Solutions for families with neuro-physical disabilities

Social Return on Investment Analysis: Evaluating Four Service Themes at Crann (October 2023 – October 2024)

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Table of Contents

List of Tables 6

List of Figures 8

1. Introduction 11

  1.1 About Crann 11

  1.2 Key Findings 13

  1.3 About this Report 14

  1.4 Scope of Research 15

  1.5 Summary 17

  1.6 Glossary 17

2. Background and Overview of the Context 19

  2.1 Disability Services in Context 19

  2.2 Crann’s Response 20

  2.3 The Services Offered by Crann that have been included in this SROI analysis 22

  2.4 Barriers and Challenges Relevant to Services Included in this SROI 24

3. Methodology 26

  3.1 Overview 26

  3.2 Principles 26

  3.4 Context: The Preceding SROI Forecast (Assured in September 2022) 33

  3.5 Overview of engagement 40

  3.6 Indicators used 42

  3.7 Measuring Change – Analysis Method 68

  3.8 Identifying sub-groups and other stakeholders 70

  3.9 Method Limitations 76

  3.10 Summary 81

4. Theories of Change 82

  4.1 Overview 82

  4.2 Theory of Change for Clients of Psychological Wellbeing Services 83

  4.3 Theory of Change for Clients of Social Capital 84

  4.4 Theory of Change for Clients of Health and Continence 85

  4.5 Theory of Change for Clients of Crann’s Personal Support and Connection Service 86

  4.6 Theory of Change for Parents of Children and Adults Attending In-Scope Services 87

5. Analysis of the change that occurred for Clients of Psychological Wellbeing 88

  5.1 Outcome: Improved mental wellbeing 89

  5.2 Outcome: Increased self-confidence and motivation 91

  5.3 Outcome: Improved ability to manage challenges 94

  5.4 Outcome: Increased support, community and social inclusion 96

6. Analysis of the change that occurred for clients of Social Capital services 99

6.1 Outcome: Improved ability to deal with challenges 100
6.2 Outcome: Increased independence 103
6.3 Outcome: Increased self-confidence 106
6.4 Outcome: Increased social inclusion, support, and community 108
7. Analysis of the change that occurred for clients of Health and Continence services 110
7.1 Outcome: Increased sense of freedom 111
7.2 Outcome: Improved ability to participate in activities and day-to-day life 113
7.3 Outcome: Feelings of empowerment and inclusion in the service provided 116
7.4 Outcome: Improved physical wellbeing 119
7.5 Outcome: Improved peace of mind and confidence in the treatment or management of the issue 121
8. Analysis of the change that occurred for clients of Crann’s Personal Support and Connection service 123
8.1 Outcome: Reduced loneliness 125
8.2 Outcome: Increased hope for the future 128
8.3 Outcome: Increased feelings of acceptance and being accommodated 130
8.6 Outcome: Increased social inclusion, support, and community 132
9. Analysis of the change that occurred for parents of children and adults attending in-scope services (secondary stakeholders) 135
9.1 Outcome: Relief about their child achieving their own outcomes 136
9.2 Outcome: Increased sense of comfort in leaving their child to attend services alone 137
9.3 Outcome: Sense of community and connection with other parents 139
10. Comparison of Forecasted and Evaluated Outcomes: Measuring Change 141
11. Understanding Social Value 144
11.1 Overview 144
11.2 Calculating Inputs 144
11.3 Calculating Value for Outcomes 145
11.4 Calculating quantities for 1st October 2023 – 1st October 2024 147
11.5 Avoiding Over-Claiming 148
11.6 Deadweight and Attribution 149
11.7 Displacement 150
11.8 Sensitivity Analysis 150
11.9 Assessment of Ratio 164
11.10 Comparison of Forecasted and Evaluated Value 166
11.11 Summary 172
12. Verification of the Final Analysis 173
12.1 Internal review and verification 173
12.2 Stakeholder validation of the framework 173
12.3 Planned engagement for verification of the assured report 173
13. Recommendations for Crann 174

13.1 Sustain and expand marketing efforts 174
13.2 Expand service reach and client-base 174
13.3 Strengthen peer support and learning initiatives 174
13.4 Further Promote community inclusion 175
13.5 Consider the potential to enhance Psychological Wellbeing Services 176
13.6 Strengthen the Personal Support and Connection Service 176
13.7 Advocacy for inclusion, accessibility and policy 177
14. Recommendations for future evaluations 179
14.1 Ensure ongoing staff engagement with the SROI programme 179
14.2 Evolve the internal management of recruitment of participants 179
14.3 Review Stakeholder Mapping and Inclusion decisions through stakeholder engagement 179
14.4 Re-validate Theories of Change prior to quantitative data collection 179
14.5 Aim for more robust sampling 180
14.6 Expand sampling to improve representativeness 180
14.7 Explore the feasibility of consistent pre- and post-intervention sampling 180
14.8 Establish longitudinal data collection 181
14.9 Explore opportunities for tracking family unit data 181
14.10 Consider joining up intake and review data with SROI 181
14.11 Run valuation workshops with fresh sample 181
14.12 Ensure comparability of results in repeat SROI Evaluations 181
14.13 Consider the role for a more holistic SROI Evaluation of Crann’s Model of Care 182
15. Be Responsive 182
16. Conclusion 184
17. Bibliography 186
17. Appendices 198
Appendix 1: Qualitative Interview Discussion Guide – Client Theory of Change Defining as part of preceding SROI Forecast (Assured in 2022) 198
Appendix 2: Quantitative Survey – Validating Theory of Change and quantifying change as part of preceding SROI Forecast (Assured in 2022) 201
Appendix 3: Qualitative Insight and Quotes that Informed Final Outcomes 216
Appendix 4: ToC Validation Groups Discussion Guide 226
Appendix 5: Outcome Measurement Surveys 229
Appendix 6: Value Game Analysis and Calculation of Average Estimated Value of Outcomes 256
Appendix 7: Value Map Data 258

List of Tables

Table 1: Themes of services included in scope for the SROI Evaluation ... 17
Table 2: Description of services offered by Crann that have been included in this SROI analysis ... 22
Table 3: Seven principles of the SROI methodology ... 26
Table 4: Stakeholder map and inclusion/exclusion decision-making ... 29
Table 5: Quantity of stakeholders engaged in Evaluation Stage 1 - Qualitative ... 31
Table 6: Themes of services included in scope for the SROI Forecast ... 34
Table 7: Overview of stakeholder engagement in the preceding SROI Forecast (Assured in 2022) ... 35
Table 8: Recommendations from the preceding SROI Forecast (Assured in 2022) and related actions taken ... 36
Table 9: Type of stakeholders engaged by stage ... 40
Table 10: Quantity of stakeholders engaged by stage ... 41
Table 11: Stakeholders engaged by stage, segmented by theme ... 41
Table 12: Stakeholders engaged pre- and post-intervention, segmented by theme ... 42
Table 13: Psychological Wellbeing indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning ... 44
Table 14: Social Capital indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning ... 48
Table 15: Health and Continence indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning ... 53
Table 16: Personal Support and Connection Service indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning ... 59
Table 17: Parents of children and adults attending in-scope services (secondary stakeholders) indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning ... 64
Table 18: Materiality thresholds ... 70
Table 19: Sample size required for segments at +/-10% variance at 95% confidence ... 71
Table 20: Sample size for client type segments in pre- and post- intervention data collection across all four themes ... 71
Table 21: Sample size for age segments in pre- and post- intervention data collection for Psychological Wellbeing ... 72
Table 22: Sample size for gender segments in pre- and post- intervention data collection across all five stakeholder groups ... 73
Table 23: Sample size for service attended segments in pre- and post- intervention data collection across three relevant themes ... 73
Table 24: Number of Crann’s clients with each primary diagnosis ... 73
Table 25: Sample size for disability/diagnosis segments in pre- and post- intervention data collection across all five stakeholder groups ... 74
Table 26: Sample size for number and age of children segments in pre- and post- intervention data collection for Parents as secondary stakeholders ... 74
Table 27: Segments included in exploratory analysis across all five stakeholder groups ... 75
Table 28: Average variance of sample achieved across themes ... 76
Table 29: Summary of outcomes experienced by clients ... 88

Table 30: Comparison of change achieved for 'improved mental wellbeing' across services attended 91

Table 31: Comparison of change achieved for 'increased self-confidence and motivation'.............................. 93

across services attended 93

Table 32: Comparison of change achieved for 'improved ability to manage challenges' across services attended 95

Table 33: Comparison of change achieved for 'increased support, community and social inclusion' across services attended 99

Table 34: Summary of outcomes experienced by clients 99

Table 35: Comparison of change achieved for 'improved ability to deal with challenges' across services attended 103

Table 36: Comparison of change achieved for 'increased independence' across services attended 105

Table 37: Comparison of change achieved for 'increased self-confidence' across services attended 107

Table 38: Comparison of change achieved for 'increased social inclusion, support, and community' across services attended 109

Table 39: Summary of outcomes experienced by clients 110

Table 40: Comparison of change achieved for 'increased sense of freedom' across services attended 113

Table 41: Comparison of change achieved for 'ability to participate in activities and day-to-day life' across services attended 115

Table 42: Comparison of change achieved for 'feelings of empowerment and inclusion in the service provided' across services attended 119

Table 43: Comparison of change achieved for 'improved physical wellbeing' across services attended 120

Table 44: Comparison of change achieved for 'improved peace of mind and confidence in the treatment or management of the issue' across services attended 123

Table 45: Summary of outcomes experienced by clients 124

Table 46: Summary of outcomes experienced by clients 135

Table 47: Self-reported change and mean distance travelled – comparison; Forecast vs. Evaluation 143

Table 48: Overview of value map results.. 144

Table 49: Cost per session, average revenue based on new client contributions.. 144

Table 50: Financial inputs overview by theme and service 145

Table 51: Stakeholder valuation of outcomes and adjustment based on distance travelled 147

Table 52: New clients that attend each service and theme during the SROI Evaluation period....................... 147

Table 53: Number removed from each theme for outcome of "increased social inclusion, support, and community" to avoid double counting 148

Table 54: Estimated deadweight and attribution of outcomes experienced by stakeholders 149

Table 55: Sensitivity analysis for social value of Crann's Services 151

Table 56: Comparing forecasted inputs with actual inputs 166

Table 57: Calculation for clients that attend each service and theme during the SROI Evaluation period 167

List of Figures

Figure 1: Crann's Model of Care Diagram 11

Figure 2: Overview of the SROI Evaluation approach undertaken by Crann between Jan 2023 and Jan 2025 ... 15

Figure 3: Proportion of all engaged stakeholders mentioning each potential secondary stakeholder group 75

Figure 4: Theory of Change for Clients of Psychological Wellbeing Services 83

Figure 5: Theory of Change for Clients of Social Capital Services 84

Figure 6: Theory of Change for Clients of Health and Continence Services 85

Figure 7: Theory of Change for Clients of Personal Support and Connection Service 86

Figure 8: Theory of Change for Parents of Children and Adults Attending In-Scope Services 87

Figure 9: Materiality achieved for Psychological Wellbeing outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit. 88

Figure 10: Analysis of the change achieved for 'improved mental wellbeing' 89

Figure 11: Comparison of distance travelled for 'improved mental wellbeing' across age and gender segments 90

Figure 12: Analysis of the change achieved for 'increased self-confidence and motivation' 91

Figure 13: Comparison of distance travelled for 'increased self-confidence and motivation' across age and gender segments 92

Figure 14: Analysis of the change achieved for 'improved ability to manage challenges' 94

Figure 15: Comparison of distance travelled for 'improved ability to manage challenges' across age and gender segments 95

Figure 16: Analysis of the change achieved for 'increased support, community and social inclusion' 96

Figure 17: Self-rated change achieved for each element of the outcome 'increased support, community and social inclusion' 97

Figure 18: Comparison of distance travelled for 'increased support, community and social inclusion' across age and gender segments 98

Figure 19: Materiality achieved for Social Capital outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit 100

Figure 20: Analysis of the change achieved for 'improved ability to deal with challenges' 100

Figure 21: Language most aligned with this outcome, according to respondents 101

Figure 22: Comparison of distance travelled for 'improved ability to deal with challenges' for children and adults with disabilities 101

Figure 23: Comparison of distance travelled for 'improved ability to deal with challenges' across gender segments 102

Figure 24: Analysis of the change achieved for 'increased independence' 103

Figure 25: Comparison of distance travelled for 'increased independence' across client type and gender segments 104

Figure 26: Analysis of the change achieved for 'increased self-confidence' 106

Figure 27: Comparison of distance travelled for 'increased self-confidence' across client type and gender segments 107

Figure 28: Analysis of the change achieved for 'increased social inclusion, support, and community' 108

Figure 29: Comparison of distance travelled for 'increased social inclusion, support, and community' across client type and gender segments 109

Figure 30: Materiality achieved for Health and Continence outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit 110

Figure 31: Analysis of the change achieved for ‘increased sense of freedom’... 111

Figure 32: Comparison of distance travelled for ‘increased sense of freedom’ across client type and gender segments 112

Figure 33: Analysis of the change achieved for ‘ability to participate in activities and day-to-day life’ 114

Figure 34: Comparison of distance travelled for ‘ability to participate in activities and day-to-day life’ across client type and gender segments.. 115

Figure 35: Analysis of the change achieved for ‘feelings of empowerment and inclusion in the service provided’ 116

Figure 36: Self-reported understanding of the term empowerment 117

Figure 37: Comparison of distance travelled for ‘feelings of empowerment and inclusion in the service provided’ across client type and gender segments 118

Figure 38: Analysis of the change achieved for ‘improved physical wellbeing’ 119

Figure 39: Comparison of distance travelled for ‘improved physical wellbeing’ across client type and gender segments 120

Figure 40: Analysis of the change achieved for ‘improved peace of mind and confidence in the treatment or management of the issue’.. 121

Figure 41: Comparison of distance travelled for ‘improved peace of mind and confidence in the treatment or management of the issue’ across client type and gender segments 122

Figure 42: Materiality achieved for Personal Support and Connection outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit 124

Figure 43: Analysis of the change achieved for ‘reduced loneliness’ 125

Figure 44: Comparison of distance travelled for ‘reduced loneliness’ across client type and gender segments 126

Figure 45: Analysis of the change achieved for ‘increased hope for the future’.. 128

Figure 46: Comparison of distance travelled for ‘increased hope for the future’ across client type and gender segments 129

Figure 47: Analysis of the change achieved for ‘increased feelings of acceptance and being accommodated’ 130

Figure 48: Comparison of distance travelled for ‘increased feelings of acceptance and being accommodated’ across client type and gender segments.. 131

Figure 49: Analysis of the change achieved for ‘increased social inclusion, support, and community’ 132

Figure 50: Comparison of distance travelled for ‘increased social inclusion, support, and community’ across client type and gender segments.. 133

Figure 51: Materiality achieved for Parents of Children and Adults Attending In-Scope Services outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit 135

Figure 52: Analysis of the change achieved for ‘relief about their child achieving their own outcomes’ 136

Figure 53: Analysis of the change achieved for ‘increased sense of comfort in leaving their child to attend services alone’... 137

Figure 54: Analysis of the change achieved for ‘sense of community and connection with other parents’ 139

Figure 55: Proportion of total net value generated by stakeholder type.. 164

Figure 56: Proportion of total net value generated by stakeholder group 164

Figure 57: Proportion of net client value generated per outcome... 165

Figure 58: Proportion of total net value generated by stakeholder type – comparison 168
Figure 59: Proportion of total net value generated by stakeholder group – comparison 169
Figure 60: Proportion of net client value generated per outcome – comparison.. 169

> *"When you come through the door at Crann, everyone is treated the same. There's no acknowledgement of mobility aids or anything, and they support everyone in the family equally."*
>
> **Parent of a child with a disability**

1. Introduction

1.1 About Crann

Crann is a registered charity based in Ovens, County Cork. The organisation was established in 2014, incorporated in 2018 and commenced operations in 2019. As of January 2025, it has a team of 25 staff and turnover of approximately €2 million per year. Crann served 646 clients with a disability and 491 family members across its suite of services between 2019 and the end of 2024. It provides evidence based, high quality services and supports for children, adults and families living with congenital, progressive, or acquired neuro-physical disabilities. Its services are focused on, but not limited to, people who have any of ten diagnoses:

- Arthrogryposis
- Cerebral Palsy
- Hydrocephalus
- Multiple Sclerosis
- Muscular Dystrophy
- Osteogenesis Imperfecta
- Spina Bifida
- Spinal Cord Injury
- Spinal Muscular Atrophy
- Stroke

Crann's vision is an inclusive partnership which empowers children, adults and families living with neuro-physical disabilities towards better health and wellbeing and increased opportunities for participation in education, work and leisure. The organisation utilises an evidence-based, best practice 2Generation (2Gen) Model of Care (illustrated in figure 1) that delivers meaningful outcomes for the children, adults and families who use its services. Services are provided through six core themes, delivering integrated, wraparound care:

- Psychological Wellbeing
- Health and Continence
- Education and Career Pathways
- Mobility
- Independent Living
- Social Capital

It is a core part of Crann's mission to provide a unique service offering and not duplicate services that are already available to people with disabilities in Ireland.

Figure 1: Crann's Model of Care Diagram

In addition to the six core themes, Crann provides a dedicated Client and Family Liaison service. This service is delivered by a specialised team, ensuring families are guided throughout their journey and that services remain coordinated, relevant, and aligned with their unique needs. This team helps families navigate the complexities of disability services, providing continuous support, resources, and expert advice.

Crann's ethos and delivery approach centres on co-ordinated care, which provides families with unique and meaningful support throughout their experience. This approach is embedded across Crann's organisation, both within and beyond service delivery contexts, and is prioritised by all staff. Although relatively intangible, this offering has been highlighted by stakeholders as highly valuable and effective in delivering distinct outcomes. For the purpose of this SROI evaluation, it has been identified through stakeholder engagement (detailed in Section 1.4) and treated as a key 'theme' in this report, under the heading of Personal Support and Connection, ensuring consistency throughout.

The Crann Model of Care, grounded in the Ascend at Aspen Two-Generation (2Gen) approach, addresses health equity by placing families at the centre of specialised, family-centred services. Health equity aims to eliminate disparities in access to and quality of care, particularly for marginalised groups, such as families of children or adults with disabilities (Braveman et al., 2023). The Crann approach recognises that disability impacts not only individuals but also their families, necessitating a holistic model that supports all family members either simultaneously or separately, fostering resilience and overall family well-being.

The Disability Capacity Review to 2032 highlights that current service provision often falls short of meeting the complex needs of individuals with disabilities and their families, necessitating a shift towards integrated, person- and family-centred approaches (Department of Health, 2021). By integrating health and social care supports tailored to the unique needs of families, Crann aligns with recommendations for a collaborative, multidisciplinary response to disability care.

Additionally, the Disability Action Plan 2024-2026 underscores the importance of enhancing access to disability services, reducing unmet needs, and supporting long-term outcomes for individuals and families (Department of Children, Equality, Disability, Integration and Youth, 2023). Crann's focus on whole-family support directly addresses these goals by providing targeted interventions that build the capacity of families to manage the challenges of disability while promoting social inclusion and participation.

Evidence shows that early and sustained interventions can break intergenerational cycles of disadvantage, particularly when they incorporate both child- and parent-focused elements (Sabol et al., 2021). Crann's model builds on this evidence, ensuring that families receive the resources and supports needed to thrive across life stages.

The Lenus study on the lived experiences of families with disabilities highlights the need for services that address systemic barriers and inequities, advocating for models that prioritise empowerment and tailored support (Daly et al., 2015). Crann's approach not only aligns with these principles but also exemplifies the implementation of effective, equity-driven disability care.

Finally, international perspectives on person-centred disability care suggest that integrated, family-centred services improve outcomes for individuals with disabilities and their families by fostering health, independence, and participation in community life (Burke & Bezyak, 2016). The Crann 2Generation model, as an innovative and equity-focused framework, has the potential to serve as a best-practice exemplar for addressing the holistic needs of families living with disability in Ireland.

Crann is the only European organisation in the 600-strong Ascend network. It is also the only organisation in the network to use the 2Generation approach for disability services.

Crann's own research confirms that its services are having a significant impact. Children, adults, siblings, and parents, in particular the child or adult family member with a disability, are reporting improved health and wellbeing, and increased opportunities for participation in work, rest, and leisure.

Crann believes in collaboration with peer organisations to improve the range and quality of supports available. It has several active collaborations in Ireland and the United States across academia and in organisations supporting people with disabilities.

In 2023/24 Crann engaged numerous strategic partners for the purpose of evidencing the 2Gen Model of Care in a disability context:

1. The Crann Centre has established Memorandum of Understanding (MoU) with both University College Cork (UCC) and Munster Technological University (MTU). These collaborations are delivering additional capacity for Engaged Research, programme development and delivery.
2. The Crann Centre has developed a strategic 3-way binational collaboration with UCC and Northwestern University Illinois. This collaboration aims to understand and address the needs of Irish families living with neuro-physical disabilities and produce translatable research.
3. Through another Bi-national collaboration Crann and Turnstone of Fort Wayne Indiana are focused on developing a curriculum and delivery modality which supports children, teen and adult learners to build and enhance their self-advocacy skills so as to increase their engagement/ attainment in education.

1.2 Key Findings

The Social Return on Investment (SROI) Evaluation, which evaluated four of the seven themes of Crann's services (inclusive of Personal Support and Connection), from 1st October 2023 to 1st October 2024 highlights the significant impact these services have had on children and adults with neuro-physical disabilities and their families. This analysis revealed a robust SROI ratio of €3.68 for every €1.00 invested (a 368% return), with sensitivity analysis indicating a range between €3.19 and €5.07, demonstrating the high value generated by Crann's integrated, family-centred approach.

The services addressed unmet needs in Ireland's disability support landscape, which continues to be shaped by systemic challenges such as underfunding, institutional legacies, and long waiting lists. Crann's tailored approach fosters empowerment and builds a sense of community, providing support that is inclusive of both individuals with disabilities and their wider family units.

Key outcomes included increased social inclusion, improved mental and physical wellbeing, and enhanced self-confidence. These align directly with the barriers identified in the context analysis, such as isolation, reduced access to healthcare, and lack of tailored supports. For parents, outcomes like reduced caregiver burden and greater confidence in their child's health, wellbeing and development were especially significant.

The SROI Evaluation further underscored Crann's success in operationalising the 2Gen Model of Care, addressing the interconnected needs of children, adults and their families. Stakeholder feedback consistently highlighted Crann as a unique provider, with clients describing their experiences as transformative and life-enhancing.

The impact delivered demonstrates that Crann's holistic model effectively addresses the nuanced and overlapping needs of people with neuro-physical disabilities, and their families. This report affirms Crann's pivotal role in creating meaningful change and advancing the inclusion of people with disabilities in Ireland. The findings provide a foundation for continued development of services which is equitably funded, and which expands Crann's reach and deepens its impact.

1.3 About this Report

Social Return on Investment (SROI) is a methodology used to evaluate the total value created by an organisation's activities on all of its stakeholders. It draws on well-established methodologies from economics, accounting, and social research.

The Social Return on Investment analysis of Crann's Services was underpinned by the seven guiding principles of social value:

- Involved stakeholders
- Understand what changes
- Value the things that matter
- Only include what is material
- Do not overclaim
- Be transparent
- Verify the result

The SROI method ascertains the value of outcomes experienced by stakeholders and is especially pertinent in valuing "soft" outcomes, or outcomes that do not have a simple market value. The social value is calculated by attributing a financial value to the quantified change experienced by stakeholders, commensurate with the size of the change. For many stakeholders, it is difficult to place a value on a "soft" outcome, like one's mental health, so SROI uses financial value as a proxy for value, allowing for comparison between the value of different outcomes that would otherwise be difficult to compare. These financial proxies represent the value of the change experienced and not the value or cost of the service provided.

The most important component of the SROI is to understand the value that the clients of the services and other stakeholders place on their outcomes, so that we can understand what they value the most. Decisions can then be made to increase that value and avoid actions that reduce it. Involving stakeholders is key to understanding this, so stakeholder views were collected qualitatively from 36 stakeholders and from 228 stakeholders using quantitative surveys during the SROI Evaluation period. Quantitative data was supported by qualitative findings from a mixture of interviews and focus groups, conducted during *Evaluation Stage 1 – Qualitative*. A comprehensive overview of the stages of research involved in the SROI Evaluation are included below, in Section 1.4 and the preceding SROI Forecast method is included at Section 3.4 to provide context. Stakeholders were given the opportunity to review the findings and confirm or clarify their perspectives as well as suggest new insights at each stage.

The value of the outcomes included in this SROI analysis represents the value created by Crann through the in-scope services included in the evaluation, that would otherwise not have happened without the intervention of those services. Any value that would have happened anyway (deadweight) or that is attributable to other interventions (attribution) has been deducted.

1.4 Scope of Research

The purpose of this SROI Evaluation was to evaluate the value created by Crann's services within the in-scope themes, between 1st October 2023 and 1st October 2024.

The in-scope themes for the SROI Evaluation were:

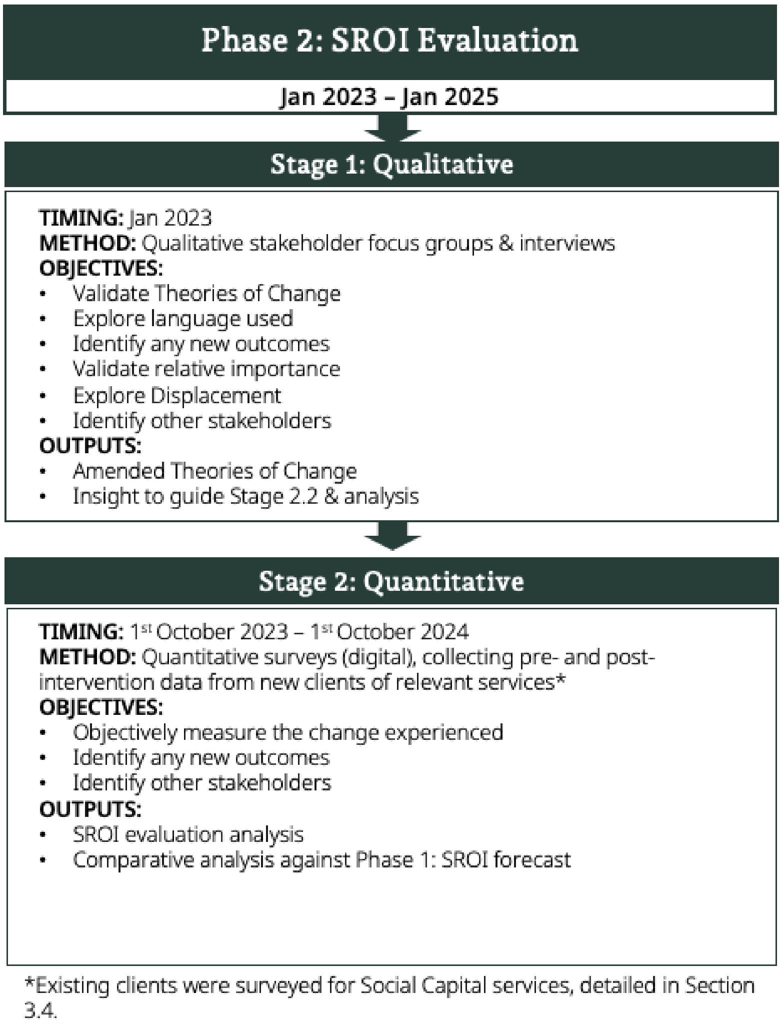
1. Psychological Wellbeing
2. Social Capital
3. Health and Continence
4. Personal Support and Connection

Stakeholder groups in-scope for the SROI Evaluation were:

- Clients of in-scope services:
    - Clients of Psychological Wellbeing services
    - Clients of Social Capital services
    - Clients of Health and Continence services
    - Clients of Personal Support and Connection services

This SROI Evaluation was preceded by an SROI Forecast, covered in detail in Section 3.4 to provide context and as such is named "Phase 2" of the SROI programme. Figure 2 illustrates the two stages of research that have been conducted by Crann as part of this SROI Evaluation. A description of the approach follows figure 2 and more detail on stakeholder engagement and methodology can be found in Chapter 3.

Figure 2: Overview of the SROI Evaluation approach undertaken by Crann between Jan 2023 and Jan 2025



Phase 2: SROI Evaluation

Jan 2023 – Jan 2025

Stage 1: Qualitative

TIMING: Jan 2023
METHOD: Qualitative stakeholder focus groups & interviews
OBJECTIVES:

- Validate Theories of Change
- Explore language used
- Identify any new outcomes
- Validate relative importance
- Explore Displacement
- Identify other stakeholders

OUTPUTS:

- Amended Theories of Change
- Insight to guide Stage 2.2 & analysis

Stage 2: Quantitative

TIMING: 1st October 2023 – 1st October 2024
METHOD: Quantitative surveys (digital), collecting pre- and post-intervention data from new clients of relevant services*
OBJECTIVES:

- Objectively measure the change experienced
- Identify any new outcomes
- Identify other stakeholders

OUTPUTS:

- SROI evaluation analysis
- Comparative analysis against Phase 1: SROI forecast

*Existing clients were surveyed for Social Capital services, detailed in Section 3.4.

The SROI Evaluation (Phase 2) began in January 2022. Within the SROI Evaluation, two stages of research were conducted.

Stage 1

Stage 1 of the Evaluation used in-person qualitative focus groups and interviews to ensure that the ToCs and other findings from the preceding SROI Forecast (Assured in 2022) were validated by stakeholders prior to the design of data collection tools for outcome measurement.

36 stakeholders were engaged in qualitative research during Stage 1 of the Evaluation and the insight gained from this qualitative engagement is included throughout this report. It has been clearly labelled each time it is referenced with *“Evaluation Stage 1 – Qualitative.”*

Stage 2

The SROI Evaluation period began later in 2023, on October 1st, to provide time for Crann and the commissioned Practitioner to validate the Forecast findings, establish an internal team, and ensure quantitative data collection tools were integrated into the service delivery approach.

Stage 2 of the SROI Evaluation used quantitative surveys to capture pre- and post-intervention data against identified indicators (covered in Section 3.6) to measure the change experienced by stakeholders during the SROI Evaluation period.

228 stakeholders were engaged in *Evaluation Stage 2 – Quantitative* across pre- and post-intervention surveys and the data collected is what this SROI Evaluation analysis and SROI Value Calculation have been based on. Each time this data is referenced in the report, it has been clearly labelled with *"Evaluation Stage 2 – Quantitative."*

1.4.3 In-scope services

The themes included in this SROI Evaluation, and the in-scope services included under them, are included in table 1.

Table 1: Themes of services included in scope for the SROI Evaluation

Theme	Services
Psychological Wellbeing	Counselling Play Therapy Sibshops
Social Capital	Social Hub Breaking Barriers Theatre Group
Health and Continence	Continence Clinic Podiatry
Personal Support and Connection	n/a - covered in section 1.1

The SROI Evaluation scope also included parents of children and adults attending in-scope services as secondary stakeholders.

1.5 Summary

Using a 2Gen Model of Care, Crann's mission is to empower families and individuals, fostering better health, wellbeing, and participation in education, work, and leisure. Services are delivered across seven core themes: Psychological Wellbeing, Health and Continence, Education and Career Pathways, Mobility, Independent Living, Social Capital, and Personal Support and Connection. Crann also offers a dedicated Client and Family Liaison service, ensuring holistic, family-centred support that addresses the complex needs of its clients.

This report presents the findings of SROI Evaluation, focusing on four of Crann's service themes: Psychological Wellbeing, Social Capital, Health and Continence, and Personal Support and Connection. It evaluates the value generated during the period from 1st October 2023 to 1st October 2024. The evaluation uses stakeholder engagement through qualitative and quantitative methods, and established methodologies to assess the impact of Crann's services and ensure alignment with client needs and priorities.

1.6 Glossary

Attribution: refers to how much of the change experienced by stakeholders is a direct result of the activity or intervention of the organisation, and how much is due to other organisations or interventions.

Deadweight: is an estimation of the amount of change that would have occurred without the intervention.

Displacement: is an assessment of how much of an outcome may have had a negative impact on other stakeholders, organisations, communities, or other potential outcomes.

Drop-off: refers to the reduction in causality between the intervention and an outcome that continues over a period of time. As time passes, the amount of that outcome which can be assigned to the intervention becomes less.

Duration: the length of time that the effect of an outcome lasts following the intervention.

Financial proxy: an estimation of a financial value for the outcome when a market value does not exist.

Inputs: the resources and investment used to create the interventions included in the SROI report.

Materiality: information is material for the SROI if its inclusion in the analysis would affect the final social value calculation, or decisions made on the basis of the SROI. An outcome is only considered to be material if it considered both significant and relevant by stakeholders.

Outcomes: the changes that are experienced by stakeholders as a result of the intervention. Both intended and unintended, as well as both positive and negative outcomes are included in an SROI.

Outputs: the amount of organisational activity, communicated in numerical units e.g., length of a service, number of participants.

Theme: a group of services offered by Crann which fit in the same area of the model of care e.g., Psychological Wellbeing

Service: an individual support offered by Crann e.g., Counselling. Services within the same area of the model of care make up a theme.

Stakeholders: people and organisations affected by the interventions included in the SROI assessment.

Theory of Change (ToC): the sequence of events and changes that lead to final well-defined outcomes for stakeholders.

Value map: a spreadsheet which contributes to and accompanies an SROI report and contains all the information and calculations for the final assessment.

2. Background and Overview of the Context

2.1 Disability Services in Context

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) describes persons with disabilities as “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (United Nations, 2006).

The most recent data from the 2022 Census in Ireland provides an updated view of the population affected by disabilities. Approximately 22% of the Irish population (1.1 million people) reported having a long-lasting condition or disability. This is a significant increase from the 13.5% reported in the 2016 Census, highlighting that the number of people affected is growing. Notably, 8% of the population experience their disability or condition "to a great extent" (CSO, 2022).

‘Neuro-physical' is a term coined by Crann to describe the cohort of clients they serve and is not a term typically used in the recording of disability prevalence in research or national statistics. In lieu of prevalence data encompassing all neuro-physical diagnoses in Ireland, we have included below data relating to the three most common diagnoses Crann’s clients have received:

- Spina Bifida occurred at a rate of 1.35 cases per 10,000 births in 2022 (EUROCAT, 2024). This represents approximately 8 cases of spina bifida in Ireland in 2022.
- Cerebral Palsy: The National Cerebral Palsy Register published in 2020 reported Cerebral Palsy occurred at a rate of 1.77 per 1000 births in Ireland in 2019 (Criag, Baker & Hensey, 2020). This represents approximately 97 cases per year.
- Stroke: Stroke is the leading cause of acquired adult neurological disability in Ireland and approximately 7,500 people in Ireland suffer from a stroke each year (HSE, 2022).

Best practice asserts the rights of people with disabilities to live as equal citizens within the community, to enjoy good health and wellbeing, to participate fully in educational, social, cultural, religious, economic, and political activities (United Nations, 2006). While substantial progress has been made in many countries in recent years, the world is still far from realising the right to the highest attainable standard of health for people with disabilities, who continue to experience a wide range of health inequities (World Health Organisation, 2022); and children and adults with disabilities in Ireland, and their families, experience significant levels of unmet need for services and supports. This impacts their health and wellbeing and limits their opportunities for participation in education, work, and leisure (Kelly & Maître, 2021 & Moloney et al., 2021). All available research confirms that both adults and children with disabilities in Ireland faced often insurmountable challenges in being able to live valued lives of their own choosing (National Disability Authority, 1996; Moloney et al., 2021; World Health Organization, 2022; Department of Health, 2021). Furthermore, Ireland’s health system ranked 22nd out of 35 countries in the Euro Health Consumer Index 2018 report, with accessibility ranked the lowest (Björnberg & Yung Phang, 2019). The 2024 Euro Health Consumer Index by Country paints a similarly concerning picture for Ireland.

The UN Convention on the Rights of Persons with Disabilities was adopted in 2006. Ireland signed the Convention in 2007, ratified it in 2018, and it entered into force from 19 April 2018 (National Disability Authority, n.d.). The Convention sets out 50 Articles intended to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity. States which ratify the UN Convention commit themselves to delivering civil and political rights to people with disabilities, and to progressive realisation of social and economic rights (United Nations, 2006). However, in October 2021, the Minister of State with responsibility for Disability advised the Oireachtas that the children’s disability teams were short 400 staff and that there are long waiting lists for many services, with over 9,000 children on a waiting list for psychological services (Oireachtas, 2021). The Disability Capacity Review to 2032 also identified significant unmet needs and projected increased demand (Department of Health, 2021). The need for sustainable services that conform to international best practice is strongly evident.

2.2 Crann's Response

Since 2019, Crann has delivered a responsive, holistic, and family-centred solution tailored to the needs of people with neuro-physical disabilities. Building on a comprehensive needs assessment, Crann adapted the Ascend at Aspen 2Generation (2Gen) approach to suit the unique requirements of a disability setting (Mosle & Patel, 2012; Collins, 2017). To evaluate the effectiveness of the 2Gen Model of Care in this context, Crann has established strategic research partnerships with University College Cork, Munster Technological University, the Northwestern University 2Generation Research Initiative, and others. This innovative and proactive approach reflects Crann's vision of transforming how services and supports for people with neuro-physical disabilities are planned, financed, and delivered.

Through its 2Gen Model of Care, Crann places the family at the centre of a coordinated and integrated suite of high-quality services that are designed to improve physical and mental wellbeing and increase participation in society, including education, work and leisure. It considers a variety of pathways for promoting positive, pragmatic, and effective outcomes for the child or adult with a neuro-physical disability and their family members. Crann approaches service provision in a holistic way, through a needs-driven approach that recognises there is no 'one-size-fits-all.'

Many noteworthy sources advise person-centred approaches for disability services (World Health Organisation & World Bank, 2011; World Health Organization, 2022; Department of Health, 2021). Crann's model of care is centred around providing ongoing integrated support for the individual and their family, through education and self-management approaches, opportunities for societal participation and accessible spaces to interact as equals, all of which put the person with a disability and their family at the centre of the experience.

The organisation takes a rights-based approach, rooted in the United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (UN General Assembly, 1993). Crann's adapted 2Gen approach acknowledges the unique dynamics and needs within families where a child or adult has a disability.

The 2Gen approach, as a response to the challenges faced by families with a child or adult with a disability, aims to address the following key issues (Chase-Lansdale & Brooks-Gunn, 2014; Mosle & Sims 2021; Sabol et al. 2021; Tach & Day, 2023):

- The 2Gen approach addresses the diverse and evolving challenges faced by families with a member who has a disability by supporting both the individual and their family simultaneously.
- The 2Gen model ensures individuals and their families receive coordinated and appropriate care.
- Emotional, financial, and logistical pressures are acknowledged by the 2Gen approach, which supports caregivers and family members to alleviate broader challenges.
- The 2Gen model provides resources and support to reduce the burdens of social and economic disadvantages and improve family wellbeing.
- Recognising the long-term nature of disability and caregiving, the 2Gen model delivers adaptable solutions that evolve with families' changing needs.
- By fostering collaboration between healthcare, social services, and education, the 2Gen approach bridges gaps in service delivery, creating a cohesive and holistic support structure for families.

Crann has developed a suite of programmes and services for children, adults and families, which are delivered by experienced professionals, on-site at the Crann Centre and online:

- **Psychological Wellbeing**
  - Counselling
  - Play Therapy
  - Sibshops (Sibfun for younger siblings and Sibshop for older siblings)
  - Parent and Family Workshops
  - Sexual Identity
  - Reflexology
  - Mindfulness Based Stress Reduction (MBSR)
- **Social Capital**
  - Social Hub
  - Breaking Barriers Theatre Group

  - Parents’ Café
  - Conservation @ Crann
  - Accessible Playground & Leisure Area
  - Youth Club
- **Health and Continence**
  - Continence Clinic
  - Podiatry
  - Dietetics
  - Pressure Ulcer Prevention Workshop
  - ‘Mind Your Back’ for Parents & Carers
  - Cervical Check
  - First Aid
  - Professional Education Courses for Nurses, SNAs, Teachers, AIMs Workers, and other professionals
- **Education and Career Pathways**
  - ‘Right Fit Programme’
  - Job Readiness; CV Preparation
  - Vocational Rehabilitation
  - 1:1 Coaching for Education & Career
  - Foundation of IT/AT Skills
  - Paediatric Occupational Therapy
- **Mobility**
  - Skills on Wheels
  - Wheelchair Skills Training
  - Transfer Training
  - Upper Limb Rehabilitation
  - Paediatric Occupational Therapy
- **Independent Living**
  - Functional Task Training
  - Cognitive Rehabilitation
  - Paediatric Occupational Therapy
  - Assistive Technology (AT)
  - Vision and Perception Rehabilitation

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2.3 The Services Offered by Crann that have been included in this SROI analysis

Four themes were in-scope for this SROI Evaluation, and seven individual services are delivered under those themes. Table 2 provides an overview of each theme and service and its delivery model to give context for the analysis

Table 2: Description of services offered by Crann that have been included in this SROI analysis

Theme	Service	Description
Psychological Wellbeing Services Focuses on the mental and emotional health of both individuals with disabilities and their families. By fostering resilience, offering coping strategies and providing emotional support, Crann helps families navigate the challenges associated with disability. This support empowers families to maintain strong, healthy relationships while managing stress and adversity.	Counselling	A one-to-one counselling service delivered in-person and online by a qualified counsellor for adults with disabilities and their family/caregivers. The aim of the counselling service is to support individuals in improving their emotional wellbeing, enhancing their coping skills, and fostering personal growth to navigate life's challenges more effectively.
	Play Therapy	A one-to-one play therapy service, delivered in-person by a qualified play therapist and provided to children and teens with disabilities, and their siblings. The aim of play therapy is to help children to express and work through complex emotions in a safe and fun space through creative and therapeutic play.
	Sibshops	A group workshop, delivered in-person, to a group of siblings (5-12 years old) of children with disabilities. The aim of Sibshops is to create a fun, facilitated, safe space for siblings to explore their feelings and experiences.
Social Capital Services Social connections are fundamental to overall well-being. Crann promotes the development of strong social networks through peer support, social groups, and community advocacy initiatives. By helping families build meaningful relationships and engage with their broader community,	Social Hub	A weekly social group for adults with disabilities, facilitated by a member of Crann's services team. The aim of the Social Hub is to provide a safe and inclusive space where adults with disabilities can come together to build meaningful social connections, enhance their social skills, and engage in activities that promote well-being and personal development.

this service area combats social isolation and strengthens the social fabric. Crann's focus on social capital ensures families feel supported, valued, and integrated within their communities.	Breaking Barriers Theatre Group	A weekly drama workshop, delivered by a team of expert facilitators, in separate offerings for children, teens and adults. The aim of Breaking Barriers Theatre Group is to create a fun, collaborative space that supports individuals with neuro-physical disabilities to develop their confidence through drama.
Health and Continence Services The 2Gen model addresses physical health needs, including healthcare, therapies, and continence care. Crann ensures that families have access to essential healthcare resources, reducing the healthcare burden on caregivers. The focus on dignified care improves comfort and quality of life for all family members, ensuring their physical well-being is met with the highest standards of care.	Continence Clinic	A clinic for individuals and families (i.e. parent and child/teen/adult where relevant), delivered by specialist nursing staff. The aim of the Continence Clinic is to provide specialised support and guidance for individuals and families dealing with continence-related issues, offering tailored care plans to address specific needs.
	Podiatry	A one-to-one podiatry clinic, delivered by a qualified podiatrist for children and adults with disabilities. The aim of the podiatry clinic is to prevent and manage foot and lower leg conditions, enhancing mobility, comfort, and overall well-being.
Personal Support and Connection This theme provides personalised, one-to-one support to individuals with disabilities and their families. By offering tailored guidance and emotional support, it helps clients navigate challenges, fosters trust, and reduces isolation. The service enhances social inclusion, strengthens relationships, and empowers families to manage their unique circumstances with confidence.		Additional support in the form of follow-ups and check-ins with clients, delivered by the services team, client liaison team and front of house staff to all clients of Crann. The aim of the Personal Support and Connection theme is to offer continuous follow-up support, reassurance, and a sense of guidance, ensuring clients feel connected and supported beyond the specific services they receive.

2.4 Barriers and Challenges Relevant to Services Included in this SROI

Disability is an integral part of the human experience, arising from the interaction between a person's health conditions and/or impairments and various environmental and personal contextual factors (World Health Organization, 2022). Originally, disability was seen as an illness that had to be diagnosed and treated; however, with the establishment of the social model of disability in the 1970s, disability has increasingly been considered a result of this interaction (Petasis, 2019). This understanding of disability is grounded in the WHO International Classification of Functioning, Disability and Health (ICF) (WHO, 2001), and the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2006).

This SROI Evaluation considers four themes of services offered by Crann: Psychological Wellbeing, Social Capital, Health and Continence, and Personal Support and Connection. This chapter will examine the barriers and challenges experienced by people with disabilities, in relation to the themes that have been included.

According to the National Ability Support System (NASS) 2023 report on people engaging with disability services, 60% of adults reported having a primary carer and 92% lived with that person. 41% of primary carers were aged 60 years and over (Casey et al., 2023). The NASS annual report 2020 reported that 84% of primary carers were parents (Casey et al., 2020). These findings underscore the significant impact that caring for a child with a disability has on the family unit, particularly on caregivers' roles and responsibilities. This demonstrates the need for family and caregiver support.

The WHO Disability Assessment Schedule 2020 was completed by 4,821 people with a disability, who were over 16 years old, and whose disability was not primarily intellectual. 54% of respondents who filled it out had primarily a neurological condition and 14% had primarily a physical disability. 85% reported some difficulty in overall interference with life and 74% reported emotional effects due to their disability. 64% experienced difficulty in joining in community activities and almost half reported difficulty in dealing with strangers: the same proportion faced difficulties in maintaining a friendship (Casey et al., 2020). This data underscores the profound impact that disability, particularly neurological and physical conditions, has on individuals' daily lives, emotional well-being, and social integration, highlighting the need for targeted support to improve community participation and social connections.

The National Physical and Sensory Disability Database reported in 2018 that people with neurological diagnoses experienced the most restriction participating in:

- Socialising (56%)
- Leisure and cultural activities (49%)
- Living with dignity (37%)
- Community life (37%).

Of those people who experienced restriction, 90% or more stated that those restrictions had a negative impact on them (Doyle & Carew, 2018). This data reveals the significant barriers individuals with neurological diagnoses face in engaging in social, cultural, and community activities, highlighting the urgent need for targeted interventions to reduce these restrictions and improve their quality of life.

According to a survey by Neurological Alliance UK conducted in 2017, a high percentage of people with a neurological diagnosis also have a comorbidity with a mental health diagnosis (Doyle, 2018). The Neurological Alliance Ireland published a report in 2020 in which less than 10% of people stated that counselling services were accessible for them and meet their needs. 9% stated that they could access the service, but it was not sufficient for their needs. 20% of adults with a neurological condition stated that they needed this service but could not get access to it, and 28% of parents stated that their child needed this but could not access it. The figure for those in need of a counselling service but who do not have access is noticeably higher for family carers (48%) and parents of a child with a neurological condition (36%) (Neurological Alliance of Ireland, 2020). This data highlights the significant gap in access to appropriate mental health support for individuals and their families, emphasising the need for improved and accessible counselling services to meet the growing demand and address the dual challenges of neurological and mental health conditions.

People with disabilities are more likely to experience loneliness and isolation, which is linked to depression and other mental health issues (Office for National Statistics, 2019). They are also more likely to experience discrimination, medical trauma and have negative social experiences more regularly; all of which contribute to lower mental wellbeing (Hackett et al., 2020). Families of people with disabilities face their own mental health challenges alongside this and often are not included in primary research, especially family members that aren't parents (Shahali et al., 2024). This underscores the compounded mental health challenges faced by individuals with disabilities and their families, highlighting the need for more inclusive research and targeted support for all family members.

Independence, self-determination, and satisfaction with participation are fundamental aspects for promoting a high quality of life and emotional wellbeing in people with disabilities (Cegarra et al., 2023). Crann's services aim to deliver against all of these outcomes for clients and seek to increase overall wellbeing for people with neuro-physical disabilities and their families.

For many people with a neuro-physical disability the area of incontinence and being able to master their own continence independently is often a major challenge (Eke et al., 2024; Dumoulin et al., 2023). Often described as the hidden disability within the disability, this issue contributes to many of the other challenges such as poorer health outcomes, mental health, isolation, independence, unemployment, and poor self-esteem (Soysal et al., 2023; Matson & Issarraras, 2019). Continence issues can affect both the person with a disability and their family or carer socially, emotionally, and behaviourally (Jaekel et al. 2023). Crann's Continence Clinic provides clients with personalised care plans to support them in improving not only their continence management but also in overcoming related challenges associated with continence issues.

Podiatry was prioritised as a service need by Crann because the client population are at high risk of pressure ulcer development and other foot health issues (Wang, 2015; Sprigle, McNair & Sonenblum, 2020). It is difficult for children and adult clients to access services and follow care due to long waiting lists in acute and primary care. As a result, a lot of people with neuro-physical disabilities end up with serious pressure ulcer issues or other conditions which could easily be prevented if access to a podiatry service was easily available (Wang, 2015; Sprigle, McNair & Sonenblum, 2020; NSW Health, 2021). For this reason and in keeping with Crann's preventative and early intervention approach to health needs, the podiatry clinic at Crann was established.

This analysis highlights the multifaceted challenges faced by people with neuro-physical disabilities and their families, including barriers to social participation, limited access to mental health and counselling services, and the impact of issues such as incontinence and podiatry-related health risks. Crann's services, guided by the 2Gen Model of Care, address these challenges through tailored, innovative solutions that promote independence, self-determination, and overall wellbeing, while also supporting families in their caregiving roles. These efforts underscore the critical importance of holistic, preventative, and family-centred care in improving quality of life for this population.

3. Methodology

3.1 Overview

Social Return on Investment (SROI) is a methodology used to evaluate the value created by an organisation's activities for its stakeholders. It draws on established principles from economics, accounting, and social research to measure and assign value to the material changes experienced by those impacted.

To understand, measure, and value the outcomes experienced by stakeholders, an SROI analysis requires extensive data collection from each stakeholder group that is potentially impacted positively or negatively. Data collected demonstrates whether a stakeholder group is experiencing a material change due to the activities of the organisation or programme being evaluated. The key stakeholder groups for Crann's services included in this SROI analysis are clients of in-scope services and parents of children and adults attending in-scope services. Data is collected from each group, and is supported by supplementary research via primary sources, including expert input, scientific research, and commentary relevant to the findings of the SROI analysis.

3.2 Principles

This SROI Evaluation has been guided by the eight principles of Social Value, which have been developed and defined by Social Value International. These principles informed the methodology, including how stakeholders were involved, how evidence was gathered and reviewed, as well as the approach to valuing outcomes. This chapter explains the key principles and the methodology used for calculating the social return of Crann's services.

Table 3: Seven principles of the SROI methodology

Principle	Description
Principle 1: Involve Stakeholders	Ensuring that stakeholders are involved in each step of the SROI process, is a fundamental part of the approach. Stakeholders were involved in defining and valuing outcomes, determining deductions and quantifying the change experienced. Clients of in-scope services (primary stakeholders) and parents of children and adults attending in-scope services (secondary stakeholders) were involved qualitatively in the identification of outcomes, values and deductions in the preceding SROI Forecast (Assured in 2022). They were also involved directly in the SROI Evaluation, qualitatively in validating the findings of the Forecast, in *Evaluation Stage 1 – Qualitative,* and quantitatively in measuring the change experienced during the SROI period, in *Evaluation Stage 2 – Quantitative*. 36 stakeholders participated qualitatively, and 228 stakeholders participated quantitatively in the SROI Evaluation. All stakeholders were asked who else was impacted, to identify other relevant stakeholder groups. Parents of children and adults attending in-scope services were the only secondary stakeholder group for whom potentially material changes were suggested by primary stakeholders. Siblings and partners as secondary stakeholders were mentioned by a small minority of respondents, but the only change reported for them was noticing the outcomes achieved by the primary stakeholder and this was deemed immaterial. This is covered in more detail in Section 3.8.2. Parents of children and adults attending in-scope services were included in the SROI Evaluation analysis as a secondary stakeholder group. More detail on the SROI Forecast analysis can be found at Section 3.3.1.

Principle 2: Understand what changes	Stakeholder engagement informed the development of Theories of Change in the preceding SROI Forecast (Assured in 2022). The methodology and process for this is included in Section 3.4.3. Focus groups and interviews were conducted in *Evaluation Stage 1 – Qualitative* to validate the forecast findings, including the Theories of Change, and deepen the understanding of the changes experienced. During these engagements, stakeholders were encouraged to share all changes they had experienced, encompassing positive and negative, and allowing for the identification of intended and unintended changes. The Theories of Change developed during the SROI Forecast were affirmed by all stakeholder groups during *Evaluation Stage 1 – Qualitative*, with only minor linguistic adjustments made to ensure accessibility and clarity. These changes are covered under the relevant outcomes in Chapters 5-9.
Principle 3: Value the things that matter	Stakeholder engagement informed our understanding of the relative importance of outcomes and the perceived value attached to them. During the preceding SROI Forecast (Assured in 2022) stakeholders were engaged to rank the outcomes they had experienced in order of importance, and they were involved in two modified value games that encouraged them to determine their own estimated value for each outcome they experienced, for the duration of one year. The outlines for the modified value game methodologies can be found within Appendix 6. To ensure comparability with the preceding SROI Forecast, the stakeholder generated values have been used to calculate the SROI ratio for this SROI Evaluation. However, this approach is listed as a method limitation in Section 3.9 and is mitigated by extensive sensitivity analysis, detailed in Section 11.8.
Principle 4: Only include what is material	Not every change experienced by stakeholders is material for the SROI analysis. Materiality means something that will affect the SROI Value Calculation or something that could affect a decision made if the information is excluded. If it could affect a decision, then the information is considered material. Outcomes were considered material for this SROI Evaluation if they were both relevant and significant to the stakeholder group. Based on this consideration, materiality of the change experienced by primary and secondary stakeholders was measured using a specific scoring system, set out in Section 3.6, to ensure all outcomes met the materiality criteria for inclusion in the value calculation.
Principle 5: Do not over-claim	It is an important consideration within the SROI Evaluation to ensure Crann is not taking responsibility for value it has not created. All value assessments have been undertaken conservatively, and sensitivity analysis has been carried out to assess the impact of more, or less, conservative decision-making around value, deductions and size of change for the outcomes included. To gain a clear understanding of the value of outcomes, it is necessary to also understand other services, people and events that might have contributed to outcomes (attribution), what could have happened without the relevant intervention (deadweight), as well as any outcomes displaced by this activity (displacement). Stakeholders were involved in informing this understanding through qualitative and quantitative research. Drop-off has not been considered in this SROI Evaluation, despite some respondents indicating that outcomes do last longer than the year in which a service was attended. This decision was taken due to the lack of longitudinally tracked data for

	clients in relation to the services included in the analysis. The data collection tools designed for this SROI Evaluation have the capacity to measure the change experienced over time by those who have attended services in the past. In the SROI Evaluation period, it was not possible to collect responses from past clients, due to the need to prioritise collecting adequate data from current clients across pre- and post-intervention surveys, but this will be built into the approach for any following SROI Evaluation, as recommended in Chapter 13. A full explanation of the valuation of outcomes and the approach taken to minimise overclaiming can be found in Chapter 11: Understanding Social Value.
Principle 6: Be Transparent	All of the calculations that were used to generate a Social Return Ratio must be clear and traceable, so that the process is transparent to any reader of the SROI report. A value map, used in the calculation of this ratio, shows a complete record of the calculations, discounts and indicators used to measure the social value of Crann's services. An overview of this value map is included in Appendix 7. The research tools used to gather data are also included in Appendices 3-6. Sensitivity analysis has been conducted, to consider alternative scenarios and test the findings of the SROI Evaluation. This testing provides a range for the SROI ratio, which is considered more accurate than a single figure ratio. Evidence of the sensitivity analysis is included in Section 11.8.
Principle 7: Verify the Results	Every effort was made to represent value for stakeholders in a way that is authentic to their experiences, and this was verified with respondents at each stage of the research process. Dedicated focus groups and interviews were conducted in *Evaluation Stage 1 – Qualitative*, to ensure that the findings from the preceding SROI Forecast were accurate and representative, before any quantitative research tools were designed. No notable changes were indicated, but some minor linguistic developments were made to ensure accessibility and clarity, based on stakeholder input. Development of the SROI model was an iterative process; preliminary findings, including the relative value of outcomes, were also verified in a verification workshop with the Crann staff prior to finalisation.
Principle 8: Be Responsive	Crann has included a statement of intent in Chapter 14 of this report to demonstrate its commitment to responding intentionally to the findings of the SROI Evaluation. Crann has already demonstrated a strong commitment to stakeholder engagement throughout the SROI Evaluation process, from involving staff in data collection to engaging clients in meaningful discussions about their experiences and outcomes. This commitment will continue as Crann acts on the insights provided.

3.3.3 The SROI Evaluation Methodology

The approach taken for this SROI Evaluation was informed by the seven principles of SROI and included seven steps, which are detailed in the following sections.

The SROI Evaluation methodology:

1. Agree the SROI Evaluation scope
2. Identify stakeholder groups
3. *Evaluation Stage 1 – Qualitative*: Validate the preceding SROI Forecast (Assured in 2022)
4. *Evaluation Stage 2 – Quantitative*: Gather data on outcomes
5. Analyse data and conduct supporting research review to clarify assumptions
6. Calculate the value generated for stakeholders

7. Verify findings, develop conclusions and recommendations
8. Report assurance by SVUK

3.3.4 Step One: Agree the SROI Evaluation scope

The scope of the project was agreed across a series of scoping sessions, with Crann's CEO, Head of Services, and the commissioned Practitioner. The agreed focus of the SROI Evaluation was to evaluate the social value generated by four themes of Crann's services: Psychological Wellbeing, Social Capital, Health and Continence, and Personal Support and Connection, in line with the preceding SROI Forecast (Assured in 2022).

The stakeholder groups in scope for this SROI Evaluation were agreed to be clients of in-scope services and parents of children and adults attending in-scope services, based on the identification of these stakeholder groups in the SROI Forecast. All stakeholders involved in the SROI Evaluation data collection at *Evaluation Stage 1 – Qualitative* and *Evaluation Stage 2 - Quantitative*, were asked who else was impacted, to identify any other relevant stakeholder groups. No other stakeholder groups were identified, as covered in Section 3.8.2.

The target audience for this SROI Evaluation is wide-ranging, encompassing multiple stakeholder groups, each of which will be interested in different aspects of the SROI Evaluation, from service effectiveness to social value creation and financial sustainability. A range of outputs will be developed by Crann, following Assurance of this report, to provide relevant and accessible reporting across stakeholder groups:

1. Internal stakeholders:
    a. Management and staff within Crann who are directly involved in service delivery and decision-making need insights into how services are delivering impact to inform operational improvements and future planning.
    b. Board members who oversee the strategic direction and performance of the organisation require evidence of impact to guide strategic decisions and ensure alignment with Crann's mission and goals.
2. Government bodies, foundations, and private donors who provide funding or support are interested in understanding the value and effectiveness of their investments.
3. Individuals using Crann's services, as well as their families, who benefit from the outcomes of the services may be interested in understanding how these services are measured and their potential long-term impact.
4. Government agencies, legislators, and advocacy groups focused on disability services, healthcare, or social welfare can use the findings to inform policies and improve service provision.
5. Local community groups, healthcare providers, and partner organisations working with Crann or in similar fields may use the findings to strengthen collaborations and improve services.
6. Research institutions or academics interested in disability services, social impact, and SROI methodologies can use the data for further studies or development of best practices.

3.3.5 Identify Stakeholder Groups

The stakeholder map was initially developed during the SROI Forecast to identify all stakeholder groups potentially affected by Crann's services. As part of the SROI Evaluation, this map was reviewed and verified through engagement with Crann and primary stakeholders, ensuring it accurately reflects those who experience material outcomes. Materiality applies to any outcome which, if omitted, would affect decisions made as a consequence. The stakeholder map distinguishes between primary beneficiaries, secondary stakeholders, and groups considered but not included in the valuation, based on the principle of materiality.

Table 4: Stakeholder map and inclusion/exclusion decision-making

Stakeholder	Included?	Notes
Primary stakeholders included in the analysis		
Clients attending in-scope services	Yes	Direct beneficiaries of in-scope services, experiencing distinct outcomes, based on stakeholder engagement.
Secondary stakeholders included in the analysis		
Parents of children and adults attending in-scope services	Yes	Indirect beneficiaries experiencing distinct outcomes, based on stakeholder engagement.

Stakeholders excluded from the analysis		
Siblings of children and adults attending in-scope services	No	Indirect beneficiaries, *not* experiencing distinct outcomes, based on stakeholder engagement.
Partners of children and adults attending in-scope services	No	Indirect beneficiaries, *not* experiencing distinct outcomes, based on stakeholder engagement.
External healthcare providers and therapists	No	Deemed *not* materially impacted due to majority of Crann's clients not accessing services independently prior to engaging with Crann
The Irish Government	No	Scale of service deemed immaterial for the Irish Government at present. Covered in table 8.
Crann staff	No	Operational outcomes (e.g. professional development, job satisfaction) could be reasonably expected to be achieved in another job – facilitators of the mission, rather than indirect beneficiaries.
Board of Directors	No	Operational outcomes (e.g. professional development, fulfilment) could be reasonably expected to be achieved in another board position – facilitators of the mission, rather than indirect beneficiaries.
The wider community	No	Clients come from diverse locations, so any indirect community impact is too dispersed to be materially attributable to Crann's services. Also a significant risk of over-claiming since any indirect impact couldn't be attributed to in-scope themes.

The decision to exclude siblings and partners as secondary stakeholders explained

During stakeholder mapping, siblings of adults and children attending in-scope services and partners of adults attending in-scope services were initially hypothesised as potential secondary stakeholders. However, during the qualitative stakeholder engagement conducted for the SROI Forecast, no clear, distinct, and material outcomes were identified for either group. Based on this lack of materiality, the decision was made to exclude both stakeholder groups from the valuation.

To ensure that all relevant stakeholders were identified, participants in the SROI Evaluation were asked to suggest any other stakeholders who were indirectly impacted by their engagement with in-scope services.

No additional stakeholder groups were identified in qualitative interviews.
In the quantitative survey, only 2% of total respondents (n=5) indicated that their sibling had been indirectly impacted, and <1% (n=2) indicated the same for their partner.
When asked to describe how these individuals had been affected, the only cited impact was that they had noticed the primary stakeholder achieving an outcome—not that they had experienced a distinct or material outcome themselves.
Given the incredibly small number of potential secondary stakeholders and the lack of distinct, attributable outcomes, these groups were not considered material for the purposes of this SROI analysis. The decision made in the SROI Forecast regarding their exclusion was therefore upheld in the SROI Evaluation, based on stakeholder engagement.

Existing research into the impact of disability on siblings and partners of people with disabilities demonstrates diametrically opposed results, with extreme positives contrasted against negative impacts. While research identifies the distinct need for interventions to support siblings of people with disabilities, literature on the experience of being a sibling of a person with a disability points in two opposing directions and demonstrates that experiences are influenced by many compounding factors (Golics et al., 2013; Múries-Cantán et al., 2022). Literature is also limited in a variety of ways, including small sample sizes, often relying on self-selection, a strong focus on adults and studies being overly specific or too generic. This significant variability in experiences means that any indirect outcomes experienced by these groups are dependent on a considerable number of factors and likelihood of distinct outcomes attributable to their sibling with a disability's attendance at in-scope services is small. This supports the data collected directly from stakeholders that led to the decision to exclude siblings as secondary stakeholders.

Research shows that people with disabilities may face more barriers to dating and establishing serious romantic partnerships, and that spouses of people with disabilities may be personally impacted by the inter-personal experience of disability, e.g. experiencing psychological distress, a change in roles and responsibilities in the case of an acquired disability, and reduced social participation (Bertschi & Meier, 2021; Nosek et al., 2001; Li & Jiang, 2021). It would be reasonable to assume that partners would be indirectly impacted by the person with a disability experiencing positive or negative outcomes relating to attending in-scope services. However, this was not evident in the data collected directly from stakeholders. This is a stakeholder-led evaluation, and it was decided to uphold the decision to exclude this stakeholder group based on stakeholder engagement. However, it has been recommended in Section 13.3 that this be reviewed and validated by re-engaging the stakeholder group prior to any future evaluation.

3.3.6 Step Two: *Evaluation Stage 1 – Qualitative*: Validate the preceding SROI Forecast (Assured in 2022)

A key recommendation for the SROI Evaluation was that focus groups were conducted to validate the preceding SROI Forecast findings prior to data collection commencing for the SROI Evaluation analysis. These were conducted in *Evaluation Stage 1 – Qualitative*. This qualitative research drew on clients who had already attended in-scope services, to ensure they could reliably report on the change experienced.

A representative small group or 1:1 interview was conducted for each client type within each theme included in the SROI Evaluation, totalling 28 primary stakeholder participants. Eight parents of children and adults attending in-scope services were engaged as secondary stakeholder participants.

Table 5: Quantity of stakeholders engaged in Evaluation Stage 1 - Qualitative

Stakeholder group	**Number of stakeholders engaged**	**Format**
Clients of Psychological wellbeing (primary stakeholders)	6	2 small focus groups 2 interviews
Clients of Social Capital (primary stakeholders)	6	2 small focus groups 1 interview
Clients of Health & Continence (primary stakeholders)	8	2 small focus groups 4 interviews
Clients of Personal Support and Connection (primary stakeholders)	8	2 small focus groups 4 interviews
Parents of children and adults attending in-scope services (secondary stakeholders)	8	2 small focus groups 1 interview

In each interview, primary stakeholder participants were first asked to share their experiences of change resulting from the in-scope services they had attended. Secondary stakeholder participants were asked to share their experiences of change resulting from their child (including adult children) with a disability attending in-scope services. Following this, with the moderator's guidance, they reviewed each change and final outcome included in the ToC. For each part reviewed, participants were asked how they related to it, the extent of change they experienced, its importance, and any potential displacement associated with it.

Interviews conducted with children were also attended by one of the child's parents and a member of the Crann front-of-house (i.e., not service delivery) team who was known to the child, for safe-guarding purposes. The parent was invited to participate in the interview by suggesting alternative language or providing their perspective if their child had difficulty answering questions. In all cases, except one (covered in Chapter 7), the parents did not participate as the children had no difficulty participating fully.

All of the Theories of Change developed during the preceding SROI Forecast (Assured in 2022) were validated by stakeholders during *Evaluation Stage 1 – Qualitative*. All stakeholders engaged had experienced the intermediate outcomes to some degree and a sufficient majority had experienced the final well-defined outcomes in all cases. Minor linguistic changes were made to the Theories of Change, based on stakeholder insight, to ensure the language used was representative of the majority experience. The individual changes made have been covered within Chapters 5 to 9.

3.3.7 Step Three: *Evaluation Stage 2 – Quantitative*: Gather data on outcomes

Indicators were proposed within the preceding SROI Forecast (Assured in 2022), identified through a combination of desk research and stakeholder engagement. The proposed indicators were reviewed following *Evaluation Stage 1 – Qualitative* to ensure relevance, and changes were made as necessary; these are detailed in Section 3.6. In *Evaluation Stage 2 – Quantitative*, a quantitative outcome measurement survey was designed for each theme, with an individual version provided for each service to ensure that question wording was specific to the service. A quantitative outcome measurement survey was also designed for secondary stakeholders. The outcome measurement surveys included both pre- and post- intervention measures, using survey routing to divide the sample into pre- and post-responses based on specific criteria. A combination of validated measures and bespoke indicators were used, and a variety of demographic data collected to enable segment analysis. The outcome measurement tools were designed in collaboration with the Crann team and were reviewed in line with the SROI Forecast and qualitative findings from *Evaluation Stage 1 – Qualitative* prior to sign off and implementation.

From 1st October 2023, the quantitative surveys were shared by the Services team, Front of House team, and the Research & Impact Lead, with new clients attending in-scope services, and their parents as secondary stakeholders. As detailed in Section 3.5, surveys were shared with existing clients of Social Capital services to ensure adequate sample. The teams tracked which clients and families had been asked to participate and ensured that no family became overwhelmed by being asked to participate in too many surveys due to their crossover between services. As clients came to the end of the service or went past the average number of sessions for on-going services, they were asked to participate in the post-intervention survey.

3.3.8 Step Four: Analyse data and conduct supporting research review to clarify assumptions

The analysis aimed to measure the overall impact of the in-scope themes by combining a distance travelled approach with a material significance threshold to evaluate meaningful change. The analysis method is covered in detail in Section 3.7.

The distance travelled approach measures the proportion of progress made toward the maximum achievable outcome, offering a scalable and equitable way to assess improvement. For outcomes with multiple indicators, a weighting method was applied to ensure variations in the number of indicators were accounted for fairly.

A material significance threshold was applied to identify meaningful changes, with adjustments based on participants' baseline scores to reflect the increasing difficulty of achieving further improvements as participants approach the ideal state. This sliding scale ensured proportionality and accurately captured significant improvements in behaviour, skills, or wellbeing. The thresholds were consistently applied across multiple indicators, using a uniform weighting approach to ensure a reliable and robust evaluation of outcomes.

This methodology ensures that the analysis accurately reflects the value created by the in-scope themes, while remaining sensitive to the nuances of participant progress and starting conditions.

To contextualise the analysis, qualitative findings were complemented by an in-depth review of existing literature and research.

3.3.9 Step Five: Calculate the value generated for stakeholders

Once analysis of all datasets was complete, the commissioned Practitioner and the Crann team consulted on inputs. All input information was gathered by the Crann team and reviewed with the commissioned Practitioner. The SROI Value Map was completed by the commissioned Practitioner, based on the input data provided by Crann and the quantitative data collected from stakeholders in *Evaluation Stage 2 – Quantitative*.

A comprehensive sensitivity analysis was conducted to assess all assumptions made within the value map, to better understand the relationship of the assumptions to the overall social value calculation. All assumptions made were informed by stakeholder data, but it is important to understand what impact alternative scenarios would have on the SROI ratio. Discounts and values have been informed by stakeholders and are not considered to be a precise representation, so alternative figures have been thoroughly tested to understand their impact on the overall value created.

A less robust assessment of materiality was applied during analysis of the preceding SROI Forecast (Assured in 2022), relying on self-reported size of change due to the absence of longitudinal data. This measure was incorporated into the quantitative data collection during *Evaluation Stage 2 – Quantitative*, enabling sensitivity analysis to be conducted based on self-reported size of change in the SROI Evaluation analysis.

A detailed explanation of the sensitivity analysis conducted can be found in Section 11.8.

3.3.10 Step Six: Verify findings, develop conclusions and recommendations

Stakeholders were invited to suggest improvements and recommendations for ways that Crann could improve its services and create more value for its stakeholders. Findings from the SROI Evaluation data collection across *Stage 1 – Qualitative* and *Stage 2 – Quantitative* were also analysed by the commissioned Practitioner and used to inform recommendations for Crann.

In line with SROI Principle 7: Verify the result, stakeholder verification of findings was conducted in *Evaluation Stage 1 – Qualitative*, prior to measuring the change experienced during the SROI period. The commissioned Practitioner also engaged the Crann team frequently to verify findings and ensure mutual understanding of results. Outcomes, values, and discounts were reviewed with stakeholders and with the Crann team to test assumptions and identify outliers. The Crann team also filled knowledge gaps, gave expert input, and ensured that Crann's services, 2Gen Model of Care, and context were accurately represented throughout the SROI analysis.

3.3.11 Step Nine: Report Assurance by SVUK

Once this SROI Evaluation report was completed, it was submitted to Social Value UK to verify the results and assess whether the methodology was undertaken in line with the seven principles of SROI.

This report has been assured by Social Value UK. The report shows a good understanding of, and is consistent with, the Social Value process and principles. Assurance here does not include verification of stakeholder engagement, data and calculations

3.4 Context: The Preceding SROI Forecast (Assured in September 2022)

Preceding this SROI Evaluation, Crann conducted an SROI Forecast analysis in 2022 (Assured in the same year), which forecasted the social value that would be created by Crann across four in-scope themes during 2023. The process undertaken for the SROI Forecast analysis has been included in brief in this section to provide context for the SROI Evaluation. A more in-depth account of the SROI Forecast methodology can be found in the Assured Report.

The in-scope themes for the Forecast were:

1. Psychological Wellbeing
2. Social Capital
3. Health and Continence
4. Personal Support and Connection

Themes 1-3 above were identified from the list of six core themes serviced by Crann in 2022, prior to the SROI Forecast, based on services that had run consistently in the 12 months prior to the analysis. The impact of

Covid-19 and related restrictions on in-person service-delivery was notable, especially considering the cohort it serves. The three themes identified as in-scope had served an adequate number of clients in the past 12 months to ensure that engaging stakeholders with recent experience of the services would be possible.

During the qualitative stakeholder engagement for the SROI Forecast, all stakeholders who were engaged identified the Personal Support and Connection theme as being a highly valuable part of their experience, and it was decided to include this in the SROI Forecast scope based on their input.

The themes included in the SROI Forecast, and the in-scope services included under them, are included in table 6.

Table 6: Themes of services included in scope for the SROI Forecast

Theme	Services
Psychological Wellbeing	A Moment for Me Counselling Play Therapy Growing in Confidence Sibshops
Community and Networks	Chat and Connect Breaking Barriers Theatre Group for Kids Breaking Barriers Theatre Group for Adults Parents' Café
Health and Continence	Continence Clinic Podiatry

There were some changes in context at Crann between the SROI Forecast and Evaluation which have directly impacted the format of this Evaluation; these are listed below:

- The theme of services named 'Community and Networks' in the SROI Forecast is now named 'Social Capital' and this new name has been used throughout this report.
- The service named 'Chat and Connect' in the SROI Forecast was re-named Social Hub and this new name has been used throughout this report.
- Two services included in the SROI forecast did not run during the SROI period, in line with service user needs and priority alignment. Both services existed within the Psychological Wellbeing theme:
  - A Moment for Me
  - Growing in Confidence
- One service was not included in the SROI Evaluation as it did not run consistently during the SROI period, again in line with service user needs. This service existed within the Social Capital theme:
  - Parents' Café

The SROI Forecast related to the period of January to December 2023 and the SROI Evaluation period for this analysis began later in 2023 to provide time for Crann and the commissioned Practitioner to validate the Forecast findings, establish an internal team, and ensure quantitative data collection tools were integrated into the service delivery approach.

3.4.1 The SROI Forecast Methodology

The SROI Forecast Method included the following steps:

1. **Agree the Scope:** The scope was determined through consultations with Crann's leadership, focusing on four key themes:
   - Psychological Wellbeing, Social Capital, and Health and Continence.

  - The Personal Support and Connection theme was added to the scope after its identification in the qualitative stakeholder engagement.

1. **Develop a Stakeholder Map:** Stakeholders were identified through consultations and research, grouped by service themes, and included primary and secondary stakeholders. Certain groups, like siblings and partners, were excluded as secondary stakeholders later due to insufficient evidence of material outcomes.
2. **Recruit Participants for Research:** A total of 32 stakeholders were recruited for qualitative interviews and 56 clients completed a survey. Due to Covid restrictions, parents acted as proxies for their children who were unable to participate in an online environment.
3. **Conduct Interviews and Develop Theories of Change:** Interviews and focus groups were conducted with primary and secondary stakeholders to identify outcomes, establish Theories of Change (ToCs), and value outcomes using two modified value games. These ToCs were verified by stakeholders in follow-ups and by the Crann team.
4. **Conduct Quantitative Research:** A detailed survey was developed to quantify stakeholder outcomes, measure impact (e.g., size, importance, attribution, deadweight), and validate the ToCs. Respondents provided both quantitative and qualitative data during this process through the use of closed and open questions. The survey was administered to both primary and secondary stakeholders.
5. **Analyse Data and Review Assumptions:** Qualitative data was coded and analysed, while quantitative data was assessed to calculate averages and confirm consistency across responses. Cross-referencing qualitative insights clarified assumptions and identified outliers.
6. **Calculate Value:** Data was entered into the SROI value map, informed by forecasts for Crann's 2023 delivery. Inputs and outputs were reviewed collaboratively by the Practitioner and the Crann team. Sensitivity testing assessed the impact of key assumptions, such as stakeholder numbers and discount rates, on the SROI ratio to ensure robustness in forecasting.
7. **Verify Findings and Develop Recommendations:** Stakeholders and Crann team members reviewed findings to verify results, refine assumptions, and suggest improvements. Recommendations were developed to enhance service delivery and future evaluations.
8. **Report Assurance by SVI:** The completed report was submitted to Social Value UK for assurance, confirming that the analysis adhered to the seven principles of SROI.

3.4.2 Overview of SROI Forecast Engagement

The experiences of stakeholders drove the SROI Forecast analysis. Stakeholders were involved throughout the process and three different stakeholder groups participated via video or phone interviews, in-person focus groups and digital surveys. Table 7 provides an overview of engagement.

Table 7: Overview of stakeholder engagement in the preceding SROI Forecast (Assured in 2022)

Stakeholder	Total number	Approach	Number engaged
Clients (primary stakeholders)	154	Qualitative interviews conducted by video conference by the commissioned researcher	15
		Quantitative digital survey	56
Parents of clients (secondary stakeholders)	Unknown Estimate ~200	Qualitative focus group conducted in-person by the commissioned researcher	13
		Quantitative digital survey	6*
Siblings of clients (secondary stakeholders)	Unknown Estimate ~150	Qualitative interviews conducted by phone by the commissioned researcher	3

3.4.3 Outputs: Theories of Change

To understand what changes for stakeholders and develop ToCs, clients (primary stakeholders) and parents of children and adults attending in-scope services (secondary stakeholders) were engaged in qualitative interviews via video conference in 2022 as part of the SROI Forecast (due to Covid restrictions). Those selected for interview had a range of backgrounds, ages, family circumstances, and had all engaged in relevant programmes within the previous 12 months.

Parent proxies were recruited for child clients, due to the challenges of engaging children in qualitative research in an online environment. Parents felt well placed to report on their children's outcomes, given their role as primary caregivers and their involvement in accessing services at Crann.

Engagement of stakeholders for the development of the ToCs involved exploring outcomes in an unprompted qualitative research setting. Stakeholders were not prompted to discuss intended outcomes and were encouraged to describe all of the changes they experienced from their perspective and in their own words, including any negative experience or change. The data collected was used to develop a ToC for each stakeholder group, which illustrated the chain of events based on stakeholder insight and consultation with experts at Crann. These ToCs were validated within the SROI Forecast in a quantitative survey which included open ended questions to provide additional context and insight.

The following steps outline how the ToCs were developed for each stakeholder group in the SROI Forecast.

1. Clients (or proxies) were interviewed by video conference to explore what change they had experienced (methodology is covered briefly in Section 3.4.1 and more detailed information can be found in the Assured Report).
2. Based on the qualitative stakeholder engagement, initial outcomes were identified based on clients' experiences.
3. Desk research, consultation with experts within Crann and analytical judgement of the commissioned Practitioner were utilised to define the well-defined final outcomes based on this data. This involved analysing the causality between outcomes in a chain of events to identify the point in the chain where the value was being created for stakeholders.
4. The well-defined final outcomes were subsequently tested in the client survey to evidence their materiality (significance and relevance) and to identify any additional outcomes.
5. The ToC diagram for the SROI Forecast was finalised based on the quantitative insights from that survey.

Stakeholders were offered opportunities throughout the process to review whether the ToC was representative of their experiences. Both the qualitative discussion guide and quantitative survey used for Theory of Change development and validation in the SROI Forecast can be found in Appendices 3 and 4.

Final outcomes were selected based on their significance to stakeholders, the proportion of participants experiencing change, and the degree of impact observed. Outcomes were assessed against materiality thresholds, ensuring only those with meaningful, measurable, and sustained effects were included in the analysis. Stakeholder validation, scale of change, and alignment with programme objectives informed the final selection process.

The ToCs can be found in Chapter 4 of this report.

3.4.4 Outputs: Assured Report

The SROI Forecast report was Assured by SVUK in September 2022.

The Assured report can be accessed via Crann's website, here.

3.4.2 The application of recommendations for the SROI Evaluation

The SROI Forecast provided a comprehensive set of recommendations aimed at effectively transitioning from SROI Forecast to Evaluation. These recommendations focused on minimising and mitigating potential limitations, and ensuring the SROI Evaluation process produced accurate, reliable, and credible results. The actions taken to implement each recommendation made are included in table 8.

Table 8: Recommendations from the preceding SROI Forecast (Assured in 2022) and related actions taken

Recommendation	**Action**
Encourage Crann staff involvement in the SROI Evaluation: - Present the SROI Forecast to Crann staff - Integrate data collection into day-to-day operations - Staff training	A comprehensive presentation was made to Crann staff in November 2022, followed by a presentation to the Board of Directors in January 2023. Buy-in from both groups was achieved during the sessions, with many staff members who had previously not engaged with the SROI programme asking in-depth questions and taking on responsibility for elements of the process. A second presentation to the Services team was made in April 2024 which focused on the data collection required and aimed to bring new staff on-board. The data collection process was integrated into the Crann team's day-to-day operations, with the Services team, Front of House team, and the Research & Impact Lead taking on responsibility for rolling out surveys to relevant stakeholders. An internal tracking system was developed by Crann's Research & Impact Lead in collaboration with the Services team to manage the level of demand for families who were eligible to participate in multiple surveys across family members. The internal system was used by the Crann team and check-ins took place during their weekly departmental meeting. The Research & Impact Lead and support team were provided with full training on the SROI programme by the Practitioner. This included an in-depth review of the SROI Forecast, a workshop session focused on designing data collection tools, and ongoing support provided as needed to ensure the success of the SROI Evaluation methodology.
Research design and sampling:	In order not to overload staff or stakeholders, data collection tools were designed to be as simple as possible. It is important to note that this SROI Evaluation is inherently complex, due to its inclusion of four themes of services, with seven core services sitting within them, each with varying client types. To simplify the process for staff and stakeholders, one survey was created for each in-scope service, along with bespoke surveys for the Personal Support and Connection theme and for parents of child and adult clients attending in-scope services. Survey routing was used to divide the sample into pre- and post-responses based on specific criteria. Staff only had one survey link to manage for their specific service, stakeholders did not need to remember which surveys they had responded to, and their survey experience was seamless. Where indicators were applicable to multiple outcomes of one service, the indicators were not repeated but were accounted for in analysis. The analysis adjusted proportions experiencing change to account for overlap between themes with the same outcomes. More robust sampling has been achieved in the SROI Evaluation by integrating data collection into the Services Team's day-to-day operations and setting targets designed to minimise variance per theme to a reasonable and practical level. Within reason, every eligible client was invited to participate. Exceptions were made where families were eligible to participate across a wide range of services and had been invited multiple times, to reduce the load and expectation on them. The tables detailing sample sizes can be found in Section 3.5. Children have been involved throughout the stakeholder engagement process for the SROI Evaluation. In *Evaluation Stage 1 – Qualitative*, children, accompanied by a parent or guardian, were recruited and provided invaluable insights. In *Evaluation Stage 2 – Quantitative*, tools designed for services involving child clients were provided to parents as the point of contact, with clear instructions to ensure children responded independently wherever possible. Where needed, parents or guardians could provide support, but children were to be actively involved in their responses.

	The decision to exclude a government stakeholder from the SROI Forecast was reviewed and upheld for the Evaluation. While Crann had initially forecasted a significant upscaling of the Continence Clinic service in 2023, potentially creating material impacts for the HSE in terms of decision-making, budgets, and workloads. Extensive exploration of stakeholder needs and Crann's strategic priorities led to a decision not to scale the service at the projected rate. As outlined in this report, the Continence Clinic continues to provide valuable support to its clients and their families. Crann's services are uniquely designed to address the needs of its clients and complement, rather than overlap with, the services provided by the Health Service Executive (HSE) and/or other providers. Stakeholders accessing the services included in this SROI Evaluation at Crann will not impact how services are accessed via the HSE. Focus groups were used to validate of the SROI Forecast findings in *Evaluation Stage 1 – Qualitative* where possible. It is important to note that many of the services provided by Crann deal with sensitive topics, e.g. Counselling, Continence Clinic, Play Therapy, and this was a key consideration when designing this stakeholder engagement. As such, one-to-one interviews were used where relevant to supplement the focus group approach in *Evaluation Stage 1 – Qualitative*. All in-person research conducted in *Evaluation Stage 1 – Qualitative* took place in Crann's bespoke accessible centre. This decision was taken with considerable intention, as finding an equally accessible space to conduct in-person sessions was impossible. Clients attending these sessions had a wide range of mobility and access needs, including some being hesitant to attend a space they were not familiar with. To ensure the location did not hinder them sharing honest insights, the sessions were held in a neutral room rather than a room they were familiar with from a particular service and were not attended by any service-delivery staff. During the qualitative research in *Evaluation Stage 1 – Qualitative*, visual tools were employed by the Practitioner to provide methods for engagement for those with comprehension or communication challenges in face-to-face interviews and groups. The discussion guide used simple language and provided points for clarifying that the participants fully understood the question, the language used in the outcomes, etc. No adult client had difficulty participating fully in the focus groups or interviews and they required only minimal clarification; any clarification needed around language relating to outcomes was explored fully and changes were made where indicated. Interviews conducted with children were also attended by one of the child's parents who was invited to participate in the interview by suggesting alternative language or providing their perspective if their child had difficulty answering questions. Except for one interview on Continence Clinic, the parents did not participate as the children had no difficulty participating fully. Questions were phrased in simple language and children were asked to explain what they understood by certain terms e.g., mental wellbeing, to confirm comprehension. Children were provided with visual scales, illustrating comparative sizes, to assist with identifying size of change.
Data collection: - Establish a baseline	Quantitative data collection, pre- and post-intervention was used for this SROI Evaluation, in *Evaluation Stage 2 – Quantitative* to ensure a baseline was captured, against which change could be measured.

- Consider other data collected by Crann - Considerations for longitudinal data collection - Consider how to mitigate value game limitation - A need for more sophisticated segmentation	A full review of existing data collected by Crann in relation to clients of in-scope services was conducted. During the SROI Evaluation period the intake process at Crann was evolving to better serve the service delivery need. The intake data is not currently aligned with the SROI outcomes, so it was decided that an in-depth analysis of the SROI data would be the most effective approach to analysis for the Evaluation. Crann is now focused on maximising the impact of its data collection and management systems to ensure a more cohesive and effective approach to tracking and demonstrating client outcomes. Quantitative data collection for the SROI Evaluation (*Evaluation Stage 2 – Quantitative*) was conducted over a 12-month period to ensure a sufficient sample size across both pre- and post-intervention stages. This approach was necessary because Crann's services operate without fixed timelines; clients can begin accessing services at any point during the year and attend a flexible number of appointments tailored to their individual needs. The decision to use a pre- and post-intervention sample composed of different individuals was carefully considered to address several practical challenges. Initial engagement with the request for participation was lower than anticipated, prompting the inclusion of all available responses to ensure robust data collection. Additionally, the overlapping nature of many services made it complex to isolate a consistent group for both stages of the quantitative data collection for this SROI Evaluation. Furthermore, the staggered entry timeline for services throughout the year meant there was not a universally defined "pre" and "post" period for participants. This flexible sampling approach allowed for sufficient data to be collected and is discussed in more detail in Section 3.9. The use of modified value games in the SROI Forecast was highlighted as a potential limitation due to their subjectivity and the potential for misunderstanding. However, value is in the eye of the beholder and the project team believes that the true worth of an outcome can only be determined by those who experience it. By directly engaging stakeholders in valuation, this SROI analysis captures diverse perspectives on what matters most to them, ensuring it reflects their priorities and lived experiences. It was also important to ensure consistency and comparability with the SROI Forecast, so the decision was taken to use the stakeholder generated values to generate the SROI ratio. We do acknowledge the potential risk of subjectivity of values determined by stakeholders and have taken the decision to include alternative concrete and quantifiable values, e.g. time cost, from other sources in the sensitivity analysis for each outcome, covered in Section 11.8, to account for this in the analysis. Segmentation data was collected for every survey response, including age, gender, client type, disability, and length of time in service where appropriate. Segments identified and used in analysis have been discussed in Section 3.8.
Consider new and evolving outcomes	In January 2023, focus groups and one-to-one interviews were conducted during Evaluation Stage 1 – Qualitative to validate the ToCs, outcomes, and deductions identified in the SROI Forecast. This process has been discussed in detail in Section 3.3.1. During *Evaluation Stage 1 – Qualitative*, all participants were asked to discuss any other changes they experienced as a result of attending in-scope services, to ensure that any other material experiences were included.

	However, all participants felt that the existing ToCs aligned with their experience. Some linguistic changes were made to the ToCs based on this qualitative stakeholder engagement, but no intermediate or final outcomes required changing, removing or adding. Insights gained from *Evaluation Stage 1 – Qualitative* also influenced the final selection of indicators for use within quantitative data collection. More detail on this can be found within Section 3.6. Further, every client who responded to a quantitative survey in *Evaluation Stage 2 – Quantitative* was asked to share any other changes they experienced that were not covered by the extensive indicators included in the data collection. No additional outcomes were identified through this process.
Calculating value: - Include volunteer inputs if relevant - Consider the higher risk of double counting due to forecasted increase in client numbers	Volunteer inputs were not relevant for the SROI Evaluation as no volunteer time was counted against relevant services during the SROI period. Services were delivered by Crann staff and paid external facilitators. The expectation of a significant influx of clients to the Continence Clinic projected for 2023 increased the potential risk of double counting. However, as Crann decided not to scale the service at this rate during the SROI period, this risk did not materialise.
Verification: - Conduct validation groups for Theories of Change	In January 2023, focus groups and one-to-one interviews were conducted during Evaluation Stage 1 – Qualitative to validate the ToCs, outcomes, and deductions identified in the SROI Forecast. This process has been discussed in detail in Section 3.3.1. The SROI results were verified with Crann through a collaborative process, ensuring that findings accurately reflected the organisation's activities, stakeholder feedback, and intended outcomes. This verification included reviewing key assumptions, outcomes, and valuations to confirm their alignment with Crann's context and stakeholder priorities.

3.5 Overview of engagement

The experiences of stakeholders have driven this SROI Evaluation. Stakeholders were involved throughout the process via interviews and focus groups (*Evaluation Stage 1 – Qualitative*), and digital surveys (*Evaluation Stage 2 – Quantitative*). The following tables provide an overview of stakeholders involved in engagement and how they were engaged.

Table 9: Type of stakeholders engaged by stage

	Engaged in SROI Evaluation Stage 1 – Qualitative	**Engaged in SROI Evaluation** Stage 2 – Quantitative
Past clients of in-scope services (primary stakeholders) and parents of children and adults who had previously attended in-scope services (secondary stakeholders), with experience of attending for a standard amount of service delivery	X	X (Social Capital only)
Clients of in-scope services (primary and parents of children and adults attending in-scope services (secondary stakeholders) during the SROI period		X

New clients entering services during the SROI Evaluation period were involved in quantitative data collection in *Evaluation Stage 2* for all in-scope themes. To ensure a sufficient sample size for analysis, continuing clients of Social Capital services were engaged in the SROI Evaluation through a retrospective pre-intervention survey and a standard post-intervention survey. Both services under this theme are ongoing, with low attrition rates and limited openings for new clients, so a new-client-only sample would have been too small for quantitative analysis. However, value has been calculated only for new clients during the SROI period.

Table 10: Quantity of stakeholders engaged by stage

	Total number of possible stakeholder engagements relevant for SROI Evaluation	Number engaged in validating outcomes, value, deductions	Number engaged for measuring change quantitatively (pre and post)
		Evaluation Stage 1 – Qualitative	Evaluation Stage 2 – Quantitative
Clients (primary stakeholders)	359	28	228
Parents of children and adults attending in-scope services (secondary stakeholders)	104	8	30

Respondents have informed understanding of multiple themes and existing clients of Social Capital were engaged to ensure adequate sample for analysis (as above).

In the SROI Evaluation, clients who had attended an in-scope service in the 6 months prior to *Evaluation Stage 1 – Qualitative*, along with their parents where relevant, were invited to participate in a focus group or interview. Selection was based on availability and ensuring representation across services and age groups.

Children were engaged in qualitative research to validate outcomes, value and deductions and ensure that the use of parent proxies had not influenced the Theories of Change representing outcomes for children attending in-scope services.

Clients who entered and completed in-scope services during the SROI Evaluation period were invited to participate in pre- and post-intervention surveys in *Evaluation Stage 2 - Quantitative*. To avoid placing undue pressure on families attending multiple services, not all eligible family members were invited to every survey. Further details on this approach are provided in Sections 3.3.2 and 3.3.6. Children were engaged in quantitative data collection.

Table 11: Stakeholders engaged by stage, segmented by theme

Theme	Total number of stakeholders relevant for SROI Evaluation	Number engaged in validating outcomes, value, deductions	Number engaged for measuring change quantitatively	Total no. engaged.
		Evaluation Stage 1 – Qualitative	Evaluation Stage 2 – Quantitative	Total
Primary stakeholders				
Psychological Wellbeing	59	6	50	83
Social Capital	16	6	52	88
Health and Continence	78	8	63	101
Personal Support and Connection	102	8	31	79
Secondary stakeholders				

Parents of children and adults attending in-scope services	104	8	30	57

Respondents have informed understanding of multiple themes and existing clients of Social Capital were engaged to ensure adequate sample for analysis (as above).

Table 12: Stakeholders engaged pre- and post-intervention, segmented by theme

Theme	Total number of new clients relevant for SROI Evaluation	Number engaged for measuring change quantitatively	Number of respondents pre-intervention	Number of respondents post-intervention
		Evaluation Stage 2 – Quantitative		
Clients (primary stakeholders)				
Psychological Wellbeing	59	52	31	21
Social Capital	16	52	25	27
Health and Continence	78	63	38	25
Personal Support and Connection	102	31	18	13
Parents of children and adults attending in-scope services (secondary stakeholders)				
Secondary stakeholders	104	30	9	21

Respondents have informed understanding of multiple themes and existing clients of Social Capital were engaged to ensure adequate sample for analysis (as above).

3.6 Indicators used

Indicators for this SROI Evaluation were developed through a combination of desk research and stakeholder engagement. These indicators were reviewed and refined following input from stakeholders in *Evaluation Stage 1 – Qualitative* to ensure their relevance and accuracy. All adjustments made to the proposed indicators, along with the rationale for each decision, are outlined in the tables below. The indicators were implemented during the SROI Evaluation, in *Evaluation Stage 2 – Quantitative*, in quantitative digital surveys. The following section relates to that Stage of research.

To effectively measure and analyse change, a scoring system was applied to the indicators. For validated tools with established scoring systems or thresholds for material significance, those predefined frameworks were adopted. However, for several outcomes, bespoke indicators were more suitable, and a custom scoring system was developed specifically for these cases.

The bespoke scoring system was devised based on the scoring systems applied within social sciences research and across various validated tools, including those used as indicators in this SROI Evaluation analysis. The scoring system is detailed below:

1. Bespoke items were grouped in “sets” based on thematic links between them.
2. Each item was scored by respondents on a scale; either 4-point or 5-point, depending on the item.
3. The score range was defined as the number achievable if all items in the set are given the lowest score (1) to the number achievable if all items in the set were given the highest score (4 or 5).
4. A score was applied to each item based on the response, i.e. 1-4 for 4-point and 1-5 for 5-point scales. Reverse scoring was applied to negatively worded statements where relevant.
5. The scores were added up for the full set of bespoke indicators to get a total score.

The materiality calculation to establish whether material change has been achieved for each set of indicators is defined in Section 3.7.4.

In the preceding SROI Forecast (Assured in 2022), materiality was indicated by self-reported size of change, as longitudinal data was not collected, and the analysis relied on post-intervention data. A ‘medium’ or ‘large’ change were assigned materiality based on the analysis.

The ‘size of change’ self-report measure was included in the quantitative digital surveys conducted during *Evaluation Stage 2 – Quantitative* to ensure comparability between the SROI Forecast and Evaluation. This self-reported data from the SROI Evaluation was incorporated into the sensitivity analysis, applying the same materiality threshold used in the Forecast, to ensure consistency within the SROI analysis. Details of the sensitivity analysis are provided in Section 11.8.

Table 13: Psychological Wellbeing indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning

Outcome	Proposed in Forecast	Indicator used	Reasoning	Scoring
Psychological Wellbeing				
Improved mental wellbeing	• CORE-10 for adult clients • YP-CORE for 11-18yr olds For children under 11, a qualitative assessment based on the same indicators used within the CORE tools, supported by Play Therapist and/or parent will be used in place of quantitative indicator to assign a change score Size of change: • No change • Small change • Medium change • Large change	• CORE-10 for adult clients • YP-CORE for 11-18yr olds Source and scales For children under 11, parent invited to complete the tool with their involvement and asked to report on the overall outcome separately. Size of change: • No change • Small change • Medium change • Large change	CORE-10 and YP-CORE (Barkham et al., 2012) are commonly used and recommended in the field of psychological wellbeing to measure a clinical score for mental wellbeing. This tool is brief and validated with primary care patients and the general population, it has also been validated with people with intellectual disabilities. A qualitative assessment was proposed, however, responses are anonymous, so it was not possible to identify stakeholder participants for specific qualitative review. Instead, parents were asked to complete the YP-CORE tool with their child's involvement but using their own observation of the child to support their response. They were also asked to report on the size of the change they observed in their child relevant to the outcome. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	CORE-10: In the full tool, 10 items are scored on a 5-point scale from 0-4. Scores for each item are added together resulting in a total score between 0-40. • We reduced the tool to 7 measures due to the risk of causing upset for clients without providing support. • Score max = 28 Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.
Increased self-confidence and motivation	Rosenberg's Self-Esteem Scale (RSES) (Sinclair et al. 2010) for clients 12 years and over.	Bespoke indicators scored on a 4-point agreement scale: • I am able to share my thoughts and opinions with others	Rosenberg's Self Esteem Scale (RSES) (was proposed in the SROI forecast. However, on further consultation with Crann, it was deemed inappropriate for use with people with disabilities due to	Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 6-24.

	Qualitative assessment by Play Therapist and/or parent of children <12 years to be used in place of RSES. Bespoke indicators, to include (scales to be 7-point): • I am able to share my thoughts and opinions with others • I feel confident to attend a group • I am motivated to take action on my personal goals • Number of acts of self-care or personal wellbeing in a month (objective) • I feel that I am becoming more independent (specific to children and adults with disabilities) Size of change: • No change • Small change • Medium change • Large change	• I feel confident to attend a group • I am motivated to take action on my personal goals • I feel that I am becoming more independent (specific to children and adults with disabilities) • I know who I am and what matters to me • I feel capable and able to live my life fully Size of change: • No change • Small change • Medium change • Large change	its focus on ability to do as equal to others, worthiness, etc. A set of bespoke indicators was proposed to support the RSES, designed by the commissioned Practitioner based on qualitative insight collected directly from stakeholders about their experience of the change. This list was expanded to include new insights gleaned during *Evaluation Stage 1 – Qualitative*, ensuring a representative picture of the experience of the change, and utilised in place of the RSES. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. We opted for a 4-point scale, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data	Size of change was self-reported on a 4-point scale from ‘no change’ to ‘a large change.’ This was used in sensitivity analysis only for the SROI Evaluation analysis.

			against the Forecast, and to support evaluation of other indicators used.	
Improved ability to manage challenges	Brief Resilient Coping Scale (Sinclair & Wallston, 2004) (validated for adults only). Qualitative assessment by Play Therapist and/or parent of children <12 years to be used in place of BRCS. Bespoke, to include (scales to be 7-point): • Number of times felt stressed/overwhelmed in previous 2 weeks period • I can approach a challenging situation calmly • I ask for help and support or share my feelings with others when I am facing a challenge • Time taken to reflect and process (scale, no time at all to taking time daily) • Self-compassion in times of challenge • Satisfaction with support system Size of change: • No change • Small change • Medium change	Brief Resilient Coping Scale (validated for adults only) – used only for parents and adults with disabilities Source Scale Bespoke indicators scored on a 5-point agreement scale (to align with BRCS): • I can approach a challenging situation calmly • I ask for help and support or share my feelings with others when I am facing a challenge • I have self-compassion in challenging times • I am satisfied with my support system • I take time to reflect on things and process them after something challenging happens Objective indicator – 6-point scale from never to every day • Frequency of feeling stressed/ overwhelmed in previous 2 weeks period	The BRCS is a 4-item measure designed to capture tendencies to cope with stress in a highly adaptive manner. It is a well-established tool and has been validated at a general population level. There is no current equivalent tool for children under 12, so bespoke indicators were used for those under 12. A qualitative assessment was proposed, however, responses are anonymous, so it was not possible to identify stakeholder participants for specific qualitative review. A further set of bespoke indicators was designed to support the BRCS, as it does not capture all of the specific facets of this outcome as described by stakeholders. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern	BRCS: Four items are scored on a 5-point Likert scale from 1-5. Scores for each item are added together, with a possible score range of 4-20. Bespoke: Items are scored on a 5-point Likert scale from 1-5. Scores for each item are added together, with a possible score range of 5-25. Objective indicator: Item is scored on a 6-point scale from 1-6. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

	- Large change	Size of change: - No change - Small change - Medium change - Large change	when considering accessibility of the data collection. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	
Improved support, community, and social inclusion	Adjusted Brief Sense of Community Scale (Peterson, Speer & Mcmillan, 2008) – “neighbourhood” replaced with “community” 7-point Likert scales – Bespoke, to include: - Having people to share feelings and challenges with - Satisfaction with social interaction - Satisfaction with support system Size of change: - No change - Small change - Medium change - Large change	Adjusted Brief Sense of Community Scale (BSOC): - “Neighbourhood” replaced with “community” - Reduced from 8 to 5 measures for relevance [Source and scale]() Bespoke indicators scored on a 4-point agreement scale to align with BSOC: - I have people to share my feelings and challenges with - I am satisfied with my support system - I have all the support that I need - I am satisfied with the level of social interaction I have currently - I feel that I am part of a community Size of change: - No change - Small change - Medium change	The BSOC represents sense of community dimensions of needs fulfilment, group membership, influence, and shared emotional connection. The tool focuses on the context of a physical neighbourhood, so it doesn’t completely fulfil the needs of the outcome but was adjusted to replace the term “neighbourhood” with “community” to fit the Crann context. Further, three measures were removed for lack of relevance, based on qualitative insight collected directly from stakeholders about their experience of the change. A further set of bespoke indicators was designed to support the BSOC as it does not capture all of the specific facets of this outcome as described by stakeholders and is not validated for use with under 18s. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale	BSOC: 5 items are scored on a 5-point Likert scale from 1-5 (reduced to 4-point to encourage decisive data). Scores for each item are added together, with a possible score range of 5-20. Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 5-20. Size of change was self-reported on a 4-point scale from ‘no change’ to ‘a large change.’ This was used in sensitivity analysis only for the SROI Evaluation analysis.

		• Large change	was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. We opted for a 4-point scale, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	

Table 14: Social Capital indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning

Outcome	**Proposed in forecast**	**Indicator used**	**Reasoning**	**Scoring**
Social Capital				
Improved independence	Bespoke, to include (scales to be 7-point): • Number of times attended services alone • Number of social connections outside of family unit • I feel inspired/motivated to do things I wouldn't have done before	Bespoke indicators scored on a 4-point agreement scale • I feel able and motivated to do things I wouldn't have done before • I am good at recognising my own abilities and successes • I have my own support network outside of my family	This outcome is nuanced so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative	Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 5-20. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

	• Degree of recognition of their own abilities • I have my own support network outside of my family • I feel comfortable going to different places without my primary carer Size of change: • No change • Small change • Medium change • Large change	• I am comfortable to be away from my family members for an hour or two • I am comfortable to be away from my family members for a longer time Size of change: • No change • Small change • Medium change • Large change	insight collected directly from stakeholders about their experience of the change. Comfort being away from family members (most common carers) was reassigned from the confidence outcome as when it was explored in *Evaluation Stage 1 – Qualitative*, it was felt to be more indicative of independence. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. We opted for a 4-point scale, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	

Increased self-confidence	Bespoke, to include (scales to be 7-point): • I feel confident to attend a group • I feel confident to voice my opinions (measured for different contexts) • I feel confident to share my feelings with others (measured for different contexts) • I feel confident asking for help and support • Level of comfort in being away from parent/carer (children and adults with disabilities only) • Recognising own abilities and successes Size of change: • No change • Small change • Medium change • Large change	Bespoke indicators scored on a 5-point Likert scale (confidence) • I feel confident to express my opinions or experiences • I feel confident to share my feelings • I feel confident asking for help and support when I need it ** Measured across 5 contexts – family, friends, at work/school/college, with new people, when attending a medical appointment Bespoke indicators scored on a 4-point agreement scale • I am good at recognising my own abilities and successes • I feel confident in a group of people I know • I feel confident in a group of people that are knew to me Size of change: • No change • Small change • Medium change • Large change	This outcome is nuanced and so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. Comfort being away from family members (most common carers) was reassigned to the independence outcome as when it was explored in *Evaluation Stage 1 - Qualitative*, it was felt to be more indicative of independence. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. We opted for a 4-point scale for some indicators, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or	Bespoke – set one: Items are scored on a 5-point Likert scale from 1-5, across 5 different dimensions. Scores for each dimension of each item are added together, with a possible score range of 5-25 per item and 15-75 for all three items together. Bespoke – set two: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 3-12. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

			disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	
Improved social inclusion, support, and community	Adjusted Brief Sense of Community Scale (Peterson, Speer & Mcmillan, 2008) – “neighbourhood” replaced with “community” 7-point Likert scales – Bespoke, to include: • Having people to share feelings and challenges with • Satisfaction with social interaction • Satisfaction with support system Size of change: • No change • Small change • Medium change • Large change	Adjusted Brief Sense of Community Scale (BSOC): - “Neighbourhood” replaced with “community” - Reduced from 8 to 5 measures for relevance Source and scale Bespoke indicators scored on a 4-point agreement scale to align with BSOC: • I have people to share my feelings and challenges with • I am satisfied with my support system • I have all the support that I need • I am satisfied with the level of social interaction I have currently • I feel that I am part of a community Size of change: • No change • Small change	The BSOC represents sense of community dimensions of needs fulfilment, group membership, influence, and shared emotional connection. The tool focuses on the context of a physical neighbourhood, so it doesn’t completely fulfil the needs of the outcome but was adjusted to replace the term “neighbourhood” with “community” to fit the Crann context. Further, three measures were removed for lack of relevance, based on qualitative insight collected directly from stakeholders about their experience of the change. A further set of bespoke indicators was designed to support the BSOC as it does not capture all of the specific facets of this outcome as described by stakeholders and is not validated for use with under 18s. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change.	BSOC: 5 items are scored on a 5-point Likert scale from 1-5 (reduced to 4-point to encourage decisive data). Scores for each item are added together, with a possible score range of 5-20. Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 5-20. Size of change was self-reported on a 4-point scale from ‘no change’ to ‘a large change.’ This was used in sensitivity analysis only for the SROI Evaluation analysis.

		- Medium change - Large change	On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. We opted for a 4-point scale, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	
Improved ability to deal with challenges	Brief Resilient Coping Scale (Sinclair & Wallston, 2004) (validated for adults only). Qualitative assessment by Play Therapist and/or parent of children <12 years to be used in place of BRCS. Bespoke, to include (scales to be 7-point):	Brief Resilient Coping Scale (validated for adults only) – used only for parents and adults with disabilities Source Scale Bespoke indicators scored on a 5-point agreement scale to align with BRCS:	The BRCS is a 4-item measure designed to capture tendencies to cope with stress in a highly adaptive manner. It is a well-established tool and has been validated at a general population level. There is no current equivalent tool for children under 12, so bespoke indicators were used for those under 12. A qualitative assessment was	BRCS: Four items are scored on a 5-point Likert scale from 1-5. Scores for each item are added together, with a possible score range of 4-20. Bespoke: Items are scored on a 5-point Likert scale from 1-5. Scores for each item are added together, with a possible score range of 5-25.

	• Number of times felt stressed/overwhelmed in previous 2 weeks period • I can approach a challenging situation calmly • I ask for help and support or share my feelings with others when I am facing a challenge • Time taken to reflect and process (scale, no time at all to taking time daily) • Self-compassion in times of challenge • Satisfaction with support system Size of change: • No change • Small change • Medium change • Large change	• I can approach a challenging situation calmly • I ask for help and support or share my feelings with others when I am facing a challenge • I have self-compassion in challenging times • I am satisfied with my support system • I take time to reflect on things and process them after something challenging happens Objective indicator – 6-point scale from never to every day • Frequency of feeling stressed/ overwhelmed in previous 2 weeks period Size of change: • No change • Small change • Medium change • Large change	proposed, however, responses are anonymous, so it was not possible to identify stakeholder participants for specific qualitative review. A further set of bespoke indicators was designed to support the BRCS, as it does not capture all of the specific facets of this outcome as described by stakeholders. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	Objective indicator: Item is scored on a 6-point scale from 1-6. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

Table 15: Health and Continence indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning

Outcome	**Proposed in forecast**	**Indicator used**	**Reasoning**	**Scoring**
Health and Continence				

Improved ability to participate in activities and day-to-day life	Bespoke, to include (scales to be 7-point): • Number of activities missed or negatively impacted • Impact on mobility • Level of participation in school/ social activity • Hours per week spent on health concern management • Perception of time spent, i.e., too much, as expected, etc. • Satisfaction with ability to participate in activities Size of change: • No change • Small change • Medium change • Large change	Bespoke indicators scored on a 5-point Likert scale: • I miss out on activities or other things I want to do • I miss school or work • I miss out on social events • Satisfaction with ability to participate in activities Objective indicators relevant for continence management only*: • Hours per week spent on continence management – split between catheterisation and bowel management ○ Less than half an hour to more than 1.5 hours (catheterisation) ○ Less than 1.5 hours to more than 4 hours (bowel) Size of change: • No change • Small change • Medium change • Large change	This outcome is nuanced and so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. Frequency was decided to be more comparable between pre- and post- intervention data than number of times, so missing out indicators were scored on a 5-point Likert scale. Hours spent on management was discovered to be relevant only for the Continence Clinic service on further exploration in *Evaluation Stage 1 – Qualitative*. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. Size of change indicator included to enable direct comparison of data	Bespoke: Items are scored on a 5-point Likert scale from 1-5. Scores for each item are added together, with a possible score range of 4-20. Objective indicator: This indicator will help us understand baseline patterns, but it won't be used to measure change or progress in this SROI analysis. We want to explore how time allocation interacts with other factors, and future analyses may incorporate this more deeply. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

			against the Forecast, and to support evaluation of other indicators used.	
Increased sense of freedom	Bespoke, to include (scales to be 7-point): • Number of times day/plans/schedule are interrupted by health concern • Time spent thinking about/ worrying about health concern (amount and scale, far too much to no time at all) • Time in between episodes of pain/ discomfort (amount and scale, nowhere near enough to no pain/discomfort) • Time in between action to manage health concern (amount and scale, nowhere near enough to no management needed) • Level of freedom to move around (mobility) • Degree to which they feel it is negatively impacting their freedom Size of change: • No change • Small change	Bespoke indicators scored on a 5-point Likert scale: • My day, plans or schedule are interrupted by my podiatry needs or management • I worry about my podiatry needs or management • I am in pain or experience discomfort because of my podiatry needs or management • I am free to do what I want to do • I feel my podiatry needs or management is negatively impacting my freedom Size of change: • No change • Small change • Medium change • Large change	This outcome is nuanced and so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. Frequency was decided to be more comparable between pre- and post- intervention data than number of times, so indicators were scored on a 5-point Likert scale for frequency. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. Size of change indicator included to enable direct comparison of data	Bespoke: Items are scored on a 5-point Likert scale from 1-5. Scores for each item are added together, with a possible score range of 5-25. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

	• Medium change • Large change		against the Forecast, and to support evaluation of other indicators used.	
Improved physical wellbeing	WHOQOL-BREF (The WHOQOL Group, 2008) adjusted for physical indicators only, to include: • Satisfaction with health • Physical pain preventing you from doing what you need • How much medical treatment needed to function in daily life • Having enough energy for daily life • How well are you able to get around • Satisfaction with ability to perform daily activities Size of change: • No change • Small change • Medium change • Large change	WHOQOL-BREF adjusted for physical indicators only, to include the below, scored on a 5-point Likert scale: • To what extent do you feel physical pain prevents you from doing what you need to do? • How much do you need medical treatment to function in your daily life? • How well are you able to get around? • How satisfied are you with your sleep? • How satisfied are you with your ability to perform your daily living activities? • How satisfied are you with your capacity for work/school? Source and scale Size of change: • No change • Small change • Medium change	The WHOQOL is a large validated and widely used tool designed by the World Health Organisation to measure generic quality of life. It is not feasible to use the full tool within this analysis because of its size, and even the brief version (WHOQOL-BREF) is too large and covers elements not relevant to this SROI analysis. The WHOQOL-BREF can be graded by domain and the domain included is Physical Health. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	WHOQOL-BREF: Indicators included are from Physical Health domain. Scores for each item are added together to generate a domain score, with a possible score range of 6-30 . Higher scores indicate better physical health. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

		- Large change		
Improved peace of mind and confidence in the treatment or management of the issue	- Rosenberg's Self-Esteem Scale (RSES) (Sinclair et al. 2010) for clients not <12 years - Qualitative assessment by Play Therapist and/or parent of children <12 years will be used in place of RSES 7-point Likert scales – Bespoke, to include: - Level of stress relating to health concern and treatment of same - Level of pain/ discomfort experienced relating to health concern - Access to services for health concern in previous 6 months: easy, comfortable, accessible, stress-free (scale, very much so to not at all) Size of change: - No change - Small change - Medium change	Bespoke indicators scored on a 4-point agreement scale: - I am stressed about my [relevant health issue] needs or management - My [relevant health issue] needs feel manageable for the long-term - I have a positive relationship with the management of my [relevant health issue] needs - I am confident to go to appointments about my [relevant health issue] needs - Appointments about my [relevant health issue] needs cause me stress or upset - Appointments about my [relevant health issue] needs are accessible for my needs Size of change: - No change - Small change - Medium change - Large change	The RSES is a short questionnaire with a clinical grading scale to generate an overall score for self-esteem. On further exploration of this outcome in *Evaluation Stage 1 - Qualitative* it became clear that self-esteem isn't the correct focus point. Confidence in this case is about confidence in the service and belief in the long-term manageability of the relevant health issue. The RSES was dropped as an indicator and replaced by bespoke indicators. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when	Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 6-24. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

	• Large change		considering accessibility of the data collection. We opted for a 4-point scale, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	
Feelings of empowerment and inclusion in the service provided	7-point Likert scales – Bespoke, to include: • Level of empowerment experienced attending health-related services in previous 6 months (scale from disempowered to empowered) • How much HCP involved client in the process • Awareness of choice and right to withdraw consent • I feel listened to and understood by healthcare professionals • I feel respected by healthcare professionals	Bespoke indicator scored on a 5-point Likert scale: • Level of empowerment experienced attending health-related services in previous 6 months Bespoke indicators scored on a 4-point agreement scale: • I feel comfortable saying no to a procedure or treatment option • I feel comfortable telling the healthcare professional that I've changed my mind about a procedure or treatment option	This outcome is nuanced and so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale	Bespoke – set 1: Item is scored on a 5-point Likert scale from 1-5. Bespoke – set 2: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 4-16. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

	Size of change: • No change • Small change • Medium change • Large change	• I feel listened to and understood by the healthcare professionals • I feel respected by the healthcare professionals Size of change: • No change • Small change • Medium change • Large change	and this was a core concern when considering accessibility of the data collection. We opted for a 4-point scale for some indicators, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against SROI Forecast, and to support evaluation of other indicators used.	

Table 16: Personal Support and Connection Service indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning

Outcome	**Proposed in forecast**	**Indicator used**	**Reasoning**	**Scoring**
Personal Support and Connection				
Reduced loneliness	• UCLA Loneliness Scale (Russel, Peplau & Ferguson, 1978) – adapted to ~10 measures (based on contextual relevance to outcome)	UCLA Loneliness Scale – adapted to 10 measures based on contextual relevance to outcome and avoiding repetitive items Source and scale	The UCLA Loneliness Scale is a 20-item validated measurement tool for loneliness. It is widely used and has been tested for reliability and validity in many settings, including with young people. A 20-item measure is too large to be viable as an indicator	UCLA Loneliness Scale: Items are scored on a 4-point scale from 1 (never) to 4 (often) and positively worded statements are reverse scored. Scores for each item are added together, with a possible score range of 10-40 (for the 10-item adjusted version used).

	Size of change: • No change • Small change • Medium change • Large change	Bespoke indicator on a scale 1-10 (1 not at all): • How lonely do you feel generally? Size of change: • No change • Small change • Medium change • Large change	for a single outcome, so the commissioned Practitioner adapted this scale to 10 measures for use in the SROI analysis. The Personal Support and Connection service is accessed by parents and by adults (and some older teens) with disabilities, so it is not necessary to take measuring loneliness in children into account. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	Bespoke indicator: One item scored 1-10. Size of change was self-reported on a 4-point scale from ‘no change’ to ‘a large change.’ This was used in sensitivity analysis only for the SROI Evaluation analysis.
Increased acceptance and feeling accommodated	7-point Likert scales – Bespoke, to include: • I have someone to ask questions to when I’m unsure • I have access to all the support we (family) need • I feel comfortable asking for what we (family) need • I feel welcomed at services • I feel cared for and supported by service-providers • I can rely on service-providers to do what’s needed, e.g., contact other organisations, follow up with me, book future appointments	Bespoke indicators scored on a 4-point agreement scale: • I have someone to ask questions to when I’m unsure what to do • I have access to all the support my family and I need • I feel comfortable asking for what my family and I need • I feel welcomed and accepted at services and appointments • I feel cared for and supported by service-providers • I can rely on service-providers to do what they promise, e.g., contact other organisations, follow up with me, book future appointments Size of change:	This outcome is nuanced and so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale	Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 6-24. Size of change was self-reported on a 4-point scale from ‘no change’ to ‘a large change.’ This was used in sensitivity analysis only for the SROI Evaluation analysis.

	Size of change: • No change • Small change • Medium change • Large change	• No change • Small change • Medium change • Large change	and this was a core concern when considering accessibility of the data collection. We opted for a 4-point scale for some indicators, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	
Increased hope for the future	7-point Likert scales – Bespoke, based on Herth Hope Index (Herth, 1992) to include: • I have a positive outlook towards life • I have hope for my child's future • I believe my child will be well cared for in future • I feel alone/ hopeless • I can see possibilities in the midst of difficulties • I have short and/ or long-range goals (for self and for child)	Adjusted Herth Hope Index and bespoke indicators, scored on a 4-point Likert scale. Source Scale For all respondents: • I have a positive outlook towards life • I feel alone/ hopeless • I can see possibilities in the midst of difficulties • I have short and/ or long-range goals for myself	The Herth Hope Index was a suitable basis for design of indicators; some items from the tool were used as is, some were adjusted for relevance, and some bespoke indicators were added. A set of bespoke indicators was designed by the commissioned Practitioner, based on the Herth Hope Index and qualitative insight collected directly from stakeholders about their experience of the change. Based on the qualitative insights, there were elements of the parent experience that differed from	Adjusted Herth Hope and Bespoke: For all respondents: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 4-16. For parents: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 4-16. For adults with disabilities: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added

	• I have a sense of direction in relation to my child's care Size of change: • No change • Small change • Medium change • Large change	For parents only: • I have hope for my child's future • I worry about my child being well cared for in future • I have short and/ or long-range goals for my child • I have a sense of direction in relation to my child's care For adults with disabilities only: • I worry about who will take care of me in future • I have hope for my future Size of change: • No change • Small change • Medium change • Large change	the experience of adults with disabilities, so there were statements relevant to all respondents and specific statements only relating to one particular group. The Herth Hope Index is scored on a 4-point agreement scale. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	together, with a possible score range of 2-8. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

Improved social inclusion, support, and community	Adjusted Brief Sense of Community Scale (Peterson, Speer & Mcmillan, 2008) – “neighbourhood” replaced with “community” 7-point Likert scales – Bespoke, to include: • Having people to share feelings and challenges with • Satisfaction with social interaction • Satisfaction with support system Size of change: • No change • Small change • Medium change • Large change	Adjusted Brief Sense of Community Scale (BSOC): - “Neighbourhood” replaced with “community” - Reduced from 8 to 5 measures for relevance Source and scale Bespoke indicators scored on a 4-point agreement scale to align with BSOC: • I have people to share my feelings and challenges with • I am satisfied with my support system • I have all the support that I need • I am satisfied with the level of social interaction I have currently • I feel that I am part of a community Size of change: • No change • Small change • Medium change • Large change	The BSOC represents sense of community dimensions of needs fulfilment, group membership, influence, and shared emotional connection. The tool focuses on the context of a physical neighbourhood, so it doesn’t completely fulfil the needs of the outcome but was adjusted to replace the term “neighbourhood” with “community” to fit the Crann context. Further, three measures were removed for lack of relevance, based on qualitative insight collected directly from stakeholders about their experience of the change. A further set of bespoke indicators was designed to support the BSOC as it does not capture all of the specific facets of this outcome as described by stakeholders and is not validated for use with under 18s. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when	BSOC: 5 items are scored on a 5-point Likert scale from 1-5 (reduced to 4-point to encourage decisive data). Scores for each item are added together, with a possible score range of 5-20. Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 5-20. Size of change was self-reported on a 4-point scale from ‘no change’ to ‘a large change.’ This was used in sensitivity analysis only for the SROI Evaluation analysis.

			considering accessibility of the data collection. We opted for a 4-point scale, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	

Table 17: Parents of children and adults attending in-scope services (secondary stakeholders) indicators proposed in preceding Forecast (Assured 2022) compared to indicators used in this SROI Evaluation, and reasoning

Outcome	**Proposed in Forecast**	**Indicator used**	**Reasoning**	**Scoring**
Parents of children and adults attending in-scope services				
Increased sense of comfort in leaving their child to attend services alone	Bespoke, to include (scales to be 7-point): • Number of times child has attended somewhere without carer in past 6 months • Degree of worry to leave child alone for service • I feel comfortable when I am not with my child • I am confident that staff can manage any need/issue that arises	Bespoke indicators scored on a 4-point agreement scale: • I feel worried to leave my child alone to attend a service or activity • I feel comfortable when I am not with my child • I am confident that service-delivery staff can manage any need/issue that arises with my child while I am not there	This outcome is nuanced and so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change.	Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 3-12. Objective indicator: Item is scored on a 5-point scale from 1-5. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

	with my child while I am not there Size of change: - No change - Small change - Medium change - Large change	Objective indicator – 4-point scale from 1-4 - Number of times child has attended somewhere without carer in past 6 months Size of change: - No change - Small change - Medium change - Large change	On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when considering accessibility of the data collection. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	
Relief about their child or children achieving their own outcomes	Bespoke, to include (scales to be 7-point): - Degree of worry parent has about child's current situation - Degree of worry parent has about child's future - Degree to which child has experienced outcomes - I feel relieved about what my child has achieved Size of change: - No change - Small change - Medium change - Large change	Bespoke indicators scored on a 4-point agreement scale: - I feel worried about my child's current challenges - I feel worried about my child's future - I feel confident that my child will achieve positive outcomes in future - My child has progressed noticeably in the past 6 months - I feel relieved about what my child has achieved Size of change: - No change - Small change - Medium change - Large change	This outcome is nuanced and so a validated tool was not found that fit the context well enough to be considered more effective than bespoke measurement. A set of bespoke indicators was designed by the commissioned Practitioner. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 5-20. Size of change was self-reported on a 4-point scale from 'no change' to 'a large change.' This was used in sensitivity analysis only for the SROI Evaluation analysis.

Sense of community and connection with other parents	Adjusted Brief Sense of Community Scale – “neighbourhood” replaced with “community” Bespoke, to include (scales to be 7-point): • Number of parents of children with disabilities they consider friends • Times per week they talk to someone who understands their experience • Satisfaction with social interaction • Satisfaction with support system Size of change: • No change • Small change • Medium change • Large change	Adjusted Brief Sense of Community Scale (BSOC): - “Neighbourhood” replaced with “community” - Reduced from 8 to 7 measures for relevance Source and scale Bespoke indicators scored on a 4-point agreement scale to align with BSOC: • I have people to share my feelings and challenges with • I am satisfied with my support system • I have all the support that I need • I am satisfied with the level of social interaction I have currently • I feel that I am part of a community Objective indicator scored on a 5-point Likert scale • Times per week they talk to someone who understands their experience Objective indicator scored on a scale from 1-20+ • Number of parents of children with disabilities they consider friends	The BSOC represents sense of community dimensions of needs fulfilment, group membership, influence, and shared emotional connection. The tool focuses on the context of a physical neighbourhood, so it doesn’t completely fulfil the needs of the outcome but was adjusted to replace the term “neighbourhood” with “community” to fit the Crann context. Further, three measures were removed for lack of relevance, based on qualitative insight collected directly from stakeholders about their experience of the change. A further set of bespoke indicators was designed to support the BSOC as it does not capture all of the specific facets of this outcome as described by stakeholders and is not validated for use with under 18s. Bespoke indicators have been designed based on qualitative insight collected directly from stakeholders about their experience of the change. On further consultation with the Crann team, it was decided that a 5-point scale was more suitable for the audience as it represents a lower cognitive load tool, is simpler and less ambiguous than a 7-point scale and this was a core concern when	BSOC: 5 items are scored on a 5-point Likert scale from 1-5 (reduced to 4-point to encourage decisive data). Scores for each item are added together, with a possible score range of 7-28. Bespoke: Items are scored on a 4-point Likert scale from 1-4. Scores for each item are added together, with a possible score range of 5-20. Objective indicator 1: Item is scored on a 5-point scale from 1-5. Objective indicator 2: Item is scored on a scale from 1-20+. Size of change was self-reported on a 4-point scale from ‘no change’ to ‘a large change.’ This was used in sensitivity analysis only for the SROI Evaluation analysis.

		Size of change: • No change • Small change • Medium change • Large change	considering accessibility of the data collection. We opted for a 4-point scale, to encourage more active engagement in the survey and reduce the number of neutral responses. The scale pushes participants to lean slightly towards either agreement or disagreement. This modification helps ensure we collect more decisive data while maintaining the integrity of participant perspectives. Size of change indicator included to enable direct comparison of data against the Forecast, and to support evaluation of other indicators used.	

3.7 Measuring Change – Analysis Method

The primary goal of the analysis conducted for this SROI Evaluation was to understand the overall impact of the in-scope themes of services across all participants, so we have used the distance travelled approach combined with a material significance threshold to assess meaningful change. The data for this analysis was collected quantitatively from stakeholders, pre- and post-intervention, in *Evaluation Stage 2 – Quantitative*.

Using average distance travelled as an approach to measure outcomes is particularly effective when the pre- and post-intervention samples differ, as in this case. It focuses on the relative progress made by participants as a group, without assuming a strict individual-level comparison. This method measures progress toward the maximum possible outcome, offering a scalable approach to outcome measurement that remains robust when participant samples vary between time points.

3.7.1. Distance travelled towards outcomes

The distance travelled approach quantifies the percentage of total possible progress made from the pre-intervention score to the post-intervention score, relative to the maximum possible score on the measurement scale.

$$\text{Distance Travelled} = \frac{\text{Post-intervention score} - \text{Pre-intervention score}}{\text{Maximum possible score} - \text{Pre-intervention score}} \times 100$$

Example: Increased Independence (Social Capital)

- Pre-intervention score = 13.08
- Post-intervention score = 16.19
- Total possible score = 20

The formula used to calculate distance travelled was applied as follows:

1. Subtract the pre-intervention score from the post-intervention score to identify the raw improvement made during the intervention:
    - *Change in score = 16.19 – 13.08 = 3.11*
2. Subtract the pre-intervention score from the maximum possible score to calculate the total amount of progress that can be made from the pre-intervention score to the maximum possible score:
    - *Total possible improvement = 20 – 13.08 = 6.92*
3. Calculate the proportion of the total improvement by dividing the raw change by the total possible progress:
    - *Proportion of improvement = 3.11 / 6.92 = 0.449 (or 44.9%)*

This method highlights how much progress participants made relative to the maximum possible outcome, offering a fair assessment of improvement.

3.7.2 Weighting of indicators

Where multiple sets of indicators were used to measure a single outcome, we applied a weighting approach. Individual indicators were equally weighted, but indicator sets varied in size, and the weight of each set was calculated based on the number of items it contained. The average distance travelled for the outcome was then determined by applying the weight of each set.

Example: Increased Self-Confidence (Social Capital)

- Two sets of indicators were used to measure self-confidence.
- Set 1 contained 3 items.
- Set 2 contained 15 items.

1. Calculate the mean distance travelled based on each set of indicators, using the formula in Section 3.7.1:

  - *Mean distance travelled of set 1 = 37.69%*
  - *Mean distance travelled of set 2 = 27.81%*
2. Calculate the weight of each set by dividing the number of items included in the set by the total number of items included for the outcome across all sets:
  - *Weight of set 1 = 3 / (3 + 15) = 0.17*
  - *Weight of set 2 = 15 / (3 + 15) = 0.83*
3. Multiply the mean distance travelled for each set by its weight to calculate the weighted distance travelled:
  - *Weighted distance travelled of set 1 = 37.69% x 0.17 = 6.28%*
  - *Weighted distance travelled of set 2 = 27.81% x 0.83 = 23.18%*
4. Calculate the weighted distance travelled for the outcome by adding the weighted distance of each set together:
  - *Weighted distance travelled for Self-confidence = 6.28% + 23.18% = 29.46%*

This approach allows for a more nuanced analysis of outcomes by factoring in the varying contributions of different indicator sets.

3.7.3 High and Low Range of Error in the Analysis

To evaluate the variability in stakeholder outcomes, the analysis utilised the high and low range of error as a measure of precision. This approach identifies the upper and lower limits around the mean distance travelled, providing an understanding of the range within which outcomes are likely to fall.

The high range of error represents the maximum estimated change, while the low range represents the minimum. Together, these bounds offer insights into both the overall trends and the spread of responses. By incorporating this range, the analysis ensures that variability across stakeholder experiences is reflected, capturing the diversity of outcomes while maintaining a focus on the central tendencies.

This approach is particularly useful in accounting for differences in stakeholder responses, as it highlights the potential for variation within the group while still providing a reliable mean value for comparison. It acknowledges the inherent uncertainties in data collection and supports the robustness of the findings by presenting a clear picture of both average outcomes and their potential variability.

3.7.4 Material Significance

Measuring materially significant change is crucial in SROI analysis, because it ensures we focus on valuing changes that have a substantial impact on stakeholders and the communities served. Establishing a system for scoring changes as materially significant versus non-significant ensures that the SROI Evaluation accurately reflects the true value created by Crann’s services. Setting clear benchmarks for material change allows us to quantify outcome measurement effectively.

A material significance threshold is a predefined cut-off point that identifies what level of change is considered meaningful. While distance travelled helps quantify progress, the threshold ensures that only changes meeting or exceeding a certain level are regarded as significant.

Some of the validated tools used in this SROI Evaluation have recognised materiality thresholds, which were used in the analysis:

- A decrease of 12.5% in clinical score in CORE-10 (where higher scores indicate greater phycological distress) indicates reliable and clinically significant improvement. NB: scoring was reversed in analysis to align with other indicators used.
- The general guideline for psychological assessment with BRCS is an increase of 5+ points (i.e. 25%) constitute a significant or material change.
- A score increase of 0.5 or larger per item on the Brief Sense of Community Scale (2.5 total, or 12.5%) typically indicates a meaningful shift in the sense of community.
- The general guideline for material change on the WHOQOL-BREF is 0.5 to 1 point change per item (i.e. 3-6 total, or 15-30%)

When setting thresholds for bespoke measures, it is important to consider beneficiaries' starting points. Cohorts with higher baseline conditions face greater challenges in achieving significant change, as improvements become harder the closer participants are to an ideal state, a concept known as the "diminishing returns principle" (Riera Prunera, 2023). Bandura's work on self-efficacy highlights that individuals with higher baseline skills or attitudes often need more targeted interventions to see noticeable changes (Bandura, 1997). This principle is widely applied in social impact contexts, where the starting point significantly affects the potential for improvement.

A material significance threshold was applied on a sliding scale, determined by stakeholders' pre-intervention baseline and the remaining distance to the ideal outcome.

Table 18: Materiality thresholds

≤ 50% of possible achievable score	25% uplift
51-74% of possible achievable score	15% uplift
≥ 75% of possible achievable score	10% uplift

The materiality thresholds were set in line with principles outlined in the Standard for Applying Principle 4: Only Include What is Material (Social Value International, 2021) and adapted to the specific context of this SROI Evaluation to ensure a robust analysis of significant outcomes. They represent meaningful and proportional improvements relative to the participants' starting positions. They account for the incremental progress expected based on baseline scores and are substantial enough to indicate real changes in behaviour, skills, or wellbeing, even when the potential for further improvement may be limited by higher pre-intervention scores.

For outcomes measured by multiple indicators, the same weighting approach described in Section 3.7.2 was used to determine the percentage distance travelled needed to meet the relevant threshold. This ensures consistency in applying the threshold across different indicators and outcomes.

To provide context for the analysis, both qualitative findings and a further review of existing research were examined.

3.7.5 Stakeholders who did not experience an outcome

This analysis uses an aggregate approach, meaning that all stakeholder responses, whether reporting significant change, minimal change, or no change, are included in the overall outcome calculations. This ensures that the valuation reflects only the net material change experienced across the stakeholder group, rather than isolating only those who reported a positive impact. Stakeholders who did not experience a material change naturally contribute to lower mean scores and reduced overall outcome values, ensuring that the analysis does not overstate impact.

In qualitative stakeholder engagement, when a stakeholder reported not experiencing a specific outcome, they had experienced other outcomes that were included in the analysis. No stakeholders engaged qualitatively reported not having experienced any of the included outcomes and no stakeholders identified additional outcomes beyond those already captured in the framework. This reinforces that the selected outcomes comprehensively reflect the material changes experienced by those engaging with in-scope services.

Since this analysis approach inherently accounts for stakeholders who did not experience a change, no separate adjustments were required to discount or exclude them from the valuation.

3.8 Identifying sub-groups and other stakeholders

3.8.1 Sub-groups

In this SROI Evaluation, sub-groups are defined as distinct segments within a stakeholder group that may experience different outcomes or levels of impact. Identifying sub-groups is essential to capturing the diverse experiences of participants and tailoring recommendations to address specific needs.

While the initial qualitative research did not reveal clear sub-group distinctions, it was hypothesised that quantitative analysis might uncover meaningful differences. Potential sub-group characteristics, such as gender, age, type of client, specific services accessed, disability diagnosis, and, for parents, the number and/or age of their children, were considered based on their relevance to stakeholders' experiences and outcomes.

Survey responses were analysed to identify sub-groups, testing for variations in outcomes across different groups. While no sub-groups consistently differed from the total sample across all outcomes, indicative differences for specific outcomes were found and are detailed in Chapters 5 to 9.

Table 19 outlines the segment sample size needed for statistically robust analysis at a +/- 10% variance with a 95% confidence level, based on the total number of stakeholders engaged in the SROI data collection. However, due to the wide variation in respondent characteristics, these sample sizes could not be achieved. Instead, a threshold of 10% representation of the total sample size for each theme was set to enable exploratory qualitative segment analysis.

Table 19: Sample size required for segments at +/-10% variance at 95% confidence

Theme	Engaged in measuring change quantitatively	Segment size for +/- 10% variance at 95% confidence	10% of total segment included for exploratory qualitative analysis
Clients			
Psychological Wellbeing	52	30	5
Social Capital	52	34	5
Health and Continence	63	38	6
Personal Support and Connection	31	23	3
Parents of children and adults attending in-scope services			
Secondary stakeholders	30	23	3

Client type
Six distinct client types were included in this SROI analysis:

- Parents of people with disabilities
- Partners of people with disabilities
- Adults with disabilities
- Teenagers with disabilities
- Children with disabilities
- Siblings of children and teenagers with disabilities

Due to the small number of responses from teenagers, it was necessary to combine children and teenagers for effective qualitative segment analysis, therefore reducing it down to 5 segments.

Client type segmentation was successfully applied to the themes of Social Capital and Health and Continence. However, segmentation was not conducted for Psychological Wellbeing or Personal Support and Connection due to smaller sample sizes, which made such analysis infeasible.

There were some indicative differences between children and teenagers with disabilities, and adults with disabilities, in relation to the size of change reported for some outcomes. These are analysed in detail in Chapters 5 to 9.

Table 20: Sample size for client type segments in pre- and post- intervention data collection across all four themes

	Total sample		Parents		Adults with disabilities		Children and teens with disabilities		Siblings		Partners	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Psychological Wellbeing	31	21	6	6	14	4	4	8	5	2	2	1
Social Capital	25	27	-	-	13	16	12	11	-	-	-	-
Health and Continence	38	25	-	-	20	14	18	11	-	-	-	-
Personal Support and Connection	18	13	5	3	12	8	-	-	-	-	1	2

Age
Age was used as a segment only for the Psychological Wellbeing theme, as the client type segments for the other themes already aligned with age categories. For Social Capital and Health and Continence, the in-scope services are exclusively for people with disabilities, with stakeholder groups naturally divided into adults (over 18) and children/teens (under 18). Likewise, the Personal Support and Connection theme applies only to adults.

Although the age range within the adult and child/teen segments was too broad for more detailed age analysis, the over- and under-18 split proved valuable for Psychological Wellbeing. This was due to the diversity of client types within this theme, which included two adult segments (adults with disabilities and parents of children and adults with disabilities) and two child/teen segments (children/teens with disabilities and siblings of children/teens with disabilities), making age segmentation a meaningful approach in this context.

Table 21: Sample size for age segments in pre- and post- intervention data collection for Psychological Wellbeing

	Psychological Wellbeing	
	Pre	**Post**
Under 18	9	9
Over 18	22	12

Gender
Four gender categories were included in the data collection:

- Girls and women
- Boys and men
- Non-binary
- Prefer not to say

61% of responses were from ‘girls and women’ and 36% were from ‘boys and men.’ Only 3% of the sample selected the other gender options, so these have not been included due to their small representation.

Crann’s client base is approximately 55% girls and women, and 45% boys and men. The slight over-representation of girls and women in the SROI sample is consistent with broader trends observed in social research, where women are generally more likely to participate in surveys across various formats and contexts (Becker, 2022).

Girls and women more frequently reported experiencing change compared to boys and men, with the reverse being less common. The potential causes for this have been explored within the relevant outcome sections in Chapters 5 to 8.

Exploratory analysis has not been included for gender segments in the Parents stakeholder group due to the smaller sample size.

Table 22: Sample size for gender segments in pre- and post- intervention data collection across all five stakeholder groups

	Girls and women		Boys and men	
	Pre	**Post**	**Pre**	**Post**
Psychological Wellbeing	22	16	9	5
Social Capital	14	13	9	13
Health and Continence	18	15	19	10
Personal Support and Connection	10	7	8	6
Parents	6	18	2	2

Service attended
Three themes have multiple service offerings within them, included in table 20 below, and these have been included for exploratory segment analysis, except for Sibshop, which did not meet the minimum 10% sample threshold.

There were some indicative differences between clients attending different services in the same theme. The potential causes for this have been explored within the relevant outcome sections in Chapters 5 to 7.

Table 23: Sample size for service attended segments in pre- and post- intervention data collection across three relevant themes

	Pre	Post
Psychological Wellbeing	**31**	**21**
Counselling	23	12
Play Therapy	5	7
Sibshop	3	2
Social Capital	**24**	**28**
Social Hub	9	13
Breaking Barriers Theatre Group	15	15
Health and Continence	**38**	**25**
Continence Clinic	26	13
Podiatry	12	12

Disability / diagnosis
It was not possible to include disability or diagnosis as a distinct segment in the analysis due to the wide distribution of responses across ten different neuro-physical disability diagnoses. While some diagnoses met the 10% threshold for inclusion under certain themes, the majority did not, reflecting the naturally small representation of certain diagnoses within the population. This variation made achieving consistent sample sizes across all diagnoses unrealistic. This is reflective of the diverse range of conditions supported by Crann, with many conditions represented by a smaller number of clients.

Table 24 outlines the number of Crann's clients with each primary diagnosis. However, many clients have dual diagnoses and may have selected multiple options in their survey responses, with all responses to the diagnosis question represented in table 24.

Table 24: Number of Crann's clients with each primary diagnosis

Diagnosis	Number of Crann clients (including attending themes not in-scope)
Arthrogryposis	10
Cerebral Palsy	136
Hydrocephalus	31
Multiple Sclerosis	36
Muscular Dystrophy	22
Spina Bifida	149

Spinal Cord Injury	52
Stroke	139
Other	71

This broad spread of diagnoses made it difficult to meet the sample size requirements across pre- and post-intervention data to conduct segment analysis for diagnosis segments in each theme. Consequently, the decision was made to exclude disability or diagnosis as a segment to ensure the findings remained robust and representative.

Table 25: Sample size for disability/diagnosis segments in pre- and post- intervention data collection across all five stakeholder groups

	Psychological Wellbeing		**Social Capital**		**Health and Continence**		**Personal Support and Connection**		**Parents**	
	Pre	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**	**Pre**	**Post**
Arthrogryposis	0	0	1	2	1	0	0	0	0	0
Cerebral Palsy	5	4	8	10	6	2	1	7	4	6
Hydrocephalus	2	2	8	8	9	7	1	2	1	3
Multiple Sclerosis	3	2	1	0	2	1	2	3	0	0
Muscular Dystrophy	0	2	0	0	0	0	0	1	0	1
Spina Bifida	7	1	12	4	10	8	1	2	1	5
Spinal Cord Injury	2	1	2	0	5	1	2	0	0	0
Stroke	8	3	0	1	7	4	1	5	1	2
Other	2	2	4	8	5	7	1	1	2	8

Number or age of children

Number and age of Parents' children was explored as a potential segment for parents of children and adults attending in-scope services (secondary stakeholders). However, no segments met the 10% minimum threshold across both pre- and post-intervention samples for inclusion in exploratory analysis.

Table 26: Sample size for number and age of children segments in pre- and post- intervention data collection for Parents as secondary stakeholders

	Pre	**Post**
Number of children		
1-2 children	7	10
3 or more children	2	11
Age of children		
4-11	6	13
12-17	3	8
18+	0	0

Table 27 indicates which segments are represented in the relevant sections of Chapters 5 to 9 for exploratory analysis.

Table 27: Segments included in exploratory analysis across all five stakeholder groups

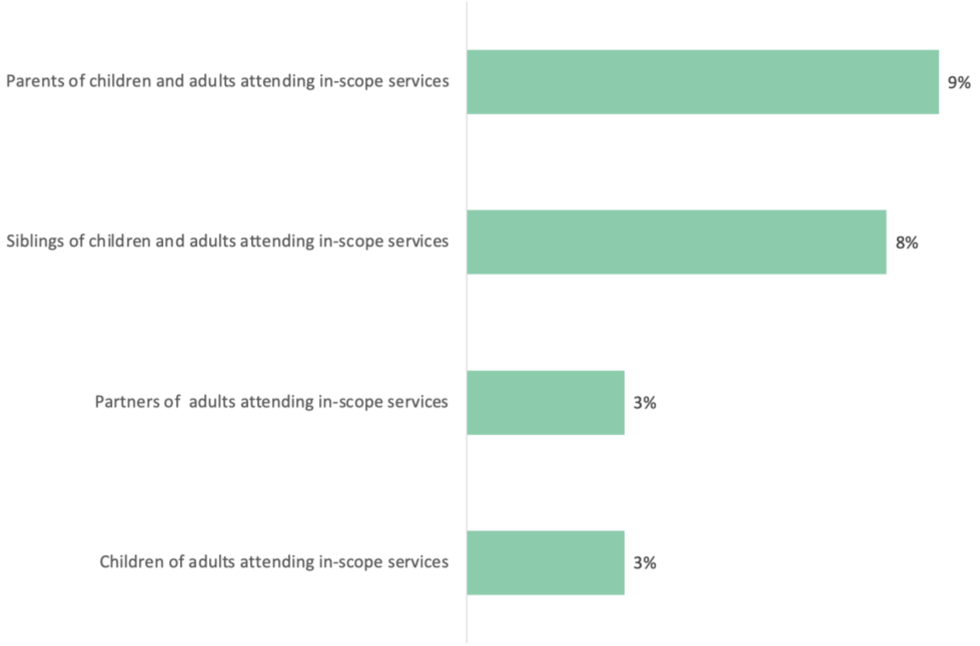
	Psychological Wellbeing	**Social Capital**	**Health and Continence**	**Personal Support and Connection**	**Parents**
Client type		X	X	X	
Age	X	X**	X**		
Gender	X	X	X	X	
Service attended	X*	X	X		
Disability diagnosis					
Number of children					

*Excluding Sibshop due to sample requirements
**Age is included under client type for these themes

3.8.2 Other stakeholders

All stakeholders that were engaged in the quantitative data collection in *Evaluation Stage 2 – Quantitative* were asked to consider whether there were other stakeholders that they believed had experienced change as a result of their participation in Crann's services (i.e. secondary stakeholders).

Figure 3: Proportion of all engaged stakeholders mentioning each potential secondary stakeholder group
n=107 (all post-intervention respondents)



Participants (60 in total; or 26% of the total sample) who suggested another stakeholder who might have been impacted were asked to describe the change they felt that stakeholder had experienced, as a secondary stakeholder (i.e. not attending services themselves).

Parents of children and adults attending in-scope services were the only secondary stakeholder group for whom potentially material changes were suggested by primary stakeholders. The changes suggested for parents of children and adults attending in-scope services aligned closely with the findings from engaging with these secondary stakeholders in the qualitative stakeholder engagement, and the outcomes already included in the ToC for this stakeholder group.

The only change reported for siblings, partners and children as secondary stakeholders was noticing the outcomes achieved by the primary stakeholder and this was deemed immaterial.

Based on the data, no additional secondary stakeholder groups have been included in this SROI analysis.

3.9 Method Limitations

All evaluations and research methodologies have limitations. This report acknowledges the specific limitations of this SROI Evaluation analysis, as detailed below. Wherever possible these limitations have been mitigated as described, and sensitivity analysis has been conducted on the data to account for potential alternative scenarios.

3.9.1 Sample robustness

Convenience sampling was employed in this SROI Evaluation due to the complexity of the sampling requirements. Crann’s service delivery spans multiple programmes under seven thematic areas, four of which are addressed by this analysis, and services cater to diverse client types. Additionally, families often engage with multiple services across the family unit, further complicating efforts to implement a more structured sampling approach. Convenience sampling allowed for practical data collection within this intricate framework while ensuring representation of the breadth of client experiences across Crann’s offerings.

The quantitative sample sizes used in this SROI Evaluation (data collected in *Evaluation Stage 2 – Quantitative*) exhibited a variance of 13-15% for core themes at a 95% confidence level. This variance falls within an acceptable range for social research but does introduce a degree of uncertainty in the results.

The quantitative sample size for Personal Support and Connection had a 24% variance at a 95% confidence level, introducing greater uncertainty in the precision and generalisability of outcome estimates. This should be considered when interpreting the results.

The overall sample size in *Evaluation Stage 2 – Quantitative* limited detailed segment analysis, as the wide variation in respondent characteristics made complex analyses less feasible.

Although Crann made efforts to engage a diverse range of stakeholders during the data collection process, the sample size and participant demographics may have influenced the generalisability of the findings. The sample may not fully represent the broad spectrum of Crann's service users or account for all possible family configurations, which could introduce biases in the data. Additionally, the varying levels of engagement from participants, some of whom may have had more significant interactions with specific services, could skew the outcomes in favour of those services. Ensuring a more representative sample in future SROI Evaluations could strengthen the validity and applicability of the results. Recommendations to achieve this are included in Chapter 13.

Table 28: Average variance of sample achieved across themes

Theme	**Total population relevant for SROI Evaluation**	**Sample achieved pre-intervention** Evaluation Stage 2 – Quantitative	**Sample achieved post-intervention** Evaluation Stage 2 – Quantitative	**Average variance at 95% confidence**
Psychological Wellbeing	59	28	22	15%
Social Capital*	16 (43 total population)	25	27	13%
Health and Continence	78	39	24	14%
Personal Support and Connection	102	10	21	24%

* To ensure a sufficient sample size for analysis, continuing clients of Social Capital services were engaged in the SROI Evaluation through a retrospective pre-intervention survey and a standard post-intervention survey. Both services under

this theme are ongoing, with low attrition rates and limited openings for new clients. However, value has been calculated only for new clients during the SROI period.

3.9.2 Pre- and post-intervention sample that was not composed of the same individuals

The decision to use a pre- and post-intervention sample composed of different individuals for outcome measurement in *Evaluation Stage 2 – Quantitative* was carefully considered to address several practical challenges. Initial engagement with the request for participation in quantitative surveys was lower than anticipated, prompting the inclusion of all available responses to ensure robust data collection. Additionally, the overlapping nature of many services made it complex to isolate a consistent group for both stages of the quantitative data collection in the SROI Evaluation (i.e. pre- and post-intervention). Furthermore, the staggered entry timeline for services throughout the year meant there was not a universally defined "pre" and "post" period for participants. This flexible sampling approach allowed for sufficient data to be collected and is discussed in more detail in Section 3.9.

This is a limitation because it does not allow for direct comparison of pre- and post- intervention measures for a fixed sample of stakeholders. However, this is a common approach used in SROI analyses and can be mitigated in analysis. Average distance travelled is an effective approach for analysing outcome measurement data when the pre- and post-intervention samples differ, because it focuses on the relative progress made by participants, rather than assuming a strict, individual-level comparison. The analysis method has been detailed in Section 3.7.

3.9.3 Challenges in comparing Forecast and Evaluation data

The comparison of SROI Forecast (preceding – Assured in 2022) and Evaluation data in this SROI analysis is influenced by the differing methodologies employed for data collection. The Forecast approach followed common SROI Forecast practices, using post-intervention self-reporting to estimate the size of change experienced for each outcome. This method allows for the estimation of anticipated value when pre- and post-intervention data are unavailable, relying on stakeholder perceptions and retrospective assessments.

In contrast, this SROI Evaluation employed a more robust methodology, collecting pre- and post-intervention data against a range of indicators. While this approach provides greater objectivity and depth in measuring change, the datasets generated by the two methods are not directly comparable. However, the self-report measures used in the SROI Forecast were replicated in the SROI Evaluation and included in the sensitivity analysis to ensure alignment and provide additional insights into the consistency of findings.

3.9.4 Parents are the point of contact for many clients

For many families at Crann, one parent is the main point of contact for all members of the family who attend services. This meant that when quantitative surveys were sent out, in *Evaluation Stage 2 – Quantitative*, to families whose children attend services, including adult children in some cases, the links were received by the parent, not by the client directly.

This was mitigated by providing clear and direct instructions on how surveys should be completed and by whom. In cases where parental support with comprehension or completion was required, parents were advised to include their child in the process of responding to the survey and to use their child's own responses as much as possible, i.e. to act as a support, not a proxy. In the case of very young clients, who may have struggled to engage, parents were encouraged to use their own observations of their child(ren) to support completion, only where the client themselves was unable to provide an answer. In the case of older children and adults who were able to complete the process themselves, parents were advised to provide the survey to the client and allow them to complete it independently.

3.9.5 A need to avoid research fatigue

It is often the most marginalised groups in society that have the most asked of them, especially by service providers. It is important to Crann that their clients do not feel they are expected to 'jump through hoops' to access services, and so avoiding research fatigue and being cautious about how much was asked of stakeholders was of core importance to the project.

Families at Crann often attend a range of services across different family members, which means that a single family might have been eligible to participate in many quantitative surveys for the SROI Evaluation. To avoid over-asking of families, a process was undertaken by the services team and Research & Impact Lead at Crann to keep track of which families had received surveys, and the service staff assessed when a family's capacity for responses had been reached based on their understanding of individual families' capacity to engage. This is in line with Crann's family-centred and bespoke approach to service delivery and client engagement. While we believe that a representative sample has been achieved within each theme of services, it is necessary to acknowledge that this approach may have limited the response from some families who had attended particular services.

3.9.6 Positive responder bias

Not all eligible individuals participated in the qualitative or quantitative research for this SROI Evaluation, and it must be acknowledged as a limitation that this may have led to positive responder bias, as those who felt most engaged with Crann were also most likely to participate in this study. It is also possible that language used in research tools, question presentation, setting and other factors may have led to positive responder bias.

An unbiased Social Value Practitioner was commissioned to conduct all stakeholder engagement and data collection design. In the qualitative research conducted during Evaluation Stage 1 – Qualitative, stakeholders were first invited to share their experiences unprompted. They were then introduced to the ToCs, presented as neutral concepts, and asked if they had any experience of outcomes in relation to the specific service. Participants were assured that "no" was a complete answer and there was no expectation that they should have experienced any or all of the outcomes.

The quantitative data collection conducted in *Evaluation Stage 2 – Quantitative* relied heavily on validated tools and other objective indicators, and all questions were asked in a direct way, avoiding emotive or leading language. All quantitative research was completely anonymous, and data was collected digitally, to mitigate positive responder bias in this setting. Further to this, a comprehensive sensitivity analysis, covered in Section 11.8, has been conducted to account for potential alternative scenarios relating to positive responder bias.

3.9.7 Online data collection and literacy requirements

The reliance on online data collection introduced certain limitations related to accessibility and literacy requirements, particularly for children, as well as for teens and adults with disabilities who may face challenges in independently completing digital surveys. To mitigate this, parents or caregivers were invited to support respondents who were unable to complete the surveys by themselves. Parents were instructed to act as facilitators rather than proxies, ensuring that the responses reflected the perspectives and experiences of the person with a disability.

While this approach helped address potential barriers to participation and improved data completeness, it introduces a degree of variability. The influence of the supporting parent or caregiver could have inadvertently shaped responses, despite guidance to use the respondent's own answers. This consideration should be considered when interpreting the results, as the facilitation process may have impacted the consistency of responses across the sample.

3.9.8 Variability in defining the post-intervention point

A key consideration in this evaluation is the variability in defining the "post-intervention" point across services. The number of sessions attended to reach the post-intervention stage differs depending on the format and delivery model of each service. This variability reflects the tailored nature of Crann's services, where the frequency and duration of engagement are adapted to suit the unique needs of each service and its clients.

While this approach aligns with Crann's person-centred and flexible delivery model, it introduces a methodological consideration. Services with a higher number of engagements may allow for more sustained or cumulative progress compared to those with fewer engagements, potentially influencing the outcomes reported at the post-intervention stage. As such, comparisons between services must account for this difference in service delivery formats to ensure that interpretations remain contextualised and meaningful.

This consideration does not indicate a flaw in the data collection or service design but underscores the importance of recognising service-specific factors when analysing and comparing results.

3.9.9 Potential to mask variability

The use of mean distance travelled as the analysis method offers a robust approach to measuring change, particularly given the use of separate samples for pre- and post-intervention data. This method effectively incorporates all stakeholder experiences by calculating the average change across all responses. However, a potential limitation is that significant differences within the group may be masked by focusing on the mean.

While this does not compromise the accuracy of the findings, it highlights the importance of complementary analyses to provide additional context where notable variations may exist. To address this, the SROI Evaluation incorporated additional analysis of variations, and extensive qualitative insight to provide a more well-rounded view of the data. This approach helped ensure that the diversity of stakeholder experiences was considered, though the inherent limitations of averaging remain a factor when interpreting the findings.

3.9.10 Inability to measure drop-off

Drop-off, which tracks the extent to which the benefits of an intervention decline over time, could not be included in this SROI Evaluation due to the lack of historical baseline data. This year's analysis focuses on the initial baseline and the change experienced by clients within the SROI Evaluation period.

While the absence of drop-off measurement limits the ability to assess the sustainability of outcomes at this stage, the establishment of a robust baseline this year lays the foundation for future SROI Evaluations. Moving forward, this baseline will allow for the measurement of drop-off and provide a deeper understanding of the long-term impact of Crann's services.

3.9.11 Subjectivity in valuation

Placing a financial value on non-economic outcomes, such as wellbeing or social inclusion, can introduce subjectivity, as it often relies on assumptions or proxies. Despite thorough explanation, opportunity for clarification and careful moderation of the value games used with stakeholders in the preceding SROI Forecast, the risk still exists that clients may not be able to equate the value of the outcomes they achieved with the potential value of another good or service. This is an inherent limitation of the SROI methodology. In an effort to mitigate this, two modified value games were used to identify values, the results of which were averaged, once notable outliers had been removed.

However, the risk of subjectivity and misunderstanding still exists to some degree because of the nature of modified value games. To ensure consistency with the SROI Forecast, the stakeholder generated values have been used to generate the SROI ratio for the SROI Evaluation but alternative, concrete and objective values from other sources, identified through desk research, have been tested for each outcome. A full sensitivity analysis has been conducted, and the valuation variable has been tested across all outcomes, covered in Section 11.8.

3.9.12 Use of estimations in SROI analysis

Estimations of each outcome's valuation, duration, attribution, deadweight, and displacement have been used in the SROI analysis. All estimations in this report have been calculated based on data and views obtained from stakeholders in the SROI Forecast and *Evaluation Stage 1 - Qualitative*. However, in some cases there were significant differences between estimations made by stakeholders, and in some cases the sample of responses was small. To account for this, estimations with less evidence were estimated conservatively. The comprehensive sensitivity analysis conducted, covered in Section 11.8, also calculated the SROI ratio range based on adjustments to these estimations.

3.9.13 Potential risk of data errors

A potential limitation of this analysis lies in the risk of errors within the data used for the SROI Evaluation. This risk arises from various stages of data collection, processing, and interpretation. While every effort was made to ensure the accuracy and reliability of the data, such as cross-checking responses, removing outliers, and validating assumptions through qualitative and quantitative methods, the possibility of inaccuracies cannot be fully eliminated. These potential errors could impact the calculated Social Value Ratio, and the conclusions drawn from the analysis. To mitigate this risk, the methodology adhered closely to the seven principles of SROI, including transparency and verification. Additionally, sensitivity testing was conducted to understand how variations in key assumptions or data inputs might affect the overall findings. Despite these precautions, it is important to acknowledge this limitation when interpreting the results.

3.9.14 Staff changes and growth

The Crann Centre commenced operations in 2019 with a core team of 3 staff. The period from 2019 to present has seen major growth in activities, service developments and the recruitment and integration of a staff team which currently numbers 25. Recruitment and integration at various levels of the organisation presented a challenge throughout the evaluation process. Changes in key roles, particularly those responsible for data collection and coordination, resulted in periods of transition that affected the consistency and continuity of the evaluation. New staff members needed to be onboarded and trained on the specific requirements of the evaluation, which led to some delays and occasional disruptions in the flow of data collection. Furthermore, the absence of staff with institutional knowledge from the preceding SROI Forecast (assured in 2022) sometimes created difficulties in maintaining a consistent approach across different stages of the process. These transitions occasionally affected the timely execution of certain evaluation activities and required additional time to ensure that new staff members were fully aligned with the project's objectives.

3.9.15 Changes in service provision and access

As stated above the period from 2019 to present was typified by a significant growth in programme development and delivery. Services were introduced to support a coordinated approach to service delivery and were live tested with children, adults and families. As Crann's services were adapted in response to emerging community needs and logistical considerations, establishing consistent data collection points was challenging at times. The Services team and Research & Impact Lead managed the data collection points internally, bearing in mind the wider context of service provision and access throughout the Evaluation period, but this may have impacted the completeness and consistency of the data collected.

3.9.16 External variables influencing outcomes

Crann's services represent one component within the broader context in which families operate. External variables, such as socioeconomic conditions, local community resources, and individual family dynamics, also significantly influence outcomes. While stakeholders have provided estimates for attribution and deadweight, and these have been incorporated to mitigate this limitation, they remain subject to the inherent constraints of estimation, as outlined in Section 3.9.12. These contextual factors, outside of Crann's control, can affect the well-being of families and individuals, complicating the attribution of outcomes solely to Crann's interventions. This must be considered when interpreting the SROI findings, as the broader social, economic, and environmental context inevitably plays a role in shaping the effectiveness of the services provided.

3.9.17 Considerations for data collection and outcome timeframes

The integrated nature of Crann's 2Gen Model of Care, encompassing multiple service areas, involves a tailored approach to addressing diverse needs. This results in natural variations in the timing and nature of outcomes, as some services lead to immediate improvements while others focus on longer-term changes. These variations reflect the unique objectives of each service but should be considered when interpreting the findings of this SROI Evaluation.

While the methodology accounts for these differences, such as by using service-specific indicators and timelines, the variation in outcome timeframes and measures highlights the importance of understanding the broader context of the results.

3.9.18 Impact of Covid-19 on SROI Forecast Comparability

A key limitation of the SROI process, encompassing both the preceding SROI Forecast and this SROI Evaluation, is the potential impact of its timing. The initial SROI Forecast was conducted in 2022 during the peak of the Covid-19 pandemic, a period characterised by unique societal and economic conditions, including disruptions to service availability, changes in stakeholder behaviours, and variations in access to supports. These factors may have influenced the outcomes and stakeholder experiences that underpin this SROI Evaluation.

The Theories of Change developed during the SROI Forecast have been validated as part of this Evaluation, in *Evaluation Stage 1 – Qualitative*. Aside from some minor linguistic changes to make them more inclusive of stakeholders’ experiences, no changes to the Theories of Change were required, nor were any new outcomes or stakeholder groups identified.

However, it is important to consider that the atypical context of the pandemic may affect the comparability of results between the SROI Forecast and Evaluation. Care should be taken when interpreting the comparison of findings between these phases. To enhance comparability between this and any future Evaluations, it has been recommended in Chapter 13 that the Theories of Change and other elements of the SROI should be re-validated prior to any subsequent SROI Evaluations.

3.10 Summary

This chapter has set out the methodology conducted to complete the SROI Evaluation analysis. Despite its limitations, this is a robust method for data collection, analysis, and value calculation. Every effort was made to mitigate limitations, both within the methodology and through sensitivity analysis. The methodology was conducted in line with the seven principles of SROI and the data collected is believed to be precise enough to support an analysis of the value created by these four themes of Crann’s services during the SROI Evaluation period.

4. Theories of Change

4.1 Overview

A clear and well-defined understanding of the change experienced by stakeholders is fundamental to an SROI analysis. Central to this is the development of a Theory of Change (ToC), which serves as both a visual diagram and a detailed narrative. The ToC outlines the sequence of changes that lead to the outcomes experienced by stakeholders, providing a structured framework to connect activities, outputs, and long-term impacts in a way that highlights how value is created.

The following ToCs were developed through extensive stakeholder engagement, during the preceding SROI Forecast (Assured in 2022). Engagement of stakeholders for the development of the ToC involved exploring outcomes in an unprompted qualitative research setting. Stakeholders were not prompted to discuss intended outcomes and were encouraged to describe all of the changes they experienced from their perspective and in their own words, including any negative experience or change. The data collected was used to develop a ToC for each stakeholder group, which illustrated the chain of events based on stakeholder insight and consultation with experts at Crann. These ToCs were validated within the SROI Forecast in a quantitative survey which included open ended questions to provide additional context and insight.

Stakeholders were offered opportunities throughout the process to review whether the ToC was representative of their experiences. Both the qualitative discussion guide and quantitative survey used for Theory of Change development and validation in the SROI Forecast can be found in Appendices 3 and 4.

Final outcomes were selected based on their significance to stakeholders, the proportion of participants experiencing change, and the degree of impact observed. Outcomes were assessed against materiality thresholds, ensuring only those with meaningful, measurable, and sustained effects were included in the analysis. Stakeholder validation, scale of change, and alignment with programme objectives informed the final selection process.

The first stage of the SROI Evaluation sought to validate the findings of the SROI Forecast and particularly the Theories of Change:

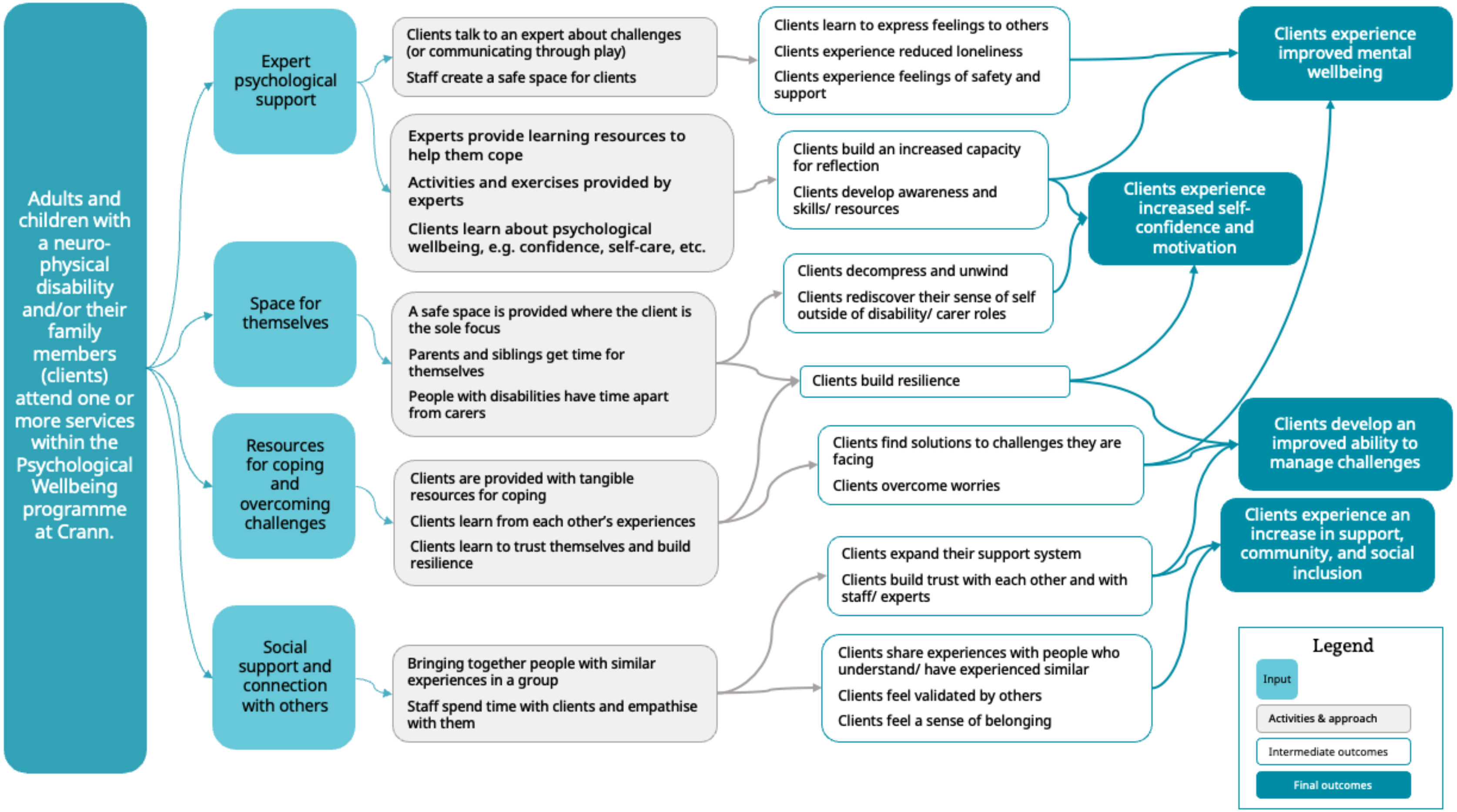
1. Representative validation groups and 1:1 interviews were conducted in *Evaluation Stage 1 – Qualitative* for each client type within each theme included in the SROI Evaluation.
2. Some linguistic changes were made to the ToCs based on the findings from this qualitative research, but no significant changes were indicated for intermediate or final outcomes.

This chapter contains the ToC diagrams for all stakeholders impacted by Crann’s services. The diagrams contain all minor linguistic changes made based on the findings from *Evaluation Stage 1 - Qualitative*. The reasoning for these changes is covered within the qualitative insights detailed in Chapters 5 to 9.

4.2 Theory of Change for Clients of Psychological Wellbeing Services

Psychological Wellbeing Services are delivered in-person, on-site at Crann as well as online in some cases. The core focus of these services is building resilience and sustaining positive mental health. The supports offered are key to dealing with challenges that arise for the person with a disability, their carers, or their family members.

Figure 4: Theory of Change for Clients of Psychological Wellbeing Services



Adults and children with a neuro-physical disability and/or their family members (clients) attend one or more services within the Psychological Wellbeing programme at Crann.

Expert psychological support

Space for themselves

Resources for coping and overcoming challenges

Social support and connection with others

Clients talk to an expert about challenges (or communicating through play)
Staff create a safe space for clients

Experts provide learning resources to help them cope
Activities and exercises provided by experts
Clients learn about psychological wellbeing, e.g. confidence, self-care, etc.

A safe space is provided where the client is the sole focus
Parents and siblings get time for themselves
People with disabilities have time apart from carers

Clients are provided with tangible resources for coping
Clients learn from each other's experiences
Clients learn to trust themselves and build resilience

Bringing together people with similar experiences in a group
Staff spend time with clients and empathise with them

Clients learn to express feelings to others
Clients experience reduced loneliness
Clients experience feelings of safety and support

Clients build an increased capacity for reflection
Clients develop awareness and skills/ resources

Clients decompress and unwind
Clients rediscover their sense of self outside of disability/ carer roles

Clients build resilience

Clients find solutions to challenges they are facing
Clients overcome worries

Clients expand their support system
Clients build trust with each other and with staff/ experts

Clients share experiences with people who understand/ have experienced similar
Clients feel validated by others
Clients feel a sense of belonging

Clients experience increased self-confidence and motivation

Clients experience improved mental wellbeing

Clients develop an improved ability to manage challenges

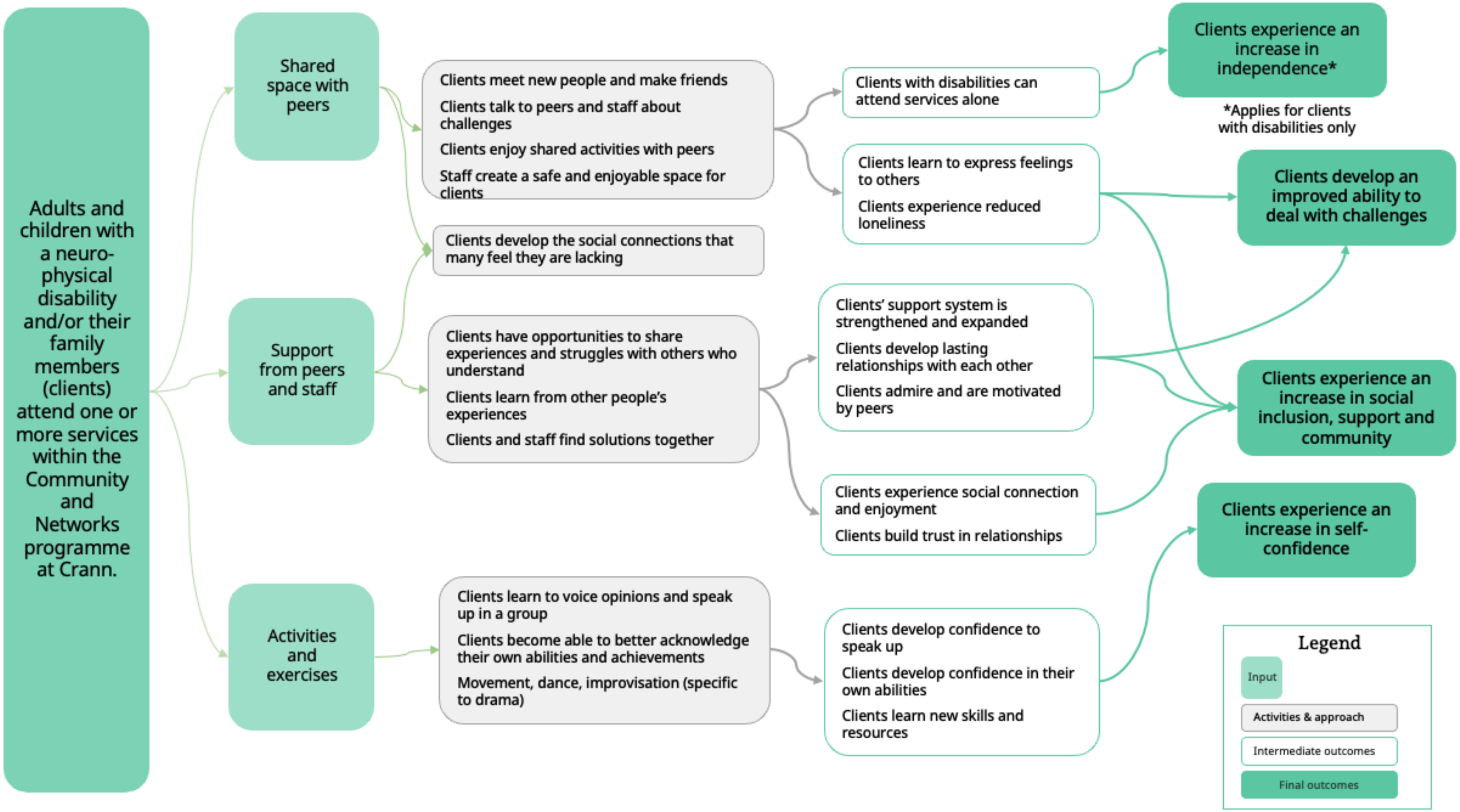
Clients experience an increase in support, community, and social inclusion

Legend
Input
Activities & approach
Intermediate outcomes
Final outcomes

4.3 Theory of Change for Clients of Social Capital

Social Capital Services are delivered both in-person at The Crann Centre and online. The core focus of these services is empowering children and adults to build their social capital and alleviate feelings of isolation and loneliness. The services offered are key to clients having peer-based interactions and meeting with others for social connections and maintaining positive mental health.

Figure 5: Theory of Change for Clients of Social Capital Services



Adults and children with a neuro-physical disability and/or their family members (clients) attend one or more services within the Community and Networks programme at Crann.

Shared space with peers

Support from peers and staff

Activities and exercises

Clients meet new people and make friends
Clients talk to peers and staff about challenges
Clients enjoy shared activities with peers
Staff create a safe and enjoyable space for clients

Clients develop the social connections that many feel they are lacking

Clients have opportunities to share experiences and struggles with others who understand
Clients learn from other people's experiences
Clients and staff find solutions together

Clients learn to voice opinions and speak up in a group
Clients become able to better acknowledge their own abilities and achievements
Movement, dance, improvisation (specific to drama)

Clients with disabilities can attend services alone

Clients learn to express feelings to others
Clients experience reduced loneliness

Clients' support system is strengthened and expanded
Clients develop lasting relationships with each other
Clients admire and are motivated by peers

Clients experience social connection and enjoyment
Clients build trust in relationships

Clients develop confidence to speak up
Clients develop confidence in their own abilities
Clients learn new skills and resources

Clients experience an increase in independence*

*Applies for clients with disabilities only

Clients develop an improved ability to deal with challenges

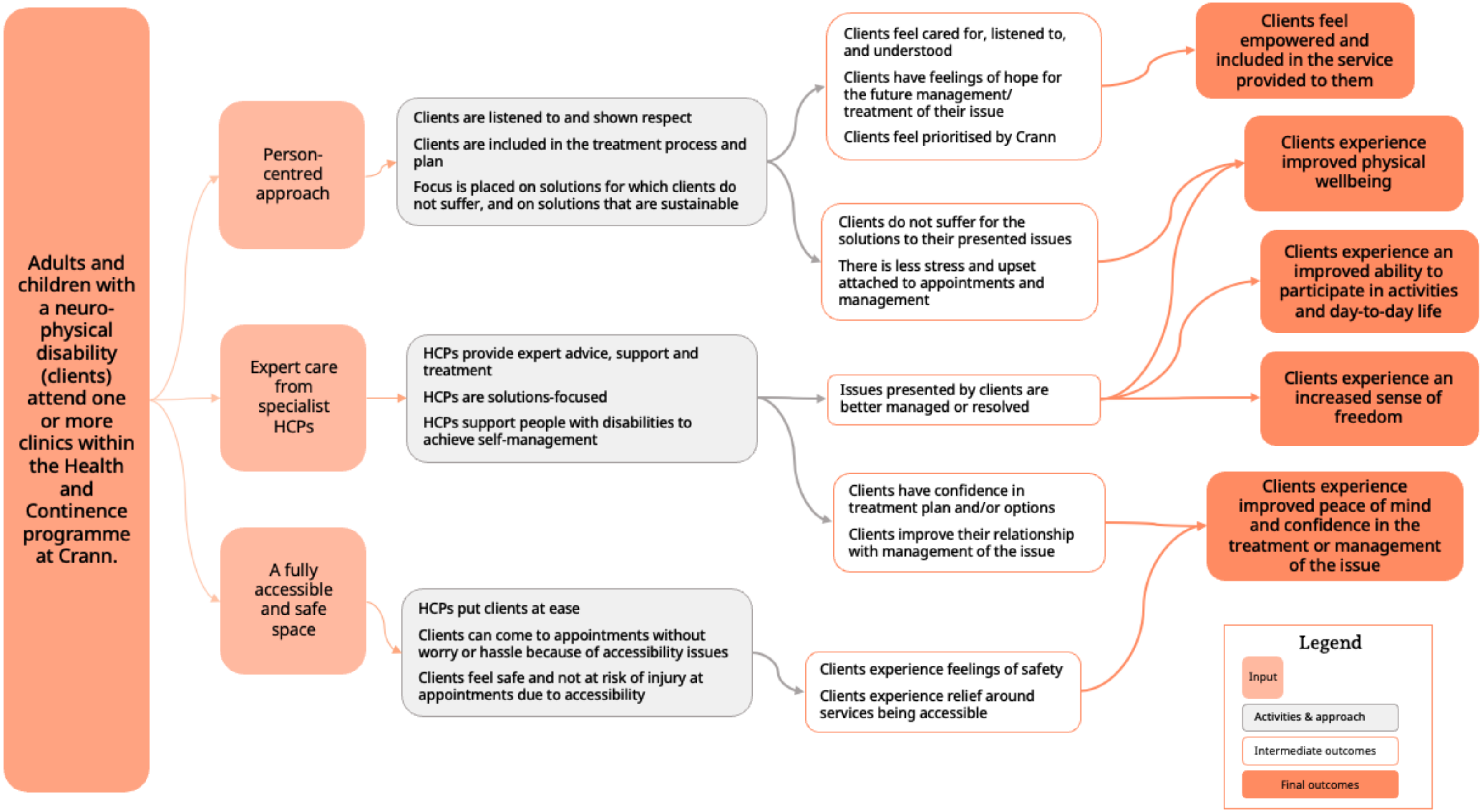
Clients experience an increase in social inclusion, support and community

Clients experience an increase in self-confidence

4.4 Theory of Change for Clients of Health and Continence

Health and Continence Services are delivered in-person, on-site at Crann, and Continence Clinic can be offered online. The core focus of these services is supporting children and adults with disabilities to overcome associated health issues. The services offered are person-centred, an approach for which the need has been highlighted by the HSE in its National Framework for Person-centred Planning in Services for Persons with a Disability (HSE, 2018). The services are focused on helping clients to achieve sustainable solutions and optimise their health.

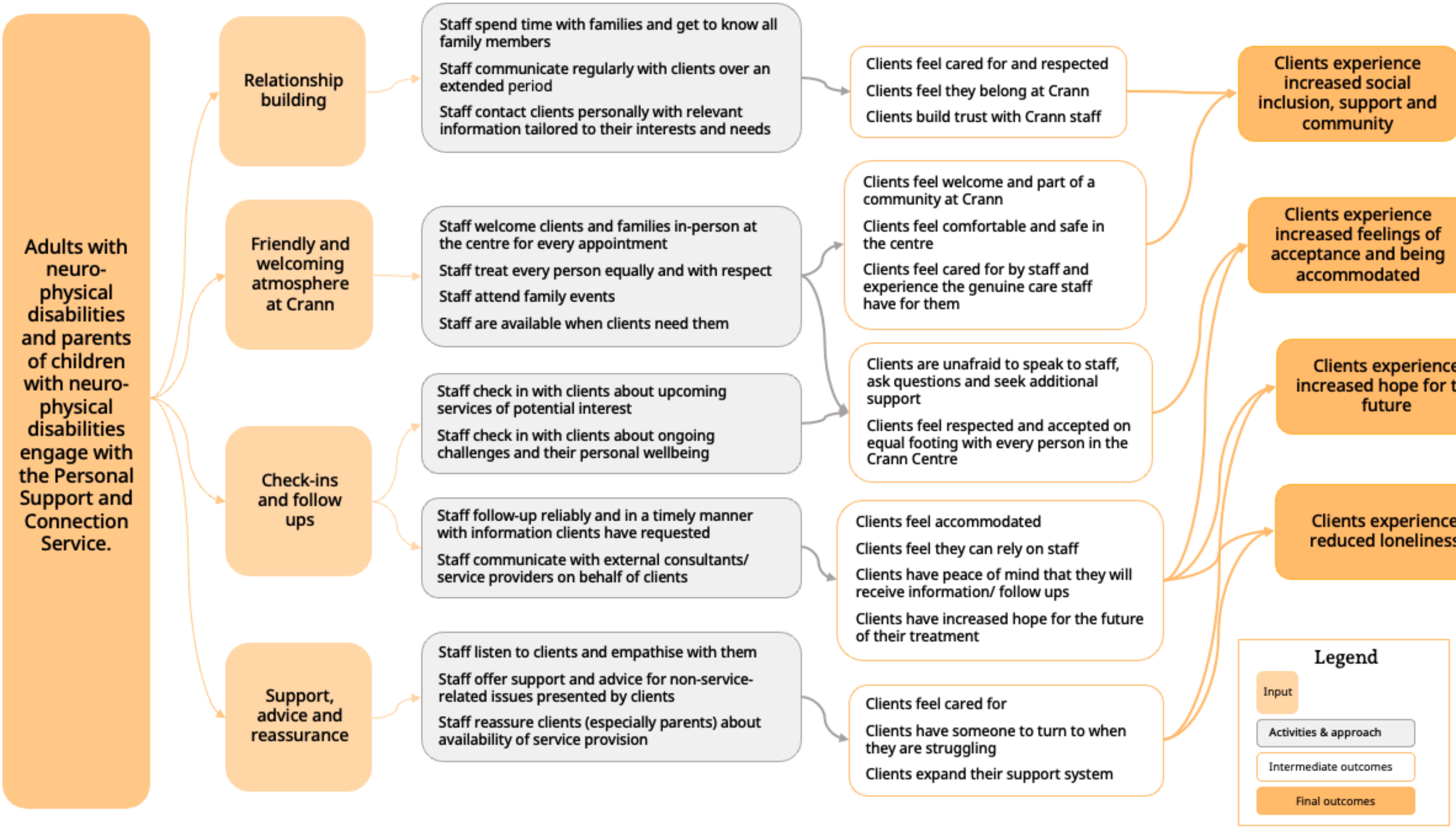
Figure 6: Theory of Change for Clients of Health and Continence Services



4.5 Theory of Change for Clients of Crann’s Personal Support and Connection Service

The Personal Support and Connection Service is delivered primarily by phone and in-person, on-site at Crann. Supporting families is core to Crann’s mission as an organisation, and this is a key part of the roles of all staff at Crann. The core focus of this is to ensure that families feel supported by Crann, and that they feel that they are an active part of a community that cares for them.

Figure 7: Theory of Change for Clients of Personal Support and Connection Service



Adults with neuro-physical disabilities and parents of children with neuro-physical disabilities engage with the Personal Support and Connection Service.

Relationship building

- Staff spend time with families and get to know all family members
- Staff communicate regularly with clients over an extended period
- Staff contact clients personally with relevant information tailored to their interests and needs

Friendly and welcoming atmosphere at Crann

- Staff welcome clients and families in-person at the centre for every appointment
- Staff treat every person equally and with respect
- Staff attend family events
- Staff are available when clients need them

Check-ins and follow ups

- Staff check in with clients about upcoming services of potential interest
- Staff check in with clients about ongoing challenges and their personal wellbeing
- Staff follow-up reliably and in a timely manner with information clients have requested
- Staff communicate with external consultants/ service providers on behalf of clients

Support, advice and reassurance

- Staff listen to clients and empathise with them
- Staff offer support and advice for non-service-related issues presented by clients
- Staff reassure clients (especially parents) about availability of service provision

Intermediate outcomes:

- Clients feel cared for and respected
- Clients feel they belong at Crann
- Clients build trust with Crann staff

- Clients feel welcome and part of a community at Crann
- Clients feel comfortable and safe in the centre
- Clients feel cared for by staff and experience the genuine care staff have for them

- Clients are unafraid to speak to staff, ask questions and seek additional support
- Clients feel respected and accepted on equal footing with every person in the Crann Centre

- Clients feel accommodated
- Clients feel they can rely on staff
- Clients have peace of mind that they will receive information/ follow ups
- Clients have increased hope for the future of their treatment

- Clients feel cared for
- Clients have someone to turn to when they are struggling
- Clients expand their support system

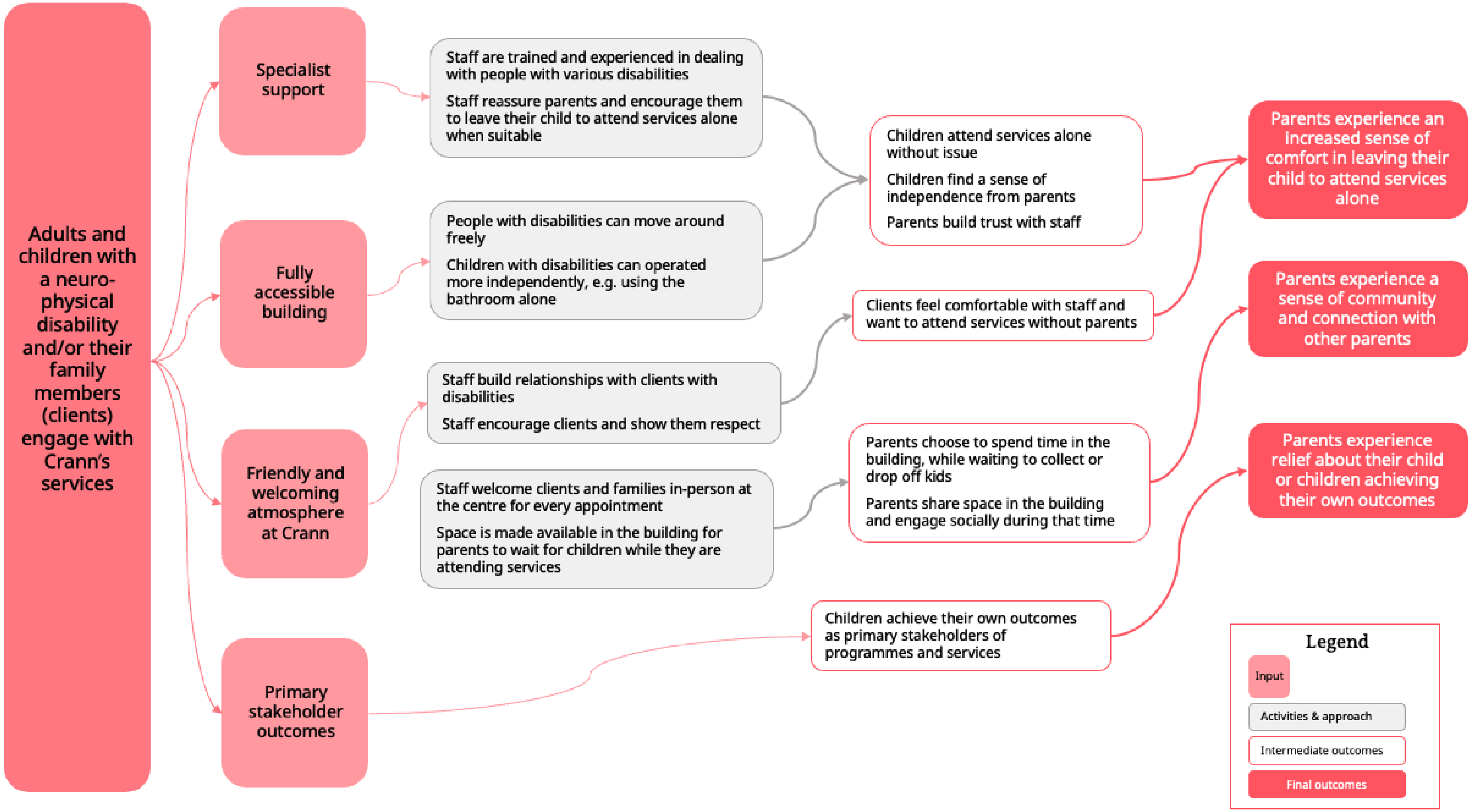
Final outcomes:

- Clients experience increased social inclusion, support and community
- Clients experience increased feelings of acceptance and being accommodated
- Clients experience increased hope for the future
- Clients experience reduced loneliness

4.6 Theory of Change for Parents of Children and Adults Attending In-Scope Services

Crann endeavours to create meaningful impact for families with neuro-physical disabilities, not only through direct impact created for the person with a disability, and not only for clients attending services themselves. Impact is created for parents as secondary stakeholders, outside of any service they might have attended, as demonstrated in the ToC diagram.

Figure 8: Theory of Change for Parents of Children and Adults Attending In-Scope Services



Adults and children with a neuro-physical disability and/or their family members (clients) engage with Crann's services

Specialist support

Fully accessible building

Friendly and welcoming atmosphere at Crann

Primary stakeholder outcomes

Staff are trained and experienced in dealing with people with various disabilities

Staff reassure parents and encourage them to leave their child to attend services alone when suitable

People with disabilities can move around freely

Children with disabilities can operated more independently, e.g. using the bathroom alone

Staff build relationships with clients with disabilities

Staff encourage clients and show them respect

Staff welcome clients and families in-person at the centre for every appointment

Space is made available in the building for parents to wait for children while they are attending services

Children attend services alone without issue

Children find a sense of independence from parents

Parents build trust with staff

Clients feel comfortable with staff and want to attend services without parents

Parents choose to spend time in the building, while waiting to collect or drop off kids

Parents share space in the building and engage socially during that time

Children achieve their own outcomes as primary stakeholders of programmes and services

Parents experience an increased sense of comfort in leaving their child to attend services alone

Parents experience a sense of community and connection with other parents

Parents experience relief about their child or children achieving their own outcomes

Legend

Input

Activities & approach

Intermediate outcomes

Final outcomes

5. Analysis of the change that occurred for Clients of Psychological Wellbeing

This chapter outlines the analysis of the change that occurred for Crann clients who accessed Psychological Wellbeing Services during the SROI period.

Table 29: Summary of outcomes experienced by clients
n=31 (pre), n=21 (post)

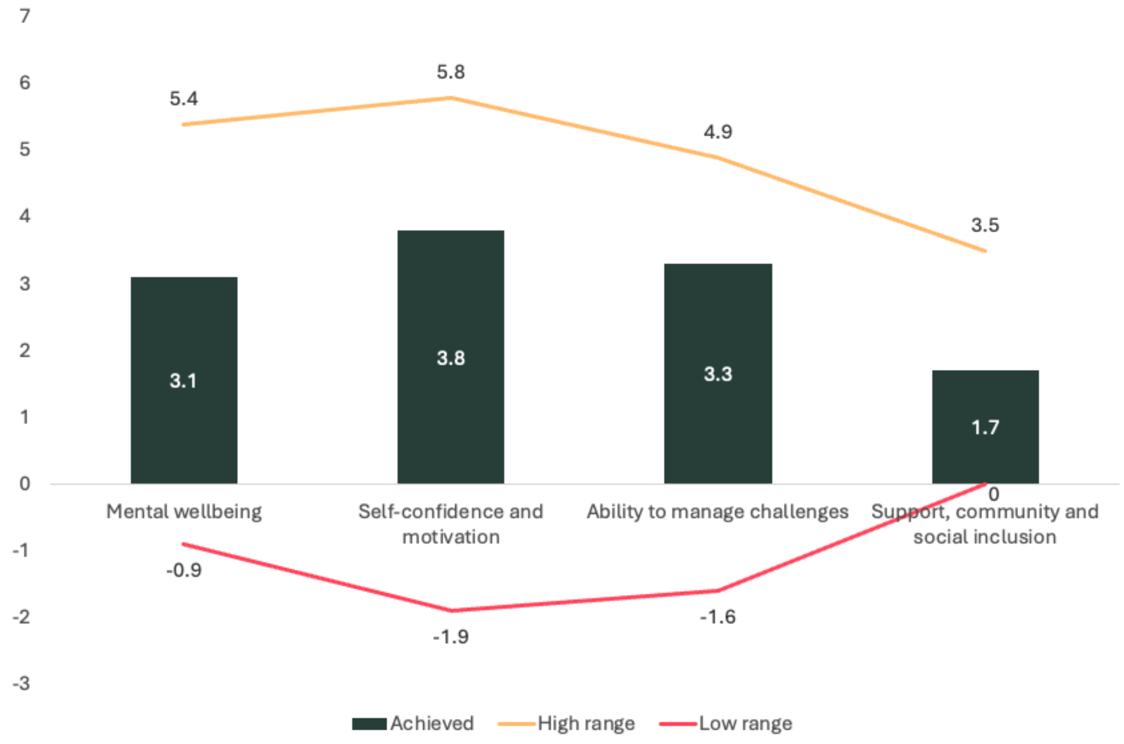
Outcome	Weighted distance travelled	Value ranking by respondents
Improved mental wellbeing	24.5%	#1
Increased self-confidence and motivation	44.9%	#2
Improved ability to manage challenges	32.7%	#3
Increase in support, community, and social inclusion	20.1%	#4

Figure 9 presents the mean distance travelled (average reported change) in scale points for the four outcomes experienced by clients of Psychological Wellbeing Services, based on aggregated quantitative data from *Evaluation Stage 2 – Quantitative*. The green bars represent the actual reported change achieved by stakeholders for each outcome. The yellow line indicates the high range of error for the materiality threshold, while the red line represents the low range of error for the materiality threshold, providing boundaries for interpreting changes as materially significant.

- "Self-confidence and motivation" achieved the highest change (3.8 scale points), within the range of error for materiality (-1.9 to 5.8 scale points), indicating meaningful progress well above the low range of error for the materiality threshold.
- "Mental wellbeing" achieved a moderate change (3.1 scale points), within the range of error for materiality (-0.9 to 5.4 scale points), reflecting notable and materially significant progress.
- “Ability to manage challenges” achieved an average change of 3.3 scale points, within the range of error for materiality (-1.6 to 4.9 scale points), demonstrating consistent progress across the sample.
- "Support, community, and social inclusion" showed the lowest achieved change (1.7 scale points), within the range of error for materiality (0 to 3.5 scale points), highlighting modest but meaningful progress for stakeholders.

This chart highlights how the achieved changes align with the range of error for materiality thresholds, offering valuable insights into the most impactful outcomes for stakeholders.

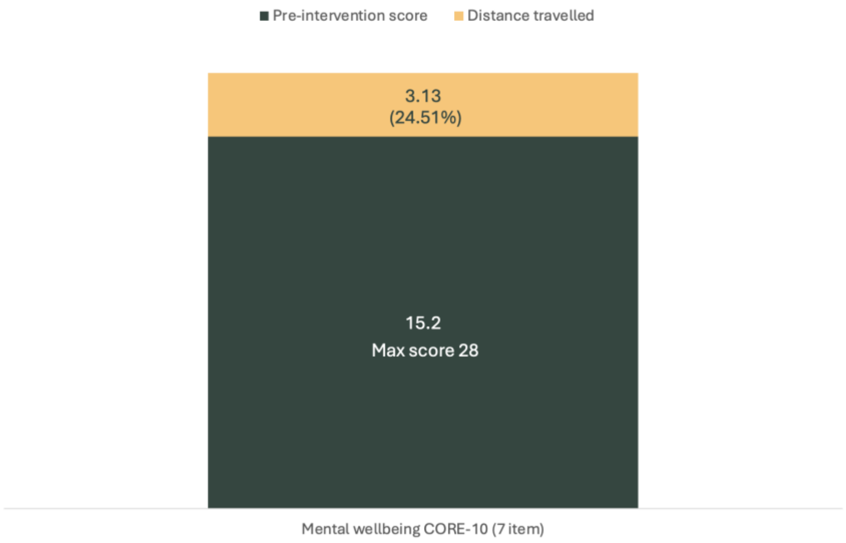
Figure 9: Materiality achieved for Psychological Wellbeing outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit.
n=31 (pre), n=21 (post)



5.1 Outcome: Improved mental wellbeing

The weighted distance travelled for the outcome ‘improved mental wellbeing’ was 24.5% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 10: Analysis of the change achieved for ‘improved mental wellbeing’
n=31 (pre), n=21 (post)



This outcome reflects improvements in mental wellbeing, characterised by increased feelings of calmness and happiness, a stronger sense of self, and a renewed commitment to self-care both mentally and physically. It also encompasses the ability to express difficult emotions and feel comfortable sharing them with others. Collectively, these changes contribute to overall enhanced psychological wellbeing.

> *"I felt I really had to re-establish myself and who I am after the isolation of Covid; Counselling really helped me do that."*
>
> **– Adult with a disability**

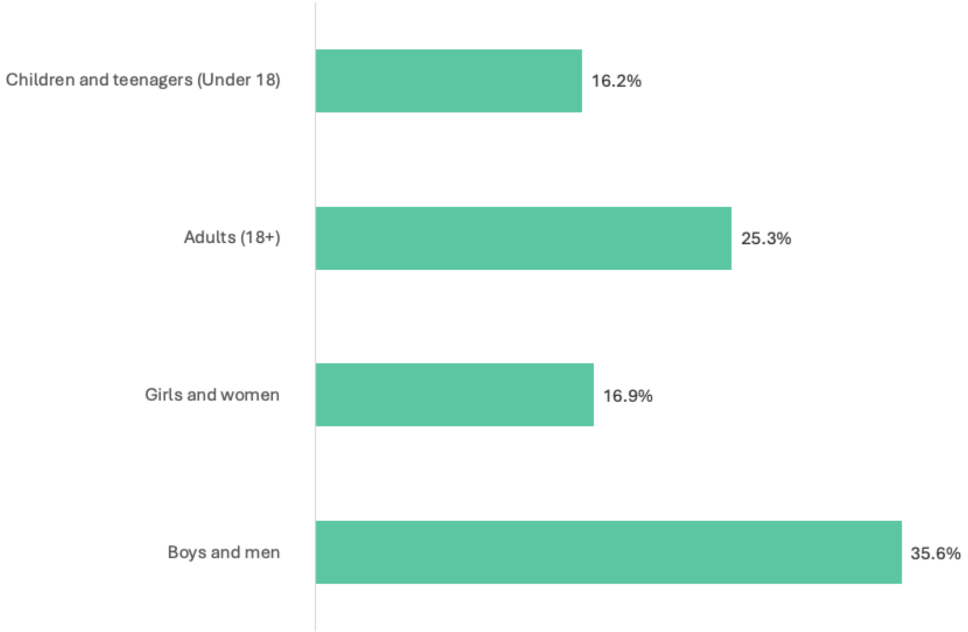
In *Evaluation Stage 1 – Qualitative*, all participants expressed that they had experienced the majority of the intermediate outcomes and agreed that they felt their mental wellbeing had improved because of their attendance at the service. Both children and adults understood the term mental wellbeing without issue and felt comfortable with the language used.

> *"I dealt with my worries in Play Therapy, and I guess I learned how to manage them if they come back, because now I know why they came in the first place."*
>
> **– Child with a disability**

Figure 11 presents the comparative distance travelled across client segments, categorised by age and gender. A detailed analysis is provided following the figure.

Figure 11: Comparison of distance travelled for 'improved mental wellbeing' across age and gender segments

Pre: n=9 (under 18), n=22 (18+), n=22 (girls/women) n=9 (boys/men)
Post: n=9 (under 18), n=12 (18+), n=16 (girls/women) n=5 (boys/men)



In *Evaluation Stage 2 – Quantitative*, change was reported at a slightly higher rate by adults than by children and teenagers. This is not a statistically significant difference but may be indicative. Adults often attend Psychological Wellbeing services with more immediate and tangible concerns that can be directly addressed and resolved in counselling, whereas younger clients often face more developmental, social and emotional challenges that may require longer-term intervention to achieve the same rate of change. Adults also have more advanced emotional skills which can enable them to process and articulate thoughts more effectively than children can, which may lead to a slightly more advanced rate of change such as the one seen here. This may explain why the rate of reported change is lower for younger clients, as their needs often evolve over time and require more ongoing support.

Boys and men reported change at a higher rate than girls and women did. It is likely that gendered social norms and expectations play a role here. Women are more likely to experience more complex pressures, especially within the context of families with disabilities, such as balancing caregiving roles, managing additional responsibilities relating to the wider family's needs, and navigating societal expectations of emotional labour. Research indicates that women are more likely to undertake caregiving duties and report a higher burden compared to men (Pacheco et al, 2024). Boys and men may also experience a greater sense of relief and progress from Psychological Services due to the relative lack of spaces they are afforded in which to discuss emotions (Counselling Directory, n.d.).

Clients of Counselling and Play Therapy* reported change at similar rates for this outcome.

Table 30: Comparison of change achieved for 'improved mental wellbeing' across services attended

Pre: n=23 (Counselling), n=5 (Play Therapy)
Post: n=12 (Counselling), n=7 (Play Therapy)

Service	Weighted distance travelled
Counselling	27.9%
Play Therapy	32.1%

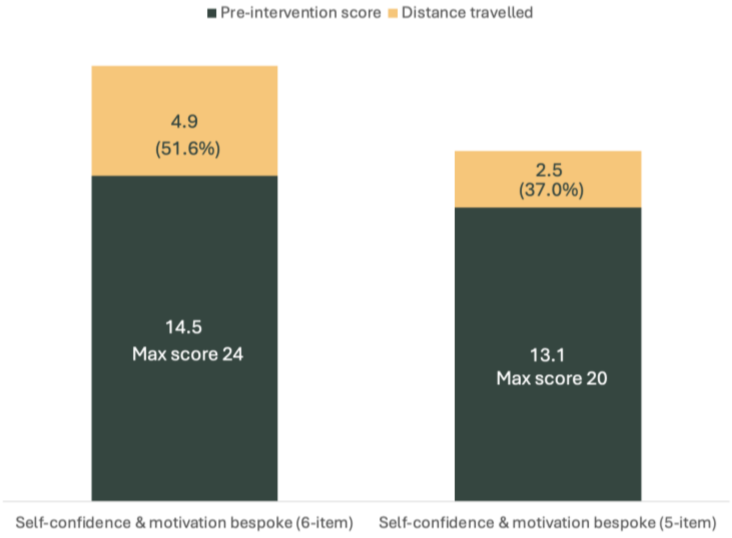
*The sample achieved for Sibshop responses was too small to be analysed as a segment and it has been included only in the theme-level analysis.

5.2 Outcome: Increased self-confidence and motivation

The weighted distance travelled for the outcome 'increased self-confidence and motivation' was 44.9% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 12: Analysis of the change achieved for 'increased self-confidence and motivation'

n=31 (pre), n=21 (post)



	# items	Weight
Set 1	6	0.55
Set 2	5	0.45

Weighted distance travelled	
Set 1	Set 2
28.1%	16.8%
44.9%	

This outcome reflects increased self-confidence, driven by shared experiences, validation, and a sense of belonging. For adults with disabilities and parents, connecting with others who understood their experiences helped them feel more capable of managing challenges, which in turn strengthened their confidence. For children, self-confidence grew through being listened to, supported, and developing trust in Crann staff and services. Many also became more motivated to take on small tasks independently and express their feelings more openly.

"I feel more like myself because I can express myself and who I am better because I have more confidence."

– Child with a disability

In *Evaluation Stage 1 – Qualitative*, all participants expressed that they had experienced the majority of the intermediate outcomes in the ToC, and most agreed that their self-confidence and motivation had increased noticeably because of their attendance at the service.

Confidence was a universally understood experience that is expressed as confidence in oneself and belief in one's abilities. An update was made to the outcome language in line with participant feedback, changing the original 'confidence' to 'self-confidence' to ensure full clarity that the outcome is not confidence in an external thing or the service. Motivation was universally understood, and the language accurately described the participants' experiences.

"I went to Dublin recently on my own for a day out. Something I would've done in the past but since Covid, I really hadn't felt able or confident enough to go out on my own like that. I felt amazing, it was great, and now I know I'll be fine to go again."

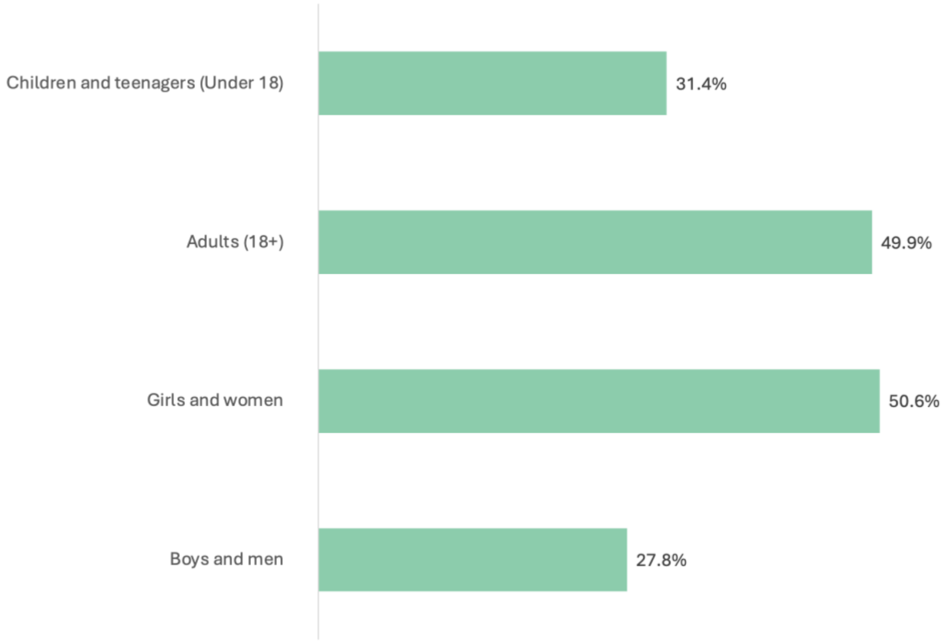
– Adult with a disability

Figure 13 presents the comparative distance travelled across client segments, categorised by age and gender. A detailed analysis is provided following the figure.

Figure 13: Comparison of distance travelled for 'increased self-confidence and motivation' across age and gender segments

Pre: n=9 (under 18), n=22 (18+), n=22 (girls/women) n=9 (boys/men)

Post: n=9 (under 18), n=12 (18+), n=16 (girls/women) n=5 (boys/men)



In *Evaluation Stage 2 – Quantitative*, change was reported at a slightly higher rate by children and teenagers than by adults. This is not a statistically significant difference but may be indicative. Children and teens are still forming their self-concept, and their sense of self-confidence may be more fragile and influenced by ongoing changes in their identity, physical development, and peer relationships. Children's lack of autonomy can limit tangible changes influenced by internal motivation and motivation can also fluctuate during adolescence due to developmental changes in goal setting and reward systems in the brain (Deci & Ryan, 2000; Harvard Center on the Developing Child, 2021).

Girls and women reported greater change in self-confidence and motivation compared to boys and men. Research suggests that men often adopt a task-oriented approach to therapy, focusing on resolving specific issues rather than exploring personal growth. This mindset can limit progress in areas requiring deeper reflection and sustained emotional effort, such as building self-confidence and motivation (Seidler et al., 2018).

Clients of Counselling reported change at a higher rate than those attending Play Therapy.* Clients of Play Therapy are all children, so the above context relating to the differences between children and teenagers, and adults applies here. Adult clients are typically more capable of articulating and setting goals during counselling, which aligns directly with improvements in motivation and self-confidence. Counselling often incorporates structured approaches like cognitive-behavioural strategies or goal-setting frameworks, which are particularly effective for fostering a sense of achievement and personal growth (Deci & Ryan, 1985; Institute for Quality and Efficiency in Health Care, 2022; Cooper & Law, 2018). Play therapy has as main objectives focused on socialisation, development of creativity, improvement of functionality, understanding and expressing feelings, difficulties and conflicts, understanding and management of ego and want (Koukourikos et al., 2021). It is possible that adult clients are more directly focused on improving their self-confidence and motivation through Counselling than are children through Play Therapy.

Table 31: Comparison of change achieved for 'increased self-confidence and motivation' across services attended

Pre: n=23 (Counselling), n=5 (Play Therapy)
Post: n=12 (Counselling), n=7 (Play Therapy)

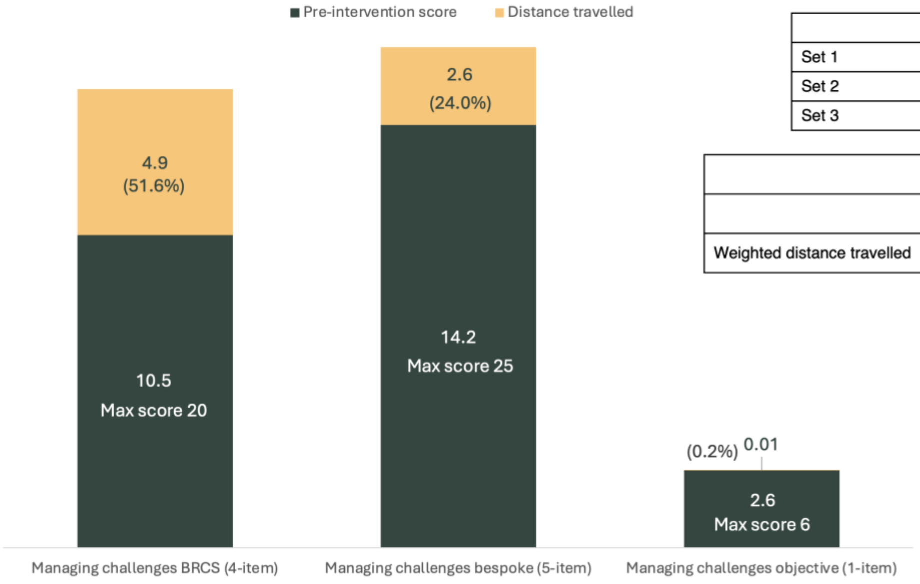
Service	Weighted distance travelled
Counselling	51.6%
Play Therapy	18.4%

*The sample achieved for Sibshop responses was too small to be analysed as a segment and it has been included only in the theme-level analysis.

5.3 Outcome: Improved ability to manage challenges

The weighted distance travelled for the outcome 'improved ability to manage challenges' was 32.7% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 14: Analysis of the change achieved for 'improved ability to manage challenges'
n=31 (pre), n=21 (post)



	# items	Weight
Set 1	4	0.40
Set 2	5	0.50
Set 3	1	0.10

	Set 1	Set 2	Set 3
	20.6%	12.0%	0.0%
Weighted distance travelled	32.7%		

Clients engaging with Crann's Psychological Wellbeing services typically faced specific challenges beforehand, including feeling disconnected from themselves, struggling to manage daily life, and lacking a supportive network that understood their needs. The services provided a space to reflect, process experiences, and share feelings, something many clients did not have before. Additionally, most clients felt they gained tools and resources to help them manage challenges independently after their engagement with the service.

> *"I am learning resources from [counsellor]. It can take time to learn to implement them all the time of course, but I do feel I am dealing with worries and challenges better."*
>
> **– Adult with a disability**

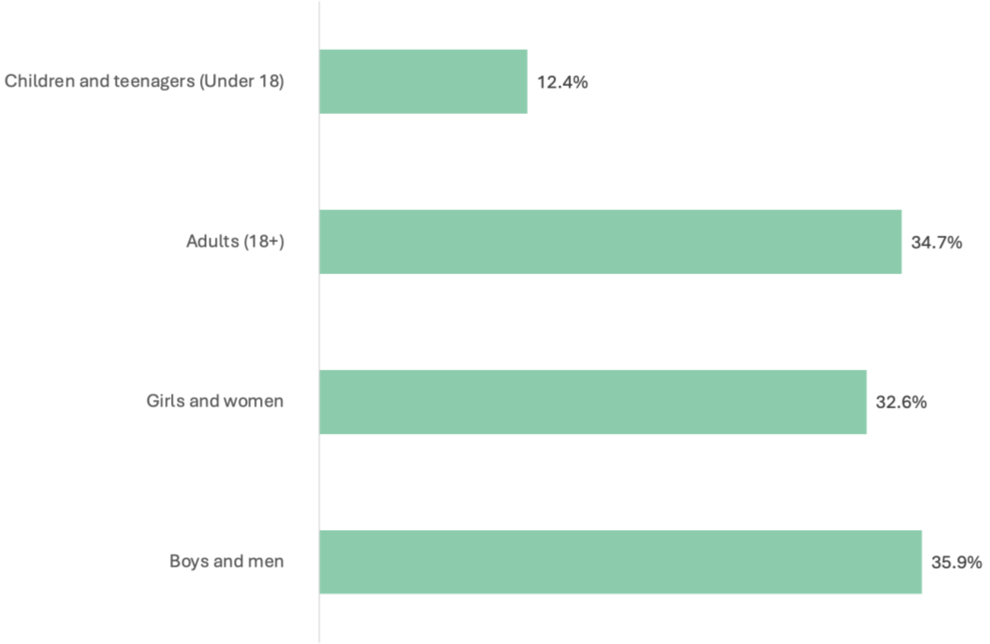
In *Evaluation Stage 1 – Qualitative*, all participants expressed that they had experienced the majority of the intermediate outcomes in the ToC. However, the final outcome, originally represented as 'improved ability to *cope with* challenges', was divisive. With further in-depth discussion it was determined that the word "cope" felt too strong for some participants. For some clients, this did feel like an accurate description, but in the interest of being more representative of the majority experience the alternative word "manage" was suggested by participants. Managing challenges was a universal experience which occurred both in the service, through working with a professional to overcome present challenges, and also outside of the service through learning new tools and resources and gaining a new perspective.

> *"I'd say my worries have definitely lessened and I've learned lots of tools to manage better. Of course, that worry about [child] won't ever go away, because I'm a parent, but things are less overwhelming generally and I can approach a challenge by asking myself how can I fix it."*
>
> **– Parent of a child with a disability**

Figure 15 presents the comparative distance travelled across client segments, categorised by age and gender. A detailed analysis is provided following the figure.

Figure 15: Comparison of distance travelled for 'improved ability to manage challenges' across age and gender segments

Pre: n=9 (under 18), n=22 (18+), n=22 (girls/women) n=9 (boys/men)
Post: n=9 (under 18), n=12 (18+), n=16 (girls/women) n=5 (boys/men)



In *Evaluation Stage 2 – Quantitative*, children and teenagers reported change at a lower rate compared to other segments. Younger children are still developing the social and emotional regulation skills necessary for managing challenges (Malik & Marwaha, 2022). Play Therapy focuses on objectives such as socialisation, fostering creativity, improving functionality, and understanding and expressing emotions, difficulties, and conflicts. It also aims to support children in managing their sense of self and desires (Koukourikos et al., 2021). These therapeutic mechanisms often help children build resilience; however, it is important to recognise that children may not develop more complex coping skills until around 7–8 years of age (Malik & Marwaha, 2022). While adolescents are more advanced in these areas, they may still lack the same capacity as adults to reflect on difficulties or consistently implement strategies to overcome them (Piaget, 1964). This developmental trajectory likely contributes to the lower reported rate of change among younger clients, as their therapeutic progress often requires more time to manifest in tangible, everyday outcomes.

Clients of Counselling reported change at a higher rate for this outcome compared to clients of Play Therapy*. This difference can also be attributed, in part, to the nature of the client groups. Play Therapy is primarily attended by children, often younger ones, who typically lack the cognitive, social and emotional regulation skills required to navigate challenges to the same extent as teens and adults who attend Counselling. Additionally, the higher number of respondents for Counselling compared to Play Therapy further influences the comparison, creating a skew in the results that should be considered.

Table 32: Comparison of change achieved for 'improved ability to manage challenges' across services attended

Pre: n=23 (Counselling), n=5 (Play Therapy)
Post: n=12 (Counselling), n=7 (Play Therapy)

Service	**Weighted distance travelled**
Counselling	36.9%
Play Therapy	-12.4%

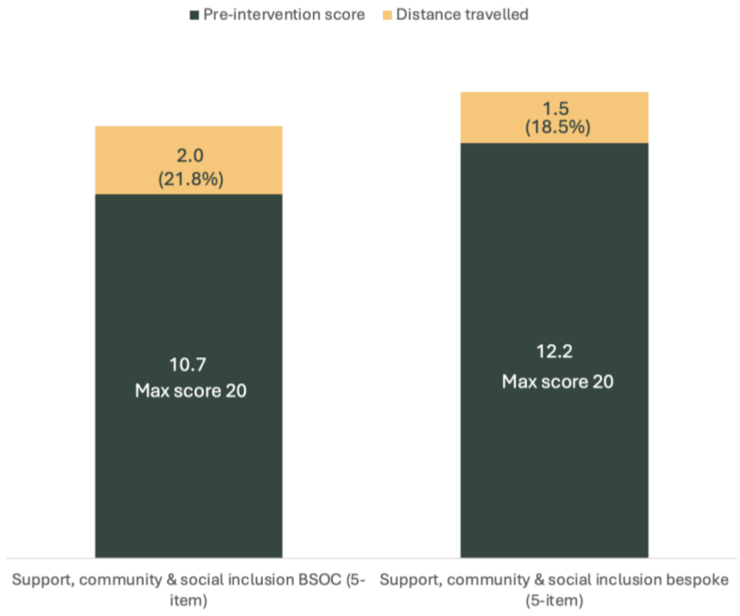
*The sample achieved for Sibshop responses was too small to be analysed as a segment and it has been included only in the theme-level analysis.

5.4 Outcome: Increased support, community and social inclusion

The weighted distance travelled for the outcome ‘increased support, community and social inclusion’ was 20.1% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 16: Analysis of the change achieved for ‘increased support, community and social inclusion’

n=31 (pre), n=21 (post)



	# items	Weight
Set 1	5	0.50
Set 2	5	0.50

	Set 1	Set 2
Weighted distance travelled	10.9%	9.2%
Average distance travelled	20.1%	

This outcome reflects a sense of connection and belonging, developed through recognising that support is available and feeling understood. Even in one-to-one services, clients experienced this outcome by feeling supported by the expert they worked with and gaining a sense of inclusion within the Crann community.

“Definitely feel less lonely and isolated because I feel [counsellor] really gets it and understands where I’m coming from. It’s not like I didn’t have support at home, but I got extra support in Counselling, and I know there is always support for me at Crann when I need it.”

– Parent of a child with a disability

In *Evaluation Stage 1 – Qualitative*, all participants experienced the majority of the intermediate outcomes and around half felt they had experienced a noticeable change in relation to the final outcome of increased social inclusion, support, and community. For those who did not relate to this outcome, they did relate strongly to having achieved an increase in support. To prioritise the piece of this outcome that the most participants related to the order of the wording was changed: “social inclusion, support, and community” to “support, community and social inclusion.”

> *“[Play therapist] feels like my friend, and I think a friend to my family too. I like my relationship with [play therapist] a lot and it does make me feel even more supported than before.”*
>
> **– Child with a disability**

When this outcome was identified in the preceding SROI Forecast (Assured in 2022) two group services were in-scope in this theme. Clients who attended an in-scope group service reported this outcome more strongly than those who attended an in-scope one-to-one service. However, material change for this outcome was reported in the SROI Evaluation by clients of one-to-one services, albeit at a lower rate compared to other outcomes within this theme.

The importance of one-to-one support remains consistent. When respondents in *Evaluation Stage 2 - Quantitative* were asked to self-rate the change they experienced across each element of this outcome, clients identified the support as the most impactful aspect, with 89% reporting a medium to large change, as shown in Figure 17. However, a significant proportion of clients also self-rated a medium or large change for ‘social inclusion’ and feeling ‘more part of a community’, indicating no need for further revisions to the outcome.

Figure 17: Self-rated change achieved for each element of the outcome ‘increased support, community and social inclusion’
n=21 (post)

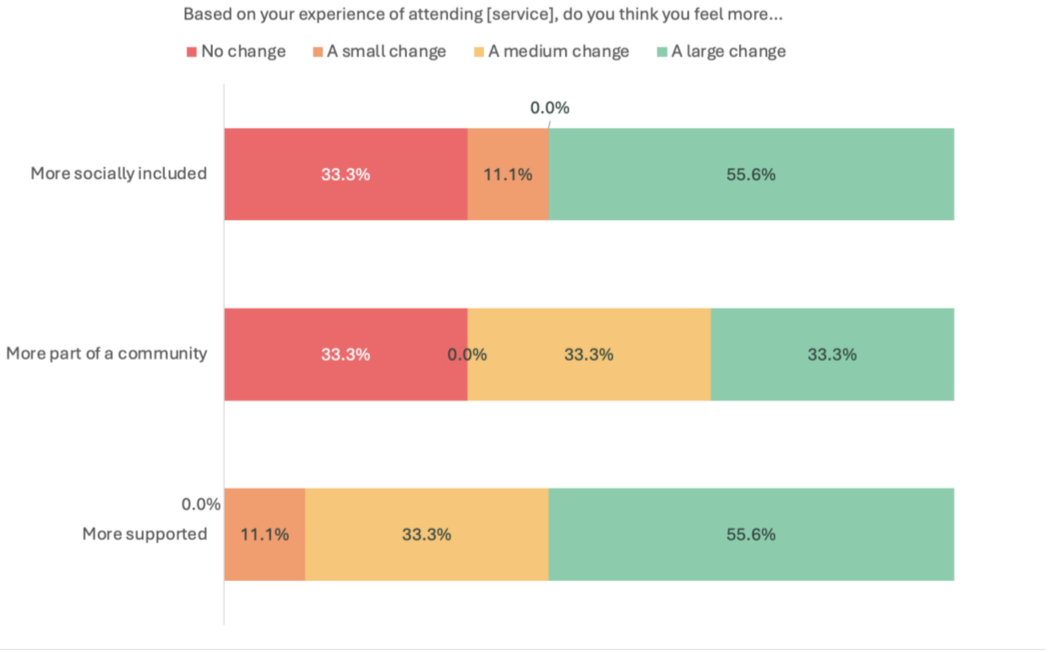
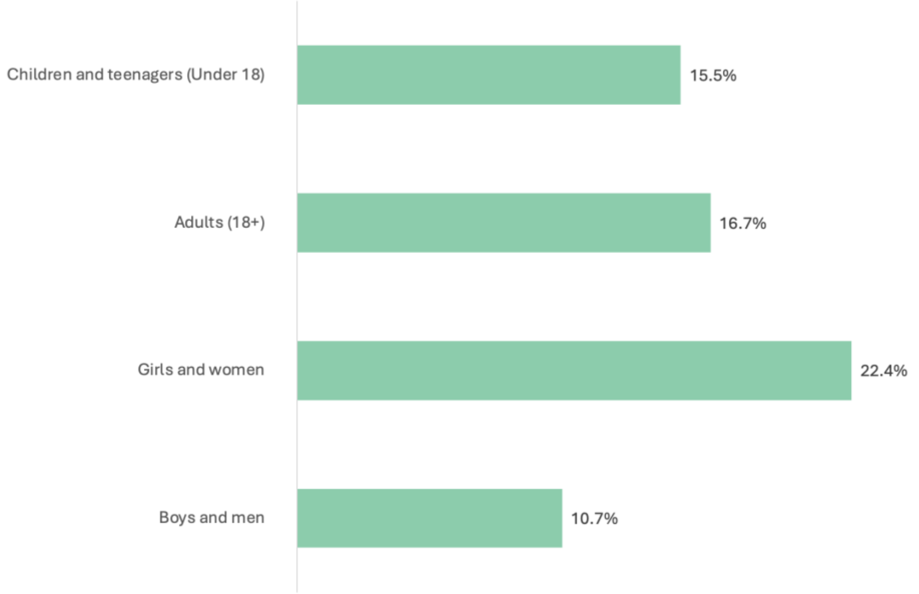


Figure 18 presents the comparative distance travelled across client segments, categorised by age and gender. A detailed analysis is provided following the figure.

Figure 18: Comparison of distance travelled for 'increased support, community and social inclusion' across age and gender segments
Pre: n=9 (under 18), n=22 (18+), n=22 (girls/women) n=9 (boys/men)
Post: n=9 (under 18), n=12 (18+), n=16 (girls/women) n=5 (boys/men)



In *Evaluation Stage 2 – Quantitative*, both clients under and over 18 reported change at the same rate for this outcome. However, boys and men reported lower rates of change than girls and women, though the difference was not statistically significant. This may reflect broader societal norms that discourage vulnerability in men, even within therapeutic settings. Men may feel pressure to downplay their need for support, which can hinder their ability to fully engage in the shared emotional exploration that fosters inclusion and connection (Seidler et al., 2018).

Clients of Counselling reported change at a slightly higher rate than those attending Play Therapy.* This is not a statistically significant difference but may be indicative. Children may not associate the therapeutic setting with broader social inclusion or support networks in the same way adults or teens attending Counselling might. Their social environments are often highly dependent on family or structured settings (e.g., school), making them less likely to perceive changes in their broader social context. For teens and adults, one-to-one psychological services might also include discussions about building social networks or improving interpersonal relationships, which could directly impact their perception of social inclusion. By comparison, therapeutic sessions with younger children tend to focus more on emotional regulation and foundational coping mechanisms, with less emphasis on broader social factors, which could explain the difference in reported rates of change.

Table 33: Comparison of change achieved for 'increased support, community and social inclusion' across services attended

Pre: n=23 (Counselling), n=5 (Play Therapy)
Post: n=12 (Counselling), n=7 (Play Therapy)

Service	Weighted distance travelled
Counselling	20.6%
Play Therapy	9.3%

*The sample achieved for Sibshop responses was too small to be analysed as a segment and it has been included only in the theme-level analysis

6. Analysis of the change that occurred for clients of Social Capital services

This chapter outlines the analysis of the change that occurred for Crann clients who accessed Social Capital Services. It is important to note that existing clients were included in data collection for Social Capital services, as detailed in Section 3.5, along with the rationale for this approach. It is important to acknowledge that caution should be exercised here with regards recall bias the over-representation of longer-term clients' experiences and potential reduced sensitivity to change and/or saturation of outcomes. This chapter should be interpreted with those limitations in mind.

Table 34: Summary of outcomes experienced by clients

n=25 (pre), n=27 (post)

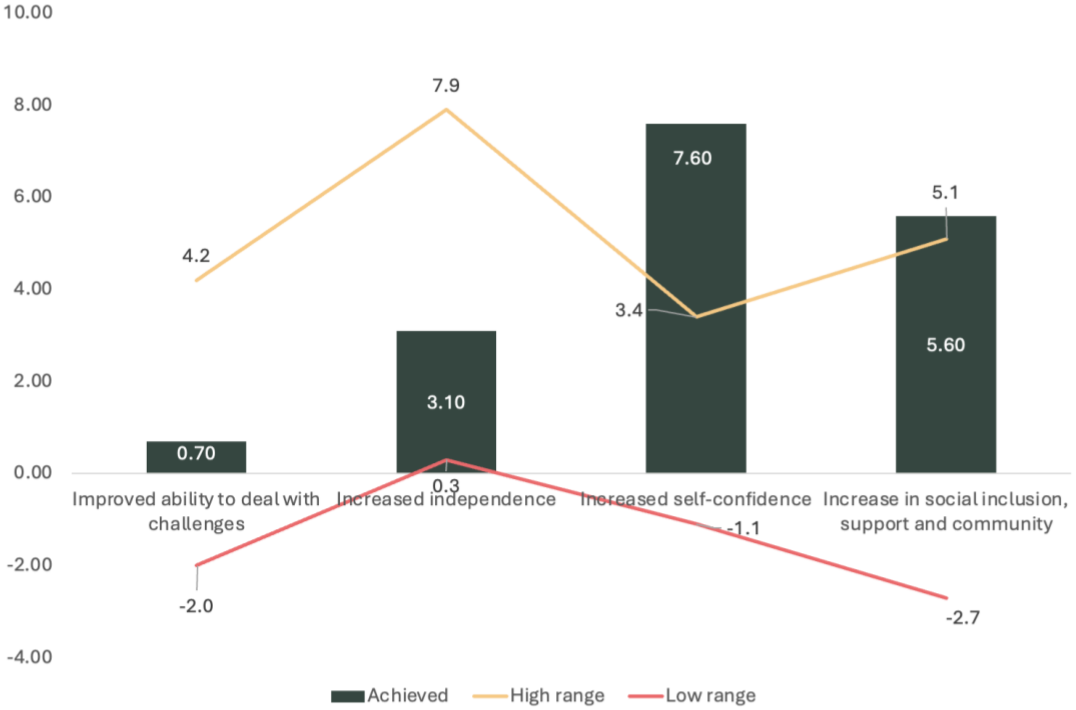
Outcome	Weighted distance travelled	Value ranking by respondents
Improved ability to deal with challenges	21.5%	#1
Increased independence	44.9%	#2
Increased self-confidence	29.5%	#3
Increase in social inclusion, support and community	54.2%	#4

Figure 19 presents the mean distance travelled (average reported change) in scale points for the four outcomes experienced by clients of Social Capital Services, based on aggregated sample data. The green bars represent the actual reported change achieved by stakeholders for each outcome. The yellow line indicates the high range of error for the materiality threshold, while the red line represents the low range of error for the materiality threshold, providing boundaries for interpreting changes as materially significant.

- "Improved ability to deal with challenges" achieved the lowest change (0.7 scale points), within the range of error for materiality (-2.0 to 4.2 scale points), indicating modest progress for this outcome.
- "Increased independence" achieved a change of 3.1 scale points, within the range of error for materiality (0.3 to 7.9 scale points), reflecting steady progress in line with expectations.
- "Increased self-confidence" achieved the highest change (7.6 scale points), exceeding the high range of error for materiality (-1.1 to 3.4 scale points), demonstrating significant progress well beyond the materiality threshold.
- "Increase in social inclusion, support, and community" achieved a change of 5.6 scale points, within the range of error for materiality (-2.7 to 5.1 scale points), reflecting meaningful and impactful progress for stakeholders.

This chart highlights how the achieved changes align with or exceed the range of error for materiality thresholds, providing insights into the most impactful outcomes experienced by clients of Social Capital Services.

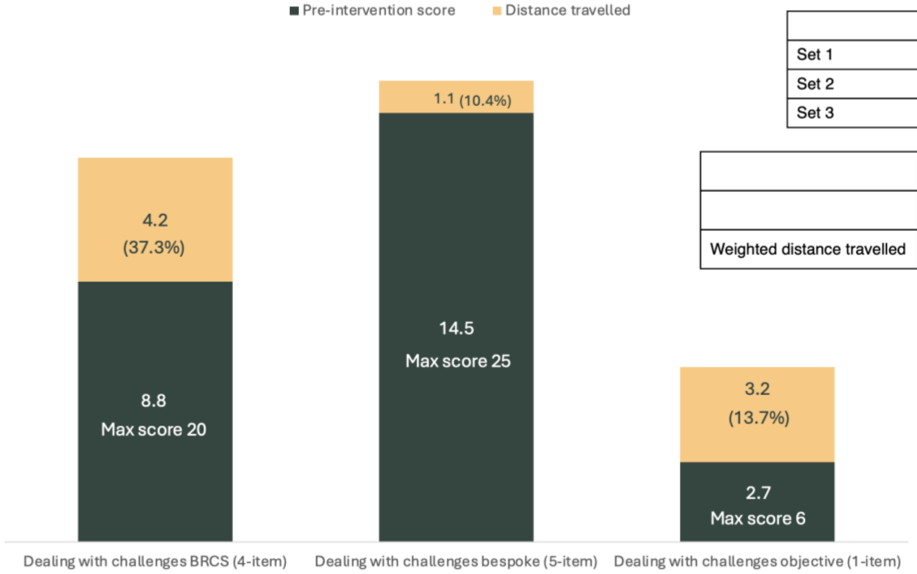
Figure 19: Materiality achieved for Social Capital outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit
n=25 (pre), n=27 (post)



6.1 Outcome: Improved ability to deal with challenges

The weighted distance travelled for the outcome ‘improved ability to deal with challenges’ was 21.5% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 20: Analysis of the change achieved for ‘improved ability to deal with challenges’
n=25 (pre), n=27 (post)



	# items	Weight
Set 1	4	0.40
Set 2	5	0.50
Set 3	1	0.10

	Set 1	Set 2	Set 3
	14.9%	5.2%	1.4%
Weighted distance travelled	21.5%		

This outcome reflects increased resilience and problem-solving ability, as clients felt better equipped to manage challenges. Engaging in discussions about their experiences and receiving support helped them develop confidence in their ability to handle difficulties when they arise.

> *"You can talk about anything you want in the group. Sometimes someone is having trouble with something, and they can ask the group for advice. We're likeminded people and have some of the same experiences and can help each other."*
>
> **– Adult with a disability**

As this outcome was experienced by verbally sharing problems and understanding solutions shared, it is less relevant for children with disabilities. The service that they engage with in the Social Capital theme is Breaking Barriers Theatre Group. The kids' sessions of this service are focused on building social capital, learning to express themselves, enjoyment, and fun. This means that while they may build resilience and become better able to deal with challenges, this is not a key outcome experienced by children attending the service, nor is it an intended outcome for that group. Breaking Barriers Theatre Group teens' and adults' sessions are more focused on confidence building and leadership development, alongside fun and social capital, both of which contribute to an increased ability to manage oneself, deal with situations confidently and feel capable of withstanding challenging times.

During *Evaluation Stage 1 – Qualitative*, most participants expressed that they had experienced the majority of the intermediate outcomes in the ToC. Two minor linguistic changes were made to intermediate outcomes for clarity, but no change to the final outcome was indicated. The word "cope" was not flagged by participants in relation to this outcome, like it was by participants of Psychological Wellbeing services; however, it was tested in the quantitative data collection for Social Capital services.

Four options were tested, as indicated in the figure 21, and there was a marginal preference for the phrase "deal with" which has been implemented in the outcome language.

Figure 21: Language most aligned with this outcome, according to respondents
n=27 (post)

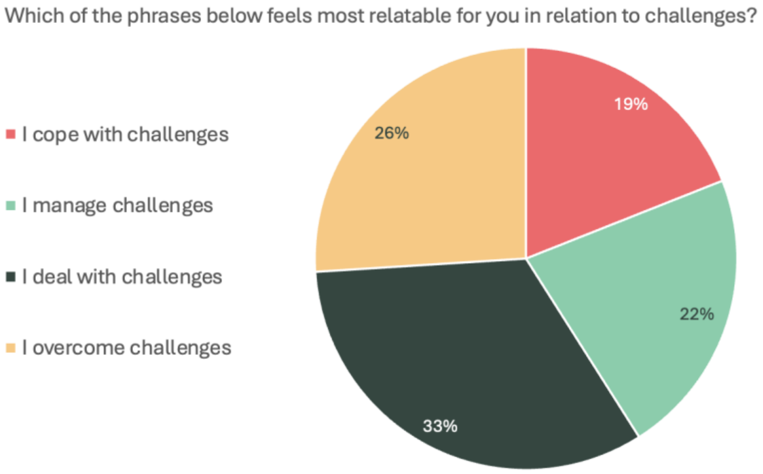
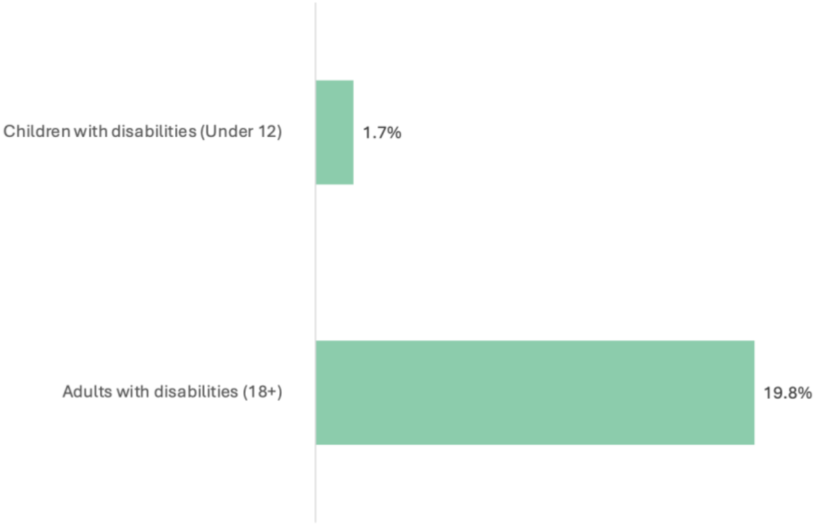


Figure 22 presents the comparative distance travelled across client segments, categorised by client type. A detailed analysis is provided following the figure.

Figure 22: Comparison of distance travelled for 'improved ability to deal with challenges' for children and adults with disabilities
Pre: n=6 (children), n=13 (adults)
Post: n=7 (children), n=16 (adults)

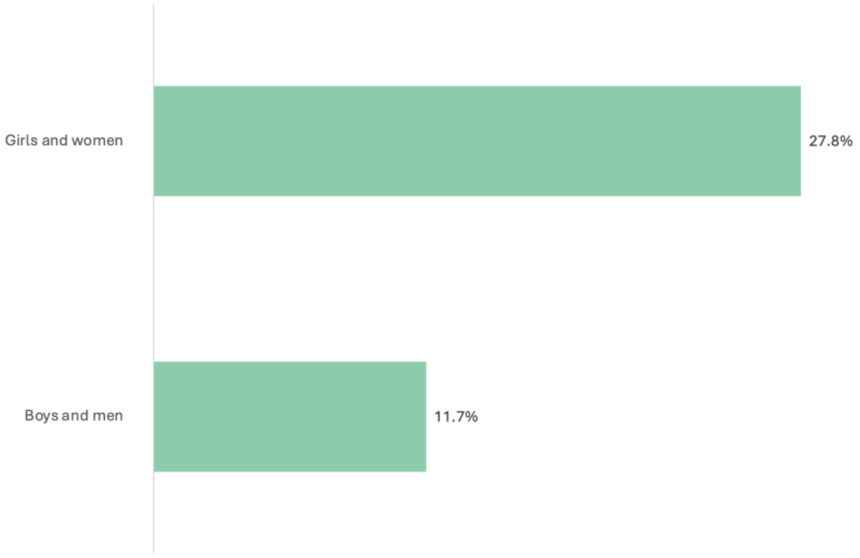


In qualitative research, this outcome was described as less relevant for children with disabilities. This was validated again in the quantitative data collection, in which children (0-12 years) overall reported a negligible change on this outcome (1.7% distance travelled), solidifying our understanding that this outcome is not relevant for children with disabilities. The sample of teenagers was not large enough to be included in segment analysis individually, but the comparison between children and adults with disabilities confirms our qualitative findings.

Figure 23 presents the comparative distance travelled across client segments, categorised by gender. A detailed analysis is provided following the figure.

Figure 23: Comparison of distance travelled for ‘improved ability to deal with challenges’ across gender segments

Pre: n=14 (girls/women) n=9 (boys/men)
Post: n=13 (girls/women) n=13 (boys/men)



In *Evaluation Stage 2 – Quantitative*, girls and women reported change at a higher rate than boys and men did. Girls and women are more likely to perceive their abilities as less favourable than boys and men do, and their pre-intervention scores for dealing with challenges were lower across the board. A key aspect of building resilience is developing the ability to recognise one's strengths and have confidence in one's ability to overcome a challenge (Cherry, 2023). Through developing this, girls and women's perceptions of themselves likely improved more significantly than boys and men's, which were already more favourable.

Girls and women are also more likely to use emotion-focused coping strategies, such as seeking social support and processing emotions, which can lead to greater resilience-building when supported by interventions (Tamres, Janicki & Helgeson, 2002; Theodoratou et al., 2023). As the Social Capital interventions build relational support networks, promote peer support, and collaborative problem-solving they might resonate more with women and girls, leading to greater improvements in resilience.

Clients of both services reported similar rates of change for this outcome.

Table 35: Comparison of change achieved for 'improved ability to deal with challenges' across services attended

Pre: n=15 (Breaking Barriers), n=9 (Social Hub)
Post: n=15 (Breaking Barriers), n=13 (Social Hub)

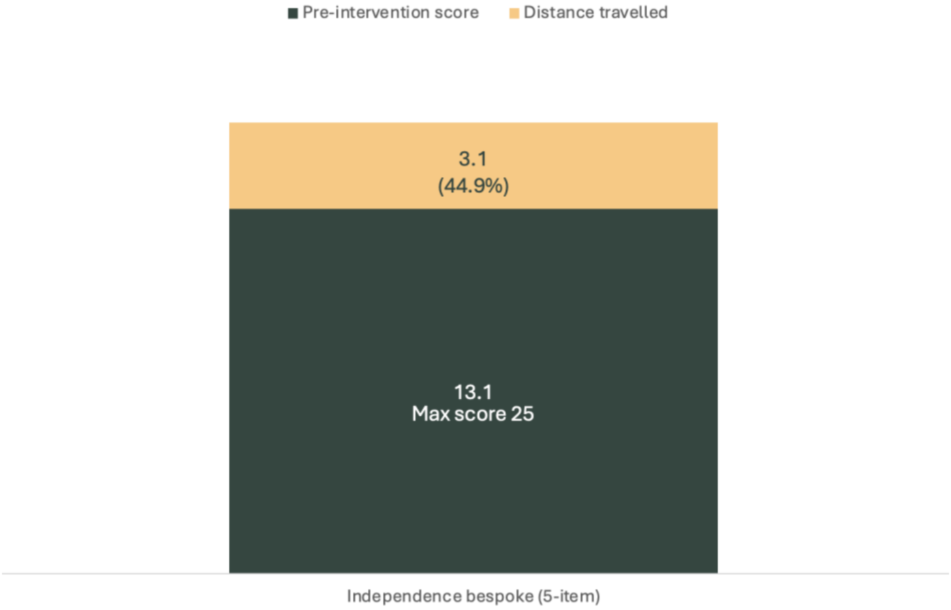
Service	**Weighted distance travelled**
Breaking Barriers Theatre Group	18.8%
Social Hub	19.1%

6.2 Outcome: Increased independence

The weighted distance travelled for the outcome 'increased independence' was 44.9% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 24: Analysis of the change achieved for 'increased independence'

n=25 (pre), n=27 (post)



This outcome reflects increased independence and social confidence. For children with disabilities, this was demonstrated by their ability to attend services alone without a parent or carer. Exposure to peers with varying levels of independence and ability also fostered motivation and self-recognition of their own capabilities.

For adults with disabilities, this outcome was linked to building relationships beyond their immediate family. Many had previously relied on direct family members for social interaction, and developing their own social networks through Social Capital Services at Crann contributed to a greater sense of independence.

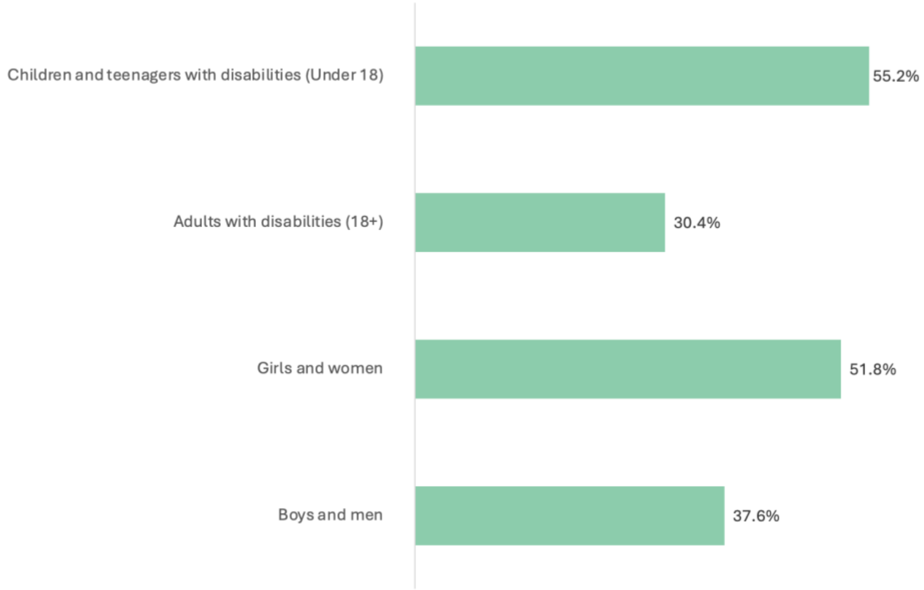
During *Evaluation Stage 1 – Qualitative*, all participants talked about this outcome spontaneously when asked about their experience of change because of Social Capital services. All participants related to this outcome and the experience was described universally as attending the service alone and getting time away from parents and carers. For adults this also encompassed making independent relationships with others outside of the home or school environment. No changes were indicated for this outcome.

> *"When you have a disability, your parents have to do more for you and be with you more, so it's great to get to go somewhere on your own! No offence, Mum."*
>
> **– Teen with a disability**

Figure 25 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 25: Comparison of distance travelled for 'increased independence' across client type and gender segments

Pre: n=12 (children and teens), n=13 (adults), n=14 (girls/women) n=9 (boys/men)
Post: n=11 (children and teens), n=16 (adults), n=13 (girls/women) n=13 (boys/men)



In quantitative data collection in *Evaluation Stage 2 – Quantitative*, adults with disabilities reported change at a lower rate than children and teens did, due to their pre-intervention scores being higher, meaning that while they achieved similar post-intervention scores to children and teenagers with disabilities, the distance travelled was smaller. It is expected for adults with disabilities to have more independence than younger people, so this is not surprising, but it is positive to see that adults still experienced a notable uplift (30.4% distance travelled).

Girls and women reported change at a slightly higher rate than boys and men did. This is not a statistically significant difference but may be indicative. As this outcome, for adults with disabilities, was related to expanding their social network and support system outside of the family unit and girls and women often benefit from increased social capital. Women also often leverage social networks to support their ability to challenge the status quo, provide resources and realise their collective agency (Franklin et al., 2005; Seff et al., 2024). This can support their ability to navigate societal structures which is intrinsically linked with independence for this cohort.

Clients of Breaking Barriers Theatre Group reported change at a higher rate than clients of Social Hub. Social Hub is an adult-only service, whereas Breaking Barriers Theatre Group also serves children and teenagers, for whom the intervention was more impactful for independence. Social Hub runs online as well as in-person, whereas Breaking Barriers Theatre Group runs in-person only in the Crann Centre, so the sense of independence in attending a service without a parent or carer is likely amplified compared to dialling in from a home environment.

Table 36: Comparison of change achieved for 'increased independence' across services attended

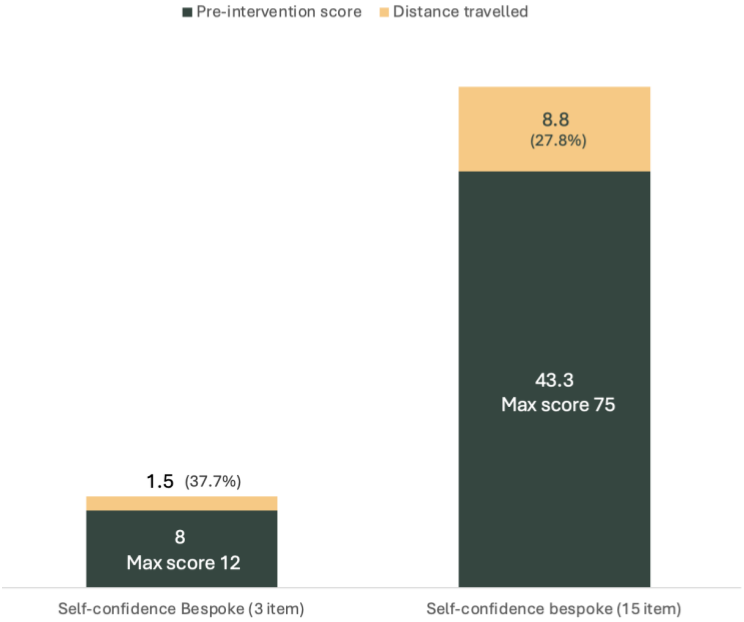
Pre: n=15 (Breaking Barriers), n=9 (Social Hub)
Post: n=15 (Breaking Barriers), n=13 (Social Hub)

Service	**Weighted distance travelled**
Breaking Barriers Theatre Group	53.9%
Social Hub	29.4%

6.3 Outcome: Increased self-confidence

The weighted distance travelled for the outcome ‘increased self-confidence was 29.5% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 26: Analysis of the change achieved for ‘increased self-confidence’
n=25 (pre), n=27 (post)



	# items	Weight
Set 1	1	0.20
Set 2	4	0.80

	Set 1	Set 2
Weighted distance travelled	2.0%	19.7%
Average distance travelled	21.7%	

This outcome reflects increased confidence in self-expression. Clients became more comfortable discussing their experiences and expressing opinions, which helped build their confidence in communication. This extended beyond the service setting, enabling them to speak up more comfortably in other environments, such as school, medical appointments, home, and other group settings.

> *“It’s probably built up my confidence too, you know from a social point of view. All the people I’ve met have been very welcoming and friendly…I think when I’m talking to another wheelchair user I don’t feel as nervous because I know that they exactly understand where I’m coming from.”*
>
> **– Adult with a disability**

For many clients with disabilities, both adults and children, attending Social Capital Services at Crann was their first experience of engaging in a group environment independently, without a parent or carer. This was particularly significant for children, some of whom had never attended an activity alone due to medical needs. Crann’s qualified staff provide the necessary support to facilitate this transition, allowing parents to step back while enabling children to participate independently, an important milestone for both the child and their family that bolstered self-confidence.

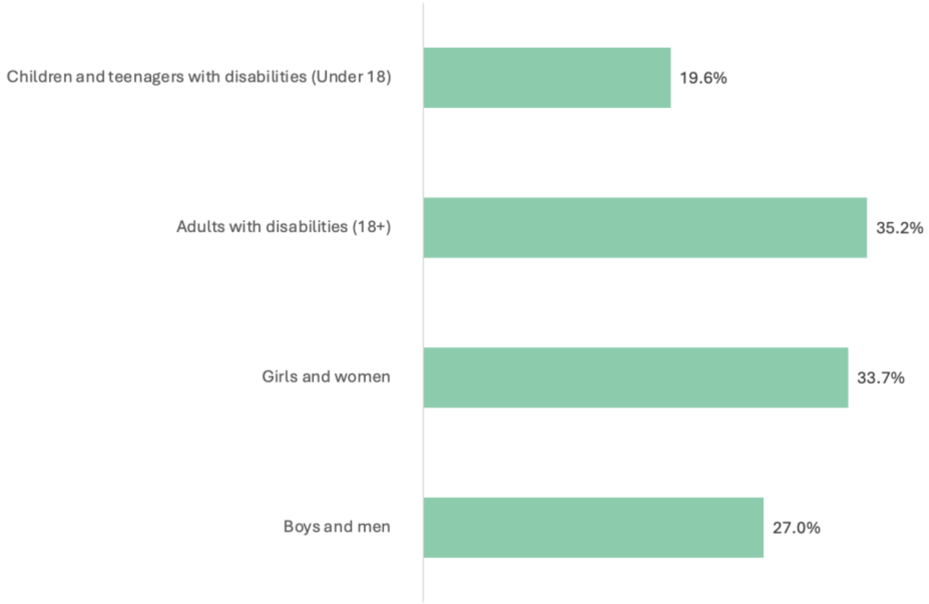
For adults with disabilities, access to peer group environments had often been limited since leaving school. Social Capital Services provided opportunities to build confidence and develop social connections. Many adults reported that these services helped them become more self-assured in various situations, fostering greater independence and social engagement.
During *Evaluation Stage 1 – Qualitative*, most participants related to this outcome and the intermediate outcomes leading to it. Confidence was a universally understood experience that was expressed as self-confidence through anecdotal storytelling. An update was made to the outcome language in line with participant feedback, to ensure full clarity that the outcome is about “self-confidence” and not confidence in an external thing or the service.

> *"I had a role in the play, and I wouldn't have been very confident to do that, but everyone in the group encouraged me, and I did it. I felt so much more confident afterwards as I overcame my nerves and did the performance."*
>
> **– Child with a disability**

Figure 27 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 27: Comparison of distance travelled for 'increased self-confidence' across client type and gender segments

Pre: n=12 (children and teens), n=13 (adults), n=14 (girls/women) n=9 (boys/men)
Post: n=11 (children and teens), n=16 (adults), n=13 (girls/women) n=13 (boys/men)



In *Evaluation Stage 2 – Quantitative*, children and teenagers with disabilities reported change at a slightly lower rate than adults with disabilities did. Teenagers are often navigating a complex phase of life, marked by rapid physical, cognitive and socioemotional development. During this time their sense of self and self-confidence can fluctuate significantly (Erikson, 1968; Pfeifer & Berkman, 2018). Interventions that aim to boost self-confidence can have a more modest impact on teens because of this. Children are typically more open to learning and development and are still forming their foundational beliefs about themselves and their abilities, but their experience of change may be moderated by their overall cognitive and emotional maturity (Eccles et al., 1993; Piaget, 1964). However, adults often experience the largest change in self-confidence from interventions because they tend to have more stable self-identities and a greater capacity for self-reflection meaning they are better equipped to process and internalise lessons learned and are less susceptible to social comparison than teens (Bandura, 1997).

Clients of both services reported similar change at similar rates for this outcome.

Table 37: Comparison of change achieved for 'increased self-confidence' across services attended

Pre: n=15 (Breaking Barriers), n=9 (Social Hub)
Post: n=15 (Breaking Barriers), n=13 (Social Hub)

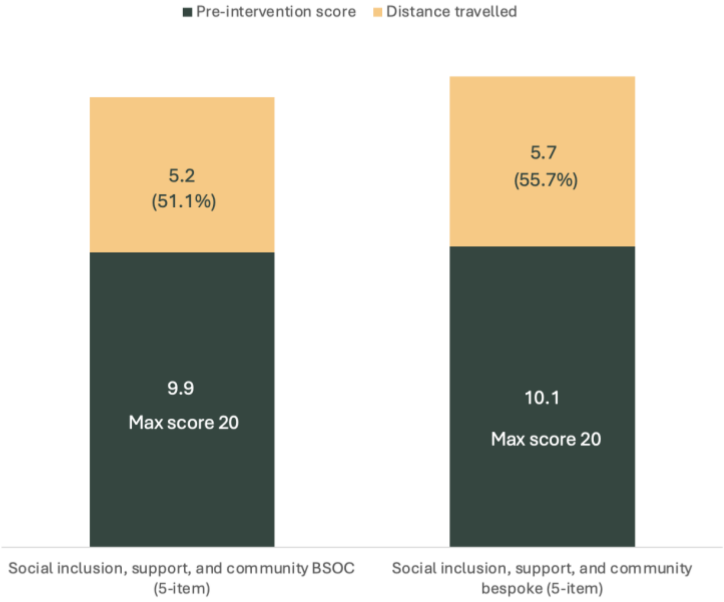
Service	Weighted distance travelled
Breaking Barriers Theatre Group	26.5%
Social Hub	31.8%

6.4 Outcome: Increased social inclusion, support, and community

The weighted distance travelled for the outcome ‘increased social inclusion, support and community was 54.2% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 28: Analysis of the change achieved for ‘increased social inclusion, support, and community’

n=25 (pre), n=27 (post)



	# items	Weight
Set 1	5	0.50
Set 2	5	0.50

	Set 1	Set 2
Weighted distance travelled	10.9%	9.2%
Average distance travelled	20.1%	

This outcome reflects a sense of belonging and social connection. Before engaging with Crann’s Social Capital Services, most clients, both with and without disabilities, lacked a peer network with shared experiences, which many described as isolating and lonely. Through these services, clients found a space where they felt understood, could share openly, and be authentic. Many also built lasting relationships that provided ongoing support and inclusion, even beyond their time at Crann.

“We’re all friends, and we meet every week in Drama. You’d obviously be more close with some people, but we’re all friends. And Social Hub has made me meet people I never would’ve met otherwise because they don’t live near here, so they don’t come to Drama.”

– Adult with a disability

During *Evaluation Stage 1 – Qualitative* all participants expressed having experienced the majority of the intermediate outcomes and agreed that they had experienced a noticeable increase in social inclusion, support and community because of their attendance at Social Capital services. Clients of the Breaking Barriers Theatre Group experienced this outcome most strongly and felt that it was a very inclusive space, more so than most other groups they have attended.

“Everyone belongs in the drama group!”

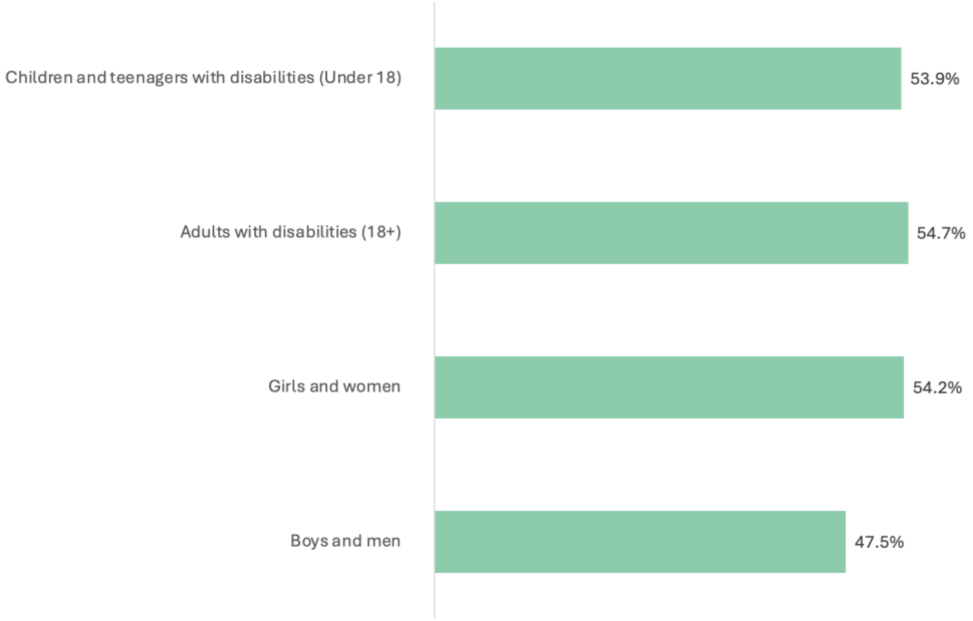
– Child with a disability

The experience of this outcome was universal in the qualitative research and related to being part of a group with other people who have had similar experiences to their own and a space in which no one is judged. No changes were indicated for this outcome.

Figure 29 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 29: Comparison of distance travelled for 'increased social inclusion, support, and community' across client type and gender segments

Pre: n=12 (children and teens), n=13 (adults), n=14 (girls/women) n=9 (boys/men)
Post: n=11 (children and teens), n=16 (adults), n=13 (girls/women) n=13 (boys/men)



In *Evaluation Stage 2 – Quantitative*, client type or gender did not influence the reported change for this outcome.

Clients of Social Hub reported change at a slightly higher rate for this outcome than clients of Breaking Barriers Theatre Group did. This is not a statistically significant difference but may be indicative. The pre-intervention scores for those who attended Social Hub were lower than for those who attended Breaking Barriers Theatre Group, likely due to the fact that most of the clients attending that service have left education and many are not in formal employment. In the qualitative research many adults with disabilities expressed that they had struggled to maintain friendships after school ended and found it more difficult to make friends as adults. Social Hub provides a judgement-free inclusive space for adults with disabilities to forge connections with others who have shared similar experiences to themselves. The service is also designed around the sharing of experiences, struggles and successes, compared to Breaking Barriers Theatre Group which is focused on expression and fun. Clients of the service have further to travel towards the outcome and the non-judgmental and inclusive social space provided to them has a more significant impact.

Table 38: Comparison of change achieved for 'increased social inclusion, support, and community' across services attended

Pre: n=15 (Breaking Barriers), n=9 (Social Hub)
Post: n=15 (Breaking Barriers), n=13 (Social Hub)

Service	Weighted distance travelled
Breaking Barriers Theatre Group	40.4%
Social Hub	57.7%

7. Analysis of the change that occurred for clients of Health and Continence services

This chapter outlines the analysis of the change that occurred for Crann clients who accessed Health and Continence Services during the SROI period.

Table 39: Summary of outcomes experienced by clients
n=38 (pre), n=25 (post)

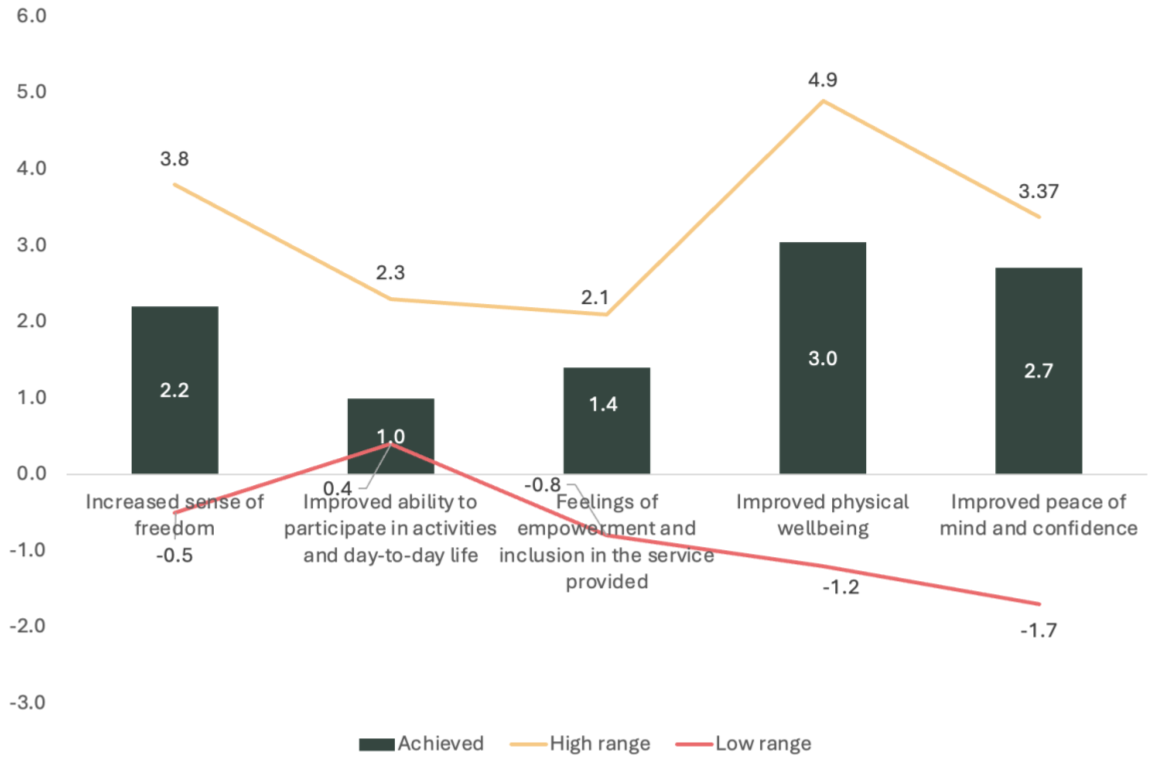
Outcome	Weighted distance travelled	Value ranking by respondents
Increased sense of freedom	24.2%	#1
Improved ability to participate in activities and day-to-day life	26.4%	#2
Feelings of empowerment and inclusion in the service provided	44.5%	#3
Improved physical wellbeing	23.9%	#4
Improved peace of mind and confidence in the treatment or management of the issue	36.3%	#5

Figure 30 presents the mean distance travelled (average reported change) in scale points for the five outcomes experienced by clients of Health and Continence Services, based on aggregated sample data. The blue bars represent the actual reported change achieved by stakeholders for each outcome. The orange line indicates the high range of error for the materiality threshold, while the yellow line represents the low range of error for the materiality threshold, providing boundaries for interpreting changes as materially significant.

- "Improved ability to participate in activities and day-to-day life" achieved the smallest change, of 1.0 scale points, within the range of error for materiality (0.4 to 2.3 scale points), indicating modest but meaningful progress.
- "Feelings of empowerment and inclusion in the service provided" achieved a change of 1.4 scale points, well within the range of error for materiality (-0.8 to 2.1 scale points), demonstrating consistent but moderate progress.
- "Increased sense of freedom" achieved a change of 2.2 scale points, within the range of error for materiality (-0.5 to 3.8 scale points), reflecting solid progress in this area.
- "Improved physical wellbeing" achieved a change of 3.0 scale points, within the range of error for materiality (-1.2 to 4.9 scale points), highlighting significant and meaningful progress.
- "Improved peace of mind and confidence" achieved a change of 2.7 scale points, within the range of error for materiality (-1.7 to 3.37 scale points), reflecting impactful progress.

This chart highlights how the achieved changes align with or fall within the range of error for materiality thresholds, offering valuable insights into the meaningful progress made by clients of Health and Continence Services across a range of outcomes.

Figure 30: Materiality achieved for Health and Continence outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit
n=38 (pre), n=25 (post)



The Continence Clinic at Crann had traditionally been classified as a service for people with disabilities. However, during *Evaluation Stage 1 – Qualitative*, it became evident that in some specific cases the clinic also served as a direct service for parents of people with disabilities.

All clients with disabilities who participated in *Evaluation Stage 1 – Qualitative* related to at least one of the five final outcomes, and those who had directly engaged with the service themselves related to all five final outcomes. No outcome was related to by fewer than half of participants with disabilities. This supported the validity of the ToC.

To address the potential variation in client type, data collection tools implemented in *Evaluation Stage 2 – Quantitative* were designed to capture key details, including who attended clinic sessions, who managed the continence routine, and who considered themselves the primary client of the service. This ensured accurate tracking of changes for the individual receiving support.

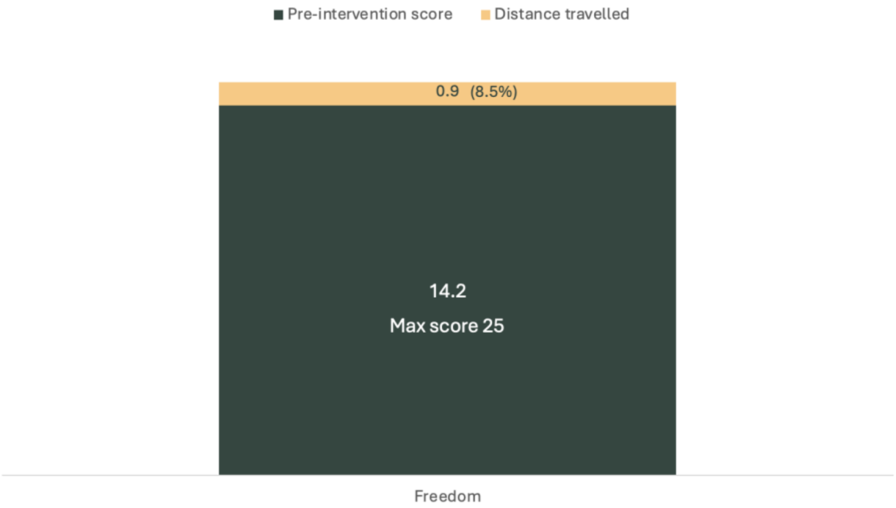
During the SROI Evaluation period, all respondents of surveys in *Evaluation Stage 2 – Quantitative* who were parents with children and teens reported attending the service together with their child, and no parent attended alone. All adult clients attended the service independently. According to the acting Health and Continence manager, the practice in 2023 involved enrolling parents and children together, with rare exceptions where a parent might have attended alone only initially before the child was engaged. This operational shift confirmed that the sample characteristics in the SROI Evaluation aligned with the broader client base of the service.

This approach to data collection and analysis ensured the SROI Evaluation accurately reflected the varied client experiences and supported robust insights into the impact of the Health and Continence services.

7.1 Outcome: Increased sense of freedom

The weighted distance travelled for the outcome 'increased sense of freedom' was 24.2% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 31: Analysis of the change achieved for 'increased sense of freedom'
n=38 (pre), n=25 (post)



This outcome reflects a greater sense of freedom, both physically and mentally. Clients who accessed continence or podiatry services experienced improvements that enabled them to move more freely, travel further from home, and, in many cases, stop thinking about their issue altogether. For many, these challenges had affected their lives for a long time with limited support, so even partial improvement led to a significant change in their sense of freedom. The ability to go about daily life without disruption from continence issues or foot pain allowed clients to feel more free and at ease.

“[Child] learned self-catheterisation from [continence specialist] for the first time. We were attending [hospital] twice a week before that to get the catheter done and [child] wasn’t doing it himself at all. He’s flying it now.”

– Parent of a child with a disability

During *Evaluation Stage 1 – Qualitative* all participants reported that the issues or challenges they presented with when they first attended Health and Continence services at Crann had been resolved or noticeably improved through better or more consistent management. Most participants agreed that they felt an increased sense of freedom due to this change.

[Child] “I have more independence and freedom to do my own thing, like going out with my friends or like I can go to matches away from school now.”

[Parent] “And now he can do his own catheter, the SNA at school has backed off so he has more freedom at school without a ‘teacher’ standing over him all the time.”

– Parent and child with a disability

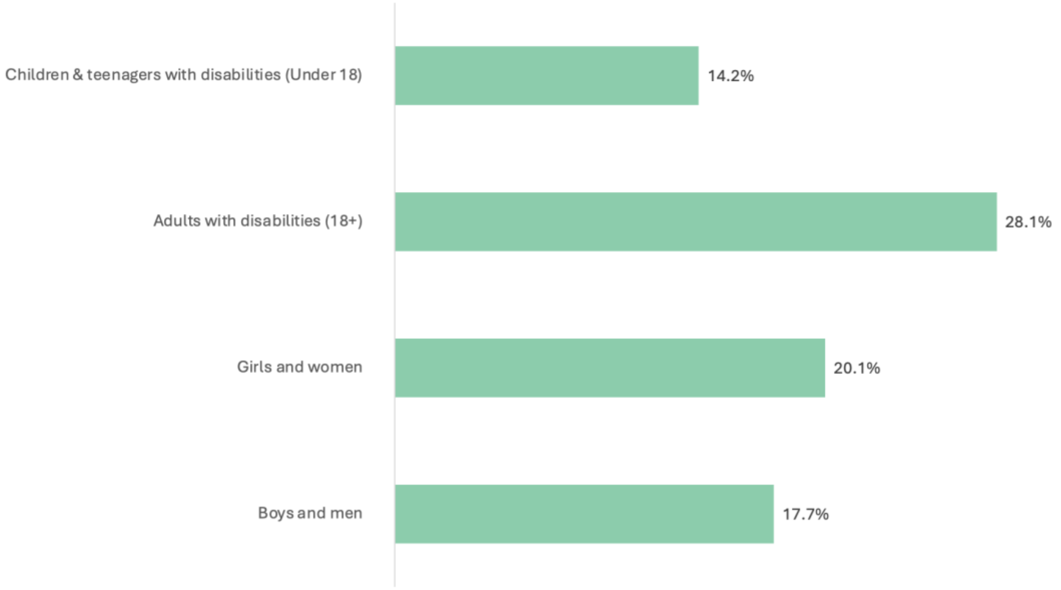
“Freedom” had a universal meaning of being able to do what they wanted to do without pain, without needing someone to support with the specific issue/challenge, without embarrassment (due to accidents), or too much forward planning. Having control over their own management routines also felt freeing for some who had previously relied on a parent or carer for this. No changes were indicated for this outcome.

Figure 32 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 32: Comparison of distance travelled for ‘increased sense of freedom’ across client type and gender segments

Pre: n=18 (children and teens), n=19 (adults), n=18 (girls/women) n=19 (boys/men)

Post: n=12 (children and teens), n=14 (adults), n=15 (girls/women) n=10 (boys/men)



In *Evaluation Stage 2 – Quantitative*, adults reported change at a slightly higher rate than children and teens did. This is not a statistically significant difference but may be indicative. Adults are more responsible for the management and planning around their own continence and podiatry issues. During childhood, and often well into adolescence, it is parents who manage the child's needs and plan to overcome challenges to access different experiences and environments. Parents managed the continence routines for all children and teens who participated in the SROI study. In contrast, adults with disabilities often possess a heightened awareness of their needs and any limitations that might impact their ability to access different experiences and environments, as they have accumulated more life experiences and are more aware of societal barriers that might restrict their autonomy.

Change was reported at a slightly higher rate by clients of Continence Clinic than clients of Podiatry. This is not a statistically significant difference but may be indicative. Continence management has been described by many clients as a significant barrier to their freedom, due to the high level of planning that can be involved, when the management routine is not optimal. In line with this documented qualitative experience, pre-intervention scores for clients of Continence Clinic were lower than those for clients of the Podiatry service. Both cohorts achieved similar uplift, with clients of Continence Clinic reporting a slightly higher uplift, but this represents a smaller proportion of the distance left to travel for them.

Table 40: Comparison of change achieved for 'increased sense of freedom' across services attended

Pre: n=26 (Continence Clinic), n=13 (Podiatry)
Post: n=12 (Continence Clinic), n=12 (Podiatry)

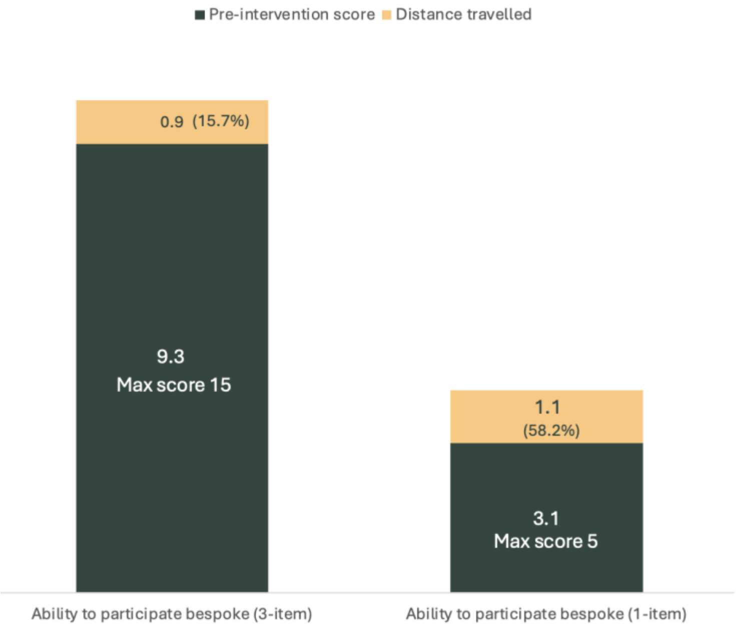
Service	**Weighted distance travelled**
Continence Clinic	14.5%
Podiatry	22.1%

7.2 Outcome: Improved ability to participate in activities and day-to-day life

The weighted distance travelled for the outcome 'ability to participate in activities and day-to-day life' was 26.4% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 33: Analysis of the change achieved for ‘ability to participate in activities and day-to-day life’

n=38 (pre), n=25 (post)



	# items	Weight
Set 1	3	0.75
Set 2	1	0.25

Weighted distance travelled	
Set 1	Set 2
11.8%	14.5%
26.4%	

This outcome reflects improved participation in daily life and activities. Many clients experienced restrictions due to their condition, with some unable to maintain their usual level of mobility or engage in activities they wanted to join. For example, podiatry issues often limited children’s ability to participate with friends at school and in extracurricular activities, reducing social interaction and enjoyment.

For those with continence issues, ineffective management routines or acute symptoms often led to significant discomfort, pain, or time-consuming toileting routines that disrupted daily life. By accessing sustainable solutions and effective management, clients could engage more freely in activities without concern for their condition.

[Parent] “We’re working on drinking more water on [continence specialist’s] advice to try and reduce bowel washouts and not have to do them at the weekend.”

[Child] “I’m excited because I’ll have more time to do things I want to do, like drawing.”

– Parent and child with a disability

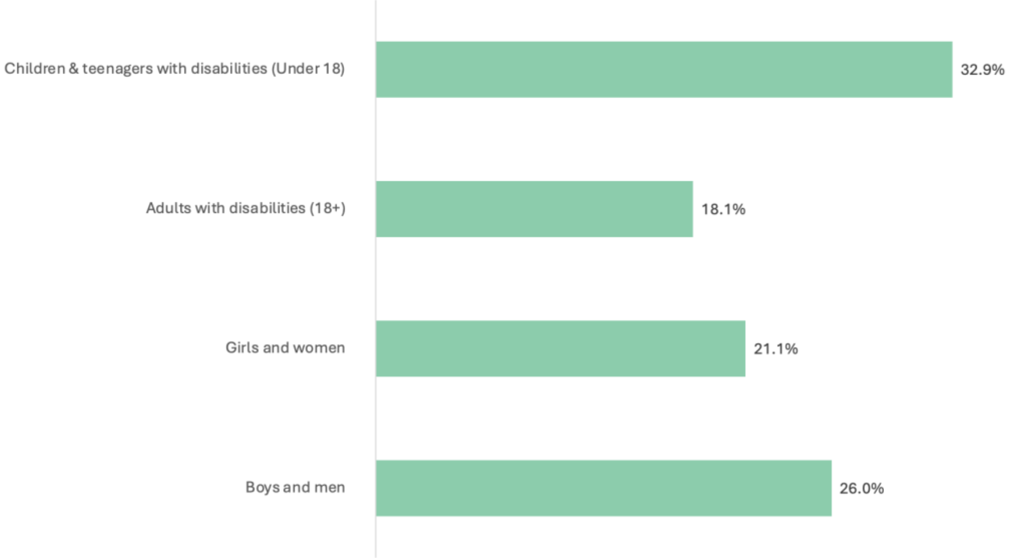
During *Evaluation Stage 1 – Qualitative*, all participants reported that the issues or challenges they presented with when they first attended health and continence services at Crann had been resolved or noticeably improved through better or more consistent management. Some participants didn’t feel that their ability to participate had been affected by their management needs prior to engaging with services at Crann, but the final outcome of improved ability to participate in activities and day-to-day life was relatable for three quarters of participants. No changes were indicated for this outcome.

“I would’ve missed my holiday because my feet had got so bad I couldn’t walk without pain, and I just wouldn’t have been able to do it. They got me in for an urgent appointment the day before my flight and got me sorted out and I could go an enjoy the time away with my mates.”

– Adult with a disability

Figure 34 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 34: Comparison of distance travelled for ‘ability to participate in activities and day-to-day life’ across client type and gender segments
Pre: n=18 (children and teens), n=19 (adults), n=18 (girls/women) n=19 (boys/men)
Post: n=12 (children and teens), n=14 (adults), n=15 (girls/women) n=10 (boys/men)



In *Evaluation Stage 2 – Quantitative*, children and teens reported change at a higher rate compared to adults. This is not a statistically significant difference but may be indicative. This may be because adults often face more deeply rooted physical and social limitations, such as employment barriers, chronic pain, or reduced mobility, which resolving continence or podiatry issues alone may not fully address (UK Government Disability Unit, 2021). While comprehensive time-use data comparing children and adults is limited, it is widely recognised that children generally participate in a broader range of daily activities than adults, including education, play, and extracurricular pursuits (Growing Up in Ireland, 2017; Rees, 2017). Many participants qualitatively reported that children’s continence or podiatry needs led to missed school days and extracurricular activities, suggesting that addressing these issues may have had a more significant impact on children’s overall participation and quality of life.

Change was reported at a slightly higher rate by clients of Continence Clinic than by clients of Podiatry. This is not a statistically significant difference but may be indicative. However, clients of the Podiatry service reported higher pre-intervention scores compared to those of the Continence Clinic and, as a result, experienced less overall change. This could be because many Podiatry clients seek treatment for routine maintenance or preventative care, rather than addressing acute or urgent issues. Consequently, their baseline ability to engage in daily activities was already higher, leaving less room for significant improvement through the service.

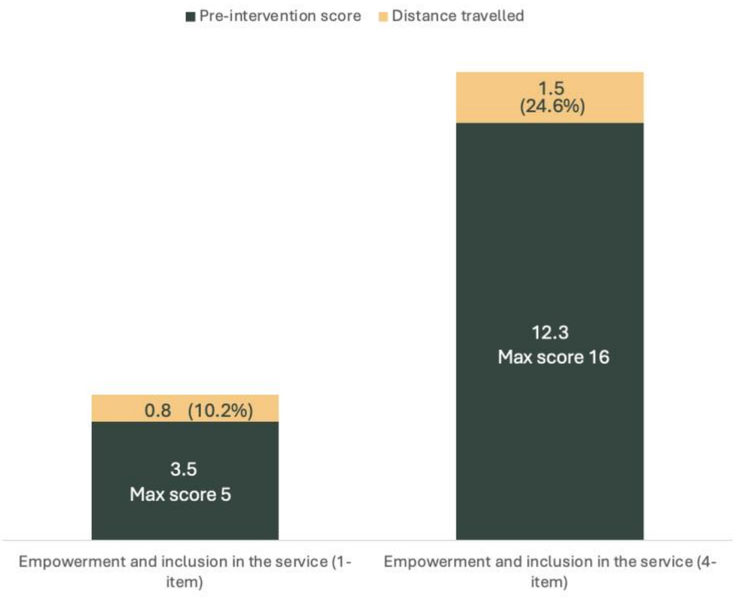
Table 41: Comparison of change achieved for ‘ability to participate in activities and day-to-day life’ across services attended
Pre: n=26 (Continence Clinic), n=13 (Podiatry)
Post: n=12 (Continence Clinic), n=12 (Podiatry)

Service	**Weighted distance travelled**
Continence Clinic	28.9%
Podiatry	21.0%

7.3 Outcome: Feelings of empowerment and inclusion in the service provided

The weighted distance travelled for the outcome ‘feelings of empowerment and inclusion in the service provided’ was 44.5% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 35: Analysis of the change achieved for ‘feelings of empowerment and inclusion in the service provided’
n=38 (pre), n=25 (post)



	# items	Weight
Set 1	1	0.20
Set 2	4	0.80

	Set 1	Set 2
Weighted distance travelled	10.9%	33.6%
Average distance travelled	44.5%	

Before engaging with Crann’s Health and Continence Services, many clients had attended other health-related services where they felt disempowered, uninformed, and not fully consulted about their treatment options.

At Crann, they experienced a different approach, where they were actively involved in decisions about their care. Many described this as the first time they felt in control of their treatment, knowing they had choices and the right to withdraw consent at any time. This sense of involvement and respect for their autonomy was deeply empowering, with some clients reporting a significant impact on their confidence in managing their own healthcare.

> *“It’s so nice not having to direct or dictate like I usually have to, because they actually listen the first time and know what you want.”*

– Adult with a disability

During *Evaluation Stage 1 – Qualitative*, all participants reported having experienced the majority of intermediate outcomes and agreed that they had felt included in the service at Crann. For many this was a different experience to other services/appointments where they had not been spoken to directly or had not been listened to by the HCP.

> *"I was never really told anything about continence management before this. I have had so many urine infections because staff in the hospital didn't listen to me when I told them what I needed."*
>
> **– Adult with a disability**

The word "empowered" was divisive, but for those that did relate to the feeling, no other word felt like a suitable alternative. Changes were not applied to this outcome prior to outcome measurement but a linguistic checkpoint was included in the quantitative data collection, to ascertain whether the term was understood by respondents.

Figure 36 illustrates the self-reported understanding of the term empowerment. Based on the significant self-reported understanding of the term empowerment by respondents (84% understood) in *Evaluation Stage 2 – Quantitative*, and the fact that the greatest change was reported for this outcome of all outcomes under the Health and Continence theme, based on indicators, the decision was taken to keep the word "empowered."

Figure 36: Self-reported understanding of the term empowerment
n=25 (post)

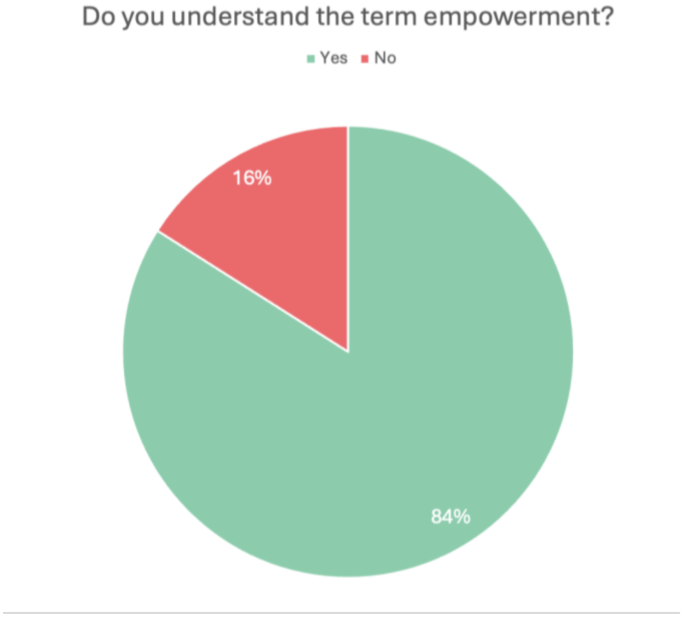
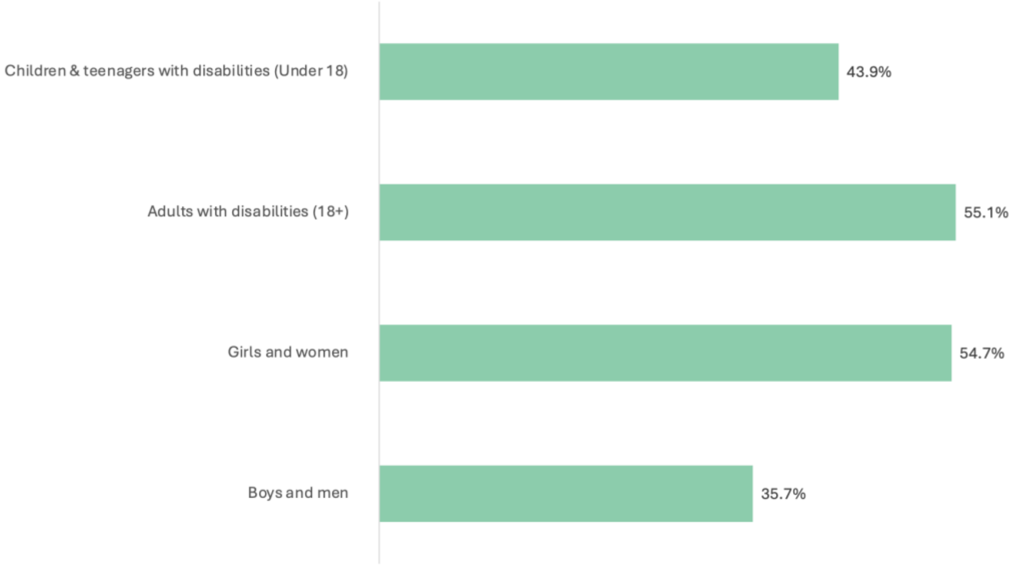


Figure 37 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 37: Comparison of distance travelled for ‘feelings of empowerment and inclusion in the service provided’ across client type and gender segments
Pre: n=18 (children and teens), n=19 (adults), n=18 (girls/women) n=19 (boys/men)
Post: n=12 (children and teens), n=14 (adults), n=15 (girls/women) n=10 (boys/men)



In *Evaluation Stage 2 – Quantitative*, children and teens reported change at a slightly lower rate than adults did. This is not a statistically significant difference but may be indicative. Children and teens are often still developing their sense of independence and decision-making skills. They may be less aware of their autonomy or lack the confidence to fully participate in healthcare decisions, making the practitioner's efforts feel less impactful (Grootens-Wiegers et al., 2017). Younger clients often rely heavily on parents or caregivers to advocate for their needs, which may reduce their perception of direct empowerment or inclusion in the decision-making process (NICE, 2021).

Boys and men reported change at a lower rate than girls and women did. Boys and men are often socialised to value independence, control, and self-reliance. Being actively included in decision-making by a healthcare practitioner might not register as empowering because it could conflict with ingrained expectations of being fully self-sufficient. Seeking medical assistance is often described in literature as being viewed as inherently making oneself vulnerable and often as a disempowering experience (Jeffries & Grogan, 2012; Mursa, Patterson & Halcomb, 2022). Research also indicates that women often favour relational and collaborative communication styles, which can make active inclusion in decision-making processes feel more natural and affirming to them. Conversely, men are generally more action-oriented in their use of language, focusing on problem-solving and direct communication. This difference suggests that men may not interpret collaborative interactions as empowering in the same way women do (Holmes, 2020).

Change was reported at very similar rates by clients of each service included in the analysis.

Table 42: Comparison of change achieved for ‘feelings of empowerment and inclusion in the service provided’ across services attended

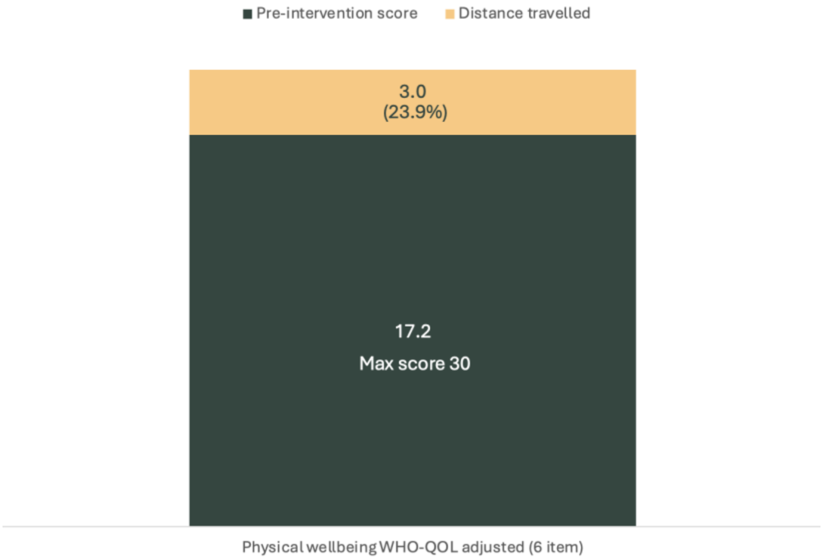
Pre: n=26 (Continence Clinic), n=13 (Podiatry)
Post: n=12 (Continence Clinic), n=12 (Podiatry)

Service	Weighted distance travelled
Continence Clinic	46.1%
Podiatry	40.4%

7.4 Outcome: Improved physical wellbeing

The weighted distance travelled for the outcome ‘improved physical wellbeing’ was 23.9% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 38: Analysis of the change achieved for ‘improved physical wellbeing’
n=38 (pre), n=25 (post)



Clients who engaged with Crann’s Health and Continence Services sought support for issues that were negatively impacting their physical health and wellbeing. As these services are solutions-focused, many experienced improved physical wellbeing.

Both Continence Clinic and Podiatry aim to provide sustainable, effective management with minimal disruption to daily life. Many clients described finally finding a solution to their issue, while others realised that previous treatments had been ineffective and were contributing to ongoing difficulties. In both cases, addressing these concerns led to a noticeable improvement in overall physical wellbeing.

> *“Now I have a routine that is mostly reliable and have no accidents, which is a big change from before. You can imagine how tough school was…”*
>
> **– Adult with a disability**

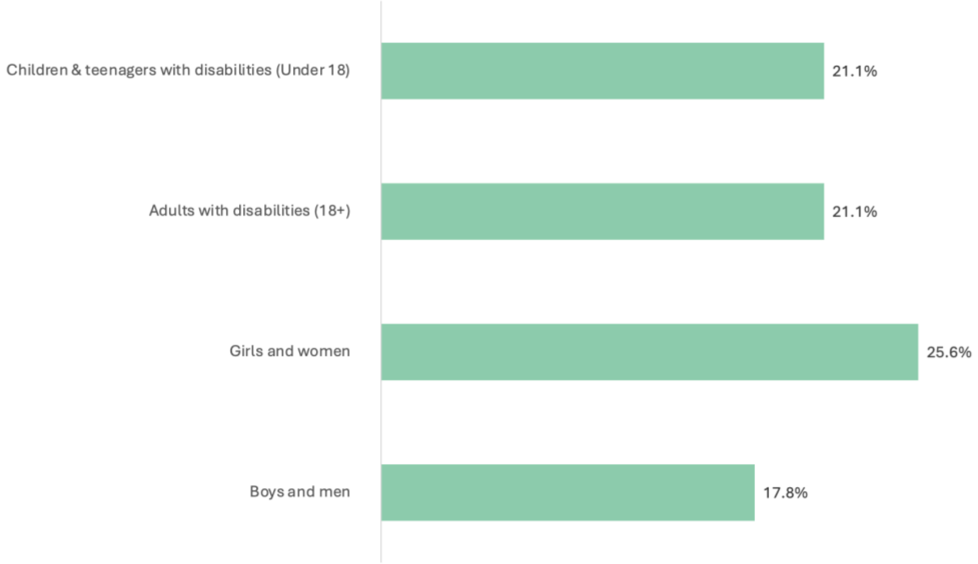
During *Evaluation Stage 1 – Qualitative*, all participants experienced the majority of the intermediate outcomes and reported an improvement in the physical wellbeing of the person receiving the treatment. Even those clients who had not directly engaged with Continence Clinic, due to their parent receiving the support and managing the continence routine, reported specific improvements to their physical wellbeing e.g., more energy, less headaches. Every participant felt they had experienced a noticeable improvement to their physical wellbeing since attending a Health and Continence service at Crann. No changes were indicated for this outcome.

> *"Definitely better physically. I would've suffered a lot with my feet and had a lot of pain. Now I can do what I want to do, free from pain and take control of my life."*
>
> **– Parent and child with a disability**

Figure 39 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 39: Comparison of distance travelled for 'improved physical wellbeing' across client type and gender segments

Pre: n=18 (children and teens), n=19 (adults), n=18 (girls/women) n=19 (boys/men)
Post: n=12 (children and teens), n=14 (adults), n=15 (girls/women) n=10 (boys/men)



In *Evaluation Stage 2 – Quantitative*, boys and men reported improvement in physical health at a slightly lower rate than girls and women did. This is not a statistically significant difference but may be indicative. Men and boys are generally less likely to seek medical help, which can lead to poorer management of chronic or acute physical conditions, negatively affecting their perceived physical wellbeing (Galdas, Cheater & Marshall, 2005; Mursa, Patterson & Halcomb, 2022).

Change was reported at a slightly higher rate by clients of Continence Clinic than by clients of Podiatry. This is not a statistically significant difference but may be indicative. Continence management often involves comprehensive treatment plans, including lifestyle changes, dietary adjustments, and medical interventions. This holistic approach can yield broader health benefits compared to podiatry interventions, which are often more focused on specific symptoms or areas of the body. Successful continence interventions often lead to a noticeable and immediate improvement in multiple aspects of daily life, including reduced physical strain, better hydration, and more restful sleep, which cumulatively enhance physical wellbeing (NHS England, 2018).

Table 43: Comparison of change achieved for 'improved physical wellbeing' across services attended

Pre: n=26 (Continence Clinic), n=13 (Podiatry)
Post: n=12 (Continence Clinic), n=12 (Podiatry)

Service	**Weighted distance travelled**

Continence Clinic	28.4%
Podiatry	17.6%

7.5 Outcome: Improved peace of mind and confidence in the treatment or management of the issue

The weighted distance travelled for the outcome ‘improved peace of mind and confidence in the treatment or management of the issue’ was 36.3% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 40: Analysis of the change achieved for ‘improved peace of mind and confidence in the treatment or management of the issue’

n=38 (pre), n=25 (post)

Many clients reported that continence issues caused stress, embarrassment, and low self-confidence. Finding solutions and receiving person-centred treatment at Crann helped them overcome these challenges. Similarly, podiatry clients often described long-standing pain that affected their mental wellbeing. Treatment that improved their condition provided relief and peace of mind.

This sense of peace of mind and confidence extended to the service itself. Many clients had previously faced inconsistent, inaccessible, or even harmful experiences when seeking continence or podiatry treatment. In contrast, Crann’s Health and Continence services were described as easy to access and comfortable. The accessible environment and person-centred approach helped even the most anxious children feel at ease, fostering trust and confidence in the service.

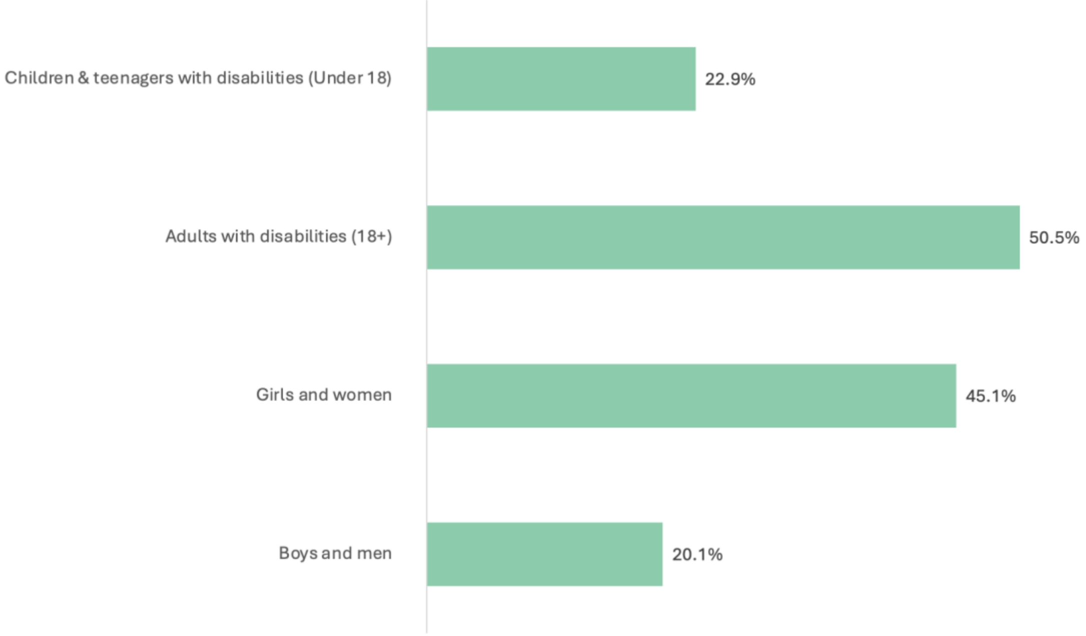
> *“The podiatrist already knew what I wanted done, even though it was a new person that time. They clearly took the time to read my notes really thoroughly before my appointment. I was really surprised by that as it doesn’t often happen!”*
>
> **– Adult with a disability**

During *Evaluation Stage 1 – Qualitative*, all participants reported having experienced most of the intermediate outcomes and most agreed that they had achieved the final outcome of increased peace of mind and confidence. Insight gained from the qualitative groups evolved our understanding of this outcome and clarified that for the majority, the confidence piece of the outcome related specifically to the treatment or management routine and did not extend to self-confidence. Most participants had gained confidence in managing their own routine, and/or felt confident in the treatment being offered to them at Crann. While self-confidence improvements were experienced by a few clients who had previously found continence management embarrassing or had accidents that led to low self-confidence. This experience was not experienced by enough clients to be materially significant, and the outcome wording was changed to reflect the experience of the majority more accurately.

> *"My mum was managing my feet before this service came to Crann and I feel much more hopeful about the future management of my feet now I can go to an external service. It's also nice not to be relying on Mum and be more on top of it myself too."*
>
> **– Adult with a disability**

Figure 41 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 41: Comparison of distance travelled for 'improved peace of mind and confidence in the treatment or management of the issue' across client type and gender segments
Pre: n=18 (children and teens), n=19 (adults), n=18 (girls/women) n=19 (boys/men)
Post: n=12 (children and teens), n=14 (adults), n=15 (girls/women) n=10 (boys/men)



In *Evaluation Stage 2 – Quantitative*, children and teens reported change at a lower rate than adults did. This is also likely due to adults being more responsible for the management and planning around their own continence and podiatry issues. As discussed above, in relation to the outcome of increased sense of freedom, during childhood, and often well into adolescence, it is parents who manage the child's needs and plan to overcome challenges. Parents managed the continence routines for all children and teens who participated in the SROI study.

Girls and women reported change at a higher rate than boys and men did. Girls and women's pre-intervention scores were lower than men's were. Women may begin with lower baseline confidence in managing certain issues (e.g., continence), making the observed improvements more noticeable and impactful. Women may also have faced barriers or negative experiences in accessing healthcare previously (World Economic Forum, 2024). When clinics prioritise respect and consent, it may represent a significant improvement, amplifying their positive perception of the care.

Change was reported at very similar rates by clients of each service included in the analysis.

Table 44: Comparison of change achieved for 'improved peace of mind and confidence in the treatment or management of the issue' across services attended

Pre: n=26 (Continence Clinic), n=13 (Podiatry)
Post: n=12 (Continence Clinic), n=12 (Podiatry)

Service	**Weighted distance travelled**
Continence Clinic	36.8%
Podiatry	32.5%

8. Analysis of the change that occurred for clients of Crann's Personal Support and Connection service

This chapter outlines the analysis of the change that occurred for Crann clients who accessed the Personal Support and Connection Service during the SROI period.

Table 45: Summary of outcomes experienced by clients
n=10 (pre), n=21 (post)

Outcome	**Weighted distance travelled**	**Value ranking by respondents**
Reduced loneliness	25.4%	#1
Increased hope for the future	22.7%	#2
Increased feelings of acceptance and being accommodated	38.3%	#3
Increased social inclusion, support, and community	56.8%	#4

The impact of the Personal Support and Connection Service at Crann was first identified during the peak of the Covid-19 pandemic, a context that significantly shaped stakeholders' experiences. Some outcomes originally reported may appear less pronounced in the SROI Evaluation due to the markedly different circumstances of the 2023–2024 period. However, the validation of the ToC in *Evaluation Stage 1 – Qualitative* and the measured distance travelled on outcomes in *Evaluation Stage 2 - Quantitative* both confirm that meaningful change continues to occur for stakeholders. This context should be considered when interpreting the results.

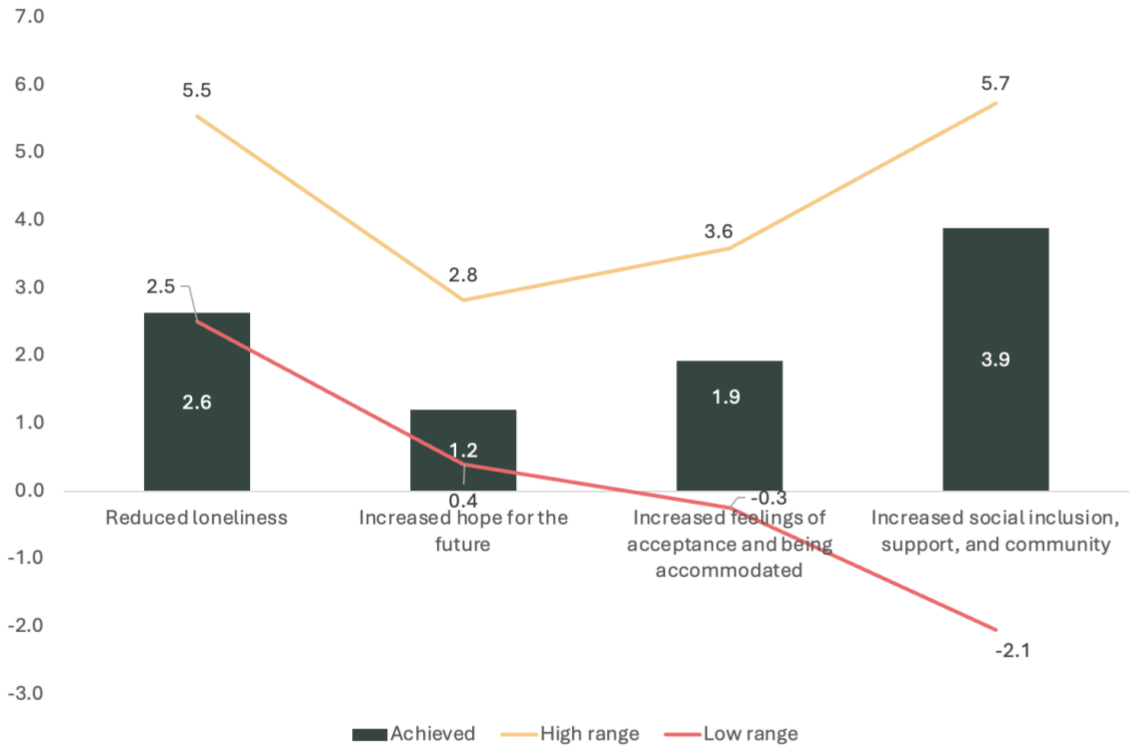
As detailed in Section 2.3, the Personal Support and Connection Service is unique in its delivery because it exists outside of the traditional service delivery context, in the form of continuous follow-up support, reassurance, and a sense of guidance provided by Crann's staff. To ensure that stakeholders were aware of what elements of Crann's support they were being asked about, it was clearly explained at each research interaction, that this related to ad hoc support they had received from the Crann team outside of any specific service they attended, including follow-ups and check-ins by service staff.

Figure 42 presents the mean distance travelled (average reported change) in scale points for the four outcomes experienced by clients of the Personal Support and Connection Service, based on aggregated sample data. The green bars represent the actual reported change achieved by stakeholders for each outcome. The yellow line indicates the high range of error for the materiality threshold, while the red line represents the low range of error for the materiality threshold, providing boundaries for interpreting changes as materially significant.

- "Reduced loneliness" achieved a change of 2.6 scale points, just above the low range of error for materiality (2.5 to 5.5 scale points), reflecting modest progress that meets the threshold for materiality but does not indicate substantial change.
- "Increased hope for the future" achieved the lowest change (1.2 scale points), within the range of error for materiality (0.4 to 2.8 scale points), suggesting positive but relatively modest progress.
- "Increased feelings of acceptance and being accommodated" achieved a change of 1.9 scale points, within the range of error for materiality (-0.3 to 3.6 scale points), demonstrating moderate and meaningful progress for stakeholders.
- "Increased social inclusion, support, and community" achieved the highest change (3.9 scale points), within the range of error for materiality (-2.1 to 5.7 scale points), highlighting significant and impactful progress in this area.

This chart highlights how the achieved changes align with or fall within the range of error for materiality thresholds, providing a nuanced view of the varying levels of progress made by clients of the Personal Support and Connection Service across different outcomes.

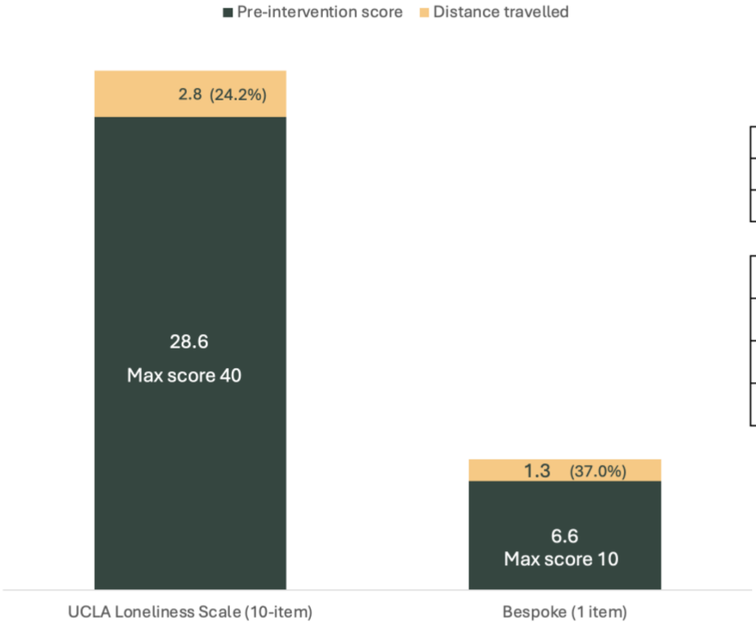
Figure 42: Materiality achieved for Personal Support and Connection outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit
n=10 (pre), n=21 (post)



8.1 Outcome: Reduced loneliness

The weighted distance travelled for the outcome ‘reduced loneliness’ was 15.2% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 43: Analysis of the change achieved for ‘reduced loneliness’
n=10 (pre), n=21 (post)



	# items	Weight
Set 1	10	0.91
Set 2	1	0.09

Weighted distance travelled	
Set 1	Set 2
22.0%	3.4%
25.4%	

Before engaging with Crann, many clients experienced loneliness, either due to having a disability and lacking peer connections or as parents of children with disabilities who felt misunderstood by others. This often left them unable to share their challenges or achievements, reinforcing feelings of isolation.

Engaging with Crann's Personal Support and Connection service provided a space where they could share experiences with someone who understood and could offer reassurance and support, helping to reduce feelings of loneliness.

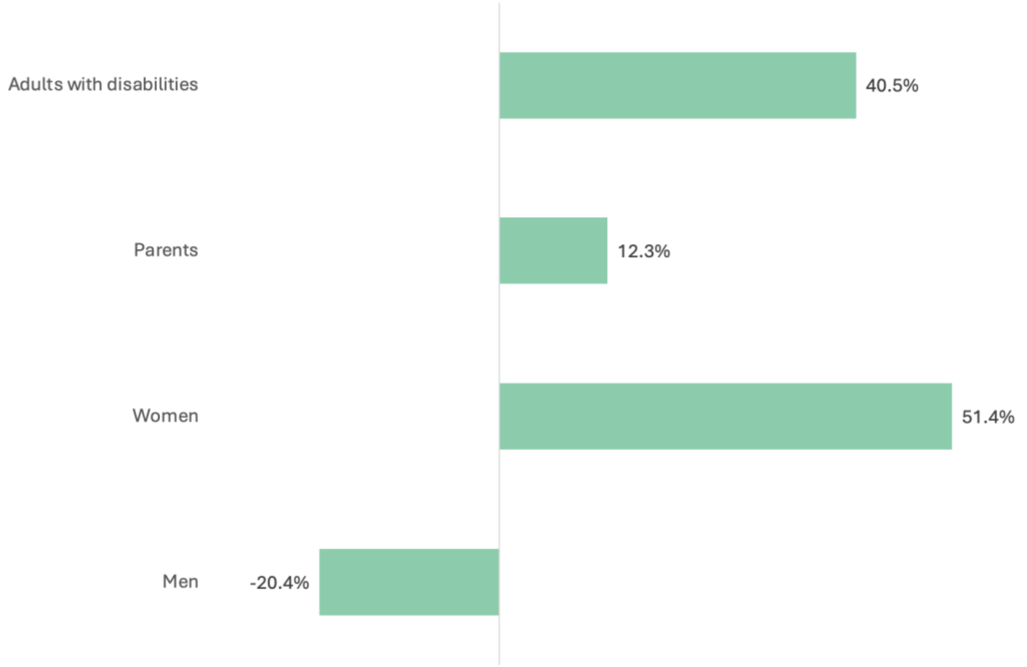
> *"I'd feel comfortable to drop in for a chat at Crann even if I didn't have an appointment, because of that community feeling. I always feel seen at Crann, which I often don't feel elsewhere, as someone with a disability."*
>
> **– Adult with a disability**

During *Evaluation Stage 1 – Qualitative*, all participants reported having experienced the majority of the intermediate outcomes and most agreed that their feelings of loneliness had been reduced because of Crann's Personal Support and Connection service. For those that related to this outcome, having someone they knew they could turn to at Crann had a big impact on them, and all agreed that the centre is a very social place to be, and that staff drive this atmosphere with their friendly attitudes. For those who lived alone or were isolated for other reasons, this outcome was felt to have a particularly high level of importance. No changes were indicated for this outcome.

Figure 44 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 44: Comparison of distance travelled for 'reduced loneliness' across client type and gender segments

Pre: n=7(adults), n=3 (parents), n=10 (girls/women) n=8 (boys/men)
Post: n=13 (adults), n=6 (parents), n=7 (girls/women) n=6 (boys/men)



In *Evaluation Stage 2 – Quantitative*, men reported a slight negative shift in loneliness, whereas women reported a significantly positive shift. Research highlights significant gender differences in how men and women engage with support services and experience emotions like loneliness. Women, whose social relationships tend to have more protective effects on physical and mental health compared to men, may derive greater emotional benefit from regular check-ins. These interactions can strengthen social connections and positively impact their experience of loneliness (Shin & Park, 2023). Conversely, men may prioritise concrete, actionable outcomes over emotional support. If services are perceived as prioritising emotional well-being over practical, goal-oriented outcomes, men may feel disengaged or undervalue the intervention, as they are often more motivated by tangible improvements that align with traditional notions of achievement and problem-solving (Staiger et al., 2020; Sunki & Soyoung, 2023).

Men are less likely to engage in additional personal supports, particularly in contexts involving emotional or interpersonal assistance. This reluctance aligns with societal norms discouraging vulnerability in men and the expectation of self-reliance (Galdas, Cheater & Marshall, 2005; Emerson et al., 2020). Men and women also experience loneliness differently: men are less likely to seek emotional support or discuss feelings of loneliness, often suppressing or denying such feelings. Women, in contrast, are more likely to address loneliness by reaching out or participating in social activities. Over time, these coping mechanisms contribute to men experiencing higher levels of chronic loneliness due to their reliance on a smaller number of relationships and less proactive approaches to social connection (Barreto et al., 2021, Barreto, Doyle & Maes, 2025).

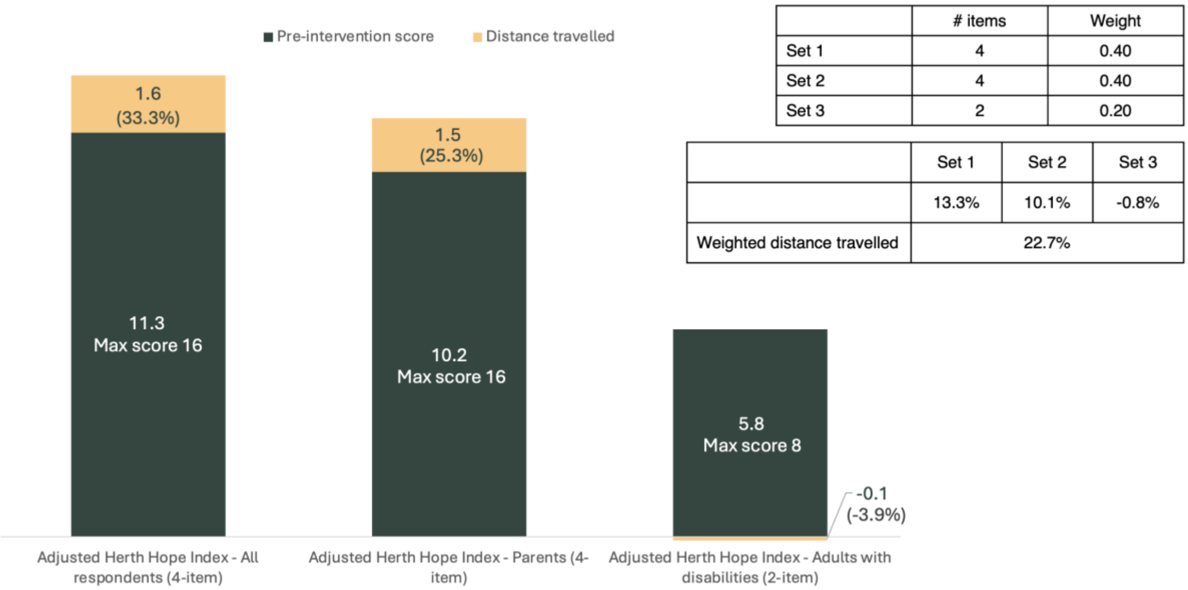
Most men in the sample were adults with disabilities, whereas the women were a more mixed group, including some parents. This variation in roles and experiences may further explain the divergent responses to support services.

Parents reported change at a lower rate than adults with disabilities did. Adults with disabilities may have more limited social networks compared to parents of people with disabilities. These support services can significantly expand their interactions, addressing gaps in social connection. Systemic barriers, such as physical inaccessibility and societal stigma, can exacerbate isolation among adults with disabilities, making interventions that promote connection particularly impactful (Tough, Siergrist & Fekete, 2017). Adults with disabilities might approach support services with an expectation or hope for increased connection, and these expectations are more likely to be met through direct engagement. Parents' loneliness may be more relational, arising from feeling unsupported or misunderstood in their caregiving role. This type of loneliness may require broader societal changes or specialised support services to fully address (Sarman & Tuncay, 2024).

8.2 Outcome: Increased hope for the future

The weighted distance travelled for the outcome ‘increased hope for the future’ was 22.7% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 45: Analysis of the change achieved for ‘increased hope for the future’
n=10 (pre), n=21 (post)



	# items	Weight
Set 1	4	0.40
Set 2	4	0.40
Set 3	2	0.20

	Set 1	Set 2	Set 3
	13.3%	10.1%	-0.8%
Weighted distance travelled	22.7%		

Clients valued the security of knowing that Crann would continue to support them for as long as needed, rather than ending support after a specific service was delivered. For adults with disabilities, this ongoing commitment provided reassurance and stability.

For parents, the additional support through the Personal Support and Connection Service offered clarity on the ways Crann would continue to help their family. This reassurance replaced feelings of panic about the future with a renewed sense of hope.

> *“It’s given me a positive outlook for the future, maybe even on a national level, if we can continue to develop services like Crann and hopefully see it spread.”*
>
> **– Parent of a child with a disability**

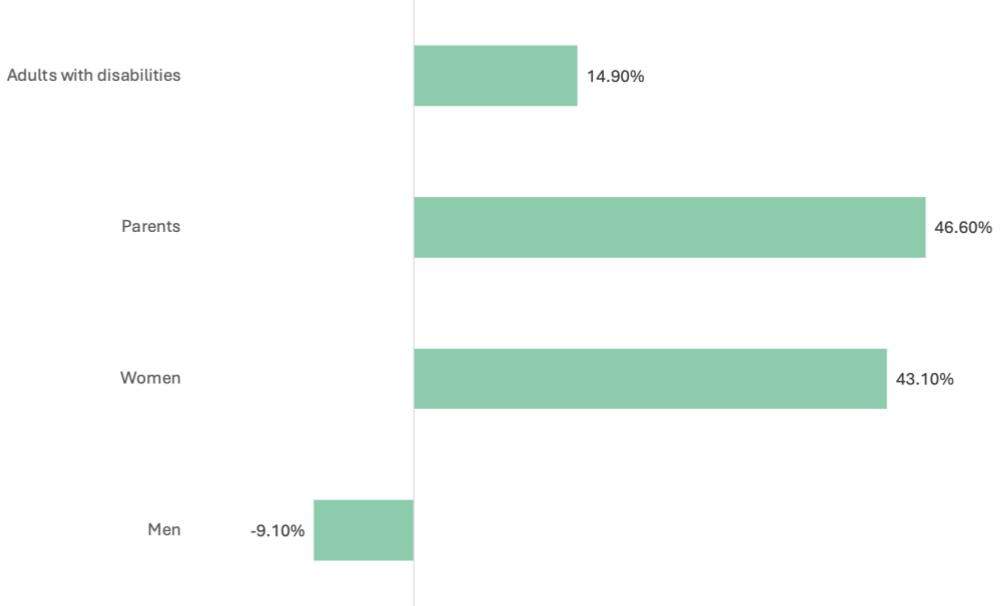
During *Evaluation Stage 1 – Qualitative*, all participants reported having experienced the majority of the intermediate outcomes. Most also agreed that they had more hope for the future because of Crann’s Personal Support and Connection service. This hope applied to their own future, due to the additional support, a service-provider that genuinely cares for them and knowing they and/or their family have access to services they need and that this support will be life-long.

> *“It’s a huge thing because you don’t always know what you will need support with, in the future, but I know Crann will do what they can to help me, always.”*
>
> **– Adult with a disability**

Figure 46 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 46: Comparison of distance travelled for 'increased hope for the future' across client type and gender segments

Pre: n=7(adults), n=3 (parents), n=10 (girls/women) n=8 (boys/men)
Post: n=13 (adults), n=6 (parents), n=7 (girls/women) n=6 (boys/men)



In *Evaluation Stage 2 – Quantitative*, parents reported change at a higher rate than adults with disabilities did. We know from the qualitative research that the uncertainty felt by parents about their children's ongoing care and ability to achieve significant positive outcomes is a highly emotional experience. This is also reflected in the outcomes achieved by parents as secondary stakeholders. It is likely that even modest improvements or reassurances about resources, support or potential for progress would have a significant material impact on their outlook. Parents also often derive hope from external sources, such as improvements in healthcare, education, or support services for their children and therefore may experience vicarious hope when they see the potential of a situation (Snyder, 2002; Hoang et al., 2024).

Conversely, adults with disabilities may have long-term lived experience of systemic barriers and unfulfilled expectations (Scope, n.d.), which might lead to lower expectations of change or future possibilities which hinders material impact on long-standing perspectives (Cherry, 2021). For adults with disabilities, hope for the future might also be linked to more personal goals, such as independence, employment, social inclusion, or healthcare access (Dunstan, Falconer & Price, 2017). As the Personal Support and Connection Service does not directly address these personal challenges, they may not have experienced a significant shift in their level of hope, even if other areas (such as overall support) improved.

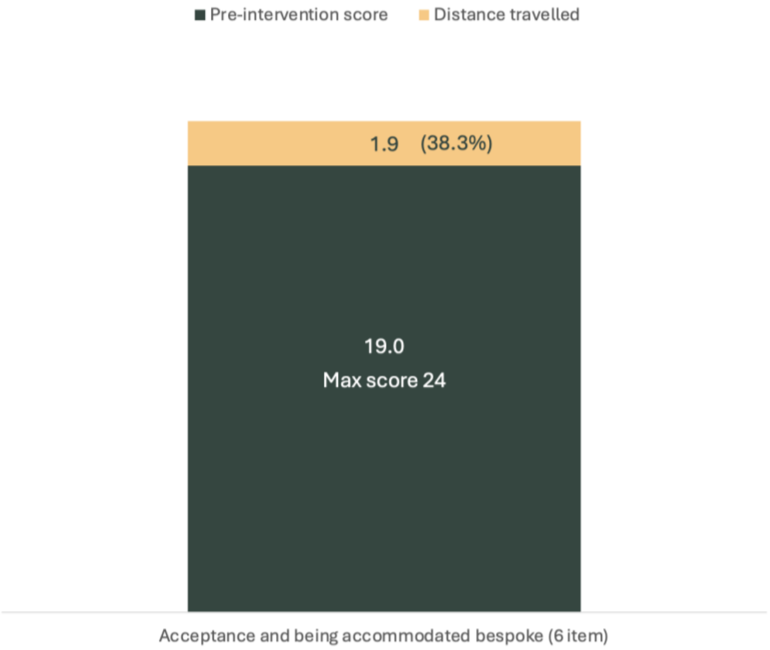
Men reported change at a lower rate than women did. Men are often socialised to value independence, strength, and self-reliance. Engaging with support services might conflict with these ideals, potentially leading to feelings of inadequacy or diminished self-worth (Mind, 2019; Nordin, Degerstedt & Granholm Valmari, 2024). Men may approach these additional support services with some hesitation or defensiveness, reducing the effectiveness of the intervention (Oliver et al., 2005; Sagar-Ouriaghli et al., 2019). They may also perceive check-ins and follow-ups outside of other services as a reminder of their perceived limitations (Sunki & Soyoung, 2023).

8.3 Outcome: Increased feelings of acceptance and being accommodated

The weighted distance travelled for the outcome ‘increased feelings of acceptance and being accommodated’ was 38.33% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 47: Analysis of the change achieved for ‘increased feelings of acceptance and being accommodated’

n=10 (pre), n=21 (post)



Many clients compared their experiences at Crann to other services, where they often felt like "just another number." In many cases, they could only engage with practitioners during scheduled appointments and had no clear support when struggling with treatment or seeking guidance. Some parents also reported being excluded from services elsewhere due to their child having a rare or undiagnosed condition, leaving them feeling unwelcome and as if they were asking for support they were not entitled to.

At Crann, the Personal Support and Connection Service fostered a sense of inclusion and accessibility. Clients felt welcomed, never viewed as a burden, and described staff as going above and beyond to accommodate their needs. Those attending other Crann services also felt reassured by the ability to easily reach specialists for questions or concerns, knowing their queries would be met with patience and a willingness to help. Many clients who had struggled to access support elsewhere, particularly those without a formal diagnosis, found Crann to be an accepting and responsive place where they received the services they needed.

“At Crann, you’re a person, not a number.”

– Adult with a disability

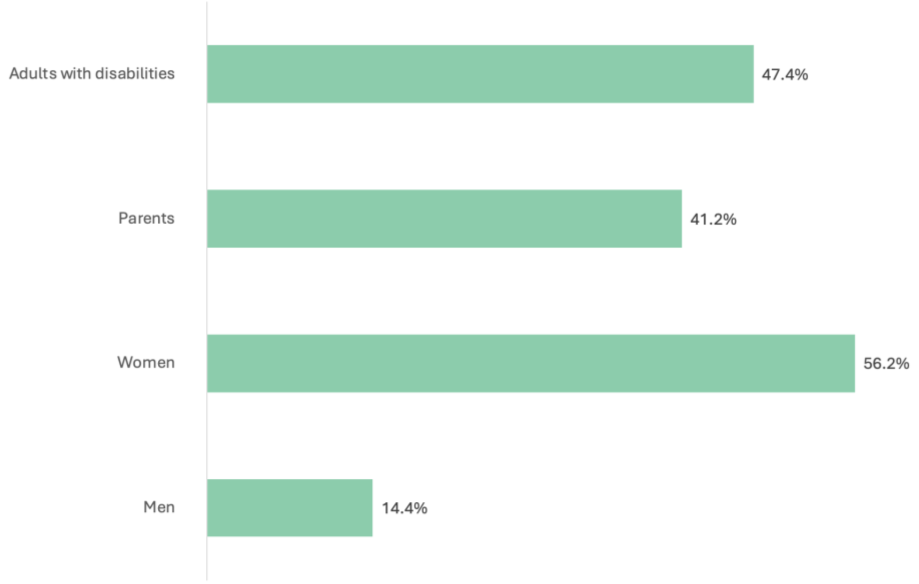
During *Evaluation Stage 1 – Qualitative*, all participants reported having experienced the majority of the intermediate outcomes. Most also felt that they had achieved the outcome of feelings of acceptance and being accommodated. Parents shared the experience that this was driven by the lack of inclusive services available for them elsewhere; for many parents this is the first time they have been included in an organisation’s service provision. They also described the experience of having to fight to work out what services they are entitled to for their child or children but that they felt that Crann are up front and open from the beginning about all the services they can avail of.

People with disabilities shared a new insight that the greatest impact of this outcome came from being treated equally with everyone else who comes through the door at Crann. An additional approach and intermediate outcome were added to the ToC to reflect this experience of acceptance for people with disabilities.

> *"I love that there's no questions about your disability, like when you're talking to people, everyone is equal and viewed the same. No one asks awkward questions like you might get in other places."*
>
> **– Adult with a disability**

Figure 48 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 48: Comparison of distance travelled for 'increased feelings of acceptance and being accommodated' across client type and gender segments
Pre: n=7(adults), n=3 (parents), n=10 (girls/women) n=8 (boys/men)
Post: n=13 (adults), n=6 (parents), n=7 (girls/women) n=6 (boys/men)



In *Evaluation Stage 2 – Quantitative*, women reported change at a higher rate than men did. Men are often socialised to value independence and self-reliance, which might make them less likely to acknowledge or internalise feelings of acceptance and accommodation (McKenzie et al., 2018). They may also set a higher threshold for recognising or valuing these improvements (Sagar-Ouriaghli et al., 2019). Women, by contrast, may place greater emphasis on interpersonal relationships and emotional support. As a result, even small changes in being accommodated or accepted might feel more impactful to women. Women might also be more attuned to, and appreciative of, interpersonal accommodations, such as feeling listened to or emotionally supported, which may have resulted in a stronger positive shift for this outcome (Tamres, Janicki & Helgeson, 2002; Shin & Park, 2023). Men commonly place more emphasis on instrumental support (i.e.

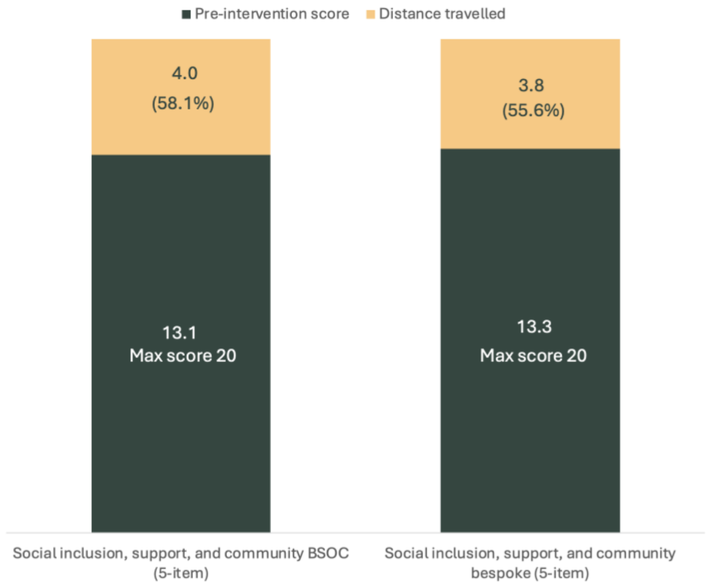
practical assistance), than on emotional support (McKenzie et al., 2018), which may reduce their overall perceived impact of these interactions on feelings of acceptance.

8.6 Outcome: Increased social inclusion, support, and community

The weighted distance travelled for the outcome 'increased social inclusion, support, and community' was 56.81% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 49: Analysis of the change achieved for 'increased social inclusion, support, and community'

n=10 (pre), n=21 (post)



	# items	Weight
Set 1	5	0.50
Set 2	5	0.50

	Set 1	Set 2
Weighted distance travelled	29.0%	27.8%
Average distance travelled	56.8%	

Some respondents reported a lack of community in their experience as a person with a disability or a parent of a child with a disability, often due to not knowing others in similar situations. While some parents of teens or older children had formed connections over the years, many had not. Adults with disabilities frequently described losing social connections outside their family after leaving school and struggling to find a new environment where they felt understood.

Clients described Crann as a community where they built connections not only with peers but also with staff, who felt like part of their support network. Many highlighted feeling understood and supported by individual team members and praised the welcoming environment created on-site.

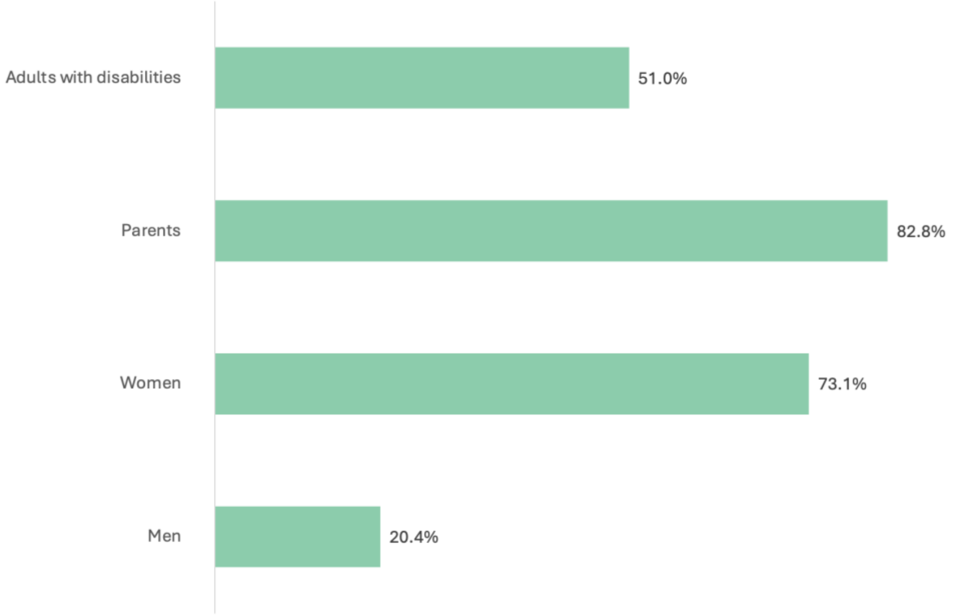
> *"I just feel that it's such an accepting, welcoming place and there's so much support here. Crann always follow through, you're always given what's promised, never left waiting and there's no judgement for asking for anything. I don't think you know how rare that is. And just the warmness and lack of formality with the staff here, it's fantastic."*
>
> **– Parent of a child with a disability**

During *Evaluation Stage 1 – Qualitative*, all participants reported having experienced most of the intermediate outcomes. Most felt they had achieved the outcome of increased social inclusion, support and community.

For those who did not relate to the final outcome, this was usually due to a self-identified lack of engagement on that level with the wider environment at the centre. Those participants who didn't relate to the final outcome did still experience some of the intermediate outcomes but didn't feel they were lacking social inclusion or support outside of Crann, so the impact of those changes was less important for them. No changes were indicated for this outcome.

Figure 50 presents the comparative distance travelled across client segments, categorised by client type and gender. A detailed analysis is provided following the figure.

Figure 50: Comparison of distance travelled for 'increased social inclusion, support, and community' across client type and gender segments
Pre: n=7(adults), n=3 (parents), n=10 (girls/women) n=8 (boys/men)
Post: n=13 (adults), n=6 (parents), n=7 (girls/women) n=6 (boys/men)



In *Evaluation Stage 2 – Quantitative* women reported change at a higher rate than men did. As discussed for previous Personal Support and Connection outcomes for which this was the case, this could be influenced by gender norms that encourage women to seek and value interpersonal relationships and emotional support, leading to greater engagement with such services (Tamres, Janicki & Helgeson, 2002; Shin & Park, 2023). Conversely, men may be less inclined to participate due to traditional masculine ideals emphasising independence and self-reliance, which can hinder their willingness to seek help and fully benefit from support services (Sagar-Ouriaghli et al., 2019). These gender differences in help-seeking behaviours and the value placed on social connections contribute to the varying degrees of positive outcomes observed between men and women in response to support interventions.

Parents also reported change at a higher rate than adults with disabilities did. This difference likely arose because parents typically approach such services from a relational and practical perspective, often seeking reassurance that their child's needs are being met and support in their role as a caregiver (Department of Children, Equality, Disability, Integration and Youth, 2022). We know from the qualitative research that they often have not received that from other services in the past. The interactions with Crann staff within the Personal Support and Connection offering provides parents with a sense of connection and recognition, as well as opportunities to address shared challenges with service staff, leading to an enhanced perception of social inclusion and support.

9. Analysis of the change that occurred for parents of children and adults attending in-scope services (secondary stakeholders)

This chapter outlines the analysis of the change that occurred for parents of children and adults attending in-scope services (secondary stakeholders) who accessed relevant services during the SROI period.

Table 46: Summary of outcomes experienced by clients
n=9 (pre), n=21 (post)

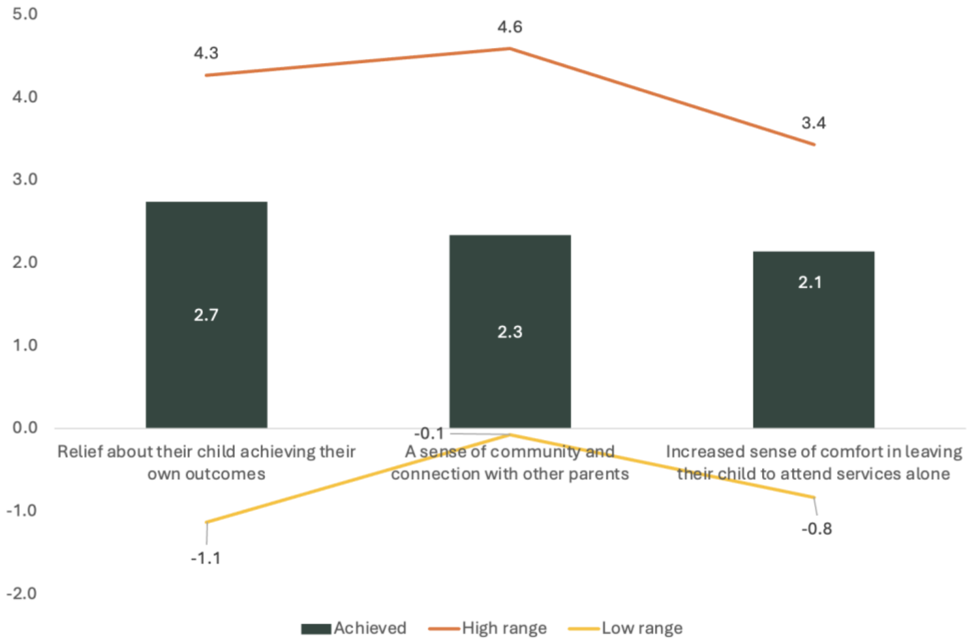
Outcome	Weighted distance travelled	Value ranking by respondents
Relief about their child achieving their own outcomes	30.1%	#1
A sense of community and connection with other parents	34.7%	#2
Increased sense of comfort in leaving their child to attend services alone	50.7%	#3

Figure 51 presents the mean distance travelled (average reported change) in scale points for three outcomes experienced by parents of children and adults attending in-scope services, based on aggregated sample data. The blue bars represent the actual reported change achieved by stakeholders for each outcome. The orange line indicates the high range of error for the materiality threshold, while the yellow line represents the low range of error for the materiality threshold, providing boundaries for interpreting changes as materially significant.

- "Relief about their child achieving their own outcomes" achieved a change of 2.7 scale points, within the range of error for materiality (-1.1 to 4.3 scale points), reflecting steady progress that is well above the low range of error for materiality.
- "A sense of community and connection with other parents" achieved a change of 2.3 scale points, within the range of error for materiality (-0.1 to 4.6 scale points), indicating meaningful progress and connection-building among parents.
- "Increased sense of comfort in leaving their child to attend services alone" achieved the lowest change (2.1 scale points), within the range of error for materiality (-0.8 to 3.4 scale points), reflecting modest but positive progress in building trust and confidence in the service.

This chart highlights how the achieved changes align with or exceed the range of error for materiality thresholds, offering insights into the outcomes most valued by parents of children and adults attending in-scope services (secondary stakeholders) and the varying levels of progress experienced across these outcomes.

Figure 51: Materiality achieved for Parents of Children and Adults Attending In-Scope Services (secondary stakeholders) outcomes (in scale-points difference) compared to high and low range of error for materiality at 95% confidence limit
n=9 (pre), n=21 (post)

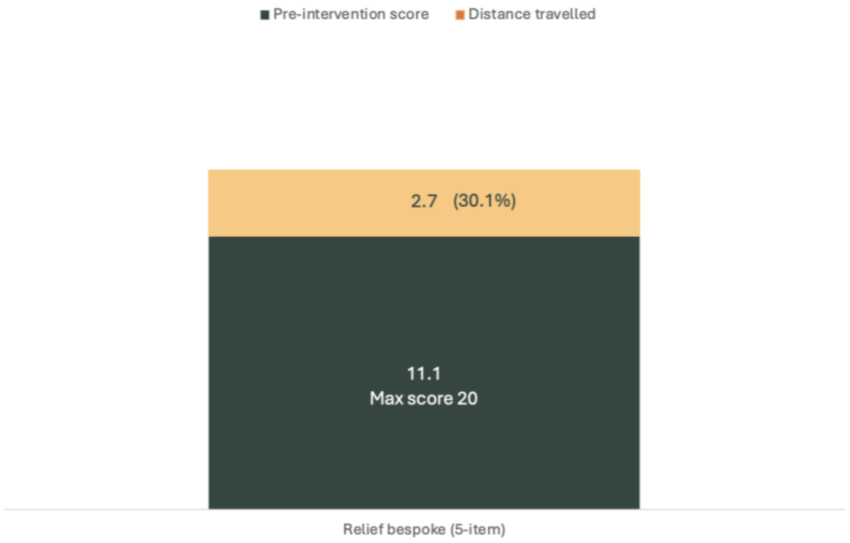


9.1 Outcome: Relief about their child achieving their own outcomes

The weighted distance travelled for the outcome ‘relief about their child achieving their own outcomes’ was 30.1% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 52: Analysis of the change achieved for ‘relief about their child achieving their own outcomes’

n=9 (pre), n=21 (post)



This outcome reflects a sense of relief for parents, closely tied to seeing their child achieve meaningful progress. While all parents experience concerns for their children, those with a child with a disability face heightened worries about their social life, psychological wellbeing, long-term health, independence, and safety. These experiences align with extensive research showing that parents of children with disabilities navigate unique stressors, including increased anxiety, over-protection, and caregiving pressures (Heiman, 2002; Piškur et al., 2012; Shahali et al., 2024).

For many parents, witnessing their child thrive with the right support provided reassurance and a shift in perspective, allowing them to recognise and celebrate their child's strengths and abilities. This aligns with findings that positive family interventions can foster a more optimistic outlook, strengthening family relationships and instilling a sense of pride (Shiju, Sabukuttan & Joy, 2023; Daly et al., 2015; Davis et al., 2010).

> *"Honestly, [child] has come such a long way since we found Crann and that just makes me feel so relieved."*
>
> **– Parent of a child with a disability**

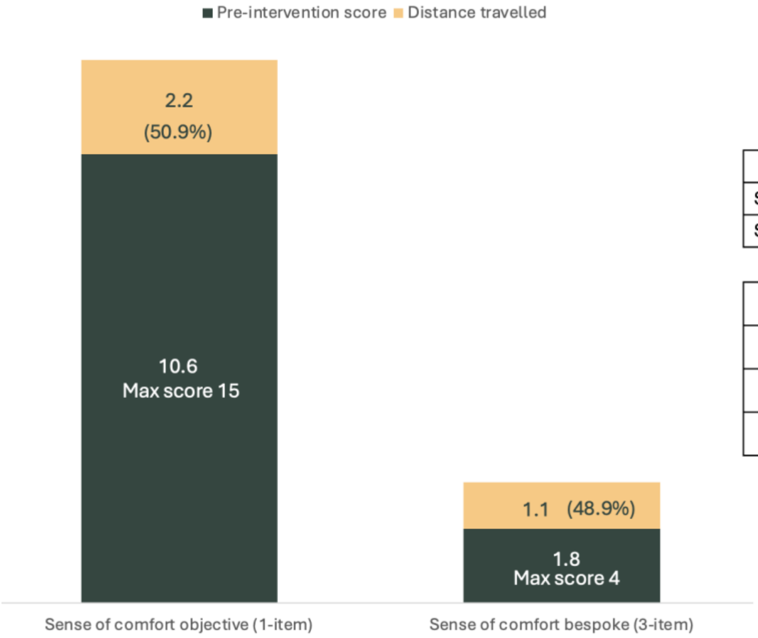
In *Evaluation Stage 1 – Qualitative*, participants confirmed they had experienced most intermediate outcomes, with all reporting experiencing 'relief about their child achieving their own outcomes.' Parents provided specific examples of what contributed to this relief, such as reduced stress about health-related appointments, their child gaining independence in managing continence routines, and their child confidently participating in social or community activities. No changes were made to this outcome.

Parents' reports highlight the profound emotional impact of their child's progress, with Crann's services offering meaningful relief from unique caregiving pressures and fostering confidence in their child's future. This underscores the critical role Crann plays in addressing both the practical and emotional needs of families.

9.2 Outcome: Increased sense of comfort in leaving their child to attend services alone

The weighted distance travelled for the outcome 'increased sense of comfort in leaving their child to attend services alone' was 50.7% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 53: Analysis of the change achieved for 'increased sense of comfort in leaving their child to attend services alone'
n=9 (pre), n=21 (post)



	# items	Weight
Set 1	3	0.92
Set 2	1	0.08

Weighted distance travelled	
Set 1	Set 2
46.9%	3.8%
50.7%	

Parents of children with disabilities often experience anxiety when placing their child in external services, perceiving many environments as impersonal and unresponsive, which reduces their confidence even when needs are clearly communicated (Ryan & Quinlan, 2017). In contrast, Crann provided a setting where parents felt a significant shift in their comfort levels, even among those who had never previously left their child alone.

The expertise and professionalism of Crann’s staff, along with proactive communication and clear reassurances, fostered trust and confidence. Parents felt assured that staff could effectively manage any challenges without requiring their presence. This increased sense of comfort was further supported by Crann’s fully accessible facilities, which alleviated concerns about mobility, toilet access, and other practical needs. Research highlights the role of accessible environments in enabling equitable participation and fostering inclusion (Banda-Chalwe, Nitz & de Jonge, 2014; Zallio & Clarkson, 2021). Universal design is also endorsed in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), emphasising its importance in ensuring accessibility, inclusion, and equality for all persons with disabilities (United Nations, 2006).

> *“The accessibility of the centre is a big part of this I think, like even having a range of toilet options in the building is so important and makes us feel more comfortable.”*
>
> **– Parent of a child with a disability**

In *Evaluation Stage 1 – Qualitative*, all participants reported having experienced a significant increase in their comfort when leaving their children to attend services at Crann. Parents described this change as a key outcome for both them and their children, fostering greater independence for the child while allowing parents to step back with confidence. Notably, some children spontaneously shared their positive experiences of being left alone at Crann during interviews, with parents corroborating these accounts and highlighting the role of both Crann’s staff and the accessible environment in creating this sense of trust.

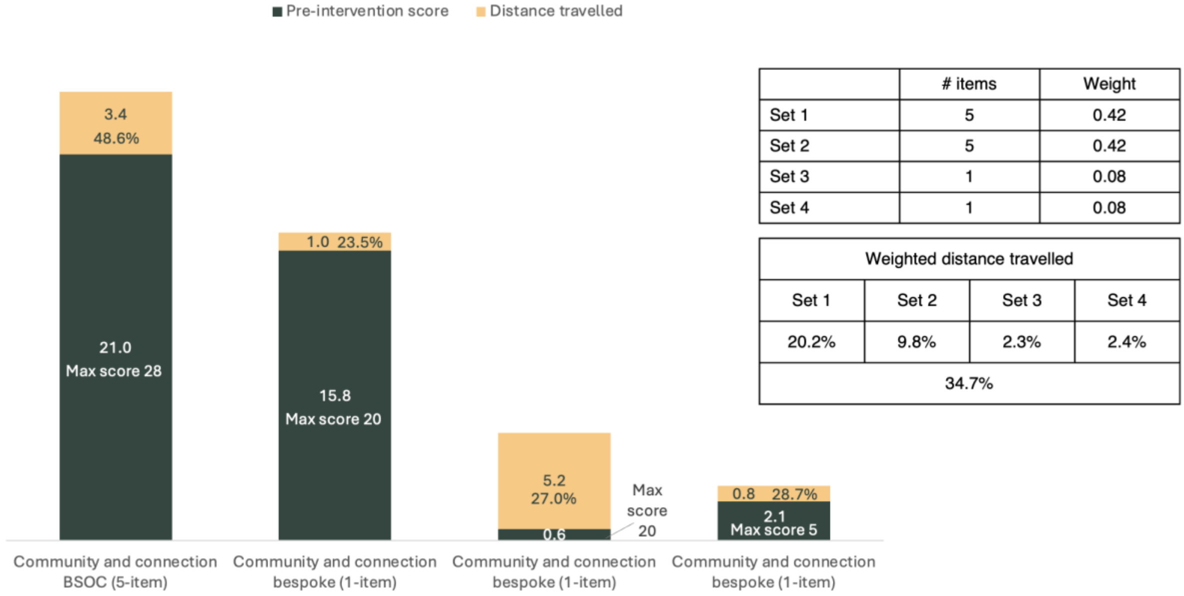
Crann’s unique combination of skilled staff, effective communication, and accessible facilities has addressed a longstanding barrier for parents of children with disabilities, fostering independence in children and confidence in parents. This outcome underscores the exceptional value of Crann’s integrated and person-centred approach.

9.3 Outcome: Sense of community and connection with other parents

The weighted distance travelled for the outcome ‘sense of community and connection with other parents’ was 34.7% and the scale-point increase achieved is within the range of error for materiality at the 95% confidence limit.

Figure 54: Analysis of the change achieved for ‘sense of community and connection with other parents’

n=9 (pre), n=21 (post)



	# items	Weight
Set 1	5	0.42
Set 2	5	0.42
Set 3	1	0.08
Set 4	1	0.08

Weighted distance travelled			
Set 1	Set 2	Set 3	Set 4
20.2%	9.8%	2.3%	2.4%
34.7%			

Many parents of children and adults with disabilities face challenges in building lasting peer connections with those who truly understand their experiences. Strong peer networks provide guidance, empathy, and practical support, as highlighted in broader research (Shiju, Sabukuttan & Joy, 2023; Davis et al., 2010).

Through their children’s participation in Crann services, parents formed meaningful relationships with other parents. Casual interactions before and after sessions, whether in the lobby or car park, often developed into deeper connections that extended beyond Crann. These relationships became a valuable source of emotional and practical support, creating a close-knit community that many parents had not experienced elsewhere.

> *“We’re a proper little community. Everyone looks out for everyone else and would help you with anything. Even for all our differences, we’ve got a common goal.”*
>
> **– Parent of an adult with a disability**

In *Evaluation Stage 1 – Qualitative*, all participants reported experiencing the outcome of a ‘sense of community and connection with other parents.’ Some parents reflected on how isolating it had been before finding this peer network, noting that sharing their feelings, fears, and concerns with others who understood their unique challenges was a profound source of comfort. Research supports this finding, showing that peer networks for parents of children with disabilities can alleviate isolation and foster positivity, hope, and belonging (Shiju, Sabukuttan & Joy, 2023; Blake, Bray & Carter, 2019).

No changes were indicated for this outcome, reinforcing its continued relevance and significance. Crann’s ability to facilitate these peer connections for secondary stakeholders underscores its broader impact, not just on children with disabilities, but also on the parents who support them, creating a supportive ecosystem that extends beyond formal service delivery.

10. Comparison of Forecasted and Evaluated Outcomes: Measuring Change

This chapter compares the forecasted change expected, based on the findings from the preceding SROI Forecast (Assured in 2022), with the actual changes observed during the SROI Evaluation. The purpose is to assess how well the SROI Forecast aligned with the lived experiences of stakeholders and the outcomes achieved. Both the SROI Forecast and Evaluation were conducted using established SROI principles, ensuring relative consistency in approach, though differences in timing, participant circumstances, service and staffing changes, and data collection methods have influenced the results. This analysis provides a critical opportunity to reflect on the programme's impact and to understand how well it met its intended objectives.

As covered in Chapter 4, all of the outcomes identified in the SROI Forecast were validated for the SROI Evaluation in *Evaluation Stage 1 – Qualitative* and no new outcomes were identified. Some linguistic changes were made to the TOCs based on the findings from the qualitative research at *Evaluation Stage 1 – Qualitative*. Therefore, the outcomes measured in the SROI Evaluation were almost identical to those measured in the SROI Forecast.

The SROI Forecast used post-intervention self-reporting of the size of change experienced for each outcome to inform the analysis, as is the generally accepted approach for forecasting value, whereas pre- and post-intervention data collection against a range of indicators was used for the SROI Evaluation, representing a significantly more robust approach to measuring the change experienced.

Table 46 highlights the differences in the size of change observed between the SROI Forecast and Evaluation. This can largely be attributed to the methodologies used. Post-intervention self-reporting in the SROI Forecast relied on participants' perceptions and retrospective assessments, which are subject to recall bias and may be influenced by their expectations or the immediacy of the intervention's impact. In contrast, the SROI Evaluation used pre- and post-intervention data collection against a range of indicators, offering a more nuanced and objective measurement of change over time. This more robust approach is likely to capture subtler, incremental changes that self-reporting may overlook or overstate, leading to a different representation of the size of change experienced.

The self-reporting measure was administered to respondents during the SROI Evaluation quantitative post-intervention data collection in *Evaluation Stage 2 – Quantitative*, in the same way as it was in the SROI Forecast in *Forecast Stage 2 – Quantitative*. This quantitative data has been included to highlight the general similarity in recalled perceptions of the size of change between the SROI Forecast sample and the SROI Evaluation sample, and its comparative difference from the size of change indicated by more objective indicators used in the SROI Evaluation in *Evaluation Stage 2 – Quantitative*. A key limitation of this analysis is the comparison of fundamentally different data sets, which may not be directly comparable due to variations in the nature of the services, client groups, and data collection approaches. These differences can introduce inconsistencies, making it challenging to draw clear, meaningful conclusions across the data sets. As a result, any comparisons made should be interpreted with caution, as they may not fully capture the nuances or complexities of each group's unique circumstances or experiences.

Self-reported material change is a categorical measure based on participants' perceptions, where respondents classify their experience of change as small, medium, or large. In contrast, the average distance travelled is a continuous measure that quantifies the actual change observed from pre- to post-intervention. While self-reporting provides valuable insight into stakeholders' perceived outcomes, it reflects subjective assessments rather than objective, statistical averages. This distinction complicates direct comparisons between the two approaches and necessitates careful interpretation to ensure that the different natures of these measurements are appropriately understood.

Additionally, the potential influence of the halo effect in self-reporting must be acknowledged. When clients access services that are highly valued or unique and not available elsewhere, their perceptions of change may be positively biased by their appreciation for the service itself. This can lead to a bias, resulting in an inflated assessment of material change, even if objective indicators suggest more moderate progress. It is essential to account for this potential bias when interpreting self-reported data to ensure a more accurate understanding of the outcomes.

In our dataset, some outcomes showed a greater perception of impact among those participating in quantitative research in the SROI Forecast survey, compared to the SROI Evaluation surveys in *Evaluation Stage 2 – Quantitative*. It is important to note that most of the differences in self-reported change outlined in table 45 are statistically nonsignificant. However, the reasons behind this contrast are worth exploring. Understanding these variations could provide valuable insights into how perceptions of change may evolve over time or under different conditions.

Participants in the SROI Forecast quantitative research had completed their engagement with services longer ago than those in the SROI Evaluation quantitative research in *Evaluation Stage 2 – Quantitative*, who responded to the post-intervention survey immediately after attending. Over time, past attendees may have had more opportunities to reflect on the service's impact, allowing them to better appreciate its value and making positive outcomes stand out more clearly, potentially reinforcing the halo effect. Additionally, given the unique nature of these services within Ireland’s disability support landscape, past participants may perceive them as increasingly impactful when compared to other services they may have accessed, which may not offer the same level of personalisation or alignment with their needs.

Conversely, participants in the SROI Evaluation quantitative research, having recently finished attending the service, may focus more on immediate and tangible short-term outcomes rather than broader, long-term changes. Their feedback is therefore less likely to be influenced by the halo effect, resulting in a more grounded but potentially less reflective assessment of the impact experienced.

While the self-reporting data is a valuable component of the analysis, these considerations demonstrate the importance of using both subjective and objective measures to ensure a balanced and accurate interpretation of results.

The indicators used for the quantitative research in *Evaluation Stage 2 – Quantitative* of the SROI Evaluation, and an overview of the SROI Forecast self-reporting approach used in the SROI Forecast are covered in Section 3.6.

It is also important to note that different individuals from the same stakeholder groups contributed to various stages of the research. This variation in participant involvement introduces the potential for differing baseline characteristics between the two groups, which could impact the comparability of the results.

The SROI Evaluation period was also influenced by some notable contextual challenges related to staff changes and fluctuations in service provision. These factors added complexity to the data collection, analysis, and overall evaluation, requiring ongoing adjustments to ensure the process remained effective and accurate. These challenges are covered in detail as method limitations in Section 3.9.

Table 47: Self-reported change and mean distance travelled – comparison; Forecast vs. Evaluation

	Self-reported material change in the SROI Forecast Stage 1 – Qualitative	**Self-reported material change in the SROI Evaluation** Stage 2 – Quantitative	**Mean distance travelled in the SROI Evaluation** Stage 2 – Quantitative
Psychological Wellbeing			
Improved mental wellbeing	71%	73%	24.5%
Increased self-confidence and motivation	71%	73%	44.9%
Improved ability to manage challenges	86%	73%	32.7%
Increased support, community, and social inclusion	71%	64%	20.1%
Social Capital			
Improved ability to deal with challenges	64%	48%	21.5%
Improved independence	73%	59%	44.9%
Increased self-confidence	77%	67%	29.5%
Increased social inclusion, support, and community	77%	59%	54.2%
Health and Continence			
Increased sense of freedom	68%	40%	24.2%
Improved ability to participate in activities and day-to-day life	60%	40%	26.4%
Feelings of empowerment and inclusion in the service provided	68%	60%	44.5%
Improved physical wellbeing	76%	48%	23.9%
Improved peace of mind and confidence in the treatment or management of the issue	68%	68%	36.3%
Personal Support and Connection			
Reduced loneliness	46%	42%	25.4%
Increased hope for the future	50%	53%	22.7%
Increased feelings of acceptance and being accommodated	54%	68%	38.3%
Increased social inclusion, support, and community	31%	53%	56.8%
Parents of children and adults attending in-scope services			
Relief about their child achieving their own outcomes	64%	71%	30.1%
A sense of community and connection with other parents	71%	67%	34.7%
Increased sense of comfort in leaving their child to attend services alone	79%	76%	50.7%

11. Understanding Social Value

11.1 Overview

The SROI analysis presented here is derived from the inputs associated with the four included themes of Crann's services and the quantitative outcomes data collected from stakeholders in *Evaluation Stage 2 – Quantitative*. This includes information on the quantity and duration of outcomes, as well as relevant deductions and assigned monetary values identified. The Social Return Ratio provides an approximate indication of the value created, rather than an exact figure. To assess the reliability of this estimate, a sensitivity analysis is conducted. This analysis explores how the social return ratio responds to variations in assumptions and judgments used in the calculations.

This chapter will explain the data used in the value map and the results of this Social Return on Investment analysis.

Table 48 provides an overview of the key results from the value map analysis, summarising the total value created, inputs, and resulting Social Return on Investment (SROI) ratio for the SROI Evaluation period.

Table 48: Overview of value map results

Total investment	€209,455.86
Total present value	€771,321.23
Net present value	€561,856.37
Social return on investment	€3.68
Social return ratio	€1:€3.68

11.2 Calculating Inputs

In this SROI Evaluation analysis, inputs were calculated based on the total revenue, investment, and overhead costs for Crann.

As described in Section 1.4, four themes of Crann's services were in scope for this SROI Evaluation. To calculate the inputs for each theme, inputs were calculated first by service and then combined in the relevant groupings to total theme input amounts.

Table 49: Cost per session, average revenue based on new client contributions

Service	Direct cost of delivery	Apport. overhead cost	Total cost per session	Average revenue per session	Actual cost per session
Psychological Wellbeing					
Counselling	€90.91	€512.64	€603.55	€38.07	€565.48
Play Therapy	€90.91	€513.00	€603.91	€39	€564.91

Sibshops	€118.18	€466.82	€585	€30	€555
Social Capital					
Social Hub	€54.55	€547.89	€602.44	-	€602.44
Breaking Barriers Theatre Group	€113.64	€489.27	€602.91	€8.63	€594.28
Health and Continence					
Continence Clinic	€77.72	€530.59	€603.32	-	€603.32
Podiatry	€45.45	€557.88	€603.33	€9.31	€594.02

The input amount included in the value map for each theme is made up of the total cost to run all in-scope services within that theme, for the number of new clients that attended during the SROI Evaluation period. This cost is inclusive of the professional running each service, revenue, and apportioned overhead allocation. No volunteer time applied to the running of the services included in the scope of this SROI Evaluation.

Overheads have been calculated using the below formula:

$$\text{Overhead for Service A} = \left(\frac{\text{Sessions in Service A (in-scope)}}{\text{Total sessions across all services (in-scope and out-of-scope)}} \right) \times \text{Total Overheads}$$

Personal Support & Connection inputs were calculated based on time spent on this service as tracked by client-facing staff, apportioned for the stakeholders of the three other themes. The Client Services team, Client Liaison team and Front of House team reported the average time they spent per week during the SROI Evaluation period, providing follow-up support to relevant new clients outside of other service settings. The time spent by all relevant staff members was multiplied by the average cost per hour to Crann of those staff members. Overheads are apportioned to the services attended by clients who availed of this support.

Table 50: Financial inputs overview by theme and service

Theme	Service	Service inputs	Total theme inputs
Psychological Wellbeing	Counselling	€93,869.30	€117,002.88
	Play Therapy	€21,468.58	
	Sibshops	€1,665.00	
Social Capital	Social Hub	€3,614.70	€6,871.17
	Breaking Barriers Theatre Group	€3,256.47	
Health & continence	Continence Clinic	€64,555.24	€81,781.81
	Podiatry	€17,226.57	
Personal Support & Connection	Personal Support & Connection Service	€3,900.00	€3,900.00

The total financial investment that was made into the Crann services included in the SROI Evaluation, for new clients only (detailed in Section 11.4), amounted to €209,555.86 for the SROI Evaluation period. In line with the standard SROI methodology, the input includes its direct investments, its self-generated revenue, and the contribution of time and human resources for the relevant services.

11.3 Calculating Value for Outcomes

Stakeholder-led valuation was chosen as the most appropriate approach for an SROI Evaluation because it recognises that "value is in the eye of the beholder." This principle acknowledges that the true worth of an outcome can only be determined by those who experience it. By directly engaging stakeholders, the SROI Evaluation captures diverse perspectives on what matters most to them, ensuring the analysis reflects their priorities and lived experiences. This approach not only enhances the relevance and accuracy of the valuation but also empowers stakeholders by giving them a central role in defining the value created by the service or intervention.

To determine the relative importance of outcomes, stakeholders ranked them based on perceived significance. This approach ensures that the relative importance reflects their lived experiences and priorities, rather than assumptions made externally. To enhance accuracy, outliers were removed to prevent disproportionately high or low rankings from distorting the overall findings. This method maintains the integrity of stakeholder perspectives by capturing a balanced representation of views while minimising the impact of extreme responses.

Stakeholders also took part in two modified value games to assign value to each relevant outcome for the duration of one year. Details of the value games are provided in Appendix 6. The final value for each outcome was calculated by averaging the mean values from both games, after removing any significant outliers.

Assigning a financial value to non-economic outcomes, like wellbeing or social inclusion, can be subjective because it often involves assumptions or proxies (e.g. substitute values used to represent intangible benefits). This limitation is discussed further in Section 3.9. To address this, alternative values based on research and objective measures (e.g., cost of time) were tested in the sensitivity analysis, detailed in Section 11.8.

In this SROI Evaluation, two of the services included in the preceding SROI Forecast (Assured in 2022) under the Psychological Wellbeing theme, and one service included under the Social Capital theme were out of scope for inclusion due to not having run during the SROI Evaluation period, as covered in Section 1.4. Values for relevant outcomes have been recalculated to exclude the input of those who attended the out-of-scope services.

The analysis method used for this SROI Evaluation was mean distance travelled (covered in Section 3.7) so the outcome values required adjusting in line with the distance travelled for each outcome. This essentially scales down the full value of the outcome to reflect partial achievement in line with the actual change reported by stakeholders. This value is then applied to all stakeholders attending the service, as it is representative of their average distance travelled as a whole group.

It is important to note that different individuals from the same stakeholder groups contributed to various stages of the research. This variation in participant involvement introduces the potential for differing baseline characteristics between the two groups, which could impact the comparability of the results.

Both the original stakeholder valuation and the adjusted value in line with distance travelled are represented in table 51.

Outcome	**Stakeholder valuation of outcome for one year**	**Distance travelled adjustment**
Psychological Wellbeing		
Improved mental wellbeing	€3,985	€976.33
Increased self-confidence and motivation	€3,115	€1,398.64
Improved ability to manage challenges	€2,915	€953.21
Increase in support, community, and social inclusion	€2,585	€519.59
Social Capital		
Improved ability to deal with challenges	€3,900	€838.50
Increased independence	€3,685	€1,654.57
Increased self-confidence	€3,095	€913.03
Increase in support, community, and social inclusion	€2,420	€1,311.64
Health and Continence		
Increased sense of freedom	€3,160	€764.72
Improved ability to participate in activities and day-to-day life	€3,080	€813.12
Feelings of empowerment and inclusion in the service provided	€2,970	€1,321.65
Improved physical wellbeing	€2,830	€676.37

Improved peace of mind and confidence	€2,635	€956.51
Personal Support and Connection		
Reduced loneliness	€3,385	€859.79
Increased hope for the future	€2,950	€669.65
Increased feelings of acceptance and being accommodated	€2,790	€1,068.57
Increased social inclusion, support, and community	€2,545	€1,445.56
Parents of children and adults attending in-scope services		
Relief about their child achieving their own outcomes	€5,300	€1,595.30
A sense of community and connection with other parents	€3,160	€1,096.52
Increased sense of comfort in leaving their child to attend services alone	€5,325	€2,699.78

Table 51: Stakeholder valuation of outcomes and adjustment based on distance travelled

11.4 Calculating quantities for 1st October 2023 – 1st October 2024

Table 52 illustrates the attendance of services during the SROI Evaluation period. It was decided that new clients attending relevant services during the SROI Evaluation period were the focus of the analysis, to ensure a clear and accurate measurement of the changes attributable to Crann’s services. It should be noted that changes in the availability and accessibility of services were influenced by factors such as staffing changes and shifting funding priorities, as well as the expansion of other services not included in the SROI Evaluation scope.

By collecting data from clients at both the beginning (pre-intervention) and end (post-intervention) of their service engagement, in *Evaluation Stage 2 – Quantitative*, the SROI Evaluation could assess the outcomes experienced and the distance travelled over the SROI Evaluation period, effectively setting a baseline for future analyses.

Existing clients of in-scope services that were ongoing were not included in the Social Value Calculation for those services, because many had already achieved partial or significant progress prior to the SROI Evaluation period, making it challenging to isolate the impact of services during this specific timeframe. Including existing clients could have introduced bias, as their outcomes might reflect historical changes rather than those directly attributable to the SROI Evaluation period. Focusing on new clients allowed for a robust analysis of the services' immediate and measurable impact while maintaining methodological clarity. However, it should again be noted that existing clients of Social Capital services were included in data collection in *Evaluation Stage 2 – Quantitative* to ensure an adequate dataset for analysis. This is covered in more detail in Section 3.5.

However, with the baseline now established, future evaluations should include existing clients to assess how outcomes are sustained or evolve over time. This would allow for a more comprehensive understanding of the long-term impact of Crann’s services while maintaining the robustness of the analysis.

Parents have again been very conservatively estimated for the SROI Evaluation, in the absence of adequate data on family units; they are estimated as one per child with a disability and one per three adults with disabilities.

Table 52: New clients that attend each service and theme during the SROI Evaluation period

Theme / Service	New clients attended during SROI Evaluation period
Psychological Wellbeing	**58**
Counselling	40
Play Therapy	8
Sibshops	10
A Moment for Me	n/a
Growing in Confidence	n/a
Social Capital	**17**
Social Hub	8
Breaking Barriers Theatre Group	9

Parents' Café	n/a
Health & continence	**78**
Continence Clinic	63
Podiatry	15
Personal Support & Connection	**102**

Due to the overlap between the Personal Support and Connection Service and other services (i.e. it is delivered to the same clients, outside of the service delivery context of other in-scope services) a total of 75 stakeholders have been removed across themes that share the outcome of "increased social inclusion, support, and community" to avoid double counting. These were removed as a proportion of those experiencing the outcome under each theme to ensure consistency.

Table 53: Number removed from each theme for outcome of "increased social inclusion, support, and community" to avoid double counting

Theme	Number removed from count	Proportion of total
Psychological Wellbeing	25	42%
Social Capital	8	44%
Personal Support and Connection	44	44%

11.5 Avoiding Over-Claiming

In any SROI analysis, financial value for outcomes is calculated, and discounts are applied. It is an important part of the report to discuss how all of these values have been calculated. If discounts are not calculated and applied to the overall value of outcomes created, then there is a high risk of over-claiming value.

Discounts include:

- Attribution: the proportion of an outcome directly experienced because of Crann's Services (only those services included in this SROI Evaluation)
- Deadweight: the proportion of an outcome that would have likely happened without Crann's Services
- Drop-off: the proportion of an outcome that will reduce year by year*
- Displacement: any outcomes that did not happen for other stakeholders because of outcomes achieved by themselves, or any negative outcomes created for other stakeholders

*Drop-off has not been included in the Social Value Calculation as there was not enough longitudinal data on stakeholder outcome duration to feel confident in assigning drop-off and including this in the calculation. The value in this analysis has been calculated for one year and will be reviewed in future evaluations based on longitudinal tracked data collected from stakeholders, for which the data collection tools have now been implemented.

To calculate the value of outcomes created, the following steps are taken:

1. Gather data from stakeholders on the financial value proxy for the outcomes for which they have experienced a material change
2. Gather data on discounts, to ensure that only the value created by the activities included in the SROI analysis is included in the calculation
3. Conduct sensitivity analysis to consider alternative scenarios that may impact the relationship between outcomes and the social value ratio

To assign a financial value to outcomes, stakeholders were involved in two modified value games that encouraged them to determine their own estimated value for each outcome they experienced for the duration of one year. This is discussed in greater detail in Chapter 3.

To ensure the value of outcomes was not overclaimed in this SROI Evaluation analysis, stakeholders were asked to provide data on each of the discounts. These discounts are represented as a percentage, which has been calculated by removing obvious outliers and calculating the median figure for the relevant stakeholder group experiencing each outcome.

Data has been collected directly from stakeholders to inform both the overall value of outcomes and the discounts applied. Stakeholders were considered to be the most reliable source for this data as it related to their own experiences, and they could explain in detail any differences or potential risks within the data.

Parent proxy data was used to establish deductions and monetary valuation because children, especially younger ones, may lack the ability to provide consistent or detailed information about their experiences and outcomes. Parents, as primary caregivers, have a comprehensive understanding of their child's needs, behaviours, and responses to services. This perspective allows them to provide reliable and insightful data that reflects the child's experience, ensuring that both the deductions and the monetary valuation of outcomes are accurate and meaningful. Additionally, using parent proxy data aligns with ethical considerations, as it avoids placing undue burden on children during the data collection process while maintaining the integrity of the SROI Evaluation. Children were invited to discuss the value of outcomes to them, in non-monetary terms, during *Evaluation Stage 1 – Qualitative* and their views were considered alongside parent proxy input.

11.6 Deadweight and Attribution

Crann's services form only one part of the broader context in which families operate. External variables, such as socioeconomic conditions, local community resources, and individual family dynamics, also play a significant role in shaping outcomes. These factors, which are outside Crann's control, can have a substantial influence on the well-being of families and individuals, complicating efforts to attribute outcomes solely to Crann's interventions.

To account for this, respondents were asked in both qualitative and quantitative research to estimate the deadweight and attribution of the outcomes they experienced. In other words, they were asked to estimate how much of the change they believed would have occurred without the intervention and how much of the change could be attributed to other interventions, organisations or even to themselves. Figures included in the value map, and reflected in table 54, were taken from the quantitative research because respondents provided more precise estimations within that methodology, due to the closed answer format. However, qualitative responses were used to validate the average calculated from quantitative responses.

Table 54: Estimated deadweight and attribution of outcomes experienced by stakeholders

Stakeholder Group	Outcome	Estimated deadweight	Estimated attribution
Clients of Psychological Wellbeing Services	Increased social inclusion, support, and community	34%	21%
	Increased confidence and motivation	27%	17%
	Improved mental wellbeing	28%	22%
	Improved ability to cope with challenges	28%	20%
Clients of Social Capital Services	Increased social inclusion, support, and community	40%	24%
	Increased confidence	43%	21%
	Improved independence	40%	25%
	Improved ability to cope with challenges	35%	19%
Clients of Health and Continence Services	Improved ability to participate in activities and day-to-day life	28%	16%
	Increased sense of freedom	34%	23%
	Improved physical wellbeing	39%	24%
	Improved peace of mind and confidence	39%	19%
	Feelings of empowerment and inclusion in the service	46%	32%
	Increased social inclusion, support, and community	29%	33%

Clients of Personal Support and Connection Service	Increased acceptance and feeling accommodated	38%	31%
	Reduced loneliness	42%	28%
	Increased hope for the future	42%	28%
Parents of children and adults attending in-scope services	Increased sense of comfort in leaving their child to attend services alone	32%	27%
	Sense of community and connection with other parents	23%	25%
	Relief about their child or children achieving their own outcomes	27%	35%

11.7 Displacement

No outcomes were discounted for displacement. Displacement is an assessment of how much of an outcome may have had a negative impact on other stakeholders, organisations, communities, or other potential outcomes.

Respondents were asked to consider whether the outcomes they had experienced could have meant that any other outcome or change had not occurred for either themselves or others. Stakeholders provided no indication or argument of potential displacement.

Outcomes experienced by stakeholders do not take the opportunity away from other stakeholders to also experience the same outcomes. Outcomes reported by stakeholders were “soft” outcomes, so there are not materials involved that are in a limited capacity or might be restricted from being accessed by one stakeholder because of being accessed by another.

Crann’s service-delivery model focuses on avoiding duplication of any services already available within disability services in Ireland, so displacement of any outcome for another organisation was not included.

Displacement was explored again during the qualitative research in the SROI Evaluation, in *Evaluation Stage 1 – Qualitative* and no potential displacement was identified by stakeholders. It remains important to note the lack of available research evidencing any potential displacement of soft outcomes, relevant to the disability services space, and even more specifically in Ireland. Due to the potential risk in the judgement to not include displacement, it has been included as part of the sensitivity analysis within this SROI Evaluation analysis.

11.8 Sensitivity Analysis

The final social return ratio is most appropriately represented as a range, reflecting the combination of data analysis, subjective indicators, and judgements about the deductions provided by stakeholders that underpin Social Value Calculations. As such, a thorough sensitivity analysis was conducted on all relevant figures within the Value Map. This analysis was conducted to consider the impact of alternative scenarios relating to the assumptions of the SROI Evaluation analysis, e.g., attribution, deadweight and valuation of outcomes, etc., and to better understand the relationship between the outcomes and the impact of Crann’s services.

The specific areas that were tested and the rationale for alternate values tested, as well as the output of the sensitivity analysis is included in table 55.

Table 55: Sensitivity analysis for social value of Crann's Services

Variable Tested	Rationale	Sensitivity Test	Adjusted Value	SROI difference	Adjusted Social Return
Clients of Psychological Wellbeing Services					
Value for "improved mental wellbeing"	The value included has been defined by stakeholders and is not exact. A global study conducted in 2020 on the cost of mental disorders estimated the median societal cost per patient of a mood disorder to be €4,492 (Christensen et al., 2020). The interactive data can be found here. This is the alternative value that was included for Improved Mental Health for the sensitivity analysis.	Value increased from €3,985 to €4,492 and weighted distance travelled applied at 24.5%.	€1,100.54	+0.02	€3.70
Value for "increased self-confidence and motivation"	The value included has been defined by stakeholders and is not exact. Tim Goodspeed and an evaluation team identified an Irish anchor value for self-confidence within their SROI Evaluation for Trinity College Dublin, "Exploring the Social Value and Return on Investment for the Trinity Centre for People with Intellectual Disabilities." The approach can be found in their SROI report (Kovacic, Forkan & Goodspeed, 2022).	Value increased from €3,115 to €7,778 and weighted distance travelled applied at 44.9%.	€3,492.32	+0.36	€4.04
Value for "improved ability to manage challenges"	The value included has been defined by stakeholders and is not exact. Cognitive Behavioural Therapy (CBT) aims to enhance clients' ability to manage challenges by helping them identify and reframe negative thought patterns, develop effective coping strategies, and promote behavioural changes that foster resilience and improved mental wellbeing. According to the HSE, treatment usually lasts for between 6 and 20 sessions (HSE, n.d.). Taking the mid-point of 13 sessions, and the average cost quoted at €70-€120, giving a mean cost of €97.50 per session, we can estimate that an average treatment would cost €1,267.50.	Value decreased from €2,915 to €1,267.50 and weighted distance travelled applied at 32.7%.	€414.47	-0.08	€3.60

Value for ‘increased support, community, and social inclusion’	The value included has been defined by stakeholders and is not exact. HACT values “feeling part of the community” at approximately £2,800 per person annually, equivalent to €3,372.69 at the time of writing.	Value increased from €2,585 to €3,372.69 and weighted distance travelled applied at 20.1%.	€677.91	+0.02	€3.70
Self-reported number of clients experiencing material change	The SROI Forecast used post-intervention self-reporting to identify the estimated proportion we could forecast experiencing material change. The self-report question was included in the data collection tools for this SROI Evaluation to ensure a direct comparison could be drawn between the two analyses.	Number of clients self-reporting material change used in place of distance travelled for all outcomes. Values adjusted back to full stakeholder generated value.	Support, community, and social inclusion: 53% = 18 Mental wellbeing: 78% = 46 Ability to manage challenges: 89% = 53 Confidence and motivation: 89% = 53	+0.92	€4.60
Clients of Social Capital Services					
Value for “increased self-confidence”	The value included has been defined by stakeholders and is not exact. Tim Goodspeed and an evaluation team identified an Irish anchor value for self-confidence within their SROI Evaluation for Trinity College Dublin, “Exploring the Social Value and Return on Investment for the Trinity Centre for People with Intellectual Disabilities.” The approach can be found in their SROI report (Kovacic, Forkan & Goodspeed, 2022).	Value increased from €3,115 to €7,778 and weighted distance travelled applied at 29.5%.	€2,294.51	+0.05	€3.73
Value for “improved ability to deal with challenges”	The value included has been defined by stakeholders and is not exact. Cognitive Behavioural Therapy (CBT) aims to enhance clients' ability to manage challenges by helping them identify and reframe negative thought patterns, develop effective coping strategies, and promote behavioural changes that foster resilience and improved mental wellbeing. According to the HSE, treatment usually lasts for between 6 and 20 sessions. Taking the mid-point of 13 sessions, and the average cost quoted at €70-€120, giving a mean cost of €97.50 per	Value decreased from €3,900 to €1,267.50 and weighted distance travelled applied at 21.5%.	€272.51	-0.02	€3.66

	session, we can estimate that an average treatment would cost €1,267.50.				
Value for 'increased independence'	The value included has been defined by stakeholders and is not exact. Independence was described by participants as attending the service alone and getting time away from parents and carers. Participants reported an average of 15 more events attended alone per month after attending the service than before. We have used the average hourly rate for a caregiver in Ireland, at the time of writing, according to Indeed this is €15.42 per hour (Indeed, 9 Dec 2024). €15.42 per event (estimated at one hour) attended which equates to €231.30 per month and €2,775.60 per year.	Value decreased from €3,685 to €2,775.60 and weighted distance travelled applied at 44.9%.	€1,246.24	-0.01	€3.67
Value for 'increased social inclusion, support, and community'	The value included has been defined by stakeholders and is not exact. HACT values "feeling part of the community" at approximately £2,800 per person annually, equivalent to €3,372.69 at the time of writing.	Value increased from €2,420 to €3,372.69 and weighted distance travelled applied at 54.2%.	€1,828.00	+0.01	€3.69
Self-reported number of clients experiencing material change	The SROI Forecast used post-intervention self-reporting to identify the estimated proportion we could forecast experiencing material change. The self-report question was included in the data collection tools for this SROI Evaluation to ensure a direct comparison could be drawn between the two analyses.	Number of clients self-reporting material change used in place of distance travelled for all outcomes	Social inclusion, support, and community: 53% = 5 Self-confidence: 58% = 9 Independence: 59% = 9 Ability to deal with challenges: 58% = 9	+0.10	€3.78
Clients of Health and Continence Services					
Value for "improved ability to participate in activities and day-to-day life"	The value included has been defined by stakeholders and is not exact. Participants reported that a personal assistant to support them for around 3.5 hours per week would help them to achieve this outcome to a similar degree. We have used the average hourly rate, at the time of writing, for a personal assistant in Ireland, according	Value increased from €3,080 to €3,532.62 and weighted distance travelled applied at 26.4%.	€932.61	+0.03	€3.71

	to Indeed this is €19.41 per hour (Indeed, 8 Dec 2024). €19.41 per hour for 3.5 hours per week equates to €3,532.62 per year.				
Value for "improved physical wellbeing"	The value included has been defined by stakeholders and is not exact. HACT values a significant, noticeable improvement in physical health (i.e. from poor to good health) at £13,080 equivalent to €15,754.10 at the time of writing. On the adjusted WHOQOL (used in this SROI Evaluation) a significant, noticeable improvement generally corresponds to 1-2 points on the 6-item section (max. 30 points) used. 3.04 points (out of a maximum 30) change was achieved on average, which aligns with the requirements for this HACT valuation.	Value increased from €5,070 to €15,754.10 and weighted distance travelled applied at 23.9%.	€3,765.23	+0.54	€4.22
Value for 'feelings of empowerment and inclusion in the service provided'	The value included has been defined by stakeholders and is not exact. Participants described that this outcome was achieved because they were consulted about their choices and made aware that they could withdraw consent at any time. HACT value for confidence in decision-making is £13,080 annually, equivalent to €15,814.35 at the time of writing. The value typically applies to a shift from a low baseline level to a high level. In our analysis participants reported a reasonably high baseline at 72% of total achievable scores for empowerment. They achieved an average 13.5% increase on the baseline, so 13.5% of the HACT value has been used.	Value decreased from €2,970 to €1,765.80 and weighted distance travelled applied at 44.5%.	€785.78	-0.07	€3.61
Value for 'increased sense of freedom'	The value included has been defined by stakeholders and is not exact. This outcome was described as occurring because a solution had been found for clients' issue. Due to that solution, they were better able to move around freely, travel further from home, and most importantly in many cases, to not think about their issue anymore. Due to the focus on mobility, we have used the cost of a motorised wheelchair as the alternate value proxy. Most of Crann's clients require customised powerchairs to meet their individual needs. Due to the bespoke nature of these chairs, no	Value decreased from €3160 to €1,133.40 and weighted distance travelled applied at 24.2%.	€274.28	-0.09	€3.59

	average value exists for these. We have used values based on a bespoke quote received by the Occupational Therapist at Crann, for one of her clients for a powerchair (Q300- Quickie Salsa HC21), inclusive of a standard foam cushion and tension adjustable backrest: ○ Cost of chair = €5,203.00 ○ Cost of motor = €326.00 ○ Cost of battery = €138.00 **Total cost = €5,667** Powerchairs are designed to last approximately five years with proper maintenance (International Wheelchair Company, n.d.). The total cost of €5,667, amortised over 5 years, to an annual cost of €1,133.40 per year.				
Value for 'improved peace of mind and confidence in the treatment or management of the issue'	The value included has been defined by stakeholders and is not exact. Participants frequently reported that through finding solutions and receiving individual person-centred treatment at Crann, they were able to overcome feelings of stress associated with the management of their issue that had existed previously. While chronic stress relating to an ongoing issue is likely to take longer to address, the HSE details that CBT treatment usually lasts for between 6 and 20 sessions (HSE, n.d.). Taking the mid-point of this at 13 sessions, and the cost of focused therapy at €125 (Centric Health, n.d.) the average cost to treat the stress of managing the condition would be €1,625.	Value decreased from €2,635 to €1,625 and weighted distance travelled applied at 36.3%.	€589.88	-0.06	€3.62
Self-reported number of clients experiencing material change	The SROI Forecast used post-intervention self-reporting to identify the estimated proportion we could forecast experiencing material change. The self-report question was included in the data collection tools for this SROI Evaluation to ensure a direct comparison could be drawn between the two analyses.	Number of clients self-reporting material change used in place of distance travelled for all outcomes	Ability to participate: 50% = 39 Sense of freedom: 50% = 39 Physical wellbeing: 50% = 39 Peace of mind and confidence: 88% = 69	+0.96	€4.64

			Empowerment and inclusion: 75% = 59		
Clients of Personal Support and Connection Service					
Value for 'increased support, community, and social inclusion'	The value included has been defined by stakeholders and is not exact. HACT values "feeling part of the community" at approximately £2,800 per person annually, equivalent to €3,372.69 at the time of writing.	Value increased from €2,585 to €3,372.69 and weighted distance travelled applied at 56.8%.	€1,915.69	+0.06	€3.74
Value for 'Reduced loneliness'	The value included has been defined by stakeholders and is not exact. This outcome was described as feeling lonely, either due to having a disability and not having peers to connect with, or due to being a parent to a child (of any age) with a disability and feeling that parents of children without disabilities did not understand their experiences. Joining a special interest group would likely bring clients in-touch with peers with whom they shared interests. However, as this outcome is specific to the experience of disability, it's important that the alternative value takes this into account. An accessible art class was chosen as the alternative proxy value for sensitivity testing as an interest group for people with disabilities that would likely bring peers with shared interests together in a shared space. The cost to join an accessible art class is €120 for 8 weeks, or €780 per year.	Value decreased from €3,385 to €780 and weighted distance travelled applied at 25.4%.	€198.12	-0.13	€3.55
Value for 'Feelings of acceptance and being accommodated'	The value included has been defined by stakeholders and is not exact. A lack of acceptance, or belonging, is a greater predictor of major depression than other factors commonly associated with depression, such as social support, conflict and loneliness (University of Michigan, 1999). HACT values relief from anxiety and depression at £36,766, equivalent to €44,253.38 at the time of writing (Trotter & Rallings, 2017). for shifting from severe or moderate distress to low or manageable. In our analysis participants reported a high baseline	Value increased from €2,790 to €4,425.34 and weighted distance travelled applied at 38.3%.	€1,694.91	+0.13	€3.81

	at 79% of total achievable scores for empowerment. They achieved an average 10% increase on the baseline, so 10% of the HACT value has been used.				
Value for 'Increased hope for the future'	The value included has been defined by stakeholders and is not exact. This outcome was described as relating to a knowledge that the Crann team would be there to support the family, and especially the person with a disability, for as long as is needed. We have used the average hourly rate for a caregiver in Ireland, at the time of writing, according to Indeed this is €15.42 per hour (Indeed, 9 Dec 2024). If each family member in an average family (2.74 persons) attended one service for one hour per week at Crann, the annual cost in equivalent carer hours would be €2,197.04 annually (CSO, 2022).	Value decreased from €2,950 to €2,197.04 and weighted distance travelled applied at 22.7%.	€498.73	-0.03	€3.65
Self-reported number of clients experiencing material change	The SROI Forecast used post-intervention self-reporting to identify the estimated proportion we could forecast experiencing material change. The self-report question was included in the data collection tools for this SROI Evaluation to ensure a direct comparison could be drawn between the two analyses.	Number of clients self-reporting material change used in place of distance travelled for all outcomes	Support, community, and social inclusion: 54% = 31 Loneliness: 42% = 43 Feelings of acceptance: 68% = 69 Hope for the future: 77% = 79	+0.64	€4.32
Parents of Children and Adults Attending In-Scope Services					
Value for outcome of "sense of community and connection with other parents"	The value included has been defined by stakeholders and is not exact. HACT values "feeling part of the community" at approximately £2,800 per person annually, equivalent to €3,372.69 at the time of writing.	Value increased from €2,585 to €3,372.69 and weighted distance travelled applied at 34.7%.	€1,170.32	+0.02	€3.70

Value for outcome of “relief about their child achieving their own outcomes”	The value included has been defined by stakeholders and is not exact. Parents described that while all parents worry about their children, this is intensified when you have a child with a disability, and you have to face very real concerns for their social life, psychological wellbeing, long-term health, ability to care for themselves into the future, and many other key considerations. Crann’s services alleviate the anxiety associated with ongoing concern or worry (National Institute of Mental Health, n.d.). HACT values relief from anxiety and depression at £36,766, equivalent to €44,253.38 at the time of writing, for shifting from severe or moderate distress to low or manageable (Trotter & Rallings, 2017). In our analysis participants reported a baseline indicative of moderate worry, with only 56% of total achievable scores for relief pre-intervention. They achieved an average 24% increase on the baseline, still representative of moderate worry, so only 24% of the HACT value has been used.	Value increased from €5,300 to €10,620.81 and weighted distance travelled applied at 30.1%.	€3,196.86	+0.40	€4.08
Value for ‘Increased sense of comfort in leaving their child to attend services alone’	The value included has been defined by stakeholders and is not exact. We have used the value of freed up time for parents as the alternate value for this outcome. The average hourly pay in Ireland, at the time of writing, according to CSO this is €29.82 per hour (CSO, 2024). If each child attends one service alone at Crann per week at one hour length, that equates to €1,550.64 per year.	Value decreased from €5,325 to €1,550.64 and weighted distance travelled applied at 50.7%.	€786.17	-0.49	€3.19
Self-reported number of parents experiencing material change	The SROI Forecast used post-intervention self-reporting to identify the estimated proportion we could forecast experiencing material change. The self-report question was included in the data collection tools for this SROI Evaluation to ensure a direct comparison could be drawn between the two analyses.	Number of clients self-reporting material change used in place of distance travelled for all outcomes	Sense of community and connection: 67% = 73 Relief about their child: 71% = 77 Sense of comfort: 76% = 83	+1.17	€4.85
Deductions					

Deadweight	Deadweight was self-reported by all stakeholder groups, and it is acknowledged that it is challenging for stakeholders to identify a precise figure for deadweight. To avoid over-claiming, this has been tested with an increase of 10% in deadweight for all outcomes and all stakeholder groups.	Deadweight increased by 10% across all outcomes for all stakeholder groups	Individual deadweight figures each increased by 10%	-0.16	€3.52
	Deadweight was self-reported by all stakeholder groups, and it is acknowledged that it is challenging for stakeholders to identify a precise figure for deadweight. The deadweight identified by stakeholders was moderate (35% average). However, the interventions delivered by Crann are fairly unique in Ireland for people with disabilities, and especially for their family members, as this is a traditionally under-served and marginalised target group. Studies show that without targeted efforts, improvements in many relevant areas are unlikely, especially in physical health (Gréaux et al., 2023) and mental health (Sashidharan et al., 2016). Data does not exist on the improvement or lack of improvement in these areas for people with disabilities and their families in Ireland in the SROI period, but it is likely reasonable to assume based on the context that without the targeted interventions offered by Crann, a smaller change would have been achieved by stakeholders. Low deadweight would typically fall between 10 to 20%, so 15% deadweight has been tested.	Deadweight decreased to 15% across all outcomes for all stakeholder groups	Deadweight decreased to 15% across all outcomes for all stakeholder groups	+0.73	€4.41
Displacement	Stakeholders reported no displacement of other outcomes because of the outcomes they achieved by attending Crann's services. To avoid over-claiming, this has been tested by including 10% displacement across all outcomes for all stakeholder groups.	Displacement of 10% included across all outcomes for all stakeholder groups	Displacement of 10% included for each outcome	-0.29	€3.39

Attribution	Attribution was self-reported by all stakeholder groups. To avoid over-claiming, this has been tested with an increase of 10% across all outcomes for all stakeholder groups.	Attribution increased by 10% across all outcomes for all stakeholder groups		-0.14	€3.54
Duration and drop off	In lieu of longitudinal data and to avoid over-claiming, duration and drop-off have been adjusted based on conservative estimates and dependent on individual outcomes' likelihood to be sustained past the end of the intervention, the reasoning for which has been covered in table 56 below.	Outcomes duration increased to two years for likely sustained outcomes at 50% drop off rate and reduced to 6 months (by adjusting value) for non-sustained outcomes.	Detailed in table 55	+1.39	€5.07

Table 55: Reasoning for outcomes increased and decreased duration for sensitivity testing

Outcome	Increase?	Reasoning
Increase in support, community, and social inclusion	Decreased duration	Outcome is based on stakeholders' interaction with Crann service delivery staff and other stakeholders through Crann's services. Once their service attendance ends, it is reasonable to assume that the outcome no longer persists.
Improved mental wellbeing	Increased duration	Crann's Psychological Wellbeing services focus on equipping clients with self-management skills to support themselves ongoing past the end of the service attendance. Research shows that this can lead to sustained improvements in mental wellbeing (Wijn & Doef, 2022).
Improved ability to manage challenges	Increased duration	Crann's Psychological Wellbeing services focus on equipping clients with self-management skills to support themselves ongoing past the end of the service attendance. Research shows that this can lead to sustained improvements in resilience and stress management (Wijn & Doef, 2022).
Increased self-confidence (and motivation – under Psychological Wellbeing only)	Increased duration	Outcome indicated by improvements in recognising one's strengths, confidence expressing opinions and feelings, and confidence asking for

		help and support. Academic research supports that interventions focusing on these aspects lead to sustained improvements in self-confidence (Speed et al, 2017).
Increased independence	Increased duration	This outcome was largely contributed to by developing a support network outside of the family unit, which most clients felt would sustain outside of the service context, as well as spending time away from family/carers leading to increased comfort with this over time. Studies have shown that independence as described by this outcome can be enhanced through social influences which lead to greater confidence in daily activities, which in turn leads to greater self-efficacy – essentially a cyclical process leading to sustained increases in independence (Nahari & Alsaleh, 2024; Bandura, 1977).
Improved ability to participate in activities and day-to-day life	Increased duration for continence clients, one-year duration for podiatry clients	This outcome is reliant on ongoing management of the issue. Clients of continence clinic achieve sustainable self-management through attendance, leading to the reasonable conclusion that this outcome would be sustained past their service attendance. Podiatry clients do not achieve self-management, and their outcome is dependent on ongoing attendance. Based on their ongoing attendance over the course of the one year included in the analysis, we can include their outcome for one year duration.
Increased sense of freedom	Increased duration for continence clients, one-year duration for podiatry clients	Sense of freedom, from pain and restriction, is reliant on ongoing management of the issue. Clients of continence clinic achieve sustainable self-management through attendance, leading to the reasonable conclusion that this outcome would be sustained past their service attendance. Podiatry clients do not achieve self-management, and their outcome is dependent on ongoing attendance. Based on their ongoing attendance over the course of the one year included in the analysis, we can include their outcome for one year duration.
Improved physical wellbeing	Increased duration for continence clients, one-year duration for podiatry clients	Improved physical wellbeing, compared to their entry-point baseline, is also reliant on ongoing management of the issue. Clients of continence clinic achieve sustainable self-management through attendance, leading to the reasonable conclusion that this outcome would be sustained past their service attendance. Podiatry clients do not achieve self-management, and their outcome is dependent on ongoing attendance. Based on their ongoing attendance over the course of the

		one year included in the analysis, we can include their outcome for one year duration.
Improved peace of mind and confidence in the treatment or management of the issue	Increased duration for continence clients, one-year duration for podiatry clients	Clients of continence clinic achieve sustainable self-management through attendance, leading to the reasonable conclusion that this outcome would be sustained past their service attendance. Podiatry clients do not achieve self-management, and their outcome is dependent on ongoing attendance. Based on their ongoing attendance over the course of the one year included in the analysis, we can include their outcome for one year duration.
Feeling empowered and included in the service provided	One-year duration for podiatry clients and decreased duration for continence clients	Outcome is based on stakeholders' interaction with Crann service delivery staff during attendance. Once their service attendance ends, it is reasonable to assume that the outcome no longer persists. Podiatry is an ongoing service, attended throughout the one-year period included in the analysis, but Continence Clinic is a bespoke service that can end once self-management is achieved.
Increased feelings of acceptance and being accommodated	One-year duration	Outcome is based on stakeholders' interaction with Crann service delivery staff during attendance. This outcome is experienced by clients under the Personal Support and Connection theme, which is ongoing and has a one-year duration in this analysis.
Reduced loneliness	One-year duration	Outcome is based on stakeholders' interaction with Crann service delivery staff during attendance. This outcome is experienced by clients under the Personal Support and Connection theme, which is ongoing and has a one-year duration in this analysis.
Increased hope for the future	One-year duration	Outcome is based on stakeholders' ongoing interaction with Crann. This outcome is experienced by clients under the Personal Support and Connection theme, which is ongoing and has a one-year duration in this analysis.
Increased sense of comfort in leaving their child to attend services alone	One-year duration	Outcome is based on stakeholders' ongoing interaction with Crann. This outcome is experienced by parents of children and adults attending in-scope services, many of whom are indirectly engaged with Crann on a consistent basis across services, especially where siblings apply. In order to not under-claim the one-year duration of this outcome has been retained in this sensitivity test.
Sense of community and connection with other parents	One-year duration	Outcome is based on stakeholders' ongoing interaction with Crann. This outcome is experienced by parents of children and adults attending in-scope services, many of whom are indirectly engaged with Crann on a

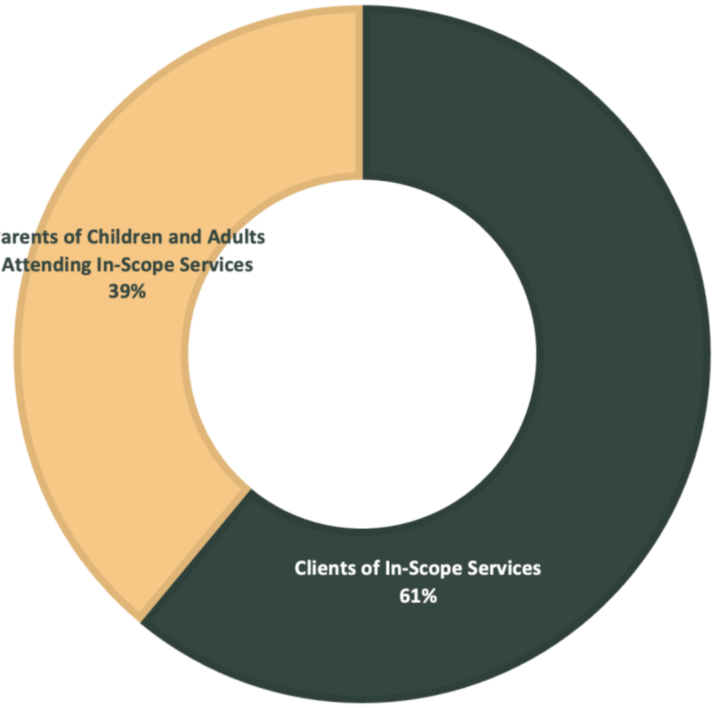
		consistent basis across services, especially where siblings apply. In order to not under-claim the one-year duration of this outcome has been retained in this sensitivity test.
Relief about their child or children achieving their own outcomes	One-year duration	Outcome is based on stakeholders’ ongoing interaction with Crann. This outcome is experienced by parents of children and adults attending in-scope services, many of whom are indirectly engaged with Crann on a consistent basis across services, especially where siblings apply. In order to not under-claim the one-year duration of this outcome has been retained in this sensitivity test.

11.9 Assessment of Ratio

By calculating the total social value generated by Crann's services during the SROI Evaluation period, the impact created can be illustrated in a variety of ways.

Figure 55 illustrates the total social value generated for each stakeholder group, during the SROI Evaluation period, with clients (primary stakeholders) receiving the highest proportion at 61%. This outcome is favourable, as it indicates that the services are effectively delivering substantial value directly to those they are designed to benefit most; the clients themselves. Prioritising value creation for primary stakeholders aligns with best practices in Social Return on Investment (SROI) analysis, ensuring that the intended beneficiaries experience meaningful and impactful outcomes.

Figure 55: Proportion of total net value generated by stakeholder type



In figure 56, the proportional social value created for each stakeholder group highlights that parents of children and adults attending in-scope services (secondary stakeholders) accounted for the highest proportion of value (39%). As the second largest stakeholder group and secondary stakeholders with no associated input costs, their overall value contribution was driven up significantly.

The second highest proportion of value (22%) was created for clients of Health and Continence Services, the second largest group of primary stakeholders. This group experienced five outcomes, compared to four or three for other groups, while achieving similar average rates of change and placing comparable average valuations on outcomes to stakeholders in other themes.

The lowest proportion of value (4%) was generated for new Clients of Social Capital Services, as this stakeholder group was by far the smallest included in the SROI Evaluation.

Figure 56: Proportion of total net value generated by stakeholder group

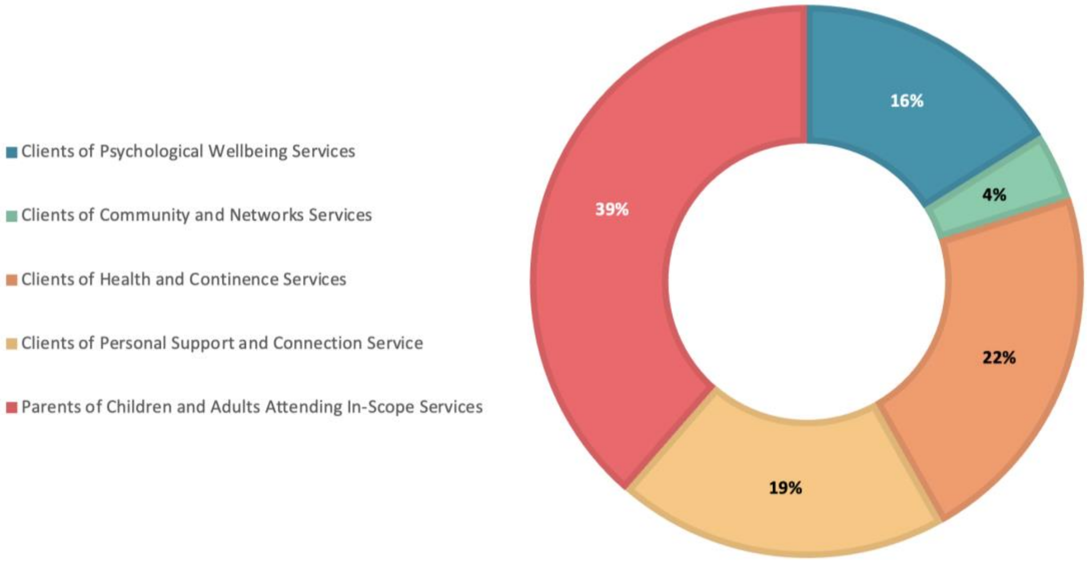
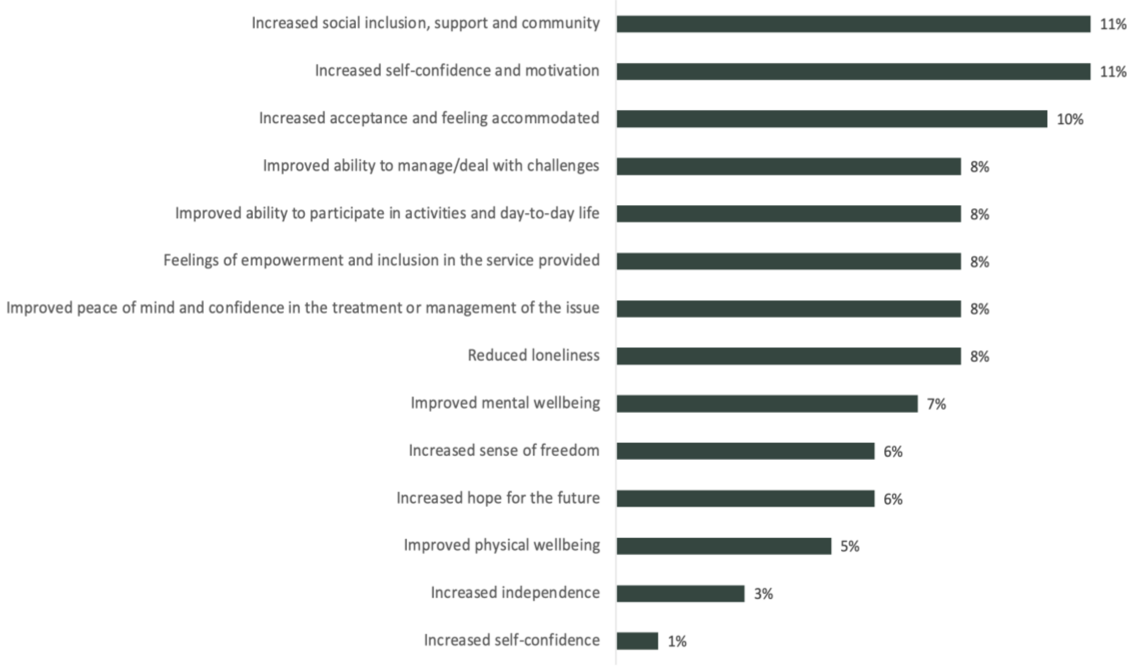


Figure 57 illustrates the social value generated for clients (primary stakeholders) by each outcome they experienced. The highest proportions of value were created by ‘increased social inclusion, support, and community’ (11%) and ‘increased self-confidence and motivation’ (11%). ‘Increased social inclusion, support, and community’ was achieved by clients across three themes, and while duplicate clients were excluded to prevent double counting, this outcome still reflects a significant number of stakeholders. Notably, clients of Social Capital Services and Personal Support and Connection Service recorded the highest levels of distance travelled for this outcome (54.2% and 56.8% respectively), a level not observed for any other outcome measured across the SROI Evaluation.

The lowest proportions of value were generated by ‘increased independence’ (3%) and ‘increased self-confidence’ (1%). While both outcomes were highly valued and notable distance travelled was achieved by stakeholders towards them, they were experienced by clients of Social Capital Services, the smallest stakeholder group included in the SROI Evaluation.

Figure 57: Proportion of net client value generated per outcome



11.10 Comparison of Forecasted and Evaluated Value

This section compares the forecasted and evaluated value of Crann's services, examining key differences in inputs, client numbers, and the overall value generated. By analysing these factors, the comparison provides insight into how actual service delivery and impact aligned with expectations set in the preceding SROI Forecast (Assured in 2022).

11.10.1 Comparing Inputs

Input costs forecasted often differ from actual input costs identified during retrospective SROI Evaluations. The predictive costs relied on assumptions about resource needs, market conditions and the wider service delivery context at Crann. Variations in service delivery personnel availability, unforeseen changes in service capacity or delivery formats (covered in Section 3.9), and the apportioning of overheads based on number of total service sessions delivered by Crann (across all services) during the SROI Evaluation period led to some notable differences in input costs.

Table 57: Comparing forecasted inputs with actual inputs

Theme	**Theme inputs forecasted**		**Theme inputs actual**	
	Financial	No. clients	Financial	No. clients
Psychological Wellbeing	€81,233	110	€117,002.88	59
Social Capital	€12,701	76	€6,871.17	16
Health & continence	€912,532	386	€81,781.81	78
Personal Support & Connection	€15,274	165	€3,900.00	102

As noted previously, Continence Clinic did not scale at the forecasted rate based on extensive exploration of the context and stakeholder needs, and taking into account Crann's strategic focus, meaning that less staff were required to deliver the service, a dedicated space of the expected scale was not required, and support staff resources were significantly less.

The time tracked by staff in delivering the Personal Support and Connection service during the SROI Evaluation period was significantly less than assumed during the SROI Forecast, and the Psychological Wellbeing services delivered during the SROI Evaluation period were predominantly one-to-one services, compared with the much larger group service representation forecasted, due to discontinued services, leading to higher input costs.

The expected economies of scale for Psychological Wellbeing and Social Capital were not realised during the SROI Evaluation period due to a smaller-than-forecasted number of clients engaging with these services. As a result, fixed costs, such as staffing and overheads, were allocated across fewer clients, leading to higher per-client input costs than anticipated in 2022. Both of these themes also included group services in the SROI Forecast that did not run during the SROI Evaluation period in response to client needs and priorities as covered in Section 1.4. Group services are generally more economical and serve a larger number of clients at once for a lower cost per client. 34 of the 110 clients forecasted for Psychological Wellbeing services were to attend group services that were not included in the SROI Evaluation and 25 of the 76 clients forecasted for Social Capital services were to attend a group service that was not included in the SROI Evaluation.

The SROI Evaluation period was also influenced by some notable contextual challenges related to staff changes, notably the absence of staff with institutional knowledge from Phase One of the SROI Process (SROI Forecast) sometimes created difficulties in maintaining a consistent approach across different stages of the process. These challenges are covered in detail as method limitations in Section 3.9.

11.10.2 Comparing quantities

Within the SROI Forecast, the intended number of clients that were projected to attend an intervention during the SROI period was calculated. A full explanation of the process undertaken for this calculation can be found in Chapter 10 of the Assured Report.

Table 58 demonstrates how the actual attendance by new clients of services during the SROI Evaluation period compares to the forecasted attendance, taking into account all adjustments made to avoid double-counting. The forecasted attendance numbers included both new and existing clients. The decision to include only new clients in the SROI Evaluation is detailed in Section 11.4.

It is important to note that different individuals from the same stakeholder groups contributed to various stages of the research. This variation in participant involvement introduces the potential for differing baseline characteristics between the two groups, which could impact the comparability of the results.

Parents have been very conservatively estimated for both the SROI Forecast and Evaluation, in the absence of adequate data on family units; they are estimated as one per child with a disability and one per three adults with disabilities.

Table 58: Calculation for clients that attend each service and theme during the SROI Evaluation period

Theme / Service	Clients forecasted in SROI Forecast	New clients attended during SROI Evaluation period
Psychological Wellbeing	**110**	**58**
Counselling	27	40
Play Therapy	29	8
Sibshops	20	10
A Moment for Me	20	n/a
Growing in Confidence	14	n/a
Social Capital	**76***	**17**
Social Hub	25	8

Breaking Barriers Theatre Group	26	9
Parents’ Café	25	n/a
Health & continence	**386**	**78**
Continence Clinic	346	63
Podiatry	40	15
Personal Support & Connection	**165**	**102**

11.10.3 Comparison of net value created

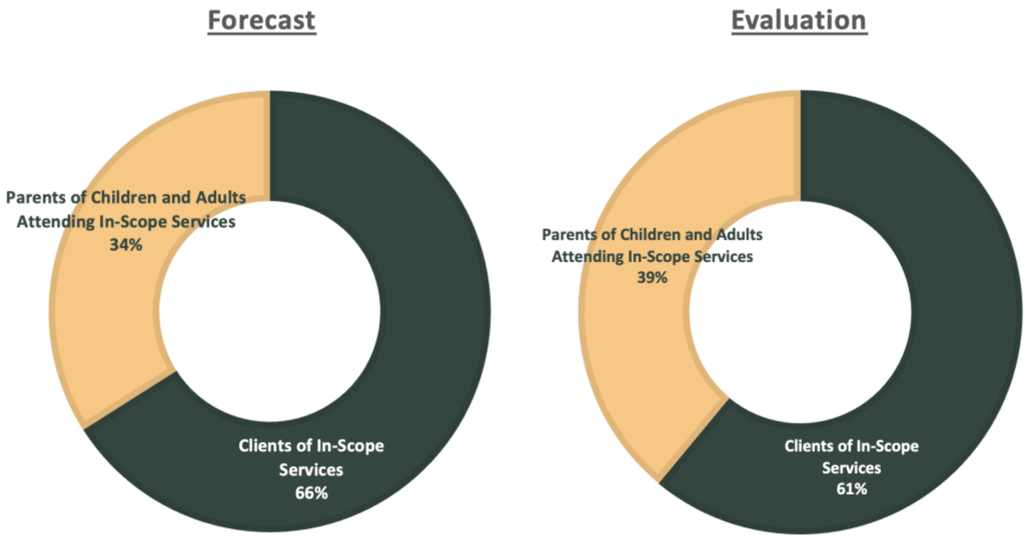
This section provides a comparison of the net value created as estimated in the SROI Forecast and as measured in the SROI Evaluation. The analysis focuses on net value by stakeholder type (primary and secondary), by stakeholder group, and by outcomes experienced by primary stakeholders. The purpose of this comparison is to assess how closely the SROI Evaluation aligns with the forecasted outcomes and to provide insights into the distribution of value creation across stakeholders and outcomes.

To ensure meaningful comparisons, net value is expressed as a percentage of total net value rather than in monetary terms. This comparison supports a better understanding of how effectively the SROI Forecast anticipated the distribution of value and where future improvements in forecasting or service delivery might be identified.

It is important to note, as detailed previously in this report, that different individuals from the same stakeholder groups contributed to various stages of the research, meaning the findings and interpretations reflect the diverse perspectives and methods employed across these stages. This variation in participant involvement may introduce differences in data collection, analysis approaches, and theoretical frameworks. Additionally, integrating results from these different stages can create challenges in maintaining consistency in assumptions, data quality, and measurement standards. While the contributions of participants at each stage enhance the depth and breadth of the study, this also highlights potential limitations in ensuring uniformity and generalisability of the findings across different contexts and populations.

Figure 58 compares the total social value generated for each type of stakeholder, primary stakeholders (clients attending in-scope services) and secondary stakeholders (parents of children and adults attending in-scope services), in both the SROI Forecast and the Evaluation for the in-scope services. The comparison between the SROI Forecast and Evaluation reveals a remarkably consistent distribution of social value, with clients accounting for 66% and parents 34% in the SROI Forecast, compared to 61% for clients and 39% for parents in the Evaluation, demonstrating strong alignment between projected and actual outcomes.

Figure 58: Proportion of total net value generated by stakeholder type – comparison



In figure 59, the comparison of the proportional social value created for each stakeholder group in the SROI Forecast and Evaluation reveals a relatively consistent distribution of social value. Clients of Social Capital Services and Health and Continence Services represented slightly smaller proportions of the value in the SROI Evaluation, reflecting their smaller stakeholder groups compared to the SROI Forecast. The Personal Support and Connection Service stakeholder group was also slightly smaller than was forecast. However, the service was delivered far more cost-effectively than anticipated, as planned changes to its delivery had not yet been implemented. This resulted in the Personal Support and Connection Service contributing a slightly larger share of the overall value generated in the SROI Evaluation.

Figure 59: Proportion of total net value generated by stakeholder group – comparison

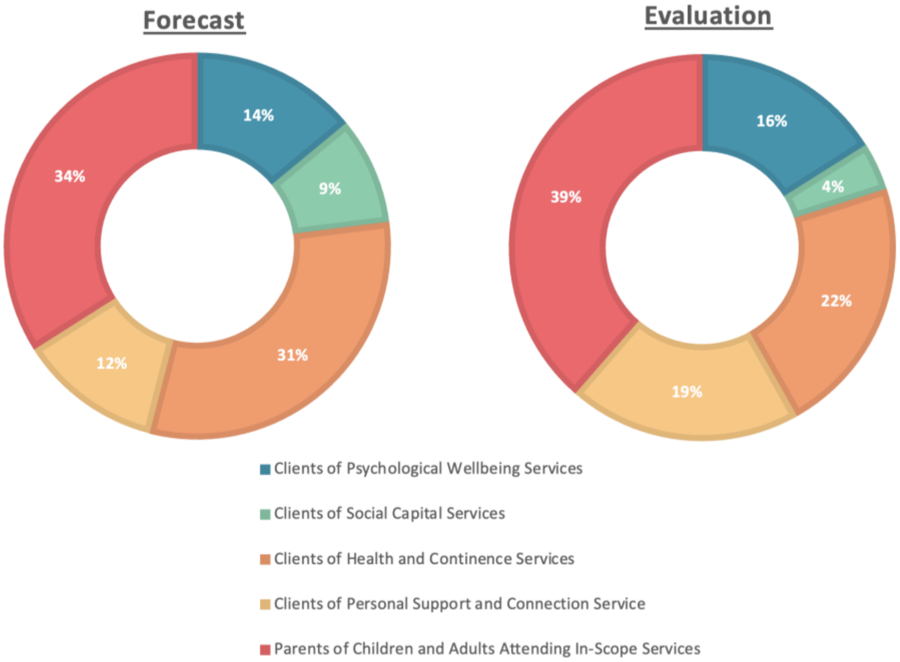
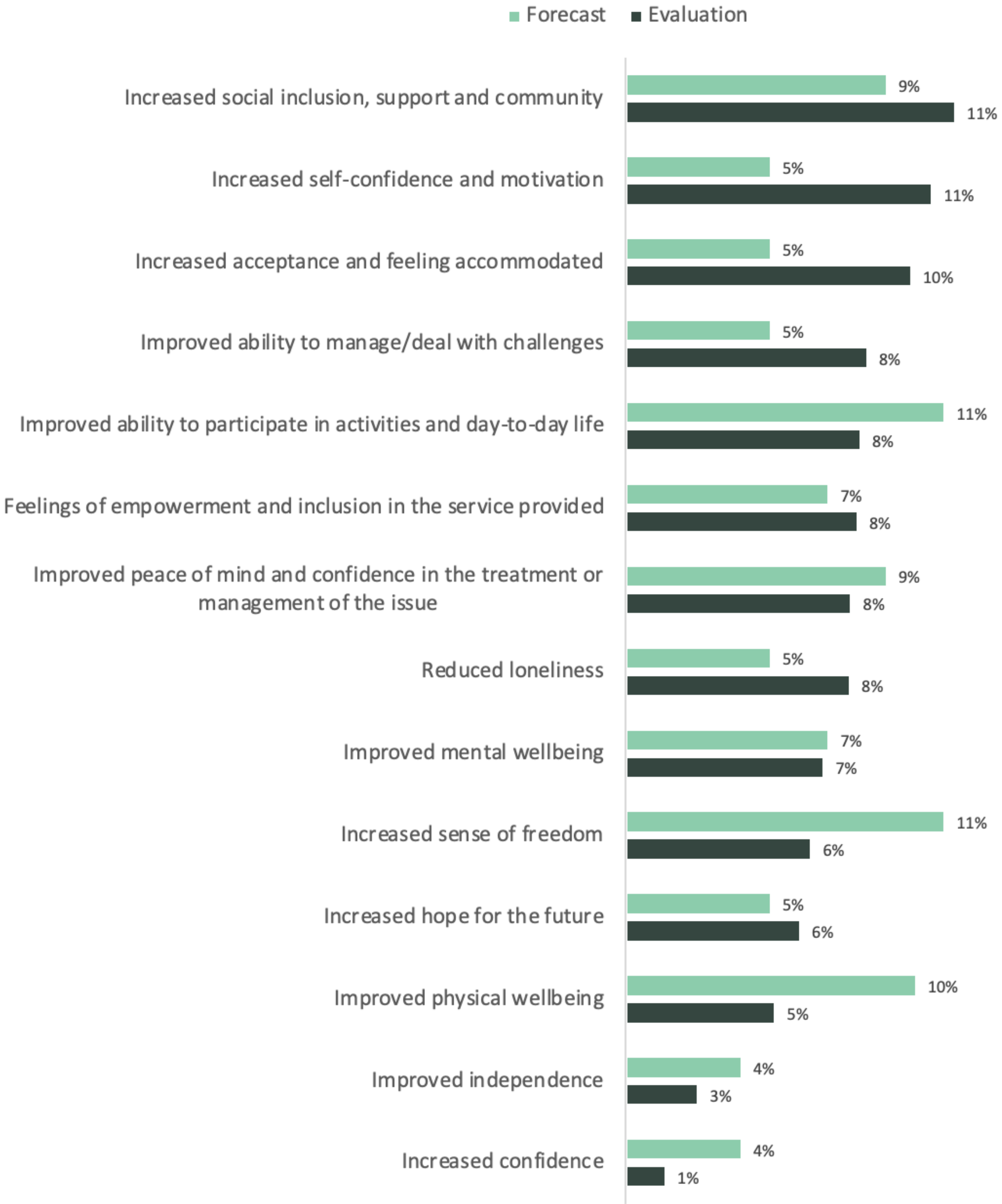


Figure 60 illustrates the social value generated for clients (primary stakeholders) by each outcome they experienced, compared across the SROI Forecast and Evaluation. Commentary on the differences follows below.

Figure 60: Proportion of net client value generated per outcome – comparison



The greatest increase in proportional value generated was ‘increased self-confidence and motivation’ (+6%). ‘Increased self-confidence and motivation’ was the second most valued outcome under Psychological Wellbeing Services and achieved the greatest distance travelled of any outcome in that theme by a notable margin. In the SROI Evaluation, the largest proportion of stakeholders self-reported this outcome, in line with the measured distance travelled. Comparatively, in the SROI Forecast, the least number of stakeholders self-reported this outcome compared to the other outcomes in the theme.

It is possible that the change in language from ‘confidence’ to ‘self-confidence,’ which was informed by qualitative insights gathered during *Evaluation Stage 1 – Qualitative*, contributed to more stakeholders relating to this outcome in the SROI Evaluation. It is also possible that having answered the objective indicator questions in the SROI Evaluation, preceding the self-report question, made stakeholders more acutely aware of the significant change that had occurred for them against this outcome.

Other considerations include the difference in population between the SROI Forecast and Evaluation. The SROI Evaluation data focused exclusively on clients who attended during the evaluation period, whereas the forecast encompassed a broader population of clients who had attended services at any time in the past 12 months. This distinction in sampling could influence the proportional value generated for specific outcomes.

Additionally, the increased proportional value of this outcome may reflect differences in the lived experiences and readiness for change among the client cohorts in the forecast and evaluation. The evaluation sample may have included clients at a point in their journey where they were more prepared to experience meaningful changes in self-confidence and motivation. Together, these factors underscore the complex interplay between language, measurement approaches, and variations in the client population, all of which shape the reported outcomes.

The second largest increase in proportional value generated was ‘increased acceptance and feeling accommodated’ (+5%). This outcome achieved the second greatest distance travelled of Personal Support and Connection Service outcomes and was self-reported by 68% of stakeholders. In the SROI Forecast, this outcome was self-reported by 53% of stakeholders, which may reflect how self-reported experiences in the SROI Forecast could have under-estimated this outcome. By the time stakeholders were engaged for the SROI Forecast, many had already been involved with Crann for some time, likely raising their baseline expectations for accommodation and acceptance. As a result, the level of change they reported may have been less pronounced compared to those experiencing the service for the first time during the SROI Evaluation period. This highlights the importance of pre- and post-measurement to fully capture the magnitude of change in stakeholder experiences. Further, the Client Liaison team was more embedded in the delivery of the Personal Support and Connection Service during the SROI Evaluation period than it had been previously, due to the team’s growth during 2023 and 2024.

The greatest decreases in proportional value generated were for ‘increased sense of freedom’ and ‘improved physical wellbeing’ (both -5%). These outcomes fall under the Health and Continence theme and were initially forecasted to be experienced by a large proportion of what was anticipated to be a significant stakeholder group. However, as detailed in Section 3.3, the scale of attendance in this theme did not materialise as expected. Both outcomes achieved moderate distance travelled compared to the other outcomes in this theme, reflecting some progress but not to the extent anticipated in the SROI Forecast.

These outcomes may also take longer to achieve significant progress compared to other outcomes within the theme, such as 'feelings of empowerment' or 'peace of mind in the management of the issue,' which are often quicker to realise. Outcomes like ‘increased sense of freedom’ or ‘improved physical wellbeing’ tend to involve more complex and sustained changes, requiring ongoing engagement, adjustments in lifestyle, or physical recovery (Espinosa & Gonzalez-Arias, 2023; Vitality Group International, 2024). This contrasts with the more immediate experience of peace of mind, or empowerment, which can often be achieved early in the intervention process through feeling confident enough to participate actively in consultations, i.e. no behaviour change must occur (Sikka, Revonsuo & Gross, 2023; Hickmann, Richter & Schlieter, 2022). As a result, these longer-term outcomes might naturally show slower progress within the SROI Evaluation period, reflecting the depth and duration of change required. It is also important to acknowledge that Crann is a needs-driven service, and these needs may have been more prominent for the group that contributed to the forecast.

Overall, except for some proportional changes in individual outcomes, as detailed in this section, the comparison of the SROI Forecast and Evaluation reveals a relatively consistent distribution of social value. This alignment between the forecasted and evaluated results underscores the reliability and accuracy of the initial forecasting process of the initial forecasting process and demonstrates the effectiveness of Crann’s service delivery in achieving its intended outcomes. The close correspondence between the anticipated and actual results demonstrates that Crann’s approach is deeply rooted in understanding and addressing stakeholder needs and priorities. As a result, the organisation is consistently able to create significant, measurable impacts that reflect the real-world experiences of its clients and their families. This consistency not only validates Crann’s capacity to plan and execute services but also highlights the organisation’s ability to reliably deliver meaningful value, ensuring that both immediate and long-term outcomes are successfully met.

11.11 Summary

The social return ratio is calculated by dividing the value of the total outcomes by the total inputs in a given time period. Based on the Social Value Calculation, it is determined that every €1.00 invested in Crann's Services results in a social return on investment of approximately €3.68 (a social return of 368%).

Based on the sensitivity analysis, the social value calculation was estimated to be between €3.19 and €5.07 for every €1 invested into services. The lowest ratio was €3.19, -13% compared to the median by using an alternate value for the outcome 'increased sense of comfort in leaving their child to attend services alone' experienced by parents as secondary stakeholders. The alternate value used was the tangible cost of saved time by parents, compared to the stakeholder assigned value which focused on the intangible feeling of comfort. The highest ratio was €5.07, +38% compared to the median by adjusting the calculation for duration and drop-off.

The ratio range of €1.88 indicates a relatively high level of confidence in the SROI ratio and suggests that the outcomes are not highly sensitive to variations in assumptions, inputs or scenarios. The median (€3.68) is close to the middle of the range (€0.34 below the midpoint), further supporting stability in the underlying assumptions. A rigorous sensitivity analysis has been conducted, and this range demonstrates that the model is robust under different plausible conditions. This relatively narrow range of SROI ratios is notable, particularly given the complexity of the evaluation of four different themes of services delivered by Crann.

12. Verification of the analysis

Ensuring the credibility and accuracy of the final SROI analysis was a key priority. The verification process involved multiple layers of internal review, stakeholder validation, and planned external engagement to confirm that the findings accurately represent the impact created through Crann's services.

12.1 Internal review and verification

The final analysis has been reviewed and verified by senior leadership at Crann, including:

- CEO
- General Manager
- Research and Impact Lead
- Head of Services

This internal review ensured that the analysis accurately reflects operational realities, aligns with existing data and reporting, and is a robust representation of Crann's impact.

12.2 Stakeholder validation of the framework

The outcomes framework and Theory of Change were validated by stakeholders through qualitative stakeholder engagement during both the SROI Forecast and SROI Evaluation. This process confirmed that the selected outcomes are meaningful, relevant, and accurately represent the changes experienced by beneficiaries.

12.3 Stakeholder verification of the final analysis

To ensure the validity and credibility of the final SROI analysis, a stakeholder verification process was undertaken. An overview report summarising key findings was shared with stakeholders through Crann's typical communication channels, providing them with an accessible and transparent account of the evaluation outcomes. Stakeholders were invited to review the findings and provide feedback on their accuracy and alignment with their own experiences and perceptions of change.

This approach allowed for final validation of the analysis from those directly impacted, ensuring that the reported outcomes and values reflect lived experiences. The open invitation for feedback also provides an opportunity to identify any overlooked insights or areas requiring further clarification.

12.4 Planned engagement for verification of the assured report

To further strengthen the validation process, Crann will conduct two structured engagements, with the support of the Practitioner, to present findings and invite feedback:

1. An open online forum for Crann families to present the findings and invite discussion which will provide an opportunity for those directly impacted by Crann's services to share their perspectives on the analysis in an interactive environment.

2. A working session with the Board of Directors to present and validate findings from their perspective, ensuring alignment with Crann's strategic direction and identify ways to integrate findings into future decision-making.

13. Recommendations for Crann

As a small organisation, Crann operates with finite resources while striving to deliver intentional, impactful, high-quality services to its clients and their families. The recommendations in this chapter are grounded in stakeholder input and the comprehensive analysis of Crann's impact, highlighting opportunities for enhancing and expanding its offerings. However, these recommendations should be considered in the context of Crann's available resources, organisational capacity, and ongoing strategic priorities. They are intended to guide sustainable growth and continuous improvement, ensuring Crann can maintain its focus on creating meaningful, long-term outcomes for its stakeholders.

13.1 Sustain and expand marketing efforts

13.1.1 Sustain investment in marketing Crann's services

Crann has made impressive strides in marketing since the 2022 SROI forecast, resulting in increased family engagement. However, stakeholders indicate that further value could be achieved if more families were made aware of Crann's services. Ongoing investment in targeted marketing is essential to ensure continued visibility and reach, enabling Crann to attract a broader audience and provide support to those in need. This is a key focus of Crann's Strategic Plan for 2023-2025.

13.1.2 Track how new families find Crann

To better understand the effectiveness of marketing strategies, it is crucial to track how new families find Crann. Stakeholder feedback suggests many clients discovered Crann by chance. Implementing a system to track and analyse how clients hear about Crann—from online platforms to word of mouth—will allow for more informed, strategic decision-making and targeted marketing efforts that align with stakeholder preferences and behaviours.

13.2 Expand service reach and client-base

13.2.1 Scale services to reach more clients

Scaling services to reach more clients is an important recommendation. During the evaluation period, Crann served fewer clients than forecasted in in-scope services because it adjusted its focus to meet client needs and priorities. It is important to note that this evaluation does not include the number of clients supported by other services. This creates an opportunity to review how services are delivered and explore cost-effective ways to expand. Group services, which can support more people with fewer resources, offer a clear option for growth. By building on existing structures and exploring new ways to reach clients, Crann can increase its impact while maintaining high-quality services.

13.2.2 Expand group service offerings for broader impact

While one-on-one services are essential, expanding group-based offerings can provide significant value for both clients and Crann's operational efficiency. It is recommended that Crann explore opportunities to boost participation in existing group programs and potentially develop new group initiatives. Group services provide a high return on investment, benefiting multiple clients at once while preserving individualised support.

13.2.3 Develop ongoing support services for siblings

Stakeholder feedback highlights the critical need for more support for siblings of individuals with disabilities. Crann's expansion of Sibshop workshops in 2024 is a positive step. However, there is an opportunity to create a more structured, ongoing sibling support program. This program could evolve from Sibshop into a long-term service offering, catering to siblings across different age groups and life stages, and fostering resilience and a sense of belonging.

13.3 Strengthen peer support and learning initiatives

In qualitative research, many clients described how engaging with people who shared similar experiences with them had helped them to achieve outcomes. Many referenced specific opportunities they had accessed through Crann for peer learning and support that had significantly benefited them and expressed an appetite for more of these opportunities.

13.3.1 Review the format and delivery of Parents’ Café model for greater engagement

While the Parents’ Café has been an important service, attendance has been lower than expected, potentially due to its informal, parent-led nature. To increase participation and engagement, Crann should consider revising the format to include structured, facilitator-led sessions or fixed-term programs. A more organised approach could help ensure a more consistent and impactful experience, making the café more attractive to a broader range of parents seeking peer support. This is under development at Crann currently, based on stakeholder feedback.

13.3.2 Introduce mixed-age peer learning activities

Crann’s Social Hub has been highly valued for providing adults with disabilities a supportive space to share experiences and seek advice. Its success highlights the importance of peer-led initiatives in fostering connection and understanding.

Stakeholder feedback also suggested that younger clients, such as children and teens, could benefit from structured opportunities to interact with older clients. These mixed-age peer learning activities could provide role models for younger participants while strengthening community ties across age groups. Building on the Social Hub’s proven impact, Crann could develop such a programme to further enhance peer learning and support between people at different life stages.

13.4 Further Promote community inclusion

Stakeholders frequently highlighted the importance of social interaction and inclusion, with many clients, particularly adults with disabilities, sharing how Crann’s services have provided them with a sense of belonging and community. For individuals who previously lacked a network of peers, this support has been invaluable. Leveraging its strong reputation in the disability sector, Crann has the opportunity to promote inclusion on a broader scale, extending its impact beyond its immediate community.

13.4.1 Volunteering opportunities

Volunteering is highly valued by Crann’s stakeholders, particularly for its ability to promote personal growth and community engagement. To enhance the impact of volunteering, Crann should focus on creating roles specifically designed for people with disabilities, allowing them to support peers in similar situations. Additionally, Crann should expand its collaborations with local organisations to provide a diverse range of volunteering opportunities, thereby creating new pathways for clients to engage meaningfully in their communities.

While volunteering is exceptionally meaningful to many, this should be balanced with meaningful paid employment, especially in the context that Ireland has the worst employment rate for persons with disabilities in the EU (Disability Federation of Ireland, 2024).

13.4.2 Employment and skill development

Crann's Impact Hub, established in 2022, is a fully inclusive and accessible co-working space located within its purpose-built Crann Centre. As part of the Career Pathways service, the Impact Hub supports clients transitioning into the workplace or setting up their own businesses. Members benefit from key supports provided by The Rubicon Centre at Munster Technological University, Cork County Council Local Enterprise Office, and the Open Doors Initiative. This innovative facility not only helps individuals build their careers but also exemplifies an inclusive work environment.

To further enhance the Impact Hub's role in promoting community inclusion, Crann could explore additional uses for this space, including:

- Accessible Spaces: Hosting workshops, networking events, and skill-building sessions for people with and without disabilities, showcasing the benefits of inclusive design.
- Shared Apprenticeships: Designing programmes where participants from diverse backgrounds collaborate on skill-building projects, fostering teamwork and connection.

These initiatives would strengthen the Hub's impact as both a resource for Crann clients and a model of inclusive professional environments, while also driving greater community participation.

13.4.3 Events and activities

Crann runs many events for its clients, including Christmas at Crann (accessible Santa experience), a summer barbeque for families, music events, theatre events (show performances), conservation events, and kids' camps, all of which are highly valued by clients and their families. It could build on these successful initiatives to offer more events that bring together Crann's client families and a diversity of people from the wider community, to further promote community inclusion.

Opportunities include:

- Community art projects by Crann's clients in collaboration with other community groups to highlight shared creativity and inclusivity.
- Hobby clubs (e.g., art, gardening, or photography) catering to diverse interests that bring together people with disabilities and people from the wider local community.

13.4.4 Mentorship

A mentorship programme connecting clients with community leaders or professionals could provide opportunities for skill development and social integration while fostering mutual understanding.

13.5 Consider the potential to enhance Psychological Wellbeing Services

Crann's primary focus in Psychological Wellbeing services is currently on one-to-one interventions, such as Counselling and Play Therapy. These services are highly valuable and appropriate for supporting clients facing specific challenges.

However, research shows that general mental wellbeing is often chronically impacted for people with disabilities and their families (Hackett et al., 2020). This presents an opportunity for Crann to consider developing a broader wellbeing-focused programme. Crann's Psychological Wellbeing team is in the process of developing a programme like this which includes art-based wellbeing elements and more.

It is recommended that Crann continue to consult with clients to ensure that this offering is developed based on stakeholder input.

13.6 Strengthen the Personal Support and Connection Service

Crann's Personal Support and Connection Service generates a high social value return with minimal investment, demonstrating its significant potential for further development. Strengthening this service could amplify outcomes for clients, creating even greater overall value.

Engaging a larger number of clients with this support in a more intentional way would enhance its impact. This could include targeted outreach and tailored support strategies to ensure that all eligible clients benefit from the service, maximising its value.

While the Personal Support and Connection Service stands as a distinct offering, Crann's Client Liaison Team plays a complementary role in enhancing client outcomes across services. Acting as a dedicated point of contact, the team helps families navigate Crann's services, achieve their goals, and access external resources. Their proactive follow-up support, provided through a direct support line, ensures ongoing guidance and reassurance. This collaboration between services and the liaison team creates a seamless, supportive experience that empowers families throughout their journey.

Crann should consider how the Client Liaison Team and the Personal Support and Connection Service overlap in purpose and functionality. Exploring ways to integrate these offerings could help expand the Personal Support and Connection Service, leveraging the strengths of the Client Liaison Team to deliver an even broader and more impactful service.

13.7 Advocacy for inclusion, accessibility and policy

Advocacy plays a vital role in fostering a more inclusive society by challenging systemic barriers and influencing positive change. Crann is well-positioned to leverage its expertise and reputation to advocate for greater inclusion, accessibility, and supportive policies for people with disabilities. This could involve the following initiatives:

13.7.1 Engage Policymakers

Crann has a history of engaging extensively with local TDs, particularly around election times, and maintains long-standing relationships with TDs in the Dáil as well as key representatives within the HSE. Crann should continue to actively participate in policy consultations and provide evidence-based recommendations to advance accessibility and inclusion at both national and local levels. By leveraging its service delivery insights, Crann can effectively inform decision-makers about the needs of people with disabilities and the societal benefits of addressing these needs.

13.7.2 Public Campaigns

Crann’s annual Walk’n’Roll and Christmas Fundraising campaigns play a vital role in raising awareness of key disability-related issues, including accessibility in public spaces and the importance of inclusive community practices. Complementing these efforts, Crann maintains a highly active social media presence and regularly launches advertising campaigns to engage new audiences, using storytelling, testimonials, and data to humanise the challenges faced by people with disabilities and showcase actionable solutions. To build on this impact, Crann should continue leveraging these platforms to promote public awareness.

13.7.3 Advocate for Inclusive Design

Crann is actively engaged in using the purpose-built and fully accessible Crann Centre as a benchmark of accessible design, work with schools, employers, and public service providers to promote universal design principles. Continued focus on this advocacy will contribute towards ensuring that wider environments and services are accessible to all individuals.

13.7.4 Coalition Building

Crann is engaged in several strategic partnerships, including with University College Cork and Northwestern University, among others. Crann should continue to collaborate with other organisations and disability advocates to further strengthen collective efforts for systemic change. By uniting voices, Crann can amplify its impact on policy and social attitudes.

Through these advocacy efforts, Crann can drive meaningful improvements in inclusion and accessibility while reinforcing its leadership in the disability space. These initiatives will not only benefit its clients but also contribute to a more equitable and inclusive society.

By implementing these recommendations, Crann can build on its strengths to create even greater value for its clients and stakeholders. These initiatives reflect the organisation’s commitment to continuous improvement, ensuring that services remain client-focused, scalable, and impactful. From enhancing service delivery to expanding advocacy efforts, these strategies position Crann as a leader in promoting inclusion, accessibility, and wellbeing for people with disabilities and their families. Through these efforts, Crann can not only deepen its impact locally but also inspire broader societal change, fostering a more inclusive and equitable community for all.

14. Recommendations for future evaluations

The recommendations outlined below are designed to strengthen Crann's approach to future SROI evaluations, building on the successes and lessons learned from the current process. By enhancing data collection methods, refining recruitment strategies, and fostering greater alignment with organisational processes, these recommendations aim to ensure that future evaluations remain robust, representative, and impactful. They also provide a roadmap for improving the depth and comparability of insights while continuing to reflect the evolving needs of Crann's clients and stakeholders.

14.1 Ensure ongoing staff engagement with the SROI programme

The involvement of Crann staff was pivotal to the success of this SROI evaluation. Their sustained efforts in engaging clients with outcome measurement research and tracking progress towards sample targets were invaluable. For future evaluations, it is essential to maintain and strengthen staff engagement to ensure continued success and accurate data collection.

Engaging staff in reflective discussions about how they perceive their service's contribution to client outcomes can also help ensure that future evaluations remain focused on capturing the most relevant and meaningful impacts. This approach would align staff insights with the evaluation objectives, ensuring that data collection and analysis reflect the core outcomes Crann aims to achieve for its stakeholders.

14.2 Evolve the internal management of recruitment of participants

Crann developed an effective internal system to manage client recruitment for this SROI evaluation. This system tracked which clients had been asked to complete specific surveys, reducing the risk of research fatigue, particularly for families attending multiple services. Evolving this system in future evaluations to consider a more stratified approach to sampling would help ensure that under-represented groups are adequately included, enabling more comprehensive insights into the diverse experiences and outcomes across stakeholder groups. This approach should take account of those who have disengaged from a service or had a lower level of engagement than average.

Clear instructions were provided to the primary point of contact in each family on who should complete each survey, ensuring data was collected from the most relevant respondent. This approach ensured the quality and accuracy of the data and should be carried forward into future evaluations.

14.3 Review stakeholder mapping and inclusion decisions through stakeholder engagement

Decisions made in the SROI Forecast regarding the inclusion or exclusion of secondary stakeholder groups were upheld in this SROI Evaluation, based on stakeholder engagement and the need for consistency. However, for future evaluations, it is recommended that the stakeholder map be reviewed and updated as necessary, with secondary stakeholders re-engaged to assess whether the rationale for their exclusion, due to a lack of distinct, material outcomes, remains valid.

14.4 Re-validate Theories of Change and deductions prior to quantitative data collection

For future evaluations, it is essential to re-validate the theories of change prior to undertaking quantitative data collection. As services evolve to meet emerging needs, and stakeholder experiences of change shift over time, the original theories of change may no longer fully reflect the pathways to impact. Re-validating these frameworks ensures that the evaluation captures the most relevant outcomes, accounts for changing stakeholder priorities, and remains aligned with the current realities of service delivery. This process should include staff involvement as per Recommendation 13.1.

Additionally, this process should include a review of the deductions applied in the SROI calculation, including deadweight, displacement, attribution, and drop-off. As stakeholder experiences change and external factors influencing outcomes evolve, previously applied deduction rates may no longer be valid. Ensuring these are tested and revalidated prior to data collection will improve the robustness of the analysis and maintain the accuracy of the reported social value.

Additionally, this process should include an exploration of entirely new outcomes that may not have been previously considered. As services and client experiences evolve, the identification of these new outcomes will be critical to maintaining a comprehensive and accurate evaluation framework. This approach will enhance the relevance and value of future SROI evaluations, ensuring they fully reflect Crann’s impact.

14.5 Aim for more robust sampling

While this SROI evaluation made significant efforts to achieve robust sampling, the variance could affect the precision of outcome estimates and the generalisability of findings to the entire client population. Future evaluations could benefit from targeted efforts to reduce variance through increased sample sizes or refined recruitment strategies, ensuring greater alignment with the broader population.

To achieve this, it is recommended to implement a stronger lead-in communications strategy. Engaging clients well in advance of the evaluation will help prepare them for the process and increase participation rates. Additionally, ensuring consistent and joined-up communication about the SROI research request across all touchpoints of the client journey will reinforce the importance of their involvement and support a more robust sample.

Stratified sampling is recommended for future evaluations to ensure that all key subgroups within the population are adequately represented in the sample. By dividing participants into strata based on relevant characteristics, such as gender, age, or disability diagnosis, this method would allow for more precise analysis of outcomes across different segments. It also reduces the risk of over- or under-representation of smaller subgroups, improving the reliability and comparability of findings.

14.6 Expand sampling to improve representativeness

To improve the generalisability of future findings, Crann should aim to diversify the participant sample. This includes targeting underrepresented groups, such as those who have had less engagement with Crann’s services and ensuring that individuals with varying levels of involvement in the included service areas are represented. Efforts to encourage participation from a broader spectrum of families would help capture a wider array of experiences and outcomes. Alongside incorporating longitudinal data collection (Recommendation 13.6), this could offer valuable insights into the long-term impact of Crann’s services, allowing for a more robust understanding of sustained outcomes over time.

14.7 Explore the feasibility of consistent pre- and post-intervention sampling

To improve the consistency and reliability of data in future evaluations, Crann could explore ways to ensure that the same individuals complete both pre- and post-intervention surveys. While the decision not to achieve this consistency in the current evaluation was not due to the data collection design but rather the practical challenges identified by Crann, implementing a unique identifier system could enable linking individual participants across survey phases.

Given the complexity of families attending multiple services and the absence of fixed entry and exit timelines for many services, it may not be feasible to achieve this for the entire sample. However, focusing on a sub-set of participants who are consistently surveyed pre- and post-intervention would provide valuable insights into individual progress while maintaining the overall approach of analysing average distance travelled for comparability between evaluations.

This targeted approach would balance the need for detailed data with the practicalities of Crann’s service delivery model, ensuring future evaluations benefit from more robust and consistent insights.

14.8 Establish longitudinal data collection

With a baseline now established, implementing longitudinal data collection for Crann's clients would provide significant value in future evaluations. This approach should include past clients, ongoing clients, and new clients to examine:

- How their outcomes align with the pre-post benchmark.
- Whether outcomes are sustained or diminish over time.
- How Crann's overall impact evolves over the long term.

Tracking longitudinal data will offer deeper insights into the lasting effects of Crann's services and support continuous improvement. Additionally, aligning longitudinal data collection with the recommendation to re-validate the ToCs prior to each evaluation would ensure that the data collected reflects evolving services and client needs. This integration would enhance the relevance and accuracy of the evaluation process while maintaining focus on the most impactful outcomes.

14.9 Explore opportunities for tracking family unit data

To enhance the accuracy of future SROI evaluations, Crann should implement a system to track how many parents are involved across its family units. By collecting specific data on the presence and engagement of parents as secondary stakeholders, Crann can eliminate the need to estimate the number of parents benefiting from its services. This approach would provide a clearer understanding of the value created for parents, offering richer insights into the ripple effects of support on the entire family and strengthening the evaluation of Crann's overall impact.

14.10 Consider joining up intake and review data with SROI

Currently, Crann's intake and review data collection operates independently of the SROI programme, using a different set of criteria for measuring progress. Future evaluations could benefit from aligning the focus of intake and review processes with the SROI outcomes. Incorporating outcome-focused discussions during qualitative intake and review meetings with families would provide valuable, consistent data and enhance the efficiency and comprehensiveness of future SROI evaluations.

This would require the implementation of embedded consent and ethical protocols, ensuring that anonymised client data from various areas of the organisation can be responsibly utilised to support evaluations and other research initiatives.

Crann could explore embedding SROI data collection into the intake and review meeting process to support other recommendations, such as achieving more robust sampling, ensuring consistent pre- and post-intervention samples, and enhancing broader sample representativeness. However, the feasibility of this approach would require careful consideration, given the volume of data needed for outcome measurement, covering multiple indicators across four or more outcomes for each service attended by each family member, and how this data collection could be seamlessly integrated into the intake and review process.

14.11 Run valuation workshops with fresh sample

Future evaluations should validate or evolve outcome valuations through stakeholder engagement. While the valuation games used in this SROI analysis are comprehensive and respected within social value practice, and the resulting values remain robust, engaging a new sample of stakeholders would enhance the evaluation.

Recruiting a fresh cohort to contribute to the valuation of outcomes would ensure that perspectives remain representative as Crann engages with more clients over time. Additionally, proxies used in sensitivity testing could be explored with this new sample to assess their accuracy and identify potential alternatives, further strengthening the evaluation framework.

14.12 Ensure comparability of results in repeat SROI Evaluations

To ensure future evaluations are directly comparable, the same indicators and segmentation questions should be used consistently across evaluations, where outcomes remain relevant. This approach will allow for seamless comparison of data sets and trends over time. In the case that new outcomes are identified, new indicators should be developed to accurately measure those outcomes.

The analysis method should also be replicated to maintain consistency in how results are calculated and interpreted. Additionally, sub-analysis of a subset of participants who are the same pre- and post-service engagement could be included, enabling deeper insights into individual progress while still supporting overall comparability.

14.13 Consider the role for a more holistic SROI Evaluation of Crann’s Model of Care

Given the integrated nature of Crann’s 2Gen Model of Care, Crann should consider adopting a systems-based approach to data analysis in future evaluations. This approach would avoid evaluating service areas in isolation and instead focus on the connections between various services. By examining how different service areas, such as psychological wellbeing, mobility, and education, work together to impact families’ overall outcomes, Crann could gain deeper insights into the collective impact of its services. Aggregating and analysing data holistically would provide a more comprehensive view of the model’s effectiveness and the cumulative benefits it delivers to families.

By implementing these recommendations, Crann can continue to improve the quality and relevance of its SROI evaluations. These actions will ensure that the evaluations accurately capture the full extent of Crann’s impact, enable meaningful comparisons over time, and provide valuable insights to inform decision-making. Strengthening these processes will not only enhance the organisation’s ability to demonstrate its value but also support its ongoing commitment to delivering meaningful outcomes for clients and their families.

15. Be Responsive

The Be Responsive principle is a relative recent addition to the SROI Principles, but represents a cornerstone of the SROI process, ensuring that organisations act on the insights and feedback gathered during the evaluation to improve services, policies, and outcomes for stakeholders. While this report represents the conclusion of the current evaluation, Crann is committed to using the findings and stakeholder feedback to inform its future practices and decision-making.

The recommendations outlined in this report reflect the voices of Crann’s stakeholders, highlighting their priorities and identifying areas where value can be maximised. Crann has already demonstrated a strong commitment to stakeholder engagement throughout the evaluation process, from involving staff in data collection to engaging clients in meaningful discussions about their experiences and outcomes. This commitment will continue as Crann acts on the insights provided.

Key areas of focus for Crann’s responsiveness include:

- Enhancing Service Delivery: Crann plans to review and adapt its services, such as exploring opportunities to strengthen the Personal Support and Connection Service, scaling group offerings, and developing more tailored support for siblings.
- Improving Data Collection and Evaluation Processes: Crann aims to refine its evaluation practices if/ when conducting another SROI process, including more robust sampling, longitudinal data collection, and aligning intake and review data with SROI outcomes. These steps will ensure that future evaluations remain comprehensive and relevant.
- Advancing Advocacy and Community Inclusion: Stakeholder feedback emphasised the importance of community inclusion and systemic advocacy. Crann is committed to expanding initiatives such as accessible events and employment pathways (including volunteering) to foster inclusion and demonstrate the value of accessible, inclusive models.

While specific actions have not yet been implemented, Crann recognises the importance of responding thoughtfully and strategically to the findings in this report. As a trusted leader in the disability sector, Crann will continue to prioritise stakeholder engagement and ensure that its services and initiatives align with the needs and priorities of those it serves.

Crann’s ongoing commitment to the Be Responsive principle will be evident in the steps taken to address these recommendations and in the continuous improvement of its services to deliver greater impact for clients and the wider community.

16. Conclusion

This Social Return on Investment (SROI) evaluation reinforces the significant impact of Crann's services and its commitment to fostering meaningful outcomes for people with neuro-physical disabilities and their families. Building on its holistic approach, Crann has successfully delivered extensive benefits, from enhancing mental wellbeing to fostering social inclusion, while ensuring that the voices of stakeholders remain central to its mission.

Throughout the evaluation process, Crann has demonstrated its commitment to understanding and valuing stakeholder experiences. The extensive stakeholder engagement conducted for the Evaluation, including focus groups and interviews in *Evaluation Stage 1 – Qualitative*, and quantitative surveys in *Evaluation Stage 2 – Quantitative* allowed stakeholders to share their perspectives, ensuring that the outcomes measured truly reflected their lived experiences. This commitment to collaboration has informed the analysis and provided valuable insights into areas for continued growth and innovation.

Key Insights
The evaluation highlights several key achievements, including:

- Positive outcomes were achieved across all themes. Crann's services have significantly improved mental wellbeing, built social connections, and increased self-confidence for clients with and without disabilities. These outcomes underscore the value of Crann's tailored support, and 2Gen Model of Care.
- By placing stakeholder priorities at the heart of its evaluation, Crann has ensured that its services align with the needs and aspirations of clients and their families.
- Crann's willingness to adapt and respond to feedback has enhanced its capacity to deliver intentional, impactful, and high-quality services, as evidenced by the robust recommendations outlined in this report.

Future Directions
The findings of this SROI evaluation provide valuable insights into the ways Crann can build on its successes and address evolving stakeholder needs. Moving forward, Crann's strategic focus should continue to centre on creating meaningful outcomes while embracing opportunities for innovation.

- Diversifying and Deepening Service Offerings: While maintaining its core programmes, Crann could explore opportunities to expand into complementary areas, ensuring a broader reach without compromising quality. Additionally, by deepening existing services, Crann can enhance their impact, providing more comprehensive support to meet the evolving needs of clients and their families.
- Enhancing Community Impact: Building on its strong reputation, Crann is uniquely positioned to lead initiatives that drive systemic change, such as advocating for policy improvements, fostering inclusive work environments, and demonstrating the benefits of accessible design. These efforts are already embedded in Crann's approach, and continued focus on these areas will further strengthen its role as a leader in creating an inclusive society.
- Deepening Stakeholder Engagement: Ongoing dialogue with clients and their families will remain crucial to ensuring that Crann's services continue to align with stakeholder priorities and create value that resonates across diverse groups. Crann's Living Lab process, established in 2024 will be a significant contributor to this.
- Strengthening Organisational Resilience: As Crann scales its impact, prioritising sustainability in operational planning will help safeguard its ability to deliver long-term benefits to stakeholders.
- Achieving Sustainable Funding: Securing diverse and stable funding sources is essential for sustaining operations and scaling impact. By diversifying income streams and leveraging its proven outcomes, Crann can maintain long-term financial resilience while continuing to innovate and deliver meaningful services.

Crann's Commitment to Responsiveness
Crann remains deeply committed to responding to the findings and recommendations presented in this report. By integrating these insights into its strategic planning, Crann will continue to evolve its services, ensuring they

meet the needs of stakeholders. This commitment reflects Crann's core value of continuous improvement, ensuring that it remains responsive, adaptable, and focused on delivering greater impact over time.

Looking Ahead

The SROI evaluation validates Crann's significant contributions to date and sets a foundation for even greater achievements. By leveraging the findings of this report, Crann is well-positioned to deepen its impact, expand its reach, and continue empowering individuals and families to thrive. This unwavering commitment ensures that Crann will continue to empower people with neuro-physical disabilities and their families to thrive, fostering independence, inclusion, and the ability to live their best lives.

17. Bibliography

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist,* 58(1), pp 5–14. https://doi.org/10.1037/0003-066X.58.1.5

Banda-Chalwe, M., Nitz, J., de Jonge, D. (2014). Impact of inaccessible spaces on community participation of people with mobility limitations in Zambia. *African Journal of Disability*, 3(1), 33. https://doi.org/10.4102/ajod.v3i1.33

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Bandura, A. (1997). *Self-Efficacy: The Exercise of Control.* New York: W.H. Freeman. [Accessed 24 Jan. 2025].

Banks, J., Grotti, R., Fahey, É. and Watson, D. (2018). Disability and Discrimination in Ireland: Evidence from the QNHS Equality Modules 2004, 2010, 2014. *Disability and Discrimination in Ireland.* [Accessed 7 Jan. 2025].

Barkham, M., Bewick, B., Mullin, T., Gilbody, S., Connell, J., Cahill, J., Mellor-Clark, J., Richards, D., Unsworth, G. & Evans, C. (2012). The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. *Counselling and Psychotherapy Research*, 1–11. http://doi.org/10.1080/14733145.2012.729069

Barr, P.J., Scholl, I., Bravo, P., Faber, M.J., Elwyn, G. and McAllister, M. (2015). Assessment of patient empowerment--a systematic review of measures. *PLoS One*, 10(5), p.e0126553. https://doi.org/10.1371/journal.pone.0126553

Barreto, M., Victor, C., Hammond, C., Eccles, A., Richins, M. T., & Qualter, P. (2021). Loneliness around the world: Age, gender, and cultural differences in loneliness. *Personality and Individual Differences*, 169, pp 110066. https://doi.org/10.1016/j.paid.2020.110066

Barreto, M., Doyle, D. M., & Maes, M. (2025). Researching gender and loneliness differently. *Annals of the New York Academy of Sciences,* 1-10. https://doi.org/10.1111/nyas.15283

Becker, R. (2021). Gender differences in survey participation and response speed: Lessons from an online panel. *Methods, Data, Analyses*, 15(2), 189–211. https://doi.org/10.12758/mda.2021.08

Bertschi, I.C., Meier, F., Bodenmann, G. (2021) Disability as an Interpersonal Experience: A Systematic Review on Dyadic Challenges and Dyadic Coping When One Partner Has a Chronic Physical or Sensory Impairment. *Frontiers in Psychology*, 1;12. https://doi.org/10.3389/fpsyg.2021.624609

Björnberg, A., Yung Phang, A. (2019). *Health Consumer Powerhouse: Euro Health Consumer Index 2018 Report.* [Accessed 16 Jan 2025]

Blake, L., Bray, L., Carter, B. (2019). “It’s a lifeline”: Generating a sense of social connectedness through befriending parents of disabled children or children with additional need. *Patient Education and Counselling*, 102(12), pp 2279-2285. https://doi.org/10.1016/j.pec.2019.07.012

Braveman, P., Arkin, E., Orleans, T., Proctor, D., and Plough, A. (2023) 'What is health equity? And what difference does a definition make?' *International Journal for Equity in Health*, 22(1). [Accessed 20 Jan. 2025].

Brick, A, Keegan, C, Wren, MA. (2020). *Baseline Utilisation of Specialist Disability Services in Ireland.* ESRI Survey and Statistical Report Series, 89. [Accessed 7 Jan. 2025].

Brown, B. B., & Larson, J. (2009). Peer relationships in adolescence. In R. M. Lerner & L. Steinberg (Eds.), *Handbook of adolescent psychology: Contextual influences on adolescent development* (3rd ed., pp. 74–103). https://doi.org/10.1002/9780470479193.adlpsy002004

Burke, J., and Bezyak, J. (2016) *Disability service models: Person-centred approaches to care.* London: Routledge. [Accessed 20 Jan. 2025]

Burke, S., Normand, C., Barry, S., and Thomas, S. (2016). From Universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis. *Health Policy*, 120, pp 235-340. https://doi.org/10.1016/j.healthpol.2015.12.001

Casey, C., O'Sullivan, M., Caffrey, N., Fanagan, S. (2020) *Annual Report of the National Ability Supports System*. HRB StatLink Series 1. [Accessed 7 Jan. 2025].

Casey, C., O'Sullivan, M., Caffrey, N., Fanagan, S. (2023). *Overview of People Engaging with Disability Services.* HRB Bulletin, National Ability Supports System (NASS). [Accessed 7 Jan. 2025].

Cegarra, B., Cattaneo, G., Ribes, A., Solana-Sánchez, J., Sauri, J. (2023). Independent living, emotional well-being, and quality of life in people with disabilities: the mediator role of self-determination and satisfaction with participation. *Frontiers in Psychology*, 14. https://doi.org/10.3389/fpsyg.2023.1279014

Centric Health (n.d.). Anxiety & Stress. [Accessed 19 Dec. 2024].

Chase-Lansdale, P. L., & Brooks-Gunn, J. (2014). Two-Generation Programs in the Twenty-First Century. *The Future of Children*, 24(1), 13–39. [Accessed 20 Jan. 2025].

Cherry, K. (2021). What is learned helplessness? [Accessed 26 Nov. 2024.]

Cherry K (2023). What is resilience? [Accessed 21 Nov. 2024].

Christensen, M.K., Lim, C.C.W., Saha, S., Plana-Ripoll, O., Cannon, D., Presley, F., Weye, N., Momen, N.C., Whiteford, H.A., Iburg, K.M., & McGrath, J.J. (2020). The cost of mental disorders: a systematic review. *Epidemiology and Psychiatric Sciences*, 29, e161. https://doi.org/10.1017/S204579602000075X

Collins, K. (2017). Developing a Community Based Service Model for Disability: Listening to the Needs of All Beneficiaries and Providers. *Journal of Pediatric Rehabilitation Medicine*, 10(3-4), pp 227-230. https://doi.og/10.3233/PRM-170448

Cooper, M., & Law, D. (Eds.). (2018). *Working with goals in psychotherapy and counselling*. Oxford University Press. https://doi.org/10.1093/med-psych/9780198793687.001.0001

Counselling Collective (n.d.). Play therapy for children with emotional challenges. [Accessed 21 Nov. 2024].

Counselling Directory. (n.d.). Why men talking about their well-being matters. [Accessed 21 Nov. 2024]

Courtenay, WH. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*. 2000 May;50(10), pp 1385-401. https://doi.org/10.1016/S0277-9536(99)00390-1

Craig, M., Baker, L., Hensey, O., 2020. The National Cerebral Palsy Register. *Irish Medical Journal*, 113(8), pp 149. [Accessed 16 Jan 2025]

CSO (2022). *Census of Population 2022 – Summary Results.* [Accessed 19 Dec. 2024].

CSO (2024). *Earnings and Labour Costs Q4 2023 (Final) Q1 2024.* [Accessed 20 Dec. 2024].

Cummins, RA. (2005) Moving from the Quality of Life Concept to a Theory. *Journal of Intellectual Disability Research*, 49, pp 699-706. https://doi.org/10.1111/j.1365-2788.2005.00738.x

Daly, L., Sharek, D., DeVries, J. at al. (2015). The impact of four family support programmes for people with a disability in Ireland. *Journal of Intellectual Disability,* 19 (1), 34-50. http://doi.org/10.1177/1744629514564584

Davidson, G., Irvine, R., Corman, M., Kee, F., Kelly, B., Leavey, G., McNamee, C. (2017). *Measuring the Quality of Life of People with Disabilities and their Families: Scoping Study Final Report.* [Accessed 07 Jan. 2025].

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior.* Springer Science & Business Media. [Accessed 24 Jan. 2025].

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, 11(4), 227–268. https://doi.org/10.1207/S15327965PLI1104_01

Department of Children, Equality, Disability, Integration and Youth (2023). *Disability Action Plan 2024-2026.* [Accessed 20 Jan. 2025].

Department of Children, Equality, Disability, Integration and Youth (2022). *Supporting Parents: A National Model of Parenting Support Services*. [Accessed 07 Jan. 2025].

Department of Health (2021). *Disability Capacity Review to 2032 – A Review of Social Care Demand and Capacity Requirements to 2032.* [Accesses 13 Jan. 2025]

Dewson, S., Eccles, J., Tackey, N. D., Jackson, A. (2001). *Guide to Measuring Soft Outcomes and Distance Travelled.* [Accessed 07 Jan. 2025].

Disability Federation of Ireland (2024). *Disability in Ireland Factsheet 2024.* [Accessed 24 Jan. 2025].

Doyle, A., Carew, A. M. (2018) *Annual Report of the National Physical and Sensory Disability Database Committee 2017 Main Findings*. HRB Statistics Series 36. [Accessed 24 Jan. 2025].

Doyle, A. (2018). *Measure of Activity and Participation – The Experience of those with a Neurological condition Registered on the National Physical and Sensory Disability Database.* HRB MAP Bulletin: Issue 9. [Accessed 24 Jan. 2025].

Dumoulin, C., et al. (2023). Conservative Management of UI and POP in Adults, including neurological patients. In L. Cardozo, E. Rovner, A. Wagg, A. Wein, & P. Abrams (Eds.), *Incontinence: 7th International Consultation on Incontinence* (pp. 989-1016). ICI-ICS. International Continence Society, Bristol UK. [Accessed 20. Jan 2025].

Dunstan, D. A., Falconer, A. K., Price, I. R. (2017) The Relationship Between Hope, Social Inclusion, and Mental Wellbeing in Supported Employment. *The Australian Journal of Rehabilitation Counselling*, 23(1), pp 37-51. https://doi.org/10.1017/jrc.2017.5

Eccles, J. S., Midgley, C., Wigfield, A., Buchanan, C. M., Reuman, D., Flanagan, C., Iver, D. M. (1993) Development during adolescence. The impact of stage-environment fit on young adolescents' experiences in schools and in families. *American Psychology*, 48(2), pp 90-101. https://doi.org/10.1037/0003-066X.48.2.90

Eke, H., Ball, S., Allinson, A., et al. (2024). Interventions to improve continence for children and young people with neurodisability: a national survey of practitioner and family perspectives and experiences. *BMJ Paediatrics Open*, 8(1). https://doi.org/10.1136/bmjpo-2023-002238

Emerson, E., Fortune, N., Llewellyn, G., Stancliffe, R. (2021) Loneliness, social support, social isolation and wellbeing among working age adults with and without disability: Cross-sectional study. *Disability and Health Journal*, 14(1). https://doi.org/10.1016/j.dhjo.2020.100965

Emerson, E., Stancliffe, R.J., Aitken, Z. et al. (2023). Disability and loneliness in the United Kingdom: cross-sectional and longitudinal analyses of trends and transitions. *BMC Public Health* 23, 2537. https://doi.org/10.1186/s12889-023-17481-y

Erikson, E. H. (1968). Identity: Youth and crisis. New York: W. W. Norton & Company. [Accessed 24 Jan. 2025].

Espinosa-Salas, S. & Gonzalez-Arias, M. (2023). *Behavior modification for lifestyle improvement.* StatPearls Publishing. [Accessed 19 Jan. 2025].

EUROCAT (2024). *EUROCAT Prevalence Data*. European Commission Joint Research Centre. Last updated April 2024. Accessed 21 Jan. 2025]

European Health Parliament (2015). *Patient Empowerment and Centredness.* [Accessed 07 Jan. 2025].

Family Carers Ireland 2022. *The State of Caring.* [Accessed 07 Jan. 2025].

Franklin, J., Bruegel, I., Lister, R., Morrow, G. (2005). *Women and Social Capital.* [Accessed 07 Jan. 2025].

Fulgosi Masnjak, R., Masnjak, M., Lakovnik, V. (2012) Perceived Subjective Wellbeing of Parents of Children with Special Needs. *Journal of Special Education and Rehabilitation*, 13. https://doi.org/10.2478/v10215-011-0019-1

Galdas, P. M., Cheater, F., Marshall, P. (2005) Men and health help-seeking behaviour: literature review. *Journal of Advanced Nursing*, 49, pp 616-623. https://doi.org/10.1111/j.1365-2648.2004.03331.x

Golics, C.J., Basra, M.K., Salek, M.S., Finlay, A.Y. (2013) The impact of patients' chronic disease on family quality of life: an experience from 26 specialties. *International Journal of General Medicine,* 18;6, pp 787-98. https://doi.org/10.2147/IJGM.S45156

Gréaux, M., Moro, M.F., Kamenov, K. et al. (2023). Health equity for persons with disabilities: a global scoping review on barriers and interventions in healthcare services. *International Journal of Equity in Health*, 22, pp 236. https://doi.org/10.1186/s12939-023-02035-w

Grootens-Wiegers, P., Hein, I.M., van den Broek, J.M. et al. (2017). Medical decision-making in children and adolescents: developmental and neuroscientific aspects. *BMC Pediatrics* 17, pp 120 https://doi.org/10.1186/s12887-017-0869-x

Growing Up in Ireland (2017). *The Lives of 9-Year-Olds: Key Findings from the Growing Up in Ireland Study.* [Accessed 17 Jan. 2025].

Hackett, R. A., Steptoe, A., Lang, R. P., & Jackson, S. E. (2020). Disability discrimination and well-being in the United Kingdom: a prospective cohort study. *BMJ Open*, 10(3), e035714. https://doi.org/10.1136/bmjopen-2019-035714

Harvard Center on the Developing Child (2021). *InBrief: Understanding the Science of Motivation.* [Accessed 17 Jan. 2025]

Headway: The Brain Injury Association (2019). *Continence Problems after Brain Injury.* Effects of Brain Injury Series. [Accessed 20 Jan. 2025].

Health Service Executive (2019). *National Strategy & Policy for the Provision of Neuro-Rehabilitation Services in Ireland.* [Accessed 07 Jan. 2025].

Heiman, T. (2002). Parents of Children with Disabilities: Resilience, Coping, and Future Expectations. *Journal of Developmental and Physical Disabilities,* 14, 159–171. https://doi.org/10.1023/A:1015219514621

Herth, K. (1992). Abbreviated instrument to measure hope: development and psychometric evaluation. *Journal of Advanced Nursing*, 17(10), 1251-9. https://doi.org/10.1111/j.1365-2648.1992.tb01843.x

Hickmann, E., Richter, P., Schlieter, H. (2022). All together now – patient engagement, patient empowerment, and associated terms in personal healthcare. *BMC Health Service Research,* 22, 1116. https://doi.org/10.1186/s12913-022-08501-5

Hoang, N.T., Yakes, K., Moran, E.G., Musherure, I., et al. (2024). Hopeful Parenting: A Systematic Literature Review on Hope among Parents. *International journal of Applied Positive Psychology*, 9, pp 1563-1587. https://doi.org/10.1007/s41042-024-00181-2

Holmes, J. (2020). Gendered talk at work: Constructing social identity through workplace interaction. In Baxter, J. (Ed.), *Language and gender research across contexts*, pp. 57–82. Springer. [Accessed 07 Jan. 2025].

Hoskin C. (2010) *Eliciting the Views of Disabled Young People on Friendship and Belonging: Authentic Voices for Action Research Engaging Schools in Change Towards Inclusion*. [Accessed 07 Jan. 2025].

HSE (2018). *A National Framework for Person-Centred Planning in Services for Persons with a Disability*. [Accessed 17 Jan. 2025].

Health Service Executive (2022). *National Stroke Strategy 2022–2027*. [Accessed 21 Jan. 2025].

HSE (n.d.). Cognitive Behavioural Therapy (CBT) Services. [Accessed 19 Dec. 2024].

Indeed (updated 9th Dec 2024). Caregiver Salaries in Ireland. [Accessed 19 Dec. 2024]

Indeed (updated 8th Dec 2024). Personal Assistant Salaries in Ireland. [Accessed 19 Dec. 2024]

Institute for Quality and Efficiency in Health Care (2022). *In brief: Cognitive behavioral therapy (CBT).* [Accessed 17 Jan. 2025].

International Wheelchair Company (n.d.). Maximize your power wheelchair's lifespan: Key tips. [Accessed 19 Dec. 2024].

Irish National Audit of Stroke (2020). *National Report 2020*. [Accessed on 16 Jan. 2025]

Jaekel, A.K., et al. (2023). Urinary and Double Incontinence in Cognitively Impaired Patients: Impacts on Those Affected and Their Professional Caregivers. *Journal of Clinical Medicine*, 12(10), 3352. https://doi.org/10.3390/jcm12103352

Jeffries, M., Grogan, S. (2012). 'Oh, I'm just, you know, a little bit weak because I'm going to the doctor's': young men's talk of self-referral to primary healthcare services. *Psychology & Health*, 27(8), pp 898-915. https://doi.org/10.1080/08870446.2011.631542

Juhn, C., Rubinstein, Y., Zuppann, C. A. (2015) The Quantity-Quality Trade-off and the Formation of Cognitive and Non-cognitive Skills. *National Bureau of Economic Research, Working Papers*. https://doi.org/10.3386/w21824

Kelly, E., Maître, B. (2021). *Identification of Skills Gaps Among Persons with Disabilities and their Employment Prospects.* ESRI Survey and Statistical Report Series Number 107. [Accessed 13 Jan. 2025]

Khoshnood, B., et al. (2015). Long term trends in prevalence of neural tube defects in Europe: population based study. *BMJ*, 351. https://doi.org/10.1136/bmj.h5949

Koukourikos, K. et al. (2021). An Overview of Play Therapy. *Materia Socio-Medica*, 33(4), pp 293-297. https://doi.org/10.5455/msm.2021.33.293-297

Kovacic, T., Forkan, C., Goodspeed, T. (2022). *Exploring the Social Value and Return on Investment for the Trinity Centre for People with Intellectual Disabilities.* [Accessed 19 Dec. 2024]

Li, L.-M.-W., & Jiang, D. (2021). The Magnifying Effect of Marital Satisfaction on the Dyadic Effect of Disabilities on Life Satisfaction. *International Journal of Environmental Research and Public Health*, 18(10). https://doi.org/10.3390/ijerph18105352

Malik, F. and Marwaha, R. (2022). *Developmental stages of social emotional development in children.* Treasure Island (FL): StatPearls Publishing. [Accessed 6 Jan. 2025].

Matson, J.L., Issarraras, A. (2019). Incontinence. In: Matson, J.L. (eds) *Handbook of Intellectual Disabilities. Autism and Child Psychopathology Series*. Springer, Cham. https://doi.org/10.1007/978-3-030-20843-1_57

McDonnell, R. et al. (2018) An Audit of Neural Tube Defects in the Republic Of Ireland for 2012-2015. *Irish Medical Journal*, 111(3), 712. PMID: 30376230

McKenzie, S.K., Collings, S., Jenkin, G., & River, J. (2018). Masculinity, Social Connectedness, and Mental Health: Men's Diverse Patterns of Practice. *American Journal of Men's Health*, 12(5), pp. 1247–1261. https://doi.org/10.1177/1557988318772732

Mental Health Reform (2020). *Pre-Budget Submission 2020*. [Accessed 07 Jan. 2025].

Mental Health Reform (2021). *Pre-Budget Submission 2022*. [Accessed 07 Jan. 2025].

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change.* Guilford Press. [Accessed 07 Jan. 2025].

Mind (2019). Get it off your chest: Men's mental health 10 years on. [Accessed 07 Jan. 2025].

Moloney, C. de Bhailís, C., Kennan, D., Kealy, C., Quinlivan, S., Flynn, E., Phiri, J. (2021) *Mind the Gap: Barriers to the realisation of the rights of children with disabilities in Ireland.* Centre for Disability Law and Policy, NUI Galway.

Mosle, A., Patel, N. (2012). *Two Generations, One Future: Moving Parents and Children beyond Poverty Together. The Aspen Institute*. [Accessed 07 Jan. 2025].

Mosle, A., Sims, M. (2021) *State of the Field. Two-Generation Approaches to Family Wellbeing*. [Accessed 07 Jan. 2025].

Múries-Cantán, O., Schippers, A., Giné, C., & Blom-Yoo, H. (2022). Siblings of people with intellectual and developmental disabilities: a systematic review on their quality of life perceptions in the context of a family. *International Journal of Developmental Disabilities*, 69(6), pp 797–810. https://doi.org/10.1080/20473869.2022.2036919

Mursa, R., Patterson, C., Halcomb, E. (2022). Men's help-seeking and engagement with general practice: An integrative review. *Journal of Advanced Nursing*, 78, 1938–1953. https://doi.org/10.1111/jan.15240

Nahari, A., & Alsaleh, A. M. (2024). Impact of Social Support and Self-Efficacy on Activity of Daily Living among Post-Stroke Patients in Saudi Arabia: A Cross-Sectional Study. *Healthcare*, 12 (16), 1564. https://doi.org/10.3390/healthcare12161564

National Disability Authority (1996). *A Strategy for Equality: Summary of the Report of the Commission on the Status of People with Disabilities.* [Accessed 06 Jan. 2025]

National Disability Authority (2016). *Paper on outcomes for Disability Services*. [Accessed 07 Jan. 2025].

National Disability Authority (n.d.). Disability Overview, Legislation, UN Convention on the Rights of Persons with Disabilities. [Accessed: 07 Jan. 2024]

National Economic and Social Council (2012). *Quality and Standards in Human Services in Ireland: Disability Services.* [Accessed 07 Jan. 2025].

National Institute for Health and Care Excellence (NICE) (2021). *Shared decision-making. NICE Guideline NG204.* [Accessed 26 Nov. 2024.]

National Institute of Mental Health (n.d.). Generalized Anxiety Disorder: When Worry Gets Out of Control. [Accessed 20 Dec. 2024]

Neurological Alliance of Ireland (2020). *"Living with a Neurological Condition in Ireland." Report on the Findings of a National Survey*. [Accessed 07 Jan. 2025].

Nordin, T., Degerstedt, F., Granholm Valmari, E. (2024). A Scoping Review of Masculinity Norms and Their Interplay With Loneliness and Social Connectedness Among Men in Western Societies. *American Journal of Men's Health*, 18(6). https://doi.org/10.1177/15579883241304585

Nosek, M. A., Howland, C., Rintala, D. H., Young, M. E., & Chanpong, G. F. (2001). National study of women with physical disabilities: Final report. *Sexuality and Disability*, 19(1), pp 5–40. https://doi.org/10.1023/A:1010716820677

NHS England (2018). *Excellence in Continence Care: Practical Guidance for Commissioners, and Leaders in Health and Social Care*. [Accessed 07 Jan. 2025].

NSW Health (2021). *Falls Prevention in NSW Health Facilities: Policy Directive (PD2021_023)*. NSW Ministry of Health, Australia. [Accessed 21 Jan. 2025].

Office for National Statistics (2019). *Disability, Wellbeing and Loneliness, UK*. [Accessed 07 Jan. 2025].

Oireachtas (2021). Debate on children's disability services, Dáil Éireann, 19 October. [Accessed 13 Jan. 2025]

Oliver, M.I., Pearson, N., Coe, N., Gunnell, D. (2005) Help-seeking behaviour in men and women with common mental health problems: cross-sectional study. *British Journal of Psychiatry*, 186(4), pp 297-301. https://doi.org/10.1192/bjp.186.4.297

O'Reilly, A., Peiper, N., O'Keeffe, L., Illback, R., & Clayton, R. (2016). Performance of the CORE-10 and YP-CORE measures in a sample of youth engaging with a community mental health service. *International journal of methods in psychiatric research*, 25(4), 324–332. https://doi.org/10.1002/mpr.1500

O'Shea, E., Kennelly, B. (2008) *The economics of mental health care in Ireland*. [Accessed 07 Jan. 2025].

Pacheco Barzallo, D., Schnyder, A., Zanini, C. et al. (2024). Gender Differences in Family Caregiving. Do female caregivers do more or undertake different tasks? *BMC Health Service Research*, 24, 730. https://doi.org/10.1186/s12913-024-11191-w

Petasis, A. (2019). Discrepancies of the Medical, Social and Biopsychosocial Models of Disability; A Comprehensive Theoretical Framework. *The International Journal of Business Management and Technology*, Vol. 3 (4). [Accessed 16 Jan. 2025]

Peterson, N. & Speer, P., Mcmillan, D. (2008). Validation of a Brief Sense of Community Scale: Confirmation of the Principal Theory of Sense of Community. *Journal of Community Psychology*, 36, 61 - 73. https://doi.org/10.1002/jcop.20217

Pfeifer, J.H., Berkman, E.T. (2018). The Development of Self and Identity in Adolescence: Neural Evidence and Implications for a Value-Based Choice Perspective on Motivated Behavior. *Child Development Perspectives*, 12(3), pp 158-164. https://doi.org/10.1111/cdep.12279

Piaget, J. (1964). Cognitive Development in Children: Development and Learning. *Journal of Research in Science Teaching*, 2, pp 176-186. https://doi.org/10.1002/tea.3660020306

Piškur, B., Beurskens, A.J., Jongmans, M.J. et al. (2012). Parents' actions, challenges, and needs while enabling participation of children with a physical disability: a scoping review. *BMC Pediatrics*, 12, 177. https://doi.org/10.1186/1471-2431-12-177

Rees, G. (2017). Children's activities and time use: Variations between and within 16 countries. *Children and Youth Services Review*, 80, pp.78-87. https://doi.org/10.1016/j.childyouth.2017.06.057

Riera-Prunera, C. (2023). Diminishing Returns. In: Maggino, F. (eds) *Encyclopedia of Quality of Life and Well-Being Research*. Springer, Cham. https://doi.org/10.1007/978-3-031-17299-1_735

Russell, D.W. (1996). UCLA Loneliness Scale (Version 3): reliability, validity, and factor structure. *Journal of Personality Assessment*, 66(1), 20-40. https://doi.org/10.1207/s15327752jpa6601_2

Russell, D., Peplau, L.A., Ferguson, M.L. (1978). Developing a measure of loneliness. *Journal of Personality Assessment*, 42(3), 290-4. https://doi.org/10.1207/s15327752jpa4203_11

Ryan, C., & Quinlan, E. (2017). Whoever shouts the loudest: Listening to parents of children with disabilities. *Journal of Applied Research in Intellectual Disabilities*, 31, pp 203-214. https://doi.org/10.1111/jar.12354

Sabol, T. J., Sommer, T. E., Chase-Lansdale, P. L., & Brooks-Gunn, J. (2021). Intergenerational Economic Mobility for Low-Income Parents and Their Children: A Dual Developmental Science Framework. *Annual Review of Psychology*, 72, 265–292. https://doi.org/10.1146/annurev-psych-010419-051001

Sagar-Ouriaghli, I., Godfrey, E., Bridge, L., Meade, L., Brown, JSL. (2019) Improving Mental Health Service Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help-Seeking. *American Journal of Men's Health*, 13(3). https://doi.org/ 10.1177/1557988319857009.

Sarman, A., Tuncay, S. (2024). Problems Experienced by Families of Children with Disabilities and Nursing Approaches. In: Bennett, G., Goodall, E. (eds) *The Palgrave Encyclopedia of Disability.* Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-031-40858-8_69-1

Sashidharan SP, White R, Mezzina R, Jansen S, Gishoma D. Global mental health in high-income countries. *British Journal of Psychiatry*, 209(1), pp 3-5. https://doi.org/ 10.1192/bjp.bp.115.179556

Scope. (n.d.). The social model of disability. [Accessed 26 Nov. 2024].

Sebastian, C., Viding, E., Williams, K.D., Blakemore, S.J. (2010) Social brain development and the affective consequences of ostracism in adolescence. *Brain and Cognition*, 72(1), pp134-45. https://doi.org/10.1016/j.bandc.2009.06.008

Seff, I., Meinhart, M., Sarraf, D., et al. (2024). Women's collectives and social support: exploring pathways and impacts among forcibly displaced women. *Frontiers of Sociology*, 9. https://doi.org/10.3389/fsoc.2024.1409332

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2018). The role of masculinity in men’s help-seeking for depression: A systematic review. *Clinical Psychology Review*, 49, 106-118. https://doi.org/10.1016/j.cpr.2016.09.002

Shahali, S., Tavousi, M., Sadighi, J. et al. (2024). Health challenges faced by parents of children with disabilities: a scoping review. *BMC Pediatrics*, 24, pp 619 https://doi.org/10.1186/s12887-024-05104-3

Shiju, K.K, Sabukuttan, K., & Joy, A.T., (2023). Navigating the Path of Acceptance: Parents’ Journey towards Embracing a Disability in Their Children A Grounded Theory Perspective. *Journal of Population Therapeutics and Clinical Pharmacology*, 30(15), 132-143. https://doi.org/10.47750/jptcp.2023.30.15.015

Shin, H. & Park, C. (2023). Gender differences in social networks and physical and mental health: are social relationships more health protective in women than in men? *Frontiers in Psychology*, 14. https://doi.org/10.3389/fpsyg.2023.1216032

Sikka, P., Revonsuo, A., Gross, J. (2023). Individual differences in peace of mind reflect adaptive emotion regulation. *Personality and Individual Differences*, 215. https://doi.org/10.1016/j.paid.2023.112378

Sinclair SJ; Blais MA; Gansler DA; Sandberg E; Bistis K; LoCicero A. (2010) Psychometric properties of the Rosenberg Self-Esteem Scale: overall and across demographic groups living within the United States. *Evaluation & the Health Professions*, 33(1), 56-80 https://doi.org/10.1177/0163278709356187

Sinclair, V.G., Wallston, K.A. (2004) The development and psychometric evaluation of the Brief Resilient Coping Scale. *Assessment*, 11(1), pp. 94–101. https://doi.org/10.1177/1073191103258144

Snyder, C. R. Hope theory: Rainbows in the mind (2002). *Psychological Inquiry*, 13(4), pp 249–275. https://doi.org/10.1207/S15327965PLI1304_01

Social Value International (2021). *Standard for applying Principle 4: Only include what is material.* [Accessed 6 Jan. 2025].

Social Value Cymru (n.d.). *Social Return on investment (SROI) Evaluation Report of Dynamic After School and Summer Programme Activities*. [Accessed 07 Jan. 2025].

Soysal, P., Veronese, N., Ippoliti, S. et al. (2023). The impact of urinary incontinence on multiple health outcomes: an umbrella review of meta-analysis of observational studies. *Aging Clinical and Experimental Research*, 35, 479–495. https://doi.org/10.1007/s40520-022-02336-0

Speed, B., Goldstein, B., & Goldfried, M. (2017). Assertiveness Training: A Forgotten Evidence-Based Treatment. *Clinical Psychology: Science and Practice*, 25. https://doi.org/10.1111/cpsp.12216

Sprigle, S., McNair, D., Sonenblum, S. (2020). Pressure Ulcer Risk Factors in Persons with Mobility-Related Disabilities. *Advances in Skin & Wound Care,* 33(3), p 146-154. https://doi.org/10.1097/01.ASW.0000653152.36482.7d

Staiger, T., et al. (2020). Masculinity and Help-Seeking Among Men with Depression: A Qualitative Study. *Frontiers in Psychiatry*, 11. https://doi.org/10.3389/fpsyt.2020.599039

Sunki, K., Soyoung, Y. (2023). Men's mental health and interventions tailored to masculinity: a scoping review. *Journal of Men's Health*, 19(11), pp 1-10. https://doi.org/10.22514/jomh.2023.111

Tach, L., & Day, E. (2023). Better Together? Multiplier and Spillover Effects in Two-Generation Initiatives. *The ANNALS of the American Academy of Political and Social Science*, 706(1), 193-223. https://doi.org/10.1177/00027162231198999

Tamres, L.K., Janicki, D., Helgeson, V.S. (2002). Sex differences in coping behavior: A meta-analytic review and an examination of relative coping. *Personality and Social Psychology Review*, 6(1), 2–30. https://doi.org/10.1207/S15327957PSPR0601_1

Theodoratou, M., Farmakopoulou, I., Kougioumtzis, G., et al. (2023). Emotion-focused coping, social support and active coping among university students: Gender differences. *Journal of Clinical Psychiatry*, 14(1), 5-9. https://doi.org/10.15406/jpcpy.2023.14.00720

Tough, H., Siegrist, J., Fekete, C. (2017). Social relationships, mental health and wellbeing in physical disability: a systematic review. *BMC Public Health*. https://doi.org/10.1186/s12889-017-4308-6

Trotter, L., Rallings, Adams M.K. (2017). *Valuing improvements in mental health: Applying the wellbeing valuation method to WEMWBS*. [Accessed 07 Jan. 2025].

UK Government Disability Unit (2021). *Research and Analysis: Exploring the everyday lives of disabled people.* [Accessed 28 Nov. 2024].

UN General Assembly (1993). *Standard rules on the equalization of opportunities for persons with disabilities: resolution*. [Accessed 07 Jan. 2025].

United Nations (2006*). "Convention on the Rights of Persons with Disabilities." Treaty Series 2515.* [Accessed 07 Jan. 2025].

University Of Michigan (1999). *Low Sense of Belonging Is a Predictor of Depression.* [Accessed 07 Jan. 2025].

Vitality Group International, Inc. (2024). *The Vitality Habit Index: Quantifying habits and their impact on health.* London: Vitality Group International, Inc. [Accessed 19 Jan. 2025].

Wang, Y., et al. (2015). A randomized controlled trial of body weight–supported gait training on an automated treadmill versus overground training in subacute stroke patients. *Archives of Physical Medicine and Rehabilitation*, 96(6), 995-1001. https://doi.org/10.1016/j.apmr.2015.01.013

Watson, D., Nolan, B. (2011). *A Social Portrait of People with Disabilities in Ireland. Department of Social protection.* [Accessed 07 Jan. 2025].

The WHOQOL Group (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28(3), pp. 551–558. https://doi.org/10.1017/S0033291798006667

Wijn, A. N. de, & Doef, M. P. van der. (2022). A meta-analysis on the effectiveness of stress management interventions for nurses: capturing 14 years of research. *International Journal Of Stress Management*, 29(2), 113-129. https://doi.org/10.1037/str0000169

World Economic Forum (2024). 6 Conditions that Highlight the Women's Health Gap. [Accessed 26 Nov. 2024.]

World Health Organization (2001). *International classification of functioning, disability and health: ICF.* [Accessed 16 Jan. 2025]

World Health Organization & World Bank (2011). *World report on disability*. [Accessed 07 Jan. 2025].

World Health Organization (2022). *Global report on health equity for persons with disabilities.* [Accessed 07 Jan. 2025].

Yaffe, Y. (2024) Parental Overprotection and Locus of Control as the Mechanisms Explaining the Relationship Between Parent and Child Anxiety: A Multiple Mediation Model. *Child Psychiatry & Human Development* (2024). https://doi.org/10.1007/s10578-024-01757-4

Zallio, M., & Clarkson, P.J. (2021). Inclusion, diversity, equity and accessibility in the built environment: A study of architectural design practice. *Building and Environment*, 206. https://doi.org/10.1016/j.buildenv.2021.108352

17. Appendices

Appendix 1: Qualitative Interview Discussion Guide – Client Theory of Change Defining as part of preceding SROI Forecast (Assured in 2022)

Intro
Thank you for making the time to speak to me. We're very grateful to you for giving your time to help us understand what impact Crann is having and make it even more impactful for the future.

This interview will explore what you feel you got out of attending [service(s)] at Crann.

Some of the things I ask you to think about or do might feel a bit unfamiliar, that's ok. There's no such thing as "getting it right" in this interview, so just answer as best you can based on your experience. If anything feels confusing or doesn't make sense to you, please do ask questions. Don't be afraid to ask me to explain anything. The most important thing is for you to feel comfortable, so if you don't want to answer something just let me know.

Everything you share will be confidential and only used for this specific project, combined with everyone else's experience and treated anonymously.

The interview will take around 45 minutes. Are you ready to begin?

Outcomes experienced
Thinking about how you felt, your behaviours and what you thought before you attended [service(s)] compared to where you're at now, what would you say the outcomes of having attended [service(s)] were for you?
Probe:

- What impact did that outcome have on your life?
- How did you feel because of that outcome?
- Did achieving that outcome mean you could do anything that you couldn't do before?

<u>Prompt for outcomes:</u>

- Circumstance
- Behaviour
- Capacity
- Awareness
- Attitude

And did you experience any negative outcomes or changes from attending [service(s)] at Crann?

Do you think there's a difference between accessing this service at Crann vs. somewhere else?

Amount of change, attribution, deadweight
<u>For each outcome participant has talked about:</u>
Thinking about [outcome] specifically, you experienced a [reduction/increase/improvement]. Before you attended [service] what rating would you have given yourself for that on a scale of 1-10? And what about now?

- Moderator to adjust wording according to outcome
- Example: outcome = reduced anxiety; before attending anxiety was a 9/10, now it is a 5/10

How long do you expect that change to last?

Of that change, how much do you think was down to [service]?
- Was there anything else that could have contributed to that change?
- Are you attending any other services that are relevant to this change?
- Have you had any support in the past that you think helped you experience this level of change this time? E.g. previous education/ training, an existing routine or behaviour?

If Crann didn't exist, what do you think would have happened?
- Would you have sought out the same or a similar service elsewhere? If so, where?
- Would any of the outcomes have occurred of their own accord?

What other service, product or experience could have helped you to achieve the same change?
- Do you think you would have experienced the same amount of change from that service, product or experience?

Relative importance/ value
If you had to rank each of the outcomes you experienced in order of how valuable they were to you, from most valuable to least valuable, what order would you put them in?

<u>Assigning monetary value:</u>
1. In the following scenario, I want you to imagine that you don't have any budgetary constraints, you have plenty of money available to you.
2. Start with the least valuable outcome: If I told you I could give you [outcome] in exchange for money, how much would you pay to have that outcome for one year without having to do anything?
3. Then value most valuable outcome
4. Then value mid outcome
5. For each outcome between the valued points: How much more valuable is this outcome than the one below it? E.g. in %, times more, etc.

<u>If above methodology isn't working:</u>
1. What three material things do you want, one very expensive, one middling and one lower end? E.g. a new car (~€20K), a luxury holiday for the family (~€7K), a new smart TV (~€500)
2. Moderator to put chosen items in the chat so participant can see them
3. Starting with lowest value outcome: do you want this outcome more or less than you want [lowest value object]? [mid value object]? [highest value object]?
4. How much more?
5. Moderator to suggest value based on amount more than material object

**Moderator to run through and confirm values for each outcome before moving on

Suggestions for improvement
Do you have any suggestions for ways that the service(s) you attended and overall service at Crann could be improved?

Additional probing questions [to be applied where relevant]
[If outcomes discussed fit within wellbeing]
Would you say that your general wellbeing has improved since attending [service(s)]?
What about your mental wellbeing?

- In what way(s) would you say this has changed?

Social Capital:
[Below questions based on identifying loneliness and integration indicators, based on scientific research review]

Do you ever feel excluded or separated from others in your community/ school/ work etc.
If yes:

- How does that feel?
- Has your experience at Crann impacted those feelings in any way?

Before you attended [service(s)] would you say you ever felt lonely?

- How about now?

Do you feel like you've found friends and/or a community here?

[For parents who express child has found community/ inclusion/ similar only]
Do you notice any impact on you yourself because your child has found this at Crann?

Continence/ Podiatry
Before attending the Continence Clinic/ Podiatry, had you seen anyone else re: continence/ podiatry?

- How did you find that interaction? Probe: comfort levels, information, support, trust/confidence
- How did Crann compare?

What, if anything, do you feel you can do now that you couldn't do before, or can do differently now that your [issue] is better managed?

What, if any, impact has attending the continence clinic had on your/ your child's overall health?

Has attending Crann changed how you view your/ your child's continence management at all?

- If so, how?

[Below questions for parents]
To what extent would you have said your child's continence management was a burden or a challenge in your own life prior to attending Crann?

- What if anything did it prevent your child from doing?
- What if anything did it prevent you yourself, or the family unit from doing?
- Has that improved at all? If so, how?

Appendix 2: Quantitative Survey – Validating Theory of Change and quantifying change as part of preceding SROI Forecast (Assured in 2022)

[SINGLE SELECT – THREE SEPARATE QUESTIONS]
Q1. Which programmes/ services have you or your child attended at Crann in the past 12 months?
This includes both online and in-person

Q1a. Psychological wellbeing
- a. A moment for me
- b. Counselling
- c. Play Therapy
- d. Sibshops
- e. Growing in Confidence
- f. None of these

Q1b. Social Capital
- a. Chat and connect
- b. Drama for kids
- c. Drama for adults
- d. Parents' Café
- e. None of these

Q1c. Health and continence
- a. Continence clinic
- b. Podiatry clinic
- c. None of these

[SINGLE SELECT MATRIX – THREE SEPARATE]
[Piped answers from Q1]
Q2. How long did you/ your child attend those programmes/ services for?
Psychological wellbeing

	1 month or less	1-2 months	2-3 months	3-6 months	6-9 months	9-12 months	12 months or more
A moment for me							
Counselling							
Play Therapy							
Sibshops							
Growing in Confidence							

Social Capital

	1 month or less	1-2 months	2-3 months	3-6 months	6-9 months	9-12 months	12 months or more
Chat and connect							
Drama for kids							

Drama for adults							
Parents’ Café							

Health and continence

	1 month or less	1-2 months	2-3 months	3-6 months	6-9 months	9-12 months	12 months or more
Continence clinic							
Podiatry clinic							

[SINGLE SELECT MATRIX]
[If a. or b. at Q1.]
[Piped from Q1.]
Q3. Who attended the clinic?

	Myself (18+)	Myself (under 18)	My child (18+)	My child (under 18)
Continence clinic				
Podiatry clinic				

[If not f. at Q1a.]
Psychological Wellbeing Outcomes

[PRESENTATION TEXT]
The following questions relate only to the programmes/ services you and/or your child have attended within the Psychological Wellbeing services at Crann.

All of the questions relate to the experience and outcomes for the person who attended the programmes / service only.

You’ve stated that you or your child attended the following:
[List of programmes piped from Psychological Wellbeing answers on Q1]

[SINGLE SELECT MATRIX]
[Piped from Q1.]
Q4. How much of a change did the person who attended the programmes /services (i.e. you or your child) experience in relation to each of the below?

	No change	A small change	A medium change	A large change
Increased social inclusion, support and community				
Increased confidence and motivation				
Improved mental wellbeing				
Improved ability to cope with challenges				

[RANKING]
[Pipe answers from Q4. – medium and large change only (materiality)]
Q5. What order of importance do the changes go in?
1 represents the most important

If you’re answering on behalf of your child, please think about how valuable the change was for <u>them</u> when considering your answer

a. Increased social inclusion, support and community
b. Increased confidence and motivation
c. Improved mental wellbeing
d. Improved ability to cope with challenges

[PRESENTATION TEXT]
For each change that you have experienced, think about what it’s given you in your life, what you can do now that you couldn’t do before, what you feel or no longer feel.

In the next question, you’re going to be asked to assign a monetary value to the change you’ve experienced. Think about what a <u>reasonable and fair</u> amount of money for that change would be, and what you would <u>realistically</u> pay to achieve this change.

<u>Please note, this is not a cost for the service you have attended, but a value for the change you have achieved.</u>

[SLIDER]
[Pipe answers from Q4. – medium and large change only (materiality)]
Q6. What would the person who attended (i.e. you or your child) realistically pay to achieve each of the changes they experienced?
If you’re answering on behalf of your child, please think about how valuable the change was for <u>them</u> when considering your answer
[Scale €1-€10,000]

a. Increased social inclusion, support and community
b. Increased confidence and motivation
c. Improved mental wellbeing
d. Improved ability to cope with challenges

[SINGLE SELECT – FOUR SEPARATE]
[Pipe answers from Q4. – medium and large change only (materiality)]
Q7. Which of the services listed below do you think would help the person who attended the programmes / services (i.e. you or your child) to achieve the same amount of change as experienced by attending them?
Increased social inclusion, support and community

a. Attending an event on a topic you are interested in
b. Having a weekly coffee with friends
c. Becoming a member of a club, e.g. sports, hobbies, etc.
d. Weekly support group/ group therapy

Increased confidence and motivation

a. A new haircut
b. Online course on building assertiveness and self-confidence
c. Learning a new skill through a class or course
d. Biweekly 1:1 life and confidence coaching

Improved mental wellbeing

a. Half-day mindfulness and meditation workshop
b. 6 sessions of online cognitive behavioural therapy
c. Biweekly support group
d. Biweekly 1:1 therapy

Improved ability to cope with challenges

  a. Half-day mindfulness and meditation workshop
  b. Online stress-management course
  c. Biweekly support group
  d. Biweekly 1:1 therapy

[SLIDER]
[Pipe answers from Q4. – medium and large change only (materiality)]
Q8. How much would you say the programmes / services were responsible for the changes they (i.e. you or your child) experienced?
On a scale of 0-100%, where 100% is completely responsible
[Scale 0-100]

  a. Increased social inclusion, support and community
  b. Increased confidence and motivation
  c. Improved mental wellbeing
  d. Improved ability to cope with challenges

[SLIDER]
[Pipe answers from Q4. – medium and large change only (materiality)]
Q9. And how much of the change would have happened anyway if Crann programmes / services weren't available?
On a scale of 0-100%, where 100% is the whole change
[Scale 0-100]

  a. Increased social inclusion, support and community
  b. Increased confidence and motivation
  c. Improved mental wellbeing
  d. Improved ability to cope with challenges

[OPEN TEXT]
[If Q9 any answer option is less than 100]
[Pipe answers from Q4. – medium and large change only (materiality)]
Q10. What/ who else was responsible for that change?
Increased social inclusion, support and community

Increased confidence and motivation

Improved mental wellbeing

Improved ability to cope with challenges

[SINGLE SELECT MATRIX]
[Pipe answers from Q4. – medium and large change only (materiality)]
Q11. How long do you think the changes the person who attended programmes / services (i.e. you or your child) experienced will last?

	1 year or less	1-2 years	2-3 years	3-5 years	More than 5 years
Increased social inclusion, support and community					
Increased confidence and motivation					
Improved mental wellbeing					
Improved ability to cope with challenges					

[OPEN TEXT]
Q12. Has the person who attended the programmes / services (i.e. you or your child) experienced any other changes not covered by the ones we've asked about so far, from the Psychological Wellbeing services specifically?
These might be positive or negative changes

[OPEN TEXT]
Q13. Thinking about other people in your/ your child's life, e.g. family, colleagues, SNAs, teachers, friends, etc., do you think anyone else has experienced their own changes because of your/ your child's attendance?

Think about their own changes, e.g. they are more relaxed, their mood has improved, etc.

Please state who and what change(s) they have experienced in the box below.

[If not e. at Q1b.]
Social Capital Outcomes
[PRESENTATION TEXT]
The following questions relate only to the programmes/ services you and/or your child have attended within the Social Capital services at Crann.

All of the questions relate to the experience and outcomes for the person who attended the programmes/ service only.

You've stated that you or your child attended the following:
[List of programmes piped from Social Capital answers on Q1]

[SINGLE SELECT MATRIX]
[Piped from Q1.]
Q14. How much of a change did the person who attended the programmes/services (i.e. you or your child) experience in relation to each of the below?

	No change	A small change	A medium change	A large change
Increased social inclusion, support and community				
Increased confidence				
Improved independence				

Improved ability to cope with challenges				

[RANKING]
[Pipe answers from Q14. – medium and large change only (materiality)]
Q15. What order of importance do the changes go in?
1 represents the most important
If you're answering on behalf of your child, please think about how valuable the change was for them when considering your answer

a. Increased social inclusion, support and community
b. Increased confidence
c. Improved independence
d. Improved ability to cope with challenges

[PRESENTATION TEXT]
For each change that you have experienced, think about what it's given you in your life, what you can do now that you couldn't do before, what you feel or no longer feel.

In the next question, you're going to be asked to assign a monetary value to the change you've experienced. Think about what a reasonable and fair amount of money for that change would be, and what you would realistically pay to achieve this change.

Please note, this is not a cost for the service you have attended, but a value for the change you have achieved.

[SLIDER]
[Pipe answers from Q14. – medium and large change only (materiality)]
Q16. What would you realistically pay to achieve each of the changes you/ your child experienced?
If you're answering on behalf of your child, please think about how valuable the change was for them when considering your answer
[Scale €1-€10,000]

a. Increased social inclusion, support and community
b. Increased confidence
c. Improved independence
d. Improved ability to cope with challenges

[SINGLE SELECT – FOUR SEPARATE]
[Pipe answers from Q14. – medium and large change only (materiality)]
Q17. Which of the services listed below do you think would help the person who attended the programmes/ services (i.e. you or your child) to achieve the same amount of change as experienced by attending?
Increased social inclusion, support and community

a. Attending an event on a topic you are interested in
b. Having a weekly coffee with friends
c. Becoming a member of a club, e.g. sports, hobbies, etc.
d. Weekly support group/ group therapy

Increased confidence

a. A new haircut
b. Online course on building your self-esteem
c. Learning a new skill through a class or course

   d. Biweekly 1:1 life and confidence coaching

Improved independence
   a. Half-day independence workshop
   b. Going out with a friend or family member who isn't a primary carer once a month
   c. Weekly class or workshop attended without parent or carer
   d. Biweekly support group/ group therapy

Improved ability to cope with challenges
   a. Half-day mindfulness and meditation workshop
   b. Online stress-management course
   c. Biweekly support group
   d. Biweekly 1:1 therapy

[SLIDER]
[Pipe answers from Q14. – medium and large change only (materiality)]
Q18. How much would you say the programmes/ services attended were responsible for the changes they (i.e. you or your child) experienced?
On a scale of 0-100%, where 100% is completely responsible
[Scale 0-100]
   a. Increased social inclusion, support and community
   b. Increased confidence
   c. Improved independence
   d. Improved ability to cope with challenges

[SLIDER]
[Pipe answers from Q14. – medium and large change only (materiality)]
Q19. And how much of the change would have happened anyway if Crann programmes/ services weren't available?
On a scale of 0-100%, where 100% is the whole change
[Scale 0-100]
   a. Increased social inclusion, support and community
   b. Increased confidence
   c. Improved independence
   d. Improved ability to cope with challenges

[OPEN TEXT]
[If Q19 any answer option is less than 100]
[Pipe answers from Q14. – medium and large change only (materiality)]
Q20. What/ who else was responsible for that change?

Increased social inclusion, support and community

Increased confidence

Improved independence

Improved ability to cope with challenges

[SINGLE SELECT MATRIX]
[Pipe answers from Q14. – medium and large change only (materiality)]
Q21. How long do you think the changes experienced will last?

	1 year or less	1-2 years	2-3 years	3-5 years	More than 5 years
Increased social inclusion, support and community					
Increased confidence					
Improved independence					
Improved ability to cope with challenges					

[OPEN TEXT]
Q22. Has the person who attended the programmes/ services (i.e. you or your child) experienced any other changes not covered by the ones we've asked about so far, from the Social Capital programmes/ services specifically?
These might be positive or negative changes

[OPEN TEXT]
Q23. Thinking about other people in your/ your child's life, e.g. family, colleagues, SNAs, teachers, friends, etc., do you think anyone else has experienced their own changes because of your/ your child's attendance?

Think about their own changes, e.g. they are more relaxed, their mood has improved, etc.

Please state who and what change(s) they have experienced in the box below.

[If not c. at Q1c.]
Health and Continence Outcomes
[PRESENTATION TEXT]
The following questions relate only to the programmes/services you and/or your child have attended within the Health and Continence services at Crann.

All of the questions relate to the experience and outcomes for the person who attended the programme/ service only.

You've stated that you or your child attended the following:
[List of themes piped from Health and Continence answers on Q1]

[SINGLE SELECT MATRIX]
[Piped from Q1.]
Q24. How much of a change did the person who attended the programmes/services experience in relation to each of the below?

	No change	A small change	A medium change	A large change

Improved ability to participate in activities and day-to-day life				
Increased sense of freedom				
Improved physical wellbeing				
Improved peace of mind and confidence				
Feelings of empowerment and inclusion in the service provided				

[OPEN TEXT]
[If a. b. or d. at Q24.]
Q24b. You've said they (i.e. you or your child) experienced improved ability to participate in activities and day-to-day life as well as an increased sense of freedom and improved peace of mind and confidence. Can you tell us in your own words, what the overall impact of those three changes has been in their (i.e. your or your child's) life?

[RANKING]
[Pipe answers from Q24. – medium and large change only (materiality)]
Q25. What order of importance do the changes go in?
1 represents the most important
If you're answering on behalf of your child, please think about how valuable the change was for <u>them</u> when considering your answer

a. Improved ability to participate in activities and day-to-day life
b. Increased sense of freedom
c. Improved physical wellbeing
d. Improved peace of mind and confidence
e. Feelings of empowerment and inclusion in the service

[PRESENTATION TEXT]
For each change that you have experienced, think about what it's given you in your life, what you can do now that you couldn't do before, what you feel or no longer feel.

In the next question, you're going to be asked to assign a monetary value to the change you've experienced. Think about what a <u>reasonable and fair</u> amount of money for that change would be, and what you would <u>realistically</u> pay to achieve this change.

<u>Please note, this is not a cost for the service you have attended, but a value for the change you have achieved.</u>

[SLIDER]
[Pipe answers from Q24. – medium and large change only (materiality)]
Q26. What would the person who attended programmes/ services (i.e. you/ your child) realistically pay to achieve each of the changes they experienced?
If you're answering on behalf of your child, please think about how valuable the change was for <u>them</u> when considering your answer
[Scale €1-€10,000]

a. Improved ability to participate in activities and day-to-day life
b. Increased sense of freedom
c. Improved physical wellbeing
d. Improved peace of mind and confidence

e. Feelings of empowerment and inclusion in the service

[SINGLE SELECT – FIVE SEPARATE]
[Pipe answers from Q24. – medium and large change only (materiality)]
Q27. Which of the services listed below do you think would help the person who attended programmes/services (i.e. you/ your child) to achieve the same amount of change as experienced by attending?
Improved ability to participate in activities and day-to-day life

a. A day out at the seaside
b. Attending a group activity twice per month
c. Becoming a member of a club, e.g., sports, hobbies, etc.
d. A personal assistant to support you for 3.5 hours per week

Increased sense of freedom

a. A day out with friends or family
b. A weekend away in Ireland
c. €20 in taxi costs per week
d. A personal assistant to support you for 3.5 hours per week

Improved physical wellbeing

a. One month of accessible gym classes
b. Six visits from a private nurse re: health issues
c. Nutrition support from an expert
d. Monthly consultation with a relevant healthcare expert

Improved peace of mind and confidence

a. Half-day mindfulness and meditation workshop
b. Online course on building your self-esteem
c. Biweekly support group
d. Biweekly 1:1 therapy

Feelings of empowerment and inclusion in the service

a. Attending an interactive workshop on a topic you’re passionate about
b. Joining Toastmasters public speaking club, and travel to and from the biweekly meetings
c. Learning a new skill through a class or course
d. Biweekly 1:1 life and confidence coaching

[SLIDER]
[Pipe answers from Q24. – medium and large change only (materiality)]
Q28. How much would you say the programmes/ services attended were responsible for the changes you experienced?
On a scale of 0-100%, where 100% is completely responsible
[Scale 0-100]

a. Improved ability to participate in activities and day-to-day life
b. Increased sense of freedom
c. Improved physical wellbeing
d. Improved peace of mind and confidence
e. Feelings of empowerment and inclusion in the service

[SLIDER]

[Pipe answers from Q24. – medium and large change only (materiality)]
Q29. And how much of the change would have happened anyway if Crann programmes / services weren't available?
On a scale of 0-100%, where 100% is the whole change
[Scale 0-100]

a. Improved ability to participate in activities and day-to-day life
b. Increased sense of freedom
c. Improved physical wellbeing
d. Improved peace of mind and confidence
e. Feelings of empowerment and inclusion in the service

[OPEN TEXT]
[If Q29 any answer option is less than 100]
[Pipe answers from Q24. – medium and large change only (materiality)]
Q30. What/ who else was responsible for that change?
Improved ability to participate in activities and day-to-day life

Increased sense of freedom

Improved physical wellbeing

Improved peace of mind and confidence

Feelings of empowerment and inclusion in the service

[SINGLE SELECT MATRIX]
[Pipe answers from Q24. – medium and large change only (materiality)]
Q31. How long do you think the changes experienced will last?

	1 year or less	1-2 years	2-3 years	3-5 years	More than 5 years
Improved ability to participate in activities and day-to-day life					
Increased sense of freedom					
Improved physical wellbeing					
Improved peace of mind and confidence					
Feelings of empowerment and inclusion in the service					

[OPEN TEXT]
Q32. Has the person who attended the programmes / services (i.e. you or your child) experienced any other changes not covered by the ones we've asked about so far, from the Health and Continence programmes / services specifically?
These might be positive or negative changes

[OPEN TEXT]
Q33. Thinking about other people in your/ your child's life, e.g. family, colleagues, SNAs, teachers, friends, etc., do you think anyone else has experienced their own changes because of your/ your child's attendance?

Think about their own changes, e.g. they are more relaxed, their mood has improved, etc.

Please state who and what change(s) they have experienced in the box below.

Personal Support and Connection outcomes
[PRESENTATION TEXT]
During research interviews, some people reported having experienced a change due to engaging with Crann outside of programmes/ services, e.g. from speaking to the team, visiting the centre, meeting people in the lobby area etc.

[SINGLE SELECT MATRIX]
[Piped from Q1.]
Q34. Thinking about your experience of Crann outside of the specific programmes / services you or your child have attended, how much of a change did the person who engaged with Crann experience in relation to each of the below?

	No change	A small change	A medium change	A large change
Increased social inclusion, support and community				
Increased acceptance and feeling accommodated				
Reduced loneliness				
Increased hope for the future				

[RANKING]
[Pipe answers from Q34. – medium and large change only (materiality)]
Q35. What order of importance do the changes go in?
1 represents the most important
If you're answering on behalf of your child, please think about how valuable the change was for them when considering your answer

a. Increased social inclusion, support and community
b. Increased acceptance and feeling accommodated
c. Reduced loneliness
d. Increased hope for the future

[PRESENTATION TEXT]
For each change that you have experienced, think about what it's given you in your life, what you can do now that you couldn't do before, what you feel or no longer feel.

In the next question, you're going to be asked to assign a monetary value to the change you've experienced. Think about what a reasonable and fair amount of money for that change would be, and what you would realistically pay to achieve this change.

Please note, this is not a cost for the service you have attended, but a value for the change you have achieved.

[SLIDER]
[Pipe answers from Q34. – medium and large change only (materiality)]
Q36. What would the person who attended (i.e. you or your child) realistically pay to achieve each of the changes they experienced?
If you're answering on behalf of your child, please think about how valuable the change was for them when considering your answer
[Scale €1-€10,000]

- a. Increased social inclusion, support and community
- b. Increased acceptance and feeling accommodated
- c. Reduced loneliness
- d. Increased hope for the future

[SINGLE SELECT – FOUR SEPARATE]
[Pipe answers from Q34. – medium and large change only (materiality)]
Q37. Which of the services listed below do you think would help the person who attended programmes/ services (i.e. you or your child) to achieve the same amount of change as experienced by attending?
Increased social inclusion, support and community

- a. Attending an event on a topic you are interested in
- b. Having a weekly coffee with friends
- c. Becoming a member of a club, e.g., sports, hobbies, etc.
- d. Weekly support group/ group therapy

Increased acceptance and feeling accommodated

- a. A day out with friends or family
- b. Going out with a friend or family member who isn't a primary carer once a month
- c. Becoming a member of a club, e.g., sports, hobbies, etc.
- d. Weekly support group/ group therapy

Reduced loneliness

- a. A day out with friends or family
- b. Having a weekly coffee with friends
- c. Becoming a member of a club, e.g., sports, hobbies, etc.
- d. Weekly support group/ group therapy

Increased hope for the future

- a. Half-day vision board workshop
- b. Monthly support group
- c. Learning a new skill through a class or course
- d. Biweekly 1:1 therapy

[SLIDER]
[Pipe answers from Q34. – medium and large change only (materiality)]
Q38. How much would you say that Crann was responsible for the changes you experienced?
On a scale of 0-100%, where 100% is completely responsible
[Scale 0-100]

- a. Increased social inclusion, support and community

b. Increased acceptance and feeling accommodated
c. Reduced loneliness
d. Increased hope for the future

[SLIDER]
[Pipe answers from Q34. – medium and large change only (materiality)]
Q39. And how much of the change would have happened anyway if Crann programmes / services weren't available?
On a scale of 0-100%, where 100% is the whole change
[Scale 0-100]

a. Increased social inclusion, support and community
b. Increased acceptance and feeling accommodated
c. Reduced loneliness
d. Increased hope for the future

[OPEN TEXT]
[If Q29 any answer option is less than 100]
[Pipe answers from Q34. – medium and large change only (materiality)]
Q40. What/ who else was responsible for that change?

Increased social inclusion, support and community

Increased acceptance and feeling accommodated

Reduced loneliness

Increased hope for the future

[SINGLE SELECT MATRIX]
[Pipe answers from Q34. – medium and large change only (materiality)]
Q41. How long do you think the changes experienced will last?

	1 year or less	1-2 years	2-3 years	3-5 years	More than 5 years
Increased social inclusion, support and community					
Increased acceptance and feeling accommodated					
Reduced loneliness					
Increased hope for the future					

[OPEN TEXT]
Q42. Has the person who attended the programmes / services (i.e. you or your child) experienced any other changes not covered by the ones we've asked about so far, from your engagement with Crann outside of specific programmes?
These might be positive or negative changes

[OPEN TEXT]
Q43. Thinking about other people in your/ your child's life, e.g. family, colleagues, SNAs, teachers, friends, etc., do you think anyone else has experienced their own changes because of your/ your child's engagement with Crann outside of specific programmes?

Think about their own changes, e.g. they are more relaxed, their mood has improved, etc.

Please state who and what change(s) they have experienced in the box below.

Appendix 3: Qualitative Insight and Quotes that Informed Final Outcomes

This appendix contains an overview of the qualitative insights that informed the development of the Theories of Change and final outcomes during the preceding SROI Forecast (Assured in 2022).

10.1 Psychological Wellbeing Outcomes

10.1.1 Improved mental wellbeing

Described most frequently as feeling calmer and/or happier, feeling more like themselves than they did before attending, having a new desire to take care of themselves both mentally and physically, learning to express difficult emotions and be comfortable sharing emotions with others.

- "[Sibling of a child with a disability] is definitely much more at ease since the play therapy. He would have been a very happy go lucky child and then during Covid we kind of started to see he looked a bit anxious and worried, an awful lot more than most kids at that stage. He wasn't himself at all, you could see it, you just knew there was something on his mind all the time. So, we went and had a chat with [play therapist], and you could see after maybe the third session, he was starting to relax a bit more. Through the play therapy we also discovered what the root of it all was for him. I don't think he'd be the way he is now if it wasn't for the play therapy." – Parent as proxy for sibling of a child with a disability
- "You can't share that stuff with other people because they don't get it, and it's hard. Sometimes you just need to be able to laugh about it, that's how you cope, and I could do that in the group because I knew the other parents got it too." – Parent of an adult with a disability
- "I didn't feel like myself at the time. I was just broken. I was so stuck, and I didn't know how to come back from that. I felt lonely and none of my friends understand, and I had to give up work when [child with a disability] was born, and I'm a career person so that's a huge thing. Then going to the [A Moment for Me service] and having the other women who were experiencing what I was, it was like a cloud being lifted. It made me think differently." – Parent of a child with a disability

10.1.2 Increased confidence and motivation

Described by adults with disabilities and parents as a sense of belonging and validation created by sharing their experiences with others who understood. By overcoming worries and challenges, their self-confidence was increased by a sense that they could cope more effectively. This also gave many clients the motivation to take better care of themselves, and to try to connect more frequently with others in a similar position to them. For children, self-confidence increased due to being listened to and supported and learning that they could rely on the Crann staff and services to support them. Children experienced motivation to become more independent and take on small tasks at home or school, and to share their feelings more.

- "I've gained a lot of weight because I've been so stressed, and unhappy, and just focusing on being mum to [child] and it's me that does most of the caring for him as my [partner] works. After the counselling I really had a new outlook and I'm eating better and exercising again, probably for the first time since [child] was born." – Parent of a child with a disability
- "[Child has their] entrance exams for secondary school soon, and [they're] such an anxious child that we just didn't tell [them], but someone let it slip at school and [they were] panicking. But [they] went for a session with [play therapist] that week and [play therapist] really put [them] at ease about it, so [they] feel much better about the exams now. [They] might still get anxious when it comes around, but [they] feel more confident coming up to it at least." – Parent as proxy for a child with a disability
- "I went to Counselling, and it really just started me on a journey. I'm now prioritising my own health, I exercise now. And just like knowing that's ok to do as well, if I take time for myself, it actually benefits everyone else, so that's my motivation now to take better care of me." – Parent of a child with a disability
- "Child with a disability] had the opportunity to spend time with kids more like her and see what they were up to as well. It highlighted an independence to her. She came out of a few sessions, and she came down the lift on her own, which never would've happened before. She was saying 'I'll do that

myself' about small things, and I think they may have asked on the course whether the kids would make their own lunch if they were hungry, and I know she wouldn't… she'd sit on the chair and ask me to get it for her. This particular day and said she'd help with the lunch." - Parent as proxy for a child with a disability

10.1.3 Improved ability to cope with challenges

The challenges reported by SROI participants were varied, including feeling unlike themselves, struggling to get on top of things, not having a support system that understood their unique challenges and not giving themselves time to reflect or process. They reported that Crann's Psychological Wellbeing Services provided them with space to reflect and process, and to share their feelings and challenges. Most didn't have a space for this in their daily life before attending Crann. In addition, most clients who engaged in Psychological Wellbeing Services felt that they gained tools and resources to help them continue to manage challenges on their own after the end of the service they engaged with.

- "You'd feel so alone sometimes when there's an issue, because your friends whose kids don't have a disability wouldn't necessarily have experienced that thing before, and you don't want to share stuff like that either really. But you can talk about those things in the group, and almost always, someone else has been there and can help you and give you advice." – Parent of a child with a disability
- "[Child] asks questions in advance now about what an experience was going to be like for [them]. It's like [they] think more about how things might impact [them] in the future too." – Parent as proxy for sibling of a child with a disability
- "I suppose it makes you look at life and look at myself rather than rushing and racing. It did make me take a moment and reflect on things for myself. It has had such a positive impact on my life because it helped me to look at all these things and appreciate what I have, and it gave me some tools that stayed with me. I confess, I'm not mindfully colouring every week or anything, but I did start walking and even simple things like taking myself off for a cup of coffee. I make more of an effort for myself and now I realise that happiness is in the small things." - Parent of a child with a disability
- "We'd be saying to [child with a disability], you know you don't need to worry about this. She'd be crying and we'd be trying to comfort her and things like that, but I think she needs someone outside of our little bubble. Someone outside of the family unit to help her learn to manage. She knows we're always here for her, but just for her to see it from the perspective of someone else was so helpful." - Parent as proxy for a child with a disability

10.1.4 Increase in social inclusion, support, and community

Described as engaging with peers with whom they shared experiences, challenges, and feelings, and through this recognising that they are not alone (group services were included in the SROI Forecast). Even for clients who engaged in a one-to-one service, this outcome was present as they felt supported by the expert they engaged with and felt invited into the community at Crann through that service.

- "It's so good for [them] to have someone outside of our own little bubble, to talk to and who cares about [them] and listens to [them]. And I think [they're] more likely to listen to [play therapist] and take it on board than [they] are with us." – Parent as proxy of a child with a disability
- "We're still in touch; we have a little WhatsApp group, and we all met for a coffee since the end of the programme. It's actually so nice because it's harder than you'd think to meet other parents of children with disabilities and even the parents you would know, you're usually just bumping into each other in the consultants' office." – Parent of a child with a disability
- "[They] wouldn't really know any other kids with a sibling with a disability and I don't think [they] really notice it yet, [they're] too young, but [they] came out of the session with some new language about disability, so they clearly all connected on that and were talking about it. It's nice to know [they have] peers in there." – Parent as proxy for sibling of a child with a disability
- "You'd have to commend them, because I don't know of anywhere else offering stuff for the family, and it is challenging to be the person living with someone with a disability sometimes. It's not easy and unless you have a child with a disability, you don't really know what it's like. Nobody can explain it to you. It's a constant worry, if it's not a medical issue, you're worried about something else. A

Moment for Me was good craic because you met other people who were in the same boat as you, and you could say what you wanted. You have to be able to make light of it too sometimes and in the context of my peers at Crann I can make fun of the challenges, but in other contexts you can't do that." - Parent of an adult with a disability

10.2 Community and Networks Outcomes

10.2.1 Increase in independence (clients with disabilities only)

Described children with disabilities being able to attend services alone without a parent or carer. It is also linked to being involved in a group with others of varying levels of independence and ability and being inspired and motivated by what others can do or recognising their own abilities through interaction with others. For adults with disabilities, this outcome was created through relationship building with peers. Many respondents were very reliant on direct family for their social interaction prior to attending. Having their own social network and a support system outside of the family unit created feelings of independence for adults with disabilities.

- "[They'd] never been anywhere without one of us really, but we're not allowed to go into drama with [them], which was good for us all honestly. [They] love heading off into the class without us and having that time for [themselves]. It's definitely given [them] more independence." – Parent as proxy for a child with a disability
- "I wouldn't really have had anyone to talk to outside of my family before, but now I can talk to the Chat and Connect group if I have a problem or a worry. It's nice to have friends of my own. I didn't really have that after I finished school." – Adult with a disability
- "Because there are all sorts of kids in the group, different ages, different disabilities…[they] hadn't really experienced that before, [they] usually only mix with kids [their] own age, or even younger, because of [their] disability [they're] often put into groups with the younger children. At Crann [they] got to see older children and teenagers with disabilities and see all the things they were able to do. It's been really helpful to push [them] forward with what they can do [themselves]." – Parent as proxy for a child with a disability
- "Whenever [child with a disability] was involved in things before, they always asked me to stay with her, because they were nervous of having her on their own because she's pre-verbal, so communication can be an issue. At Crann, she goes in there on her own with all her peers and I'm outside. And then she comes out when it's all finished, and you know she's had a great time with all her buddies. Really, it's the sense of independence and the growth and confidence that it's given her." - Parent as proxy for a child with a disability

10.2.2 Improved ability to cope with challenges

Described as becoming more well-equipped to deal with challenges because of having the opportunity to share them with peers who understood and often had similar experiences and offered solutions and support. This support made clients feel that they could deal with things better when a challenge arises.

- "You can talk about anything you want in the group. Sometimes someone is having trouble with something, and they can ask the group for advice. We're likeminded people and have some of the same experiences and can help each other." – Adult with a disability
- There are other parents in the group whose child might be older or they're further on their journey, and that's amazing and so helpful. It can be really lonely and confusing and it's hard to find the right information, but someone else in the group might say, "did you know you're entitled to this support" or "have you contacted this place for services" and that's information you wouldn't have otherwise. So, you sort of feel like things are easier to deal with, when you have these other parents in your corner." – Parent of a child with a disability
- "We talk about things that we might find difficult as a wheelchair user, things we might have to take into consideration if for example we were going travelling or like during the storms talking about what if the electricity goes out and how that impacts hoists and stuff like that. Like you couldn't have those conversations really with someone who wasn't in a wheelchair as they wouldn't understand." – Adult with a disability

10.2.3 Increase in social inclusion, support, and community

Described by all participants as being related mostly to spending time with peers who understood them. This was true across all client types, regardless of age or whether they had a disability. Most clients, both with and without a disability, did not have an existing network of peers who shared similar experiences before engaging with Crann Social Capital Services. This was described as “isolating,” “lonely,” and “difficult” by many participants. Since engaging with Crann’s Social Capital Services most clients felt they had found a space where they belonged, they could share openly and be authentic, and many felt that they had built lasting relationships that would continue to make them feel included and supported even if they stopped attending Social Capital Services at Crann.

- “Sure, I never met any of these people before, until Parents’ Café. I think I met [parent] and [parent] at the Christmas Party actually, but other than that I didn’t know anyone. And now they’re like my family. No joke, I tell them things before I tell anyone else, they’re the first people I ask when I need advice or help, other people just don’t get it like they do. It really is a family here.” – Parent of a child with a disability
- “Seeing [them] heading off in with [their] buddies, and [they’re] always so happy to go, [they] look forward to drama every week, to see the gang and [teacher] too. [They’re] the only wheelchair user in school, so [they] love being in a group of people like [them] and having the craic.” – Parent as proxy for a child with a disability
- “I widened my friendship group and I got to meet people from other parts of the country who I would never have met before, so there was a social aspect. Like-minded people could get together and discuss what was on our minds or what we were interested in. I probably was lacking that before.” – Adult with a disability

10.2.4 Increased confidence

Related to spending time in a group environment with peers and becoming more comfortable and confident speaking about their experiences and expressing opinions to those peers. This applied to all client types and was described in the same way by both clients with disabilities and parents. The confidence they gained through speaking about their experiences in a group also helped them to be more comfortable speaking up in other environments, e.g., at school, medical appointments, at home and in other group settings.

- “It’s actually made [them] bossier! [They’ll] tell [sibling] now that [they] don’t want to play a particular game and want to do something else. In the past [sibling] would’ve always dictated what they were doing together and [child with a disability] would’ve gone along with it, I think just happy [their sibling] wanted to play with [them], but not anymore.” – Parent as proxy for a child with a disability
- “I don’t feel half as isolated as I used to. And it’s probably built up my confidence too, you know from a social point of view. All the people I’ve met have been very welcoming and friendly and you do build up a relationship with them… Sometimes I’d get nervous when talking to someone if I haven’t met them before or if they’re relatively new to me. But I think when I’m talking to another wheelchair user I don’t feel as nervous because I know that they exactly understand where I’m coming from.” – Adult with a disability
- “I’m more confident in talking with people, especially people I didn’t know before. It was a small bit scary at the start. In school I would have had some people to chat with, but when I left school, I wouldn’t. I’ll speak up now, I was kind of shy…I kind of still am but I suppose it’s given me confidence to kind of get onto the people I don’t know.” – Adult with a disability
- “She’s kind of blossomed with those friendships and also because of the drama group and the way it’s been set up. It’s enabled her to make friends and friends with people that are slightly older than her. It was good to see her meet these people and it kind of pushed her. Like she knows she’ll be able to do things like they can when she’s older and you know, to see people moving on with their disability themselves.” – Parent as proxy for child with a disability

10.3 Health and Continence Outcomes

10.3.1 Empowerment and involvement in the service

Prior to engaging with Crann's Health and Continence Services, many clients had attended a service elsewhere. It was reported by the majority of clients surveyed that their previous experiences left them feeling a sense of disempowerment and not being consulted or fully aware of their choice in the course of treatment they were receiving. At Crann, clients felt that they were put at the centre of all consultations and treatments. For many, this was the first time they had experienced this. It was described as empowering, because they were consulted about their choices and made aware that they could withdraw consent at any time.

- "Crann is so much nicer than the doctor. They're not at all pushy, it's very much a case of try this out and see how you get on. Then they'll constantly check in and make sure everything is going ok for you. You feel like a team, they're so reliable and actually want to know if you're not getting on ok. You'd lose hope relying on people honestly, but they're always there." – Adult with a disability
- "They're research-based, client-based and person-centred. Honestly, it's so important. You feel like you're partners. As people with disabilities, we're always having to settle, always feeling like Oliver Twist if we have to ask for something, but at Crann I feel I can ask for what I need and they'll do everything they can to give me that, because we're a team and they're genuinely trying to meet people's needs and working with the service users." – Adult with a disability
- "She went to see [podiatrist] and she totally put [child with a disability] at ease. She explained that she'd go very slowly and she kept telling her 'you know, you're in control here, you tell me if I'm doing too much or if I'm hurting you. You tell me and I'll stop straight away.' And then [child] was very comfortable letting her do what she needed to do that day, despite being so nervous and scared to go in there because of the last experience. We've been back three times since and now [child] can chat away during the session." – Parent as proxy for child with a disability

10.3.2 Improved physical wellbeing

Described by most as having finally found a solution to their issue and experiencing an overall improvement in their physical wellbeing. It was described by others as finding new solutions to issues they thought had already been solved elsewhere but have since realised those solutions were not fit for purpose and were negatively impacting their overall physical wellbeing.

- "The bowel routine used to take us hours! [They'd] have to sit there for hours, and it was really uncomfortable, and [they] hated it, so [they'd] scream and cry the whole way through…for hours. It was awful. I had to stay with "them" for the whole thing. But now it's over so quickly, it's no issue, no tears, nothing. The stress of it before, [they] used to nearly make [themselves] sick with the crying." – Parent as proxy for a child with a disability
- "It's this kind of constant pain and discomfort, and because of Covid, it went on and on, I never really managed to get it looked at. If I went to the GP, I'd have to be taking off all my compression stockings and everything, and they never have time for that. So, I just put up with it, and hoped it wasn't anything too serious. But the podiatrist sorted it right out, no pain!" – Adult with a disability
- "I could say to [child with a disability] every day, 'how's your toe today?', because I'm looking at it and it looks awful, and she'd say, 'oh no, it's fine' and she'd go about her business. It could've bled one day, and she'd still say it was fine. Then coming back in the car after the podiatry appointment she says to me, 'that feels a lot better now.' Despite telling me it was fine before, straight away she obviously got relief from it." – Parent as proxy for child with a disability
- "We switched to a system called Peristeen and it's so effective. It gives you a better quality of life. Previously I had to take loads of medications for my bowel management, and that's time consuming and it makes your bowel programme unpredictable. And for me, taking a tonne of medications makes me feel unwell, like I don't feel good. So, to be able to have [Crann staff member] say something else would work, to be taught to use it and to have the atmosphere be such that you feel totally comfortable asking questions, that was really great." – Adult with a disability

10.3.3 Improved ability to participate in activities and day-to-day life

Many clients described how their issues were causing them to miss out on activities and sometimes caused them to be unable to go about their daily life. In the case of podiatry, ambulant or semi-ambulatory clients described being unable to maintain their usual level of mobility due to pain. In the case of continence, for clients who were experiencing acute symptoms or had a continence-management routine in place that was not working effectively, they were often immobilised by pain or discomfort, or a toileting routine that took hours every day to complete. By finding sustainable and effective solutions and management routines, these clients were able to participate in activities and daily life without concern for their continence.

- "We went to a family event recently, and [they] were able to just enjoy the day; we all were. No one had to think about changing [them] and [they] didn't have to stop playing or feel embarrassed to be taken off for that in the middle of it. [They] made it all the way through without an accident or anything. I don't think we ever thought we'd be there." – Parent as proxy for a child with a disability
- "I was becoming more and more unwell with it, and it's impossible to continue as normal when you feel so sick. After that trip to the GP, I knew I needed someone else to help me get better so I could get back to normal." – Adult with a disability
- "I feel confident about being able to stay here in Ireland now. I can live my life here now I know I have [Crann staff member] on my team if I need her. I've always wanted to live in Ireland, and when I arrived and all this kicked off, I felt like I might have to go back, because I couldn't get the medical care I needed. But now I have it." – Adult with a disability
- "Beforehand I would've had [child with a disability] out of school, resting, because she feels she needs to be involved in everything, even when she can't really partake like the other children. She wasn't really able to be on it properly without making it worse. But since she got the bit of intervention from podiatry, she's happier in herself now and heading off to school this morning." – Parent as proxy for a child with a disability

10.3.4 Increased sense of freedom

Described as occurring because a solution had been found for clients' continence or podiatry-related issue, depending on which service they had attended. Due to that solution, they were better able to move around freely, travel further from home, and most importantly in many cases, to not think about their issue anymore. Freedom in this outcome describes both physical and mental freedom. Being able to go about their day without interruption because of continence management or pain in their feet allows clients to feel free.

- "I live alone, I can drive myself, I do have a home help who comes to get me showered and dressed in the mornings, because that's so important for your wellbeing, you know? But after the kidney stone got caught in the catheter, I was in so much pain and discomfort, I had a fever, I couldn't get out of my bed for anything. Being able to call [staff] and get that support to get it sorted – [they were] truly so helpful and even followed up with the consultant for me to get me in there quicker – then I was back to myself again and I'm free to do as I please again now." – Adult with a disability
- "I don't know what would've happened [without Crann], honestly. No one even ever had a conversation with us about it. We found Crann ourselves, and it's been life changing. We don't even have to think about changing or whether there's an accessible bathroom anymore!" – Parent as proxy for a child with a disability
- "I'm excited that I don't have to go through the same thing for the rest of my life. It's head wrecking to be stuck doing the same thing even though it isn't working for you. I could be multiple times a day, and I run my own business so I have to plan things around it and knowing I could be ages trying to sort it out, and what if I'm late for a client then. I'll be free now to work my day, see my clients, knowing I won't have to rush into the bathroom in between appointments." – Adult with a disability
- "The toe has been throbbing for the last six or eight months, and then within a week or two of having it done, my toe is back to normal! The relief of knowing it was just a broken toenail, not a fungal infection or anything like that and like just with ease and without pain, she removed it. I didn't come home with a big bandage on my foot, the whole procedure was done very professionally and no major drama and then I could just get on with it again." – adult with a disability

10.3.5 Improved peace of mind and confidence

many clients reported that their struggle with continence issues created feelings of stress and in some cases embarrassment, and for many it led to low self-confidence. Through finding solutions and receiving individual person-centred treatment at Crann, many were able to overcome those feelings of stress and low confidence. These feelings of peace of mind and confidence also applied to the service itself. For many, their experience of trying to access services for continence management and podiatry treatment before engaging with Crann's Health and Continence services had been at best inconsistent and at worst, damaging. Attending Health and Continence services at Crann was described as easy and comfortable. The accessible space was a big factor for many clients, and the person-centred approach helped even the most anxious children to overcome their fears of engaging in health-focused services after previous bad experiences.

- "I was able to call [staff] when the public health nurse couldn't manage something for me, because that's her specialty, and she knows. And if she doesn't, she can go to the urology team in the hospital for me and get further information. Then she's very prompt to come back and relay all the information that is required. Her service is invaluable." – Adult with a disability
- "We had been to a podiatrist before and [child with a disability] would not go back! [They] came home almost in more pain than they went in with. It took some convincing to get [them] into [podiatrist] at Crann, but now [they] head in with no issue at all. [They'd] be a very anxious child, but [they] don't even get worried now about going." – Parent as proxy for a child with a disability
- "I started to become unwell as a result of having significant bowel issues that I'd never had before. I tried to go through my GP, but that process was awful, and they didn't listen to me. So, I was getting sicker and sicker, and I was afraid I'd end up in the emergency room and I'd heard such horror stories, as it was during the pandemic. And then I found the Continence Clinic at Crann, and it was just an amazing experience. [Crann staff member] was so knowledgeable, I actually felt like they were listening to me, that we were working together on a problem, and they understood my lifestyle and how I wanted to live. It gave me that confidence that they would be the person who could help me here." – adult with a disability

10.4 Personal Support and Connection

10.4.1 Increased social inclusion, support, and community

Clients reported that they lacked a sense of community around their experience as a person with a disability or a parent to a person with a disability. This was due to not knowing many people in situations like their own. Adults with disabilities often described having lost their connection with others outside of the family unit once they left school, and not having found a replacement environment in which to forge new connections with others who they felt understood them. Clients who experienced this outcome described Crann as a community, and a place in which they had forged connections with the Crann staff, who also felt like community and a support network. Many described how they felt understood and supported by individual members of the team and praised their ability to create a sense of community on-site.

- "It's a big change because we'd never have been in the community set ups or meet ups…When we switched over to Enable, there wasn't any community. It felt like we were never really being given the opportunity to be part of a community anywhere." – Parent of a child with a disability
- "I love it, it's a really happy place to be, it's comfortable, it's really homely. It's similar to other organisations, but less clinical. It's a community! I'm not saying that they don't have clinical expertise, but it's a lovely environment." – Adult with a disability
- "I've made a lot of friends at the Crann Centre, and I've built up a relationship with the staff too in a really positive way. I feel that, when I started communicating with the staff at the Crann Centre, I found I got to know them a lot more but what I also found was that I felt I could talk to them about anything." – Adult with a disability
- "It was my first impression of Crann, and I thought, oh my god they understand, and they care…It was the first place as well where if someone says they're going to do something, you can put it out of your head because they are actually going to do it! There's no chasing of any kind. It saves you so much time and stress and worry, which is so important when you have a child with additional needs." – Parent of a child with a disability

10.4.2 Increased feelings of acceptance and being accommodated

Described predominantly in relation to other services clients had accessed elsewhere. In many cases, respondents described feeling “like just another number” when accessing services at other organisations and explained how they could not engage with the expert, practitioner, or consultant from those services, except during their specified appointment times. Some parents also reported not being able to access services because their child has a rare condition or has not yet received a formal diagnosis. Parents who described this situation often felt excluded from services. Clients described how engaging with Crann’s Personal Support and Connection Service, made them feel welcomed, as if nothing they asked was too much trouble, and they often felt that staff went above and beyond to accommodate them.

- “[As child’s mother, the impact of that was] it was so welcoming, it felt absolutely great, the fact that they welcomed us and the family in and there was that acceptance…everything’s under control, take a bit of space, take some time for yourself. You were at peace of mind that you knew [child with a disability] was in a good place and around good people.” – Parent of a child with a disability
- “[Staff] was so good to follow up every so often and let me know another Moment for Me was running and to see if I had time to do it.” – Parent of a child with a disability
- “We never had a smooth path with [child], we were always being told ‘you can’t stay here,’ ‘you have to go there,’ ‘there isn’t space for you,’ etc. so we faced an awful lot of almost rejection, begging to be let in somewhere, and then you’re almost like ‘oh god, thank you so much for having me!’ So, with Crann it was much more nurturing and supportive and it’s like ‘we’re here, welcome. What can we do?’” – Parent of a child with a disability
- “It was absolutely an amazing experience. What I found beneficial about it is that it was done on the phone or Zoom. I could’ve chosen to do it in person, but I was living remotely…the fact I didn’t have to go to the centre was really amazing. As a person with a disability, I feel that we are always having to traipse ourselves everywhere…so that was a real benefit.” – Adult with a disability

10.4.3 Increased hope for the future

described as relating to a knowledge that the Crann team would be there to support the family, and especially the person with a disability, for as long as is needed. For adults with disabilities, the security of knowing Crann will support them on an ongoing basis and not sign them off once a specific service has been delivered was described as being highly valuable. The additional support offered through the Personal Support and Connection Service reassured parents of all the ways Crann would support them and their child on an ongoing basis. This was enough to create hope for that parent, where there had previously been a sense of panic about the future.

- “I love that about Crann, you don’t just do the course, they kind of say to [adult with a disability], “would you be interested in giving a course?”. [They] love that because it gives [them] great self-esteem and [they] can see that [they] can help people too. It’s the same with the voluntary work. It gives [them] a sense of worth and a belief that [they] can help people in the future too. It’s about the feeling that [they’re] helping kids that went through what [they] went through. [They’d] have loved to have that as a kid. That’s the best thing we’ve got out of it.” – Parent of an adult with a disability
- “You never have to fight. You feel that you have someone in your corner, and they have your child and your family’s interests at heart. It’s the whole family; no matter what happens with the child in the future, it impacts the whole family.” – Parent of a child with a disability
- “Adult client] was at a loose end in between courses and everything, and it was great, I called [staff member] for support…I suppose it was more emotional support for me as well and she said, ‘we’re here for all [adult client’s] adult life,’ and she spoke to [adult client] too, and just even to know that was fantastic. I knew he would be taken care of.” – Parent of an adult with a disability
- “I know if in the future there’s any issues for [sibling] because I always worry about what the effect [child with a disability’s] condition has on him. It’s amazing to know that support is there too if it’s ever needed. Not only for [child with a disability], but for [sibling] too.” – Parent of a child with a disability

10.4.4 Reduced loneliness

Described as feeling lonely prior to engaging, either due to having a disability and not having peers to connect with, or due to being a parent to a child (of any age) with a disability and feeling that parents of children without disabilities did not understand their experiences. Both groups often felt that they couldn't share their experiences, struggles or wins, because others wouldn't understand or be able to support them, and this made them feel alone. Through engaging with Crann's Personal Support and Connection service, respondents felt they had found someone that they could share these experiences with, who understood and had the capacity to offer them reassurance and support.

- "I think it's the people that work there. I know [partner] has had a lot of contact with the people that work there, more so than I have, and I've always heard [them] say they're very open and it's like a community. You know if you ring, you're going to get someone who will talk to you…with other services, you could ring, you could email, you may be lucky enough to get something back but you're not holding out any hope." – Parent of a child with a disability
- "Obviously [other organisation] were incredible, but to be fair to them, they're a service for [adult with a disability] not me. Even though, if I rang any of them concerned about [them], they would be so kind to me obviously but ultimately my main goal is [them] and they would meet [their] medical and physical needs and they're so important as [they're] growing up…it's a whole range of services for [them], which is great, but that is their role…I wouldn't really be in touch with any service for me." – Parent of an adult with a disability
- "They were just so lovely, and I suppose I felt in a safe emotional space, when I went in it was very relaxing and I felt everyone felt the same sense of a nice safe space. I suppose in general in life I would be guarded but unless I feel very comfortable in a situation I wouldn't let the guard down, but I most definitely did there." – Parent of an adult with a disability

10.5 Outcomes for parents of children and adults attending in-scope services

10.5.1 Increased sense of comfort in leaving their child to attend services alone

Parents frequently expressed hesitancy and worry about leaving their children unattended in most service contexts outside of Crann, and in many cases the child had never been left to attend any service or activity alone without the parent. However, most parents agreed that they do not feel this sense of discomfort or worry about leaving their child alone to attend services at Crann. Some parents who had never left their child alone to attend anything before now delight in sending them off to their sessions at Crann, and do not give it another thought until they collect them. This increased sense of comfort, compared to how they feel in other service contexts, is credited to the Crann staff and the centre itself.

- "You'd just be more comfortable to go away and leave [them] to go into the class on their own. I don't think I ever felt that anywhere else, like I'd always have to be there in case." – Parent of a child with a disability
- "Sometimes [they] dribble on [themselves] but I have no qualms that the staff would help clean [them] up a bit and say nothing about it. It's nice to know [they] can be happy and comfortable here and get that bit of independence to do something without me too." – Parent of a child with a disability
- "You'd actually feel comfortable leaving them at Crann. Like for drama, [child with a disability] heads in on his own, not even a backwards glance, and that feels amazing as a parent to be able to do that. Like in other activities, you just wouldn't feel comfortable about could the teacher handle him if there was something he needed, would they be able to help him with the bathroom, things like that. But you know at Crann, there's never any issue and everyone here is so experienced you'd have no fear." – Parent of a child with a disability

10.5.2 Sense of community and connection with other parents

many parents shared the challenges they faced in building lasting connections with peers who truly understood their experiences. There was a strong consensus that having these connections was invaluable for gaining guidance, empathy, and practical support. Through their children's attendance at Crann services, many parents have forged these connections with other parents whose children are attending the same sessions.

Parents often take the time before and after a session to meet in the lobby of the building or spend time speaking with each other while they wait in the carpark during a session.

- “I’ve made some of my closest friends here. I actually really missed the drop-off and pick-up chats during Covid, and then even when things opened up a bit of course we couldn’t all sit or stand inside having the chat while we waited because there’s so many of us. Some days you’d be stood out in the car park getting the news in the freezing cold even.” – Parent of a child with a disability
- “We’re a proper little community. Everyone looks out for everyone else and would help you with anything. Even for all our differences, we’ve got a common goal.” – Parent of an adult with a disability
- “It really is like a family here. You’d meet the same parents at drop off and pick up, and you’d get chatting and over the years we’ve become really close. Like I’d go to some of the parents I’ve met through Crann before anyone else if we were struggling with something or needed advice. We might never have met otherwise, but we’re a real community.” – Parent of a child with a disability

10.5.3 Relief about their child or children achieving their own outcomes

Relief was directly tied to observing their child or children achieving meaningful outcomes. Parents emphasised that while all parents worry about their children, this worry is significantly heightened for those with a child with a disability, due to additional concerns about their child’s social life, psychological wellbeing, long-term health, independence, and safety. For many parents, seeing their child progress through Crann’s services provided a profound sense of relief; a reassurance that their child could thrive in their own way with the right support.

- “I guess relief would be the overwhelming feeling. Just to see [them] thriving and achieving so much. Especially to see the friendships and know [they’re] happy here.” – Parent of a child with a disability
- “Honestly, [child with a disability] has come such a long way since we found Crann and that just makes me feel so relieved.” – Parent of a child with a disability
- “You’d just be so happy to see them progressing and gaining the bit of independence. It really feels like a relief, like you didn’t realise you were holding your breath until you breathed out.” – Parent of a child with a disability

Appendix 4: ToC Validation Groups Discussion Guide

Intro

- MRS and accreditation
- Project: to understand your experience of coming to Crann so we can make Crann even better
- If you don't want to answer a question, that's no problem, just let me know

Q1. How do you find attending [service] at Crann?
Probe: do you feel comfortable, is it enjoyable, hard, helpful, etc.

Q2. Do you think anything changed for you after you started coming to [service] at Crann?
Probe: did you feel different after you attended than you felt before? Could you do anything different after you attended than you could before?

Moderator to indicate and read through printed feeling cards on the table/ wall
Q3. Which ones of these feelings would you associate most with how you felt after coming to [service]? You can choose as many as you like

- Feelings/experiences from relevant Theory of Change were displayed for participants to browse
  - Example: I felt cared for, I felt supported, I felt included, I felt safe, etc.

Q3b. Are there any feelings that you had that were not represented here?
Probe: Were there any negative feelings you experienced?

Q4. Last year, we talked to some other clients of [service], and they told us about some of the changes they experienced. We'd like to know what you think about those changes in relation to your own experience.

It's important to remember that everyone's experience is different, so maybe none of these apply to you, or some do, and some don't, that's completely valid. We want to know about your own experience.

Moderator to introduce each outcome

- Do you feel this applies to you?

For outcomes experienced, moderator to work through Q5-Q8 for each one
Q5. How would you describe the change?

Q6. Can you tell me how big or small this change felt to you?

Q7. Of that change, how much do you think was directly because of [service]?

Q8. Would you use any different words to name the change that make more sense for you?
Probe: Some outcomes had specific words identified for validation and these were probed here, e.g. "self-esteem instead of confidence," "manage instead of cope with"

Q9. How important were these changes to you? How do they compare to each other in terms of importance?
Probe: Can you put them in order?

Q10. Can you think of anyone or anything that may have experienced a negative impact, or experienced less of a positive impact because of [service]?
Probe: for example, were there resources used here that would mean someone else couldn't access support, or did people stop using another service in Cork because they were coming to Crann?

Personal Support and Connection ToC – relevant for teens and adults with disabilities and parents who had attended a service

Q1. When you come into the Crann Centre, do you ever have a chat with some of the staff here? Or do you ever speak to any of the staff on the phone?

Q1. How would you describe the experience of engaging with the Crann staff outside of the services you attend?
Probe: do you feel comfortable, do you feel that they care, do you feel part of a community, do you get follow ups and check ins promptly

Q2. Do you think anything changed for you or how you felt after you came to the Crann Centre and had support from the staff?
Probe: did you feel different after you attended than you felt before? Could you do anything different after you attended than you could before?

[Moderator to indicate and read through printed feeling cards on the table/ wall]
Q3. Which of these feelings would you associate most with how you feel about the support from the Crann staff, outside of specific services? You can choose as many as you like

- I feel cared for and respected
- I trust the staff at Crann
- I feel welcome and part of a community at Crann
- I feel that my needs are accommodated by the staff at Crann
- I feel safe and comfortable at the Crann Centre
- I can ask questions and get additional support from staff when I need it
- I trust that I will receive follow ups and check ins from staff when they are due
- I have more hope for the future because of the staff at Crann
- I have someone I can turn to when I'm struggling because of the staff at Crann

Q3b. Are there any feelings that you had that were not represented here?
Probe: Were there any negative feelings you experienced?

Q4. Last year, we talked to some Crann clients who had engaged with the Crann staff outside of the services that they attended, and they told us about some of the changes they experienced. We'd like to know if you feel like those changes are things you also experienced.

It's important to remember that everyone's experience is different, so maybe none of these apply to you, or some do, and some don't, that's completely valid. We want to know about your own experience.

Moderator to introduce each outcome

- Do you feel this applies to you?

For outcomes experienced, moderator to work through Q5 & Q6 for each one

Q5. How would you describe the change?

Q6. Can you tell me how big or small this change felt to you?

Q7. Of that change, how much do you think was directly because of [service]?

Q8. Would you use any different words to name the change that make more sense for you?
Probe:

- Accommodated à cared for/ prioritised
- Hope for the future à belief in support
- Loneliness à Isolation

Q9. How important were these changes to you? How do they compare to each other in terms of importance?
Probe: Can you put them in order?

Q10. Can you think of anyone or anything that may have experienced a negative impact, or experienced less of a positive impact because of [service]?
Probe: for example, were there resources used here that would mean someone else couldn’t access support, or did people stop using another service in Cork because they were coming to Crann?

Appendix 5: Outcome Measurement Surveys

The below surveys are outline versions for each theme. A separate survey following this outline was produced for each service included in the analysis, to ensure that the specific service attended by the respondent was named in each relevant question and in some cases, language was simplified to support children in responding to questions. A full set of surveys can be provided on request.

Psychological Wellbeing Survey

Intro

We are currently undertaking a research study to understand the value of Crann's services. The study is called the Social Return on Investment (SROI), and it can only be successful with the participation of Crann clients.

- The survey should take around 10-15 minutes to complete.
- It's your choice whether you participate or not. Your decision will not affect your ability to access services.
- You will not be asked to share any personal details.
- Your answers are completely anonymous & stored in a secure database.
- Your response will only be used for research completed by the Crann Centre.
- All anonymous responses will be analysed by an independent researcher, not the Crann team.

Should any of the questions cause you upset, please link in with Crann's client and family liaison team [contact provided here].

If you are agreeable to participate, please click the Start button below.

Alternatively, if you would like support filling out the form, speak to [Research Lead Contact info here] to arrange a time to speak.

[Separate page]

This survey is related to a Psychological Wellbeing service and may contain questions or topics that could evoke an emotional response or discomfort. Remember, you can withdraw at any time if you do not wish to proceed. If you find yourself feeling overwhelmed or in need of further support while participating, please know that you can contact our client family liaison team for assistance.

[contact provided]

Your wellbeing is important to us, and we are here to help.

Q1. Are you currently attending [service]?

a. I am about to start attending [service]
b. I am currently attending [service]
c. I am no longer attending [service]

If no longer attending

Q1b. How long ago did you stop attending [service]?

a. Less than 6 months ago
b. 6-12 months ago

   c. More than 12 months ago

Those who have attended counselling already
Q2. Approximately how many sessions have you attended?
[Relevant session brackets listed]

Q3. Are you?
   a. A parent of a person with a disability
   b. An adult with a disability (18+)
   c. A teen with a disability (13-17)
   d. A partner of a person with a disability
   e. A sibling of a person with a disability

Q4. What is your gender?
   a. Man
   b. Woman
   c. Non-binary
   d. Other
   e. Prefer not to say

Q5. How old are you?
[drop down]

Parents only
Q6. How old is your child with a disability?
[drop down]

Q7. What diagnosis do you/ your child have in relation to their disability?
   a. Spina Bifida
   b. Hydrocephalus
   c. Cerebral Palsy
   d. Muscular Dystrophy
   e. Osteogenesis Imperfecta
   f. Arthrogryposis
   g. Spinal Muscular Atrophy
   h. Spinal Cord Injury
   i. Stroke
   j. Multiple Sclerosis
   k. Spinal Muscular Atrophy
   l. Other (specify)

Improved mental wellbeing
Q8. Below are 10 statements about how you have been feeling OVER THE LAST WEEK. Please read each statement and think how often you felt that way in the last week. Then tick the box which is closest to this.

This question uses a validated tool called CORE-10.
5-POINT SCALE: Not at all; Only occasionally; Sometimes; Often; Most or all of the time
If a. or b. at Q3. – parents and adults with disabilities
   a. I have felt tense anxious or nervous
   b. I have felt I have someone to turn to for support when needed

c. I have felt able to cope when things go wrong
d. Talking to people has felt too much for me
e. I have had difficulty getting to sleep or staying asleep
f. I have felt unhappy
g. Unwanted images or memories have been distressing me

If c. at Q3. – teens with disabilities

a. I have felt edgy or nervous
b. I haven't felt like talking to anyone
c. I've felt able to cope when things go wrong
d. There's been someone I felt able to ask for help
e. My thoughts and feelings distressed me
f. It's been hard to go to sleep or stay asleep
g. I've felt unhappy
h. I've done all the things I wanted to

Post-intervention

Q9. Based on your experience of attending [service], do you think that your mental wellbeing improved?

a. No change
b. A small change
c. A medium change
d. A large change

Increased confidence and motivation

Q10. The statements below relate to feelings of confidence and motivation.
Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.

4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

a. I am able to share my thoughts and opinions with others
b. I feel confident to attend a group
c. I am motivated to take action on my personal goals
d. I know who I am and what matters to me
e. I feel capable and able to live my life fully
f. I feel that I am becoming more independent (if b. or c. at Q3. – people with disabilities only)

SLIDING SCALE: 0-10+

Q11. How many times have you done something just for you in the past 2 weeks? e.g. gone to a class, taken time for yourself, gone for a walk, gone out with a friend, read a book for enjoyment, etc.

Post-intervention

Q12. Based on your experience of attending [service], do you think you have more confidence and motivation now?

a. No change
b. A small change
c. A medium change
d. A large change

Improved ability to manage challenges

Q13. The statements below relate to dealing with difficult situations.

Please read each statement and think how much each one describes your behaviour and actions.
Then tick the box which is closest to this.

This question uses a validated tool called the Brief Resilience Coping Scale.
5-POINT SCALE: Does not describe me at all; does not describe me; neutral; describes me; describes me very well
If a. or b. at Q3.

a. I look for creative ways to alter difficult situations
b. Regardless of what happens to me, I believe I can control my reaction to it
c. I believe I can grow in positive ways by dealing with difficult situations
d. I actively look for ways to replace the losses I encounter in life

All

a. I can approach a challenging situation calmly
b. I ask for help and support or share my feelings with others when I am facing a challenge
c. I have self-compassion in challenging times
d. I am satisfied with my support system
e. I take time to reflect on things and process them after something challenging happens

Q14. How often would you say you’ve felt stressed/overwhelmed in the last 2 weeks?

a. Every day
b. Most days
c. A couple of times a week
d. Once a week
e. Less than once a week
f. Never

Post-intervention
Q15. Based on your experience of attending [service], do you think you are more able to manage challenges now?

a. No change
b. A small change
c. A medium change
d. A large change

Increase in support, community, and social inclusion
Q16. The statements below relate to feelings of support and community.
Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.
4-POINT SCALE: strongly disagree; disagree; agree; strongly agree
If a. or b. at Q3.

a. I am part of a community that helps me fulfil my needs
b. I belong in a community
c. I have a say about what goes on in my community
d. I feel connected to a community of like-minded people
e. I have a good bond with others in my community

All

a. I have people to share my feelings and challenges with
b. I am satisfied with my support system
c. I have all the support that I need

d. I am satisfied with the level of social interaction I have currently
e. I feel that I am part of a community

Post-intervention

Q17. Based on your experience of attending [service], do you think you feel more…

	More supported	More part of a community	More socially included
No change			
A small change			
A medium change			
A large change			

Post-intervention

Q18. Have you experienced any change because of attending [service] that we have not included in this survey that you'd like to tell us about? This can be a positive or not positive change.

Post-intervention

Q19. Do you think that anyone else has experienced any change of their own because you have attended [service] at Crann?

a. No
b. Yes, my child or children
c. Yes, my partner
d. Yes, other (please specify)

Those who think others have experienced change

Q20. What change or changes do you think they have experienced?

[Outro]

Many thanks for your response. If you found yourself feeling overwhelmed or in need of further support while participating in this survey, please know that you can contact our client family liaison team for assistance.
[contact provided]

Your wellbeing is important to us, and we are here to help.

Social Capital Survey*

*The decision was taken to engage continuing clients of Social Capital services in the evaluation through a retrospective pre-intervention survey and a standard post-intervention survey. The two services included in the SROI evaluation under the Social Capital theme are ongoing services and both have very low attrition rates and spaces for new clients do not open regularly. To ensure that the sample size would be sufficient to analyse, regardless of the potentially very small number of new clients for whom value was generated, existing clients had to be engaged. Value has only been counted for new clients during the SROI period.

Intro

We are currently undertaking a research study to understand the value of Crann's services. The study is called the Social Return on Investment (SROI), and it can only be successful with the participation of Crann clients.

- The survey should take around 10-15 minutes to complete.
- It's your choice whether you participate or not. Your decision will not affect your ability to access services.
- You will not be asked to share any personal details.
- Your answers are completely anonymous & stored in a secure database.
- Your response will only be used for research completed by the Crann Centre.
- All anonymous responses will be analysed by an independent researcher, not the Crann team.

If your child is attending, this survey is designed to be completed by yourself and your child, together. If possible, please support your child to answer the questions for themselves.

If you are agreeable to participate, please click the Start button below.

Alternatively, if you would like support filling out the form, speak to [research lead contact] to arrange a time to speak.

Q1a. Are you currently going to [service]?
d. I am about to start going to [service]
e. I am currently going to [service]
f. I am no longer going to [service]

No longer attending
Q1b. How long ago did you stop attending [service]?
a. Less than 6 months ago
b. 6-12 months ago
c. More than 12 months ago

Q1c. Approximately how long have you been going to [service]?
a. I have only been once
b. Less than 3 months
c. 3 to 6 months
d. 6 months to 1 year
e. 1 to 2 years
f. More than 2 years

Currently attending
Q1d. Have you previously filled in this survey about [service]?
You would have received the invite to participate around 6 months ago. Even if you have completed it before, we'd love your input.
a. Yes
b. No
c. I'm not sure

Q2. Are you?
f. An adult (18+)
g. A teen (13-18)
h. A child (0-12)

Q3. How old are you?

[drop down]

Q4. What is your gender?

- Boy / Man
- Girl / Woman
- Non-binary
- Other
- Prefer not to say

Q5. What diagnosis do you have in relation to your disability?

m. Spina Bifida
n. Hydrocephalus
o. Cerebral Palsy
p. Muscular Dystrophy
q. Osteogenesis Imperfecta
r. Arthrogryposis
s. Spinal Muscular Atrophy
t. Spinal Cord Injury
u. Stroke
v. Multiple Sclerosis
w. Spinal Muscular Atrophy
x. Other (specify)

Retrospective pre-attendance
[Text presentation]
All of the questions from this point on are about how you felt before you started coming to [service]. If you've been attending [service] for some time, try to think back to a time before you had attended and answer based on how you felt then, not how you feel now.

Increased independence

Retrospective pre-attendance
Q6a. Before you started coming to [service], how many times in an average month did you attend a service or activity alone, without a family member?
Sliding scale – 0-10+

Retrospective pre-attendance
Q7a. Before you started coming to [service], roughly how many times in a typical week did you meet people to socialise, outside of your family? Including at activities or classes
Sliding scale – 0-10+

Retrospective pre-attendance
Q8a. The statements below relate to feelings of independence.
Please read each statement and think back to how much you related to each one before you started coming to [service].
Then indicate how much you agree with each of the statements.
4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

a. I felt able and motivated to do things I hadn't done before

b. I was good at recognising my own abilities and successes – indicator is also counted for confidence outcome
c. I had my own support network outside of my family
d. I was comfortable to be away from my family members for an hour or two
e. I was comfortable to be away from my family members for a longer time

f. and g. relate to increased self-confidence – included here for formatting

f. I felt confident in a group of people I knew
g. I felt confident in a group of people that were new to me

Post-attendance

Q6b. How many times in the last month have you attended a service or activity alone, without a family member?

Sliding scale – 0-10+

Post-attendance

Q7b. Roughly how many times in a typical week do you meet people to socialise, outside of your family? Including at activities or classes

Sliding scale – 0-10+

Post-attendance

Q8a. The statements below relate to feelings of independence.
Please read each statement and think how much you relate to each one now.
Then indicate how much you agree with each of the statements.

4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

a. I feel able and motivated to do things I haven't done before
b. I am good at recognising my own abilities and successes – indicator is also counted for confidence outcome
c. I have my own support network outside of my family
d. I am comfortable to be away from my family members for an hour or two
e. I am comfortable to be away from my family members for a longer time

f. and g. relate to increased self-confidence – included here for formatting

f. I feel confident in a group of people I know
g. I feel confident in a group of people that are new to me

Post-attendance

Q9. Based on your attendance at [service], do you think you have become more independent?

a. No change
b. A small change
c. A medium change
d. A large change

Increased self-confidence

Retrospective pre-attendance

Q10a. How confident did you feel about each of the things below before you attended [service], with each of the types of people?

a. I felt confident to express my opinions or experiences

	Not at all confident	Not very confident	A little confident	Fairly confident	Very confident	N/A
With my family						

With my friends						
At work, school or college						
With people who are new to me						
When attending an appointment with my GP, consultant, or another medical professional						

b. I felt confident to share my feelings

	Not at all confident	Not very confident	A little confident	Fairly confident	Very confident	N/A
With my family						
With my friends						
At work, school or college						
With people who are new to me						
When attending an appointment with my GP, consultant, or another medical professional						

c. I felt confident asking for help and support when I need it

	Not at all confident	Not very confident	A little confident	Fairly confident	Very confident	N/A
With my family						
With my friends						
At work, school or college						
With people who are new to me						
When attending an appointment with my GP, consultant, or another medical professional						

Post attendance

Q10b. How confident do you feel about each of the things below, with each of the types of people?

a. I feel confident to express my opinions or experiences

	Not at all confident	Not very confident	A little confident	Fairly confident	Very confident	N/A
With my family						

With my friends						
At work, school or college						
With people who are new to me						
When attending an appointment with my GP, consultant, or another medical professional						

b. I feel confident to share my feelings

	Not at all confident	Not very confident	A little confident	Fairly confident	Very confident	N/A
With my family						
With my friends						
At work, school or college						
With people who are new to me						
When attending an appointment with my GP, consultant, or another medical professional						

c. I feel confident asking for help and support when I need it

	Not at all confident	Not very confident	A little confident	Fairly confident	Very confident	N/A
With my family						
With my friends						
At work, school or college						
With people who are new to me						
When attending an appointment with my GP, consultant, or another medical professional						

Post-attendance

Q11. Based on your attendance at [service], do you think you have more self-confidence?

a. No change
b. A small change
c. A medium change
d. A large change

Improved ability to cope with challenges

Retrospective pre-attendance

Q12a. The statements below relate to dealing with difficult situations.

Please read each statement and think about what you were like and how you felt before you started coming to [service] at Crann. How much does each statement describe how you used to be?

5-POINT SCALE: Does not describe how I was at all; does not describe how I was; Describes how I was a little; Does describe how I was; describes how I was very well

If a. or b. at Q2. – Adults and teens

e. I looked for creative ways to alter difficult situations
f. Regardless of what happened to me, I believed I could control my reaction to it
g. I believed I could grow in positive ways by dealing with difficult situations
h. I actively looked for ways to replace the losses I encountered in life

All

f. I could approach a challenging situation calmly
g. I asked for help and support or shared my feelings with others when I was facing a challenge
h. I was kind to myself in challenging times
i. I had a great support system
j. I took time to think about things after something challenging happened

Retrospective pre-attendance

Q13a. How often would you say you felt stressed/overwhelmed before you started attending [service]?

g. Every day
h. Most days
i. A couple of times a week
j. Once a week
k. Less than once a week
l. Never

Post-attendance

Q12b. The statements below relate to dealing with difficult situations.

Please read each statement and think how much each one describes how you are and how you feel now. Then tick the box which is closest to this.

5-POINT SCALE: Does not describe how I was at all; does not describe how I was; Describes how I was a little; Does describe how I was; describes how I was very well

If a. or b. at Q2. – Adults and teens

a. I look for creative ways to alter difficult situations
b. Regardless of what happens to me, I believe I can control my reaction to it
c. I believe I can grow in positive ways by dealing with difficult situations
d. I actively look for ways to replace the losses I encounter in life

All

e. I can approach a challenging situation calmly
f. I ask for help and support or share my feelings with others when I am facing a challenge
g. I am kind to myself in challenging times
h. I have a great support system
i. I take time to think about things after something challenging happens

Post-attendance

Q13b. How often would you say you've felt stressed/overwhelmed in the last 2 weeks?

a. Every day
b. Most days
c. A couple of times a week
d. Once a week
e. Less than once a week
f. Not at all

Post-attendance

Q14. Based on your experience of attending [service], do you think you are more able to manage challenges now?

e. No change
f. A small change
g. A medium change
h. A large change

Post-attendance

Q15. Which of the phrases below feels most relatable for you in relation to challenges?

a. I <u>cope</u> <u>with</u> challenges
b. I <u>manage</u> challenges
c. I <u>deal with</u> challenges
d. I <u>overcome</u> challenges

<u>Increase in social inclusion, support and community</u>

Retrospective pre-attendance

Q16a. The statements below relate to feelings of support and community.
Please read each statement and think back to how much you related to each one <u>before you attended</u> [service]. Then indicate how much you agree with each of the statements.

4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

If a. at Q2. - adults

f. I was part of a community that helped me fulfil my needs
g. I belonged in a community
h. I had a say about what went on in my community
i. I felt connected to a community of like-minded people
j. I had a good bond with others in my community

All

a. I had people to share my feelings and challenges with
b. I was satisfied with my support system
c. I had all the support that I need
d. I was satisfied with the level of social interaction I had before I attended drama
e. I felt that I was part of a community

Post-attendance

Q16b. The statements below relate to feelings of support and community.
Please read each statement and think how much you relate to each one <u>now</u>.
Then indicate how much you agree with each of the statements.

4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

If a. at Q2. - adults

k. I am part of a community that helps me fulfil my needs
l. I belong in a community
m. I have a say about what goes on in my community

n. I feel connected to a community of like-minded people
o. I have a good bond with others in my community

All

f. I have people to share my feelings and challenges with
g. I am satisfied with my support system
h. I have all the support that I need
i. I am satisfied with the level of social interaction I have currently
j. I feel that I am part of a community

Post-attendance

Q16. Based on your experience of attending [service], do you think you feel:

	More supported	More part of a community	More socially included
No change			
A small change			
A medium change			
A large change			

Post-attendance

Q17. Have you noticed any other change because of attending [service] that we have not included in this survey that you'd like to tell us about? This can be a positive or not positive change.

Post-attendance

Q18. Do you think that anyone else has experienced any change of their own because you have attended [service] at Crann?

e. No
f. Yes, my parent
g. Yes, my sibling(s)
h. Yes, other (please specify)

Those who think others have experienced change

Q19. What change or changes do you think they have experienced?

Health and Continence Survey

Intro

We are currently undertaking a research study to understand the value of Crann's services. The study is called the Social Return on Investment (SROI), and it can only be successful with the participation of Crann clients.

- The survey should take around 10-15 minutes to complete.
- It's your choice whether you participate or not. Your decision will not affect your ability to access services.
- You will not be asked to share any personal details.
- Your answers are completely anonymous & stored in a secure database.
- Your response will only be used for research completed by the Crann Centre.

- All anonymous responses will be analysed by an independent researcher, not the Crann team.

If you are agreeable to participate, please click the Start button below.

Alternatively, if you would like support filling out the form, speak to [contact info research lead] to arrange a time to speak.

[Continence only] A note for parents:
If you are not a parent, please skip to the next page to begin.

All of the questions in this survey are asked to the person who attended the service. This may be yourself, your child or adult child.

If you have attended the clinic alone and manage your child's continence routine, answers should be given from your point of view as the person attending sessions and your observation of your child or their input as the person whose continence routine is being impacted.

If your child or adult child has attended the clinic (with or without you) and is able to engage in this process, we encourage them to complete the survey themselves or you to complete the survey with their involvement.

Q1. Are you currently going to [service]?
  g. I am about to start going to [service]
  h. I am currently going to [service]
  i. I am no longer going to [service]

No longer attending
Q1b. How long ago did you stop attending [service]?
  d. Less than 6 months ago [post-attendance]
  e. 6-12 months ago [Drop off]
  f. More than 12 months ago [Drop off]

Those who have attended already
Q2. How many times have you attended [service]?
[Relevant drop down]

Q3. Are you?
  a. I am a parent of a child with a disability (0-12)
  b. I am a parent of a teen with a disability (13-17)
  c. I am a parent of an adult with a disability (18+)
  d. I am a teen with a disability (13-17)
  e. I am an adult with a disability (18+)

[Continence only] Q4. Who attends the continence clinic?
  a. I attend the sessions alone
  b. I attend the sessions with my child only shown to parents
  c. I attend the sessions with my parent only shown to teens and adults

[Continence only] Q5. Who manages the continence routine?
only shown to parents

a. I (and/or my partner) manage my child's continence routine
b. My child and I (and/or my partner) both manage their continence routine
c. My child manages their own continence routine all the time

only shown to teens and adults

d. I manage my own continence routine all the time
e. I manage my own continence routine with support from my parent/partner/someone else
f. My parent/partner/someone else manages my continence routine

parents only

Q6. What is your child's gender?

f. Boy
g. Girl
h. Non-binary
i. Other
j. Prefer not to say

parents only

Q7. What is your child's age?
[drop down]

parents only

Q8. What diagnosis does your child have in relation to their disability?

a. Spina Bifida
b. Hydrocephalus
c. Cerebral Palsy
d. Muscular Dystrophy
e. Osteogenesis Imperfecta
f. Arthrogryposis
g. Spinal Muscular Atrophy
h. Spinal Cord Injury
i. Stroke
j. Multiple Sclerosis
k. Spinal Muscular Atrophy
l. Other (specify)

adults and teens only

Q9. What is your gender?

a. Boy/ Man
b. Girl/ Woman
c. Non-binary
d. Other
e. Prefer not to say

adults and teens only

Q10. What is your age?
[drop down]

adults and teens only

Q11. What diagnosis do you have in relation to your disability?

a. Spina Bifida

b. Hydrocephalus
c. Cerebral Palsy
d. Muscular Dystrophy
e. Osteogenesis Imperfecta
f. Arthrogryposis
g. Spinal Muscular Atrophy
h. Spinal Cord Injury
i. Stroke
j. Multiple Sclerosis
k. Spinal Muscular Atrophy
l. Other (specify)

[Continence only] Parents who attend with or without their child
All of the following questions are written in first and second person i.e. “you” questions and “I” statements.

As you have attended Continence Clinic yourself, either with or without your child, please consider the experience of both yourself and your child when answering these questions.

Some questions e.g., those about physical comfort, will obviously apply to your child only, but many will be applicable to both of you who are affected by Continence Clinic.

Improved ability to participate
Q12. How often do you find the below things happen for you due to your [H&C] needs?
5-POINT SCALE: Not at all; Only occasionally; Sometimes; Often; Most or all of the time; N/A
a. I miss out on activities or other things I want to do
b. I miss school or work
c. I miss out on social events

[Continence only] Q13a. How much time per day do you spend doing catheterisation?
Include all of the time spent, even if someone else helps you with this.
a. Less than half an hour
b. Half an hour to 1 hour
c. 1 hour to 1.5 hours
d. More than 1.5 hours
e. Not applicable

[Continence only] Q13b. How much time per week do you spend on your bowel management routine?
Include all of the time spent, even if someone else helps you with this.
a. Less than 1.5 hours
b. 1.5 to 2 hours
c. 2 to 3 hours
d. 3 to 4 hours
e. More than 4 hours
f. Not applicable

Q14. How satisfied are you with your ability to participate in daily activities? E.g., school, work, social events, fun activities, etc.
a. Not at all satisfied
b. Not very satisfied

c. Neither satisfied nor unsatisfied
d. Fairly satisfied
e. Very satisfied

Post-attendance

Q15. Based on your experience of attending [service] at Crann, how much do you think that your ability to participate in the things you need to and want to do improved?

e. No change
f. A small change
g. A medium change
h. A large change

Increased sense of freedom

Q17. The statements below relate to feelings of freedom.
Please read each statement and think how much you relate to each one.
Then rate the statement on a scale of 1 to 5, where 1 is not at all and 5 is Most or all of the time
5-POINT SCALE: Not at all; Only occasionally; Sometimes; Often; Most or all of the time

a. My day, plans or schedule are interrupted by my continence needs or management
b. I worry about my continence needs or management
c. I am in pain or experience discomfort because of my continence needs or management – indicator is also counted for physical wellbeing and confidence outcomes
d. I am free to do what I want to do
e. I feel my continence needs or management is negatively impacting my freedom

Post-attendance

Q18. Based on your experience of attending Continence Clinic at Crann, how much do you feel that you have more freedom now?

a. No change
b. A small change
c. A medium change
d. A large change

Improved physical wellbeing

Q19. The statements below relate to your physical wellbeing.
Please read each statement and think how much you relate to each one.
Then rate the statement on the scale beside it.
5-POINT SCALE: Not at all, a little, a moderate amount, very much, an extreme amount

a. To what extent do you feel physical pain prevents you from doing what you need to do?
b. How much do you need medical treatment to function in your daily life?

5-POINT SCALE: Very poor, poor, fair, good, very good

c. How well are you able to get around?

5-POINT SCALE: Very dissatisfied, dissatisfied, fair, satisfied, very satisfied

d. How satisfied are you with your sleep?
e. How satisfied are you with your ability to perform your daily living activities?
f. How satisfied are you with your capacity for work/school?

Post-attendance

Q20. Based on your experience of attending Continence Clinic at Crann, how much do you feel that your physical wellbeing has improved?

a. No change
b. A small change

c. A medium change
d. A large change

Improved peace of mind and confidence in the treatment/ management of my needs

Q21. The statements below relate to your confidence in the treatment and/or management of your continence needs currently.
Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.

4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

a. I am stressed about my continence needs or management
b. My needs feels manageable for the long-term
c. I have a positive relationship with the management of my continence
d. I am confident to go to appointments about my continence needs
e. Appointments about my continence needs cause me stress or upset
f. Appointments about my continence needs are accessible for my needs

Post-attendance

Q22. Based on your experience of attending Continence Clinic at Crann, how much do you feel that you have confidence in the treatment and/or management of your continence needs?
a. No change
b. A small change
c. A medium change
d. A large change

Feelings of empowerment and inclusion in the service provided

Q23. Do you understand the term empowerment?
a. Yes
b. No

Display text

Empowerment is when the power is given to you to do something yourself, or when you are becoming stronger and more confidence in controlling your life or claiming your rights.

Q24. How much do you feel that you have been empowered by the continence services you have attended in the past 6 months? e.g. urology, renal, colorectal
a. Very empowered
b. Fairly empowered
c. A little empowered
d. Not very empowered
e. Not at all empowered
f. I haven’t attended any continence services

Q25. How much do each of the statements below apply to your experience when you have attended continence services in the past 6 months? Then indicate how much you agree with each of the statements.
4-POINT SCALE: strongly disagree; disagree; agree; strongly agree
a. I feel comfortable saying no to a procedure or treatment option
b. I feel comfortable telling the healthcare professional that I’ve changed my mind about a procedure or treatment option
c. I feel listened to and understood by the healthcare professionals

    d. I feel respected by the healthcare professionals

Post-attendance

Q26. Based on your experience of attending Continence Clinic at Crann, how much do you feel that you were empowered by and included in the service?

    a. No change
    b. A small change
    c. A medium change
    d. A large change

Post-attendance

Q27. Have you experienced any change because of attending Continence Clinic at Crann that we have not included in this survey that you'd like to tell us about? This can be a positive or not positive change.

☐

Post-attendance

Q28. Do you think that anyone else has experienced any change of their own because you have attended continence clinic at Crann?

    i. No
    j. Yes, my parent (adults and teens only)
    k. Yes, my other children (parents)
    l. Yes, my partner (parents and adults)
    m. Yes, other (please specify)

those who think others have experienced change

Q29. What change or changes do you think they have experienced?

☐

Personal Support and Connection Survey

Intro

We are currently undertaking a research study to understand the value of Crann's services. The study is called the Social Return on Investment (SROI), and it can only be successful with the participation of Crann clients.

- The survey should take around 10-15 minutes to complete.
- It's your choice whether you participate or not. Your decision will not affect your ability to access services.
- You will not be asked to share any personal details.
- Your answers are completely anonymous & stored in a secure database.
- Your response will only be used for research completed by the Crann Centre.
- All anonymous responses will be analysed by an independent researcher, not the Crann team.

All of the questions in this survey relate specifically to your experience of change created by engaging with Crann outside of specific services that you have attended.

If you are agreeable to participate, please click the Next button below.

Alternatively, if you would like support filling out the form, speak to [research lead contact] to arrange a time to speak.

Q1. Are you?

f. I am a parent of a child with a disability (0-12)
g. I am a parent of a teen with a disability (13-17)
h. I am a parent of an adult with a disability (18+)
i. I am a partner of an adult with a disability
j. I am a teen with a disability (13-17)
k. I am an adult with a disability (18+)

Q2. Have you had your intake meeting with Crann?

j. We are awaiting our intake meeting with Crann
k. We have had our intake meeting within the past month
l. We have had our intake meeting more than 1 month ago
m. We have had our intake meeting more than 6 months ago
n. We have had our intake meeting more than 12 months ago

Q3. What is your gender?

f. Boy/ Man
g. Girl/ Woman
h. Non-binary
i. Other
j. Prefer not to say

Q4. What is [you/ your partner/ your child] age?
[drop down]

Q5. What diagnosis do [you/ your partner/ your child] have in relation to your disability?

a. Spina Bifida
b. Hydrocephalus
c. Cerebral Palsy
d. Muscular Dystrophy
e. Osteogenesis Imperfecta
f. Arthrogryposis
g. Spinal Muscular Atrophy
h. Spinal Cord Injury
i. Stroke
j. Multiple Sclerosis
k. Spinal Muscular Atrophy
l. Other (specify)

The following questions all relate to your experience of engaging with Crann, outside of any services you have attended. This applies to interactions with Crann staff and others around the Centre, phone calls, emails, or other communications from the staff.

When answering these questions, try to bear in mind your experience of engaging with Crann outside of any specific service.

Increase in social inclusion, support and community

Q9. The statements below relate to feelings of support and community.
Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.
4-POINT SCALE: strongly disagree; disagree; agree; strongly agree
parents & adults only

p. I am part of a community that helps me fulfil my needs
q. I belong in a community
r. I have a say about what goes on in my community
s. I feel connected to a community of like-minded people
t. I have a good bond with others in my community

All

f. I have people to share my feelings and challenges with
g. I am satisfied with my support system
h. I have all the support that I need
i. I am satisfied with the level of social interaction I have currently
j. I feel that I am part of a community

Post-intervention
Q9. Based on your experience of engaging with Crann, do you think you feel:

	More supported	More part of a community	More socially included
No change			
A small change			
A medium change			
A large change			

<u>Increased feelings of acceptance and being accommodated</u>
Q10. The statements below relate to feelings of acceptance.
Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.
4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

a. I have someone to ask questions to when I’m unsure what to do
b. I have access to all the support my family and I need
c. I feel comfortable asking for what my family and I need
d. I feel welcomed and accepted at services and appointments
e. I feel cared for and supported by service-providers
f. I can rely on service-providers to do what they promise, e.g., contact other organisations, follow up with me, book future appointments

Post-intervention
Q11. Based on your experience of being engaged with Crann, do you feel more accepted and accommodated than you did before?

i. No change
j. A small change
k. A medium change
l. A large change

<u>Increased hope for the future</u>
Q12. The statements below relate to feelings of hope.
Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.

4-POINT SCALE: strongly disagree; disagree; agree; strongly agree
All

a. I have a positive outlook towards life
b. I feel alone or hopeless
c. I can see possibilities in the midst of difficulties
d. I have short and/or long-range goals for myself

parents only

e. I have hope for my child's future
f. I worry about my child being well cared for in future
g. I have short and/ or long-range goals for my child
h. I have a sense of direction in relation to my child's care

adults and teens only

i. I worry about who will care for me in future
j. I have hope for my future

Q13. How hopeful do you feel about the future of disability services in Ireland?
On a scale from 1-10, where 1 is not at all and 10 is very hopeful
10-POINT SCALE

Post-intervention
Q14. Based on your experience of being engaged with Crann, do you feel that you have more hope for the future than you did before?

a. No change
b. A small change
c. A medium change
d. A large change

Reduced loneliness
Q15. The statements below relate to feelings of loneliness.
Please read each statement and think how much you relate to each one.
Then indicate how often each of the statements below is descriptive of you.
4-POINT SCALE: I often feel this way (O); I sometimes feel this way (S); I rarely feel this way (R); I never feel this way (N)

a. I have nobody to talk to
b. I feel as if nobody really understands me
c. There is no one I can turn to
d. My interests and ideas are not shared by those around me
e. I feel completely alone
f. I am unable to reach out and communicate with those around me
g. I feel isolated from others
h. I feel shut out and excluded by others
i. My social relationships are superficial
j. I am unhappy doing so many things alone

Q16. On a scale of 1-10, how lonely do you feel generally?
10-POINT SCALE

Post-intervention
Q17. Based on your experience of being engaged with Crann, do you feel that you are less lonely than you were before?

e. No change

f. A small change
g. A medium change
h. A large change

Q18. Have you attended a service at Crann yourself?
a. Yes
b. No

Q19. Which service or services have you personally attended?

parents only
a. Counselling
b. A Moment for Me
c. Parents' Café
d. Other (please specify)

adults and teens only
a. Counselling
b. Chat and Connect
c. Breaking Barriers Theatre Group for Adults
d. Continence Clinic
e. Podiatry
f. Other (please specify)

partners only
a. Counselling
b. Other (please specify)

Post-intervention

Q20. Have you experienced any change because of engaging with Crann that we have not included in this survey that you'd like to tell us about? This can be a positive or not positive change.

Parents Survey

Intro

We are currently undertaking a research study to understand the value of Crann's services. The study is called the Social Return on Investment (SROI), and it can only be successful with the participation of Crann clients.

- The survey should take around 10-15 minutes to complete.
- It's your choice whether you participate or not. Your decision will not affect your ability to access services.
- You will not be asked to share any personal details.
- Your answers are completely anonymous & stored in a secure database.
- Your response will only be used for research completed by the Crann Centre.
- All anonymous responses will be analysed by an independent researcher, not the Crann team.

All of the questions in this survey relate specifically to your experience of change created because of your child's attendance at Crann's services, not any service you have attended yourself.

If you are agreeable to participate, please click the Start button below.

Alternatively, if you would like support filling out the form, speak to [research lead contact] to arrange a time to speak.

Q1. Are you?

- l. I am a parent of a child with a disability (0-12)
- m. I am a parent of a teen with a disability (13-17)
- n. I am a parent of an adult with a disability (18+)
- o. Other [close]

Q2. Has your child attended services at Crann?

- o. They have not attended any services yet
- p. They have attended services at Crann in the past 6 months
- q. They have attended services in the past but have not attended any service in the past 6 months

If c or d at Q2
Q2b. What services has <u>your child</u> (or children) attended?
Parents of children who have attended

- a. Play Therapy
- b. Breaking Barriers Theatre Group for kids
- c. Continence Clinic
- d. Podiatry
- e. Other (please specify)

Parents of adults who have attended

- f. Counselling
- g. Chat and Connect
- h. Breaking Barriers Theatre Group for Adults
- i. Continence Clinic
- j. Podiatry
- k. Other (please specify)

Q3. What is your gender?

- k. Man
- l. Woman
- m. Non-binary
- n. Other
- o. Prefer not to say

Q4. What is your age?
[drop down]

Q5. What is your child's age?
[drop down]

Q6. What diagnosis does your child have in relation to their disability?

a. Spina Bifida
b. Hydrocephalus
c. Cerebral Palsy
d. Muscular Dystrophy
e. Osteogenesis Imperfecta
f. Arthrogryposis
g. Spinal Muscular Atrophy
h. Spinal Cord Injury
i. Stroke
j. Multiple Sclerosis
k. Spinal Muscular Atrophy
l. Other (specify)

Increased sense of comfort in leaving their child to attend services alone

Q7. The statements below relate to your comfort level in leaving your child to attend services or appointments alone.
Please read each statement and think often you feel that way.
Then rate the statement on a scale of 1 to 5, where 1 is not at all and 5 is Most or all of the time.
5-POINT SCALE: Not at all; Only occasionally; Sometimes; Often; Most or all of the time

a. I feel worried to leave my child alone to attend a service or activity
b. I feel comfortable when I am not with my child
c. I am confident that service-delivery staff can manage any need/issue that arises with my child while I am not there

Q8. How many times has your child been somewhere without you or another family member in the past 6 months? e.g. an extra-curricular activity, an appointment, a social event

a. None
b. 1-5
c. 5-10
d. 10+

Post-intervention

Q9. Based on your experience of your child attending services at Crann, do you feel that you are more comfortable for them to attend services alone than you were before?

i. No change
j. A small change
k. A medium change
l. A large change

Sense of community and connection with other parents

Q10. The statements below relate to feelings of support and community.
Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.
4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

a. I can get what I need at Crann
b. Crann helps me fulfil my needs
c. I feel like a member of the community at Crann
d. I belong at Crann
e. I have a say about what goes on at Crann
f. I feel connected to the community at Crann
g. I have a good bond with others at Crann

h. I have people to share my feelings and challenges with
i. I am satisfied with my support system
j. I have all the support that I need
k. I am satisfied with the level of social interaction I have currently
l. I feel that I am part of a community

Q11. How many other parents of children with disabilities do you currently consider to be friends?
SLIDER: 1-20+

Q12. How often do you get to speak to someone who understands your experience of being a parent to a child with a disability?
5-POINT SCALE: Not at all; Not very often; sometimes; fairly often; very often

Post-intervention
Q13. Based on your experience of your child attending services at Crann, do you feel that you have a greater sense of connection and community with other parents than you had before?

a. No change
b. A small change
c. A medium change
d. A large change

Relief about their child or children achieving their own outcomes
Q14. The statements below relate to how you feel about your child’s or children’s progress. Please read each statement and think how much you relate to each one.
Then indicate how much you agree with each of the statements.
4-POINT SCALE: strongly disagree; disagree; agree; strongly agree

a. I feel worried about my child’s current challenges
b. I feel worried about my child’s future
c. I feel confident that my child will achieve positive outcomes in future
d. My child has progressed noticeably in the past 6 months
e. I feel relieved about what my child has achieved

Post-intervention
Q15. Based on your experience of your child attending services at Crann, do you feel that you have experienced greater relief about the outcomes they have achieved than you did before?

a. No change
b. A small change
c. A medium change
d. A large change

Post-intervention
Q20. Have you experienced any change because of your child attending services at Crann that we have not included in this survey that you’d like to tell us about? This can be a positive or not positive change.

Post-intervention
Q21. Do you think that anyone else has experienced any change of their own because of your child attending services at Crann?

n. No

- o. Yes, my child’s sibling(s)
- p. Yes, my partner
- q. Yes, other (please specify)

Post-intervention

Q22. What change or changes do you think they have experienced?

Appendix 6: Value Game Analysis and Calculation of Average Estimated Value of Outcomes

The value of each outcome was calculated by calculating the average of two figures generated by the same group of stakeholders across two modified value games, detailed below.

Value game one: Participants asked to assign the value they would realistically pay to achieve the change

Qualitative Question Format: Assigning monetary value

1. In the following scenario, I want you to imagine that you don't have any budgetary constraints, you have plenty of money available to you.
2. Start with the least valuable outcome: If I told you I could give you [outcome] in exchange for money, how much would you pay to have that outcome for one year without having to do anything?
3. Then value most valuable outcome
4. Then value mid outcome
5. For each outcome between the valued points: How much more valuable is this outcome than the one below it? E.g. in %, times more, etc.

Quantitative Question Format: Assigning monetary value

What would the person who attended (i.e. you or your child) realistically pay to achieve each of the changes they experienced for one year?
If you're answering on behalf of your child, please think about how valuable the change was for them when considering your answer

[Scale €1-€10,000]

[Scale defined based on data collected in qualitative interviews]

Value game two: Participants asked to choose another service or experience that would help them to achieve the same or a similar amount of change

Qualitative Question Format: Choosing a financial proxy

What other service, product or experience could have helped you to achieve the same change?

- Do you think you would have experienced the same amount of change from that service, product or experience?

Quantitative Question Format: Choosing a financial proxy

Which of the services listed below do you think would help the person who attended programmes /services (i.e. you/ your child) to achieve the same amount of change as experienced by attending?

[NB: € values not to be included in participant-facing survey]
Improved ability to participate in activities and day-to-day life

a. A day out at the seaside (approx. €50)
b. Attending a group activity twice per month (approx. €300 per year)
c. Becoming a member of a club, e.g., sports, hobbies, etc. (approx. €1000 per year)
d. A personal assistant to support you for 3.5 hours per week (approx.€2,000 per year)

The above is an example question from the Client Survey and represents the financial proxy options for one outcome. The financial proxy options were selected based on the answers given by clients in the qualitative interviews, and expert input. Each outcome was presented with four financial proxy options on a value scale from €50-€2000. This scale of value was in line with the financial values for the proxies chosen by clients in the interviews. The financial value of the proxies was not shown to participants, and they are included in the question above only as a label within this example.

Calculating the average value for an outcome

The average value for each outcome, provided by respondents across the two modified value games in the quantitative data, were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency, and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.

Appendix 7: Value Map Data

Who and how many?		At what cost?		Outputs	What changes?	How much?	
Stakeholders		Inputs			Outcomes Outcome description	Indicator and source	Quantity (scale)
Who do we have an effect on? Who has an effect on us?	How many in group?	What will/did they invest and how much (money, time)?	Financial value (for the total population for the accounting period)	Summary of activity in numbers.	What is the change experienced by stakeholders?	Describe how you measured the described outcome (including any sources used)	Number of people experiencing described outcome.
Clients of Psychological Wellbeing Services	59	Cost of all staff delivering the services (delivery time, preparation time, administration). Materials and consumables. Overheads and % Of Depreciation charge apportioned for stakeholder group	117002.88	166 x 1.5 hour sessions of counselling delivered to 40 clients. 38 x 1.5 hour sessions of play therapy delivered to 9 clients. 3 x 2-hour Sibshop sessions delivered to 10 clients total.	Increase in support, community, and social inclusion	Adjusted Brief Sense of Community Scale (BSOC): -"Neighbourhood" replaced with "community" -Reduced from 8 to 5 measures for relevance Source and scale: https://www.researchgate.net/publication/229567281_Validation_of_a_Brief_Sense_of_Community_Scale_Confirmation_of_the_Principal_Theory_of_Sense_of_Community Bespoke indicators scored on a 4-point agreement scale to align with BSOC: •I have people to share my feelings and challenges with •I am satisfied with my support system •I have all the support that I need •I am satisfied with the level of social interaction I have currently •I feel that I am part of a community	34
					Improved mental wellbeing	•CORE-10 for adult clients •YP-CORE for 11-18yr olds Source and scales: https://www.corc.uk.net/outcome-experience-measures/core-measurement-tools-core-10/ For children under 11, parent invited to complete the tool with their involvement and asked to report on the overall outcome separately.	59
					Improved ability to manage challenges	Brief Resilient Coping Scale (validated for adults only) – used only for parents and adults with disabilities Source: https://www.hsph.harvard.edu/health-happiness/brief-resilient-coping-scale-brcs/ Scale: https://emdrfoundation.org/toolkit/brcs.pdf Bespoke indicators scored on a 5-point agreement scale (to align with BRCS): •I can approach a challenging situation calmly •I ask for help and support or share my feelings with others when I am facing a challenge •I have self-compassion in challenging times •I am satisfied with my support system •I take time to reflect on things and process them after something challenging happens Objective indicator – 6-point scale from never to every day •Frequency of feeling stressed/ overwhelmed in previous 2 weeks period	59
					Increased self-confidence and motivation	Bespoke indicators scored on a 4-point agreement scale: •I am able to share my thoughts and opinions with others •I feel confident to attend a group •I am motivated to take action on my personal goals •I feel that I am becoming more independent (specific to children and adults with disabilities) •I know who I am and what matters to me •I feel capable and able to live my life fully	59

	How long?			How valuable?			How much caused by the activity?				Still material?
Amount of change per stakeholder (depth)	Duration of outcomes	Outcomes start		Express the relative importance (value) of the outcome			Deadweight %	Displacement %	Attribution %	Drop off %	Impact calculation
				Weighting	Valuation approach (monetary)	Monetary valuation					
Describe the average amount of change experienced (or to be experienced) per stakeholder.	How long (in years) does the outcome last for?	Does the outcome start in Period of activity or in the Period after?	Sum of duration and outcome start	How important is this outcome to stakeholders? (e.g. on a scale of 1-10) (N.B. To make comparison between outcomes possible, your analysis should be consistent in the type of weighting used).	Describe the monetary valuation approach used to express the relative importance (value) of each outcome. (N.B. If your analysis does not use monetary valuation of outcomes, please use the Value Map (non-SROI) tab of this spreadsheet).	How important is the outcome to stakeholders (expressed in monetary terms)?	What will happen/what would have happened without the activity?	What activity would/did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Number of people (quantity) times value, less deadweight, displacement and attribution
20.1% mean distance travelled	1	period of activity	2	2.8/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2585 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	519.59	34%	0%	21%	0%	9,211.08
24.5% mean distance travelled	1	period of activity	2	3.31/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3985 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious	976.33	28%	0%	22%	0%	32,350.11
32.7% mean distance travelled	1	period of activity	2	2.38/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2915 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	953.21	28%	0%	20%	0%	32,393.89
44.9% mean distance travelled	1	period of activity	2	2.8/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3115 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative	1,398.64	27%	0%	17%	0%	49,998.72

Who and how many?		At what cost?		Outputs	What changes?	How much?	
Stakeholders		Inputs			Outcomes	Indicator and source	Quantity (scale)
					Outcome description		
Who do we have an effect on? Who has an effect on us?	How many in group?	What will/did they invest and how much (money, time)?	Financial value (for the total population for the accounting period)	Summary of activity in numbers.	What is the change experienced by stakeholders?	Describe how you measured the described outcome (including any sources used)	Number of people experiencing described outcome.
Clients of Community and Networks Services	16	Cost of all staff delivering the services (delivery time, preparation time, administration). Materials and consumables. Overheads and % Of Depreciation charge apportioned for stakeholder group	6871.17	30 x 1.5 hour sessions of Chat and Connect delivered to 8 unique new clients across the SROI period (group sessions). 44 x 1.5 hour sessions of Breaking Barriers Theatre Group delivered to 16 new clients	Increase in social inclusion, support, and community	Adjusted Brief Sense of Community Scale (BSOC): -"Neighbourhood" replaced with "community" -Reduced from 8 to 5 measures for relevance Source and scale: https://www.researchgate.net/publication/229567281_Validation_of_a_Brief_Sense_of_Community_Scale_Confirmation_of_the_Principal_Theory_of_Sense_of_Community Bespoke indicators scored on a 4-point agreement scale to align with BSOC: •I have people to share my feelings and challenges with •I am satisfied with my support system •I have all the support that I need •I am satisfied with the level of social interaction I have currently •I feel that I am part of a community	9
					Increase in self-confidence	Bespoke indicators scored on a 5-point Likert scale (confidence) •I feel confident to express my opinions or experiences •I feel confident to share my feelings •I feel confident asking for help and support when I need it ** Measured across 5 contexts – family, friends, at work/school/college, with new people, when attending a medical appointment Bespoke indicators scored on a 4-point agreement scale •I am good at recognising my own abilities and successes •I feel confident in a group of people I know •I feel confident in a group of people that are knew to me	16
					Increase in independence	Bespoke indicators scored on a 4-point agreement scale •I feel able and motivated to do things I wouldn't have done before •I am good at recognising my own abilities and successes •I have my own support network outside of my family •I am comfortable to be away from my family members for an hour or two •I am comfortable to be away from my family members for a longer time	16
					Improved ability to deal with challenges	Brief Resilient Coping Scale (validated for adults only) – used only for parents and adults with disabilities Source: https://www.hsph.harvard.edu/health-happiness/brief-resilient-coping-scale-brcs/ Scale: https://emdrfoundation.org/toolkit/brcs.pdf Bespoke indicators scored on a 5-point agreement scale (to align with BRCS): •I can approach a challenging situation calmly •I ask for help and support or share my feelings with others when I am facing a challenge •I have self-compassion in challenging times •I am satisfied with my support system •I take time to reflect on things and process them after something challenging happens	16

Amount of change per stakeholder (depth)	Duration of outcomes	Outcomes start		Express the relative importance (value) of the outcome			Deadweight %	Displacement %	Attribution %	Drop off %	Impact calculation
				Weighting	Valuation approach (monetary)	Monetary valuation					
Describe the average amount of change experienced (or to be experienced) per stakeholder.	How long (in years) does the outcome last for?	Does the outcome start in Period of activity or in the Period after?	Sum of duration and outcome start	How important is this outcome to stakeholders? (e.g. on a scale of 1-10) (N.B. To make comparison between outcomes possible, your analysis should be consistent in the type of weighting used).	Describe the monetary valuation approach used to express the relative importance (value) of each outcome. (N.B. If your analysis does not use monetary valuation of outcomes, please use the Value Map (non-SROI) tab of this spreadsheet).	How important is the outcome to stakeholders (expressed in monetary terms)?	What will happen/what would have happened without the activity?	What activity would/did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Number of people (quantity) times value, less deadweight, displacement and attribution
54.2% mean distance travelled	1	period of activity	2	3.07/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2420 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	1,311.64	40%	0%	24%	0%	5,382.97
29.5% mean distance travelled	1	period of activity	2	3.27/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3095 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	913.03	43%	0%	21%	0%	6,578.20
44.9% mean distance travelled	1	period of activity	2	2.29/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3685 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value	1,654.57	40%	0%	25%	0%	11,912.90
21.5% mean distance travelled	1	period of activity	2	1.92/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3900 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	838.50	35%	0%	19%	0%	7,063.52

Who and how many?		At what cost?		Outputs	What changes?	How much?	
Stakeholders		Inputs			Outcomes Outcome description	Indicator and source	Quantity (scale)
Who do we have an effect on? Who has an effect on us?	How many in group?	What will/did they invest and how much (money, time)?	Financial value (for the total population for the accounting period)	Summary of activity in numbers.	What is the change experienced by stakeholders?	Describe how you measured the described outcome (including any sources used)	Number of people experiencing described outcome.
Clients of Health and Continence Services	78	Cost of all staff delivering the services (delivery time, preparation time, administration). Materials and consumables. Overheads and % Of Depreciation charge apportioned for stakeholder group	81,781.81	107 x 1.5 hour sessions of Continence clinic delivered to 63 clients. 29 x 1.5 hour sessions of Podiatry delivered to 15 clients.	Improved ability to participate in activities and day-to-day life	Bespoke indicators scored on a 5-point Likert scale: •I miss out on activities or other things I want to do •I miss school or work •I miss out on social events •Satisfaction with ability to participate in activities	78
					Increased sense of freedom	Bespoke indicators scored on a 5-point Likert scale: •My day, plans or schedule are interrupted by my podiatry needs or management •I worry about my podiatry needs or management •I am in pain or experience discomfort because of my podiatry needs or management •I am free to do what I want to do •I feel my podiatry needs or management is negatively impacting my freedom	78
					Improved physical wellbeing	WHOQOL-BREF adjusted for physical indicators only, to include the below, scored on a 5-point Likert scale: •To what extent do you feel physical pain prevents you from doing what you need to do? •How much do you need medical treatment to function in your daily life? •How well are you able to get around? •How satisfied are you with your sleep? •How satisfied are you with your ability to perform your daily living activities? •How satisfied are you with your capacity for work/school? Source and scale: https://www.who.int/tools/whoqol	78
					Improved peace of mind and confidence in the treatment or management of the issue	Bespoke indicators scored on a 4-point agreement scale: •I am stressed about my [relevant health issue] needs or management •My [relevant health issue] needs feel manageable for the long-term •I have a positive relationship with the management of my [relevant health issue] needs •I am confident to go to appointments about my [relevant health issue] needs •Appointments about my [relevant health issue] needs cause me stress or upset •Appointments about my [relevant health issue] needs are accessible for my needs	78
					Feel empowered and included in the service provided	Bespoke indicator scored on a 5-point Likert scale: •Level of empowerment experienced attending health-related services in previous 6 months Bespoke indicators scored on a 4-point agreement scale: •I feel comfortable saying no to a procedure or treatment option •I feel comfortable telling the healthcare professional that I've changed my mind about a procedure or treatment option •I feel listened to and understood by the healthcare professionals •I feel respected by the healthcare professionals	78

	How long?			How valuable?			How much caused by the activity?				Still material?
Amount of change per stakeholder (depth)	Duration of outcomes	Outcomes start		Express the relative importance (value) of the outcome			Deadweight %	Displacement %	Attribution %	Drop off %	Impact calculation
				Weighting	Valuation approach (monetary)	Monetary valuation					
Describe the average amount of change experienced (or to be experienced) per stakeholder.	How long (in years) does the outcome last for?	Does the outcome start in Period of activity or in the Period after?	Sum of duration and outcome start	How important is this outcome to stakeholders? (e.g. on a scale of 1-10) (N.B. To make comparison between outcomes possible, your analysis should be consistent in the type of weighting used).	Describe the monetary valuation approach used to express the relative importance (value) of each outcome. (N.B. If your analysis does not use monetary valuation of outcomes, please use the Value Map (non-SROI) tab of this spreadsheet).	How important is the outcome to stakeholders (expressed in monetary terms)?	What will happen/what would have happened without the activity?	What activity would/did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Number of people (quantity) times value, less deadweight, displacement and attribution
26.4% mean distance travelled	1	period of activity	2	3.75/5	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3080 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value	813.12	28%	0%	16%	0%	38,358.45
24.2% mean distance travelled	1	period of activity	2	3.62/5	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3160 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value	764.72	34%	0%	23%	0%	30,313.19
23.9% mean distance travelled	1	period of activity	2	4.40/5	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2830 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	676.37	39%	0%	24%	0%	24,458.08
36.3% mean distance travelled	1	period of activity	2	3.62/5	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2635 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative	956.51	39%	0%	19%	0%	36,863.70
44.5% mean distance travelled	1	period of activity	2	2.15/5	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2970 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	1,321.65	46%	0%	32%	0%	37,854.17

Who and how many?		At what cost?		Outputs	What changes?	How much?	
Stakeholders		Inputs			Outcomes Outcome description	Indicator and source	Quantity (scale)
Who do we have an effect on? Who has an effect on us?	How many in group?	What will/did they invest and how much (money, time)?	Financial value (for the total population for the accounting period)	Summary of activity in numbers.	What is the change experienced by stakeholders?	Describe how you measured the described outcome (including any sources used)	Number of people experiencing described outcome.
Clients of Personal Support and Connection Service	102	Cost of all staff delivering the services (delivery time, preparation time, administration). Materials and consumables. Overheads and % Of Depreciation charge apportioned for stakeholder group	3,800.00	2.5 hours per week spent *outside of delivering other services* by services team, front of house and client liaison team between phone calls and in-house check-ins with new clients	Increased social inclusion, support and community	Adjusted Brief Sense of Community Scale (BSOC): -"Neighbourhood" replaced with "community" -Reduced from 8 to 5 measures for relevance Source and scale: https://www.researchgate.net/publication/229567281_Validation_of_a_Brief_Sense_of_Community_Scale_Confirmation_of_the_Principal_Theory_of_Sense_of_Community Bespoke indicators scored on a 4-point agreement scale to align with BSOC: •I have people to share my feelings and challenges with •I am satisfied with my support system •I have all the support that I need •I am satisfied with the level of social interaction I have currently •I feel that I am part of a community	57
					Increased feelings of acceptance and being accommodated	Bespoke indicators scored on a 4-point agreement scale: •I have someone to ask questions to when I'm unsure what to do •I have access to all the support my family and I need •I feel comfortable asking for what my family and I need •I feel welcomed and accepted at services and appointments •I feel cared for and supported by service-providers •I can rely on service-providers to do what they promise, e.g., contact other organisations, follow up with me, book future appointments	102
					Reduced loneliness	UCLA Loneliness Scale – adapted to 10 measures based on contextual relevance to outcome and avoiding repetitive items Source and scale: https://sparqtools.org/mobility-measure/ucla-loneliness-scale-version-3/ Bespoke indicator on a scale 1-10 (1 not at all): •How lonely do you feel generally?	102
					Increased hope for the future	Adjusted Herth Hope Index and bespoke indicators, scored on a 4-point Likert scale. Source: https://pubmed.ncbi.nlm.nih.gov/1430629/ Scale: http://www.npcrc.org/files/news/herth_hope_index.pdf For all respondents: •I have a positive outlook towards life •I feel alone/ hopeless •I can see possibilities in the midst of difficulties •I have short and/ or long-range goals for myself For parents only: •I have hope for my child's future •I worry about my child being well cared for in future •I have short and/ or long-range goals for my child •I have a sense of direction in relation to my child's care For adults with disabilities only: •I worry about who will take care of me in future •I have hope for my future	102

	How long?			How valuable?			How much caused by the activity?				Still material?
Amount of change per stakeholder (depth)	Duration of outcomes	Outcomes start		Express the relative importance (value) of the outcome			Deadweight %	Displacement %	Attribution %	Drop off %	Impact calculation
				Weighting	Valuation approach (monetary)	Monetary valuation					
Describe the average amount of change experienced (or to be experienced) per stakeholder.	How long (in years) does the outcome last for?	Does the outcome start in Period of activity or in the Period after?	Sum of duration and outcome start	How important is this outcome to stakeholders? (e.g. on a scale of 1-10) (N.B. To make comparison between outcomes possible, your analysis should be consistent in the type of weighting used).	Describe the monetary valuation approach used to express the relative importance (value) of each outcome. (N.B. If your analysis does not use monetary valuation of outcomes, please use the Value Map (non-SROI) tab of this spreadsheet).	How important is the outcome to stakeholders (expressed in monetary terms)?	What will happen/what would have happened without the activity?	What activity would/did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Number of people (quantity) times value, less deadweight, displacement and attribution
56.8% mean distance travelled	1	period of activity	2	2.75/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2545 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	1,445.56	29%	0%	33%	0%	39,196.21
38.3% mean distance travelled	1	period of activity	2	2.91/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2790 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious	1,068.57	38%	0%	31%	0%	46,627.69
25.4% mean distance travelled	1	period of activity	2	2.78/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3385 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative	859.79	42%	0%	28%	0%	36,622.93
22.7% mean distance travelled	1	period of activity	2	2.67/4	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €2950 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	669.65	42%	0%	28%	0%	28,523.88

Who and how many?		At what cost?			What changes?	How much?	
Stakeholders		Inputs		Outputs	Outcomes Outcome description	Indicator and source	Quantity (scale)
Who do we have an effect on? Who has an effect on us?	How many in group?	What will/did they invest and how much (money, time)?	Financial value (for the total population for the accounting period)	Summary of activity in numbers.	What is the change experienced by stakeholders?	Describe how you measured the described outcome (including any sources used)	Number of people experiencing described outcome.
Parents of clients - secondary stakeholders	109	No associated costs - secondary impact created by services delivered to client stakeholders		Conservatively forecasted as 1 parent per child with a disability and 1 parent for every 3 adults with a disability attending the included services.	Increased sense of comfort in leaving their child to attend services alone	Bespoke indicators scored on a 4-point agreement scale: •I feel worried to leave my child alone to attend a service or activity •I feel comfortable when I am not with my child •I am confident that service-delivery staff can manage any need/issue that arises with my child while I am not there Objective indicator – 4-point scale from 1-4 •Number of times child has attended somewhere without carer in past 6 months	109
					Sense of community and connection with other parents	Adjusted Brief Sense of Community Scale (BSOC): -"Neighbourhood" replaced with "community" -Reduced from 8 to 7 measures for relevance Source and scale: https://www.researchgate.net/publication/229567281_Validation_of_a_Brief_Sense_of_Community_Scale_Confirmation_of_the_Principal_Theory_of_Sense_of_Community Bespoke indicators scored on a 4-point agreement scale to align with BSOC: •I have people to share my feelings and challenges with •I am satisfied with my support system •I have all the support that I need •I am satisfied with the level of social interaction I have currently •I feel that I am part of a community Objective indicator scored on a 5-point Likert scale •Times per week they talk to someone who understands their experience Objective indicator scored on a scale from 1-20+ •Number of parents of children with disabilities they consider friends	109
					Relief about their child or children achieving their own outcomes	Bespoke indicators scored on a 4-point agreement scale: •I feel worried about my child's current challenges •I feel worried about my child's future •I feel confident that my child will achieve positive outcomes in future •My child has progressed noticeably in the past 6 months •I feel relieved about what my child has achieved	109

	How long?			How valuable?			How much caused by the activity?				Still material?
Amount of change per stakeholder (depth)	Duration of outcomes	Outcomes start		Express the relative importance (value) of the outcome			Deadweight %	Displacement %	Attribution %	Drop off %	Impact calculation
				Weighting	Valuation approach (monetary)	Monetary valuation					
Describe the average amount of change experienced (or to be experienced) per stakeholder.	How long (in years) does the outcome last for?	Does the outcome start in Period of activity or in the Period after?	Sum of duration and outcome start	How important is this outcome to stakeholders? (e.g. on a scale of 1-10) (N.B. To make comparison between outcomes possible, your analysis should be consistent in the type of weighting used).	Describe the monetary valuation approach used to express the relative importance (value) of each outcome. (N.B. If your analysis does not use monetary valuation of outcomes, please use the Value Map (non-SROI) tab of this spreadsheet).	How important is the outcome to stakeholders (expressed in monetary terms)?	What will happen/what would have happened without the activity?	What activity would/did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Number of people (quantity) times value, less deadweight, displacement and attribution
50.7% mean distance travelled	1	period of activity	2	2.23/3	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €5325 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious	2,699.78	32%	0%	27%	0%	146,078.62
34.7% mean distance travelled	1	period of activity	2	1.44/3	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €3160 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value for each outcome. The average values were cross-checked against qualitative data to ensure consistency and a representative value was calculated. Obvious outliers and false responses were removed before averages were calculated.	1,096.52	23%	0%	25%	0%	69,023.19
30.1% mean distance travelled	1	period of activity	2	2.45/3	Value is based on weighted distance travelled achieved by all clients. The value proxy for this outcome, achieved fully, was: €5300 Valuations provided by respondents across two modified value game approaches (free valuation and value proxies)were combined to calculate the average value	1,595.30	27%	0%	35%	0%	82,509.71