology Bulletin; 11(1), pages 63 to 74.

- Marital status** – people who were married or in a civil partnership were much less likely to report experiencing loneliness 'always/often': see Figure 7.8. Only 2.5% of those married or in a civil partnership were 'always/often' lonely compared to over 8% for those single, separated/divorced or widowed. This evidence corroborates the SHS findings cited earlier in this Section which show that loneliness is much more prevalent for adults living alone in Scotland compared to those living in households with partners (see Figure 7.5).



Source: ONS analysis of CLS 2016/17 data; n = 10,057

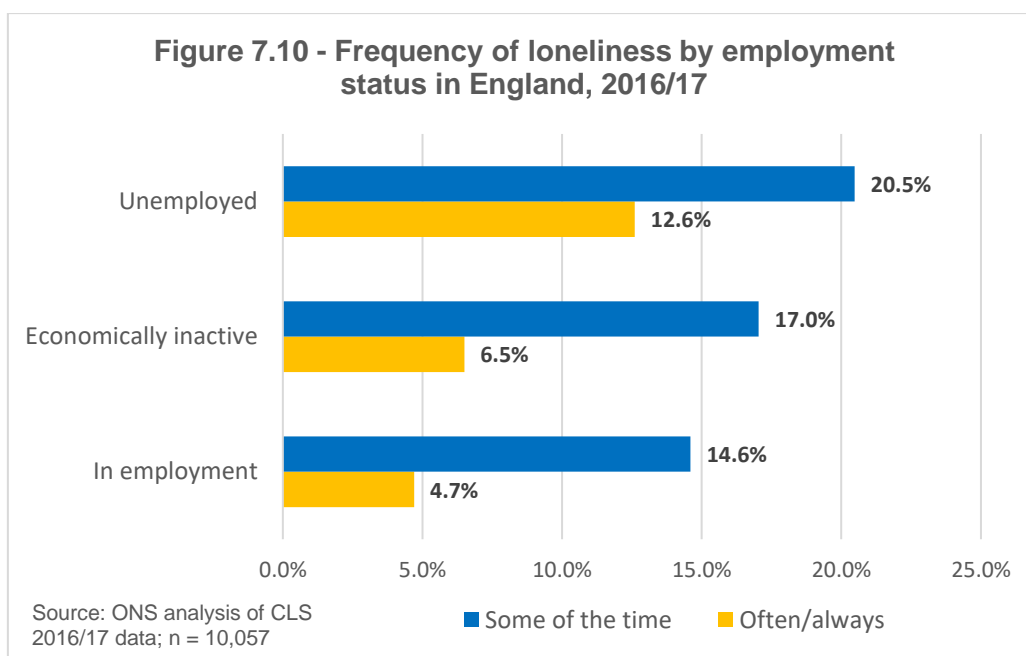
- General health** - People in poor health or who have conditions they describe as 'limiting' were at particular risk of feeling lonely more often: 25.8% of those reporting 'very bad' health were 'always' or 'often' lonely, compared to only 2.9% whose self-reported health was 'very good': see Figure 7.9.



Source: ONS analysis of CLS 2016/17 data; n = 10,057

- **Long-term illness or disability** - Those who reported having a long-term illness or impairment were much more likely to report feeling lonely 'often/always' and 'some of the time':
 - *Often or always lonely* – 8.8% of adults with a long-term illness or impairment are often or always lonely, which compares to 4% for those without a long-term illness or impairment.
 - *Lonely 'some of the time'* – the corresponding figures are 21.3% vs. 13%.

The SHS results corroborate this finding with 9% of those with a long-term health condition experiencing loneliness 'most, almost all, or all of the time'. This compares to the much lower figure of 2% for those with no long-term health condition.
- **Unemployed** – People who were unemployed (and seeking work) were more likely to report loneliness 'often/always' than those in employment or self-employment: see Figure 7.10.



Which factors independently affect loneliness? The Office for National Statistics also conducted logistic regression analysis, which is good for identifying which specific characteristics and circumstances are most strongly related to loneliness. Key highlights are summarised in Table 7.4.

Those subject to loneliness are more likely to:

- Be young – aged 16 – 24
- Have a long-term health condition or impairment
- Have caring responsibilities
- See family and friends infrequently
- Never chat to their neighbours.

Table 7.4 - Factors impacting on loneliness in England, 2016/17

From 34 characteristics and circumstances included in the analysis, 13 were found to have an impact on loneliness. Key findings include:

- **Age** - those aged 75 or over are 63% less likely to report loneliness than those aged 16 to 24 years. (The SHS presents conflicting evidence, in that those aged 75+ have the highest incidence of loneliness of all age groups in Scotland.)
- **Health and disability** – those with a long-term health condition or impairment were 56% more likely to report loneliness than those without.
- **Carers** - those who have caring responsibilities were found to be 37% more likely to report loneliness than those who do not.
- **Family and friends** – those who see friends and family less than once a month or never were 84% more likely to be lonely than those who meet up with friends and family daily.
- **Neighbours** - those who never chat to their neighbours were 43% more likely to feel lonely than those who do.

Source: ONS Analysis of CLS 2016/17 ¹⁶⁶

Persona profiles of loneliness - the ONS team also used a statistical technique called Latent Class Analysis to group individuals with similar patterns of characteristics including reported experience of loneliness. Three sets of characteristics were found to be associated with greater risk of feeling lonely more often and one set with the lowest risk of feeling lonely: see Table 7.5

Table 7.5 – Persona characteristics for the most and least lonely in England, 2016/17

<u>Widowed older homeowners</u> (the more lonely)	<u>Unmarried middle-agers</u> (the more lonely)
Characteristics: <ul style="list-style-type: none"> • widowed • in worse general health • living alone • homeowners • have a long-term physical or mental health condition • aged 65 years or older 	Characteristics: <ul style="list-style-type: none"> • single (never married), separated, or divorced • living alone but more likely to be renting than owning their own home • have a long-term physical or mental health condition • in worse general health • aged 35 to 64 years
Loneliness probability: 69% reported they felt lonely occasionally or more frequently, compared to 46% in the sample overall.	Loneliness probability: 81% reported they felt lonely occasionally or more frequently, compared to 46% in the sample overall.

¹⁶⁶ [Loneliness: What characteristics and circumstances are associated with feeling lonely?](#) Office for National Statistics, April 2018

<p><u>Younger renters</u> (the more lonely)</p> <p>Characteristics:</p> <ul style="list-style-type: none"> • single, separated, or divorced • living with others • renting • little trust and sense of belonging to their neighbourhood • in 'good' or 'very good' health without any long-term health conditions or disabilities • aged 16 to 34 years <p>Loneliness probability: 61% reported that they felt lonely 'occasionally' or more frequently, compared with 46% of the sample overall.</p>	<p><u>Married homeowners</u> (the least lonely)</p> <p>Characteristics:</p> <ul style="list-style-type: none"> • living with a partner in a marriage or civil partnership • better general health • own their own home • do not live alone • are aged 35 years or older (though skewed more towards 65 years and over) <p>Loneliness probability: Only 15% of individuals in this group reported that they felt lonely "occasionally" or more frequently, compared with 46% of the sample overall.</p>
<p>Source: ONS Analysis of CLS 2016/17 ¹⁶⁷</p>	

The ONS analysis provides a fascinating insight into how loneliness crosses all age groups – everyone is vulnerable – but some much more so than others. Also, the factors linked to loneliness are often interrelated and their inter-play is complex. For some, one key life event can be the tipping point into loneliness, such as bereavement, while for others it can be a cumulative effect of multiple factors which could impact on the frequency and the intensity of loneliness.

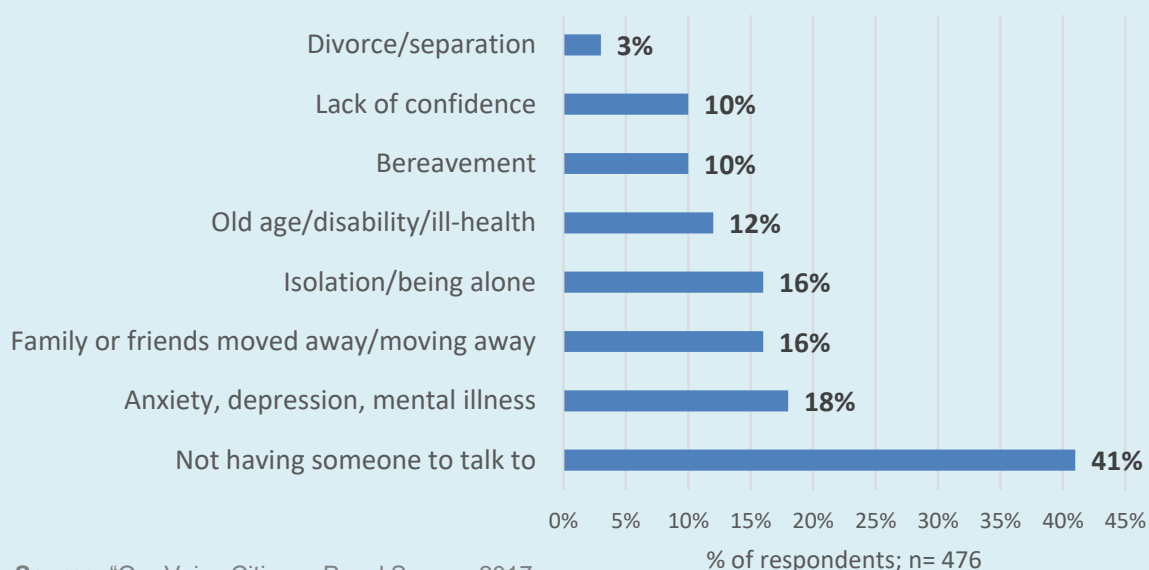
Scottish level data which corroborates some of the ONS findings includes not just the SHS data cited above, but also the evidence from the "Our Voice Citizens Panel Survey", which identifies social connectedness, mental health, general health, disability and bereavement as important 'causal factors' of loneliness in Scotland: see Figure 7.11.¹⁶⁸

The Zubairi Report examines the 'triggers, life stages and issues' relating to loneliness.¹⁶⁹ The evidence was drawn from qualitative research with under-represented demographics in Scotland. The research highlights the two-way cause and effect dynamics associated with loneliness: people's problems can make them lonely, and loneliness can trigger or exacerbate people's problems. Examples quoted include:

¹⁶⁷ [Ibid](#)

¹⁶⁸ Our Voice Citizens Panel Survey: 2nd Survey Report, Scottish Health Council; Aug 2017

¹⁶⁹ [The Zubairi Report: The lived experience of social isolation and loneliness in Scotland](#), Zubairi, K. (Nov 2018) Voluntary Health Scotland

Figure 7.11 - Main causes of loneliness in Scotland

- **Children and young people** – “.....were recognised as potentially suffering from loneliness and isolation, mainly in the form of bullying and segregation within schools.”
- **Older age:** “...[there are] re-occurring instances of older people feeling lonely, many feel that it is too late for them to make new friends and develop new social interests.”
- **Bereavement:** “We had a situation where a gentleman’s wife had arranged all their social interactions and now that she has passed he has lost all of his social life and connections.”
- **Socio-economic factors:** “Having a low income affects your quality of life – your quality of life is completely diminished. You cannot even afford your bus fare to even go to the park – you feel completely isolated – you are stuck in the house.”
- **Alcohol and drug dependency:** “If you are lonely you can start abusing alcohol and drink – because it gives you something in your life, even if that is an excuse to go to buy it – a walk to the shop.”
- **Social anxiety:** “People who are extremely lonely experience anxiety.” “Anxiety really impacts on your confidence.”
- **Loss of identity:** “People, due to a number of reasons –becoming a student, retirement, parenthood, migration, bereavement, illness, change of relationships - can lose their identity and sense of self. This can trigger loneliness, which makes people introspective... you lose yourself even more.”
- **Lack of open and neutral spaces:** ‘Stuck at home’ was a recurring phrase when discussing loneliness and social isolation – participants always came back to this central idea that you have nowhere to go except your home.
- **Transport:** “....this [transport] is a hot topic in many community council meetings – bus services being cut or routes changed. It is an important factor in people being able to get out and about for groceries or out to meet people and do things.”

- **Black and Minority Ethnic Communities and new Scots:** the Zubairi research highlights the increased risk of loneliness in the BAME community in Scotland due to the inter-sectionality with factors such as poverty, poor housing, unemployment and poor quality public spaces.

7.4 Consequences of social isolation and loneliness

Homo sapiens is a social species. Social bonds have been essential for our evolution and survival. Social connectedness has been hard-wired into our genes. We are social animals as a result of which isolation does not suit our social nature. Hence, the consequences of social isolation and loneliness can be very detrimental.

'The Lonely Society?' discusses the potential adverse consequences of loneliness for our physical and mental health.¹⁷⁰ The report draws upon the work of Cacioppo, J. T. and Patrick, W. (2008).¹⁷¹ They established five possible causal pathways to ill-health:

- Loneliness makes it harder for people to regulate themselves and leads to self-destructive habits, such as overeating or relying on alcohol. Loneliness weakens willpower and perseverance over time, so people who have been lonely for a while are more likely to indulge in behaviour that damages their health.
- Research shows that although young lonely and non-lonely people are unlikely to say they are exposed to causes of stress, middle-aged people who are lonely report more exposure to stress.
- Lonely people are more likely to withdraw from engaging with others and less likely to seek emotional support, which makes them more isolated. This becomes a vicious circle. "*..... if loneliness is persistent or recurring, the person finds it even harder to relate to others. One of the paradoxes of loneliness is that it leaves people less able to forge the relationships which they crave.*"¹⁷²
- Tests show that loneliness affects the immune and cardiovascular systems.
- A proven consequence of isolation for physiological resilience and recovery is linked to the basic human need for sleep. Lonely people experience more difficulties sleeping, and sleep deprivation is known to have the same effects on metabolic, neural and hormonal regulation as ageing.

Other evidence highlights the positive health benefits from social connectedness due to being in love, happy marriages and strong friendship networks.¹⁷³

Research conducted by the Mental Health Foundation in Scotland has highlighted the adverse consequences of loneliness on young people's mental health:

¹⁷⁰ [The Lonely Society?](#) Griffin, J.(undated) Mental Health Foundation

¹⁷¹ Cacioppo, J. T. and Patrick, W. (2008) *Loneliness: Human Nature and the Need for Social Connection* New York: W. W. Norton and Company

¹⁷² [The Lonely Society?](#) Griffin, J.(undated) Mental Health Foundation

¹⁷³ Ibid

“More than half of 18-24 year olds experience depression when they feel lonely, with 42% saying it leads to anxiety. 67% say their mental health worsens as a result of feeling lonely.....Loneliness can contribute to stress, anxiety, depression, paranoia and cognitive decline, and it is a well-known factor in suicide. It can be both a cause and effect of mental health problems.”¹⁷⁴

Finally, the Zubairi Report cites a range of evidence on the linkages between loneliness and health.¹⁷⁵ In particular, it stresses the importance of the linkages to mental health:

Zubairi Report – Tripartite relationship between loneliness, social isolation and mental health

Our research has identified a tertiary relationship between physical and mental health and loneliness and social isolation; with each negatively impacting on the other, resulting in chronic loneliness and social isolation.

Participants noted a bi-directional relationship between mental health and loneliness and social isolation: where loneliness and social isolation drive down mental health and poor mental health increases loneliness and social isolation, resulting in a self-perpetuating cycle.

Many research participants highlighted that symptoms of clinical depression were often very similar to severe chronic loneliness, citing personal experiences of how the two occurred simultaneously. There is also evidence that draws the correlation between loneliness and isolation and suicide.

The participants also noted that there is a lot of stigma around mental health which can lead to social isolation. *“People pull back from normal life when it becomes difficult to explain their condition or situation to friends and family – it is easier to isolate yourself.”*

7.5 Summary of key findings on social isolation and loneliness

Based on the newly published SHS 2018 data, the Community Life Survey in England and other Scottish research, one can draw the following conclusions:

- **Loneliness is a major problem** – around 27% of Scotland's adult population have experienced feelings of loneliness in the last week, and 64% of pupils in S4 experienced some feeling of loneliness in the last week.

¹⁷⁴ [Mental Health Foundation research on young people in Scotland](#) Research conducted by YouGov, news post by MHF, Jan 2018

¹⁷⁵ [The Zubairi Report: The lived experience of social isolation and loneliness in Scotland](#), Zubairi, K. (Nov 2018) Voluntary Health Scotland – pages 5 and 6.

- **No one is immune** – social isolation and loneliness can affect everyone in society at any stage in their lives. The evidence suggests that there are a multitude of factors which can trigger loneliness, not just the condition of being socially isolated.
- **Adverse impacts** – loneliness is not only triggered by, but can also exacerbate, a range of personal factors such as mental ill-health, having an impairment, bereavement, divorce/separation, addictions, eating conditions and poor diet.
- **Vicious circle** – if loneliness becomes persistent or recurring, then people find it even harder to relate to others. One of the paradoxes of loneliness is that it leaves people less able to forge the relationships which they crave.
- **Some are more predisposed to loneliness than others** – analysis of the Scottish Household Survey and the Community Life Survey in England highlights the following groups in society as being at particular risk:
 - Young adults aged 16 – 34
 - Widowed pensioners aged 65+
 - Adults living alone irrespective of age
 - Single parents living alone with their children
 - Those with a long-term health condition or impairment
 - Those with caring responsibilities
 - Those who see family and friends infrequently
 - Those who never chat to their neighbours.
- **Are we becoming lonelier?** – We don't have the evidence to answer this question but changing conditions in society give grounds for why we may be becoming lonelier over time. Factors include:
 - The potential adverse impacts of social media, particularly on young people. Research undertaken by the Mental Health Foundation in Scotland shows that technology, including social media could be exacerbating social isolation.¹⁷⁶ Eighty two percent of 18 – 24 year olds say that spending time face-to-face with others improves their mental health. In contrast 30% say that technology, such as social media, is causing them to feel lonely as it has replaced face-to-face contact.
 - The major increase in the number of people living alone in Scotland. The number of single person households has increased from 722,000 in 2001 to 904,000 in 2016, a 25% increase.¹⁷⁷ A further 28% increase is projected up to 2041. See further discussion in Section 8 on Community Engagement.

¹⁷⁶ Ibid

¹⁷⁷ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017 – National Records of Scotland, Aug 2018](#)

7.6 Contribution of volunteering to social isolation and loneliness

Volunteering can play a major role in preventing, mitigating or eliminating social isolation. Although more challenging to address, volunteering can also help people to combat loneliness. It can achieve these outcomes in three main ways through:

- The engagement of volunteers who are isolated and lonely which improves their social connections, allowing them to make friends and feel more integrated in society;
- The provision of services such as befriending which are targeted at those who are experiencing, or susceptible to, social isolation and loneliness; and
- The prevention of social isolation and loneliness for those who are already volunteering.

Volunteering can also confer other benefits linked to the alleviation of social isolation and loneliness – in particular, the bi-directional relationship between people's mental health and their social isolation and loneliness.

a) The benefits which volunteering confers on volunteers

A lot of volunteering is by its very nature a social activity. It is about volunteering with others to help others. It is therefore not surprising that in Volunteer Scotland's report on 'Volunteering, Health and Wellbeing' 23 out of the 24 studies we reviewed, important social connectivity and social capital benefits arising from volunteering were identified.¹⁷⁸ Although 14 of these papers did not overtly reference social isolation and loneliness, in many cases the links were implicit through reference to social connectedness such as 'getting volunteers out of the house', 'engaged with society', 'making new friends', etc.

Furthermore, of the nine studies specifically focused on examining the relationship between volunteering and social isolation and loneliness, six identified a strong positive impact on how volunteering can mitigate or eliminate social isolation and loneliness, two provided some limited evidence of positive impact and in only one study was the 'jury still out'.

Volunteer characteristics - the people who appear to benefit the most from volunteering in terms of developing social connections are those experiencing various forms of disadvantage or exclusion which, in turn, are contributors to social isolation and loneliness. The examples identified in the research include:

- **Those with mental ill-health** - eight studies identified improved mental health as a result of volunteering. This was corroborated by the frequent reference to the alleviation of depression for those most isolated and lonely:

¹⁷⁸ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

*"[volunteering provides] physical and mental health benefits – buffering loneliness, isolation and depression."*¹⁷⁹

- **Linkage to older people** – six out of the eight studies were focused on the benefits of volunteering and its contribution to the wellbeing of older people. In particular, this appears to affect those who are retired, don't have a job or 'purpose in life' and suffer from a reduction in 'role identities'. The evidence from Section 8 provides supporting evidence for this conclusion in that the incidence of loneliness is higher for older people, especially those over age 75, those who are widowed and those who are in ill-health.
- **Asylum seekers and refugees** – a programme led by Voluntary Action Sheffield's Volunteer Centre to support asylum seekers and refugees to become volunteers provides strong qualitative evidence of the benefits of volunteering:

*"They [new arrivals] become really isolated and their mental health deteriorates. They don't want to stay at home, so volunteering gives them a reason to get out of bed every day.....Socialising and meeting other women, feeling that they are not alone or isolated is a really valuable part of the whole volunteering process."*¹⁸⁰

- **Armed forces veterans** – this includes the isolation and loneliness suffered by armed forces personnel who are challenged by reintegrating with society outside the military.¹⁸¹
- **Other volunteer characteristics** – this includes those with low levels of wellbeing and those who are disadvantaged and disengaged from society.

Case study – Impact of volunteering on reducing social isolation

'Inspiring Futures (IF): Volunteering for Wellbeing'¹⁸²

Background - the Imperial War Museum North and Manchester Museum undertook a social return on investment study of its work to provide inclusive volunteering opportunities across 10 heritage venues. Over the period 2013 – 2016 the project, funded by the Heritage Lottery Fund, trained and supported 231 participants from Greater Manchester into volunteering positions within museums. There was a specific aim to focus on recruitment of young people aged 18 – 25, older people aged 50+ and armed forces veterans.

Objective - IF decided to choose heritage settings as they were considered engaging and stimulating, yet safe and reflective spaces. It was hoped that using this type of space would help to prevent and break the vicious cycles of low self-belief, isolation, exclusion, demotivation, depression and rejection that many of the participants had encountered in the past.

¹⁷⁹ "The impact of volunteering on the health and wellbeing of the over 50s in Northern Ireland" (Summary Report) – Volunteer Now and the University of Ulster (undated)

¹⁸⁰ New Beginnings Project – Evaluation Report; Rattenbury, E. and Bryce, M. (2010)

¹⁸¹ Inspiring Futures: Volunteering for Wellbeing; Final Report 2013 – 2016, Social Return on Investment – Warby, A.; Envoy Partnership on behalf of IWM North and Manchester Museum

¹⁸² Ibid

Volunteer impact – Claire was cited as an example of how the volunteering experience helped her overcome significant social isolation issues: *“Before Claire got into IF she felt really stuck in a rut and really shut-off and isolated, with very low confidence.... she felt like she had no plan, felt very self-conscious and had very few friends.”* Through the IF volunteer program, Claire had the opportunity to meet new people, improve her communication and inter-personal skills, build her confidence, and secure a job with a clear career direction.

“I needed to try and interact with people I hadn't met before, and new audiences. IF gave me that. I felt trusted and respected, and that I was making a difference to visitors....”
(Claire, volunteer)

Overarching impact – *“The IF model has been unique in providing both a stimulating and reflective environment in tackling social isolation and wellbeing inequalities. It helps people from disadvantaged or vulnerable backgrounds to believe in themselves. This project increases confidence and self-worth and most importantly it helps people to realise their full potential to take that next step in supporting their own wellbeing.”*

Volunteer benefits: the Scottish evidence – the NCVO ‘Time Well Spent’ research has revealed important benefits for Scottish volunteers:¹⁸³

- *Motivation to start volunteering* – 21% of volunteers who started volunteering in the last 12 months (labelled as ‘recent volunteers’) indicated that ‘meeting new people and making friends’ was a motivation to start volunteering. This proportion is higher for those in the lower socio-economic groups C2DE (26%) compared to ABC1 (18%);
- *Benefits from volunteering:*
 - 71% of recent volunteers said it ‘helps me feel less isolated’. Interestingly, a higher proportion of volunteers from lower socio-economic backgrounds (C2DE) derived this benefit (77%) than from higher socio-economic backgrounds (ABC2) at 68%.
 - 80% of recent volunteers said that ‘I meet new people’ was a benefit of volunteering

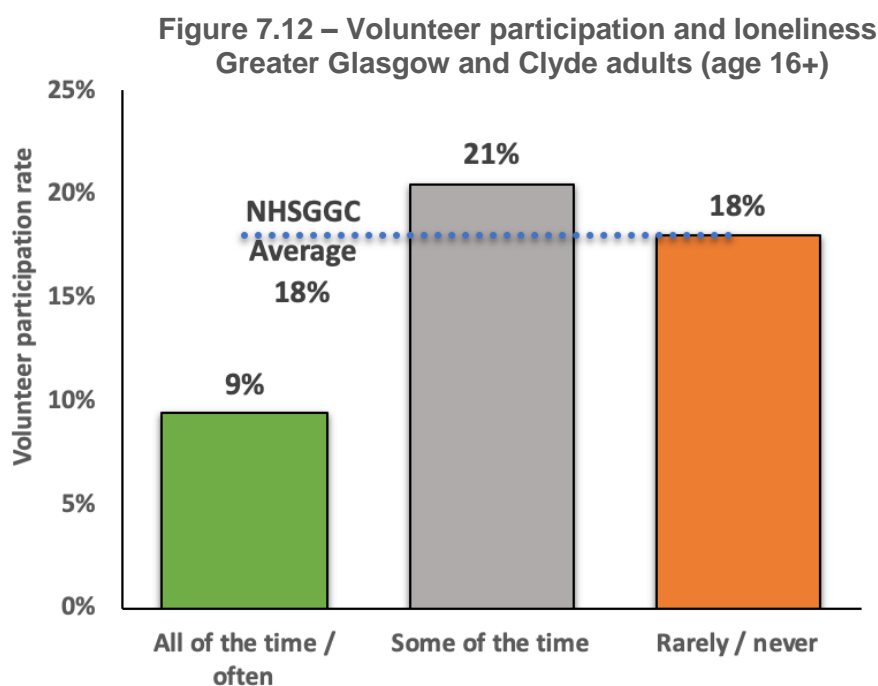
Also, from the evidence in the Volunteer Scotland’s literature review there is a strong read-across to the factors highlighted in the Zubairi Report.^{184,185} However, it is important to point out that the omission of characteristics linked to social isolation and loneliness such as being young, having an impairment or having caring responsibilities most likely reflects the fact that the research identified by Volunteer Scotland’s literature review did not cover these areas.

¹⁸³ ‘Time Well Spent’ – NCVO; January 2019 – analysis of the Scottish dataset by Volunteer Scotland; publication due early 2020

¹⁸⁴ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

¹⁸⁵ [The Zubairi Report: The lived experience of social isolation and loneliness in Scotland](#), Zubairi, K. (Nov 2018) Voluntary Health Scotland

Engaging the isolated and lonely – Volunteer Scotland's analysis of the NHS Greater Glasgow and Clyde (NHSGGC) Health and Wellbeing Survey highlights the much lower volunteering participation rate for those who are frequently lonely: see Figure 7.12.¹⁸⁶



For those who are lonely 'all of the time' or 'often' the volunteering participation rate for adults in Greater Glasgow and Clyde is only 9%, which is exactly half of the average volunteering rate of 18% for the whole adult population. Furthermore, the data highlights two other interesting issues:

- Firstly, that the highest volunteering participation rate (21%) is for those who are lonely 'some of the time'. Initially, this finding appeared counter-intuitive as Volunteer Scotland expected a linear inverse relationship between volunteering and loneliness – the lower the loneliness the higher the volunteering participation rate. However, an explanatory hypothesis is that people in this category are experiencing some element of loneliness which is acting as a spur to their engagement in society (for example through volunteering) to help combat loneliness; and
- Secondly, that there is a 'tipping point' in the frequency and degree of loneliness which impacts on volunteering participation. The hypothesis is that once loneliness becomes sufficiently acute a point is reached beyond which the individual's loneliness affects their ability, interest or willingness to volunteer. This results in a vicious circle of loneliness leading to less engagement in society which in turn exacerbates the problems of loneliness. Similar negative spirals affecting people's health and wellbeing have been evidenced elsewhere in this report, most notably in relation to mental health (Section 6) and general health (Section 5).

¹⁸⁶ NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18 – analysis by Volunteer Scotland, publication in early 2020

The implications of this analysis are that those who could benefit most from volunteering (the acutely lonely) are the least likely to be volunteering. This is another example alongside mental health and disability where the symptoms of ill-health and low wellbeing become the barriers to people's engagement in society. As a consequence, the remedial benefits which can flow from activities such as volunteering are not attained. See further discussion of this topic under 'Reaching those most in need' in sub-section 6.7 b).

b) The benefits which volunteering confers on beneficiaries

Formal volunteering helps combat social isolation and loneliness not only for volunteers but also for the beneficiaries of their services. There are a myriad of charities operating in Scotland which are either set up specifically to address this issue, such as Befriending Networks, or which help mitigate social isolation and loneliness as part of their wider service offer. Examples of charities with strong volunteering contributions include:

- Age Scotland
- Royal Blind and Scottish War Blind
- Befriending Networks
- University of the Third Age Scotland
- Poppy Scotland
- Epilepsy Connections
- Chest Heart and Stroke Scotland
- Contact the Elderly
- British Red Cross
- Health in Mind

As explained by the Chief Executive of Befriending Networks:

*"In order to tackle social isolation and loneliness, it's vital that a range of options exists to meet the differing needs of those living in our communities, across all ages and stages. At Befriending Networks, our members are a key resource, with volunteers and befrienders often at the frontline in local communities. Befriending often supports those who are most marginalised and excluded in our society and who may be living with chronic isolation and loneliness. Providing that more formalised support to help them engage with their community, after first having the opportunity to build relationships, self-esteem and confidence, can make all the difference. But it's not all one way – the mutuality of the relationship between befriender and befriended is often what's most valued and becoming a volunteer befriender provides significant benefits for the volunteers themselves."*¹⁸⁷

The Fife Gingerbread case study example cited in the Scottish Government's "A Connected Scotland" strategy also illustrates vividly the contribution of volunteering:¹⁸⁸

¹⁸⁷ [A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger connections](#) – Scottish Government, 18 Dec 2018

¹⁸⁸ Ibid

Case Study - Fife Gingerbread

Rachel was referred to the Fife Teen Parent Project by the Family Nurse Partnership when her daughter Amelia was born. She was isolated and experiencing domestic abuse. However, after splitting from her partner and moving to a new area, Rachel contacted the Teen Parent Workers via Facebook to say she was ready and keen to access support services. Rachel met directly with a support worker once a week to build up a relationship – this included attending a Bookbug session at the local library, meeting for a coffee and a blether, and taking Amelia to the local park to get used to their new local community.

After six weeks of building this rapport with her support worker, Rachel felt she was ready to start attending groups with other Mums. Rachel was able to build and maintain positive friendships with other Mums in the group, helping build her confidence and self-esteem. Since, Rachel and Amelia have gone from strength to strength. With a bit of support, Rachel's determination to succeed has helped her build a peer-support network, secure a part-time job and become a self-sufficient provider for her family.

Informal volunteering - it is also important to give recognition to the contribution of informal as well as formal volunteering in helping to address the problems of social isolation and loneliness. For the first time the Scottish Household Survey 2018 included a new set of questions on informal volunteering. The most common informal volunteering activity amongst Scottish adults was 'keeping in touch with someone who might be lonely at 18%, followed by babysitting/looking after children 15%, and doing shopping, errands and paying bills at 12%.¹⁸⁹

This finding has important implications for community engagement. Neighbourhoods where people know each other, help one another and feel part of the community are more likely to engender a spirit of informal volunteering, with the attendant benefits which flow from this, such as a reduction in social isolation and loneliness. See further discussion in Section 8 – Community Engagement.

c) The methods by which volunteering can reduce social isolation and loneliness

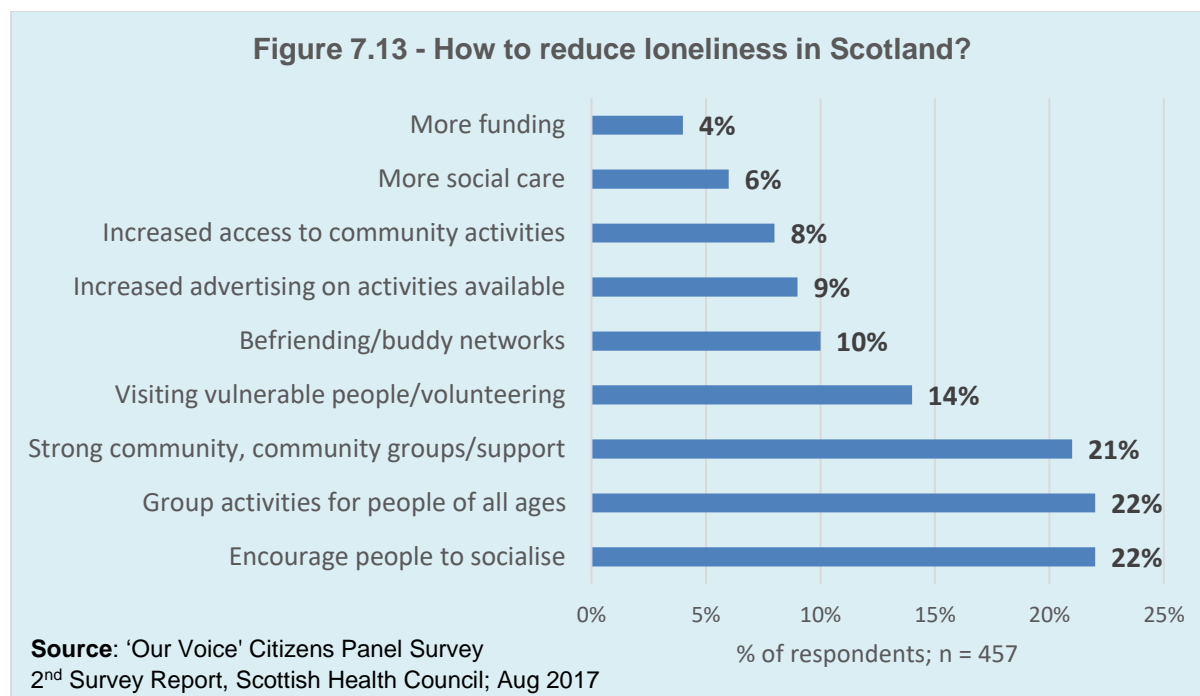
Age UK's report provides a critical appraisal of the main methods for volunteering engagement:

- Befriending – 1-2-1 support over the phone or face-to-face
- Supporting groups – where the primary objective is not necessarily social isolation and loneliness
- Community involvement – which is discussed in more detail in the next Section.¹⁹⁰

¹⁸⁹ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

¹⁹⁰ [Loneliness and Isolation: Evidence Review](#) – Age UK (undated)

All are believed to be important, although good practice to maximise impact is critical. The importance of these engagement methods is supported by the 'Our Voice' Citizens' Panel Survey, where group engagement was the most popular followed by visiting vulnerable people and befriending services: see Figure 7.13.¹⁹¹



The contribution of the health service and, in particular, the role of General Practitioners has received much greater attention through the focus on social prescribing in the last few years. The establishment of the Community Link Worker Programme in 2017 by the Scottish Government and the publication of the Royal College of General Practitioners (RCGP) 10-point Action Plan to tackle loneliness all point towards an increased role for the voluntary sector and volunteers to play a bigger part in helping to improve the health and wellbeing of Scotland's population.^{192,193}

This new approach is also supported by evidence from the Zubairi Report which identified shortcomings in healthcare professionals who do not always recognise or acknowledge loneliness and social isolation:

*"Healthcare continuum needs to better understand how to recognise loneliness and social isolation and provide the support that is needed". "District nurses and healthcare staff in general need to be given training on how to recognise loneliness and social isolation".*¹⁹⁴

¹⁹¹ Our Voice Citizens Panel Survey: 2nd Survey Report, Scottish Health Council; Aug 2017

¹⁹² [Scottish Government's Community Link Worker Programme](#) – Briefing May 2017

¹⁹³ [Tackling Loneliness - A Community Action Plan](#) – Royal College of General Practitioners; May 2018

¹⁹⁴ [The Zubairi Report: The lived experience of social isolation and loneliness in Scotland](#), Zubairi, K. (Nov 2018) Voluntary Health Scotland

Reference was also made to the time pressures which general practitioners are under and the impact this has on treating issues such as loneliness. Addressing these issues is central to the Royal College of General Practitioners' Action Plan:

*"All too often, GPs are the only human contact which chronically lonely patients have. Three out of four GPs across the UK say they see between one and five people a day who have come in mainly because they are lonely. These moments of meaningful connection matter."*¹⁹⁵

As part of its 10-point Action Plan the RCGP is calling for an end to 10 minute appointments so that GPs can spend a longer, more appropriate time with patients and get to know what really matters to them.

¹⁹⁵ [Tackling Loneliness - A Community Action Plan](#) – Royal College of General Practitioners; May 2018

8. Community engagement

8.1 Community engagement context

A Scottish Government Priority - Community empowerment is a top policy priority for the Scottish Government. The Community Empowerment (Scotland) Act, 2015 is focused on helping communities do more for themselves and have more say in the decisions that affect them.¹⁹⁶

“Research has shown that when communities feel empowered, there is:

- *greater participation in local democracy*
- *increased confidence and skills among local people*
- ***more people volunteering in their communities***
- *greater satisfaction with quality of life in the neighbourhood*

Better community engagement and participation leads to the delivery of better, more responsive services and better outcomes for communities.”¹⁹⁷

The National Performance Framework helps to operationalise these impacts through the Community National Outcome:

Community National Outcome:

We live in communities that are inclusive, empowered, resilient and safe.

Vision [extract]

We live in friendly, vibrant and cohesive communities which value diversity and support those in need. We are encouraged to volunteer, take responsibility for our community and engage with decisions about it. Our communities are resilient, safe and have low levels of crime.

Our older people are happy and fulfilled and Scotland is seen as the best place in the world to grow older. We are careful to ensure no-one is isolated, lonely or lives in poverty or poor housing. We respect the desire to live independently and provide the necessary support to do so where possible.

Community development – a fundamental issue in achieving this National Outcome characterised by community engagement and empowerment is ‘community development’. Section 8 is focused on an examination of the evidence relating to how effectively engaged communities are across Scotland; and the contribution of volunteering in helping to achieve this engagement. However, it neatly side-steps the key question as to how communities ‘develop’ or ‘evolve’ to enable this engagement to happen in the first place. Hence, no matter how significant the contribution of volunteering is, in principle, to community engagement and the health and wellbeing benefits which can flow from this, this has no bearing unless ‘communities’ are functioning effectively as communities.

¹⁹⁶ [Community Empowerment \(Scotland\) Act 2015](#) – Scottish Parliament

¹⁹⁷ Scottish government web page on community engagement:
<https://www.gov.scot/policies/community-empowerment/>

This is a major research area in its own right. Indeed, Volunteer Scotland is supporting a PhD research programme with the University of Strathclyde over the period 2019 – 2022 investigating this very topic.¹⁹⁸ What are the characteristics of 'associational life', can they be influenced, and what role, if any, does volunteering play in this? The broad hypothesis to be tested is that neighbourhoods and communities with strong associational life are more likely to be or become engaged and empowered communities? To conclude, this aspect of 'community development' is not addressed as part of Section 8. However, it will form a major research focus for Volunteer Scotland over the next three to four years.

8.2 Evidence on community engagement

Evidencing community engagement - success in meeting the Community National Outcome will help to deliver a more engaged society, where people trust and value their neighbours; feel safe in their community; work together collaboratively to tackle local issues; feel that they are an integral part of their local community; make friends and improve their social capital; and do not feel isolated or lonely.

As in previous Sections authoritative national data from the Scottish Household Survey, Scottish Health Survey and the National Records of Scotland has been drawn upon, supplemented by evidence from several 'one-off' studies. The 'community' focus in this study is on the people and relationship aspects of community engagement (relevant to volunteering), not crime statistics, housing quality, or green space/land access issues.

People's engagement with their neighbours

As evidenced in sub-section 7.2 there are a minority who have limited engagement with friends or neighbours in their neighbourhood and who don't feel a sense of belonging:

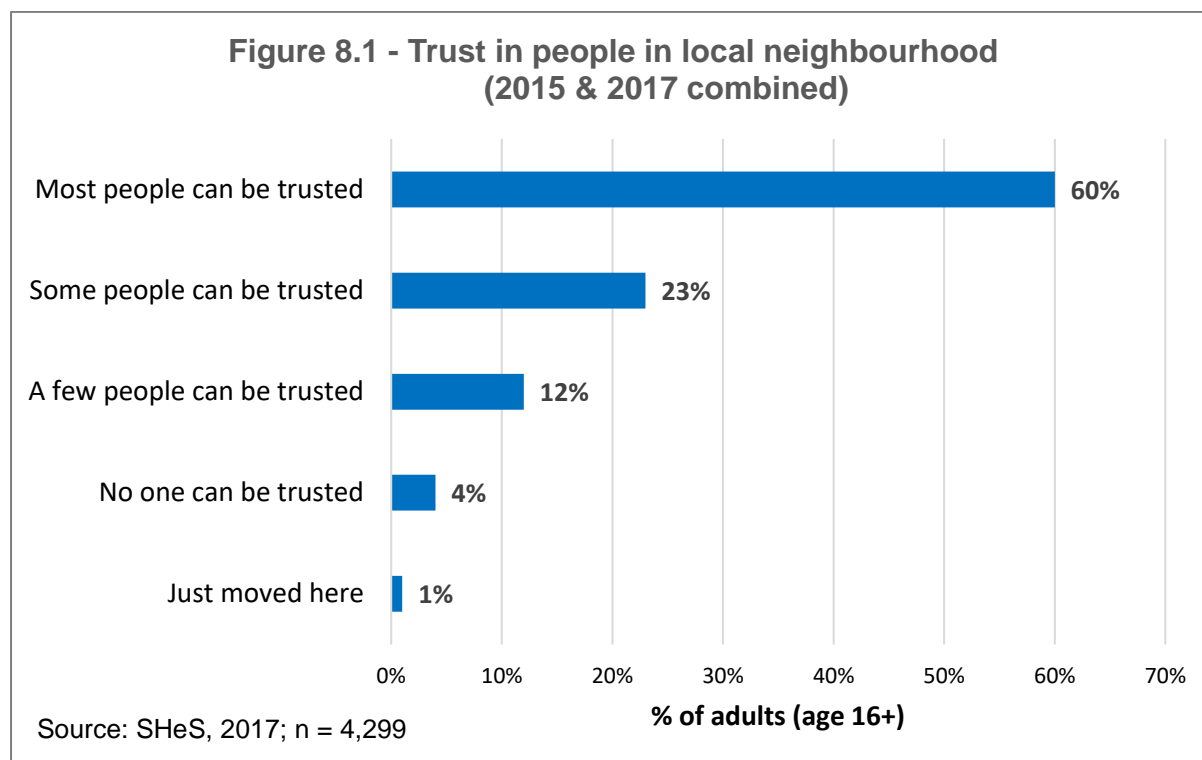
- 18% of people disagree or are uncertain about turning to their friends/neighbours for advice (see Table 7.1)
- 13% of people disagree or are uncertain about relying on friends/neighbours to look after their home (see Table 7.1)
- 21% of people do not feel a strong sense of belonging to their neighbourhood.¹⁹⁹

Trust in people in the local neighbourhood also varies markedly, from 60% who think that most people can be trusted to 16% who think only a few or no one can be trusted: see Figure 8.1.²⁰⁰

¹⁹⁸ [What we do together: Associational life, volunteering and the benefits for health and wellbeing](#) – PhD research 2019 - 2022 led by the University of Strathclyde and supported by Volunteer Scotland (in progress)

¹⁹⁹ [Scottish Household Survey 2017 - Annual Report](#) – Scottish Government; Sept

²⁰⁰ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report – Scottish Government; Sept 2018



The inverse of these findings suggest that the majority of people do feel that they belong to their neighbourhood and that most people can be trusted. However, there is other evidence which indicates that we are leading more insular lives divorced from our neighbourhoods and that this problem is getting worse. For example, 'The Big Lunch' commissioned research from the Centre for Economics and Business Research which highlights the disconnect in local communities across the UK:²⁰¹

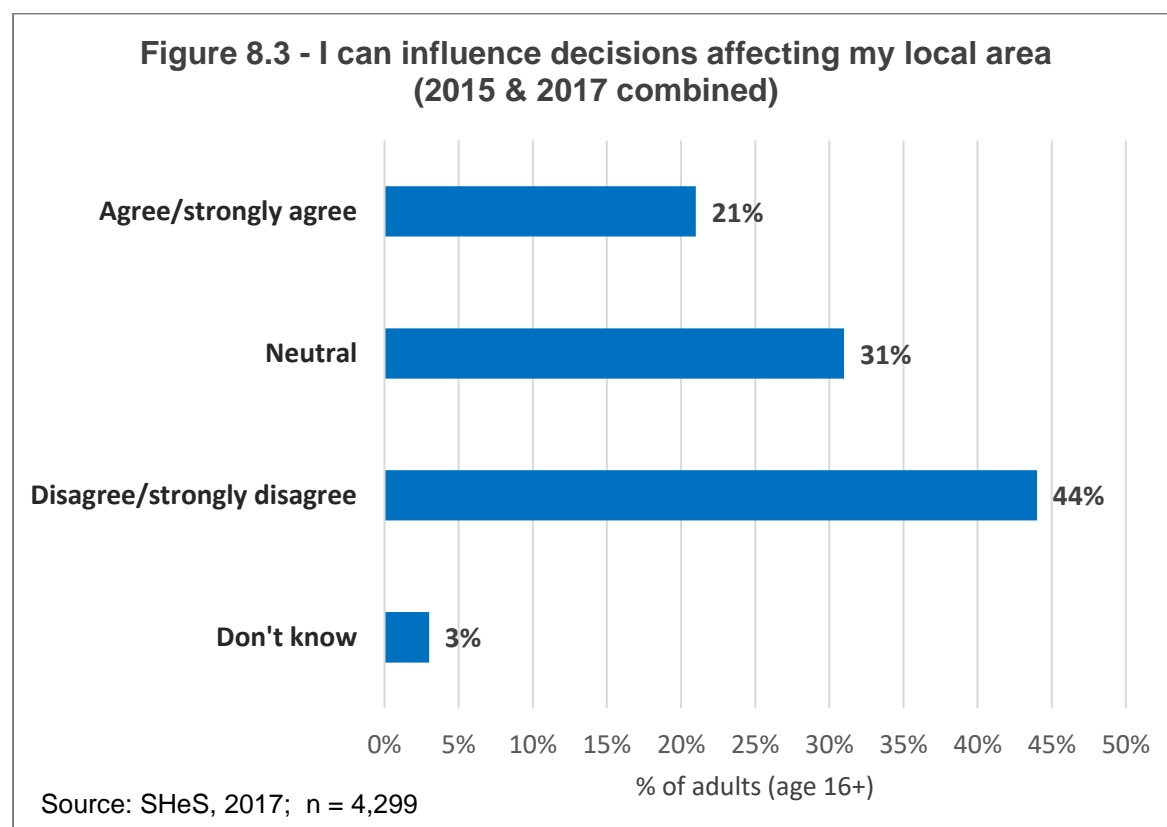
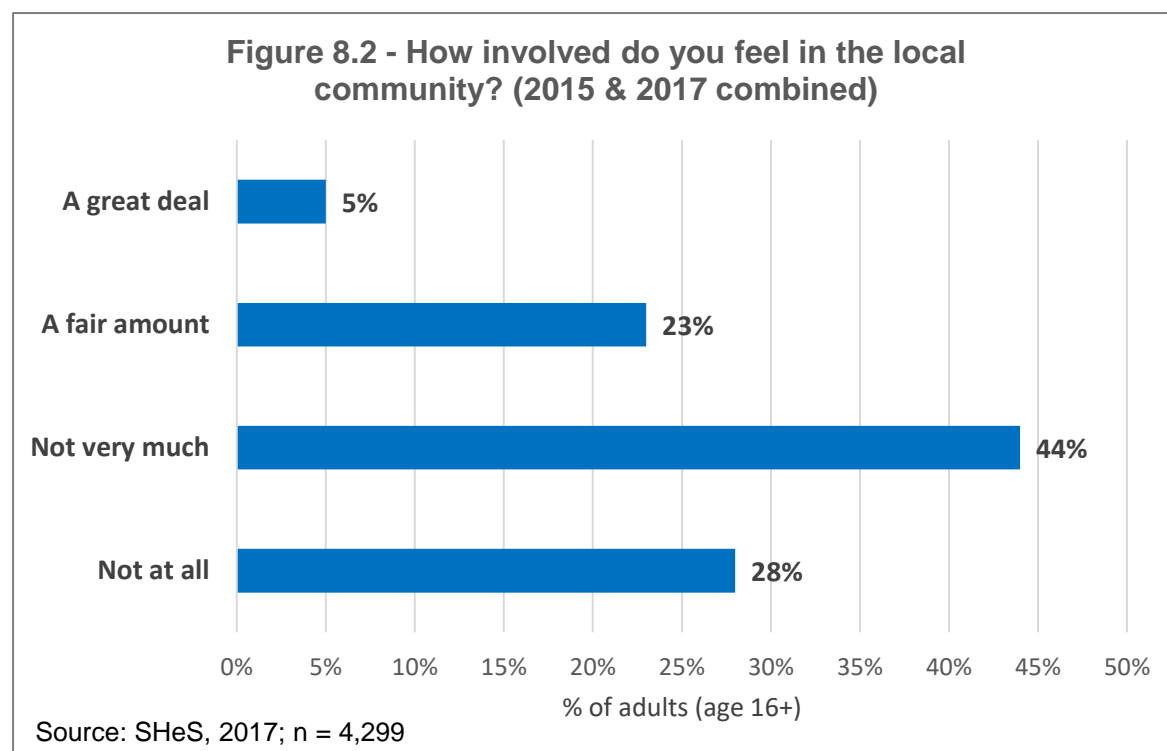
- More than half of the UK feel distant from their neighbours
- One in five people in the UK have never spoken to their neighbours
- 71% don't feel they know their neighbours well
- A fifth have no-one in their neighbourhoods outside their immediate family they could call on if they needed help or support
- 76% believe people were closer to their neighbours 20 years ago than they are today
- Three quarters believe it would be better for our communities if we were closer to our neighbours, but the same proportion feel there are barriers to doing so.

People's involvement in their local community

When one examines people's active engagement in their local community, the results are even more discouraging:

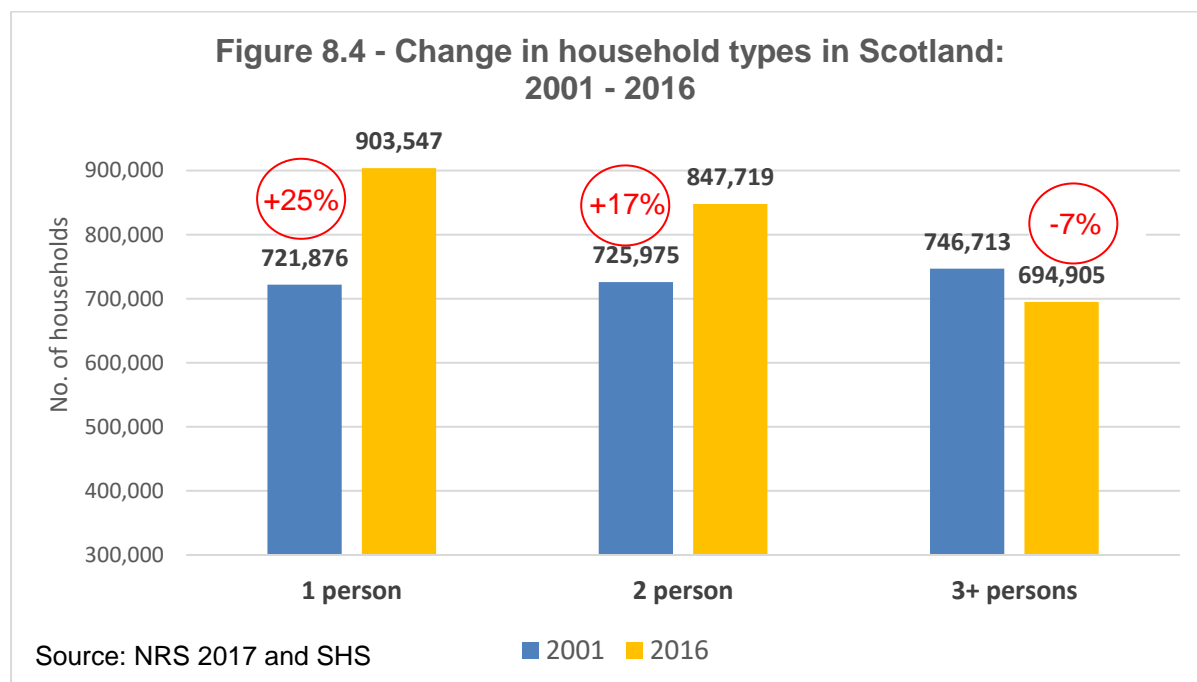
²⁰¹ [Closing the distance between us](#) – 'Happy City' and 'What Works Centre for Wellbeing', Jan 2019

- 72% of people are either 'not at all' or 'not very much' involved in their local community – see Figure 8.2
- 44% of people 'disagree/strongly disagree' that they can influence decisions in their local area – see Figure 8.3.



Possible factors contributing to lack of community engagement

More people are living alone - there has been a 25% increase in the number of people living in single households in Scotland over the last 15 years – see Figure 8.4. Single person households have become the most common type, increasing from 722,000 to 904,000 over the period 2001 – 2016. Furthermore, this trend is projected to continue with an estimated 1,142,000 single person households by 2041, a further 28% increase.²⁰²



The extent to which people living on their own adversely affects community engagement is open to debate. Clearly, there are thousands of people in Scotland who live alone but are still very engaged in their local communities. Indeed, the very fact that they live alone may stimulate them into more social engagement than would otherwise be the case.²⁰³

However, we know from research on social isolation and loneliness (see evidence relating to 'Widowed older homeowners' and 'Unmarried middle-agers' - Table 7.5), that people who live alone are at higher risk of social isolation and loneliness. The recently published Scottish Household Survey 2018 gives evidence for Scotland: see Figure 7.5. There is a marked difference in feelings of loneliness for single adult households compared to multiple adult households:

- 35% to 40% of single adults and single parent households are 'sometimes, often or always' lonely
- 12% to 19% of multiple adult households are 'sometimes, often or always' lonely.²⁰⁴

²⁰² [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

²⁰³ [Single person households and social policy: Looking forwards](#) (Full Report) – Bennett, J. and Dixon, M. (2006), Joseph Rowntree Foundation

²⁰⁴ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

Research by the Joseph Rowntree Foundation (JRF) also shows that loneliness and other adverse impacts are greater when living alone is driven by necessity rather than choice – for example due to:

- those who are living alone because of bereavement;
- those who are having to live alone because of relationship breakdown;
- those of working age who lose their job (plus all those who are without work);
- those who were living with relatives who no longer wish to accommodate them;
- those who leave some form of institutional care without clear prospects.²⁰⁵

Linked JRF research which examines the relationship between living alone, social capital and health highlights the problems of increased loneliness, and poorer mental and physical health.²⁰⁶ Regarding **community development** the report concludes:

“....the increase in people living alone raises significant challenges in community cohesion and participation, and there may be a case for greater investment in community development to counteract the harmful impacts of social isolation.”

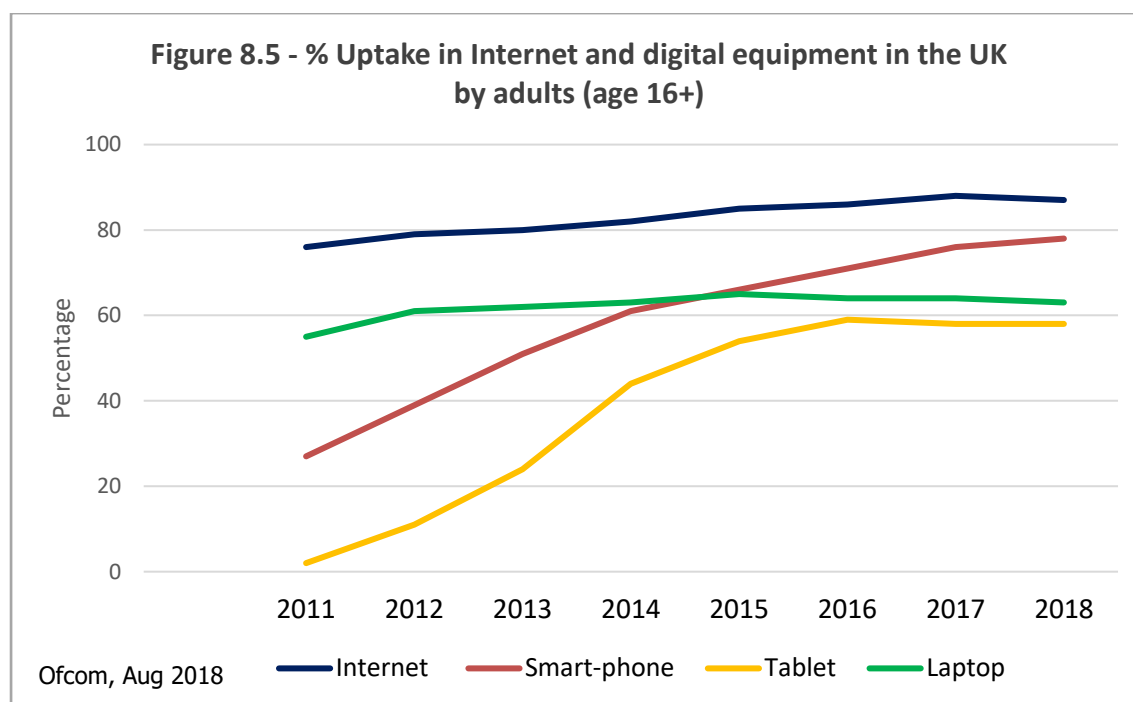
Digital vs. face-to-face communication – there has been a dramatic growth in digital and online engagement in the last decade. We are spending an increasing proportion of our time using digital technologies and our consumption of TV shows no appreciable decline. The Ofcom statistics for the UK demonstrates this increased uptake and increasingly intensive use of digital technologies:²⁰⁷

- *Percentage uptake in Internet and digital technologies* – this has been particularly noticeable for tablets and smartphones where uptake has increased by over 50% from 2011 to 2018 (see Figure 8.5):
 - Tablets – up from 2% to 58%
 - Smartphones – up from 27% to 78%
- *Time spent online* – in 2017 UK adults spent an average of 3 hours and 26 minutes a day online, equivalent to 24 hours in a week! This time has nearly doubled since 2007 when it was 12 hours and 6 minutes in a week.
- *Time spent watching broadcast TV* – although time spent watching TV has been declining due to ‘competition’ from time spent online and other digital entertainment (for example, 44% of UK adults own a games console), the average was still 3 hours and 23 minutes per day in 2017, down from 4 hours and 7 minutes in 2012. Interestingly, those aged 55+ accounted for more than half of all viewing in the UK. The evidence from this report suggests that this will be due not just to increased time availability due to retirement, but also due to increased social isolation and loneliness as people age, particularly the ‘older old’.

²⁰⁵ [Briefing on the growth in one-person households](#) (summary report) – Palmer, G. (2006), Joseph Rowntree Foundation

²⁰⁶ [Single person households and social policy: Looking forwards](#) (Full Report) – Bennett, J. and Dixon, M. (2006), Joseph Rowntree Foundation

²⁰⁷ [Communications Market Report](#) (Interactive Report) – Ofcom, Aug 2018



Although this dramatic growth in online usage and social media during the last decade has conferred many advantages, there is growing evidence that it is also having an adverse impact on society. In particular, the adverse impacts of social media on the health and wellbeing of young people is receiving much greater attention. There is evidence that this is contributing to increased loneliness and poorer mental health.

For example, the Mental Health Foundation's research shows that technology, including social media could be exacerbating social isolation:

- 30% say that technology, such as social media, is causing young people in Scotland to feel lonely as it has replaced face-to-face contact. In contrast,
- 82% of young people say that spending time face-to-face with others improves their mental health.²⁰⁸

Young people are spending less time with others and more time on their own, with potential adverse impacts on the time they can devote to community engagement activities. In principle, the same can be said for adults and older people, who are also more digitally engaged than ever before. The more time we spend online, using social media and watching TV the less time we have to engage with people in society face-to-face.

However, it is important to present a balanced assessment of the contribution of digital technologies. There are definitely upsides as well as downsides. In particular, the Internet and mobile communications technologies are very important for those who are isolated and subject to barriers to their engagement in society.

²⁰⁸ [Young Scots, loneliness and depression](#) - Mental Health Foundation; Jan 2018

Ofcom evidence supports this finding:

“Most adults acknowledged the value of being connected, with three-quarters agreeing that being online helps them maintain personal relationships. But they also acknowledge its drawbacks, such as interrupting face-to-face communications with others.”²⁰⁹

Evidence from those the Chronic Illness Research Project demonstrates how important digital and online communications are for those who are housebound and ‘energy impaired’.²¹⁰ It remains a critical route to engagement with society for those experiencing chronic illness, notwithstanding the major barriers they have to face. See further case study evidence in Section 5 under the Chronic Illness Research project.

Disadvantage is a major barrier – the extensive evidence base relating to people's health and wellbeing presented in this report shows that being disadvantaged increases the chances of exclusion from society and a poorer level of community engagement. This includes all the parameters discussed including mental ill-health, physical ill-health, disability, unemployment, social isolation and loneliness. Examples include:

- **Mental health** is strongly associated with social exclusion and as a result is a key indicator of health inequalities in Scotland.²¹¹
- **Long-Term Conditions (LTCs)** are conditions of 12 months or more and can relate to either mental and/or physical health and includes those disabled people. LTCs affected 45% of adults in Scotland in 2017.²¹² Clearly, having one or more LTCs can greatly impact one's ability and interest in engaging with society.
- **Lonely people** are more likely to withdraw from engaging with others and less likely to seek emotional support which makes them more isolated. This becomes a vicious circle.²¹³
- **Unemployed** people are much more likely to report loneliness ‘often/always’ than those in employment or self-employment.²¹⁴ This creates another barrier to their engagement in society.

²⁰⁹ [Communications Market Report](#) (Summary Report) – Ofcom, Aug 2018

²¹⁰ [Stories of Our Lives](#) – Case studies from the Chronic Illness Inclusion Project's emancipatory research on benefits and work; Hale, C. (editor) – The Centre for Welfare Reform; May 2019

²¹¹ [Mental Health: Inequality Briefing](#) – NHS Health Scotland, 2017

²¹² [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

²¹³ [The Lonely Society?](#) Griffin, J.(undated) Mental Health Foundation

²¹⁴ [Loneliness: What characteristics and circumstances are associated with feeling lonely?](#) Office for National Statistics, April 2018

8.3 Summary of key findings on community engagement

From the evidence reviewed in this Section one can draw the following conclusions:

- **We are becoming less neighbourly** – many people don't know their neighbours or speak to them and this breakdown in neighbourliness has been getting worse over the last 20 years.
- **We are poorly engaged with our local community:**
 - 72% of people are either 'not at all' or 'not very much' involved in their local community
 - 44% of people 'disagree/strongly disagree' that they can influence decisions in their local area²¹⁵
- **Contributory factors include:**
 - *More people are living alone* – single person households have become the most common household type, increasing from 722,000 to 904,000 over the period 2001 – 2016. Furthermore, this trend is projected to continue with an estimated 1,142,000 single person households by 2041, a further 28% increase.²¹⁶
 - *Digital vs. face-to-face communication* – there has been a dramatic growth in online engagement and uptake in digital technologies in the last decade with adverse consequences for the amount of time we devote to face-to-face communication. There is also emerging evidence on the adverse impacts of social media on mental health, particularly for young people in Scotland. However, we must also recognise the important contribution of digital technologies, especially the Internet, in facilitating communication for those who are isolated, susceptible to loneliness or who have disabilities which compromise their engagement in society.
 - *Impact of being disadvantaged* - the evidence presented in this report shows that being disadvantaged increases the chances of exclusion from society and a poorer level of community engagement. This includes the following parameters: mental ill-health, physical ill-health, disability, unemployment, social isolation and loneliness.

8.4 Relationship between volunteering and community engagement

Understanding the relationship between volunteering and community engagement is complex and poorly researched. One of the key conclusions from the University of Stirling's literature review confirms the limited evidence base:

²¹⁵ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

²¹⁶ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

*"The relatively limited evidence on community-level outcomes suggests that volunteering has potential to support the development of social networks, solidarity and mutual help within communities, and increasing both bonding and bridging social capital."*²¹⁷

The relatively limited evidence base has been analysed from both sides of the relationship:

- From the perspective of the possible contribution of volunteering to community engagement; and
- From the perspective of communities and the possible impact their level of engagement may have on volunteering.

Once again, this analysis highlights the important correlation versus causation issue, which the evidence base reviewed in this study cannot resolve.

At the outset it is important to highlight that most volunteering is 'local' (81%), and it is most commonly undertaken in community spaces such as community halls (39%) – physical spaces located in the community for the benefit of the community.²¹⁸

It is also important to distinguish between 'communities of place' and 'communities of interest'. A lot of Government policy is focused on the former which is central to the community engagement agenda. A key goal of Government is to foster more engaged and sustainable communities where people feel they are part of their local neighbourhood and are contributing to it. A lot of the evidence identified also tends to be focused on communities of place, which is the focus of sub-section 8.4. However, sub-section 8.5 also addresses the contribution of digital and online communications to communities of interest.

a) The contribution of volunteering to community engagement

In Volunteer Scotland's report on "Volunteering, Health and Wellbeing" the following characteristics of volunteering were identified as playing an important part in supporting community engagement and wellbeing:²¹⁹

- **Local delivery** – notwithstanding online volunteering, most volunteering is a local affair. It is embedded within a community for the benefit of that community. The local nature of volunteering is a key factor. For example, in some of the most deprived areas of Glasgow the route to successful engagement with disengaged youths was through youth clubs and sports clubs often operating not just in the local community but at the street level where young people 'hang out';²²⁰

²¹⁷ [Literature Review to Inform the Development of Scotland's Volunteering Outcomes Framework](#) – University of Stirling; April 2019

²¹⁸ 'Time Well Spent' – NCVO; January 2019 – analysis of the Scottish dataset by Volunteer Scotland; publication due early 2020

²¹⁹ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

²²⁰ [Young People and Volunteering: Attitudes and Experiences in Areas of Multiple Deprivation](#), Davies, J. (2018)

- **Social capital** – volunteering builds social relationships between volunteers, beneficiaries, staff and other voluntary bodies located in the community. This leads to enhanced social networking, improved understanding of each other and more cohesive communities. This finding is reinforced by the conclusion of the University of Stirling literature review:
*“When successful, volunteering can build social capital and connections both within and between communities.”*²²¹
- **Reciprocity** – in social psychology ‘reciprocity’ is the social norm of responding to a positive action with another positive action. Hence, if a volunteer helps someone in the community the beneficiary is more likely to respond with another positive action. This leads to a virtuous circle of community members helping each other – this mutuality and sharing are important;
- **‘Spillover’ effects** – *“.....giving and volunteering are associated with strong spillover effects. Unlike the negative externalities associated with income (when our neighbours get a fancy new car we feel less happy with our old car) volunteering and reciprocity are associated with positive externalities, or spillovers. In other words, if you live in a community with high levels of volunteering, even if you do not volunteer, your subjective wellbeing will still tend to be increased by all that goodwill and social capital building around you.”*²²²
- **Co-production** – *“....Boyle et al (2010) argue that the involvement of the public and local people in shaping and delivering public services not only creates a person-centred service which is more responsive to the needs of local people, but also fosters a sense of responsibility and community activism where people take control of their own lives and local services, create and develop social networks and galvanise resources for the local community. For Boyle et al this, in turn, strengthens community resilience, promotes wellbeing and undermines the culture of dependency on statutory services.”*²²³

b) The contribution of community engagement to volunteering

A range of neighbourhood and community engagement indicators have been cross-tabulated with volunteering participation in both the Scottish Household Survey 2016 and the NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18.²²⁴ The results are summarised in Table 8.1.

²²¹ [Literature Review to Inform the Development of Scotland's Volunteering Outcomes Framework](#) – University of Stirling; April 2019

²²² Wellbeing and Policy - O'Donnell, G., Deaton, A., Durand, M., Halpern and D, Layard, R. (2014), Legatum Institute

²²³ Volunteering and health: evidence of impact and implications for policy and practice – Paylor, J. (2011); Institute for Volunteering Research

²²⁴ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019 and NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18 – analysis by Volunteer Scotland, publication in early 2020

Table 8.1 – Relationship between Community Engagement and Volunteering		
Response to statements	Volunteering Participation Rate %	
	Agree strongly / very strongly	Disagree strongly/ very strongly
Scotland – SHS 2016¹		
I can influence decisions affecting my local area.	35%	25%
I can rely on friends/relatives in neighbourhood for help.	28%	20%
Greater Glasgow and Clyde – NHSGGC 2017/18²		
I feel I belong to this area	18%	15%
I feel valued as a member of my community	19%	14%
By working together people in my neighbourhood can influence decisions that affect my neighbourhood	20%	15%
If I have a problem, there is always someone to help me	17%	20%
This is a neighbourhood where neighbours look out for each other	17%	19%
Sources: 1. Scottish Household Survey 2016 - Volunteering cross-sectional analysis – Volunteer Scotland, Oct 2019 2. NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18 – analysis by Volunteer Scotland, publication in early 2020		

A not unrealistic hypothesis is that if people feel they belong to their area, can influence local decisions, feel valued as a member of their local community, and are able to rely on friends and relatives for help then volunteering participation in such communities will be higher than would be the case if they did not feel these positive 'engagement' factors.

The evidence from Table 8.1 highlights significantly higher volunteering participation rates for people who respond positively rather than negatively to the list of neighbourhood and community engagement statements:

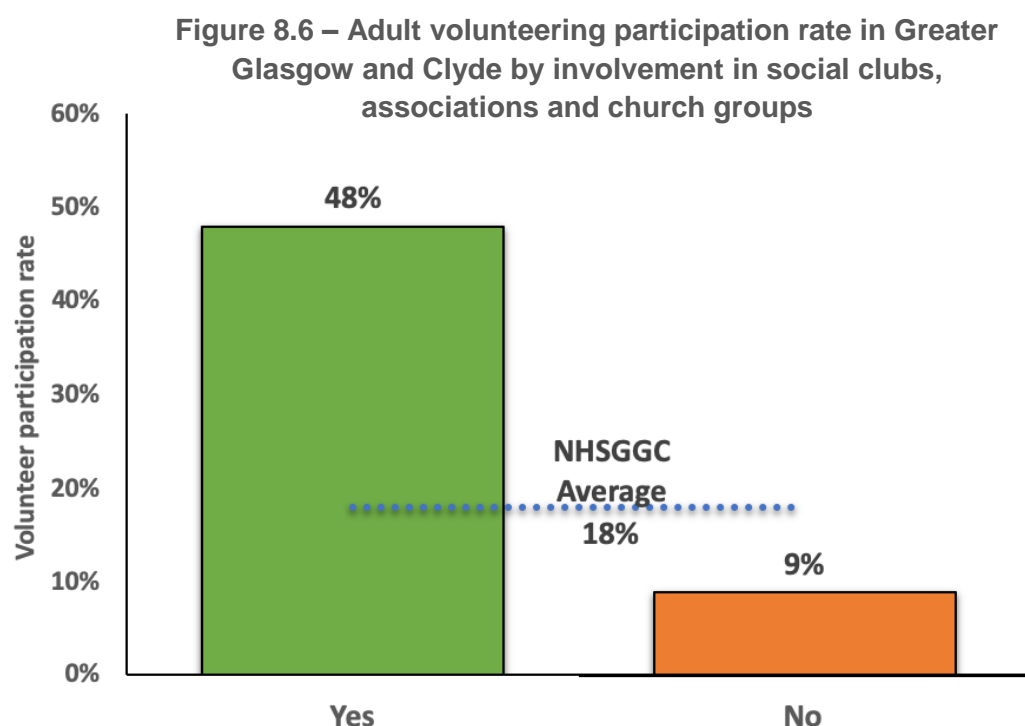
- Evidence for volunteering in Scotland:** the volunteering participation rate for those who can influence decisions affecting their local area is 35%, which is 10% higher than for those who feel strongly that they cannot influence decisions (25%). Similarly, for those who can rely on friends or relatives for help the volunteering participation rate is 28%, 8% higher than for those who feel strongly that they cannot rely friends or relatives (20%). In addition, for those who feel strongly that they belong to their immediate neighbourhood the volunteering participation rate is 28% vs. 24% who do not feel strongly (not included in Table 8.1).
- Evidence for volunteering in Greater Glasgow and Clyde:** a similar correlation between engagement and volunteering is evidenced for Greater Glasgow and Clyde, for 'feeling of belonging to the area', 'feeling valued as a member of my community' and 'people in my neighbourhood can influence decisions that affect my neighbourhood'.

However, for the two statements relating to 'support' the results are reversed. The volunteering rate for those who feel strongly that 'if I have a problem there is always someone to help me' is only 17%, compared to 20% for those who disagree strongly. Similarly, for 'neighbours who look out for each other'.

There is no obvious explanation why there are higher volunteering participation rates in Greater Glasgow and Clyde where there is a lack of people to turn to for help, and where neighbours do not look out for each other? Could it be that the lack of local support and neighbourliness fosters a more independent minded spirit which leads to engagement in society through volunteering rather than through your immediate neighbours?

Notwithstanding these two inverse relationships between volunteering and neighbourhood engagement in Greater Glasgow and Clyde, the majority of the evidence does support a positive linear relationship: the stronger the neighbourhood and community engagement the higher the volunteering participation rate.

Involvement in clubs and associations – perhaps the most convincing statistic supporting this positive relationship relates to whether a person has an associational life through involvement in 'social clubs, associations, church groups or anything similar': see Figure 8.6. For those involved in clubs and groups the volunteering participation rate in Greater Glasgow and Clyde is 48% compared to only 9% for those not involved.²²⁵



Source: NHS GGC 2017/18, n = 7,834

²²⁵ NHS Greater Glasgow and Clyde Health and Wellbeing Survey 2017/18 – analysis by Volunteer Scotland, publication in early 2020

Research by Davies, J. (2018) identified the 'participant-to-volunteer pathway' for young people engaging in local sports clubs and youth groups.²²⁶ It is a plausible hypothesis that a similar relationship exists for adults as well. Anecdotally we know that being involved in clubs and group activities often leads to volunteering roles because such groups are often 100% volunteer led and run and their survival depends on the active engagement of 'members' as volunteers. This evidence would support a community to volunteering causal relationship.

Rural vs. urban engagement - the Highlands and Islands of Scotland have had some of the highest adult volunteering participation rates over the period 2007 – 2017.²²⁷ For example, the average participation rates over this 11 year period were:

- Eilean Siar (Western Isles) – 47%
- Shetland Islands – 46%
- Highland Region – 43%
- Orkney Islands – 36%

This compares to an average Scottish adult volunteering participation rate of 28%. There is a lack of research evidence on why there are such large differentials. However, anecdotally there are perceptions that this higher volunteering engagement in rural locations is down to cohesive and intimate communities, fostered by their smaller size where people tend to know each other, and where reciprocity and mutuality are the basis for 'survival'.

The equivalent hypothesis for urban areas is the converse, whereby community engagement characteristics are weaker and volunteering rates are often lower than the national average. The Scottish Household Survey evidence shows that the proportion of people feeling lonely is lowest for those in 'accessible rural' areas (16%) followed by 'remote rural' areas (19%). In urban areas the proportions are always above 20%.²²⁸

Overall assessment of the relationship between volunteering and community engagement – the evidence in this sub-section can be argued both ways – volunteering is good for communities and communities are good for volunteering. In practice, it is quite likely that both factors explain the positive community-volunteer correlations illustrated in Table 8.1 and Figure 8.6. However, on the basis of the evidence considered we just do not know the relative significance of each factor.

²²⁶ [What we do together: Associational life, volunteering and the benefits for health and wellbeing](#) – PhD research 2019 - 2022 led by the University of Strathclyde and supported by Volunteer Scotland

²²⁷ [Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, Jan 2019

²²⁸ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

However, what this evidence does tell us is that communities are fundamentally important either as a beneficiary from volunteering and/or as a stimulus to volunteering. Given the importance of understanding the contribution of communities Volunteer Scotland is supporting a PhD research programme with the University of Strathclyde over the period 2019 – 2022.²²⁹ As explained in sub-section 8.1 this research will be exploring the characteristics of 'associational life' and what role, if any, volunteering plays in this?

8.5 Volunteering and factors impacting on community engagement

Sub-section 8.2 identified two factors which may be impacting on community engagement over and above factors relating to disadvantage and deprivation:

- The significant increase in the number of single person households
- The impact of the Internet on how society communicates

Section 8 concludes by examining the relationship between volunteering and factors impacting on community engagement.

a) Household size

As discussed earlier there has been a 25% increase in the number of people living in single households in Scotland over the period 2001 – 2016. Single person households have become the most common type, increasing from 722,000 to 904,000 over the period 2001 – 2016. Furthermore, this trend is projected to continue with an estimated 1,142,000 single person households by 2041, a further 28% increase.²³⁰

Some research suggests that the growth in solo living may have beneficial effects, as well as negative effects, on social capital. Contrary to weakening the social fabric of neighbourhoods, evidence from the Joseph Rowntree Foundation suggests that the reverse may be true.²³¹ People living alone spend more time volunteering than other groups – they are amongst the most likely to be active in at least one voluntary organisation (ONS 2001).²³²

However, the more up-to-date evidence reviewed in Sections 7 and 8 contradicts this finding. There is a strong correlation between single person households and being lonely. Between 35% to 40% of single adults and single parent households are 'sometimes, often or always' lonely, compared to 12% to 19% of multiple adult households.²³³

²²⁹ [What we do together: Associational life, volunteering and the benefits for health and wellbeing](#) – PhD research 2019 - 2022 led by the University of Strathclyde and supported by Volunteer Scotland

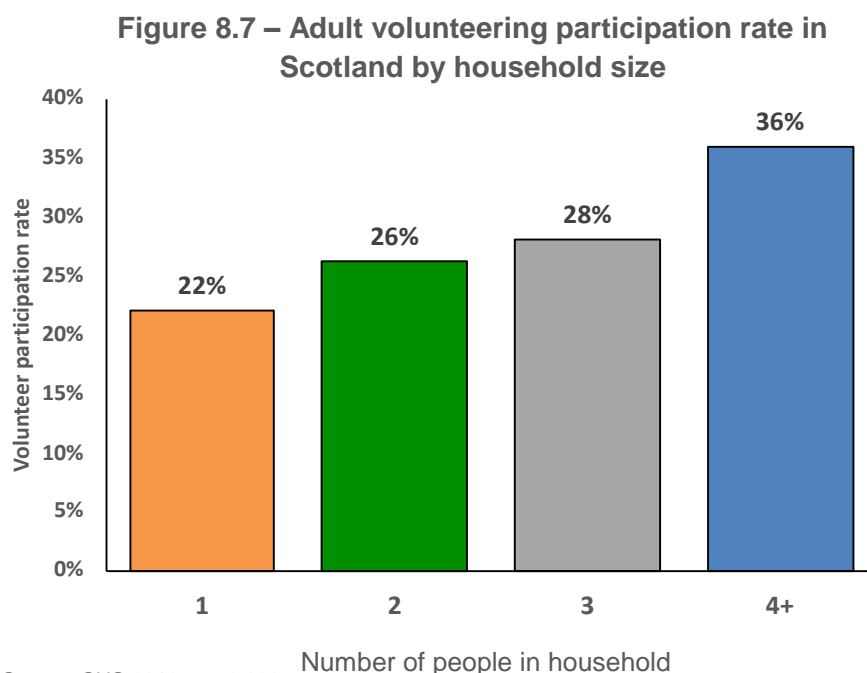
²³⁰ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#) National Records of Scotland, Aug 2018

²³¹ [Single person households and social policy: Looking forwards](#) (Full Report) – Bennett, J. and Dixon, M. (2006), Joseph Rowntree Foundation

²³² [Office of National Statistics \(ONS\) \(2001\)](#) - Time use survey; London: TSO.

²³³ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

Furthermore, this evidence may also help to explain why volunteering participation in single person households is lower than in households with two or more people: see Figure 8.7. For single adult households the volunteering participation rate is 22% increasing to 36% for households with four or more occupants.²³⁴



b) Digital and online communication

As discussed earlier in this Section the dramatic growth in digital and online engagement in the last decade is impacting on the way we communicate with each other. There is emerging evidence on the potential harmful effects of the Internet and online communication on mental health and wellbeing and on loneliness, especially for younger people.

However, there is an important upside to this technology and volunteering is benefiting. The Internet is vitally important in the delivery of volunteering services across Scotland. Twenty-four percent of adults aged 18+ deliver their volunteering either 'exclusively', 'very often' or 'often' online. A further 22% are 'sometimes' online in the delivery of their volunteering.²³⁵

Also, digital and online communication plays a pivotal role in facilitating volunteer participation, especially for communities of interest where the 'community' is geographically dispersed. This enables volunteering to confer health and wellbeing benefits that would not otherwise be achievable.

²³⁴ [SHS 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

²³⁵ 'Time Well Spent' – NCVO, Jan 2019 – analysis of the Scottish TWS data by Volunteer Scotland – publication pending

This is especially important for disabled people as it enables them to overcome the barriers to their engagement in volunteering. For example, in the NCVO Time Well Spent research the proportion of the adult population in Great Britain volunteering exclusively online was 4% for the non-disabled but was 10% for the disabled.²³⁶ The equivalent figures for Scotland were 3% for non-disabled and 9% for the disabled.²³⁷

²³⁶ [Time Well Spent, Full Report](#) – NCVO, Jan 2019

²³⁷ 'Time Well Spent' – NCVO, Jan 2019 – analysis of the Scottish TWS data by Volunteer Scotland – publication pending

9. Challenges, opportunities and priorities

9.1 Overview

The focus of this report has been a detailed assessment of authoritative data relating to factors which impact on the health and wellbeing of Scotland's population. This has included demographic and labour market data (Sections 3 and 4), physical and mental health (Sections 5 and 6), social isolation and loneliness (Section 7) and community engagement (Section 8).

What the evidence tells us is that for all the main fields examined there are serious health and wellbeing challenges facing Scotland. Furthermore, these are long-term problems with no 'quick fixes'. The data also shows that many of these problems have been deteriorating over time and that this is projected to continue. This was the rationale for setting the 20-year time horizon of 2020 – 2040 for this report.

However, the good news is that volunteering can play a key role in helping to address and mitigate these challenges. Therefore, the objective of this final Section is to present an overarching assessment of the evidence to help inform:

- **Government** – this includes Scottish Government policy and strategy relevant to the broad contribution of volunteering across the [National Performance Framework](#); and local government policies and practice within individual local authorities. Guidance for national and local government and stakeholders is contained in: [The contribution of volunteering to a healthier and happier Scotland: How organisations can help to influence policy and practice in Scotland](#).
- **Stakeholders** – this includes national bodies (such as SCVO, Volunteer Scotland, Voluntary Health Scotland, etc.), NHS Boards and Health and Social Care Partnerships, Scottish Volunteering Forum members, Cross Party Group on Volunteering members, the Third Sector Interfaces (TSIs) and others with a vested interest in collaborating to maximise the contribution of volunteering for the benefit of Scotland. In particular, it is hoped that the guidance on proposed volunteering priorities will help inform the implementation of [Volunteering for All: National Framework](#)'; and
- **Volunteer Involving Organisations (VIOs)** – this includes organisations across the voluntary, public and private sectors that currently may or may not engage volunteers. It is important for VIOs to understand the contribution of volunteering to the health and wellbeing of volunteers and local communities. The findings of this report highlight why individual organisations should examine their own volunteering practice and its contribution to Scotland's health and wellbeing. This includes not just charities and voluntary organisations, but also Employer Supported Volunteering (ESV) in the public and private sectors as well. Practical guidance on how VIOs can achieve this is contained in [Optimising health and wellbeing benefits from volunteering: Good practice for engaging and supporting volunteers](#).

The remainder of Section 9 is structured as follows:

- **Challenges** – a short summary of the key challenges relating to Scotland's health and wellbeing;
- **Opportunities** – how volunteering can help to address or mitigate these challenges;
- **Priorities** – through demographic, sectoral and geographic analysis the report highlights specific groups in society where volunteering has a particularly important role to play.

9.2 Challenges

Demographic and labour market challenges – Scotland's population is ageing, and this is projected to continue. We are living longer but not healthier lives. It is projected that there will be an additional 428,000 people aged 65+ by 2041, comprising 25% of the population (up from 19% in 2017). In contrast, the working age population aged 16 – 64 is projected to decline by 144,000.²³⁸ These demographic trends will have major implications for:

- **Our economy** – a vibrant economy depends on a growing and skilled workforce. Scotland is projected to have fewer people of working age, which may act as a constraint on our future growth. Furthermore, the increased proportion of retired people will act as a fiscal constraint on Government, due to lower tax revenues and increased costs;
- **Our health sector** – an ageing population which is living longer, combined with advances in medicine and science, will exacerbate the unrelenting upward trend of increasing demands on our very hard-pressed NHS; and
- **Our society** – the change in age structure will have implications both for our older people and the challenges they face relating to their health and wellbeing, and for inter-generational engagement across our society.

Health and wellbeing factors – despite people living longer, we are not living healthier lives and there are worrying trends in mental health and the linked issue of social isolation and loneliness. Scotland is facing major health and wellbeing challenges, many of which are growing in significance over time. These health and wellbeing issues are also particularly important for the most deprived communities in Scotland. See a summary of the key evidence in Table 9.1.²³⁹

²³⁸ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

²³⁹ The data sources cited in Table 9.1 are not repeated in Section 9. The reader is referred to the respective Sections of the Report.

Table 9.1 – Summary of health and wellbeing challenges facing Scotland

Health and wellbeing domains	A major problem	A growing problem	Adversely affecting the disadvantaged
Physical health (Section 5)	<ul style="list-style-type: none"> Scotland has one of the lowest life expectancies in Western Europe. 'Healthy life expectancy' (HLE) for men is 59.3 years vs. their 'Life Expectancy' (LE) of 77.1 years. Women's HLE is 62.7 years vs. their LE of 81.1 years. The proportion of adults with Limiting Long-Term Conditions (LTCs) increases substantially to 40% for those aged 55 – 64; then to 45% for those 65-74; and 56% for those 75+. 	<ul style="list-style-type: none"> During 2008 – 2017 the proportion of adults with a Limiting Long-Term Condition (LTC) increased from 41% to 45% A 25% increase in diabetes in Scotland's population over the period 2008 – 2015 Over the period 2009 – 2016 the expected percentage of life rated as 'healthy health' deteriorated for men from 79% to 77% (but remained static for women) 	<ul style="list-style-type: none"> Life expectancy varies by up to 28 years for men and 25 years for women, between the most and least affluent areas of Scotland. In SIMD Q1 22% of the population have doctor-diagnosed cardiovascular disease or diabetes. This declines to 12% for Q5.
Mental health (Section 6)	<ul style="list-style-type: none"> 17% of adults had a GHQ-12 score of 4 or more, which is indicative of a possible psychiatric disorder 22% of young people aged 16 – 24 had a GHQ-12 score of 4+ (the highest proportion of the population) 11% of adults report two or more symptoms of depression & anxiety 784 residents in Scotland committed suicide in 2018 	<ul style="list-style-type: none"> Over the period 2008/09 – 2016/17 the mental health of adults deteriorated: <ul style="list-style-type: none"> Depression – up from 8% to 11% Anxiety – up from 9% to 11% Self-harm – up from 3% to 6% Attempted suicide – up from 4% to 6% 15% increase in registered suicides in Scotland between 2017 - 2018 	<ul style="list-style-type: none"> Variations in the mental health of adults between SIMD Q1 and Q5: <ul style="list-style-type: none"> GHQ-12 (score of 4+) – 24% vs. 14% of the adult population Depression – 20% vs. 5% Anxiety – 17% vs. 7% Self-harm – 10% vs. 7% Attempted suicide – 12% vs. 4% Suicide rate – three times higher in SIMD decile 1 vs decile 10.
Social isolation and loneliness (Section 7)	<ul style="list-style-type: none"> Social isolation – 27% of adults meet family, friends or colleagues less than once a week Loneliness – 21% of adults are lonely 'some of the time' to 'all of the time'. 64% of pupils in S4 experienced some feeling of loneliness in the last week No one is immune – social isolation and loneliness can affect everyone in society at any stage in their lives. 	<ul style="list-style-type: none"> Lack of time series evidence from Scotland. However, research highlights factors which may exacerbate our loneliness: <ul style="list-style-type: none"> 30% of 18 – 24 year olds say that technology incl. social media is making them feel lonely. The number of people living in single person households has increased from 722,000 to 904,000 over the last 15 years. 	<ul style="list-style-type: none"> Loneliness triggered by, but also exacerbated by, factors such as mental ill-health, disability, bereavement, divorce/separation, addictions, eating conditions and poor diet. 28% of those living in SIMD Q1 experienced some degree of loneliness in the last week, compared to 16% living in Q5.

Community engagement - 'Community engagement' is a complex term to define let alone evidence. However, this research suggests that:

- We are becoming less neighbourly – many people don't know their neighbours or speak to them and this breakdown in neighbourliness has been getting worse over the last 20 years.
- We are poorly engaged with our local community:
 - 72% of people are either 'not at all' or 'not very much' involved in their local community.
 - 44% of people 'disagree/strongly disagree' that they can influence decisions in their local area.²⁴⁰

Contributory factors include:

More people are living alone – single person households have become the most common household type, increasing from 722,000 to 904,000 over the period 2001 – 2016. Furthermore, this trend is projected to continue with an estimated 1,142,000 single person households by 2041, a further 28% increase.²⁴¹

- *Digital vs. face-to-face communication* – there has been a dramatic growth in online engagement and uptake in digital technologies in the last decade with a concomitant reduction in the amount of time we devote to face-to-face communication. There is also emerging evidence on the adverse impacts of social media on mental health, particularly for young people in Scotland. However, we must balance this evidence with the upsides of technology, whereby those who face challenges can often find solace and shared communities of interest through social media and the Internet. Allowing people to engage virtually can be very important for disabled people, those moving to new areas and those facing a personal crisis, etc.
- *Impact of being disadvantaged* - the evidence presented in this report shows that being disadvantaged increases the chances of exclusion from society and a poorer level of community engagement. This includes the following parameters: mental ill-health, physical ill-health, disability, unemployment, social isolation and loneliness.

9.3 Opportunities

The omnipresent and inherent flexibility of volunteering is such that many of the challenges outlined in this report can be addressed by volunteering if we adopt an innovative and proactive approach. Volunteering cannot solve the health and wellbeing problems facing society, but it can certainly make an important contribution in reducing and/or mitigating many of them. It can best achieve this by integrating volunteering into wider social policy responses to societal change. The objective of this sub-section is therefore to identify the main avenues through which volunteering can help to achieve these positive outcomes.

²⁴⁰ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

²⁴¹ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

Demographic and labour market opportunities

Our ageing population is likely to result in a major shift in the age profile of our volunteers: see Table 9.2. On the assumption that volunteering participation rates by age band in 2016 remain constant, then by 2041 it is projected that there will be 102,000 more volunteers aged 65+, but with a reduction of 41,000 volunteers aged 16 – 64: see Table 9.2.^{242, 243}

This would result in a net additional 61,000 volunteers and 8.3 million volunteering hours p.a. This reflects not just the net growth in Scotland's projected population, but also the fact that those aged 65 – 74 volunteer 47% more hours than younger age groups: an average of 13.4 hours per 4 weeks compared to 9.1 hours per 4 weeks for those aged 16 – 64.²⁴⁴

Table 9.2 – Projected change in volunteers and volunteering hours by 2041			
	Age 16 – 64	Age 65+	Change
Change in no. of volunteers by 2041	- 41,000	+102,000	+61,000
No. of volunteering hours p.a. in 2041	- 4.8 million hours	+ 13.1 million hours	+8.3 million hours
Sources: NRS Population Projections 2017 and SHS volunteering participation rates (2016)			

This demographic restructuring may have implications not just for the age of our volunteers but also for the nature of the volunteering roles they are able to fulfil. For example, it is possible that older volunteers may not be as fit and able to undertake the more physically demanding roles currently undertaken by our younger volunteers.

The opportunities which arise from this growing but older volunteering resource include:

- **Support for our ageing population** – the care and support needs of our older people are increasing, and the increased supply of volunteers aged 65+ have a key role to play in supporting them. The age group 65 – 74 are typically fitter and more able to provide support for those aged 75+, where multi-morbidities and other needs tend to be more prevalent. The volunteer roles are many including healthcare roles, befriending, walking groups, sport and physical activity, music and dance, etc.

²⁴² The assumption of static volunteering participation rates by age band is not unrealistic when one examines the relatively stable rates between 2007 – 2017:

[Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, 2018

²⁴³ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)

National Records of Scotland, Aug 2018 & SHS 2016, Ibid

²⁴⁴ Analysis of SHS 2016 data by Volunteer Scotland – not published.

- **Inter-generational opportunities** – as discussed in the next sub-section on 'Priorities', some of Scotland's health and wellbeing challenges are often most acute for younger and older people. There are opportunities to use the skills and experience of older volunteers to engage, support and 'coach' our younger people. Vice-versa our younger people have a lot to offer our older people in terms of their knowledge of technology, education, youthful and fun perspective, and the trust and confidence which they can engender in older people. This is a powerful social engagement model which confers bi-directional benefits.
- **Improving the supply of skilled adults** – the working age population aged 16 – 64 is projected to decline by 144,000 by 2041 and it is imperative that all measures are taken to support our increasingly hard-pressed labour force.²⁴⁵ The unemployment rate reached a record low of 3.3% in February 2019, with 93,000 people unemployed (from the economically active).²⁴⁶ As cited in the recent EY ITEM Club Report: *"It would also seem that the additional demand in the economy has been met not by investment or job creation, but by employees working longer hours. Again, this is not the most desirable formula for growth."*²⁴⁷

Volunteering can help improve labour market efficiency by supporting the integration of the following groups into work:

- **Supporting young people** – volunteering already plays a key role in developing the soft and hard skills of our young people which aids their transition into work. This focus should be maintained.
- **Long-term unemployed** – similarly, volunteering can be a vital stepping stone on the road back into employment for the long-term unemployed.
- **Refugees** – volunteering supports refugees not only in their transition into employment in Scotland, but also in their wider integration into society.
- **Economically inactive**²⁴⁸ – there has been a major contraction in the number of economically inactive women in Scotland as they move back into work, with the proportion declining from 33.2% in 1997 to 26.0% in 2019.²⁴⁹ Volunteering can play a key role for those women who would like to return to work, through confidence building and skills development.

Improving physical and mental health

Volunteering already provides a major contribution to Scotland's health and wellbeing but, given the seriousness of the health challenges facing our society, it is essential that we optimise its contribution. There are three 'delivery channels' we need to focus on:

²⁴⁵ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#)
National Records of Scotland, Aug 2018

²⁴⁶ [Scotland's Labour Market Statistics](#) – Scottish Government, Dec 2018 – Feb 2019

²⁴⁷ [EY Scottish ITEM Club 2019 Forecast: Challenges Ahead](#) – EY, Dec 2018

²⁴⁸ Definition of the 'Economically Inactive': Individuals aged 16-64 who are neither employed nor unemployed under ILO definitions. There are many reasons why people may be inactive and not considered an active part of the labour supply: they may have a long-term illness or disability, be studying for a qualification, staying at home to look after their family, or have retired.

²⁴⁹ [Scotland's Labour Market Tables and Charts](#) – Scottish Government, April 2019 (see Chart 9 – Inactivity rate by gender (age 16 – 64))

- **Capitalising on the health and wellbeing benefits for volunteers:** the evidence from Volunteer Scotland's report highlights the potential health and wellbeing benefits from volunteering:²⁵⁰
 - *Physical health* – encouraging the adoption of healthy lifestyles and practices; increasing the level of physical activity through volunteering; helping older people to maintain their functional independence; and enhancing people's ability to cope with personal illness;
 - *Mental health* – volunteering can improve the mental health of volunteers through increasing their social connectedness; providing them with a sense of purpose linked to task satisfaction and sense of fulfilment; enhancing their skills, building confidence and improving resilience and self-efficacy; increasing self-esteem and self-respect; and just by having fun and being happy – referred to as the 'Helper's High'.
- **Maximising the health and wellbeing benefits from physical activity and sport:** there are c. 280,000+ volunteers who help to deliver sport and physical activities across Scotland's 13,000 sports clubs and c. 900,000 members.^{251, 252} They undertake a myriad of roles including administration, event organisation, coaching, refereeing and governance. They in turn are supporting the health and wellbeing of the 2.3 million adults in Scotland who are involved in physical activity or sport (51% of the population aged 16+ have participated in physical activity or sport in the last four weeks, excluding walking). If walking is included these figures rise to 3.5 million adults or 79% of the adult population.²⁵³ Furthermore, there are encouraging signs that participation in physical activity and sport is increasing, from 73% of the adult population in 2007 to 80% in 2018.²⁵⁴ To conclude, volunteering provides a vital contribution to sport and exercise as an integral element of a multi-layered approach to preventative medicine across Scotland.
- **Supporting the NHS and health charities** – 200,000+ people volunteer in the health and social care sector in Scotland.²⁵⁵ Volunteers help to inform, educate, manage and support the population on a wide range of health and wellbeing conditions. They fulfil an invaluable role in helping to prevent illness, support early diagnosis, assist in the recovery of patients and provide an all-important aftercare support role.

²⁵⁰ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

²⁵¹ [Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, 2018; and [Young People Volunteering in Scotland](#) – Volunteer Scotland, 2016

²⁵² [Sport 21 2003 - 2007: The National Strategy for Sport](#) – [sportscotland](#); March 2003

²⁵³ [Scottish Household Survey 2016: Chapter 8 - Physical Activity and Sport](#) – Scottish Government, Sept 2017

²⁵⁴ [Scottish Household Survey, 2018 - Chapter 8 Physical Activity and Sport](#) – Scottish Government; Sept 2019

²⁵⁵ [Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, 2018 & [Young People Volunteering in Scotland](#) (YPiS) – Volunteer Scotland, 2016

Tackling social isolation and loneliness

A lot of volunteering is by its very nature a social activity, which is often conducted in clubs, groups and societies. It is about volunteering with others to help others. This is one of the key attributes of volunteering – it improves our social connectedness. This helps to address problems of social isolation and loneliness in three main ways:

- The engagement of volunteers who are isolated and lonely and improving their social connections, allowing them to make friends and feel more integrated in society;
- The provision of services such as befriending which are targeted at those who are experiencing, or susceptible to, social isolation and loneliness; and
- The prevention of social isolation and loneliness for those who are already volunteering.

The strong bi-directional linkages between mental health and social isolation and loneliness must also be recognised. Preventing, alleviating or mitigating problems of social isolation and loneliness can have a direct beneficial effect on people's mental health and vice-versa – improving mental health can help people to become more integrated in society.

Community engagement

A key goal of Government is to foster more engaged and sustainable communities where people feel they are part of their local neighbourhood and are contributing to it. Volunteering is central to the achievement of more engaged communities due to its unique characteristics.²⁵⁶

- **Local delivery** – notwithstanding online volunteering, most volunteering is a local affair. It is embedded within a community for the benefit of that community. The local nature of volunteering is a key factor;
- **Social capital** – volunteering builds social relationships between volunteers, beneficiaries, staff and other voluntary bodies located in the community. This leads to enhanced social networking, improved understanding of each other and more cohesive communities;
- **Reciprocity** – when a volunteer helps someone in the community the beneficiary is more likely to respond with another positive action. This leads to a virtuous circle of community members helping each other – this mutuality and sharing are important;
- **'Spillover' effects** – if people live in a community with high levels of volunteering, even if they do not volunteer, their subjective wellbeing will still tend to be increased by the goodwill and social capital building around them.

²⁵⁶ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

- **Co-production and empowering individuals** – the involvement of people in shaping and delivering their local services not only creates a person-centred service which is more responsive to the needs of local people, but also fosters a sense of responsibility and community activism where people take control of their own lives and local services, create and develop social networks and galvanise resources for the local community.

Volunteering participation is positively correlated with communities which have the following characteristics:

- Where people feel they belong to their community, where they feel valued by their community, where they can influence decisions in their community and where they trust people in their community;
- Smaller rural communities where people tend to know each other, and where reciprocity and mutuality are often the basis for 'survival'; and
- Where people are involved in social clubs, associations and community groups.

Digital and online communication also plays a pivotal role in facilitating volunteer participation, especially for communities of interest where the 'community' is geographically dispersed. This enables volunteering to confer health and wellbeing benefits that would not otherwise be achievable. This is especially important for disabled people as it enables them to overcome the barriers to their engagement in volunteering. For example, in the NCVO Time Well Spent research the proportion of the adult population in Great Britain volunteering exclusively online was 4% for the non-disabled but was 10% for the disabled.²⁵⁷ The equivalent figures for Scotland were 3% for non-disabled and 9% for the disabled.²⁵⁸

Engaging those experiencing disadvantage

The strongest message which stands out from all this research is that the more disadvantaged a person is the more important the contribution of volunteering is likely to be. The evidence is compelling on two counts:

- Firstly, the much higher incidence of health and wellbeing problems for those who experience disadvantage. Using the SIMD as a proxy for 'disadvantage' it is clear that Scotland's physical and mental health problems are much more prevalent in quintile 1 (the most deprived 20% of areas in Scotland) compared to quintile 5 (the least deprived 20% of areas in Scotland) – see evidence in Table 9.1 and Sections 5, 6 and 7; and

²⁵⁷ [Time Well Spent, Full Report](#) – NCVO, Jan 2019

²⁵⁸ 'Time Well Spent' – NCVO, Jan 2019 – analysis of the Scottish TWS data by Volunteer Scotland – publication pending

- Secondly, the higher positive impact of volunteering on people's health and wellbeing if they are living in deprived areas and/or are subject to aspects of disadvantage including mental and physical ill-health, disability, refugee or asylum seeker status, loneliness, etc. – see evidence in Volunteer Scotland's report "Volunteering, Health and Wellbeing".²⁵⁹

However, the irony is that those who can benefit most from volunteering are the people least likely to be volunteering. This is not just a key challenge, but also a key opportunity. If we want to achieve a fairer and more equal society in Scotland, then volunteering has a crucially important role to play. Using volunteering as a means of reaching and supporting those experiencing disadvantage in Scotland should be a top strategic priority in the roll-out of the 'Volunteering for All: National Framework'.²⁶⁰

The objective of the next sub-section is to provide evidence-based guidance on how support for volunteering can be targeted to achieve the maximum benefit for society. This is not a 'one size fits all solution'. This Report highlights how the nature and extent of the health and wellbeing benefits vary significantly across different groups.

9.4 Priorities

To facilitate the prioritisation process Volunteer Scotland has considered the whole corpus of evidence collected in this research study to identify possible cross-cutting themes which have an important influence on the attainment of health and wellbeing benefits from volunteering. Three pervading themes stand out as having a disproportionately significant impact on the nature and extent of people's health and wellbeing:

- **Demographic focus** – from the evidence reviewed in Sections 3 – 7 age is the most important demographic variable linked to the health and wellbeing of our society. There are variations relating to gender, but these are more modest in comparison to age.
- **Sectoral focus** – from the evidence reviewed in Sections 5 – 8 specific volunteering sectors have been identified as being particularly important in conferring health and wellbeing benefits. A holistic review of the contribution by sectors has therefore been completed, based on the classification used by the Scottish Household Survey. It examines a range of volunteering domains such as supporting children's activities, local community groups, sport and exercise, health and social care, religious groups, etc.

²⁵⁹ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

²⁶⁰ [Volunteering for All: Our National Framework](#) – Scottish Government, April 2019

- **Geographic focus** – the evidence reviewed in Sections 5 – 8 highlights how the health and wellbeing benefits from volunteering are particularly important for those living in areas of deprivation. Clearly, there is a strong correlation between high deprivation and urban areas, but it is important to get down to the local /micro communities where there can be hotspots of deprivation. Appropriate consideration must also be given to disadvantaged areas within rural communities.

It is important to acknowledge that the three cross-cutting themes used in this analysis have been derived exclusively from the evidence reviewed in this study and have been selected using the judgement of Volunteer Scotland. Not all variables can be known or predicted. Therefore, it is quite possible that alternative themes using new evidence and other people's judgement could change the focus of the prioritisation process.

However, for the purposes of this report Volunteer Scotland believes that the evidence supports strongly the three themes selected notwithstanding that there may be other cross-cutting themes which should also be considered. What is perhaps more challenging is the interpretation of the evidence within each theme.

a) Demographic focus

The three main indicators of health and wellbeing covered by this report – physical health, mental health and social isolation and loneliness – have been used to score the following adult age classifications:

- *Young* – age range 16 – 24
- *Early mid-life* – age range 25 - 44
- *Later mid-life* – age range 45 – 64
- *Younger old* – age range 65 – 74
- *Older old* – age range 75+

Given the range of evidence examined and its variation across age groups a subjective assessment has been used for the scoring of specific age bands. This is not a 'scientific' exercise and the scores could be finessed upwards and downwards based on personal interpretation of the evidence.

However, the process is helpful in distinguishing important health and wellbeing variations across the age spectrum: see Table 9.3. This is as, if not more, important than the overall scoring by age group. A five-mark rating system has been used, with one cross indicating that a high proportion of the age group has good health and wellbeing, up to five crosses which indicates that a much lower proportion of the age group has good health and wellbeing. The higher the total score the poorer the health and wellbeing of that age group. As the table shows there is considerable variation between the indicators and how they impact on the age cohorts.

Table 9.3 – Ranking of health and wellbeing indicators by age					
Indicators of poor health and wellbeing	Young 16 - 24	Early mid-life 25 - 44	Later mid-life 45 - 64	Younger old 65 - 74	Older old 75+
Physical ill-health	×	×	×	×	×
Mental ill-health	×	×	×	×	×
Social isolation*	×	×	×	×	×
Loneliness*	×	×	×	×	×
Total score	10	10	11	8	13
Source: Volunteer Scotland – subjective assessment of quantitative evidence from Sections 5 - 7 Note: *Definitions for 'social isolation' and 'loneliness' and the differences between them are explained at the beginning of Section 7.					

This ranking system is based on an assessment of the evidence presented in Sections 5 – 7, to which the reader is referred. This sub-section does not attempt to summarise the evidence again.

In overview, this analysis tells us three things:

- That all age groups have health and wellbeing challenges, but that the nature of these challenges vary between age groups. For example, physical ill-health is most prevalent for the over 75s, whereas mental ill-health is most prevalent for young adults aged 16 – 24.
- The 'older old' aged 75+ stand out as the age cohort facing the greatest health and wellbeing challenges.
- In contrast, the 'younger old' aged 65 – 74 face the least health and wellbeing challenges.

Young (aged 16 – 24)²⁶¹ – they have the poorest mental health of all the age groups. Young people have the worst General Health Questionnaire mental health score of any age group, the worst statistics for anxiety and self-harm, and the second highest attempted suicide rate.²⁶²

The emerging evidence also indicates that although they are the most socially connected age group – 86% of those aged 16-24 meet people socially at least once a week compared to the Scottish average of 77% – nearly one in four young people experienced feelings of loneliness in the last week.²⁶³ This highlights the importance of distinguishing between social isolation and loneliness. You can be the most socially connected young person, but still be experiencing loneliness.

²⁶¹ The age band 16 - 24 for 'young' is the youngest age category for adults reported in the main Scottish Government statistical publications. However, ideally, we would like to be able to report on the health and wellbeing of young people under the age of 16.

²⁶² [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

²⁶³ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

These are also two areas where volunteering can make an important contribution to improving the health and wellbeing of young people. Volunteer Scotland's research on Young People in Scotland highlighted the fact that wellbeing factors such as 'making new friends', 'feeling part of a team', 'increasing confidence' and 'having fun' were cited more frequently than most of the career and vocational benefits.²⁶⁴ The research underpinning the Youth Volunteering Innovation Project provides further evidence on the importance of health and wellbeing factors in addition to career and skills benefits.²⁶⁵

This report's findings that young people face major health and wellbeing challenges supports the Scottish Government's policy for the last 15 years of prioritising volunteering for young people. Other factors in support of a continued focus on youth volunteering for the period 2020 – 2040 include:

- The emerging evidence that the mental health and loneliness challenges facing young people are not improving – if anything they are deteriorating over time (this represents an evidence gap at present – especially for the under 16s and for loneliness data in Scotland);
- The complementary benefits which volunteering confers to young people in helping them develop their skills and achieve positive educational and employment outcomes.

Our analysis on adults aged 16+ is driven by available public data, a lot of which is focused on adults and not young people under 16. However, the evidence which we have managed to gather on the health and wellbeing of children suggests that the challenges facing the 16 – 24 age group extend to children in S1- S3 and into primary school as well. The mental health and loneliness problems facing our young people start much earlier than 16 but deteriorate towards mid-to-late teens.²⁶⁶ This has important implications for volunteering. It is important to start the engagement process with young people in primary school, not just secondary school as part of the 'participant-to-volunteer' journey.²⁶⁷

Mid-life (25 – 64) – from the health and wellbeing evidence for this working age group, one can discern two main trends:

- *Early mid-life (26 – 44)*: some of the health and wellbeing issues affecting the young (16 – 24) also flow through to the 26 – 44 year old age group, but to a less severe extent, particularly for mental ill-health and loneliness for those aged 35 - 44; and
- *Later mid-life (45 – 64)*: there is a noticeable increase in physical ill-health and limiting long-term conditions in this age group (see Sections 5 and 6 for detailed evidence). For example:

²⁶⁴ [Young People Volunteering in Scotland, 2016](#) – Volunteer Scotland, Jan 2017

²⁶⁵ [Youth Volunteering Innovation Project](#) – Young Scot, Project Scotland and Scottish Government – March 2019

²⁶⁶ [Scotland's mental health: Children and young people](#) – Briefing Paper - NHS Health Scotland; 2014

²⁶⁷ ["Youth Volunteering in Deprived Areas of Glasgow"](#) – Dr James Davies, June 2018

- Limiting long-term conditions:²⁶⁸
 - 21% of 35 – 44 age group
 - 28% of 45 – 54 age group
 - 40% of 55 – 64 age group
- Cardio-vascular disease or diabetes:²⁶⁹
 - 9% of 35 – 44 age group
 - 13% of 45 – 54 age group
 - 26% of 55 – 64 age group

What this tells us is that early intervention is much better than cure. So, if we are to enhance the health and wellbeing of people in Scotland then we need to start engaging much earlier to encourage the adoption of healthy behaviours, and leverage other health and wellbeing benefits from volunteering, before the health conditions present themselves. The implications are that:

- We should focus on the young and 'early mid-life' age groups to try and establish the health and wellbeing benefits from volunteering at an early age;
- We should focus on types of volunteering roles which are most likely to generate these benefits, including:
 - Socially engaged volunteering roles where volunteers are working in teams and where face-to-face engagement is the norm – this facilitates social connectedness, helping to minimise the risk of loneliness, and with potential spin-off benefits for mental health and wellbeing
 - Volunteering involving sport and exercise and/or activities demanding physical activity which can result in physical and mental health benefits.
 - Volunteering roles which involve the outdoors and our engagement with the natural and historic environment – again providing physical and mental health benefits
 - Volunteering roles which involve creativity, arts and culture – providing mental and physical health benefits through, for example, dance and music – and also social engagement.
 - Volunteering roles which give sufficient engagement (frequency and hours of volunteering) to enable the potential health and wellbeing benefits to flow through – referred to as the 'dose-response' effect.

Younger old (aged 65 – 74) – in contrast to the wide-ranging support for volunteering amongst the young in Scotland, older people have not received the same focus and encouragement. Volunteer Scotland believes this is a missed opportunity, particularly for the 'younger old' given their characteristics:

- *High volunteering participation* – they had the second highest volunteering participation rate in 2017 at 30% – see Table 9.4;²⁷⁰

²⁶⁸ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report - Scottish Government, Sept 2018

²⁶⁹ Ibid

²⁷⁰ [Scottish Household Survey 2017](#) – Chapter 11 Volunteering: Scottish Government; Sept 2018

Table 9.4 – Adult volunteering participation and hours by age in Scotland				
Age group	Volunteering participation ¹ rate	Average no. of volunteering hours per month ²	Projected population 2041 ³	% change in projected population 2017 - 2041 ³
16 - 24	29%	9.3	560,000	-5.6%
25 - 34	23%	7.0	684,000	-7.2%
35 - 44	33%	8.0	669,000	0.7%
45 - 54	29%	9.6	769,000	-2.9%
55 - 64	(45 – 59)	11.8	669,000	-5.5%
65 - 74	30% (60 – 74)	14.4	650,000	15.2%
75+	20%	11.5	790,000	76.4%
Sources: (1) SHS, 2017; (2) SHS, 2016; (3) NRS 2017				

- *Highest volunteering hours* – their volunteers contribute more volunteering hours per month than any other age group at 14.4 hours per month – see Table 9.4;²⁷¹
- *More available time* – unlike the economically active adults aged 16 – 64, who are often time poor and stressed with performing multiple roles, those aged 65+ are often retired and are more likely to have the time to devote to volunteering. However, we should also be aware of the increasing pressures on this age group due to later retiral ages and trends towards increased family and caring responsibilities;
- *Health and wellbeing benefits* – we know that physical ill-health starts to become a major problem for the over 65s, so volunteering can play a key role in keeping them active and fit – both mentally and physically; and
- *Large and growing demographic* – this cohort is projected to grow from 565,000 in 2017 to 650,000 in 2041, an increase of 85,000.²⁷²

The contribution of the 'younger old' to volunteering and the health and wellbeing of Scotland's population could be increased through:

- Boosting their participation rate above 30%
- Stimulating their engagement with both the 'older old' and the young – the latter providing important inter-generational benefits;
- Initiating volunteering programmes which link the 'younger old' to healthcare, sport and exercise – all of which helps enhance the health and wellbeing of Scotland's population – see further discussion later in this sub-section; and
- Ensuring that the volunteering roles for the 'younger old' are designed to maximise their own health and wellbeing benefits (although this principle applies to all age groups).

²⁷¹ [Scottish Household Survey 2016](#) – Chapter 11 Volunteering: Scottish Government; Sept 2017

²⁷² [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#) – National Records of Scotland, Aug 2018

- There is also the opportunity to review volunteer roles for this age group to facilitate their long-term volunteering engagement into the 75+ age category and beyond (for example, taking into account the physical demands of volunteering roles).

Older old (age 75+) – they are a high need group in terms of health and wellbeing indicators due to the following factors:

- *Ill-health* – the increasing problem of physical ill-health and multi-morbidities for the over 75s. For example, 56% of this age group have limiting long-term health conditions, by far the highest of any age group.²⁷³
- *Social isolation and loneliness* – the over 75s have the highest proportion of people who experience loneliness and are the second most socially isolated age group. The Scottish Household Survey shows that one in four (26%) of those aged 75 plus have been 'sometimes, often or always lonely' in the last week – the highest percentage of any age adult age group in Scotland.²⁷⁴
- *Absence of 'role identities'* – for the over 75s the likelihood of having multiple roles which engage them with people reduces dramatically. This includes not having a job, their partner dying, no parental responsibilities in the household, etc. For example, the Communities Life Survey shows that the proportion of adults aged 16+ who are 'often' or 'always' lonely increases from 2.5% for those who are married to 9.9% for those widowed.²⁷⁵
- *A large and growing demographic* – we know that there is projected to be an additional 428,000 people over the age of 65 by 2041.²⁷⁶ However, the majority of this growth will be in the 'older old' aged 75+, which is projected to grow from 448,000 in 2017 to 790,000 by 2041, a massive increase of 76% and an additional 342,000 people. This compares to a 4.9% projected growth in Scotland's total population during this period.²⁷⁷

Therefore, the engagement of the 'older old' in volunteering should be actively encouraged. However, the contribution of volunteering to the health and wellbeing of the 'older old' starts to change as they move from being volunteers to being the recipients of volunteering services. For example, the volunteering participation rate for the age group 65 – 74 was 30% in 2017, but this reduces to 20% for those aged 75+: see Table 9.4.²⁷⁸ So, we need to consider the 'older old' both from the point of view of deriving benefits from volunteering (for those who are fit enough to do so) and being supported by volunteers to improve the quality of their health and wellbeing in older age.

²⁷³ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report

²⁷⁴ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

²⁷⁵ [Loneliness: What characteristics and circumstances are associated with feeling lonely?](#) Office for National Statistics, April 2018

²⁷⁶ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#) – National Records of Scotland, Aug 2018

²⁷⁷ Ibid

²⁷⁸ [Volunteering in Scotland: Trends from the SHS 2007 - 2017](#) – Volunteer Scotland, Dec 2018

Volunteering is therefore doubly important for the older old, especially given the projected demographic change where 1 in 7 of Scotland's population will be aged 75+ by 2041: see Table 9.4.²⁷⁹ The implication of this analysis is that volunteering which supports health, social care and befriending services for older people will need to be expanded very significantly over the next 20 years.

b) Sectoral focus

All volunteering can, in principle, deliver important health and wellbeing benefits for volunteers. In that sense all volunteering sectors are equally important. However, if one examines the wider health and wellbeing benefits discussed in this report, not just to volunteers but to wider society, four characteristics of volunteering's contribution stand out as being central to the realisation of health and wellbeing benefits – see Figure 9.1:

- **Age focus** – volunteering supporting the specific health and wellbeing needs of different age groups – from younger to older
- **Health and wellbeing focus** – volunteering directly supporting the health and wellbeing of Scotland's population through activities which impact on people's physical and mental health, and through support to health and social care services
- **Community focus** – volunteering fostering stronger local communities and neighbourhoods
- **Social capital focus** – volunteering facilitating social engagement and connectedness.

Like the three prioritisation themes discussed earlier in Section 9, these four sectoral characteristics are based on the evidence reviewed in this report and the judgement of Volunteer Scotland in its assessment of the evidence. Not all variables can be known or predicted. Therefore, it is quite possible that alternative sectoral characteristics could be identified using new evidence and other people's judgement which could change the analysis and findings below.

Notwithstanding this caveat, what is clear from the evidence is that volunteering's sectoral contribution to Scotland's health and wellbeing varies according to the specific focus of each sector. Some are particularly strong in community engagement; others have a direct impact on health and wellbeing through, for example, sport and physical activity; others are particularly good at facilitating social connectedness; and for others it is due to their focus on specific age demographics. Furthermore, some sectors stand out as being particularly strong across multiple characteristics in Figure 9.1.

²⁷⁹ [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#) – National Records of Scotland, Aug 2018

Figure 9.1 – Contribution of volunteering sectors to health and wellbeing

Volunteering with children and young people – volunteering with pupils in school and with children and young people outside school is the most popular area to volunteer in Scotland, comprising more than 1 in 5 of all volunteers (see Table 9.5).²⁸⁰ This sectoral focus is particularly important due to:

- The fact that a higher proportion of young people have mental ill-health compared to all other age groups in Scotland. Also, younger adults are one of the age groups most susceptible to loneliness, along with those aged 75+. Nearly one in four (23%) of those aged 16 – 24 experienced loneliness in the last week.²⁸¹

²⁸⁰ [Scottish Household Survey 2017](#) – Chapter 11 Volunteering: Scottish Government; Sept 2018 & [Young People and Volunteering in Scotland, 2016](#) – Volunteer Scotland; Jan 2017

²⁸¹ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

Table 9.5 – Volunteering sectors in Scotland			
Sectors	No. of volunteers		
	Adults 16+ (2017)	Young 11-18 (2016)	Total¹
Children's activities within schools	266,000	45,000	311,000
Children's /youth activities outside schools	253,000	57,000	310,000
Sport and exercise	215,000	72,000	287,000
Local community & neighbourhood groups	240,000	18,000	258,000
Hobbies, recreation, arts, social clubs	215,000	34,000	249,000
Health, disability and social welfare	202,000	13,000	215,000
Religious groups	190,000	10,000	200,000
Older people	139,000	16,000	155,000
Environmental protection	89,000	6,000	95,000
Education for adults	76,000	N/A	76,000
Safety, first aid	51,000	12,000	63,000
Wildlife groups	51,000	7,000	58,000
Political groups	51,000	3,000	54,000
Citizens groups	51,000	N/A	51,000
Domestic animal welfare	38,000	7,000	45,000
Justice and human rights	38,000	3,000	41,000
Total no. of volunteers²	1,257,000	146,000	1,403,000
Sources: SHS 2017 and Young People Volunteering in Scotland, 2016 Notes: ¹ The youth and adult figures are not strictly additive due to an age overlap. However, the youth volunteering figure is underestimated due to the exclusion of volunteering in private schools. We therefore believe that the overall total is a good estimate of total formal volunteering in Scotland. ² People can volunteer in more than one category, so the columns do not sum to the total number of volunteers.			

- Volunteering provides the opportunity for early engagement to help address these health and wellbeing challenges at primary school, secondary school and in the important transition period into adulthood.
- Volunteering is often delivered by young people for young people. For example, the proportion of volunteers aged 16 – 24 choosing to volunteer with young people outside school is 34%, which is considerably higher than for older age groups.²⁸²

²⁸² [Scottish Household Survey Annual Report, 2017](#) – Scottish Government; Sept 2018

Hence, there is an important win-win, whereby young people derive health and wellbeing benefits both as volunteering providers and as volunteering beneficiaries.

Volunteering in sport and exercise – not only do the 287,000 volunteers supporting sport and physical activities derive health and wellbeing benefits from their volunteering (the third most popular volunteering sector in Scotland – see Table 9.5), but crucially they help to contribute to the active participation of 51% of Scotland's adult population in physical activity and sport (excl. walking) in the last four weeks, equivalent to 2.3 million people. The equivalent figures for sport participation including walking are 79% and 3.6 million adults (see Table 5.5 in Section 5 for data table).²⁸³

Furthermore, we know that there is a strong correlation between volunteering and sport. In 2016, 36% of adults were engaged in both volunteering and sport/exercise (excl. walking) equivalent to 820,000 volunteers. Also, the reach of these volunteers into Scotland's deprived communities is much higher with a volunteering rate of 27% in quintile 1 of SIMD and 30% in quintile 2 (see Figures 5.8 and 5.9 in Section 5). Hence, we know that not only is volunteering good for sport, but also that sport is good for volunteering.²⁸⁴

The proportion of young volunteers who choose to volunteer in sport and exercise is also high:

- 23% of adult volunteers aged 16 – 24 volunteer in sport and exercise (the fourth most popular volunteering sector for young people).²⁸⁵
- 49% of secondary school pupil volunteers aged 11 - 18 volunteer in sport and exercise (the most popular volunteering sector for pupils).²⁸⁶

This is important for the health and wellbeing of both the young volunteers and the young people they are supporting to take part in sport and exercise.

Volunteering in sport also provides important contributions to community wellbeing as many clubs are strongly embedded within their local community. Sport also supports the development of social capital as the organisation, management and delivery of sport is usually dependent on close teamwork. Other 'non-sport' physical activities such as walking, going to the gym, etc., may or may not confer these health and wellbeing benefits as this will depend on the nature of the activity and the extent to which it is based on community engagement and team working.

Local community and neighbourhood groups – a key goal of Government is to foster more engaged and sustainable communities where people feel they are part of their community and are contributing to their community. The challenges are significant due to the level of disconnect in society:

²⁸³ [Scottish Household Survey 2016: Chapter 8 - Physical Activity and Sport](#) – Scottish Government, Sept 2017

²⁸⁴ [Scottish Household Survey 2016 - Volunteering cross-sectional analysis](#) – Volunteer Scotland, Oct 2019

²⁸⁵ Ibid

²⁸⁶ [Young People and Volunteering in Scotland, 2016](#) – Volunteer Scotland; Jan 2017

- 72% of people are either 'not at all' or 'not very much' involved in their local community – see Figure 8.2 (Section 8).²⁸⁷
- 44% of people 'disagree/strongly disagree' that they can influence decisions in their local area – see Figure 8.3. (Section 8).²⁸⁸

Volunteering has a key role to play in helping to bridge the barriers between people and their communities. Most volunteering is 'local' (81%), and it is most commonly undertaken in community spaces (39%) such as community halls – physical spaces located in the community for the benefit of the community.²⁸⁹ Volunteering also helps to build people's social capital in the process of fostering community engagement. It is the fourth most popular sector for volunteering, with 258,000 volunteers helping to support their local community or neighbourhood groups: see Table 9.5.

Hobbies, recreation, arts and social clubs – it is difficult to be prescriptive on the health and wellbeing benefits flowing from this diverse volunteering category, but the following overarching contributions stand out:

- There are particularly strong health and wellbeing benefits derived from arts and culture:
 - Improved physical health through performing arts such as dance
 - Improved mental health through all aspects of artistic and cultural engagement in activities such as music, art, drama, etc.
- Arts and social clubs are often strongly embedded within their local community, which can help to foster improved community engagement and wellbeing.
- 'Hobbies, recreation, arts and social clubs' are typically socially based activities which helps to foster the development of individuals' social capital and connectedness with society.

Also, the adult volunteering participation rate for those who attended a cultural event (excl. reading) in the last 12 months is 36%, which is significantly higher than the Scottish volunteering rate of 27%: see Figure 9.2. Furthermore, the volunteering engagement in areas of deprivation is higher than the national average:

- Quintile 1 (the 20% most deprived areas in Scotland) – the volunteering participation rate is 31%, compared to the national average for Q1 of 18%
- Quintile 2 (the next 20% most deprived areas in Scotland) – the volunteering participation rate is 30%, compared to the national average for Q2 of 22%.

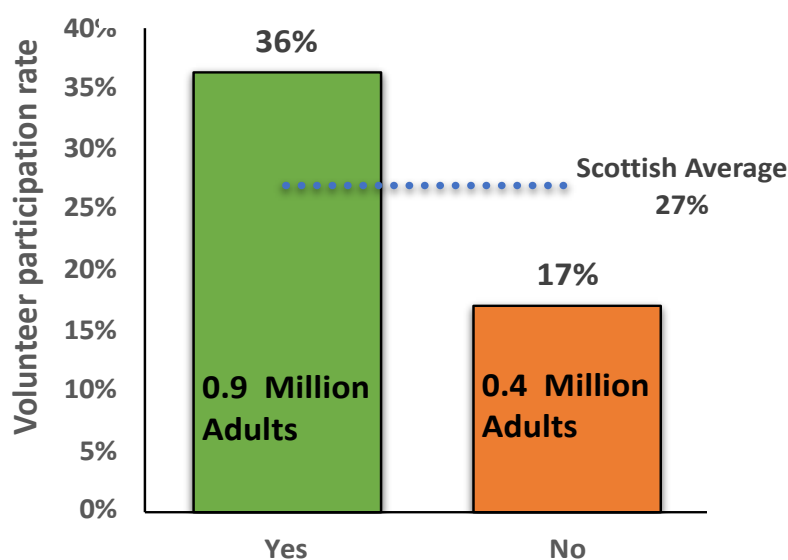
Clearly, the 'reach' of volunteering in deprived areas is enhanced if people are involved in some form of cultural attendance. This mirrors a similar finding for people's engagement in physical activity and sport. Is this indicative of people's engagement in society through activities such as culture and sport also being linked to engagement in volunteering?

²⁸⁷ [Scottish Health Survey - 2017 edition](#) – Volume 1, Main Report - Scottish Government, Sept 2018

²⁸⁸ Ibid

²⁸⁹ 'Time Well Spent' – NCVO; January 2019 – analysis of the Scottish dataset by Volunteer Scotland; publication due early 2020

Figure 9.2 – Adult volunteering participation rate by cultural attendance in Scotland (excl. reading)



Source: SHS 2016, n = 9,630

This is the fifth most popular 'sector' for volunteering, with 249,000 volunteers supporting hobbies, recreation, arts and social clubs.

Volunteering in health, disability and social welfare - the 215,000 volunteers in this 'sector' help Scotland's population on a wide range of health, disability and social welfare conditions, in both the NHS (c. 6,500 volunteers²⁹⁰) and across a very wide range of charities. These volunteers deliver an invaluable role in helping to prevent illness, support early diagnosis, complement the treatment and recovery of patients and provide an all-important aftercare support. Without this volunteer support the health and wellbeing of Scotland's population would be very seriously affected.

Religious groups – 200,000 volunteers provide a vitally important contribution to the operation, management and sustainability of religious groups across Scotland, which in turn helps to deliver important health and wellbeing benefits:

- Religious groups usually have a defined geographic catchment and are an important element of community life, which in turn helps to foster community wellbeing.
- Religious groups by their very nature are highly sociable which helps to build social capital and connectedness for their members.
- Religious groups provide invaluable health and wellbeing benefits for society, not just in the pastoral support for their own members, but from their outreach work such as drop-in centres for the homeless, to supporting refugees and asylum seekers, etc.
- Volunteers in religious groups are drawn disproportionately from older people.

²⁹⁰ Estimate of volunteers in NHS in Scotland – Scottish Health Council, May 2019

- Although 15% of Scotland's volunteers are involved with religious groups, this figure increases to 25% for 60 – 74 year olds and an incredibly high figure of 38% for those aged 75 plus.²⁹¹ As demonstrated in the 'demographic focus' sub-section above, this volunteering engagement is likely to be conferring vitally important health and wellbeing benefits for the over 75 plus age group.

Volunteering with older people – as explained under the 'demographic focus' discussion in the sub-section above, older people are a strategic priority for support due to:

- The much higher incidence of ill-health and multi-morbidities in those aged over 65;
- Their susceptibility to social isolation and loneliness due to 'multiple role absences';
- The very large increase in the number of older people aged 75+ which is projected to grow from 448,000 in 2017 to 790,000 by 2041, a major increase of 76% and an additional 342,000 people. This compares to a 4.9% projected growth in Scotland's total population during this period.²⁹²

Other sectors – for some sectoral classifications it is more difficult to be prescriptive on potential health and wellbeing benefits, because the nature of the volunteering activities in the 'sector' are so broad and varied. However, what one can be sure about is that there will be a wide range of health and wellbeing benefits both for the volunteers involved and for the beneficiaries of their work. Examples include:

- *Environmental protection* (95,000 volunteers) – both for the natural and historic environment a lot of volunteering work is out of doors, often in culturally and scenically rich environments. This has the potential to confer health and wellbeing benefits for the volunteers involved. Team work is also a common feature of environmental work which can confer important social capital and connectivity benefits.
- *Education for adults* (76,000 volunteers) – this volunteering confers important mental health benefits for those benefiting from adult education, especially those who are unemployed, not economically active or who are retired. Clearly, there are also potentially important health and wellbeing benefits for the volunteers themselves.
- *Safety and first aid* (63,000 volunteers) – the key health and wellbeing benefits from this sector relate to its preventative role in protecting people from physical harm and risk to life, and in mitigating any injuries or illnesses through first aid.
- *Wildlife Groups* (58,000 volunteers) – there are mental and physical health benefits from working outdoors and social capital and connectivity benefits from group working.²⁹³

²⁹¹ [Scottish Household Survey Annual Report, 2017](#) – Scottish Government, Sept 2018

²⁹² [Scotland's Population: The Registrar General's Annual Review of Demographic Trends - 2017](#) – National Records of Scotland, Aug 2018

²⁹³ Rogerson, M., Barton, J., Bragg, R. & Pretty, J. (2017) - The health and wellbeing impacts of volunteering with 'The Wildlife Trusts' – University of Essex

- *Political groups* (54,000 volunteers) – the effective functioning of a democratic society is supported by the work of volunteers campaigning for causes and political parties. The effective functioning of democracy and the championing of important societal issues helps to support and enhance the health and wellbeing of individuals, communities and the overall nation.
- *Citizens' Groups* (51,000 volunteers) – there is a lack of clarity on what this sector comprises, given the overlap with 'political groups' as both have a focus on societal issues or political causes. Indeed, it has now been removed as a response option in the Scottish Household Survey 2018.
- *Domestic animal welfare* (45,000 volunteers) – a high proportion of adult volunteers involved in domestic animal welfare is drawn from younger people aged 16 – 34.²⁹⁴ This is a popular area for volunteering with possible linkages to future career choices. It is expected that health and wellbeing benefits will flow from this volunteering through the mitigation of issues such as mental ill-health and loneliness. However, another societal benefit is the impact of healthy pets on family wellbeing, where pets are often central to the family unit.
- *Justice and human rights* (41,000 volunteers) – in a similar fashion to 'political groups' the main health and wellbeing benefits derived by this sector relate to the protection, defence and support of those either subject to, or at risk of, criminal and human rights abuses, and miscarriages of justice. Volunteers provide an incredibly important role in society by helping those who are often least able to defend themselves. This includes those subjected to sexual abuse, domestic abuse, exploitation of minors, modern slavery, refugees and asylum seekers, etc.

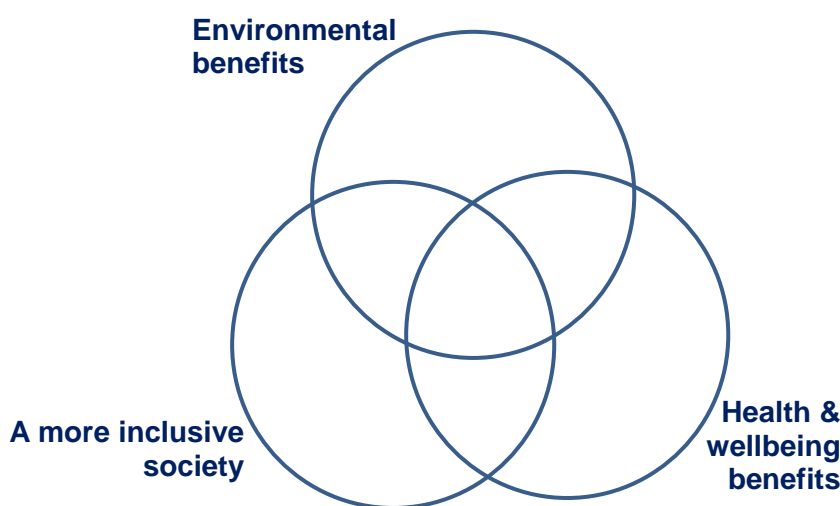
Overview of sectoral prioritisation – this analysis highlights the diverse contributions of volunteering across different sectors. This is one of the key virtues of volunteering – it is multi-faceted and omnipresent throughout society. This report also highlights how important it is for sectors to optimise the health and wellbeing contribution from their volunteering. This includes:

- Providing volunteering opportunities which maximise the health and wellbeing of different age groups through:
 - Socially connected roles
 - Creative and stimulating roles
 - Roles which foster physical activity
 - Roles which are outdoors, not just indoors
- Reaching more volunteers from disadvantaged backgrounds as we know the health and wellbeing benefits can be so much greater.

²⁹⁴ [Scottish Household Survey Annual Report, 2017](#) – Scottish Government, Sept 2018

This represents a 'win-win-win' as three mutually-reinforcing dimensions support each other. For example, if we take the natural environment then volunteering not only helps the environment, but it can also achieve important health and wellbeing benefits for volunteers whilst also achieving a more inclusive society: see Figure 9.3. 'Action Earth Enhanced Grants 2019' managed by Volunteering Matters and funded by Scottish Natural Heritage is a good example of how support can be focused on the environment, those with health or social needs, engaging those disadvantaged by their health or social needs and supporting areas of deprivation across Scotland.²⁹⁵

Figure 9.3 – The 'win-win-win' from environmental volunteering



c) Geographic focus

The Scottish Index of Multiple Deprivation (SIMD) is based on 38 indicators of deprivation grouped into seven 'domains': income; employment; health; education, skills and training; housing; access to services; and crime.

This report has drawn heavily on the evidence of health and wellbeing in areas of deprivation – in particular, it has examined the variation between quintile 1 (the 20% most deprived areas of Scotland) and quintile 5 (the 20% least deprived areas of Scotland).

What the evidence has shown is that indicators of physical and mental ill-health and loneliness are often much higher in quintiles 1 and 2 compared to quintile 5. This is not unexpected given that health is one of the seven domains of deprivation in the SIMD. However, the SIMD encompasses a much wider scope to deprivation which is helpful when trying to encompass other aspects of disadvantage in society. And we also know from our research that the contribution of volunteering is greatest for those experiencing disadvantage and exclusion, whatever the cause.²⁹⁶

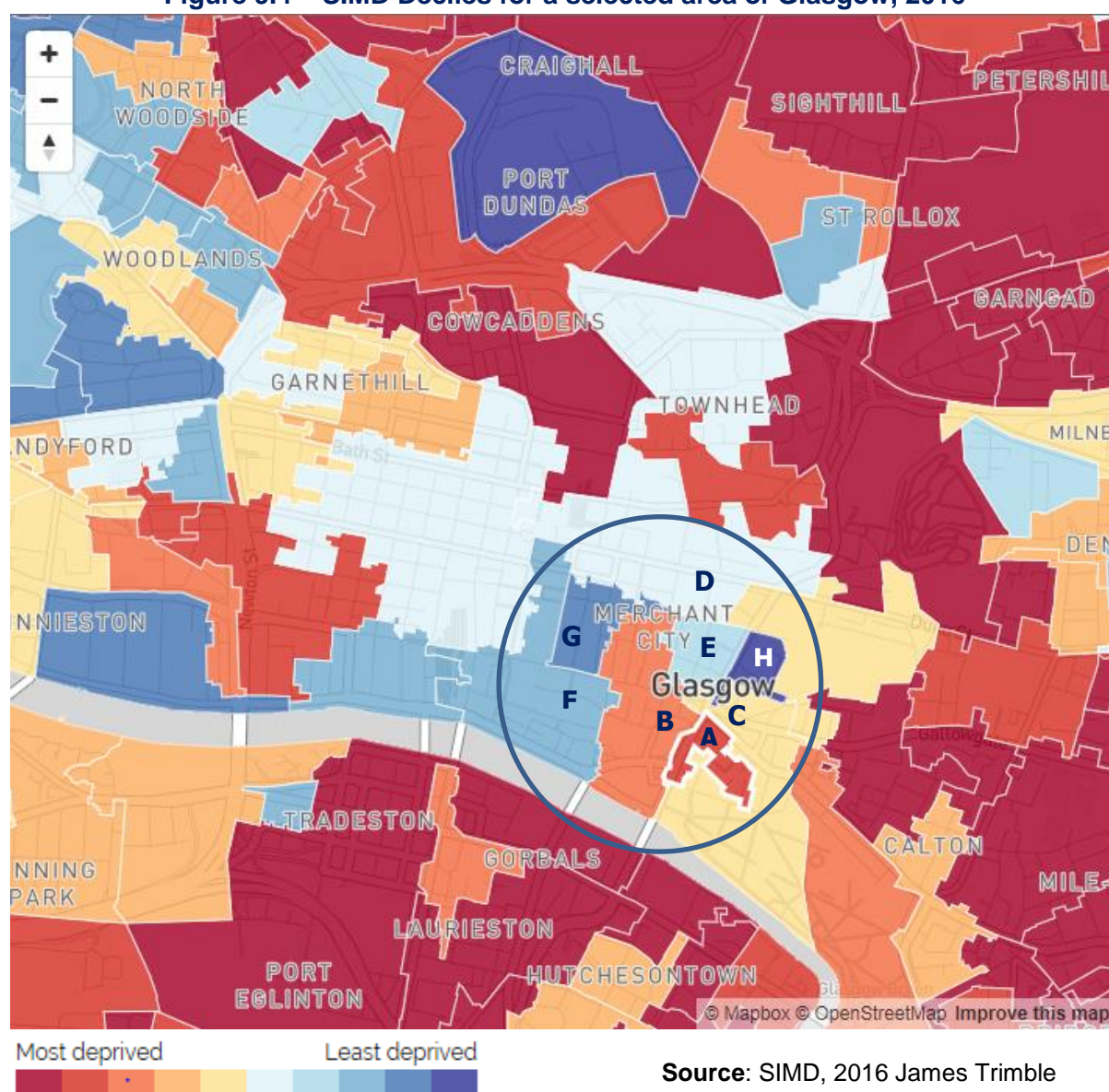
²⁹⁵ [Action Earth Enhanced Grants 2019](#) – Volunteering Matters

²⁹⁶ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) Volunteer Scotland, Dec 2018

So, when considering the contribution of volunteering, geography does matter. SIMD data is helpful in providing a proxy for comparing between areas which are disadvantaged versus those not disadvantaged, identifying where volunteering can have a greater and lesser and impact respectively. However, there are several caveats to this overarching assessment.

Firstly, deprivation can be very location specific and hence it can be important to drill down to more precise geographic zones such as deciles (10% most deprived areas) and virgintiles (5% most deprived areas). For example, if we examine the SIMD for Glasgow City – the most deprived local authority area in Scotland with 48% of the population living in quintile 1 – there is a predominant 'sea of red' (see colour key in Figure 9.4). However, if one examines the geography more closely – see the circled area – what is a very small geography encompasses decile 2 up to decile 10. Table 9.6 gives the domain data for locations A – H.²⁹⁷

Figure 9.4 – SIMD Deciles for a selected area of Glasgow, 2016



Source: SIMD, 2016 James Trimble

²⁹⁷ [SIMD Maps, 2016](#) – James Trimble

Table 9.6 – SIMD Deciles for selected areas of Glasgow, 2016								
SIMD Domains	Decile ranking for geographic areas A - H – see Figure 9.2							
	A	B	C	D	E	F	G	H
Income	3	3	5	7	8	10	10	10
Employment	3	4	5	7	8	10	10	10
Health	2	3	8	7	9	10	10	10
Education, skills and training	6	3	7	6	6	6	10	10
Housing	1	1	1	1	1	1	1	1
Geographic access to services	5	6	5	5	5	5	7	4
Crime	1	1	1	1	1	1	1	5
Overall SIMD Decile	2	3	5	6	7	8	9	10
Source: James Trimble SIMD Maps, 2016								

Table 9.6 also shows how domains vary (or not) between areas. For example, income, employment and health all vary markedly between areas. In the case of health, Area A is in the 10 – 20% poorest health areas of Scotland, whereas Area H is in the top 10% of highest health areas. In contrast the decile positions for housing, access to services and crime do not vary that much.

The Table also shows the incidence of multiple deprivation factors in one geography. Deprivation is due to a range of factors which are often reinforcing and part of a vicious circle which it is difficult to break out of. We know that the areas with the most deep-rooted deprivation have been consistently amongst the 5% most deprived communities since the start of the SIMD dataset in 2004.²⁹⁸

The second key caveat is that not everyone who is deprived lives in a deprived area; and vice-versa not everyone living in a deprived area is deprived.²⁹⁹ For example, there are no deprived data zones (representing the 15% most deprived areas of Scotland) in any of the Western Isles, Shetland or Orkney islands, but there are still people experiencing significant deprivation in these remote island communities.³⁰⁰

The final and most important caveat is that there are many aspects of disadvantage which occur outside areas of deprivation. Disability, gender orientation, conditions of mental health, etc., are prevalent across society irrespective of geography and deprivation areas. Yet volunteering has an equally important role to play in supporting the health and wellbeing of these people.

²⁹⁸ [Introducing the Scottish Index of Multiple Deprivation, 2016](#) – Scottish Government, 2016

²⁹⁹ Ibid

³⁰⁰ Ibid

10. Conclusion and recommendations

10.1 Conclusion

This report has highlighted the major challenges facing our society in terms of demographic change, labour market and skills shortages, mental and physical ill-health, social isolation and loneliness, and poorly connected and engaged communities. However, it also presents wide-ranging evidence on the extraordinary contribution of volunteering in helping to address these challenges and in improving the health and wellbeing of Scotland's people. It achieves this through:

- Improving the health and wellbeing of volunteers
- Supporting activities and sectors which foster the health and wellbeing of the wider population such as physical activity and sport
- Supporting Scotland's health and social care sector.

Volunteering also fosters social connectedness and is embedded in communities for the benefit of those communities. It is inextricably linked to the health and wellbeing of engaged communities and resilient neighbourhoods.

Finally, the greatest health and wellbeing impact from volunteering is for those who are most disadvantaged and excluded in society, and this applies both to the volunteers themselves and those who they are supporting.

This is a really 'good news' story for volunteering and for Scotland's health and wellbeing. It is also a strong foundation upon which to further develop the contribution of volunteering. As evidenced in this report there are big societal challenges facing Scotland over the next 20 years and it is vitally important that volunteering is responsive, adaptable and focused in managing this change. The recommendations to help achieve this are now described.

10.2 Recommendations

This report is set within a 20 year timeframe from 2020 – 2040. This length of time is appropriate given the long-term nature of the societal changes facing Scotland:

- The change in the demographic structure of Scotland is projected to continue for the next 20 years.
- The health and wellbeing challenges facing Scotland are deep-rooted and will require long-term support to be addressed effectively.
- Optimising the contribution of volunteering to Scotland's health and wellbeing will require a long-term vision and sustained support if a significant change from the status quo is to be effected.

The following recommendations are therefore long-term in nature. Volunteer Scotland believes they will have a long 'shelf-life' given the factors outlined above. They are also 'high-level' recommendations. There has been no attempt to repeat numerous detailed priorities and guidance specified in Section 9, to which the reader is referred.

Those responsible for volunteering policy and practice in Scotland need to be aware of and act upon, where appropriate, the following recommendations to enhance the contribution of volunteering to Scotland's health and wellbeing:

1. **Manage demographic change** – consider what impacts the projected increase of c. 430,000 people aged 65+ and the projected contraction of c. 145,000 people aged 16 – 64 by 2041 will have on volunteering services and beneficiaries.
2. **Optimise volunteer engagement** – reflect on the implications for volunteer recruitment of the projected c. 100,000 additional volunteers aged 65+ (giving an additional 13 million hours p.a.) and the projected contraction of c. 40,000 volunteers aged 16 – 64 (giving 5 million fewer hours p.a.) by 2041.
3. **Understand health and wellbeing by age** – target and customise volunteering to address the health and wellbeing needs of different age groups:
 - *Young (aged 16 – 24)* – young people have the worst General Health Questionnaire mental health score of any age group, the worst statistics for anxiety and self-harm, and the second highest attempted suicide rate. Although they are the most socially connected age group nearly one in four young people are likely to have experienced feelings of loneliness in the last week.
 - *Early mid-life (26 – 44)*: some of the health and wellbeing issues affecting the young also flow through to the 26 – 44 year old age group, but to a less severe extent, particularly for mental ill-health and loneliness for those aged 35 – 44.
 - *Later mid-life (45 – 64)*: there is a noticeable increase in physical ill-health and limiting long-term conditions in this age group. Early intervention is much better than cure, so there needs to be earlier engagement to encourage the adoption of healthy behaviours, and leverage other health and wellbeing benefits from volunteering, before the health conditions present themselves.
 - *Younger old (aged 65 – 74)* – in contrast to the wide-ranging support for volunteering amongst the young in Scotland, older people have not received the same focus and encouragement. This is a missed opportunity, particularly for the 'younger old' given their characteristics:
 - Second highest volunteering participation rate
 - Highest volunteering hours of any age group
 - More available time for volunteering
 - Increasing physical ill-health
 - 15% increase in population to 650,000 by 2041
 - *Older old (aged 75+)* – they have the worst health and wellbeing indicators of any age group:
 - 56% of this age group have limiting long-term health conditions, by far the highest of any age group

- The highest proportion of people who experience loneliness and the second most socially isolated age group
- Absence of role identities such as not having a job, partner dying, no parental responsibilities in the household, etc.
- 76% increase in population to 790,000 by 2041, an additional 342,000 people.

4. Develop volunteering roles which optimise health and wellbeing – focus on the types of volunteering roles and activities which are most likely to generate health and wellbeing benefits:

- Socially engaged volunteering roles where volunteers are working in teams and where face-to-face engagement is the norm – this facilitates social connectedness, helping to minimise the risk of loneliness, and with potential spin-off benefits for mental health and wellbeing.
- Volunteering involving sport and exercise and/or activities demanding physical activity which can result in physical and mental health benefits.
- Volunteering roles which involve the outdoors and our engagement with the natural and historic environment – again providing physical and mental health benefits.
- Volunteering roles which involve creativity, arts and culture – providing mental and physical health benefits through, for example, dance and music – and also social engagement.
- Volunteering roles which give sufficient engagement (frequency and hours of volunteering) to enable the potential health and wellbeing benefits to flow through – referred to as the 'dose-response' effect.

5. Ensure volunteering 'sectors' play to their strengths – volunteering's sectoral contribution to Scotland's health and wellbeing varies according to the specific focus of each sector. Some are particularly strong in community engagement; others have a direct impact on health and wellbeing through, for example, sport and physical activity; others are particularly good at facilitating social connectedness with mental health and social inclusion benefits; and for others it is due to their focus on specific age demographics. Those with sectoral responsibilities should understand their sectoral strengths to optimise health and wellbeing benefits: see the detailed discussion by sector in Section 9.

6. Facilitate community engagement – 81% of volunteering is locally based in Scotland and the evidence shows that volunteering is good for community wellbeing and communities are good for volunteers' wellbeing. It is important that people feel that they belong to their community, feel valued, and where they can influence decisions in their community. Volunteer engagers and community organisations have a key role to play in facilitating this community engagement process through social clubs, associations, religious groups and community groups.

7. **Support communities of interest** – in addition to communities of place, volunteering should support the health and wellbeing of people through communities of interest. Digital and online communication is important where the 'community' is geographically dispersed. Virtual volunteering is also good at facilitating volunteering engagement with those subject to exclusion and isolation: for example, those who are housebound, disabled people or are isolated due to being new to an area and not having local contacts such as refugees and asylum seekers. Digital technology enables them to overcome the barriers to their engagement in volunteering.
8. **Target support to the disadvantaged and excluded** - the strongest message which stands out from all this research is that the more disadvantaged a person is the more important the contribution of volunteering is likely to be to their health and wellbeing. However, the irony is that those who can benefit most from volunteering are the people least likely to be volunteering. This is not just a key challenge, but also a key opportunity. If we want to achieve a fairer and more equal society in Scotland, then volunteering has a crucially important role to play. Using volunteering as a means of reaching and supporting those experiencing disadvantage in Scotland should be a top strategic priority in the roll-out of the 'Volunteering for All: National Framework'.
9. **Adopt good practice in engaging and supporting volunteers** – it is important that volunteer involving organisations and those involved in Employer Supported Volunteering understand the contribution of volunteering to the health and wellbeing of volunteers and local communities and how best to optimise these benefits. Detailed practical guidance is presented in this accompanying resource: [Optimising health and wellbeing benefits from volunteering: Good practice for engaging and supporting volunteers.](#)
10. **'Influencers' to provide leadership in policy and practice** – this includes national and local government, national bodies (such as SCVO, Volunteer Scotland, Voluntary Health Scotland, etc.), NHS Boards and Health and Social Care Partnerships, Scottish Volunteering Forum members, Cross Party Group on Volunteering members, the Third Sector Interfaces (TSIs) and others with a vested interest in collaborating to maximise the contribution of volunteering for the benefit of Scotland. Guidance for these influencers is presented in this accompanying resource: [The contribution of volunteering to a healthier and happier Scotland: How organisations can help to influence policy and practice in Scotland.](#)

National bodies, key stakeholders and volunteer involving organisations should focus on those recommendations which have the most relevance to them. Focus is important. Also, going from high level recommendations to action on the ground will require the development of customised solutions that are bespoke to the health and wellbeing characteristics of the organisations involved, the sector they are in and the beneficiaries they are supporting.

It is also important to make clear that these recommendations are 'work-in-progress'. The expectation is that they will be further developed and refined as more evidence and practical experience comes to light. This reflects the fact that there are still significant evidence gaps, which Volunteer Scotland and others will be working on to resolve over the coming years.

10.3 Research gaps

Specific evidence gaps include:

- **The contribution of informal volunteering to health and wellbeing** – the informal volunteering dataset from the Scottish Household Survey 2018 has not been analysed as part of this study. However, it is interesting to note that the most common activity undertaken in the last 12 months was 'keeping in touch with someone who is at risk of being lonely', comprising 18% of informal volunteers.³⁰¹
- **Understanding loneliness and the relationship to social isolation** – notwithstanding the new questions in the Scottish Household Survey 2018, there are significant evidence gaps relating to the absence of time series data; the issue of the severity of loneliness versus the incidence of loneliness (the latter is the focus of data collection to date); and the inter-relationship between being isolated and being lonely.
- **Volunteering in mid-life** – there is a lot less evidence on the health and wellbeing benefits of those aged 35 – 64 than there is for younger and older age groups.
- **Community wellbeing** – understanding the relationship between volunteering and community engagement is complex and poorly researched. One of the key conclusions from the University of Stirling's literature review was the limited evidence base in this area. The current PhD research being supported by Volunteer Scotland is addressing this specific area.³⁰²
- **Causal mechanisms** – in Volunteer Scotland's literature review the causal relationship between volunteering participation and health and wellbeing outcomes was often uncertain.³⁰³ This evidence gap has persisted within the current research study, as interesting correlations between volunteering participation and health and wellbeing indicators have been revealed through the analysis of the Scottish Household Survey and the NHS Greater Glasgow and Clyde Health and Wellbeing Survey. However, until such time as Scotland has a longitudinal dataset relevant to this area of research, this is likely to remain an unresolved issue.

³⁰¹ [Scottish Household Survey 2018 - Annual Report](#) – Scottish Government; Sept 2019

³⁰² [What we do together: Associational life, volunteering and the benefits for health and wellbeing](#) – PhD research 2019 - 2022 led by the University of Strathclyde and supported by Volunteer Scotland

³⁰³ [Volunteering, Health and Wellbeing: What does the evidence tell us?](#) – Volunteer Scotland, Dec 2018

10.4 Volunteering Outcomes Framework

Finally, building upon the high level recommendations in sub-section 10.2 we have used the report's evidence to develop a list of priorities which will help to give focus to the rollout of the '**Volunteering for All: National Framework**' (see Figure 10.1) and support the attainment of Scotland's National Outcomes in the **National Performance Framework** (see Table 10.1).^{304, 305} However, it is important to point out that this is an illustrative exercise, and it will require further development and 'stress-testing' with partners leading the rollout of the Framework.

Figure 10.1– National Volunteering Outcomes Framework



³⁰⁴ [Volunteering for All: Our National Framework](#) – Scottish Government, April 2019

³⁰⁵ [National Performance Framework](#) - Scottish Government

Table 10.1 – Volunteering Priorities Supporting Scotland's National Outcomes (illustrative examples)			
National outcomes ¹	Age	Sector	Place
<p>We are well educated, skilled and able to contribute to society</p> <p>(Volunteering and participation are valued, supported and enabled from the earliest possible age and throughout life)</p>	<ul style="list-style-type: none"> • Young people – developing the skills and experience to help young people in their careers and wider engagement with society. • Returning to work – supporting those interested in returning to work from the 'economically inactive' (mainly women in the recent past) • Long-term unemployed, refugees, etc. – building relevant skills and experience to provide a bridge into society and employment. 	<ul style="list-style-type: none"> • Children's groups – supporting the 310,000+ volunteers helping children inside and outside school • Older people – supporting the 155,000 volunteers helping older people – a key priority in that 1 in 4 of Scotland's population will be aged 65+ by 2041. • Education – for both children and adults (76,000 adult volunteers) 	<p>Applicable to all places but with a particular relevance to deprived communities where volunteering has a very important role to play in engaging those excluded from society. Volunteering can help to build skills and confidence as a stepping stone into employment. Such benefits are usually greatest for those living in deprived communities.</p>
<p>We are healthy and active</p>	<ul style="list-style-type: none"> • Young people – supporting those who have the poorest mental health of all age groups and also those who suffer from loneliness • Older people – supporting those who have the poorest physical health and are at greatest risk of loneliness of all age groups 	<ul style="list-style-type: none"> • Sport and exercise – supporting the 280,000+ volunteers who help the 3.5 million adults participating in sport and exercise • Healthcare, disability and social welfare – supporting the 215,000 volunteers who help address a wide range of 	<p>Applicable to all places but with a particular relevance to deprived communities where volunteering has a very important role to play in engaging those excluded from society. Volunteering can support the physical and mental health of people and encourage the adoption of healthy behaviours.</p>

Table 10.1 – Volunteering Priorities Supporting Scotland's National Outcomes (illustrative examples)

National outcomes ¹	Age	Sector	Place
	<ul style="list-style-type: none"> • Mid-life – supporting people to be healthier and more active before the onset of illness (age 30s – 50s). Also, helping to improve their social connectivity. Those aged 35 – 59 meet less often socially compared to any other age group. 	health, disability and social welfare conditions.	
<p>We live in communities which are inclusive, empowered, resilient and safe</p> <p>(The places and spaces where we volunteer are developed, supported and sustained.)</p>	Applicable to all ages	<ul style="list-style-type: none"> • Local community and neighbourhood groups – supporting the 258,000 volunteers who help to achieve more inclusive, empowered, resilient and safer communities across Scotland. • Also, the other sectors which are strongly embedded in community life, including: <ul style="list-style-type: none"> ○ Hobbies, recreation, arts and social clubs ○ Sport and exercise ○ Religious groups 	<ul style="list-style-type: none"> • Excluded groups – the contribution of volunteering in helping those at risk of exclusion, disabled people, gender orientation, social isolation, subject to ill-health, the unemployed, asylum seekers and refugees, etc.

Table 10.1 – Volunteering Priorities Supporting Scotland's National Outcomes (illustrative examples)			
National outcomes ¹	Age	Sector	Place
<p>We tackle poverty by sharing opportunities, wealth and power more equally.</p> <p>(There are diverse, quality and inclusive opportunities for everyone to get involved and stay involved)</p>	Applicable to all ages	<p>Applicable to all sectors, but having particular resonance with:</p> <ul style="list-style-type: none"> • Religious groups – the contribution of the 200,000 volunteers involved in pastoral care of their members and outreach support to the disadvantaged. • Political groups – the impact of 54,000 volunteers in addressing societal inequalities. • Justice and human rights – the 41,000 volunteers protecting people and supporting victims of justice and human rights abuses. 	<ul style="list-style-type: none"> • Deprived communities – tackling poverty and disadvantage through volunteering in the most deprived areas of Scotland (people living in quintile 1 of the SIMD)
<p>Note: ¹ These are the four National Outcomes embedded in the National Volunteering Outcomes Framework – see Figure 10.1. Relevant Volunteering Outcomes are in brackets.</p>			

Feedback – Volunteer Scotland would welcome feedback on both the report's findings and the implications outlined above.

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