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# Equality outcomes

## Social Return on Investment Analysis

A report by nef for the Equality and Human Rights Commission and Local Government Improvement and Development.

# Contents

# Section 1. Introduction and background

The primary aim for the state when commissioning any public service is to provide improved outcomes for service users and their wider communities. As the public sector spends over £236 billion – 15% of GDP – on contracts with external organisations for goods, work, and services, public procurement provides an opportunity[1] for authorities to meet equality objectives. This should be facilitated by the Equality Act, which strengthens the legal obligation of public bodies to consider the needs of women, disabled people, and ethnic minorities as well as age, sexual orientation, gender reassignment, and religion or belief in procurement decisions.

Public authorities, however, have not always utilised their potential to achieve equality outcomes through procurement in a way that helps deliver broader corporate objectives, and supports the aims of the PSED. Although some consideration of equality is often given in the procurement process, this has a tendency to focus on use of pre-qualification questions and standard contract clauses, rather than using procurement to achieve equality outcomes. This is amplified by a failure of performance measures to capture the wider economic and social benefits.

An improved understanding of the wider economic and social benefits may also help public authorities comply with The Public Services (Social Value) Act (2012). The act places a new obligation on public authorities to actively consider how a service being procured might improve the economic, social and environmental wellbeing of the relevant area; and how a public authority might secure that improvement through procurement.[1]

This report uses the principles of Social Return on Investment (SROI) to identify the economic benefits for service users, society and the state of including equality outcomes in commissioning and procurement processes. Identifying and articulating the wider economic and social benefits will enable public bodies to deliver better value for money for communities and the state.

[1] See cabinet office policy note on the Act, available at:http://www.cabinetoffice.gov.uk/sites/default/files/resources/Public_Services_Social_Value_Act_2012_PPN.pdf

We focus our case study on a mental health day service consortium in Camden which was commissioned using an outcomes commissioning model known as the Sustainable Commissioning Model (SCM). While the project directly relates to mental health, a disability issue, the project was not explicitly designed with equalities in mind. Providers, however, were invited to demonstrate how they would meet wider community outcomes including reducing stigma and discrimination and increasing community cohesion as part of the tendering process. The main research took place in 2010.

This report has been commissioned by the Equality and Human Rights Commission and Local Government Improvement and Development.

# Section 2. Outcomes

The public sector has a duty to eliminate discrimination and promote equality of opportunity across all its functions, including when procuring goods and services from suppliers in the private and third sectors. This means public authorities have to build relevant equality considerations into the procurement process, to ensure that all their functions meet the requirements of the Equality Act, regardless of who is carrying them out. Whilst the legal obligation to consider the needs of women, disabled people, and ethnic minorities is well established, the Public Sector Equality Duty (PSED) extends this to cover age, sexual orientation, gender reassignment, and religion or belief.

Public authorities must take equality into account when:

- defining needs;
- taking relevant steps to purchase works, goods or services to meet those needs; and
- managing the performance of contractors.

Relevance and proportionately are the key guiding principles. Where it is clear that a product or service is likely to have little or no relevance in terms of equality, public authorities may not need to take action beyond some standard clauses in the terms and conditions.

In this case study, we focus on an approach taken by the London Borough of Camden and its use of the SCM. This model is innovative for several reasons but crucially it enables a range of community outcomes to be specified on the tender document, some of which relate to equality. The tender was won by a consortium of third sector organisations made up of the Holy Cross Centre Trust (HCCT), Camden Mind, and the Volunteer Centre Camden (hereafter referred to as the Consortium).

## The sustainable commissioning model (SCM)

The commissioning model was developed by **nef** (the new economics foundation) in partnership with Camden Local Authority and supported by HM Treasury through the Invest to Save budget. The Mental Health Day Care Service in Camden was the first pilot of the model. The model represents a move away from service specifications based on narrowly defined activities to one that requires potential suppliers to deliver the service to meet service level and wider community outcomes.

The SCM has outcomes, rather than activities and outputs, at the heart of the process and tender. This means the space on the tender document where commissioners often specify the exact activities they want the

providers to deliver is left blank. This enables providers (and service users) to use their knowledge of the area to demonstrate how they can meet needs at the local level and realise greater public benefit for wider community objectives. The model was designed to allow providers to innovate and, in the case of the mental health provider, this encouraged them to embed co-production and time banking into the way they delivered the service.

Another feature of the SCM is that two different 'types' of outcomes are included. These are a set of service-level outcomes (that in this case more specifically related to mental health) and a set of wider community outcomes that the provider should meet. This means that those providers who are delivering a range of wider community benefits can be recognised and rewarded for doing so. Thus a commissioner can meet equality objectives and deliver multiple outcomes without necessarily spending more money.

This approach is very different from other commissioning strategies (such as payment by results) because it means that outcomes can be delivered across departmental silos. In the tender for the service, the wider community outcomes were drawn from Camden's sustainable community strategy, and many of them have direct links to equality objectives. Other outcomes related to the environment, such as reducing carbon emissions and increasing recycling.

Some examples of the wider community outcomes that linked to equality included:

- Reducing the stigma and discrimination towards mental health in Camden.
- Enhancing well-being for service users with complex needs/multiple diagnoses.
- Ensuring citizens are more active and that there is greater community cohesion.
- Maximising opportunities for education and training for priority groups.
- Improving life chances for Camden's young people.
- Increasing numbers of vulnerable adults living independently in their own homes.
- Reducing crime and antisocial behaviour.
- Increasing access to skills and employment for priority groups (older people, carers, parents returning from work, people with mental or physical ill health).

Although the required outcomes were prescribed in the tender, providers were invited to add additional outcomes that they thought they could achieve, either at a service or Camden Community level. A full range of outcomes in the tender is set out in Appendix 1.

In total the tender was made up of seven weighted schedules, many of which contained other references to equalities. Some examples are given in Focus Box 1.

**Focus Box 1. Examples of requirements of the tender in relation to equalities**

*Schedule 1: Outcome framework and provider method statement*

This section included the outcomes tables and asked organisation how the outcomes would be delivered. In the tender response the Consortium detailed how it would develop its service to be accessible to women, young people, LGBT, and ethnic minority groups and detailed its experience working with these groups.

*Schedule 2: Service user involvement*

Within this section there was a question about how the service would involve service users from particular protected groups. The question asked: How would you adapt your service to engage, motivate and support: black and ethnic minority groups; younger people; women; economically inactive citizens?

*Schedule 3: Partnership working*

In this schedule, the Consortium outlined the range of partnerships they had developed with ethnic minority community organisations and community centres that would support the service.

*Schedule 5: Staff recruitment, retention, management, and quality*

This asked providers to demonstrate how they would ensure that the recruitment process for new staff identified sensitivity and an awareness of working with people with mental health problems, complex needs, young people, and ethnic minorities. It asked for sample interview questions used in the recruitment process. In the response to this question the Consortium provided details of its Equality Policy in relation to employees and volunteers.

This section also asked how the recruitment process would respond positively to specialist service issues of people from diverse ethnic backgrounds.

# Section 3. Social Return on Investment

This report bases its approach to measurement on a methodology known as Social Return on Investment (SROI). In a nutshell, this tool attaches a value to all of the outcomes that are identified as resulting from an organisation's or a programme's activities. This allows a fuller picture of the benefits that flow from the investment of time, money, and other resources.

## An outline of SROI

SROI is a principle-led evaluation technique that shares some roots with social accounting and cost-benefit analysis. It is stakeholder led, which means it values those things that matter to people who are affected by a programme. The stages of how to conduct an SROI are set out in the Focus Box 2 and this report is broadly structured around each of these stages.

**Focus Box 2. Social return on investment process**

Carrying out an SROI analysis involves six stages:

**1. Establishing scope and identifying key stakeholders**. Before beginning an SROI it is important to have clear boundaries about what the SROI analysis will cover, who will be involved in the process, and how.

**2. Mapping outcomes**. Through engaging with stakeholders an impact map, or theory of change, is developed which shows the relationship between inputs, outputs, and outcomes.

**3. Evidencing outcomes and giving them a value.** This stage involves finding data to show whether outcomes have happened and then valuing them.

**4. Establishing impact.** Having collected evidence on outcomes and monetised them, those aspects of change that would have happened anyway or are a result of other factors are eliminated from consideration.

**5. Calculating the SROI.** This stage involves adding up all the benefits, subtracting any negatives, and comparing the result to the investment. This is also where the sensitivity of the results can be tested.

**6. Reporting, using, and embedding**. The last step involves sharing findings with stakeholders and responding to them, embedding good outcomes processes, and verifying the report.

# Section 4. Establishing scope and selecting stakeholders

## The scope of the SROI

The first stage in undertaking an SROI is scoping which elements or parts of an organisation will be included. The focus of this research is on the equality dimension of the commissioning process. In reality, however, equality is integral to most of the outcomes that result from the Camden case study for two reasons:

1. The service is for people with mental health issues so the core service outcomes have an equalities impact with respect to disability.
2. The majority of the community outcomes that were specified on the tender document have a link with equality.

Thus, it is not appropriate to look separately at just those outcomes that relate to equality. Instead, we looked broadly at the activities of the Consortium as a whole, but with particular focus on those outcomes that had more of an equalities impact, and on the activities at HCCT and Mind in Camden.

The tender was awarded for a three-year period but the focus of this SROI is for the year 2009/2010 as this is the year for which the most detailed outcomes information is available.

## Identifying stakeholders

The intention of the SROI is to capture the most relevant impacts of the Consortium. While the service clearly has effects on a wide range of people, it is important that only those that are material are included. A stakeholder is considered material if its omission has the potential to significantly change the overall findings and alter decisions made on the basis of the SROI results. We apply this principle in the selection of both stakeholders and outcomes below.

In the SROI model, we have included four key stakeholder groups which are listed below. This does not include everyone who uses the service and some more detail on stakeholders is given in Appendix 2.

1. Service users

   In this report, service users are defined as people who have a mental health issue who have been referred to the service (of which there were 541 in 2009/2010). Although all service users have a mental health condition, in reality they are still a very diverse group. To reflect this diversity, service users are disaggregated into two groups – 'type A' and 'type B.' Type A has more severe and enduring mental health conditions and type B more moderate ones. (see Appendix 2 for more information).

2. Support Time Recovery (STR) volunteers
   The Consortium works in a way that involves service users and volunteers in the delivery of the service and time bank helps to facilitate this. All volunteers are members of the time bank but in this stakeholder group we refer specifically to a separate sub-set of the time bank membership who has completed the accredited STR training programme. STR volunteers are included as a separate group because they have specific outcomes related to their training and involvement in the service.

3. Community
   This stakeholder group includes the wider time bank membership beyond people who are already counted as service users above. It also represents local community organisations who have partnered with the Consortium to accept time credits and make their services more accessible to people with mental health issues.

4. State
   This includes all state budgets including Camden Council, as well as savings to central government departments.

# Section 5. Mapping outcomes

## Introduction and background

### *The theory of change*

In this section we develop a 'theory of change' of the activities of the Consortium. Essentially this tells the story of the relationship between the activities, outputs, and outcomes to help understand what changes as a result.

### *Multistakeholder analysis*

In performing this analysis, it is important to include the material[2] outcomes that accrue to all the stakeholder groups who are affected by the work of the Consortium. To understand what these outcomes were a range of different people were interviewed including project staff, service users, time bank members, and volunteers. Most of the interviews were done at HCCT and some at Mind in Camden. For a full audit of the stakeholder research conducted please see Appendix 3.

## How does the Consortium work?

The first part of the theory of change involves understanding the activities of the Consortium. Driven mainly by HCCT, there are several fundamental elements to how it delivers services which include co-production, the training programme for volunteers, and a focus on delivering activities in the community.

### *Co-production*

The delivery of services across the Consortium is based on co-production. Co-production is a term which describes a particular way of approaching public services: it means that services are designed and delivered in equal partnership with the people who use those services. The approach includes a strong emphasis on incorporating the strengths and assets of service users and the wider community in the delivery of services, developing people's skills and capabilities, and supporting peer support networks.

This operates in several ways. Volunteers and service users are responsible for delivering many of the activities. This enables a much greater range of activities to be offered and often users can choose from a larger menu of things to do. Service users, who in other organisations might be seen and treated as passive recipients, have a strong role in influencing and developing the service. It also means the service can be open for more hours and in the evenings and weekends which would not have been possible without the use of volunteers, improving accessibility for different groups, with different needs.

The benefits of co-production go far beyond increasing capacity, however, and can enhance the quality and sustainability of the project. People who have experience of mental health issues and are on a mental health recovery pathway may be best placed to support others in this journey and may also provide a source of inspiration as to how to do this. It also gives users the opportunity to develop new skills and take on extra responsibility delivering these services which can aid mental health recovery. Staff and users at Holy Cross centre, for example, testified to the therapeutic impact of co-production. Rather than being the passive recipients of a service, users can bring their own skills to the service and be valued for their contribution. One service user describes how the time bank can encourage people to get more involved in the service:

> *Before, people came in, sat at the table, and expected soup, coffee and tea. Now, from the group of people that come, there is always someone who, for instance, says I'm going to clean the tables today. I'm going to go half an hour earlier to set up everything. It makes people more involved in Holy Cross.*
>
> Service user, White European Male

Whilst the whole Consortium uses co-production it seems that HCCT is really leading and driving this agenda forward. The principles of co-production extend to work with community partner organisations many of whom accept time credits in exchange for services, such as theatre tickets, gym sessions, or room bookings.

### *Accredited Support Time Recovery (STR) training*

The Consortium offers volunteers and service users the opportunity to take accredited training to become a foundation STR worker. These volunteers work alongside senior and intermediate STR paid workers and free up the time of paid workers to undertake more complex tasks.[3] To take the training, volunteers have to earn enough time credits (140) to 'pay' the course fees. STR volunteers are from diverse backgrounds; HCCT recently ran a programme targeted at older people. Staff feel that the diverse backgrounds of volunteers encourages diverse attendance of service users.

*It makes the volunteers more demonstrative of the people that use the services. I think they found it easier to empathise with service users… they have more diversity of life experience.*

HCCT, staff member

There are also a number of important outcomes that accrue to the STR volunteers themselves as this is a very practical qualification, and many people who take the training go on to paid work.

### *Delivering in the community*

The Consortium also has a key focus on delivering activities within the community. This ranges from running activity sessions in community settings to encouraging partners to make their activities more accessible to people with mental health conditions, for example, by running mental health awareness training and enabling people to take time credits as payment for activities. This is often a significant change for some service users who are used to relying on activities within one of the centres. It also helps partner organisations to have an increased awareness of how they can make their services accessible and potentially reduce stigma and discrimination against people with mental health issues.

## What changes?

The tender specified a broad range of outcomes of which only five are included in the SROI: improved mental health, employability, more social networks, community cohesion, and reduced stigma and discrimination. The impact map in Figure 4.1 is a synthesised description of how these outcomes are achieved by the organisation.

In this section we define in more detail what these outcomes mean to the stakeholders we spoke to in our research. In Section 5 we go on to evidence and value these outcomes.

### *Mental health recovery*

Mental health recovery is one of the core outcomes of the service and the activities of the Consortium are designed to achieve this aim. Achieving a sustainable recovery from a mental health condition, however, is a complex and dynamic process and in reality can be driven by many factors. Within the mental health field there is a general consensus that, although the treatment of distressing and disabling conditions is important, recovery-focused practice must promote wider well-being and the recovery of 'meaningful, satisfying, and contributing lives.'[4]

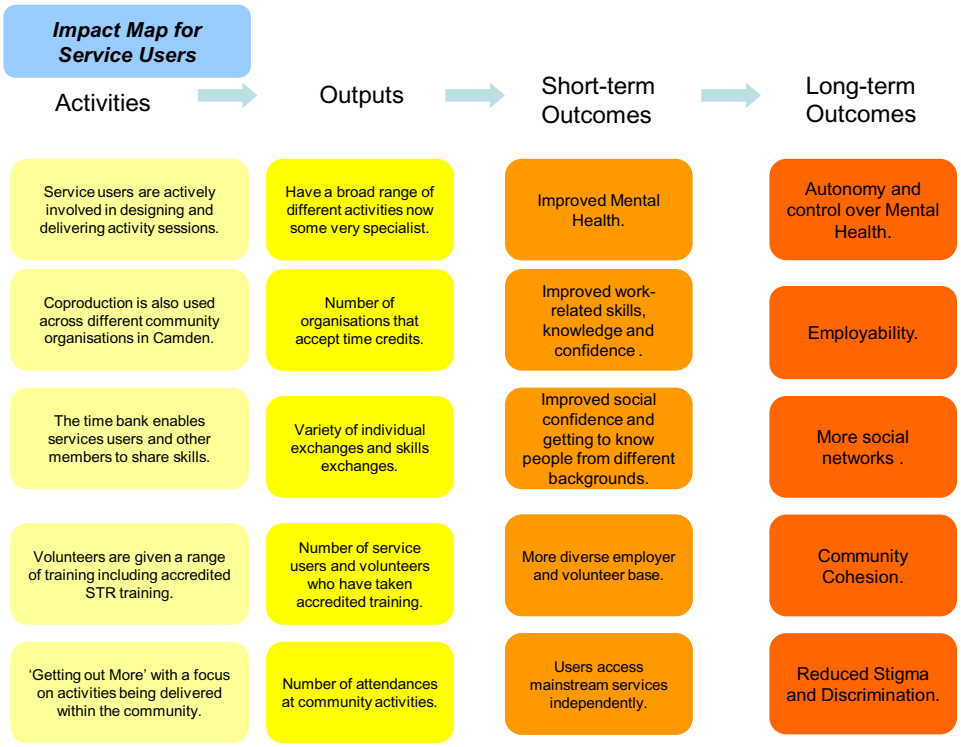


***Figure 4.1. Consortium Impact map for service users at the***

This means that as well as providing support time and group therapy sessions, the Consortium also has a range of activities to enable people to build social networks and contribute to the centre. The volunteering opportunities for service users build confidence and can lead to improved mental health as shown in Case Study 1.

**Case Study 1. Volunteer**

Jack[1] has been volunteering at Holy Cross for some time. He has mental health issues but doesn't live in Camden so isn't technically classified as a service user for the Consortium. He was interested in volunteering and was put in touch with Holy Cross. He has tried lots of other places to volunteer but particularly likes the atmosphere at Holy Cross. One of the things he likes about the centre is the diversity of the people that use it and feels the time bank can also help to see different people's skills.

*People can often surprise you…like one guy from Israel, I always knew he was good on the piano, but his artwork is brilliant and when you watch him play table tennis and table football he is really lively and he plays with a real passion.*

Although Jack is not a service user of the mental health services at the Consortium, he talks about the positive effects coming to Holy Cross has had on his health.

*I had a consultant psychiatrist and he wrote me a letter when he discharged me back to the GP and he said he had known me for a long time and that due to the volunteering my social confidence and self-esteem had improved vastly.*

The Consortium is able to open at weekends and outside of normal working hours which means people have somewhere to go on every day of the week and staff can be aware of when they are not there. This social space is very important as described by an STR worker:

> *One of the first signs of people getting ill again or relapsing is they start isolating themselves. That social interaction, particularly for people that don't have a lot of family, and this is their only social place, then that is worrying. Outside of their medication they need that discipline and motivation to keep going and the social is very important.*
>
> STR worker

### *Employability*

The Consortium does not see employment as one of its primary functions and where possible it works with other Camden services that support people back to work. Despite this, our research pointed to some important employment outcomes and by providing people with work experience and skills many volunteers at the centre go on to get paid work.

Whilst we don't have outcomes data on employment disaggregated by protected groups, staff reported that many people who have gone on to get work are older or ethnic minorities. These are groups that would have been less likely to volunteer otherwise; for example, information the London Borough of Camden Place survey shows that ethnic minorities are half as likely to volunteer as White groups.[5]

Employability outcomes accrue to STR volunteers as well as service users. Indeed many of the 191 people who have taken this qualification at the centre have gone on into paid work. These volunteers particularly valued the vocational nature of the training and many felt this was pivotal to them gaining employment.

> *A lot of it came from the experience, I did the Level 2 training here, but most of it was the experience of working at a senior level at a young age and having done lots of things at the same time.*
>
> Volunteer STR worker

### *Social networks*

This outcome refers to the expansion of connections that one individual has with other individuals. There are two types of such 'connections':

1. Connections with similar people, i.e. individuals with similar demographic characteristics.
2. Connections with people who are different, such as those from different ethnic groups, or people who have mental health problems.

These two types of social relations have also come to be understood as 'bonding' capital, and 'bridging' capital. Bridging capital, where the ability to make connections

with other groups is enhanced, is particularly relevant for community cohesion. However, both types of connections help to lower social isolation which results in better mental health outcomes.[6]

Interviewees expressed the benefits of bonding and bridging relationships in different ways. For example, one homeless service user felt that meeting others in a similar position to his had made him feel more comfortable with his own predicament:

> *So you don't feel alien because of the situation that you are in.*
>
> Service user, White English male

People also felt there were specific benefits of meeting people from different backgrounds and for some this was the opportunity to learn new skills or improve their English, as shown in Case Study 2. Interviewees often reflected on the diversity of people who come to the centre, highlighting the ways they had benefited from mixing with others.

The atmosphere at HCCT encourages mixing between people from different groups including people from different backgrounds and socio-economic status. One student volunteer commented that coming to the centre had made her realise that she had a much more privileged background compared to some of the service users. Despite this she went on to say that she had added some of the people she had met as friends on facebook and been able to get to know people from different backgrounds:

> *That's why I love Holy Cross because it brings together people from all over the world… so I find that we are able to have very meaningful conversations even if you have only met them once. I think this is also because of the way the time is structured; the sessions are 3 hours which is a good amount of time.*
>
> Volunteer

### *Reduced stigma and discrimination*

Reduced stigma and discrimination was an outcome specified in the original contract. It is particularly relevant in this study because users and volunteers include people with mental health problems, who are homeless, members of racial and religious minority groups, and those with refugee and political asylum status. These groups can often be stereotyped in a negative way, and are subject to discrimination in several aspects of their life which can result in social exclusion.

As well as support for individual service users, the Consortium works with other community organisations and private sector organisations in Camden to overcome stigma and discrimination outside of the service. Some of this is done through the time bank where people can spend time credits on activities or services they would be otherwise unable to afford. The Consortium has also run mental health awareness training for staff in other organisations to increase awareness of mental health.

> *We want our services to be more reflective of the local community; it makes us a better organisation if we have a mix of people from different backgrounds.*
>
> Organisation which accepts time bank credits

We spoke to several organisations about their motivation for allowing people to spend their time credits with them. All expressed a desire to increase the diversity of their clientele and ensure that their services were inclusive. When asked why this was a particular aim, several expressed a belief that an increased mix of clients would result in reduced discrimination and negative stereo-typing which in turn would lead to greater harmony in the local community.

**Case Study 2.** Time bank **member**

Sara[1] initially came to the Consortium on the recommendation of a friend in 2008. This was soon after she arrived in England from Iraq seeking asylum and at a very stressful period in her life. Getting advice and emotional support and help with the asylum application were very important to her. She also particularly valued the opportunity to be involved in the time bank and to be able to offer something to others in return for the help she got from the centre.

Over the first year, she was involved in time banking activities. She started off by earning a lot of credits working in the kitchen and spent some of these taking training in food hygiene. She also got more involved in individual exchanges. One of these exchanges was with a mental health service user who was a former maths teacher. He gave her tuition in exchange for time credits and encouraged her to take a maths exam.

One of the key outcomes for Sara was being able to mix with people from different backgrounds which helped her to learn English. The time bank meant she could give something back in exchange and thus contribute and feel valued.

*When I do it I feel my English becomes better, and it improves my confidence. I feel I do something. I try to forget my problems. I take inspiration from the people around me. They give me something I needed. I feel support(ed)... In return I give all of my time here. All my time. Because I feel they give me so much. As an asylum seeker I have nothing. So I give my time.*

As Sara has been involved in the centre for longer than most, she sees her role as giving support to others and helping them to get more involved with the time bank. She also spends her time credits on some of the activities in the community. She likes the fact that the gym offer times when there are women-only fitness sessions. She encourages other time bank members to go there too.

After gaining citizenship in the UK she has also just got a job. She attributes this to being able to improve her English in the centre and gaining skills and work related training qualifications.

### *Community cohesion*

Community cohesion is a term that can mean different things to different people. Officially it has been referred to ‘togetherness’ or the ‘glue’ that holds a community together. This can include social relationships and interactions between people which

ultimately leads to mutual respect and understanding between disparate groups, and the coalescence of common values and shared goals for community.

Community cohesion became a key buzzword in policy in the wake of the Bradford riots in 2001. The racially charged atmosphere from which the violence emerged was seen as all too indicative of what can happen when a community is divided on racial and/or religious lines. The government invested millions in initiatives that aimed to increase understanding and cohesion between disparate groups, and countless policy documents were issued detailing the need and best ways to help communities to gel. The HCCT centre provides a useful example of how services can be delivered in a way that strengthens community cohesion.

Figure 4.2 illustrates the interdependent relationship between increased social networks, reduced stigma and discrimination, and community cohesion. In reality, the three perform as both inputs and outputs, reinforcing each other. However, social networks are a key starting point, and in the HCCT context, these networks are enabled through the use of co-production and time banking.

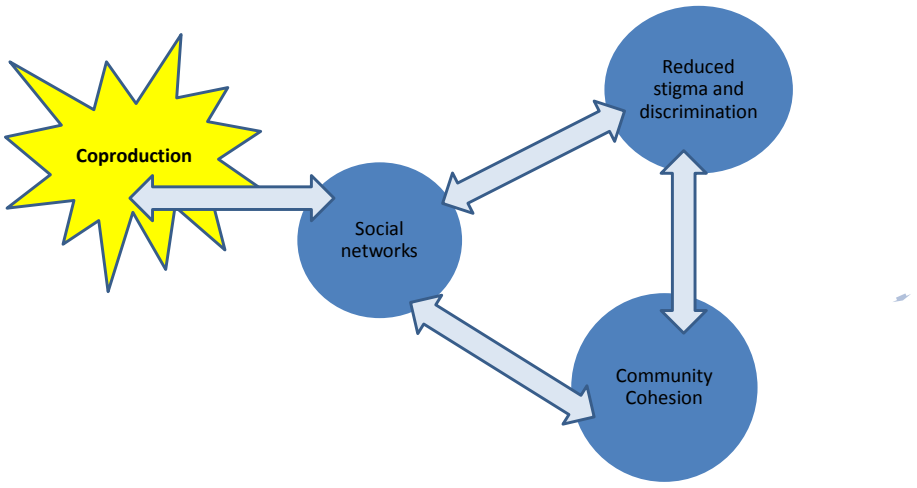


***Figure 4.2. The relationship between social networks, reduced stigma and discrimination, and community cohesion.***

'Community cohesion' differs from 'social networks' because it is not only about being 'friends' but building a strong and unified society. Again, the diversity of the centre is key to achieving this outcome. One service user noted that:

> *I can honestly say this is the most diverse place – sometimes it's hard to tell who are staff and who are users. Everyone just mucks in.*
>
> Service user

The examples described in Case Studies 1 and 2 both illustrate how, through co-production and mixing with others, service users and volunteers have changed their attitudes to some other groups, and felt much more able and confident to mix with

people from different backgrounds. Furthermore, these new relationships have had positive effects on their well-being.

Given that the method of delivering services has resulted in increased volunteering, reciprocity, better understanding between people of different origins and backgrounds while making the community a better place, HCCT offers an insight into how to achieve key objectives of the Big Society.

# Section 6. Evidencing outcomes and giving them a value

This stage identifies indicators that demonstrate the extent to which the outcomes have happened and the value of these outcomes to the different stakeholders involved in the service.

## Outcomes indicators

Indicators are a way of knowing that an outcome has taken place. The use of outcomes indicators is consistent with the principles of SROI and the guidance on SROI published by the Cabinet Office.[7] A full list of indicators used to evidence the occurrence of outcomes is presented in Table 6.1.

In general it is best to balance subjective (generally self-reported) and objective (generally observable) indicators. For example, two indicators are used to evidence the outcome of improved mental health. The first is the number of people who have self reported an improvement based on the outcomes star (subjective) and the second is the number of people who are volunteering in mainstream settings (objective). The outcomes and indicators used for service users are shown in Table 6.1. A complete list of all outcomes indicators used and their data source is given in Appendix 4.

## Distance travelled towards outcomes

Many of the outcomes that are set out in the impact map may take many years to achieve and it is important that outcome indicators are able to take account of distance travelled towards outcomes. This is particularly the case with mental health recovery where the journey towards recovery may include relapses and good and bad days, or people may feel worse in the short term as they gain greater self-awareness.

The original mental health contract stipulated use of the Mental Health Recovery Star. The outcomes star was initially developed in the homeless sector but has since been adopted for several other service areas including the version the Consortium began using for mental health recovery. Each outcomes star is underpinned by the same journey of change – a model of the steps that service users will typically go through before they reach ‘self reliance’ or a stage where they have control and autonomy over that outcome in their lives.

The outcomes star is useful for giving information about distance travelled towards outcomes for individuals. This means that service providers can report to commissioners what the service user's starting point is before the intervention and track progress towards lots of different outcomes.[8] It can also highlight particular areas where progress is not being made, or where there are gaps in the provision of support provided.

Although initially providers felt the outcomes star would be a positive and useful tool, it proved quite long and involved for use in the day service where key work is not a core element of delivery.[9] To overcome this, the Consortium worked with Triangle Consulting to develop a day service version of the Recovery Star. This is a five-point star retaining the integrity of the underlying model of change. The Consortium is also working with Substance Cooperative to introduce the Substance Project Reporting System (SPRS) to build an online database for recording details of service users, activities, and specific outcomes. The data from this was not available at the time of this report.

The approach taken in this SROI model was to break two of the outcomes (improved mental health and employability) into three different sub-outcomes. This enabled the model to value the distance a person may travel towards autonomy over mental health, or towards employment. Mental health stability is included as an outcome because although recovery is the ultimate goal, a crucial part of the work of the Consortium is to pick up warning or trigger signs in service users and prevent them having a relapse or crisis. Prevention from relapse or a crisis has a value to these people and the state.

## Outcomes data collection

Once indicators have been established, data is collected to establish the extent to which the outcomes have occurred. In general we have used outcomes data from the providers. This was not always available and some of the outcomes are not those that are currently reported to commissioners and funders. In some cases we have made estimates. These are detailed in Appendix 4.

## Outcomes and equalities

In the previous section we looked at the equalities requirements set out in the tender. This section looks at how these activities brought about outcomes. We look at two elements. First, is there any evidence of who uses what services, of who gets training or jobs, or of improved social networks by equalities groups. Secondly, we look at how this new approach impacts different groups (positively and negatively).

*Table 6.1.Outcome indicators for service users*

| Outcome | Outcome categories | Indicators |
|---|---|---|
| Improved mental health | Significant increase in mental health | Number of service users who have made a 'large positive change' in mental health on the outcomes star.<br>Number of service users engaged in activities independently of the service. |
| | Some positive change to mental health | Number of service users who have made 'more modest improvements'' in mental health on the outcomes star.<br>Number of service users currently volunteering in the service. |
| | Stability to mental health | Number of service users who have stayed stable in mental health. |
| Employability | In employment | Number of service users who go on to get work. |
| | People 'work ready' | Number of service users volunteering in mainstream settings.<br>Number of service users attending training and education in mainstream settings.<br>Number of service users referred to employment support services, job broker, work experience or placements. |
| | People who have made some progress. | Number of service users currently volunteering in the service.<br>Number of service users who have taken training and education within the service. |
| Social networks | Mixing with people from the same background | Number of service users with an increased score on the 'social networks' scale of the star. |
| | Mixing with people from different backgrounds | Estimate of the number of hours in the time bank where people mix with people of different backgrounds |
| Less stigma and discrimination | Accessing services that would not have otherwise | Number of credits spent in the community. |
| Community cohesion | Giving back | Number of service users volunteering. |
| | Feeling safe | Estimate of the number of service users at risk of crime. |

### *Who uses the service?*

In terms of numbers of people accessing the service, there was a general feeling among users, staff, and volunteers that there was a real mix of people from different backgrounds, with the exception of an underrepresentation of the Bangladeshi community.

It is important to understand what the background demographics are in Camden and the incidences of mental health issues by protected groups. It may be appropriate for some protected groups to be overrepresented as users of some services if this reflects greater need.

In general, black population groups are overrepresented in national and local surveys of inpatient admissions and a number of related measures including admission to Psychiatric Intensive Care and use of the Mental Health Act.[10] In contrast Asian groups are underrepresented in adult Community Mental Health Team (CMHT) caseload and admissions. It is difficult to assess why Asian groups are underrepresented. It could be a failure of services to be adequately reaching out to this group; it could be because mental health incidences are lower; or it could be that there are greater community support networks. The Camden mental health needs assessment also identified other groups who were particularly susceptible to mental health issues: the transient population (both daily movement across borough boundaries and national and international moves) and the homeless and hostel population.[11]

When you compare the absolute percentages of time bank members with the background population of Kings Cross Ward (where HCCT is based) there does appear to be a good representation of all groups (Figure 6.1). Looking in more detail at ethnic categories and at the difference between groups and the general population, there seems to be significant underrepresentation of the Bangladeshi Community (Figure 6.2). This difference falls if compared to the average CMHT caseload across Camden (also shown in Figure 6.2 in red legend). It is not possible to say whether this is because members of the Bangladeshi Community are less likely to experience mental health issues, or because they are underrepresented among the CMHT caseload for other reasons as outlined above. There are fewer White British time bank members in relation to the proportion of White British in the Kings Cross ward; however, there is not a significant difference when compared to the CMHT caseload for this ethnic group. This suggests that fewer members of this group access the service because there are fewer members with mental health issues.

There was also no evidence of Lesbian, Gay, Bisexual, and Transgender (LGBT) users of the centre, although frontline staff did think there were several LGBT service users, even if they had not disclosed this.[12]

### *What are the outcomes of different equalities groups?*

The intention of this research was to assess the extent to which different protected groups may have made progress towards outcomes, or the

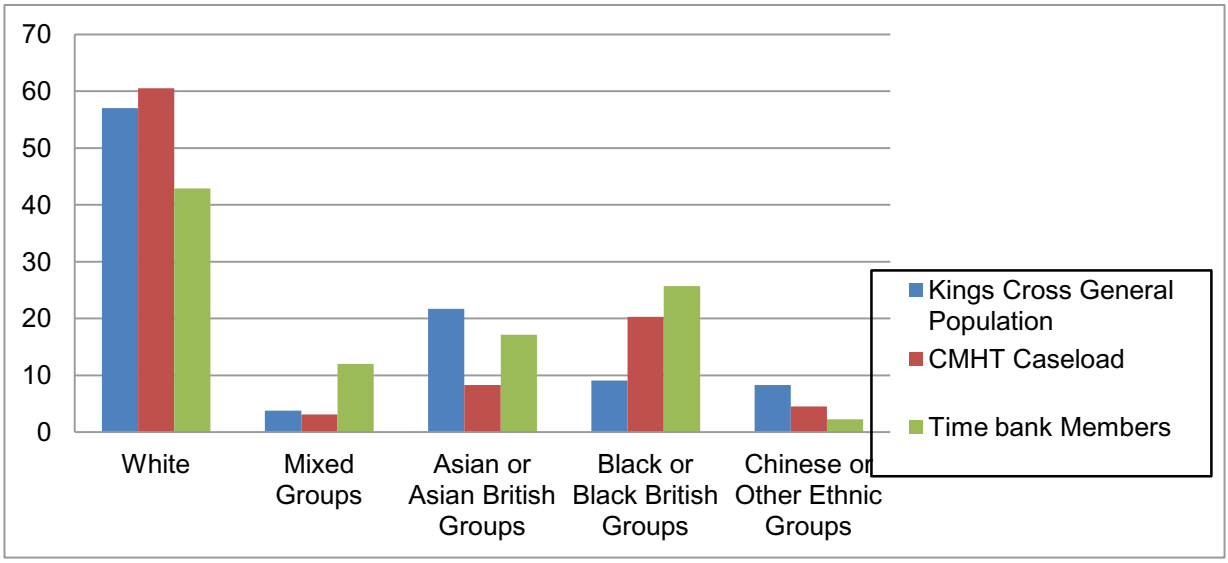


***Figure 6.1. Comparison of ethnicity of the general population, the CMHT caseload, and time bank membership.***

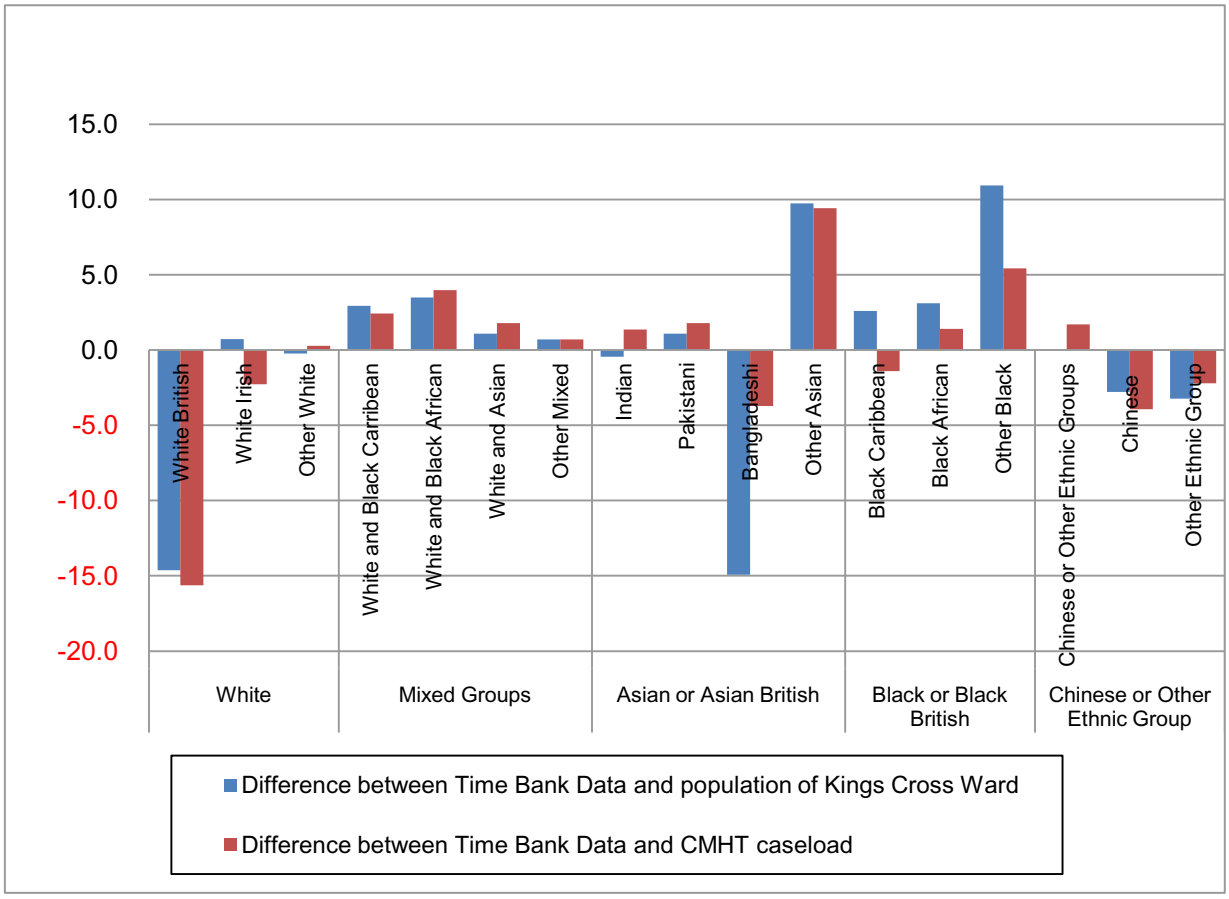


***Figure 6.2. Comparison of ethnicity of time bank members and the general population in Kings Cross and the CMHT caseload.***

extent to which better outcomes may have been achieved for some protected groups. In reality this is challenging because, while the service complies with statutory requirements to monitor users by protected characteristics, this doesn't necessarily apply to outcomes. For example, the Consortium monitors the equalities background of the number of people accessing different training courses (an output) but it doesn't capture this for the numbers of people who go on to gain employment (an outcome).

However, we know that employment outcomes for particular protected groups are particularly poor. A report published by the ONS drawn from the Psychiatric Morbidity Survey found that, compared to people without a mental disorder, people with a psychotic mental health condition have double the rate of unemployment or economic inactivity.[13] Although we don't know the proportion of those who go on to find work who had psychotic mental health issues, there is evidence from the Consortium that a number of people with severe and enduring mental health conditions are involved in the time bank and are taking steps back to work. We have built this into our analysis of deadweight (see section 7 for more details on deadweight).

Also although there is no data collected on the number of people engaged in social activities by protected characteristics, there is anecdotal evidence that time bank members, and particularly refugee groups, have made considerable progress with social networks. There is also qualitative evidence that they have been able to spend time credits taking part in activities that they would not been able to afford if they had not had time credits. These include activities such as visiting the British Library, trips to venues such as Kew Gardens, and getting free tickets to Wigmore Hall. Evidence from Sport England for national indicator data shows that people from a non-white background were much less likely to take part in cultural activities:[14] 62.8% of non-white people attended a museum or art gallery in the last 12 months compared to 85.2% of white people. Similarly 58% of people with a limiting disability had visited a museum or art gallery in the last 12 months compared to 81% of people without.

Also the nature of the service and the bottom-up nature of the commissioning process meant there were some outcomes that occurred that were not included in the contract. Some of these were very specific to particular population groups in Camden. For example, when the tender went out, it may not have been obvious that there would be a reasonably large number of refugees from Iran and Iraq, yet the service was able to respond to this new community group in a proactive way. This is good because it shows a frontline service being able to respond to need and to support the integration of new refugee groups. It does mean that the outcomes measurement process in place may not capture this work adequately. It may take a while for the performance management system to 'catch up'.

## Monetising outcomes

The next step in the construction of the economic model is to attach monetary values to the outcomes. For individuals and the community, the monetary figures reflect how much they value the occurrence of that outcome. This includes things that are not traded, and for which there is no price in the typical sense. While there is no conclusive way to place value on such changes, a range of different techniques are used depending on the stakeholder. The outcomes that are valued for each stakeholder are

set out in Table 6.2. More detail on the methodology for attaching proxies to specific outcomes is given in the focus box and a full list of proxies are set out in Appendix 5.

***Table 6.2. Summary of which outcomes were valued to which stakeholder.***

| Outcome | Stakeholder to which outcome valued | | | |
|---|---|---|---|---|
| | **Service User** | **STR volunteer** | **Community** | **State** |
| Improved mental health | Y | | | Y |
| Employability | Y | Y | | Y |
| Social networks | Y | | Y | Y |
| Less stigma and discrimination | Y | | Y | Y |
| Community cohesion | Y | Y | Y | Y |

**Focus Box 3. Using stakeholders to determine value**

Stakeholder interviews were important in the process of determining financial proxies to help guide what the value of the outcome is to them.

***Social networks***

When time bank members were asked why they valued being able to mix with people from different backgrounds, they often talked about being able to learn new skills, a new language, or learn about different cultures.

*If I had not found this place I would have been miserable. I would have been on my own wandering the streets…. By meeting people from other countries I get lots of education.*

Male, Iraqi

Based on this, a proxy was used for how much these sorts of activities would cost, such as the cost of a cooking lesson. This doesn't mean that time bank members would have spent the same amount on education in the market, or that money actually changes hands but it gives some idea of the generic value of these outcomes. There are also some associated outcomes for the state if people from different backgrounds get on and people are able to gain access to free English tuition, which otherwise the state may have provided in the form of ESOL (English for speakers of other languages).

***Community cohesion***

Traditionally community cohesion is seen as difficult to measure and difficult to value. Yet in our interviews people had clear ideas of what coming to the service meant to them, particularly around being able to help people and give something back, as this quote from an elderly time bank member shows:

*I help people learn English. I have helped a lot of people, I think to myself, they struggle to get on the computer before. I feel good about helping them*

Male, Iraqi, time bank member

From this a proxy was constructed using the London Living Wage to capture the value of their time. Understanding the value the state places on community cohesion is more difficult as it is often expressed as the prevention of worse things happening, such as crime or religious extremism. Although this would be valid as a cost saving, we don't have specific evidence on the extent to which crime had decreased or if extreme views are less common. It would also not be realistic to expect a provider operating in two wards in Camden to have an influence on borough wide statistics.

We do know that the state spends a significant amount on projects to promote community cohesion and we can take some portion of this as a measure of the 'willingness to pay' of the state. There are also some costs savings that relate from reduced spending on separate services if people with mental health issues and refugees can access mainstream services.

# Section 7. Establishing impact

The previous section identified the outcomes that result from the Consortium. This section focuses on impact. In SROI terms, this means taking into account what would have happened anyway, the contribution of others and the length of time the outcomes last.

### *Deadweight and attribution*

The first stage is to subtract the effects of deadweight (what would have happened anyway) and attribution (the role of other organisations and factors) to determine the value created that can be attributed to the Consortium. In this study, deadweight and attribution have been calculated separately for each of the outcomes identified and for each of the stakeholders. A full explanation is provided in Appendix 6.

### *Displacement*

Displacement is the extent to which the outcome has occurred at the expense of other outcomes. Displacement is best explained through an example. Many STR volunteers went on to paid employment. Whilst this has obvious benefits to individuals, in some cases they may have displaced the employment outcome for another person in Camden. Whilst this doesn't detract from the positive outcome for individual STR volunteers, it means the outcomes for the state must take account of this displacement effect. Thus for the state it is not accurate to include the increased tax take and reduced benefits payments (unless the programme actually creates new jobs).

### *Benefit period and outcome drop-off*

Although we are only looking at the activities of the Consortium over 2009/2010, some of the interventions have long-lasting impacts. Therefore it is reasonable to project some of the outcomes into future years. Faced with a lack of longitudinal evidence about these long-term effects, this report is conservative about the benefit period and has only projected outcomes beyond the year-long programme for the autonomous element of mental health and some of the community outcomes. In addition, 'drop-off' is taken into account. This captures the extent to which the impact the

Consortium has in sustaining the identified outcomes becomes less important as time goes on.

# Section 8. Calculating the SROI

## Calculating inputs

The total contract value of the mental health day service over three years was £2,011,591 or £689,515 for the year of 2009/2010. In addition to this investment of funding from Camden Council, the service relies on service users and time bank members investing their time and energy which have been valued at the London Living Wage to total £137,119. Therefore the value of the total input included in the model is £826,634 and this was used to calculate the SROI ratio. It is also possible to give a ratio for the return on the investment made by Camden which excludes the volunteer time.

## SROI ratio

Over 2009/2010 the Consortium generated over £4,700,000 in social value. With an investment of £826,634, this is an SROI of approximately £5.75 for every £1 invested. Looking solely at the returns of the contract value from Camden Council, that is a return on investment of nearly £7.00.

## Value by stakeholder

This section analyses in more detail what this social value is composed of and which stakeholders benefit.

### *For service users*

- Over £1,700,000 in social value is generated for service users. This comes primarily from improvements in mental health. Many service users also valued being able to contribute to the service through the time bank and mixing with people from different backgrounds.

- Considering the ROI (return on investment) for the service users alone, without the wider benefits for the state or the community, the ratio is still just over £2.00 for every £1 invested.

### *For the STR volunteers*

- Nearly £300,000 of social value is generated for volunteers who take part in the STR training scheme.
- The majority of these participants are not service users. As they are not primary beneficiaries, the Consortium doesn't currently collect or report back on outcomes for this group to Camden Council. Whilst it is possible to identify a number of positive outcomes for this group, such as improved mental health and social networks, these have been excluded from the SROI due to a lack of evidence or outcomes data for them. If they were included, the SROI ratio would be higher.

### *For the community*

- It is estimated that over £400,000 of social value is generated for the community due to the activities of the Consortium.
- As for STR volunteers, there is no detailed outcomes information for time bank members who are not mental health service users. Information about the number of time bank exchanges taking place has been used as an indication of some outcomes, such as social networks, for this stakeholder group. However our interviews suggest there are other important outcomes for this stakeholder group, such as improved mental health, employment, improved education, integration, etc. Given the lack of outcomes data, these outcomes have not been included in the model so the figure here is likely to be significantly underestimated.
- The social value generated for these two stakeholder groups (STR volunteers and the community) is significantly less than for service users, and to some extent this is to be expected. There are also some outcomes to the state which correspond to cost savings from the outcomes for other time bank members (for example, the value of ESOL classes, and the value to the state of community cohesion).

### *For the state:*

- Over £2,000,000 of social value is generated for the state.
- Nearly half (or just over a million) of this value comes from cost savings associated with the mental health and employability outcomes of service users. The rest of the value is related to outcomes relating to social networks, stigma and discrimination, and community cohesion.
- Isolating the value created to the state from the investment of Camden gives an ROI of over £3.40 for every £1 invested.

- There are some outcomes that did come up in interviews that were not included in the model. For example, service users and volunteers said they valued having somewhere safe to go in their neighbourhood. Whilst we can give this as a value to the individuals involved we have no evidence that this does actually lead to a reduction in crime, so this is not included.

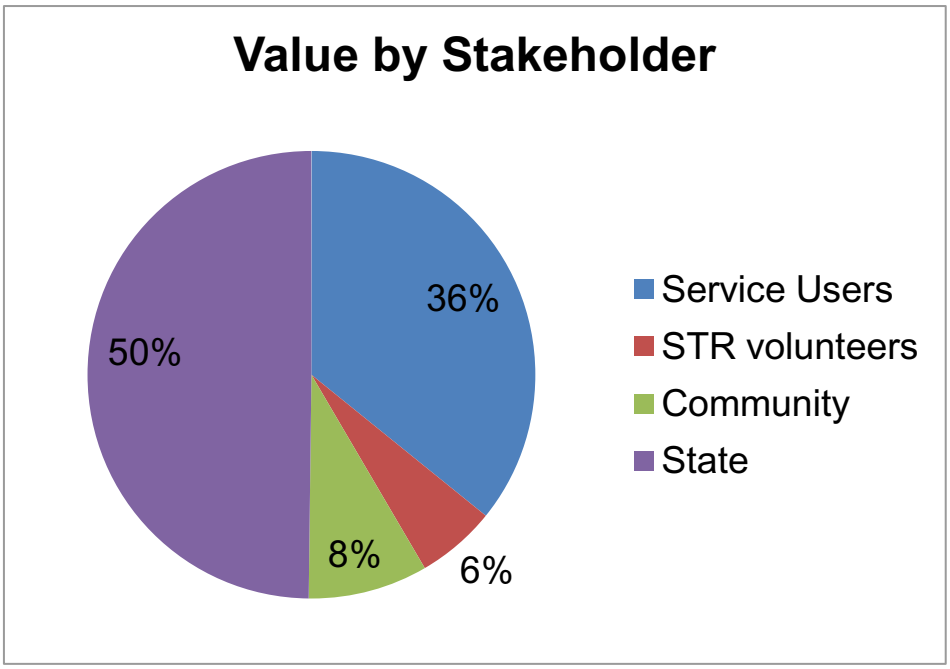


*Figure 8.1. Value by stakeholder*

### *How much of this value is attributable to the SCM?*

Commissioners will be interested in which of the outcomes generated by the Consortium are attributable to the approach taken by Camden to commission for wider outcomes and equalities. It is not strictly possible to do this as the outcomes that relate to mental health cannot accurately be viewed in isolation from the delivery mechanism of time banking and co-production. Co-production enables people to build social networks and develop skills – these outcomes have a value in their own right – but they also have positive feedback loops with mental health.

So it is possible to isolate the total value of the outcomes relating solely to mental health which adds up to over £2,900,000 (made up of over £1,000,000 to service users and £1,947,733 to the state). This gives an SROI of over £3 for every £1 invested. Yet these mental health outcomes are inextricably linked to the way the Consortium embeds co-production through its services and there is no guarantee these would have happened had the service been commissioned differently.

# Section 9. Conclusions

This report has applied the SROI methodology to a pilot mental health day service in Camden. This service was commissioned using an outcomes-based commissioning model which meant a variety of outcomes explicitly relating to equality were included on the tender. SROI analysis found that for every £1 invested in the service by the local authority, £5.75 in social value is generated.

These findings challenge the view that including equality outcomes on the tender is more expensive or just 'nice to have'. In reality there is no clear line between those activities that relate solely to the 'core' of the service (i.e. mental health) and those outcomes that relate to other service areas or the wider community (community cohesion or social networks) although public sector budgets are often delineated in this way. Our interpretation of how the Consortium works is that because it delivers with other community partnerships and builds social networks and volunteering within its service, it generates better mental health outcomes for service users. This also has other benefits for the community as a whole such as improved community cohesion and reduced discrimination. Indeed public services can only effectively deliver change if they proactively work towards economic and social outcomes at the same time.

In our model, the focus on equality outcomes generated savings for the commissioning body in several ways. On one level, encouraging and supporting people to play a greater part in the design of services increased the capacity of the service and meant they can stay open outside traditional service delivery hours. This saves the Council money and allows more to be delivered with the same amount of funding. Importantly, however, it gives people the opportunity to contribute, to learn new skills, and to improve their confidence which has important positive impacts on their mental health. The partnership approach and method of delivering services in the community encourages service users to rely less on their service in the longer term, and also addresses some of the wider inequalities issues, such as stigma and discrimination, that can perpetuate poor mental health and lack of social cohesion.

Finally, this study demonstrates that the accessibility of the centres to many different groups, together with the use of co-production and time banking,

creates a conducive atmosphere for everyone to build networks with those different to themselves. This results in outcomes not only beneficial for mental health users, but wider society. Breaking down stereotypes and opening people's minds to other cultures is no easy task, and yet there was evidence to suggest that it occurred both often and quite naturally in this scenario. This included links between asylum seekers, people with mental health issues and university students. Most promising was the clear chain of causation between meeting and understanding new people, and wanting to give back. While this may not have been the original objective of the core service, it is a by product that has enormous ramifications for the way in which services ensure that diverse members of our society have the opportunity to meet and help each other.

# Appendix 1. Outcomes in the original tender documentation

The tables below are adapted from the original tender documentation of the mental health day care services. As explained in Section 2 of the main report the tender document left the activities and outputs columns blank for providers to fill in.

***Table A1.1. Service Outcomes specified on the tender.***

| 1. Activity | 2. Outputs | 3. Service outcomes | 4. Suggested Indicators | 5. Way of measuring |
|---|---|---|---|---|
| | | Enhanced psychological well-being | • Service users report increase in well-being<br>• Service users report reduced isolation<br>• Service users are integrated in to mainstream services and are independent of the Day care | OUTCOMES STAR:<br><br>OTHER: |
| | | Enhanced physical well-being | Service users report eating well, reduce dependence on alcohol, drugs, or cigarettes and take more exercise | OUTCOMES STAR:<br><br>OTHER: |

| 1. Activity | 2. Outputs | 3. Service outcomes | 4. Suggested Indicators | 5. Way of measuring |
|---|---|---|---|---|
| | | Enhanced well being for service users with complex needs/multiple diagnoses | • Awareness of problem<br>• Reduction in consumption of drugs or alcohol<br>• Maintenance of abstinence from drugs, alcohol | OUTCOMES STAR:<br>OTHER: |
| | | Service users finding meaningful employment, training, or voluntary activity | Number for service users finding satisfactory employment, training, or voluntary activity | OUTCOMES STAR:<br>OTHER: |
| | | Improving educational outcomes for service users | Number of service users attaining qualifications, e.g. NVQ2 or higher | OUTCOMES STAR:<br>OTHER: |
| | | Better and more stable accommodation situation for service users | • Service users claiming housing benefit without support<br>• Decrease in number of service users who are homeless | OUTCOMES STAR:<br>OTHER: |
| | | Increasing positive social contacts/networks for service users | • Service users report positive relationships with family/friends<br>• Service users helping peers or others in the community<br>• Service users engage in more leisure activities, e.g. attends clubs | OUTCOMES STAR:<br>OTHER: |

| 1. Activity | 2. Outputs | 3. Service outcomes | 4. Suggested Indicators | 5. Way of measuring |
|---|---|---|---|---|
| | | Reducing the stigma and discrimination against mental health in Camden. | Positive shift in attitudes and behaviour towards service users amongst:<br>• Camden employers and statutory and non-statutory service agencies<br>• Community generally | OUTCOMES STAR:<br>OTHER: |
| | | **[ADDITIONAL SERVICE OUTCOMES]** | | |

***Table A1.2 Community outcomes specified on the tender.***

| **1. Social outcomes: creating benefits for the broader community, beyond service users**<br>*'A Connected Camden Community where people lead active, healthy lives'* | | | | |
|---|---|---|---|---|
| **Activity** | **How delivered** | **Camden Community outcomes** | **Indicators [your activities contribute to]:** | **Way of measuring** |
| | | Citizens are more active and there is greater community cohesion (p. 26) | • New groups of people are working together including on projects, or socialise together<br>• Diverse groups of people have a better understanding of one another<br>• Increased volunteering in Camden to above national average and community self-help<br>• Increased voting and membership of local groups | |
| | | Increased numbers of vulnerable adults living independently in their own homes (p. 29) | • Adults (under 65) with learning difficulties or mental health difficulties are able to continue to live at home<br>• Older people (65+) with learning difficulties or mental health difficulties are able to continue to live at home | |
| | | People are healthier and make healthier choices (p. 28) | • People in the community experience improved health outcomes e.g. smoking cessation weight management, exercise, or balanced nutrition | |

| Activity | How delivered | Camden Community outcomes | Indicators [your activities contribute to]: | Way of measuring |
|---|---|---|---|---|
| | | Improved life chances for Camden's young people (p. 29) | • Young people have better health and fitness<br>• Young people smoke and drink less and use fewer drugs<br>• Young people are regularly involved in sports, or other extra-curricular activities | |
| | | Reduced crime and anti-social behaviour [Safe Camden] (p. 32) | • More adults who have offended do not offend again<br>• More young people who have engaged in antisocial behaviour do not do so again, or do not commit crimes<br>• More young people receive mentoring | |

| **2. Economic outcomes: creating economic benefits within Camden beyond the service itself**<br>*'A strong Camden economy that includes everyone'* | | | | |
|---|---|---|---|---|
| **Activity** | **How delivered** | **Camden Community outcomes** | **Indicators [your activities contribute to]:** | **Way of measuring** |
| | | Increase access to skills and employment for priority people, carers, parents returning from work, people with mental or physical ill health) [Priority groups take up sustainable jobs] (pp. 21-23) | • Increased number of vocational opportunities for local priority groups<br>• More affordable and accessible childcare | |
| | | Maximise opportunities for education and training for priority groups (p. 23) | • More priority groups receiving meaningful training and demonstrate learning (e.g. receive a qualification, or progress to further education, employment, or voluntary work as a result) | |

| **3. Environmental Outcomes: enhancing the Camden environment beyond the service itself**<br>*'A Sustainable Camden that adapts to a growing population'* | | | | |
|---|---|---|---|---|
| **Activity** | **How delivered** | **Camden Community outcomes** | **Indicators [your activities contribute to]:** | **Way of measuring** |
| | | Reducing waste<br>(p.15) | • [If your organisation is based in Camden] Decreased amount of organisational waste month on month, year on year<br>• Decreased amount of in the wider community (e.g. service users and their families, neighbours, or relevant educational activity) | |
| | | Reducing energy usage & CO2 emissions<br>(p.15) | • [If your organisation is based in Camden] Decreased energy usage month on month, year on year within the organisation<br>• Decreased amount of waste due to service's activity in the wider community e.g. service users and their families, neighbours, etc.)<br>• More people cycle, walk, use public transport or shop locally | |
| | | Increasing recycling<br>(p.15) | • [If your organisation is based in Camden] Increased % of rubbish recycled month on month, year on year by your organisation<br>• Increased percentage of rubbish recycled due to activity in the wider community (e.g. service users and their families, neighbours, etc.) | |

# Appendix 2. Stakeholder definitions

Across the Consortium service users take on responsibility for delivering sessions and there are fewer distinctions between service users and volunteers and staff. This section outlines definitions used in this report.

### Service user

This refers to people who have been referred to the service for a mental health issue. There were 541 service users reported in the last outcomes report, roughly half of whom were on the CPA approach. Although all service users have a mental health condition, in reality they are still a very diverse group and we have further disaggregated this group in the model.

#### *Further disaggregation of the service user group*

For the purposes of the SROI, service users have been disaggregated into two further groups. This is to recognise that within the service user group there is great diversity and a range of different mental health conditions. We have categorised these into two groups: type A and type B.

The first group (type A) has more severe and enduring mental health conditions and more complex issues. All are on the CPA approach. The second group (type B) has less severe issues, or have severe and enduring issues but are self-managing them better. They are more likely to have self referred and are not on the CPA approach.

In reality it is not possible to draw any clear distinctions between service users and we wouldn't encourage this approach in service delivery. The reason for this disaggregation is to try and capture the fact that the outcomes, value (to individual and the state), attribution, deadweight, and displacement will all vary according to the background characteristics and different starting points of different service users.

### Time bank members

This refers to signed-up members of the Consortium time bank. There were 394 time bank members at the last time bank report, over half of whom were also service users (206). We do not count time bank members as a separate stakeholder. However, participation in the time bank is captured for service users. We also look at how participation in the time bank can

lead to increased social networks and community cohesion in the community.

### STR volunteers

This refers specifically to a subset of the wider time bank membership who has taken the accredited STR qualification. Over the course of three years, 191 people have taken this qualification. We distinguished STR volunteers as a separate stakeholder group, from other time bank members, because they have material employment outcomes.

# Appendix 3. Stakeholder audit trail

Table A3.1 shows an audit of the interviews conducted.

| Stakeholder | Method of engagement | No. engaged |
|---|---|---|
| Service users | Service users at HCCT and Crossfields were interviewed. | 7 |
| STR volunteers | One STR volunteer and two paid STR worker were interviewed at HCCT and Crossfields. | 3 |
| Community | People who are members of the time bank and other volunteers at the centre and two partner organisations were interviewed. | 11 |
| State | Policy documents to gather proxies for the state we consulted and interviews carried out with five staff at the Consortium and at Camden Council (excluding the two paid STR workers). | 5 |

# Appendix 4. Outcomes data collection

*Table A4.1. Outcome Indicators for the stakeholder group of Service Users*

| Outcome ( and sub-outcome if applicable) | Indicators * | Outcome incidence | Data source |
|---|---|---|---|
| Improved mental health (a significant increase in mental health) | Number of service users who have made a 'large positive change' in mental health on the outcomes star | 129 | **nef** calculation based on data from the Consortium in 2009 and 2010. Indicator uses the proportion of service users who had made a large positive change on the outcomes star in 2009 (11 out of 46 service users who completed two readings of the outcomes star in 2009). This proportion (24%) was then applied to the number of service users in 2010 (as there is not detailed analysis of outcomes star data in 2010). |
| | Number of service users engaged in activities independently of the service | 160 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |

| Outcome ( and sub-outcome if applicable) | Indicators * | Outcome incidence | Data source |
|---|---|---|---|
| Improved mental health (some positive change to mental health) | Number of service users who have made a 'more modest improvement' in mental health on the outcomes star | 212 | **nef** calculation based on data from the Consortium in 2009 and 2010. Indicator uses the proportion of service users who had made more modest improvements on the outcomes star in 2009. (18 out of 46 service users who completed two readings of the outcomes star in 2009). This proportion (40%) is then applied to the total number of service users in 2010 (as there is not detailed analysis of outcomes star data in 2010). |
| | Number of service users currently volunteering in the service | 293 | **nef** calculation based on data from the Consortium in the 1 Jan - 31 Mar 2010 outcomes report. Calculated by subtracting the number of service users volunteering in mainstream settings (59) from the total number of service users volunteering in the service and in the community (352). |
| Improved mental health (stability to mental health) | Number of service users who have stayed stable in mental health | 144 | **nef** calculation based on data from the Consortium in 2010. Indicator uses the proportion of those service users who have had two readings of the outcomes star and have remained stable in 2010 (32 out of 120 service users who completed two readings of the outcomes star in 2010). This proportion (27%) is then applied to the number of service users in 2010. |
| Employability (in employment) | Number of service users who go on to get work | 20 | Data from the consortium (1 Jan - 31 Mar 2010 outcomes report). |

| Outcome (and sub-outcome if applicable) | Indicators * | Outcome incidence | Data source |
|---|---|---|---|
| Employability (people 'work ready') | Number of service users volunteering in mainstream settings. | 59 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| | Number of service users attending training and education in mainstream settings | 67 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| | Number of service users referred to employment support services, job broker, work experience or placements | 61 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Employability (people who have made some progress). | Number of service users currently volunteering in the service | 293 | **nef** calculation based on data from the Consortium in the 1 Jan - 31 Mar 2010 outcomes report. Calculated by subtracting the number of service users volunteering in mainstream settings (59) from the total number of service users volunteering in the service and in the community (352). |
| | Number of service users who have taken training and education within the service | 134 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Social networks (mixing with people from the same background) | Number of service users with an increased score on the 'social networks' scale of the star | 307 | **nef** calculation based on data from the Consortium in 2010. Indicator uses the proportion of those service users who have had two readings of the outcomes star and have and increased score on social networks in 2010 (68 out of 120 service users who completed two readings of the outcomes star in 2010). This proportion (57%) is then applied to the number of service users in 2010. |

| Outcome (and Sub Outcome if applicable) | Indicators * | Outcome incidence | Data Source |
|---|---|---|---|
| Social Networks (mixing with people from different backgrounds) | Estimate of the number of hours who are doing 121 exchanges and mixing with people of different backgrounds | 3970 | **nef** calculation based on the estimate of the number of hours of time bank exchanges that are completed by service users (from time banking two-year summary report 206 time bank members are service users out of a total membership of 394 people). Using this proportion (52%) and multiplying by the total number of time bank hours in a year. This is then multiplied by **nef** estimate of the number of time bank exchanges that enable people to mix with people from different backgrounds (80%). |
| Less stigma and discrimination | Number of credits spend in the community | 1904 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Community cohesion (giving back) | Number of service users volunteering (combining service and community) | 352 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Community cohesion (feeling safe) | Estimate of the number who feel safe | 271 | **nef** estimate based on interviews: Half of the service users we spoke to spoke about valuing the centre as somewhere to come, particularly at weekends. |

* where there is more than one indicator for an outcome, the average has been taken.

*Table A4.2. Outcome Indicators for the stakeholder group of STR volunteers.*

| Outcome (and Sub Outcome if applicable) | Indicators * | Outcome incidence | Data source |
|---|---|---|---|
| Employability (in work) | Estimate of the number of people who do the STR training who go on to get a job | 32 | The Consortium does not monitor the number of STR volunteers that go on to paid employment after completing the training, but given their knowledge outcomes for volunteers estimate that approximately 3/4 do. We have used a more conservative figure of 50% in the model (therefore 50% of 64). |
| Employability (work ready) | Estimate of number of people completing the training course over one year | 64 | **nef** estimate based on a yearly average (191 people completed the course over the three years of the Consortium). |
| Community cohesion (giving something back) | Estimate of annual hours done by STR volunteers | 14000 | Consortium outcomes report estimates that there are 100 volunteers working in the centre at any one time. Assume give on average 140 hours each (this is the 'cost' in hours of an accredited training course). |

*Table A4.3 Outcome indicators for the community.*

| Outcome (and Sub Outcome if applicable) | Indicators * | Outcome incidence | Data source |
|---|---|---|---|
| Social networks (connections with similar people) | Estimate of the number of hours of time bank activity where people develop networks with people of similar groups to them | 906 | **nef** estimate based on 20% of time bank hours (of a yearly total of 4529 that are earned by people who are not service users). |
| Social networks (connections with people from different backgrounds) | Estimate of the number of hours time bank activity where people mix with people from different backgrounds (for community) | 3623 | **nef** estimate based on 80% of time bank hours (of a yearly total of 4529 that are earned by people who are not service users). |
| Community cohesion (giving back) | Estimate of the number of hours in the time bank that are not service users | 4529 | **nef** estimate based on proportion of time bank members that are not service users. |
| Community cohesion (feeling safe) | Estimate of the number of time bank members who feel safer as a result of using the service | 38 | **nef** estimate based on the interviews of the number who reported feeling safer (50%) applied to the number of time bank members who are not service users. |
| Reduced stigma and discrimination (Time bank members able to access more services) | Number of credits spend in the community | 1904 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Reduced stigma and discrimination among community organisations | Number of community partners actively collaborating to be more accessible to people with mental health problems | 69 | Data from the Consortium: Total currently from 1 Jan - 31 Mar 2010. |

*Table A4.4. Outcome indicators for the State.*

| Outcome (and Sub Outcome if applicable) | Indicators * | Data source | Outcome incidence |
|---|---|---|---|
| Improved mental health for service users (a significant increase in mental health) | Number of service users who have made a 'large positive change' in mental health on the outcomes star | 129 | **nef** calculation based on data from the Consortium in 2009 and 2010. Indicator uses the proportion of service users who had made a large positive change on the outcomes star in 2009 (11 out of 46 service users who completed two readings of the outcomes star in 2009). This proportion (24%) was then applied to the number of service users in 2010 (as there is not detailed analysis of outcomes star data in 2010). |
| | Number of service users engaged in activities independently of the service | 160 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Improved mental health for service users (some positive change to mental health) | Number of service users who have made a 'more modest improvements;" in mental health on the outcomes star. | 212 | **nef** calculation based on data from the Consortium in 2009 and 2010. Indicator uses the proportion of service users who had made more modest improvements on the outcomes star in 2009. (18 out of 46 service users who completed two readings of the outcomes star in 2009). This proportion (40%) is then applied to the total number of service users in 2010 (as there is not detailed analysis of outcomes star data in 2010). |
| | Number of service users currently volunteering in the service | 293 | **nef** calculation based on data from the Consortium in the 1Jan - 31 Mar 2010 outcomes report. Calculated by subtracting the number of service users volunteering in mainstream settings (59) from the total number of service users volunteering in the service and in the community (352). |

| Outcome (and Sub Outcome if applicable) | Indicators * | Data source | Outcome incidence |
|---|---|---|---|
| Improved mental health for service users (stability to mental health) | Number of service users who have stayed stable in mental health | 144 | **nef** calculation based on data from the Consortium in 2010. Indicator uses the proportion of those service users who have had two readings of the outcomes star and have remained stable in 2010 (32 out of 120 service users who completed two readings of the outcomes star in 2010). This proportion (27%) is then applied to the number of service users in 2010. |
| Employability - in relation to the outcomes from service users (In employment) | Number of service users who go on to get work. | 20 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Employability - in relation to the outcomes from service users (people 'work ready') | Number of service users volunteering in mainstream settings. | 59 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| | The number of service users attending training and education in mainstream settings | 67 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| | Number of service users referred to employment support services, job broker, work experience or placements | 61 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |

| Outcome (and Sub Outcome if applicable) | Indicators * | Data source | Outcome incidence |
|---|---|---|---|
| Employability - in relation to the outcomes from service users (number of people who have made some progress) | Number of service users doing volunteering in the time bank. | 293 | Data from the Consortium (1Jan - 31 Mar 2010 outcomes report). |
| | Number of service users who have taken training and education within the service | 134 | Data from the Consortium (1 Jan - 31 Mar 2010 outcomes report). |
| Employability - in relation to the outcomes from STR volunteers (in work) | Estimate of the number of people who do the STR training who go on to get a job | 32 | **nef** estimate: The Consortium do not monitor the number of STR workers that go on to paid employment after completing the training, but staff estimate that approximately 3/4 do. We have used a more conservative figure of 50% in our model (therefore 50% of 64). |
| Employability - in relation to the outcomes from STR volunteers (training) | Number of people completing the training course over one year | 64 | **nef** estimate based on a yearly average (191 people completed the course over the three years of the Consortium). |
| Social networks for community (Connections with people from different backgrounds) | People who use the centre and are mixing with people from different backgrounds | 150 | **nef** estimate assuming that 80% of time bank members (who are not service users) are mixing with people from different backgrounds. |
| Social networks for service users (Connections with people from different backgrounds) | Estimate of number of people with increased social networks who have DAA issues | 153 | **nef** estimate: In interviews with service users about half of them valued the fact that there the centre was a place that was drug free. We can't assume this applies to all service users who have taken only those with an increased score on the social networks arm (306) and taken 50% of this number (based on the fact that in our interview sample around 50% said this was important). |

# Appendix 5. Financial proxies used

*Table A5.1 Financial proxies used for service users.*

| Outcome (and sub-outcome if applicable) | Disaggregated service user group | Proxy | Source of proxy |
|---|---|---|---|
| Improved mental health (a significant increase in mental health) | Type A | £7,620 | **nef** estimate based on an improved QYAL estimate derived by the Sainsbury Centre for Mental Health (2003).[15] The Sainsbury study estimate the loss of a QALY for a person with a severe mental health issue will be 0.3520 per year. The value of a QALY used by NICE is £30,000. Therefore a person with a severe mental condition, on average, has a reduction in QYAL of £10,560. The figure of £7620 was obtained by assuming that they person is likely to move towards the level of quality of life of a person mild and moderate mental health. |
| | Type B | £2,940 | **nef** estimate based on Sainsbury Centre for Mental Health (2003).[16] The Sainsbury study estimate the loss of a QALY for a person with a severe mental health issue will be 0.098 per year. The value of a QALY used by NICE is £30,000. Therefore a person with a severe mental condition, on average, has a reduction in QYAL of £2,940. |

| Outcome (and sub-outcome if applicable) | Disaggregated service user group | Proxy | Source of proxy |
|---|---|---|---|
| Improved mental health (some positive change to mental health) | Type A | £3,810 | **nef** estimate based on the calculations above, assume that some improvements in quality of life. |
| | Type B | £1,470 | **nef** estimate based on the calculations above, assume that some improvements in quality of life. |
| Improved mental health (stability to mental health) | Type A | £1,905 | **nef** estimate based on the calculations above, assume that some improvements in quality of life for stability. |
| Employability (in employment) | n/a | £11,132 | Based on annual income from DWP evidence on Incapacity Benefit leavers. The destination of benefit leavers 2004 survey has given income figures per benefits group. The wage has been uprated by average earnings for a 2009/2010 equivalent wage.[17] |
| Employability (people 'work ready') | n/a | £1,589 | Improved confidence and skills - based on confidence training and increased income from gaining a skill. Calculated by value of confidence training (£1,195) added to increased earnings from qualification (£394). |
| Employability (people who have made some progress). | n/a | £1,269 | Improved confidence and skills - based on confidence training and increased income from gaining a skill. Calculated by value of confidence training (£1,195) added to cost of skills training with external providers (£74.15). |

| Outcome (and sub-outcome if applicable) | Disaggregated service user group | Proxy | Source of proxy |
|---|---|---|---|
| Social networks (same background) | n/a | £520 | Average annual spend on social activities. |
| Social networks (different backgrounds) | n/a | £30 | Price of a cooking lesson. |
| Less stigma and discrimination | n/a | £7.45 | Estimated market value of a time credit. In the community time credits can buy theatre tickets, gym sessions etc. On average use London living wage. |
| Community cohesion (giving something back) | n/a | £1,820.00 | Value of time spent volunteering. Assume volunteering for half day a week on average. |

*Table A5.2. Financial proxies for STR volunteers.*

| Outcome (and sub-outcome if applicable) | Proxy | Source of proxy |
|---|---|---|
| Employability (in work) | £16,395 | Estimate of salary taken from Annual Earnings for bottom 20th percentile of employees from Annual Survey of Hours and Earnings, ONS (2008). |
| Employability (work ready) | £1,589 | Improved confidence and skills - based on confidence training and increased income from gaining a skill. |
| Community cohesion (giving something back) | £7 | Value of time spent volunteering based on the London Living Wage. |

*Table A5.3. Financial proxies for the community.*

| Outcome (and sub-outcome if applicable) | Proxy | Source of proxy |
|---|---|---|
| Social networks (connections with similar people) | £24 | Counselling per hour (modifying cost of counselling downwards, as cost is from psychotherapy). **nef** calculation based on Kings Fund (2008).[18] |
| Social networks (connections with people from different backgrounds) | £37 | London Living Wage and cooking lesson. |
| Community cohesion (giving something back) | £7 | Value of time spent volunteering based on the London Living Wage. |
| Reduced stigma and discrimination (time bank members being able to access more services) | £7 | Estimate of the market value of a time credit. In the community time credits can buy theatre tickets, gym sessions etc. On average use London Living Wage. |
| Reduced stigma and discrimination among community organisations | £3,402 | Amount an organisation would be willing to pay to make accessible for people with a physical disability - Cost of fitting a concrete ramp and stairlift from unit costs from PSSRU (2009).[19] |

***Table A5.4. Financial proxies for the State (note in the majority of cases the cost savings to the state relate to the outcomes for other stakeholders above).***

| Outcome (and sub-outcome if applicable) | Disaggregated service user group | Proxy | Source of proxy |
|---|---|---|---|
| Improved mental health for service users (a significant increase in mental health) | Type A | £12,808 | Reduced service use: proxy to capture going from medium reliance on mental health services to low reliance. Composite proxy calculated by reduced visits from Care Coordinator, reduced (although still positive likelihood) of acute intervention, and reduced likelihood of accessing crisis resolution teams and assertive outreach team.[20] |
| | Type B | £1,585 | Reduced service use: proxy to capture going from medium to low reliance on services for mild to moderate mental health issues. Calculated from the average spend on depression (£2,085) minus the average spend on medication for depression as model assumes that the person is still likely to be taking medication.[21] |
| Improved mental health for service users (some positive change to mental health) | Type A | £8,950 | Reduced service use: proxy to capture going from high reliance on services to medium reliance. Composite proxy calculated reduced (although still positive likelihood) of acute intervention, and reduced likelihood of accessing crisis resolution teams and assertive outreach team. |
| | Type B | £971 | Reduced service use: proxy to capture small reduction in service use for mild to moderate mental health conditions: Cost of a course of counselling sessions. |
| Improved mental health for service users (stability to mental health) | Type A | £5581 | Reduced risk of having an acute intervention. |

| Outcome (and sub-outcome if applicable) | Disaggregated service user group | Proxy | Source of proxy |
|---|---|---|---|
| Employability - in relation to the outcomes from service users (in employment) | n/a | £5,332 | Annual Benefits Payment for IB. |
| Employability - in relation to the outcomes from STR volunteers (in work) | n/a | £10,067 | Difference of the costs and tax revenue to the state between an individual being unemployed in comparison to having a job with £13,500 pay. Takes into account indirect taxes such as consumption taxes.[22] |
| Employability - in relation to the outcomes from STR volunteers (training) | n/a | £1,734 | Total training costs (including cost of providing NVQ training and some support costs) from **nef** calculations based on PSSRU (2009).[23] |
| Social networks – in relation to community (Connections with similar people) | n/a | £2,085 | Cost of depression from Kings Fund (2008).[24] |
| Social networks - in relation to community (Connections with people from different backgrounds) | n/a | £350 | ESOL lessons. |
| Social networks in relating to service users (connections with people from different backgrounds) | n/a | £1,048 | Cost per problematic drug user in health costs.[25] |

| Outcome (and sub-outcome if applicable) | Disaggregated service user group | Proxy | Source of proxy |
|---|---|---|---|
| Stigma and discrimination | n/a | £133,500 | Cost of a law suit for disability based on the average of three lawsuits. |
| Community cohesion (reduced need to provide specialist services for people with mental health issues) | n/a | £76131 | Proxy to capture the value of enabling other community providers and private providers to make their services more accessible to people with mental health issues, and thus reducing the need for state to provide this (based on the cost of a ramp and wheelchair access).[26] |
| Community cohesion (value of people from different backgrounds forming meaningful relationships) | n/a | £80014.5 | Proxy to capture value of community cohesion to Camden based on the amount Camden spends on initiatives to promote it. Used estimate for Camden of the amount spent on Preventing Violent Extremism.[27] |

# Appendix 6. Attribution, deadweight, and displacement

Tables A6.1 to A6.3 provide an illustration of the attribution and deadweight considerations used in assigning values. Tables A6.4 to A6.6 give specific calculations for each stakeholder.

***Table A6.1. Deadweight: What would have happened without the activity?***

| Category | Assigned deadweight |
|---|---|
| 1. Low: The outcome would not have occurred without the Consortium | 0% |
| 2. Quite low: The outcome would have occurred but only to a limited extent | 25% |
| 3. Medium: There is an approximately 50% chance that the outcome would have occurred anyway | 50% |
| 4. Quite high: The outcome was likely to have occurred in a significant part any way | 75% |
| 5. High: The outcome would have occurred in totality anyway | 100% |

*Table A6.2. Attribution.*

| Category | Assigned attribution |
|---|---|
| 1. Low: The outcome is completely as a result of the work of other people or organisations | 0% |
| 2. Quite low: The outcome is mostly due to other people or organisations | 25% |
| 3. Medium: Other organisations and people have a significant role to play in generating the outcome | 50% |
| 4. Quite high: The outcome is mostly due to the consortium | 75% |
| 5. High: The outcome is completely as a result of the work of the Consortium. No other organisations are attributable | 100% |

*Table A6.3. Displacement.*

| Category | Assigned displacement |
|---|---|
| 1. Low: There is no displacement effect. | 0% |
| 2. Quite low: There is a very small displacement effect | 25% |
| 3. Medium: There is a significant displacement effect | 50% |
| 4. Quite high: There is a large displacement effect | 75% |
| 5. High: The outcome will be fully displaced | 100% |

*Table A6.4, Deadweight rates for each stakeholder group.*

| Outcome | Deadweight | Deadweight rationale |
|---|---|---|
| Service users:<br>All outcomes for service user type A | 25% | Employment is the outcome for which it is easiest to find evidence from a control comparison group. In the Kings Fund (2008) *Paying the Price*: estimates from the PMS survey suggest that around 70% of people with psychosis are out of work. This is a reasonable control group for Type A service users. It is highly unlikely this group would have gone into work without the intervention of the Consortium. We have applied this to all outcomes for the type A service users. |
| Service users:<br>All outcomes for service user type B | 50% | As above, the Kings Fund estimates from the PMS survey suggest around 58.85% of people with depression are out of work. We have approximated this to the lower deadweight band and that it is more likely that outcomes would have occurred anyway with service users with less severe mental health issues. We have applied this to all outcomes for the type B service users. |
| STR volunteers – All outcomes | 50% | STR volunteers are recruited from some service users and there has been targeted recruitment on older people. We assume that these groups would have a similar likelihood of getting into work without the service as type B service users. |
| Community – All Outcomes | 25% | Our research suggests that many of the community outcomes would have been very unlikely to have happened without the activities of the Consortium enabling people from different backgrounds to interact in a meaningful and unique way.<br>It is hard to look for control groups of community outcomes, but analysis of some of the Camden Place Survey results for 2008 can give us some indication of what would have happened anyway. In Camden overall in 2008 the participation in regular volunteering was 24.7%. However, the number of people participating at least once a week was 12% for white groups and 6% for BME groups, which would indicate a rate of deadweight much lower than this. Thus, an estimate that 25% of the outcomes would have happened anyway is reasonable.<br>In terms of how different groups get on together, Camden has a relatively high number of people who believe that people from different backgrounds get on well together (81.7%). However this is not the same as the outcomes we are looking at in the community, which is that people form meaningful relationships with people from different backgrounds. This may correspond better to the number of people who definitely agree that people from different backgrounds (as opposed to those who tend to agree). The indicator for this is much lower at 10% overall. |

*Table A6.5. Attribution rates for each stakeholder group.*

| Outcome | Attribution | Attribution rationale |
|---|---|---|
| Service users:<br>All outcomes for service user type A | 75% | In general staff felt that service users with more severe and enduring mental health services were less likely to be accessing employment services, or other social networks outside of the Consortium. Whilst service users with a severe and enduring mental health issue have a care co-ordinator, this is a statutory service so their involvement would already be picked up in deadweight. Thus we assume that the attribution is low for other organisations or factors. |
| Service users:<br>All outcomes for service user type B | 50% | In our interviews staff felt that service users with less severe and enduring mental health issues were more likely to be accessing other social networks and services that relate to these outcomes. In many cases the service has an enabling role, supporting the person to access other services, referring them to other services and also building their confidence and their own capabilities. Our estimate is that other services take around 50% of the credit for the outcomes. |
| STR volunteers – All outcomes | 75% | STR volunteers we interviewed who got a job felt that the accredited training in a mental health setting was highly attributable for them going on to get work in a related field. Their own motivation and participation on the course is also useful, which we attribute at 25%. |
| Community – All outcomes | 50% | The Consortium delivers community activities by working in partnership with other community organisations who must also take some share of the credit. Also some of these outcomes are achieved by service users and other time bank members bringing their skills and experience to aid delivery of the service. Thus these community organisations must take some share of the credit. |
| State – All outcomes | | As per other stakeholder group – in general value to the state is a cost saving associated with an outcome that accrues to another service users. Thus the deadweight will correspond to that for the service user in question |

*Table A6.6. Displacement rates for each stakeholder group.*

| Stakeholders and outcomes | Displacement | Displacement rationale |
|---|---|---|
| Service users | 0% | No displacement effect identified |
| STR volunteers | 0% | No displacement effect identified |
| Community | 0% | No displacement effect identified |
| State – Employment outcomes in relation to service users (employment is the only outcome we have applied displacement to). | 50% | This is based on an estimate from a DWP study in Realising Ambitions who note the difficulty of quantifying substitution between jobs on a work programme for people with mental health issues. In a recession, as fewer jobs are available, it is likely that some programme participants may take jobs at the expense of the other non-programme participants. They use assumptions of additionality of are left at 49 and 56 per cent, we use 50%.[28] |

*Table A6.7. Benefit period and drop-off for selected outcomes.*

| Outcome and stakeholder | Benefit period (years) | Drop-off |
|---|---|---|
| 1. Autonomy and control over mental health for service users. We assume that, for those service users who have reached a stage in their recovery where they are taking control over their recovery, there will be a longer-term effect of the intervention. We have not projected value into the future for service users who have not reached a stage of autonomy or self control over recovery. | 5 | 50% |
| 2. Social networks and reduced stigma and discrimination – for the community<br>We assume that if people in the community begin to stop having negative and stereotypical views of others, it is likely these will persist (even without further interventions from the centre). | 5 | 50% |

Note: The model only projected value forward for the future for the two outcomes listed above in table A6.7.

# Appendix 7. Sensitivity analysis

A number of assumptions were varied to test the sensitivity of the model:

- **Financial proxies** were systematically varied and demonstrated lower sensitivity than attribution and deadweight. The outcomes (and associated financial proxies) for mental health did not include any savings in housing costs. Staff felt that the service helped users to maintain independent living by picking up on trigger signs of mental health, and referring any service users who were having housing problems to advice services. We didn't include housing costs because there was no outcomes data on the number of service users who stayed in the same home. If, however, we assume that a number of the service users with severe mental health issues did avoid going into supported accommodation then this has a significant increase on the SROI ratio (which increases to £7.72).
- **Disaggregation of service users:** In our report we have disaggregated service users into two types: those with more severe and enduring mental health issues (type A), and those with more moderate mental health issues (type B). We assumed that the outcomes would have happened to those two groups in roughly the same proportion as those groups fall in the service user population. However, it may be the case that service users who have less severe mental health issues are much more likely to achieve outcomes around improved mental health. We therefore weighted the proportions so that type B achieved the long term outcomes. This does have a significant decrease on the SROI ratio (which decreases to £ 4.91).
- **Deadweight and attribution:** Both have high sensitivity in the model. For example, if we assume that deadweight is 0% (i.e. none of the outcomes would have occurred without the work of the Consortium) then the ratio increases to £8.29.

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Authors

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# Endnotes

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[2] Materiality is the accountancy term for ensuring that all the areas of performance needed to judge an organisation's performance are captured.

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