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Further information about this report and the South West Well-being evaluation is available at http://westbank.org.uk/ or contact:

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I’m still here. If I hadn’t have had something to look forward to, I don’t know what… I would have done, yeah, because things get pretty crazy and… yeah, it was a lifeline, and I was very reluctant and sad to give it up. But yeah, it has given me a sort of hope to try and persevere and do things on my own.
Dreamtime Arts participant

You can cry, I don’t think I would cry in front of my son, when they are not here it does mean you can cry, because you don’t want to transfer that to them, you hold it all in when they are around, but when they are not here it means you can be in a safe place and you can cry, which such a release.
Dreamtime Arts participant

The fact that you have got people to talk to who know about your story anyway, the fact that it is in this safe environment that is quite calm, there is no pressure, your child is being looked after and you can deal with things by making stuff.
Dreamtime Arts participant

With a child you do get a bit submerged, if things are really difficult, are really stressful, if you don’t break that, it gets magnified, it just spirals and they you are….. but then you can come here. It lifts you out of that place, and sometimes that’s what you need, to pick you out and plop you in a better place again.
Dreamtime Arts participant

If the question is whether it is worthwhile then more than anything I have ever been too worthwhile.
Dreamtime Arts participant
EXECUTIVE SUMMARY

Aim

Dreamtime Arts

Importance of mental health and wellbeing – Perinatal mental health

What is Social Return on Investment?

Method

Project participants

Findings

Limitations of the study

Conclusions and recommendations

INTRODUCTION

Aim

Big Lottery South West Well-being Programme

Wellspring Healthy Living Centre

WHLC Wellbeing Project

Dreamtime Arts

Lawrence Hill and Easton Wards

2. LITERATURE REVIEW

What do we mean by mental health and wellbeing?

What do we mean by mental illness?

Determinants of mental health and wellbeing

Perinatal Mental Health Problems

Impact of mental illness

National Policy Context

Local Policy Context

Access to mental health services

Interventions to promote mental wellbeing and prevent mental illness

Public Mental Health Interventions

Asset-based community development

Psychosocial interventions

Peer support approach

Health and the Arts

SOCIAL RETURN ON INVESTMENT

What is Social Return on Investment?

The six stages of SROI analysis

Stage 1: Establishing Scope and Identifying Key Stakeholders.

Scope

Key stakeholders

Project Participants

Stage 2: Mapping inputs and outcomes

Mapping inputs

Mapping outputs - data collection methods

Stage 3: Evidencing outcomes and giving them a value

Qualitative data analysis – stories of change

Quantitative data analysis

Mental Ill-health: Depression

Mental Ill health: Anxiety

Overall Life Satisfaction

Physical activity

Longer-term outcomes
Making a judgement on outcomes 47
Putting a value on the outcome 48

Stage 4: Establishing impact 51
   Deadweight 51
   Displacement 52
   Attribution 52
   Drop-off 53
   Calculating the impact 53

Stage 5: Calculating the SROI. 55
   Projecting in to the future 56
   Net present value 56
   Social Return on Investment 57
   Sensitivity analysis 57
   Changes to estimates of deadweight, attribution and drop-off 57

Stage 6: Reporting, using and embedding 59

CONCLUSION AND RECOMMENDATIONS 59
   Summary of findings 59
   Limitations 60

REFERENCES 70

ABBREVIATIONS 74

APPENDICES 75
   Appendix 1 – Stakeholder List 75
   Appendix 2 – Participant focus group questions 75
   Appendix 3 – Stakeholder Interview Questions 76
EXECUTIVE SUMMARY

Aim
The aim of this research was to evaluate the impact of the Big Lottery Funded Wellspring Healthy Living Centre’s (WHLC) Dreamtime Arts project on its participants and demonstrate the social value that the project is creating using the Social Return on Investment (SROI) methodology. The evaluation focuses on the first nine months of operation of the project (April-December 2014) and includes all those who registered with the project and received an intervention during this time (n=24).

Dreamtime Arts
The aim of Dreamtime Arts is to improve the health and wellbeing of women with pre-school children. It is a free to access art based group programme for local women with pre-school age children who are experiencing low to mild levels of anxiety, depression or isolation. Dreamtime Arts is based on the following models:

   a) Asset-based community development
   b) Psycho-social interventions
   c) Peer-support.

The programme is based in East Bristol and is accessed by referral from either a family support worker, a health visitor or GP. It offers participants a term of ten, two hour-long group art sessions, led by a trained artist/facilitator and supported by an onsite crèche. Dreamtime Arts is delivered at WHLC, and the two local children’s centres of Bannerman Road and the Limes.

No previous art experience is necessary for participants. The support provided also includes assistance to access other elements of the services available at WHLC as well as to other local art-based programmes. Participants are able to attend up to two terms of Dreamtime Arts.

Importance of mental health and wellbeing – Perinatal mental health
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.¹

It is estimated that taken together, perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country. Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother and over a fifth of total costs (£1.7 billion) are borne by

¹ Faculty of Public Health. Better Mental Health for All. http://www.fph.org.uk/better_mental_health_for_all
the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion).²

Treatment and support for women with perinatal mental health problems are provided by a mix of universal and specialist services and there is long-standing agreement in guidance from the National Institute for Health and Care Excellence (NICE) and other national bodies on how these services should be organized and what they should provide.

Despite this, the current provision of services is widely described as patchy, with significant variations in coverage and quality around the country. For example:

- About half of all cases of perinatal depression and anxiety go undetected and many of those, which are detected, fail to receive evidence-based forms of treatment.³
- Specialist perinatal mental health services are needed for women with complex or severe conditions, but less than 15% of localities provide these at the full level recommended in national guidance and more than 40% provide no service at all.⁴
- Just 3% of Clinical Commissioning Groups (CCGs) in England have a strategy for commissioning perinatal mental health services and a large majority have no plans to develop one.⁵

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 measuring social value of which there are many. SROI captures value often left out of more traditional methods of economic evaluation such as cost benefit analysis.

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 participant focus groups and interviews with key stakeholders. Two focus groups of four participants were undertaken and six interviews undertaken with WHLC staff and other key stakeholders.

⁴ Ibid.
⁵ Ibid.
**Project participants**
Health data for project participants was not collected but analysis of referral criteria allows us to conclude that all participants satisfied at least one or more of the following categories:

- Currently suffering from a low to moderate level mental health disorder, notably post-natal depression or anxiety;
- Survivors of domestic violence and abuse;
- Socially isolated.

**Findings**
SROI analysis found that the total impact for the 24 participants who received an intervention in the first 9 months of the Dreamtime Arts project is £100,414. The net SROI ratio, which takes account of the amount invested is: 1 : 2.54. This means that the SROI analysis estimates that for every £1 spent on the Arts Dreamtime project there is £2.54 of social value created. The table below provides a summary of all the outcomes included in the SROI analysis and the way in which they were valued.

**Table 1: Summary of all outcomes included in the SROI analysis and the way in which they were valued.**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quantity</th>
<th>N (scaled up for n=24)</th>
<th>Financial Proxy</th>
<th>Value per participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants reporting reduced symptoms of anxiety</td>
<td>Reduction in 47% participants where data available</td>
<td>11</td>
<td>The cost of six sessions of counseling</td>
<td>11x180= £1,980</td>
</tr>
<tr>
<td>Number of participants who report improved social wellbeing and improved relationships with partner and other family members</td>
<td>Improvement in 85% participants where data available</td>
<td>20</td>
<td>Cost of social club membership and attendance at activities</td>
<td>20x100= £2,000</td>
</tr>
<tr>
<td>Number of participants reporting improved physical activity</td>
<td>Improvement in 42% participants where data available</td>
<td>10</td>
<td>Cost of gym membership/local activity session. Calculated as 1 session per fortnight for one year.</td>
<td>10x50.40= £504</td>
</tr>
<tr>
<td>Number of participants reporting improved mental well-being.</td>
<td>Improvement in 93% participants where data available</td>
<td>22</td>
<td>A course of CBT to build psychological resilience and self-esteem</td>
<td>22x930= £20,460</td>
</tr>
</tbody>
</table>
Analysis of quantitative outcome data collected by the project provides clear evidence of significant benefits for Dreamtime Arts participants in terms of reduced symptoms of anxiety and depression, improved social and mental wellbeing and increased levels of low level physical activity. There is also evidence that the Dreamtime Arts programme also had an impact in terms of suicide reduction and supporting participants into accessing child-care services.

Stakeholders interviewed identified a number of positive things about the project; particularly the informal nature of the project and the fact that the programme is presented as a group art activity rather than an intervention for people with mental health issues. They felt that this made it much more appealing to members of the local community who might not attend a more formal mental health intervention because of the stigma surrounding mental health and concerns over keeping custody of children.

Participants themselves felt that they benefitted from the opportunity to have some time to themselves away from the responsibilities of child-care, the opportunity to carry out creative activities in a friendly, relaxed and therapeutic atmosphere and the friendship, emotional support and sense of community that they received from their peers. It was clear from the focus groups that the personal attributes of the project facilitators were highly valued and considered as key to the success of the project.

Some concerns were raised about the project, which focused on the challenges of making it equally accessible to all members of the local community, securing ongoing funding for the project so that more women could continue to benefit from it and a shortage of viable follow-on options for the participants when they had finished the Dreamtime Arts programme.
Limitations of the study

There are some limitations to this evaluation and SROI. The number of participants with matched base and follow up data was small, so there is some uncertainty about the veracity of the quantitative analysis. In a similar vein, although one third of the total cohort took part in qualitative data collection, the views of this group may not necessarily be fully representative of the cohort as a whole. The evaluation was not able assess the impact of the programme on a number of stakeholder groups, including the 40 children of the participants who attended Dreamtime Arts during the assessment period and the friends and family of these participants. Additionally, there were some benefits that were important to stakeholders but which cannot be monetized due to a lack of indicative quantitative evidence and the lack of appropriate financial proxies. It is likely that some of the wider and more long-term impacts of the Dreamtime Arts programme on WHLC have either not fallen within the scope of the project or have been significantly undervalued.

Conclusions and recommendations

In this SROI report we have monetized the benefits of the Dreamtime Arts project to its participants and the broader community in Lawrence Hill Ward, Bristol. The report demonstrates a significant social return for the investment and the feedback from participants and stakeholders clearly illustrate the programme’s positive impact on participant’s wellbeing and how their lives have changed.

A key concern for Dreamtime Arts is securing ongoing funding once the current Big Lottery funding ends. It is difficult to quantify the impact that discontinuing Dreamtime Arts might have on the local community and other local services. It is likely that those who have benefitted from the service and those who might benefit from it in the future will simply slip back through the gaps in services that exist, an important consideration given that just 3% of CCGs in England having a strategy for commissioning perinatal mental health 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 maximize the benefit provided by the project to the Lawrence Hill Ward, for example by integrating the referring family support workers and health visitors more closely with the project as a means of ensuring that more of those who are referred attend the group and that referees and attendees are representative of the need within the local population.

Recommendations are:

6 PSSRU The Cost of Perinatal Mental Health Problems,
http://eprints.lse.ac.uk/59885/1/_lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauert,Bauer_Costs_perinatal_mental_2014_Bauer_Costs_perinatal_2014_author.pdf
• To continue to seek to make the Dreamtime Arts programme as accessible to as many different women in the local community as possible, with a particular focus on helping women to attend for the first time and on ensuring that attendees continue to reflect the diversity of the local population as much as possible.

• To further strengthen the link between the project and the health visitors and family support workers referring to it. Giving health visitors a chance to pop in to the group from time to time and closer engagement with the Arts and Wellbeing officer would give referrers a clearer picture of programme impact and help them in deciding who could be appropriately referred. Their attendance would have the additional benefit of giving mums an opportunity to ask questions about health related issues. Health visitors could also play a role in supporting women to attend the group for the first time, possibly by taking them there the first time.

• Acknowledging the central importance of the facilitator(s) in helping to generate the positive outcomes of the programme, WHLC should ensure look at ways to enhance their support to the project facilitators / artist in preparing for the groups. With additional support they could spend time contacting people who have been referred to the group but who have not yet attended reducing barriers to initial engagement. The support of an appropriate volunteer (for example an art therapy student) in facilitating the group should be considered.

• To explore ways to continue to support women who have completed the Dreamtime Arts programme in finding and accessing follow-on services. There is a current lack of appropriate services with crèche facilities for participants to attend after they have finished Dreamtime Arts. It is important that WHLC work with other community organizations, service providers and commissioning bodies to ensure that appropriate and accessible services are available for this high-risk group. Supporting participants to stay in touch with each other and to set-up their own informal groups and meet-ups after the Dreamtime group has finished would help to embed the positive outcomes generated by the programme.
INTRODUCTION

Aim
The aim of this research was to evaluate the impact of the WHLC’s Dreamtime Art project on its participants and explore the social value that the project creates using the SROI methodology. Dreamtime Arts is aimed at improving the mental health and resilience of women with pre-school children living in the Lawrence Hill ward in Bristol who are currently struggling with mild to moderate mental health needs such as: stress, depression and anxiety.

The evaluation focuses on the first 9 months (April - December 2014) of operation of the Dreamtime Arts project and includes all those who registered with the project and received an intervention during this time. This amounts to 24 women, six of whom attended the Dreamtime Arts programme twice during this period.

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 Dreamtime Arts;
- To produce a working document that can be used to demonstrate the social value of investing in Dreamtime Arts;
- To use this initial report as a base for identifying the changes necessary to sustain and improve the social value of Dreamtime Arts and associated activities at Wellspring Health Living Centre WHLC.

Big Lottery South West Well-being Programme
Dreamtime Arts is part of the Big Lottery funded South West Well-being Programme (SWWWB); a programme that seeks to improve the well-being of people in poor health, experiencing isolation and living in socially disadvantaged neighborhoods in the south west of England. Eight local projects deliver a broad base of linked social, non-medical alternatives to provide positive health promotion. These 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 promoting positive physical, social and mental states.

Wellspring Healthy Living Centre
Founded in 2004, by Barton Hill Residents, WHLC is a charitable company limited by guarantee which came about as part of the ten-year New Deal for Communities (NDC) regeneration programme in the Barton Hill, Lawrence Hill, Redfield and the Dings areas in Bristol. It was funded by Community at Heart, the organisation set-up to oversee this programme.
The vision of WHLC is to create a healthier, happier and more resilient community through supporting local people to improve their health and wellbeing and to build the confidence to achieve their goals and transform their lives.

The mission of WHLC is to engage with its community, empowering those within it to take control of their physical, mental and emotional wellbeing through accessible, affordable, innovative, high quality services, which have an impact on their daily lives.

From the centre, WHLC deliver health and wellbeing services to a broad range of participants aiming to address depression, reduce social isolation and increase confidence. WHLC uses a community development approach to address the health inequalities in the area.

**WHLC Wellbeing Project**

WHLC received Big Lottery funding to provide a suite of activities as part of a Wellbeing project. The Wellspring Wellbeing project is part of the SWWB portfolio of projects led by Westbank in Devon. The Wellspring Wellbeing Project activities cover many aspects of wellbeing including: mental health, diet, physical activity and community connections.

They include:

- Dreamtime Arts group: for women suffering from low-level depression, anxiety, stress or feel isolated, who have pre-school children;
- Polish Women’s Wellbeing Service: a 1:1 and group interventions for women suffering from low-level depression, anxiety, stress or feeling isolated, or who are survivors of domestic abuse;
- Kitchen on Prescription: course for those with heart disease, diabetes or hypertension aiming to increase skills, knowledge and confidence of how to maintain a healthy diet;
- Weaning Class: for parents with infants to increase knowledge, skills and confidence of how to wean on to healthy foods;
- Physical Activity and Healthy Eating Class: for parents and children 3-5 years, aiming to increase skills, knowledge and confidence in maintaining healthy diets for pre-school children, and to increase physical activity;
- Bike Loan Scheme; available at weekends and school holidays and aiming to increase physical activity.

**Dreamtime Arts**

As outlined above, Dreamtime Arts is one of the WHLC Wellbeing Project activities funded by the Big Lottery. The focus of this evaluation and SROI analysis is on this project. The aim of Dreamtime Arts is to improve the health and wellbeing of women
with pre-school children. It is an art based group programme for local women with pre-school age children who are experiencing low to mild levels of anxiety, depression or isolation. Dreamtime Arts is based on the following public health models:

a) Asset-based community development;

b) Psycho-social interventions;

c) Peer-support.

The programme is accessed by referral from a family support worker, health visitor or GP. It offers participants a term of ten, two hour-long group art sessions, led by a trained artist/facilitator. These sessions are held in the purpose built art room at the WHLC and are supported by the onsite crèche. The art-sessions provide mums with a chance for some time away from the children and an opportunity to do something just for themselves in the company of other mothers. No previous art experience is necessary. The support provided also includes support in accessing other elements of the services available at WHLC as well as to other local art-based programmes. Mums are able to attend a second term of Dreamtime Arts if and when it is mutually agreed between the individual and the facilitator that it would benefit the participant. WHLC run classes at Bannerman’s Road Children’s Centre and The Lime’s Children’s Centre. Data from these satellite projects were be included in the analysis.

Dreamtime Art was identified as of particular interest for a SROI analysis as it was one of the more established wellbeing interventions provided by WHLC. UWE was keen to evaluate a broad spread of Wellbeing Interventions across the SWWB consortium. As an arts based activity the Dreamtime Arts programme offered a unique opportunity to look at a different type of intervention to others in the existing portfolio.

**Table 2: Dreamtime Arts Service Model**

<table>
<thead>
<tr>
<th>Eligibility criteria:</th>
<th>Women with pre-school children who live in postcode area BS5; women with low to moderate common mental health disorders, namely post-natal depression and anxiety; those women who are survivors or victims of domestic violence and abuse; those who expressed feeling isolated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Group art classes run by trained facilitator which providing mums with emotional support, a chance for some time away from their children, and the opportunity to engage in creative activities in the company of other mothers.</td>
</tr>
<tr>
<td>Outcomes:</td>
<td>Improved health and wellbeing. Referral to other local services.</td>
</tr>
<tr>
<td>Data collected:</td>
<td>WHLC’s registration form and weekly register. PHQ9, GAD7, Friendship Scale, Office for National Statistics (ONS) Wellbeing Questions; taken at baseline and follow up at five weeks and ten weeks of the programme.</td>
</tr>
</tbody>
</table>
The budget for Dreamtime Arts for the year 2014/15 was set at £18,223. This includes funding for a lead artist, a Wellbeing Worker, general overheads and running expenses for the project and some funding for training WHLC staff and volunteers and project participants.

**Lawrence Hill and Easton Wards**

The eligibility criteria for referral to the Dreamtime Arts groups were that it was limited to participants resident within the BS5 postcode area, which consists of the wards of: Easton and Lawrence Hill. These wards are ethnically diverse, with a higher than average proportion of young people and with higher than average levels of deprivation across a range of indices including: income, employment, health and disability, education skills and training, barriers to housing and services, living environment and crime.

As of the 2011 census, Easton had a population of 13,508 and Lawrence Hill a population of 18,874, making a total catchment area of 32,382. Both wards have a higher proportion of children (22.4% and 24.2% respectively) than the city of Bristol as a whole (18.4%) and a lower proportion of residents over the age of 65 (8.8% and 8.1% compared to the Bristol average of 13.1%) Both Easton and Lawrence Hill have a higher percentage population belonging to a Black of Minority Ethnic (BME) group (37.9% and 55.2% respectively) than Bristol as a whole (16%). Lawrence Hill is the only ward in Bristol with a majority of residents belonging to a BME group. The proportion of residents not speaking English as a main language in Easton and Lawrence Hill was 16.4% and 28% respectively. This is also higher than the average in Bristol (8.5%). The proportion of residents in Easton and Lawrence Hill in receipt of Out of Work Benefits (15.4% and 26.2% respectively) is also higher than the Bristol average (12.1%). All of the Lower Layer Super Output Areas (LSOAs) within Lawrence Hill ward are within the most deprived 10% in England and all of the LSOAs within Easton ward are more deprived than the national average.7

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7Bristol City Council (2013) Neighbourhood Partnership Statistical Profile 2013: Ashley, Easton and Lawrence Hill NP08


2. LITERATURE REVIEW

The aim of the Dreamtime Arts project is to improve the health and wellbeing of women with pre-school children, to increase self-confidence and self-esteem, to reduce levels of depression and/or anxiety, to increase access to support for those with health and social issues in partnership with the Health Visiting team, reduce isolation and increase an individual’s network of supportive friendships. A literature review was undertaken to provide context and supporting evidence to intervention. The literature review considered the epidemiology of mental health and illness, particularly postnatal mental health, the national policy context, and the evidence community and public health interventions to improve mental wellbeing.

What do we mean by mental health and wellbeing?
The World Health Organisation (WHO)\(^8\) 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 wellbeing thus comprises two main elements, feeling good and functioning well.

The Foresight Mental Capital and Wellbeing Project\(^9\) 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 Organisation\(^10\) is:

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


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

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 people, 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, labeling and exclusion, have an important bearing on the experience of mental illness.

Determination 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

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themselves and the environment in which they live, and are often complex and interrelated\textsuperscript{12}. 

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.

The incidence of most mental health problems does not change in the perinatal period: pregnant women and new mothers have the same level of risk as other adults, although the effects of these illnesses are likely to be more significant at this critical period in their lives. However for certain serious mental the risk of developing or experiencing a recurrence of the illness does increase after childbirth.

It is known that rates of postnatal depression are higher amongst women experiencing disadvantages such as poverty or social exclusion. The risk of depression is also twice as high amongst teenage mothers. In addition the stress caused by issues such as poor housing, domestic violence and poverty can exacerbate symptoms of anxiety and depression.\textsuperscript{13}

\textbf{Table 3: Determinants of mental health and wellbeing}

<table>
<thead>
<tr>
<th>Level</th>
<th>Adverse factors</th>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual attributes</td>
<td>Low self-esteem $\Leftrightarrow$</td>
<td>Self-esteem, confidence</td>
</tr>
<tr>
<td></td>
<td>Cognitive/emotional immaturity $\Leftrightarrow$</td>
<td>Ability to solve problems and manage stress or adversity</td>
</tr>
<tr>
<td></td>
<td>Difficulties in communicating $\Leftrightarrow$</td>
<td>Communication skills</td>
</tr>
<tr>
<td></td>
<td>Medical illness, substance use $\Leftrightarrow$</td>
<td>Physical health, fitness</td>
</tr>
<tr>
<td></td>
<td>Loneliness, bereavement $\Leftrightarrow$</td>
<td>Social support of family &amp; friends</td>
</tr>
<tr>
<td>Social circumstances</td>
<td>Neglect, family conflict $\Leftrightarrow$</td>
<td>Good parenting / family interaction</td>
</tr>
<tr>
<td></td>
<td>Exposure to violence/abuse $\Leftrightarrow$</td>
<td>Physical security and safety</td>
</tr>
<tr>
<td></td>
<td>Low income and poverty $\Leftrightarrow$</td>
<td>Economic security</td>
</tr>
<tr>
<td></td>
<td>Difficulties or failure at school $\Leftrightarrow$</td>
<td>Education achievement</td>
</tr>
</tbody>
</table>

\textsuperscript{12} World Health Organisation (WHO) 2012. Risks To Mental Health: An Overview Of Vulnerabilities And Risk Factors \url{http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf}

\textsuperscript{13} NSPCC. Prevention in mind. All Babies Count: Spotlight on Perinatal Mental Health, \url{http://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf}
<table>
<thead>
<tr>
<th>Work stress, unemployment</th>
<th>Satisfaction and success at work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental factors</td>
<td>Poor access to services</td>
</tr>
<tr>
<td></td>
<td>Equality of access to services</td>
</tr>
<tr>
<td></td>
<td>Social justice, tolerance, integration</td>
</tr>
<tr>
<td></td>
<td>Social equality</td>
</tr>
</tbody>
</table>

Adapted from WHO

Perinatal Mental Health Problems

The perinatal period refers to the period during pregnancy and the first year after childbirth. Perinatal mental health problems are very common, affecting between 10%\(^{15}\) and 20%\(^{16}\) of women at some point during the perinatal period.

Much previous work on perinatal health has focused on postnatal depression, however mental health problems often occur during the antenatal period and problems go beyond depression to include anxiety, psychosis, post-traumatic stress disorder and other conditions.

If untreated, these illnesses can have a devastating impact on women and their families. They are one of the leading causes of death for mothers during pregnancy and the year after birth whilst recent advances in neuroscience and other disciplines clearly suggest that psychological distress during pregnancy is also a significant risk factor for a range of adverse outcomes in the child.

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 health\(^{17}\). It is estimated that mental health problems impose a total economic and social cost of over £105bn a year\(^{18}\). 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


\(^{16}\) PSSRU. The costs of perinatal mental health problems, http://eprints.lse.ac.uk/59885/1_/lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer,%20M_Bauer_Costs_perinatal_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

\(^{17}\) Faculty of Public Health. Better Mental Health for All. http://www.fph.org.uk/better_mental_health_for_all

mental illness falls on patients and their families, with the impact on quality of life costing £53.6bn.

Taken together, perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country. Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion).

The average cost to society of one case of perinatal depression is about £74,000, and the average cost of perinatal anxiety is about £35,000 per case, with nearly three-quarters (72%) of these costs relating to adverse impacts on the child rather than the mother. The costs of perinatal psychosis to the mother alone (there is a lack of evidence regarding the impact of perinatal psychosis on the child) is about £47,000 per case.

The development and escalation of perinatal mental illnesses can often be prevented through early identification and appropriate management. Even if the illness itself is not preventable, it is possible to prevent many of the negative effects of perinatal mental illness through appropriate care and treatment. There are thus strong health and economic arguments for investment in services, which prevent and treat perinatal 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 versa.

More recently there have been calls for mental health to be valued equally with physical health or “Parity of Esteem”. This was enshrined in law by the Health and Social Care Act 2012.
Parity of esteem means that, when compared with physical healthcare, mental healthcare is characterized by:

- 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.

There is a wealth of evidence and expert consensus about what works in tackling perinatal mental illnesses and growing awareness of the importance of investment in services.

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 ages 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**

Improving Mental Wellbeing and reducing Social Isolation was identified as a priority in Bristol City Council’s Health and Wellbeing strategy of October 2013. Their Health and Wellbeing Board is currently putting together an Action Plan for the strategy and is seeking to “Identify, coordinate, and promote initiatives to address social isolation, and

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24 Royal College of Psychiatrists. Parity of esteem. [https://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx](https://www.rcpsych.ac.uk/policyandparliamentary/whatsnew/parityofesteem.aspx)

jointly agree priorities for action based on good evidence, national best practice and work together to deliver them.\textsuperscript{26}

The strategy provides relevant local context to the Dreamtime Arts project in highlighting how tackling social isolation can improve mental wellbeing and the likelihood of experiencing positive mental health. Of relevance to the Dreamtime Arts programme, the strategy argues that reducing loneliness and social isolation requires action on the part of many agencies, community groups and individuals, and highlights the need to build community resilience and promote wellbeing.\textsuperscript{27}

**Access to mental health services**

Considering mental health problems affect about one in four people, of 1000 people at risk 250 will experience a mental health problem. Of these the vast majority (about 230) 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 hospital\textsuperscript{28}.

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 all\textsuperscript{29}. 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 2015\textsuperscript{30}; this means that even when these targets are reached 85% will not have access to these services.

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.

\textsuperscript{26} Bristol Health and Wellbeing Strategy, October 2013  

\textsuperscript{27} Bristol Health and Wellbeing Strategy, October 2013  

\textsuperscript{28} Joint Commissioning Panel for Mental Health. Practical Mental Health Commissioning. A framework for local authority and NHS commissioners of mental health and wellbeing services  

\textsuperscript{29} CMOs Annual Report: employment is good for mental health (2014)  

\textsuperscript{30} NHS England. Valuing mental health equally with physical health or “Parity of Esteem”  
http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/
Treatment and support for women with perinatal mental health problems are provided by a mix of universal and specialist services and there is long-standing agreement in guidance from NICE and other national bodies on how these services should be organized and what they should provide.

Despite this, the current provision of services is widely described as patchy, with significant variations in coverage and quality around the country. For example:

- About half of all cases of perinatal depression and anxiety go undetected and many of those, which are detected, fail to receive evidence-based forms of treatment.\(^{31}\)
- Specialist perinatal mental health services are needed for women with complex or severe conditions, but less than 15% of localities provide these at the full level recommended in national guidance and more than 40% provide no service at all.\(^{32}\)
- Just 3% of CCGs in England have a strategy for commissioning perinatal mental health services and a large majority have no plans to develop one.\(^{33}\)

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 difficulties\(^{34}\).

As a result of the relatively high levels of deprivation in Easton and Lawrence Hill Wards, the data suggests that not only are those living in BS5 likely to be at greater risk of mental health problems than those living in more affluent areas, but they are also more likely to experience difficulties in accessing support - such as talking therapies – for said mental health problems.

**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 Dreamtime Arts project.

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\(^{31}\) PSSRU. The costs of perinatal mental health problems,
[http://eprints.lse.ac.uk/59885/1/_lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer,%20M_Bauer_Costs_perinatal%20mental%202014_Bauer_Costs_perinatal_mental%202014_author.pdf](http://eprints.lse.ac.uk/59885/1/_lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer,%20M_Bauer_Costs_perinatal%20mental%202014_Bauer_Costs_perinatal_mental%202014_author.pdf)

\(^{32}\) Ibid.

\(^{33}\) Ibid.

Public Mental Health Interventions
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. There is good evidence that women with perinatal mental illness can benefit from services, which increase their social support, such as support groups, or befriending services.

Asset-based community development
The Dreamtime Arts programme draws on three models, one of which is asset based community development (ABCD) model. ABCD is a localised and bottom-up way of strengthening communities through recognising, identifying and harnessing existing 'assets' (skills, knowledge, capacity, resources, experience or enthusiasm) that individuals and communities have and which can pay a role in improving and strengthening local communities. Instead of a needs based approach that focuses on what a community lacks, the approach focuses on utilising the ‘assets’ that are already there, facilitating the empowerment of individuals and communities by helping them to identify and share their strengths and to work together to create their own social innovations. 35 Lynne Freidli claims that mental health is significantly socially determined and the identification of social networks and practice that sustains community resilience should be an aim of both local government and health practitioners. 36

Work by the IDeA and the Young Foundation 37 on happiness and well-being demonstrates the potential of community and neighbourhood empowerment to improve the wellbeing of individuals and communities in three ways:

1. Control: by giving people greater opportunities to influence decisions, through participative and direct democracy rather than formal consultation exercises
2. Contact: by facilitating social networks and regular contact with neighbours
3. Confidence: by enabling people to have confidence in their capacity to control their own circumstances.

However, there remains a limited evidence base showing a link between actions to strengthen individual and community assets, and improved health. Measuring the impact of asset-based approaches on health outcomes is complex, and evidence that the approach can improve health and wellbeing largely comes from case studies at present. 38

35 London Borough of Croyd Council https://www.croydon.gov.uk/community/advice/abcommunity-dev
Psychosocial interventions

Psychosocial interventions are those that emphasize the role of psychological or social factors in mental illness rather than biological factors. NICE recommends a range of psychological interventions for postnatal depression depending on the circumstances. The guideline provides evidence on self-help approaches, listening visits, CBT and Interpersonal Psychotherapy alongside the use of anti-depressant medication for treatment of mild to moderate postnatal depression.

Peer support approach

Dreamtime Arts is a peer-support group led by a facilitator who leads a range of arts and craft activities that support health and wellbeing. The importance of social relationships in the treatment of disease and the maintenance of health and wellbeing has drawn the attention of scientists and practitioners across a large number of behavioural science and health disciplines.

Social support can lower the risk of mental illness, reduce symptoms, and improve the quality of life of people affected. Maintaining a social support network can be difficult for women with mental illness and a new baby, and therefore services can play an important role in facilitating and fostering social support networks.

Prospective population studies have established associations between measures of social relationships and mortality, psychiatric and physical morbidity and adjustments to and recovery from chronic diseases. Furthermore, interventions designed to alter the social environment and the individual’s transactions within it have been successful in facilitating psychological adjustment, aiding recovery from traumatic experiences, and even extending life for individuals with serious chronic disease.

A myriad of research has focused on the relevance of peer support with individuals who have undergone maturational or developmental life transitions. In particular, childbearing women have received considerable attention centering on the use of peer interventions to enhance prenatal care among low-income women and improve perinatal outcomes in teenagers, Hispanic migrant farmworkers, and 'high-risk' individuals.

mothers. Integrated into the postpartum period, the augmentation of social relationships (through general mother-to-mother support groups) have also been advocated. Peer support has also been employed to facilitate adjustment in women suffering from postpartum depression. These improve the mental health of mothers and young children by buffering the effects from families with significant psychosocial morbidity.

A systematic review of the literature on postpartum are found that for women at high risk of either family dysfunction or post-partum depression, peer support produced was seen as profa statistically significant reduction in Edinburgh Postnatal Depression Scores (15% vs. 52.4%, OR 6.23, 95% CI 1.40 to 27.84, p<0.01).

Health and the Arts

Since the early 1980s arts have occupied an increasingly prominent position within UK health care settings. The role of arts has been defined in relation to general changes in patterns of illness and health care in Western societies. Arts may have a key role to play in response to increased prevalence of mental health conditions, such as depression and anxiety, which demand new ways of thinking about treatment and care.

There is also an increasing body of work indicating that participation in arts-based projects can promote health and wellbeing. However, relatively little empirical evidence exists regarding the impact of arts in mental health.

References

52 Daykin, N., and Byrne, E., 2006. The impact of visual arts and design on the health and wellbeing of patients and staff in mental health care: A systematic review of the literature.
SOCIAL RETURN ON INVESTMENT

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 being 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. SROI can help to improve services in a range of ways.53

SROI measures 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 being created by measuring social, environmental and economic outcomes and uses monetary values to represent them. 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. 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.

It can help to:
- Understand the social, environmental and economic value created by your work;
- Maximise the positive change you create and identify and manage any negative outcomes arising from your work;
- Reconsider which organisations or people you should be working with, or improve the way you engage with your stakeholders;
- 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.

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The six stages of SROI analysis
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.
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 Dreamtime Arts programme run by the Wellspring Healthy Living Centre in Bristol, UK. The analysis focuses on the first 9 months of operation of the Dreamtime Arts programme and includes outcomes for all those participants who registered with the programme and received an intervention during this time (April 2014-Dec 2014).

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 impact of the Dreamtime Art programme was prepared by the Arts and Wellbeing Officer. A table outlining this initial list and reasons for inclusion in qualitative interviews are included in Appendix 1.

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

The list of stakeholders interviewed included:

- Project participants
- Dreamtime Arts Lead Artist – Facilitator of Dreamtime Art groups.
- WHLC Arts and Wellbeing Officer – Lead for the Dreamtime Arts programme and facilitator of Dreamtime Art groups.
- WHLC Chief Executive
• WHLC Trustee & Bristol City Council Public Health Advisor
• 2xWHLC Health Visitors

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. However, within the scope of this evaluation, it was not possible to interview participant’s partners, family members or friends.

Project Participants
The main beneficiaries of Dreamtime Arts are the clients who attend the Dreamtimes Art programme. Beneficiaries were all women with children who lived within BS5 postcode area. They also suffer from low to moderate common mental health depression and anxiety and/or are survivors or victims of domestic violence and abuse and/or expressed feeling isolated.

Data collected by the project provides insight into the demographics of the project participants. During the first 9 months of operation of Dreamtime Arts (April 2014-Dec 2014), 24 women attended at least one term (six of these women received two terms) of the Dreamtime Arts programme. In total, these participants attended 199 sessions out of a maximum possible total (given that not all started at the beginning of any one term) of 294 sessions.

This gives an average attendance rate of 68% with each participant attending an average of just over 8 sessions each. Attendance can be broken down into the following groups: attended for at least part of one term (n=16); attended for at least part of two terms (n=7); attended for at least part of more than three terms (1). Of the 24 participants, 58% attended at least three quarters of the available Dreamtime Arts sessions, 79% attended at least two thirds of the available sessions and just 21% attended less than half of the available sessions.

The average attendance rate for the three programme sites is as follows:

• Wellspring Healthy Living Centre: 63% (n=10)
• The Limes Nursery and Children’s Centre: 68% (n=11)
• Bannerman Road Community Academy and Children’s Centre: 80% (n=3)

The average attendance rates for the first term attended was: 66% (n=16), for the second term: 65% (n=7) and for the third term 80% (n=1).
Table 4: Attendance data for the 24 project participants.

<table>
<thead>
<tr>
<th>Total number of sessions attended</th>
<th>Possible number of sessions could have attended</th>
<th>Attendance Rate (%)</th>
<th>Dreamtime Group Attended</th>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>7</td>
<td>100</td>
<td>The Limes</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>100</td>
<td>WHLC</td>
</tr>
<tr>
<td>18</td>
<td>21</td>
<td>86</td>
<td>The Limes</td>
</tr>
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<td>10</td>
<td>12</td>
<td>83</td>
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</tr>
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<td>21</td>
<td>26</td>
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</tr>
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<td>4</td>
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</tr>
<tr>
<td>4</td>
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<td>Bannerman Road</td>
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<td>15</td>
<td>19</td>
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<td>16</td>
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<td>18</td>
<td>WHLC</td>
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<td>The Limes</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>8</td>
<td>The Limes</td>
</tr>
</tbody>
</table>

The data presented in Table 5 are for these 24 participants. Limited information is available about those who did not engage meaning that we do not have demographic data for these individuals or any information pertaining as to why they did not attend. All were female. Many participants reported being in touch with other services provided by WHLC. 95% of referrals came from health visitors and family support workers. The other 5% were referred by their GP/Primary care.

The average age of the participants was 34 years (SD 5.5); the majority (62.5%) were white British and the large majority (87.5%) spoke English as their first language.

Dreamtime Arts does not collect employment or health data for the project participants. However, all women referred to the project meet the terms of reference and so at the point of reference will be:
• Experiencing a low to moderate common mental health disorder, namely post-natal depression and anxiety;
• Survivors or victims of domestic violence and abuse;
• Feeling isolated.

All data available from project participants has been included in quantitative data analysis. In total two focus groups were undertaken with project participants (8 participants in total) to gather qualitative data.

Table 5: Project participants – demographics (n=24)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>100%</td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-22 years</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>23-27 years</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>28-32 years</td>
<td>8</td>
<td>33.3%</td>
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<td>33-37 years</td>
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<td>38-42 years</td>
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<td>16.7%</td>
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<td>43-47 years</td>
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</tr>
<tr>
<td>48+ years</td>
<td>2</td>
<td>8.3%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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<tr>
<td>White British</td>
<td>15</td>
<td>62.5%</td>
</tr>
<tr>
<td>Black or Black British - Caribbean</td>
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<td>12.5%</td>
</tr>
<tr>
<td>Mixed – White and Black Caribbean</td>
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</tr>
<tr>
<td>Asian or Asian British</td>
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<td>4.2%</td>
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<td>Black or Black British – African</td>
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<td>4.2%</td>
</tr>
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<td>Black or Black British – African Somali</td>
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<td>4.2%</td>
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<tr>
<td>Black or Black British</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>White Other</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td><strong>First Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>21</td>
<td>87.5%</td>
</tr>
<tr>
<td>Somali</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>Lao</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td>Not Known</td>
<td>1</td>
<td>4.2%</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>100%</td>
</tr>
</tbody>
</table>

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 total expenditure for Dreamtime Arts in 2014/15 was £18,223. This includes funding for a full-time Wellbeing Worker, general overheads and running expenses for the project and some funding for training for WHLC staff and volunteers and project participants. This figure does not include the unpaid overtime of the Dreamtime lead Artist although this is factored into the impact map.

Table 6: Dreamtime Arts expenditure 2014/15

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>9,043</td>
</tr>
<tr>
<td>Management and Administration</td>
<td>3,324</td>
</tr>
<tr>
<td>Rent and Services</td>
<td>461</td>
</tr>
<tr>
<td>Crèche</td>
<td>2,610</td>
</tr>
<tr>
<td>Room Hire (including catering and provisions)</td>
<td>885</td>
</tr>
<tr>
<td>Telephone, Stationery, Printing and Postage</td>
<td>-</td>
</tr>
<tr>
<td>Materials</td>
<td>303</td>
</tr>
<tr>
<td>Equipment</td>
<td>-</td>
</tr>
<tr>
<td>Dreamtime Artists Fees</td>
<td>1,597</td>
</tr>
<tr>
<td>Membership and Advertising</td>
<td>-</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>18,223</td>
</tr>
</tbody>
</table>

Mapping outputs - data collection methods
Quantitative and qualitative data have been used to inform this SROI. The WHLC Arts and Wellbeing Officer has established methods for 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
  o Gender
  o Age
  o Race/Ethnicity
  o Number of Children
  o First Language

• Wellbeing Questionnaire Data – baseline, 5 weeks, 10 weeks (final session)
  o Mental Ill-health: Depression (PHQ-9)
  o Mental Ill health: Anxiety (GAD-7)
  o Physical activity
  o General Life Satisfaction
  o Social wellbeing (Friendship Scale)
  o Personal Wellbeing (ONS)

### Impact Map 1: Inputs and Output

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended/unintended changes</th>
<th>Inputs</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who do we have an effect on? Who has an effect on us?</td>
<td>What do you think will change for them?</td>
<td>What do they invest?</td>
<td>What is the value of the inputs in currency (£)?</td>
</tr>
<tr>
<td>Big Lottery funders</td>
<td>Intended project outcomes achieved</td>
<td>Funding</td>
<td>18,223</td>
</tr>
<tr>
<td>WHLC project staff including Arts and Wellbeing officer, Crèche staff and centre manager.</td>
<td>Time, commitment, skills and experience</td>
<td>Time - cost included in funding above</td>
<td>0</td>
</tr>
<tr>
<td>Lead Artist</td>
<td>Time commitment, skills and experience</td>
<td>Unpaid overtime – cost not included in funding above (50 hours)</td>
<td>812.50</td>
</tr>
<tr>
<td>Project participants – women with pre-school children who live in BS5; who are; experiencing low to</td>
<td>Reduced Depression</td>
<td>Time</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Reduced social isolation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved Wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Category</td>
<td>Description</td>
<td>Time</td>
<td>Notes</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>Supported into using crèche / child-care options – Increased independence</td>
<td></td>
<td>moderate mental health disorders, survivors or victims of domestic violence and abuse, feeling isolated.</td>
</tr>
<tr>
<td>Children of the project participants</td>
<td>Reduced social isolation / increased social contact</td>
<td>Time</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Increased independence / reduction of separation anxiety</td>
<td></td>
<td>40 children attended one or more ten-week terms of the crèche facilities at WHLC for two hours a week (13 children attended for two terms).</td>
</tr>
<tr>
<td></td>
<td>Improved emotional, cognitive and physical development as a result of improvement in mother’s wellbeing and ability to care for child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and friends of project participants</td>
<td>Improvement in mental health of participants could impact on their relationships with others, and perhaps also on others caring responsibilities.</td>
<td>Time and support to participants</td>
<td>0</td>
</tr>
<tr>
<td>Staff from WHLC and local partner organisations that refer to Dreamtime Arts</td>
<td>Referral route to and from project for extra support for their clients.</td>
<td>Time, commitment, skills and experience</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td><strong>£19,034,73</strong></td>
</tr>
</tbody>
</table>
**Stage 3: Evidencing outcomes and giving them a value**

This stage involves finding data to show whether outcomes have happened and then monetizing the impact to assess their value. As discussed above, the Arts and Wellbeing officer has established methods for collecting baseline and follow-up data from project participants. This enabled quantitative data analysis to be undertaken. Qualitative data captured through two focus groups undertaken with project participants tell, alongside interviews with a range of other stakeholders, the stories of change experienced by project participants and enables us to document outcomes to be valued.

Details of the qualitative focus group and interview schedules are included, alongside the tools used to collect quantitative data, in the appendices.

**Qualitative data analysis – stories of change**

The following data and quotes from Dreamtime Art participants and stakeholders give a sense of how participants felt about first attending the project, as well as providing useful indicators of the impact the programme has had on them, and thus of the project outcomes.

*I did an art degree and that’s my main thing that I like in life, and of course as soon as you have a baby you have to give everything up forever and you can’t just get art stuff out because that is just silly. I don’t really have parents nearby who look after him so I’d never had a break from him, ever, so the childcare bit of it was absolutely amazing.*

Project participant

*I was quite low, the doctors rang me regularly to keep a check on me, and I think the doctor must have got in touch with the health visitor because I didn’t know anything about the art-group. I got a message from the health visitor saying there is a place on the art group for you where your son can go in the crèche and I thought oh god that sounds awful because I can’t stand doing art things!*  

Project participant

*I saw this happening and asked about it. I was really excited, but also nervous, not about meeting the group but about leaving my boy in the crèche for the first time, because I had never done that before.*

Project participant

These quotes give a sense of the range of reasons why, once referred by their GP, family support worker or health visitor, women attended the Dreamtime Arts groups and some of the hurdles they had to overcome in attending. Some women were excited about the arts and crafts dimension of the programme, whilst others were excited about having a break from childcare. Conversely, other participants found the
arts and craft element off-putting or were worried about leaving their children in the crèche.

I had one mum who went and she wrote to me telling me it was wonderful, and several of the mum’s I have referred, it was difficult to get them out, they enjoyed it so much. Initially it might have been for mental health issues but then it became a social outlet.

Stakeholder, health visitor who refers to Dreamtime Arts

The feeling of community, that I’m not the only person feeling like this, that is hugely relieving for a lot of mums. One mum said to me ‘I don’t have to talk about anything, I don’t have to disclose my feelings, it’s not like that in groups’, its ok if they do but they don’t feel like there is an obligation.

Stakeholder, health visitor who refers to Dreamtime Arts

It is about the community supporting each other, rather than being seen as going through treatment, physical intervention and the risk associated with it. They just come for a social activity, an opportunity for people to offload their stress, where they can spend time with other mothers and share their experiences, you are not just dealing with the symptoms but you are dealing with the root of the problem as well.

Stakeholder, WHLC Trustee & Bristol City Council Public Health Advisor

The list below provides a summary of the positive outcomes experienced by individual participants identified from qualitative data:

- Improved mental wellbeing: more positive outlook, lower levels of stress and anxiety;
- Mental stimulation as a result of creative endeavor;
- Sense of pride and self-worth as a result of creative achievement;
- Increased confidence: in self as an individual and as a mother;
- Reduced social isolation: new friendships, support network and sense of community;
- Improved relationships with partner and other family members;
- Increased resilience and ability to manage stress;
- Increased sense of independence: confidence to use child-care;
- Suicide prevention.

Quantitative data analysis

Quantitative data provides supporting evidence for the stories outlined above and enables estimates to be made of how many project participants experience the outcomes described. The results show improvements in all aspects of wellbeing measured.
Mental Ill-health: Depression

Depression is assessed as part of the Dreamtime Arts programme using the nine-point Patient Health Questionnaire (PHQ-9). Developed by Kroenke et al., the PHQ-9 is one of the most commonly used depression measurement scales. PHQ-9 has the following answer categories: not at all, various days, more than half the days and almost every day. Respectively zero, one, two or three points were scored and a summed score of the nine questions was calculated. The questions refer to the situation in the previous two weeks. This questionnaire is based on the Diagnostic and Statistics Manual of Mental Disorders-IV (DSM-IV) criteria for diagnosing major depressive disorders in patients with medical illnesses. It provides a score 0-27. Cut-off points of: 5, 10, and 15 represent mild, moderate, and severe levels of depressive symptoms.

Scores for 26 participants were available at baseline; 6 (23%) had a score of 15 or more (mean score 18.5) indicating that they had severe depressive symptoms, 10 (38%) had a score of 10 or more indicating that they had moderate depressive symptoms, and a further 6 (23%) had a score of 5 of more indicating that they had mild depressive symptoms. Only four participants (15%) had a score of less than 5.

Matched scores for the first and final session were available for 19 participants.

They show a fall in the mean score from 11.74 (SD 5.84) to 10. (SD 5.17)

**Chart 1: Individual changes in depression score between first and final session (n=19)**

When explored further the data shows that the majority (53%) experienced a reduced score between start and end of the intervention (mean score -5, SD 4.2) indicating less depressive symptoms, one participant (5%) experienced no change and 8 (42%) experienced an increased score (mean score +2.1, SD 1.7).

---

Scores were available for a matched sample of 19 participants.

P value and statistical significance:
The two-tailed P value equals 0.1291
By conventional criteria, this difference is considered to be not statistically significant.

Confidence interval:
The mean of first session minus second session equals 1.74
95% confidence interval of this difference: From -0.56 to 4.03

The available data does however show that the majority of participants did experience a reduced depression score. The number of participants who reported a reduction in depressive symptoms, alongside other positive qualitative findings and the quantitative
evidence available, suggests that the Dreamtime Arts programme has had a positive impact on some participant’s depression.

**Mental Ill health: Anxiety**

Anxiety is assessed as part of the Dreamtime Arts programme using the seven point Generalized Anxiety Disorder Questionnaire developed by Spitzer et al\(^5\). The GAD-7 score is calculated by assigning scores of: 0, 1, 2, and 3, to the response categories of *not at all, several days, more than half the day,* and *nearly every day,* respectively, and adding together the scores for seven questions. Possible scoring range is 0-21. Scores of 5, 10, and 15 are taken as the cut off points for: mild, moderate, and severe anxiety, respectively. The questions refer to the situation in the previous two weeks.

Scores for 26 participants were available at baseline; 4 (15%) had a score of 15 or more (mean score 8.8, SD 5.9) indicating that they had severe symptoms of anxiety, 10 (38%) had a score of 10 or more indicating that they had moderate symptoms of anxiety, and a further 8 (31%) had a score of 5 of more indicating that they had mild symptoms of anxiety. Only 4 participants (15%) had a score of less than 5.

Matched scores for the first and final session were available for 19 respondents.

They show a fall in the mean score from 10.74 (SD 4.74) to 9.68 (SD 5.55).

**Chart 3: Individual changes in anxiety score between first and final session (n=19)**

When explored further the data shows that the majority (56%) experienced a reduced score between start and end of the intervention, indicating less symptoms of anxiety, six participants (23%) experienced no change and 4 (21%) experienced an increased score, indicating greater symptoms of anxiety.

Scores were available for a matched sample of 19 participants.

**P value and statistical significance:**
- The two-tailed P value equals 0.2886
- By conventional criteria, this difference is considered to be not statistically significant.

**Confidence interval:**
- The mean of first session minus final session equals 1.05
- 95% confidence interval of this difference: From -0.97 to 3.08

The available data however show that the majority of participants did experience a reduced anxiety score. The number of participants who reported a reduction in symptoms of anxiety, alongside other positive qualitative findings and the quantitative evidence available, suggests that the Dreamtime Arts programme has had a positive impact on some participant’s anxiety.

**Overall Life Satisfaction**
Overall life satisfaction was assessed using the 4 ONS wellbeing questions. These widely used questions have a 10-point rating: (0 very low, and 10 very high).

All things considered, how satisfied are you with your life as a whole nowadays? Matched scores for the first and final session were available for 14 respondents. They show an increase in the mean score from 4.79 (SD 1.48) to 6.50 (SD 0.94)
P value and statistical significance:
The two-tailed P value equals 0.0005. By conventional criteria, this difference is considered to be statistically significant.

Confidence interval:
The mean of final session minus first session equals 1.64
95% confidence interval of this difference: From 0.63 to 2.65

Overall how happy did you feel yesterday?
Matched scores for the first and final session were available for 13 respondents. They show an increase in the mean score from 5.21 (SD 1.76) to 6.5 (SD 1.61)
Chart 6: How happy did you feel yesterday? Start (series 1) and Finish (series 2) ($n=13$)

P value and statistical significance:
The two-tailed P value equals 0.0568
By conventional criteria, this difference is considered to be not statistically significant.

Confidence interval:
The mean of final session minus first session equals 1.29
95% confidence interval of this difference: From -0.04 to 2.61

Overall how anxious did you feel yesterday?
Matched scores for the first and final session were available for 13 respondents. They show an increase in the mean score from 4.79 (SD 2.08) to 5 (SD 2.22)

Chart 7: How anxious did you feel yesterday? Start (series 1) and Finish (series 2) ($n=13$)
P value and statistical significance:
The two-tailed P value equals 0.6844
By conventional criteria, this difference is considered not to be statistically significant.

Confidence interval: The mean of final session minus first session equals 0.21
95% confidence interval of this difference: From -0.90 to 1.33

Overall to what extent do you feel the things you do in your life are worthwhile?
Matched scores for the first and final session were available for 14 respondents. They show an increase in the mean score from 5.86 (SD 1.46) to 7.21 (SD 1.31)

Chart 8: Overall to what extent do you feel the things you do in your life are worthwhile? Start (series 1) and Finish (series 2) (n=14)

P value and statistical significance:
The two-tailed P value equals 0.0011
By conventional criteria, this difference is considered to be very statistically significant.

Confidence interval:
The mean of final session minus first session equals 1.36
95% confidence interval of this difference: From 0.66 to 2.06

Overall 13 (93%) of the matched pairs showed an overall increase in Wellbeing score when the four aggregate scores were combined.

P value and statistical significance:
The two-tailed P value equals 0.0036
By conventional criteria, this difference is considered to be very statistically significant.

Confidence interval:
The mean of final session minus first session equals 3.86
95% confidence interval of this difference: From 1.51 to 6.21

Social Isolation
Social isolation was measured using the 6-item friendship scale. Each item is scored 1-5 to the response categories Never, Occasionally, About half the time, Most of the time and Always. The responses are added and six then being removed from the total, producing a possible score of 0-24. A score of 0-15 indicates low friendship acuity, 16-18 indicates moderate friendship acuity and 19-24 indicates high friendship acuity.

Matched scores for the first and final session were available for 13 respondents. They show an increase in the mean score from 12.85 (SD 3.44) to 14.85 (SD 3.21).

Chart 9: Individual changes in friendship scale score between first and final session (n=13)

When explored further, the data shows that 11 (85%) participants experienced an increased friendship scale score, indicating increased friendship acuity with one participant experiencing no change, and 1 participating experiencing a decreased friendship scale score.

---

Chart 10: Friendship scale scores for individual participants at start (series 1) and finish (series 2) (n=13)

P value and statistical significance:
The two-tailed P value equals 0.0031
By conventional criteria, this difference is considered to be very statistically significant.

Confidence interval:
The mean of final session minus first session equals 2.00
95% confidence interval of this difference: From 0.82 to 3.18

Physical activity
The Wellbeing questionnaire asks participants to list how many days in the past week they have undertaken mild, moderate and vigorous exercise.

At baseline 26 participants completed this question. Matched scores for the baseline and final session were found for 19 participants regarding the mild and moderate exercise questions and for 18 participants with regards to the vigorous exercise question.

During the last week, on how many days did you walk for at least 10 minutes at a time? Matched scores for this question showed an increase in the mean score from 5.42 days (SD 1.68) to 5.79 days (SD 1.69). Nine (47%) of the matched pairs showed an increase in the number of days they walked for at least ten minutes at a time between baseline and final session. Nine matched pairs showed no change and one pair showed a decrease.

There is a single outlying participant in this data set (see figure eleven). This result shows a drop in exercise from seven days a week of walking at least ten minutes a day, to one day per week and is a remote outlier in relation to the rest of the data set. The same participant’s response to the moderate exercise question also reveals this same
drop from seven days to one day. If this anomalous finding is removed from the data set, the mean score changes to 5.33 (SD 1.68) for the baselines score and 6.06 for the final session (SD 1.26).

**Chart 11: During the last week, on how many days did you walk for at least 10 minutes at a time? Baseline (series 1) and Final session (series 2) (n=19)**

P value and statistical significance (with outlier removed):
The two-tailed P value equals 0.0032
By conventional criteria, this difference is considered to be very statistically significant.

Confidence interval:
The mean of final session score minus baseline session scores equals 0.72
95% confidence interval of this difference: From 0.28 to 1.17

During the last week on how many days did you do moderate exercise?
The mean of the final session scores were 0.56 lower than the baseline scores (confidence interval -0.13, 1.24). However these findings were not statistically significant.

During the last 7 days, on how many days did you do vigorous physical activities?
The mean of the final session scores were 0.18 higher than the baseline scores (confidence interval -1.09, 0.74). However, these findings were not statistically significant.

**Longer-term outcomes**
Because of the short-term nature of the work it is not always possible to know what happens to participants in the longer term or indeed how much is attributable to the project. However, analysis of qualitative data collected at each session and discussion with the Dreamtime Artist and the Arts and Wellbeing Worker officer identified some stories of further change.

The Artist and Wellbeing Worker were aware of:
- Participants have set up an online etsy shop (www.etsy.com/uk) to sell items that they learnt to make during the Dreamtime Arts programme;
- Participants are going on to enroll in other classes at WHLC including the Art-shine group;
- Participants enrolling in a creative class at City of Bristol College;
- Participants supporting each other by looking after each other’s children, and in one case even assisting in the running of their small business.

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.

Table 7: example chain of events

<table>
<thead>
<tr>
<th>Reason for accessing Dreamtime Arts</th>
<th>Immediate outcomes experienced Dreamtime Arts group sessions</th>
<th>Outcomes measured through data tools</th>
<th>Longer term impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low mood</td>
<td>Feeling of being listened to, understood, encouraged, reassured and emotionally supported</td>
<td>Depression</td>
<td>Getting out more, attending other classes as able to leave child with friends/family due to increased confidence of mother and child / child able to attend nursery/other groups</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>Anxiety</td>
<td>Increased sense of self-worth, lower levels of stress and increased ability to care for children leading to improved social, cognitive and emotional outcomes for child</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td>Wellbeing</td>
<td>Improved relationship with partner</td>
</tr>
<tr>
<td>Child suffering from separation anxiety</td>
<td>More relaxed as a result of having a break from child-care more able to cope</td>
<td>Social Isolation</td>
<td>Network of friends able to assist with child-care and provide emotional support</td>
</tr>
<tr>
<td>Struggling to care for child but unwilling / unable to take break from child-care</td>
<td>Increased self-esteem as a result of doing something for oneself</td>
<td>Physical activity</td>
<td>Improved sense of wellbeing</td>
</tr>
<tr>
<td>Waiting to attend Dreamtime Arts</td>
<td>Social interaction for child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long term impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting out more, attending other classes as able to leave child with friends/family due to increased confidence of mother and child / child able to attend nursery/other groups</td>
</tr>
<tr>
<td>Increased sense of self-worth, lower levels of stress and increased ability to care for children leading to improved social, cognitive and emotional outcomes for child</td>
</tr>
<tr>
<td>Improved relationship with partner</td>
</tr>
<tr>
<td>Network of friends able to assist with child-care and provide emotional support</td>
</tr>
<tr>
<td>Improved sense of wellbeing</td>
</tr>
</tbody>
</table>
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 focused 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 the income of the project participants were low and thus they had a limited ability to pay. When identifying proxies it is important to remember that we are not interested in whether money actually changes hands.

All 8 of the participants interviewed in the two focus groups would have been willing to pay something to attend the service. Perhaps more significant than the amount of money that women were willing to pay, which they were reluctant to discuss, was the fact that both focus groups talked about how they had thought about setting up their own groups so that they could continue to meet and carry out creative activities, but were struggling to do this as a result of the cost of child-care.
There is such a motivation to keep it going on, they all discuss whether they could hire me at a different time, and hire a space, but it just wouldn’t be the same for them with the children, so that has kind of been the stumbling block, so they get together and have a cup of tea.
Dreamtime Stakeholder, Lead Artist.

We would all pay a contribution towards it [An Art group], but we were told it would be so expensive...
Dreamtime participant.

You have to hire the room and hire the people, and there have to be two people.
Dreamtime participant.

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

Impact Map 2: Outcomes included in SROI

<table>
<thead>
<tr>
<th>How would the stakeholder describe the changes?</th>
<th>How would you measure it?</th>
<th>Where did you get the information from?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced symptoms of anxiety</td>
<td>Number of participants reporting reduced symptoms of anxiety</td>
<td>GAD-7 Anxiety recorded at baseline and follow-up</td>
</tr>
<tr>
<td>Improved social wellbeing</td>
<td>Number of participants who report improved social wellbeing and improved relationships with partner and other family members</td>
<td>Friendship Scale- social wellbeing recorded at baseline and follow-up. Participant and stakeholder interview</td>
</tr>
<tr>
<td>Improved levels of physical activity</td>
<td>Number of participants reporting improved physical activity</td>
<td>Number of days mild, moderate and strenuous exercise recorded at baseline and follow up</td>
</tr>
<tr>
<td>Improved mental well-being.</td>
<td>Number of participants reporting improved mental well-being</td>
<td>ONS 4 Wellbeing Questions recorded at baseline and follow-up</td>
</tr>
<tr>
<td>Reduced symptoms of depression</td>
<td>Number of participants reporting reduced symptoms of depression</td>
<td>PHQ-9 Depression recorded at baseline and follow-up</td>
</tr>
<tr>
<td>Support into use of crèche / child-care</td>
<td>Number of participants who successfully use crèche for the first time</td>
<td>Participant and stakeholder interview</td>
</tr>
<tr>
<td>How would the stakeholder describe the changes?</td>
<td>How would you measure it?</td>
<td>Where did you get the information from?</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>Number of participants who state that attending Dreamtime Arts prevented them from committing suicide</td>
<td>Participant and stakeholder interview</td>
</tr>
</tbody>
</table>

**Impact Map 3: Outcomes and proxy values**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Proxy</th>
<th>Evidence Source for Proxy</th>
<th>Value per unit £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced symptoms of anxiety</td>
<td>Cost of counseling</td>
<td>Cost of local counseling service – initial 6-week course. <a href="http://www.counselling-directory.org.uk/region_85.html?uqs=752606">Link</a></td>
<td>£30/session for 6 weeks £180</td>
</tr>
<tr>
<td>Improved social wellbeing</td>
<td></td>
<td>The contact is generally for an hour per week or fortnight. The cost to public services of 12 hours of befriending contact is Estimated at £60, based on the lower end of the Cost range for befriending interventions. <a href="http://www.pssru.ac.uk/project-pages/unit-costs/2014/">Link</a></td>
<td>£60-120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost of social club membership and attendance at activities <a href="http://www.spicebristolcardiff.com">Link</a></td>
<td>£144/year</td>
</tr>
<tr>
<td>Improved physical activity</td>
<td>Cost of gym membership/local activity</td>
<td>Gym casual session (Healthy Hearts) <a href="http://www.everyoneactive.com/Uploads/Media/Price_Lists/Easton.pdf">Link</a></td>
<td>£ 2.10/week</td>
</tr>
<tr>
<td>Improved mental well-being.</td>
<td>A course of CBT to build psychological resilience and self-esteem</td>
<td>A course of CBT to build psychological resilience and self-esteem. A course of CBT may last for 10 sessions at £93 per session <a href="http://www.pssru.ac.uk/uc/uc.htm">Link</a></td>
<td>£930</td>
</tr>
<tr>
<td>Reduced symptoms of depression</td>
<td>Six sessions of CBT</td>
<td>The cost of six sessions of CBT at £93 per session <a href="http://www.pssru.ac.uk/uc/uc.htm">Link</a></td>
<td>£558</td>
</tr>
<tr>
<td>Support into use of crèche / child-care</td>
<td>Eight hours of crèche provision</td>
<td>The cost of eight hours of crèche provision <a href="http://www.familyandchildcaretrust.org/chi">Link</a></td>
<td>£35</td>
</tr>
<tr>
<td>Outcome</td>
<td>Proxy</td>
<td>Evidence Source for Proxy</td>
<td>Value per unit £</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>

**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 Dreamtime Arts 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 Dreamtime Arts. It was clear from conversations with the participants that they felt very little would have changed for the project participants without this programme.

An alternative way to calculate deadweight is to look at population level data. The Public Health Outcomes Framework[^57] includes some measures of population wellbeing captured by the ONS Annual Population Survey. Data about two aspects of wellbeing (low happiness, high anxiety) is available for each Local Authority in England for two time periods; 2012/13 and 2013/14. This data suggests that overall there may have been some small but significant increase in wellbeing at a population level; however in Bristol there may have actually been a small decrease during the same time period.

These population level changes indicate that none of the improvement in wellbeing for Dreamtime Arts participants may have happened without the project and in fact that wellbeing might have decreased without the project. However, given that many participants did engage in other projects whilst attending Dreamtime Arts, it would 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, in attending Dreamtime Arts, have participants stopped attending an alternative value generating activity in order to be there? Interviews with stakeholders and participants revealed very limited evidence of displacement. Many participants said that without the Dreamtime programme they would still be stuck at home with their young children, with many of the mothers never having even used child-care before.

Displacement for this project has thus been calculated at 5%. This is a relatively low value but given the type of intervention and the fact that participants involved are young mothers,

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 your organisation). It shows the part of deadweight for which there may be 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.

This again is difficult to judge. Many participants were receiving support from other services and agencies in addition to the Dreamtime Art programme. However, the reasons for this contact were different, and indeed many clients and other stakeholders described the lack of alternative services available to meet the specific needs met by Dreamtime Arts.

In selecting outcomes and financial proxies to include in the SROI great efforts have been made to take into account what proportion of change it would be reasonable to assign to Dreamtime Arts alone. Given the efforts to take into account attribution within the proxies themselves, and reflecting on values for attribution used in similar SROI calculations undertaken as part of the SWWB evaluation it was felt that 20% attribution is a fair estimate.

**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 Her Majesty’s Treasury Green Book 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 Dreamtime Arts provides only a short intervention in the lives of participants who often have quite complex and chaotic lives, it is difficult to judge how long the impact of Dreamtime Arts 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.

**Impact Map 4: Outcomes and Values for cohort**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quantity</th>
<th>n</th>
<th>Financial Proxy</th>
<th>Value per participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants reporting reduced symptoms of anxiety</td>
<td>Reduction in 47% participants where data available</td>
<td>9</td>
<td>The cost of six sessions of counseling</td>
<td>9x180= £1,620</td>
</tr>
<tr>
<td>Number of participants who report improved social wellbeing and improved relationships with partner and other family members</td>
<td>Improvement in 85% participants where data available</td>
<td>11</td>
<td>Cost of social club membership and attendance at activities</td>
<td>11x100= £1,100</td>
</tr>
</tbody>
</table>

---

58 Refer to Weld, S., Healthy Connections – For All Healthy Living Centre, South Ward, Weston-super-Mare, Evaluation and Social Return on Investment (SROI) Analysis
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quantity</th>
<th>n</th>
<th>Financial Proxy</th>
<th>Value per participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants reporting improved physical activity</td>
<td>Improvement in 42% participants where data available</td>
<td>8</td>
<td>Cost of gym membership/local activity session. Calculated as 1 session per fortnight for one year.</td>
<td>8x50.40= £403.20</td>
</tr>
<tr>
<td>Number of participants reporting improved mental well-being.</td>
<td>Improvement in 93% participants where data available</td>
<td>13</td>
<td>A course of CBT to build psychological resilience and self-esteem</td>
<td>13x930= £12,090</td>
</tr>
<tr>
<td>Reduced symptoms of depression</td>
<td>Reduction in 53% participants where data available</td>
<td>10</td>
<td>The cost of six sessions of CBT</td>
<td>10x558= £5,580</td>
</tr>
<tr>
<td>Support into use of crèche / child-care</td>
<td>Valid for 50% of participants who took part in focus groups</td>
<td>4</td>
<td>Eight hours of crèche provision</td>
<td>4x35= £140</td>
</tr>
<tr>
<td>Suicide Prevention</td>
<td>Stated by one (12.5%) of participants who took part in focus groups</td>
<td>1</td>
<td>The value of delayed suicide prevention for one year</td>
<td>1x66,797= £66,797</td>
</tr>
</tbody>
</table>

**Total value = £87,730.20**

**Impact Map 5: outcomes and values scaled up for all 24 participants**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Quantity</th>
<th>( N ) (scaled up for n=24)</th>
<th>Financial Proxy</th>
<th>Value per participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants reporting reduced symptoms of anxiety</td>
<td>Reduction in 47% participants where data available</td>
<td>11</td>
<td>The cost of six sessions of counseling</td>
<td>11x180= £1,980</td>
</tr>
<tr>
<td>Number of participants who report improved social wellbeing and improved relationships with partner and other family members</td>
<td>Improvement in 85% participants where data available</td>
<td>20</td>
<td>Cost of social club membership and attendance at activities</td>
<td>20x100= £2,000</td>
</tr>
<tr>
<td>Number of participants reporting improved physical activity</td>
<td>Improvement in 42% participants where data available</td>
<td>10</td>
<td>Cost of gym membership/local activity session. Calculated as 1 session per fortnight for one year.</td>
<td>10x50.40= £504</td>
</tr>
</tbody>
</table>
Outcome | Quantity | Financial Proxy | Value per participant
---|---|---|---
Number of participants reporting improved mental well-being. | Improvement in 93% participants where data available | A course of CBT to build psychological resilience and self-esteem | 22x930= £20,460
Reduced symptoms of depression | Improvement in 53% participants where data available | The cost of six sessions of CBT | 13x558= £7,253
Support into use of crèche / child-care | Valid for 50% of participants who took part in focus groups | Eight hours of crèche provision | 12x35= £420
Suicide Prevention | Stated by one (12.5%) of participants who took part in focus groups | The value of delayed suicide prevention for one year | 1x66,797= £67,797

Due to the extremely high value generated by 1 year of suicide prevention and the fact that only one of the participants from the focus groups stated this outcome, this outcome has not been scaled up. If this outcome were to be scaled, an additional £135,594 of social value could be added.

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

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 24 participants who received an intervention in the first year of the Dreamtime Arts project calculated from this analysis is £65,252.24. Full details of how this has been calculated are shown in the impact map below.

**Stage 5: Calculating the SROI.**
The sections above present all the information required to calculate an SROI. This final section summarizes the financial information recorded in the previous stages to

Total value = £100,414
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 24 participants who attended the Dreamtime Arts group in the first 12 months of the Dreamtime Arts project. This and includes information about outcomes for no longer than 3 years after the intervention began. SROI allows value of the change in future years to be projected and the value over all projected years totaled.

There is an absence of data recording the long-term post intervention outcomes. It is possible that some of the impacts observed in participants will last in to the future and therefore continues to be of value to participants and the wider community. The concept of drop-off is discussed above. Since Dreamtime Arts provides only a short intervention, it is difficult to judge how long the impact of Dreamtime Arts alone is likely to last and what proportion can be attributed to it in the longer term. Other SROI reports have used drop-off values in the range of 10% for wellbeing outcomes. However this seems low, especially given the feedback from the project participants.

> I definitely feel more confident and I definitely feel happier when I go away from here, so yeah that has changed things in my broader life because my partner has benefitted from it, but unfortunately I can’t see that extending on much further than the time that I spend here because if I don’t come here and I don’t gain that snippet of happiness then it’s just going to be normal day to day craziness doing what I do.
> Dreamtime Participant.

The SROI therefore caps the duration for all outcomes to a maximum of three years and estimates a drop off of up to 75% for many outcomes. These percentages are detailed on the impact map.

**Net present value**
Using these assumptions the Present Value of the Dreamtime Arts benefits can be calculated for the first year of the project and subsequent years. Deducting the total input (£19,035.50) provides the Net Present Value (NPV).

**Table 8: Net Present Value calculation (12 months)**

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input (12 months)</td>
<td></td>
<td></td>
<td>£19,035.50</td>
</tr>
<tr>
<td>Present value of each year</td>
<td>£67,999.87</td>
<td>£1,026.00</td>
<td>£769.50</td>
</tr>
<tr>
<td>Present value of each year after discounting</td>
<td>£65,700.36</td>
<td>£957.78</td>
<td>£694.04</td>
</tr>
<tr>
<td>Total Present Value (PV)</td>
<td></td>
<td></td>
<td>£67,352.18</td>
</tr>
<tr>
<td>Net Present Value (PV minus the investment)</td>
<td></td>
<td></td>
<td>£48,316.68</td>
</tr>
</tbody>
</table>
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 Dreamtime Arts the ratio is 1:3.54

This means that the analysis estimates that for every £1 invested in Dreamtime Arts there is £3.54 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 Dreamtime Arts the ratio is 1:2.54

This means that the analysis estimates that for every £1 spent on Dreamtime Arts there is £2.54 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. It is also worth noting that the SROI ratio could be significantly higher than the 3.54 stated, if for example the
outcome for suicide prevention is scale up to the entire cohort; then the ratio more than doubles to £8.18. When estimating the economic cost of post-natal depression, the PSSRU estimated that three quarters of the costs to society incurred by perinatal depression, anxiety and psychosis related to adverse impacts on the child rather than the mother. This analysis has focused almost entirely on the benefit of the Dreamtime Arts group to the mothers, as we were unable to measure any long-term impact on the children. Even if the long term benefits to the children of the participants was only estimated to be equal to that experienced by the mothers, the SROI ratio would double to £7.08.

Table 9: Sensitivity analyses - changes to estimates of deadweight, attribution and drop-off

<table>
<thead>
<tr>
<th>Sensitivity Analysis</th>
<th>Social Return Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings from analysis</td>
<td>£3.54</td>
</tr>
<tr>
<td>Increasing deadweight to 50%</td>
<td>£1.97</td>
</tr>
<tr>
<td>Increasing displacement to 20%</td>
<td>£2.98</td>
</tr>
<tr>
<td>Increasing attribution to 50%</td>
<td>£2.21</td>
</tr>
<tr>
<td>Changing drop-off to 75% for all outcomes</td>
<td>£4.49</td>
</tr>
<tr>
<td>Changing drop-off to 50% for all outcomes</td>
<td>£5.92</td>
</tr>
<tr>
<td>Removal of depression, anxiety and social wellbeing outcomes (to avoid double counting with improved mental wellbeing)</td>
<td>£3.06</td>
</tr>
<tr>
<td>Removal of suicide prevention for one year outcome</td>
<td>£1.22</td>
</tr>
<tr>
<td>Doubling value to take into account unmeasured positive outcomes for child</td>
<td>£7.08</td>
</tr>
<tr>
<td>Scaling up suicide prevention for one year outcome to full cohort</td>
<td>£8.18</td>
</tr>
</tbody>
</table>

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 SROI ratio of £1.77.

The outcome valued highest in the analysis is delayed suicide prevention for one year, accounting for around two thirds of the total value of the project. However, even removing the value generated by this outcome (which could be significantly higher as this was the only outcome that wasn’t scaled up for the whole cohort), the SROI ratio remains positive. Other outcomes that have a relatively high value are improved

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60 PSSRU The costs of perinatal mental health problems, http://eprints.lse.ac.uk/59885/1/_lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer,%20M_Bauer_Costs_perinatal_mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf
mental wellbeing, reduced symptoms of depression, improved social wellbeing and reduced symptoms of anxiety.

Table 10: value of outcomes in SROI

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed suicide prevention for one year</td>
<td>£45,689.15</td>
</tr>
<tr>
<td>Improved mental wellbeing</td>
<td>£13,994.64</td>
</tr>
<tr>
<td>Reduced symptoms of depression</td>
<td>£4,961.74</td>
</tr>
<tr>
<td>Improved social wellbeing</td>
<td>£1,368.00</td>
</tr>
<tr>
<td>Reduced symptoms of anxiety</td>
<td>£1,354.32</td>
</tr>
<tr>
<td>Improved levels of physical activity</td>
<td>£344.74</td>
</tr>
<tr>
<td>Support into use of crèche / child care</td>
<td>£287.28</td>
</tr>
</tbody>
</table>

Arguably reduced symptoms of depression and anxiety and improved social wellbeing all relate to improved mental wellbeing. Omitting all of these outcomes other than that for improved mental wellbeing reduces the social value ratio to £3.06.

These calculations show that even when significant changes are made to the analysis the results still show clear evidence of social value being created by the Dreamtime Arts programme.

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 Arts and Wellbeing officer and other staff at the WHLC, Big Lottery funders and other Big Lottery South West Wellbeing Programmes as well as commissioners and service providers in Bristol. 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 SROI 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 WHLC 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. Perinatal mental illness has a serious negative impact on the mother but also an adverse effect on the cognitive, emotional and physical development of her offspring. There are therefore clear financial and health benefits to investing in public perinatal-mental health interventions and mental health services. This is particularly true in areas such as Lawrence Hill ward where risk factors for, and prevalence of mental illness is high, and local residents find it particularly difficult to access appropriate services.
This evaluation demonstrates that Dreamtime Arts is a valued project amongst the community and those working for WHLC. The SROI provides a financial measure of this value; that for every £1 spent on Dreamtime Arts there is £3.54 of social value created.

The total impact for the 24 participants who received an intervention in the first 15 months of the Dreamtime Arts project calculated from this analysis is £100,414.

Analysis of quantitative outcome data collected by the project provides clear evidence of benefit to those who participated in the Dreamtimes Art groups in terms of improved feelings of mental being, reduced symptoms of anxiety and depression, increased social connectedness and peer support, and an increase in the number of days a week in which they undertook low level exercise.

There is also evidence that these improvements enabled participants to start accessing child-care and to increase their use of other appropriate support services.

The evaluation provides further evidence to support the use of art and a peer support approach to help those with mild to moderate mental health needs.

**Limitations**

There are some limitations to this evaluation and SROI. The number of participants with matched baseline and follow-up data was small, so there is some uncertainty in the results of quantitative analyses; hence only a few of the validated items provide statistically significant results.

A broader range of external stakeholders would also have allowed for the gathering of a broader range of opinions with regards to the awareness of and perception of the group amongst the local community.

The feedback provided by those involved in the data collection process highlights some of the challenges and limitations of the questionnaire based quantitative data collection strategy.

> There are a myriad of different influences on your life all of the time and you don’t really know what’s making you feel better or worse. Every time I had to fill in one of those questionnaires, and it sort of asks you to look back over the last two weeks of the last four weeks, and every time I have thought, if I was having a good day I would have imagined that the last four weeks had been alright and if I wasn’t I would have imagined that the last four weeks have been hell... that’s basic psychology isn’t it.
> Dreamtime participant.

Here a project participant draws attention to the difficulty of objectively thinking back over the past two or four weeks (as required by some of the data collection tools used). There is a very real risk that if a participant was feeling particularly good or bad on the day that they completed the wellbeing questionnaire, that this could impact on their
response and thus shroud the true extent of the change they experienced over the
course of the programme. Due to this small sample size it is therefore also possible that
this could then lead to an over-statement or understatement of change in the cohort as
a whole.

The first form is likely to be a very Pollyanna kind of cheerful version of how they are
feeling, because they don’t trust us yet. In their first class, they don’t know what this
is all about, they don’t know about any potential for their children to be taken away.
I’ve heard mums, naturally they will lie to their health visitor about how they are
feeling... that is why it is hard analyzing the data.
Dreamtime stakeholder, Arts and Wellbeing Officer.

Here the Arts and Wellbeing officer draws attention to an issue that was also
highlighted by health visitors referring to the project; namely a common perception
amongst some mothers that if they were to disclose the true extent of their mental ill-
health they may risk losing their child to social services resulting in a possible bias
whereby at the beginning of intervention, when participants were still unsure about
the possible risks of accurately describing how they were feeling, mothers may
overstate how well they were resulting in less of an overall change from the beginning
to the end of the intervention.

With regards to the qualitative data collection, it is important to remember that only 8
of the 24 mothers who participated in the Dreamtime Arts programme during the
period of evaluation took part in the focus groups and that the views of these women
may therefore not be wholly representative of the other two thirds of the cohort. It is
possible that the participants who were willing to turn up to the focus groups were
those who had benefitted the most from the programme and therefore most able and
willing to attend. However, while it is true that the qualitative data may not be
representative of the participants as a whole, it would be wrong to presume that any
bias would result in an overstatement of the impact of Dreamtime Arts as those
participants who did not attend the focus group may not have attended not because
they didn’t benefit from the programme but because of their child-care responsibilities
etc. and it is equally possible that the qualitative data collected understates the impact
of the programme on the cohort as a whole.

There will be some benefits that are important to stakeholders but which cannot be
monetized. With regards to this evaluation it is notable that the focus group
participants talked passionately about how attending the Dreamtime Arts impacted on
their values, creating a sense of solidarity, of pride and belief in themselves as women,
and was starting to create a shift in previously entrenched attitudes they had about
themselves in relation to both learning and figures of authority towards a realization of
their own potential.

My small things feel like massive achievements. It’s kind of a bit weird actually, it was
almost like facing these kind of weird fears from being at school, where art had just
made me feel absolutely terrible, I felt like a child but it’s almost like it unleashed something, some kind of trauma in my past.
Dreamtime Participant.

I think what was good about this, it was just actually me realizing oh I am creative, we are all creative, any of us can be creative. But you are not led to believe that from an early age... even your career advisors, ‘you are not good at this, you should be doing that’, not saying the world is yours, you can explore anything, you can improve at anything, it’s all about putting you into boxes and actually, I created a human being, I am creative, we are all creative.
Dreamtime Participant.

These changes were clearly important for the participants and in the long run could have significant impact on their lives in terms of their relationships and the likelihood of them engaging in education and accessing other services involving figures of authority (GPs etc.). Due to the short-term nature of this evaluation, it is impossible to know what the long-term impact of these changes will be and therefore to put a value on them.

Perhaps most significantly of all, we know from the available evidence that much of the cost of perinatal mental illness arises from the adverse impacts of the condition on the children of the sufferer. Again, due to the short-term nature of the evaluation we have not been able to factor in the long-term value generated through improved emotional, educational and physical development for the participants’ child, with the evidence suggesting that this value could add up to a total sum two or three times the value of the outcomes generated for the mother. The impact of this missing value is that the total social return of Dreamtime Arts might have been undervalued significantly.

It is also likely that some of the wider impacts of Dreamtime Arts have not been captured in the analysis. For example the degree to which the promotion and success of Dreamtime Arts may have increased the number of people in the local community benefitting from other WHLC services through raising awareness and via word of mouth. However, it is very difficult to value this without any outcome data.

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, 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 a small over-estimated value.

PSSRU, 2014, The costs of perinatal mental health problems,
http://eprints.lse.ac.uk/59885/1/_lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer,%20M_Bauer_Costs_perinatal,%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf
Enhancing service delivery

Despite the lack of negative outcomes, a number of challenges and suggestions around service delivery were identified through stakeholder feedback. It is felt that, if considered, these areas have the potential to allow the Dreamtime Arts programme to generate additional value and enhanced service delivery.

These observations can be grouped into five key themes relating to different aspects of the project:

- Access: referring to the group and helping mothers attend the group for the first time.
- Follow on: helping women to access other activities once they have completed the Dreamtime Arts programme.
- The length and frequency of the group.
- Support and training for the Dreamtime Arts facilitators.
- Increasing the involvement of the Health Visitors with the project.

Access

One of the key areas of potential additional value creation relates to accessing the Dreamtime Arts programme. The group did not have a waiting list and mothers who wanted to attend the programme where able to do so rapidly once they had been referred. It is also worth noting that one of the strengths of the project is that because it is not sold as a formalized mental health intervention but rather as a creative class that tends to give mums a break from child-care and a chance to talk to each other, the group is much more accessible to this difficult to reach group than more structured mental health interventions.

IAPT themselves, Bristol LIFT themselves recognize that mothers with pre-school age children who are experiencing mental health difficulties are a difficult group to engage with.

Stakeholder, Arts and Wellbeing officer.

There are medical interventions, there are some mainstream services, but are they accessible? People don’t like to go into mental health services, some communities don’t even have a term for mental health, you are a young mother, you have children, you have social services involved, you are unlikely to access any kind of medicalised, structured mental health services through GPs. There are not many services that really meet the needs of the local population and this one of the ways to do things differently.

Stakeholder, WHLC Trustee & Public Health Advisor for Bristol City Council

The Dreamtime Arts intervention was seen as being a much more effective way of helping mothers with perinatal mental health issues to access support, as participants do not feel the same stigma or fear in attending then they would to a more structured, medicalised service that is seen more overtly as being: for people with mental health problems. The feedback from the focus groups was that the atmosphere at the groups was friendly and welcoming, and the participants spoke extremely fondly of the group.
facilitators often describing them as being like friends. Once women attend the Dreamtime group for the first time, they tend to continue to attend regularly, with overall average attendance running at 68%. While drop-out rates for the programme appear to be low, and despite the apparent strength of this approach and the efforts clearly being made to make the programme as accessible to the local community as possible, a number of issues relating to access were still identified. Both the Lead Artist and the Arts and Wellbeing officer identified that helping women to attend programme to attend for the first time remains an ongoing challenge that needed more resource.

*It is sometimes quite hard to get from the referral process to them actually coming to the group. They say yes I really want to come and I’m really interested and then they don’t turn up. It’s hard, it’s scary and the kids are going to a crèche which maybe they have never done before.*

Dreamtime Stakeholder, Lead Artist.

Feedback from health visitors referring to the Dreamtime Arts programme was that more than half of the women they referred to the group did not ever attend. While it is natural that not all of those referred to the group will attend, especially given the challenges in attending outlined in the quote above, helping more women to attend the group for the first time would potentially enable those most in need of support to attend, as well as allowing the group to operate at full capacity for more of the time, which in turn would allow the creation of increased social return.

An additional potential issue with regards to access was highlighted by health visitors referring to the Dreamtime Group at WHLC.

*The interesting thing is that the Dreamtime group is predominantly white and middle class but we know that mental health issues are cross-cultural.*

Dreamtime Stakeholder, Health Visitor

*The woman who I have referred, the white middle class women attend and the women who don’t attend are from another ethnic origin.*

Dreamtime Stakeholder, Health Visitor

Looking at the demographic data for BS5, the three largest ethnic groups are White English (37.7%), Black African (18.3%) and Black Other (9.3%)\(^2\). The majority of Dreamtime participants were White British (62.5%) followed by Black or Black British – Caribbean (12.5%) and a whole range of single individuals from a range of other ethnic backgrounds. While there is no comparable data available with regards to class or social grade, it does appear that the cohort of Dreamtime participants is over-represented by White British women, relative to the Ethnic makeup of BS5 as a whole.

\(^2\) ONS 2011.
However it is important to note that even when all other factors have been taken into account, evidence suggests that those from Black ethnic background are significantly less likely to participate in all types of art and craft activities; including painting/drawing.63

It is also worth noting that WHLC continue to undertake a number of different strategies to engage with the range of communities within the local area including services for immigrants from Central and Eastern European countries, the Gypsy Roma community and the Somali Community, and should continue to seek innovative ways of ensuring that its services continue to be accessible to all communities within the local area.

Follow On
The second challenge identified concerns what happens when participants have finished the Dreamtime Arts programme. The key issue identified here, by the Lead Artist, Arts and Wellbeing Officer and project participants themselves is that the participants often find that there is no suitable service available for them to attend when they have finished attending the Dreamtime Arts programme and that longer term impacts may be harder to embed if participants do not have somewhere to go next.

There is definitely a danger there [that the lack of follow up may effect the longevity of impact], particularly in the current model where we can only really offer them one term... however the nice thing about the arts is that they have some tangible reminders that they have had a moment of confidence or that they have had a moment of connection with someone else or that they did something skillful, but there is a danger that it is only a drop in the ocean. To mitigate that I hope that they would have had a positive experience of the Wellspring, that they feel safe here and that this might be a place to come if they were really struggling.

Dreamtime Stakeholder, Arts and Wellbeing Officer

Although the Dreamtime facilitators seek to use a range of other programmes (including the Art Shine programme at WHLC), they estimated that only 25% of participants are able to access these groups because of the absence of crèche facilities. Improving the referral pathways onwards from the Dreamtime Arts programme could significantly increase the longevity of the outcomes generated by the Dreamtime programme and help to embed this positive change.

The Length and Frequency of the Group
According to the current model, the vast majority of participants (75%) attended the Dreamtime Arts programme for one 10-week term only, with only a further six (25%) accessing two terms of the Dreamtime. Feedback from project participants and the

Arts and Wellbeing Officer was that it may be more beneficial to attend the group more frequently or for a longer period of time to increase the beneficial outcomes.

*It seems that if we can offer them one or two terms that there has generally been more of a chance for them to build that community.*
Stakeholder, Arts and Wellbeing Officer

*If they could make it thirty weeks or something, I just find for example, this first time I didn’t really sit down and enjoy until week four or week six actually, for the first month my son did not settle...*
Project Participant

*But I think for longer weeks, I think I did it for quite a while anyway, but I just want it to go on forever until he goes to school.*
Project Participant

All of the project participants who took part in the two focus groups mentioned that they would like to be able to attend the group for longer. The reasons given for this were that often by the time the participants and their children had settled into the group and the crèche respectively, there were only a small number of sessions left for them to enjoy. The length of each session was generally agreed to be just about right although some participants felt that an additional hour would give them more time to settle into the artwork. Participants also mentioned that they would like to attend the group more frequently (twice a week was the most suggested frequency) as it would allow the feel good factor of having attended the group (and of looking forward to it) to benefit them for the entire week.

Support and training for the Dreamtime Arts facilitators
Increasing the support and training available for the lead project artist could help to mitigate the possibility of potential negative outcomes – such as staff burnout or a reduction in the quality of the groups - occurring in the future. It became apparent from the stakeholder interviews that the artist was spending a considerable number of hours a week preparing for the groups. The Artist also felt that having the support of a volunteer or health visitor during the running of a group would also be useful. It was noted that although the artist felt well supported by colleagues at WHLC continuing to ensure that staff have the opportunity to offload and debrief is extremely important. This is especially important given that the most challenging aspect of the facilitator role was considered to be managing the different levels of anxiety and depression within the group.

*The group that I used to run which was a similar mums group, I always had either a*
volunteer or a health trainer, somebody else there which was quite useful. The health trainer could then point them on to other services, the other mental health services that were available if they were really feeling like they were struggling and they really needed it.
Dreamtime Stakeholder, Lead Artist.

Involvement of the Health Visitors
The final area where additional value could potentially be generated relates to the health visitors, who provide one of the main sources of referral to the Dreamtime project. From the stakeholder interviews it became apparent that the health visitors could become more involved in the project and that it would be beneficial for them to attend the Dreamtime Arts groups from time to time.

We talk to the Arts and Wellbeing officer, but prior to her taking over we didn’t get any guidance as such [with regards to referring to the project]... we haven’t even been round to see how it is actually run, we should know what we are advocating... especially as we are judging whether or not we should be referring to this group.
Dreamtime Stakeholder, Health Visitor

This could have a positive benefit not only in terms of the quantity and quality of referrals to the project but could also benefit the participants of the Dreamtime Arts programme as the health visitors would be available to answer health and baby related questions when they popped into the group and even potentially to attend with mothers attending the group for the first time, helping to embed participants in the group.

There was one health visitor who used to come to the group sometimes, I think she was supporting a particular mum, but she came along to a couple of sessions and that was really helpful actually, something like that so that the health visitors know exactly what is happening and they could even come with somebody who particularly felt that they needed it, they could maybe come with them for the first session, something like that would be really helpful I think.
Dreamtime Stakeholder, Lead Artist

Recommendations
In this SROI report we have monetised the benefits of the Dreamtime Arts project to its participants and the community in Lawrence Hill ward, Bristol. 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 Dreamtime Arts is securing ongoing funding once the current Big Lottery funding ends. It is difficult to quantify the impact that discontinuing Dreamtime
Arts might have on the local community and other local services. It is likely that those who have benefitted from the service and those who might benefit from it in the future will simply slip back through the gaps in services that exist, an important consideration given that just 3% of CCGs in England have a strategy for commissioning perinatal mental health services.64

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 achieve sustainability. It also highlights ways in which improvements could be made to the project to maximize the benefit provided by the project to the local community.

- To continue to seek to make the Dreamtime Arts programme as accessible to as many different women in the local community as possible, with a particular focus on helping women to attend for the first time.

- To further strengthen the link between the project and the health visitors and family support workers referring to it. Giving health visitors a chance to pop in to the group from time to time and closer engagement with the Arts and Wellbeing officer would give referrers a clearer picture of what the programme is like and help them in deciding who is most appropriate for the group. Their attendance would have the additional benefit of giving mums an opportunity to ask questions about health related issues while they are in attendance. Health visitors could also play a role in supporting women to attend the group for the first time, possibly by taking them there the first time.

- Acknowledging the central importance of the facilitator(s) in helping to generate the positive outcomes of the programme, WHLC could look at ways of supporting the project facilitators / artist in terms of the additional preparatory hours they give.

- Additional time could also be spent contacting people who have been referred to the group but who have not yet attended which could have a significant impact in helping mothers to attend for the first time. The support of an appropriate volunteer (for example an art therapy student) in facilitating the group should be considered.

- To continue to support women who have completed the Dreamtime Arts programme in finding and accessing appropriate services. There is a currently a lack of appropriate services with crèche facilities for participants to attend after they have finished Dreamtime. It would be helpful if WHLC could work with other community organizations, service providers and commissioning bodies to ensure that appropriate and accessible services are available for this high-risk group. Supporting participants to stay in touch with each other and to set-up their own

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informal groups and meet-ups after the Dreamtime group has finished would also help to embed the positive outcomes generated by the programme.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABCD</td>
<td>Asset based community development</td>
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<tr>
<td>BME</td>
<td>Black or Minority Ethnic</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>ESRC</td>
<td>Economic and Social Research Council</td>
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<td>GAD7</td>
<td>Generalized Anxiety Scale</td>
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<td>HMT</td>
<td>Her Majesty’s Treasury</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>LSOA</td>
<td>Lower Layer Super Output Area</td>
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<td>NDC</td>
<td>New Deal for Communities</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health &amp; Care Excellence</td>
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<td>NPV</td>
<td>Net Present Value</td>
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<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<td>PHQ9</td>
<td>Patient Health Questionnaire</td>
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<td>PSSRU</td>
<td>Personal Social Services Research Unit</td>
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<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
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<td>PV</td>
<td>Present Value</td>
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<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>SROI</td>
<td>Social Return on Investment</td>
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<td>SWWB</td>
<td>South West Wellbeing</td>
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<tr>
<td>WHLC</td>
<td>Wellspring Healthy Living Centre</td>
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<td>WHO</td>
<td>World Health Organization</td>
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APPENDICES

Appendix 1 – Stakeholder List

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<tr>
<th>Stakeholder</th>
<th>Reason For Inclusion in evaluation</th>
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<tbody>
<tr>
<td>Project Participants</td>
<td>Primary participants who are likely to be experiencing significant outcomes if intervention is successful</td>
</tr>
<tr>
<td>Dreamtime Arts project staff (Lead Artist, Arts and Wellbeing Officer)</td>
<td>Directly involved in the delivery of the service and so well placed to reflect on the project, its strengths and weaknesses and the outcomes delivered for the participants</td>
</tr>
<tr>
<td>WHLC Staff (Health Visitors, Chief Executive)</td>
<td>Route of referral into the Dreamtime Arts programme and source of strategic oversight / relationship between Dreamtime Arts and the rest of WHLC respectively.</td>
</tr>
<tr>
<td>WHLC Trustee &amp; Bristol City Council Public Health Advisor</td>
<td>Source of valuable insight re. broader public health and commissioning context</td>
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-Do you think the crèche was a positive experience for your children?
-Can you describe to me the difference between how you would feel coming into the Dreamtime Arts group and how you would feel when you left?
-How you started doing any new things since you started coming to Dreamtime Arts?
-Did you stop any other activities to be able to come to Dreamtime Arts? Have you started any new activities since finishing Dreamtime Arts?
-Can you give me a sense of how important Dreamtime Arts has been to you?

Is there anything else that you would like to add?

Appendix 3 – Stakeholder Interview Questions

Dreamtime Arts – Stakeholder Interview Schedule
Thankyou for agreeing to take part in this evaluation. The aim of this interview is to help us find out more about your engagement with the Dreamtime Arts programme, perceptions of the project and what kind of impact you think it is having. The findings from this interview will form part of an evaluation report on the Dreamtime Arts programme. Your views will, alongside the views of all other consulted stakeholders will be used to inform the final evaluation report.

Introduction
Can you start by telling me a bit about yourself and your involvement with the programme?
-Organisation and role within the organisation
-How and when did you/your organization get involved in the programme?
-Were you already involved with WHLC?
-What is your personal involvement with the Dreamtime Arts programme?

Aims of Dreamtime Arts
-What do you think are the aims of the Dreamtime Arts programme?
-Who would you say is the target population of the programme?
-Do you feel that the programme is succeeding in reaching its target population?
-Do you feel that the aims and target population of the programme are appropriate given the specific needs of the local community?
-Do you refer/signpost people you work with to the Dreamtime Arts programme? What has your experience of referring to Dreamtime Arts been like? Where else would you refer people if Dreamtime Arts did not exist?

What changes?
-What kind of an impact do you think the Dreamtime Arts programme has on those individuals who participate in its activities?
-What kind of an impact do you think the programme has on the wider community?
-What are the benefits of the programme?
-What do you think are the most / least effective aspects of the programme? In your opinion, how could the programme be improved?
-Do you think there are any downsides / negative consequences of the programme?
-How significant do you think the changes brought about by the Dreamtime Arts programme are?
-Do you think there are other services in the local community that are similar to Dreamtime Arts?
-What do you think the impact would be if Dreamtime Arts no longer existed?
-How effectively do you think Dreamtime Arts measures and communicates the value of the work it undertakes?
-How long do you think the impact of the Dreamtime Arts programme lasts? Do you think the current mechanisms for onwards referral / participant support following the end of the programme are sufficient?

What else could account for these changes?
-What other services and sources of support are available for this client group in the local community?
Are you aware of participants accessing these services whilst attending Dreamtime Arts?