



Examining the impact of a Volunteer-Delivered counselling service for people experiencing sight loss: a mixed methods evaluation

Debra Gray & Rachel Manning

To cite this article: Debra Gray & Rachel Manning (2022): Examining the impact of a Volunteer-Delivered counselling service for people experiencing sight loss: a mixed methods evaluation, *Disability and Rehabilitation*, DOI: [10.1080/09638288.2022.2125591](https://doi.org/10.1080/09638288.2022.2125591)

To link to this article: <https://doi.org/10.1080/09638288.2022.2125591>



© 2022 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.



Published online: 21 Sep 2022.



Submit your article to this journal [↗](#)



Article views: 86



View related articles [↗](#)



View Crossmark data [↗](#)

Examining the impact of a Volunteer-Delivered counselling service for people experiencing sight loss: a mixed methods evaluation

Debra Gray^a  and Rachel Manning^b 

^aDepartment of Psychology, University of Winchester, Winchester, UK; ^bSchool of Psychology, University of Buckingham, Buckingham, UK

ABSTRACT

Purpose: This article describes a mixed methods evaluation of a volunteer-delivered counselling service for people experiencing sight loss, to identify the outcomes, benefits, and challenges of this model of service provision within rehabilitation services.

Materials and method: A mixed methods approach was used, with both outcome and process evaluation components. Outcomes for 817 service users were assessed pre-and-post service use, using standardised (CORE10) measures. Semi-structured interviews and surveys with 22 volunteer counsellors and 4 senior counsellors were conducted, to understand their experiences of the format, content, and delivery of the service.

Results: Clients presenting for counselling experienced significant levels of self-reported depression, anxiety, and feelings of bereavement. Analysis showed a significant positive change in clinical outcomes for service users who received volunteer-delivered counselling services. Volunteer counsellors saw the unique and specialist nature of the service as critical for its impact on clients, and reported benefits of volunteering for this service, including developing their skills with this client group.

Conclusions: Volunteer-delivered counselling can be effective for people affected by sight loss, providing accessible and much-needed psychological support, which is relevant given current pressures on health and social care services. There are key lessons for future models of this type.

ARTICLE HISTORY

Received 9 March 2022
Revised 17 August 2022
Accepted 13 September 2022

KEYWORDS

Mental health; vision disorders; visual impairment; volunteering; counselling; emotional support

► IMPLICATIONS FOR REHABILITATION

- Vision loss can have a profound negative impact on people's emotional and mental well-being, with many advocating for counselling and emotional support (CESS) to be included in low vision rehabilitative services.
- Despite this, access to psychological support is often overlooked in low vision rehabilitation, and access to CESS services is often poor.
- This study evaluated a volunteer-delivered CESS service, demonstrating that this model of service delivery is effective for this group.
- There are clear advantages to a volunteer-delivered model for those with sight loss, in terms of widening access, supporting integrated rehabilitative care, and reducing health inequalities.

Introduction

"Emotional support, beyond frontline help at hospitals, really needs to be recognised as an integral pathway of responding to sight impairment."
[Senior Counsellor, Site 3].

Vision loss can have a profound negative impact on people's emotional and mental well-being [1,2]. Studies show robust evidence of significantly higher rates of depression in people experiencing sight loss compared to the general population [3–5] and compared to those with other forms of sensory loss such as hearing impairment [6–8]. Sight loss can lead to feelings of bereavement and loss, panic and distress, and anxiety [1], particularly around the time of diagnosis [9] and if vision loss is accompanied by the relinquishment of valued activities, a reduction in perceived quality of life [5,10]. Researchers have additionally pointed to higher mortality rates [8,11] and risk of suicide [12] for this

group. There is also convincing evidence that people with sight loss are more likely to feel lonely, and lack social support [2,13]. Loss of vision can affect relationships with partners, family and friends, especially as some people find it harder to relate to the person with restricted vision [14], which can feed into a 'spiral of decline' for those affected by sight loss [15]. There is therefore a clear need to deal with the negative emotions surrounding sight loss, if "depression, illness, accidents, self-neglect, and social isolation are to be minimised and/or avoided" [16].

On this basis, it has been recommended that counselling and emotional support be offered to blind and partially sighted people as an integral part of low vision rehabilitation services, both at the critical time of diagnosis and on a continuing basis to facilitate a positive adjustment to the client's changing circumstances [2,17–20]. This need has also been highlighted in various standards and guidelines [21–24]. However, despite these

CONTACT Debra Gray  Debra.Gray@winchester.ac.uk  Department of Psychology, University of Winchester, Winchester, UK

© 2022 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

recommendations, access to psychological support for this group is often poor. For example, data from the NETWORK 1000 Survey, which is one of the largest surveys of the experiences of those with sight loss in the UK, indicates that less than 2% of those, aged over 18, diagnosed with vision loss access counselling in any form in the year after diagnosis [25]. The reasons for this are multifactorial. The mental health impact of vision loss is often overlooked in low vision rehabilitation, with a focus instead on the physical and/or functional aspects of vision loss [26,27], even though evidence shows that poor mental health reduces the effectiveness of these interventions. There is also evidence that people with vision loss also have significant barriers to accessing emotional help and support, due to fears around maintaining independence [28,29], and scepticism on the part of the visually impaired about the ability of those who had a sight to truly understand the issues involved with sight loss [29]. This is compounded by a shortage of dedicated counselling services for those with visual impairment, and a shortage of knowledgeable mental health providers or rehabilitation officers with training or experience in treating the emotional impact of vision impairment [20]. Indeed, mental health clinicians rate visual impairment as one of the most difficult populations to serve for reasons such as a lack of funding, accessibility, and expertise [29,30].

A volunteer-delivered service

One model that may help to alleviate these pressures, is the use of volunteers to deliver counselling and emotional support services to those with sight loss. In the United Kingdom, service providers have increasingly turned to volunteers to deliver a variety of health and social care services, as a way of dealing with rising financial and capacity issues [31,32]. In England, around 3 million people volunteer regularly across health and social care settings, and there are plans to increase training and accreditation schemes to double the number of volunteers in the NHS over the next 10 years [33]. There are clear advantages to this model for the provision of counselling and emotional support for those with sight loss, in terms of widening access, supporting integrated rehabilitative care, and reducing health inequalities. This model could also facilitate more specialist peer support, which can be more acceptable to patients who may be unfamiliar or uncomfortable with formal mental health treatment [18]. This may be particularly important for those who have experienced sight loss, who have been found to have negative views of formal counselling, especially if provided by a sighted person with little or no understanding of the issues surrounding sight loss [29].

Currently, there is little evidence as to whether a volunteer-delivered service is an effective and acceptable model for delivering emotional support to those affected by sight loss. There are very few published descriptions and evaluations of interventions of this type, which are necessary to facilitate replication and application as well as to identify outcomes, benefits, and challenges that may be critical to effectiveness. A key element to the success of this model is the volunteers themselves. However, despite this, relatively little attention has been directed to the experiences of those working in volunteer-staffed services, and the ways in which they might best be supported. Volunteering is often cited as beneficial to the individual volunteer [31–39]. However, the changing nature of volunteer involvement in pressured health and social care settings necessitates a more detailed examination of their experience, and those that manage them – as well as the impact of this on the quality and efficacy of the service that is delivered.

The current study

The current study seeks to address these questions through an evaluation of a volunteer-delivered counselling and emotional support service (CESS) for people adjusting to serious sight loss. The evaluation was part of a three-year project run by a national charity ('The Charity'), which secured funding from the Department of Health, Health and Volunteering Fund to design and deliver free counselling to those affected by sight loss, where volunteers provided the core counselling service. This paper reports the findings from a mixed-methods evaluation of this three-year volunteer-delivered CESS project, focussing on the following objectives:

1. To examine the efficacy of a volunteer-provided model of counselling provision for people experiencing sight loss; and
2. To examine the experiences of volunteer counsellors and their managers, identifying themes in relation to volunteer outcomes and impacts.

Materials and methods

The CESS project

The Counselling and Emotional Support Service (CESS) was delivered in four sites across England: Site 1 in South England, Site 2 in London, Site 3 in the North of England, and Site 4 in the East of England, with each site covering a large geographic area. In each location, a Senior (qualified and accredited) Counsellor co-ordinated the delivery of counselling services through teams of volunteer counsellors, who were recruited through counselling training courses, or because they themselves had experienced sight loss. All volunteer counsellors received a week of intensive training on the impacts of sight loss. The counselling was integrated into a comprehensive package of care and rehabilitative services. All clients underwent an initial assessment by the Senior Counsellor, typically followed by 6 to 12 (mean sessions 6.8) one-to-one, 50-min counselling sessions with a volunteer counsellor. The counselling model was humanistic and person-centred, and all counselling was free. Sessions took place either in a dedicated counselling room or in the client's home. All volunteer counsellors were provided with specialist training by The Charity in the emotional implications of sight loss. Where possible, clients were offered access to counsellors who have visually impaired themselves.

Design

A mixed methods approach was adopted, drawing on guidelines for conducting and reporting mixed research [40]. The service user evaluation was conducted using a single group pre/post-intervention design. The volunteers' experiences were captured qualitatively, to determine their views on the content, format, and delivery of the program

Service user evaluation

A total of 844 clients were accepted into CESS across all project sites and all project years. There were missing outcome data for 27 participants, who were excluded. A total of 817 clients were entered into SPSS™ 21 for analysis. Client demographics for these 817 clients are provided in Table 1.

Clinical outcomes for all clients were assessed via the Clinical Outcomes in Routine Evaluation (CORE) System [<http://www.cor-eims.co.uk/index.html>], which is widely used to evaluate service quality and outcomes. Pre-counselling, all clients completed the Therapy Assessment Form (TAF, V2), which captures information

Table 1. Demographic data for clients, by site.

	Site 1 South of England [N = 320]	Site 2 London [N = 183]	Site 3 North of England [N = 136]	Site 4 East of England [N = 178]
Age [mean years]	60.23	51.05	55.32	59.79
Gender [%]				
Female	62.8%	56.7%	62.3%	65%
Male	37.2%	43.3%	37.7%	35%
Ethnicity [%]				
White	88.2%	54.8%	89.6%	88.9%
Black, Black British, Caribbean or African	2.7%	19.9%	–	2.8%
Asian or Asian British	3.3%	14%	3.5%	3.3%
Other Ethnic Background	5.8%	11.3%	6.9%	5%
Employment status [%]				
Full time paid	6.7%	8.6%	6.9%	7.2%
Part time paid	7%	5.9%	6.9%	6.1%
Receiving sickness/ incapacity benefit	43.6%	12.4%	25.7%	25.6%
Retired	26.1%	22.6%	32.6%	42.8%
Unemployed	8.5%	41.4%	14.6%	7.8%
Other	8.1%	13.3%	10.5%	9.1%

about presenting problems and their severity, current and previous use of services, and risk. At their first and last session, each client also completed a CORE10, a measure of general psychological distress [41,42]. The limitations of the use of this measure with this group must be noted. CORE10 measures are designed for sighted clients to complete independently and were not available in alternative formats for sight loss clients at the time of the service. The CORE10 measures were therefore completed by the counsellor in consultation with the client, which limits the independence of the data [although volunteer counsellors were trained by Senior Counsellors in this method of administration]. Finally, all counsellors completed an End of Therapy Form (EOT, V2) which captured session attendance, a review of presenting problem severity and risk and how therapy ended (i.e., planned, or unplanned endings). Data were collected by counsellors during routine appointments and provided to the study team in an anonymised format for data analyses.

Data were analysed using a mixed ANOVA with CORE-10 scores (before and after) as the within-subjects factor, and gender and ethnicity as between subjects' factors. Gender and ethnicity were included as noted risk factors for psychological distress in this cohort [27,28] Cohen's proposed commonly used guidelines were used for ranking the effect size (small, partial $\eta^2 = .01$; moderate, partial $\eta^2 = .06$; large, partial $\eta^2 = .14$). Statistical significance was set at $p < .05$ [43].

Volunteer and managers experiences

Qualitative data were collected from volunteer and Senior Counsellors to examine volunteer experiences, outcomes and impacts, and issues relating to service delivery. In Years 1 and 2, all volunteer counsellors from all sites were invited to take part in one-on-one in-depth interviews. The interviews were audio-recorded and transcribed for analysis. In Year 3, counsellor experiences were captured using a qualitative survey focussing on the same areas as the interviews, with participants additionally asked to identify learning points for feedback. 22 respondents from a possible total of 27 took part across the two-time points. The Senior Counsellor from each of the four project sites was interviewed in Year 3. Questions focused on their experiences of working for the service, their management of volunteers, the benefit of CESS to clients, and services improvements and areas of good practice. Given the low numbers of Volunteer and Senior Counsellors involved in the project, and therefore the risk of identification, we have not provided a detailed table of demographics for these groups. However, the counsellors were a mix of ages, ranging from early adulthood to mid-60's, and both men and

women took part. Two of the counsellors that took part in the evaluation had visual impairment. Data from both groups of counsellors [volunteer and senior] were analysed together by both researchers using thematic analysis [44,45], to identify common themes.

Ethics

The project was conducted in accordance with the British Psychological Association Code of Human Research Ethics, 2014. Ethical approval for the project was granted by the University of the West of England [HLS/12/11/123].

Results

Service user evaluation

Pre-Counselling clinical data

The CORE10 produces a summative score of psychological distress (range 0–40), where a score of more than 10 is indicative of clinical levels of distress. The mean CORE10 score for all clients at baseline (before entering therapy) was 18.95 (SD = 7.172; see Table 2). 9.6% of clients fell beneath the clinical cut-off level (10) and 72.2% had scores above 15 indicating moderate-severe levels of clinical distress. In line with this, around 25.4% of clients counselled were assessed as being at risk for suicide; the majority of these were assessed as mild or moderate, e.g., where suicide is discussed but there is no indication of active intention. 58.7% of clients were already on medication for psychological problems. Most clients also presented for therapy with more than one severely rated problem or concern, depression, anxiety, and physical problems being the most common, with 65.8% of clients presenting with 4 or more. This indicates that clients were commonly impacted by multiple and overlapping psychological issues. Levels of clinical distress were not significantly predicted by age or ethnicity, but women reported significantly higher mean levels of psychological distress compared to men ($t = 2.656$, $df = 810$, $p = 0.008$; CI: 0.358, 2.388).

Clinical change

To determine statistically significant improvements in psychological distress between pre-treatment and post-treatment a mixed ANOVA was conducted, comparing the client's pre- and post-CORE10 scores, as well as whether there were any significant differences by gender or ethnicity (see Table 2).

As there are only two levels of the repeated measures factor, no tests of sphericity were needed. All other assumptions were

Table 2. Mean and SD for CORE10 pre- and post-counselling by Gender and Ethnicity.

		Pre-Counselling CORE10 M [SD]	Post-Counselling CORE-10 M [SD]
All		18.952 [SD = 7.173]	11.011 [SD = 7.154]
Gender	Male	17.958 [SD = 0.530]	10.495 [SD = 0.4933]
	Female	19.278 [SD = 0.360]	11.194 [SD = 0.369]
Ethnicity	Asian or Asian British	20.089 [SD = 7.093]	13.6 [SD = 8.388]
	Black, Black British, Caribbean or African	18.569 [SD = 7.283]	11.417 [SD = 6.078]
	White	18.78 [SD = 7.149]	10.61 [SD = 6.954]
	Other ethnic background	20.903 [SD = 7.174]	13.972 [SD = 7.158]

met. The repeated measures ANOVA for the intervention (pre-counselling, post-counselling) showed a significant improvement in psychological distress for all clients across the two-time points ($F = 125.14$, $df = 1$; $p < 0.001$; $\eta^2 = .18$). There were no significant effects for gender or ethnicity.

The post-therapy assessment shows a drop in the mean number of people reporting severe problems with depression ($t = 6.344$, $df = 314$, $p < 0.001$) and anxiety ($t = 4.856$; $df = 314$, $p < 0.001$), with most clients reporting benefits in more than one area, suggesting that clients attending CESS experienced global improvements in psychological distress.

Volunteer and senior counsellor experiences

The major themes that were developed from the analysis of data from counsellors¹ were: 1) the importance of a specialist service; 2) the rewarding experience of an effective, professional service; and 3) the fragility of service resources.

The importance of a specialist service

Counsellors talked of how being a *specialist*, and therefore unique, sight loss service was what made it effective and valuable: clients did not have to 'educate' counsellors on the nature of sight loss and their needs, and could safely discuss their experience, facilitating the transition into counselling, as exemplified in the following contribution: *"being understood and not judged by a counsellor who was familiar with the impact of sight loss - validating their experiences and then looking at how to make positive changes."* The specialist nature of the CESS was also key to the recruitment of both senior and volunteer counsellors, many of whom wanted to work with this specific client group in a specialist way. Providing access to counsellors with sight loss was a particular perceived positive aspect of CESS, and volunteer counsellors without sight loss appreciated having colleagues with sight loss as team members to provide specialist advice and knowledge. Volunteer counsellors who had sight loss saw themselves as having an important role in terms of modelling positive experiences of living with sight loss. Overall, this expertise and specialist knowledge were seen to enhance the quality of the service they provided and helped to create a 'link-pin' between services for clients in the sense that improvements to client's self-awareness and self-confidence made it easier for them to access other services and support that they needed, in non-specialist settings.

The rewarding experience of an effective, professional service

Volunteer counsellors reported a high level of satisfaction with their experience of the service, and a range of benefits themselves. Counsellors reported a strong feeling of personal reward and empowerment in seeing positive change in their clients, as one volunteer counsellor stated, they felt *"privileged to see a transformation in someone."* Counsellors had a sense that they were changing lives and making a difference. All volunteer counsellors spoke of the skills they had developed through training

and client contact. The training provided enhanced the feeling of providing a professional service to clients. Funded CPD and supervision were greatly valued, and volunteer counsellors were appreciative of volunteer patterns that enabled them to maintain other placements or work. For trainee volunteer counsellors, a particular benefit of the placement was the ability to accumulate client hours required by their external training.

Volunteer counsellors emphasised their positive experiences of support provided by their Senior Counsellor (SC), describing them as *"phenomenal," "an amazing ambassador," "has built and maintained a gold standard of service,"* and these were key to their continued volunteering for the service. Effective SCs engendered a sense of being part of a team-driven, and therefore effective, service, *"Regular team meetings, group supervision and 1:1's with [SC] made me feel I was really well supported and a valuable member of a very committed team."* When volunteers felt that their own needs were met and they functioned effectively as a team, they were able to enhance the service to clients, *"A team of counsellors working in this field can bring their joint experience to bear for the client group."* Similarly, SCs derived satisfaction from the team-focussed nature of the work, as explained by one SC: *"I have loved meeting the challenge of successfully developing a project that responded and supported a number of people in need, of working creatively within communities and having worked with a super team of volunteer counsellors."*

The fragility of service resources

For SCs, providing the level of support to ensure that quality service was established and delivered was a considerable task. Some counsellors felt more paid posts were needed to ensure effective and consistent service delivery, and administrative support was also felt to be lacking at some sites, with some SCs taking on such tasks, and volunteer counsellors commenting on the amount of paperwork they had to do themselves. Some SCs felt their role was resourced, and that they were working well beyond their job description:

"The role should have been full time from the start. Stop making counselling roles part time. Part timers end up working harder and making up for the lack of hours, but the public expect a 5-day service and you need it."

In contrast to volunteer counsellors, some SCs felt a lack of support and management which made it difficult to establish a strategy in their regions. Without clear guidelines at the start and without adequate induction, some SCs felt unsure of what was expected from them. While some SCs felt that a lack of direction gave them more freedom to deliver the CESS in their own way, others reported a *"stressful amount of confusion"* and a lack of leadership of the service. The importance of getting things right from the start was illustrated by one SC who commented on a *"culture of retrospective catch-up"* that had developed due to a lack of clear information. All SCs felt that the service would have benefitted from being led by one or two people, particularly by someone who had worked with sight loss, who could co-ordinate

the CESS nationally and ensure more consistency of practice. For some SC's the lack of other (particularly permanent) staff led to a great deal of lone working, which impacted their wellbeing greatly. As explained by one SC: *"I have worked greatly in isolation, facing a huge number of logistical problems."* The impact of lone working for one SC was the main reason why they chose to leave the CESS.

Several practical and logistical issues impacted both counsellor experience and service delivery. For example, the challenges of volunteer recruitment varied considerably by site and was a particular problem in areas with fewer local training establishments. This in turn impacted the amount of client work that could be done, with some SCs feeling that this hadn't been factored into the project plan, suggesting that the service didn't seem *"thought through"* in terms of practical operation. Limited counselling facilities impacted the amount and timetabling of sessions; some premises were *"set up for office work, not service delivery."* For example, the provision of home visits was seen as a beneficial part of CESS, but in most sites, this was not possible for practical, safety and competency reasons. Counsellors also pointed to additional services that could have benefitted clients, for example: *"Being able to offer a mix of telephone counselling once clients have engaged with face to face would have been supportive for a small number."* The inaccessible format of documents, including the CORE tools, was also highlighted.

Working with volunteers brought unique challenges. Complex issues arose in relation to the management of volunteers. While some SCs described their experience of working with volunteer counsellors as *"exciting and creative,"* some difficulties were experienced where volunteer practices were unsatisfactory. SCs were sometimes unsure of how to deal with this given the volunteer counsellor's volunteer status. SCs also felt that there were limitations in what could be expected of volunteers, and there were also questions over the commitment of some volunteers. Moreover, while some volunteer counsellors could work with clients with complex needs, others had less developed skills and therefore so their capacity for counselling was more limited. SCs had to assess this, and additional supervision was offered in some cases to address *"skills gaps."* The logistics of managing volunteer counsellors who had additional commitments, particularly when combined with part-time working of SCs, also meant that counselling and supervision could be challenging to schedule.

Discussion

The purpose of this study was to evaluate a volunteer-delivered counselling service for people experiencing sight loss, who are historically underserved by emotional support services [29], to identify the outcomes, benefits, and challenges of this model of service provision. This study clearly supports the wealth of existing evidence that suggests that there is a real and urgent need to provide accessible and appropriate counselling to those affected by sight loss [2,16–19,28]. In line with other research in this area, those coming to CESS presented with a variety of concerns, including depression, anxiety, feelings of bereavement and loss [20]. Moreover, most clients appear to be impacted by multiple and overlapping issues, each with high-rated levels of severity. More emphasis, therefore, needs to be placed on psychological and emotional support interventions as an integral part of rehabilitative services for those experiencing sight loss, to support clients in maintaining and/or improving their psychological wellbeing [28].

To our knowledge, this is the first study that has assessed the efficacy of a volunteer-delivered rehabilitative service for this group, and our evaluation demonstrates that volunteer-delivered services can provide specialist, accessible and appropriate counselling for this group. CORE-10 data from clients showed a significant decrease in psychological distress for clients, highlighting that the provision of time-limited and accessible volunteer-delivered face-to-face counselling has played a role in facilitating positive adjustment for those impacted by sight loss. The findings from counsellors emphasise the benefits of this specialist service for clients, as a 'safe' space to discuss issues that may not be understood anywhere else. Indeed, specialist training and access to visually impaired counsellors is seen as a key element of the success of the service and is in line with what previous research has shown that having someone who understands their lived experience is vitally important to those impacted by sight loss [29].

Uniquely, our study also highlights the experiences of the volunteers in providing counselling and emotional support service for those affected by sight loss. We found that, in general, volunteer counsellors within this service had positive – and at times transformative – experiences, receiving good support, and developing skills. For volunteer counsellors, well-structured placements which included support and training enhanced volunteer commitment and would therefore benefit from attention in any similar services. Where trainee counsellors provide volunteer resources, more formal links with training establishments could be beneficial.

These volunteer experiences are important to understand because they are central to the quality and efficacy of services, and vital for the recruitment, retention, and sustainability of volunteers [46]. In addition, such experiences speak to the ways in which volunteering can have a range of positive benefits for volunteers themselves [46–48]. It is because of these recognised benefits of volunteering that the NHS has sought to place volunteering at the heart of interventions such as social prescribing, on the understanding that those who benefit from social prescribing should ideally end up volunteering in the community group that they have joined [33]. While beyond the scope of our data, this project is suggestive that there could be important opportunities in developing volunteer-delivered services that integrated more volunteers from within the sight loss community. This could provide a 'double benefit' for those volunteers and service users, ensure the on-going sustainability of services, and further embed a unique and intrinsic understanding of sight loss within those services. Further empirical work on how this could best be done is needed.

In terms of facilitating the volunteer experience, it seems clear that the Senior Counsellor (SC) role was crucial to the success of this project. Their experiences speak to the challenges in trying to run an efficient and effective service with volunteers, including issues around building capacity, practical limitations, and leadership of CESS. These issues need to be addressed in any future service delivery of this type, as they impacted significantly on the SC and meant that some left the project early. Those new to volunteer management may need specific induction and training, particularly in performance management. Practical issues, and the need to develop a more stable funding regime to assure clients of on-going support were all areas that would benefit from more attention. In particular, the potential impact of isolation for counsellors should not be underestimated, with processes put in place from the start to alleviate this. While our study has focussed on volunteer counsellor involvement in the provision of services for sight loss clients, our findings could inform volunteer counselling services for other

long-term health conditions, and in other healthcare settings in which volunteers are involved in service delivery.

This project is not without limitations. This project has used established measures (CORE System) but as noted, these were limited by the method of data collection. Work is needed to facilitate better quality data collection for people with sight loss, and we hope that this article will stimulate this. The non-experimental design of the study, of course, is a key limitation. The lack of a control group means that we cannot reliably attribute clinical change solely to the provision of the CESS. However, it must be said that our design did include all clients who were accepted for counselling through the service, thereby reducing selection bias. Moreover, clients were accepted onto the service on a rolling basis across the three years, which may have reduced history bias. Nonetheless, findings must be interpreted with caution, and as associative rather than causal. Further research in this area can address this limitation, ideally comparing different forms of service provision or using a time-series design. The timeframe and anonymity of clients to the authors meant that, while we were able to describe change over time, we have not undertaken a longer-term examination of the effects of service provision. Our mixed-method approach did facilitate a more detailed examination of this experimental service, with the qualitative dimension enabling us to look in depth at the perspective of professionals delivering this service. Additional research with this client group is clearly needed and could help to ensure the wider availability of accessible data collection formats. The limitations and implications discussed above additionally represent potential lines of future inquiry.

Note

1. In this analysis, the general term 'counsellors' is used to refer to both volunteer and Senior Counsellors where analysis relates to data from both groups. Where specific points within the analysis were characteristic of a particular group only, this is indicated in the text.

Disclosure statement

The authors report there are no competing interests to declare.

Funding

This work was supported by 'The Charity', as part of funding received from the Department of Health, Health, and Volunteering Fund.

ORCID

Debra Gray  <http://orcid.org/0000-0002-3907-1653>

Rachel Manning  <http://orcid.org/0000-0002-8450-4104>

Data availability statement

No data are available. Permission was not given at the time of data collection from The Charity, clients, or counsellors to make the data publicly available. As the service is no longer in operation it is not possible to seek this permission retrospectively.

References

- [1] Hinds A, Sinclair A, Park J, et al. Impact of an interdisciplinary low vision service on the quality of life of low vision patients. *Br J Ophthalmol*. 2003;87(11):1391–1396.
- [2] Thurston M, McLeod J, Thurston A. Counselling for sight loss: using systematic case study research to build a client informed practice model. *Br J Vis Impair*. 2013;31(2):102–122.
- [3] Burmedi D, Becker S, Heyl V, et al. Emotional and social consequences of age-related low vision. *Vis Impair Res*. 2002;4(1):47–71.
- [4] Evans JR, Fletcher AE, Wormald RPL. Depression and anxiety in visually impaired older people. *Ophthalmology*. 2007;114(2):283–288.
- [5] Horowitz A, Reinhardt JP, Boerner K. The effect of rehabilitation on depression among visually disabled older adults. *Aging Ment Health*. 2005;9(6):563–570.
- [6] Carabellese C, Appollonio I, Rozzini R, et al. Sensory impairment and quality of life in a community elderly population. *J Am Geriatr Soc*. 1993;41(4):401–407.
- [7] Schneider JM, Gopinath B, McMahon CM, et al. Dual sensory impairment in older age. *J Aging Health*. 2011;23(8):1309–1324.
- [8] Wahl H-W, Heyl V, Drapaniotis PM, et al. Severe vision and hearing impairment and successful aging: a multidimensional view. *Gerontologist*. 2013;53(6):950–962.
- [9] Parrish RK. Visual impairment, visual functioning, and quality of life assessments in patients with glaucoma. *Trans Am Ophthalmol Soc*. 1996;94:919–1028.
- [10] Rovner BW, Casten RJ. Neuroticism predicts depression and disability in age-related macular degeneration. *J Am Geriatr Soc*. 2001;49(8):1097–1100.
- [11] Jacobs JM, Hammerman-Rozenberg R, Maaravi Y, et al. The impact of visual impairment on health, function and mortality. *Aging Clin Exp Res*. 2005;17(4):281–286.
- [12] De Leo D, Hickey PA, Meneghel G, et al. Blindness, fear of sight loss, and suicide. *Psychosomatics*. 1999;40(4):339–344.
- [13] Alma MA, Van der Mei SF, Melis-Dankers BJ, et al. Participation of the elderly after vision loss. *Disabil Rehabil*. 2011;33(1):63–72.
- [14] Cruse K. Mental health issues for people with sight problems. London: Mind; 1999.
- [15] Hodge S, Eccles F. Loneliness, social isolation and sight loss. London: Thomas Pocklington Trust; 2003.
- [16] Khan S. The emotional demands of sight loss-introducing a counselling service. *NEW Beac*. 2004;32(5):32–35.
- [17] Nicholls T. RNIB Bristol counselling project. In: International congress series. 2005;1282:211–215.
- [18] McBride S. Patients with severe sight loss: emotional support and counselling. *Optom Today*. 2005;23:36–37.
- [19] Thetford C, Robinson J, Knox P, et al. Long-term access to support for people with sight loss. *Br J Vis Impair*. 2011;29(1):46–59.
- [20] Barrow A, Ting L, Patel V. Creating a holistic support service for people with vision impairment. *Br J Gen Pract*. 2018;68(672):318–319.
- [21] UK Vision Strategy Team. UK Vision Strategy 2013–2018; 2013.
- [22] Low Vision Services Consensus Group. Low vision services; recommendations for future service delivery in the UK. London: Low Vision Services Consensus Group; 1999.
- [23] Low Vision Working Group. Recommended Standards for Low Vision Services. 2007: NHS eye care services

- programme document. NHS Eyecare Services Programme; 2007.
- [24] UK Vision Strategy. A vision 2020 UK initiative led by RNIB. London: RNIB; 2008.
- [25] Douglas G, Pavey S, Corcoran C. Network 1000. Access to information, services, and support for people with visual impairment. Vision 2020 UK/University of Birmingham; 2008.
- [26] Nyman SR, Gosney MA, Victor CR. Emotional well-being in people with sight loss: lessons from the grey literature. *Br J Visual Impairment*. 2010;28(3):175–203.
- [27] Nollett CL, Bray N, Bunce C, et al. High prevalence of untreated depression in patients accessing low-vision services. *Ophthalmology*. 2016;123(2):440–441.
- [28] van der Aa HP, Comijs HC, Penninx BW, et al. Major depressive and anxiety disorders in visually impaired older adults. *Invest Ophthalmol Vis Sci*. 2015;56(2):849–854.
- [29] Thurston M. An inquiry into the emotional impact of sight loss and the counselling experiences and needs of blind and partially sighted people. *Couns Psychother Res*. 2010;10(1):3–12.
- [30] England Vision Strategy Priorities. VISION UK; 2018. [cited 2019 Nov 8]. Available from: <https://www.visionuk.org.uk/england-vision-strategy-priorities-2/>.
- [31] Casiday R, Kinsman E, Fisher C, et al. Volunteering and health: what impact does it really have? London: Volunteering England; 2008.
- [32] Department of Health. Opportunities for volunteering scheme 2007. Department of Health; 2007. Available from: https://webarchive.nationalarchives.gov.uk/20130123184000/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_075142.
- [33] NHS. The NHS long term plan; 2019. <https://www.longterm-plan.nhs.uk/>.
- [34] Cole MB, Macdonald KC. Retired occupational therapists' experiences in volunteer occupations. *Occup Ther Int*. 2011;18(1):18–31.
- [35] Hansen T, Aartsen M, Slagsvold B, et al. Dynamics of volunteering and life satisfaction in midlife and old age: findings from 12 European Countries. *Soc Sci*. 2018;7(5):78.
- [36] Musick MA, Wilson J. Volunteering and depression: the role of psychological and social resources in different age groups. *Soc Sci Med*. 2003;56(2):259–269.
- [37] Van Willigen M. Differential benefits of volunteering across the life course. *J Gerontol B Psychol Sci Soc Sci*. 2000;55(5):S308–S318.
- [38] Piliavin JA, Siegl E. Health benefits of volunteering in the Wisconsin longitudinal study. *J Health Soc Behav*. 2007;48(4):450–464.
- [39] Thoits PA, Hewitt LN. Volunteer work and well-being. *J Health Soc Behav*. 2001;42(2):115–131.
- [40] Leech NL, Onwuegbuzie AJ. Guidelines for conducting and reporting mixed research in the field of counseling and Beyond. *J Couns Dev*. 2010;88(1):61–69.
- [41] Barkham M, Bewick B, Mullin T, et al. The CORE-10: a short measure of psychological distress for routine use in the psychological therapies. *Couns Psychother Res*. 2013;13(1):3–13.
- [42] Evans C, Connell J, Barkham M, et al. Practice-based evidence: benchmarking NHS primary care counselling services at national and local levels. *Clin Psychol Psychother*. 2003;10(6):374–388.
- [43] Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101.
- [44] Braun V, Clarke V. What can “thematic analysis” offer health and wellbeing researchers? *Int J Qual Stud Health Well-Being*. 2014;9:26152.
- [45] Cohen J. Statistical power analysis for the behavioral sciences. (2nd ed.). Hillsdale, NJ: L. Erlbaum Associates, 1988. pp. xxi–567.
- [46] Gray D, Stevenson C. How can ‘we’ help? Exploring the role of shared social identity in the experiences and benefits of volunteering. *J Community Appl Soc Psychol*. 2020;30(4):341–353.
- [47] Bowe M, Gray D, Stevenson C, et al. A social cure in the community: a mixed-method exploration of the role of social identity in the experiences and well-being of community volunteers. *Eur J Soc Psychol*. 2020;50(7):1523–1539.
- [48] Jenkinson CE, Dickens AP, Jones K, et al. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health*. 2013;13(1):773–770.