Real-Improvement

Leeds Survivor Led Crisis Service: Full SROI Evaluation Report

A Social Return on Investment Analysis

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Revised for assurance April 2012

This report has been submitted to an independent assurance assessment carried out by The SROI Network. The report shows a good understanding of the SROI process and complies with SROI principles. Assurance here does not include verification of stakeholder engagement, data and calculations. It is a principles-based assessment of the final report.

LSLCS Full SROI Evaluation Report

Contents

Executive Summary

This report represents the second and final stage of a full Social Return on Investment (SROI) analysis of Leeds Survivor Led Crisis Service (LSLCS). It follows an interim report produced in May 2011 and includes further detail to meet assurance standards required by the SROI Network for accreditation. Key conclusions and recommendations from the interim report remain valid, and are already being taken forward by LSLCS.

LSLCS works with people in crisis and at risk of suicide, and has established itself as an integral and vital part of the Leeds mental health care network. It is already widely recognised for the success of its work and the effectiveness of its evaluation, and is regarded as a role model for similar services elsewhere. This report aims to further strengthen this work and help LSLCS deliver an even more effective service to those in crisis and to the community of Leeds.

The report identifies benefits for LSLCS's key stakeholders, including the visitors and callers who use its services, their partners and families, NHS and social care organisations in Leeds, and the wider community both locally and nationally. By examining the changes these stakeholders experience and giving an equivalent financial value to these changes, it identifies two visitor/caller groups where LSLCS has the greatest impact in terms of SROI:

- those who would have committed suicide but for the intervention of LSLCS and other services
- those whom LSLCS helps to overcome crisis, and who then recover and resume normal life, which may include commencing or resuming work

SROI analysis measures the impact of these changes by giving them an equivalent financial value, and this can be compared with the cost of resourcing the organisation (including in-kind support from volunteers). The resulting figure is known as the SROI ratio, and for LSLCS this is calculated as £5.17 of social value generated for every £1 invested. This figure is an approximation, and can be more accurately represented by stating that the SROI ratio for LSLCS lies within the range of £4.00 to £6.50 of social value generated for every £1 invested.

Using the figure of £5.17, the total added social value generated by LSLCS over one year works out as £1,757,843.73 in 2010. This figure should increase for 2011 due to an increase in LSLCS's capacity from June 2011.

Recommendations in Section 7 include two from the interim report, covering short-term visitors and callers who use the Connect helpline only, which LSLCS is already progressing,. Three further recommendations are included in this full report. The first confirms that LSLCS could deliver more social value still if it were able to increase its capacity further;. The second is that it should continue its efforts to raise awareness of its services, particularly for those not currently in contact with mental health services. The third recommends seeking further objective evidence of change, to complement the excellent feedback from visitors and callers.

Section 1: Introduction and Context

1.1. Background to LSLCS

Leeds Survivor Led Crisis Service (LSLCS) was established in 1999 following a campaign by a group of service users. Initially run in partnership with social services, the service became a registered charity in 2001. It provides a place of sanctuary and support, as an alternative to hospital admission and other statutory services, for people in acute mental health crisis. It continues to be governed and managed by people with direct experience of mental health problems, and has its own unique approach to managing crisis. LSLCS's mission is to provide high quality, person centred, radical and innovative services to people experiencing mental health crisis.

LSLCS is jointly funded by NHS Leeds and Leeds City Council Adult Social Care. it also receives a small amount of funding from Leeds Personality Disorder Network, part of the Leeds Partnership NHS Foundation Trust. It has previously received charitable funding from the Tudor Trust, but this ceased in April 2010; it does however continue to receive a small number of private donations.

1.2. Services: Dial House, Connect, Groups

LSLCS is based at Dial House in Leeds and provides:

- a place of sanctuary open 6pm to 2am Friday to Monday (prior to June 2011 this was Friday to Sunday only), where a team of trained support workers is available to provide one-to-one support to those who need it. In 2010, 163 visitors made a total of 981 visits to Dial House (157 visitors in 2009; this report takes 160 as an annual average).
- a telephone helpline known as Connect, open 6pm to 10:30pm every night of the year. This service, staffed mainly by volunteers, provides emotional support and information for people in distress, and currently receives around 5000 calls a year
- social and support groups for Dial House visitors based on self-help and therapeutic support. These currently run on Wednesday, Thursday and Friday afternoons and are informal groups largely organised by the visitors themselves.

The aim behind all of these services is both to alleviate immediate crisis, reducing the need for hospital admission or other statutory services, and to provide therapeutic support which – together with other mental health services – will eventually help individuals to stabilise their condition and in many cases effect a full recovery. LSLCS itself describes its primary outcomes as:

- Reducing risk / preventing worse happening
- Supporting people to resolve or better manage crisis

These are supported by two further outcomes:

- Reducing loneliness and isolation
- Reducing visits to Dial House (through attending group work)

A NOTE ON TERMINOLOGY:
LSLCS does not use the term "service users"; rather, it uses the terms "visitors" and "callers" for those who use Dial House and the Connect helpline respectively (these groups overlap as many people use both services). We have followed this terminology throughout this report. Similarly, because the system operates essentially through self referral, the term "signpost" has been used rather than "referral" to describe how visitors and callers first come into contact with LSLCS.

1.3. The Wider Context: Mental Health Services in Leeds

LSLCS works closely with other mental health services across Leeds. Restructuring and budget cuts resulted in the only comparable non-NHS crisis provision in Leeds, the Leeds Crisis Centre, closing in April 2011. This was part of an ongoing strategy across the city, intended both to rationalise existing services and to move from palliative day care provision towards services that help people manage and improve their condition, in many cases enabling them to return to work.

Many visitors and callers use other mental health services alongside LSLCS; in many cases LSLCS forms part of their care plan. It is important to understand LSLCS as contributing to care and recovery for these individuals, rather than being solely responsible for it. SROI calculations take account of this primarily through Attribution (Section 6.2).

1.4. The SROI Methodology

Social Return on Investment (SROI) is a methodology for measuring an organisation's social, economic and environmental impact. It identifies and measures the changes that are experienced by the organisation's 'stakeholders' - the people and organisations that are affected by it or who contribute to it. It then uses financial proxies to value all significant outcomes for stakeholders, even where these outcomes reflect changes that are not normally considered in financial terms. This enables a ratio of costs to benefits to be calculated, so that for example, a ratio of 1:4 indicates that an investment of £1 delivers £4 of social value. Full information can be found on the SROI Network web sites: http://www.thesroinetwork.org or http://www.sroi-uk.org.

Seven guiding principles apply to any SROI analysis:
- Involve stakeholders
- Understand what changes
- Value the things that matter
- Only include what is material
- Do not over claim
- Be transparent
- Verify the result

This report is intended for SROI accreditation and hence aims to meet the standards contained in SROI Network guidance on assurance for accredited practitioner status. Annex 7 details how each question within the accreditation criteria has been addressed within this report and provides relevant cross-references.

1.5. Use of SROI for LSLCS: Purpose and Scope

This is an evaluative SROI report; in other words it considers retrospectively the value that LSLCS has achieved rather than anticipating the impact of future developments. Activity during 2010 has been taken as the basis for this evaluation, together with funding for financial year 2010-11.

LSLCS has been very supportive of this evaluation and the use of SROI methodology, and believes it is particularly relevant in the services it offers. The purpose of this evaluation is threefold:

- to provide further evidence of the social value that LSLCS contributes to the Leeds area and beyond. This information may be helpful to funding organisations, including the possibility of future support from charitable trusts
- as part of LSLCS commitment to continued improvement, to help identify how its services might be further enhanced to add greater value
- if possible, to make a forward projection on the possible impact of any future increase in funding.

This full report contains complete details of how the SROI has been calculated, and is intended for assurance and accreditation by the SROI Network. A shorter summary version of this report is being produced for wider circulation.

Although a number of different service aspects are provided (Dial House, Connect helpline, group work), LSLCS sees itself very much as providing a holistic service and hence this evaluation aims to address the collective impact of all of these different service aspects. This accounts for the vast majority of work that LSLCS undertakes. However, there are a few callers who use the Connect helpline only and never visit Dial House, and for reasons explained in Section 4.4 it has not proved possible yet to measure the change that these callers experience. For this reason the impact on these individuals has been excluded from this analysis.

LSLCS also gives a small amount of time to speaking at conferences and supporting other mental health organisations, and it derives a small income from this consultancy-type work. This particular aspect is not included within the scope of this SROI evaluation, because it is not central the core purpose of the organisation.

The calculation also excludes the asset value of Dial House itself. The property was jointly purchased by the NHS and Leeds City Council, and would revert to NHS use it LSLCS were to relinquish it. At present LSLCS pays simply for maintenance and decoration, and this is included in service costs.

1.6 Activities Undertaken

Compiling this report has involved a range of consultation and research activities including:

- Review of documents:
    - LSLCS reports and accounts
    - LSLCS summary of visitor feedback and survey results (visitors and volunteers)
    - Various external research and policy documents

Specific references are noted in the text and a full list of documentary information sources is shown in Annex 4

- Consultation with stakeholders:
  - Manager & staff
  - Volunteers (through survey feedback)
  - Chair of Trustees
  - Visitors and callers - in groups and 1:1
  - Family members (limited - see Sections 1.7 & 2.4)
  - External stakeholder: Leeds Adult Social Care
  - External stakeholder: NHS Leeds (Leeds PCT)
  - External stakeholder: NHS Leeds (Crisis Resolution & Home Treatment Team)
  - External stakeholder: Leeds Personality Disorder Network

  Details of consultation activities and numbers involved are shown in Section 2.4
- Preparation of the Impact Map (Annex 1, also summarised in tables within this report)
- Desk research on indicators and financial proxies

1.7. Constraints on the Evaluation Process

Given the sensitive nature of its work, data gathering for this SROI analysis has been constrained by the need not to interfere with LSLCS's normal operations, or to exacerbate in any way the situation of individual visitors/callers. This has meant that for example:

- Interviews with visitors and callers were restricted to those who volunteered, and these were probably not a complete cross-section of those with whom LSLCS. However, other feedback gathered from questionnaires and indirectly via staff is likely to be more representative.
- It was not considered appropriate to directly involve partners or family members (other than those seen in group discussions) for reasons explained in Section 2.4.
- Limited information is available on callers who use the Connect helpline only, although LSLCS is exploring ways to do this in the future (see Section 7)

In addition, LSLCS and statutory bodies do not share confidential data. This means for example that it is not possible to track the progress of individuals across these services ; LSLCS may not know which of its visitor/callers use NHS or Adult Social Care services, and vice versa.

1.8. Acknowledgements and Thanks

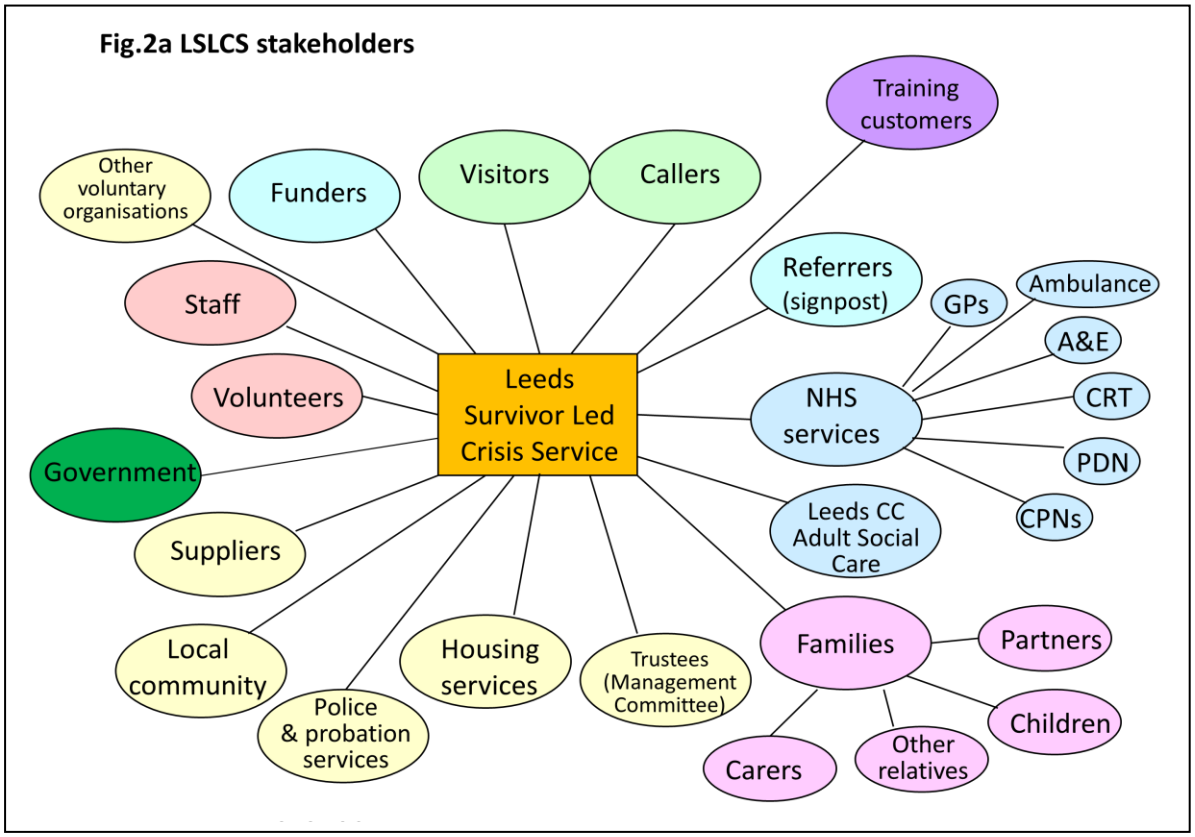
This report has been researched and compiled by Andy Bagley of Real-Improvement, an experienced management consultant with specialist expertise in performance management and evaluation. A great deal of help and information has been provided by LSLCS staff, visitors and callers, and representatives from outside organisations with an interest in the service. Andy would like to record sincere appreciation and gratitude for all support and assistance received, and to the many people who have given their time so willingly to assist this project.

Section 2: Key Stakeholders

2.1. Stakeholder Identification

The identification of stakeholders for this evaluation was undertaken through discussion with LCLCS staff (a stakeholder mapping exercise was undertaken with a staff group in January 2011), manager and Board chair, supported by later discussions with external stakeholders as part of 1:1 interviews. This identified a broad range of stakeholder groups, shown below:

Fig.2a LSLCS stakeholders



NB: Although visitors and callers are shown separately, most users of LSLCS services fall into both categories (i.e. they both visit Dial House and use the Connect helpline). For analysis purposes they are treated as a single group (later subdivided into visitor/caller categories as explained in Section 4.)

The following subsections explain which of these stakeholders are included in the SROI analysis, which are not, and why. Where stakeholders have been excluded this does not mean that they are unimportant, simply that the change they experience is either not material to this evaluation or is not significant in SROI terms.

2.2. Stakeholder Groups Included:

The stakeholder groups included in this SROI analysis are those who experience *material* change. This means that the change they experience is both relevant to the service that LSLCS provides and is significant in terms of the value of that change. The definition of relevance here includes changes

linked to the core purpose of the service (see Section 1.2) and changes that arise as a consequence of the service (intended or otherwise).

The following paragraphs explain the stakeholder groups included and why each of these is considered material to this evaluation:

VISITORS AND CALLERS

The most important beneficiaries of LSLCS are the visitors and callers who use its services. In some cases the impact can be life-saving. In many other instances the individual will be kept safe from harm, experience an improved quality of life and greater ability to cope with their condition, and may make a full recovery which enables them to take up or return to paid employment. (Helping people return to employment is not part of LSLCS's core purpose, but is nevertheless an outcome for some of its visitors/callers - an unintended benefit in SROI terms).
Relevant because this is the purpose of LSLCS and significant because the effect is potentially huge.

NHS SERVICES (ACCIDENT & EMERGENCY, AMBULANCE)

Accident and emergency services at hospital facilities around Leeds treat people who have self harmed or attempted suicide. Ambulance services transport such people to hospital and in some cases give immediate paramedic treatment. LSLCS has a significant impact in reducing demand for these services and this involves a cost saving which is captured within this analysis.
Relevant because LSLCS reduces demand on the NHS and provides a more suitable service, significant because there is clear evidence that substantial benefits are achieved (see Section 3.2).*

NHS SERVICES (CRT and CPNs)

The Crisis Resolution and Home Treatment Team (abbreviated to CRT) is the unit within the NHS Partnership Trust which provides mental health care services to people in acute crisis. This includes the Becklin centre, an inpatient facility for those needing admission, and a range of other treatment services, some provided by Community Psychiatric Nurses (CPNs) in the patient's own home. CRT recognises that LSLCS provides a more appropriate alternative for many of the people it deals with, and this also reduces demands on its own services.
Relevant and significant for the same reasons as NHS A&E, ambulance services above).*

NHS SERVICES (PERSONALITY DISORDER NETWORK)

The Leeds Personality Disorder Network (PDN) forms part of the Leeds NHS Partnership Trust, and brings together staff from a range of different agencies, including LSLCS and other voluntary groups, to work with people who suffer from personality disorder. The network provides a community-based alternative for those who might otherwise need highly specialised out-of-area inpatient care. LSLCS forms part of the care plan for some of these individuals, and PDN funds one LSLCS post.
Relevant and significant for the same reasons as NHS A&E, ambulance services above).*

LEEDS CITY COUNCIL ADULT SOCIAL CARE

Leeds Adult Social Care provides social care and support for those with mental health problems. Its services include accommodation, housing support, day centres and respite care, together with a range of other services commissioned from voluntary organisations, of which LSLCS is one. A substantial number of LSLCS visitors and callers also use other social care services.
Relevant and significant for the same reasons as NHS A&E, ambulance services above)*

*NB: Section 4 and the Impact Map (Annex 1) consider the impact of LSLCS on these various NHS and Local Authority services combined, rather than separately. The rationale for this is explained in Sections 3.3. The set of public services included is slightly modified in the case of 'Group 0' on the impact map (cases where suicide is averted) - see Annex 2.

FAMILIES (Partners and family members)
Many LSLCS visitors and callers live with partners or other relatives, or have other close family connections even if they live alone. As explained in Section 2.4, only very limited feedback from this group has been possible, but from evidence available we know that they experience relief from stress and anxiety, and respite from care responsibilities, as well as (in the most extreme circumstances) avoiding the loss of a loved one .
Relevant because this group experiences change as a direct result of LSLCS services and significant because of the amount and value of respite and relief they experience.

LSLCS STAFF AND VOLUNTEERS
LSLCS has permanent employees, bank staff (reserves it can all on) and volunteers. All of these groups find working for LSLCS very rewarding, and everyone speaks very highly of the teamwork and mutual support the organisation engenders (see Section 3.4 for further details).
Relevance for these groups is addressed in Section 3.6 (staff are not always considered relevant in SROI analyses but there is particular justification in the case of LSLCS). Significance is covered in Sections 5.6 and 5.7, which show the value of change these groups experience.

GOVERNMENT (in respect of welfare benefits expenditure)
Economic benefits will be experienced by the country as a whole where individuals recover from crisis sufficiently to move out of the benefits system and into paid employment.
Relevant because, although getting people back to work is not the primary purpose of LSLCS, it is a direct consequence for some visitors/callers and is consistent with wider mental health strategy (see Section 1.3) linked to its funding. Significant because the potential saving to public expenditure are substantial.

2.3. Stakeholder Groups Not Included:

Some stakeholders from Fig.2a have been excluded because they fall outside the scope of what is considered material to this analysis. This means that any change they experience is either not relevant to the work of LSLCS being evaluated, or that its impact is not significant (this can include organisations that interact with LSLCS but do not experience any material change as a result of these interactions). The following paragraphs explain why these stakeholder groups are not included on this basis:

FUNDERS (NHS AND LEEDS CITY COUNCIL)
LSLCS is jointly funded by NHS Leeds and Leeds City Council. Contract, and service level agreements with these organisations specify a number of expected outputs. However, these organisations do not experience any material change in their role as funders; the real benefits to them are better

provision and reduced demand for NHS and adult social care services, and these are captured in the stakeholder groups included (Section 2.2). (Excluded as not relevant)

LOCAL COMMUNITY
Local residents have no direct dealings with Dial House, and it has no relevant impact on them. (Excluded as not relevant)

SUPPLIERS
Dial House purchases small quantities of food from local shops and uses a local taxi company to bring visitors to and from Dial House. The sums involved are very small and not significant for evaluation purposes. (Excluded as not significant)

HOUSING SERVICES
Some LSLCS visitors and callers have housing problems and there is frequent liaison with housing services. However, the benefits here accrue to the individuals rather than to housing services. (Excluded as not relevant)

POLICE AND PROBATION SERVICES
Although the police sometimes bring people to Dial House, it is one of a number of 'places of safety' to which they could take these individuals. Like housing services, liaison with police and probation services benefits the individual rather than the service. (Excluded as not relevant)

NHS SERVICES (GENERAL PRACTITIONERS)
Some signposting to LSLCS comes direct from GPs, and LSLCS is trying to encourage more of this. Most GPs still refer patients in crisis to secondary mental health services within the NHS (who may then refer on to LSLCS), and hence there is no evidence that LSLCS directly impacts of GP services, for example by reducing patient visits. (Excluded as not relevant)

TRUSTEES (MANAGEMENT COMMITTEE)
LSLCS has a Board of Trustees, known as the Management Committee, which oversees its work and fulfils a governance role. Board members make a valuable contribution to the work of LSLCS, but do not experience any material change as a results of its activities. (Excluded as not relevant)

REFERRERS ('SIGNPOST')
Signposting often comes from the NHS and Social Care organisations included as key stakeholders. Impact is considered in terms of the outcomes achieved from referral, rather than referral as such. Similarly, signposting from partners and family members is considered as part of the change for this group. (Excluded as not relevant)

OTHER VOLUNTARY ORGANISATIONS
LSLCS interacts with many other voluntary organisations in the mental health care field, but none of these organisations duplicate or significantly overlap with LSLCS's core purpose (LSLCS visitors/ callers rarely use other agencies such as Samaritans or Mind). Their contribution to the changes that visitor/callers experience is addressed through Attribution (Section 6.2) rather than as separate stakeholders. (Excluded as not relevant)

CUSTOMERS FOR TRAINING

These are other organisations for which LSLCS provides training, consultancy or other guidance. This 'non-core' area of LSLCS work is outside the scope of this SROI analysis (Section 1.5). (Excluded as not relevant)

2.4. Stakeholder Involvement

A summary of stakeholder involvement, for those stakeholders that are material, is shown below:

Table 2b: Summary of Stakeholder Involvement

Stakeholder	Size of Group	Material?	No. Involved	How Involved
Visitors & callers	Approx 160 visitors per year. No. of callers not known	Yes - very	Approximately 18 by interview, larger number (up to 100) via other feedback methods	Group and individual interviews, LSLCS own questionnaires, comment book and discussion groups
NHS Services (A&E)	3 NHS Trusts plus Ambulance service	Yes	1	Interview with NHS Leeds Commissioning Manager
NHS Services (CRT)	1 specialist unit	Yes	1	Interview with CRT Manager
NHS Services (CPNs)	1 service	Yes	1	Covered by interview above with CRT
NHS Services (PDN)	1 specialist network	Yes	1	Interview with Clinical Services Manager
Leeds CC Adult Social Care	1 department	Yes	1	Interview with Leeds CC Commissioning Manager
LSLCS staff	14 staff (including manager) plus 8 bank staff	Yes	12-15	Group discussion on two occasions, further feedback via manager and deputy manager
LSLCS volunteers	55	Yes	16	Survey feedback gathered by LSLCS
Partners and Families*	138*	Yes	2*	Two seen as part of group interviews, see note below re wider involvement*
Government	Various departments (DWP, HMRC, Local Authorities for HB)	Yes		Not directly consulted

Where other stakeholder groups are not considered material, this is explained in Section 2.3.

All group and individual interviews, including those conducted by telephone, were recorded in contemporaneous notes by the consultant. Feedback gathered from surveys and other visitor comments was compiled by LSLCS itself. NHS and Leeds CC stakeholders have also had the opportunity to comment on draft and interim versions of this report, and feedback has been incorporated where appropriate.

*PARTNERS AND FAMILIES

In discussion with LSLCS, it was agreed not to attempt consultation with partners and families for two reasons:

1) LSLCS provides services that are confidential and anonymous. Partners and family members may not be aware that their partner or relative is in contact with LSLCS, and LSLCS does not always know whether the visitor/caller has any family or significant partner relationships.

2) Abuse (past or present) is an issue for more than 50% of LSLCS visitors/callers, often being a contributory factor to their mental health problems. Sadly, in some cases this abuse has come from family members, and it would be wholly inappropriate to contact families where this might be the situation.

Information on what changes for partners and families (where appropriate) has therefore come from:

- Two family members who joined a group discussion with LSLCS visitors
- Accounts from visitors/callers on the impact for their families
- General (not case-specific) feedback from staff who have talked 1:1 with visitors

LSLCS also identified the proportion of visitors with families or significant partners by reviewing all visitors who received 1:1 support during May 2011. Of 37 visitors seen during this month:

- 25 were in family settings or had significant relationships with family or partner
- 4 did not have significant family or partner relationships
- In 8 cases the family/partner situation was not known

Discussion with LSLCS staff suggest these numbers are typical. This gives a figure of 86% of visitors, for whom the information is known, who have significant family or partner relationships, equivalent to 138 visitors per year.

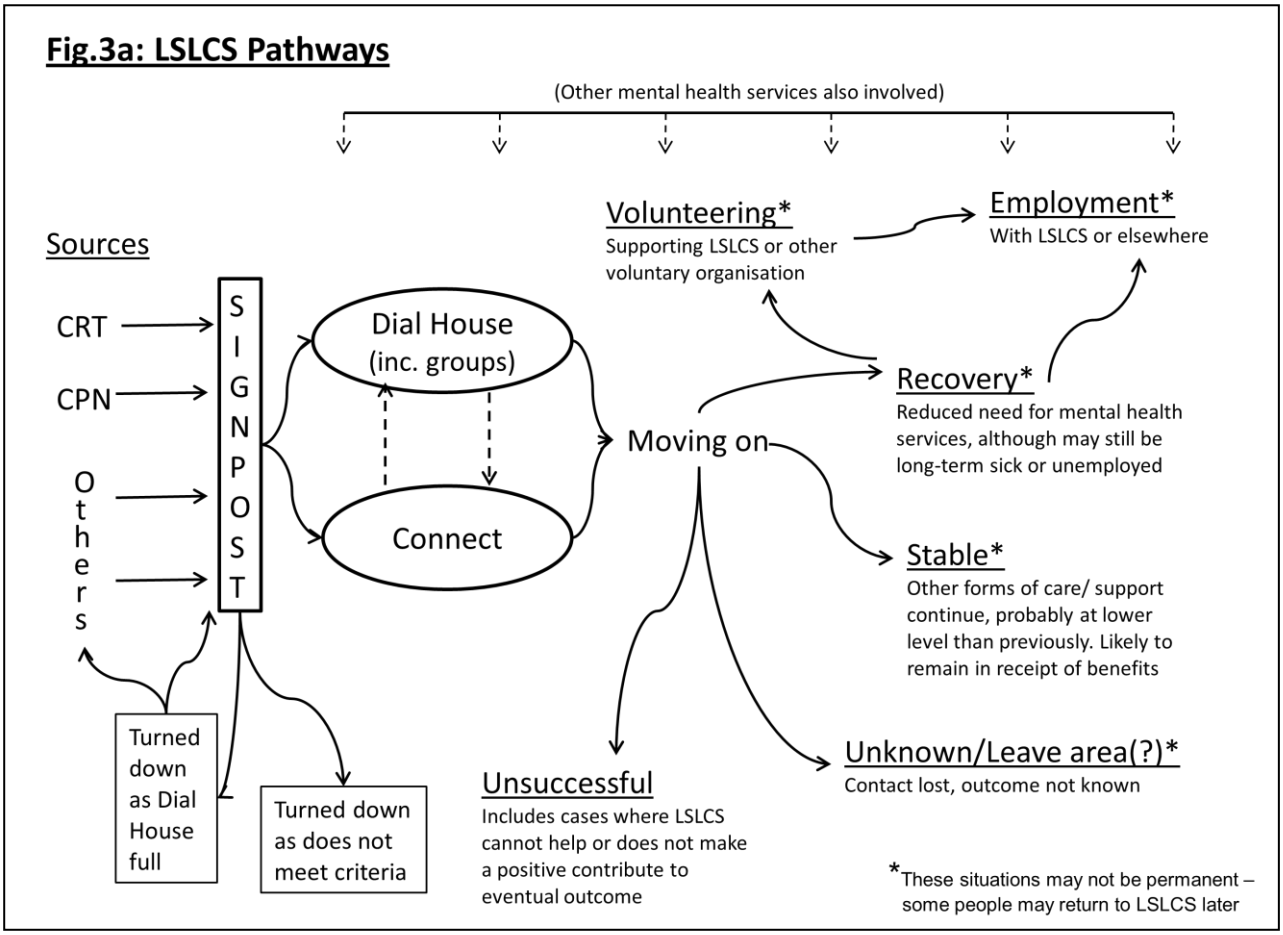
Section 3: Understanding What Changes

3.1. Visitors/Callers: Change Pathways

Initial discussion with LSLCS staff and with visitors/callers themselves established that the extent and duration of visitor/caller contact with LSLCS varies considerably. This discussion also identified that these contacts could be broadly grouped into a number of different routes or 'change pathways', and led to the development of the diagram at Fig.3a below that illustrates these pathways.

This should be interpreted a broad depiction of what happens, and the reality is not as linear as the diagram might suggest (in particular, some people return to use LSLCS again having initially moved on, and this is taken account of in the analysis in Sections 4 and 5).

Fig.3a: LSLCS Pathways



Initial signposting to the service comes through a number of routes, primarily the Crisis Resolution Team, Community Psychiatric Nurses and Personality Disorder Network. Individuals will then spend a period of time using either Dial House or Connect, or most commonly both. This period of time could be as short as one call or one visit, or could be as long as several years. It is not intended to be indefinite (the aim is always to help people overcome crisis and move on), and LSLCS has put a great deal of effort into ensuring that its most frequent visitors can genuinely make progress rather than continuing to rely on its services. There are however a small number of cases where LSCS support seems likely to continue for the foreseeable future; the best that can be hoped for these individuals is to maintain them safe from self-harm.

During the period that visitors/callers spend in contact with LSLCS, they are supported in a number of ways:

- In the majority of visits (76% in 2010) the visitor choose to talk one to one with a support worker, and all callers receive telephone advice and support. LSLCS has its own compassionate and non-judgemental support philosophy which many visitors/callers find particularly helpful.
- For all visitors, Dial House is a place of sanctuary, a safe environment where they can relax and escape from the pressures that cause them to feel in crisis.
- Visitors can also use Dial House facilities such as a computer with Internet access, and a bathroom (much appreciated by those who do not have a bath where they live)
- Isolation is reduced; simply having people around them or someone to talk to is therapeutic for many visitors/callers.
- Some visitors are helped by Dial House group sessions, or just by talking to other visitors.
- Dial House staff can sometimes assist with practical issues, for example helping visitors/callers make better use of NHS and other mental health support services, or advice on housing.

After this period of involvement with LSLCS, one of a number of things may happen. In a small number of cases, the person may find that LSLCS cannot help, and they go back to (or remain with) other parts of the mental health system. The worst-case scenario is that the person takes their own life; however, this virtually never happens in cases that LSLCS is aware of. In the last five years, there is only one known instance of a death, and this was through the cumulative effect of years of self harm rather than a specific incident – the person was understood to have "died happy".

In many cases, particularly where people use the Connect service only, LSLCS has no way of knowing what subsequently happens to the person, or even if they are still in the Leeds area. In a few instances it finds out later if the person re-contacts the service - this can happen after a period of years and sometimes just to say thank you. However, the anonymity of Connect callers makes it difficult to gather comprehensive information (see Section 4.4).

In other cases, involvement with LSLCS will help the visitor or caller to stabilise their condition and cope better with their situation, thereby reducing their need for crisis support and other support services generally. Such individuals may never be in a position to return to work and are likely to continue relying on Social Security benefits, but should have a reduced need for care services.

In the most positive outcomes, individuals will experience a good degree of recovery and can progress beyond needing support into roles where they become net contributors to society. Some 'short-term' visitors and callers may already be in paid employment, and LSLCS is helping them through a temporary crisis to get "back on their feet"(quote from someone in this position). For longer-term visitors/callers, progress may initially be through some kind of volunteering role, and some move on from there to paid employment. (In some cases the volunteering and employment is with LSLCS itself or other metal health-related services).

Analysis in this report is based on the numbers of visitors/callers who move through these various pathways, and considers the impact of these routes for visitors themselves and other stakeholders.

Finally, Fig.3a also highlights a possible negative outcome where requests for visits are refused because Dial House is full on a particular night and/or the person requesting a visit was not given priority. Account is taken of this unintended negative consequence in Section 5.4.

3.2.Evidence of Change for Visitors/Callers

Below are a selection of visitor/caller quotes (LSLCS have many more) taken from interviews, questionnaires, telephone reviews and the Dial House comments book. Together with statistical information (Section 3.5 and Annex 5), these provide evidence of the changes experienced by visitors and support the broad classifications described in Section 3.5. Some of them also illustrate how LSLCS differs from other services, relevant to attribution (Section 6.3).

“You have saved my life and given me the will to live”

"Sometimes coming to the house stops me from attempting suicide"

“Can I first start by saying my life is one big struggle. I suffer with manic depression and at the moment Dial House is keeping me alive. I don’t have much family that supports me or friends. What you all are offering to me and I am sure lots of other people is not just somebody to talk to but a life line. I hope that all the staff here can just stop a minute to realise how much you all are cared and loved by me. Thanks so much for saving my life on so many occasions.”

“I started to come to Dial House about 2½ years ago. When I turned up I was suffering from bad depression and drug addiction. I was very messed up, the staff here stuck by me and didn’t judge me, they also helped me believe in myself which gave me a little hope and helped me on my way to rehab. I am doing really well and Dial House are still here for me, I am so grateful for Dial House. Thank you.”

“The help I have had to deal with my immediate crisis I try to use with regards to things long term. I have attended the coping with crisis group which helped me identify coping strategies and I now try to put them in place”

"I am learning to cope differently but I am so used to cutting or taking overdoses"

"I used to take about 20 overdoses a year and self harm. I now haven't taken an overdose for 14 months, or hurt myself for 2 years."

"Dial House keeps me safe, out of hospital, and away from A&E"

“I haven’t taken an overdose since January. Last year I had 18 overdoses – 18 hospital admissions. Since using Dial House I haven’t taken one. I haven’t been in hospital once.”

“This time last year, my A&E admissions were much higher. I was there nearly every other night. This is drastically reduced. You help me manage it [crisis] better”

“It has made me feel wanted. I can talk to someone who listens. I leave feeling warm, rather than with a cold heart as if I’ve got nowhere.”

“It's like a sanctuary here, I calmed down as soon as I walked in, feel safe and more like me again”

"Thank you for all your wonderful warmth and for making me feel a worthwhile person tonight.”

"Thank you for accepting me. These past two weeks you have really helped me. The unconditional support here is amazing. You are there for me when no one else understands. This is really a special place and nowhere else is like this. Staff are amazing. Thank you so much."

"Thank you so much for your care and support during my recent crisis. Being able to come to a place of sanctuary and speak on the phone really helped me get through a very distressing time. Thank you."

"Thank you Dial House for helping my recovery. I am well and in full time employment"

"It is different to other services – it is easier to talk to staff. Staff are nice. They don't judge you or put a label on you – saying 'that's what's wrong with you."

"Most of all what I celebrate about your service is not being 'done to'…others, statutory services want power, they ask 'who are you?', establish the role and that's very disempowering. I've never had this at all from Connect or Dial House."

Connect staff also quote an example of a regular caller (who to the best of their knowledge did not access any other support) who achieved his long held ambition of qualifying as a bus driver and gained paid work.

Whilst this feedback is very comprehensive, it is essentially subjective evidence of change. It should ideally be supported by corresponding objective evidence of change, for example from NHS sources in terms of clinical improvements to visitors'/callers' mental health. At present this is not possible because data on individuals is not shared between LSLCS and the NHS or Leeds CC (see Section 1.7). Change has therefore been assessed on the best evidence available. However, we have recommended that LSLCS considers how such objective evidence might be gathered in future, as this would strengthen the reliability of any future SROI analysis, and of its evaluation in general.

3.3. Inputs, Outputs and Outcomes

The table below summarises the input contribution, outputs and outcomes achieved from the perspective of the different stakeholders in relation to the pathways illustrated in Fig.3a.

Stakeholder Group	Group includes:	Inputs	Outputs	Outcomes (what changes?)	Notes
Funders (included for input only)	NHS Leeds CC PDN	Funding	Meeting contract and SLA output requirements	Outcomes captured below for services run by funders	SROI ratio may also be of interest to these stakeholders
Visitors and callers	Caller-only contacts	Time	No. of calls Time spent on calls	Range of outcomes shown by Pathways map (Fig.3a). Benefits can include: - Avoiding premature death - Better quality of life and ability to cope - Chance to return to work	Most are regular callers, with a smaller number of one-off callers
	Visitors & callers (inc. group	Time	No. of calls No. of visits Time spent in		Almost all visitors are callers as well, and SROI considers

	members)		Dial House	either as a volunteer or (later) paid employment Negative outcome possible if visit request refused.	these aspects together. Only a minority of visitors are group members
NHS services	A&E Ambulance CRT & PDN Other MH	Time (liaison)	No. of patients Time spent with patients	Improved overall service capability and results - ability to handle increased demand with more appropriate service provision, better mental health outcomes for the community as a whole*	Very little evidence that these services currently assess the impact of LSLCS beyond referral numbers
Leeds CC Adult Social Care		Time (liaison)	No. of clients Time spent with clients		
Partners and Families	Partners, relatives, carers	Time, support	No. of visits Time visitors spends in DH	Respite, reduced stress and anxiety, relief when progress made	Not involved for all visitors/callers
Employees	Employees Bank staff	Time, skills, commit-ment, knowledge, experience	Hours worked Number of contacts	Employment (for paid staff) Personal satisfaction and fulfilment from work, team spirit and LSLCS ethos	
Volunteers	Unpaid DH volunteers		Hours worked Number of contacts	Personal satisfaction and fulfilment, development opportunities, experience towards paid employment	
Govern-ment	DWP HMRC LAs for HB	No direct contri-bution	Number of benefit recipients Tax receipts	Reduced benefits expenditure, increased tax receipts, for those who move into paid employment	Part of wider local & national strategy, other mental health services also contribute to this

Table 3b: Summary of Inputs, Outputs and Outcomes

The Impact Map (Annex 1) is an expanded version of this table, with outcomes detailed for different visitor groups and extra columns to the right covering for example: how outcomes are measured, financial proxies for these outcomes, what would have happened anyway, calculated SROI value.

*When considering outcomes, the change experienced by various NHS services and Leeds ASC have been combined, because it is not possible to separately identify the outcome for each. All of these services experience improved overall capability and ability to handle increased demand with more appropriate service provision, resulting in better mental health outcomes for the community as a whole. But because information is not shared between these services and LSLCS it is not possible to track the relative impact on each (see also Section 5.3).

3.4 Valuing Inputs

The various inputs are valued for SROI calculation purposes as follows

FUNDERS
This is the actual amount of funding that LSLCS received for 2010-11 from NHS Leeds, Leeds City Council Adult Social Care, and the Personality Disorder Network (combined figure £370,910).

VISITORS/CALLERS and PARTNERS/FAMILIES
As is conventional with SROI analysis, the time spent by visitors/callers interacting with LSLCS is not given a value, as they are the principal beneficiaries of the service. The same principle has been applied to partners and families, as they are supporting their relative rather than LSLCS directly.

NHS and LEEDS CC
The input of these organisations specifically to LSLCS is covered by their commissioning arms as funders (see above). There may be a small additional time commitment involved in liaison with LSLCS, but this is not given a value as it is likely that the same time would be spent on other liaison if LSLCS was not there.

STAFF
Working time of employed staff is paid for by the income received from funders, so no additional input is costed for this. See Section 5.4 for further detail.

VOLUNTEERS
Volunteers are in a different position to staff because their time is not paid for, but still represents an additional input, in kind, for LSLCS. For this reason (in common with many similar SROI analyses) an input value has been attributed to volunteers, and the figure used here is £8 per hour (source: ONS data on median pay for part-time work of this kind).

The number of hours worked each week by volunteers varies, but is approximately:
Connect: 5 volunteers (average) x 3 hour shift x 7 days = 105
Dial House: 1 volunteer x 5.5 hour shift x 3 per week = 16.5
Total 121.5 hours x 52 x £8 = £50,544 p.a. - this is the figure shown on the Impact Map (Annex 1)

CENTRAL GOVERNMENT
No input costs are associated with central government as it makes no direct contribution.

3.5. Visitor Patterns and Subsequent Outcomes

LSLCS records the number of visits each visitor makes to Dial House, and as part of this project was able to analyse this data. This analysis, reproduced in Annex 5, took visitors each year from 2006 to 2010 and analysed the subsequent pattern of visits for different individuals.

This shows that visitors can broadly be grouped into four categories:

1) People who continue to use the service often, and hence become long term frequent visitors
2) People who use the service extensively in one year (or a short period spanning two years) and then make a few visits in later years
3) People who make a few visits in most years
4) People who visit 1-3 times and then never return

These categories are an approximation and can never be precise as every visitor is unique. But they are helpful in identifying likely outcomes, and the interpretation below draws on discussions with visitors themselves, with staff and with other stakeholders.

For people in category (1), the most probable long-term outcome is stabilisation. These individuals often suffer from longer-term mental health problems, and even where LSLCS reduces their reliance on crisis support, many will never return to work. Some of these individuals do progress on to greater recovery however, and these are some of LSLCS's greatest success stories. NB: These cases are not shown separately on the Impact Map because the numbers in group 4a (see Section 5) who return to work are adjusted to take account of these.

For people in category (2), the pattern indicates that they make an initial recovery and then either experience some form of relapse or at least need further support later on. For analysis purposes, this group is treated as having initially recovered but not fully sustained this recovery. Again, stabilisation is an appropriate description, and the person will continue to use LSLCS services intermittently.

People in category (3) are those for whom LSLCS provides longer-term support. It includes some people who attend group work at LSLCS, and many individuals will also use Connect more frequently, in both cases to reduce the need for more frequent weekend visits. (Again, there may be a few here who eventually recover and commence work, but group 4a will take account of these.)

People could be in category (4) for a number of reasons. A few may find LSLCS of no help, and so fall into the 'Unsuccessful' outcome from the diagram. In a substantial number of cases, the eventual outcome is unknown - they may leave the area or otherwise be "lost" to the system (or at least unknown to LSLCS). There is strong evidence though that in a number of cases shorter-term LSLCS visitors/ callers are able to overcome their crisis, and will return to paid employment (some will never leave it) - see Section 4.

NB: Analysis in the next section also introduces a fifth category, which we have termed 'Group 0'. These are people who would, were it not for LSLCS and other mental health services, have committed suicide. These individuals could come from any of the four groups above, but the change they experience is quite different, because in their case it is literally the difference between life and death. Section 4 addresses the impact of change for this group.

3.6. Outcomes for Other Stakeholders

Each of the visitor/caller pathways illustrated in Fig.3a and described above entails different outcomes, both for the visitors/callers themselves and for most other stakeholders. Section 4.6 summarises these outcomes and Section 5 explains the financial proxies used to value them. In addition, there are two stakeholder groups who experience changes and outcomes which are not dependent on these pathways and visitor groups: staff and volunteers.

STAFF

In many SROI analyses, paid staff are not considered material because they are not the primary beneficiaries of the organisation's work, and because the salary they receive is covered by the organisation's funding. It can thus be argued that the outcomes they experience in terms of financial benefit and job satisfaction are cancelled out by the input cost of their salary, or that they could obtain similar outcomes by being employed elsewhere.

Discussion with LSLCS staff however made it clear that they derive benefits well beyond the purely financial; they value the experience of working at Dial House, the benefit of the work they do and the ethos and team spirit of LSLCS very highly. Almost all staff have personal experience of mental health problems (hence the 'survivor-led' part of LSLCS' title). Even if employment does not form a formal part of their therapy, they believe that the contribution they are making is very important to them personally; they have a sense of vocation far beyond that they would experience in any other job. Some would almost certainly not be working at all were it not for LSLCS.

As explained in Section 5.7, discussions with staff showed that some of the valued the experience of working at LSLCS so highly that they would not work anywhere else instead at any price; others felt they would need to at least double their salary to justify moving.

These aspects of personal fulfilment and well-being are taken forward in the SROI analysis as explained in Section 5.

VOLUNTEERS

In some respects the experience of volunteers is similar to staff, although different aspects apply to different volunteers.

At any one time LSLCS has between 35 and 40 volunteers, most of them working on the Connect helpline. It finds these volunteers through local advertising and word-of-mouth, and the changes they experience through working with LSLCS fall generally into two categories:

- Those who want to give something to the community and do it because they believe it is a worthwhile cause
- Those for whom, in addition, it forms part of career development, gaining knowledge and experience that they will use when working in the mental health sector

Both of these categories include people with direct experience of mental health problems. Again, Section 5 explains how these outcomes are valued.

Section 4. Outcomes and Evidence

4.1. Establishing a Basis for Outcomes

Evidencing outcomes and putting a value on them is complex for LSLCS, because it has to analyse:

1. different outcomes that apply to the different visitors/caller groups identified in Section 3; and
2. for each group, the value for various different stakeholders from
   - the period that visitors/callers spend in contact with Dial House and Connect
   - the period after they move on in one of the ways depicted in the diagram at Fig.1

This section explains how this analysis has been carried out and Section 5 explains the financial proxies used. The full calculation is shown in the Impact Map (Annex 1 - separate document). This takes a one-year investment period and considers the outcomes achieved during that year and the four years thereafter, for all stakeholders included

Using categories 1-4 from Section 3 and the data in Annex 5 the percentage of visitors in each group can be calculated approximately as follows:

Table 4a: Percentage of visitors in each of Groups 1 to 4

1) People who continue to use the service often, and hence become long term frequent visitors	7.5%
2) People who use the service extensively in one year (or a short period spanning two years) and then make a few visits in later years	12.5%
3) People who made a few visits in most years	30%
4) People who visit 1-3 times and then never return	50%

NB: These figures are a percentage of visitors, not a percentage of visits (for obvious reasons, visitors in the first two categories account for a much higher proportion of actual visits). These percentages also have to be modified for the impact of 'Group 0' as explained below.

4.2. The Impact of Possible Suicide

Before applying the percentages above to the number of visitors in any one year, we have first "top slice" a proportion to take account of people who would have committed suicide but for the intervention of mental health services including LSLCS (not necessarily LSLCS alone). This has been one of the most difficult factors to address within this project. There is no doubt that LSLCS makes a significant contribution to averting suicide in some of its visitors and callers. Evidence to support this is demonstrated by:

- the proportion of visit requests where suicide is a 'presenting issue' (i.e. the person has the intention and the means to commit suicide), which is consistently over 50%
- those visitors who explicitly state, in interviews or other feedback, that they would be dead were it not for LSLCS
- the high level of confidence that statutory local authority and NHS services place in LSLCS's ability to help people in severe crisis

- the known risk profile for some of the people LSLCS deals with (i.e. characteristics such as single, unemployed, socially isolated, etc)

Against this, it can be argued that many people who intend to commit suicide lack the means or determination to carry it through, and also that those who contact LSLCS must have some residual wish for life that causes them to make this contact. From this we conclude that only a small (but still significant) proportion of those who express a wish to commit suicide would actually do so if LSLCS did not intervene.

We have used the figure of 5% (8 visitors per year) as a conservative estimate of this proportion, based on the following evidence:

- LSLCS's May 2010 visitor survey asked visitors how they would have coped if they could not have come to Dial House. Out of 31 responses, several indicated they would have self harmed, one said "I think I would have died or runaway" and another simply said "I would have died".
- LSLCS's May 2011 visitor survey asked the same question. In this instance out of 51 responses, 10 people explicitly stated that they would have killed themselves and several others said they would have tried.
- Comments compiled from the visitors book maintained by LSLCS, covering the period 2006-2009: in the category 'Reducing Risk/Preventing Worse Happening' include 38 comments, 4 of which refer explicitly to Dial House having saved the person's life.
- The November 2009 review by NHS Leeds and Leeds Adult Social Care surveyed Dial House visitors: One of 12 responses to the question "Does the service help keep you well?" replied "Without Dial House I would definitely end my life"

Whilst we cannot be sure that these comments are representative of all Dial House visitors, the resulting figure of 8 per year is also considered plausible given that a city the size of Leeds should expect around 70 suicides per year based on national average data (9.2 suicides per 100,000 population age 15 & over in 2008 - source: latest available figures from ONS). We have reviewed suicide rate data for the Leeds area (source: Draft Mental Health Needs Assessment, April 2011), which uses a different basis to the ONS figures, and this indicates that the suicide rate for Leeds is slightly higher than the regional and national averages; we conclude that it would be difficult to adequately justify a higher percentage figure for LSLCS against this background.

4.3. Other Cases - The Remaining 95%

Using the figure of 5% for Group 0, we apply percentages from the previous table to the remaining 95% to arrive at the following overall percentage figures. These percentages are then multiplied by 160 (average number of visitors per year over the period 2009-10), to give the actual number of visitors in each category. These numbers are shown in brackets below, and also on the Impact Map.

Table 4b: Visitor numbers for Groups 0 to 4b

Group 0: People who would have committed suicide but for the intervention of LSLCS and associated services	5% (8 people)
Group 1: People who continue to use the service often, and hence become long term frequent visitors	7.125% (11 people)

Group 2: People who use the service extensively in one year (or a short period spanning two years) and then make a few visits in later years	11.875% (19 people)
Group 3: People who make a few visits in most years	28.5% (46 people)
Group 4a: People who visit 1-3 times and then never return (believed to have recovered and be economically active)	11.875% (19 people)
Group 4b: People who visit 1-3 times and then never return (outcome unknown - no assumption made about economic activity)	35.625% (57 people)

In addition, as shown above, category 4 has been split into two. It is divided between those who are believed to have made a full recovery and are economically active (e.g. have returned to work) (4a) and those - a much higher proportion - for whom the outcome is unknown because they cannot be traced and are in effect lost to the system (4b).

The proportion of short-term visitors who make this type of recovery is estimated at 11.875% (19 individuals) of all visitors in a year. The justification for this estimate comes from:

- A research paper *Healthcare and Social Services Resource Use and Costs of Self Harm Patients* (February 2010) which identifies a significant number of self harm patients who, subsequently tracked over periods of up to 10 years, showed long-term costs to the mental health system of close to zero. This strongly indicates a good level of recovery for these individuals - 20 out of a total sample size (including those who could not be traced) of 150.
- Informal feedback gathered by CRT, who signpost about 50% of the referrals they receive on to other services, including LSLCS. CRT staff follow up these individuals by telephone after a short period; in some cases they receive an appreciative response confirming that the person had experienced a short-term crisis which they have now overcome.
- An NHS Leeds study of A&E admissions for patients who had one or more episode of self harm during 2009/10. This showed that the great majority of such patients (83.4%) had only one self harm related inpatient spell during this period. (This analysis has to be taken in context, because it deals with inpatient admissions only, and we know that some people who repeatedly self harm will be treated only as outpatients, or may avoid hospital entirely. Nevertheless, it indicates that there are many people for whom self harm, and associated crisis, is a one off or short-term episode).
- Experience of Dial House staff who can recall instances of short-term visitors they have supported whom they believed were in full-time work, and who have received calls (via Connect) from people who have recovered, thanking LSLCS for its support.
- Written comments from visitors also make reference to short-term crisis. An example from a message card: "Thank you so much for your care and support during my recent crisis. Being able to come to a place of sanctuary and speak on the phone really helped me get through a very distressing time. Thank you."

4.4. Connect Callers

The groupings shown above are based solely on information relating to visitors, although many of these will be Connect callers as well. Because Connect callers are anonymous it is not possible to gather comparable data on caller numbers and call frequency from those who use the Connect

service only, nor is sufficient information available on the outcomes these individuals experience. (LSLCS knows the number of calls Connect receives, but not the number of callers. It is also not generally feasible to gather feedback on the service as part of the call, although LSLCS is investigating other ways in which it could capture such feedback in the future.) For this reason outcomes associated with those who use the Connect service only have had to be excluded from this SROI analysis (although see Sensitivity Analysis at Annex 3).

4.5. Basis of Cost-Benefit Analysis: The Impact Map

The Impact Map at Annex 1 shows the cost-benefit analysis as currently calculated. The following table gives a brief summary of how this Impact Map calculation is derived, again based on 160 visitors per year to Dial House. The table is divided into a number of sections corresponding to the different groups identified in Sections 3 and 4. The duration of impact is summarised in the right-hand column; Section 6.4 then converts these durations to drop-off values in the Impact Map.

Table 4c: Summary of Impact Map Valuations

Category	No. of people	Value whilst with LSLCS per individual (taken as Year 1)	Value beyond Year 1 per individual
Group 0: Suicide averted	8	Difference between life and death, calculated as the annual equivalent of lifetime costs of suicide for all relevant stakeholders (See Annex 2). Effect is permanent except for those NHS and other public service costs that apply only at or shortly after the time of death	
Group 1: Long-term frequent	11	To individual: Value of LSLCS service	To individual: Value of LSLCS service (continues with reduced number of visits)
		To partners/families: Value of respite and relief from anxiety	To partners/families: Value of respite and relief from anxiety (continues with reduced number of visits)
		To NHS & Leeds CC: No. of visits x cost of alternative service provision	To NHS & Leeds CC: No. of visits x cost of alternative service provision (continues with reduced number of visits)
Group 2: Frequent in one year	19	To individual: Value of LSLCS service	To individual: Value of LSLCS service (continues with reduced number of visits)
		To partners/families: Value of respite and relief from anxiety	To partners/families: Value of respite and relief from anxiety (continues with reduced number of visits)
		To NHS & Leeds CC: No. of visits x cost of alternative service provision	To NHS & Leeds CC: No. of visits x cost of alternative service provision (continues with reduced number of visits)
Group 3: Long-term infrequent	46	To individual: Value of LSLCS service	To individual: Value of LSLCS service (same number of visits)
		To partners/families: Value of respite and relief from anxiety	To partners/families: Value of respite and relief from anxiety (same number of visits)
		To NHS & Leeds CC: No. of visits x cost of alternative	To NHS & Leeds CC: No. of visits x cost of alternative service provision (same number

		service provision	of visits)
Group 4a: Recovery assumed	19	To individual: Value of LSLCS service plus economic benefits of working	To individual: Economic benefits of working (Value of LSLCS service lasts only for current year, benefits of working remain unchanged)
		To partners/families: Value of respite and relief from anxiety	To partners/families: No additional value (need has ceased)
		To NHS & Leeds CC: No. of visits x cost of alternative service provision	To NHS & Leeds CC: Nil (need has ceased)
		To the state: Reduction in benefits, increase in tax receipts	To the state: Reduction in benefits, increase in tax receipts (remains unchanged)
Group 4b: Outcome unknown	57	To individual: Unknown	Nil (no credit claimed) as no need identified
		To partners/families: Value of respite and relief from anxiety	
		To NHS & ASC: No. of visits x cost of alternative service provision	

Groups 1-4 will also experience a negative impact when requests for a visit are refused (Section 5.2)

One other potential negative outcome was also identified in discussion with LSLCS: that of visitors being upset or distressed by other visitors when they are at Dial House. This occurs infrequently and its effect is marginal; it does not undermine the overall value of the visit for the person who is distressed, and only one formal complaint was made about this in the whole of 2010. On this basis its impact is considered to be negligible and this outcome is not taken forward to the valuation stage.

The full Impact Map (Annex 1) also includes staff and volunteers, where impact and valuations are not dependent on the visitor/caller groups.

Section 5. Valuing the Outcomes

The SROI methodology places a value on changes for all stakeholders through use of financial proxies (equivalents). This section describes the financial proxies used for the Impact Map and how these have been developed. A set of tables at the end of this section then summarises the total value of outcomes for each key stakeholder.

5.1. Financial Proxy for Averting Suicide

The financial proxy applied to visitor/caller 'Group 0' is critical as it has a major impact on the SROI calculation. Because of its complexity and possible options, it is shown in Annex 2 rather than here. To convert the proxy for visitors/callers and partners/relatives to an annual figure we have divided by 30, based on the average life expectancy of people in the age range that LSLCS deals with.

Option 2 from this Annex has been used for the Impact Map, as it appears to represent the most realistic application of the principles involved. The alternative of using Option 1 is considered in the Sensitivity Analysis (Annex 3).

5.2. Value of LSLCS to Visitors/Callers

This financial proxy covers all visitors/callers except those in 'Group 0' where different considerations apply (see Annex 2) and Group4b - see below.Visitors and callers were asked to place a value on their use of LSLCS services, for example what they would consider reasonable for a visit to Dial House if (hypothetically) they had to pay for the service and could afford to. Many visitors could not answer this question because they described the service as "priceless", and those who did put a value on it varied widely between £40 per session and around £15,000 per year. We have taken an estimate of £100 per session as an estimate based on this range of responses.

This proxy can also be derived in another way, as the cost of alternative intervention designed to achieve the same outcome. In this case the nearest equivalent is likely to be 1:1 psychotherapy. People who can afford private psychotherapy (not the case for many LSLCS visitors) can pay anything from £40 to £180 per hour, £50-£70 per hour being a common figure (source: www.mind.org.uk). For LSLCS the average visit duration in 2010 was 3 hours 38 minutes, and 76% of visitors chose to have 1:1 support within that time. This suggest that £100 per visit is around the right figure for an equivalent to an evening visit based on this proxy. (NB: LSLCS staff are not professional psychotherapists, but what is at stake for someone in severe crisis may well be higher, hence a visit may be of greater value to them.)

This proxy has been applied to visitor groups 1,2,3, and 4a. It cannot be justified for Group 4b because the outcome for these individuals is unknown, and we cannot prove that LSLCS had any value for them personally.

Similar considerations apply to negative outcomes where visits are refused (this applies only to visits declined because Dial House is full or the person is not prioritised, not to instances where referral to LSLCS is inappropriate). Although the alternative of a call to Connect is always offered, many visitors

in this situation report that they feel worse than if they had not made the request in the first place. We have used the same proxy figure explained above to as the best representation of the negative value that people in this situation experience.

For visitor/callers in group 4a, there are also economic benefits - the increase in income they experience when moving into or returning to employment . This proxy, taken at minimum wage levels, is calculated at £4,458 per year (source: VOIS database - New Economics Foundation analysis based on DWP figures: difference in income between the minimum wage and benefits; 2008 figure of £4307 uprated to £4,458 for 2010 based on 3.5% rise in minimum wage over this period.)

5.3 Value of LSLCS to Other Service Providers (NHS and Leeds CC)

This financial proxy covers all visitor/caller except those in 'Group 0' (see below) and addresses the cost to statutory services (NHS Leeds and Leeds CC Adult Social Care) of alternative service provision if LSLCS was not there for its visitors/callers. These alternative services could include:

- the CRT team, either through home visit or admission to the Becklin Centre
- NHS accident and emergency departments, including ambulance and paramedic services
- other forms of psychiatric support from CPNs or the Personality Disorder Network
- additional costs to adult social care

A proxy is needed here as actual data is not available; records are not generally shared between the NHS, Leeds CC and LSLCS, so the NHS and Leeds CC have no means of auditing the financial impact of LSLCS on its services (and may not even know which of its patients/clients attends LSLCS).

Feedback from visitor surveys and comments indicates that about two-thirds of visitors would have sought or needed alternative provision for each visit had Dial House not been able to accommodate them. Some even assert that they would use A&E services much more frequently - in other words one attendance at Dial House might save avoid several visits to A&E. On balance, rather than assuming that this evens out, we have estimated that some alternative provision would be needed in 75% of visits to Dial House.

Although there will be many instances where actual costs are higher or lower, we have used a figure of £306.50 as the approximate cost of such alternative provision, based on the average of:

- CRT's per-day cost of an inpatient bed with standard nursing care (£315 per day - source: local figure quoted by head of CRT in telephone discussion following meeting in March 2011)
- Paramedic + A&E average costs for minor injuries not leading to admission (£298 per instance - source: Unit Costs of Health & Social Care 2010 (PSSRU))

75% of this figure gives a cost to statutory services of £230 per instance, and this is the figure used on the Impact Map.

NB: In cases where Dial House has to refuse a visit, the individual may well end up using A&E or other NHS services. However, there are no shared records that enable such cases to be tracked, hence such instances are viewed as a lost opportunity for benefit rather than an actual cost to NHS Leeds or Leeds CC.

The financial proxy for 'Group 0' visitors/callers covers a different situation, explained in Annex 2.

5.4 Value of LSLCS to Partners and Families

This is the value of relief from stress and anxiety, and respite from care responsibilities (which could otherwise be 24/7), experienced by the partners and families of LSLCS visitors and callers. The proxy used here is the cost achieving the same outcome by other means, in this case the cost of 1:1 care provision (not treatment) in the visitor/caller's own home from a private agency in order to provide the same level of relief and respite.

A figure of £13.49 per hour has been used here based on local agency charges for home care costs (source: hourly maximum paid by Leeds City Council to external agencies for home care workers, quoted by Community Care UK). The average length of stay in Dial House is 3 hours 38 minutes, and this has been rounded up to 4 hours per visit as care agencies will normally change for travel time as well as actual attendance.

The financial proxy used for visitors in Group 0 is significantly different, because it deals with the potential death of a loved one. This is explained in Annex 2.

5.5 Value of LSLCS to Central Government (Welfare Benefits)

For those individuals who recover and return to work we have assessed a saving in Social Security benefits (including housing and other 'passported' benefits) of £8,749.00 per year . This is calculated as follows:

- Incapacity Benefit lower rate 2010: £68.95pw = £3,585.40pa (Source: DWP benefit rates)
- 'Passported' benefits: £99.30pw = £5,163.60pa (source: VOIS database - value of passported benefits including housing, council tax breaks, free prescriptions and travel. Based on 2008 prices in London we have taken 2010 values in Leeds to be similar)
- Total: £8,749.00 per year

Whilst the government will also gain through increased Income Tax take when individuals return to work, this is a transfer of income rather than new value created. It is considered to be covered within the economic benefits to individuals of earnings (see 5.2 above) to avoid double-counting.

These figures should be modified on the basis that not everyone who recovers will return to work - particularly given current levels of unemployment. 71% of the UK adult population are currently working (source: ONS data, May 2011). However, there are two factors to be balanced against this:

- People may be out of work but still economically active (for example if they are supporting a partner or family member who is in work, or if they are volunteering)
- A small number of people from Groups 1-3 will eventually return to work. These have not been counted elsewhere, so are counted as offsetting those from Group 4a who do not find work.

For these reasons the percentage of visitors in Group 4a (which in any case represents only 11.875% of all LSLCS visitors) has been adjusted when calculating the savings in welfare benefits, although a multiplier of 85% has been used rather than 71% to take account of the factors above.

(NB: Equipping people to move to or return to employment is not a core purpose of LSLCS. It does however play a significant role in a sequence of positive change that enables some people to achieve

this, and hence is a relevant outcome for SROI, even if unintended. Although the numbers involved are relatively small, the benefits in financial equivalence terms are substantial, and the contribution of other agencies to this sequence of change is addressed through Attribution in Section 6).

5.6 Value of LSLCS to Staff

Staff are not usually included in an SROI assessment because their time input is covered by funding and they benefit through the salary they are paid. With LSLCS however it became clear from staff discussions that the organisation was far more important to staff than the value of their salary alone. Staff valued the experience, the service they are providing, and ethos and teamwork of LSLCS very highly, and this is reflected in the very low staff turnover LSLCS has (See Section 3.6)

This was valued through a staff discussion group at which members of LSLCS staff were asked to note down (individually and in secret) what additional salary payment it would take for them to leave LSLCS. Several declined to answer on the basis that they would not work anywhere else at any price; amongst those who did reply the consensus was that they would need to at least double their present salary to gain an equivalent level of satisfaction elsewhere. To avoid over-claiming, the proxy for each member of staff values the change they experience as the same amount again as the salary they receive (equivalent to doubling their salary).

Rather than examining individual salaries, this proxy has been derived by taking the total annual salary bill for LSLCS (source: LSLCS budget 2010-11) and taking the same amount as representing the additional benefit achieved.

5.7 Value of LSLCS to Volunteers

Section 3.5 describes the outcomes experienced by volunteers, and is based on LSLCS having at least 35 volunteers at any one time. These outcomes have been valued by taking the cost of external professional training designed to achieve a similar effect. For all volunteers this includes training designed to improve confidence, self-esteem and sense of well-being. For those who have a mental health care career path in mind (estimated as slightly less than half of the total based on survey feedback), specific training in self-harm and crisis management has been added.

5.8 Summary of Financial Proxies and Valuations

Tables 5a to 5e on the following pages summarise the financial proxies used and the value of change for each relevant stakeholder, broken down for each of the visitor/caller groups 0 to 4b (except for staff and volunteers where these groups are not an issue). The same information is incorporated in the Impact Map (Annex 1), here with visitor/caller groups as the start point. Drop-off (the last column) is explained in more detail in Section 6.4.

Table 5a: Visitors/Callers

Visitor/caller group	Description of change	Indicator	Quantity (Year One)	Proxy description	Information source	Proxy value per instance	Total change value (first year)	Drop-off in subsequent years
Group 0: Suicide averted	Suicide averted - avoidance of premature death	Benefits to the individual of avoiding premature death	8 visitors	Average earnings data modified for LSLCS visitors	See Annex 2	£2,772 per visitor	£2,772 (attribution applies)	None (effect is permanent)
Group 1: Long-term frequent	Reduced risk of self-harm, improved ability to manage, eventual stabilisation	Visitors/callers who report these improvements following visits	11 visitors, 39 visits each	Cost of private therapy of equivalent value	Visitor answers and Mind data (www.mind.org.uk)	£100 per session	£42,900	50% per year after year one
Group 2: Frequent in one year	Reduced risk of self-harm, improved ability to manage, limited recovery	As above	19 visitors, 14 visits each	As above	As above	As above	£26,600 (attribution applies)	90% impact remains after year one
Group 3: Long-term infrequent	Reduced risk of self-harm, improved ability to manage, stabilisation	As above	46 visitors, 3 visits each	As above	As above	As above	£13,800	100% drop-off (need unchanged)
Group 4a: Believed to have recovered	Ability to overcome crisis and manage a return to normal life	As above	19 visitors, 2 visits each	As above	As above	As above	£3,800	None (effect is permanent)
	Transition from benefits to receiving income from earnings	Number of visitors/callers who experience these economic benefits	16 visitors (19 x 85% - see 5.4)	Value of extra income received	DWP benefit rates and other VOIS data	£4,458	£71,328 (attribution applies)	None (see footnote to Table 5d)
Group 4b: Out-come unknown	Outcome unknown as they cannot be traced	n/a	57 visitors, 2 visits each	n/a	n/a	n/a	£0	n/a
Negative: All groups if visit request refused	Disappointment, distress, may need to use other services	Number of instances in which these outcomes occur	343 instances per year	Cost of private therapy of equal value	As above (Mind data)	As above	£34,300	Counted for current year only

Table 5b: NHS Leeds and Leeds CC Adult Social Care

Visitor/caller group	Description of change	Indicator	Quantity (Year One)	Proxy description	Information source	Proxy value per instance	Total change value (Year One)	Drop-off in subsequent years
Group 0: Suicide averted	Public services which would have been required at or shortly after the time of death are not needed	Reduction in public services required, due to death being averted	8 visitors	Cost of public services needed to deal with suicide	See Annex 2	£8010	£64,080 (attribution applies)	Drops to zero after year one
Group 1: Long-term frequent	Better patient/client care, reduced demand for statutory services	Extent to which LSLCS visits reduce demand for NHS/ ASC services	11 visitors, 39 visits each	Actual cost data provided by NHS Leeds & Leeds CC	NHS Leeds and Leeds CC	£230	£98,670	50% per year after year one
Group 2: Frequent in one year	As above	As above	19 visitors, 14 visits each	As above	As above	As above	£61,180 (attribution applies)	90% impact remains after year 1
Group 3: Long-term infrequent	As above	As above	46 visitors, 3 visits each	As above	As above	As above	£31,740	100% drop-off (need unchanged)
Group 4a: Believed to have recovered	As above	As above	19 visitors, 2 visits each	As above	As above	As above	£8,740	Drops to zero after year one
Group 4b: Outcome unknown	As above	As above	57 visitors, 2 visits each	As above	As above	As above	£26,220	Drops to zero after year one

Table 5c: Partners/Families

Visitor/caller group	Description of change	Indicator	Quantity* (Year One)	Proxy description	Information source	Proxy value per instance	Total change value (initial year)	Drop-off in subsequent years
Group 0: Suicide averted	Having a partner / family members still alive who would otherwise have died	Effect on partners / family members of a loved one still alive who would otherwise have died	8 visitors	Human costs data modified for profile of LSLCS visitors	See Annex 2	£36,629	£293,032 (attribution applies)	None (effect is permanent)
Group 1: Long-term frequent	Relief from stress and anxiety, respite from care responsibilities	Partners and family members who report relief and respite as a result of LSLCS visits	9 visitors*, 39 visits, 4 hours per visit	Cost of alternative 1:1 care provision	Cost of private 1:1 home care provided by local agency	£13.50 per hr for 4 hrs (inc travel)	£12,150	50% per year after year one
Group 2: Frequent in one year	As above	As above	16 visitors*, 14 visits, 4 hours per visit	As above	As above	As above	£17,280	90% impact remains after year one
Group 3: Long-term infrequent	As above	As above	40 visitors*, 3 visits, 4 hours per visit	As above	As above	As above	£6,480	100% drop-off (need unchanged)
Group 4a: Believed to have recovered	As above	As above	16 visitors*, 2 visits, 4 hours per visit	As above	As above	As above	£1,728	Drops to zero after year one
Group 4b: Outcome unknown	As above	As above	49 visitors*, 2 visits, 4 hours per visit	As above	As above	As above	£5,292	Drops to zero after year one

*Visitor numbers calculated by multiplying number of visitors in groups 1-4 by 86% (proportion of visitors with partners/families)

Table 5d: Central Government

Visitor/caller group	Description of change	Indicator	Quantity (Year One)	Proxy description	Information source	Proxy value per visitor	Total change value (Year One)	Drop-off in subsequent years
Group 0: Suicide averted	Does not apply to this group	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Group 1: Long-term frequent	Does not apply to this group	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Group 2: Frequent in one year	Does not apply to this group	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Group 3: Long-term infrequent	Does not apply to this group	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Group 4a: Believed to have recovered	Fewer benefit claims made where people are working	Number of visitors/callers for whom savings in benefits and increased tax income are achieved	16 visitors (19 people x 85% as explained in Section 5.4)	Savings on social security benefits (including HB & 'passported' benefits)	Benefits and tax rates data	£8,749	£139,984	None (see below)*
Group 4b: Outcome unknown	Does not apply to this group	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* No drop off has been applied here because although a few of these people may subsequently lose their jobs, this will be offset by a small number of people from other visitor/caller groups who progress sufficiently to find work (or become economically active - see Section 5.5)

Table 5e: LSLCS Staff and Volunteers

Stakeholder Group	Description of change	Indicator	Quantity per year	Proxy description	Information source	Proxy value per year	Total change value (Year One)	Drop-off in subsequent years
LSLCS Staff	Increased personal fulfilment, sense of value and job satisfaction, being part of LSLCS team	Staff who report experiencing these outcomes (counted as one group for LSLCS staff as a whole)	1 x total salary costs	Additional salary needed to persuade staff to leave LSLCS (double)	Staff discussion group feedback Salary data: LSLCS budget 2010-11	£285,474	£285,474	100% as benefit is renewed each year
LSLCS Volunteers	Increased personal fulfilment through being able to help others, greater knowledge and understanding	Volunteers who report experiencing this outcome	35	Cost of course on communication skills from Skills Audio	SROI VOIS database 'improved confidence and self-esteem'	£1,363	£47,705	100% as valued separately for each year
	As above plus experience towards future career in mental health care or other employment	Volunteers who report experiencing this outcome	15	Cost of training to achieve equivalent level of knowledge	Cost of 15 days training with APT self-harm and crisis management (www.apt.ac) (5 x £4,998 for average 11 people)	£2,272	£34,080	100% as valued separately for each year

Section 6: Assessing the Impact of LSLCS

The Impact Map starts by assessing the total value of the change experienced by each of the various stakeholder groups. This section considers how much of this change is due to the work of LSLCS as opposed to that of other organisations or other external factors.

6.1. What Would Have Happened Anyway (SROI technical term is 'deadweight')

This addresses whether the change experienced by stakeholders would have happened anyway, without the intervention of LSLCS. In other words, would any visitors/callers have achieved recovery or stabilisation had LSLCS not been there? The answer here is considered to be no, for the following reasons:

- LSLCS's visitors/callers are individuals in severe crisis and at risk of suicide, not people simply with depression or other disorders from which they might recover unaided.
- LSLCS screen all visit requests and refuse those that do not meet their criteria of severe crisis (See Fig.3a) - i.e. those who might recover anyway or with alternative help.
- The service that LSLCS provides is unique; there is no other service in the Leeds area that provides this type of support, including the facility for visits, for people in crisis.
- Services provided by NHS and Leeds ASC may in some cases complement LSLCS but do not duplicate them. Where these services are relevant, their impact is considered through attribution (Section 6.3) rather than here.

LSLCS acknowledges that change and improvement can be brought about through outside factors unconnected with any mental health services - for example if a visitor finds a new partner. However, this can work both ways - for example bereavement or relationship breakdown may exacerbate an already difficult situation. On balance these positive and negative factors are likely to cancel each other out (for the LSLCS population as a whole rather than for individuals).

The conclusion is that there is no evidence that any of the changes and outcomes described in the previous sections would have happened without the involvement of LSLCS in the change process, and hence no modification for this factor has been made on the Impact Map.

6.2. Displacement

Displacement tests whether LSLCS activity has simply moved something - shifted a benefit or a problem from one area to another rather than changing it. The only respect in which this might apply to LSLCS is for those individuals who progress into paid employment , if in doing so they deprive someone else of a job. The Impact Map does not factor in this possibility, for three reasons:

- such an assumption is dependent on macro-economic factors (e.g. unemployment levels) which cannot be accurately predicted for the future. (Although unemployment is currently high, there were still 468,000 job vacancies in the last quarter of 2010 (Source: ONS statistics))

- the model used by the government in its *No Health without Mental Health* White Paper does not take account of such displacement when estimating the financial benefits of its current strategy, nor is it considered in other government 'welfare to work' schemes
- those who find work do so either in the mental health field (where there are vacancies) or in the general employment field; in neither case are they displacing others from any specific field or group who might otherwise obtain such employment. In other words, sufficient vacancies exist in these fields of work that displacement should not be an issue.

Some of those whom LSLCS loses contact with may subsequently find work other geographical areas, but no value is claimed for these callers/visitors because we do not have the evidence to prove this.

6.3. Attribution

This deals with the question of whether any of the change is attributable to other services rather than solely to LSLCS. It is certainly the case that many visitors/callers continue to receive psychiatric treatment, medication or other forms of care and counselling alongside their contact with LSLCS. There are a few visitors and callers who, from discussions with LSLCS support staff, are believed to use LSLCS services only, but these are in the minority.

Leeds NHS Partnerships Trust views LSLCS as part of an integrated service moving people away from dependence on care and on - in as many cases as possible - towards work. Other 'non-LSLCS users' could well follow a similar route to that depicted in Fig.1, but it LSLCS contributes positively to all those that use its services.

For many parts of the Impact Map, attribution to other services is shown as 0%. This applies where change is assessed on the basis of each visit to Dial House (totalled to give the change for one year), and is justified because:

- visitors/callers are putting a value on their experience of LSLCS alone, not on their experience of the wider mental health care system; or
- the cost of alternative service provision is being assessed - by definition this is a replacement for LSLCS rather than being a co-contributor with it

So for example the needs of Group 3 (long-term infrequent visitors) remain essentially unchanged over time. LSLCS is basically keeping them on an even keel, preventing them from getting worse and helping them maintain their coping strategies. Each visit is thus a separate event that helps keep the person as well as they can be - it is not part of a course of therapy. Because in this instance we are concerned only with the effect of LSLCS, not with this group's wider experience of mental health care, there is no attribution elsewhere.

Group 1 is treated in a similar way, although in this case there is a very gradual change over time based on the cumulative effect of all of their visits/calls to Dial House.

There are two cases where attribution is very important however, and these are:

- cases where the individual makes a recovery and is able to return to work (Group 4a)
- cases where suicide is averted (Group 0)

For visitors in Group 4a, visits to Dial House contribute to a very significant change, namely their recovery. Given that most of these individuals are signposted to LSLCS by CRT or other parts of the NHS, it is likely that some other therapy or intervention is going on as well that may also contribute to this recovery. In this instance it is appropriate to consider the total change experienced by each visitor, and attribute part of this to LSLCS and part elsewhere. The impact map lines for group 4a which relate to the economic benefits of working and fewer benefit claims made therefore include attribution.

The same principle applies to Group 0 where change is the difference between life and death. Here it would risk over-claiming to assume this is due solely to LSLCS, so again the indicator is the number of visitors rather than the number of visits, and the figures are subject to attribution.

In both of these cases, 50% of the value has been attributed to other parts of the mental health system, including other voluntary organisations, on the following basis:

- For most visitors/callers, their treatment and therapy involves a wide range of interactions with NHS professionals and other organisations, including LSLCS, together with medication. It would not be feasible to assess separately the impact of all these varied interactions.
- Many visitors/callers attribute most if not all of their recovery (or at least improved ability to cope) to LSLCS, and this includes some short-term visitors. There is insufficient evidence to say that this applies to all visitors/callers however, particularly for Group 4b where contact is lost.
- Advice in the New Economics Foundation publications *Small Slices of a Bigger Pie* (2011) recommends taking 50% as a starting point, and this advice seems appropriate here, at least until such time as more comprehensive feedback is available from a full range of LSLCS visitors (see Sections 7.2 and 7.3).

A modified attribution level of 33% has also been taken in one other case: that of visitors who use LSLCS intensively in one year and less in later years (Group 2). In this case there is some permanence to the change, and the extent of LSLCS involvement together with feedback from individuals in this category indicates that LSLCS has played the major role in achieving this change. However, because of the very low drop-off, some attribution has been included to recognise the likely contribution of other services to sustaining this group's improvement. Essentially, evidence indicates that the change is mostly due to LSLCS intervention, so attribution to other services of less than 50% has been used here.

Possible variations to these attribution levels are considered in the sensitivity analysis at Annex 3.

6.4. Drop-Off

This question considers whether the change produced by LSLCS is permanent, or is eroded in subsequent years. Here, the different patterns of visits for each visitor group enable us to identify drop-off much more accurately than would be the case if we had to assume an aggregate annual percentage. Section 4.5 and Table 4c explain the duration of change for each visitor group, and should be read in conjunction with this subsection.

Note that we are talking here about the extent to which the effects of change in the first year remain during subsequent years. Hence for example the drop-off for Group 3 is 100% because they require a similar level of support in the following years.

1. For group 1 (long-term visitors) turnover figures indicate that about 50% of these cease to become frequent visitors in each subsequent year. (These are replaced by new long-term visitors so that the overall number of frequent visitors remains roughly constant.)
2. For group 2 (frequent in one year with fewer subsequent visits), we have calculated based on data in Annex 5 that visits drop to an average of 10% of the initial level after year 1. This means that in effect 90% of the improvement - and its effects on stakeholders relevant to this group - remains. This drop-off is treated as continuing at the same rate as the impact of visits made in year 1 gradually diminishes.
3. For group 3 (long-term infrequent visitors) the pattern of visits remains fairly constant through the years, with no significant reduction. This means that none of the impact lasts beyond the current year, so drop-off is 100%.
4. For groups 4a and 4b, all of the visits occur within a limited period with none in subsequent years, so the benefits of the visits themselves only apply to the current year - drop-off is 100% beyond that. For the 4a group (recovery) however, the benefits of a return to paid work should endure in subsequent years. No drop-off has been assumed in this instance because any regression would place these individuals in group 2 rather than 4a.
5. Negative consequences of visits refused: visit refusals are one-offs and the negative impact is immediate. Although roughly the same number of refusals occur each year, there is no lasting effect into subsequent years from each instance of refusal . Drop-off is therefore 100%.

6.5. Cost - Benefit Analysis

The Impact Map (Annex 1) derives a cost-benefit figure through the standard financial practice of taking the total benefit over a five-year period and dividing it by the total cost invested. In this case the investment cost has been taken as the total funding LSLCS received from NHS Leeds and Leeds CC for the financial year 2010-11, plus the value of volunteer time.

The resulting figure of £5.17 benefit per £1 invested may be considered the 'headline figure' for this SROI analysis. It should however be viewed in the context of the Sensitivity Analysis in Annex 3, from which we recommend that a range of between £4.00 and £7.00 is used to describe the SROI for LSLCS.

Using the figure of £5.17, the total added social value generated by LSLCS over one year works out as £1,757,843.73 in 2010. This figure should increase for 2011 due to the increase in LSLCS's capacity from June 2011.

Section 7: Discussion and Recommendations

7.1. Building on the Interim Report

This section presents conclusions and recommendations from the SROI analysis, building on those already presented in the interim report.

From the impact map, the two visitor/caller groups where LSLCS appears to achieve the greatest value (in SROI terms) are:

- 'Group 0', where suicide is prevented: although the actual number of suicides prevented may appear small, the relative value is very high
- Group 4a, where LSLCS plays a role in helping people overcome crisis, from which they then progress to recover and resume normal life

It is important to stress that this does not mean that other visitors/callers are less important. This is particularly so as 'Group 0' is not a separately identifiable group of individuals, but represents a proportion drawn from all of the other groups. There is no reliable way of knowing who, from all of these other groups, might take their own life without support from LSLCS and hence no suggestion that LSLCS should scale down the support it provides for any individual in crisis.

The interim report noted that much of LSLCS's own evaluation data came from visitors (who might also be Connect callers) in Groups 1 to 3, as these are the people from whom feedback can most easily be gathered. It was much more difficult to gather feedback from those in Group 4 (short-term visitors) and those who use the Connect helpline only. The interim report made the following two recommendations (1 and 2 below)in this respect, and these still remain valid:

7.2. Confirming the Impact on Short-Term Visitors

LSLCS has hitherto drawn its success stories mainly from its longer-term visitors, and some of these are undoubtedly remarkable: individuals for whom LSLCS has provided a route from the verge of suicide to recovery, through volunteering and eventually to paid employment. However, analysis shows that more than 50% of visitors to Dial House attend on no more than three occasions, and we have defined these as 'short-term visitors'.

It is known that many people who commit suicide have had no prior contact with any mental health services. It therefore seems likely that at least some of LSLCS's short-term visitors may be the tip of an iceberg - the few who seek help to resolve a short-term crisis that many others succumb to. We believe that LSLCS may well have some "hidden" success stories here - hidden because the short term and confidential nature of contact makes it very difficult to track outcomes for these people.

The significance of this is twofold:

- It would be valuable to track such cases where possible to confirm that, at least for a proportion of these visitors, LSLCS has provided a significant step on their route to a full recovery
- If this is confirmed to be the case, then LSLCS could increase its impact significantly if it was able to reach more people in short-term crisis

Recommendation 1: We recommend further research to establish the outcomes for short-term visitors to Dial House. Subject to this research, LSLCS should liaise with NHS Leeds (and in particular with GPs) to find ways of encouraging more people in short-term crisis to come forward and use its services to help them.

7.3. Feedback on the Value of the Connect Helpline

Where people are in contact with LSLCS both as visitors to Dial House and as callers to Connect (which is the case with many people), feedback on both aspects of LSLCS can be gathered through their contacts with Dial House. Connect however is an anonymous service, and unless callers are already known to LSLCS or choose to disclose their identity, LSLCS has no way of contacting them subsequently, for evaluation or any other purpose.

At the moment, feedback from those who use the Connect service only is limited to a few cases where individuals have got in touch subsequently to give their thanks and report progress. More comprehensive feedback would help LSLCS identify exactly where the Connect service adds most value and hence target further improvement. Clearly, getting such feedback without compromising the anonymity on which the service relies is problematic; however, we know that others working in this field (e.g. Samaritans) gather feedback in similar situations, and we believe that knowledge could be shared here.

Recommendation 2: We recommend that LSLCS should investigate ways to gather feedback from callers who only use its Connect helpline, in order to establish how the service helps them and what changes they experience through using it.

Both of these first two recommendations may in due course help to produce a more accurate SROI ratio figure, although this is not their prime purpose. We believe that the recommendations can help LSLCS understand the impact of its services for visitor and caller groups not fully captured in its current evaluation methods. Through this understanding, LSLCS should be able to target and strengthen its services still further, and substantially increase the positive impact it already achieves.

LSLCS has accepted and has already started to implement both of these recommendations.

This final report adds three further recommendations based on SROI analysis. All of these relate to issues that LSLCS is already aware of:

7.4. Increasing Capacity

The negative impact of instances where Dial House has to refuse a visit highlights an issue that LSLCS has long recognised: that of demand exceeding its capacity. In 2011 LSLCS received additional NHS funding which has allowed it to open on a fourth evening - Monday as well as Friday to Sunday as previously. This has had the effect of increasing both the number of visits and the number of visitors,

although pro-rata to those already being received - it has not significantly increased the *proportion* of new visitors to Dial House.

Visits are still being refused when Dial House is full however, and this demonstrates that LSLCS could help more people still if it had more capacity. In SROI terms this would increase the total social value the organisation delivers. Broadly speaking the current SROI ratio would remain valid up to the point that LSLCS can meet all demand, and hence further funding would return much greater social value up to that point. This should also be seen against a background of demand which is continuing to increase, due at least partly to the current economic climate and its impact on individuals and families.

Increased capacity could come either from opening Dial House for longer or more evenings, or possibly by opening a second centre elsewhere in Leeds.

Recommendation 3: We recommend that LSLCS should continue its efforts to seek further funding, in order to increase its capacity still further and enable it to help more people in crisis.

7.5. Increasing Outreach

LSLCS has already sought to increase awareness of its services amongst the Leeds community, for example though GPs and by strengthening its links with other voluntary and mental health organisations. It remains likely however that some people that it could help are unaware of the service, particularly those not currently in contact with mental health services.

This recommendation goes hand-in-hand with the previous one in that the value of greater capacity would be maximised if outreached could also be enhanced. It particularly applies because many of those reached might fall into Groups 0 or 4a from the visitor analysis, which are the groups for which the SROI return is highest.

Recommendation 4: We recommend that LSLCS should seek new ways to promote awareness of its services to people in crisis, particularly for those not currently in contact with mental health services.

7.6. Refining Indicators

LSLCS's evaluation of its services, and related outcome indicators in this SROI analysis, rely primarily on feedback from visitors/callers, corroborated in some cases by staff feedback and LSLCS records. Whilst this data is extremely valuable, it is essentially subjective and would be strengthened if other more objective data was available, for example from NHS sources. This should seek to confirm the extent to which LSLCS improves visitors'/callers' mental health, and the impact that this has for visitors/callers themselves and for others. We recognise that confidentiality issues and a lack of shared data on individuals makes this difficult. However we recommend that LSLCS should consider how this might be done, to provide even stronger evidence of its success in the future.

Recommendation 5: We recommend that LSLCS should investigate how more objective clinically-based evidence of the impact of its services might be gathered in future.

7.7. Response from LSLCS

The following is the text of a letter received from the manager of LSLCS in response to the draft report and recommendations, confirming their agreement with this report and its findings:

Dear Andy,

I am writing to acknowledge and thank you for the SROI report you have prepared for Leeds Survivor Led Crisis Service. I can confirm that we agree with the content and findings of this report, and we believe that it gives an accurate description of the changes that our visitors, callers and other key stakeholders experience.

We are also very grateful for the insight the report has given us into how LSLCS works, and for the recommendations it puts forward. We agree with these recommendations and are taking action on all of them. For example:

- Last November the Charities Evaluation Service led a workshop for us on how to get more feedback from short term visitors and Connect callers. From this we are modifying the questionnaires and comment cards we use so that we can identify visitors who have been to Dial House on 1 to 3 occasions, and also doing more analysis based on staff experience with these visitors. We also plan to run an exercise with Connect callers asking those who are willing to give telephone feedback to a member of our Management Committee immediately after their call.
- We are looking at ways to increase our funding. We are cautious about applying for 'one-off' funding because we do not want to provide extra services and then have to withdraw them when funding expires. But we are exploring ways of increasing voluntary donations to LSLCS and ensuring that these are sustained.
- We have gathered some further ideas on increasing outreach (thanks for your help on this), including higher profile in directories, better use of social media and other ways of contacting people at risk. We would also like to look again at how we increase awareness of GPs as this is patchy at the moment.

Thank you again for your help and we will keep in touch.

Annex 1: Impact Map

This is attached as a separate document in MS Excel.

Annex 2: Financial Proxy for Suicide Averted

This annex describes how proxy figures for the cost of suicide have been determined (Section 5.1). The proxy applied to the Impact Map is thus the saving achieved by averting suicide.

Given that LSLCS prevents suicide in at least a small proportion of its visitors, we need proxy figures for the value generated each case. Although visitors were interviewed in the course of this project, it was not possible to use with them any of the three principal methods used to produce valuations in other situations (stated preference methods, revealed preference methods, life satisfaction approach). In all cases, interviewees were unable to conceive of their own life as anything other than priceless, and were also preoccupied with giving what they believed to be the 'right' answers in support of LSLCS.

Costs are therefore based on external research, where a number of academic papers have attributed a total cost per case of suicide in various countries including England. This research has been widely accepted and forms the basis of current Government suicide prevention policy as described the government White Paper *No Health Without Mental Health: Supporting Document – The Economic Case for Improving Efficiency and Quality in Mental Health* (February 2011), and consultation on *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives* (July 2011).

The methodology used in these and other reports (see Annex 4) is fully consistent with SROI principles because it examines the changes experienced by all relevant stakeholders and puts a financial equivalent value on these changes. Here, the key stakeholders include:

- The person themselves
- NHS and other public services at or shortly after the time of death
- Partners and families

These are broadly the same categories as apply to Groups 1-4 in the Impact Map, with some slight differences (e.g. inclusion of coroner services). Option 2 below examines these stakeholders in more detail and modifies the figures used to better match the profile of LSLCS visitors/callers.

On this basis, there are two possible approaches to calculating this financial proxy for LSLCS:

1. To accept the national average figure for England quoted in these government documents; or
2. To rework the calculation on which this national average is based, modifying it for known features of LSLCS visitors

These alternatives are described in detail below:

1. National Average Data

Using previous academic research, the government White Paper *No Health Without Mental Health: Supporting Document – The Economic Case for Improving Efficiency and Quality in Mental Health* quotes an average cost per suicide in England of £1.7m (based on 2009 values). This figure is a total lifetime cost that takes account of lost output, other economic factors, and the effects of distress suffered by relatives of the person who has committed suicide, as well as direct costs to the police, NHS and coroner service. It is thus an all embracing figure that covers all stakeholder groups.

Similar studies in other countries have also sought to put a value on the economic cost of suicide (see references in Annex 4). Although the methods used vary somewhat, all of these studies broadly classify costs into three categories:

1. Direct costs: services required at the time of death or shortly after (medical services, other emergency services, funeral costs and coroner costs; the cost of damage caused at the time of death can also be included if relevant). These costs are by far the smallest component of those included, and typically account for less than 1% of the total 'lifetime costs'.

2. Indirect costs: costs to society (can also be viewed as costs to the individual) arising from lost productivity and absence from the workforce. These are generally calculated by estimating the pre-tax income that the person would otherwise have earned had their working life not been terminated prematurely. This calculation is not limited to those in paid employment, but takes account of intangible market income from those who are economically inactive but nevertheless contribute to society (parents, carers, volunteers etc).

3. Intangible costs: effects of the loss of life itself - pain and suffering experienced by partners, family and others. These 'human costs' are calculated by reference to studies in the road traffic sector (in the UK by the Department for Transport), which assess people's willingness to pay for safety improvements that lead to a reduced risk of death. By extrapolation, these yield a figure where that risk is reduced to zero.

Examples of the figures produced by these studies include:
- Ireland: £1,400,000 per case (2001/02)
- Scotland: £1,290,000 per case (2004)
- New Zealand: £1,158,768 per case (2005)
- England: £1,670,000 per case (2009)

All these costs are per suicide; the full economic cost to the nation each year is calculated by multiplying these figures by the number of suicides in that year.

The assumptions behind this costing methodology are not universally accepted. Counter arguments include:
- many of those who commit suicide suffer from some mental illness or psychiatric disorder, and would need continuing treatment had they continued to live. Economic cost calculations should take account of the savings that result from not having to give this treatment.
- These same individuals are less likely to be working, and hence will not be as economically productive as the averages used to calculate the figures above. Social Security payments and other welfare costs e.g. housing could also be saved where these individuals take their own lives.

However, amongst academic studies these arguments clearly represent a minority view. The UK government's current mental health strategy (No Health Without Mental Health) accepts estimates based on the three elements shown above without mitigation. There are a number of arguments to support this:
- a relatively high proportion of suicides occur amongst working age men, and there is evidence that certain professions, such as doctors, dentists, nurses and police have higher than average suicide rates (Source: Dept of Health *Consultation on Preventing Suicide in England*). It can be

argued that these professions contribute a higher than average value to the national economy, and hence that they tend to counterbalance those whose economic contribution is smaller
- the ultimate aim of any suicide prevention strategy is not just the avoidance of death, but always to return the individual to as full a state of health as possible, where they can make their maximum contribution to society.
- above all, it seems immoral to make policy decisions that affect people's lives based on a perceived value of those individuals to society. All aspects of health services in the UK are based on equality and access for all and it would be inconsistent to treat suicide prevention, or its valuation, any differently.

2. Modified Data

This approach accepts the basic premise on which national average suicide costs are calculated, but considers the extent to which LSLCS visitors/callers are typical of those who commit suicide overall. Here there are clearly a number of marked differences, including:

- Overall, three times as many men as women commit suicide, whereas LSLCS has almost twice as many female visitors as male
- Many referrals to LSLCS come via the mental health system, whereas a significant proportion of suicides have no previous contact with mental health services (although they may well have been in touch with their GP).

These differences can be addressed by adopting the principles on which national average data is calculated, and modifying the calculation to take account of differences between LSLCS visitors/ callers and the national profile. This approach has a precedent, in that a similar modified calculation has been made for military personnel (reference: Judgements Required in the Defence Domain when Developing the Value of an Accident Event when Deciding on ALARP Status; R. L. Maguire, RS2A Ltd, 2009)

Stake-holder	Compo-nent	DfT calcul-ation (£)*	LSLCS calcu-lation (£)	Notes
Visitor/ caller	Loss of output / earnings	616,364	81,668 (2,722 per year*)	Assumes only a small proportion will return to work, although it is very likely that some short-term visitors will do so, and this figure (calculated as 13.25%) also takes account of those who are net contributors in other ways
Partners and family members	Human costs	1,213,879	1,098,880 (36,629 per year*)	Slightly lower because of the smaller proportion of LSLCS visitors in a family setting**. LSLCS feedback indicates 14% of visitors do not have significant family or partner relationships; ONS data gives a comparable figure of 10% for adults under 65 living alone and we have taken half of this (5%) as the likely equivalent proportion of the adult population with no significant family or partner relationship.

NHS and other public services	Medical and ambulance	5,800	5,800	Medical/ambulance and police costs are likely to be lower for a suicide than for a road accident, although this is balanced by higher coroner costs so the same overall figures are used.
	Police costs	1,909	1,909	
	Insurance and admin costs	301	301	Costs involved are small and no significant difference anticipated
	Sub-total	8010	8010	Sub-total for NHS and other public services. This is a one-off cost only, not averaged over 30 years
Third parties	Damage to property	11,026	0	The great majority of suicides do not involve any significant damage to property. 'Third parties' are therefore not included as a key stakeholder in SROI analysis.
All	TOTAL	1,849,279	1,188,558	

*Figures in brackets in fourth column are annual equivalent costs, derived by dividing the 'lifetime' total figure by 30 (average life expectancy had the person not died). These are the figures that appear on the impact map for visitors/callers and partners/family members.

**Note: even where a particular individual has no close family or friends on whom their death might impact, LSLCS is conscious of the potential impact on other visitors. A single suicide might be seen as "giving permission" to others and hence create a sort of chain reaction with much higher human costs. However, there is no hard data to substantiate this, so to avoid over-claiming this factor has not been used to modify the calculation.

Data uses figures from DfT Transport Analysis Guidance (TAG) Unit 3.4.1 - Accidents Sub-Objective, published April 2011. DfT figures are those in Table 3 from this document, updated to 2010 prices using an inflation factor of 3.3% (Source: ONS consumer prices index).

Costs of continuing medical treatment and welfare benefits are excluded from the above calculation for the same reasons as in option 1.

This option (Option 2) has been used for the Impact Map, as it appears to represent the most realistic application of these principles. The alternative of using Option A is considered in the Sensitivity Analysis (Annex 3).

Annex 3: Sensitivity Analysis

Many assumptions and approximations have been built in to this SROI analysis. This Annex tests the effect of varying these assumptions on the overall SROI ratio (based on recalculating figures within the Impact Map). It is emphasised that the 'headline' SROI ratio (Section 6.5) remains the best estimate of the value that LSLCS generates, and that this is if anything a conservative figure, so that the actual SROI ratio is more likely to be higher than it is to be lower.

The figures quoted below have been derived by substituting revised data, matching the variations quoted, into the Impact Map and using MS Excel to do the necessary calculations. A set of supplementary annexes has been prepared to demonstrate this calculation, numbered A3.1 to A3.9 to correspond to the paragraphs below (with and b versions where sensitivity is both up and down).

A3.1. Connect-Only Callers: Changing Input Assumptions

The analysis excludes the impact on callers who use the Connect service only (because this cannot currently be measured) but includes the full input costs associated with responding to these callers. It is not possible for LSLCS to measure what proportion of time its staff and volunteers on the Connect helpline spend with such callers, but if we were to estimate this as 20% and reduce volunteer input costs accordingly, the SROI ratio figure would increase to £5.29 per £1 invested.

Estimates on the relative proportion of visitors in each group can be varied in many ways, but by far the most critical variations relate to the size of groups 0 and 4a:

A3.2. Size of Group 0

We have used the figure of 5% as the proportion of visitors who would end their lives but for the intervention of LSLCS (and others). Some people associated with the service believe this may be an underestimate. If we were instead to assume this group size to be 10%, then the SROI ratio would increase to £6.93 per £1 invested. Conversely, if a lower figure of 2.5% is used, the SROI ratio reduces to £4.28 per £1 invested.

A3.3. Size of Group 4a

The proportion of people who recover and become economically active is also an estimate, although believed to be a conservative one at 11.875% of all visitors. Reducing this figure to 7.5% would reduce the SROI ratio to £4.73, increasing it to 20% would increase the SROI ratio to £5.97 per £1 invested.

A3.4. Financial Proxy for Averting Suicide

Annex 2 explains the options on this, and option 2 (modified data) has been used on the Impact Map. If option 1 (national average data) were used instead the SROI ratio would rise to £6.05 per £1 invested.

A3.5. Value of LSLCS to Visitors/Callers

The proxy of £100 per visit is an approximation. Reducing this estimate to £50 would result in an SROI ratio of £4.97, raising it to £150 would increase the SROI ratio to £5.36 per £1 invested.

A3.6. Value of LSLCS to Other Service Providers

Again, an estimate has been used here. Reducing this estimate to £150 would reduce the SROI ratio to £4.84, increasing the estimate to £300 would increase it to £5.45 per £1 invested.

A3.7. Value of LSLCS to Volunteers

Current SROI calculations use a proxy figure of £1363 for all volunteers with an additional £2272 for 15 of them. These again are estimates, but changing these has a limited impact on the SROI ratio. For example decreasing these amounts by 50% would yield an SROI ratio of £5.07, increasing by 50% would give an SROI figure of £5.26 per £1 invested.

A3.8. Attribution

One of the most difficult things to assess is the impact of LSLCS in comparison to that of other parts of the mental health care system that work with its visitors and callers. The current estimates of 50% and 33% (in those situations where attribution applies) are intended as cautious approximations – many visitors cite LSLCS as main thing if not the only thing that helps them, although we cannot be sure that these views are representative of all visitor groups.

Increasing the impact attributable to other organisations to 65% for groups 0 and 4a and 50% for group 2 would produce an SROI ratio figure of £4.15, decreasing it to 35% and 20% respectively (i.e. raising the importance of LSLCS itself) would raise the SROI ratio to £6.15 per £1 invested.

A3.9. Inclusion of Staff as Material to the SROI

Sections 3.6 and 5.6 explain why - exceptionally in this case - LSLCS staff are considered material to the evaluation. Should this value not be taken into account the SROI ratio would reduce to £4.51 per £1 invested.

Whilst these sensitivity factors are not mutually exclusive (i.e. several of them could operate together) it is more likely that variations will balance out rather than all operate positively or negatively. Overall, we can say with some confidence that the SROI ratio for LSLCS lies between £4.00 and £6.50 per £1 invested.

This analysis also demonstrates that the factors most sensitive to change are:

- The financial proxy used in cases where suicide is averted
- The size of groups 0 (suicide averted) and 4a (recovery and return to employment)
- The attribution estimated as coming from other organisations

The second of these factors appears to be the one over which LSLCS has most direct control, and this links to recommendations in Section 7.

Annex 4: Information Sources

The following documents have been reviewed in compiling this report. Where information is cited in a particular part of the report, this is shown in the 'X-ref' column.

LSLCS Documents and Sources

Author/Publisher	Title	Date	X-ref
LSLCS	Report of the Year 2009	March 2010	
LSLCS	Report of the Year 2010	March 2011	
LSLCS	Director and Trustees' Report and Accounts for the year ended 31 March 2010	December 2010	
LSLCS	Budget 2010-11	Dec. 2010	Section 5.6 Table 5e
LSLCS	Visitor feedback summary 2006-09	Dec. 2010	Section 4.2 Section 5.3
LSLCS	May 2010 Dial House Visitor Feedback Questionnaire	May 2010	Section 4.2 Section 5.3
LSLCS	May 2011 Dial House Visitor Feedback Questionnaire	May 2011	Section 4.2 Section 5.3
LSLCS	Analysis of New Visitors for the Years 2006-2010	March 2011	Annex 5
LSLCS	Dial House Volunteer Satisfaction Questionnaire 2011	Oct 2011	Section 3.5 Section 5.7

External Documents and Sources

Author/Publisher	Title	Date	
Association for Psychological Therapies	Cost of Training in Self-Harm and Crisis Management: http://www.apt.ac/courses.html	Accessed December 2011	Section 5.7 Table 5e
Community Care UK	Cost of domiciliary home care in Leeds: http://www.communitycare.co.uk/blogs/adult-care-blog/2011/08/comparing-leeds-inhouse-and-external-care-costs.html	Accessed December 2011	Section 5.4 Table 5c
Dept for Transport	Value of prevention of road accidents: Transport Analysis Guidance Unit 3.4.1: The Accidents Sub-Objective, Table 3	April 2011	Annex 2
Dept of Health	No Health Without Mental Health: A cross-government mental health strategy for people of all ages	February 2011	Section 6.2 Annex 2
Dept of Health	No Health Without Mental Health: Supporting document - the economic case for improving efficiency and quality in mental health	February 2011	Section 6.2 Annex 2
Dept of Health	Consultation on Preventing Suicide in England	July 2011	Annex 2
Dept of Health with LSE PSSRU and Kings College London	Mental Health Promotion and Mental Illness Prevention: The Economic Case	January 2011	
Dept of Work and Pensions	Benefit rates & minimum wage rates 2010: http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/documents/digitalasset/dg_193028.pdf	Accessed December 2011	Section 5.2 Section 5.5 Table 5d

Demos	The Truth About Suicide	August 2011	
Health Service Executive / Dept of Health and Children (Republic of Ireland)	Kennelly, Ennis & O'Shea: Reach Out - Irish National Strategy for Action on Suicide Prevention	2005	Annex 2
HM Treasury and DWP	Fujiwara & Campbell: Valuation Techniques for Social Cost-Benefit Analysis	July 2011	Annex 2
King's Fund	Paying the Price: The cost of mental health care in England to 2026	2008	
LSE PSSRU	Curtis: Unit Costs of Health & Social Care 2010	2010	Section 5.3 Annex 5b
Mind UK	Cost of private counselling: http://www.mind.org.uk/help/medical_and_alternative_care/making_sense_of_counselling	Accessed January 2012	Section 5.2 Table 5a
New Economics Foundation	Small Slices of a Bigger Pie: Attribution in SROI	2011	Section 6.3
New Zealand Govt. Ministry of Health	The Cost of Suicide to Society	December 2005	Annex 2
NHS Leeds and Leeds Adult Social Care	Leeds Survivor Led Crisis Service Review	November 2009	Section 4.2
NHS Leeds	Draft Mental Health Needs Assessment	April 2011	Section 4.2
NHS Leeds	Self Harm Inpatient Activity Analysis	October 2010	Section 4.3
NHS Leeds	Employment Support Development in Leeds Mental Health Services	October 2010	Section 1.3
Office for National Statistics	Statistical Bulletin: Suicide Rates in the United Kingdom, 2006-2009	January 2011	Section 4.2
Office for National Statistics	Annual Survey of Hours and Earnings, 2010 Revised Results: Table 1.5a Hourly pay for part-time employees	November 2011	Section 3.3
Office for National Statistics	% of UK adult population working: UK Labour Market Statistics	May 2011	Section 5.5
Office for National Statistics, Women & Equality Unit	Walby: The Cost of Domestic Violence	September 2004	
RS2A Ltd	R. L. Maguire: Judgements required in the defence domain when developing the value of an accident event when deciding on ALARP status	2009	Annex 2
Scottish Executive Social Research	Evaluation of the First Phase of *Choose Life:* the national strategy and action plan to prevent suicide in Scotland	2006 (quotes 2004 data)	Annex 2
Social Psychiatry & Psychiatric Epidemiology	Sinclair, Gray, Rivero-Arias, Saunders, Hawton: Healthcare and Social Services Resource Use and Costs of Self-Harm Patients	February 2010	Section 4.3
Suicidology Online	Doessel & Williams: The Economic Argument for a Policy of Suicide Prevention	2010, 1:66-75	Annex 2
Suicidology Online	Yang & Lester: is There an Economic Argument for Suicide Prevention?	2010, 1:88-91	Annex 2
VOIS database	Moving from unemployment to employment: Increase in annual earnings over benefits for single individual working full-time	Accessed December 2011	Section 5.2

VOIS database	Value of 'passported' benefits including housing, council tax breaks, free prescriptions and travel	Accessed December 2011	Section 5.5
VOIS database	Improved confidence & self-esteem: Cost of communications course from Skills Audio	Accessed December 2011	Section 5.7 Table 5e

Annex 5: Dial House Visitor Analysis 2006-2010

A. Visitor Data 2006-2010

The first part of this Annex reproduces analysis compiled by LSLCS itself on the number of visits made by each individual visitor over the period 2006-2010. It forms the basis of the different visitor groups identified in Section 3.

The visitor first visited us in 2006

There were **54** people who visited us for the first time in 2006 (the first visitor to do so was v520)

Of these, 40 (74%) visited 1-3 times in 2006,

Of these 40 visitors, 19 (48%) did not visit us in subsequent years

Of the 54 new visitors for 2006, the pattern of visits for 0 visitors indicates they have become long term frequent visitors.

Of the 54 new visitors for 2006 the pattern of visits for 8 visitors indicates a peak of crisis with higher visits in one or two years

	2006	2007	2008	2009	2010
536	17	1	1	0	0
531	6	2	1	2	1
568	4	2	0	0	5
548	3	20	20	1	9
587	2	17	19	4	7
589	1	5	3	0	1
599	1	10	5	5	3
590	1	16	0	0	0

The visitor first visited us in 2007

There were **22** people who visited us for the first time in 2007 (the first visitor to do so was v590)

Of these, 17 (77%) visited 1-3 times in 2007

Of these 17 visitors, 15 (88%) did not visit us in subsequent years

Of the 22 new visitors for 2007, the pattern of visits for 2 visitors indicates they have become long term, frequent visitors.

	2007	2008	2009	2010
605	69	52	35	51
630	1	39	6	42

Of the 22 new visitors for 2007, the pattern of visits for 3 visitors indicates a peak of crisis with higher visits in one or two years

	2007	2008	2009	2010
600	1	0	6	0
613	6	5	1	0
599	10	5	5	3

The visitor first visited us in 2008

There were **72** people who visited us for the first time in 2008 (the first visitor to do so was v684)

Of these, 51 (71%) visited 1-3 times in 2008
Of these 51 visitors, 35 (69%) did not visit us in 2009 or 2010

Of the 72 new visitors for 2008, the pattern of visits for 10 visitors would suggest they have become long term frequent visitors

	2008	2009	2010
685	33	67	59
687	66	66	14
700	22	16	13
712	44	15	7
738	13	44	29
743	5	3	11
748	4	25	31
754	6	14	18
757	1	62	43
758	2	46	18

Of the 72 new visitors for 2008, the pattern of visits for 8 visitors indicates a peak of crisis with higher visits in one or two years

	2008	2009	2010
691	46	18	2
694	3	5	2
711	4	31	7
715	14	2	0
717	15	4	1
724	7	5	0
734	7	7	0
752	2	8	0

The visitor first visited us in 2009

There were **69** people who visited us for the first time in 2009 (the first visitor to do so was v760).

Of these, 57 (83%) visited 1-3 times in 2009, and 51 (74%) did not visit in 2010.

I have not shown any more analysis for 2009, as there is not enough meaningful data (i.e. we need full figures for 2011 visits) to show either potential long term frequent visitors or those visitors who have peaks of crisis.

Notes re 2010 Visitors who made 1-3 Dial House Visits

107 visitors had 1-3 visits in 2010. This is 66% of all 2010 DH visitors.

58 people who made 1-3 visits in 2010 had not visited DH in previous years.

In 2010, 85% of the new visitors that year, visited 1-3 times.

49 people who made 1-3 visits in 2010 had visited Dial House in previous years.

For 8 of these 49 people their pattern of visits indicates a peak of crisis with higher visits in one or two years:

	2006	2007	2008	2009	2010
488	10	47	24	3	1
371	23	29	4	16	2
691			46	18	2
460	42	4	1	1	1
512	8	19	21	0	1
599	1	10	5	5	3
717			15	4	1
786				9	3

For 41 of these 49 people, their pattern of visits is consistently low over the previous years.

9 people made 1-8 visits in all 6 years being studied (2006-10) or in 5 of the 6 years.

	2006	2007	2008	2009	2010
228	4	3	5	3	3
16	8	6	1	1	1
176	1	8	3	3	1
531	6	2	1	2	1
373	2	4	3	0	1
509	2	4	1	2	1
589	1	5	3	0	1
483	1	1	0	2	1
331	2	0	0	1	1

32 people made 1-6 visits in 2 or 3 of the years being studied (2006-10)

- 3 people made 1-3 visits in 2010 and also visited pre 2006.
- 3 people made 1-6 visits in 2006 and 1-3 visits in 2010.
- 2 people made 1-6 visits in 2007 and 1-3 visits in 2010.
- 2 people made 1-6 visits in 2006, 2007 and 2010.

- 9 people made 1-6 visits in 2008 and 1-3 visits in 2010.
- 6 people made 1-6 visits in 2009 and 1-3 visits in 2010.
- 7 people made 1-6 visits in 2008 and 2009 and 1-3 visits in 2010.

Number of Visits 2010	Number of visitors
1	65
2	29
3	15
4	7
5	4
6	5
7	7
8	2
9	2
10	2
11	3
12	1
13	2
14	1
15	1
16	1
18	2
19	1
20	2
25	1
29	1
30	1
31	1
34	2
42	1
43	1
51	1
59	1
66	1

B. Visitor Group Percentage Calculations

This second part of Annex 5 explains how the proportions in each visitor group have been worked out. This can never be a precise calculation as every individual's pattern of visits is different, but is judged to give a sufficient basis for assessing visit patterns and corresponding outcomes. Annex 3 considers sensitivity analysis, particularly in respect of visitors/callers in Groups 0 and 4a; changing assumptions on other groups sizes would have a much smaller impact on the SROI ratio.

Group 1: Long term frequent visitors:

The figure of 7.5% is based on LSLCS Annual Reports for 2009 and 2010 which record 13 people as being frequent visitors in 2010 and 11 in 2009. This gives an average of 12 out of an average number of 160 visitors over these two years, which is 7.5%. This figure is broadly supported by analysis from Part A of this Annex, which shows 12 new long-term frequent visitors out of 148 new visitors total over these three years - an average of 8.1%.

The number of long-term frequent visitors at any one time remains broadly constant, and this would be explained with a drop-off rate of 33%, with new frequent visitors replacing those who manage to stabilise their condition. (An intake of 4 new long-term visitors per year is also indicated by figures in Part A of this Annex for the three years 2006-08, where 12 new visitors in total became long-term frequent visitors.)

Group 2: People Who Use the Service Extensively in One Year

The percentage here is derived from figures for 2006 - 2008 shown in Annex 5A above. Cumulatively, 18 out of 148 new visitors for these years indicated a 'peak of crisis' with fewer visits subsequently; this is 12.5%.

Group 3: People Who Make a Few Visits in Most Years

The 2010 analysis notes 41 people (25% of the total of 163 for 2010) whose pattern of visits is "consistently low over the years". However, this relates only to those who made 1-3 visits in that year, and needs to be extended to take account of those who made more than three visits but are still in the 'few visits' category (examples in the table below the figure of 41 in Annex 5A). This extends the category to 50 out of 163, rounded to 30%.

Group 4: People Who Make 1-3 Visits and Never Return

This category applies to anyone who does not fall within the first three categories. By subtraction from 100%, this must be 50% of the total. (Note that these 1-3 visits are not necessarily in the same calendar year, so this is feasible in the context of the number of new visitors in any one year). NB: Subdivision between Groups 4a and 4b is explained in Section 4.3 rather than here.

The average number of visits per group is calculated from the above percentages, correlated to match the total number of visits made in 2010. (The figure for number of visits made by Group 1 visitors is the average of the 11 most frequent visitors in 2010.)

Annex 6: Sample Questionnaires

This Annex shows the survey questions used by LSLCS in its annual surveys of visitors and volunteers.

A. Visitors

LSLCS issues a simple questionnaire to all visitors in May of each year. Responses to these questions provided valuable data on visitors' propensity to take their own life, and on the consequences had they not been able to visit Dial House.

1. Give a score out of 10 (1 being able to cope and 10 being extremely in crisis) for how you felt:*
   a) when you made the request to visit Dial House.
   b) when you arrived at Dial House
   c) after your support session at Dial House

2. What prompted you to request a visit tonight?

3. How has visiting Dial House helped you cope tonight?

4. How would you have coped if you could not have come to Dial House?

5. Would you have accessed another service? If yes, which service?

6. Do you have any comments about the support you received from staff tonight?

7. What has it been like being around other visitors?

8. Was this your first visit? If not, roughly how many times have you visited Dial House before tonight?

9. Any other comments?

(NB: Whilst these scores confirm an increased ability to cope after each visit, they are not used as the main evidence of change experienced by visitors/callers - see Section 3.2)

B. Volunteers

The volunteer questionnaire is issued by LSLCS to all of its volunteers annually. Information on their experience and value of change was drawn particularly from Sections B and H.

A: PERSONAL
1) How long have you been volunteering at LSLCS?
2) Status: (Are you currently active/on a break)?
3) Age?
4) How would you describe your? (Optional):
   a) Gender:
   b) Sexuality:

c) Ethnicity:

5) Have you personally experienced mental distress
6) Would you consider yourself to have a disability?

B: MEETING YOUR INDIVIDUAL NEEDS

1) What brought you to volunteering at LSLCS?
2) How has volunteering met your needs?

C: OVERALL SATISFACTION

1) How satisfied are you with your role at LSLCS overall?
2) What aspects of volunteering at LSLCS do you enjoy or feel positive about?
3) What aspects of volunteering at LSLCS don't you enjoy or feel negative about?
4) Do you have any further comments on any of the above or overall satisfaction as a volunteer with LSLCS?

D: HOW YOU ARE TREATED AT WORK

1) Do you feel that you are supervised, supported and treated in a manner consistent with the person centred approach? Empathy, congruence, unconditional positive regard?
2) Do you feel that you are treated with 'kindness, warmth and respect'?
3) Do you have any comments on any of the above or how you are treated at work as a volunteer with LSLCS?

E: HOW ARE YOU MANAGED AND SUPPORTED

1) How would you describe the standard of debriefing you receive from shift supervisors?
2) How could this be improved?
3) How would you describe the standard of supervision you receive through the supervision group which you attend?
4) How could this be improved?
5) Do you have any further comments on any of the above or how you are managed and supported at work as a volunteer with LSLCS?

F: BEING VALUED

1) Do you feel valued as a volunteer at LSLCS?
2) What do you feel the organisation does to make you feel valued?
3) What could the organisation do to make you feel more valued within the service?
4) Do you have any further comments on any of the above or on being valued as a volunteer with LSLCS?

G: COMMUNICATION AND PLANNING

1) Do you feel part of the LSLCS team?
2) Do you feel your views are listened to by the service?
3) Do you feel able to influence the services?
4) Is there anything you would like to change about the services provided?
5) Do you feel your feedback is acted upon?

6) Do you have any further comments on any of the above or on communication and planning as a volunteer with LSLCS?

H: PROFESSIONAL DEVELOPMENT

1) Do you feel you have enough opportunity to develop your skills, or learn new ones?
2) What skills do you feel you have gained through volunteering at LSLCS?
3) What do you think of the training which is provided for volunteers during the year in terms of:
    a) The quantity of training which is provided?
    b) The quality of the training which is provided?
    c) The relevance of the training which is provided?
4) Are there any topics you would like to be covered by future training?
5) Do you have any further comments on any of the above or on professional development as a volunteer with LSLCS?

I: WORKING CONDITIONS

1) How would you rate the following:

a) The physical environment you work in?
b) The general atmosphere/ambience?
c) The expenses which are provided to volunteers?

2) Do you have any further comments on any of the above or working conditions as a volunteer with LSLCS?

J: OTHER

1) Do you have any suggestions for improvements that would benefit volunteers, staff, visitors or callers, or anything else you want to share with us?

Annex 7: Meeting the Assurance Criteria

This Annex lists the questions on which assurance by the SROI Network is based, and details how the report addresses these, with appropriate references.

Involving Stakeholders

Assurance question	Response	Reference
1. Is the process for deciding which stakeholders are relevant for inclusion in the analysis clear and sound?	A list of all stakeholders was initially agreed with LSLCS staff and managers, and subsequently refined to determine which of those stakeholders were material to the evaluation. This has been further tested by circulation of draft reports to key stakeholders.	Section 2.1
2. Have all stakeholders considered to experience material changes - positive & negative/intended or unintended - been consulted about what changes for them?	LSLCS visitors and callers have been consulted through a number of routes. Other stakeholders have also been consulted as listed in the report - note that full involvement of families/carers is limited	Table 2b
3. For an evaluative report, are total and sample numbers of stakeholders clear and is there any reason to think that an insufficient number of stakeholders have been consulted?	Consultation in various forms has engaged as many visitors/callers as possible. Whilst we cannot be sure this is fully representative we believe that there is sufficient evidence of what changes for all groups.	Table 2b
4. For a forecast report, where fewer stakeholders have been engaged, is there clear justification for sample size used or are there clear plans and recommendations cited in the report to address this during any future planned cycle of analysis?	Not applicable as this is not a forecast report.	n/a
5. Is there clarity around how initial engagement data has been gathered and recorded?	All group and individual interviews, including telephone interviews, were recorded in contemporaneous notes. Survey feedback was gathered and compiled by LSLCS staff.	Section 2.4
6. Is there evidence of open ended stakeholder inquiry about what changes have been experienced, including unintended or negative change?	All stakeholder inquiries have been open-ended, through encouraging comments and continued feedback (see examples in Section 3.2). This has identified some unintended and negative consequences.	Sections 2.4 3.1 and 3.2
7. Does initial stakeholder engagement have a clearly explained link to outcomes claimed in the report.	Initial engagements identified change pathways and range of outcomes illustrated in Fig.3a. Subsequent analysis of visitor data confirmed the relevance of these outcomes and the numbers taking each route.	Sections 3.1 and 4.1

Additional Guidance Points (reflecting a higher standard of good practice)

Assurance question	Response	Reference
Have significant stakeholders been fully involved in determining indicators	This formed part of the discussions with the stakeholders consulted	Sections 2.4 and 5
Have significant stakeholders been fully involved in determining financial proxies	To a limited extent. LSLCS manager was consulted about the proxy for suicide averted, and in turn has discussed other proxies with LSLCS staff	Annex 2
Is there evidence of significant stakeholders being consulted at all stages where appropriate and useful to the analysis	Yes, through circulation of draft interim, interim and draft final reports, and through ongoing discussions with LSLCS manager.	Section 2.4
Have significant stakeholders been involved in reviewing the account	Yes, as above through circulation of draft reports.	Section 2.4

Understand What Changes

Assurance question	Response	Reference
1. Has the author made clear that the analysis is either a forecast or evaluative study?	This is an evaluative study. Lessons for the future may well be learned from it, but it is not a forecast study in SROI terms.	Section 1.5
2. Has a clear scope and timescale that distinguishes between the investment period and projected period for outcomes been stated for the SROI analysis?	The investment period considered is one year (2010 for costs used). The projected period for outcomes is considered for the concurrent year and subsequent four years as shown on the Impact Map	Sections 1.5 and 4.1, & Impact Map
3. Is the rationale for choices made around activities included and excluded clear and convincing?	The only excluded activities are those connected with LSLCS external consultancy work (see also Section 4.4 re Connect-only callers)	Sections 1.5 and 4.4
4. Is the theory of change explicit and for stakeholders considered significant to the change analysis, are the relationships between input, output and outcome clearly demonstrated in the report and adjudged to be reasonable?	Theory of change is illustrated by the LSLCS pathways diagram (Fig.3a). Although this diagram applies primarily to visitors/callers, the Table 3b summary and the Impact Map examine the changes experienced by all stakeholders on each of these pathways.	Section 3.1, Figs 3a & 3b, and Impact Map
5. Have unintended and negative outcomes been considered and included?	Unintended outcomes include the possibility of some visitors/callers recovering sufficiently to take up employment (since this is not a core	Section 3.1 and Fig 3b

	purpose of LSLCS's service). Negative outcomes can occur when visit requests are refused and the person concerned feels worse than before.	
6. In an evaluative report are there enough stakeholders included at the data gathering stage to support the quantity of change relating to each outcomes?	Data gathered from various sources including surveys and interviews gives the best coverage we can get in terms of numbers, and is supported by data analysis on quantity of change	Table 2b & Sections 4.1 4.2 & 4.3
7. Is the theory of change corroborated in the report through reference to other supporting data where necessary?	This is corroborated through the links between the pathways diagram, Table 4c and the Impact Map, which show how each route affects the different stakeholder groups involved.	Fig 3a, Table 4c, Impact Map
8. Are the indicators reasonable and do they provide adequate information to show that the change is measurable?	This is explained in Table 4c and the Impact Map, and their links to financial proxies detailed in Section 5	Table 4c Impact Map
9. Where appropriate have objective as well as subjective indicators been used without double counting?	Indicators are a mix of objective and subjective metrics relevant to the change being measured. These do not overlap or double-count.	Table 4c, Impact Map
10. Do all outcomes relate properly to the stakeholder for which they are claimed?	Yes. This is confirmed by the inclusion of a separate lines in Table 4c and the impact map for each relevant stakeholder for each visitor/caller group.	Table 4c, Impact Map
11. Is there a clear chain of events applied and reported in determining different outcomes and quantities of outcomes for stakeholders, including what happens to those in the cohort who do not experience a given outcome?	This is covered through the way in which the theory of change and the Impact Map address outcomes for different visitors/caller groups, and the proportion of visitors/callers who experience each outcome.	Sections 3.1, 3.5 and 4.1.
12. Are the claimed outcomes clearly explained in the report, including unintended and negative change and have outcomes alone been taken forward to valuation?	All outcomes are explained and have been taken forward to valuation (although see Section 4.4 re Connect-only callers)	Sections 3.4 & 3.5, Table 4c, Sect. 5
13. Does the model include figures for the duration of outcomes with explanations?	Yes as shown on the Impact Map and other explanations in sections 4 and 5.	Section 5.8, Impact Map
14. Is the Impact map clear and transparent and is the reporting of change completely consistent with Impact map contents?	Yes –covered in Impact Map.	Table 4c and Impact Map

Additional Guidance Points (reflecting a higher standard of good practice)

Assurance question	Response	Reference
Has the analysis dealt with distance travelled? Is there an analysis of the chain of cause and effect between short, medium and longer term outcomes?	This is linked to question 13, and the implications of lifetime change.	Section 5.8, Impact Map

Value the Things that Matter

Assurance question	Response	Reference
1. Have all relevant inputs by significant stakeholders been included and valued and if not valued have reasons been given?	Yes, as shown in Section 3.3	Section 3.3
2. For an evaluative study, have all the material outcomes been given a value	Yes, as above and in the Impact Map	Impact Map
3. For a forecast study, where some outcomes have not been valued, does the report cite specific requirements and recommendations for valuation over any ensuing cycle.	Not applicable.	n/a
4. Are the financial proxies evidenced in the report adjudged to be reasonable and appropriate to the outcome.	Section 5 gives details of proxies used, together with Annex 2 for financial proxies in cases where suicide is averted	Section 5 Annex 2
5. Are Financial Proxies appropriate to the stakeholder for whom the value is claimed?	Section 5 and the Impact Map explain valuations for stakeholders in various situations corresponding to different change pathways	Section 5 Impact Map
6. In a forecast study, where an identified outcome is not recorded with at least one indicator and financial proxy, is there a reasonable explanation for the exclusion?	Not applicable.	n/a
7. In a forecast study, in cases where outcomes have not been measured and valued, does the report include recommendations for capturing the value in any ensuing cycle of analysis?	Not applicable.	n/a

Additional Guidance Points (reflecting a higher standard of good practice)

Assurance question	Response	Reference
Has a range of financial proxies been varied in sensitivity analysis?	Sensitivity analysis at Annex 3 considers variation for all significant variables on which the SROI calculation is based	Annex 3
Is there a statement on issues arising from the use of financial proxies in this analysis?	Yes, this particularly applies to cases where suicide is averted	Annex 2

Only Include What is Material

Assurance question	Response	Reference
1. Is there explanation in the report to justify what materiality test has been brought to bear on decisions to include and exclude outcomes (or stakeholders who do not experience material outcomes).	This is covered by the inclusion/exclusion of stakeholder groups in Section 2, and by consideration of relevant outcomes in Section 4. This is based on the outcomes experienced by different stakeholders in relation to the pathways illustrated in Fig.3a.	Section 2, Fig 3a, Section 4, Table 4c
2. Are reasons given for situation in which no material changes were expected to occur to excluded stakeholders	This is covered through consideration of Stakeholders within Section 2.3.	Section 2.3
3. Is there evidence that materiality tests have been applied to stakeholders and outcomes during the whole process as part of decisions around significance for deadweight, value, quantity of change and around relevance relating to initial inclusion of outcomes rather than just at the beginning	For each of the visitor/caller groups derived from the pathways diagram (Fig 3a), subsequent analysis considers the quantity of change and associated value for all stakeholders. What would have happened anyway (deadweight) and other modifications to outcomes are similarly considered for all stakeholders in respect of each visitor/caller group.	Fig 3a, Tables 4a and 4b, Section 6
4. Is there anything that would lead the assessor to conclude that there have been exclusions that would lead to different stakeholder decisions and conclusions about the activity	Covered through consideration of stakeholders in Section 2 and the explanation of materiality considerations in response to Question 3 above.	As above + Sections 2.2 & 2.3
5. In a forecast report where materiality tests cannot yet be applied to stakeholders or outcomes, has this been explored in sensitivity analysis and recommendations for any ensuing cycle of the analysis?	Not applicable.	n/a

Additional Guidance Points (reflecting a higher standard of good practice)

Assurance question	Response	Reference
Have the scope of the study, the analysis of change, the included outcomes and the claimed impact been based on a comprehensive analysis of materiality issues that have been explained in the report?	See response to questions 1 and 3 above.	As above.

Do Not Over-Claim

Assurance question	Response	Reference
1. Have all inputs that would lead to the included outcomes been given a value for calculation of the SROI ratio?	Yes, as shown in Section 3.3 and the Impact Map.	Section 3.3, Impact Map
2. Has double counting been avoided, for example when choosing more than one indicator per outcome?	Double counting has been avoided by using single indicators for all inputs and outcomes, and by ensuring that these do not overlap	Section 3.3, Section 5
3. Has double counting been avoided through clarity of reporting on the chain of events that might lead to different outcomes for the stakeholder group?	This is covered by the above, and by identifying the different outcomes relevant to different visitors/caller groups.	Section 3.3 & 3.4, Table 4c, Section 5
4. Are the numbers of outcomes claimed per stakeholder group out of the total membership of that group credible and reasonable?	This is explained in the analysis sections of the main report which justify the numbers and percentages used in the Impact Map.	Tables 4.1 & 4.2, Section 5
5. For an evaluative analysis are the figures used for deadweight and attribution based on trends and benchmarks or a systematic and clearly explained estimation process using information from stakeholders or other external information?	Yes, this is explained in the sections of the main report that address what would have happened anyway (deadweight) and attribution, and explain the figures used in the Impact Map.	Section 6
6. For a forecast analysis are the figures estimated for deadweight and attribution subject to sensitivity analysis and plans for better data capture over the ensuing period?	Not applicable.	n/a
7. Does the analysis discuss decisions on displacement and include a figure if appropriate with reasonable and convincing	Displacement is considered to be zero, for reasons explained in Section 6.	Section 6.2

explanation?		
8. Does the analysis consider how outcomes drop-off over time?	This varies for different visitors/caller groups, and is derived from the way these groups are defined. This is explained in Section 6 and taken forward to the Impact Map.	Section 6.4, Impact Map
9. For an evaluative analysis, are durations used based on research evidence?	This is covered by analysis of visitor/caller groups in Section 3.4 and corresponding valuations in Section 5, Section 6.4 (drop-off) and the Impact Map.	Section 3.4, Section 6.4, Tables 5a-5e
10. For a forecast study where durations used have not been based on research evidence – is there a reasonable explanation and is it clear that any assumptions made have been subjected to sensitivity analysis and are to be monitored in the future?	Not applicable.	n/a

Additional Guidance Points (reflecting a higher standard of good practice)

Assurance question	**Response**	**Reference**
Has a full counterfactual been included for deadweight?	Not relevant to this particular SROI analysis for reasons explained in 6.1	Section6.1
Has primary research been conducted in assessing attribution?	Not undertaken as attribution only applies to specific situations within this SROI analysis	Section 6.3
Has drop off varied over time, or to different stakeholder groups?	This is included in the analysis based on different stakeholder groups.	Tables 5a-5e Section 6.4

Be Transparent

Assurance question	**Response**	**Reference**
1. Is there an audit trail both of what is and what is not included relating to stakeholders, outcomes and financial proxies?	The report explains what has been included, what has been excluded, and why in relation to stakeholders outcomes and financial proxies, including aspects where full inclusion has not been possible.	Section 1.7, Section 2.4, Section 4.4
2. Is the sensitivity analysis adjudged to include appropriate	Annex 3 includes a full sensitivity analysis examining the impact of	Annex 3

elements relevant to the study with clear information on which aspects and which assumptions have been assessed for sensitivity?	changing all of the significant variables within the SROI calculation	
3. Are all data sources referenced?	All data sources are referenced in the text and listed in an Annex.	Annex 4
4. Is there enough information on the data set and are all calculations set out in a way that makes it possible for the calculation to be replicated and to arrive at the same result of social return?	All calculations are explained in the main report and shown in the impact map. Calculations relating to the relative size of each visitor/caller group are explained in Annex 5.	Sections 3.3, 4.1, 4.2 and 5
5. Where appropriate is there information on the source of financial proxies, detailed enough that would enable the reader to refer?	Yes, full details of all sources is shown in the Annex to the main report, and can be checked if required.	Annex 4

Additional Guidance Points (reflecting a higher standard of good practice)

Assurance question	**Response**	**Reference**
Is there enough information on data and sources included that would allow a full audit of the report?	Information on data sources should be sufficient to allow a full audit.	Section 1.6, Annex 4

Verify the Result

Assurance question	**Response**	**Reference**
1. Has the report been reviewed by at least one stakeholder?	The final report has been reviewed by LSLCS manager and staff, earlier drafts and the Interim Report were reviewed by other external stakeholders (NHS and Leeds CC representatives)	Section 2.4
2. If there has not been a formal process for review by stakeholders – is there an explanation that is reasonable and does the report contain recommendations that would address such a process in the near future?	Not applicable, although this can be reviewed when further evidence is available following actions that LSLCS is already taking in response to report recommendations.	n/a

Additional Guidance Points (reflecting a higher standard of good practice)

Assurance question	Response	Reference
Has the report been subject to independent peer review?	Another consultant with specific experience of mental health issues was asked to review the report but has not yet responded to it.	
Has there been a formal documented process for review by stakeholder?	Not as yet, although this may come following actions that LSLCS is already taking in response to report recommendations.	

Annex 8: Glossary of Abbreviations Used

A&E	Accident and Emergency
ALARP	As Low As Reasonably Practicable
CC	City Council
CPN	Community Psychiatric Nurse
CRT	Crisis Resolution Team (full title: Crisis Resolution and Home Treatment Team)
Dept	Department
DH	Dial House
DWP	Department of Work and Pensions
GDP	Gross Domestic Product
GP	General Practitioner
HB	Housing Benefit
HMRC	Her Majesty's Revenue and Customs
LA	Local Authority
Leeds CC	Leeds City Council (refers to Adult Social Care Department)
LSLCS	Leeds Survivor Led Crisis Service
LSE	London School of Economics
MH	Mental Health
MS	Microsoft
n/a	Not applicable
NHS	National Health Service
ONS	Office for National Statistics
PCT	Primary Care Trust
PDN	Personality Disorder Network
PSSRU	Personal Social Services Research Unit
SROI	Social Return on Investment
UK	United Kingdom
VOIS	VOIS is a database of existing and previously-used financial proxies used for SROI purposes. It can be found on the SROI Network web site