Received: 16 July 2021 | Revised: 12 January 2022 | Accepted: 21 February 2022

DOI: 10.1111/hsc.13775

Health and Social Care in the community WILEY

ORIGINAL ARTICLE

Understanding volunteer retention in a complex, community-centred intervention: A mixed methods study in Ontario, Canada

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Funding information
This study was funded by the Ontario Ministry of Health and Long-Term Care (program implementation) and by David Braley (program evaluation). The Canadian Red Cross led the volunteer program at four of the six implementation sites, and were, in part, supported financially by Aviva. Funders had no part in the design, implementation, or evaluation of this study, nor did they have access to the data.

Abstract

Volunteers are critical to supporting health care systems worldwide. For organisations that rely on volunteers, service to clients can be disrupted when volunteers leave their roles. Volunteer retention is a multi-layered phenomenon. In this mixed methods case-control study, we compared two naturally-occurring volunteer groups supporting a complex primary care-based programme for older adults in the community: volunteers retained by the programme, and volunteers that left. Our objectives were to describe differences between the groups and also understand how compassion changed over time for those that stayed. We collected quantitative data on demographics, the UCLA Geriatric Attitudes Scale, the Professional Quality of Life Index, the Basic Empathy Scale, the Reasons for Volunteering subscale of the Volunteerism Questionnaire and the 5-level EQ-5D. Qualitative data were collected through focus groups/interviews. Overall, 78 volunteers completed surveys and 23 participated in focus groups/interviews. Volunteers that stayed were more likely to be a little older and were a slightly higher proportion male than those who left. They also had significantly less positive attitudes towards older adults, descriptively lower Cognitive Empathy and descriptively higher Secondary Traumatic Stress. Compared to volunteers who left, volunteers retained were more likely to have said they were volunteering for Enhancement or Social purposes; however, these differences were non-significant. Over time, Compassion Satisfaction decreased with a medium effect size for those that stayed, and Burnout decreased with a small effect size. Volunteers that stayed described more logistical and client-related aspects of the programme were working well. We recommend that volunteer programmes communicate positive programme impacts that could enhance volunteers' development, communicate any client impacts to volunteers to reinforce volunteers' purposes for volunteering (thus reinforcing that their work is meaningful), and ensure logistical aspects of volunteer role work well.

KEYWORDS
burnout, empathy, motivation, personal satisfaction, primary health care, volunteer retention, volunteers

1 | INTRODUCTION

Volunteers are critical to the wellbeing and function of communities as they contribute time and expertise to a variety of sectors, including the health care system (Dale et al., 2008; Gilburt et al., 2018; Hunt et al., 2011; Moore et al., 2021; Webel et al., 2010). The value of volunteers in health care has been well demonstrated in helping improve patient experiences, patient outcomes and costs (Dolovich et al., 2019; Handy & Srinivasan, 2004; Hotchkiss et al., 2009, 2014; Kaczorowski et al., 2011; Luger et al., 2016; Sales et al., 2013). One contingency of programmes working with volunteers is that there is no strict contractual obligation, meaning volunteers can easily and unpredictably leave (Cnaan & Cascio, 1998). For organisations that rely on volunteers, service disruptions can occur while new volunteers are recruited and trained. Furthermore, though volunteers are not reimbursed monetarily, there are significant financial and opportunity costs associated with the recruitment, training and management of volunteers (Brudney, 2016; Oliver et al., 2018; Tang et al., 2010b). Therefore, retention of volunteers is critical to the sustainability and efficiency of organisations.

Volunteer retention is a complex phenomenon. There are multiple interwoven factors that impact whether volunteers continue with an organisation. Two key components of volunteer retention are individuals' initial motivation for volunteering and satisfaction with the volunteer role (Bidee et al., 2017; Chevrier et al., 1994; Claxton-Oldfield & Claxton-Oldfield, 2012; Lowenberg-DeBoer & Akdere, 2018; Okun et al., 2016; Tang et al., 2010b; Van Vianen et al., 2008). Other reasons to volunteering include to use or improve existing skills, for socialisation, for personal growth, and to enhance career opportunities (Clary & Snyder, 1999; Cook & Speevak Sladowski, 2013; Lowenberg-DeBoer & Akdere, 2018; Merrilees et al., 2020). Identified reasons for volunteer cessation include other commitments taking priority, family crisis, burnout, a decline in health or a general lack of time (Claxton-Oldfield & Claxton-Oldfield, 2012; Tang et al., 2010b).

Altruistic motivations are the most commonly reported reasons why people volunteer (Akintola, 2011; Cook & Speevak Sladowski, 2013; Lowenberg-DeBoer & Akdere, 2018; Merrilees et al., 2020). Encompassed within altruism is the trait of empathy. The empathy-altruism hypothesis suggests that empathy provokes the prosocial motivation to help others in need (Batson et al., 1991); those that volunteer may be motivated by empathy. Indeed, studies have found that people who volunteer in certain settings (e.g. hospices), have higher levels of empathy compared to non-volunteers or non-hospice volunteers (Claxton-Oldfield & Banzen, 2010; Egbert & Parrott, 2003).

Satisfaction with the volunteer role pertains to the entire spectrum of volunteers' experiences. For example, good volunteer management practices by the organisation are a key factor that contributes to volunteer satisfaction (Bidee et al., 2017; Chevrier et al., 1994; Claxton-Oldfield & Claxton-Oldfield, 2012; Hurst et al., 2019; Lowenberg-DeBoer & Akdere, 2018; Senses-Ozyurt & Villacana-Reyna, 2016; Tang et al., 2010a; Trent et al., 2020; Walk et al., 2019). Other factors related to volunteer satisfaction include volunteers' awareness that they are helping others (linked with altruistic motivation to volunteering), the relationships and connections developed while volunteering, the perception of having a voice (i.e. being able to provide feedback and opinions), and volunteers being older in age (Chevrier et al., 1994; Claxton-Oldfield & Claxton-Oldfield, 2012; Cnaan & Cascio, 1998; Kulik, 2007; Trent et al., 2020). Conversely, some of the aspects that can lead volunteers to feel dissatisfied include role ambiguity, being underutilised, unclear boundaries and limitations, feeling undervalued, negative experiences, and not being able to do as much as they would have liked to in their role (Claxton-Oldfield & Claxton-Oldfield, 2008, 2012; Hurst et al., 2019; Tang et al., 2010b). Factors causing dissatisfaction such as lack of training or role ambiguity as well as younger age are associated with higher rates of burnout and compassion fatigue, a more complex phenomena of burnout which accounts for the emotional investment of caring for another (Figley, 2002; Kulik, 2007; Morse et al., 2020).

In this study, we included volunteers within Health TAPESTRY, a complex primary care-based programme aimed at helping older adults stay healthier for longer (Dolovich et al., 2019; Mangin et al., 2020). In Health TAPESTRY, community volunteers visit older

What is known about this topic

- Volunteer retention is critical to the sustainability and efficiency of organisations that rely on volunteers.
- Motivation and satisfaction are two key components in volunteer retention, however many other factors contribute.

What this paper adds

- Volunteers that were retained with the programme were more likely to, descriptively: be older, have less positive attitudes toward older adults, have higher Cognitive Empathy and Secondary Traumatic Stress, and report more personal enhancement and social reasons for volunteering.
- Volunteers that stayed and left had differences in the feedback about the programme.

adult clients in their homes to conduct health-related questionnaires and goal setting exercises, help clients connect to community-based health and social services, provide a social connection, and link clients back to their interprofessional primary care teams for further support and ongoing follow-up through custom programme technology (Gaber et al., 2020; Oliver et al., 2018).

In this paper we use the volunteer programme for Health TAPESTRY as an exemplar to further understand volunteer recruitment, with a goal of building and retaining the strongest volunteer population possible, in order to support clients' health. While general volunteer retention and satisfaction studies are plentiful in the literature, we did not find any that directly compared people that stayed to volunteer with a programme and those that left. Note that impacts on clients, the implementation of Health TAPESTRY, and other aspects related to the volunteer programme will be described elsewhere. The objectives of this study were a) to understand and describe the differences between two groups of volunteers within Health TAPESTRY: volunteers who left the programme and those who remained; and b) for those that stayed, to understand how their compassion changed over time during volunteering with Health TAPESTRY.

2 | METHODS

2.1 | Design

We conducted a case-control study (nested within a larger cohort study) comparing two naturally-occurring groups within the Health TAPESTRY volunteer programme: (i) those who continued to volunteer with the programme until its completion and (ii) those who stopped volunteering with the programme. By 'naturally-occurring,' we mean that the volunteers themselves chose to stay or leave, and this study used those groups. We used convergent mixed methods design, specifically the parallel-databases subtype, with qualitative and quantitative data collected in parallel throughout the programme implementation, analysed separately but with equal emphasis, and converged together during the data interpretation phase (Creswell & Plano Clark, 2018).

2.2 | Programme, participants, and setting

Health TAPESTRY was implemented in six sites across Ontario, Canada with volunteer visits conducted between March 2018 and March 2020. Two volunteers visited each client in their home and asked health and social related questions as well as conducted a goal setting exercise with the client using a custom web-based application and tablet computers. Summaries of clients' responses were sent to clients' primary care teams, who then created and implemented a plan of care for each client. The primary care clinics could also involve the volunteers in implementing the plan of care when appropriate. For example, volunteers would return to the client's home and provide information about community resources and programmes. Volunteers would then visit clients six months after the initial visit to complete the surveys once again.

For the purpose of this study, a volunteer was defined as an individual who completed all the necessary training (one in-person session and the online training modules) and completed at least one client visit; they may have joined at any point during programme implementation. Volunteers conducted as many visits as was feasible based on their schedule and interest; this ranged from a single visit for some volunteers to over sixty for the most active. During the volunteer programme evaluation period, all current Health TAPESTRY volunteers were invited to participate in this study via email once they completed their training. Recruitment was rolling as volunteers could start participating in the study at any point until the larger cohort study ended. While there were no other inclusion or exclusion criteria for this study, individuals had to be over 18 years of age and speak English to volunteer with Health TAPESTRY. For the purposes of this study on volunteer retention, we defined volunteers that left as those who either formally stopped participating (i.e. informed the volunteer coordinator that they were discontinuing), or those who were lost to follow up (i.e. not responding to the volunteer coordinator attempts to contact them) prior to the larger cohort study ending.

2.3 | Data collection and outcomes

We collected data on demographics (age, gender, race, education, language(s) spoken, and years of volunteering). All volunteers provided demographic information, but only the demographics from those that consented to this evaluation are included in this manuscript. For other missing data, we used pairwise deletion by only calculating each instrument's score for participants that had each variable from that instrument. The UCLA Geriatric Attitudes Scale measured attitudes toward older people, with a summed score ranging from 14 to 70, and higher values indicating more positive attitudes (Reuben et al., 1998), $\alpha = 0.71$ in the sample included in this paper. The Basic Empathy Scale (BES) measured the three factors of empathy as described by Carré et al. (2013): *Emotional Contagion*, or 'catching' others' emotions (5 items, ranges from 5–25, $\alpha = 0.84$ in our sample); *Cognitive Empathy*, or understanding others' emotions (8 items, with 2 reverse-coded, ranges from 8–40, $\alpha = 0.78$); and *Emotional Disconnection*, or separation from others' emotions (6 items, ranges from 6–30, $\alpha = 0.70$) (Carre et al., 2013; Jolliffe & Farrington, 2006), higher scores indicate stronger correlations with that factor. The ProQOL score measures three separate subscales: *Compassion Satisfaction* (feeling satisfied with the role and with helping; $\alpha = 0.87$ at baseline and 0.81 at 12-months), *Burnout* (feeling unhappy, disconnected or insensitive to the work; $\alpha = 0.64$ at baseline and 0.80 at 12-months) and *Secondary Traumatic Stress* (preoccupation with thoughts of people you have helped; $\alpha = 0.67$ at baseline and 0.56 at 12-months); higher scores on each subscale represent stronger identification with that outcome (Stamm, 2010).

The EQ-5D-5L was used to measure quality of life, with the five numeric responses to the five questions converted to an index score; we used the Canadian value set in this paper (scores range from −0.148 to 0.949, with higher scores indicating higher quality of life) (Brooks, 1996; EuroQol, 1990; Xie et al., 2016). The *Reasons for Volunteering* subscale of the Volunteerism Questionnaire (Clary & Snyder, 1999) was used to understand motivations to volunteer. The subscale includes thirty different possible reasons for volunteering which can be combined into six functions served by volunteering: Values, Understanding, Enhancement, Career, Social and Protective (i.e. use of volunteering to reduce negative feelings) (Clary & Snyder, 1999). The surveys were completed at multiple timepoints as part of the overall evaluation, but this paper only includes baseline surveys, with the exception of the ProQOL. For the ProQOL, the most recent completion is included to gauge volunteers' compassion satisfaction and compassion fatigue at their most current time with the programme or evaluation. The UCLA Geriatric Attitudes Scale, BES, ProQOL, EQ-5D-5L and Volunteerism Questionnaire were administered via LimeSurvey on a server hosted locally.

Qualitative data from focus groups and interviews were used to understand volunteer satisfaction in the programme and further understand motivations to volunteer. All volunteers were invited via email to focus groups at the approximate six-month mark in their community. Focus groups were held in community-sites with two research team co-facilitators trained in qualitative research (including HB, RC, JD, SD, JG, CK and FP), at least one of whom was physically present with participants. Focus groups were semi-structured using a question guide (see Appendix 1), audio recorded, and transcribed into intelligent verbatim by a professional transcriptionist. The question guide was developed for the larger trial with the intent of programme improvement and was based on normalisation process theory (NPT) (May et al., 2009), though NPT is not the framework used in this specific evaluation. Co-facilitators made field notes during the sessions. For sites with very small volunteer pools, individual interviews were held over the phone instead with a single facilitator, otherwise using the same methods. Programme implementation data were also used, with the volunteers' reasons for leaving (each may have reported one or more reasons) tracked in aggregate form by the volunteer coordinator at each site and presented for the entire volunteer pool. This study received ethics approval from the Hamilton Integrated Research Ethics Board (#3967). All participants provided written consent.

2.4 | Data analysis

The means of the two groups of volunteers (those who stayed and those who left) were compared through independent samples *t*-tests for the following variables: age; years of volunteer experience; the UCLA Geriatric Attitudes Scale score; the BES subscale scores (Emotional Contagion, Cognitive Empathy and Emotional Disconnection); the ProQOL subscale scores (Compassion Satisfaction, Burnout and Secondary Traumatic Stress); the EQ-5D-5L health today from 0–100 and index score; and each function within the Reasons for Volunteering scale (Values, Understanding, Enhancement, Career, Social and Protective). Gender was compared descriptively. A paired sample *t*-test was used to compare the ProQOL for volunteers that stayed at baseline and 12 months. Cohen's d was used as a measure of effect size (with a value below 0.20 considered negligible, from 0.20 considered small, from 0.50 medium and from 0.80 large) (Cohen, 1988); as we expected to be under-powered. Cohen's d was calculated by dividing the mean difference between groups by the pooled standard deviation. Significance was set a priori at $p = 0.05$. To understand whether any of the group differences may have potentially be explained by other variables, we also tested correlation between each of the variables, with a Pearson's correlation coefficient, *r*, of 0.5 or higher being considered a strong correlation.

Focus group/interview data were analysed using the steps of thematic analysis, but through a semantic rather than reflexive orientation (Braun & Clarke, 2006). First, a basic coding framework was developed by JG and FP based on the question guide categories and adapted through the first few transcripts, a method which ensured we would retain the question categories that would help us seek to understand programme improvement. Afterwards, the data was coded inductively by SD, JG and FP (all identified as female and were aged in their twenties and thirties). The coders and other team members regularly met to resolve any discrepancies and ensure themes were being understood the same way. Rigour was considered throughout and fostered through methods such as triangulation of multiple methods and coders, the use of thick description, and the use of participants' own words (Lincoln & Guba, 1985; Patton, 1999). Analyses were conducted using NVivo 12. While the qualitative dataset used in this study was initially collected and coded for an overall qualitative evaluation of Health TAPESTRY, for this study we extracted only the volunteers in the groups included in this paper. Afterwards, we probed the commonalities and differences in themes and the frequency of themes between the two groups, in order to understand the meaningful differences.

3 | RESULTS

3.1 | Participants

Overall, 78 volunteers (out of the total 127 Health TAPESTRY volunteers) completed surveys at baseline and 23 volunteers participated in a focus group or interview (overall there were five focus groups and two interviews). These groups did not overlap entirely as recruiting was pragmatic and participation was optional. Both groups largely represented the overall demographics of the volunteer pool with a range of ages (from 18 to mid-70s) and years of volunteer experience (0–40), more female volunteers than male, more European/white volunteers than any other ethnicity, and over 90% who spoke English as a first language (see Table 1).

TABLE 1 Demographics of participants

Variable	Volunteers who completed surveys at baseline ($n = 78$)	Volunteers in focus groups/interviews ($n = 23$)
Age (years)		
Range	18–75	18–78
Mean (*SD*)	40.90 (20.74)	55.86 (21.50)
Gender[a]		
Female, *n* (%)	55 (78.6)	20 (87.0)
Male, *n* (%)	15 (21.4)	3 (13.0)
Ethnicity[a]		
African/Black, *n* (%)	4 (12.9)	0 (0.0)
Arab/Middle Eastern, *n* (%)	1 (3.2)	1 (11.1)
East Asian, *n* (%)	3 (9.7)	0 (0.0)
European/White, *n* (%)	14 (45.2)	7 (77.8)
South Asian, *n* (%)	5 (16.1)	0 (0.0)
Other, *n* (%)	3 (9.7)	1 (11.1)
Highest level of education[a]		
High school, *n* (%)	9 (12.7)	2 (8.7)
Enrolled in Bachelor's, *n* (%)	14 (19.7)	4 (17.4)
Community college, *n* (%)	11 (15.5)	6 (26.1)
Bachelor's, *n* (%)	17 (23.9)	4 (17.4)
Master's, *n* (%)	13 (18.3)	5 (21.7)
Professional degree, *n* (%)	6 (8.5)	2 (8.7)
PhD, *n* (%)	1 (1.4)	0 (0.0)
Primary language[a]		
Arabic, *n* (%)	2 (2.8)	2 (8.7)
Cantonese, *n* (%)	1 (1.4)	0 (0.0)
English, *n* (%)	68 (95.8)	21 (91.3)
Secondary language[a]		
Arabic, *n* (%)	2 (3.4)	0 (0.0)
English, *n* (%)	39 (66.1)	15 (78.9)
French, *n* (%)	4 (6.8)	1 (5.3)
Hindi, *n* (%)	1 (1.7)	0 (0.0)
Mandarin, *n* (%)	1 (1.7)	0 (0.0)
Punjabi, *n* (%)	3 (5.1)	0 (0.0)
Tagalog, *n* (%)	1 (1.7)	1 (5.3)
Urdu, *n* (%)	1 (1.7)	0 (0.0)
Other, *n* (%)	7 (11.9)	2 (10.5)
Years of volunteer experience		
Range	0–40	0–40
Mean (*SD*)	7.13 (8.81)	11.26 (11.16)

[a]Missing values are not included. Other response options were provided to these questions, however only those response options that had data for at least one of the groups are listed in this table. All percentages are based on valid responses.

3.2 | Quantitative comparison of groups

Table 2 shows the quantitative data comparison for volunteers that stayed ($n = 40$) and volunteers that left ($n = 33$). While the age range was the same for volunteers that stayed and those that left, the average age for volunteers that stayed was a little higher. The group that stayed had negligibly more years of experience. The proportion of females in the group that left was larger than in the group that stayed.

Comparing the two groups at baseline we found that the group that left had significantly more positive attitudes toward older adults according to the UCLA Geriatric Attitudes Scale than the group that stayed ($p = 0.004$). All other differences between groups were non-significant (yet under-powered). Cognitive Empathy for volunteers that stayed had a difference of a small to medium effect compared to those that left. Secondary Traumatic Stress was slightly higher in the group that stayed. Volunteer quality of life had a small positive effect size comparing between groups seen in both the 'your health

TABLE 2 Comparison between volunteers that stayed and volunteers that left

Variable	Volunteers that stayed ($n = 40$)	Volunteers that left ($n = 33$)	Mean difference (stayed – left), (95% CI)	Effect size (Cohen's d)
Age in years				
Range	18–75	18–75	4.77 (−5.10, 14.64)	0.23
Mean (*SD*)	43.05 (21.11)	38.28 (20.30)		
Gender, *n* (%)				
Female	29 (65.9)	26 (76.5)	N/A	N/A
Male	10 (22.7)	5 (14.7)		
Missing	5 (11.4)	3 (8.8)		
Years of volunteering				
Range	0–40	0–40	1.29 (−3.20, 5.78)	0.14
Mean (*SD*)	7.70 (9.34)	6.41 (8.20)		
UCLA geriatric attitudes score; mean (*SD*)	53.46 (5.08)	56.91 (4.52)	−3.45 (−5.73, 1.17)	0.72[a]
BES subscale; mean (*SD*)				
Emotional contagion	15.50 (3.12)	15.06 (4.03)	0.44 (−1.24, 2.12)	0.12
Cognitive empathy	31.66 (2.45)	32.91 (3.40)	−1.25 (−2.64, 0.14)	0.42
Emotional disconnection	12.58 (2.23)	12.12 (3.42)	0.46 (−9.33, 1.84)	0.16
ProQOL subscales; mean (*SD*)				
Compassion satisfaction	40.63 (4.71)	39.68 (6.41)	0.95 (−1.85, 3.76)	0.17
Burnout	16.03 (3.57)	16.23 (4.99)	−0.20 (−2.33, 1.94)	0.05
Secondary traumatic stress	14.94 (3.40)	14.13 (2.43)	0.81 (−0.66, 2.28)	0.27
EQ-5D-5L; mean (*SD*)				
Health today (0–100)	84.63 (11.90)	82.12 (13.17)	2.51 (−3.35, 8.36)	0.2
Index score	0.89 (0.12)	0.91 (0.04)	0.02 (−0.06, 0.02)	0.22
Reasons for volunteering by function; mean (*SD*)				
Values	30.15 (4.34)	30.52 (3.68)	−0.37 (−2.27, 1.54)	0.09
Understanding	27.88 (6.65)	28.58 (5.18)	−0.70 (−3.53, 2.13)	0.12
Enhancement	22.59 (6.81)	19.18 (7.92)	3.41 (−0.05, 6.87)	0.47
Career	18.25 (11.23)	19.91 (10.22)	−1.66 (−6.72, 3.40)	0.15
Social	15.65 (8.03)	13.97 (7.59)	1.68 (−1.99, 5.35)	0.22
Protective	16.43 (7.55)	15.09 (6.60)	1.34 (−2.01, 4.68)	0.19

[a]$p < 0.05$; UCLA scores range from 14–70, with higher scores indicating more positive attitudes towards older adults (Reuben et al., 1998); BES: Emotional Contagion scores range from 5–25, Cognitive Empathy scores range from 8–40, and Emotional Disconnection scores range from 6–30, higher scores indicate stronger correlation with that factor (Carre et al., 2013; Jolliffe & Farrington, 2006); ProQOL: For each factor (Compassion Satisfaction, Burnout, Secondary Traumatic Stress), low levels are 43 or less, average levels are around 50, and high levels are 57 or more (Stamm, 2010); EQ-5D-5L scores range from −0.148 to 0.949 with higher scores indicating higher quality of life (Brooks, 1996; EuroQol, 1990; Xie et al., 2016).

today' 0–100 scale from the EQ5D and the EQ5D index score, though with each trending in opposite directions (volunteers that stayed had a slightly higher 'health today' but a slightly lower index score). Volunteers that stayed were more likely to agree the most with the Reasons for Volunteering functions of Enhancement (a medium effect size) and Social (a small effect size). Only negligible differences were found between volunteers that left and volunteers that stayed for Emotional Contagion, Emotional Disconnection, Compassion Satisfaction, Burnout, and the following Reasons for Volunteering: Values, Understanding, Career, and Protective.

There were multiple strong within-scale correlations in the Reasons for Volunteering Subscale (Enhancing and Protect, $r = 0.78$; Career and Understanding, $r = 0.61$; Understanding and Enhancing, $r = 059$; Values and Understanding, $r = 0.54$; and Social and Enhancing, $r = 0.51$). There were also strong correlations between Compassion Satisfaction and Burnout—a known association, $r = -0.70$, and between age and the reason for volunteering of Understanding, $r = -0.50$.

3.3 | Qualitative comparison of groups

As volunteer satisfaction with a programme is a concept that includes varied elements, we focused on the volunteers' responses to the questions about what was working well versus not working well overall. Many of the themes of things that were working well were not meaningfully different between groups. Both groups of volunteers felt that working with a volunteer partner in homes worked well; home visits to clients were successful, comfortable, and enjoyable; and volunteer coordinators (paid employees that were responsible for recruiting, training, and managing the volunteers, and scheduling client visits) were responsive, approachable, and prompt.

One theme that was working well that was substantially more salient for volunteers that stayed than those who left, was scheduling, *'It's been super easy to be a Health TAPESTRY volunteer… we fill out a spreadsheet and our availability, and then we match it up to the client's availability'* (V4). More of those that stayed also described feeling well trained in the programme's combined in-person and online training sessions. As one volunteer put it, *'I thought that the training was very good. We had a chance to work with [Volunteer coordinator] and she explained everything very well. We got to look at different scenarios of what we might come up against … I thought it was very well organised'* (V22). The ones that stayed were also more likely to describe that they actually provided information to clients about community resources. One volunteer said, *'There is a book that we have been given with the organisations in [City] that could help many of the patients, you know, if they have a particular problem… you could say, "Well, this maybe would help you"'* (V14). Finally, volunteers that stayed were also more likely to say they felt the programme was actually reaching clients in need (in whatever way the volunteers defined 'in need'). One volunteer said, *'I've certainly seen patients in need… We saw one guy who was really smart, organised, lived alone, very crisp, but you sense he was depressed'* (V21).

The aspects that were not working well were more variable. Again, some themes did not show much differentiation between groups, namely: glitches with the technology, training gaps, and the perception that not all clients fit the programme. Volunteers that stayed were more likely to talk about issues with the actual surveys and their wording, or with the goal setting process. As one volunteer described, *'Some of the questions are quite difficult, they're very lengthy, it's over the client's head. A lot of times we would have to paraphrase it'* (V16).

Several themes that were described as not working well were more likely to be brought up by volunteers that left the programme. Only volunteers who left felt that client recruitment is missing the people who would benefit most. One volunteer who left said, *'One of the gaps in the programme is that I don't think it's identifying seniors who are generally genuinely in risk. I've only done between 12 and 15 visits, but out of that I would say two were in risk'* (V23). Another common theme among those that left was that volunteers felt they were not connecting clients to community services, when they would have liked to take that role or know that this had been done. As one volunteer remarked, *'We leave it with [the primary care team], and we don't hear anything back, so we don't know what happens, to be quite honest'* (V13). Finally, more volunteers that left also described a lack of connection or communication between clinic and volunteers.

3.4 | Professional quality of life over time

For volunteers that stayed, we measured the three subscales of the ProQOL at baseline and 12-months (see Table 3). Compassion Satisfaction decreased significantly over time ($p = 0.031$) with a medium effect size. Burnout also decreased slightly with a small effect

TABLE 3 ProQOL subscales over time for volunteers that stayed

ProQOL subscales	*n*	Baseline Mean (*SD*)	12-month Mean (*SD*)	Mean difference (95% CI)	Effect size (Cohen's d)
Compassion satisfaction	21	40.86 (5.77)	37.67 (3.95)	−3.19 (0.3, 6.1)	0.65[a]
Burnout	21	15.57 (3.60)	14.71 (3.96)	−0.86 (−1.1, 2.8)	0.23
Secondary traumatic stress	20	14.30 (3.26)	14.55 (3.07)	0.25 (−2.33, 1.8)	0.08

[a]$p < 0.05$

TABLE 4 Volunteers' reasons for leaving based on programme tracking

Reason	Times Mentioned, *n* (%) *N* = 80
Moved	21 (26.3)
School or work commitments	17 (21.3)
Too busy	13 (16.3)
No response; lost to follow-up	9 (11.3)
Unknown reason, decided not to continue	8 (10.0)
Personal reasons (health, family care)	5 (6.3)
Issue with programme	4 (5.0)
Changed to different volunteer programme	3 (3.8)

size ($p = 0.371$). Secondary Traumatic Stress had only a negligible change ($p = 0.804$).

3.5 | Volunteers' reasons for leaving

Based on programme data collected for the entire volunteer pool—that is, what volunteers told volunteer coordinators when they left the programme, over a quarter of volunteers that left the programme left simply because they moved (26.3%). Other common reasons that volunteers gave for leaving were that they were busy with school or work specifically (21.2%) or too busy in general (16.3%). Some were lost to follow-up (11.3%) or did not give a specific reason for leaving (10.0%). Several left for personal reasons that were higher priority, such as dealing with their own health, taking care of their family or a pregnancy (6.3%). Four (5.0%) had an issue with the Health TAPESTRY programme that prompted their leaving such as disliking the surveys, feeling overwhelmed with the process, or not feeling the programme was making a difference. Finally, three volunteers left (3.8%) as they switched to another volunteer programme offered by the same organisation (See Table 4).

4 | DISCUSSION

Overall, based on the surveys and compared to the volunteers that left the programme, the volunteers that stayed with the programme were older, included a slightly higher proportion of males, had less positive attitudes toward older adults (the only significant result), scored higher on both Cognitive Empathy and Secondary Traumatic Stress, and were more likely to say they were volunteering for Enhancement or Social reasons. Based on the qualitative data, these volunteers that stayed were more likely to feel scheduling worked better, felt more trained, felt they were able to give community resources, felt the programme was actually reaching clients in need, and were more likely to talk about issues with the surveys or goal setting exercise over other issues.

However, it is important to note that some of these differences may not be particularly meaningful for comparison purposes, as over a quarter of the volunteers stated that they only left the programme because they moved. Other main reasons that volunteers gave the Volunteer Coordinators as the reasons they were leaving were mostly around busyness with school, work, or in general (approximately 38%) or they were simply lost to follow-up without a reason give (11.3%). While at first glance this may seem to be unrelated to programme elements or even to personal traits, we posit that it may actually be connected. How people choose to prioritise how they spend their time may be related only to external factors (such as work hours) but it also has the potential to be related to internal programme factors (such as their satisfaction with the programme). As we do not know for sure why the volunteers in this programme stated the reasons for leaving that they did, we probed the elements that we could in an attempt to understand further.

The fact that the volunteers that stayed were slightly older makes sense as the second most common reason for leaving was commitments with school or work, which would not apply to retired individuals but would be very common among the university and college student volunteers who are by nature more transient in location and ability to commit time. In other studies, age and gender had mixed results regarding retention with some finding that older (Cnaan & Cascio, 1998; Hank & Erlinghagen, 2010; Okun et al., 2016; Van Vianen et al., 2008) or female (Van Vianen et al., 2008) volunteers were more likely to continue or intend to continue volunteering, others finding no differences regarding age and gender (Butrica et al., 2009; McNamara & Gonzales, 2011; Tang et al., 2010b), and one finding that old age was a reason to cease volunteering (Claxton-Oldfield & Claxton-Oldfield, 2012). Based on the knowledge of the programme and volunteers, it would not be surprising if older volunteers were also more likely to say they were volunteering for Social reasons (another more common trait of volunteers that stayed), though these variables were not found to be correlated. Health was listed as a reason to leave in our study, which may be consistent with old age being a reason to cease volunteering. The EQ5D results do not show a clear picture since those that stayed had a more positive number for 'your health today', and those that left had higher index scores; however, both of these were small effect sizes.

When looking at the quantitative and qualitative data in convergence, there were some comparable concepts that provided meaningful information. One area is the concept of connection. Interestingly, volunteers that left had significantly more positive attitudes toward older adults at baseline, which would not have been expected. They also had higher Cognitive Empathy than those that stayed. The qualitative results showed more frustration from the volunteers that left in terms of them saying that they were not able to connect clients to community services, there was a lack of connection with the clinic, and that recruitment was missing clients in need. Perhaps for the volunteers that left, their motivation for volunteering (i.e. working with older adults) was not realised in their role, leaving a greater gap between expectations and reality. Furthermore, we know that altruistic motivations are important reasons why people choose to volunteer, and the Values category which describes volunteering

for humanitarian reasons is the most common in both of our groups, with only a negligible difference between groups. However, volunteers that stayed were more likely to have Enhancement as a reason for volunteering, which refers to personal growth and development through volunteering, as well as Social reasons (Clary & Snyder, 1999). Those that stayed potentially also had personal goals within the programme beyond wanting to be altruistic.

Volunteers that stayed were more likely to talk about the elements of the programme that were working well: how scheduling was done, they felt well trained, they felt able to inform clients about community resources and that the programme is reaching clients in need. Volunteers that left were more likely to describe the opposite of these ideas: that client recruitment was missing individuals who would benefit most, that volunteers are not connecting clients to community services, and that there is a lack of connection or communication between the volunteers and clinics. Good volunteer management practices by the organisation are key factors that contribute to volunteer satisfaction such as showing appreciation and recognition, including volunteers within the team, providing good communication and feedback, delivering adequate training, providing role flexibility and autonomy, ensuring volunteer expectations match the position, and having strong, inclusive leaders (Bidee et al., 2017; Chevrier et al., 1994; Claxton-Oldfield & Claxton-Oldfield, 2012; Hurst et al., 2019; Lowenberg-DeBoer & Akdere, 2018; Senses-Ozyurt & Villacana-Reyna, 2016; Tang et al., 2010a; Trent et al., 2020; Walk et al., 2019). Though volunteers at the same sites experienced the same volunteer management practices, they did not always have the same views on their success. Those that stayed were more likely to describe two areas not working well, but they were areas that only people who were invested in the programme might deeply notice: issues with the surveys and issues with goal setting. However, compassion satisfaction decreased significantly in those that stayed indicating that they felt less satisfied with their role or with helping. This sounds contradictory but could be linked to the issues they were more likely to talk about in the qualitative—issues with surveys and goal setting—for example if they felt not enough progress could be made on clients' goals.

The study had some limitations. Since participation was optional and recruitment pragmatic based on this, the entire Health TAPESTRY volunteer pool did not participate in the evaluation, thus there is potential for selection bias. A further limitation was the number of participants in each naturally-occurring group was not large enough to draw conclusions with certainty. It is also important to note that this was a study of volunteers with one particular programme, a programme that is rooted in primary care and takes place in the community, so generalisability or repeatability to other programmes or in other contexts is not guaranteed.

5 | CONCLUSION

We found useful multilayered data on characteristics of which volunteers remain and which volunteers leave a programme like Health TAPESTRY, along with the reasons for retention versus leaving. We found that the volunteers that stayed were likely to have a personally meaningful reason for volunteering such as enhancing personal skills, rather than volunteering *only* with an aim of helping and contributing to society (which we found was a reason for volunteering common across all volunteers). We found other aspects associated with retention that related to expectations and satisfaction that will be useful for others planning volunteer programmes.

For future programmes, we recommend two key things to aid in volunteer retention based on our results that enhance volunteers' experience of the meaningful work within their role. First, support volunteers' internal motivations behind volunteering, for example by developing better segmented and targeted volunteer recruitment strategies that focus on how the specific programme could impact volunteers' personal and professional growth. Second, ensure that volunteers are aware of how clients are being helped by the programme by clearly communicating this information to volunteers at the outset and during the programme. Though volunteers will naturally come and go from any community-based programme as their lives change, our results suggest methods that may help with volunteer retention and have the potential to mitigate the significant financial and opportunity costs associated with the recruitment, training and management of volunteers.

ACKNOWLEDGEMENTS

The authors thank all the team members who allowed us to be able to implement and evaluate Health TAPESTRY and its associated volunteer program in six sites across Ontario. Specifically, the authors thank Emily Chan, Doug Wayne, Henry Stevenson, and Colin Smith for their contributions to the volunteer program portion of Health TAPESTRY with the Canadian Red Cross; Cherie Gagnon and Mackenzie Berthiaume for their support in coordinating local volunteer programs; Ruta Valaitis for her oversight of data collection and analysis; Housne Begum for data collection; and our Health TAPESTRY governance team (https://bit.ly/3eaaESs). Lastly, we would like to issue a big thank you to all Health TAPESTRY volunteers, clients, associated primary care sites, and staff.

CONFLICT OF INTEREST

None.

AUTHOR CONTRIBUTION

Jessica Gaber contributed to conceptualisation, investigation, formal analysis and writing—original draft. Rebecca Clark contributed to investigation and writing—original draft. Larkin Lamarche contributed to conceptualisation and writing—review & editing. Julie Datta, Samina Talat, Sarah Marentette-Brown, and Sivan Bomze contributed to conceptualisation and writing—review & editing. Fiona Parascandalo and Stephanie Di Pelino contributed to investigation, formal analysis, writing—review & editing. Doug Oliver contributed to conceptualisation. David Price contributed to conceptualisation

and funding acquisition. Louise Geoffrion contributed to investigation and writing—review & editing. Dee Mangin contributed to conceptualisation, funding acquisition and writing—review & editing.

DATA AVAILABILITY STATEMENT

The datasets analysed during the current study are not publicly available since they contain identifying information, but are available from the corresponding author on reasonable request.

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How to cite this article: Gaber, J., Clark, R. E., Lamarche, L., Datta, J., Talat, S., Bomze, S., Marentette-Brown, S., Parascandalo, F., Di Pelino, S., Oliver, D., Price, D., Geoffrion, L., & Mangin, D. (2022). Understanding volunteer retention in a complex, community-centred intervention: A mixed methods study in Ontario, Canada. *Health & Social Care in the Community*, *30*, 2259–2269. https://doi.org/10.1111/hsc.13775