LEEDS SURVIVOR-LED CRISIS SERVICE

A Social Return on Investment Analysis

Real-Improvement

June 2018

Leeds Survivor Leeds Crisis Service

Social Return on Investment Analysis, June 2018

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This Social Return on Investment (SROI) report revises and updates an original SROI analysis undertaken during 2010-2011 and reported in May 2012. It refers back to that original report for comparison and when explaining some of the SROI rationale but does not require knowledge of that report; this is a complete SROI report in its own right.

The original SROI report was Assured by the SROI Network (as it then was – now Social Value UK). This new report is based on that original and has been produced by the same consultant, who is an Accredited Practitioner for Social Return on Investment, although it has not gone through a separate assurance process.

Executive Summary

This report presents a Social Return on Investment (SROI) analysis of Leeds Survivor-Led Crisis Service (LSLCS). It follows up a previous SROI report published in 2012, using fresh analysis and updated valuation data to revise the conclusions from that report in the light of the many changes and new initiatives that LCLCS has undertaken since then.

LSLCS is a registered charity that works with people in crisis and at risk of suicide. It does this through a number of different services; those within the scope of this report are:

- Its crisis service at Dial House, open five nights a week for people in crisis (termed 'visitors') to receive emotional support, or simply use as a place of sanctuary
- The Connect telephone and text helpline, open every night of the year, again to provide emotional support (people who use this service are known as 'callers')
- Dial House at Touchstone, LSLCS's specialist BME service open two nights a week
- Groups for self-help and therapeutic support, which run during the daytime at Dial House.

SROI is a rigourous and comprehensive evaluation method with two distinguishing characteristics:

- It considers the long-term outcomes for all 'key stakeholders' – all individuals and groups significantly affected by the work the organisation does
- It puts a financial value on all these outcomes, including 'intangibles' – health, wellbeing and other emotional benefits that are not always considered by other analysis methods.

The method used is explained in Section 2 and Appendix 1. This approach produces a SROI ratio, calculated by dividing the total added value for all stakeholders (known as the social value), by the investment needed to achieve that added value.

For LSLCS in 2017-18, this SROI ratio is between £7.50 and £12.50 of social value delivered per £1 invested in the organisation. The 'headline' figure, derived from the Impact Map (see separate Annex to this report), is £9.69 per £1 invested. This relies on a number of assumptions and estimates however, and the effect of varying these estimates, as shown in Appendix 2, produces the more reliable range of £7.50 to £12.50 per £1 invested.

This ratio is significantly higher than that shown in the 2012 report. Whilst some of this is due to updated, and more reliable, valuation figures being used, most of it is due to the increased capacity of LSLCS and the much greater number of people that it is now able to help. Even so, LSLCS has to decline a significant number of visit requests because it is full, and its SROI ratio would be higher still if it did not have this capacity issue.

SROI analysis also shows how these figures are broken down. For example, the key stakeholders on whom LSLCS has the greatest impact are:

- Visitors, callers and group members themselves, who benefit emotionally and make progress towards recovery
- Partners, families and friends of visitors and callers, who are reassured when loved ones are safe, and avoid the severe emotional distress that suicide can cause
- Statutory services – NHS (including A&E and ambulance services), Adult Social Care and police. Here, LSLCS reduces the demand on these services, both for emergency situations and longer-term; figures indicate that LSLCS's value in terms of savings to statutory services – even without the benefits to visitors, callers and others – is more than twice the amount it receives in funding from the NHS.

Other key stakeholders include staff, volunteers, taxi companies (who take people to and from Dial House and Touchstone), and other voluntary sector organisations (who benefit when LSLCS visitors and callers are able to volunteer with them).

Further analysis in this report identifies several broad visitor classifications, based on how often and over what period they visit LSLCS. These are shown here with the approximate proportion of visitors in each Group, and numbers for 2017-18.

Group 0: People who would have ended their own life but for the intervention of LSLCS and associated services	5% (21 people)
Group 1: Frequent visitors – people who use the service often (more than 20 times per year on average) over a period of several years	4.75% (20 people)
Group 2: People who use the service extensively over a short period spanning one or two years, and then make a few visits in subsequent years	14.25% (60 people)
Group 3: Occasional visitors – people who make a small number of visits over several years	14.25% (60 people)
Group 4a: People who visit 1-3 times within a year and then never return (believed to have recovered and be economically active)	15.44% (65 people)
Group 4b: People who visit 1-3 times within a year and then never return (outcome unknown - no assumption made about economic activity)	46.31% (195 people)
Group 5: Members of Dial House groups who are not also visitors or callers	55 people

These broad categories enable the changes that different visitors and other stakeholders experience to be valued more accurately than if they were treated as a single homogeneous group. This analysis indicates that, in terms of return on investment, LSLCS achieves the most significant overall value for:

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

This does not mean that other visitors and callers are less important, particularly as 'Group 0' is not a separate group of individuals, but a proportion drawn from all other groups. It is impossible to say who might take their own life without support from LSLCS, and hence no suggestion that it should modify the support it provides for any individual in crisis. It does however suggest ways in which LSLCS could get more targeted feedback to improve its services still further. This, together with a number of other recommendations arising from this report's conclusions, is presented in Section 9.

Section 1: Introduction

1.1. Scope and Purpose of this Report

This report presents a Social Return on Investment (SROI) analysis of Leeds Survivor-Led Crisis Service (LSLCS), often known as Dial House after its main building. The SROI methodology is explained in Section 2, and this report follows up an original SROI analysis carried out by the author in 2010-11 and reported in 2012.

LSLCS has developed significantly since then, so this report reviews and updates the findings, data and evaluation from the earlier report. It is intended to provide up-to-date information for:
(a) Local commissioners and other funders, to evidence the value that LSLCS achieves;
(b) Other parts of the UK that are considering adopting the LSLCS model of support; and
(c) LSLCS itself, to help identify ways in which it could improve its services further still

The LSLCS services covered in this SROI analysis (see Section 1.2 for details) include:
- Core crisis services at Dial House
- The Connect telephone and text helpline
- Dial House at Touchstone, LSLCS's specialist BME service
- Groups which run during the daytime at Dial House

LSLCS describes the people who use its services as visitors or callers, depending on which of these they use.

LSLCS is also connected with two other projects: Leeds Suicide Bereavement Service and the 'Well-Bean' Crisis Café, located near St James's Hospital in Lincoln Green. These are funded separately however, and are not included in this SROI analysis.

Throughout the text, the earlier SROI report is referred to as the 2012 report, even though much of the data it used came from 2010-11.

1.2. Background to LSLCS

Leeds Survivor Led Crisis Service (LSLCS) was established in 1999 following a campaign by a group of service users. Initially run in partnership with Social Services, the service became a registered charity in 2001. It provides out-of-hours support, offering a high-quality alternative to statutory services within a homely environment, for people in acute mental health crisis and at risk of suicide. In 2017, LSLCS employed 23 full-time-equivalent staff (including bank staff), and was supported by 20-24 volunteers, mostly working on its Connect helpline.

LSLCS's approach is person-centred, radical and innovative. It is non-judgemental and does not seek to direct or advise. Rather, LSLCS believes that each person's experience of crisis is unique, and it provides a space where each person can utilise their own experience to help themselves and others through the sharing of problems, alternatives and solutions. Staff receive in-depth training in this approach, and many are also either qualified or qualifying counsellors. LSLCS has always been governed, managed and staffed by people with direct experience of mental health problems.

LSLCS's main building at Dial House in Leeds provides:

- A place of sanctuary open 6pm to 2am five days per week (every night except Tuesdays and Thursdays) where a team of trained support workers is available to provide one-to-one support to those who need it, or visitors can just relax if they prefer. Dial House can accommodate up to 10 visitors each night, and in received 2397 visits from 382 different visitors between April 2017 and March 2018.
- Social and support groups for LSLCS visitors based on self-help and therapeutic support. These meet weekly during the daytime, and currently include deaf support, creativity, MyTime (social group), coping with crisis, hearing voices, LGBT and Trans. There is also a forum which meets occasionally for long-term visitors.

In addition, LSLCS has space at Touchstone, another Leeds mental health charity, which provides:

- A specialist crisis service for black and minority ethnic (BME) communities, open every Tuesday and Thursday evening from 6pm to 11pm. This service received 746 visits from 73 visitors in 2017-18. A new daytime group for BME men has recently been launched here as well.
- A base for LSLCS's telephone/text/online helpline known as Connect, open 6pm to 2am every night of the year. This service, staffed mainly by volunteers, provides emotional support and information for people in crisis, and received 6959 calls and other contacts in 2017-18. (Calls are anonymous, so LSLCS cannot tell how many different callers this represents; however, it knows that 310 people contacted Connect for the first time over this twelve-month period.)

Within this framework, LSLCS provides specialist services for deaf visitors and callers. As well as the deaf support group, a BSL interpreter is available on Mondays evenings at Dial House, and deaf callers can also use Connect via text or social media.

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

- Reducing risk / preventing worse happening
- Supporting people to resolve or better manage crisis
- Reduced loneliness and isolation
- Reduced use of Dial House or other crisis and emergency services

Other outcomes linked to the government's *No Health without Mental Health* strategy are shown in Section 1.5.

LSLCS is funded mainly by NHS Leeds CCG (it was previously funded jointly by the NHS and Leeds City Council Adult Social Care, but the CCG has now assumed full responsibility). It also receives a small amount of funding from the Leeds Personality Disorder Network, part of the Leeds & York Partnership NHS Foundation Trust (LYPFT), and a small amount in voluntary donations and legacies. Its BME services at Touchstone are funded by the Big Lottery and support for deaf visitors by the Tudor Trust.

1.3. LSLCS Service Developments since 2011-12

Prior to June 2011 Dial House was open just three nights per week from 6pm to midnight, and Connect operated only from 6pm to 10.30pm. Increased funding has enabled the service to expand substantially since then, with Dial House open more evenings and longer hours, the Connect service

open until 2am, and the BME service at Touchstone operating since 2013. There are also more groups and more people attending these groups.

This expansion has enabled LSLCS to support an increased number of visitors and callers, and to offer more support to those most in need. At the same time, reductions in NHS and other public service provision have led to a substantial increase in demand, so that LSLCS still cannot offer places to everyone who would like to visit. The graph below shows the steady increase in visits over the last 12 years since 2006. (NB: this graph shows calendar years and is the number of visits, not the number of visitors, including Dial House at Touchstone from 2013 onwards.)

Fig 1.1: LSLCS: Number of visits per year

This increase does not mean that LSLCS is dealing with people at lower levels of crisis than in earlier years. If anything, the reverse is true: the proportion of visitors for whom suicide is a 'presenting issue' (i.e. where the person has the intention and the means to end their own life) has historically been slightly above 50% and is now around 65%. LSLCS used to feel that those to whom it declined a visit would be safe on that occasion; now it is concerned that this may not be true in some instances.

N.B. This graph also shows that, despite increased capacity, LSLCS is having to decline a higher proportion of visit requests: in 2012, 29.4% of all visit requests were declined due to the service being full; in 2017 this figure was 38.2%. There is also a marked difference between LSLCS's two locations on the 2017 figure – Dial House declined 43.1% of visit requests whereas Dial House at Touchstone declined just 8.4%.

Intensive Support Project: LSLCS is also currently piloting a new way of working with some of its long-term visitors (those who visit frequently over a period of several years). This seeks to 'take under one roof' a small number of frequent visitors who are also well known to, and frequent users of, NHS and other statutory services. The idea is to provide a guaranteed level of intensive support for these visitors, so that all support comes from LSLCS instead of their using both LSLCS and other

services. Preliminary results are promising and indicate potential savings, but LSLCS has not yet secured additional funding for this work.

Throughout, LSLCS's principles and ways of working have not changed. It remains a person-centred service managed and staffed by people with direct experience of mental health problems.

1.4. Other Mental Health Services in Leeds

LSLCS works closely with other mental health services across Leeds. Restructuring and budget cuts resulted in the only comparable non-NHS crisis provision in Leeds, the Leeds Crisis Centre (run by Leeds City Council), closing in 2011. This was part of an ongoing strategy across the city, intended to rationalise existing services and move from palliative day care provision towards services that help people manage and improve their condition, in many cases enabling them to return to work. As mentioned in Section 1.2, this reduction in NHS and Local Authority provision has led to steadily increasing demands on LSLCS.

Within the NHS, the first point of contact for people in crisis is often their GP, and LSLCS has taken steps to raise GPs' awareness of its services. Beyond this, specialist mental health services provide by LYPFT include a Crisis Assessment Service, Intensive Community Service, Acute Liaison Psychiatry Service, Personality Disorder Network and Community Mental Health Teams, together with inpatient services at the Becklin Wing of St James's hospital. Other NHS services such as ambulances and Accident & Emergency units can often be involved as well, particularly in cases of self-harm.

Other Leeds CC services can also be involved. Some visitors also attend day-care centres run by the Council, and some may receive other support from Adult Social Care, although it is not possible to verify this as confidentiality rules preclude the sharing of data on individuals.

Leeds also has a thriving voluntary and community sector (VCS), with many organisations involved in supporting people with mental health problems. None of these VCS organisations duplicates LSLCS's role in providing crisis support and out-of-hours services however.

Many visitors and callers use these other services alongside LSLCS; in many cases LSLCS forms part of their care plan. It is important to understand LSLCS as contributing to care, support and recovery for these individuals, rather than being solely responsible for it. SROI calculations take account of this primarily through Attribution (Section 7.3).

1.5. Mental Health and Suicide: The National Picture

Current government mental health policy is based on the strategy document *No Health Without Mental Health*, published in 2011. This lists a number of intended outcomes:

- More people will have good mental health
- More people with mental health problems will have good physical health
- More people with mental health problems will recover
- More people will have a positive experience of care and support
- Fewer people will experience stigma and discrimination

LSLCS works towards all of these outcomes, as well as those noted in Section 1.2.

Alongside this, the profile of mental health has been raised substantially in recent years, with campaigns such as Time to Change and Heads Together, including the involvement of the Royal

Family. Government data however indicates that increases in funding have not kept pace with increasing prevalence of mental health issues and consequent support needs. For example, survey data from 2014 showed that 6.4% of people reported having ever self-harmed, up from 2.4% in 2000[1].

In 2012, the government published a strategy more specific to suicide: *Preventing Suicide in England A cross-government outcomes strategy to save lives*. This led to local suicide prevention strategies being developed across the country, and work done in Leeds as part of this agenda is nationally recognised: The Local Government Association suicide prevention guidelines[2] used the Leeds Suicide Bereavement Service as a best practice case study.

In Great Britain in 2016, there were 5,965 deaths where the cause was identified as suicide, with men three times more likely than women to take their own lives[3]. This suicide rate has been fairly static since 2006, having gradually declined over the previous 25 years. The most recent suicide audit for Leeds covered the period 2011-13, and noted a suicide rate of 9.5 deaths per 100,000 people in Leeds – comparable with the national average[4].

There is some evidence linking suicide to poverty. Historically, the suicide rate in the UK reached its highest level in 1934, at the peak of the economic depression[5]. Anecdotally, austerity and associated reductions in welfare benefits may be a factor in current suicide rates which are thought to be gradually rising again.

[1] Source: *Mental health statistics for England: prevalence, services and funding*, House of Commons briefing paper, April 2018
[2] Source: *Suicide Prevention: A Guide for Local Authorities*, Local Government Association, February 2017
[3] Source: *Suicides in the UK: 2016 registrations*, Office for National Statistics, December 2017
[4] Source: *Audit of Suicides and Undetermined Deaths in Leeds 2011-2013*, Office of the Director of Public Health, Leeds City Council, September 2016
[5] Source: *Suicide in England and Wales 1861-2007: A time trends analysis* Thomas & Gunnell, University of Bristol, published in International Journal of Epidemiology, April 2010

Section 2: Evaluation Method

2.1. Social Return on Investment (SROI)

The SROI methodology used in this report measures all aspects of an organisation's social, economic and environmental impact. It identifies and measures the changes experienced by the organisation's stakeholders – the people and organisations that are affected by it or who contribute to it. It then uses financial proxies to value all significant outcomes for stakeholders, even where these outcomes reflect changes that are not normally considered in financial terms. This enables a ratio of costs to benefits to be calculated, so that for example, a ratio of 1:4 indicates that each £1 invested delivers £4 of social value. Full information can be found on the Social Value UK web site: http://www.socialvalueuk.org

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

This is an evaluative SROI report; in other words it considers retrospectively the value that LSLCS has achieved rather than anticipating the impact of future developments. Analysis and valuations are based on the financial year April 2017 to March 2018.

2.2. Evaluation Methods

Information for this SROI analysis has been gathered from a range of sources, including:

- Interviews with visitors, callers and group members, conducted either 1:1 or in group discussions by the consultant. A total of 40 people were seen in this way, through meetings with groups at Dial House and Touchstone, including callers at a Connect Open Day in May 2018.
- Discussions with LSLCS staff, managers and trustees: 24 people in total were seen at meetings and focus groups discussions, and the consultant spoke informally to many others when at Dial House and Touchstone.
- Interviews with external representatives from NHS, Leeds City Council, and other third sector organisations who work in partnership with LSLCS. The consultant interviewed seven such contacts by telephone.
- Statistics from the database maintained by LSLCS. This records (anonymously) data such as which visitors visit on each night and how many calls Connect receives.
- Survey data collected by LSLCS from its visitors and group members through questionnaires and feedback cards. LSLCS also records verbal feedback from Connect callers.
- Performance returns to NHS and Leeds City Council, which include quantitative and qualitative information compiled by LSLCS

- Other service reviews and reports, such as the Year 4 Monitoring Report for Dial House at Touchstone compiled for the Big Lottery.

All of this information was gathered over the period February to May 2018, and is in addition to information gathered over 2010-11 for the original SROI report.

2.3. Constraints on the Evaluation Process

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

- Interviews with visitors could not be done during normal crisis support opening hours, and were restricted to those were available and willing to talk at other times. Whilst a total of 40 visitors and callers were seen on other occasions, these were not a complete cross-section of those with whom LSLCS works (in particular, visitors who use the service a few times and then never return could not be interviewed). However, LSLCS gathers evaluation comments and feedback from many other visitors and this, together with the experience of staff, is more representative.
- It was not considered appropriate to directly involve partners or family members for reasons explained in Section 6.1.
- Because calls to the Connect helpline are anonymous, it is impossible to tell exactly how many different callers use the service, or how many of these are also visitors to Dial House. LSLCS has explored ways of gathering feedback from its callers however – see Section 4.6.

In addition, LSLCS and statutory bodies do not share confidential personal data. This means for example that it is not possible to track the progress of individuals across different services; LSLCS knows that many of its visitor and callers use NHS and/or Adult Social Care services, but does not know how many or how often. These issues are addressed in Section 6.4.

Finally, there is the issue of assessing what might have happened to visitors and callers had LSLCS not been there to support them. Whilst many visitors and callers say they would have died without LSLCS, research suggests the proportion would have been smaller than this, and comparison of suicide rates between Leeds and elsewhere do not prove otherwise. Nevertheless, there is no doubt that LSLCS has saved the lives of some of its visitors and callers, and Section 4.3 explains how this is taken into account.

2.4. Acknowledgements and Thanks

This report and analysis has been compiled by Andy Bagley of Real-Improvement. Andy is an experienced management consultant with specialist expertise in performance management and evaluation. He is an Accredited Practitioner on Social Return on Investment, and has worked extensively on SROI analyses and other evaluations in the field of mental health.

A great deal of help and information has been provided by LSLCS staff, visitors and callers, and representatives from outside organisations with an interest in the service. Andy would like to record sincere appreciation and gratitude for all support and assistance received, and to the many people who have given their time so willingly to assist this project.

Section 3: Stakeholders – Who LSLCS Has an Effect On

3.1. Stakeholder Identification

The identification of stakeholders was first undertaken in 2011 through discussions with LSLCS staff (including a stakeholder mapping exercise with a staff group), manager and Board chair, supported by later discussions with external stakeholders as part of 1:1 interviews. This was developed further with staff and managers for the current analysis, in the light of how LSLCS has expanded and changed since then. The result is summarised below, with those groups closer to the centre of the diagram being defined as 'key stakeholders' for SROI purposes:

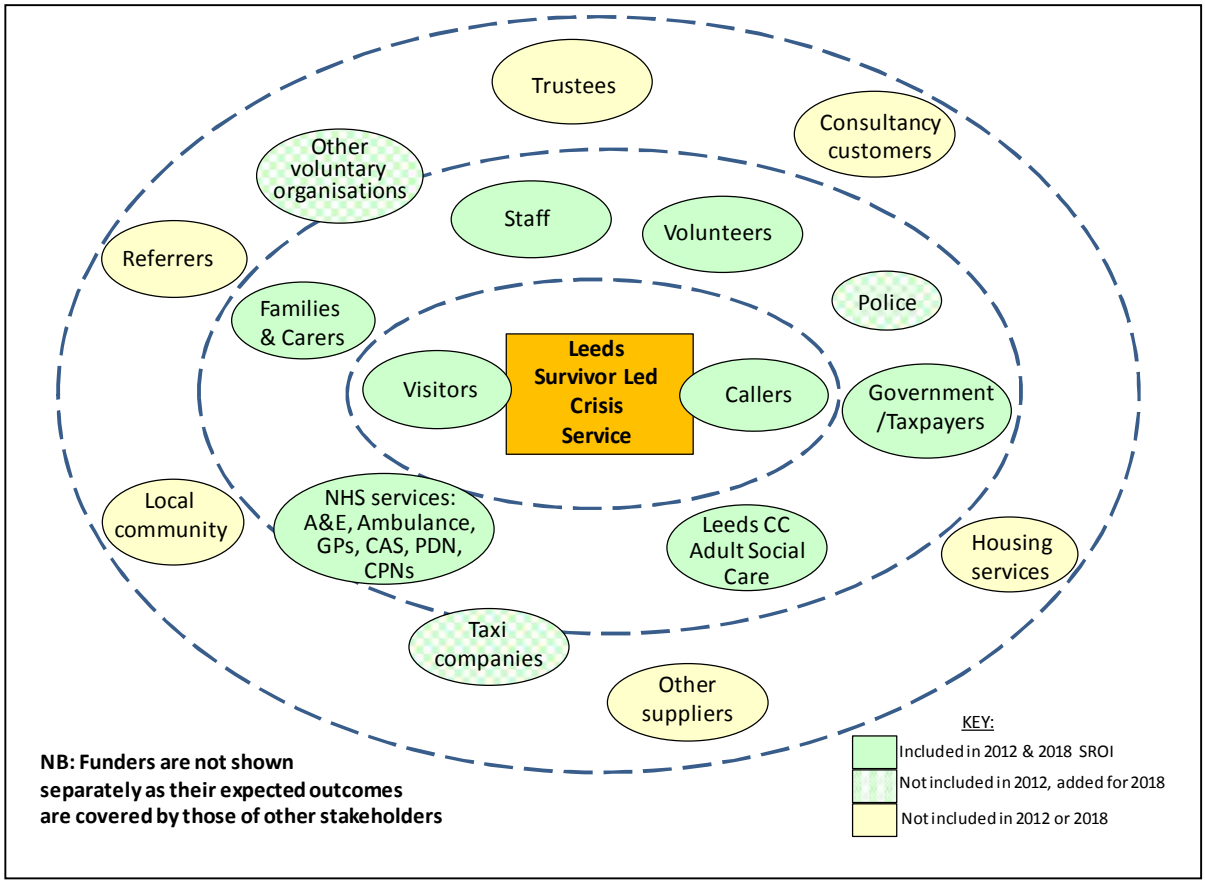


Fig.3.1: Stakeholder diagram

Police, taxi services and other voluntary organisations have been added to 2012 list of stakeholders.

3.2. Stakeholder Groups Included

The table on the next page shows the groups included from the stakeholder diagram above, and summarises inputs, outputs and outcomes for them. This table forms the starting point for the SROI Impact Map (see Annex).

Stakeholder Group	Inputs	Outputs	Outcomes	Notes
Funders (input only)	Funding	Contract requirements met	Outcomes covered below for NHS and LA services	SROI data may be useful for these stakeholders
Visitors, callers and group members	Time	Number of calls or visits, time spent in Dial House or in Connect conversations	Outcomes can include: - Avoiding premature death - Better quality of life and ability to cope - Chance to return to work either as a volunteer or in paid employment Negative outcome possible if visit requests refused.	Outcomes will vary depending on the caller/visitor's situation and the nature of their interaction with LSLCS – see analysis of sub-groups in Section 3.3.
NHS services Leeds CC Adult Social Care	Time (liaison)	Number of patients or clients seen by LSLCS, time spent with them	Improved overall service capability and results, ability to handle increased demand with more appropriate service provision, better mental health outcomes for the community as a whole	NHS monitoring of LSLCS outcomes is mainly qualitative, based on LSLCS aims and *No Health without Mental Health* objectives
Partners, family members and friends	Time, support	Number of visits, time visitors or callers spend with LSLCS	Respite, reduced stress and anxiety, relief when progress made	Not involved for all visitors/callers
Police	Time (liaison)	Number of instances of police involvement avoided	Reduced police costs (or able to use police time on other work) where LSLCS reduces need to use S136 or other interventions	Analysis of LSLCS long-term visitors pilot includes police time and associated costs
Local taxi firms	Time	Number of journeys to/from Dial House	Income from supplying taxi services to LSLCS visitors	Main LSLCS contract is with a single taxi company
Other voluntary organisations	No direct input	Number of LSLCS visitors volunteering	Value of volunteering support provided by LSLCS visitors and callers	A few LSLCS visitors /callers volunteer elsewhere
Employees	Time, skills, commitment, knowledge, experience	Hours worked, number of contacts	Employment (paid staff) Personal satisfaction and fulfilment from work, team spirit and LSLCS ethos	
Volunteers		Hours worked, number of contacts	Personal satisfaction and fulfilment, development opportunities, experience towards paid employment	
Central Government	No direct input	Number of benefit recipients, tax receipts	Reduced benefits expenditure and increased tax receipts, for those who move into paid employment	Part of wider local & national strategy, other mental health services also contribute to this

Fig.3.2. Summary of inputs, outputs and outcomes for key stakeholders

3.3. Visitor Sub-Groups

LSLCS works with people in crisis and at risk of suicide, as it always has. The key characteristics of its visitors and callers are therefore unchanged since the 2012 report. This report identified four key visitor sub-groups based on their patterns of visits:

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

LSLCS now has visitor data available for a continuous period of more than 12 years, since the start of 2006. Detailed analysis of this data shows that these four categories are still the most relevant way to identify different visitor categories and associated outcomes, although the definitions have been refined and the percentage of visitors in each group has changed as shown in the table below:

	% of visitors in this group: 2011	% of visitors in this group: 2017-18	Number of visitors in group: 2011	Number of visitors in group: 2017-18
Group 1: Frequent visitors – people who use the service often (more than 20 times per year on average) over a period of several years	7.5%	5%	12	21
Group 2: People who use the service extensively over a short period, and then make a few visits in subsequent years	12.5%	15%	20	63
Group 3: Occasional visitors – people who make a small number of visits over several years	30%	15%	48	63
Group 4: People who visit 1-3 times within a year and then never return	50%	65%	80	274

Fig.3.3. Basic visitor sub-group definitions and numbers

The last two columns are based on annual visitor numbers of 160 in the 2012 report (this was actually the average number of visitors over 2009-10), and 421 visitors in 2017-18[6].

There are two main reasons for the shift in these group percentages as LSLCS's capacity and services have expanded:

- All other things being equal, LSLCS gives priority to new visitors over more frequent visitors that it already works with
- LSLCS works to manage the number of long-term visitors it has and support their recovery, for example through the groups that it runs and the long-term visitors project (Section 1.3)

This shift means that a higher proportion of visitors made 1-3 visits in 2017 (76%) than was the case in 2010 (66%). Even so, roughly 5% of LSLCS visitors accounted for 50% of all visits made in 2017-18.

[6] Source: LSLCS data on number of visitors: 382 to Dial House and 73 to Dial House at Touchstone, total 455. However, 46% of Dial House at Touchstone visitors also visited Dial House in 2017, so a deduction of 34 (46% x 73) has been made to avoid counting the same visitors twice, resulting in a net total of 421.

NB: Analysis in the next section also introduces two further visitor categories:

- One category is termed 'Group 0', for consistency with the 2012 report. These are visitors who, were it not for LSLCS and other mental health services, would have ended their own life. These individuals could come from any of the four groups above, but the change they experience is quite different, because in their case it is literally the difference between life and death.
- A further category is termed Group 5, and these are people who use the Dial House groups but are not current users of its crisis services as visitors or callers – although some may have used these services in the past.

Section 4 addresses the impact of change for these two additional groups.

3.4. Valuing Inputs

LSLCS's total income for the financial year 2017-18 was £809,422. This figure is the starting point for calculating input for this SROI, as it represents the actual cost of providing LSLCS's services. However, two deductions are made from this, covering the cost of running the two services not included in this analysis (see Section 1.1): The Well-Bean Crisis Café and the Suicide Bereavement Project. The total sum involved is £52,575, leaving a balance of £756,847 used as the input figure in the Impact Map.

Working time of employed staff is paid for by the income received from funders, so no additional input is added for this. Volunteers are in a different position however, because their time is not paid for but still represents an additional input, in kind, for LSLCS. For this reason (in common with many similar SROI analyses) an input value has been attributed to volunteers.

In the 2017-18 financial year, volunteers worked a total of 7454 hours[7] and this is given a value of 11.49 per hour[8], making a total input value of £85,646.46.

3.5 Stakeholder Groups Not Included

The following stakeholder groups are not included in this SROI analysis for the reasons shown.

FUNDERS (NHS, BIG LOTTERY, TUDOR TRUST)
LSLCS receives most of its funding from NHS Leeds CCG. Contract and service level agreements specify expected outputs and outcomes. However, this and other funding organisations do not experience any material change in their role as funders. The real benefits to them are better outcomes for the target population and reduced demand for NHS and Adult Social Care services; these are captured in the stakeholder groups included (Section 3.2).

LOCAL COMMUNITY
Local residents have no direct dealings with Dial House, and it has no relevant impact on them.

SUPPLIERS
Taxi firms are included in Section 3.2 above. Dial House also uses other suppliers, for example purchasing small quantities of food from local shops. However, the sums involved are very small and not significant for evaluation purposes.

[7] Source: Data from LSLCS based on number of shifts worked by volunteers. Most but not all of these were on the Connect helpline.
[8] Source: ONS data on average pay for work in health & social care (taken as nearest equivalent for LSLCS): £425 for 37-hour week = £11.49 per hour (Figure for March 2018 published by ONS May2018)

HOUSING SERVICES

Some LSLCS visitors and callers have housing problems and there is frequent liaison with housing services. However, the benefits here accrue to the individuals rather than to housing services.

TRUSTEES (MANAGEMENT COMMITTEE)

LSLCS has a Board of Trustees, known as the Management Committee, which oversees its work and fulfils a governance role. Board members make a vital contribution to the work of LSLCS, but are not included as key stakeholders for SROI purposes because they do not experience a significant level of material change through their role as Trustees (as distinct from other connections they may have with LSLCS), as a result of its activities.

REFERRERS ('SIGNPOST')

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

CUSTOMERS FOR CONSULTANCY/TRAINING

These are other organisations for which LSLCS provides training, consultancy or other guidance. This 'non-core' area of LSLCS work falls outside the scope of this SROI analysis.

Section 4: Outcomes for Visitors and Callers

4.1. Chain of Events and Theory of Change

Discussions with LSLCS staff and visitors established that the extent and duration of visitor/caller contact with LSLCS varies considerably. This discussion also identified that these contacts could be broadly grouped into several different routes or 'change pathways'. The original 2012 pathways diagram has been refined to the version shown below.

This should be interpreted a broad depiction of what happens; the reality is not as linear as the diagram might suggest (for example, some people return to use LSLCS again having initially moved on; analysis in Sections 4 to 6 takes account of this).

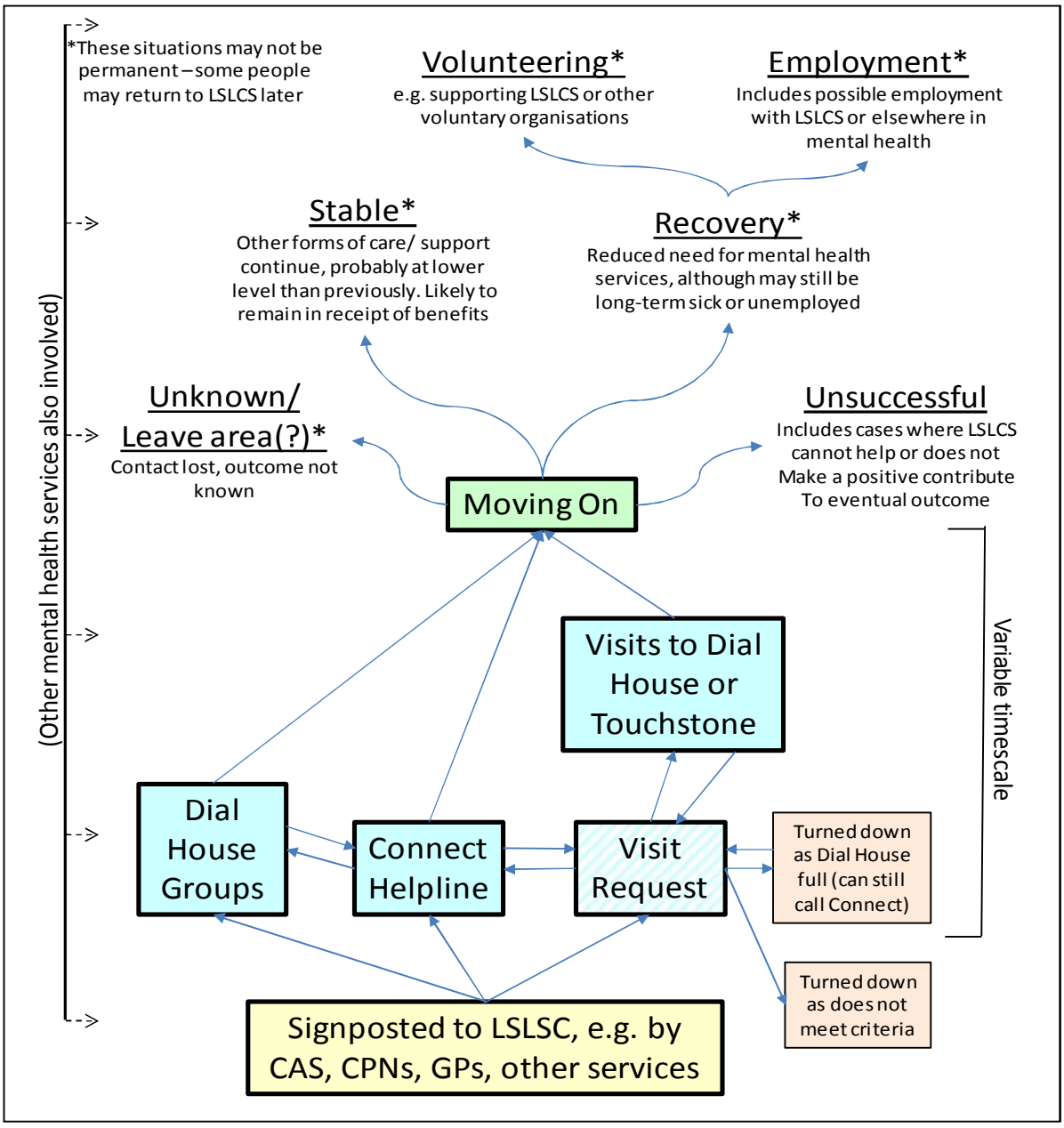


Fig.4.1: LSLCS Change Pathways

Visitors/callers are not formally 'referred' to LSLCS. Rather, agencies such as the NHS Crisis Assessment Team, Community Psychiatric Nurses, the Personality Disorder Network or another Third Sector organisations may 'signpost' people to the service. Alternatively, people may hear about LSLCS though wider publicity and contact it direct. Individuals will then spend a period using Dial House, Dial House at Touchstone, or Connect (or more than one of these), and may become members of one or more Dial House groups as well.

This period could be as short as one call or one visit, or could be as long as several years. It is not intended to be indefinite (the aim is always to help people overcome crisis and move on), and LSLCS has put a great deal of effort into ensuring that its most frequent visitors can genuinely make progress rather than continuing to rely on its services. There are however a small number of people for whom LSCS support seems likely to continue for the foreseeable future; the best that can be hoped for these visitors is to maintain them safe from self-harm.

During the period visitors/callers spend in contact with LSLCS, they are supported in several ways:

- In the majority of visits (about 60% in 2017-18) the visitor chooses to talk 1:1 with a support worker, and all callers receive 1:1 telephone support. LSLCS has its own compassionate and non-judgemental philosophy which visitors/callers find particularly helpful
- For all visitors, Dial House and Dial House at Touchstone are places of sanctuary, safe environments where they can relax and escape from the pressures that exacerbate their crisis
- Visitors can also use Dial House facilities such as a computer with Internet access, and a bathroom (much appreciated by those who do not have a bath where they live)
- Isolation is reduced; simply having people around them or someone to talk to is therapeutic for many visitors – although socialising is not compulsory, and those who prefer to be on their own can be
- Dial House staff can sometimes assist with practical issues, for example helping visitors/callers make better use of NHS and other mental health support services, or with advice on housing.

After this period of involvement with LSLCS, one of several things may happen. In some cases, the person may find that LSLCS cannot help, and they go back to (or remain with) other parts of the mental health system or other forms of support. The worst-case scenario is that the person takes their own life; however, this virtually never happens in cases that LSLCS is aware of – the one significant exception is covered in Section 5.1.

In many cases, particularly where people use the Connect service only, LSLCS has no way of knowing what subsequently happens to the person, or even if they are still in the Leeds area. In a few instances it finds out later if the person re-contacts the service – this can happen after a period of years and sometimes just to say thank you. However, the anonymity of Connect callers makes it difficult to gather comprehensive information (see Section 5.3).

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

In the most positive outcomes, individuals will experience a good degree of recovery and can progress beyond needing support into roles where they become net contributors to society. Some 'short-term' visitors and callers may already be in paid employment, and LSLCS is helping them through a temporary crisis to get "back on their feet" (quote from someone in this position). For

longer-term visitors/callers, progress may initially be through some kind of volunteering role, either with LSLCS or elsewhere, and some move on from there to paid employment.

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

Finally, Fig.4.1 also highlights a possible negative outcome where requests for visits are declined because Dial House is full on a particular night and/or the person requesting a visit was not given priority. This is covered in Section 4.7, with associated valuation in Section 5.5.

4.2. Visitor Patterns and Subsequent Outcomes

Table 3.3 shows the proportion of visitors in each of Groups 1 to 4, based on their pattern of visits. Evidencing outcomes for each of these groups takes account of the different outcomes that apply to various stakeholders (not just visitors themselves) from:
(a) the period that visitors/callers spend in contact with Dial House and Connect; and
(b) the period after they move on in one of the ways depicted in the diagram at Fig.4.1.

For example, visitors in Groups 1 and 3 show a need for LSLCS support which continues for several years (albeit at very different levels). Visitors in Group 4 on the other hand may well recover after being supported by LSLCS, although this outcome is far from certain given the difficulty of maintaining contact with this Group. In any event, they do not show the continuing need evident in other Groups.

The rest of this section explains how this analysis has been carried out and Sections 5 and 6 explain the financial proxies used. The full calculation is shown in the Impact Map (Annex 1 - separate document). This takes a one-year investment period and considers the outcomes achieved during that year and the four years thereafter, for all stakeholders included.

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

4.3. The Impact of Possible Suicide

Before applying the Table 3.3 percentages to the number of visitors in any year, analysis must first take account of people who would have taken their own life but for the intervention of mental health services including LSLCS (not necessarily LSLCS alone). This remains one of the most difficult factors to address within this analysis. There is no doubt that LSLCS makes a significant contribution to averting suicide in some of its visitors and callers. Evidence to support this is demonstrated by:

- the proportion of visit requests where suicide is a presenting issue (i.e. the person has the intention and the means to end their own life), which has always been over 50% and is now around 65%
- those visitors who explicitly state, in interviews or other feedback, that they would be dead were it not for LSLCS
- the high level of confidence that statutory services place in LSLCS's ability to help people in severe crisis
- the known risk profile for some of the people LSLCS deals with (i.e. characteristics such as single, unemployed, socially isolated, etc)

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

A figure of 5% (21 visitors in 2017-18 including Dial House at Touchstone) has been used as a conservative estimate of this proportion, based on the following evidence:

- Analysis from the 2012 report analysed feedback from visitor surveys, visitor book comments and a November 2009 review by NHS Leeds and Leeds Adult Social Care identified a significant proportion of cases where visitors stated they would have taken their own life were it not for LSLCS. The original estimate of 5% came from this analysis, and the situation of LSLCS visitors has not significantly changed since.
- One question from LSLCS's Dial House visitor questionnaire of February 2018 asked visitors "How would you have coped if you could not have come to Dial House?" Of 88 respondents, 8 (9%) replied "Would have made a suicide attempt/be dead".
- Further comments from LSLCS visitor surveys and Connect feedback in 2017 support this view, with many respondents using comments such as "I wouldn't be alive", "I would have acted on my thoughts", "You've saved my life tonight", "You've stopped my suicide attempts".
- Interviews conducted by the consultant with visitors and members of the Coping with Crisis group confirmed that some visitors felt that they would not be here if not for LSLCS.

Whilst we cannot be sure that these comments are representative of all Dial House visitors, the resulting figure of 21 per year is also considered plausible given that a city the size of Leeds should expect between 70 and 75 suicides per year based on latest data (9.5 suicides per 100,000 population age 15 & over in 2011-13[9]). Using a higher percentage figure would suggest that Leeds has a potentially much higher propensity for suicides that comparable English cities, and this is not felt to be realistic.

4.4. Other Cases – The Remaining 95%

Using the figure of 5% for Group 0, we apply percentages from the previous table to the remaining 95% to arrive at the following overall percentage figures. These percentages are then multiplied by 421 (number of visitors for 2017-18 – see Section 3.3), to give the actual number of visitors in each category. These numbers are shown in brackets below, and in the Impact Map.

Table 4.2: Visitor numbers for Groups 0 to 5

Group 0: People who would have ended their own life but for the intervention of LSLCS and associated services	5% (21 people)
Group 1: Frequent visitors – people who use the service often (more than 20 times per year on average) over a period of several years	4.75% (20 people)
Group 2: **Group 2**: People who use the service extensively over a short period spanning one or two years, and then make a few visits in subsequent years	14.25% (60 people)

[9] Source: *Audit of Suicides and Undetermined Deaths in Leeds 2011-2013*, Office of the Director of Public Health, Leeds City Council, September 2016

Group 3: Occasional visitors – people who make a small number of visits over several years	14.25% (60 people)
Group 4a: People who visit 1-3 times within a year and then never return (believed to have recovered and be economically active)	15.44% (65 people)
Group 4b: People who visit 1-3 times within a year and then never return (outcome unknown - no assumption made about economic activity)	46.31% (195 people)
Group 5: Members of Dial House groups who are not also visitors or callers (not included in total of 421 – see Section 4.5)	55 people (see Section 4.5)

In addition, as shown above, category 4 has been split into two. It is divided between those who are believed to have made a full recovery and are economically active (e.g. have returned to work or never had to stop working) (4a) and those – a much higher proportion – for whom the outcome is unknown because they cannot be traced and are in effect lost to the system (4b).

There are some indications that these group percentages vary between visitors to Dial House and Dial House at Touchstone, with the latter having fewer long-term visitors and more visitors in or returning to work. However, analysing this is complex because of visitors who use both houses, and should not affect figures for this SROI because this aggregates visits to both.

The proportion of short-term visitors who make the progress described as Group 4a is estimated at 15.44% of all visitors in a year (25% of those in Group 4). The justification for this estimate comes from feedback to LSLCS and academic studies on the impact of psychological interventions (particularly talking therapies) on the risk of repeat self-ham or suicide attempts:

- NHS commentary on Danish research, conducted over a 20-year period, which indicated that psychological therapy was associated with a 27% reduced risk of self-harm within one year and with a 25% reduced risk of death from suicide[10].
- A research paper from 2010[11] which identifies a significant number of self-harm patients who, subsequently tracked over periods of up to 10 years, showed long-term costs to the mental health system of close to zero. This strongly indicates a good level of recovery for these individuals – 20 from a total sample size (including those who could not be traced) of 150.
- Informal feedback gathered by CAS, on referrals they signpost to other services, including LSLCS. CAS follows up these individuals by telephone after a short period; in some cases they receive an appreciative response confirming that the person had experienced a short-term crisis which they have now overcome.
- An NHS Leeds study of A&E admissions for patients who had one or more episode of self-harm during 2009/10[12]. This showed that the great majority of such patients (83.4%) had only one self-harm related inpatient spell during this period. (This analysis has to be taken in context, because it deals with inpatient admissions only, and some people who repeatedly self-harm will be treated only as outpatients or may avoid hospital entirely. Nevertheless, it indicates that there are many people for whom self-harm, and associated crisis, is a one-off or short-term episode).
- Experience of Dial House staff who can recall instances of short-term visitors they have supported whom they believed were in full-time work, and who have received calls (via Connect) from people who have recovered, thanking LSLCS for its support.

[10] Source: Therapy reduces risk of suicide or self-harm https://www.nhs.uk/news/mental-health/therapy-reduces-risk-of-suicide-or-self-harm/

[11] Source: *Healthcare and Social Services Resource Use and Costs of Self Harm Patients*, Sinclair et al, Social Psychiatry and Psychiatric Epidemiology, February 2010

[12] Source: *Self harm Inpatient Activity Analysis*, NHS Leeds Information Services, October 2010

- Written comments from visitors also refer to short-term crisis. Two examples, one from a message card and one from a letter, are shown here.

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

"Hope all is well with you all. Don't know if you remember me or not but I used to use the service. I have lived in Lincolnshire now for 3 years and wondered would I be able to nip into Dial House to see you all. My life has totally changed and it's all thanks to you. Without you all I wouldn't be here now married and pregnant with a little boy. I would love to see you all and thank you all face to face for everything you have ever done for me."

4.5. Group Members

Many members of the groups that meet at Dial House are visitors or callers as well. Some are not however, and in any case the groups serve a different purpose to LSLCS's visitor and caller services. Rather than immediate support, they aim to help group members strengthen their ability to self-manage, cope better with crisis and improve their general mental health.

Feedback from group members interviewed for this SROI analysis showed that they benefit over and above their experience as visitors/callers through:

- The chance to 'switch off' from outside pressures in a peaceful, relaxed and safe space
- Improved confidence and better ability to manage crisis, anxiety or depression – for some group members, this reduces their need to use LSLCS visitor and caller services, or NHS crisis services
- Social time, friendship and mutual support with other group members, including sharing information on other support and opportunities available. Some groups have arranged outings together
- Development opportunities; for example, some long-term visitors are involved in interviewing new volunteers and prospective new members of staff

Moreover, group members felt that these benefits were long-term and that, through reduced levels of anxiety and depression, they helped members to improve their wellbeing and overall quality of life.

For group members who are also visitors or callers, Impact Map calculations on drop-off (Section 7.4) take account of this longer-term effect. For those group members who are not also visitors or callers – estimated as 55 in 2017-18[13] – a separate valuation is made as explained in Section 5.3.

4.6. Callers

The 2012 report did not include a separate valuation for the Connect helpline because anonymity meant that very little data was available on the number of callers and the outcomes achieved for

[13] Source: LSLCS data, which shows 140 group members in 2017 and an average of 39.5% of group members over the ten years since 2008 who are not visitors or callers

them. Since then, LSLCS has made efforts to gather more feedback from callers and develop its knowledge of caller characteristics from staff and volunteers' experience. Key points learned are:

- In the twelve months April 2017 to March 2018, Connect received 5985 calls, 277 of which were from new (first-time) callers, and 974 online calls, 33 of which were from new callers. This makes a total of 6959 calls including 310 new callers.
- The majority of calls come from people who are, or have been, LSLCS visitors. People often call Connect if their request for a visit to Dial House has been declined. Connect has some frequent callers in the same way that Dial House and Dial House at Touchstone have frequent visitors (a few people say they call Connect every day). Connect staff and volunteers know that at least some of these callers never visit.
- Although it is impossible to know exactly how many callers are not also visitors, the Connect service estimates that around 35% of their calls on an average night will come from people who do not visit Dial House or Dial House at Touchstone.
- Although callers' feedback is qualitative, it shows that the outcomes that Connect achieves are similar to those for LSLCS visitors. The quote to the right shows a striking example of this, and is not unusual in the type of calls that Connect receives. Some callers are in a similar state of crisis to visitors, and simply wish to guard their anonymity by calling rather than visiting in person. Online callers may also not wish to let anyone else in their household know that they are calling.

> "I had taken an overdose and just wanted to talk with someone while I died, I ended up giving the worker my name and address and she called an ambulance, she helped me see there was another way to stop the pain I was in"

- Other callers are not in immediate crisis, but are very lonely, as illustrated by the example quotes below:

> "It's really great. Connect is a lifeline to me. I have no friends. I feel very lonely. Without Connect I don't know what I'd do."

> "I wasn't in crisis, but I felt very lonely and it helped that feeling."

This range of views was echoed by feedback given to the consultant when he attended the Connect Open Day. Two former Dial House visitors, who now use Connect, also mentioned the reassurance of Dial House still being there should a serious crisis ever occur for them.

Connect is funded on the basis that callers generally are in a lower state of crisis that LSLCS visitors. Although – as one of the examples above shows – this is not always the case, this SROI analysis takes account of this through the lower valuation given to Connect calls, as explained in Section 5.4.

Callers also have an alternative: that of the national Samaritans service, and some callers use this service as well as Connect. (For older callers there is also The Silver Line, although this focuses more on friendship, help and advice.) Discussion with LSLCS staff and visitors highlighted several differences however:

- Samaritans is not a local service, so callers cannot normally speak to the same person on different occasions, link with visits to Dial House, or discuss other local mental health services.

- Samaritans will stay talking to someone who is suicidal but do not otherwise intervene, whereas Connect will try if possible to get practical help where it is needed, as in the example above.
- Where suicide is not an immediate threat, Samaritans can time-limit calls to 15 minutes, whereas Connect callers can stay on the line for up to an hour.

Because of these essential differences, calculations in the Impact Map and Appendix 2 do not treat Samaritans as a free alternative to Connect.

Overall this indicates that, although the method of contact is very different, Connect callers experience similar outcomes to LSLCS visitors and hence probably span the same six categories as visitors (i.e. groups 0 to 4b). However, because the actual number of callers is unknown, the Impact Map (Annex 1) shows them separately and uses a different valuation based on the number and duration of calls – see Section 5.4.

4.7. Negative Outcomes

An unintended negative outcome can occur when visit requests are declined because Dial House is full or other visitors have a higher priority (this does not include instances where referral to LSLCS is not appropriate in the first place). Although the alternative of a call to Connect is always offered, many visitors in this situation report that they feel worse than if they had not made the request at all. LSLCS records the number of visit requests declined – a total of 1975 in 2017-18.

Two accounts given to the consultant by visitors illustrate the potential impact of visits declined:

One visitor was felt so bad when his request was declined that, rather than stay at home, he drove and parked outside Dial House all evening, just to be close to that source of support even if he could not access it.

Another visitor did not in fact have his request declined, but felt sure that he would be declined based on previous experience. As a result he self-harmed and had to be treated in hospital.

Other comments from visitors to the consultant were mainly about the need to expand LSLCS's capacity services further, and needing a larger space than Dial House can provide for some of its groups. These other comments do not significantly affect outcomes relevant to the Impact Map, although they influence recommendations in Section 9.

Section 5: Valuing the Outcomes for Visitors and Callers

The SROI methodology places a value on changes for all stakeholders through use of financial proxies (equivalents). This section describes the financial proxies used for visitors and callers, and how these have been derived. These are summarised in a table at the end of Section 8. Appendix 1 also gives a summary of the valuation methods referred to in this section.

5.1. Visitors in Group 0

The financial proxy applied to visitor Group 0 is based on the cost of suicide which LSLCS helps to avert. This figure has a major impact on the SROI calculation and is based on studies in the UK and elsewhere on the total lifetime cost of suicide, including:

- Direct costs (e.g. emergency services, coroner) at the time of death or shortly after
- Indirect costs through loss of earnings, productivity or other contribution to the economy
- Intangible costs, such as the pain and suffering experienced by relatives and friends

Using previous research, government policy documents quote an average cost per suicide in England of £1.7m (the exact figure is £1,703,822[14]). This is a total lifetime cost, and has been converted to an annual figure by dividing by 30, based on the average life expectancy of people in the age range that LSLCS deals with. This gives a figure of £56,794 per person for one year.

The 2012 report modified this figure for LSLCS visitors, based on their being more socially isolated than most people, and hence that their death would not affect as many partners/relatives. LSLCS experience since then however shows this is not the case:

> Two years ago, a frequent visitor to Dial House, also well known to other mental health services in Leeds, took her own life whilst she was in hospital sectioned under the Mental Health Act. This lady was a high-profile mental health campaigner, blogger and member of several forums, and her death had a profound effect on other members of the LSLCS community, both staff and visitors. LSLCS staff worked particularly hard to ensure that none of their other visitors were prompted by this event to take their own lives, and were successful in this respect. Nevertheless, the event remains a deeply moving one for everyone who knew her.

This illustrates the profound effect that any suicide can have on other people, and for this reason, the full value of £56,794 has been used in the current analysis. This is subdivided into the three categories above, corresponding to three stakeholder groups in the Impact Map:

- Visitors & callers (indirect costs): 33%[15] = £18,742
- Partners, family members and friends (intangible costs): 65% = £36,916
- NHS and other public services (direct costs): 2% = £1,136

[14] There are many different ways to value a life, and the full economic costs of suicide in particular. This figure is the one used by the UK Government, and originates from Department for Transport data on the cost of road accident fatalities: *Reported Road Casualties in Great Britain 2012 Annual Report: a valuation of road accidents and casualties in Great Britain in 2012.*

[15] Source for percentages: Department for Transport: *Total value of prevention of reported accidents by severity and cost elements, GB 2016* https://www.gov.uk/government/statistical-data-sets/ras60-average-value-of-preventing-road-accidents

N.B. This financial proxy includes all stakeholders for this visitor group, so the following subsections apply to visitor groups 1-4 only. However, this overall figure for Group 0 is derived from the contribution of different stakeholders, so SROI principles are fully maintained in this respect.

5.2. Other Visitors

This financial proxy covers all visitors except those in 'Group 0' (see above), Group 4b (see below) and Group 5 (see Section 5.3). The 2012 report used a method known as Willingness to Pay (WTP) to place a value for visitors on each visit they make, based on the cost of equivalent 1:1 private psychotherapy. Although SROI developments since then have raised the alternative option of well-being valuation, WTP is still considered most appropriate valuation method for visitors, because

(a) it applies to all situations shown in the Change Pathways Diagram (Fig.4.1.), irrespective of the extent of recovery that visitors may achieve; and
(b) where visitors' well-being remains at the same level, well-being valuation is not feasible because it is not possible to gauge how much worse they might be without visits to LSLCS.

Asking visitors to put a value on their use of LSLCS services (e.g. what they would consider reasonable for a visit to Dial House if – hypothetically – they could afford to pay for the service) proved difficult for the 2012 report. Many visitors could not answer this question because they felt the service was "priceless", and those who did put a value on it varied widely between £40 per session and around £15,000 per year. That report took an estimate of £100 per session based on the range of responses.

This proxy can also be derived in another way, as the cost of alternative intervention designed to achieve the same outcome. In this case the nearest equivalent is likely to be 1:1 psychotherapy. People who can afford private psychotherapy (not the case for many LSLCS visitors) can pay anything from £40 to £100[16] per hour or more. For LSLCS the average visit duration between July 2017 and March 2018 was just over 3 hours and about 60% of visitors chose to have 1:1 support within that time[17]. This suggest that £100 per visit is around the right figure for an equivalent to a crisis support visit based on this proxy. (NB: LSLCS staff are not professional psychotherapists, but what is at stake for someone in severe crisis may well be higher, hence a visit may be of greater value to them.)

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

For visitors in Group 4a, there are further benefits: as well as the increase in income they gain, people moving from benefits to employment also experience an increase in their overall wellbeing. The proxy used here is £14,433 per year for someone moving into full-time employment and £11,588 for someone moving into self-employment[18] (these figures take account of both increased income and wellbeing aspects). This valuation includes cases where LSLCS is helping people to stay in work where they might otherwise lose their jobs.

[16] Source: NHS online information - https://www.nhs.uk/conditions/psychotherapy/availability/
[17] Source: LSLCS records. Taking a weighted average over Dial House and Dial House @ Touchstone, the figures are 3 hours 3 minutes average visit length and 59.5% of visitors having 1:1 support (this percentage might be higher but Dial House does not always have the capacity for 1:1 support for everyone who request it).
[18] Source: Both figures from HACT Social Value Bank v4, May 2018

Based on national data, the self-employment figure has been taken to apply to 15% of this group[19]. Rather than sub-divide Group 4a again, a weighted average of £14,013.27 has been used to represent the proxy value for all of Group 4a.

These figures are modified further on the basis that not everyone who recovers will return to work. 75.6% of the UK adult (age 16-65) population are currently working[20] (more than 98% of visits to LSLCS are made by visitors aged 65 or under[21]). However, there are two factors to be balanced against this:

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

For these reasons the percentage of visitors in Group 4a (which in any case represents just 15.44% of all LSLCS visitors) has been adjusted when calculating the savings in welfare benefits, although a multiplier of 85% has been used rather than 75.6% to take account of the factors above.

Finally, these figures for Group 4a visitors are adjusted for attribution as shown in Section 7.3, because their recovery may well have been supported by other services as well.

5.3. Group Members

These are visitors who use only Dial House's various visitor groups and do not visit or call in the evenings for crisis support. For these group members, relief from crisis is not the most appropriate indicator; improved wellbeing is a more valid means of valuing outcomes.

To measure this, a short survey form was designed which asked group members:

(a) How long they had been in touch with LSLCS
(b) How they rated their overall life satisfaction (i) when they first contacted LSLCS and (ii) now, on a scale of 0-10[22]
(c) How much of this improvement was because of LSLCS

11 group members completed this form, and this showed a mean average improvement *per year* of 1.8 on a 0-10 scale[23]. This has been converted to 18% of a valuation based on the value of 'Relief from Depression/Anxiety' of £36,766[24], giving a per-year value of £6,617.88, and this is applied to the 55 group members who were not either visitors or callers in 2017-18. This figure is then further modified for attribution as explained in Section 7.3 as on average respondents attributed 'most' of their improvement to LSLCS.

[19] Source: *Trends in self-employment*, Office for National Statistics, February 2018. The weighted average is calculated as (0.85x£14,433)+(0.15x£11.588) = £14,013.27.
[20] Source: *UK Labour Market*, Office for National Statistics, May 2018
[21] Source: LSLCS data – age breakdown of visitors to Dial House for 2016-17
[22] This matches the first of four questions used by the Office for National Statistics to measure wellbeing in the UK: "Overall, how satisfied are you with your life nowadays?" See https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/surveysusingthe4officefornationalstatisticspersonalwellbeingquestions
[23] A similar form, but referring to coping with crisis rather than life satisfaction, was used with group members who are also visitors. These showed a lower per-year improvement, consistent with visitors from Groups 1 and 2 of the SROI analysis.
[24] Source: HACT Social Value Bank v4, May 2018

5.4. Callers

'Callers' refers here to people who call the Connect helpline, and this also includes people who make contact by text or via social media. Here, it is impossible to know exactly how many different callers LSLCS has, and so the only way to value these is based on the number of calls received.

Evidence in Section 4.6 indicates that callers experience similar outcomes to visitors, and hence a valuation based on WTP is appropriate. The actual value is lower however, because:

(a) the average length of contact is shorter – around 30 minutes[25], and
(b) although some callers are in acute crisis, the overall level of crisis experienced by callers is less than that of visitors

A figure of £25 has been used as the WTP value of a half-hour private counselling session conducted by telephone[26]. This means that the total value to callers from the 6959 calls received by Connect in 2017-18 have a total value of £173,975. This value applies to both new and existing callers, and is irrespective of whether or not they also visit Dial House or Dial House at Touchstone.

5.5. Negative Outcomes

Section 4.7 describes how a declined visit can lead to negative outcomes. The alternative of a call to Connect is always offered, but many visitors in this situation report that they feel worse than if they had not made the request in the first place. The same proxy value from Section 5.2 (£100) has been used to represent the negative value that people in this situation experience. (Someone whose visit request is declined will have a negative valuation from this, but it could partially offset by a positive value if they then call Connect.). For the 1,957 visits declined over the period April 2017 – March 2018, this comes to a total of £195,700.

[25] Source: LSLCS data (two different records yield slightly different figures for average call length; 30 minutes is the average of the two and the best estimate for valuation purposes).
[26] Source: Internet review of similar telephone counselling services offered privately (e.g. Relate) https://www.relate.org.uk/about-us/faqs/how-much-does-telephone-counselling-service-cost

Section 6: Outcomes and Valuations for Other Stakeholders

The outcomes and valuations in this section apply to the involvement of other stakeholders with all LSLCS visitors, callers and group members other than those in Group 0, which are covered in Section 5.1.

6.1. Partners, Family Members and Friends

LSLCS very rarely has direct contact with partners and family members, but it knows that most of its visitors and callers have these relationships, either living with them or in close touch. For reasons of confidentiality, it was not considered feasible to contact these family members for this SROI report, although feedback was gathered from visitors themselves, from LSLCS staff, and from one family member seen during interviews for the 2012 report.

The change family members and friends experience is that of relief from stress and anxiety, and respite from giving care and support (which might otherwise be 24/7), whilst the visitor is with, or supported by, LSLCS. The proxy used is the cost achieving the same outcome by other means, in this case the cost of 1:1 care provision (not treatment) in the visitor's own home from a private agency, to provide the same level of relief and respite.

A figure of £14.90 per hour has been used here based on local agency charges for home care costs[27]. The average length of an LSLCS visit (averaged for Dial House and Dial House at Touchstone) is 3 hours 3 minutes[28] and this has been rounded up to 3.5 hours per visit as care agencies will normally change for travel time as well as actual attendance.

This valuation applies only to those visitors who have significant partner or family relationships, estimated as 86% of all visitors[29]. This has been rounded down to 75% for the Impact Map, because there are likely to be a few visitors where family members do not know that they use LSLCS. This valuation has is not applied to callers, because there is insufficient evidence of outcomes for partners, family members and friends in this situation – indeed, some callers contact Connect online precisely because they do not want their families to know they are calling.

6.2. Staff

Staff are often not included in SROI analyses because their time input is covered by funding and they benefit through the salary they are paid. It is clear from staff discussions however that LSLCS is far more important to its staff than the value of their salary alone. Staff value the experience, the service they are providing, and ethos and mutual support of LSLCS very highly, and this is reflected in the very low staff turnover LSLCS has always had. Several members of staff have progressed over time from being visitors, to volunteers, and eventually to being paid staff members; they believe that the support they continue to receive as staff members is important for their ongoing wellbeing.

This was originally valued through a staff discussion group at which members of LSLCS staff were asked to write down (individually and in secret) what additional salary payment it would take for

[27] Source: standard hourly rate for care and support listed by Leeds City Council, 2018
[28] Source: LSLCS data for July 2017 – March 2018
[29] Source: LSLCS data provided for 2012 report

them to leave LSLCS. Several declined to answer on the basis that they would not work anywhere else at any price; amongst those who did reply the consensus was that they would need to at least double their present salary to gain an equivalent level of satisfaction elsewhere. Further staff discussions for this current report confirm that this estimate is still valid. To avoid over-claiming, the proxy for each member of staff values the change they experience as the same amount again as the salary they receive (equivalent to doubling their salary).

Rather than examining individual salaries, this proxy has been derived by taking LSLCS's total expenditure on wages and salaries of £618,631[30] and taking the same amount as representing the additional benefit achieved.

6.3. Volunteers

In some respects, the experience of volunteers is similar to staff, and they praise the supportive atmosphere that LSLCS provides. It finds these volunteers through local advertising and word-of-mouth, and has between 20 and 24 volunteers at any one time (an average of 22 is used here for valuation purposes), most of them working on the Connect helpline.

Feedback from volunteers comes from the consultant's discussion with some of these volunteers, together with an online survey conducted by LSLCS in October 2017. The outcomes that volunteers experience through working with LSLCS vary for individuals, but generally fall into two categories:

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

Both these categories can include people with direct experience of mental health problems, for example former LSLCS visitors and callers who want to continue their personal journey and give something back to the organisation.

The 2012 report valued these by taking the cost of external professional training designed to achieve a similar outcome. Since then, better alternatives have become available, and wellbeing valuation can now be used to give a more realistic value for thee outcomes:

- For all volunteers there is a personal value purely from volunteering, and the figure used here is £3,249 per year[31]
- For those who have a mental health care career path in mind (estimated as slightly less than half of the total based on survey feedback), an additional value of £1,567 has been added for the personal value of work-related training/experience[32].

6.4. Statutory Services (NHS, Leeds CC Adult Social Care, Police)

This financial proxy covers all visitors except those in 'Group 0' (see Section 5.1, which covers all stakeholders for this Group) and addresses the cost to statutory services of alternative provision if LSLCS was not there for its visitors/callers. These alternative services could include:

[30] Source: LSLCS accounting data for 2017-18
[31] Source: HACT Social Value Bank v4, May 2018
[32] Source: HACT Social Value Bank v4, May 2018

- the NHS Crisis Assessment Service (CAS) team, for example through home visits
- NHS accident and emergency (A&E) services, including ambulance and paramedic call-outs
- inpatient psychiatric admissions (normally to the Becklin Centre at St James's Hospital)
- police call-outs, which may or may not result in Section 136 referral (Dial House is one of several 'places of safety' to which the police can bring people bring people under Section 136 of the Mental Health Act). Police can also be involved when people with mental health problems go missing.
- other forms of psychiatric support from CPNs, the Intensive Community Service, Acute Liaison Psychiatry Service or Personality Disorder Network
- additional costs to Adult Social Care, for example through social workers or use of day centres

A proxy is needed here as actual data is not available; records are not generally shared between these statutory services and LSLCS, so they have no means of auditing the financial impact of LSLCS on its services (and may not even know which patients/clients attend LSLCS). Data gathered for LSLCS's intensive support pilot (see Section 1.3) has provided some illustrative examples of how its frequent visitors use other services, based on self-reported visitor feedback. These highlight a wide variety of usage and do not provide costings linked directly to LSLCS visits, although they do show that LSLCS visits can avoid multiple other interventions or longer in-patient stays.

Previous feedback from visitor surveys and comments indicates that about two-thirds of visitors would have sought or needed some alternative provision for each visit had LSLCS not been able to accommodate them. The proportion of Dial House visits where suicide is a presenting issue (65% – see Section 1.3) supports this estimate. As noted above, some visitors also assert that they would use NHS services much more frequently – in other words one visit to Dial House might avoid several A&E attendances or an extended inpatient stay. On this basis, the Impact Map calculation estimates that some alternative per-day provision would be needed in 75% of visits to Dial House.

Although there will be many instances where actual costs are higher or lower, a figure of £342.67 is used to calculate the approximate cost of such alternative provision, based on the average of:

- a CAS crisis support contact (£299[33])
- the per-day cost of an inpatient bed with standard nursing care (£331[34])
- ambulance call-out (£250[35]) and subsequent A&E treatment (£148[36]) (total £398), excluding any subsequent admission

To this, an addition for police involvement including Section 136 referral has been made for an estimated 10% of instances[37] (10% x £275[38] = £27.50). This gives a total of £370.17. 75% of this figure gives an average cost to statutory services of £277.63 per instance, and this is the figure used on the Impact Map.

In practice, these savings to NHS, ASC and Police services are not 'cashable' (i.e. they do not actually reduce spending), but enable these services to give better provision for other people. The figures are a sound proxy for social value on this basis.

[33] Source: local data provided by NHS Leeds CCG to LSLCS for Intensive Support Project calculation
[34] Source: local data provided by NHS Leeds CCG to LSLCS for Intensive Support Project calculation
[35] Source: local data provided by NHS Leeds CCG to LSLCS for Intensive Support Project calculation
[36] Source: *Reference costs 2016/17: highlights, analysis and introduction to the data*, NHS Improvement, November 2017
[37] Source: Estimate based on self-reported data from long-term visitors as part of LSLCS's Intensive Support Project
[38] Source: local data provided by NHS Leeds CCG to LSLCS for Intensive Support Project calculation

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

No savings to NHS or other public services are assumed for people in Group 5, who use Dial House group work only.

Outcomes arising from Connect services to callers are more difficult to gauge, because the number of callers is unknown. However, although callers are assessed as lower risk, their feedback makes it clear that some of them would require alternative crisis or emergency services if Connect was not there to support them. Using qualitative feedback gathered by Connect, an assumption has been made that 5% of calls avoid the need for alternative intervention by statutory services – 348 calls in 2017-18. This estimate takes account of several factors based on caller feedback, for example:

- Some callers may have been declined a visit by Dial House and a few of these may still be at risk
- Some regular callers refer to Connect "keeping them safe", which suggests that the cumulative effect of several calls may avert self-harm or a suicide attempt
- Many other callers are not at immediate risk, and talk about Connect reducing loneliness, anxiety, depression or sleeping badly.

6.5. Taxi Services

LSLCS normally pays for taxis to bring visitors to Dial House or Touchstone and take them home again afterwards. The great majority of trips use a single taxi company with which LSLCS has a dedicated contract. Although not included in the original SROI analysis, the number of visitors that LSLCS now has means that the amount involved is substantial and justifies inclusion because of its impact on this taxi firm's business. The figure of £80,494 applies here[39], based on actual expenditure by LSLCS. (N.B. This is not of course a deliberate objective for LSLCS. It is nevertheless a relevant and significant outcome for SROI purposes.)

6.6. Government/Taxpayers

Equipping people to move into or return to employment is not a core purpose of LSLCS. It does however play a significant role in a sequence of positive changes that enables some people to achieve this (see Fig.4.1.), and hence is a relevant outcome for SROI, even if unintended. In a few cases, visitors and callers are already in work, and LSLCS helps them remain so. Although the numbers are relatively small, the benefits in financial equivalence terms are substantial, and the contribution of other agencies to this sequence of change is addressed through Attribution in Section 7.3.

Where individuals recover and return to work, the saving in Social Security benefits is assessed at £7935.20 per year. This is calculated as follows:

- ESA rate age 25+ 2017-18: £73.10 = £3,801.20pa[40]
- Housing benefits: £79.50pw = £4,134.00pa[41]

[39] Source: LSLCS accounting data for 2017-18
[40] Source: DWP benefit rates 2017-18
[41] Source: DWP data on average Housing Benefit for Leeds, October 2017

The number of visitors that this valuation applies to is calculated in the same way as explained in Section 5.2 for visitors in Group 4a themselves.

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

6.7. Other Organisations

As noted in Section 1.4, many visitors and callers may use other voluntary sector services in Leeds as well, although these services do not duplicate LSLCS. These other organisations may benefit however where a LSLCS visitor or caller is well enough to do voluntary work with them.

Discussion with visitors indicates that such volunteering is likely to include co-facilitation (with staff members) of support groups, representation at various forums including meetings with NHS managers, and interviewing prospective new members of staff (this is a role some visitors perform for LSLCS itself).

No detailed data is held on this type of volunteering activity, so an estimate of 10% of LSLCS visitors has been used as a basis for valuation (i.e. 42, based on the total of 421 visitors calculated at Section 3.3). The value of this time to the organisations who benefit is calculated from the national average of 13.5 minutes per day spent volunteering[42] (= 82.125 hours per year), multiplied by the national minimum wage for 2017-18 of £7.50 per hour[43], giving a total of £615.94 per volunteer.

[42] Source: Office for National Statistics, *Changes in the value and division of unpaid volunteering in the UK: 2000 to 2015*
[43] Source: UK Government national minimum wage rate 2017-18 for age 25 and over

Section 7: Assessing the Impact of LSLCS

The full SROI calculation is shown on the Impact Map, and summarised in the next section. Analysis starts by assessing the total value of the change experienced by each of the various stakeholder groups. These values are then modified to estimate how much of this change is due to the work of LSLCS as opposed to that of other organisations or external factors. This section explains how these modifications are calculated.

7.1. What Would Have Happened Anyway[44]

This addresses whether the change experienced by stakeholders would have happened anyway, without the intervention of LSLCS. Given that LSLCS provides a unique signposted service for those in severe crisis and at risk of suicide, it is unrealistic to suppose that its visitors and callers would 'get better' on their own without outside help (although other services also contribute - see Attribution in 7.3 below).

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

The conclusion is that there is no evidence that any of the changes and outcomes described in the previous sections would have happened without the involvement of LSLCS in the change process.

7.2. Displacement

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

- such an assumption is dependent on macro-economic factors (e.g. unemployment levels) which cannot be accurately predicted for the future. (Although the unemployment rate is currently 4.2%, there were still 806,000 job vacancies in the quarter February-April 2018[45].)
- the model used by the government in its *No Health without Mental Health* White Paper does not take account of such displacement when estimating the financial benefits of its current strategy, nor is it considered in other government 'welfare to work' schemes
- those who find work do so either in the mental health field (where there are vacancies) or in the general employment field; in neither case are they displacing others from any specific field or group who might otherwise obtain such employment. In other words, sufficient vacancies exist in these fields of work that displacement should not be an issue.

Some of those whom LSLCS loses contact with may subsequently find work other geographical areas, but no value is claimed for these callers/visitors because there is insufficient evidence to prove this.

[44] The SROI technical term is 'deadweight', avoided here because of the context of LSLCS
[45] Source: Office for National Statistics, *UK Labour Market, May 2018*

7.3. Attribution

This is an important aspect of many SROI calculations, and here deals with the question of whether any of the changes in Sections 3 to 5 are attributable to other services rather than solely to LSLCS. It is certainly the case that many visitors/callers continue to receive psychiatric therapy, medication or other forms of care and counselling alongside their contact with LSLCS. There are a few visitors and callers who, from discussions with LSLCS staff, are believed to use LSLCS services only, but these are in the minority.

Leeds CCG views LSLCS as part of an integrated service moving people away from dependence on care and on – in as many cases as possible – towards being able to self-manage and maintain their health. Other 'non-LSLCS users' could well follow a similar route to that depicted in Fig.4.1, but it LSLCS contributes positively to all those that use its services.

For many parts of the Impact Map, attribution to other services is shown as 0%. This applies where

- visitors/callers are putting a value on their experience of LSLCS alone, not on their experience of the wider mental health care system (this particularly applies to long-term frequent visitors); and
- the cost of alternative service provision is being assessed – by definition this is a replacement for LSLCS rather than being a co-contributor with it

There are two cases where attribution is particularly significant however, and these are:

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

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

- For most visitors/callers, their treatment and therapy involves a wide range of interactions with NHS professionals and other organisations, including LSLCS, together with medication. It would not be feasible to assess separately the impact of all these varied interactions.
- Many visitors/callers attribute most if not all of their recovery (or at least improved ability to cope) to LSLCS, and this includes some short-term visitors. There is insufficient evidence to say that this applies to all visitors/callers however, particularly for Group 4b where contact is lost.
- Recommended SROI practice is to take 50% as a starting point[46], and this seems appropriate here, at least until such time as more detailed feedback is available.

Modified attribution levels have also been taken in several other lines on the Impact Map:

- Visitors who use LSLCS intensively in one or two years and less in later years (Group 2). Here, whilst the above factors still apply, the extent of LSLCS involvement together with feedback from individuals in this category suggests that LSLCS has played the major role in improving their ability to manage; attribution to other parts of the healthcare system of less than 50% is therefore appropriate, and a figure of 33% has been used here.

[46] Source: *Small Slices of a Bigger Pie*, New Economics Foundation, 2011

- Group 5 (Dial House group members who are not also visitors or callers) attributed 'most' of the improvement in their wellbeing to LSLCS, so here 25% has been attributed to other sources of support.
- Other voluntary sector organisations who benefit from LSLCS visitors acting as volunteers with them are also very likely to have been involved in supporting those volunteers, so attribution of 75% for these organisations has been assumed here.

Several of the more significant attribution estimates are tested for the effects of varying these, as explained in Appendix 2.

7.4. Drop-Off

This question considers whether the change produced by LSLCS is permanent, or is eroded in subsequent years. Here, the different patterns of visits for each visitor group enable drop-off to be identified more accurately than would be the case if an aggregate annual percentage was assumed.

NB: This addresses the extent to which the outcomes of change in the first year remain during subsequent years. Hence for example the drop-off for Group 3 is 100% because they require a similar level of support in the following years.

1. For Group 1 (long-term frequent visitors), LSLCS figures show some turnover as some people cease to become frequent visitors and new long-term visitors arrive, so that the overall number in this group remains roughly constant. On average, people tend to stay in this category roughly four to five years, so a drop-off figure of 80% has been used (i.e. 20% of the improvement has a lasting effect) to take account of this.
2. For Group 2 (frequent in a short period with fewer subsequent visits), figures suggest that visits drop to an average of 10% of the initial level after year 1. This means that in effect 90% of the improvement – and its effects on stakeholders relevant to this group – remains permanent.
3. For Group 3 (long-term infrequent visitors) the pattern of visits remains fairly constant through the years, with no significant reduction. This means that none of the impact lasts beyond the current year, so drop-off is 100%.
4. For Groups 4a and 4b, all of the visits occur within a limited period with none in subsequent years, so the benefits of the visits themselves only apply to the current year – drop-off is 100% beyond that. For the Group 4a (recovery) however, the benefits of a return to paid work should endure in subsequent years. No drop-off has been assumed in this instance because any regression would place these individuals in group 2 rather than 4a.
5. For Group 5 (group members who are not also visitors or callers), feedback suggests that they need to keep coming to the group to maintain the wellbeing benefits achieved; a drop-off of 100% has been taken as there is insufficient evidence of longer-term outcomes.
6. Similar considerations apply to callers. Because callers are anonymous it is impossible to track longer-term outcomes, so only the value of each call at that point in time can be considered. Drop-off is therefore 100%.
7. The negative consequences of visits declined apply only at the point that this takes place – the visitor is free to ask again on future night – so again drop-off is 100%.

Section 8: Conclusions – The SROI Ratio

The Impact Map (see separate Annex) derives a cost-benefit figure through the standard financial practice of taking the total benefit over a five-year period and dividing it by the per-year cost invested to achieve that benefit. In this case the investment cost has been taken as LSLCS's total budget for 2017-18, less the amounts for the Bereavement Service and Crisis Café (not included in this SROI), plus the value of volunteer time.

The resulting figure of £9.69 of social value achieved per £1 invested is the 'headline figure' for this SROI analysis. However, many assumptions underpin this calculation, and the effect of varying these assumptions is considered in Appendix 2: Sensitivity Analysis. From this, the SROI ratio for LSLCS can be more confidently quoted as being between £7.50 and £12.50 per £1 invested. Using the headline figure of £9.69, the total added social value generated by LSLCS over one year works out as £7,436,862 in 2017-18.

All these figure show a substantial increase from the original SROI report of 2012. Some of this is due to updated, and more accurate, valuation figures being used. Much of it however is due simply to the increased capacity of LSLCS and the larger number of visitors and callers it is now able to reach. LSLCS's budget has roughly doubled since 2010-11, but the number of visitors has increased more than 2½ times, and the number of visits (an indication of the level of support it can offer) almost threefold. Within this, the proportion of short-term visitors has also increased, and this too has a positive impact on the SROI ratio because at least some of these visitors are expected to make a full recovery.

Tables 8a to 8d below summarise data from the Impact Map and present the figures it shows in a slightly different format. Rather than using visitor group classifications as the starting point, these four tables show the outcomes and associated valuations for key stakeholders. Not surprisingly, these show the greatest value for visitors, callers and group members themselves, even if just the outcomes for Year 1 (i.e. the year for which the investment is made) are considered. This is further emphasised by the following table, which shows the value of immediate and longer-term outcomes for different stakeholders.

Stakeholder	Value in Year 1	Net Value over 5 years*
Visitors, callers, group members	£1,069,879	£3,171,991.10
Partners, families and friends	£530,232	£2,076,123.33
Statutory services	£724,350	£1,339,334.98
All other stakeholders	£1,018,530	£1,389,629.00

Fig.8.1: Summary of value for different stakeholders

*In calculating the SROI ratio, the original investment is deducted from the total of these figures. All cost figures in the tables in this section are rounded to the nearest £1.

These figures, together with the Impact Map itself, also enable other conclusions to be drawn, for example:

- The value LSLCS provides for partners, family members and friends comes mainly from instances where suicide is averted, because the very large human costs of pain and suffering are avoided.
- For statutory services (primarily the NHS, but also police and local authority services), even if the value to visitor/callers and their relatives is not considered, the value that LSLCS delivers exceeds

the amount it receives via Leeds CCG for the current year. The return over 5 years is more than twice the amount invested by the CCG.

- The negative impact of visit requests declined has a significant impact on the value LSLCS achieves for its visitors overall. If LSLCS were able to accept all these visit requests, its in-year value (i.e. Year 1 in these calculations) for visitor/callers would increase by around 30%.

From the various visitor group classifications (see Sections 3.3 and 4.4), LSLCS achieves the greatest return on investment for are:

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

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

As was the case with the 2012 report, visitors in Group 4 are the most difficult to contact because their engagement with LSLCS is, by definition, short-term. Most of the feedback available comes from visitors in Groups 1,2,3, and 5, together with callers in similar situations. as these are the people from whom feedback can most easily be gathered. The recommendations in Section 9 take account of this issue, together with other findings from this report as a whole.

Table 8a: Visitors/Callers

Visitor/caller group	Description of change	Indicator	Quantity (Year One)	Proxy description	Information source	Proxy value	Total change value, year 1	Drop-off in after year 1
Group 0: Suicide averted	Suicide averted - avoidance of premature death	Benefits to the person of avoiding premature death	21 visitors	Part of overall value of suicide avoided	See Section 5.1	£18,742 per visitor	£196,791 (attribution applies)	None (effect is permanent)
Group 1: Long-term frequent	Reduced risk of self-harm, improved ability to manage	Visitors who report these outcomes	20 visitors, 62 visits each	Cost of private therapy of equivalent value	Visitor answers and costs data	£100 per visit	£124,000	80% per year after year 1
Group 2: Frequent in one year	Reduced risk of self-harm, better able to manage, recovery	As above	60 visitors, 23 visits each	As above	As above	As above	£92,460 (attribution applies)	90% impact remains after year 1
Group 3: Long-term infrequent	Reduced risk of self-harm, better able to manage, stabilisation	As above	60 visitors, 3 visits each	As above	As above	As above	£18,000	100% drop-off (need unchanged)
Group 4a: Believed to have recovered	Ability to overcome crisis, resume normal life & return to work	Economic and wellbeing value of recovery	55 visitors (65 x 85% - see 5.2)	Value of extra income received	Wellbeing value of employment	£14,013	£385,365 (attribution applies)	90% impact remains after year 1
	Ability to overcome crisis, resume normal life (not working)	Visitors who report these outcomes	10 visitors, 2 visits each	Cost of private therapy of equivalent value	Visitor answers and costs data	£100 per visit	£2,000	None (effect is permanent)
Group 4b: Out-come unknown	Outcome unknown as cannot be traced	n/a	195 visitors 2 visits each	n/a	n/a	n/a	£0	n/a
Group 5: Dial House group members only	Relief from anxiety & depression, improved quality of life	Improved overall life satisfaction	55 visitors per year	Value of improved wellbeing	HACT Social Value Bank	£6,618	£272,988 (attribution applies)	100% drop-off (need unchanged)
Callers	Reduced risk of self-harm, relief from loneliness	Callers who report these outcomes	6959 calls per year	Cost of private counselling of equivalent value	Caller answers and costs data	£25 per call	£173,975	50% per year after year 1
Negative: All groups if visit request refused	Disappointment, distress, may need to use other services	Number of times this outcome occurs	1957 instances per year	Cost of private therapy of equal value	Visitor answers and costs data	£100 per instance	£195,700	Counted for current year only
Total value to visitors, callers and group members in Year 1							**£1,069,879**	

Table 8b: Partners, Family Members and Friends

Visitor/caller group	Description of change	Indicator	Quantity* (Year One)	Proxy description	Information source	Proxy value	Total change value, year 1	Drop-off in later years
Group 0: Suicide averted	Having a partner/ family members still alive who would otherwise have died	Emotional effect of suicide on partners/ family members	21 visitors	Human costs – pain and suffering	External research and government policy	£36,916	£387,618 (attribution applies)	None (effect is permanent)
Group 1: Long-term frequent	Relief from stress and anxiety, respite from care responsibilities	Partners and family members who report these outcomes	15 visitors*, 62 visits per year, 3 hours per visit	Cost of alternative 1:1 care provision	Cost of private 1:1 home care provided by local agency	£14.90 per hr for 3.5 hours (w/travel)	£64,666	80% per year after year 1
Group 2: Frequent in one year	As above	As above	45 visitors*, 14 visits per year, 3 hours per visit	As above	As above	As above	£48,218 (attribution applies)	90% impact remains after year 1
Group 3: Long-term infrequent	As above	As above	45 visitors*, 3 visits per year, 3 hours per visit	As above	As above	As above	£9,387	100% drop-off (need unchanged)
Group 4a: Believed to have recovered	As above	As above	49 visitors*, 2 visits per year, 3 hours per visit	As above	As above	As above	£5,085	Drops to zero after year 1
Group 4b: Outcome unknown	As above	As above	146 visitors*, 2 visits per year, 3 hours per visit	As above	As above	As above	£15,258	Drops to zero after year 1
Total Value to Partners, Family Members and Friends in Year 1							**£530,232**	

*Visitor numbers calculated by multiplying number of visitors in groups 1-4 by 75% (proportion of visitors with partners/families)

Table 8c: Statutory Services (NHS, Leeds CC Adult Social Care, Police)

Visitor/caller group	Description of change	Indicator	Quantity (Year One)	Proxy description	Information source	Proxy value	Total change value, year 1	Drop-off in later years
Group 0: Suicide averted	Public services at or shortly after time of death, which are not needed	Reduction in public services required, due to death being averted	21 visitors	Cost of public services to deal with suicide	External research & government policy	£1,136	£11,928 (attribution applies)	Drops to zero after year 1
Group 1: Long-term frequent	Better patient/client care, reduced demand for statutory services	Extent to which LSLCS visits reduce need for NHS, ASC and police services	20 visitors, 62 visits per year, 75% of these visits	Actual cost data via NHS Leeds CCG & national data	NHS Leeds CCG & national data	£278	£295,196	80% per year after year 1
Group 2: Frequent in one year	As above	As above	60 visitors, 23 visits each, 75% of these visits	As above	As above	As above	£192,523 (attribution applies)	90% impact remains after year 1
Group 3: Long-term infrequent	As above	As above	60 visitors, 3 visits each, 75% of these visits	As above	As above	As above	£31,740	100% drop-off (need unchanged)
Group 4a: Believed to have recovered	As above	As above	65 visitors, 2 visits each, 75% of these visits	As above	As above	As above	£27,069	Drops to zero after year 1
Group 4b: Outcome unknown	As above	As above	195 visitors, 2 visits each, 75% of these visits	As above	As above	As above	£81,207	Drops to zero after year 1
Callers	As above	As above	6959 calls per year, 5% of these calls	As above	As above	£278	£96,615	Drops to zero after year 1
Total Value to Statutory Services (NHS, Leeds CC Adult Social Care, Police) in Year 1							**£724,350**	

Table 8d: Other Stakeholders

Stakeholder	Description of change	Indicator	Quantity (Year One)	Proxy description	Information source	Proxy value	Total change value, year 1	Drop-off in later years
Central Government (for visitor Group 4a only)	Reduced welfare expenditure where people move into work	Number of visitors for whom savings in welfare benefits are achieved	55 visitors (65 x 85% as explained in Section 5.2)	Reduced expenditure on welfare benefits	Benefits rates data (including housing benefit)	£7,935	£218,218 (attribution applies)	None* (see below)
LSLCS Staff	Increased personal fulfilment, value and job satisfaction as part of LSLCS team	Staff who report these outcomes (counted for LSLCS staff as a whole)	1 x total salary costs	Added salary needed to persuade staff to leave LSLCS	Staff feedback, salary data: LSLCS accounts 2017-18	£618,631	£618,631	100% as benefit is renewed each year
LSLCS Volunteers	Increased personal fulfilment through volunteering in LSLCS environment	Volunteers who report experiencing this outcome	22	Wellbeing value of volunteering	HACT Social Value Bank 2018	£1,363	£47,705	100% as benefit is renewed each year
	Value of training/ experience towards a future career in mental health	Volunteers who report experiencing this outcome	10	Wellbeing value of work-related experience	HACT Social Value Bank 2018	£2,272	£34,080	100% as benefit is renewed each year
Taxi companies	Increased business due to taking visitors to & from LSLCS	Amount of increased business due to LSLCS	1 (mainly one firm)	Actual amount paid in taxi fares	LSLCS accounts 2017-18	£80,494	£80,494	100% as benefit is renewed each year
Other voluntary sector organisations	Increased capacity due to LSLCS visitors/ callers who volunteer with them	Number of hours contributed by volunteers	42 visitors, estimated 3449 hours per year	Value based on minimum wage rates for over 25s	National data: volunteering & minimum wage rates	£7.50	£19,402 (attribution applies)	100% as benefit is renewed each year
Total Value to Other Stakeholders in Year 1							**£1,018,530**	

Section 9: Recommendations

This final section makes some recommendations for LSLCS, based on findings of this SROI analysis.

Recommendation 1: LSLCS should continue its efforts to seek more long-term funding, and find ways of developing its services further to meet increased demand.

Despite LSLCS opening Dial House more days and having both Dial House at Touchstone and the Crisis Café as additional resources, requests for visits to Dial House are more likely to be declined now than they were in 2011-12. This is said to be due a reduction in alternative NHS and Local Authority support services over this period, although the higher profile of LSLCS may also be a factor. The social value that LSLCS delivers would be increased still more it was able to see more visitors.

Whilst opening Dial House seven nights a week might be one option, other alternatives should also be considered, such as using other premises (as has been done successfully at Touchstone), and other ways of meeting the needs of frequent visitors, as suggested below.

Recommendation 2: LSLCS should continue to liaise with NHS commissioners and other public service providers, to develop new solutions for long-term frequent users of crisis services.

Although around 65% of LSLCS's visitors are new to the service, visits from long-term frequent visitors (Group 1 in the Impact Map analysis) account for almost half of all visits to LSLCS. Moreover, LSLCS's Intensive Support Project (Section 1.3) shows that these visitors are also frequent users of other services at other times. If pilot work proves successful, this 'single provider' approach could achieve substantial cost savings as well as improving capacity for Dial House.

NB: This recommendation and the previous one recognise that public funds are under great pressure, and that increased funding for LSLCS is unlikely to deliver 'cashable' savings in return. These options should however be considered in the wider context of best use of resources overall, to benefit the wider public and patient community.

Recommendation 3: LSLCS should look for new ways to understand and measure the outcomes it achieves for short-term visitors.

Since 2012, LSLCS has done much to get more feedback from its visitors and callers, including survey cards, Connect follow-ups and annual visitor surveys and postal questionnaires. However, relatively little of this feedback comes from short-term visitors, and this gives little indication of whether or how they have progressed since visiting Dial House. Other ways of getting more timely feedback, for example through emails or texts a few weeks after a visit, could be tried. Further information of this type would help to validate significant assumptions in this report and would further evidence LSLCS's objective of 'More people with mental health problems will recover'.

Recommendation 4: LSLCS should consider ways to assess the long-term benefits of its services in helping visitors and callers to recover.

The only written survey conducted specifically for this SROI analysis was that mentioned in Section 5.3 for Dial House group members. Other LSLCS surveys focus mainly on the immediate impact of

using Dial House (including Touchstone) or Connect, although include questions about feeling able to manage crisis better. There is an opportunity to capture more data around longer-term recovery through questions like the one used in Section 5.3, so that LSLCS can gauge the longer-term impact of its work.

(N.B. This should not be seen as an attempt to 'move on' people who really need LSLCS's support, as people who report some recovery could still slip back if support is withdrawn. It could though enable further insight into what aspects of LSLCS's work best support longer-term recovery.)

Recommendation 5: LSLCS should seek some form of regular liaison or contact point with the Police.

LSLCS's visitors are known to have contact with the police (mainly when Section 136 is used but there may be other occasions too, such as when people go missing) and this report makes estimates on use of police resources. No-one from the police was interviewed for this SROI analysis however, as LSLCS does not have a designated contact with the service. Setting up such a contact could help to confirm assumptions on police costs, explore better ways of working and add weight to LSLCS's proposals on intensive support.

Recommendation 6: LSLCS should consider using other spaces for meetings of its larger groups, particularly the deaf group.

Many visitors appreciate the 'homeliness' of Dial House and say that this atmosphere – completely different from any clinical setting – is one of the things that makes it special. However, the rooms are too small for large meetings, and some groups are very cramped when they meet there. This particularly applies to the LGBT group and the deaf group (a larger space would also help this group see each other sign). LSLCS should investigate the feasibility of accommodating some groups in larger spaces nearby (for example, Christ Church next door).

Recommendation 7: LSLCS should continue its efforts to increase the number of men using its services.

This last recommendation addresses a widely recognised issue with suicide generally: men are more likely than women to take their own life, but less likely to seek help when in crisis – hence the majority of visits to Dial House (around 70%) are made by women. There are clearly no 'quick fix' answers here, but LSLCS should engage with commissioners and other public service providers to find ways of increasing its ability to reach men in crisis. New forms of publicity, wider awareness amongst GPs, and liaison with other Third Sector organisations are all avenues that could be explored.

LSLCS could also analyse the gender breakdown of some of the visitor and caller situations described in this report, for example Group 4 (short-term visitors) and instances where visit requests are declined. Identifying gender trends here could help to ensure that men can access LSLCS services in ways that benefit them most.

Report Annex: The full Impact Map is provided as separate document in MS Excel

Appendix 1: Valuation Methods

There are various ways in which SROI analyses and similar evaluation methods can give financial valuations to outcomes achieved. This Appendix summarises the four main methods available. Much more detail can be found in *Valuation Techniques for Social Cost-Benefit Analysis*, by Fujiwara and Campbell, published by HM Treasury and DWP in 2011. It should be emphasised that all these methods are approximations; it is not possible to identify precise costs, as these will vary for every individual situation.

Direct Financial Benefits (Cost Savings or Increased Income)

These are known cost savings or other direct financial benefits. In this report for example, an exact figure is available for the value to taxi companies, and known unit costs are used to estimate the value achieved for statutory services such as the NHS, police and local authority.

Willingness to Pay (WTP)

This assesses how much a person or organisation might be prepared to pay for a service (or pay to avoid something worse happening) if they had to. This report uses this method to assess the value the LSLCS achieves for visitors and callers, and it also forms part of the way in which government figures on the full economic costs of suicide are compiled.

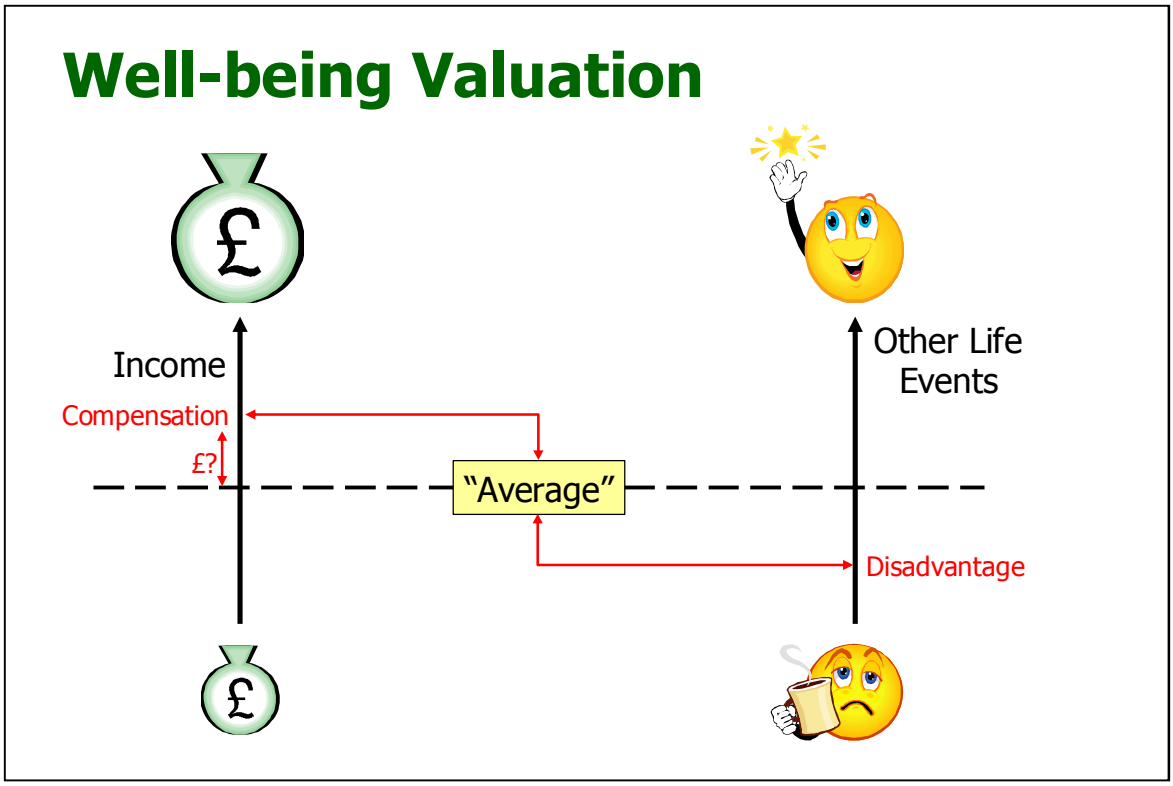
Revealed Preference

This is similar to WTP except that it infers from a person's behaviour how much they value goods or services. A commonly-cited example is the effect on house prices of local schools – how people value a good education for their children is indicated by how much extra they are prepared to pay to live close to a good school. This technique has not been used in this report.

Well-being Valuation ("Life Satisfaction")

This is the most complex (and possibly contentious) of the valuation methods. It basically asks how much financial compensation someone with a given disadvantage would have to receive to bring their overall life satisfaction back to the same level as someone without that disadvantage. Its use in this report is limited, although it has been used to assess the value of LSLCS for volunteers, and for Dial House group members who are not also visitors or callers.

The diagram on the next page illustrates this principle. It relies on the idea of an 'average' level of personal well-being (life satisfaction) for the UK. This is recognised statistical data, collected and published annually by the Office for National Statistics. This level of well-being is dependent partly on a person's income and partly on everything else going on in their life. By applying statistical techniques to data from ONS and other national surveys, it is possible to calculate how much extra income someone with a disadvantage would have to receive to bring their life satisfaction back up to the average. Conversely, the same principle can assess how much income someone with a specific benefit or advantage would have to give up in order to bring their well-being level 'back to normal'.



Several data sources are available on well-being valuation. The HACT Social Value Bank, quoted in this report, is one of the most commonly-used. Such valuations must be used with care, bearing in mind that

(a) they are averages, not specific to individuals

(b) where outcomes are non-binary (i.e. where partial achievement is possible) the degree of improvement must also be considered – hence the percentages applied to well-being valuations for Dial House group members

(b) two separate well-being valuations can only be applied to the same case if there is no 'overlap' between them (i.e. they are not double-counting the same thing). In this report, two well-being valuations are applied to some volunteers, but only because the two are measuring separate things and do not overlap.

Appendix 2: Sensitivity Analysis

The analysis in this report includes many estimates and assumptions, as explained throughout the text. Consistent with SROI principles (Section 2.1), these estimates err on the side of caution, to avoid over-claiming the outcomes that LSLCS achieves. Further assurance can be gained by calculating the effect of varying these estimates, and this is known as sensitivity analysis. The paragraphs below show this analysis for the most significant (in terms of their impact on the SROI ratio) assumptions and estimates in this report.

2a: Size of Group 0

The Impact Map uses a figure of 5% as the proportion of visitors who would end their lives but for the intervention of LSLCS (and others). Some people associated with the service feel this may be an underestimate. If we were instead to assume this group size to be 7.5%, then the SROI ratio would increase to £11.24 per £1 invested. Conversely, if a lower figure of 2.5% is used, the SROI ratio reduces to £8.11 per £1 invested.

2b: Size of Group 4a

The proportion of people who recover and become economically active is also an estimate, although intended to be a conservative one at 15.44% of all visitors. Reducing this figure to 7.5% would reduce the SROI ratio to £8.31, increasing it to 30% would increase the SROI ratio to £12.39 per £1 invested.

2c: Value of LSLCS to Visitors and Callers

The proxy of £100 per visit is an approximation. Reducing this estimate to £50 would result in an SROI ratio of £9.50, raising it to £200 would increase the SROI ratio to £10.07 per £1 invested. (This calculation assumes the same variation for the negative value of visits declined (Section 5.5)).

2d: Impact on Other Service Providers

The figure of £277.63 per instance of alternative provision (Section 6.4) is fairly robust. The more uncertain figure is what proportion visits to LSLCS would require this alternative provision. Here, an estimate of 75% has been used. Reducing this to 50% would reduce the SROI ratio to £9.16; increasing it to 90% would increase the ratio to £10.00 per £1 invested.

2e: Attribution

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

Increasing the impact attributable to other organisations to 65% for groups 0 and 4a and 50% for group 2 would produce an SROI ratio figure of £7.57, decreasing it to 35% and 20% respectively (i.e. raising the importance of LSLCS itself) would raise the SROI ratio to £11.72 per £1 invested.

Whilst these sensitivity factors are not mutually exclusive (i.e. several of them could operate together) it is more likely that variations will balance out rather than all operate positively or negatively. Overall, we can say with some confidence that the SROI ratio for LSLCS lies between £7.50 and £12.50 per £1 invested.

This analysis focuses on the factors most sensitive to change. Other estimates could be varied with much less effect on the SROI ration (for example, changing the attribution of other organisations to visitors/callers who volunteer elsewhere from 75% to 25% would alter the SROI ration by around 1p). From this, the factors most subject to variation are:

- The size of Groups 0 (suicide averted) and 4a (recovery and return to employment)
- The attribution estimated as coming from other organisations

The first of these factors appears to be the one over which LSLCS has most direct control, and this links to the recommendation in Section 9 on seeking further information from short-term visitors.

Appendix 3: List of Reference Sources

A great deal of information for this report was provided by LSLCS, including past reports, monitoring data and its (anonymous) visitor and caller database. The table below lists additional reference sources that the consultant used.

Source	Publication or website
BARCA	Insight Report into Preventing Male Suicide in LS12: Final Report August 2014
Department of Health	No Health without Mental Health, 2011
	No health without mental health: A cross- Government mental health outcomes strategy for people of all ages *Supporting document* – The economic case for improving efficiency and quality in mental health
	Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives, 2017
Department for Transport	Reported Road Casualties in Great Britain 2012 Annual Report: a valuation of road accidents and casualties in Great Britain in 2012
	The Accidents Sub-Objective, TAG Unit 3.4.1, 2011
	Total value of prevention of reported accidents by severity and cost elements, 2016
Department for Work & Pensions	Benefit rates 2017-18
	Data on average Housing Benefit for Leeds, October 2017
	National minimum wage rate 2017-18 for age 25 and over
HACT	Social Value Bank v4, May 2018
House of Commons briefing papers	Mental Health Policy in England, August 2017
	Mental health statistics for England: prevalence, services and funding, April 2018
	Suicide Prevention: Policy and Strategy, February 2018
International Journal of Epidemiology	Suicide in England and Wales 1861-2007: A time trends analysis Thomas & Gunnell, University of Bristol, April 2010
Leeds City Council	Audit of Suicides and Undetermined Deaths in Leeds 2011-2013, Office of the Director of Public Health, September 2016
	Crisis Care Concordat on Mental Health, 2014
	Help to pay your non-residential social care and support costs, 2017-18
	Suicide Prevention – the Leeds Approach, 2017
Local Government Association	Suicide Prevention: A Guide for Local Authorities, February 2017
London School of Economics	General hospital costs in England of medical and psychiatric care for patients who self-harm: a retrospective analysis, Tsiachristas et al, 2017
New Economics Foundation	Small Slices of a Bigger Pie, 2011
NHS Improvement	Reference costs 2016/17: highlights, analysis and introduction to the data
NHS Leeds Information Services	Self-harm Inpatient Activity Analysis, October 2010
NHS online sources	Therapy reduces risk of suicide or self-harm: https://www.nhs.uk/news/mental-health/therapy-reduces-risk-of-suicide-or-self-harm/
	Psychotherapy services: https://www.nhs.uk/conditions/psychotherapy/availability/
NICE	Preventing suicide in community and custodial or detention settings: NICE guidelines, draft for consultation, February 2018
Office for National Statistics	Average weekly earnings by sector, May 2018
	Changes in the value and division of unpaid volunteering in the UK: 2000 to 2015
	Suicides in the UK: 2016 registrations, December 2017
	Surveys using the 4 Office for National Statistics personal well-being questions
	Trends in self-employment, February 2018
	UK Labour Market, May 2018

Relate	https://www.relate.org.uk/about-us/faqs/how-much-does-telephone-counselling-service-cost
Samaritans	Suicide Statistics Report, 2017
Social Psychiatry and Psychiatric Epidemiology	Healthcare and Social Services Resource Use and Costs of Self Harm Patients, Sinclair et al, February 2010
Social Value UK	The Value of a Life, 2016

Appendix 4: Glossary of Abbreviations

The following abbreviations are used in the text of this report:

A&E	-	Accident and Emergency
ASC	-	Adult Social Care
BME	-	Black and Minority Ethnic
BSL	-	British Sign Language
CAS	-	Crisis Assessment Service
CC	-	City Council
CCG	-	Clinical Commissioning Group
CPN	-	Community Psychiatric Nurse
DWP	-	Department for Work and Pensions
ESA	-	Employment Support Allowance
GP	-	General Practitioner
HACT	-	Housing Associations' Charitable Trust
HM	-	Her Majesty's
LGBT	-	Lesbian Gay Bisexual and Transgender
LSLCS	-	Leeds Survivor-Led Crisis Service
LYPFT	-	Leeds and York Partnership Foundation Trust
NHS	-	National Health Service
NICE	-	National Institute for Health and Care Excellence
ONS	-	Office for National Statistics
PDN	-	Personality Disorder Network
SROI	-	Social Return on Investment
UK	-	United Kingdom
VCS	-	Voluntary and Community Services
WTP	-	Willingness to Pay