



University of the
West of England

The Balsam Centre Wellbeing Support Project

Evaluation and Social Return on Investment Analysis

Summary Report

Key Points

- The aim of this research was to evaluate the impact of the Big Lottery funded Wellbeing Support project on its participants. The research also sought to assess the wider social value that the project is creating using a Social Return on Investment (SROI) analysis.
- The Balsam Centre's Wellbeing Support Project is aimed at improving the mental health, wellbeing, and resilience of people with mental health needs in Wincanton and South Somerset. The project offers individual therapy alongside group-based arts, craft and social horticultural activities.
- SROI is a framework for measuring and accounting for change in ways that are relevant to the people or organisations that experience or contribute to it. It seeks to capture social, environmental and economic outcomes and uses monetary values to represent them.
- Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health.
- The evaluation includes data from 128 people who took part in individual therapeutic sessions during the first 22 months of the project; 80 of whom also took part in group-based activities

Key Findings

- Over a third of people self-refer, with the rest referred from over 10 agencies including NHS services. Baseline assessments show that participants have a wide range of mental health and wider social problems, including a minority with complex and severe difficulties.
- The evaluation found clear evidence of benefits of the Wellbeing Support Project to its participants using before-and-after validated questionnaires. After 4-6 months, 9 out of 10 participants (N=53) showed reduced signs of depression, anxiety, and improved life impact / wellbeing scores.
- Participant self-reports and project records provided evidence of wider positive impacts on community engagement, volunteering, employment, education and training. Multiple data sources suggest reductions in GP visits and the avoidance of crisis support from NHS mental health services.
- Participants and agency partners attribute the benefits of the Wellbeing Support Project to a history of strong local engagement; to the flexible, holistic and social approach; and to the personal qualities of staff and volunteers at the Balsam Centre and The Growing Space (a sister agency).
- SROI analysis identified a significant social return for the investment made; for every £1 spent on the Wellbeing Support Project there is £3.21 of social value created.

Balsam Centre Wellbeing Support Project

The Balsam Centre's Wellbeing Support Project is aimed at improving the mental health, wellbeing and resilience of people with mental health needs in Wincanton and the surrounding area of South Somerset.



The Wellbeing Support Project offers participants a flexible number of 1:1 sessions with a Wellbeing Worker who uses an integrative therapeutic approach to support participants emotionally, explore their situation, identify future strategies and develop personal goals. The support provided also includes referral and introduction to other elements of the Balsam Centre's group-based activities, these include art and craft groups and social horticultural activities at the Growing Space – a sister charity.

All adults with mild to moderate mental health needs living in Wincanton and surrounding area are eligible for the project. In addition the service is available to young people, mainly 14-16 years old, on referral from education and social care services.

Previous evaluation of the Balsam Centre and partner organisations' services¹ identified positive changes in mental health, personal and social well-being for participants. The current evaluation sought to build upon this evidence, and to examine the wider social and economic value of a leading Balsam Centre project.

¹ Jones, M., Kimberlee, R. *et al.* (2013) The Role of Community Centre-based Arts, Leisure and Social Activities in Promoting Adult Well-being and Healthy Lifestyles. *Int. J. Environmental Research & Public Health*, 10 (5). 1948-1962. doi.org/10.3390/ijerph10051948

Importance of mental health & wellbeing

Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health².

It is estimated that mental health problems impose a total economic and social cost of over £105bn a year³. The economy loses more than £30bn a year from sickness absence and unemployment caused by mental ill health, while treating mental health problems cost the NHS and social care over £21bn a year. But the majority of the financial burden of mental illness falls on patients and their families, with the impact on quality of life costing £53.6bn.

Access to Mental Health Support

Despite a wealth of published evidence about effective interventions to promote mental wellbeing and prevent and treat mental illness, both anxiety and depression often go undiagnosed and many individuals do not seek treatment. Certain groups are known to have particular difficulty in accessing mental health services, especially those in low income groups and those with other health and social problems. This is relevant to Wincanton and the surrounding rural area in Somerset which has few community services and has pockets of social deprivation.

There is good evidence that interventions that seek to improve wellbeing at individual and community levels can help to increase resilience to the wider impacts of the social determinants of health and risky behaviours. Changes may also impact on health and social care service use, limiting dependence on more costly intensive services. Supporting social engagement and reducing social isolation also provides benefits to the wider community by enabling a possible 'harnessing' of potential contribution to the community through, for example volunteering and caring responsibilities¹¹.

² Faculty of Public Health. Better Mental Health for All. <http://www.fph.org.uk/better-mental-health-for-all>

³ Centre for Mental Health. The economic and social costs of mental health problems in 2009/10. http://www.centreformentalhealth.org.uk/pdfs/economic_and_social_costs_2010.pdf

Research Aim and Methods

This research is part of a wider University of the West of England (UWE)-led study of projects funded by the Big Lottery under the South West Well-being Programme (SWWB). In this study we sought to evaluate the impact of the Balsam Centre's Wellbeing Support Project on its participants, and examine the social value that the project is creating using Social Return on Investment (SROI) analysis. Finally we used the RE-AIM framework to review the learning from evaluation.

What is Social Return on Investment?

SROI is a framework for measuring and accounting for change in ways that are relevant to the people or organisations that experience or contribute to it. It seeks to measure social, environmental and economic outcomes and uses monetary values to represent them. SROI captures wider forms of value often left out of more traditional methods of economic evaluation such as cost benefit analysis.

Interest in social value has been raised by [The Public Services \(Social Value\) Act](#) (2013). The Act requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area.

The act defines social value as *"the benefit to the community from a commissioning/ procurement process over and above the direct purchasing of goods, services and outcomes"*.

The evaluation focuses on 22 months operation of the Wellbeing Support Project (June 2013-March 2015) and includes all those who registered and took part in project activities and during this time ($n=128$). Participants completed baseline and follow up questionnaires at 4-6 months following enrolment. The measures covered depression (PHQ9), anxiety (GAD7), wellbeing and life impact (LIQ). Staff recorded self-reported personal and social difficulties, goals - and changes at 4-6 months.

Project Participants

The main beneficiaries of the Wellbeing Project are the participants who receive 1:1 therapeutic support and, in the majority of cases, also take part in group

activities. Of the 128 registered participants, 37% self-referred or attended through a personal recommendation. A wide range of agencies made referrals including GPs (12%), Health Visitors (8%), Family Support Workers (11%) and Youth Workers (7%).



Sixty eight percent of participants were female and 98% defined themselves as White British. The modal age bracket for adults was 35-44 (range 16-84). A minority (20.4%) were in any kind of paid employment; 30.4% were unemployed and 18% described themselves as long term sick or disabled. Forty one percent reported having childcare responsibilities and 11.7% reported caring for an adult.

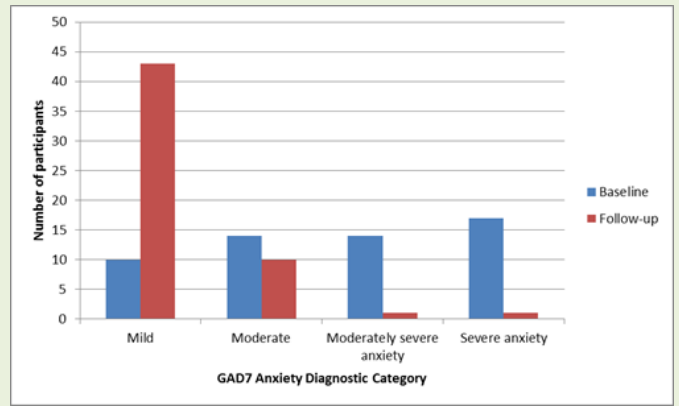
Self-reported Health Issues at Registration

A majority of participants (68%) reported at least one mental health problem. However it is likely that there is significant under reporting, many participants come to the project with complex needs that are only disclosed at a point after registration.

Issue	n	%
Depression	80	68%
Low mood	49	45%
Anxiety / panic attacks	34	31%
Physical ill health / pain management	19	18%
Self esteem (under 24 year olds)	10	9%
Bipolar disorder	8	7%
Alcoholism	5	5%
Bereavement	3	3%
Suicidal ideation and/or self harm	3	3%

Over half (55.5%) of participants said they had at least one long term physical condition or disability, including muscular sclerosis, joint pain, diabetes and cardio-vascular disease. A small number of participants reported having a learning disability.

Chris enrolled with the Wellbeing Support Project, said that his mental health suffered due to low income, isolation and poor physical health: *“I felt like I was falling from the sky. I arrived here from another part of the country after losing my job and all my money. I’d had a heart attack and I’d broken my legs in an accident. I didn’t have any friends, any social contacts”*



Outcomes for Depression

Using the PHQ9 tool, matched scores for the baseline and follow-up were available for 54 participants aged 16 years old and over. A paired T test showed statistically significant difference ($p < 0.001$) between these mean scores (baseline mean 12.8, SD 5.8; follow-up mean 5.2, SD 4.7). Fifty two per cent ($n = 28/54$) reported a change from ‘severe’ to ‘moderate’ depression to ‘mild’ or ‘moderate’ depression.

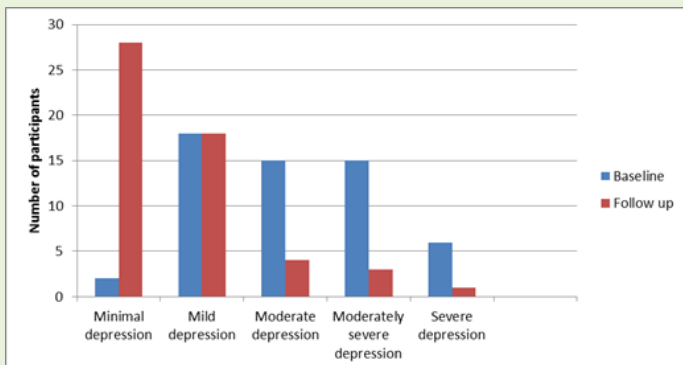
Mild to severe depressive symptoms fell from 98% ($n = 53$) at baseline to 27% ($n = 15$) at follow up. There was a positive change in the raw measurement score in depressive symptoms for 53 out of 54 (98%) participants.

Outcomes for Wellbeing

Using the LIQ tool, matched scores were available for 53 participants 16 years old and over. A paired T test showed statistically significant difference ($p < 0.001$) between these mean scores (baseline mean 17.7, SD 8.3; follow-up mean 7.5, SD 6.9). There was a positive change in the score for 48 out of 53 (90%) of participants.

Sue and Bryony appreciated the therapeutic approach: *“For me it’s a kind of time out, I feel so supported. I don’t feel judged...I can be myself.”* Sue

“[The Wellbeing Worker] is very hands on. She actually helps sort the problem out and doesn’t just signpost on to others.” Bryony



Outcomes for Anxiety

Using the GAD7 tool, matched scores for the baseline and follow-up were available for 55 participants 16 years old and over. A paired T test showed statistically significant difference ($p < 0.001$) between these mean scores (baseline mean 11.8, SD 4.15; follow-up mean 5.9, SD 3.7). Fifty three per cent ($n = 29/55$) reported a change from ‘moderately severe’ and ‘severe’ anxiety to ‘moderate’ or ‘mild’ anxiety. Nearly all (91%, $n = 50/55$) had a positive change in the raw measurement score.

Additional Reported Outcomes

Project exit and review records provided descriptive data for 124 participants on a wide range of areas of change:

- 27 individuals reporting reduced GP attendance as a result of taking part in the Project activities.
- 3 people who obtained full time paid employment and 4 people who obtained part time work in the period of engagement with the Wellbeing Support Project.
- 20 people who retained their jobs in difficult circumstances or returned to work early.
- 26 people who tried reported engagement in volunteering or supporting the delivery of community activities. These were both activities at the Balsam Centre and in other local settings.

- 7 referrals to other counselling/ listening services or talking therapies in the area.
- 12 engaging more effectively with social care (statutory or voluntary sector services) – particularly for people with learning disabilities and older people - for assessment for support services. Most of these have related to maintaining independent living.
- 7 people who went on to register for vocational or non-vocational qualifications as a direct result of exploring their goals with the Wellbeing Support Project.
- 3 people who reported improved physical activity and healthier eating.

Jim felt that the Wellbeing Support Project helped his confidence: “I used to go out at night to avoid contact with people. I wouldn’t even have made eye contact before. But now they can’t shut me up. I managed to stand up and read a poem in front of 200 people!”

Social Return on Investment Analysis

The SROI analysis involves a stage-based process that involves mapping outcomes from the perspective of stakeholders; defining the relationship between inputs, outputs and outcomes; evidencing outcomes and giving them a value; identifying those aspects of change that would have happened anyway or are a result of other factors to ensure that they are taken out of the analysis; and then calculating the SROI.

Inputs

The annual budget for the Balsam Centre Wellbeing Support Project is £50,263. This includes funding for a full time Wellbeing Support Worker, general overheads, running costs and additional expenses associated with delivering group-based sessions.

Outputs – Delivering the Project

Analysis of 128 records shows a mean number 9.9 (SD 12.1) one-to-one therapeutic sessions per client. The therapeutic model is based upon at least 6 sessions. The Project registered an average of 1.6 new clients per week. After factoring in wider costs, it is estimated that the 1:1 therapeutic element of the

project costs £45 per hour to deliver. Over time the flow of new client registrations has increased, such that the cost is nearer to £36 per hour when running at project capacity.



Records of group-based activities suggest an average attendance of 8 participants, although this is an estimate given the semi-structured format of the activities. Groups were attended by 80 out of the 128 participants who are the focus of the present study. It is estimated that group activities cost £13.70 per session for these participants. This includes wider costs, although arguably further Balsam Centre, Growing Space and volunteer costs might be factored in.

Valuing outcomes

In SROI we use financial proxies to estimate the social value of non-traded goods to different stakeholders. By estimating this value through the use of financial proxies, and combining these valuations, we arrive at an estimate of the total social value created by an intervention.

The table at the end of this report provides a summary of all the outcomes included in the SROI analysis and the way in which they were valued.

Some participants found it hard to put a value on service: “I would be in the looney bin by now if it wasn’t for therapy. I nearly lost everything” Jane

“[The Wellbeing Support Worker]’s help has been invaluable for me - worth her weight in gold” Brian

“I don’t know what I could have done without [counselling] and the group. I really think I wouldn’t be here. I would have ended it...I can’t put a price on that.” Miriam



Calculating the Social Value

SROI analysis found that the net SROI ratio which takes account of the amount invested is 1:3.21. This means that the SROI analysis estimates that for every £1 spent on Wellbeing Support Project there is £3.21 of social value created.

The total impact for the 128 participants who participated in 22 months of the Wellbeing Support Project calculated from this analysis is £156,979. Whilst project participants are the greatest beneficiaries of Wellbeing Support Project (58%) there is also substantial benefit to local NHS services (19%), and the wider fiscal system (DWP) in terms of savings related to Employment and Support Allowance (18%), as well as the Balsam Centre (3%) and the Local Authority (1%).

Strengths and Limitations of the Research

The evaluation and SROI built upon a good set of quantitative baseline and follow-up data collected by the Balsam Centre. Questionnaires used validated measures and the research team externally audited the data collection process. Additional written records held by staff provided supplementary information on the quantitative records.

There are also a number of limitations. Within the timescale and resources it was not possible to collect data for longer-term outcomes beyond 4-6 months from enrolment. Some benefits important to stakeholders have not been monetised. Wider impacts of the Wellbeing Support Project on the Balsam Centre and the local community have not been captured in the analysis. It was beyond the scope of the study to fully explore the costs and benefits of the combined Balsam Centre and Growing Space activities. This means that the study did not capture some of the benefits for members of the local community who take part in open day and other Centre activities that run in parallel to the Wellbeing Support Project.

Conclusion and Recommendations

In this evaluation and SROI report we have monetised the benefits of the Wellbeing Support Project to its participants and other agencies working with the community in Wincanton and surrounding area. The report demonstrates a significant social return for the investment made, and the feedback from participants and stakeholders clearly illustrate the programme's positive impact to participants' mental health, wellbeing and life circumstances. These findings fit with theories of change for integrated interventions that seek to improve mental wellbeing at an individual level and promote community participation through supported group-activities.

Balsam Centre Wellbeing Support Project Model



Using the Re-AIM review framework⁴ we can summarise some key areas of learning from the evaluation:

- **Reach.** The project clearly reaches adults, and some young people, with mild to moderate mental ill health in the target area. Some adults with higher levels of mental ill health and social need accessed the therapeutic service.
- **Effectiveness.** There is baseline-follow up evidence of short-term impacts. There is plausible evidence of longer term and wide ranging personal and social effects. No negative outcomes to participants or partner agencies were identified. SROI analysis helps communicate the overall social value of the project.

⁴Glasgow R et al (1999) Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *Am J Public Health* 89:1322-1327.

- **Adoption.** The project evolved from locally felt needs, is integrated with other community activities. Partner agencies are supportive, although there are occasional inappropriate referrals.
- **Implementation.** The project draws upon a clear set of agency values. Delivery costs compare favourably to similar initiatives. Further development would help refine the model and help transfer the learning to other settings.
- **Maintenance.** The project is well established and has good 'participant throughput'. There is positive qualitative evidence of long term effects and the SROI analysis modelled effects for three years post intervention. Secure funding represents a major problem for the future of the project.

What is the RE-AIM Framework?

RE-AIM is a useful framework for reviewing community projects that have public health goals.

Reach

Does the intervention reach the target population?

Effectiveness

Does the intervention achieve the assumed goals, without negative outcomes?

Adoption

Was the intervention broadly adopted at the community level?

Implementation

Was the intervention consistently implemented at a reasonable cost?

Maintenance

Does the intervention have the ability to be sustained, with long-lasting effects?

A key concern for the Balsam Centre is securing ongoing funding once the current Big Lottery funding ends. This report provides a tool for working with local commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.

It also highlights ways in which improvements could be made to the project to maximise benefit to individuals and other local projects and services in the Balsam Centre and in Wincanton and surrounding area. For example since the Balsam Centre is a provider of community and family services there is opportunity for the Wellbeing Support Project to work more closely with the local GP and Primary Care services to target their registered patients, working with the Practice and perhaps also the IAPT service to take referrals and work with clients to identify solutions that

enable them to help themselves, and also to access other support services more appropriately.

Key recommendations arising from this study are:

- Use this report as a tool to demonstrate the value of the Wellbeing Support Project and the Balsam Centre and for working with local commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.
- Explore opportunities for undertaking a whole system evaluation and SROI of the Balsam Centre to provide insight in to the ways in which it benefits the local community and promotes health and wellbeing in Wincanton and the surrounding area.
- Identify ways for other local services, particularly the GP Practice and IAPT service, to take appropriately refer clients to Balsam Centre services, and to access other support services.
- Review data collection methods used by the Wellbeing Support Project in light of the outcomes captured by this SROI and identify ways to capture all relevant outcomes to project and future funders whilst ensuring that paperwork is minimised.

This study was led by Mat Jones (UWE), Sarah Weld (Specialty Public health Registrar), Olly Biggs (UWE), Dr Richard Kimberlee (UWE) and Phil Aubrey (Well UK).

We would like to acknowledge and thank all the Balsam Centre staff – particularly Sue Place and Debbie Kendall - participants and partner agency staff for their support and assistance in undertaking this research.

Photographs in this report show work produced by participants in the Balsam Centre Wellbeing Support Project Arts & Craft Groups

April 2015

For the full **SROI Report** and the SWWB programme evaluation go to:

<http://westbank.org.uk/>

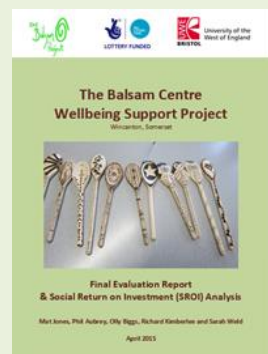
or contact:

matthew.jones@uwe.ac.uk

For details on the Balsam

Centre contact:

Sue.Place@balsamcentre.org.uk



Social Return on Investment – outcomes included and their values

Outcome Indicator	n (%)	Financial Proxy	Value per participant
Number of participants reporting positive change in diagnostic category for moderately severe/ severe anxiety and depression.	66 (52%)	Cost of counselling.	£240
Number of participants reporting reduced GP attendance.	27 (21%)	Cost of GP appointment – average. Calculated as 1 fewer appointments per participant per year.	£42
Number of participants who report improved social wellbeing and improved relationships with partner, other family members or friends.	42 (32%)	Cost of social club membership and attendance at activities.	£50
Number of participants reporting improved physical activity and diet.	3 (2%)	Cost of gym membership/local activity session. Calculated as 1 session per fortnight per participant.	£124.40
Number of participants reporting improved ability to perform day-to-day tasks in their lives.	115 (90%)	A course of CBT to build psychological resilience and self-esteem.	£930
Number of participants reporting engagement in volunteering or supporting the delivery of community activities.	26 (20%)	Economic value of volunteer time. Calculated as 1 hour per week for 6 months.	£335.92
Number of participants reporting having obtained paid employment.	5 (4%)	Employment and Support Allowance (overall fiscal benefit to government from a workless claimant entering work).	£8,632
Number of participants reporting better work life balance or working patterns.	25 (20%)	Life coaching style course - Managing Yourself and Personal Effectiveness Training Course.	£480
Number of participants reporting retention of employment or early return to employment.	20 (16%)	Workplace mental wellbeing intervention.	£83
Number of participants referred to other 1 to 1 counselling/ listening services.	7 (5%)	Preparation for counselling.	£240
Number of participants engaging more effectively with support services for people with learning disabilities or older people.	12 (9%)	Cost of sessions with social care support worker. Calculated as 8 sessions per participant.	£120
Number of participants who report registering for a course and/or achieving new qualification.	7 (5%)	Cost of part time course at a further education college.	£300
Prevention of referral to secondary mental health services.	12 (9%)	Cost of secondary mental health care outreach service for 6 months.	£3,832

The Balsam Centre Wellbeing Support Project

Wincanton, Somerset



Final Evaluation Report & Social Return on Investment (SROI) Analysis

Mat Jones, Phil Aubrey
& the UWE SROI Research Group

April 2015

ACKNOWLEDGEMENTS

The study has been led by Mat Jones, Associate Professor of Public Health at the Public Health and Wellbeing Research Group, University of the West of England (UWE) Bristol. This report builds upon a similar study led by Sarah Weld, Public Health Specialty Registrar of a Wellbeing Project at the For All Healthy Living Centre, Weston-super-Mare. We are indebted to Sarah for use of her report format, the literature review and method of analysis. Olly Biggs (UWE) and Phil Aubrey (Well UK) have been involved in the data collection and review of the report. Richard Kimberlee (UWE) has also supported the design and review of the study.

We would like to acknowledge and thank all the staff at the Balsam Centre for their support and assistance in undertaking this evaluation, particularly Sue Place and Debbie Kendall. Thanks also go to the stakeholders who agreed to be interviewed for the project, particularly the project participants who shared their stories, as well as the staff from the many partner agencies in Wincanton.

Further information about this report or the South West Well-being evaluation can be found at <http://westbank.org.uk/> or contact

Mat Jones,
Faculty of Health and Applied Sciences,
University of the West of England,
Tel: 0117 3288769
Email: matthew.jones@uwe.ac.uk

Jaine Keable,
South West Well-being Manager,
Westbank,
Farm House Rise,
Exminster,
Exeter, EX6 8AT.
Tel: 01392 824752.
Email: j.keable@westbankfriends.org

CONTENTS

EXECUTIVE SUMMARY	11
Aim	12
The Balsam Centre’s Wellbeing Support Project	12
Importance of mental health and wellbeing	2
What is Social Return on Investment?	13
Social Value	13
Method	13
Project Participants	13
Findings	14
Strengths and Limitations	6
Conclusion and Recommendations	6
1. INTRODUCTION	18
1.1 Aim	18
1.2 Purpose	18
1.3 Big Lottery South West Well-being Programme	18
1.4 The Balsam Centre and the Wincanton area	19
1.5 Balsam Centre’s “South West Well-being” Wellbeing Project: “Touchwood”	19

1.6	Wellbeing Support Project	19
2.	LITERATURE REVIEW	21
2.1	What do we mean by mental health and wellbeing?	22
2.2	What do we mean by mental illness?	22
2.3	Determinants of mental health and wellbeing	23
2.4	Social isolation	24
2.5	Impact of mental illness	25
2.6	National Policy Context	25
2.7	Local Policy Context and Access to Service Provision	26
2.8	Interventions to promote mental wellbeing and prevent mental illness	28
	Interventions for mild to moderate common mental health disorders	29
3.	SOCIAL RETURN ON INVESTMENT	30
3.1	What is Social Return on Investment?	30
3.2	Stage 1: Establishing Scope and Identifying Key Stakeholders.	31
	Scope	31
	Key stakeholders	31
	Project Participants	31
3.3	Stage 2: Mapping inputs and outcomes	33
	Mapping inputs	33
	Mapping outputs - data collection methods	34
3.4	Stage 3: Evidencing outcomes and giving them a value	37
	Qualitative data analysis	37
	Quantitative data analysis	40
	Outcomes for Young People	43
	Making a judgement on outcomes	43
	Putting a value on the outcome	44
	Negative outcomes	44
	Outcomes and proxy values	45
3.5	Stage 4: Establishing impact	47
	Deadweight	47
	Displacement	48
	Attribution	49
	Drop-off	49
	Calculating the impact	49
3.6	Stage 5: Calculating the SROI.	52
	Projecting in to the future	52
	Net Present Value	52
	Social Return on Investment	53
	Sensitivity analysis	53
3.7	Stage 6: Reporting, using and embedding.	55
4.	CONCLUSION AND RECOMMENDATIONS	55
4.1	Summary of findings	55
4.2	Strengths and limitations	56
4.3	Recommendations	57
5.	APPENDICES	59
5.1	Appendix 1 – List of Potential Stakeholders	59
5.2	Appendix 2 – Impact Map	60
	Appendix 3 - Participant interview questions	60
5.3	Appendix 4 – Stakeholder Interview Questions	61

EXECUTIVE SUMMARY

Aim

The aim of this research was to evaluate the impact of the Balsam Centre's Wellbeing Support Project on its participants, and demonstrate the social value that the project is creating using the method of Social Return on Investment (SROI). The evaluation focuses on 22 months operation of the Wellbeing Support Project (June 2013-March 2015) and includes all those who registered and took part in project activities and during this time ($n=128$).

The Balsam Centre's Wellbeing Support Project

The Balsam Centre's Wellbeing Support Project is aimed at improving the mental health, wellbeing, independence personal relationships and resilience of people with mental health needs in Wincanton and the surrounding area of South Somerset.

The Wellbeing Support Project is a service targeted at people experiencing mental ill health, primarily anxiety, low mood and depression, and who are not accessing services. It offers participants a flexible number of 1:1 sessions with a Wellbeing Worker who uses an integrative multi-theoretical psychotherapeutic approach to support participants emotionally, to explore their situation, identify future strategies to improve their situation and to develop personal goals. The support provided also includes referral and introduction to other elements of the Balsam Centre's group-based activities, these include art and craft based creativity groups and therapeutic horticultural activities at the Growing Space – a sister charity. When appropriate, onward referrals are also made to other local agencies for specialist support.

All adults with mild to moderate mental health needs living in Wincanton and surrounding area are eligible for the project. Given that common mental health problems affect up to 15% of the population at any one time, based on a population size of 7,500 in the Wincanton area it can be estimated that around 600 adults might benefit from the Wellbeing Support Project at any time. In addition the service is available to young people, mainly 14-16 year old, on referral from education and social care services.

Importance of mental health and wellbeing

Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health⁵.

It is estimated that mental health problems impose a total economic and social cost of over £105bn a year⁶. The economy loses more than £30bn a year from sickness absence and unemployment caused by mental ill health, while treating mental health problems cost the NHS and social care over £21bn a year. But the majority of the financial burden of mental illness falls on patients and their families, with the impact on quality of life costing £53.6bn.

Despite a wealth of published evidence about effective interventions to promote mental wellbeing and prevent and treat mental illness both anxiety and depression often go undiagnosed and many individuals do not seek treatment. Certain groups are known to have particular difficulty in accessing mental health services, especially those in low income groups and those with other health and social problems. This is relevant to Wincanton and the surrounding rural area in Somerset which has few community services and has pockets of social deprivation.

⁵ Faculty of Public Health. Better Mental Health for All. http://www.fph.org.uk/better_mental_health_for_all

⁶ Centre for Mental Health. The economic and social costs of mental health problems in 2009/10. http://www.centreformentalhealth.org.uk/pdfs/economic_and_social_costs_2010.pdf

There is good evidence that interventions that seek to improve wellbeing at individual and community levels can help to increase resilience to the wider impacts of the social determinants of health and risky behaviours. Changes may also impact on health and social care service use, limiting dependence on more costly intensive services. Supporting social engagement and reducing social isolation also provides benefits to the wider community by enabling a possible ‘harnessing’ of potential contribution to the community through, for example volunteering and caring responsibilities¹¹.

What is Social Return on Investment?

Social Return on Investment (SROI) is a framework for measuring and accounting for change in ways that are relevant to the people or organisations that experience or contribute to it. It tells the story of how change is created by measuring social, environmental and economic outcomes and uses monetary values to represent them. SROI is one approach to economic evaluation of which there are many. SROI captures value often left out of more traditional methods of economic evaluation such as cost benefit analysis.

Social Value

Whilst there is no single accepted definition of social value it is clear from the definition of SROI above and the way in which it is described in other key documents that it refers to measures of impacts of programmes, organisations and interventions that include wider social, economic and environmental benefits.

Interest in social value has been raised by The Public Services (Social Value) Act⁷ which came into force on 31 January 2013. The Act requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental well-being of the area. The act defines social value as:

“the benefit to the community from a commissioning/procurement process over and above the direct purchasing of goods, services and outcomes”.

Being able to demonstrate the social value of a project may therefore support business cases and applications for funding.

Method

Quantitative and qualitative data have been used to inform this SROI. Measures of mental health and wellbeing collected from participants as part of the project’s outcome monitoring were analysed together with qualitative data collected through project monitoring and research interviews with participants and key stakeholders. Twelve interviews were undertaken with project participants and relatives of participants (all in person) and six with staff from Balsam Centre partner agencies (mixture of in person and telephone interviews).

Project Participants

The main beneficiaries of Wellbeing Support Project are the clients who engage with the project and receive an intervention. During 22 months of operation of Wellbeing Support Project (June 2013 to March 2014), the project received 128 referrals (self-referral and referral from partner agencies) to 1:1 sessions with the Wellbeing Support Worker.

Sixty eight percent of participants were female and 98% defined themselves as White British. Participants came from a wide range of age groups, with the modal age bracket being 35-44. A minority (20.4%) were in any kind of paid employment; 30.4% were unemployed and 18% described

⁷ <https://www.gov.uk/government/publications/social-value-act-information-and-resources/social-value-act-information-and-resources>

themselves as long term sick or disabled. Forty one percent reported having childcare responsibilities and 11.7% reported caring for an adult.

Over half (55.5%) of participants said they had at least one long term condition or disability. Most reported more than one condition. Commonly reported conditions included mental health conditions such as depression, anxiety and panic attacks; and physical ill health such as muscular sclerosis, joint pain, diabetes and cardio-vascular disease. A small number of participants reported having a learning disability.

Findings

SROI analysis found that the net SROI ratio which takes account of the amount invested is 1:3.21. This means that the SROI analysis estimates that for every £1 spent on Wellbeing Support Project there is £3.21 of social value created.

The total impact for the 128 participants who participated in 22 months of the Wellbeing Support Project calculated from this analysis is £156,979. Whilst project participants are the greatest beneficiaries of Wellbeing Support Project (58%) there is also substantial benefit to local NHS services (19%), and the wider fiscal system (DWP) in terms of savings related to Employment and Support Allowance (18%), as well as the Balsam Centre (3%) and the Local Authority (1%).

The table below provides a summary of all the outcomes included in the SROI analysis and the way in which they were valued.

Social Return on Investment – outcomes included and their values

Outcome	n (%)	Financial Proxy	Value per participant
Number of participants reporting positive change in diagnostic category for moderately severe/ severe anxiety and depression.	66 (52%)	Cost of counselling.	£240
Number of participants reporting reduced GP attendance.	27 (21%)	Cost of GP appointment – average. Calculated as 1 fewer appointments per participant per year.	£42
Number of participants who report improved social wellbeing and improved relationships with partner, other family members or friends.	42 (32%)	Cost of social club membership and attendance at activities.	£50
Number of participants reporting improved physical activity and diet.	3 (2%)	Cost of gym membership/local activity session. Calculated as 1 session per fortnight per participant.	£124.40
Number of participants reporting improved ability to perform day-to-day tasks in their lives.	115 (90%)	A course of CBT to build psychological resilience and self-esteem.	£930
Number of participants reporting engagement in volunteering or supporting the delivery of community activities.	26 (20%)	Economic value of volunteer time. Calculated as 1 hour per week for 6 months.	£335.92

Outcome	n (%)	Financial Proxy	Value per participant
Number of participants reporting having obtained paid employment.	5 (4%)	Employment and Support Allowance (overall fiscal benefit to government from a workless claimant entering work).	£8,632
Number of participants reporting better work life balance or working patterns.	25 (20%)	Life coaching style course - Managing Yourself and Personal Effectiveness Training Course.	£480
Number of participants reporting retention of employment or early return to employment.	20 (16%)	Workplace mental wellbeing intervention.	£83
Number of participants referred to other 1 to 1 counselling/ listening services.	7 (5%)	Preparation for counselling.	£240
Number of participants engaging more effectively with support services for people with learning disabilities or older people.	12 (9%)	Cost of sessions with social care support worker. Calculated as 8 sessions per participant.	£120
Number of participants who report registering for a course and/or achieving new qualification.	7 (5%)	Cost of part time course at a further education college.	£300
Prevention of referral to secondary mental health services.	12 (9%)	Cost of secondary mental health care outreach service for 6 months.	£3,832

Analysis of quantitative outcome data collected by the project provides clear evidence of significant and lasting benefit to those who receive an intervention from the Wellbeing Worker in terms of improved feelings of reduced signs of anxiety and depression, as well as improved overall life impact. There is also evidence that these improvements, and the changes made as a result of the signposting and practical advice and tools given to participants, results in a reduction in GP appointments; and more appropriate use of other support services. There is evidence that the Wellbeing Support Project is having an impact on people with high or severe levels of mental ill health as well and those with very complex life problems, as addressing the difficulties of people with mild to moderate mental ill health.

Longer term outcomes captured qualitatively include significant life changes such as gaining or maintaining employment in paid or voluntary and community work; gaining new educational qualifications; and improvements in social relationships.

The evaluation provides further evidence to support the use of integrated mental health therapeutic approaches to help those with mild to moderate mental health needs. It also provides some insight in to how participants experience a client-led and holistic intervention. The flexibility of the model appears to allow the practitioner to work with a wide range of clients and to coordinate with colleagues specialising in community development, horticultural therapy and volunteer support. This approach offers a non-medicalised approach that appears attractive to people seeking an alternative to NHS-led services. The flexibility of brief support interventions offered at short notice is attractive for people chronic mental health conditions and at risk of relapse. This model also holds attractions for funders and policy makers seeking to support low cost and sustainable community services.

Stakeholders interviewed identified a wide number of positive things about the project; in particular that it is a local and well integrated with other services in the area; and that the Wellbeing Worker's proactive approach means that those referring are confident that even difficult clients will be followed up and well supported rather than getting lost in the system or falling through the gaps. It was clear from all the interviews conducted that the personal attributes of the Wellbeing Worker and Balsam Centre colleagues were highly valued and key to the success of the project.

Participants and one family member expressed deep concern imminent end of grant funding for the project. There was concern not only about how withdrawal would affect service users, but also the impact on the community of investing so much time and effort in developing a project, raising expectations about availability of a new service and then losing it when the funding goes.

Strengths and Limitations

A key strength of this SROI was that it built upon a good set of quantitative baseline and follow-up data collected by the Wellbeing Support Worker. This meant that there was paired data for many of the project participants that could be incorporated in to the evaluation. Additional written records held by staff provided supplementary information on the quantitative records.

There are also some limitations. Although data completeness was good, the number of participants with follow-up data was small, particularly in terms of longer term follow-up so there is some uncertainty in the results of quantitative analyses. There will be some benefits that are important to stakeholders but which cannot be monetised. It is also likely that some of the wider impacts of the Wellbeing Support Project on the Balsam Centre and the local community have not been captured in the analysis.

Conclusion and Recommendations

In this evaluation and SROI report we have monetised the benefits of the Wellbeing Support Project to its participants and other agencies working with the community in Wincanton and surrounding area. The report demonstrates a significant social return for the investment made, and the feedback from participants and stakeholders clearly illustrate the programme's positive impact to participants' mental wellbeing and wider measures of social wellbeing and reduced isolation. These findings fit with theories of change for integrated interventions that seek to improve mental wellbeing at an individual level and promote community participation.

A key concern for the Balsam Centre is securing ongoing funding once the current Big Lottery funding ends. It is difficult to quantify the impact that discontinuing the Balsam Centre Wellbeing Support Project might have on the local community and other local services. However a previous 20 month break in a similar service prior to June 2013 led to increased pressures on NHS, Social Care and other local community services. It is likely that those who might benefit from the service will experience mental health-related difficulties that are avoidable and that have harmful impacts on families, their community and local services.

This report provides a tool for working with local mental health and public health commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.

It also highlights ways in which improvements could be made to the project to maximise benefit to individuals and other local projects and services in the Balsam Centre and in Wincanton and surrounding area. For example since the Balsam Centre is a provider community and family services there is opportunity for the Wellbeing Support Project to work more closely with the local GP and Primary Care services to target their registered patients, working with the Practice and perhaps also the IAPT service to take referrals and work with clients to identify solutions that enable them to help themselves, and also to access other support services more appropriately.

Recommendations are:

- Use this report as a tool to demonstrate the value of the Wellbeing Support Project and the Balsam Centre and for working with local commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.
- Explore opportunities for undertaking a whole system evaluation and SROI of the Balsam Centre to provide insight in to the ways in which it benefits the local community and promotes health and wellbeing in Wincanton and the surrounding area.
- Identify ways for other local services, particularly the GP Practice and IAPT service, to take appropriately refer clients to Balsam Centre services, and to access other support services.
- Review data collection methods used by the Wellbeing Support Project in light of the outcomes captured by this SROI and identify ways to capture all relevant outcomes to project and future funders whilst ensuring that burden of paperwork is minimised for participants and project staff.

INTRODUCTION

Aim

The aim of this research was to evaluate the impact of the Balsam Centre's Wellbeing Support Project on its participants, and demonstrate the social value that project is creating using the method of Social Return on Investment (SROI). The Wellbeing Support Project is aimed at improving the mental health and resilience of people with mental health needs, such as stress, depression and anxiety in Wincanton and the surrounding area of south Somerset.

The evaluation focusses on 22 months of operation of the Wellbeing Support Project (June 2013-March 2015) and includes all those who registered with the project and received an intervention during this time ($n=128$).

The objectives for this analysis were:

- To produce an Impact Map and SROI Report.
- To identify suitable indicators that would enable the measurement of outcomes and social impact of the Wellbeing Support Project.
- To produce a working document that can be used to demonstrate the social value of investing in the Wellbeing Support Project.
- To use this initial report as a base for identifying the changes necessary to sustain and improve the social value of the Wellbeing Support Project and associated activities at the Balsam Centre.

Purpose

There is a particular need for an evaluation and analysis of the Wellbeing Support project to provide evidence to support bids for future funding for the project beyond March 2015. A key audience for the findings of the SROI analysis will be potential future funders. This includes local commissioners (CCG and Local Authority) as well as national funding agencies such as the Big Lottery.

The Balsam Centre is interested in the concept of SROI and how it could be used to demonstrate the value of other services and projects it offers. This evaluation will therefore also provide a useful test of the methods on a discrete project which is characteristic of the overall work of the agency and that the Wellbeing Support project is appropriate for this to inform potential future wider SROI analysis.

Big Lottery South West Well-being Programme

The Wellbeing Support Project is part of the Big Lottery funded South West Well-being Programme (SWWB); a programme that seeks to improve the well-being of people in poor health, experiencing isolation and living in socially disadvantaged neighbourhoods in the south west of England. The SWWB Programme is led by Westbank CHC based in Exminster Devon. Eight agencies in the South West of England each deliver a community-based project to offer non-medical alternatives to positive health promotion that include lunch clubs, community kitchens, weight management groups, community allotments, befriending groups, collective arts and creative activities. The projects share an emphasis on bottom-up community involvement and informal social networks. For individual participants the focus is on positive physical, social and mental states, as opposed to the absence of pain, discomfort and incapacity.

The SWWB Programme is being funded by the Big Lottery fund and the funding for this SROI evaluation and the evaluation of other SWWB projects has also been provided by the Big Lottery. The University of the West of England, Bristol (UWE) has been commissioned by the Westbank CHC and

the SWWB consortium to undertake these evaluations as a means of obtaining a clearer picture that will help them to make more intelligent investment and funding decisions in the future.

The Balsam Centre and the Wincanton area

The Balsam Centre, otherwise known as Wincanton Community Venture (WCV), is a voluntary sector organisation located in South Somerset district. Its mission statement is “to reduce inequalities, and provide health, social and cultural opportunities for individuals and communities in its area of benefit.”

The organisation hosts a healthy living centre - with rooms for community activities and meetings - a children’s centre and acts as a base for a health visitor team. Private and voluntary sector partners offer additional activities at the Centre and it has evolved into the principal local venue for community and interest groups. The Centre collaborates with primary health care, local school family support services and debt advisory services. The Growing Space, a social and horticultural therapeutic agency, neighbours the Centre and shares some facilities.

The Balsam Centre serves residents in Wincanton and the surrounding rural area of about 70 square miles, taking in five main settlements and many smaller ones. Some wards in and around Wincanton are in the second least deprived quintile for England, however there are pockets of deprivation and it is in these communities that the project seeks to specifically address health inequalities. The Centre focuses its activities in designated postcode areas with a total population of about 7, 500 people.

Balsam Centre’s “South Wes Well-being Programme” Wellbeing Project: “Touchwood”

As part of the South West Well-being Programme, the Balsam Centre has delivered a set of activities that are collectively titled the “Touchwood” project. Touchwood shares the overall wellbeing focus of the SWWB programme and covers:

1. Wellbeing Support Project. This initiative is the focus of this report and is described more fully below.
2. Men and Sheds. An initiative focused on addressing social isolation for older men.
3. Forest School. An initiative focused on promoting the health, wellbeing and social exclusion of vulnerable children and families.

These Touchwood activities sit alongside other community activities delivered within the Balsam Centre and at satellite centres in South Somerset.

Wellbeing Support Project

The Wellbeing Support Project provides 1:1 counselling and wellbeing support sessions with a trained therapist. The service is available through referrals from partner agencies, other Balsam Centre practitioners and self-referral. Client confidentiality is an important aspect of the service.

According to the Balsam Centre, the Wellbeing Support Project offers an integrative multi-theoretical psychotherapeutic approach, or ‘integrative MTP’⁸. The approach draws upon several techniques, elements and schools of therapeutic practice in order to meet the needs of the client. The belief is that ‘no one size fits all’ and that the therapeutic work should fit the client’s personality and circumstances. Integrative MTP is holistic in the sense that it seeks to address the affective, behavioural, cognitive and physiological experiences of the client, as well as addressing wider social and spiritual aspects. The therapist considers why particular approaches resonate and effect change

⁸ Brooks-Harris, J. E. (2007). *Integrative multitheoretical psychotherapy*. Cengage Learning. See also <http://www.multitheoretical.com>

within the client. As part of an ongoing process, this means that the therapeutic approach becomes tailored to the client - as opposed to the client being required to fit one therapeutic model.

The integrative MTP approach reflects the accumulated learning of the therapist and proposes the inadequacy of applying a single therapeutic model to the complexity and variety of clients' difficulties. According to this perspective, no single or group of therapies demonstrates superior efficacy to any other: newer therapies may be just as effective as the more traditional models and some research suggests successful outcomes based upon integrative practice. As Prochaska and Norcross (2010) conclude: 'The helping profession has definitely moved in the direction of theoretical integration rather than allegiance to a single therapeutic approach. There has been a concerted movement toward integration of the various theories.'

The integrative MTP approach includes a step-by step method to promote change:

Step 1. The therapist listens to the client, notes the client's areas of concern and offers emotional support.

Step 2. The therapist explores the clients' thoughts, actions, feelings, physical health, interpersonal relations, social systems and cultural contexts to determine which area/s are of most concern to the client.

Step 3. The therapist and client collaboratively identify two or three areas that will form the initial focus of the therapy.

Step 4. The therapist supports a multi-theoretical conceptualisation of the client's problem

Step 5. The therapist and client collaboratively choose interventions from a catalogue of key strategies for each of the seven areas of client functioning as described in Step 2.

The therapeutic relationship, environment and process aims to enable clients to become empowered, more aware and to use their own resources to promote healing, facilitate wholeness and maximise their full potential. This helps them begin to set goals and practise new behaviours in order to move beyond their limitations and discover greater life satisfaction. The psychological alliance/relationship formed at Step one is crucial to the subsequent processes. The effectiveness of the subsequent steps require the therapist to have flexibility, focus and develop a meaningful relationship with the client in order to support the client to begin to explore the self so that change and life satisfaction can become a reality. The aim in using this approach is to ensure changes made are long lasting, thus empowering clients beyond and outside the therapeutic experience. The service also offers brief therapy approaches which are shorter term and are goal or solution focussed if appropriate.

In many cases the 1:1 integrative MTP sessions are followed by, or can run in parallel with, group-based activities delivered by the Balsam Centre or other agencies. These provide an opportunity for participants to explore how they are feeling through art, craft and creativity, exercise and healthy eating. Participants are often both recipients of social support and also contributors towards support of others in the group activities. In some instances participants take on active volunteering roles to help run and develop group activities.

Table 1: Wellbeing Support Project, Balsam Centre. Summary of the service model

Eligibility criteria:	Adults (18years+) and young people/children, if appropriate, living in Wincanton and surrounding rural locality and who are experiencing low to moderate mental health difficulties (depression, low mood, anxiety).
-----------------------	--

Referral route:	Various, including GPs, Mental Health Teams, Health Visitors, School, Parent Family Support Workers, Social Workers and self-referral.
Intervention:	Integrative Multi-theoretical Psychotherapy (MTP), a client-led, tailored and 'holistic' therapeutic approach. In 1:1 step-based sessions, the therapist offers emotional support, explores problems and contexts, helps identify priorities, develops a shared understanding, and supports strategies for action. Subsequently, or in parallel, most participants are invited to take part in group-based creative and social activities. These activities are delivered at the Balsam Centre.
Main Outcomes:	Improved mental and emotional wellbeing, which can include return to education, work, improved relationships, better physical health, improved self-esteem and self-worth and confidence. Referral to other services.
Data collected:	<p><u>Registration.</u> This form covers demographics and referral path.</p> <p><u>Baseline.</u> The questionnaire covers mental ill health and life impact. At this point client goals and issues worked on are recorded.</p> <p><u>Interim assessments.</u> These records are used as a basis for reflection in 1:1 sessions, but are not recorded on the client database.</p> <p><u>Follow up.</u> This questionnaire is administered at the end of a set of 1:1 sessions and covers the same items as the baseline questionnaire. At this point reflection on changes made, self-perceived outcomes, relapse prevention measures are recorded. Follow up questionnaires are not administered at fixed points but are typically after 8 weeks.</p> <p><u>Group participant records.</u> Individuals that go on from 1:1 sessions to take part in group activities provide a range of feedback. There is some use of mental well-being and friendship questionnaire scales.</p>

The annual budget for the Wellbeing Support Project is £50,263. This includes funding for a full-time Wellbeing Worker, general overheads and running expenses for the project and some funding for training for Balsam Centre staff and volunteers and project participants.

LITERATURE REVIEW

The aim of the Wellbeing Support Project is to provide project participants experiencing mental ill health such as anxiety, depression or isolation with support in 1:1 sessions with a Wellbeing Worker to improve their situation and to develop goals for improving their health and wellbeing. A pragmatic therapeutic approach is used.

A literature review was undertaken to provide context and supporting evidence to this method of intervention. The literature review considered the epidemiology of mental health and illness, particularly mild to moderate mental ill health, the national policy context, and the evidence for community based and public health interventions to improve mental wellbeing.

A brief overview of community development work and client-led therapy is provided.

What do we mean by mental health and wellbeing?

The World Health Organisation⁹ defines mental health as

“a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

The concept of well-being thus comprises two main elements, feeling good and functioning well.

The Foresight Mental Capital and Wellbeing Project¹⁰ defines mental wellbeing as

“a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.”

The Foresight Report links mental well-being to mental capital, which it defines as

“This encompasses a person’s cognitive and emotional resources. It includes their cognitive ability, how flexible and efficient they are at learning, and their “emotional intelligence”, such as their social skills and resilience in the face of stress. It therefore conditions how well an individual is able to contribute effectively to society, and also to experience a high personal quality of life.”

What do we mean by mental illness?

There is no agreed definition for mental illness; it is usually defined through medical diagnosis. One definition provided by the World Health Organisation¹¹ is

“the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions.”

Mental illnesses can be grouped into those deemed to be common and those that are severe and enduring.

Common mental health problems include a range of conditions relating to low mood and anxiety, which can affect people’s ability to work, study or maintain relationships. Common mental health problems affect up to 15% of the population at any one time¹². They include depression, generalised anxiety disorder, panic disorder, agoraphobia, social anxiety disorder, specific phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), mixed anxiety and depressive disorder, and medically unexplained symptoms.

⁹ World Health Organisation (WHO). Mental health: a state of well-being.

http://www.who.int/features/factfiles/mental_health/en/

¹⁰ Foresight Mental Capital and Wellbeing Project (2008). Final Project report. The Government Office for Science, London.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292450/mental-capital-wellbeing-report.pdf

¹¹ World Health Organisation (WHO). The ICD-10 Classification of Mental and Behavioural Disorders

<http://www.who.int/classifications/icd/en/bluebook.pdf>

¹² National Institute of Health and Care Excellence (NICE). Common mental health disorders: Identification and pathways to care. NICE guidelines [CG123] Published date: May 2011

<https://www.nice.org.uk/guidance/cg123/ifp/chapter/common-mental-health-problems>

Severe and enduring mental health conditions include psychosis (schizophrenia, schizoaffective and delusional disorders and psychosis with substance abuse); bipolar disorder; eating disorders; emotional dysregulation disorders, and conduct disorders. It is estimated that around 5 people in every 100 will be affected by one of these conditions in their lifetime.

A person diagnosed with a mental health problem can be affected to different degrees at different times.

- A mild mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life.
- A moderate mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual.
- A severe mental health problem is when a person has many symptoms that can make their daily life extremely difficult.

There is a complex relationship between mental illness, mental health and mental wellbeing. For some, mental illness can be seen on a continuum with mental wellbeing, as we all experience periods of better or worse mental health. For others mental illness and mental wellbeing should be viewed separately as you can suffer from mental illness but have good levels of mental wellbeing. Societal responses, such as stigma, labelling and exclusion, have an important bearing on the experience of mental illness.

Determinants of mental health and wellbeing

There are known risk factors and protective factors for mental health and wellbeing; these include individual attributes, the social circumstances in which persons find themselves and the environment in which they live, and are often complex and inter-related¹³.

Certain groups in society may be particularly susceptible to experiencing mental health problems, including those who are unemployed, have a low income and are living with debt. People with chronic health conditions and some minority groups are known to be at particularly high risk. Some groups also experience greater barriers in accessing help and support.

Table 1: Determinants of mental health and wellbeing

<i>Level</i>	<i>Adverse factors</i>	<i>Protective factors</i>
Individual attributes	Low self-esteem	↔ Self-esteem, confidence
	Cognitive/emotional immaturity	↔ Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔ Communication skills
	Medical illness, substance use	↔ Physical health, fitness
	Loneliness, bereavement	↔ Social support of family & friends

¹³ World Health Organisation (WHO) 2012. Risks To Mental Health: An Overview Of Vulnerabilities And Risk Factors http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf

Social circumstances	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Education achievement
	Work stress, unemployment	↔	Satisfaction and success at work
Environmental factors	Poor access to services	↔	Equality of access to services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social inequalities	↔	Social equality

Adapted from WHO¹⁴

Social isolation

The table above shows that whilst individual attributes can determine mental health and wellbeing social circumstances and environmental factors also play an important role. The Wellbeing Support Project is aimed not only at improving mental health but also reducing social isolation, thus improving the resilience of individuals and the local community.

There is strong evidence that social isolation and loneliness impact upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services¹⁵.

Social isolation is characterised by an absence of social interactions, social support structures and engagement with wider community activities or structures. It can be created or imposed through marginalisation or discrimination by families or communities or through deteriorating mental health or mental capacity. Lack of social networks and support and chronic loneliness can cause long-term damage to physical and mental health.

Social support is particularly important in increasing resilience and promoting recovery from illness. However, in the most deprived communities many report severe lack of support, making people who are at greater risk less resilient to the detrimental health effects of social and economic disadvantage.

There is good evidence that interventions that seek to improve wellbeing at individual and community levels, can help to increase resilience to the wider impacts of the social determinants of health and risky behaviours. For the individual, mitigating loneliness will improve quality of life. Changes may also impact on health and social care service use, limiting dependence on more costly intensive services. Supporting social engagement and reducing social isolation also provides benefits to the wider community by enabling a possible 'harnessing' of potential contribution to the community through, for example volunteering and caring responsibilities¹¹.

¹⁴ WHO and the Calouste Gulbenkian Foundation. Social determinants of mental health. http://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health

¹⁵ Social Care Institute for Excellence. Preventing loneliness and social isolation: interventions and outcomes <http://www.scie.org.uk/publications/briefings/files/briefing39.pdf>

Impact of mental illness

Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health¹⁶.

It is estimated that mental health problems impose a total economic and social cost of over £105bn a year¹⁷. The economy loses more than £30bn a year from sickness absence and unemployment caused by mental ill health, while treating mental health problems cost the NHS and social care over £21bn a year. But the majority of the financial burden of mental illness falls on patients and their families, with the impact on quality of life costing £53.6bn.

Mental health problems can lead to poor physical health; suicide and self-harm; alcohol misuse, smoking and obesity, all leading to a reduction in life expectancy, as well as unemployment; crime; stigma, discrimination and social exclusion. Among people under 65, nearly half of all ill health is mental illness. Research suggests that the degree of disability imposed by depression is 50% higher than that for angina, asthma, arthritis or diabetes¹⁸.

There are thus strong health and economic arguments for investment in services which prevent and treat mental health problems.

National Policy Context

Historically mental health has been far less well recognised by health services than physical health, and physical and mental health treatments have been viewed and delivered as separate health services. As a result investment in health services and research for mental health has been much lower, and there have been lower treatment rates for mental health conditions than physical health conditions. This means that people with poor mental health are more likely to have poor physical health that goes untreated or treated too late and vice versa¹⁹.

More recently there have been calls for mental health to be valued equally with physical health or “Parity of Esteem”²⁰. This was enshrined in law by the Health and Social Care Act 2012²¹. Parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised by²²:

- equal access to the most effective and safest care and treatment,
- equal efforts to improve the quality of care,
- the allocation of time, effort and resources on a basis commensurate with need,
- equal status within healthcare education and practice,
- equally high aspirations for service users, and
- equal status in the measurement of health outcomes.

¹⁶ Faculty of Public Health. Better Mental Health for All. http://www.fph.org.uk/better_mental_health_for_all

¹⁷ Centre for Mental Health. The economic and social costs of mental health problems in 2009/10. http://www.centreformentalhealth.org.uk/pdfs/economic_and_social_costs_2010.pdf

¹⁸ Moussavi, S et al. 2007. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet* Volume 370, No. 9590, p851–858, 8 September 2007 [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61415-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61415-9/fulltext)

¹⁹ Royal College of Psychiatrists 2013. Whole-person care: from rhetoric to reality Achieving parity between mental and physical health <https://www.rcpsych.ac.uk/pdf/Parity%20of%20esteem%20sum.pdf>

²⁰ NHS England. Valuing mental health equally with physical health or “Parity of Esteem” <http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/>

²¹ Health and Social Care Act 2012 <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

²² Parity of esteem. <https://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx>

In addition to this increased focus on mental health services and treatment in health policy it has been recognised that public health has an important role to play in protecting and promoting mental wellbeing.

In 2011 the Department of Health published No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages²³ which sets out shared objectives to improve people's mental health and wellbeing and improve services for people with mental health problems.

No Health without Mental Health outlined 6 key objectives:

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

These objectives show the change of national policy focus to include prevention as well as treatment and it is now well acknowledged that the greatest opportunities to reduce the levels of mental ill health in the population in the long term lie in mental health promotion, as well as mental illness prevention and early intervention.

Local Policy Context and Access to Service Provision

In the 2013 Local Authority Mental Health Profile released by Public Health England, Somerset performs better or is broadly in line with the national average in respect of most indicators. However the report also states that 'Somerset scores significantly worse than the national average in terms of the percentage of adults with depression and the rate of emergency hospital admissions for self harm' According to the Mental Health Needs Assessment for Somerset (2011):

- In Somerset, over 4,500 people were diagnosed with depression for the first time by their GP in 2012/13. The number of patients who have a history of depression is 6.2% for Somerset as a whole, varying by practice from 1.4% to 12.2%.
- The number of people per head of population in contact with mental health services in Somerset is slightly higher (2332 per 100,000) than the England rate (2176)
- 18% of Somerset people with mental illness are in residential nursing care, much lower than the England figure (33%) or Somerset's Office of National Statistics (ONS) cluster group (26%)
- The Somerset Audit of Physical Health Checks for People with Severe Mental Illness 2011 found that people with these types of mental illnesses are less likely to have their physical health problems diagnosed and treated. Additionally, people with physical health problems often have undiagnosed mental health problems - having a physical illness increases the chances of developing mental health problems by 6.4 times.

Mental ill health is closely linked social deprivation. According to local authority summaries South Somerset district is ranked 202nd most deprived out of 326 local authorities²⁴. However, the 2013 Somerset Local Authority Mental Health Profile²⁵ states that

"Whilst there are many areas of affluence within Somerset there are also significant pockets of deprivation which experience higher levels of unemployment, lower educational attainment

²³ Department of Health 2011. The mental health strategy for England.

<https://www.gov.uk/government/publications/the-mental-health-strategy-for-england>

²⁴ English Indices of Deprivation 2010 – Somerset Summary. Available at:

<http://www.somersetintelligence.org.uk/files/Somerset%20IMD%202010%20Summary.pdf>

²⁵ Somerset Local Authority Mental Health Profile 2013. Available at:

<http://www.somersetintelligence.org.uk/mental-health.html>

and poorer health and wellbeing. These areas can be masked in the statistics by areas of higher affluence nearby. Similarly, rural deprivation is a significant problem in many areas [...]. In these areas there needs to be a greater emphasis on local communities providing support and resilience.”

Similarly the Balsam Centre’s own review (December 2012) of local social conditions and service provision in the Wincanton area concluded:

“In the last few years, Wincanton has seen demographic change, creating conditions that have exposed more people to the pressures that can lead to poor mental health. Major housing development and increased population have taken place without commensurate development of infrastructure or provision of employment. All but one of the few local major employers have either re-located out of the area or collapsed during this period. Employment across the area of benefit is characterised by being low skilled, low wage and part time. The great majority of people accessing the Balsam Centre are struggling financially. The cost of basic necessities as well as house prices and rents have risen as the villages of South Somerset have become popular for retirement and as a rural ‘lifestyle’ location for more affluent buyers. This presents additional layers and extremes of social, cultural and economic inequality that are both visible and divisive.”

In terms of access to services, nationally the vast majority (about 230) of people with mental ill health will seek advice from their GP and about 130 are subsequently diagnosed as having a mental health problem. Only between 20 and 30 are referred to a specialist mental health service, and fewer than 10 are ever admitted to a mental health hospital²⁶.

Many individuals do not seek treatment, and both anxiety and depression often go undiagnosed. In fact there is evidence that currently there is a very significant overall treatment gap in mental healthcare in England, with about 75% of people with mental illness receiving no treatment at all²⁷. NHS England aims to ensure that at least 15% of those with anxiety or depression have access to a clinically proven talking therapy services by 2015²⁸; this means that even when these targets are reached 85% will not have access to these services.

NHS Somerset’s Clinical Commissioning Group’s Somerset Joint Strategy for Mental Health and Emotional Wellbeing (August 2013) describes trends countywide that are repeated at local level. At the time of the report the ‘Increasing Access to Psychological Therapies’ (IAPT) service was overstretched and treating less than 15% of people with depression and anxiety in Somerset. Certain groups are known to have particular difficulty in accessing mental health services, especially those in low income groups and those with other health and social problems. The complexity of these patients needs mean that they are unlikely to be well supported by local Improving Access to Psychological Therapies (IAPT) services, which are mainly set up to deal with relatively straightforward cases of anxiety and depression, while at the same time the severity of their mental health conditions is generally insufficient to meet the clinical thresholds for treatment which are set by specialist or secondary mental health services.

²⁶ Joint Commissioning Panel for Mental Health. Practical Mental Health Commissioning. A framework for local authority and NHS commissioners of mental health and wellbeing services [http://base-uk.org/sites/base-uk.org/files/\[user-raw\]/11-06/practical-mental-health-commissioning.pdf](http://base-uk.org/sites/base-uk.org/files/[user-raw]/11-06/practical-mental-health-commissioning.pdf)

²⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf

²⁸ NHS England. Valuing mental health equally with physical health or “Parity of Esteem” <http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/>

Analysis of data from survey data from a major Economic and Social Research Council (ESRC) funded study of emotional support found that despite much lower levels of subjective well-being and higher rates of serious mental health difficulties in those on low incomes, those in the poorest households are no more likely than those in the most affluent households to have been in receipt of talk-based support. They are, by contrast, almost twice as likely to have been prescribed drugs in the face of emotional difficulties²⁹.

Interventions to promote mental wellbeing and prevent mental illness

There is a wealth of published evidence about effective interventions to promote mental wellbeing and prevent and treat mental illness. However, only a minority of people with a mental disorder currently receive any treatment. This section highlights evidence that provides context to the development of a theory of change and impact map for the Wellbeing Support project.

Public Mental Health

Public mental health interventions promote mental health and wellbeing and reduce the impact of mental disorder and poor wellbeing and can reduce health and social inequalities; help achieve parity of mental health with physical health; and deliver large economic savings and benefits.

Good evidence exists for a range of public mental health interventions. Of most relevance to the Wellbeing Support Project are early interventions which seek to improve outcomes and reduce associated inequalities³⁰.

Stepped care

A key feature of mental health services is the stepped care model. In stepped care the least intensive intervention that is appropriate for a person is typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment³¹. This means that the majority of people will be supported in the community often with help from their GP.

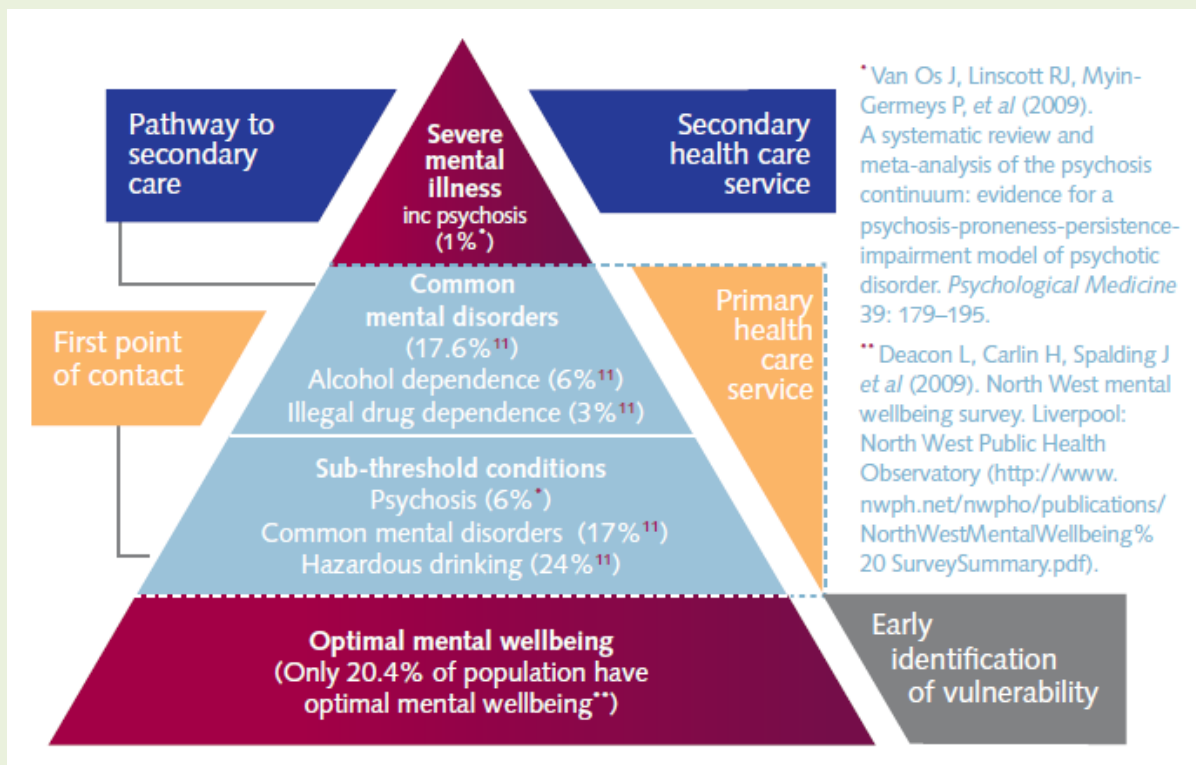
The most common method of treatment for common mental health disorders in primary care is psychotropic medication, despite the strong evidence of effectiveness for psychological therapy and the fact that these treatments are generally preferred by patients. This is due to the limited availability of psychological interventions.

Figure 1: Stepped Care Model

²⁹ Anderson S, Brownlie J. Build it and they will come? Understanding public views of 'emotions talk' and the talking therapies. *British Journal of Guidance & Counselling* 2011, vol: 39, (1), pp: 53-66

³⁰ Joint Commissioning Panel for Mental Health. Practical Mental Health Commissioning. A framework for local authority and NHS commissioners of mental health and wellbeing services [http://base-uk.org/sites/base-uk.org/files/\[user-raw\]/11-06/practical-mental-health-commissioning.pdf](http://base-uk.org/sites/base-uk.org/files/[user-raw]/11-06/practical-mental-health-commissioning.pdf)

³¹ Commissioning stepped care for people with common mental health disorders. National Institute of Health and Care Excellence (NICE). Commissioning stepped care for people with common mental health disorders. NICE commissioning guides [CMG41] Published date: November 2011 <http://www.nice.org.uk/guidance/cm41/chapter/3-a-stepped-care-approach-to-commissioning-high-quality-integrated-care-for-people-with-common>



Interventions for mild to moderate common mental health disorders

The National Institute for Health and Care Excellence (NICE) recommends the following for treatment and referral advice for sub-threshold symptoms and mild to moderate common mental health disorders (Step 2).

For people with persistent sub-threshold depressive symptoms or mild to moderate depression, offer or refer for one or more of the following low-intensity interventions:

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- a structured group physical activity programme
- a group-based peer support (self-help) programme (for those who also have a chronic physical health problem)

For people with generalised anxiety disorder that has not improved after psychoeducation and active monitoring, offer or refer for one of the following low-intensity interventions:

- individual non-facilitated self-help
- individual facilitated self-help
- psychoeducational groups

For people with mild to moderate panic disorder, offer or refer for one of the following low-intensity interventions:

- individual non-facilitated self-help
- individual facilitated self-help

The Improving Access to Psychological Therapies (IAPT) programme was designed to support NHS commissioners and service providers in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for stepped care for people suffering from depression and anxiety disorders, and this tends to be the main focus when commissioning local services; however other approaches and more targeted services also exist. The integrative multi-theoretical psychotherapeutic

(MTP) approach delivered through the Balsam Centre's Wellbeing Support Project is broadly consistent with NICE guidelines on the role of facilitated self-help and psychoeducational groups for the treatment of mild to moderate mental health disorders.

SOCIAL RETURN ON INVESTMENT

What is Social Return on Investment?

Social Return on Investment (SROI) is one of a number of approaches to economic evaluation. SROI captures value often left out of more traditional methods of economic evaluation such as cost benefit analysis.

SROI is a framework for measuring and accounting for change in ways that are relevant to the people or organisations that experience or contribute to it³². It tells the story of how change is being created by measuring social, environmental and economic outcomes and uses monetary values to represent them. It is thus a method of measuring social value. This enables a ratio of benefits to costs to be calculated. For example, a ratio of 3:1 indicates that an investment of £1 delivers £3 of social value. It should be emphasised that SROI is about value, rather than money. Money is simply a common unit and as such is a useful and widely accepted way of conveying value.

SROI is intended to help:

- understand the social, environmental and economic value created by an initiative;
- maximise the positive change created and identify and manage any negative outcomes arising from an initiative;
- reconsider which organisations or people to work with, or improve the way in which stakeholders are engaged;
- find ways to collect more useful, better quality information.

There are seven principles of SROI that underpin how it should be used:

1. **Involve stakeholders.** Stakeholders should inform what gets measured and how this is measured and valued.
2. **Understand what changes.** Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended and unintended.
3. **Value the things that matter.** Use financial proxies in order that the value of the outcomes can be recognised.
4. **Only include what is material.** Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact.
5. **Do not over claim.** Organisations should only claim the value that they are responsible for creating.
6. **Be transparent.** Demonstrate the basis on which the analysis may be considered accurate and honest and show that it will be reported to and discussed with stakeholders.
7. **Verify the result.** Ensure appropriate independent verification of the account.

Carrying out an SROI analysis involves six stages:

1. Establishing scope and identifying key stakeholders.
2. Mapping outcomes through engagement with stakeholders to develop an impact map (also called a theory of change or logic model) which shows the relationship between inputs, outputs and outcomes.

³² The SROI Network. The SROI Guide. <http://www.thesroinetwork.org/sroi-analysis/the-sroi-guide>

3. Evidencing outcomes and giving them a value. This stage involves finding data to show whether outcomes have happened and then giving them a monetary value.
4. Establishing impact. Identifying those aspects of change that would have happened anyway or are a result of other factors to ensure that taken out of the analysis.
5. Calculating the SROI. This stage involves adding up all the benefits, subtracting any negatives and comparing the result with the investment. This is also where the sensitivity of the results can be tested.
6. Reporting, using and embedding. This vital last step involves verification of the report, sharing findings with stakeholders and responding to them, and embedding good outcomes processes.

Stage 1: Establishing Scope and Identifying Key Stakeholders.

Scope

The purpose of this SROI analysis is to evaluate the Wellbeing Support project run by the Balsam Centre, Wincanton, Somerset. The analysis focusses on the first 22 months of operation of the Wellbeing Support project and includes outcomes for all those participants who registered with the project and received an intervention during this time (June 2013-Mar 2015).

Key stakeholders

Stakeholders are people or organisations that experience change (positive and negative) as a result of an intervention. They are best placed to describe the change. The purpose of stakeholder involvement is to help identify the most important outcomes to the project and to set out an understanding of those outcomes that has been informed by stakeholders.

A list of stakeholders who experience change or affect the Wellbeing Support project was prepared by the Balsam Centre Manager together with the evaluation lead. A table outlining this initial list and reasons for inclusion in qualitative interviews included in Appendix 1.

In total six interviews were undertaken with staff from the Balsam Centre and other partner agencies (mixture of in person and telephone interviews).

The list of stakeholders interviewed included:

- Wellbeing Support Project Worker
- Balsam Centre Manager
- Balsam Centre Volunteer Co-ordinator
- Balsam Centre Children and Families Worker
- Growing Space Manager (a partner agency)
- GP based in Wincanton

Initial stakeholder mapping noted that family and friends of project participants might benefit from the project as improvement in mental health of participants could impact on their relationships with others, and perhaps also on others caring responsibilities. Project participants were invited to bring a partner, family member or friend with them. One participant took up this offer.

Project Participants

The main beneficiaries of the Wellbeing Project are the participants who take part in the project and receive 1:1 therapeutic support. All adults with mild to moderate mental health needs living in Wincanton and the surrounding area are eligible for the project. Based on a population size of 7,500 in Wincanton surrounding area it can be estimated that around 600 adults are affected by a common mental health problem at any time, and thus might benefit from the Wellbeing Support Project.

Data collected by the project provides insight in to the demographics of the project participants. During the 22 months of operation of the Wellbeing Support Project (1st June 2013 to 31st March 2015), the project received 128 referrals (self-referral and referral from partner agencies), of whom 79 attended one or more sessions with the Wellbeing Worker. The data presented in Table 3 are for these 128 participants. Limited information is available about those who did not engage.

Many participants reported being in touch with other services in addition to the Wellbeing Support Project. This is demonstrated in data about referral route collected by the Wellbeing Worker.

Table 2: Source of referral (n=128)

Referral route	<i>n</i>	%
Self-referral/recommended by friend/family member	48	37.5%
GP	16	12.5%
Family support worker	14	10.9%
Health Visitor	10	7.8%
Growing Space Project (affiliated with Balsam Centre)	10	7.8%
Youth worker	9	7%
Balsam Centre Volunteer Coordinator	8	6.3%
Common Assessment Framework [no practitioner specified]	3	2.4%
NHS mental health therapist	3	2.4%
Job centre	3	2.4%
MIND	2	1.6%
Social worker	1	0.8%
School	1	0.8%
Missing	0	0%

Referring agencies included the GP services, the Health Visiting Team, Family Support Workers; social care staff and other workers based in the Balsam Centre.

Sixty eight percent of participants were female and 98% defined themselves as White British. Participants came from a wide range of age groups, with the modal age bracket being 35-44. A minority (20.4%) were in any kind of paid employment; 30.4% were unemployed and 18% described themselves as long term sick or disabled. Forty one percent reported having childcare responsibilities and 11.7% reported caring for an adult.

Over half (55.5%) of participants said they had at least one long term condition or disability. Most reported more than one condition. Commonly reported conditions included mental health conditions such as depression, anxiety and panic attacks; and physical ill health such as muscular sclerosis, joint pain, diabetes and cardio-vascular disease. A small number of participants reported having a learning disability. Given non-responses and the wording of the registration question it is likely that there is significant under reporting of mental health conditions.

Table 3: Project participants – demographics (n=128)

	<i>n</i>	%
Sex		
Female	87	68%

Male	41	32%
Missing	0	0%
Age group		
8-15	10	7.8%
16-24	13	10.2%
25-34	21	16.4%
35-44	30	23.4%
45-54	20	15.6%
55-64	17	13.3%
65-84	17	13.3%
Missing	0	0%
Ethnicity		
White British	126	98.4%
Other	1	0.8%
Missing	1	0.8%
Employment status		
Unemployed	39	30.4%
Long-term illness or disability benefits	23	18%
Retired	16	12.5%
Student (school/FE college)	15	11.7%
Employed/self-employed: full-time	13	10.2%
Employed/self-employed: part-time	13	10.2%
Maternity leave	5	3.9%
Missing	4	3.1%
Any long-term illness, health problem or disability?		
No	71	55.5%
Yes	53	41.4%
Missing	4	3.1%
Child carer status		
No	72	56.3%
Yes	53	41.4%
Missing	3	2.3%
Adult carer status		
No	109	85.2%
Yes	15	11.7%
Missing	4	3.1%

Stage 2: Mapping inputs and outcomes

SROI is an outcomes-based measurement tool. The aim of this stage is to map outcomes to develop an impact map (also called a theory of change or logic model) which shows the relationship between inputs, outputs and outcomes. Sections of the impact map are included throughout this chapter however the report is best understood when read together with the full impact map – Appendix 2.

Mapping inputs

The investment, in SROI, refers to the financial value of the inputs. Inputs are what stakeholders are contributing in order to make the activity possible and are used up in the course of the activity –

money or time, for example. The annual budget for the Balsam Centre’s Wellbeing Support project was £50,263 (£92,149 for 22 months). Balsam Centre staff interviewed reported that the running costs were evenly distributed over the course of the project so, for example, the initial start-up costs were not higher than the running costs later on in the project.

The staffing costs included funding for:

- Wellbeing Worker: 1 FTE
- Support staff/line management:
 - Manager: 0.057 FTE
 - Administrator: 0.046 FTE
 - Finance Officer: 0.069 FTE
 - Total support staff 0.1716 FTE

Other costs cover general overheads and running expenses for the project and some funding for training for Balsam Centre staff and volunteers. No other costs were identified in input mapping.

Table 4: Wellbeing Support Project budget for 22 month and 12 month periods

	22 month period	12 month period
Item	Cost (£)	Cost (£)
Salaries National Insurance & Pensions	61,019.21*	33,283.20*
Rent	1213.5	661.9
General running expenses	5621	3066
Producing information	37	20.18
Training for staff and volunteers	908	495.27
Training for beneficiaries	252	137.45
Travel for staff and volunteers	911	496.90
Consultancy & advice/evaluation	1100	600
Tutor costs	280	152.73
Activity costs	1765.47	962.98
TOTAL DIRECT COSTS	73107.37	39877.42
Organisation overheads - line management (included in Salaries above)	-	-
Organisation overheads - accommodation	8059	4395.82
TOTAL OVERHEADS	8059	4395.82
TOTAL ALL COSTS	81166.37	44272.46

* This excludes Growing Space staff support (0.22 fte; £499.20 per month; £5990.40 per annum; £10,982.40 for 22 months)

Mapping outputs - data collection methods

Quantitative and qualitative data have been used to inform this SROI. The Wellbeing Support Worker and the Balsam Centre main office team have established a number of methods for recording project activity and collecting baseline and follow-up data from project participants. The data recorded is outlined below. Stakeholder engagement was undertaken using qualitative interviews with

individuals. Project specific questions appropriate for each of the stakeholder groups were developed for this process as outlined in Appendix 3 and 4.

- Registration Form Data
 - Gender
 - Age
 - Race/Ethnicity
 - Postcode
 - Source of Referrals
 - Employment Status
 - Carer status (child/adult)
 - Illness and Disability
 - Wellbeing Questionnaire Data – baseline, final follow-up, and interim assessments
 - Mental Ill-health: Depression
 - Mental Ill health: Anxiety
 - Overall Life Impact
 - Client Aims and Potential Solutions
 - 1:1 Session and Group Attendance Logs
 - Exit Record
- In addition, participants who also attend linked group-based sessions at the Balsam Centre complete specific questionnaires including the Friendship Questionnaire and the Short Warwick Edinburgh Mental Wellbeing Questionnaire.

Impact Map 1: Inputs and Outputs

Stakeholders	Intended/unintended changes	Inputs		Outputs
		What do they invest?	What is the value of the inputs in currency (£)	
Who do we have an effect on? Who has an effect on us?	What do you think will change for them?	What do they invest?	What is the value of the inputs in currency (£)	Summary of activity in numbers
Big Lottery funders	Intended project outcomes achieved	Funding	81,166	
Balsam Centre project staff including Wellbeing Worker, Centre Manager and Volunteer Coordinator	Time, commitment, skills and experience	Time - cost included in funding above	0	1 full-time Wellbeing Support Worker. Line management from Centre Manager.
Project participants – residents of Wincanton and surrounding area with low mood/anxiety/ depression	Improved mental ill health and wellbeing (depression, anxiety, overall life impact).	Time	0	128 referrals attending one or more sessions with the Wellbeing Worker.
	Reduced social isolation			
	Improved confidence			
	Signposting and access to other services			

	Reduction in GP appointments and improved use of Primary Care and Social Care resources			
	Confidence developed to take up and maintain employment, volunteering and education opportunities			
	Increased sense of independence and ability to do things alone rather than seeking support from services.			
Family and friends of project participants	Improvement in mental health of participants could impact on their relationships with others, and perhaps also on others caring responsibilities.	Time and support to participants	0	Family and friends of 128 participants attended one or more sessions with the Wellbeing Worker.
Staff from Balsam Centre local partner organisations	Referral route to and from project for extra support for their clients.	Time, commitment, skills and experience	0	Referral to Wellbeing Support Project: GP/Primary Care – 19, other partner agency - 53

Total

£81,166

Mapping Outputs: Delivery of 1:1 Therapeutic Sessions

The Wellbeing Support Project does not offer a fixed number of 1:1 therapeutic sessions. Instead the number of sessions provided is intended to match the needs of the client. Analysis of 128 records shows that the mean number of sessions was 9.9 but that there is a wide range from 1 to 71 (standard deviation 12.1). The number of sessions per client falls broadly into 3 groups:

- 25% of clients (n=32) take part in 1 to 3 sessions.
- 50% of clients ((n=63) take part in between 4 to 12 sessions.
- 25% of clients take part in 13 to 71 (n=33) sessions, with the bulk of these between 13 to 24 sessions.

If we assume 74 active project weeks over a 22 month period, the Wellbeing Support Project has been registering an average of 1.6 new clients per week. However this gives a limited picture. Project records show rising service demand over time, with an increased flow of new client registrations, a growth in high need registrations, and the retention of clients that have high level longer term needs.

Sessions are typically up to 1 hour, although clients seeing the Wellbeing Worker over a longer period might have appointments as short as 30 minutes. Sessions are offered on a weekly, fortnightly, monthly or ad hoc basis. Over the 22 month period 1,262 1:1 sessions were recorded with clients. This does not include telephone consultations or email correspondence with clients.

The Wellbeing Worker typically spends 0.7 fte, or 3.5 days a week, in the delivery of 1:1 therapeutic sessions with clients, or in activities linked to these sessions. An estimation of the unit service cost over a 22 month period can be made as follows:

$(\text{Staff fte for 1:1 work} \times \text{Total service cost}) / \text{Total number of sessions} = \text{Unit cost per session}$

$(0.7 \times \text{£}81,166) / 1,262 = \text{£}45.00$

This figure includes on costs and overheads.

Mapping Outputs: Delivery of Group Sessions

Wellbeing Support Project staff assist with the delivery of 2 half day creativity and wellbeing groups and 1 horticultural therapy group per week. This work takes up about 0.3 fte, or 1.5 days per week. An average number of 8 people attend these groups. Assuming 74 active project weeks, over a 22 month period this adds up to 222 group sessions. An estimation of the unit service cost per participant can be made as follows:

$(\text{Staff fte for group work} \times \text{Total service cost}) / \text{Total sessions delivered} / \text{Average number of participants} = \text{Unit service cost per participant}$

$(0.3 \times \text{£}81,166) / 222 / 8 = \text{£}13.70$

For the creativity and wellbeing groups, this figure includes on costs and overheads. However for the horticultural therapy groups it covers all costs apart from some additional costs for the Growing Project to host the sessions.

Stage 3: Evidencing outcomes and giving them a value

This stage involves finding data to show whether outcomes have happened and then giving them a monetary value. Quantitative data analysis was undertaken using the records collected by the Balsam Centre. Qualitative data captured by the Wellbeing Worker and through interviews with project participants and stakeholders provide further examples of change experienced by project participants and enable outcomes to be explored further and to be valued.

Details of qualitative interview schedules and tools used to collect quantitative data are included in the appendix.

Qualitative data analysis

The following data from the Wellbeing Support project participants and stakeholders give a sense of the reasons why clients seek help from the project, and provide useful indicators for the impact the support they receive from the Wellbeing Worker has on them and thus the project outcomes.

Perspectives of Service Users and Relatives of Service Users

We interviewed 11 Wellbeing Support Project service users and 1 partner of a service user. Three interviewees were male and nine were female. One was under the age of 18. All had had engagement with the project for over 6 months. The majority had taken part in other Balsam Centre activities and were therefore familiar with the wider work or the organisation.

The list below summarises the positive outcomes reported by these interviewees

- Improved mental wellbeing: anxiety, life satisfaction, personal mental wellbeing, social wellbeing.
- Reduction in GP appointments and improved use of Primary Care resources
- Reduction in medication use – antidepressants and other medications

- Suicide prevention
- Support and confidence development to access other services and sessions
- Getting home sorted
- Reduced social isolation
- Confidence developed to take up and maintain employment and volunteering opportunities
- Improved relationships with partner and other family members
- Resolution of family break up or family crises
- Ability to cope better with past and situations
- Use of relaxation techniques and mindfulness
- Assertiveness
- Getting ready for other services
- Help with being referred to other services
- Work-life balance
- Increased sense of independence and ability to do things alone rather than seeking support from services.
- Increased physical activity levels and participation in a local wildlife support group.
- Increased confidence, resilience and improved parenting skills

Chris enrolled with the Wellbeing Support Project, said that his mental health suffered due to low income, isolation and poor physical health: *“I felt like I was falling from the sky. I arrived here from another part of the country after losing my job and all my money. I’d had a heart attack and I’d broken my legs in an accident. I didn’t have any friends, any social contacts”*

The one partner of a service user who was interviewed reported a number of indirect benefits. These included relief from the stress and anxiety associated with caring for a person with long term mental ill health, an improved social relationship with her partner, introduction to a new circle of friends and inspiration to take up new activities herself.

Some participants reported being in touch with other services, in addition to the Wellbeing Support Project. Here it was important to understand the links. For example, some interviewees maintained pre-existing contact with GP and social care services and were doing to in order to have a supplementary source of support. Other interviewees attended new community activities as a result of having greater confidence following their engagement with the Wellbeing Support Project. For some interviewees the Wellbeing Support Project gave them the confidence and motivation to engage effectively with other services.

Sue and Bryony appreciated the therapeutic approach: *“For me it’s a kind of time out, I feel so supported. I don’t feel judged...I can be myself.”* Sue

***“[The Wellbeing Worker] is very hands on. She actually helps sort the problem out and doesn’t just signpost on to others.”* Bryony**

The dominant theme from the interviews with service users and relatives was that the Wellbeing Support Project was providing a valued and excellent quality of service. The positive personalities, skills and commitment of Balsam Staff were strongly emphasised by participants. Interviewees struggled to identify any negative features of the project. It was difficult for interviewees to separate

out the Wellbeing Support Project from other aspects of the Balsam Centre’s activities. In some cases, it was evident that personal outcomes came about from the combined experience of engagement with the Balsam Centre, as opposed to 1:1 sessions or specific group activities. Similarly, participation in Growing Space (horticultural/gardening) activities was similarly referred to in the context of the wider Balsam Centre services. Although further interviews with people taking part in Growing Space activities would have given us a better understanding in this respect.

Jim felt that the Wellbeing Support Project helped his confidence: *‘I used to go out at night to avoid contact with people. I wouldn’t even have made eye contact before. But now they can’t shut me up. I managed to stand up and read poem in front of 200 people!*

Most interviewees found difficult to put a value on the service or to compare the service to other experiences, services or goods. Four other services were referred to by way of comparison: GP visits, private counselling sessions, NHS IAPT sessions and leisure centre activities. In all instances the Wellbeing Project [or Balsam Centre/Growing Space] services were reported to be ‘better’ in terms of ‘easy access’, ‘friendliness’, ‘being listened to’ or other characteristics. Ten out of 12 interviewees did not have income to dispose on these types of services, so felt unable to put a price them with any sense of realism.

Some participants found it hard to put a value on service: *“I would be in the looney bin by now if it wasn’t for therapy. I nearly lost everything” Jane*

‘[The Wellbeing Support Worker]’s help has been invaluable for me - worth her weight in gold’ Brian
“I don’t know what I could have done without [counselling] and the group. I really think I wouldn’t be here. I would have ended it...I can’t put a price on that.” Miriam

Wellbeing Support Project Records

The Wellbeing Worker records some of the issues raised by the participant as areas they would like to work with. Most participants come with more than one issue. Many participants come to the project with complex needs. The table below shows the most frequently raised issues. The interviews with the Wellbeing Worker showed that these figures are likely to be an under-recording of the issues experienced. Relationship and interpersonal problems were not recorded separately, possibly because it is implicit to the therapeutic approach that social issues usually underpin mental and physical health problems.

Table 5: Issues worked with. Data available for 108 cases out of 128

Issue	n	%
Depression	80	68%
Low mood	49	45%
Anxiety / panic attacks	34	31%
Physical ill health / pain management	19	18%
Self esteem (under 24 year olds)	10	9%
Bipolar disorder	8	7%

Alcoholism	5	5%
Bereavement	3	3%
Suicidal ideation and/or self harm	3	3%

The Wellbeing Support Project Worker records changes at every 1:1 session and asks clients to reflect on their current emotional state. After the completion of a number of sessions, the Wellbeing Worker and client record on an Exit Record major outcomes and measures to prevent relapse. This information is held in a confidential personal file. A summary is recorded on an anonymised spreadsheet. Descriptive data was available for 124 participants and recorded a wide range of areas of change. Some key changes are as follows:

- 27 individuals reporting reduced GP attendance as a result of taking part in the Project activities
- 3 people who obtained full time paid employment and 4 people who obtained part time work in the period of engagement with the Wellbeing Support Project
- 20 people who retained their jobs in difficult circumstances or returned to work early.
- 26 people who tried reported engagement in volunteering or supporting the delivery of community activities. These were both activities at the Balsam centre and in other local settings.
- 7 referrals to other counselling/ listening services or talking therapies in the area.
- 12 engaging more effectively with social care (statutory or voluntary sector services)– particularly for people with learning disabilities and older people - for assessment for support services. Most of these have related to maintaining independent living.
- 7 people who went on to register for vocational or non-vocational qualifications as a direct result of exploring their goals with the Wellbeing Support Project.
- 3 people who reported improved physical activity and healthier eating.

Quantitative data analysis

Quantitative data puts into context the verbal and written accounts of participants and other stakeholders. It also enables estimates to be made of how many project participants experience the outcomes described.

Mental Ill-health: Depression

Depression was assessed by the Wellbeing project using the PHQ-9 Questionnaire. This has a possible scoring range from 0-27. The PHQ-9 is described in more detail at the Pfizer website: <http://www.phqscreeners.com/>

Participants (n=8) under 16 years old did not complete the PHQ9 form. Matched scores were available for 54 out of 120 participants 16 years old and over. Three participants did not complete the questionnaire due to being at a point of crisis at the point of first meeting. Five participants declined to complete the questionnaire. Data was missing for 2 participants at follow up. Data were missing for 56 participants

Matched scores for the baseline and follow-up were available for 54 participants. A paired T test showed statistically significant difference ($p > 0.001$) between these mean scores (baseline mean 12.8, SD 5.8; follow-up mean 5.2, SD 4.7).

The following table sets out the formal thresholds for interpreting the PHQ9 scores.

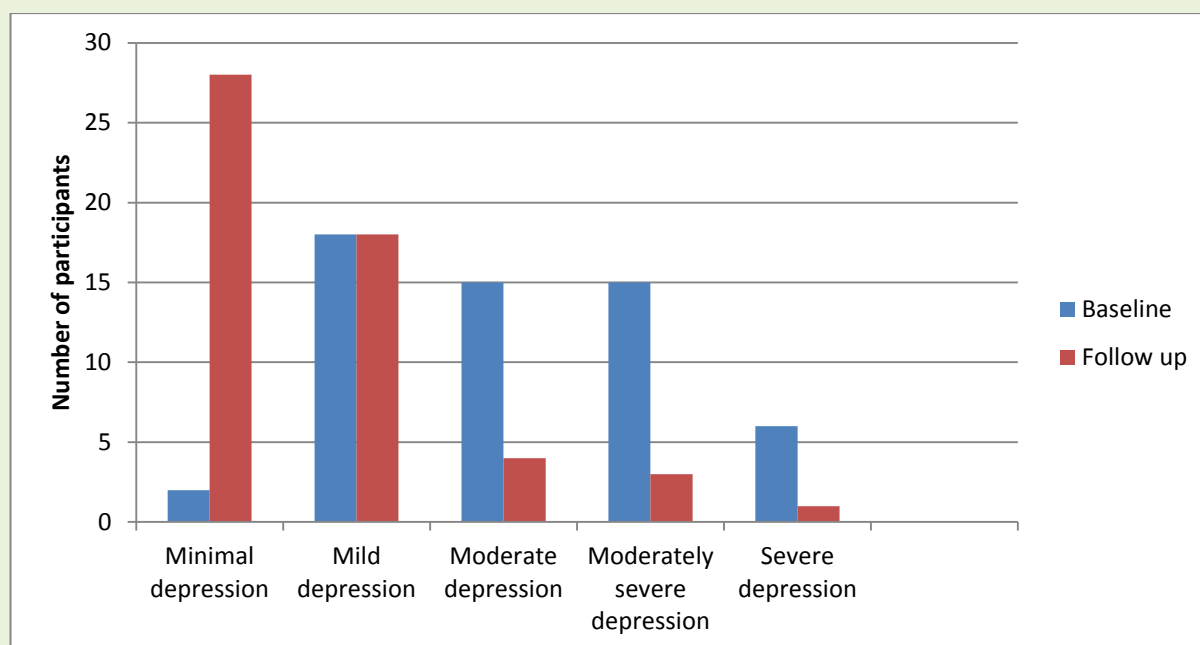
Table 7: Interpreting PHQ-9 Scores

Diagnosis	Total score	For score	Action
Minimal depression	0-4	≤ 4	The score suggests the patient may not need depression treatment
Mild depression	5-9	5-14	Physician uses clinical judgement about treatment, based on patient’s duration of symptoms and functional impairment
Moderate depression	10-14		
Moderately severe depression	15-19	>14	Warrants treatment for depression
Severe depression	20-27		

Chart 1 shows a clear shift from higher to lower categorisations of depressive symptoms recorded at baseline and follow-up. There are a number of ways in which these results can be summarised:

- Out of 54 participants, 28 (52%) reported a change from ‘severe’ to ‘moderate’ depression to ‘mild’ or ‘moderate’ depression.
- Out of 54 participants, 53 (98%) had mild to severe depressive symptoms at baseline. This fell to 15 (27%) at follow up.
- There was a positive change in the raw score in depressive symptoms for 53 out of 54 (98%) participants.

Chart 1. Baseline and Follow-up Diagnostic Categories for Participants using PHQ9 (N= 56, 2 missing at follow up)



Mental Ill health: Anxiety

The Wellbeing project used the GAD7 questionnaire to assess anxiety. GAD-7 total score for the seven items ranges from 0 to 21. The scores represent: 0-5 mild; 6-10 moderate; 11-15 moderately severe anxiety; and 15-21 severe anxiety.

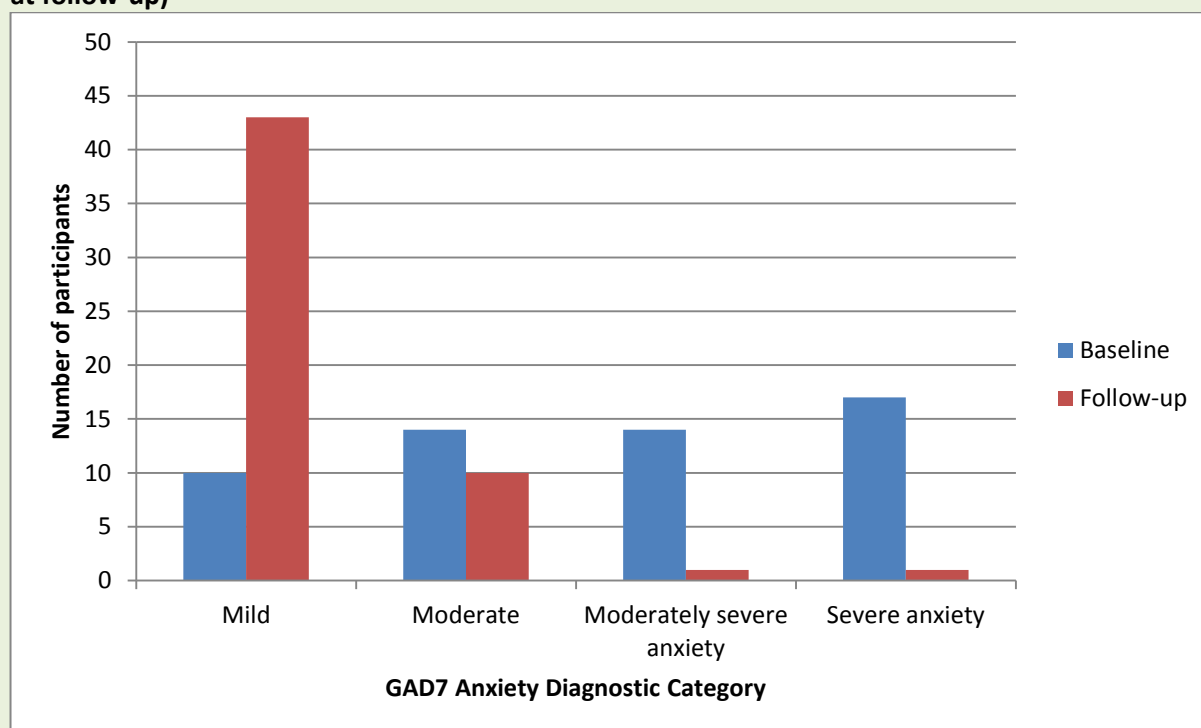
Participants (n=8) under 16 years old did not complete the GAD7 form. Matched scores were available for 55 out of 120 participants 16 years old and over. Three participants did not complete the questionnaire due to being at a point of crisis at the point of first meeting. Five participants declined to complete the questionnaire. Data were missing for 57 participants

Matched scores for the baseline and follow-up were available for 55 participants. A paired T test showed statistically significant difference ($p > 0.001$) between these mean scores (baseline mean 11.8, SD 4.15; follow-up mean 5.9, SD 3.7).

Chart 2 shows a clear shift from higher to lower categorisations of symptoms for anxiety recorded at baseline and follow-up. As with the depression assessment, there are a number of ways in which these results can be summarised:

- Out of 55 participants, 29 (53%) reported a change from ‘moderately severe’ and ‘severe’ anxiety to ‘moderate’ or ‘mild’ anxiety.
- There was a positive change in the raw score for 50 out of 55 (91%) of participants.

Chart 2: Baseline and Follow-up Diagnostic Categories for Participants using GAD7 (N= 55, 0 missing at follow-up)



It is notable that the assessment tool results suggest that the Wellbeing Support Service is working with a significant proportion of people with severe mental ill health. Using PHQ9, 12.5% of participants fall into the diagnostic category of severe depression. For GAD, 29% of participants meet the threshold for severe anxiety.

Overall Life Impact

The Life Impact Questionnaire asks participants to reflect on problems that affect their ability to do certain day-to-day tasks in their lives. It asks them to score how much their problem impairs their ability to carry out five areas of activity. The areas cover work; home management; social leisure activities; private leisure activities; family and relationships. Each area is scored from 0 (‘not at all’) to 8 (‘very severely’). The Life Impact Questionnaire has a total score range from 0 to 40, with a high score indicating a very severe negative impact of the problem.

Participants (n=8) under 16 years old did not complete the Life Impact Questionnaire. Matched scores were available for 53 out of 120 participants 16 years old and over. Three participants did not complete the questionnaire due to being at a point of crisis at the point of first meeting. Five participants declined to complete the questionnaire. Data were not available for 59 participants

Matched scores for the baseline and follow-up were available for 53 participants. A paired T test showed statistically significant difference ($p > 0.001$) between these mean scores (baseline mean 17.7, SD 8.3; follow-up mean 7.5, SD 6.9). There was a positive change in the score for 48 out of 53 (90%) of participants.

Outcomes for Young People

The Wellbeing Support project works with a wide range of demographic groups. Over the funding period the project 18% (n=23) of participants were aged under 25, with most aged between 14-24. 'Self esteem' is recorded as the main issue worked with for this group although records show that the project is also addressing eating disorders, abuse, neglect, bullying, exclusion and stigma associated with learning disabilities or other social issues and the leading referring agencies are youth workers, the local school and family health workers. Quantitative assessment of outcomes in terms of depression, anxiety and overall life impact reflect the strong positive pattern for the Wellbeing Support Project as a whole, although due to the low number of matched data we have not been able to do a sub-group paired T test.

Making a judgement on outcomes

When deciding on which outcomes to include in an SROI there are a number of factors to consider including the project objectives as well as the views of stakeholders. It is also important to consider whether the outcomes identified in the data should be considered as separate or intermediate outcomes in a chain of events – this is what is meant by the theory of change

This can be understood better by considering the story of one of the participants interviewed for the project.

Table 6: Example chain of events

Reason for accessing The Wellbeing Support Project	Immediate outcomes experienced during 1-1 sessions	Outcomes measured or recorded through data tools	Longer term impact
Low mood Feeling that GP cannot meet needs	Feeling of being listened to and emotionally supported Practical skills for managing day to day life activities Support to contact other services for support	Depression Anxiety Overall Life Impact Self-reported outcomes	Taking up a new hobby Improved relationship with partner Joining local wildlife group Meeting new people Improved sense of wellbeing

A key decision to make is what outcome in the chain should be valued. This has been done by making a judgement about what is important and what is measurable. Every effort has been made to ensure that the decision process is transparent with explanations provided as to why outcomes have been included and why not.

Putting a value on the outcome

The purpose of valuation is to reveal the value of outcomes and show how important they are relative to the value of other outcomes. All value is, in the end, subjective. In SROI we use financial proxies to estimate the social value of non-traded goods to different stakeholders. By estimating this value through the use of financial proxies, and combining these valuations, we arrive at an estimate of the total social value created by an intervention.

This step therefore involves identifying appropriate financial values for the outcomes experienced by project participants as a result of the project. Values are thus a way of presenting the relative importance to a stakeholder of the changes they experience.

For some outcomes identifying a value is relatively easy as there are clear, measurable cost savings often with nationally recognised indicators e.g. the savings from reduced GP appointments. SROI also gives values to things that are harder to value so are routinely left out of traditional economic appraisal. There are several techniques available. For this SROI methods used with stakeholders focussed mainly on stated preference and contingent valuation. This approach assesses people's willingness to pay, or accept compensation, for a hypothetical thing. Stakeholders were asked in interviews:

- If there was a charge for the service how much do you feel you would be willing to pay?
- Can you compare it to something else just as important to you?

This method had limitations, particularly since many of the project participants had low incomes and thus limited ability to pay. When identifying proxies it is important to remember that we are not interested in whether money actually changes hands. It also doesn't matter whether or not the stakeholders in question could afford to buy something – they can still place a value on it. This was discussed in interviews and is summarised in the section above.

Negative outcomes

SROI should also take account of the cost of negative outcomes. A few potentially negative consequences of the project were identified. These focussed particularly on the short term funding for the project; and the impact of investing so much time and effort in developing a project, raising expectations about availability of a new service and then losing it when the funding goes might have on the community. Interviews with stakeholders also highlighted some possible overlap and confusion about the difference between services, particularly the local IAPT NHS service for anxiety and depression. It is difficult to put a value on these concerns. Potential impact is discussed in the section on displacement.

No individual level negative outcomes were identified for project participants or their friends and family. This is interesting as often in projects of this nature participants report problems that 'surface' as a consequence of engagement that can't be addressed by the project. It is therefore of some concern that no such adverse consequences were identified. This may be because none occurred, or may be because of limitations in the interview questions used.

Outcomes and proxy values

The final set of outcomes and financial proxies presented have been identified through data analysis, stakeholder interviews, discussion with the Wellbeing Worker and colleagues in the SROI team at the University of the West of England, and review of published SROI reports.

Table 7: Outcomes included in SROI

How would the stakeholder describe the changes?	How would you measure it?	Where did you get the information from?
Reduced symptoms of anxiety and depression	Number of participants reporting reduced symptoms of anxiety and depression	Scaling question - anxiety and depression recorded at baseline and follow-up
Reduced GP attendance	Number of participants reporting reduced GP attendance	Wellbeing Worker Exit Record
Improved social wellbeing and improved relationships with partner, other family members or friends	Number of participants who report improved social wellbeing and improved relationships with partner, other family members or friends	Wellbeing Worker Exit Record
Improved physical activity	Number of participants reporting improved physical activity	Wellbeing Worker Exit Record
Improved ability to perform day-to-day tasks in their lives	Number of participants reporting improved ability to perform day-to-day tasks in their lives.	Scaling question – life impact questionnaire (excluding measure for work)
Volunteer engagement and/or support for a community group activity	Number of participants reporting engagement in volunteering or community group activity	Participant and stakeholder interview
Employment or return to work	Number of participants reporting having obtained employment (PT or FT)	Wellbeing Worker Exit Record
Retention of employment or early return to work after sickness	Number of participants reporting retention of employment or return to work following sickness	Participant and stakeholder interview
Better work life balance or working pattern	Number of participants reporting better work life balance or working pattern	Participant interview, exit questionnaire
Referral to other 1:1 counselling/ listening services	Number of participants referred to other counselling/ listening services	Participant and stakeholder interview
Referral to social care support	Number of participants referred to social care support team	Wellbeing Worker Exit Record
Engagement in further education	Number of participants who report registering for a course and/or achieving new qualification	Participant and stakeholder interview and Wellbeing Worker Exit Record
Prevention of referral to secondary mental health services	Estimate based upon number of participants attending service in crisis, severe anxiety or other severe mental ill health e.g. suicidal ideation	Participant and stakeholder interview. Wellbeing Worker Record

Table 8: Outcomes and proxy values

Outcome	Proxy	Evidence Source for Proxy	Value per unit £
Reduced symptoms of anxiety and depression	Cost of counselling	Cost of local counselling service – initial 6 week course. http://www.wessexcounsellingservice.co.uk	£40/session for 6 weeks £240
Reduced GP attendance	Cost of GP appointment – average	Cost of GP appointment http://www.pssru.ac.uk/uc/uc.htm	£42/GP appointment
Improved social wellbeing and improved relationships with partner, other family members or friends	Cost of social club membership and attendance at activities	Cost of social club membership and attendance at activities (£12 per annum) and attendance at activities (£5 per month) http://www.theoldbarncub.com/index.htm	£42/year
Improved physical activity and diet	Cost of gym membership/local activity	Gym and physical activity classes at Wincanton Sports centre for those on means tested benefits http://www.ledleisure.co.uk/adult-unlimited	£ 140.25/ 6 months
Improved ability to perform day-to-day tasks in their lives	A course of CBT to build psychological resilience and self-esteem	A course of CBT to build psychological resilience and self-esteem costs. A course of CBT may last for 10 sessions at £93 per session http://www.pssru.ac.uk/uc/uc.htm	£930
Volunteer engagement and/or support for a community group activity	Economic value of volunteer time	Estimated from average hourly wage in England (ONS 2013) http://www.ons.gov.uk/ons/rel/ashe/annual-survey-of-hours-and-earnings/2013-provisional-results/stb-ashe-statistical-bulletin-2013.html http://www.volunteering.org.uk/component/gpb/is-there-any-way-of-measuring-the-economic-value-of-the-work-our-volunteers-are-doing	£12.92/hour
Employment or return to work	Employment and Support Allowance (overall fiscal benefit to government from a workless claimant entering work)	This valuation is the overall fiscal benefit to the government of a workless claimant on Employment and Support Allowance/Incapacity Benefit entering work. It is comprised of savings made by the Department of Work and Pensions in benefits payments, and savings made by NHS in improved health of the individual.	£8,632 per claimant per year.
Retention of employment or early return to work after sickness	Workplace mental wellbeing intervention	Multi-component intervention to promote wellbeing in the workplace. Cost is estimated at £83 per employee per year. http://www.pssru.ac.uk/project-pages/unit-costs/2014/	£83/person

Outcome	Proxy	Evidence Source for Proxy	Value per unit £
Better work life balance or working pattern	Life coaching style course - Managing Yourself and Personal Effectiveness Training Course	Managing Yourself and Personal Effectiveness Training Course http://www.revolutionlearning.net/managing-yourself-personal-effectiveness-training-course/	£480
Referral to other counselling/ listening services	Preparation for counselling	Cost of local counselling service – initial 6 week course. http://www.wessexcounsellingservice.co.uk	£40/session for 6 weeks £240
Referral to social care support	Cost of sessions with social care worker	Cost of intervention estimated from average salary of housing officer for a year. http://www.prospects.ac.uk/housing_manager_officer_salary.htm £15/hour for 8 sessions	£120
Engagement in further education	Cost of a bursary for an apprenticeship at Yeovil College	Example taken from apprenticeship full bursary in finance section of http://www.yeovil.ac.uk	£500/course
Prevention of referral to secondary mental health services	Cost of secondary mental health care	Assertive outreach teams provide intensive support for people with severe mental illness who are 'difficult to engage' in more traditional services http://www.pssru.ac.uk/project-pages/unit-costs/2014/	£7,664 average cost per case

Stage 4: Establishing impact

Establishing impact involves identifying those aspects of change that would have happened anyway or are a result of other factors to ensure that this is taken out of the analysis. This is important as it reduces the risk of over claiming and means that the results are more credible.

There are some key concepts within this stage:

Deadweight

Deadweight is a measure of the amount of outcome that would have happened even if the activity had not taken place. It is calculated as a percentage. Since implementation of the Wellbeing Support project was not planned as a controlled study there is no direct comparison group available to estimate deadweight from. Deadweight was explored in interviews with participants and stakeholders through questions about what would have happened without the Wellbeing Support project. Findings from these interviews suggested that very little would have changed for the project participants without the Wellbeing Support project.

It was clear from conversations with participants and other stakeholders that many participants were in touch with services other than the Wellbeing Support project. This was for a number of different issues. Most reported frequent contact with their GP for physical health problems. Discussions with stakeholders highlighted the benefits they saw for their services, with many feeling that the Wellbeing Support project helped them to engage with other services. This would suggest that the changes seen in participants are unlikely to have happened anyway.

An alternative way to calculate deadweight is to look at population level data. The Public Health Outcomes Framework³³ includes some measures of population wellbeing captured by the Office for National Statistics (ONS) Annual Population Survey. Data about two aspects of wellbeing (low happiness, high anxiety) is available for each Local Authority in England for three time periods; 2011/12, 2012/13 and 2013/14. This data suggests that overall there may have been some small positive changes at a population level, particularly for anxiety levels; however in Somerset these changes do not appear to be statistically significant.

Figure 2: Self-reported wellbeing scores in England and Somerset 2011/12- 2012/13

	Period	Value	Lower CI	Upper CI
People with low happiness score				
Somerset	2011/12	10.5	8.2	12.8
	2012/13	11.5	8.8	14.1
	2013/14	10.1	7.6	12.6
England	2011/12	10.8	10.3	11.3
	2012/13	10.4	9.9	10.9
	2013/14	9.7	9.2	10.2
People with high anxiety score				
Somerset	2011/12	18.8	15.9	21.7
	2012/13	20.2	17.3	23.1
	2013/14	15.8	13.1	18.5
England	2011/12	21.8	21.3	22.3
	2012/13	21	20.5	21.5
	2013/14	20	19.5	20.5

Source: Public Health Outcomes Framework

These population level changes indicate that some improvements in wellbeing for Wellbeing Support Project participants may have happened without the project. However the project and interview data suggests that other more practical changes such as accessing other services, taking up volunteering opportunities and developing practical strategies to address issues would not have happened. It would therefore seem reasonable to apply a deadweight value of 10% which is a similar value to that used in other similar SROI evaluations.

Displacement

Displacement is another component of impact and is an assessment of how much of the outcome displaced other outcomes. For example, has the increased involvement in community groups and volunteering observed in the Wellbeing Support Project participants meant that they have stopped volunteering somewhere else or doing other things with a social value? Interviews with stakeholders and participants revealed very limited evidence of displacement. Many participants said that without the Wellbeing Support Project they would still be “at home, not doing much”. A clear benefit of the Wellbeing Support Project identified by participants was the Wellbeing Worker’s flexibility in booking

³³ Public Health England Public Health Outcomes Framework <http://www.phoutcomes.info/>

appointment times. This meant there was no evidence that participants missed out on other activities or took time away from work, volunteering or caring responsibilities to attend.

The evaluation did highlight some possible overlap between services, particularly Somerset's main IAPT NHS service for anxiety and depression. However, participants themselves seemed clearer on the differences and also why they felt that the Wellbeing Support Project was more appropriate for them than IAPT service which they felt was inflexible in terms of therapeutic approach and appointments. There was little evidence that contact with the Wellbeing Support Project was displacing contact with IAPT service. Displacement for this project has thus been calculated at 5%. This is a relatively low value. Different values are used in the sensitivity analysis to explore this further.

Attribution

Attribution is an assessment of how much of the outcome was caused by the contribution of other organisations or people. Attribution is calculated as a percentage (i.e. the proportion of the outcome that is attributable to the organisation delivering the activity). It shows the part of deadweight for which you have better information and where you can attribute outcome to other people or organisations. This stage is more about being aware that your activity may not be the only one contributing to the change observed than getting an exact calculation. Information was gathered from stakeholders about attribution in qualitative interviews.

Although participants often had contacts with other agencies, there was strong evidence from the interviews that the Wellbeing Support Project was mainly linked to changes in the lives of participants. There were some occasions where the project was described as complementing other services, such as the GP service. However the main theme was that there were no local services that offered the same sort of approach. A further complication for some was that the 1:1 support was very much linked to other Balsam Centre-based activities – it was hard for some individuals to separate out the different activities or to break down the whole experience.

This analysis has adopted a very similar method to that of other SROI studies conducted with the South West Well-being Programme. Building on this work, 25% attribution was felt to be a reasonable basis for estimation.

Drop-off

Drop-off is used to account for the fact that the amount of outcome attributed to the project is likely to be less or, if the same, will be more likely to be influenced by other factors in future years. It is only calculated for outcomes that last more than one year. The HM Treasury Green Book³⁴ recommends that costs and benefits occurring in the first 30 years of a programme, project or policy be discounted at an annual rate of 3.5%, and recommends a schedule of declining discount rates thereafter.

Since the Wellbeing Support project provides only a short intervention in the lives of participants who often have quite complex and chaotic lives and are accessing a wide range of services for support it is difficult to judge how long the impact of the Wellbeing Support project alone is likely to last. For most outcomes drop-off is likely to be much higher than 3.5% although this will vary between outcomes. This is discussed further in Stage 5.

Calculating the impact

This stage involves adding up all the benefits, subtracting any negatives and comparing the result with the investment.

³⁴ The HM Treasury Green Book <https://www.gov.uk/government/publications/green-book-supplementary-guidance-discounting>

Impact for each outcome is calculated as follows:

- Financial proxy multiplied by the quantity of the outcome gives a total value.
- Deduct any percentages for deadweight or attribution.
 - Deadweight: 10%
 - Displacement: 5%
 - Attribution: 25%
- Repeat for each outcome (to arrive at the impact for each)
- Add up the total (to arrive at the overall impact of the outcomes included)

The total impact for the 128 participants who received an intervention in 22 months of the Wellbeing Support project calculated from this analysis is £156,979. Full details of how this has been calculated are shown in the impact map below.

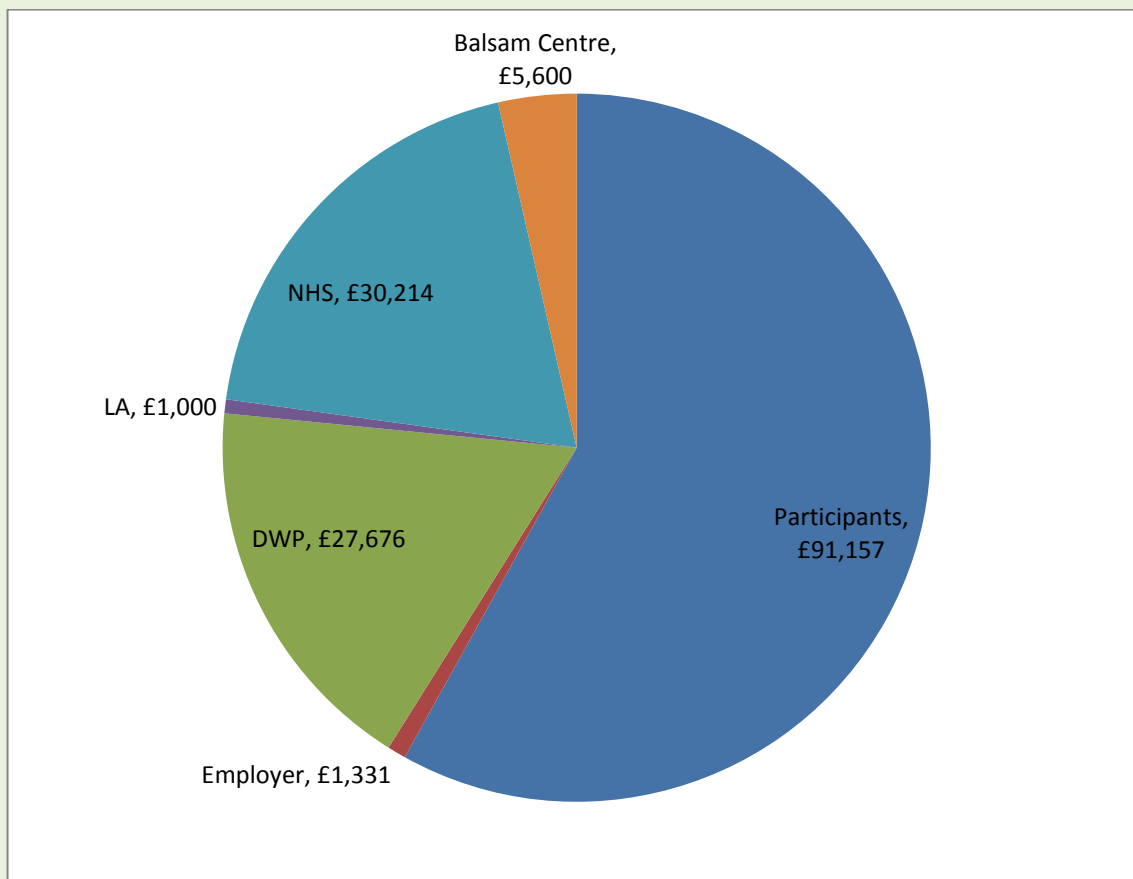
Impact Map 2: outcomes and values

Outcome	Quantity	n	Financial Proxy	Value per participant
Number of participants reporting positive change in diagnostic category for moderately severe/severe anxiety and depression	Positive change for 52% participants where data available	66	Cost of counselling	£240
Number of participants reporting reduced GP attendance	27 recorded in exit record by Wellbeing Worker	27	Cost of GP appointment – average. Calculated as 1 fewer appointments per participant per year.	£42
Number of participants who report improved social wellbeing and improved relationships with partner, other family members or friends	42 recorded in exit records by Wellbeing Worker	42	Cost of social club membership and attendance at activities	£50
Number of participants reporting improved physical activity and diet	3 recorded by Wellbeing Worker	3	Cost of gym membership/local activity session. Calculated as 1 session per fortnight per participant.	£124.40
Number of participants reporting improved ability to perform day-to-day tasks in their lives.	Improvement in 90% participants where data available	115	A course of CBT to build psychological resilience and self-esteem	£930
Number of participants reporting engagement in volunteering or supporting the delivery of community activities	66% out of 39 attending community group activities reported in exit form by Wellbeing Worker.	26	Economic value of volunteer time. Calculated as 1 hour per week for 6 months	£335.92
Number of participants reporting having obtained paid employment	3 FT and 4 PT recorded by Wellbeing Worker	5	Employment and Support Allowance (overall fiscal benefit to government from a workless claimant entering work)	£8,632
Number of participants reporting better work life balance or working patterns	25 recorded by Wellbeing Worker	25	Life coaching style course - Managing Yourself and Personal Effectiveness Training Course	£480

Outcome	Quantity	n	Financial Proxy	Value per participant
Number of participants reporting retention of employment or early return to employment	20 recorded by Wellbeing Worker	20	Workplace mental wellbeing intervention	£83
Number of participants referred to other 1 to 1 counselling/ listening services	7 recorded by Wellbeing Worker	7	Preparation for counselling	£240
Number of participants engaging more effectively with support services for people with learning disabilities or older people	12 recorded by Wellbeing Worker and in participant interviews	12	Cost of sessions with social care support worker. Calculated as 8 sessions per participant.	£120
Number of participants who report registering for a course and/or achieving new qualification	7 recorded by Wellbeing Worker	7	Cost of part time course at a further education college	£300
Prevention of referral to secondary mental health services	Estimate based upon 8 participants recorded as attending the service in crisis and an additional 17 with a score for severe anxiety (n=24, 18%). Assessment that 50% would have been referred (n=12) with serious mental health conditions.	12	Cost of secondary mental health care outreach service for 6 months	£3,832

The chart below shows where the impacts lie. Whilst participants are the greatest beneficiaries of the value created (58%) there is also substantial benefit to local NHS services (19%), and the wider fiscal system (DWP) in terms of savings related to Employment and Support Allowance (18%), as well as the Balsam Centre (3%) and the Local Authority (1%).

Figure 3: Distribution of value of impact



Stage 5: Calculating the SROI.

The sections above present all the information required to calculate an SROI. This final section summarises the financial information recorded in the previous stages to provide the financial value of the investment and the financial value of the social costs and benefits.

Projecting in to the future

The value shown above is based on calculations from the outcome data available from the 128 participants who received an intervention in 22 months of the Wellbeing Support project and includes information about outcomes for no longer than 12 months after the intervention began. SROI allows value of the change in future years to be projected and the value over all projected years totalled.

Feedback from Balsam staff and external stakeholders, notably a local GP, suggests that some of the project impacts are life changing –and therefore are experienced over a long period of time. Since the Wellbeing Support Project offers, potentially a large number of 1:1 sessions and ongoing membership of Balsam Centre activity groups, it is possible that the project can deliver a longer term impact compared to short-term interventions. Nevertheless it is difficult to quantify the duration of the impacts partly because of the diversity of the client group’s needs and social circumstances. Using our estimates for similar schemes under the South West Well-being programme this SROI analysis caps the duration for all outcomes to a maximum of three years and estimates a drop off of up to 50% for many outcomes. These percentages are detailed on the impact map.

Net Present Value

Using these assumptions the Present Value of the Wellbeing Support Project benefits can be calculated for the first 22 months of the project and subsequent years. Deducting the total input (£81,166) provides the Net Present Value (NPV).

Table 9: Net Present Value calculation (22 months)

	Year 1	Year 2	Year 3	
Input (22 months)				£81,166
Present value of each year	£156,979	£78,442	£39,628	
Present value of each year after discounting	£151,671	£73,226	£35,742	
Total Present Value (PV)				£260639
Net Present Value (PV minus the investment)				£179473

This calculation is perhaps a bit confusing because it is based on 22 months of data. Scaling down to just 12 months provides the following values.

Table 10: Net Present Value calculation (12 months)

	Year 1	Year 2	Year 3	
Input (12 months)				44272.46
Present value of each year	[..]	[..]	[..]	
Present value of each year after discounting	£82780	£39941	£19495	
Total Present Value (PV)				£142216
Net Present Value (PV minus the investment)				£97944

Social Return on Investment

Social return

The social return is expressed as a ratio of present value divided by value of inputs.

$$\text{SROI ratio} = \frac{\text{Present Value}}{\text{Value of inputs}}$$

For the Wellbeing Support Project the ratio is 1:3.21

This means that the analysis estimates that for every £1 invested in the Wellbeing Support Project there is £3.21 of social value created.

Net social return

It perhaps makes more sense to take account of the amount invested in this calculation. An alternative calculation is the net SROI ratio. This divides the net present value by the value of the investment.

$$\text{Net SROI ratio} = \frac{\text{Net Present Value}}{\text{Value of inputs}}$$

For the Wellbeing Support Project the ratio is 1:2.21

This means that the analysis estimates that for every £1 spent on the Wellbeing Support Project there is £2.21 of social value created.

Sensitivity analysis

The calculations above are based on a great number of assumptions. Sensitivity analysis allows these assumptions to be tested to assess the extent to which the SROI results would change if some of the assumptions made in the previous stages were changed. The aim of such an analysis is to test which assumptions have the greatest effect on the model.

The standard requirement is to check changes to:

- estimates of deadweight, attribution and drop-off;
- financial proxies;
- the quantity of the outcome; and
- the value of non-financial inputs

No non-financial inputs were included in the analyses. Sensitivity analyses based on changes to other assumptions were undertaken.

Changes to estimates of deadweight, attribution and drop-off

Repeating the analyses with changes to estimates of deadweight, attribution and drop-off indicates that substantial changes would have to be made to the assumptions in order for the ratio change from positive to negative.

Table 11: Sensitivity analyses - changes to estimates of deadweight, attribution and drop-off

	Sensitivity Analysis	Social Return Ratio
1	Findings from analysis	£3.21
2	Increasing deadweight to 50%	£1.78
3	Increasing displacement to 20%	£2.70
4	Increasing attribution to 50%	£2.14
5	Changing drop-off to 75% for all outcomes	£2.43
6	Changing drop-off to 10% for all outcomes	£4.90
7	2-4 above, drop-off 50%	£1.00
8	2-4 above, drop-off 10%	£1.53

Changes to financial proxies and quantity of outcome

The table below shows the estimated values associated with each of the outcomes identified. Halving the value of all the outcomes/number of participants experiencing them gave a social return ratio of £1.60.

Table 12: Value of outcomes in SROI in rank order

Outcome	Impact
Improved confidence and overall mental wellbeing	£120,018
Prevention of referral to secondary mental health services	£51,603
Return to work	£48,434
Reduced symptoms of anxiety and depression	£17,775
Improved work life balance	£13,466
Volunteer engagement	£9,801
Engagement in further education	£3,928
Improved social wellbeing	£3,065
Retention of employment	£2,329
Referral to other counselling/ listening services	£1,885
Reduced GP attendance	£1,273
Better engagement with social care services	£923
Improved diet and physical activity	£472

Table 14 summarises and ranks the values of the outcomes. As would be expected from the aims of the project, value of the overall improvements in mental wellbeing – particularly confidence – figures highly in the outcomes. Other outcomes including those relating to the impact on mental health services and employment account for significant areas of value. Evidence of the impact of the project on employment and education is perhaps harder to evidence within the evaluation period. If we remove these outcomes, the social value ratio becomes £2.57.

These calculations are likely to show that even when significant changes are made to the analysis the results still show clear evidence of social value being created up to 3 years after the Wellbeing Support Project.

Stage 6: Reporting, using and embedding

This SROI report includes a large amount of qualitative, quantitative and financial information which will be useful to the Balsam Centre, Big Lottery funders and other Big Lottery South West Wellbeing Programme as well as commissioners and service providers in Somerset. The section below sets out conclusions and recommendations based on all the learning gained from undertaking this research and should be relevant to all stakeholders.

The final stage of Social Return on Investment will go beyond the publication of this report and involves sharing findings with stakeholders and responding to them. This will be planned and undertaken by UWE in partnership with the Balsam Centre and Westbank.

CONCLUSION AND RECOMMENDATIONS

Summary of findings

Mental wellbeing is a fundamental component of good health. Mental illness is hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health. There are therefore clear financial and health benefits to investing in public mental health interventions and mental health services. This holds true areas such as South Somerset where the risk factors and prevalence of mental illness are high in some demographic groups, and where local residents find it difficult to access appropriate services.

This evaluation demonstrates that Wellbeing Support Project is a valued project amongst the community and those working for the Balsam Centre and other agencies in Wincanton and South Somerset district. The SROI provides a financial measure of this value; that for every £1 spent on the Wellbeing Support Project there is £3.21 of social value created.

The total impact for the 128 participants who participated in 22 months of the Wellbeing Support Project calculated from this analysis is £156,979. Whilst project participants are the greatest beneficiaries of Wellbeing Support Project (58%) there is also substantial benefit to local NHS services (19%), and the wider fiscal system (DWP) in terms of savings related to Employment and Support Allowance (18%), as well as the Balsam Centre (3%) and the Local Authority (1%).

Analysis of quantitative outcome data collected by the project provides clear evidence of benefit to those who receive support from the Wellbeing Support worker and Balsam Centre Colleagues in terms of improved feelings of wellbeing and reduced signs of depression and anxiety. There is also evidence that these improvements, and the changes made as a result of the signposting and practical advice and tools given to participants, results in a reduction in GP appointments; more appropriate use of other support services; and take up or preparedness for employment, education and caring activities.

Longer term outcomes captured qualitatively include significant life changes such as improved family and wider social relationships, developing careers and volunteering opportunities.

The evaluation provides further evidence to support the use of integrated mental health therapeutic approaches to help those with mild to moderate mental health needs. It also provides some insight in to how participants experience a client-led and holistic intervention. The flexibility of the model appears to allow the practitioner to work with a wide range of clients and to coordinate with colleagues specialising in community development, horticultural therapy and volunteer support. This approach offers a non-medicalised approach that appears attractive to people seeking an alternative to NHS-led services. The flexibility of brief support interventions offered at short notice is attractive for people chronic mental health conditions and at risk of relapse. This model also holds attractions for funders and policy makers seeking to support low cost and sustainable community services.

Stakeholders interviewed identified a wide number of positive things about the project; in particular that it is a local and well integrated with other services in the area; and that the Wellbeing Worker's proactive approach means that those referring are confident that even difficult clients will be followed up and well supported rather than getting lost in the system or falling through the gaps. It was clear from all the interviews conducted that the personal attributes of the Wellbeing Worker and Balsam Centre colleagues were highly valued and key to the success of the project.

Participants and one family member expressed deep concern imminent end of grant funding for the project. There was concern not only about how withdrawal would affect service users, but also the impact on the community of investing so much time and effort in developing a project, raising expectations about availability of a new service and then losing it when the funding goes.

Strengths and limitations

A key strength of this SROI is the excellent methods for collecting baseline and follow-up data from project participants established by the Wellbeing Worker. This meant that there was paired data for many of the project participants that could be incorporated in to the evaluation, and also useful qualitative data to support it.

Robust data collection is essential for service evaluation and SROI analysis. Our study suggests that some data collection, particularly the weekly assessments, are of limited value for the evaluation (although they may be a valuable tool for reflection, goal setting and relationship building). Although the Balsam Centre now has an excellent database to help monitor and track activities, there is further work needed to bring together the different strands of activity recording and to streamline some data collection in order to avoid unnecessary paperwork.

One area where changes were anticipated in the project plan and were also reported by interviewees concerns physical activity and diet. These areas are not simple to measure, although some work on this is in place for group-based activities. Paired baseline and follow-up data for these behaviours was not comprehensively available and would have supported further analysis of the benefits for participants.

There are some limitations to this evaluation and SROI. Although the completeness of dataset for mental ill health was good, data on the longer term changes for participants was not available – beyond the information provided at interview. This makes it particularly difficult to estimate the duration of the changes for participants. Furthermore, it appears that there are major changes for some participants that are hard to validate or quantify. For example, reports of the prevention of suicide and major life crises are hard to substantiate, but nevertheless indicate significant benefits for individuals and statutory services.

Important wider impacts of the Wellbeing Support Project – and of the Balsam Centre more generally - have not been fully captured in this report. This is a significant limitation because the ethos and service model of the Centre is to promote the connections between activities, such that participants can benefit from the whole experience and support facilities of the community centre. Given that some Wellbeing Support Project participants were reported to also volunteer and champion the work of the Balsam Centre, there are added forms of value that would benefit from further exploration in an SROI analysis.

There will be some benefits that are important to stakeholders but which cannot be monetised. For example many of the stakeholders interviewed highlighted the important work the Wellbeing Worker had done to promote the Wellbeing Support Project amongst other local agencies and the community which had also raised their awareness of other services and support offered by the Balsam Centre. This may have increased the number of people in the local community benefitting from other Balsam Centre services and community activities but it is very difficult to value this without outcome data. Although we have been able to estimate some of the value of Balsam services for the friends and families of participants, this is a further area where it is difficult to fully estimate the benefits.

SROI should also take account of the cost of negative outcomes. Whilst a few potentially negative consequences of the project were identified no individual level negative outcomes were identified for project participants or their friends and family which could be included in the SROI analysis. This may be because none occurred, or may be because of limitations in the methods used. If this is the case then the SROI will have over-estimated value. Given the confidentiality of the service, we did not feel it was appropriate to do postal or email survey to all registered participants. A potential solution might have been to invite public feedback through newspaper and community-board notice.

Recommendations

In this SROI report we have monetised the benefits of the Wellbeing Support Project to its participants and other agencies working with the community in Wincanton and the surrounding area. The report demonstrates a significant social return for the investment made, and the feedback from participants and stakeholders clearly illustrate the programme's positive impact to participants' wellbeing and how their lives have changed.

A key concern for the Balsam Centre is securing ongoing funding once the current Big Lottery funding ends. It is difficult to quantify the impact that discontinuing the Balsam Centre Wellbeing Support Project might have on the local community and other local services. However a previous 20 month break in a similar service prior to June 2013 led to increased pressures on NHS, Social Care and other local community services. It is likely that those who might benefit from the service will experience mental health-related difficulties that are avoidable and that have harmful impacts on families, their community and local services.

This report provides a tool for working with local mental health and public health commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project. It also highlights ways in which improvements could be made to the project to maximise benefit to individuals and other local projects and services at the Balsam Centre and more widely in South Somerset.

Undertaking a whole system SROI of the Balsam Centre – and the sister agency the Growing Space - could provide great insight in to the ways in which it benefits the local community and promotes health and wellbeing. We hope that this evaluation has provided a useful test of the methods and encouragement to explore their wider use.

The evaluation has highlighted the important role the Wellbeing Support Project has in meeting the needs of local people who often fall through gaps in existing service provision. This includes those with multiple health conditions, including mental health problems who, for various reasons, are difficult to manage in universal primary care services because of the complexity of their situation. These patients can be frequent users of health services such as the GP. With the Balsam Centre working closely with local GP services there is opportunity for the Wellbeing Support to target these patients further, working with the Practice and perhaps also the IAPT service to take referrals and work with clients to identify solutions that enable them to help themselves, and also to access other support services more appropriately.

Recommendations are:

- Use this report as a tool to demonstrate the value of the Wellbeing Support Project and the Balsam Centre and for working with local commissioners and other funding bodies to identify possible sources of funding to secure ongoing delivery of the project.
- Explore opportunities for undertaking a whole system evaluation and SROI of the Balsam Centre to provide insight in to the ways in which it benefits the local community and promotes health and wellbeing in Wincanton and the surrounding area.
- Identify ways for the Balsam Centre to work even more closely with other local services, particularly the GP Practice and IAPT service, to take referrals and work with clients to identify solutions that enable them to help themselves where appropriate, and also to access other support services more appropriately.
- Review data collection methods used by the Wellbeing Support Project in light of the outcomes captured by this SROI and identify ways to capture all relevant outcomes to project and future funders whilst ensuring that burden of paperwork is minimised for participants and project staff.

APPENDICES

Appendix 1 – List of Potential Stakeholders

STAKEHOLDER	REASON FOR INCLUSION
Project participants	Primary participants who are likely to be experiencing significant outcomes if intervention is successful
Family & friends of project participants	Improvement in mental health of participants could impact on families who may have previously had significant caring responsibilities
Balsam Centre – staff and volunteers	Route for referral for those clients who staff and volunteers have concerns about, route to recruitment of participants to other projects/services, improved attendance of clients because of their improved mental wellbeing, source of internal advice on mental health issues.
Local GPs and Health Professionals	Potential savings in health spending and reduction in workload and waiting times if participants' mental health improves.
Somerset Council –including Mental Health, High Impact Families, Social Care, Public Health, and Safeguarding Team	<p>At population level service providing support to objectives to improve access to low level support and improve mental health and wellbeing.</p> <p>At individual level route for referral for those clients who staff have concerns about, route to recruitment of participants to other projects/services, improved attendance of clients because of their improved mental wellbeing.</p>
Local Mental Health Services	Potential savings in health spending and reduction in workload and waiting times if participants' mental health improves.
Local and voluntary services	Route for referral for those clients who staff and volunteers have concerns about, route to recruitment of participants to other projects/services, improved attendance of clients because of their improved mental wellbeing.
Local Schools	Route for referral for those clients who staff have concerns about.
DWP/Job Centre Plus	Potential for reductions in benefit payments and increased state income from taxes where employment is increased

Appendix 2 – Impact Map

The Impact Map is available on request as a separate Excel Spreadsheet

5.3 Appendix 3 - Participant interview questions

BALSAM CENTRE WELLBEING SUPPORT PROJECT **– PARTICIPANT INTERVIEW QUESTIONS**

Thank you for agreeing to take part in this evaluation. The aim of this interview is for us to find out more about your experience of and the support you received from the Balsam Centre’s Wellbeing Support Project and how things have changed for you since. The findings will form part of an evaluation report on the work of the Balsam Centre. Your views and those of all consulted as part of the evaluation will be used to inform the final evaluation report.

INTRODUCTIONS

Can you tell me a bit about yourself and your involvement with the Wellbeing Support Project?

- Name and background info – local resident?
- Did you attend 1-1 sessions with the Wellbeing Worker?
- When did you start/finish attending sessions?
- How did you hear about the project?
- Why did you choose to attend? What did you expect?
- Were you already accessing other services at the Balsam Centre?

BEFORE TAKING PART IN BALSAM CENTRE’S WELLBEING PROJECT

Can you tell me a bit about how things were for you before accessing Wellbeing activity?

- How were you feeling in general prior to joining the project?
- How was your mental wellbeing?
 - Existing / historical contact with mental health services / medication?
 - Suffering from depression / anxiety?
 - Sleep?
 - Isolated? Confidence?
- How was your physical health?
- Were you accessing any other health services?
 - GP
 - Mental health
- How was your lifestyle?
 - Diet, activity, smoking, alcohol, drug use
 - Relationship with family / community
 - Employment / Education
 - Receiving support from any other services / people?
 - Expectations of what the group was going to be like / what might change?

HOW DID YOU FIND THE BALSAM CENTRE’S WELLBEING PROJECT?

- Practicalities – getting there, appointment times, frequency of appointments, length of contact

- Did you miss many sessions – why was this?
- What did you like / not like?
- Did you access any other services as a result of attending project?
- Did you give anything up to attend project?
- If there was anything you could have changed what would it be?
- Were you using any other services at the same time?
- Did the project match your expectations? How is it different to these?

WHAT CHANGED FOR YOU?

- Do you feel like anything has changed for you as a result of coming to the project?
 - Changes to employment / educational status / volunteering? (More/Less)
 - Changes to Physical Health – exercise / diet / smoking / drinking
 - Changes to Mental Health – purpose / happiness / confidence / friendships
 - Changes to relationships with family / community / friends
 - Carrying out new activities? Join / Leave any new activities / groups?
 - Frequency of GP visits – more or less engagement with other services? Has the type of service changed?
- How important was this change?
- How would someone else know that this had happened and what would we show them? Could you measure it?
- Were all the changes positive?
- Were all the changes expected or was there anything that you didn't expect that changed?
- Which of these changes will make the biggest difference to you?
- How long do you think the change will last?

COULD ANYTHING ELSE ACCOUNT FOR THESE CHANGES?

- What other services/support were you accessing at the same time?
- Did anyone else contribute to the experience/change?

WHAT HAPPENED AFTER YOU LEFT THE BALSAM CENTRE ACTIVITY?

- How did you feel about leaving the service?
- Did you move to any other group/service? How do they compare to the Balsam Centre?

WHAT IS THIS SERVICE WORTH?

- If there was a charge for the service how much do you feel you would be willing to pay?
- Can you compare it to something else just as important to you?
- Which other ways might you achieve the same changes?

1.4 Appendix 4 – Stakeholder Interview Questions

BALSAM CENTRE WELLBEING SUPPORT PROJECT **– STAKEHOLDER INTERVIEW QUESTIONS**

Thank you for agreeing to take part in this evaluation. The aim of this interview is for us to find out more about your experience of and contact with the Balsam Centre's Wellbeing Project and what you think about the impact it's having. The findings will form part of an evaluation report on the Balsam

Centre's project activities. Your views and those of all consulted as part of the evaluation will be used to inform the final evaluation report.

INTRODUCTIONS

Can you tell me a bit about yourself and your involvement with the Balsam Centre's Wellbeing project?

- Name:
- Organisation and role within the organisation
- How and when did you/your organisation get involved with the Balsam Centre?
- Were you already working with other services at the Balsam Centre?
- How do you work together with the project?

AIM OF THE BALSAM CENTRE'S WELLBEING PROJECT ACTIVITIES

- What do you think are the aims of the Balsam Centre's Project activities?
- Who do you think it is targeted at?
- Do you think the aims and target groups are right to meet the needs of the local community?
- Do you refer/signpost people you work with to the project?

WHAT CHANGES?

- What impact do you think the Balsam Centre's Wellbeing project activities have on their participants / the wider community?
 - What are the benefits?
 - What do you think are the most / least effective aspects of the programme?
 - What are the negative or unintended consequences?
- How important are these changes?
- How would someone else know that this had happened and what would we show them? Could you measure it?
- How long do you think the change will last?
- How do you think Balsam Centre's Wellbeing activities compare with other similar projects/services?
- What would participants do if the activities weren't there?

COULD ANYTHING ELSE ACCOUNT FOR THESE CHANGES?

- What other services/support are you aware of participants accessing at the same time?
- Do you think anyone else contributes to the experience/change?

WHAT IS THIS SERVICE WORTH?

- If there was a charge for the service how much do you feel you would be willing to pay?
- Can you compare it to something else just as important?
- Which other ways might you achieve the same changes?