Speakeasy 2010/11:

A Social Return on Investment (SROI) Analysis

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.

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Executive summary

Speakeasy is a sexual health project that offers courses to parents to help them acquire the knowledge and confidence to communicate with their children about sex. The project has been running since 2002. Since 2006 Speakeasy has been supported with central funding from the Department for Education.

The FPA, the independent national charity which administers the programme, commissioned RM Insight to conduct a forecasted Social Return on Investment (SROI) analysis in order to quantify the social value created by Speakeasy in England for the 2010/11 financial year.

Extensive primary research was undertaken with key stakeholders to identify the material outcomes that result from the project. Key outcomes included:

- Improvements in sexual health practices for children of parents who completed the course.
- Improved family relations and communication.
- Improved self-confidence and well-being for parents who completed the course.
- Improved social networks for parents completing the course.

Research indicated that the changes triggered by the course are differentiated by the extent to which participants were already talking with their children about sex and were confident in doing so. As a result, parents and their children were split into two categories for the SROI model:

- 'Low communication' families
- 'High communication' families

The SROI analysis estimates the total value of benefits to children and parents across the two household categories and to the state to be £11 million. Given input costs of £490,000, this translates into an overall social return on investment of 1:21.

Of the total value created by Speakeasy, £1 million accrued to the state. This value was made up of savings on support for teenage parents and NHS savings on pre/post natal care and STI treatment. The value to the state represented a return of £2.15 for every pound of public money invested in the project.

The most significant difference – representing 88% of the total value – is made to children and parents in households where there is poor quality communication with children about sex prior to starting the course. In these households, the project has the potential to introduce a family environment of

communication and openness about sex which is strongly correlated with positive sexual health practices of teenage children.

1.0 Introduction

The Speakeasy parent course is a UK initiative that aims to help parents talk with their children about sex and relationships. The nationally accredited course is delivered in a variety of community settings and supports parents to be more confident, knowledgeable and open in talking about a range of matters related to sex and relationships.

Administered by FPA (formerly the Family Planning Association), an independent national charity, the course has been subject to extensive research and evaluation since the project was established in 2002.

The present study uses stakeholder engagement and the existing research base to forecast the social value created by Speakeasy in England for the 2009/10 financial year. This is used to calculate a social return on investment (SROI) ratio for the project.

Speakeasy is supported by central funding from the Department for Education and has support from local authorities that covers the administration and delivery of courses.

As well as calculating the overall social return, the study estimates the total value of benefits created to the state, at local and national level, from improvements in sexual health and forecasts the social return that is achieved per pound of public money invested in the Speakeasy project.

The report is structured as follows:

Section 2 provides an overview of the Speakeasy project

Section 3 sets out the methodology for the SROI analysis, including all assumptions, and details the theory of change underpinning the project

Section 4 presents the findings of the SROI study

Section 5 concludes the report

2.0 The Speakeasy project

The Speakeasy course offers an inclusive group-based approach for parents to gain knowledge, skills and confidence to help them communicate with their children about sex and sexual health. The course is usually run by two facilitators with a background in parenting support. All facilitators are trained and supported through a nationally accredited facilitator training programme that began in 2003.

The course is typically delivered to groups of around six to 10 people over the course of eight sessions. Parents are encouraged to gain greater confidence when talking about issues which are often considered taboo or embarrassing. The Speakeasy course is registered for accreditation with the Open College Network (OCN). For parents who wish to do so, the course and portfolio work arising from it can be used to gain OCN credits at level one or two.

A variety of teaching methods are employed on the course including; collage, role play, games and written work. Each session lasts approximately two hours and the course typically follows the structure shown in Table One.

Week	**Topics**
Taster Session	How we learn. What children need. Course outline. OCN accreditation.
Week One	Hopes, fears, expectations, group agreement, language and the words we know, pre course evaluation
Week Two	Naming body parts. Physical and emotional changes during puberty.
Week Three	Needs of children at different stages of their life. Age-appropriate information, learning opportunities with children.
Week Four	Collage exercises on stereotypes and media pressures and how to deal with them. Communication role play.
Week Five	Methods of contraception. Information on Sexually Transmitted Infections.
Week Six	Sex and Relationships Education (SRE) policy. Useful resources.
Week Seven	Safe from harm. Child safety. Review and completion of portfolio. Post course evaluation.

The project is nationally administered by FPA. Since 2006 the Department for Education (formerly the Department for Children, Schools and Families) has provided central funding for the project in England under the Children, Young People and Families grant programme. Trained facilitators deliver Speakeasy courses locally under the administration of local authorities.

2.1 History

The Speakeasy model came from an informal parent/FPA facilitator discussion group in Northern Ireland in 1995. The group talked about issues around talking to their children about sex, relationships and growing up. It was agreed that it would be useful to establish a course where parents could learn and discuss how to engage with their children on these issues. Funded by regional health boards, the project delivered courses in local community centres. The parents involved in the initial discussion group chose the name 'Speakeasy'.

Progress in Northern Ireland encouraged FPA to explore developing the project in England. A grant from the BIG Lottery fund helped to establish a three year project in 2002 with staff based in London, Birmingham and Manchester. Staff initially delivered training directly to parents but the success of the project led to a shift in focus towards training of course facilitators.

By 2005 the Speakeasy course was being delivered in local authorities across the nine government regions, with a particularly strong presence in the North West, North East and Yorkshire and Humber. Further grant support from the BIG Lottery fund and new support from the Parenting Fund and the Department of Education and Skills (DfES) in 2006 enabled the project to train more course facilitators and strengthen national administration. In many areas the project became part of local authority's and PCT's parent support and teenage pregnancy strategies. Working from community centres, health clinics, schools, and Children's Centres, Speakeasy courses have usually been targeted at 'Teenage Pregnancy hotspots' in disadvantaged communities.

2.2 Speakeasy 2010/11

In 2010/11 Speakeasy courses were run in 44 local authorities across England in all nine government regions. Proportionately high numbers of courses were run in the North West (13), London (10) and the South East (15). Relatively few courses were run in the East Midlands (3) and the South West (4). Nearly all courses were run in 'Teenage Pregnancy hotspots' defined as wards ranked in the top 20% for teenage conception rates across England (where more than 6% of girls aged 15-17 become pregnant in one year). All these wards were also recognised areas of multiple deprivation.

A total of 104 courses were run during 2010/11 with a total of 1368 participants starting courses and 1140 completing.

3.0 Methodology and theory of change

Social Return on Investment (SROI) is an adjusted cost-benefit analysis that quantifies the value of social, environmental and economic outcomes that result from an intervention.

An SROI analysis proceeds via six key steps:

1) Establishing scope and identifying key stakeholders
2) Mapping outcomes
3) Evidencing outcomes and giving them a value
4) Establishing impact
5) Calculating the SROI
6) Reporting, using and embedding

This section provides an audit trail of the SROI analysis for Speakeasy.

3.1 Establishing scope and identifying key stakeholders

The scope of this report is restricted to the activities of Speakeasy in England for the 20010/11 financial year.

The SROI is a forecast with the social value created in 2010/11 projected from the actual outcomes observed from participants in the course during the year and from previous years.

The key stakeholders identified as likely to experience change as a result of the Speakeasy course were the parents completing the Speakeasy course and the children of those parents. Only parents who completed the full three days of the course were considered likely to be materially affected by it and therefore included in the scope of the study.

Wider impact among extended family and local community reported in previous research was considered but discounted because the benefit was likely to be small and this population would be difficult to access.

Secondary stakeholders identified, who were likely to experience change as result of changes in behaviour of key stakeholders, were local health services and local and national government services concerning policing, employment and taxation. These government agencies were considered likely to have a material benefit if key stakeholders made behavioural changes as a result of the project.

3.2 Mapping outcomes

Stakeholder engagement is conducted to establish the theory of change, or logical framework, for the intervention. This is a description of how inputs are used to deliver activities that, in turn, result in changes (outcomes) for stakeholders. The involvement of stakeholders at this stage ensures that the SROI measures and values the outcomes that are most important to those directly experiencing the change.

It was decided that stakeholder engagement with parents and children would be undertaken in two stages. First, both groups would be interviewed to gather open-ended feedback on what, if anything, had changed for them as a result of the project (Parent Interview, Children Interview - Appendix 1). The interview would solicit feedback on all changes experienced by the stakeholder, including consideration of positive, negative, intended and unintended outcomes. This information gathering would be continued until the point at which new issues were no longer solicited and therefore it could be reasonably assumed that all material outcomes had been identified.

Second, drawing on the results of the interviews, a survey would be conducted for both groups that would gather quantifiable information on the extent to which these changes had been experienced, their duration, drop-off and approximate weightings and valuations (Parent Survey, Children Survey - Appendix 2). This evidence gathering would be conducted with a representative sample of respondents to ensure accuracy of the outcomes data produced.

Population and sample size details of the stakeholder engagement conducted are provided in Table 3.1 below.

Table 3.1 Stakeholder engagement audit trail

Stakeholder	Method of engagement	Number engaged	Population size	Confidence level	Confidence interval
Parents	Telephone interviews	52	1140	N/A	N/A
	Online survey	152		95%	7.4
Children	Telephone interviews	30	2394	N/A	N/A
	Online survey	164		95%	7.39
State	Policy analysis	N/A	N/A	N/A	N/A

The key findings of the stakeholder engagement and the theory of change for the Speakeasy programme are presented in Box 3.1. The Speakeasy impact map in Table 3.2 specifies how these changes relate to project activities and how the changes occur over time.

Box 3.1 Stakeholder engagement findings and Speakeasy theory of change

The stakeholder engagement indicated that the key changes experienced by families are differentiated by the degree of confidence of parents in talking about sexual health. The Speakeasy course makes its key impact by contributing to a lasting confidence among parents. Parents who gain confidence as a result of attending the course feel more comfortable about talking about sexual health with their children. As a result, these parents become significantly more proactive about talking about sex, engaging in more frequent and better quality conversations with their children. This proactive behaviour seems to set up a virtuous cycle of family communication about sex in which children themselves become comfortable about initiating conversations. This enhanced sexual communication within the family is usually maintained through the adolescence of the child.

Conversely, parents who enter the course with high levels of confidence about talking about sex with their children generally do not experience more frequent family communication about sex. These 'confident' parents are also more likely to have a reasonably good knowledge of sexual health before the course. They are

less likely to experience an increase in knowledge and an increase in confidence after taking the course.

The stakeholder engagement research suggested that families fall into two categories, each with distinct journeys of change:

- 'Low communication' families (A) - where parents have low levels confidence about talking about sex with their children. Parents often also have limited knowledge about sexual health.

- 'High communication' families (B) - where parents have high confidence about talking about sex with their children. Parents often also have good knowledge about sexual health.

The most significant change is experienced by families in the 'low communication' households, or category A. In these circumstances attending the Speakeasy course has the potential to lead to significantly enhanced communication between parents and children about sex. In turn, more frequent and better quality conversations are correlated with more confident attitudes and better knowledge about sex for the children when teenagers. Teenage children in these families reported positive sexual health practices of abstinence and safe sex. These findings concur with academic research that suggests that more proactive and better quality conversations about sex are associated with positive sexual health practices by the children involved. These children are likely to exhibit lower incidence of sexual intercourse and higher incidence of safe sex practices. The positive sexual practices reported by these children showed only a small drop-off over time suggesting that practices are for the most part maintained through adolescence once established.

'High communication' families, or category B, experience much less change from the project. These parents report limited increases in confidence and knowledge as a result of attending the course. Relatively few of these parents reported increased frequency of conversations with children compared to what they expected would have happened if they hadn't attended the course. These parents reported that their conversations on sexual health were either equally informed or slightly more informed compared to what might have been the case if they hadn't attended the course. Feedback from their children indicated that conversations with their parents had not noticeably increased after completion of the course. Children reported that the quality and frequency of these conversations had

Table 3.2 Speakeasy impact map

Stakeholder	Activity	Initial changes	Medium-term changes	Long-term changes
Parent A	Complete Speakeasy course.	▪ Significantly improved confidence talking about sexual health with children ▪ Improved knowledge of sexual health	▪ Improved engagement with children on sexual health ▪ Improved self-confidence ▪ Improved social networks/friendships ▪ Better general engagement with children	▪ Better family relations- Increased individual well-being ▪ Improved self-confidence ▪ Stronger social networks in community
Parent B	Complete Speakeasy course		▪ Improved social networks/friendships	▪ Stronger social networks in community
Child/Young Person A	Responds to parent experience of attending course	▪ Improved communication about sex with parents	▪ Improved knowledge of sexual health ▪ More likely to abstain from intercourse or practice safe sex. ▪ Better engagement with parents	▪ Better engagement with parents ▪ Reduced risk of STIs ▪ Reduced risk of unwanted pregnancies ▪ Reduced risk of becoming young parent ▪ Reduced of economic disadvantage and ill health because of young parenthood
Child/Young Person B	Responds to parent experience of	No material changes		

	attending course			
State, both local and national		▪ No changes in short term	▪ Reduced NHS spending on STI treatment and ante/post natal care ▪ Reduced cost of supporting teenage parents with high likelihood of becoming NEETs	▪ Reduced NHS spending on STI treatment and ante/post natal care ▪ Reduced cost of supporting teenage parents with high likelihood of becoming NEETs ▪ Reduced costs of Special Educational Needs (SEN) support for children of NEET teenage mothers.

3.3 Outcome indicators and data

The SROI was carried out as an evaluative analysis based on outcomes verified through stakeholder surveys.

Outcomes were included in the final model only where there was robust evidence they were relevant and where they were material in their impact.

One outcome that was analysed but considered insufficiently material was the reduced number of children of NEET teenage mothers who were likely to exhibit anti-social behaviour and commit offences as young adults. This figure was calculated using the reduction in sexual risk as a result of Speakeasy in conjunction with academic research on the incidence of children of NEET teenage mothers committing anti-social behaviour and offences as young adults (Scott, 2001 and Copeland, 2007). It was estimated that Speakeasy was likely to result in 0.3 less children incurring this burden on the state. As this figure amounted to less than one child it was considered immaterial to the total value of the project.

A number of other potential outcomes were discounted because of lack of evidence or measurement difficulties. For example, previous research and comments made by some parents during interviews suggested that more open attitudes towards discussing sex may have circulated beyond immediate family environments to include extended family and neighbourhood friends. Reports of this outcome, however, were limited and first-hand verification was considered impractical for the scope of this study. Another potential outcome mentioned by some parents but not included in the final model was an impact on educational attainment for children as a result of improved parental support and improved child confidence. A small number of parents suggested that this might have occurred in their case. Children, however, did not mention this in their accounts of the changes related to the Speakeasy course. Further stakeholder engagement with children may have solicited evidence of this outcome, but the likely small numbers involved and the practical difficulties involved in gathering this evidence and attributing it to the effect of the course, meant that it had to be discounted. Recommendations on how these outcomes might be investigated in future SROI evaluations are included in the reporting stage, 4.7.

Parent and children interviews indicated that course participants had had different experiences as a result of the course. Some participants reported that the course had given them improved knowledge and confidence in talking about sexual health with their children. These qualities, they indicated, had encouraged them to be more proactive about these conversations, being more open to concerns raised by children and initiating dialogue on the subject. Reflecting this, some but not all children reported that discussion on sex with their parents had become more open and more informed. For the parents, fostering more open and better quality discussions about sex was usually considered a major achievement and was often a source of considerable satisfaction. These parents also reported knock-on benefits as

result of this improved engagement with their children on sex. Many noted improvements in their general self-confidence and also individual well-being. As one parent commented, “It was a real challenge to feel confident enough to talk openly about sex with my daughter. It gave me a real boost once I did... I felt much more able to deal with other personal challenges.” Also noting a knock-on effect on confidence and well-being, another parent commented “I felt I had achieved something really special when I started talking about sex with my son. I felt good about myself.”

A second group of parents and children reported relatively low impact. Parents and children, for example, reported that the course had had little impact on practices in the home. These parents reported that they had already been fairly knowledgeable about sexual health and were confident about discussing these issues with children. The course had given them confidence that they were doing the right thing and they continued talking openly about sexual health with their children. For example, one parent commented “the course was good but it didn’t really change what was happening at home. We were already talking about these things with the kids.” Another parent made a similar point about the effect of the course, saying “It was good to hear that I was doing the right thing. I felt that I was more or less on track and I continued with the conversations.”

The parent and children surveys were then used as a second stage of stakeholder engagement to solicit further feedback from stakeholders on the material outcomes that had been identified in the interviews. Parents and children were asked to reflect on their personal situation and situations within the family at three key stages: before the course was started, immediately after completion of the course, and at the time of interview. Because the course had been completed by the parent from six months up to eight years prior to the interview, responses gave insight into the duration of changes experienced. Respondents were asked to provide information on a five point scale allowing for quantitative comparisons of before and after-course estimates. To ensure the reliability of findings questions were designed to capture both subjective and objective indicators of outcomes. For example, ‘improved self-confidence’ was measured by asking parents to rate themselves on a 1-5 self-confidence scale as well as by asking them to score how frequently they went out with friends.

Table 3.3 sets out the indicators and source for each outcome.

Details on each outcome are as follows:

- **Parent A - Improved engagement with children on sexual health**

This was a key intended outcome for the project and the one that was most commonly identified by parents in interviews. This outcome was the distinguishing feature for A Parents and acted as a necessary condition for ‘improved self-confidence’ and ‘increased individual well-being’ outcomes.

Parents who did not register this improved engagement only reported making new friends as a benefit from doing the course (Parents B).

To reflect the importance of the quality of engagement the indicator chosen was based on a combination of questions, first, gauging how informed conversations on sexual health were, and second, assessing the frequency of conversations before and after the course (Parent Survey Q6/7, 18/19). Only respondents who reported a post-course improvement on both questions were counted as achieving this outcome.

- **Parent A – Improved self-confidence**

This was an intended outcome for the project and one that was commonly identified by parents in interviews. Most parents identifying this outcome regarded it as distinct from 'improved engagement with children' and 'increased individual well-being', suggesting that it was appropriate to count it as a separate outcome. A Parents who did not register an 'improvement in self-confidence' were self-confident generally but had previously lacked confidence talking about sex with their children.

To ensure that only significant improvements in self-confidence were registered a two point increase on the five point scale was chosen as a measure (Parent Survey Q8/21). In addition, an objective indicator, a higher post-course score on the 'going out with friends' question (Parent Survey Q12/25) was used as an additional indicator. Only respondents who reported a post-course improvement on both questions were counted as achieving this outcome.

- **Parent A – Increased individual well-being due to better family relations**

This was not an intended outcome for the project but one that was identified by a substantial minority of parents in interviews. Parents indicated this condition was distinct from self-confidence; in other words, it was possible to experience improved self-confidence without also having increased well-being. To ensure reliable measurement, both subjective and objective indicators were used to measure this change. A subjective well-being index was created from questions on positive feelings and personal resilience (Parent Survey Q9/10, 22/23). In addition, an objective indicator measuring the frequency of family socialising was included (Parent Survey Q11/24). Only respondents who reported a post-course improvement on both questions were counted as achieving this outcome.

- **Parent A/B – Improved social networks**

This was an unintended outcome for the project but one that was widely identified by parents in interviews. Responses to the survey show that it was unrelated to other outcomes and occurred whether other changes had been experienced or not. To ensure reliable measurement respondents were asked whether they had made friends in the course and, if they had, whether they

had had social contact with them outside of the class (Parent Survey Q26). Only respondents who answered both questions positively were counted as achieving this outcome.

- **Children A – Better engagement with parents**

This was an intended outcome for the project and one that was frequently identified by children in interviews. Children recognised the effort by parents to engage with them on sexual health and valued it in terms of its contribution to better engagement generally. For example, they highlighted how parents were more open and approachable in general.

To reflect this focus on better engagement in general, the indicator used questions asking whether parents were approachable and understanding on subject of sex (Children Survey Q4/13) and frequency of family socialising (Children Survey Q9/19). Only respondents who reported a post-course improvement on both questions were counted as achieving this outcome.

- **Children A – Improved sexual health practices**

This was an intended outcome for the project and one that was commonly identified by children in interviews. Children recognised that improved family discussion of sexual matters had contributed to improved knowledge and confidence on sexual health. They also reported that these acquired qualities had likely made a difference to their sexual behaviour, making them more cautious and responsible.

To strengthen the reliability of the indicator as a measure of sexual health practices attributable to improved family discussion, a combination of questions were used. First, a higher post-course score on knowledge and confidence on sexual health were required (Children Survey Q5,6,15,16). Second, a high likelihood score (4-5 on a five point scale) on an abstinence question and/or a positive answer on use of safe sex (Children Survey Q27/28). Only respondents who reported a post-course improvement on all these questions were counted as achieving this outcome.

The above data, however, was not sufficient to provide an indication of the likely impact on avoidance of STIs and pregnancies. Responses to questions in the Children Survey gave an indication of whether the teenage child was more likely to practice safe sex or avoid intercourse than before their parent attended the course. But this information did not enable us to identify the quantitative impact on sexual practice. To provide this additional information we drew on the findings of a random control study from the United States that examined the relationship between sexual risk communication of parents with their teenage children and incidence of sexual intercourse and use of condoms when intercourse took place[1].

[1] Hutchinson,2003. Considerable academic research has been undertaken examining the relationship between parent-child communication about sex and the sexual behaviour of adolescent children. Not all studies in this field have shown a positive relationship between communication and sexual behaviour. However, many of these inconsistencies have been attributed to crude measures and simplistic

The Hutchinson study of the role of parent-child sexual risk communication in reducing sexual risk behaviours provided the most appropriate match for the Speakeasy intervention among recent academic studies. The study examined the relationship between conversations about sexual risk between mother and daughter and reports of subsequent sexual behaviors[2]. Each teenage girl was asked at the beginning of the study if their mother had talked with them about sexual intercourse, birth control, AIDs, STIs or condoms. Each topic was treated as a separate item and each 'Yes' answer scored a point producing a total score out of five. At three, six and 12 month follow-ups, each girl was asked to report on their sexual behaviour during the intervening period with questions covering the number of male sexual partners, number of episodes of sexual intercourse, and number of days in which respondent had had unprotected intercourse.

The study found that mother-daughter sexual health communication was associated with fewer episodes of sexual intercourse and increased incidence of unprotected sex. Each one-point increase in sexual health communication was associated with an 11% reduction in the number of sexual episodes at the follow-up. Furthermore, each one point increase in sexual risk communication was associated with 19% fewer days of unprotected intercourse. Overall, the more topics covered in this communication the more sexual episodes were reduced and safe sex increased where intercourse took place.

It is important to take into account the differences between the intervention of the Hutchinson study and the intervention that takes place with Speakeasy. The parent-child communication in the Hutchinson study was between mother and daughter rather than between either parent and child of either sex. While Speakeasy is open to both mothers and fathers, in practice over 95% of participants are mothers. The fact that the communication is exclusively with daughters may have given the intervention a stronger impact because the female partner in sexual relations carries the potential burden of pregnancy and therefore a greater incentive to act on advice heeding caution. This

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conceptualisations of the communication process (Miller, 1998, p.1542). Where research has examined the content and process of parent-child communication results have been consistently positive. Of particular relevance to Speakeasy, studies have found a strong correlation between openness of discussion about sex. For example, one study concluded, "Parent-teenage discussions about sexuality and sexual risk were associated with an increased likelihood of teenagers' condom use, but only if parents were open, skilled and comfortable in having those discussions" (Whitaker, 1999, p.117). Another study reported that "The positive effects of parent-child communications appear to be mediated by several critical factors: the frequency and specificity of communications; the quality and nature of exchanges; parental knowledge, beliefs and comfort with the subject matter; and the content and timing of communications" (Blake, 2001, p.52).

[2] All the participants in the study were sexually experienced. Obviously this is an important difference to the Speakeasy intervention where parents usually start communication with their child at or prior to the onset of puberty. Academic studies that have examined the impact of the timing suggest that, while sexual communication is correlated with low risk sexual activity whether it takes place before or after a young person becomes sexually experienced, the former situation has greater impact (Miller, 1998, Blake, 2001). This would suggest that using the Hutchinson study as a benchmark for measuring impact is likely to underestimate the positive impact on teenager's sexual behaviour. Nonetheless, the Hutchinson study was considered an appropriate match for the Speakeasy intervention because it examined the impact of different levels of communication between parent and child and also considered impact in terms of condom use and incidence of sexual intercourse.

influence, however, might be reasonably expected to be counterbalanced by the impact of the different timings of respective interventions. As discussed in the footnote above, the earlier communication that takes place with Speakeasy is likely to be more effective in discouraging teenage sexual activity than when the communication coincides with sexual activity as with the Hutchinson study.

Taking these factors into account it seems that the intervention used in the Hutchinson study and the Speakeasy intervention are sufficiently similar for us to use the former to help inform our understanding of the likely impact of the project. To make a valid inference from the Hutchinson study it is critical to make a reasonable judgement about what level of communication in the study is equivalent to the communication and impact observed in the Speakeasy project. The findings of the Hutchinson study identify a chain of influences that result in improved sexual practices. Parental conversations with the daughter lead to improved confidence and knowledge about sex which are in turn acted on either by avoiding intercourse or by practicing safe sex. This is a very similar process to that observed for Parents A for Speakeasy, who exhibited improved confidence leading to improved engagement with their children, which in turn led to improved confidence about sex for children and higher likelihood that they would avoid intercourse or use safe sex.

It was decided therefore that category A families, where Speakeasy parents and children had reported significantly improved sexual communication and improved sexual practice on the part of teenage children would be an appropriate match for the Hutchinson study. These A families consisted of parents and children who reported all of the following conditions:

- two point or more increase in confidence after the Speakeasy course.
- conversations about sex with their children better informed than they would have been had they not attended the course.
- frequency of conversations same or higher than what would have happened had they not attended the course.

To make an appropriate inference from the Hutchinson findings we conservatively assumed that the degree of improvement in conversations reported by A parents was comparable to a three point increase in the Hutchinson communication score. In effect, this meant that an increase in confidence and knowledge about talking about sex *is comparable to* an increase in conversations that cover one topic to conversations that cover four topics of sexual health (see Table 3.4), i.e. a change from a teenager having no sexual health conversations to a teenage having one or more conversations that cover sexual intercourse, condoms, and STIs.

Table 3.4

	Speakeasy category A benchmark	**Hutchinson study benchmark**

criteria	- 2 pt increase in communication confidence - Increase in 'informed' rating for conversations about sex - Frequency of conversations at or above non-course estimate	- 3 pt increase in no. topics discussed by parent with teenage child
Example	- Increase in confidence in talking about sex from 'low' to 'high' - Increase from 'uninformed' to 'informed' rating. - Increase in frequency of conversations from once every three months to once a month	- Change from one sexual health topic covered in conversations with parent to four topics cover in conversations

Using the findings from the Hutchinson study we can therefore infer that this change in communication is likely to lead to a 33% reduction in the number of episodes of sexual intercourse than would have been the case if the same parent had not taken the course. Similarly, if, as the study suggests, each 1 point increase is associated with 19% fewer days of unprotected intercourse, this 3 point improvement in conversations is likely to lead to 57% fewer days of unprotected intercourse.

Assuming that condom use is 80% reliable in preventing pregnancies and STIs (allowing for incorrect use, breakage, etc.) the aggregate reduced sexual risk for children of Speakeasy parents would be:

46% + 33% = 79% reduced risk for children of Speakeasy parents compared to children of parents who have not taken the course.

It is important to take note that the above projection of actual sexual behaviour (and hence sexual health) of Speakeasy A children is a forecast based on the evaluative data gathered from the stakeholder surveys. The interviews and survey responses from Children A suggested that they had met the conditions – higher quality of conversations with parents about sex, increased confidence and better knowledge on the subject - found in the Hutchinson study to be associated with abstinence and safe sex practice. In addition, the survey responses found evidence of attitudinal changes likely to be correlated with abstinence (Appendix 1, Children Interview Q7, 17, 27) and

condom use (Children Interview Q8, 18, 28). This data, however, does not offer direct evidence of actual behaviour or sexual health. Unfortunately it was beyond the scope of this study to monitor the sexual behaviour and/or incidence of pregnancies, terminations and STIs of the children in the years following their parent's attending the course. Gathering this evaluative data on sexual health would significantly strengthen the study and this action is included in the recommendations highlighted in 4.7.

- **Children A – avoidance of NEET (Not in Education, Employment or Training) outcomes**

The NEET-related outcomes – avoidance of economic disadvantage and poor emotional well-being – were given indicators based on the likely reduced numbers of teenage mothers and fathers based on the lower risk of pregnancy exhibited by Children A. Using ONS and NICE figures on the number of teenage pregnancies that lead to birth and then grow up in various disadvantaged conditions, we calculated the likely number of each case avoided. The calculation for Speakeasy was made as follows:

Ave. of 6% girls 15-17 in 'Teenage Pregnancy Hotspots' likely to become pregnant in one year (ONS conceptions, 2008); 54% of which lead to birth (NICE, 2007)); 90% of teenage mothers become NEETs - 38% of young fathers likely to be unemployed; 20% of teenage mothers experience depression soon after birth of child.

Starting with base number of Speakeasy Children A- 1240= 620 female/620 male the above statistics translate into (numbers rounded up to nearest whole number) the following numbers:

37 teenage girls likely to become pregnant per year without the intervention; 20 of these pregnancies likely to lead to birth leading to 18 NEET teenage mothers; 4 teenage mothers experiencing depression after birth of child.

Assuming that 50% of children born under these conditions have a father responsible for their welfare = 4 unemployed young fathers.

79% reduction in sexual risk as result of Speakeasy is likely to result in 16 fewer pregnancies,14 fewer NEET teenage mothers, 3 fewer teenage mothers experiencing depression, and 3 fewer unemployed young fathers, per year.

- **State (local and national)**

All the government outcomes identified were related to savings estimated as a result of improved sexual health of teenage children A. Health-related indicators were the likely reduction of treatment of STIs, pregnancies,

terminations, and deliveries as a result of safer sex and lower conceptions. NEET-related indicators were savings estimated as a result of the reduced welfare and social services burden and loss of tax revenue of fewer teenage mothers and children growing up in NEET households.

Some of these state savings were likely to be cash savings, for example where the absence of a treatment or service meant less expenditure, e.g. where a course of drugs is used to treat an STI, reduced welfare benefits or loss of tax revenue due to joblessness. In other cases where savings were derived from reducing the burden on fixed resources (e.g. staff and facilities) the calculated figure would represent resource reallocation rather than an immediate cash benefit.

Statistical details of these outcomes were as follows:

<u>reduction in STI transmission</u>
Total new STI diagnoses (HPA, 2009) for persons under 25 = 216,230 = 1.14% of population (19,016,100)

Annual no. children A likely to contract STIs without intervention = 1.14% of 1676 (Children A) = 19

79% reduction in sexual risk as result of Speakeasy is likely to result in 15 fewer cases of new STI diagnoses per year.

<u>reduction in pregnancies and terminations due to reduced no. of teenage pregnancies</u>
As above for likely number of teenage pregnancies per year to female children A without intervention = 37; 54% of which lead to birth (20 cases), 46% to abortions (17 cases).

79% reduction in sexual risk as result of Speakeasy is likely to result in 16 fewer births during teenage years and 13 fewer terminations. As NEET mothers are likely to have 50% more children overall than women who delay motherhood, the total fewer births incurred over the lifetime of the women affected will be 8.

<u>reduced number of children of NEET teenage mothers who require Special Educational Needs (SEN) support through schooling</u>
As above for likely number of teenage pregnancies per year to children A without intervention leading to birth = 20 infants; 20% of which are likely to require SEN support through schooling.

79% reduction in sexual risk as result of Speakeasy is likely to result in 16 fewer births to teenage females, therefore avoiding 3 children with educational difficulties who are likely to require SEN support through schooling.

Table 3.3 Outcome indicators

Stakeholder	Outcome	Indicator(s)	Source
Parent A	Improved engagement with children on sexual health	Higher level of confidence about talking with children about sex, and conversations better informed and at or above pre course frequency. Indicator is the percentage of parents who report 2 point improvement in confidence, report that conversations about sex are more informed AND that frequency is at or above pre course level. (Q6/18, Q7/19, Parent Survey)	Stakeholder Engagement Parent Survey (corroborated by Coleman and Ramm, 2009).
	Improved self-confidence	Longer term improved self-confidence: parents who report 2 point improvement in confidence about talking with children about sex since starting course AND report higher score on 'going out with friends'. (Q8/21, Q12/25 Parent Survey)	Stakeholder Engagement Parent Survey (corroborated by Ramm and Coleman, 2008b).
	Improved social networks	Made friends in course AND had social contact with them outside of course. (Q26 Parent Survey).	Stakeholder Engagement Parent Survey (corroborated by Ramm and Coleman, 2008b)
	Increased individual well-being due to better family relations	Pre/post course improved well-being score AND higher frequency of family socialising (Q9,10,11,22,23,24 Parent Survey)	Stakeholder Engagement Parent Survey (corroborated by Coleman and Ramm, 2009, p.39).
Parent B	Improved social networks	As for Parent A	As for Parent B
Child/Young Person A	Better engagement with parents	Children reporting that parents were more approachable and understanding since completing course AND higher score on frequency of family	Stakeholder Engagement Children Survey (corroborated by Coleman and Ramm,

		socialising. (Q4/13, Q3/19 Children Survey)	2008a).
	Improved sexual health practices	Higher score on knowledge and confidence on sexual health AND high likelihood score (4-5) on abstinence and/or use of safe sex (Q5,6,15,16, 27/28 Children Survey). Projected impact on avoidance of intercourse and increased use of safe sex was based on findings from Hutchinson study[3].	Stakeholder Engagement Children Survey AND findings on sexual risk reduction by Hutchinson sexual risk communication study).
	Avoidance of economic disadvantage experienced by teenage mothers, 16-30	Based on low risk sexual behaviour of teenage children in category A families. Calculated according to ONS conception data, birth/termination data, and likelihood that teenage mother will live in an unemployed household.	Stakeholder Engagement Children Survey indicators for sexual practices AND findings on sexual risk reduction by Hutchinson study.
	Avoidance of poor emotional well-being experienced by teenage mothers, 16-24	Based on projected low risk sexual behaviour of teenage children in category A families. Calculated according to ONS conception data, birth/termination data, and likelihood that teenage mother will be NEET and will experience depression soon after birth of child.	Stakeholder Engagement Children Survey indicators for sexual practices AND findings on sexual risk reduction by Hutchinson study.
	Avoidance of economic disadvantage experienced by young fathers, 16-30	Based on projected low risk sexual behaviour of teenage children in category A families. Calculated according to ONS conception data, birth/termination data, and likelihood that teenage father will be unemployed.	Stakeholder Engagement Children Survey indicators for sexual practices AND findings on sexual risk reduction by Hutchinson study.
State (local and national)	Reduced spending on treatment of STIs	Based on projected low risk sexual behaviour of teenage children in category A families.	Stakeholder Engagement Children Survey indicators for sexual practices AND findings

[3] Hutchinson, 2003.

			on sexual risk reduction by Hutchinson study. HPA, 2009.
	Reduced no. of terminations due to reduced teenage pregnancies	Based on sexual practice projections above, and ONS conception and birth statistics and percentage of pregnancies that lead to termination.	As above, NICE, 2007
	Reduced births to teenage girls	Based on sexual practice projections above, and conception and birth statistics, percentage of pregnancies that lead to birth, and higher numbers of children had by teenage mothers. (NICE, 2007).	As above, NICE, 2007, Goodman, 2004.
	Reduced spending on support for teenage mother NEETs	Based on sexual practice projections above, and conception and birth statistics and proportion of teenage mothers likely to become long term NEETs (NICE, 2007).	As above, NICE, 2007
	Reduced spending on SEN support through schooling	Based on sexual practice projections above, and conception and birth statistics and proportion of teenage mothers who are NEETs and have children who require SEN support through schooling.	As above, NICE, 2007, Berrington, 2005, KPMG, 2006.

3.5 Determining impact

SROI is concerned with analysing the extent to which the changes observed are attributable to the project. A number of changes or outcomes may be observed but not all of them may be a result of the project. To measure the impact of the project, we needed to consider whether, and to what extent, other factors influenced the achievement of these outcomes, how the impact attributable to the project varied over time, and whether outcomes achieved by the project were simply displacements of phenomena elsewhere. The objective in this part of the SROI process is to really understand the role of the activity in creating valued change in people's lives not just what the change is.

The first three factors to be taken into consideration are:

- **Deadweight** – the counterfactual, or what would have occurred in the absence of the intervention
- **Attribution** – the credit that the intervention can take for any outcomes that are observed if there are also other actors involved
- **Displacement** – whether benefits are truly additional or moved to/from elsewhere

Deadweight, attribution and displacement are subtracted from observed outcomes to arrive at the impact of the intervention.

Details on how these factors were calculated for the outcomes were as follows:

3.5.1 Deadweight

The study drew on two key sources to estimate the possible degree deadweight in the outcomes reported. First, questions in the parent and children interviews asked if reported changes would have occurred in the absence of the influence of the course. Parents were asked if the changes in their own behaviour would have occurred without attending the course (Parent Interview Q9). Similarly, children were asked if the changes they had experienced would have occurred without the changes in their parents' behaviour prompted by the course (Children Interview Q7).

Regarding the outcomes related to engagement with children on sexual health, parents reported that, because the barriers to achieving this were so formidable, it was highly unlikely to have occurred without the changes prompted by the course. For the other outcomes parents acknowledged that some degree of change might have occurred independently of the course. They maintained that although their estimation of these outcomes was made exclusively in view of the influence of Speakeasy, it may be the case that some of these changes may have occurred anyway. In the light of this feedback it was decided to calculate deadweight for 'improved engagement with children on sexual health' at 10% and the other parent outcomes at 20%.

The feedback from children suggested that conversations with parents broaching sexual health had been significant in improving overall engagement with parents. Children considered sexual matters a sensitive matter that parents could easily handle poorly. Children therefore responded positively when parents handled these issues in an open and sensitive manner. For this reason they generally felt that the 'better engagement with parents' they experienced was largely attributable to the discussions which had been prompted by the course. Children did not discount the possibility, however, that this change would have happened anyway. On this basis deadweight was calculated for 'better engagement with parents' at 20%.

Second, the Hutchinson random control study provided reliable insight into the likely impact on sexual practices exclusively attributable to sexual risk communication from a parent. The study compared results from an intervention group where teenagers were exposed to conversations about sexual health with a parent to results from a control group where these conversations were absent. Other factors were sufficiently similar to suggest that the findings regarding sexual practice were likely to apply to the Speakeasy intervention. The social and developmental context for the two interventions – involving disadvantaged communities, young people through adolescence and situated in Western developed societies – were sufficiently similar to suggest that the Hutchinson results were a reliable indicator of what would have occurred independent of other factors. Added to this, was the absence of any 'deadweight' factor mentioned by children in regards to the 'improved sexual health practices' outcome. Children responding to this question in the interview reported that this behaviour would not have occurred without the supportive environment prompted by attendance of Speakeasy.

Taking the strength of this evidence into account it was decided to discount the possibility of any deadweight for 'improved sexual health practices'. Because the remaining health and NEET-related outcomes are wholly derived from estimates of children's sexual practice (avoided pregnancies and reduced STIs) deadweight was also discounted for these outcomes.

3.5.2 Attribution

The calculation of attribution considers whether and how other actors may have contributed to outcomes. Unlike deadweight this does not focus on environmental influences but rather on specific interventions that may have had an influence on outcomes associated with the project. In the case of Speakeasy factors that could have been relevant included school initiatives on sexual health, public health information campaigns, parenting programmes, TV programmes, local health initiatives and so forth.

The study drew on questions asked in the parent and children interviews to consider whether and how outcomes might have been influenced by other interventions. Parents and children were asked to consider whether the changes they reported had been influenced by other experiences (Parent

Survey Q10, Children Survey Q8). Interviewees responding positively were then asked to estimate the proportionate weight of these influences versus that of Speakeasy.

Some parents and children responded to this question by acknowledging that they had been exposed to TV programmes about teenage sexual health. No other influences were mentioned. However, parents reported that knowledge had not instigated the behavioural changes they had undertaken. While information had been gained from the TV programme it had had no effect on confidence about addressing the issue. The confidence developed as a result of the course had been the critical factor in them initiating discussion of sexual matters with their children. Children reported that the knowledge acquired from TV programmes was important but had not been decisive in prompting behavioural change. The key factor for them had been the supportive atmosphere in the home concerning acting responsibly about sex. This change had played the major role in facilitating improved engagement with parents and, in turn, improved sexual health practices.

Parents, however, did not report third party influences on 'improved self-confidence', 'increased individual well-being' and 'improved social networks'. All these outcomes were specifically attributed to the influence of the course. Similarly, children reported no significant third party influences on 'better engagement with parents' and attributed this change to the breakthrough achieved in talking about sexual health, prompted by Speakeasy.

Taking the comments from parents and children into account, it was decided to calculate attribution relatively low (proportion attributed to other actors) where third party influences were mentioned. The parent outcome 'improved engagement on sexual health' was calculated at 10%. Attribution for other parental outcomes was discounted. For children's sexual practice attribution was calculated at 20%. Because the remaining health and NEET-related outcomes were wholly derived from estimates of children's sexual practice (avoided pregnancies and reduced STIs) attribution for these outcomes were also calculated at 20%.

For the parent 'social network' outcomes no reports of other influences were mentioned and therefore attribution was calculated at 0%.

3.5.3 Displacement

Displacement was not relevant for most outcomes in this study as the Speakeasy course was considered unlikely to lead to negative personal changes for non-Speakeasy parents and children. For example, teenage children whose parents did not attend the course were unlikely to engage in worse sexual behaviour as a result of a neighbour attending. Nonetheless, displacement was identified by stakeholders as possibly relevant to the social networks outcome for parents. New friendships might have been made even if the course had not been attended if other social activities had been

undertaken in that time slot. However, because most parents acknowledged that a social activity was unlikely to have taken the place of the Speakeasy course this potential for displacement was estimated as relatively small and calculated at 10%.

Table 3.5 Deadweight

Stakeholder	Outcome(s)	Deadweight	Rationale	Source(s)
Child/Young person A	Sexual health practice	0%	Deadweight accounted for by random control in Hutchinson study. Children reported that change would not have occurred without supportive environment prompted by Speakeasy.	Hutchinson, 2003, Stakeholder Engagement Children Interview Q7.
	Better engagement with parents	20%	Children reported that supportive environment around sexual health had been instrumental in improving general engagement with parents. However, acknowledged that other factors could have played a role.	Stakeholder Engagement Children Interview Q7.
	Avoidance of economic disadvantage experienced by teenage mothers	0%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice.	Hutchinson, 2003, Stakeholder Engagement Children Interview Q7.
	Avoidance of poor emotional well-being experienced by teenage mothers	0%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice.	Hutchinson, 2003, Stakeholder Engagement Children Interview Q7.
	Avoidance of economic disadvantage experienced by young fathers.	0%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice.	Hutchinson, 2003, Stakeholder Engagement Children Interview Q7.
Parent A	Improved engagement with children on sexual	10%	Parents reported that because barriers to achieving this were	Stakeholder Engagement Parent Interview Q9

	health		significant, it was highly unlikely to have occurred without the changes prompted by the course.	
	Improved self-confidence	20%	Parents estimated attribution of Speakeasy but acknowledged other factors may have played a part.	Stakeholder Engagement Parent Interview Q9
	Improved social networks	0%	Parents reported that friendships made would not have taken occurred without course.	Stakeholder Engagement Parent Interview Q9
	Increased individual well-being	20%	Parents identified link between more open discussion at home, better family relations that arose and personal satisfaction from these changes. Parents reported that Speakeasy probably predominant influence but other factors may have played a part.	Stakeholder Engagement Parent Interview Q9
Parent B	Improved social networks	0%	Parents reported that friendships made would not have taken occurred without course.	Stakeholder Engagement Parent Interview Q9
State	Reduced spending on treatment of STIs	0%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice of Children A	Hutchinson, 2003, Stakeholder Engagement Children Interview Q7.
	Reduced spending on terminations	0%	As above	As above
	Reduced spending on births to teenage girls	0%	As above	As above
	Reduced spending on NEETs arising from	0%	As above	As above

	teenage motherhood.			
	Reduced spending on SEN support through schooling	0%	As above	As above

Table 3.5 Attribution

Stakeholder	Outcome(s)	Attribution to other actors	Rationale	Source(s)
Child A	Improved sexual health practice	20%	Children reported that requisite knowledge that informed more responsible sexual practice was partly gained from third party sources, i.e. TV programmes. Most influence, however, reported as coming from discussion prompted by Speakeasy.	Stakeholder Engagement Children Interview Q8
	Better engagement with parents	0%	Children reported that no third parties had been influential in improving engagement with parents.	Stakeholder Engagement Children Interview Q8
	Avoidance of economic disadvantage experienced by teenage mothers	20%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice	Stakeholder Engagement Children Interview Q8
	Avoidance of poor emotional well-being experienced by teenage mothers	20%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice	Stakeholder Engagement Children Interview Q8
	Avoidance of economic disadvantage experienced by young fathers	20%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice	Stakeholder Engagement Children Interview Q8
Parent A	Improved engagement with child on sexual health	10%	Parents reported that some knowledge about teenage sexual health had been gained from TV programmes but this had only played a	Stakeholder Engagement Parent Interview Q10

			small part in leading to engagement with children on subject.	
	Improved self-confidence	0%	Parents specifically attributed self-confidence to improved engagement with children on sexual health. No third party influences reported.	Stakeholder Engagement Parent Interview Q10
	Improved social networks	0%	Parents specifically attributed friendships to attendance at course and discounted third party influences.	Stakeholder Engagement Parent Interview Q10
	Increased individual well-being	0%	Parents specifically attributed individual well-being to improved engagement with children on sexual health. No third party influences reported.	Stakeholder Engagement Parent Interview Q10
Parent B	Improved social networks	0%	As for Parent A	Stakeholder Engagement Parent Interview Q10
State	Reduced spending on treatment of STIs	20%	N/A: Outcome was wholly derived from outcome above on improved sexual health practice of Children A.	Stakeholder Engagement Children Interview Q8
	Reduced spending on terminations	20%	As above	As above
	Reduced births to teenage girls	20%	As above	As above
	Reduced costs of avoiding NEETs arising from teenage motherhood	20%	As above	As above
	Reduced spending on SEN support through	20%	As above	As above

	schooling

3.6 Benefit period and drop off

Outcomes often last beyond the initial intervention. Where this is the case, SROI projects value into the future. A drop off rate is applied to acknowledge that outcomes are not maintained at the same level over time.

The benefit period and drop off rate for outcomes was calculated for outcomes as follows:

The study drew on stakeholder engagement and academic research to calculate the extent to which outcomes were likely to be diminished over the years after completion of the course and the likely duration of the benefit period. Because the stakeholder surveys sampled parents (and children) who had completed the course at various points in the past it was possible to identify how quantified outcomes changed over time. For example the mean of children's 'sexual practice' scores was compared for responses one, two, three and four years after completion of the course. This analysis revealed various levels of annual drop-off for sexual practice and engagement with parents outcomes for children. Similarly for parent outcomes, responses indicated different levels of drop-off, with 'increased well-being' and 'improved social networks' particularly high.

Drop-off levels were sometimes sufficiently high to dictate the benefit period. For example, an annual drop-off of 10% meant that children's improved engagement with their parents was projected for a total of 10 years rather than the 'window of opportunity' benefit period of 16 years during which it could be expected that this situation might arise. The general rule applied to calculate benefit periods was the period in which parents and children would be expected to live together and for parents to have an opportunity to have a formative influence on a child's behaviour. Accordingly, outcomes that were related specifically to sexual matters were judged to begin when a child was 12, and outcomes that were related to general discussions were judged to begin when a child was 8. Survey responses regarding friendships made on the course suggested that on average these relationships lasted no more than five years.

Academic research was used to estimate the benefit period of avoided health and NEET-related outcomes. Some of these conditions usually persist over an extended period of years and therefore incur annual costs. Others, like poor emotional well-being are usually a one-off condition associated with teenage motherhood and therefore was treated as a one-off cost.

Table 3.6 sets out the benefit periods and drop off rates for the Speakeasy SROI model.

All future value (calculated on the impact map) is discounted by a further 3.5% to arrive at its present value. This discount is a standard accounting technique used to express the declining value of an investment over successive years.

Table 3.6 Benefit period and drop off

Stakeholder	Outcome(s)	Benefit period	Drop off (annual)	Rationale	Source
Child/Young Person A	Better engagement with parents	Child age 8-24	10%	Level of parents' approachability/understanding and frequency of family socialising shows decline over years after course. Outcome considered for likely duration of time living at home.	Stakeholder Engagement Children Survey, Q4/13, 9/19. Corroborated by longitudinal findings in Coleman and Ramm, 2008.
	Improved sexual health practice	Child age 12-24	5%	Scores on knowledge/confidence on sexual health and reported likelihood on abstinence and/or use of safe sex declines slightly over years after course. Outcome considered for likely duration of time living at home.	Stakeholder Engagement Children Survey, Q5,6,15,16,27,28.
	Avoidance of economic disadvantage experienced by teenage mothers	Child age 16-30	5%	As above on sexual practice. Research indicates that economic disadvantage lasts at least until age 30.	As above and Berrington, 2005
	Avoidance of poor emotional well-being experienced by teenage mothers	Child age 16	100%	Condition can be resolved if appropriate treatment is given. As outcome is avoidance, condition is treated as a one-off situation that	Berrington, 2005

				arises soon after child birth.	
	Avoidance of economic disadvantage experienced by young fathers	Child age 16-30	5%	As above on sexual practice. Research indicates that economic disadvantage lasts at least until age 30.	Berrington, 2005
Parent A	Improved engagement with child on sexual health	Child age 8-24	10%	Parents reported improved quality and frequency of conversations with child shows decline over years after course. Outcome considered for likely duration of time child living at home.	Stakeholder Engagement Parent Survey, Q31/32.
	Improved self-confidence	Child age 8-24	8%	Parents reporting improvement in self-confidence and score on 'going out with friends' shows decline over years after course. Outcome considered for likely duration of time child living at home.	Stakeholder Engagement Parent Survey, Q31/32
	Increased individual well-being	Child age 8-24	15%	Parents reported improved well-being and frequency of family socialising shows significant decline over years after course. Outcome considered for likely duration of time child living at home.	Stakeholder Engagement Parent Survey, Q22/23, 11/24
	Improved social networks	5 years	20%	Proportion of parents who reported they had lost contact with friends made on course over subsequent years.	Stakeholder Engagement Parent Survey Q39.

					Corroborated by Ramm and Coleman, 2008b
Parent B	Improved social networks	5 years	20%	As for Parent A	As for Parent A
State	Reduced spending on treatment of STIs	12 years	5%	As for improved sexual health practice of Child A	NICE, 2007, Coles, 2010.
	Reduced spending on terminations	12 years	5%	As above	Berrington, 2005
	Reduced spending on births to teenage girls	12 years	5%	As above	Berrington, 2005
	Reduced costs of avoiding NEETs arising from teenage motherhood	20 years	5%	As above. Research indicates that teenage mother NEETs remain in this condition for an average of 20 years.	Berrington, 2005
	Reduced spending on SEN support through schooling.	9 years	5%	As above. Research indicates that where children of NEET mothers require SEN support it is usually maintained KS2 through KS4.	Copeland, 2007, KPMG, 2006

3.7 Financial proxies

Non-traded outcomes were valued on the basis of stated preference valuations offered by parent and children stakeholders. Survey questions were designed to elicit valuations according to recommendations of best practice made by the Department of the Environment, Transport and Regions (Pearce, 2002). Respondents were asked to rank the value of the outcomes they had reported. They were then asked to identify a paid-for activity that produced a similar or related experience to the outcome in question. The respondent was then asked to indicate the fraction or multiple of that activity that was likely to produce a similar quantity to the outcome in question. This process therefore arrived at a stakeholder-defined equivalent which could be readily translated into a monetary figure. The advantage of this method was that it avoided asking stakeholders to simply give a financial value for a non-traded good.

Details of the financial proxies created for outcomes were as follows:

Soliciting valuations for outcomes was undertaken in two stages. First, in the stakeholder interviews, parents and children were asked to give a preliminary assessment of the relative importance of the outcomes they had identified and identify an equivalent paid-for activity. Interviewees were asked to rank the changes they had identified in order of importance (Parent Interview, Q14) and then to identify a paid-for equivalent which produced a similar or related experience to the outcome in question (Parent, Q15).

The ranking of outcomes produced fairly consistent results. Parents considered ‘improved engagement with children on sexual health’ the most important to them, and in descending order, ‘improved self-confidence’, ‘increased individual well-being’ and ‘improved social networks’. Children considered ‘better engagement with parents’ more important than ‘improved sexual health’.

The identifying of equivalent paid-for activities produced a range of responses. The most frequently identified equivalents were chosen as the most appropriate proxy for each outcome were as described in Table 3.7

	Outcome	Financial proxy
Parent	Improved engagement with child on sexual health	Hourly private tuition for child
	Improved self-confidence	day self-esteem course
	Improved social networks	Restaurant meal for 2
	Increased individual well-being	Annual family day excursion
Child	Better engagement with parents	Days on holiday
	Improved sexual health practices	Expenditure on personal health

The second stage of soliciting valuations from stakeholders was undertaken in the parent and children surveys. Using the financial proxies identified in the interviews, respondents were asked to identify the equivalent impact of the outcome as a fraction or multiple of the paid-for activity (Parent Survey Q40-43, Children Survey Q30,31). For example, parents were asked to identify how many days of a self-esteem course would generate approximately the amount of self-confidence gained from attending the Speakeasy course. Again, the final valuation for each outcome was based on the average response made stakeholders, which was then translated into a cost based on a typical market value or the average expenditure indicated by the ONS Living Costs survey.

Stated preference valuations were not solicited from children for the outcomes avoided as a result of improved sexual health, i.e. avoidance of NEET-related outcomes. These outcomes were considered too abstract to generate meaningful valuations from stakeholders. Instead it was decided to use market-based valuations from equivalent populations for these outcomes. For example, the value of avoiding the economic disadvantage typically experienced by teenage mother NEETs was calculated as the difference in income between an average salary for young people in work and Job Seeker's Allowance (ONS 2009 Labour Force Survey).

Valuations for state outcomes were based on published costings for the relevant state support, health care, and lost tax contributions. The specific burden on state services for each outcome was estimated according to academic research on the subject as referenced in Table 3.8.

Table 3.8 provides a full list of the financial proxies used in the Speakeasy SROI.

Table 3.8 Financial proxies

Stakeholder	Outcome	Financial proxy description	Value (per individual unless stated)	Source
Parent A	Improved engagement with children on sexual health	Value of estimated equivalent to improved engagement on sexual health with child: 15 hrs private tuition for child	£300	Stakeholder Engagement Parent Survey Q42
	Improved self-confidence	Value of estimated equivalent to improving self-esteem: 2x 4hr course on improving self-esteem	£216	Stakeholder Engagement Parent Survey Q40 Aquaris coaching: www.aquaris.co.uk
	Improved social networks	Value of estimated equivalent to new friendships made: restaurant meal for 2	£40	Stakeholder Engagement Parent Survey Q43
	Increase individual well-being due to better family relations	Value of estimated equivalent to improved well-being due to better family relations: 2x annual family day excursions.	£200	Stakeholder Engagement Parent Survey Q41
Parent B	Improved social networks	As for Parent A	£40	Stakeholder Engagement Parent Survey Q43
Child/Young Person A	Better engagement with parents	Value of estimated equivalent to improved engagement with parents: 3 days holiday	£600	Stakeholder Engagement Children Survey Q30
	Improved sexual health practices	Value of estimated equivalent to improved sexual health: 50% of ave. annual spend on	£132.60	Stakeholder Engagement Children Survey Q31, ONS 2009 Living Costs and

		personal health		Food Survey
	Avoidance of economic disadvantage experienced by teenage mothers	Difference in income between ave salary for young person and Job Seeker's Allowance	£138.65/week	ONS 2009 Labour Force Survey, ASHE 2009, Berrington, 2005.
	Avoidance of poor emotional well-being experienced by teenage mothers	Cost of private counselling sessions to treat depression	14 x £60	BACP Guidance
	Avoidance of economic disadvantage experienced by young fathers	Difference in income between ave. salary for young people and Job Seeker's Allowance	£138.65/week	ONS 2009 Labour Force Survey, ASHE 2009, Berrington, 2005.
State	Reduced NHS spending on STIs	No. of new STI diagnoses likely to be avoided as result of improved sexual health practices of Child/Young Person A. NHS costings.	£26	NICE, 2007.
	Reduced NHS spending on terminations	No. of terminations likely to be avoided as result of improved sexual health practices of Child/Young Person A: ONS Conceptions of women aged under 18; 46% of which likely to lead to abortion. NHS costings.	£542	NICE, 2007.
	Reduced NHS spending on ante/post natal care and	Number of pregnancies avoided that lead to birth: 2008 ONS Conceptions to women	£2,811.40	NICE, 2007, Goodman, 2004.

	deliveries.	aged under 18; 54% of which likely to lead to birth. NHS costings. Teenage mothers likely to have 50% more children than women who delay motherhood.		
	Reduced public finance cost of avoiding NEETs arising from teenage motherhood.	Reduced no. of teenage mother NEETs: 2008 ONS Conceptions to women aged under 18, 54% likely to lead to birth, 90% of teenage mothers likely to become NEETs.	£7,538	Coles, 2010.
	Reduced spending on SEN support through schooling.	Reduced no. of children of NEET teenage mothers who require SEN support through schooling. Ave. annual costs of SEN support per pupil.	£634.78	Berrington, 2005, KPMG, 2006.

3.8 Input costs

Speakeasy received a grant of £269,000 in 2010/11for central costs from the Department for Education. Additional costs were incurred at the local authority level for administration and delivery of the courses. Four local authorities- Medway, Stockport, Kent, and Durham - employed a full time staff member to administer the project at a cost of approximately £25,000 each. Administration responsibilities in the remaining 40 local authorities were estimated at 3 hours a week incurring an annual cost of £2,000 for each local authority.

All 44 local authorities incurred the cost of employing facilitators to deliver the course. With a total of 104 courses delivered in 2010/11, each involving two facilitators working for a total of 16 hours at a cost of £12 per hour, this came to a total of £39,936.

The total of administration and delivery costs for local authorities was £219,936.

Table 3.8 sets out the input costs of the project. All costs were supplied by FPA.

Table 3.8 Input costs

Category	Description	Total cost, England
Department for Education funding	Children, Young People and Families grant	£269,000
Local authority: administration and delivery of courses in 44 local authorities using full time/part time staff	In kind support	£219,936
Total public spending (DfE + LA)		*£488,936*
Total input costs		***£488,936***

4 Findings

The SROI analysis shows that the Speakeasy project creates value for children, parents and the state. Most significantly, improved sexual health of children is likely for parents who begin the course with low confidence about talking with their children about sex. The individuals in these families also gain a range of other social benefits including:

- Improved engagement between parents and children.
- Improved self-confidence and well-being for parents.
- Improved social networks within local community.
- Reduction in long term negative outcomes (e.g. unemployment, poor health and educational difficulties) that are associated with teenage pregnancies and teenage child-raising.

The total value of the benefits accruing to the Speakeasy programme in England for the 2010/11 financial year was estimated to be £10.5 million. This is the value created to all beneficiaries of the project.

Given input costs of £490,000, this translates into an overall social return on investment of 1:22.

The value of benefits accruing solely to the state is £1 million. This is largely derived from a reduction in NHS costs related to ante/post natal care and deliveries and savings resulting from fewer numbers of teenage mother NEETs.

Given combined spending at local and central government level of about £500,000, every £1 of public money invested in Speakeasy is forecast to create a return to the state of £2.15.

4.5 Share of value

The total value of benefits is derived from outcomes across four stakeholders:

- Children/Young Persons in 'Low Confidence' families (Child A)
- Parents in 'Low Confidence' families (Parent A)
- Parents in 'High Confidence' families (Parent B)
- state, at both local and central level

Chart 4.1 shows the breakdown of social value across these four stakeholders.

Speakeasy makes the greatest difference to children and parents in families where there is not a tradition of open and informed conversation about sexual health: 88% of the total value created from the project flows to children and parents in these 'Low Confidence' families.

In these families, the completion of the course has the potential to lead to parents feeling much better equipped to relate to their children about sex. With improved self-confidence and better information about the subject these parents initiate open and informed discussion with their children. These discussions around sex often become regular features of family life. Parents gain a sense of empowerment from these improved family relations. Children also benefit from improved engagement with their parents.

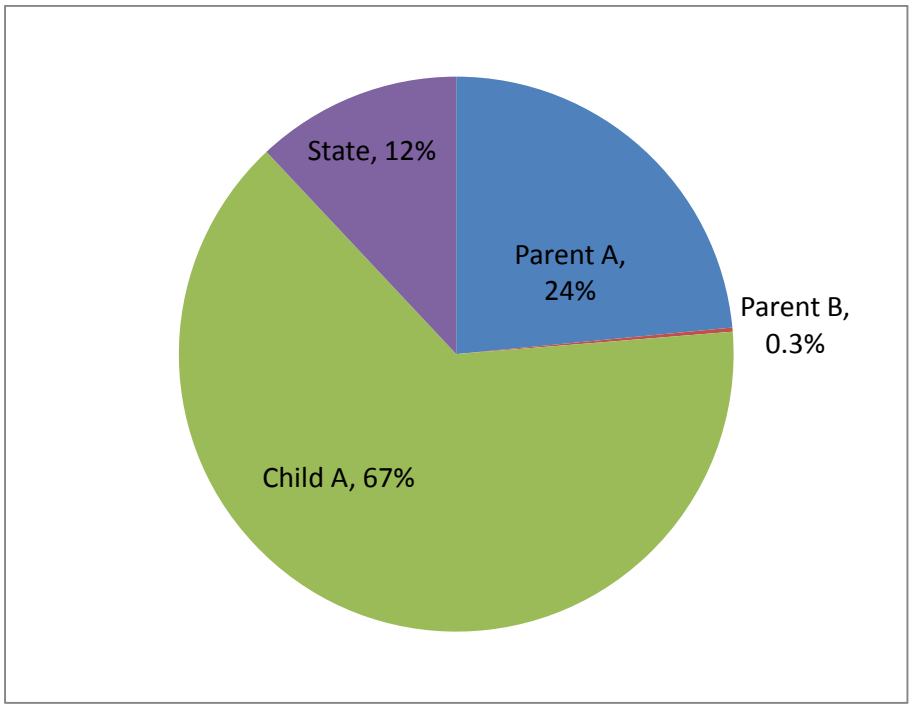
The new open approach towards sex within the family, in turn, is strongly correlated with the children, when teenagers, adopting low risk sexual practices. As these sexual health discussions are often maintained through children's adolescence the benefits of low risk sexual behaviour accrue over an extended period. Young people who engage in low risk sexual behaviour are less likely than their counterparts to catch STIs, become pregnant or become parents.

By comparison, families where there was a tradition of open and informed conversation about sexual health benefit only marginally from the project. Children of parents in this category already enjoyed the benefits of open communication about sex and therefore did not experience any material change as a result of a parent attending the course. Similarly, the parents themselves did not benefit from improved self-confidence and becoming better informed. The only tangible benefits gained by parents were friendships and improved social networks. This outcome represented less than 1% of the total value. Despite this being a small share of value, parents falling into this category still stressed the value of the course. During stakeholder engagement interviews these parents often said that while they do not believe the course had changed their behaviour it had served as a valuable reminder that they were 'doing the right thing'.

The value of benefits to the state represents an 11% share of the total value created. This value is derived from improved outcomes of young people in low confidence families and is composed of:

- £1.1 million in social value due to a reduction in the number of NEETs arising from teenage motherhood.
- £250,000 reduced NHS expenditure on STI treatment, pre/post natal care, deliveries and terminations.

Chart 4.1



4.6 Sensitivity Analysis

This step in the SROI methodology systematically varies assumptions in order to test for areas of sensitivity in the model. These are assumptions that, when changed, significantly affect the ratio. A key issue worthy of attention with the Speakeasy model is the large proportion the total value produced by the Child A outcome, 'better engagement with parents'. This outcome is calculated at producing £6.5M in value, representing 50% of total value produced by the project. By testing the sensitivity of changes to the key assumptions of the outcome we can investigate whether and to what extent the total ratio is affected.

A further issue worthy of attention was the calculation of the monetary value of in-kind inputs provided by the local authorities involved in the administration and delivery of the Speakeasy courses. Because this figure represents a substantial proportion (45%) of total input costs it is important to test whether the total ratio is substantially affected by a higher estimate.

Another issue investigated was the robustness of proposed state outcomes by considering the sensitivity of changes to NEET costs, the largest single contribution to the value of state outcomes in the model.

Finally, we used a sensitivity analysis to test the lower level of the confidence interval of 7% for the samples of both parents and children. The sample sizes gave 95% confidence that the proportions estimated for the parent and children groups were within 7% of their true figure. That means that, at worst,

the quantities estimated were 7% too high. To test for the impact of this possibility all the quantities were reduced by 7%.

Full details of the sensitivity analyses conducted are set out in Appendix 4.

The model was largely resistant to changes in the assumptions tested. Introducing substantially more conservative assumptions for the 'better engagement with parents' outcome did not significantly reduce the total benefits or SROI ratios. The largest impact among the changes tested, was caused by reducing the valuation by 50%, which reduced the SROI ratio by 25%. Similarly, doubling the estimated cost of local authority support did not have a major impact on ratios, reducing the overall SROI and State ratios by 18%.

Details of the six sensitivity tests undertaken and the results were as follows:

1. **Reducing the benefit period of 'better engagement with parents' from 16 to 8 years**

   This change had limited effect on total benefits and the overall SROI ratio. Benefits were reduced from £10.4M to £9.1M and the ratio from 21.31 to 18.62. State ratios were unaffected by the change.

2. **Reducing the valuation of 'better engagement with parents' from £600 to £300**

   This change had some effect on aggregate outcomes. Total benefits were reduced from £10.4M to just under £7.8M and the overall SROI ratio fell from 21.31 to 15.86. State ratios were unaffected by the change.

3. **Increasing the drop-off for 'better engagement with parents' from 10% to 20%**

   This change had limited effect on total benefits and the overall SROI ratio. Benefits were reduced from £10.4M to £8.5M and the ratio from 21.31 to 17.31. State ratios were unaffected by the change.

4. **Testing the lowest scenario of the confidence interval by reducing quantities**

   The sample size used for the parent and children surveys produced a 95% confidence that findings had a confidence interval of 7% (see Table 3.1). This meant that, at worst, the proportion of parents and children estimated in each category was 7% too high. To see the impact of this lowest scenario produced by the confidence interval we

reduced quantities of parents and children by 7%. This change produced only a modest reduction in total benefits and only limited impact on the overall return, which became 19.83. State social returns experienced small reductions, with an overall state ratio of £2.01 and a DoE ratio of £3.65.

5. Increasing local authority costs by 50%

This change had no effect on total benefits but some effect on the overall SROI ratio. The SROI ratio was reduced from 21.31 to 17.38. The overall State ratio was reduced from £2.15 to £1.75 while the DoE ratio remained unchanged.

6. Reducing NEET costs by 50%

The study used recent academic research to identify the likely costs to the state of a teenage mother who, after having her first child, is neither in employment, education nor training (NEET). The research identified average costs over a lifetime for a teenage mother NEET. The most conservative estimate for this aggregate cost was used for the SROI model. To test the sensitivity of this variable the yearly NEET costs were reduced to £3,769. This change produced only a modest reduction in total benefits and very limited impact on the overall return, which became 20.46. State social returns experienced some reduction, with an overall state ratio of £1.30 and a DoE ratio of £2.37.

4.7 Recommendations

The courses were very positively received by parents, nearly all of whom said they had gained something from completing the course. During stakeholder engagement parents remarked that the course had offered an innovative approach to learning that made the experience enjoyable as well as rewarding. Only those parents that before the course had an open style of communicating about sex did not experience improved sexual health communication with their children as a result of attending the course. If the FPA or local authorities delivering Speakeasy course wanted to maximise benefits of delivering the course it might be possible to do this by selecting applicants on the basis on their reported confidence/knowledge levels on talking to their children about sex. No suggestions for significant changes were received from stakeholder parents.

Given the popularity of the Speakeasy course, the sole recommendations emerging from this SROI study relate to data gathering and outcome measurement. Specifically, it is recommended that the FPA set up a systematic framework for monitoring social outcomes from parent and child

stakeholders. Data gathering should cover the range of outcomes identified in this study including self-confidence, well-being and family relations of stakeholders as well as the intended outcomes, sexual practice and parent-child communication on sexual health. FPA should also aim to gather data on the impact of the course beyond the immediate family by interviewing and surveying relations and friends the family are in contact with. Previous research has offered anecdotal reports regarding wider impact and systematic research would enable investigation and measurement of this phenomenon. Resources permitting it may also be possible to investigate whether better engagement by parents and children regarding sexual health has a knock-on effect in improving parental support for children's education. Longitudinal survey questions can identify whether parental support on education is correlated with improved engagement on sexual health. To achieve conclusive findings, however, it would be necessary to create a control group of families who had not received the intervention, and observe how behaviours differed with the Speakeasy families.

Further development of data gathering would also provide an opportunity to corroborate the impact on sexual health of Speakeasy teenage children. The current study relied upon the outcomes observed in the Hutchinson study and attitudinal changes of children regarding sexual practice to project likely sexual behaviour. Projected changes in sexual behaviour – abstinence and safe sex – were then used to calculate a range of sexual health outcomes, including avoidance of STIs, avoided pregnancies and abortions, and avoidance of social and health conditions associated with teenage parenthood (e.g. poor well-being and NEET). The significant contribution of these sexual behaviour-related outcomes to the total calculated value of the project makes it important to gather direct evidence on sexual health if at all possible.

A study of Speakeasy would therefore be significantly strengthened if all the Speakeasy children and those in the proposed control group were monitored in the years following parents attending the course. These children could be surveyed annually for an extended period asking for incidence over the previous 12 months of key sexual health conditions, including diagnosed STIs, pregnancies, and terminations. This longitudinal data would provide robust evaluative evidence on the impact of the project on sexual health.

Finally, a further improvement related to research on outcomes would be to gather feedback from the different state agencies that are affected by the project outcomes. For example, it would be useful to interview representatives from the Department of Work and Pensions, local health services, and local education services to gain feedback on the theory of change and valuations proposed. This additional contribution to stakeholder engagement would strengthen the overall SROI analysis.

5. Reporting

The report has been sent in advance of publication to all participants in the parent survey. Recipients were encouraged to offer feedback. Responses received expressed support for the veracity of findings. Some comments suggested that monetary valuations of non-traded outcomes were inherently problematic and difficult to assess. Respondents further suggested that questions could be better worded to ensure that interviewees understood that they were being asked to identify what paid-for activity generated an equivalent outcome to the Speakeasy outcome.

The FPA are committed to proactively disseminating the report to stakeholders who have been involved in the project. When the report is launched FPA will make the report available on its website and distribute hard copies to families via local partners. A number of local events aimed at parents and children are scheduled to advertise the report and encourage interest in the project.

6. Conclusion

Sexual health is central to health and well-being. As young people grow up they make choices regarding sexual behaviour that can have a dramatic impact on their own personal development and wider society. Attitudes and behaviour towards sex are developed early in life and go on to impact sexual behaviour in later life.

FPA's Speakeasy project is premised on the notion that the family is a primary source of socialisation for children and young people and can have a strong influence on sexual attitudes and behaviours. The Speakeasy course is designed to give parents the skills and confidence to support their children in their sexual development and help them make informed choices about sexual behaviour.

The present study has forecast the social value created by Speakeasy in England for the 20010/11 financial year.

Based on stakeholder engagement and existing research, material outcomes that result from the project were identified. These included:

- Improved sexual health practices of young people in families where parents are lacking in confidence prior to starting the course.
- Reduction in the incidence of negative long term outcomes (e.g. unemployment, poor health, and educational disadvantage) associated with teenage motherhood.
- Improved family relations and engagement between parents and children.
- Improved social networks.

The SROI analysis estimates that the total value created by Speakeasy to children, parents/carers and the state exceeds the costs of the project, with a return on investment ratio of 1:22.

The value of benefits to the state, at local and national level, is estimated to be £1.2 million. This is made up of savings on costs associated with young parenthood and health costs associated with pregnancies, terminations and STIs.

A teenage girl who becomes pregnant typically costs the state an additional £400,000 over her lifetime as a result of economic inactivity, welfare support and health services. Speakeasy is calculated to generate £1M in benefits by reducing the number of teenage mother NEETs. The value to the state generated by Speakeasy represents a return of £2.42 for every pound of public money invested in the project.

The most significant difference – representing 88% of the total value – is made to children and parents in families where there is not a tradition of open and informed conversation about sexual health. In these families, the course contributes to greater confidence about talking about sex and leads to more

open and informed discussion with their children. These discussions around sex often become regular features of family life. As research has shown, these conversations have a significant impact on encouraging teenage children to act responsibly in regards to sex.

The course was well received by parents that participated in the SROI analysis and no significant suggestions for improvement were received.

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Appendix 1

Speakeasy Parent Interview

1. When did you complete the Speakeasy course?

2. Ages of children?

3. What was your experience of the course? Please explain

4. Did the course have any effect on yourself? If yes, please explain…Please consider any negative effects if you haven't already done so.

5. How long did this change last?

6. Did it have any effect on how you interact with others? If yes, please explain. Please consider any negative effects if you haven't already done so.

7. How long did this change last?

8. Please give examples of things you did as a result of that change…

9. If 4 or 6=Yes, Do you think the changes in your knowledge/attitudes/behaviour would have occurred without attending the course? Please explain.

10. If 4 or 6=Yes, Do you think the changes in your knowledge/attitudes/behaviour you mention have been influenced by exposure to other initiatives or experiences? Please explain.

11. To confirm- you have said you experienced the following changes as a result of the course

12. Are there any other changes you have experienced not already mentioned? Please explain.

13. Do these changes have value to you in their own right or are they primarily important because they lead to another activity? Please explain

Your responses indicate that you experienced changes in….

14. Please rank these changes in order of importance, 1=least important 4=most important

15. If you had to compare these experiences with things that you pay for (which result in similar experiences), what would be the equivalent of answer 1, answer 2, etc?

Speakeasy Children (teenagers) Interview

Your parent completed a course on sexual health in [month/year].
I would like you to think about whether and how things have changed for you personally and within the family since then.

1. Thinking back to [month,year], were you aware that your parent was taking the course? If yes, please explain how.

2. What changes, if any, do you remember in your parent's behaviour? Please explain…Please consider any negative effects if you haven't already done so.

3. Have the changes in your parent's behaviour continued since [month, year]? Please explain.

4. Did these changes affect in any way your knowledge, attitudes or behaviour? Please explain. Please consider any negative effects if you haven't already done so.

5. If 4=Yes, Were these changes lasting? Please explain.

6. If 4=Yes, Were these changes that were reinforced or influenced by other factors at a later stage? Please explain.

7. If 4=Yes, Do you think the changes in your knowledge/attitudes/behaviour would have occurred without the changes in your parents' behaviour? Please explain.

8. If 4 or 6=Yes, Do you think the changes in your knowledge/attitudes/behaviour you mention have been influenced by exposure to other initiatives or experiences? Please explain.

9. Are there any other changes you have experienced not already mentioned? Please explain.

10. To confirm- you have said you experienced the following changes as a result of your parent attending the course…

11. Do these changes have value to you in their own right or are they primarily important because they lead to another activity? Please explain

12. Please rank these changes in order of importance, 1=least important 2=most important

13. If you had to compare these experiences with things that you pay for (which result in similar experiences), what would be the equivalent of…answer 1, answer 2, etc?

Appendix 2

Speakeasy Parent Survey

Before course

1. Overall knowledge about sexual health, 1-5 scale, 1=very poor knowledge, 5=very good knowledge

Knowledge of following subjects…1-5 scale, 1=very poor knowledge, 5=very good knowledge

2. Sexually Transmitted Infections – STIs
3. Contraception
4. Sexual relationships

5. How confident were you talking about sex/body changes with your children? 1-5 scale, 1=very unconfident, 5=very confident

6. Please estimate how informed were these conversations? 1-5 scale, 1=very poorly informed, 5=very well informed

7. What was the frequency of these conversations?

    - More than once a week
    - Once a week
    - Once a fortnight
    - Once a month
    - Once every three months
    - Once every six months
    - Once a year or less
    - Did not have these conversations

8. Overall, how self-confident were you? 1-5 scale, 1=very unconfident, 5=very confident

Well-being measure (composite index measuring positive feelings and resilience)

9. I felt good about myself- 1-5 scale, 1=strongly disagree 5=strongly agree

10. When things went wrong in my life, it generally took me a long time to get back to normal, 1-5 scale, 1=strongly agree 5=strongly disagree

Objective indicators of self-confidence and well-being based on family relations

11. Frequency of family socialising together (not including mealtimes and lasting 1 hour or more), 1-5 scale, 1=not at all or rarely, 2=once a week, 3=twice a week, 4=2-3 times a week 5=every day or more

12. Going out with friends and/or extended family1-5 scale, 1=not at all or rarely, 5=once a week or more

<u>Immediately after course</u>

13. Overall knowledge about sexual health, 1-5 scale, 1=very poor knowledge, 5=very good knowledge

Knowledge of following subjects…1-5 scale, 1=very poor knowledge, 5=very good knowledge

14. Sexually Transmitted Infections – STIs
15. Contraception
16. Sexual relationships

17. How confident were you talking about sex/body changes with your children? 1-5 scale, 1=very unconfident, 5=very confident

18. Please estimate how informed were these conversations? 1-5 scale, 1=very poorly informed, 5=very well informed

19. What was the frequency of these conversations?

- More than once a week
- Once a week
- Once a fortnight
- Once a month
- Once every three months
- Once every six months
- Once a year or less
- Did not have these conversations

Thinking about what might have happened if you hadn't attended the Speakeasy course:

20. What would the likely frequency of these conversations have been?
    - More than once a week
    - Once a week
    - Once a fortnight
    - Once a month
    - Once every three months
    - Once every six months
    - Once a year or less

- Probably would not have had these conversations
- Don't know

21. Overall, how self-confident were you? 1-5 scale, 1=very unconfident, 5=very confident

Well-being measure (composite index measuring positive feelings and resilience)

22. I felt good about myself- 1-5 scale, 1=strongly disagree 5=strongly agree

23. When things went wrong in my life, it generally took me a long time to get back to normal, 1-5 scale, 1=strongly agree 5=strongly disagree

Objective indicators of self-confidence and well-being based on family relations

24. Frequency of family socialising together (not including mealtimes and lasting 1 hour or more), 1-5 scale, 1=not at all or rarely, 2=once a week, 3=twice a week, 4=2-3 times a week 5=every day or more

25. Going out with friends and/or extended family1-5 scale, 1=not at all or rarely, 5=once a week or more

26. Did you make friends in course? – If so, have you had social contact with these friends outside of course (eg phone conversation, social meeting, or social outing)

Now

27. Overall knowledge about sexual health, 1-5 scale, 1=very poor knowledge, 5=very good knowledge

Knowledge of following subjects…1-5 scale, 1=very poor knowledge, 5=very good knowledge

28. Sexually Transmitted Infections – STIs
29. Contraception
30. Sexual relationships

31. How confident are you talking about sex/body changes with your children? 1-5 scale, 1=very unconfident, 5=very confident

32. Please estimate how informed are these conversations? 1-5 scale, 1=very poorly informed, 5=very informed

33. What is the frequency of these conversations?

- More than once a week

- Once a week
- Once a fortnight
- Once a month
- Once every three months
- Once every six months
- Once a year or less
- Do not have these conversations

34. Overall, how self-confident are you? 1-5 scale, 1=very unconfident, 5=very confident

Well-being measure (composite index measuring positive feelings and resilience)

35. I feel good about myself- 1-5 scale, 1=strongly disagree 5=strongly agree

36. When things go wrong in my life, it generally takes me a long time to get back to normal, 1-5 scale, 1=strongly agree 5=strongly disagree

Objective indicators of self-confidence and well-being based on family relations

37. Frequency of family socialising together (not including mealtimes and lasting 1 hour or more), 1-5 scale, 1=not at all or rarely, 2=once a week, 3=twice a week, 4=2-3 times a week 5=every day or more

38. Going out with friends and/or extended family1-5 scale, 1=not at all or rarely, 5=once a week or more

39. Are you still in contact with any friends you made on course?

Valuation of outcomes

Your responses indicate that you experienced changes in [dynamic routing] a) self-confidence b)well-being c)engagement on sexual health with children d)social networks

Please rank these factors in order of importance to you, 1=least important 4=most important

Please try to value these experiences by estimating an equivalent with the following things that you pay for. Please estimate how your experience compares to the suggested examples: i.e. whether it is equal to a fraction of the example, a rough equivalent, or a number of times of that example.

40. Your improvement in self-confidence:

    A 4 hour course on improving self-esteem

41. Your improvement in well-being due to better family relations:

    Family day excursion, eg to theme park or beach

42. Your improved engagement on sexual health with your children:

    Hourly private tuition on a school subject a child is struggling with

43. Your improved social life due to friends made on course:

    Meal for two with drinks in restaurant

Speakeasy Children (teenagers) Survey
Your parent completed a course on sexual health in [month/year].
I would like you to think about the conversations about sex with your parents, your own knowledge and confidence about sex, and your own sexual behaviour as well as your general relationship with your parents. I will ask you to assess how these things have changed (if at all) since your parent took the course.

<u>Before parent attended course</u>

1. How confident were you talking about sex/body changes with your parents? 1-5 scale, 1=very unconfident, 5=very confident

2. How often did you have conversations about body changes or sexual health?

    - More than once a week
    - Once a week
    - Once a fortnight
    - Once a month
    - Once every three months
    - Once every six months
    - Once a year or less
    - Did not have these conversations

3. Please estimate how informed were these conversations? 1-5 scale, 1=very poorly informed, 5=very well informed

4. 'My parents were approachable and understanding on the subject of sex'? 1-5 scale, 1=disagree strongly, 5= agree strongly

5. [If age applicable] How confident did you feel about the subject of sex? 1-5 scale, 1=very unconfident, 5=very confident

6. Please estimate your overall knowledge about sexual health at that time, 1-5 scale, 1=very poor knowledge, 5=very good knowledge

7. [If age applicable] What was the likelihood of you having sexual intercourse if the situation arose? 1-5 scale, 1=highly unlikely, 5=highly likely

8. [If age applicable] If you did have sexual intercourse, what was the likelihood of using condoms? 1-5 scale, 1=highly unlikely, 5=highly likely.

9. Frequency of family socialising together (lasting 1 hour or more), 1-5 scale, 1=not at all or rarely, 2=once a fortnight, 3=once a week, 4=2-3 times a week 5=every day or more

<u>Immediately after parent attended course</u>

10. How confident were you talking about sex/body changes with your parents? 1-5 scale, 1=very unconfident, 5=very confident

11. How often did you have conversations about body changes or sexual health?

    - More than once a week
    - Once a week
    - Once a fortnight
    - Once a month
    - Once every three months
    - Once every six months
    - Once a year or less
    - Did not have these conversations

12. Please estimate how informed were these conversations? 1-5 scale, 1=very poorly informed, 5=very well informed

13. Were your parents approachable and understanding on the subject of sex? 1-5 scale, 1=disagree strongly, 5= agree strongly

14. [If age applicable] How informed did you feel about the subject of sex? 1-5 scale, 1=very uninformed, 5=very informed

15. [If age applicable] How confident did you feel about the subject of sex? 1-5 scale, 1=very unconfident, 5=very confident

16. Please estimate your overall knowledge about sexual health at that time, 1-5 scale, 1=very poor knowledge, 5=very good knowledge

17. [If age applicable] What was the likelihood of you having sexual intercourse if the situation arose? 1-5 scale, 1=highly unlikely, 5=highly likely

18. [If age applicable] If you did have sexual intercourse, what was the likelihood of using condoms? 1-5 scale, 1=highly unlikely, 5=highly likely.

19. Frequency of family socialising together (lasting 1 hour or more), 1-5 scale, 1=not at all or rarely, 2=once a fortnight, 3=once a week, 4=2-3 times a week 5=every day or more

Now

20. How confident are you talking about sex/body changes with your parents? 1-5 scale, 1=very unconfident, 5=very confident

21. How often do you have conversations about body changes or sexual health?

    - More than once a week
    - Once a week
    - Once a fortnight
    - Once a month
    - Once every three months
    - Once every six months
    - Once a year or less
    - Did not have these conversations

22. Please estimate how informed are these conversations? 1-5 scale, 1=very poorly informed, 5=very well informed

23. Are your parents approachable and understanding on the subject of sex? 1-5 scale, 1=disagree strongly, 5= agree strongly

24. How informed did you feel about the subject of sex? 1-5 scale, 1=very uninformed, 5=very informed

25. How confident do you feel about the subject of sex? 1-5 scale, 1=very unconfident, 5=very confident

26. Please estimate your overall knowledge about sexual health, 1-5 scale, 1=very poor knowledge, 5=very good knowledge

27. What is the likelihood of you having sexual intercourse if the situation arose? 1-5 scale, 1=highly unlikely, 5=highly likely

28. [If age applicable] If you did have sexual intercourse, what would be the likelihood of using condoms? 1-5 scale, 1=highly unlikely, 5=highly likely.

29. Frequency of family socialising together (lasting 1 hour or more), 1-5 scale, 1=not at all or rarely, 2=once a fortnight, 3=once a week, 4=2-3 times a week 5=every day or more.

Valuation of outcomes

Your responses indicate that you experienced changes in [dynamic routing] a) better engagement with parents b) improved sexual health

Please rank these factors in order of importance to you, 1=least important 2=most important

Please try to value these experiences by estimating an equivalent with the following things that you pay for:

Your improved engagement with parents:

30. A week holiday to European destination

Your improved sexual health

31. Average weekly expenditure by 14-18 year olds on personal healt

Appendix 3 SROI Model

Stakeholders	Stakeholders' Objectives	Inputs		Outputs	The Outcomes								Deadweight %	Displacement %	Attribution %	Drop off %	Impact	Outcomes Total
Who changes? Who wants change?	What they want to change	What they invest (description)	What they invest (value £)	Summary of activity (quantified)	Description	Indicator	Source	Quantity	Duration	Financial Proxy Description	Value	Source	What would have happened anyway?	What activity did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Outcomes times proxy less attribution and deadweight	
Parent A	seek to gain confidence and knowledge about talking to children about sexual health	complete Speakeasy course	0	Course completed	Improved engagement with children on sexual health	conversations more informed AND at or above pre course frequency	Stakeholder Engagement Parent Survey (70% of parents) - Q6/18, 7/19	798	16	Value of estimated equivalent (15 hrs private tuition for child) to improved engagement on sexual health with child	£300.00	Stakeholder Engagement Parent Survey - Q42 (ASHE 2009)	10%	0%	10%	10%	£193,914	£1,579,813.44
					Improved self-confidence	2 pt improvement in self-confidence AND higher score on 'going out with friends'.	Stakeholder Engagement Parent Survey (65% of parents A) - Q8/21, 12/25	519	16	Value of estimated equivalent (2x 4 hr course on improving self-esteem) to improvement in self-confidence	£216.00	Stakeholder Engagement Parent Survey - Q40 Aquaris coaching)	20%	0%	10%	8%	£80,715	£743,188.70
					Improved social networks	Made friends in course AND social contact with them.	Stakeholder Engagement Parent Survey (70% of parents A) - Q26	559	5	Value of estimated equivalent (restaurant meal for 2) to new friendships made	£40.00	Stakeholder Engagement Parent Survey - Q43	0%	10%	0%	20%	£20,124	£67,648.84
					Increased individual well-being due to better family relations	Parent reported improved well-being AND higher frequency of family socialising	Stakeholder Engagement Parent Survey (45% of parents A) - Q22/23, 11/24	359	16	Value of estimated equivalent (2x annual family day excursions) to improved well-being due to better family relations	£200.00	Stakeholder Engagement Parent Survey - Q41	20%	0%	10%	15%	£51,696	£319,050.11
Parent B	seek to gain confidence and knowledge about talking to children about sexual health	complete Speakeasy course	0	Course completed	Improved social networks	Made friends in course and AND social contact with them.	Stakeholder Engagement Parent Survey (70% of parents B) - Q26	239	5	Value of estimated equivalent (restaurant meal for 2) to new friendships made	£40.00	Stakeholder Engagement Parent Survey - Q43	0%	10%	0%	20%	£8,604	£28,923.21

Stakeholders	Stakeholders' Objectives	Inputs		Outputs	The Outcomes								Deadweight %	Displacement %	Attribution %	Drop off %	Impact	Outcomes total
Who changes? Who wants change?	What they want to change	What they invest (description)	What they invest (value £)	Summary of activity (quantified)	Description	Indicator	Source	Quantity	Duration	Financial Proxy Description	Value	Source	What would have happened anyway?	What activity did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Outcomes times proxy less attribution and deadweight	
Child/Young Person A		child of parent who completes course	0	respond to conversations about sex with parent	Better engagement with parents	Children reporting that parents were more approachable and understanding since completing course AND higher score on frequency of	Stakeholder Engagement Children Survey - Q4/13, 9/19	1676	16	Value of estimated equivalent (3 days holiday) to improved engagement with parents	£600.00	Stakeholde Engagement Children Survey - Q29	20%	0%	0%	10%	£804,480	£6,554,082.32
			0		Improved sexual health practices	Higher score on knowledge and confidence on sexual health AND high likelihood score (4-5) on abstinence and/or use of safe sex.	Stakeholder Engagement Children Survey (74% of Children A) - Q5,6,15,16 27/28	1240	12	Value of estimated equivalent (50% of annual spend on personal health) to improved sexual health	£132.60	Stakeholder Engagement Children Survey - Q30 (ONS 2009 Living Costs and Food Survey)	0%	0%	20%	5%	£131,539	£1,209,213.33
Young Person A - females at risk of becoming teenage mothers			0		avoidance of economic disadvantage experienced by teenage mothers aged 16-30.	Reduced no. of teenage mother NEETs.	ONS Conceptions to women aged under 18, 2008: 54% of which lead to birth: 90% of teenage mothers become NEETs	14.2	14	Difference in income between ave. salary for young people and Job Seeker's Allowance = 138.65/week.	£7,209.80	ONS 2009 Labour Force Surey, ASHE 2009, Berrington, 2005.	0%	0%	20%	5%	£81,903	£839,222.48
			0		avoidance of poor emotional well-being experienced by teenage mothers	Reduced no. of teenage mother NEETs.	ONS Conceptions to women aged under 18, 2008: 54% of which lead to birth:90% of teenage mothers become NEETs; 20% of which likely to	2.8	1	Cost of private counselling sessions to treat depression: 14 x £60	£840.00	BACP Guidance	0%	0%	20%	100%	£1,908	£1,908.48
Young Person A - males at risk of becoming young fathers			0		avoidance of economic disadvantage experienced by young fathers aged 16-30.	Reduced no. of young fathers	No. of births to women aged under 18, as above, 50% of which have responsible father; 38% of young fathers likely to be unemployed.	3.0	14	Difference in income between ave. salary for young people and Job Seeker's Allowance = 138.65/week.	£7,209.80	ONS 2009 Labour Force Surey, ASHE 2009, Berrington, 2005.	0%	0%	20%	5%	£17,304	£177,300.52

The Outcomes								Deadweight %	Displacement %	Attribution %	Drop off %	Impact	Outcomes total
Description	Indicator	Source	Quantity	Duration	Financial Proxy Description	Value	Source	What would have happened anyway?	What activity did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Outcomes times proxy less attribution and deadweight	
Reduced transmission of STIs	Number of STI diagnoses likely to be avoided.	2009 Total no. new STIs diagnosed for young people (0- 24), HPA.	15.1	12	Cost of NHS STI treatment	£26.00	NICE, 2007.	0%	0%	20%	20%	£314	£1,461.51
Reduced number of terminations due to reduced no. of teenage pregnancies	Number of teenage pregnancies likely to be avoided.	ONS Conceptions to women aged under 18; 2008; 46% of which lead to abortions.	13.4	12	NHS cost of terminations	£542.00	NICE, 2007.	0%	0%	20%	5%	£10,272	£94,428.42
Reduced births to teenage girls	Number of deliveries avoided as a result of reduced number of teenage pregnancies.	ONS Conceptions to women aged under 18; 2008; 54% of which lead to birth.	15.8	12	NHS ave cost of antenatal care and delivery	£2,811.40	NICE, 2007.	0%	0%	20%	5%	£35,491	£326,262.65
Reduced public finance cost of avoiding NEETs arising from teenage motherhood.	Reduced no. of teenage mother NEETs.	ONS Conceptions to women aged under 18, 2008: 54% of which lead to birth:90% of teenage mothers become NEETs.	14.2	20	Annual welfare payment costs, lost tax contributions, public finance costs.	£7,538.00	Coles, 2010.	0%	0%	20%	5%	£85,632	£1,098,678.56
Reduced educational costs of avoiding provision of SEN support for children of NEET teenage mothers.	Reduced no. of children of NEET teenage mothers who require SEN support.	children of teenage mothers 20% more likely to require SEN support through primary and secondary school.	3.2	9	Ave. annual per pupil cost of SEN support through schooling	£634.78	Berrington, 2005, KPMG, 2006.	0%	0%	20%	5%	£1,625	£12,017.17

Net Present Value (NPV)	£10,417,142
Investment	£488,936
Social Return	**£21.31**
State Social Return	£2.15
DfE Social Return	£3.90

Appendix 3: Sensitivity analysis

BASE SCENARIO

Total Benefits	£10,417,142
Total Inputs	£488,936
SROI Ratio	21.31

Ratio of value created for the State/total government funding	£2.15
Ratio of value created for DfE funding	£3.90

1. Change: benefit period of 'better engagement with parents' reduced from 16 to 8 years.

Total Benefits	£9,105,917
Total Inputs	£488,936
SROI Ratio	18.62

Ratio of value created for the State/total government support	£2.15
Ratio of value created for DfE funding	£3.90

2. Change: Valuation of 'better engagement with parents' reduced from £600 to £300

Total Benefits	£7,755,996
Total Inputs	£488,936
SROI Ratio	15.86

Ratio of value created for the State/total government funding	£2.15
Ratio of value created for DfE funding	£3.90

3. Change: D
parents' inc

Total Benefit	
Total Inputs	
SROI Ratio	

Ratio of value cre for the State/to government fund	
Ratio of value cre for DfE fundin	

4. Change: Lowest confidence interval test – parent/children quantities reduced by 7%

Total Benefits	£9,693,376
Total Inputs	£488,936
SROI Ratio	19.83

Ratio of value created for the State/total government funding	£2.01
Ratio of value created for DfE funding	£3.65

5. Change: Valuation of local authority inputs increased by 50%

Total Benefits	£10,417,142
Total Inputs	£599,504
SROI Ratio	17.38

Ratio of value created for the State/total government funding	£1.75
Ratio of value created for DfE funding	£3.90

6. Change: R

Total Benefit	
Total Inputs	
SROI Ratio	

Ratio of value cre for the State/to government fun	
Ratio of value cre for DfE fundin	