

# Leeds Survivor Led Crisis Service

## A Social Return on Investment Analysis



## Summary Report

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Real-Improvement

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## A Social Return on Investment Analysis: Summary Report

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All of the quotes in this report, and the poem on page 9, come from LSLCS visitors and callers. Pictures are from Dial House.

**This is a summary of a full report which has been submitted to an independent assurance assessment carried out by The SROI Network. The full report has been assured as showing a good understanding of the SROI process and complies with SROI principles. This assurance does not include verification of stakeholder engagement, data and calculations; it is a principles-based assessment of the full report. This summary report has not been assured as a separate document. The full report is available on request from Andy Bagley at Real-Improvement: please contact [andy@real-improvement.com](mailto:andy@real-improvement.com) or [www.real-improvement.com](http://www.real-improvement.com).**

## Section 1: Introduction

This report summarises a full Social Return on Investment (SROI) analysis prepared for Leeds Survivor Led Crisis Service (LSLCS). The full report has been assured by the SROI Network, and includes further detail the standards this requires. This summary contains all of the key information relevant to the analysis.

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

### 1.1. Background to LSLCS

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

LSLCS is jointly funded by NHS Leeds and Leeds City Council Adult Social Care. It also receives a small amount of funding from Leeds Personality Disorder Network, part of the Leeds Partnership NHS Foundation Trust.

LSLCS is based at Dial House in Leeds and provides:

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

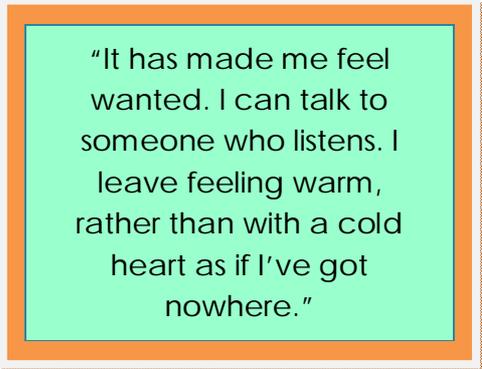


The aim behind all of these services is both to alleviate immediate crisis, reducing the need for hospital admission or other statutory services, and to provide therapeutic support which – together with other mental health services – will eventually help individuals to stabilise their condition and in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

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

These are supported by two further outcomes:

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



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

### 1.3. The Wider Context: Mental Health Services in Leeds

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

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

### 1.4. The SROI Methodology

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

Seven guiding principles apply to any SROI analysis:

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

## 1.5. Use of SROI for LSLCS: Purpose and Scope

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

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

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

The full SROI report contains complete details of how the SROI has been calculated, and is intended for assurance and accreditation by the SROI Network. This summary version is intended for more general circulation.

“Dial House is mint! It’s proper ace, it’s decent, proper nice. Staff are really good, they listen and people are well nice to be around. It’s cool to be around people who know what you have been through and who understand you – people who don’t judge you.”

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

LSLCS also gives a small amount of time to speaking at conferences and supporting other mental health organisations, and it derives a small income from this consultancy-type work. This particular aspect is not

included within the scope of this SROI evaluation, because it is not central the core purpose of the organisation.

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

## 1.7. Constraints on the Evaluation Process

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

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

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

## 1.8. Acknowledgements and Thanks

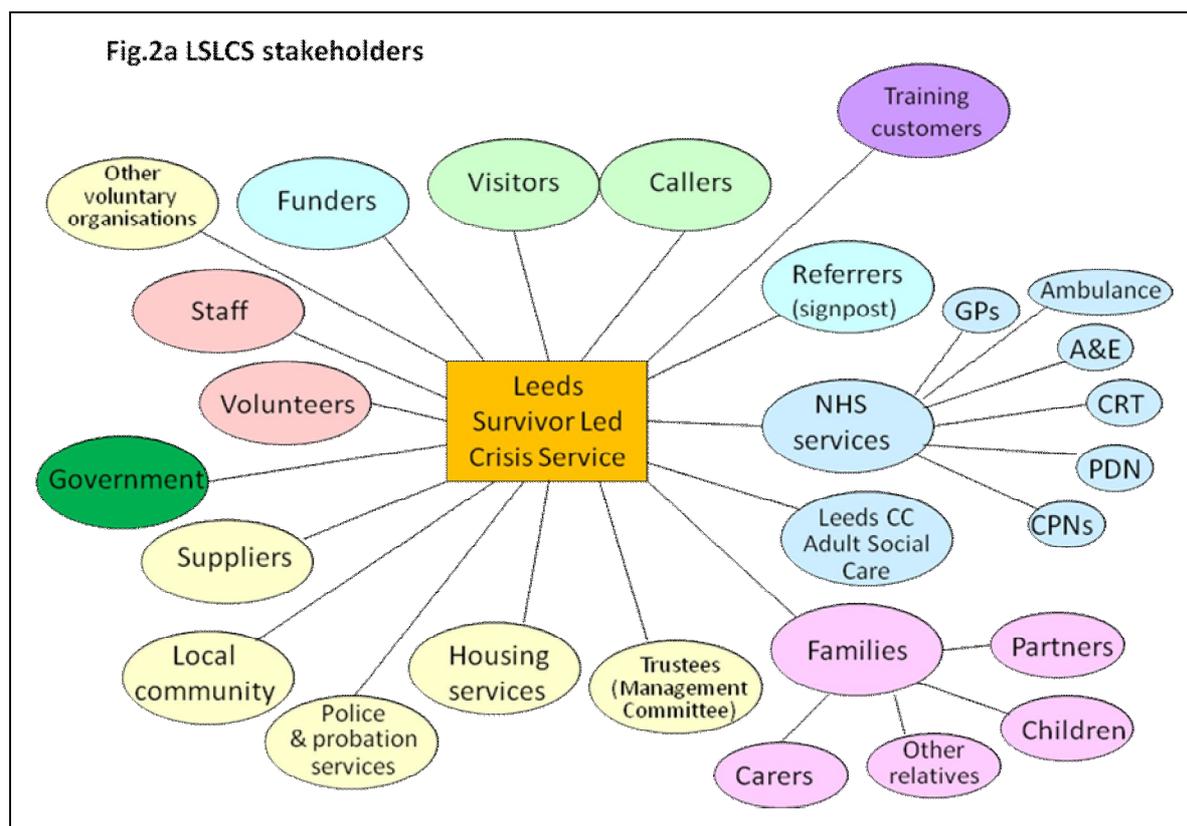
The full report and this summary have researched and compiled by Andy Bagley of Real-Improvement, an experienced management consultant with specialist expertise in performance management and evaluation. A great deal of help and information has been provided by LSLCS staff, visitors and callers, and representatives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



## Section 2: Key Stakeholders

### 2.1. Stakeholder Identification

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



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

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

### 2.2. Stakeholder Groups Included:

#### VISITORS AND CALLERS

The most important beneficiaries of LSLCS are the visitors and callers who use its services. In some cases the impact can be life-saving. In many other instances the individual will be kept safe from harm, experience an improved quality of life and greater ability to cope with their condition, and

may make a full recovery which enables them to take up or return to paid employment. (Helping people return to employment is not part of LSLCS's core purpose, but is nevertheless an outcome for some of its visitors/callers - an unintended benefit in SROI terms).

#### NHS SERVICES (ACCIDENT & EMERGENCY, AMBULANCE)

Accident and emergency services at hospital facilities around Leeds treat people who have self harmed or attempted suicide. Ambulance services transport such people to hospital and in some cases give immediate paramedic treatment. LSLCS has a significant impact in reducing demand for these services and this involves a cost saving which is captured within this analysis.

#### NHS SERVICES (CRT and CPNs)

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

#### NHS SERVICES (PERSONALITY DISORDER NETWORK)

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

#### LEEDS CITY COUNCIL ADULT SOCIAL CARE

Leeds Adult Social Care provides social care and support for those with mental health problems. Its services include accommodation, housing support, day centres and respite care, together with a range of other services commissioned from voluntary organisations, of which LSLCS is one. A substantial number of LSLCS visitors and callers also use other social care services.

NB: Section 4 considers the impact of LSLCS on these various NHS and Local Authority services combined, rather than separately. The rationale for this is explained in Section 3.4.

#### FAMILIES (Partners and family members)

Many LSLCS visitors and callers live with partners or other relatives, or have other close family connections even if they live alone. Only very limited feedback from this group has been possible, but from evidence available we know that they experience relief from stress and anxiety, and respite from care responsibilities, as well as (in the most extreme circumstances) avoiding the loss of a loved one.

#### LSLCS STAFF AND VOLUNTEERS

LSLCS has permanent employees, bank staff (reserves it can all on) and volunteers. All of these groups find working for LSLCS very rewarding, and everyone speaks very highly of the teamwork and mutual support the organisation engenders (see Section 3.4 for further details).

#### GOVERNMENT (in respect of welfare benefits expenditure)

Economic benefits will be experienced by the country as a whole where individuals recover from crisis sufficiently to move out of the benefits system and into paid employment.

### 2.3. Stakeholder Groups Not Included:

#### FUNDERS (NHS AND LEEDS CITY COUNCIL)

LSLCS is jointly funded by NHS Leeds and Leeds City Council. Contract, and service level agreements with these organisations specify a number of expected outputs. However, these organisations do not experience any material change in their role as funders; the real benefits to them are better provision and reduced demand for NHS and adult social care services, and these are captured in the stakeholder groups included (Section 2.2).

A number of other stakeholders were considered but not classified as 'key', because they do not experience significant and relevant change directly as a result of LSLCS's work. These include:

- Local community
- Suppliers
- Housing services
- Police and probation services
- NHS services (general practitioners)
- Trustees (management committee)
- Referrers ('signpost')
- Other voluntary organisations
- Customers for training

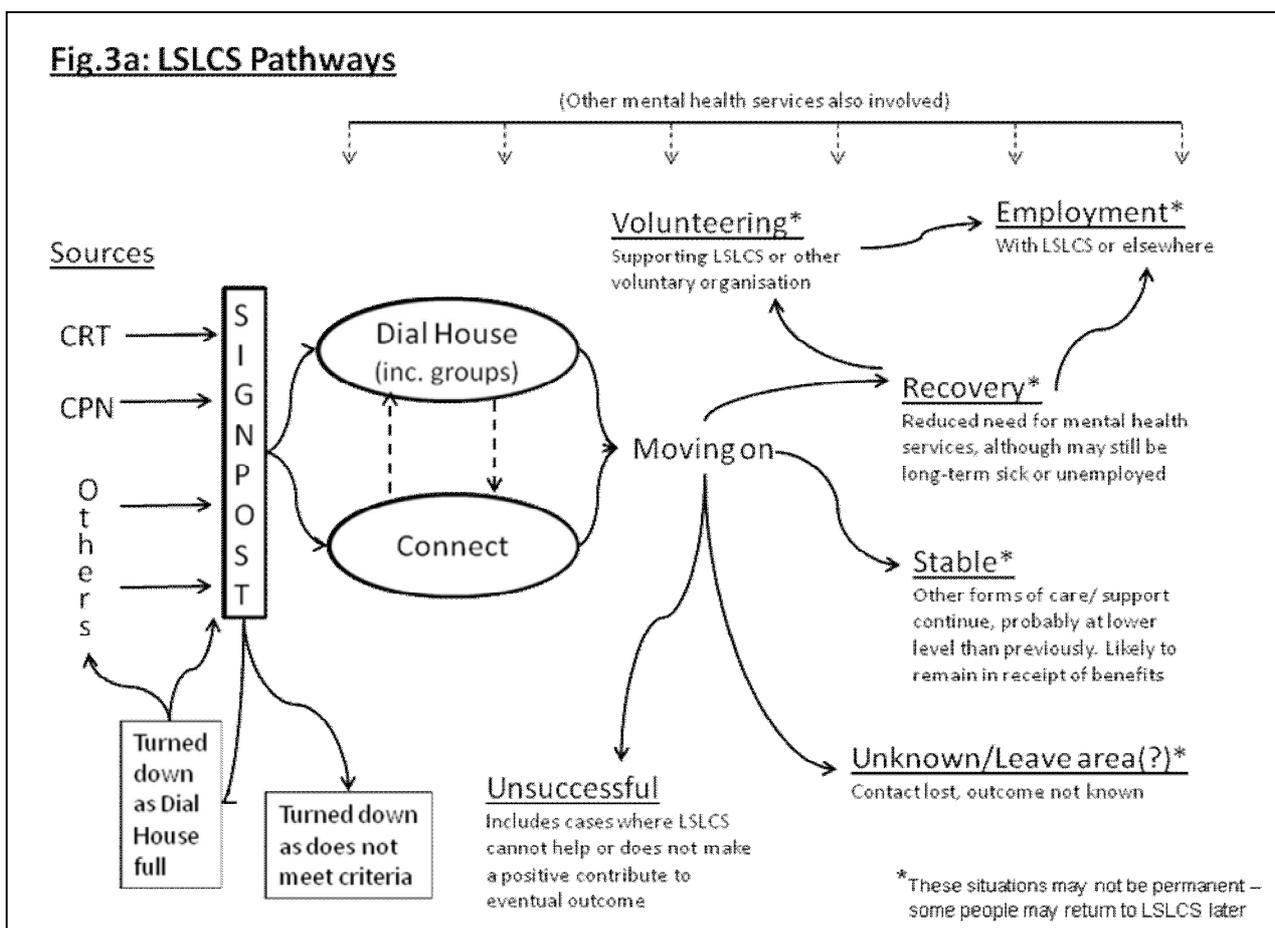
"You help me through anger, chase away fears  
You hug me in sadness and wipe away tears  
Stay by my side when the world turns away  
Help me see joy when skies are grey.  
You were sent into my life angels from above  
You are never there to judge, and all you give is love  
Always reaching out a helping hand  
Showing me a better way than I had planned  
Helping me stand on my own two feet  
Giving me strength when I am feeling weak  
You have helped me so much, much more than you know  
You give me an inner strength and will not let it go.  
When life gets you down and there's nowhere to turn  
They'll help you through  
And share your concern  
If they could catch a star  
They would do that just for you  
And share with you its beauty  
When you're feeling blue."

### Section 3: Understanding What Changes

#### 3.1. Visitors/Callers: Change Pathways

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

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



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

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

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

"Just a short note to say thanks to Katharine for helping me to wash my hair. It seems like such a simple thing to help with, but it is the fact that Dial House are there to help with everything including simple things which makes Dial House such a unique and fantastic place."

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

In many cases, particularly where people use the Connect service only, LSLCS has no way of knowing



what subsequently happens to the person, or even if they are still in the Leeds area. In a few instances it finds out later if the person re-contacts the service - this can happen after a period of years and sometimes just to say thank you. However, the anonymity of Connect callers makes it difficult to gather comprehensive information (see Section 4.4).

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

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

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

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

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

### 3.2. Inputs, Outputs and Outcomes

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

**Table 3b: Summary of Inputs, Outputs and Outcomes**

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

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

### 3.3 Valuing Inputs

The various inputs are valued for SROI calculation purposes as follows

#### FUNDERS

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

#### VISITORS/CALLERS and PARTNERS/FAMILIES

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

#### NHS and LEEDS CC

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

#### STAFF

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

#### VOLUNTEERS

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

#### CENTRAL GOVERNMENT

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

### 3.4. Visitor Patterns and Subsequent Outcomes

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

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

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

"I started to come to Dial House about 2 ½ years. When I turned up I was suffering from bad depression and drug addiction. I was very messed up, the staff here stuck by me and didn't judge me, they also helped me believe in myself which gave me a little hope and helped me on my way to rehab. I am doing really well and Dial House are still here for me, I am so grateful for Dial House. Thank you."

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

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

For people in category (2), the pattern indicates that they make an initial recovery and then either experience some form of relapse or at least need further support later on.

For analysis purposes, this group is treated as having initially recovered but not fully sustained this recovery. Again, stabilisation is an appropriate description, and the person will continue to use LSLCS services intermittently.

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

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

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

### 3.5. Outcomes for Other Stakeholders

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

#### STAFF

Paid staff are often not considered material in SROI analyses because they are not the primary beneficiaries of the organisation's work, and because the salary they receive is covered by the organisation's funding. Discussion with LSLCS staff however made it clear that they derive benefits beyond the purely financial; they value the experience of working at Dial House, the benefit of the work they do and the ethos and team spirit of LSLCS very highly. These aspects of personal fulfilment and well-being are taken forward in the SROI analysis as explained in Section 5.

#### VOLUNTEERS

In some respects the experience of volunteers is similar to staff, although different aspects apply to different volunteers. At any one time LSLCS has between 35 and 40 volunteers, most of them working on the Connect helpline. It finds these volunteers through local advertising and word-of-mouth, and the changes they experience through working with LSLCS fall generally into two categories:

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

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

## Section 4. Outcomes and Evidence

### 4.1. Establishing a Basis for Outcomes

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

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

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

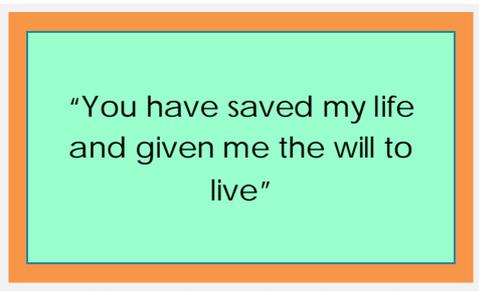
Using categories 1-4 from Section 3 and the data analysis (Annex 5 in the full report) the percentage of visitors in each group can be calculated approximately as follows:

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

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

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

### 4.2. The Impact of Possible Suicide



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

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

some of its visitors and callers. Evidence to support this is demonstrated by:

- the proportion of visit requests where suicide is a 'presenting issue' (i.e. the person has the intention and the means to commit suicide), which is consistently over 50%
- those visitors who explicitly state, in interviews or other feedback, that they would be dead were it not for LSLCS

- the high level of confidence that statutory local authority and NHS services place in LSLCS's ability to help people in severe crisis
- the known risk profile for some of the people LSLCS deals with (i.e. characteristics such as single, unemployed, socially isolated, etc)

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

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

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

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

### 4.3. Other Cases - The Remaining 95%

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

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

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

Group 0: People who would have committed suicide but for the intervention of LSLCS and associated services	5% (8 people)
Group 1: People who continue to use the service often, and hence become long term frequent visitors	7.125% (11 people)
Group 2: People who use the service extensively in one year (or a short period spanning two years) and then make a few visits in later years	11.875% (19 people)
Group 3: People who make a few visits in most years	28.5% (46 people)
Group 4a: People who visit 1-3 times and then never return (believed to have recovered and be economically active)	11.875% (19 people)
Group 4b: People who visit 1-3 times and then never return (outcome unknown - no assumption made about economic activity)	35.625% (57 people)

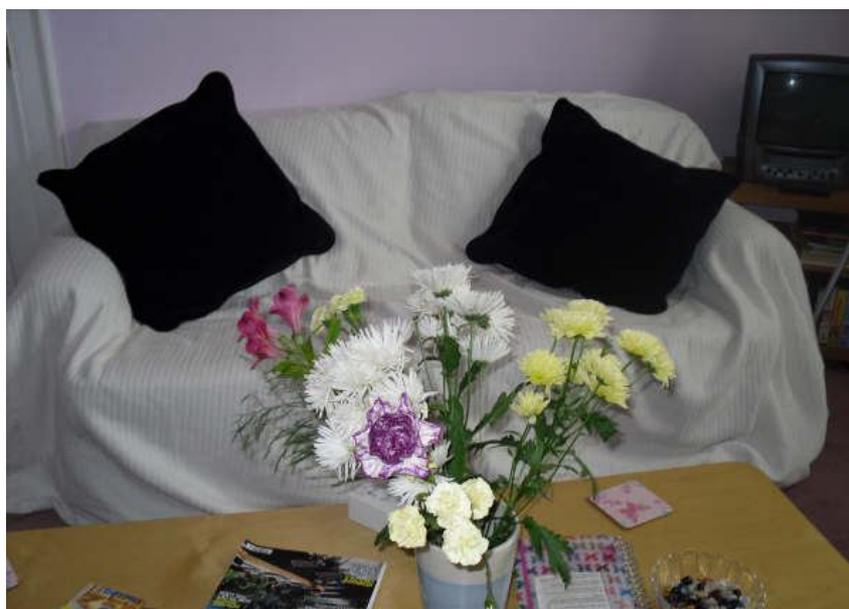
In addition, as shown above, category 4 has been split into two. It is divided between those who are believed to have made a full recovery and are economically active (e.g. have returned to work) (4a) and those - a much higher proportion - for whom the outcome is unknown because they cannot be traced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

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

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

#### 4.4. Connect Callers

The groupings shown above are based solely on information relating to visitors, although many of these will be Connect callers as well. Because Connect callers are anonymous it is not possible to gather comparable data on caller numbers and call frequency from those who use the Connect service only, nor is sufficient information available on the outcomes these individuals experience. (LSLCS knows the number of calls Connect receives, but not the number of callers. It is also not generally feasible to gather feedback on the service as part of the call, although LSLCS is investigating other ways in which it could capture such feedback in the future.) For this reason outcomes associated with those who use the Connect service only have had to be excluded from this SROI analysis.



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

The following table gives a brief summary of how the full Impact Map calculation is derived, based on 160 visitors per year to Dial House. The table is divided into a number of sections corresponding to the different groups identified in Sections 3 and 4.

**Table 4c: Summary of Impact Map Valuations**

Category	No. of people	Value whilst with LSLCS per individual (taken as Year 1)	Value beyond Year 1 per individual
Group 0: Suicide averted	8	Difference between life and death, calculated as the annual equivalent of lifetime costs of suicide for all relevant stakeholders (See Section 5.1)	
Group 1: Long-term frequent	11	To individual: Value of LSLCS service	To individual: Value of LSLCS service
		To partners/families: Value of respite and relief from anxiety	To partners/families: Value of respite and relief from anxiety
		To NHS & Leeds CC: No. of visits x cost of alternative service provision	To NHS & Leeds CC: No. of visits x cost of alternative service provision

Group 2: Frequent in one year	19	To individual: Value of LSLCS service	To individual: Value of LSLCS service
		To partners/families: Value of respite and relief from anxiety	To partners/families: Value of respite and relief from anxiety
		To NHS & Leeds CC: No. of visits x cost of alternative service provision	To NHS & Leeds CC: No. of visits x cost of alternative service provision
Group 3: Long-term infrequent	46	To individual: Value of LSLCS service	To individual: Value of LSLCS service
		To partners/families: Value of respite and relief from anxiety	To partners/families: Value of respite and relief from anxiety
		To NHS & Leeds CC: No. of visits x cost of alternative service provision	To NHS & Leeds CC: No. of visits x cost of alternative service provision
Group 4a: Recovery assumed	19	To individual: Value of LSLCS service plus economic benefits of working	To individual: Economic benefits of working
		To partners/families: Value of respite and relief from anxiety	To partners/families: No additional value
		To NHS & Leeds CC: No. of visits x cost of alternative service provision	To NHS & Leeds CC: Nil
		To the state: Reduction in benefits, increase in tax receipts	To the state: Reduction in benefits, increase in tax receipts
Group 4b: Outcome unknown	57	To individual: Unknown	Nil (no credit claimed)
		To partners/families: Value of respite and relief from anxiety	
		To NHS & ASC: No. of visits x cost of alternative service provision	

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

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

The full SROI analysis also includes staff and volunteers, where impact and valuations are not dependent on the visitor/caller groups.

"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."

## Section 5. Valuing the Outcomes

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

### 5.1. Financial Proxy for Averting Suicide

The financial proxy applied to visitor/caller 'Group 0' is critical as it has a major impact on the SROI calculation. The full report contains a detailed explanation of this calculation, which 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

Published studies use national average data, and this has been modified for this SROI analysis by repeating the calculation with adjusted figures appropriate to LSLCS visitors/callers. The total lifetime cost has then 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 financial proxy includes all stakeholders for this visitor/caller group, so the following subsections apply to visitor/caller 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. Value of LSLCS to Visitors/Callers

This financial proxy covers all visitors/callers except those in 'Group 0' above (and 4b - see below).

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

Visitors and callers were asked to place a value on their use of LSLCS services, for example what they would consider reasonable for a visit to Dial House if (hypothetically) they had to pay for the service and could afford to. Many visitors could not answer this question because they described the service as "priceless", and those who did put a value on it varied widely between £40 per session and around £15,000 per year. We have taken an estimate of £100 per session as an estimate based on this range of responses.

This proxy can also be derived in another way, as the cost of alternative intervention designed to achieve the same outcome. In this case the nearest equivalent is likely to be

1:1 psychotherapy. People who can afford private psychotherapy (not the case for many LSLCS visitors) can pay anything from £40 to £180 per hour, £50-£70 per hour being a common figure

(source: www.mind.org.uk). For LSLCS the average visit duration in 2010 was 3 hours 38 minutes, and 76% of visitors chose to have 1:1 support within that time. This suggests that £100 per visit is around the right figure for an equivalent to an evening visit based on this proxy. (NB: LSLCS staff are not professional psychotherapists, but what is at stake for someone in severe crisis may well be higher, hence a visit may be of greater value to them.)

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

Similar considerations apply to negative outcomes where visits are refused (this applies only to visits declined because Dial House is full or the person is not prioritised, not to instances where referral to LSLCS is inappropriate). Although the alternative of a call to Connect is always offered, many visitors in this situation report that they feel worse than if they had not made the request in the first place. We have used the same proxy figure explained above to as the best representation of the negative value that people in this situation experience.

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

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

This financial proxy covers all visitors/callers except those in 'Group 0' (Section 5.1) and addresses the cost to statutory services (NHS Leeds and Leeds CC Adult Social Care) of alternative service provision if LSLCS was not there for its visitors/callers. These alternative services could include:

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

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

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

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

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

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

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

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

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

#### **5.4 Value of LSLCS to Partners and Families**

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

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

#### **5.5 Value of LSLCS to Central Government (Welfare Benefits)**

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

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

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

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

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

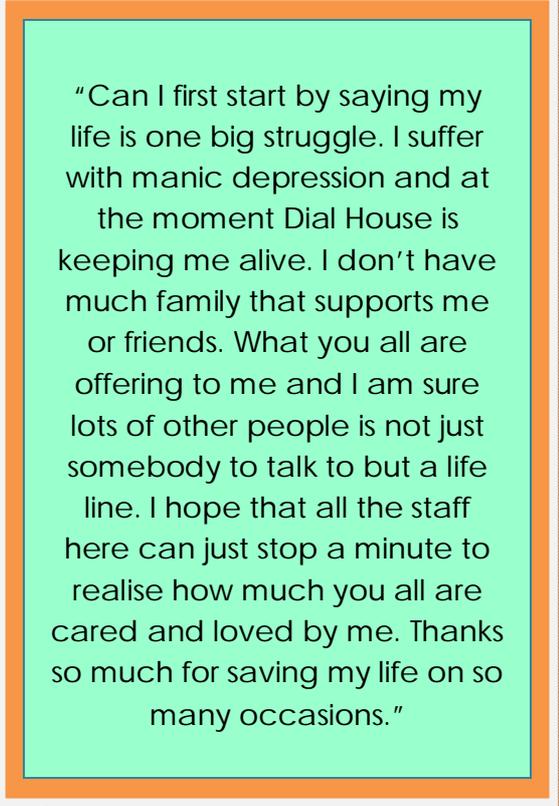
For these reasons the percentage of visitors in Group 4a (which in any case represents only 11.875% of all LSLCS visitors) has been adjusted when calculating the savings in welfare benefits, although a multiplier of 85% has been used rather than 71% to take account of the factors above.

(NB: Equipping people to move to or return to employment is not a core purpose of LSLCS. It does however play a significant role in a sequence of positive change that enables some people to achieve this, and hence is a relevant outcome for SROI, even if unintended. Although the numbers involved are relatively small, the benefits in financial equivalence terms are substantial, and the contribution of other agencies to this sequence of change is addressed through Attribution in Section 6).

## 5.6 Value of LSLCS to Staff

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

This was valued through a staff discussion group at which members of LSLCS staff were asked to note down (individually and in secret) what additional salary payment it would take for them to leave LSLCS. Several declined to answer on the basis that they would not work anywhere else at any price; amongst those who did reply the consensus was that they would need to at least double their present salary to gain an equivalent level of satisfaction elsewhere.



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

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

### 5.7 Value of LSLCS to Volunteers

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

### 5.8 Summary of Financial Proxies and Valuations

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



**Table 5a: Visitors/Callers**

Visitor/caller group	Description of change	Indicator	Quantity (Year One)	Proxy description	Information source	Proxy value per instance	Total change value (first year)	Drop-off in subsequent years
Group 0: Suicide averted	Suicide averted - avoidance of premature death	Benefits to the individual of avoiding premature death	8 visitors	Value to all of averting suicide	See Section 5.1	£39,619* per visitor	£316,952 (attribution applies)	None (effect is permanent)
Group 1: Long-term frequent	Reduced risk of self-harm, improved ability to manage, eventual stabilisation	Visitors/callers who report these improvements following visits	11 visitors, 39 visits each	Cost of private therapy of equivalent value	Visitor answers and Mind data (www.mind.org.uk)	£100 per session	£42,900	50% per year after year one
Group 2: Frequent in one year	Reduced risk of self-harm, improved ability to manage, limited recovery	As above	19 visitors, 14 visits each	As above	As above	As above	£26,600 (attribution applies)	90% impact remains after year one
Group 3: Long-term infrequent	Reduced risk of self-harm, improved ability to manage, stabilisation	As above	46 visitors, 3 visits each	As above	As above	As above	£13,800	100% drop-off (need unchanged)
Group 4a: Believed to have recovered	Ability to overcome crisis and manage a return to normal life	As above	19 visitors, 2 visits each	As above	As above	As above	£3,800	None (effect is permanent)
	Transition from benefits to receiving income from earnings	Number of visitors/callers who experience these economic benefits	16 visitors (19 x 85% - see 5.4)	Value of extra income received	DWP benefit rates and other VOIS data	£4,458	£71,328 (attribution applies)	None (see footnote to Table 5d)
Group 4b: Outcome unknown	Outcome unknown as they cannot be traced	n/a	57 visitors, 2 visits each	n/a	n/a	n/a	£0	n/a
<b>Negative: All groups if visit request refused</b>	<b>Disappointment, distress, may need to use other services</b>	<b>Number of instances in which these outcomes occur</b>	<b>343 instances per year</b>	<b>Cost of private therapy of equal value</b>	<b>As above (Mind data)</b>	<b>As above</b>	<b>£34,300</b>	<b>Counted for current year only</b>

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

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

**Table 5c: Partners/Families**

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

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

**Table 5d: Central Government**

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

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

**Table 5e: LSLCS Staff and Volunteers**

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

## Section 6: Assessing the Impact of LSLCS

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

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

This addresses whether the change experienced by stakeholders would have happened anyway, without the intervention of LSLCS. 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 6.3 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).

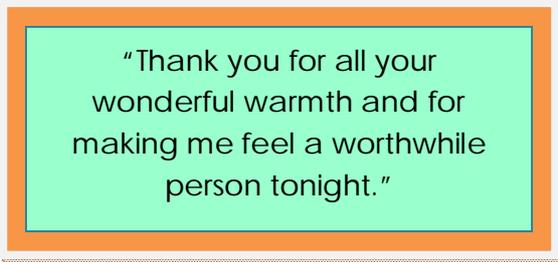
The conclusion is that there is no evidence that any of the changes and outcomes described in the previous sections would have happened without the involvement of LSLCS in the change process.

### 6.2. Displacement

Displacement tests whether LSLCS activity has simply moved something - shifted a benefit or a problem from one area to another rather than changing it. The only respect in which this might

apply to LSLCS is for those individuals who progress into paid employment, if in doing so they deprive someone else of a job. 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 unemployment is currently high, there were still 468,000 job vacancies in the last quarter of 2010 (Source: ONS statistics))
- the model used by the government in its *No Health without Mental Health* White Paper does not take account of such displacement when estimating the financial benefits of its current strategy, nor is it considered in other government 'welfare to work' schemes
- those who find work do so either in the mental health field (where there are vacancies) or in the general employment field; in neither case are they displacing others from any specific field or group who might otherwise obtain such employment. In other words, sufficient vacancies exist in these fields of work that displacement should not be an issue.



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

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

### 6.3. Attribution

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

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

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

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

- 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 very important 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.
- Advice in the New Economics Foundation publications *Small Slices of a Bigger Pie* (2011) recommends taking 50% as a starting point, and this advice seems appropriate here, at least until such time as more comprehensive feedback is available from a full range of LSLCS visitors (see Sections 7.2 and 7.3).

A modified attribution level of 33% has also been taken in one other case: that of visitors who use LSLCS intensively in one year and less in later years (Group 2). Here, whilst the above factors still apply, the extent of LSLCS involvement together with feedback from individuals believed to be 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% therefore seems appropriate.

## 6.4. Drop-Off

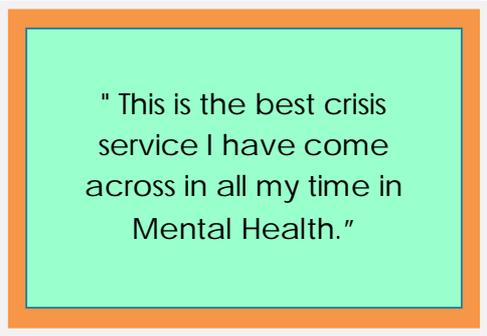
This question considers whether the change produced by LSLCS is permanent, or is eroded in subsequent years. Here, the different patterns of visits for each visitor group enable us to identify drop-off much more accurately than would be the case if we had to assume an aggregate annual percentage.

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

1. For group 1 (long-term visitors) turnover figures indicate that about 50% of these cease to become frequent visitors in each subsequent year. (These are replaced by new long-term visitors so that the overall number of frequent visitors remains roughly constant.)
2. For group 2 (frequent in one year with fewer subsequent visits), we have calculated 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 4a group (recovery) however, the benefits of a return to paid work should endure in subsequent years. No drop-off has been assumed in this instance because any regression would place these individuals in group 2 rather than 4a.
5. The negative consequences of visits refused recur each year, essentially unchanged, so again drop-off is 100%.

## 6.5. Cost - Benefit Analysis

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



" This is the best crisis service I have come across in all my time in Mental Health."

The resulting figure of £5.17 benefit per £1 invested may be considered the 'headline figure' for this SROI analysis. However the full report also includes a Sensitivity Analysis, which analyses the impact of varying all of the significant assumptions used to calculate this figure. From this we recommend that a range of between £4.00 and £7.00 per £1 invested is used to describe the SROI for LSLCS.

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

## Section 7: Discussion and Recommendations

### 7.1. Building on the Interim Report

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

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

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

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

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

### 7.2. Confirming the Impact on Short-Term Visitors

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

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

The significance of this is twofold:

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

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

### 7.3. Feedback on the Value of the Connect Helpline

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

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

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

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

LSLCS has accepted and has already started to implement both of these recommendations. The final report adds three further recommendations based on SROI analysis.

### 7.4. Increasing Capacity

The negative impact of instances where Dial House has to refuse a visit highlights an issue that LSLCS has long recognised: that of demand exceeding its capacity. In 2011 LSLCS received additional NHS funding which has allowed it to open on a fourth evening - Monday as well as Friday to Sunday as previously. This has had the effect of increasing both the number of visits and the number of visitors, although pro-rata to those already being received - it has not significantly increased the *proportion* of new visitors to Dial House.

Visits are still being refused when Dial House is full however, and this demonstrates that LSLCS could help more people still if it had more capacity. In SROI terms this would increase the total social value

the organisation delivers. Broadly speaking the current SROI ratio would remain valid up to the point that LSLCS can meet all demand, hence further funding would return much greater social value up to that point. This should also be seen against a background of demand which is continuing to increase, due at least partly to the current economic climate and its impact on individuals and families. Increased capacity could come either from opening Dial House for longer or more evenings, or possibly by opening a second centre elsewhere in Leeds.

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

## 7.5. Increasing Outreach

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

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

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

## 7.6. Refining Indicators

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

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

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