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Evaluation of the Coronavirus Community Support Fund

Value for Money Report Annex C: Summary of Evidence for the Cost-Benefit Analysis

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1 Introduction

This Annex accompanies the CCSF Value for Money Report. It provides summaries of the evidence for the outcomes that are included in the cost-benefit model described in that report. These outcomes are:

1. People who were better supported to access the healthcare they needed.
2. People who were better supported to access the social care services they needed.
3. People whose physical health was better.
4. People's short-term basic needs were better met (e.g. money, food, clothing, shelter).
5. People who had more social contact / People who felt less lonely.
6. People of all ages who were better protected from harm, violence or abuse.
7. Children and young people whose education and development was better.
8. People whose mental health and wellbeing was better.

For each outcome, we have looked at the secondary research to identify potential proxy outcomes / measures that would provide an appropriate beneficiary value for that outcome. The evidence cited below include brief summaries of our review of the literature and have been written for the general reader.

In each section below we have focused on:

- How the pandemic has affected the specified outcome.
- Evidence of the effectiveness of social sector organisations in addressing that outcome.
- Approaches to valuing the outcome.
- Conclusions from the literature on how to estimate monetary values of outcomes achieved by beneficiaries, alongside estimates of the level of change anticipated for those beneficiaries.¹

1.1 Methodology

Papers were identified through a review of Google Scholar; Web of Science, University of Sussex's library database, the Cochrane Review database, and NICE Evidence Database, as well as a review of the grey literature (primarily through Google). Snowballing methods were used to identify further papers via reviewing the bibliography of papers reviewed (when the paper identified was not part of a systematic review).

Search Criteria

Search terms included various forms of economic evaluation—for example, “cost benefit analysis”, “cost effectiveness analysis”, “CBA”, “SROI”, “value for money”, “monetisation”, “monetization”, and “break

¹ For this report we have followed the convention of the CCSF Impact Evaluation Report in reporting the estimated number of grantholders and beneficiaries after extrapolating the grantholder survey results by

even analysis”. Language associated with our preliminary cohorts was included alongside the search criteria—for example, “advice”, “domestic violence”, “education”, “mental health”, “physical health”, “loneliness”, and “basic needs.” Additional searches by target group also took place using the same terms identified in the grantholder survey.

Process

We undertook an initial “pre-sift” of each paper to assess its relevance, which included consideration of whether each paper would be likely to include estimates of the effectiveness of interventions or provide monetary estimates of outcomes. Some papers added are very recent, because they help provide up-to-date data on outcomes during COVID. One limitation of the literature that we were conscious of was that a lot of studies populating the evidence base occurred prior to the pandemic, so there was concern about the applicability of findings.

Once a paper was added to the database, we used a range of criteria to judge the relevance, value, and quality of the paper. This helped us make preliminary judgements on which papers we should focus on (i.e., authoritative papers). This acted as a guiding tool for us—but it had its limitations. There were some papers where there was a clear line in the sand. Papers that did not provide any data which supported an estimate of the extent of change for beneficiaries were considered low value. Greater emphasis was placed on systematic reviews and meta-analyses that covered the broad evidence.

However, we recognise this has limitations, as charitable evaluations are typically only looking at a single charity / intervention. Conversely, some systematic reviews can be too specific and driven to a particular intervention type—which would not produce a reliable estimate applicable to all grantholders stating an outcome.

2 People who were better supported to access the healthcare they needed

2.1 How the pandemic affected access to healthcare

The provision of health services in 2020 dropped significantly in the early months of the pandemic. Hospitals were asked to suspend non-urgent surgery and focus on patients suffering from COVID, and to minimise the risk of infection during treatment. GPs replaced face-to-face appointments with online and phone consultations.

At the same time, patients sought less care, partly due to lower levels of activity during lockdown, but also because of patient concerns about getting infected and burdening the NHS. In the first three months of the pandemic, 14% of patients aged 50 years or older reported not seeking help from a GP even when they felt they needed such care (Propper, 2020).

The decreases were stark. The IFS (Burn, 2021) found that compared to the same period in 2019, between March and December 2020 there were:

- 1.2 million (21%) fewer non-COVID emergency inpatient admissions.
- 2.9 million (34%) fewer elective (planned) inpatient admissions.
- 17.1 million (22%) fewer outpatient appointments².

Emergency inpatient admissions almost returned to their 2019 level by August 2020, but elective and outpatient volumes remained low, and emergency inpatient admissions began to decline again in September 2020. Within this general decline, there was some variation across geographies, services, and populations, as noted by the IFS study:

- The North and the Midlands generally saw larger reductions in hospital activity than the South and the East of England.
- There were 57% fewer trauma and orthopaedic elective admissions compared with only 7% fewer for nephrology. Paediatrics experienced the largest reduction in emergency admissions (41%).
- The most deprived local areas saw 23% fewer emergency admissions in March to December 2020, compared with a 20% reduction in the least deprived areas. This gap is larger in absolute terms as more deprived areas have more emergency admissions.
- Since older people are the largest users of hospital care, older people were, unsurprisingly, the most affected per capita. However, in relative terms, children (under-18s) had the largest percentage declines in both elective (37%) and emergency (39%) inpatient admissions.

² More information on hospital activity is available on the NHS digital dashboard: <https://digital.nhs.uk/dashboards/activity-in-nhs-hospitals>

- The largest percentage decreases in elective inpatient admissions were among white and Asian people, while the largest percentage decreases in emergency inpatient admissions were among Asian, Black, and mixed ethnicity people (Burn, 2021).

Primary care consultations fell by approximately 30% from before mid-March 2020 to June 2020³. In the first three months of the pandemic, 14% of patients aged 50 years or older reported not seeking help from a GP even when they felt they needed such care (Propper, 2020).

A consequence of this is that waiting lists for elective care are the longest they have been since the current definition began in 2007. By February 2021, 4.7 million were waiting for treatment, including 388,000 waiting for more than a year (NHS Digital, 2021).

This fall in both supply and demand created conditions where many people needed help in accessing appropriate health services.

2.2 Effectiveness of social sector organisations at influencing access to health care

What do social sector organisations do?

Grantholders conducted a range of activities to improve people's access to healthcare. These could be direct, such as referring people to health services, providing translation services, or picking up prescriptions. But more often it was indirect, through services such as signposting, advice, and information that aimed to improve the choices people made and may have led to people accessing healthcare or changing their lifestyle in some other way.

What is the state of the evidence base?

Unfortunately, there is limited evidence on the effectiveness of VCSE organisations in helping people to access health services, as noted in the following work:

- A 2004 review of NHS-run services to improve access to primary care found 32 studies but concluded that the evidence base was insufficient to make overall judgements on how to improve access to care (Chapman, 2004).
- A 2018 review of the effectiveness of "visiting services" in remote and rural areas of high-income countries found only seven papers that provided some information about the impact or effectiveness of services and concluded that the evidence base was not sufficient to comment on their effectiveness (Carey, 2018).
- A 2006 systematic review on the health, social and financial impacts of welfare rights advice found that "*there is little evidence either that welfare rights advice in healthcare settings does or does not have health and social effects*" (Adams, 2006).
- In 2015, the University of Surrey reviewed the provision of advice of social welfare issues on behalf of the Low Commission⁴ and found "*some evidence to show positive impacts [of advice giving] on health and on health costs (although this needs further work)*" (Cookson, 2014).

³ (<https://www.health.org.uk/news-and-comment/charts-and-infographics/use-of-primary-care-during-the-covid-19-pandemic>).

⁴ The Low Commission was chaired by crossbench peer and disability rights campaigner Lord Low CBE in 2012. The commission developed a strategy for access to advice and support on social welfare law in England and Wales.

- The weakness of the evidence base is due to the methodological and practical difficulty of researching how effective VCSE organisations are in increasing access to health services, in particular the problem of finding robust counterfactuals. Lack of evidence is not the same as evidence of no impact.

What does the evidence tell us?

How VCSE organisations in general increase access to health services is not well defined; it happens in a myriad of ways. Thus, it is difficult to draw conclusions on the effectiveness of CCSF grantholders and the value of their services from this research.

One way VCSE organisations help increase access to health services is by providing information, advice, and guidance (IAG) services, including outreach. Some IAG providers do provide data on the effectiveness of their advice. Most notably, the Citizens Advice Bureau (CAB) surveys their clients to help assess the impact of their services. They report their services resolved problems for 65% of clients who had consumer issues (CAB, 2020a), and that 78% of their clients said they would not have been able to resolve their problem without them (CAB, 2020). But there is not comparable evidence for clients seeking advice on accessing health services specifically.

Otherwise, there is some literature on the effectiveness of IAG services related to health, but this tends to be IAG that is related to addressing specific health problems, such as obesity and smoking, rather than accessing health services in general.

Applying the research to CCSF grantholders and beneficiaries

The limited research on the effectiveness specifically of IAG, such as that provided by CAB, shows the potential for CCSF grantholders to improve beneficiary access to health services. But it is inappropriate to simply apply findings from CAB's services across different VCSE organisations supporting increasing access to different types of health services for different populations.

2.3 What is the value of accessing health services?

There is a similar lack of robust data or evidence on the value of increased access to health services.

A systematic review and meta-analysis of community engagement programmes designed to reduce inequalities in health (including, but not limited to, increasing access to services) found only 21 economic evaluations out of the total of 391 included in the review (O'Mara-Eves et al 2013). The authors found that *"No firm conclusion can be made about the economic case for community engagement. A number of largely positive economic analyses address a range of different community engagement mechanisms, but these are thinly spread across health topic areas and most have significant methodological limitations."*

Assessing the value of increased access to health services faces two conceptual challenges in addition to the methodological challenges:

- Firstly, the value of accessing health services would seem to be indirect and come from improved health (and possibly other) outcomes that flow from increased access. It is not clear how to assess the value of increased access to health services separately from improved health outcomes. People do value having opportunities they do not take up or actually benefit from, but assessing the monetary value of this is very complex.

- Secondly, increasing access to health services is likely to increase public sector costs that will be net against any improved health or other outcomes.

Hence, the value of increased access to health services is often treated as an issue of equity rather than economic benefit.

Some providers of IAG have conducted cost-benefit analyses (CBA) or Social Return on Investment (SROI) analyses to estimate the value of advice, typically a mix of benefits to the beneficiaries of the service and to public services. For example:

- In 2015 the Centre for Economic Empowerment of NICVA commissioned a cost-benefit analysis of clients receiving advice in Northern Ireland. They reported that general advice produced an SROI ratio of £20 of social value for every £1 invested, via such impacts as fewer tribunals, reductions in debt to be paid, increased employment of volunteers, and so forth (Williamson, 2015).
- The Institute of Public Research (IPR) at the University of Bath calculated an SROI ratio between £33 and £50 of social value for every £1 invested over a 5-year period for the 80 clients who participated in the research. The size of the return was mainly due to financial gains made by clients through debt reduction or income gained (Farr, 2014).

But several issues with studies on the value of advice makes them unsuitable for our analysis:

- They are typically conducted or commissioned by the providers of IAG and are not peer reviewed, and hence are subject to bias.
- They sometimes include benefits which are excluded from a cost-benefit analysis because they are transfer payments, where something valuable is taken from one group and given to another. For example, 85% of the value noted in the Farr study (referred to above) included welfare payments and debt reduction as benefits in the ratio. These would be excluded from a cost-benefit analysis. The value to the CAB clients from reduced debt or increased income would be exactly offset by the cost or loss to taxpayers and lenders.
- They are often based on authors making significant judgment calls in the absence of robust data. This makes the results difficult to compare. For this reason, Social Value International (which promotes the use of SROI) does not recommend using such ratios to compare different projects and services.
- Importantly for this study, they do not specifically address the value of increased access to healthcare. The value is derived from other outcomes.

2.4 Application to the CCSF value for money model

Values

As other CCSF outcomes included improved physical and mental health, it would seem appropriate to assign values to those outcomes rather than increased access.

However, of the estimated 2,720 grantholders whose activities helped increase access to health services, only about one-half (estimated 1,450) also reported that their beneficiaries improved their

physical health. This implies there are many beneficiaries who have increased access to health but whose physical health did not improve. One explanation for this paradox may be that some grantholders may perceive access to health services as a valuable outcome for people with chronic or deteriorating conditions (such as older people) but do not necessarily associate increased access to health services with improved health. Another explanation is that the access achieved by beneficiaries was for mental health services instead of physical health.

In the absence of better evidence, we will assume that for beneficiaries, the value of access of health services by itself (i.e., without a corresponding improvement in health) is relatively low, and the ability of grantholders to make a difference is unknown. One way to assess the value of access to health is to treat spending in the UK as an approximate willingness to pay for access to healthcare. In 2019, this was £3,371 per capita (ONS, 2021), which is the figure used in the main report (see Chapter 2, Table 2.6).

Level of change

Overall, because the evidence for the effectiveness of VCSE organisations in increasing access to healthcare is limited, we have to assume a fairly weak impact. Hence, we have opted for a conservative estimate of between 1-5% improvement.

Distribution of grantholders

A third (33%) of grantholders stated that their services had contributed to people being “better supported to access the healthcare they needed”. This equates to an estimated 1,120,200 beneficiaries receiving the outcome (after extrapolation and adjusting for grantees’ perception of the proportion of beneficiaries receiving the outcome).

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3 People who were better supported to access the social care services they needed

3.1 How the pandemic affected access to social care

The pandemic significantly affected access to social care services via a complex interplay of changes in supply and demand for services.

First, supply of social care services was reduced. The King's Fund (Bottery, 2020) reported that some services, particularly care homes, closed temporarily for new clients to stop the virus spreading. Directors of Adult Social Services reported that more than 8 in 10 providers were concerned about taking on more clients. Other services closed permanently (such as Age UK Essex Home Help Service) or suspended services because they found it difficult to operate while restrictions were in place.

Major VCSE organisations also reported falls in service provision:

- A survey by Mencap of c.1,000 people in July 2020 found that nearly two-thirds of carers said the amount of social care support their loved one received from the Local Authority had decreased (Mencap, 2020).
- In a survey of over 2,000 people affected by Parkinson's disease, around half of those receiving paid care before COVID-19 said they were receiving less care by July 2020 (Simpson et al, 2020).
- A survey of 1,100 people living with multiple sclerosis found that of those who need support with everyday living, such as washing or getting dressed, nearly one in five (18%) found this was reduced or cancelled (Multiple Sclerosis Society, 2020).

At the same time, some social care needs may have increased due to the lockdown, though it is not a clear picture. A survey of Directors of Adult Social Services during May 2020 reported that:

- Nearly half (53%) indicated that there had not been an increase in unmet need between March and May 2020, but nearly a quarter (23%) felt that there had been an increase of 1-5% and around one in ten (11%) indicated that there had been an increase of 6-10%.
- One in five believed that, in general, people were not discharged to the right place in the initial stages of the pandemic.
- Nearly three-quarters (74%) believed that temporary closure of services, such as day services, led to an increase in people 'presenting with need' to their Local Authorities.
- Nearly seven in ten (71%) indicated that people declining services they were offered led to people presenting need.

The Care Quality Commission found that admissions to care homes fell by more than a quarter among publicly funded clients and by two-thirds among self-funders. Use of home care also fell in the early months, though it had recovered to 94% of pre-COVID levels by July 2020 (Bottery, 2020).

In addition, Carers UK estimated there were 4.5 million people who were new to caring in the early months of the pandemic (Carers UK 2020).

3.2 Effectiveness of social sector organisations at influencing access to social care

What do social sector organisations do?

Approximately one-quarter (2,540 out of 8,177) of grantholders are estimated to have helped beneficiaries access the social care they needed. They supported people in several ways, including providing referrals to social care services, supporting in needs assessments or eligibility applications, triaging services, and more general signposting of services. Some grantholders were involved in providing social care services—for example, through socially prescribed interventions.

What is the state of the evidence base?

Unfortunately, there is no robust quantitative data that generally applies to how effective VCSE organisations are in helping beneficiaries access social care. While individual evaluations of particular services can state summary statistics—for instance, on referrals to specialist support—there appear to be no systematic reviews or meta-analyses covering grantholders supporting access to social care. But, as above, the absence of research does not imply there is no effect.

What does the evidence tell us?

Similar to access to healthcare, we can look to the research on the effectiveness of IAG services, but we were not able to find any research that addressed how effective VCSE organisations are at increasing access to social care. The research that does exist tends to focus on the effectiveness of IAG on debt and financial issues, or employment opportunities, more than accessing social care services.

While the evidence at an aggregate level is limited, there is evidence on individual activities or services provided by VCSE organisations within individual evaluations. For instance, the Working for Carers Evaluation Report 2016-2019 (Burnley et al, 2019) provides the numbers of carers referred to specialist support. Similarly, an independent evaluation of the criminal justice Unlock Helpline (Wilkinson, 2016) provides evidence around supporting individuals to get access to their criminal record and looking at eligibility for DBS checks. This evidence is only tangentially relevant and does not help us come to a measure of effectiveness of the experience of change faced by CCSF beneficiaries, but it gives a sense of the level of outcomes that might be possible.

Another example is the evaluation of the Reducing Social Isolation and Loneliness Grant programme (Cameron & Roberts, 2016), which provided small and large grants (similar sizes to those provided by the CCSF). This found the following rises in outcomes compared to the baseline:

- The proportion of respondents who knew where to go if they had worries about their health increased by a very small amount, from 87% to 88% (baseline n=641; follow-on survey n=195).
- Those who felt like they could access local health and social care services increased from 75% to 86% (baseline n=641; follow-on survey n=195).

A scoping review on access to information about social care services, conducted by Baxter et al (2006), noted some of the limitations in capturing evidence on access to social care even for new government projects: *“even when these development projects are completed, they will not provide evidence on the effectiveness or appropriateness of the methods that they have been developing of providing information and improving its accessibility.”*

How applicable is the research to CCSF grantholders and beneficiaries?

As with access to health services, the limited research on the effectiveness of IAG shows the potential for CCSF grantholders to improve beneficiary access to social care. But the evidence does not provide usable estimates of the likely impact of grantholders, nor the value of the outcomes that would be replicable for the research.

3.3 What is the value of access to social care?

The issues described above on valuing access to healthcare also apply to valuing this outcome. The direct value of increased access is likely to be improved in physical health and mental health and wellbeing; increasing access to social care is likely to lead to increased public sector costs; and evidence provided in SROI models is either not directly relevant or does not comply with HM Treasury guidance on cost-benefit analysis.

3.4 Application to the CCSF value for money model

How VCSE organisations increase access to social care services is not well defined; it happens in a myriad of ways specific to each organisation and applies to a multitude of different social care offerings. This, and limitations from the literature, make it difficult to draw conclusions on the effectiveness of CCSF grantholders and the value of their services from this research. Again, the absence of robust research does not imply there is no effect.

As the secondary literature does not provide useful data to help assess the value to beneficiaries of increased access to social care services by CCSF grantholders, we propose replicating the customised and conservative approach to assessing the value of increased access as was used for improving access to healthcare. It would be unreasonable if other CCSF outcomes including improved physical and mental health were a lower value than increased access to social care.

Values

In the absence of better evidence, we will assume that for beneficiaries, the value of access of social care services by itself (i.e., without a corresponding improvement in wellbeing) is relatively low. One way to assess the value of access to social care is to treat UK spending on social care as an approximate willingness to pay for access to social care. In 2019, this was £390 per capita (ONS, 2021).

Level of change

We estimate grantholders being able to increase access to social care within the 1-5% range to account for the fact that the weak evidence base means the potential effect is essentially unknown.

Distribution of Grantholders

31% of grantholders' respondents stated that their services had contributed to people being “better supported to access the social care services they needed”. This equates to an estimated 830,200 beneficiaries receiving the outcome (after extrapolation and adjusting for grantees' perception of the proportion of beneficiaries receiving the outcome).

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4 People whose physical health was better

4.1 How the pandemic affected people's physical health

The UK government identified four types of health impact from COVID-19 (HM Government, 2020):

1. Health impacts from catching COVID-19.
2. Health impacts from catching COVID-19 but made worse through not getting the right care in the event of the NHS being overwhelmed.
3. Health impacts from changes to health and social care made to respond to COVID-19, such as changes to emergency care, changes to adult social care, changes to elective care and changes to primary and community care.
4. Health impacts caused by social distancing and growing deprivation.

As of early May 2021, approximately 4.6 million people have had the virus (Johns Hopkins Coronavirus Map). Of this, approximately 1.7% were experiencing self-reported long-COVID, or symptoms persisting for more than four weeks after they first suspected they had COVID-19 that were not explained by something else (ONS).

As of July 2021, approximately 130,000 people have died from COVID-19 in the UK (GOV UK, 2021), although arguably a more accurate number of the actual deaths related to COVID-19 is the estimate of excess deaths. This has been estimated to be approximately 85,000 for England and Wales between March and the end of December 2020 (Isalm, 2021).

Indirect health effects of COVID-19 include:

- A sharp rise in anxiety rates in March 2020, although these have since returned to normal.
- A fall in physical activity among adults, particularly from mid-March to mid-May 2020.

There are also some effects that would have had a positive impact on health, such as:

- Evidenced reduction in air pollution, a major source of ill health (Air Quality Expert Group, 2020).
- Less vehicle traffic, potentially bringing benefits from fewer accidents (DFT, 2021).

4.2 Effectiveness of social sector organisations at influencing health

What do social sector organisations do?

It's widely recognised that VCSE organisations and community groups can help improve physical health. Many run projects and interventions designed to improve health through providing information and guidance. Others address social determinants of health, such as housing, education, and employment, as well as providing the social contact that is known to contribute to improved physical and mental health. Hence, the 2010 Marmot Review of social determinants of health and health inequities

recommended including civil society partners in co-creating efforts to improve health and reduce health inequities. Similarly, a report on community-centred approaches for health and wellbeing prepared for Public Health England reported that *“the skills and knowledge, social networks and community organisations, are building blocks for good health”* (South, 2015).

The role of VCSE organisations in promoting health was noted in a recent editorial in the Lancet:

“Apart from money and care, many VCSE organisations provide trustworthy information resources for patients and families. Such resources are particularly important during the COVID-19 pandemic—a time when misinformation has become so prevalent. Beyond direct service provision, VCSE organisations have important roles in the health-care sector, from representing the patient voice and advocacy, to addressing socioeconomic disparities that can result in poor health and outcomes, to funding research and clinical trials.” (Haematology, 2020).

What is the state of the evidence base?

Notwithstanding this recognition, there are four issues that make it very difficult to know what difference VCSE organisations (collectively or individually) make (directly or indirectly) to improving health:

- The interplay between social and behavioural factors that affect health, and which VCSE organisations influence directly or indirectly, is very complex.
- The systems that deliver health services, namely the NHS and social care services, are also complex, and differ in time and place.
- There are a multitude of ways in which VCSE organisations seek to affect health and the delivery of health services.
- As a consequence of the above, and because of how VCSE organisations are funded and operate, it is difficult to collect good evidence that can be generalised.

What does the evidence tell us?

Possibly the best source of evidence on the role of VCSE organisations in improving health comes from a 2013 systematic review and meta-analysis funded by the National Institute of Health Research. This covered 319 studies from various countries divided into three broad models of community engagement in promoting health:

- Community empowerment, or mobilising communities into action.
- Peer / lay models of delivering services.
- Patient / consumer involvement in service development.

The study focused on the extent to which community-based models reduce health inequities specifically, rather than generally improving health. This distinction is unlikely to be significant as many VCSE organisations focus on disadvantaged groups.

The study concluded that:

“Public health interventions using community engagement for disadvantaged groups are effective in terms of health behaviours, health consequences, participant self-efficacy and perceived social support

outcomes... These findings appear to be robust and not due to systematic methodological biases. There are also indications from a small number of studies that interventions can improve outcomes for the community and the engagees.”

However, the report also caveated that *“there is significant variation in the effectiveness of interventions – some interventions were more effective than others, and not all interventions benefited the participants.”* A meta-analysis of a sub-set (131) of these studies found a standardised effect size of 0.33 (with a range between 0.26 and 0.40 within a 95% confidence limit of statistical significance, indicating small to moderate effectiveness)⁵⁶.

Another relevant study was a review of 86 articles and reports about social prescribing schemes (Chatterjee, 2018). Just under half of these included evaluation of primary data on health. Social prescribing is a mechanism for linking patients with non-medical support within the community⁷ and thus are a sub-set of the broader range of community-based health projects. The social prescribing schemes sought to achieve a range of improvements in mental health, psychosocial outcomes, physical health, and reduced use of statutory health services. But the evidence of the effectiveness of these interventions is limited. The review concluded with, *“Social prescribing therefore has the potential to improve the health and wellbeing of patients presenting with psychosocial needs by accessing resources and social support from outside of primary care.”*

How applicable is the research to CCSF grantholders and beneficiaries?

The CCSF grantholders and their beneficiaries are diverse, making it difficult to apply evidence from any single study. The benefit of conclusions from the NIHR-funded systematic review and meta-analysis are that they summarised the results of multiple studies, and hence covered a similar diversity of delivery mechanisms and health issues that made the results useful for the purpose of this study. The downside is that it included research from outside the UK, which limits our applicability to apply the research in a UK context. Of the 319 studies included in the main study, 26 were from the UK. Of the 131 studies included in the meta-analysis, only five were from the UK.

The review of social prescribing was restricted to the UK and hence likely comparable to some of the grantholders supported by the CCSF. But, as noted above, the evidence was inconclusive, and we were unable to map the CCSF projects to a clear typology of services.

4.3 What is the value of physical health?

While economic evaluations are key to the approval of medical interventions, they are rare in the evaluation of community-based programmes and projects. As noted above, the 2013 systematic review by O'Mara et al. found only 21 economic evaluations, thinly spread across health topics, and from which no firm conclusion can be made about the economic case for community engagement.

⁵ This can be thought of as making a change of one-third of a standard deviation. As two thirds of a population (with a 'normal' distribution) fall within one standard deviation of the average, a change of one-third of a standard deviation is often considered a medium change, though this depends on whether the outcome being measured is easy to change or not.

⁶ Cochrane notes that the standardised mean difference is used *“as a summary statistic in meta-analysis when the studies all assess the same outcome, but measure it in different ways... The SMD expresses the size of the intervention effect in each study relative to the variability observed in that study”*. The range of an SMD is from -1 to 1. Depending on the variable being viewed, larger SMD's indicate greater effectiveness. In the case of the NIHR review; the variable is the 'extent of health inequality reduction', so a positive SMD equates to a positive effect.

⁷ CentreForum Mental Health Commission, 2014, p. 6.

Community-based interventions for which robust economic evaluations do exist show a wide variation in their cost-effectiveness. A recent review of 43 economic evaluations of public health interventions—some of which are similar to community-based services run by VCSE organisations—calculated 138 incremental cost-effectiveness ratios (ICERs) or the incremental cost of achieving a Quality-Adjusted Life Year (QALY) for variations of the interventions. Of the 138 variations, 35 (25%) were cost-saving, 53 (38%) had ICERs between £0 and £20,000, 4 (3%) had ICERs between £20,000 and £30,000, 43 (31%) were over £30,000, and 3 (2%) were both more costly and less effective than the comparison intervention and therefore clearly not good value for money. The median ICER was £7,843, but the inter-quartile range was between £75 and £61,814. In other words, while nearly two-thirds would be considered good value for money when compared against NICE's guideline of £20,000 per QALY, there is substantial variation in the cost-effectiveness of public health interventions. Some (those for whom the ICER is over £20,000) do not represent good value for money (Owen, 2017).

QALYs were also used in a review of the cost-effectiveness of health-related lifestyle advice (HRLA) delivered by peer or lay advisers. The review found limited evidence to suggest that HRLAs are cost-effective for improving health-related knowledge, behaviours, or health outcomes. The range of Incremental Cost-Effectiveness Ratios was wide, from £6,000 for quitting smoking; to £14,000 for a telephone-based type 2 diabetes management; and to £250,000 for promotion of mammography attendance and for HIV prevention amongst drug users (Pennington, 2017).

Using self-reported assessment of physical wellness, a study of a home help service in the UK calculated a mean gain in QALY of 0.042, equivalent to a value of £840 per person (Bauer, 2016).

Some community organisations have conducted or commissioned Social Return on Investment (SROI) studies to assess their value. For example:

- Jones et al (2020) conducted an SROI on a health precinct community hub for people with chronic conditions. They estimated a base case SROI ratio of £5.07 of social value generated for every £1 invested. Sensitivity analysis yielded estimates of between 2.60:1 and 5.16:1.
- The Social Prescribing Network reviewed four studies that calculated SROI. Patients, Local Authorities (LAs) and the Department of Work and Pensions (DWP) were commonly cited stakeholders. Improved mental wellbeing outcomes and higher rates of employment were examples of positive externalities considered in SROI but excluded from ROI analysis. The mean SROI was £2.30 per £1 invested in the first year (Polley, 2017).
- Social Value Cymru (2017) conducted an SROI of a social prescribing model by Mantell Gwynedd, finding a return of £3.42 in social return for every £1 invested over two years (Social Value Cymru, 2017).

Such studies suffer from the same issues noted above regarding access to healthcare, namely the risk of bias and the role of discretion in terms of what is valued and what is not, which limits comparability. Furthermore, the benefits typically included in such studies are not just limited to the value of physical and mental health benefits to people, but also savings to government. Thus, from the perspective of this project, they combine benefits to people and benefits to government.

4.4 Application to the CCSF VfM model

Values

For lack of a better estimate to incorporate improvements in physical health, we have used the Quality-Adjusted Life Year (QALY). This is a value widely used in assessing health benefits. As grantholders typically do not seek to increase health directly (it is one of the least common outcomes) and there is little quantitative evidence on how much of a difference community-based health interventions make in terms of a QALY, we feel like this is a sensible unit value. For this analysis we use the Department of Health's value of a QALY of £60,000 (Glover & Henderson, 2010), as referenced in the HM Treasury Green Book.

Level of change

Given the large variations in effectiveness and the limitations discussed above, we have estimated the change in units of outcome as 1-5 days of a QALY (i.e. 0.27% - 1.37% of a year). These are judgements based on our interpretation of the evidence.

Distribution of grantholders

Nearly two-fifths (39%) of grantholders' respondents stated that their services had contributed to people's physical health being better. This equates to an estimated 1,211,500 beneficiaries receiving the outcome (after extrapolation and adjusting for grantees' perception of the proportion of beneficiaries receiving the outcome).

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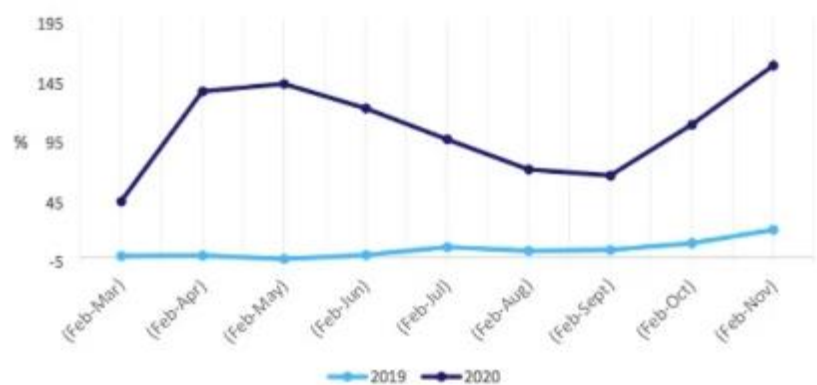
5 People's short-term basic needs were better met

5.1 How the pandemic affected short-term basic needs

Food, Toiletries, and Household Items

The pandemic left many families unable to buy food. Loopstra (2020) estimated that in April 2020 the number of adults who were 'food insecure' had quadrupled, with 8.1 million people experiencing food insecurity and 3 million people going hungry during the first few weeks of lockdown. This crisis endured as the year dragged on. With winter approaching, the Trussell Trust (2020) forecasted a 61% increase in food parcels needed across its UK network from October to December 2020 compared to the previous year. The Salvation Army (2020) reported that the number of food parcels distributed by a bank in Liverpool had increased ten-fold. When the Independent Food Aid Network reviewed data across 83 UK food banks, they found a 110% rise in demand from February to November 2020 compared to the same period in the previous year.

Figure 5.1: Percentage change in the number of emergency food parcels distributed by 83 UK independent food banks 2019 and 2020. Source: (Independent Food Aid Network, 2020)



Around half of the people who used a food bank at the start of the pandemic had never needed one before (Trussell Trust, 2020). The food foundation (2021) estimated that over one in five households had lost income since the start of the pandemic (22%), with 4.7 million adults and 2.3 million children going hungry or struggling to buy food over the previous 6 months.

Loopstra (ibid) identified three core sources of the rise in food insecurity:

- 1) People who were already in financial difficulty.
- 2) People who were newly economically vulnerable (i.e., those who had lost work or free school meals for their children while schools were closed).
- 3) People isolating or shielding who could not get provisions.

Demographically, unemployed people, adults with disabilities, those with dependents, and ethnic minority groups were all more likely to be at risk of food insecurity (Loopstra, ibid). People with severe medical conditions that compromised their immunity also faced increased hardship (Food Foundation, 2021).

The Food Foundation found poverty or low income to be the main reason for food insecurity (55% of their sample). Social isolation was also a significant factor (31%), as were shortages of food in shops (23%).

In response to the rise in hunger, many VCSE organisations and community interest companies repurposed their offer towards food support. For example, in Bradford, 42% of the services providing food during the pandemic were 'new' (Graven et al, 2020).

Food banks are the main way of providing food support, yet the data on their use is poor. Garrett (2017) notes that food bank data tends not to distinguish between one-off and repeat users, so the true prevalence of food bank use in Britain is unknown. She estimated that there were more visits to food banks by working-age and one-person households.

COVID restrictions significantly affected food banks' operations, forcing them to adopt telephone or electronic referral systems, or dispense with the requirement for referral all together (Barker, 2020). More worryingly, food banks themselves found it hard to get food because of fewer donations and supermarkets having less surplus stock.

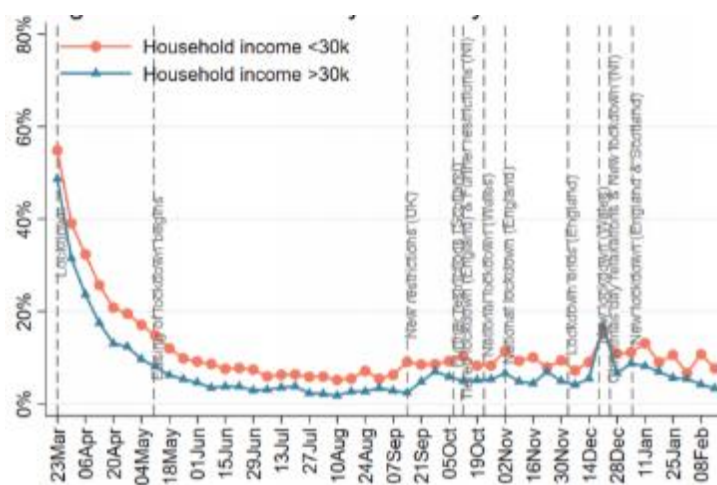
Demand for volunteers rose as VCSE organisations tried to provide food to people who were shielding. Many food banks faced shortages in volunteers towards the end of 2020 as fatigue and exhaustion set in (Hargrave, 2021). The need for personal protective equipment (PPE) added an extra layer of complication for those trying to provide food (Papadaki et al, 2021).

Other types of food support included door-to-door services like 'Meals on Wheels'; 'Soup Kitchens' that provide a mix of hot and cold food; and free school meals. While evidence for demand for these services is patchy, organisations providing them reported an increase in demand from new users during the pandemic. Food delivery services also provided supplementary services, such as encouraging clients to eat, keep physically active, and continue to take medication, as well as helping with chores and making welfare and safety checks (Papadaki et al, 2021).

UCL's COVID-19 social study assessed the psychological and social experiences of the crisis for over 70,000 respondents between March 2020 and February 2021 (Fancourt et al, 2021). The study found food security stress levels considerably dropped between March and June 2020 as food became more available (in part because shop shelves were no longer emptying so quickly), non-essential shops reopened, and schools began to return. However, households with lower incomes still faced more food-related stress compared to people with higher incomes (see Figure 5.2).

In summary, we can see a clear increase in food bank support as the sector responded to a genuine increase in hunger across the population. Support was mostly targeted at the economically vulnerable, but also at people who were shielding. The main period of food insecurity stress was at the start of the pandemic, and it later declined during the summer. However, food bank use remained significantly higher compared to pre-2020 levels. People

Figure 5.2: Levels of food security stress by household income.
Source: (Fancourt et al, 2021)



who were socially isolated worried less about food as time went on. However, those on lower incomes continued to use food banks and experienced higher food security stress throughout the pandemic.

Financial Support

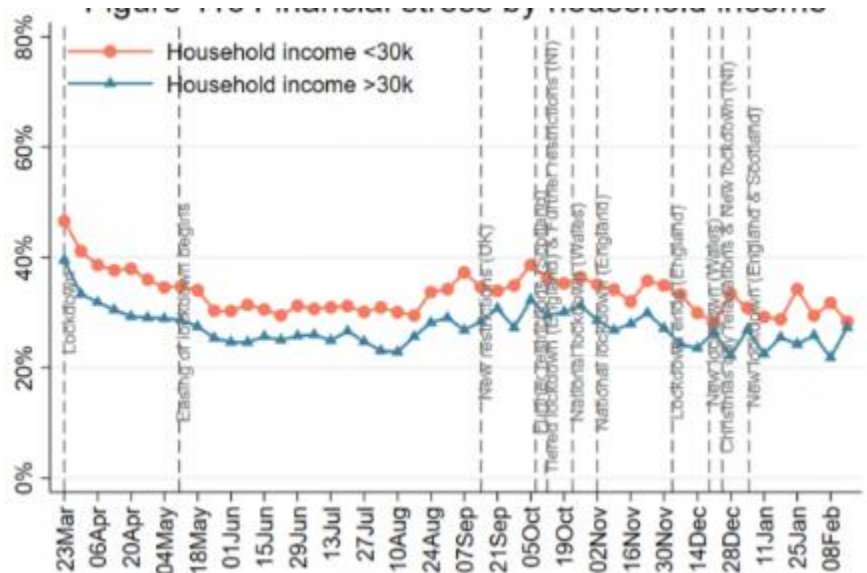
Braga et al (2021) reported “a rapid increase in financial distress during the COVID-19 pandemic across all UK nations and regions, with households in London experiencing the highest relative increase in financial vulnerability.” This was based on a financial vulnerability index with six factors: 1) carrying defaulted debt; 2) using alternative financial products; 3) claiming social benefits; 4) lacking emergency savings; 5) holding a high-cost loan; and 6) relying heavily on credit.

According to the Legatum Institute (2020), there was a 16% increase in financial vulnerability between Q1/Q2 2020; by summer 2020, 444,000 more people were in poverty, in part due to the fall in employment. The Financial Lives survey (FCA, 2021) found that the number of adults with low ‘financial resilience’ (i.e., the ability of people to withstand life events that affect their income) increased by 3.5 million between March and October 2020. Analysis by Step Change (2021) found COVID to be the fifth most common reason for debt during the period.

Analysis by NPC and Turn2Us looked at benefit calculator use as a proxy indicator for the number of people requiring financial assistance. They found a 60% rise in demand for the service between January and June 2020 compared to the same period in 2019. In March 2020, demand was more than 250% higher than the same period in the previous year. They also found a change in the characteristics of those seeking support. Local Authorities with less deprivation saw the sharpest increases, alongside people with mortgages. The number of users with a disability also rose significantly.

Since the rollout of Universal Credit, VCSE organisations have become increasingly important as grant providers (Big Issue, 2019). It often takes five weeks for people receiving Universal Credit to get their first payment, so VCSE organisations have had to fill the gap. The pandemic increased people’s financial insecurity, thus increasing benefit reliance, which in turn increased demand for charitable ‘stopgap’ support. At the same time, people have tried to reduce their spending. For example, in June 2020, mortgage payment deferrals hit a peak of 1.8 million. This fell to approximately 130,000 by December 2020 (Carter, 2021).

Figure 5.3: Financial stress by household income. Source (Fancourt et al, 2021)



UCL’s COVID-19 study (see Figure 5.3) also looked at financial stressors—for instance, the ability to repay debt—and found that households with lower household income felt higher levels of stress during the whole grant period.

Housing and Homelessness

The government tried to minimise the effect of the pandemic on homelessness through an eviction ban and providing hotel rooms. Data from the COVID-19 Emergency Accommodation survey estimates that 14,610 rough sleepers were given emergency accommodation in response to the pandemic (ONS, 2020) and that statutory homelessness dropped 11% from April to 19th June compared to the previous year. This was largely thanks to the “Everyone In” scheme and the ban on private rented sector evictions (ONS, 2020a).

The Homelessness Monitor (Crisis UK, 2021) noted that “*thanks to temporary protective measures (especially income protection programmes and eviction moratoria), the COVID-19 pandemic triggered no immediate overall increase in homelessness applications. The number judged as threatened with homelessness fell back significantly between April-June 2020 (down 35 per cent on the previous quarter)*”.

By Q4 2020, 62,250 households were assessed as homeless or threatened with homeless, a reduction of 9% on the previous year, while the number of households in temporary accommodation had risen from 88,310 to 95,370 compared to the previous year. Shelter (2020) noted that in March 2020 one in four privately renting adults (27%) feared becoming homeless (2.2 million people).

Another Crisis report (Crisis, 2020) noted that Local Authorities and voluntary groups reported increases in demand (and need) for services from the start of the pandemic. Over half (53%) of services across Great Britain reported an increase in homelessness in their area, with a further 73% stating demand of their services had increased since the start of the pandemic.

ADASS (2020) stated that there was a 40% increase in the proportion of rough sleepers presenting with social care needs to Local Authorities. In part, this is attributable to the government directing all Local Authorities to find emergency accommodation for all rough sleepers, which provided an obvious incentive for people to come forward.

5.2 Effectiveness of social sector organisations at influencing short term needs

What do social sector organisations do?

Meeting short-term basic needs means providing essential goods and services to beneficiaries. In our grantholder survey, we separated these into the categories shown in Table 5.1.

Table 5.1: Types of Short-Term Basic Needs

Type of short-term basic need support provided	Estimated no. of grantholders (extrapolated)	% of all grantholders	% of grantees providing short-term basic needs
Food	2850	29	79
Toiletries and hygiene products	1990	20	56
Essential household items	1680	17	47
Clothing	920	9	26
Emergency cash grants	380	4	11
Accommodation	470	4	10
Other	2280	12	33
Don't know	27	0.2	0.5

Source: Ipsos MORI Grantholder Survey.

Most grantholders gave out food, so this is the focus of our review. For the purposes of VfM assessment, we have combined food with ‘toiletries and hygiene products’, ‘essential household items’ and ‘clothing’ because these items are generally also donated by food banks and there is no separate literature about them. In contrast, emergency cash grants and accommodation have their own providers, and enough has been written about them for us to consider them separately.

What is the state of the evidence base?

The evidence gives us a positive, if limited, picture of the effectiveness of grantholders in meeting short-term basic needs. Most studies focus on the perceptions of people using a particular service—whether they found it useful, etc.—and this kind of evidence is subject to a range of biases and so only helpful as a guide.

The literature is strongest for accommodation support, where there have been several systematic reviews of major interventions, although VCSE sector engagement in these services is more limited. The evidence on food, and the immediate relief of short-term basic needs, is more limited, especially when it comes to understanding what it helps people achieve in the longer term. Rather, the literature has tended to focus on what drives food bank use and the nutritional quality of food bank provision. The evidence of financial support (i.e., cash grants) is weakest in the UK context.

What does the evidence tell us?

Food, Toiletries, Household Items

Most evidence on the effectiveness of VCSE interventions focusing on essential item support is qualitative, including process evaluations, exploratory pilot studies, and annual reports. There is little empirical evidence and few systematic reviews.

A review on the quality of food provided by food banks (Bazerghi, 2016) found that, *“while food banks have an important role to play in providing immediate solutions to severe food deprivation, they are limited in their capacity to improve overall food security outcomes due to the limited provision of nutrient-dense foods in insufficient amounts, especially from dairy, vegetables and fruit.”* In addition, some of the data showed that food banks are not always able to *“ameliorate short or long-term food insecurity”*. Effect sizes were not provided.

An illustrative example of a perception-based study would be the independent evaluation of Stoke on Trent Foodbank (Wider Impact Consultancy, 2017), which reported that:

- 83% of participants reported their stress and anxiety levels fell after being given emergency food.
- More than 70% said they have been positively supported through signposting to or from other partner agencies.

Similarly, a Social Return on Investment study for FareShare by NEF (2018) surveyed VCSE organisations who receive food from Fareshare, known as Community Food Members (CFMs). They found that out of 568 CFMs, 77% believed that FareShare food had improved their client’s diet and that 62% agreed with the statement that the ‘food provision had made clients worry less about money’. They also estimated that Fareshare created £51 million of social-economic impact through redistributing surplus food to communities. These outcomes included better employment prospects; improved financial situations; improved mental health; and increased knowledge and access to other services. However,

the report acknowledges that evidence was limited, and the analysis included “intuition to assess long-term trends in outcome incidence”.

Better evidence comes from the US. An et al (2018) conducted a systematic review of **food pantry interventions** in the USA, five of which were Randomised Control Trials. They found that they were effective at improving participants’ diet-related outcomes, including their nutritional knowledge, cooking skills, food security status and fresh produce intake. Additionally, the interventions helped clients improve their food selection, and reduced participants’ glycaemic level. In addition, ‘**Food display interventions**’ helped pantry clients select healthier food items, and diabetes management interventions reduced participants’ glycaemic level.

Campbell et al (2015) conducted a systematic review of **home-delivered meal programmes** for people struggling to afford food, which found some positive results. However, many of the studies found were descriptive (qualitative) and did not report on outcomes systematically. Further limitations of the literature included the use of cross-sectional rather than longitudinal data, small sample sizes, and/or focus on a particular setting or participant population—all of which weakened the conclusions.

A systematic review of **breakfast clubs** in the UK by Lambie-Mumford & Sims (2018) found a “*stark lack of robust and systematic evidence on these projects, despite their popularity*”. The interventions reviewed found a mixed bag of evidence on outcomes relating to education, health, social inclusion, and family life.

Financial Support

There are few high-quality evaluations looking at the effect of direct loans or grants in the UK. As elsewhere, conclusions are generally drawn from the perceptions of beneficiaries rather than robust or longitudinal analysis.

An internal evaluation of Family Actions’ Open Doors Programme (Family Action, 2016) looked at the outcomes of approximately 1,100 grants of average value £321 between 2013 and 2015. Two thirds of beneficiaries claimed the grants had helped them “enormously”. Outcomes included a significant increase in subjective wellbeing and beneficiaries experiencing a greater sense of control, trust, resilience and security. Only 11% of beneficiaries said they felt “in control” of their lives before receiving the grant, compared to 56% afterwards. Nearly 90% felt that their situation would have worsened if they had not received the grant.

Greater Manchester Poverty Action (2020) highlighted the benefits that a “cash first” approach can provide by increasing dignity, removing stigma, and giving people choice and control. The report cites evidence from the Local Government Association—which called for more of this support for those facing financial hardship and added that “*providing direct cash payments will maximise flexibility and choice*”. The Child Poverty Action Group (2020) highlighted that direct cash replacement of free school meals in lockdown was significantly more popular than a voucher scheme.

The Independent Food Aid Network has started working on the role of shopping vouchers instead of or alongside food vouchers, as a step towards pushing for a “cash first” approach. They found that in the right circumstances vouchers can be a more effective way (compared to food parcels, for instance) of ensuring people get the right support, although they do not provide quantitative data demonstrating the higher effectiveness of this approach (IFAN, 2021).

Housing and Homelessness

The evidence on housing and homelessness interventions is stronger than for food banks and direct cash grants, although it is not always clear where VCSE organisations lie in the provision of services. For instance, a systematic review and meta-analysis conducted by Aubry et al (2020) found permanent supportive housing and income assistance are effective at increasing longer-term housing stability. However, permanent supportive housing interventions did not have a measurable effect on psychiatric symptoms, substance use, income, or employment outcomes when compared with other social services. Furthermore, income interventions, including housing subsidies, ensured that people were more stably housed, though again there was no clear effect of income interventions on mental health and employment outcomes.

There have been multiple systematic reviews of Housing First projects that provide “*access to settled, independent housing which is not conditional on the person being ‘housing ready’*” (NIHR, 2021). Crisis (2018) note that the volume of evidence exceeds any other housing interventions. An evaluation of nine England based housing first interventions conducted by the University of York (Bretherton & Pleace, 2015) found the housing first clients experienced the following outcomes:

- ‘Very bad or bad’ physical health fell from 43% one year before using Housing First to 28%.
- ‘Very bad or bad’ mental health fell from 52% one year before using Housing First to 18%.
- Drug use fell from 66% one year before using Housing First to 53%.

There is also economic research on the value of housing and homelessness interventions. For instance:

- The Institute for Health and Human Development (IHHD) (2015) conducted an SROI of a homeless shelter in Haringey. They found a minimum SROI ratio of £4 per £1 invested.
- The Glasgow Association for Mental Health Housing Support Services (GAMH) (2012) conducted an SROI of their activities of community support services, housing-related support, and homelessness support. They found £3 in social value per £1 invested.
- Crisis conducted 165 interviews and case studies looking at the economic cost to the government of preventing homelessness. They found that the average cost of intervention to be between £1,554 - £4,726 and the cost of homelessness to be between £11,733 - £20,128 in public service use over a 12-month period. The research did not look at the value for beneficiaries directly.

These studies are useful for understanding the benefits to the exchequer and to wider society. However, they do not demonstrate the value of such services specifically to beneficiaries.

In summary: How applicable is the research to CCSF grantholders and beneficiaries?

Food, Toiletries, Household Items: In summary, we can be confident that food banks and cash grants clearly respond to an immediate need and are appreciated by those who use them. But there is limited robust or quantitative evidence of their effectiveness beyond meeting those immediate needs and how they might help people to achieve other outcomes.

Financial Support: Overall, there is limited evidence of the effectiveness of direct cash grants to beneficiaries within the UK context; with only one study providing quantitative data. But equally, no evidence was found to suggest that cash grants within the UK context were ineffective.

Housing and Homelessness: Overall, we found a strong likelihood that housing and homelessness interventions are effective at improving longer-term housing stability. The impact on other goals is less certain.

5.3 What is the value of short term basic needs?

Intuitively, receiving emergency support should be significantly valuable to beneficiaries. This intuition is supported by the research noted above and our interviews with CCSF grantholders. But translating this to a monetary value of support provided by CCSF grantholders is complicated by:

- The change in emergency needs over the course of the pandemic. The greatest period of need seems to have been prior to the period covered by the CCSF grant.
- The variation in duration and intensity of support provided by grantholders. For example, this could range between providing just one food parcel and providing support over six months.
- Evidence that the nutritional quality of food bank packages are typically not enough to sustain a full diet, and therefore food banks only partially address food needs.
- Evidence that, for some beneficiaries, increased social contact was as important as the material support or even more so. Evidence from the CCSF qualitative research suggests this was a more important criteria for some beneficiaries.

Conceptual issue

Alleviating basic needs could be seen as a transfer payment, whereby something of value (e.g., money) is transferred from one group to another without any increase in value. Taxes and welfare payments are transfer payments. Transfer payments are ignored in cost-benefit analyses because the costs equal the benefits.

But there are two reasons why we are not treating services to meet basic short-term needs as a transfer payment. First, in the case of the CCSF, some of the people who received support via food banks or housing support may have gone into a far worse crisis without it. The support may therefore have prevented the need for future charity or public services. In doing so, the support created value (by reducing the consumption of future resources). In addition, providing supplies (e.g., food) that are needed in an emergency may create more value, in terms of improving wellbeing, than providing those same supplies under normal circumstances when they are not needed so urgently.

As elsewhere, our best source is the HACT Social Value Bank database. The Social Value Bank provides monetary values of a variety of outcomes, based on regression analysis of national survey data on the wellbeing and circumstances of people's lives (Fujiwara et al, 2013). For example, the value of being able to pay for housing is estimated at £7,347. This is based on the finding that answering "no" to the question: "In the last 12 months have you had any difficulties paying for your accommodation?" has an impact on wellbeing equivalent to an increase in annual income of £7,347.

5.4 Application to the CCSF value for money model

Values

We used wellbeing values from the HACT social value bank to estimate the value of beneficiaries' short-term basic needs being met. Specifically, we used the following values:

- Food, Toiletries, Household Items: the value of being debt-free (£1,593) as a lower bound estimate and the value of “Living comfortably or doing alright compared to just about getting by or finding it quite / very difficult” (£8,917) as a higher bound estimate.
- Financial Support: the lack of a clear evidence base on the effectiveness of financial cash grants means we have not provided a value for this outcome.
- Housing and Homelessness: a lower bound estimate from individuals feeling like they are “Able to pay for housing” (£7,347) and a higher bound estimate of moving from temporary to secure housing (without dependent children) (£8,036).

Level of change

Given the uncertainty of the data on effectiveness and the limitations discussed above, we estimate CCSF grantholder services create between 1% and 5% of this value for food and toiletries, etc. and between 5% and 10% for housing and homelessness. These are judgements based on our interpretation of the evidence.

Distribution of grantholders

Forty-four percent of grantholders’ respondents stated that their services had contributed to “People’s short-term basic needs were met better (e.g. financial, food, clothing, shelter)”. This equates to an estimated 1,573,600 beneficiaries receiving food and basic supply support, and an estimated 93,100 receiving accommodation support (after extrapolation and adjusting for grantees perception of the proportion of beneficiaries receiving the outcome).

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6 People who had more social contact / People who felt less lonely

6.1 How the pandemic affected social contact and loneliness

Loneliness is a significant public health issue, associated with a heightened risk of numerous mental and physical illnesses, including anxiety, depression, obesity, cognitive decline, and mortality (NIA, 2019).

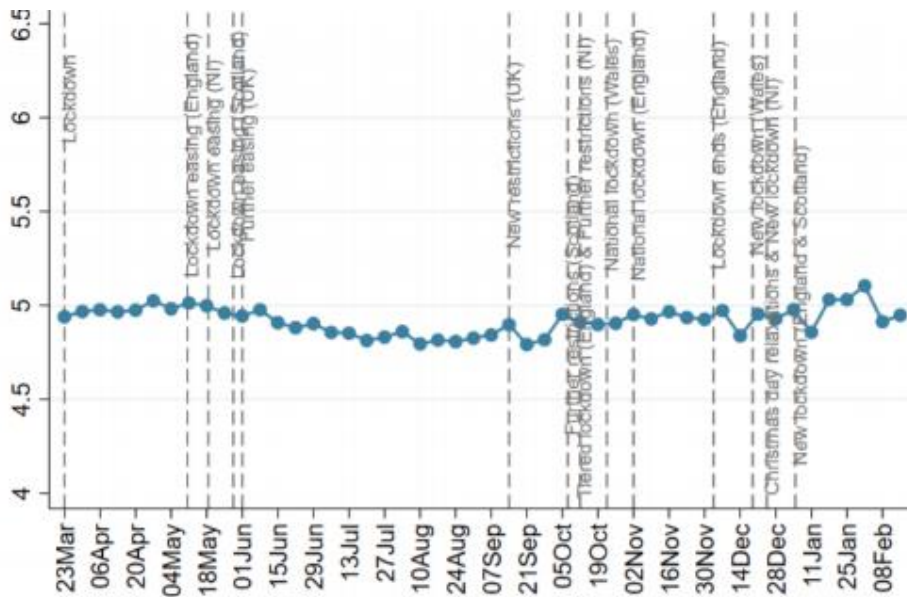
Social isolation is often associated with loneliness⁸: People who are socially isolated already lack the social contacts to reach out for support, which puts them at higher risk of depression, anxiety, suicide, and physical health issues such as strokes (CDC, ND).

Lockdown naturally limited social contact between people, thereby increasing their risk of experiencing loneliness—either for the first time or more severely than before. Moreover, it was more difficult to get help as ‘stay at home’/lockdown orders severely limited face-to-face interventions by public and voluntary services.

Who was affected?

Between 3rd April and 3rd May 2020, ONS (2020) reported an increase in the number of people who identified as “lockdown lonely”, equivalent to 14% of the population. This was a subset of individuals who had said their overall wellbeing had been affected by the pandemic. However, this is self-reported data, and more reliable tracking studies indicate the actual effect of the pandemic was smaller. For example, Fancourt et al (2021) looked at aggregate loneliness from the start of the pandemic into 2021 and found a fairly constant picture (see Figure 6.1). ONS also reported similar levels of chronic loneliness (“often” or “always” feeling lonely) between 3rd April and 3rd May 2020 (5%) to pre-lockdown levels.

Figure 6.1: Loneliness (measured by the UCLA-3 loneliness scale). Source: Fancourt et al (2021)



⁸ Loneliness is the feeling of being alone, whereas social isolation is characterised by a lack of social connections. These factors are highly conflated in the empirical literature hence we treat the literature together for this section. Where it is meaningful and helpful to do so we attempt to separate these concepts out.

Aggregate figures hide significant variation between groups of people, and it seems that lockdown meant some people felt less lonely and some people felt lonelier. Research from ONS (2021), Bu et al (2020) and Fancourt et al (2021) identified the groups who were prone to increased loneliness during the pandemic. These differences are set out below. Where possible, we have highlighted differences on the UCLA-3 loneliness scale (a higher score indicates increased loneliness, with 10 being the maximum), using data by Fancourt et al (2021):

- Younger adults, specifically those aged 18-30 (average score 5.5) compared to people aged 60+ (4.4).
- Women (average score of 5.1) compared to men (4.7).
- Households with income less than £30,000 (5.2) compared to those with income above (4.6).
- People with mental health conditions (6.3) compared to those with no diagnosis (4.6).
- People living in urban areas (5) compared to people living in villages (4.6).
- Ethnic minorities (5.3) compared to White people (4.9).
- People with a physical health diagnosis (5.1) compared to no diagnosis (4.9).

Additionally, Bu et al (2020) highlight that the economically inactive (or people in areas with high unemployment) are also more likely to experience loneliness. Conversely, a study by Groarke et al (2020) found that protective factors for avoiding loneliness included having higher levels of social support, being married or co-habiting, and living with a greater number of adults.

Loneliness and isolation are often assumed to be associated with old age. However, the evidence on this is not clear cut. ONS (2018, 2020) report that feelings of loneliness actually tend to decrease with age (possibly due to increased resilience), and that age by itself is not considered a significant factor for being chronically lonely. Of more significance was being disabled, having a medical health condition, being divorced, living alone, or being in rented accommodation. Conversely, Age UK (2018) argue that “chronic loneliness” is more likely to be felt by older cohorts and that there are 1.4 million chronically lonely older people in the UK. This would represent over half the chronically lonely population, which according to ONS (2020) is 2.6 million people across Great Britain.

Bu et al (2020) used data from the UCL COVID-19 Social Study, a large non-random panel study of the psychological and social experiences of over 70,000 adults (aged 18+ years) in the UK during the first few weeks of the COVID-19 pandemic. Most significantly, this study found that **people who were most lonely prior to COVID-19 were even lonelier during the pandemic.**

Digital exclusion was a significant factor exacerbating social isolation during the pandemic. ONS (2020i) estimated that there are 1.9 million households without access to the Internet; and millions more economically vulnerable people who are reliant on pay-as-you-go services. Additionally, adults unfamiliar with technologies (such as smartphones, the Internet, or tablets) are also at risk of social isolation. Age UK (2021) estimated that nearly two million over 75's in the UK (approximately 42% of this age group) were not using the Internet due to not having access or not knowing how.

Overall, we can say that while the proportion of the population who experienced chronic loneliness appears to have remained stable during the COVID-19 epidemic, a new class of ‘Lockdown Lonely’

people emerged who still required support—although the loneliness and social isolation they experienced was more likely to be mild in nature as opposed to chronic (severe) loneliness.

6.2 Effectiveness of social sector organisations at influencing loneliness and social isolation

What do social sector organisations do?

Many grantholders provided interventions that supported lonely or socially isolated people during the pandemic, which was a time of increased stress. Activities varied a lot: very many grantholders did outreach work (for example, through befriending), while others worked hard to establish online networks and communities. Often, reductions in loneliness were achieved incidentally as a bi-product of delivering other services—for example, providing advice, food deliveries, mobile libraries, etc. Grantholders also gave lots of people opportunities to get involved, volunteer and contribute to their communities.

What is the state of the evidence base?

So far there has been a lack of high-quality evaluation looking at the effects of interventions on social isolation or loneliness—for instance, very few randomised or quasi-randomised trials. Similarly, there has been a lack of economic evaluation. Part of the problem is that few studies have looked at loneliness and social isolation as a singular factor—it is often seen as a contributing factor to something else (McDaid et al, 2017).

This lack of evidence is partly down to the lack of general models or theories about how to tackle loneliness, as well as the context-specific and flexible nature of most interventions. As noted by Fakoya et al (2020): *“There is no one-size-fits-all approach to addressing loneliness or social isolation, and hence the need to tailor interventions to suit the needs of people, specific groups or the degree of loneliness experienced.”*

What does the evidence tell us?

The studies that have been done do not indicate that interventions have a particularly powerful effect on reducing social isolation and loneliness.

Most notably, a systematic review of reviews conducted by the What Works Centre for Wellbeing (Victor et al, 2018) looked at 14 systematic reviews and unpublished literature on a range of interventions (mostly targeted at older age groups⁹). While there was no evidence that the interventions did harm, results from controlled study designs and care homes stated that there was **no effect of interventions on loneliness, and therefore the effectiveness of interventions to alleviate loneliness is limited.** This observed non-effect of interventions on loneliness occurred *“regardless of setting (care home or community), mode of delivery (individual or group) or type of activity.”* Of main interest to the CCSF evaluation was the review’s assessment of ‘care in the community’—i.e., interventions outside a care home, which were closest to what CCSF grantholders provided. Here, some studies have suggested these are “potentially effective” in that they produce small improvements in loneliness, but overall, the evidence is weak.

It is important to stress that this review’s conclusions were not definitive. They noted the general lack of evidence on loneliness interventions for adults of all ages, and particularly the lack of evidence for

⁹ There was some minor representation on LGBT groups, men’s groups, and vulnerable adults.

interventions focused on children. Also, loneliness was rarely the main outcome in the interventions reviewed, and the majority of the studies were too small-scale to be able to find measurable effects.

Other systematic reviews have been more positive. Poscia et al (2018) found that tailored interventions (targeting the needs of the individuals), interventions using technology (such as companion robots and telephone befriending) and community engaged arts programmes had proved successful. The review found that 6 out of 11 group interventions reviewed significantly reduced loneliness and social isolation, as did 1 in 4 mixed interventions (individual and group) and all 3 individual interventions. Unfortunately, the study did not provide effect sizes, so it only gives us indicative information for this evaluation.

A review of loneliness interventions for non-elderly adults conducted by Bessaha et al (2020) covered 54 quantitative studies and found that interventions involving technology and support groups can significantly reduce loneliness. The review also looked at interventions across several groups and found that there is evidence to support both individual and group interventions alongside technology-based interventions (e.g., virtual self-help groups). However, once again, effect sizes are not provided.

Eccles and Qualter (2021) conducted a meta-analysis of loneliness interventions targeted at young people (39 papers), finding a mean positive effect size of ($g=0.411$). Interventions that focused on social and emotional skills had the largest effect sizes, followed by interventions which included psychological therapy.

Noone et al (2020) conducted a rapid review of using video calls to reduce social isolation, specifically among older people. Having reviewed three cluster quasi-randomised trials, the evidence was uncertain and suggested that video calls make “little to no difference in scores on” either the UCLA Loneliness Scale or Geriatric Depression scale, or in their quality of life over three to six months. The authors noted that after a year there may be a small reduction in depression compared to usual care.

Effect sizes of interventions were presented in a meta-analysis of loneliness interventions conducted by Masi et al (2011), breaking interventions into five separate areas: 1) improving social skills, 2) enhancing social support, 3) increasing opportunities for social interaction, and 4) addressing maladaptive social cognition. Overall, addressing maladaptive social cognition (i.e., cognitive behavioural therapy) appeared to produce the best results in reducing loneliness.

How applicable is the research to CCSF grantholders and beneficiaries?

The research provides a mixed picture about the effectiveness of interventions to tackle loneliness. The Victor et al (2018) review found limited to no effect of interventions on loneliness, as did the Noone et al review (2020). However, some positive effect on reducing loneliness was found in Bessaha et al (2020) and Poscia et al (2018), particularly for interventions aimed at a non-older population and involving digital technology. For younger people, the meta-analysis conducted by Eccles & Qualter presents a significant result and a clear effect size.

Another limitation of the systematic reviews is that they did not focus on charitable provision of interventions and many of the interventions mentioned were not delivered by VCSE organisations. This makes it difficult to produce a singular estimate for “depth”.

Based off the evidence above, we believe it is therefore appropriate to state that most beneficiaries will have received “low change” intervention, with the Home Office-backed Victor et al study (2018) acting as our principal source. Our estimate for the level of change is presented below.

6.3 What is the value of social contact and reduced social isolation?

Whilst the evidence for loneliness interventions may be slim, there have been several studies into the economic costs of loneliness.

Fulton and Jupp (2015) estimated a total cost of being chronically lonely of £11,725 per person over a 15-year period. 40% of this cost occurred within the first 5 years of being lonely, partially due to their modelling assumptions that the annual costs of loneliness associated with GP visits, A&E visits and unplanned admission will last for two years. 20% of the costs were associated with residential care. This is based on an estimate that older people who are lonely are on average 3.5 times more likely to enter Local Authority-funded residential care, compared to people who are never lonely. In addition, lonely people accessed healthcare services at 1.3-1.8 times the rate of non-lonely people, probably because they were more likely to develop certain health conditions.

Mihalopoulous et al (2020) conducted a systematic review of 'cost of illness' and economic evaluation studies related to loneliness interventions and found that economic estimates ranged from an incremental cost effectiveness ratio (ICER) of £2900 to £15,962 per Quality-Adjusted Life Year (QALY) for different interventions. Similarly, the study found conflation between the terms 'loneliness' and 'social isolation', and variation in measurement approaches, meaning that the economic cost could not be measured appropriately via a meta-analysis.

McDaid et al (2017) estimated the health and social care services costs to a cohort of people aged over 65 over a ten-year period. They conservatively estimated that costs per individual to these services due to loneliness could be at or above £1,700 per person, while costs for older people who were most severely lonely could be greater than £6,000.

The most authoritative source is the DCMS report on Loneliness Monetisation by Peytrignet et al (2020). Through multivariate analysis of data from Understanding Society (USoc) and the Community Life survey, they found that loneliness (whether infrequent or persistent) had a significant and negative impact on wellbeing. On this basis, the authors conservatively estimated that the cost of severe loneliness is equivalent to at least £9,537 per person per year, which may be higher (up to £17,043) due to causality effects and links with other outcomes. For instance, does low wellbeing produce loneliness, or is it the other way round? Similarly, it is hard to disentangle the link between loneliness and depression.

The study also looked at additional costs to the exchequer:

- **The impact of loneliness on health.** The authors drew from the modelling of McDaid et al (2017), which looked at the additional healthcare costs attributed to severe loneliness in older people—either through hospital admissions, or increased outpatient care or GP visits. They have also looked at the impact of loneliness on workdays lost, based off estimates by New Economics Foundation (2017). This leads to a combined estimate of health costs of £109 per person per year.
- **The productivity impacts on loneliness.** Again, the authors use data from NEF, estimating that employees experiencing loneliness are 1.3% less productive than those who do not feel lonely. This equates to productivity costs of £330 per person per year.

The table below summarises these values for the health, productivity, and wellbeing impacts of loneliness by severity. They note that the values set out in this report can be applied to a generally lonely cohort (aged 16+), and that while health impacts have only been estimated for those over 65, they made adjustments so that these values can be applied to the average person affected by loneliness.

Table 6.1: Loneliness monetisation valuation, by severity

Impacts	Lack of, to mild loneliness	Mild to moderate loneliness	Moderate to severe loneliness
Health	Evidence NA	Evidence NA	£109
Productivity	Evidence NA	Evidence NA	£330
Wellbeing	£6,429	£8,157 to £9,537	(at least) £9,537
Total	£6,429	£8,157 to £9,537	(at least) £9,976

Source: Peytrignet et al (2020).

We can also draw on the Wellbeing Valuation Approach used by the HACT Social value bank. In particular, for increased social contact, the database records the value individuals place on being part of a group or interacting with neighbours.

6.4 Application to the CCSF value for money model

Major questions remain about how to apply beneficiary-specific monetary values relating to loneliness. We do not know the proportion of grantee beneficiaries who experienced severe loneliness, compared to those who experienced mild to moderate loneliness, which affects the values we can apply to each segmentation class. We do, however, have an authoritative, government-backed estimate of the value of the wellbeing cost of loneliness to beneficiaries from the Peytrignet et al (2020) research.

The conflation of social isolation and loneliness in the literature is unhelpful. We do not know the proportion of beneficiaries who are socially isolated, and who therefore benefit significantly from social contact, compared to those who are experiencing mild loneliness and would only benefit somewhat from social contact. Also, in the grantholder survey data there was a strong correlation between social contact and improved loneliness: two thirds of grantholders (67%) said their intervention had decreased *both* loneliness and social isolation and 17% stating either. Only 17% of grantholders selected neither of these options.

Values

On beneficiary valuation of outcomes values, we used the wellbeing mid-point estimate of mild to moderate loneliness reduction (£8,847 per year). For 5% of beneficiaries (aligned with ONS population estimates of the population who are chronically lonely), we applied the moderate to severe loneliness of £9,976.

For increased social contact, a beneficiary value estimate from the HACT Social Value Bank was used—namely, “Being a member of a social group”, valued at £1850.

Level of Change

Given the uncertainty of the data on effectiveness and the limitations discussed above, we estimate CCSF grantholder services create between 1% and 5% of change in social contact and feelings of loneliness. These are judgements based off our interpretation of the evidence.

Distribution of grantholders

Nearly four fifths (79%) of grantholders' respondents stated that their services had contributed to people feeling less lonely; and 70% stated that their services had contributed to increasing social contact. This equates to an estimated 163,100 beneficiaries feeling less lonely, and an estimated 23,700 receiving more social contact after extrapolation (adjusting for grantees' perception of the proportion of beneficiaries receiving the outcome, and for the likelihood of double-counting beneficiaries against those who had improved mental health).

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7 People of all ages who were better protected from harm, violence or abuse

7.1 How the pandemic affected the risk of harm, violence or abuse

Domestic violence and child abuse

As with the other outcomes discussed, the COVID-19 lockdown had the combined effect of exposing more people to risk (or more severe risk), while also making it harder to access services that could help. In the context of harm, violence or abuse, lockdown measures put people in greater proximity to abusers and created extra pressures on people that could have triggered problems. Lockdown measures also reduced access to statutory and voluntary services, which could have prevented abuse or helped people recover from it.

The increase in demand for services is illustrated by Refuge (2020), who recorded a 61% increase in calls to their National Domestic Abuse Hotline between April 2020 and February 2021. Similarly, ONS (2020) found that 259,324 domestic abuse-related offences were recorded between March and June 2020, representing a 7% increase from the year before. NPC analysis of data from Buttle UK (NPC, 2020), a charity specifically supporting children and young people, found a 23% increase in cases relating to domestic abuse.

UCL's COVID-19 social study (Fancourt et al, 2021) looked at the psychological and social experiences of 70,000 people from March 2020 to February 2021. The study found the proportion of participants who reported being physically or psychologically abused throughout the pandemic was relatively stable at c.7%. The research suggested that certain groups were more vulnerable: those with a diagnosed mental or physical health condition; younger people; those with lower household income; ethnic minority households; and households living with children. The authors also stressed that their figures might underestimate the prevalence of abuse, as people living with those responsible might be unwilling to disclose or complete the questionnaire.

There is also evidence on the effect of the pandemic on child abuse. One specialist children's hospital reported a 1,493% increase in new cases over a single month (BMJ, 2020) and there was a 27% increase in serious incident notifications (i.e., if a child dies or is seriously harmed) between April and September 2020, compared to the previous year (GovUK, 2021).

There is not yet any evidence on whether the pandemic influenced the severity of cases (Pedersen et al, 2021). One challenge has been that during lockdown, population surveys have been difficult to conduct effectively, as perpetrators/oppressors are likely to be present during the completion of the survey (Feder, 2021). However, Sharma & Borah (2020) noted that following national incidents such as the New Zealand Christchurch earthquake and Hurricane Katrina, both sexual and physical assaults were more severe. ONS (2020) note that while domestic abuse victim services have seen an increase in demand, it does not necessarily indicate that the number of victims also rose; instead, it is possible that existing cases could have become more severe, and that alternative coping mechanisms were not available.

Both of these points allude to the idea that the severity of domestic abuse may have been higher than it was pre-pandemic.

Other forms of harm, violence or abuse

Domestic violence is not the only type of violence, harm or abuse that occurred during lockdown. The ONS 2021 Crime Survey looked at patterns of crime between April 2020 and March 2021. Total crime (excluding computer fraud) was down 19% over the past year, but this obfuscates lockdown-driven variations in different types of crime. While robberies fell by 34% and burglaries by 30%, fraud increased by 24% and computer misuse offences (hacking) by 85%.

Violent crime levels fell, with homicides, knife crime and firearm offences all down by around 15%. However, although the overall numbers of victims of violent crime dropped, the number of offences recorded saw a smaller decrease.

ONS has not yet published data on hate crime during the pandemic period. The appendices of the ONS 2021 Crime Survey suggests that, while “racially or religiously aggravated assault with injury” fell by 16% in April 2020-March 2021 compared to the previous year, and “racially or religiously aggravated assault without injury” fell by 11%, there was a 53% rise in racially or religiously aggravated harassment.

Overall, we can state that the picture of violence, harm and abuse since March 2020 has changed significantly. While there has been a fall in total crime, including violent crime, cases of domestic violence or harassment have increased.

7.2 The effectiveness of social sector organisations in influencing harm, violence or abuse

What do social sector organisations do?

Grantholders reported that they protected people from specific types of harm, as shown in Table 7.1 below.

Table 7.1: Types of harm, violence, and abuse support provided by grantholders

Type of support from harm, violence, or abuse provided	Estimated no. of grantholders (extrapolated)	% of all grantholders	% of grantees supporting people at risk of harm, violence or abuse
Protection from domestic abuse	1070	13	72
Protection from self-harm	790	10	53
Protection from child abuse	470	6	31
Protection from hate crime (including racial, homophobic, religious and / or disability)	440	5	29
Other	250	3	17

Source: Ipsos MORI Grantholder Survey.

Protection from child abuse and domestic abuse were the two most commonly reported outcomes. While protection from self-harm is also included, we will not explore this here as it is covered in our section on improved mental health and wellbeing.

What is the state of the evidence base?

There are a wide variety of domestic violence interventions delivered to different populations. Overall, there is some evidence on their effectiveness, but the evidence base is less conclusive about those delivered by VCSE organisations or in community settings, compared to those provided through public service provision.

With the exception of domestic abuse, the evidence on other types of support from harm, violence or abuse is fairly thin. While there are some examples of evaluations of interventions to address hate crime (such as Pullerits et al, 2020), these typically are not quantitative and do not provide effect sizes.

What does the evidence tell us?

As the most cited outcomes achieved by grantholders, this section focuses on the effectiveness of social sector organisations in preventing or helping people recover from domestic abuse and child abuse.

Hackett et al (2016) conducted a meta-analysis of domestic violence interventions, looking only at studies where the effect size was calculable. This revealed 17 relevant studies and 348 effect sizes. Outcomes reported were coded into six categories ranging from reduced behavioural problems (aggression, or alcohol use) to improved psychological adjustment (depression, anxiety, or happiness); and family relations (mother–child relations, affection, or quality of interaction).

The overall mean effect size of interventions was $d = 0.755$ ([SE] = 088)¹⁰, indicating that the domestic violence interventions had a medium–large effect on reducing victim suffering and achieving other positive outcomes. In terms of outcomes achieved, the largest mean effect size was for reducing maltreatment events, $d=1.118$, and the smallest was for improving family relations, $d=.478$. But all were still positive and significant.

A review of the literature by Shorey et al (2014) found that “advocacy programmes”, which help women access community resources, appear to be broadly effective. Outcomes across multiple studies reported less physical and psychological abuse, less PTSD, less depression, greater readiness to leave abusive partners, and general improvements in quality of life. They also found that counselling appears to have a positive impact, improving coping skills and life functioning. One of the studies (Bybee & Sullivan, 2002, 2005) followed people for three years, and showed that increasing the social support of women and increasing their ability to access community resources helped them avoid abuse over the long-term.

A systematic review by the British Columbia Centre of Excellence for Women’s Health (2013) supports these conclusions. They found:

- Moderate evidence that advocacy services may improve women’s access to community resources; reduce rates of intimate partner violence; improve safety; decrease depression; and improve parenting stress and children’s wellbeing.
- Moderate evidence that skill building (teaching, training, experiential learning, or group learning) with victims of partner violence has positive effects on victims’ coping, wellbeing, decision-making abilities, and safety, as well as on the reduction of coercive and violent behaviour experienced by the individual who has experienced domestic violence.

¹⁰ To learn more about how to interpret Cohen’s D and Standard errors, we recommend viewing this visualisation by Kristoffer Magnusson: <https://rpsychologist.com/cohend/>

- Counselling interventions promote a range of positive outcomes, including reducing incidence of depression and increasing empowerment among individuals who have experienced domestic violence.

However, they also reported:

- Weak evidence on prevention programmes in community settings for high-risk women.
- Limited evidence on primary prevention programmes for children and young people, with only slight reductions in violent behaviours reported.

Finally, a review by Her Majesty's Prison and Probation Service's on the effectiveness of programmes for people **convicted** of intimate partner violence (IPV) concluded that the evidence is "inconsistent and inconclusive" in this area.¹¹

Regarding child abuse, the evidence is weaker again. We did find a systematic review covering RCTs of interventions to reduce child abuse (Levey et al, 2017). Though this did not look specifically at VCSE sector implementation, the paper notes the use of paraprofessionals—i.e., individuals in the community with some training in child abuse. All the studies involved a home visiting intervention, which may not be very applicable to grantholders during COVID, but they were all effective at improving outcomes in relation to child abuse.

How applicable is the research to CCSF grantholders and beneficiaries?

The evidence on the effectiveness of domestic violence interventions is varied and stronger than some of the other evidence summaries addressed in this report. The evidence on the role of VCSE organisations specifically delivering interventions is more limited. Interventions appear to demonstrate moderate levels of effectiveness for creating change.

7.3 What is the value of preventing violence, harm and abuse?

As noted by Logan (2012), most estimates of the cost of partner violence are made at the aggregate rather than an individual level. For instance, Trust for London (2011) calculated the cost of domestic violence across England as equivalent to £5.5 billion, consisting of £1.6 billion for physical and mental health costs; £1.2 billion in criminal justice costs; £268 million in social services costs; £185.7 million in housing and refuge costs; £366.7 million in civil legal costs; and £1.8 billion in lost economic output. Similarly, Waters et al (2004), Walby (2009), and Walby & Olive (2013) all produce estimates at the aggregate level.

More recent data specifically relating to VCSE organisations comes from an independent evaluation of Refuge (NEF, 2021) applying Social Return on Investment (SROI) to their three main services. This report calculated an average SROI ratio of £8.24 per £1 invested over three years. The main source of value is from increased safety (59%); improved social wellbeing (21%); improved economic wellbeing (12%); and improved health (8%).

One of the most authoritative sources on the economic costs of domestic abuse is by Oliver et al (2019). The paper uses data from the Crime Survey for England and Wales on the number of victims by type (likelihood of suffering injury, emotional harm) and the severity of abuse, to estimate the unit costs of

¹¹ We currently do not know the proportion of grantholders working with perpetrators of domestic violence/domestic abuse. We assume this to be a smaller part of the sample.

physical injury and emotional harm. They conclude an overall estimate of £34,015 per case of domestic abuse, broken down by elements in the table below. The report acknowledges limitations to the research in terms of sample sizes, incomplete data, and the exclusion of costs relating to children and wider family (which would produce higher estimates).

Table 7.2: Unit costs of domestic abuse in England and Wales for 2016/17

Costs in Anticipation	Costs as a consequence				Costs in response				Total
	Physical and emotional harm	Lost output	Health services	Victim services	Police costs	Criminal Legal	Civil legal	Other	
£5	£24,300	£7,245	£1,200	£370	£645	£170	£70	£5	£34,015

7.4 Application to the CCSF value for money model

The cost estimates in the section above demonstrate that interventions that prevent the likelihood of harm, violence and abuse can be very valuable. This is supported by our interviews with grantholders. However, translating this into a monetary value of support provided by the CCSF has several complications. These include:

- The variation in duration and intensity of support provided by grantholders. For example, this could range from a single helpline call to refuge support for the whole six months.
- Different interventions to different target groups within the outcome could vary outcome values significantly. For instance, grantholders working with perpetrators (through interventions in the criminal justice system) or non-domestic violence crime (such as grantholders who support individuals who have been victims of fraud) may vary significantly in their estimate from a domestic violence intervention.
- Even looking within domestic violence, we do not know the proportion of grantholders working on prevention, compared to the consequences of violence and abuse along the continuum.

Values

On the wellbeing value faced by those who experience domestic violence, we use the mid-point estimates provided in the NEF evaluation for “Willingness to pay to avoid serious physical trauma” along with the “Willingness to pay to avoid psychological trauma” costs. This equates to $(£26,333.88 + £5103.79) / 3^{12} = £10479.22$.

Level of change

Estimates from the empirical literature states that there is a medium to medium-large effect of domestic violence interventions on outcomes related to victim suffering (by public and non-public sources). Therefore, we base the estimated change in unit of outcome within the 5-10% range. These are judgements based on our interpretation of the evidence.

¹² The SROI was estimated over a three-year period.

Distribution of grantholders

Almost a fifth (19%) of grantholders' respondents stated that their services had contributed to people being "better protected from harm, violence, or abuse". This equates to an estimated 285,800 beneficiaries receiving the outcome (after extrapolation and adjusting for grantees' perception of the proportion of beneficiaries receiving the outcome).

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8 Children and young people whose education and development was better

8.1 How the pandemic affected young people and education

Children's education was significantly disrupted by the pandemic. Schools in England closed on 20th March 2020 and mostly remained that way until September 2020. There was another round of closures from January to March 2021. Even when open, teachers reported that social distancing requirements hindered the effective working of their schools.

In September 2020, a survey of teachers by the National Foundation for Educational Research (NFER) found that nearly all teachers (98%) said their pupils were behind, with the average estimate being by three months. A further study by NFER found that:

- Year 2 pupils' attainment in reading was significantly lower in autumn 2020 compared to a standardised sample from 2017, representing a COVID-19 gap of around two months' progress.
- Year 2 pupils' attainment in mathematics was significantly lower in autumn 2020 compared to a standardised sample from 2017, representing a COVID-19 gap of around two months' progress.

NFER (2019) also found a "disadvantage gap" in reading and mathematics in Year 2 students (7-year-olds) eligible for free school meals (FSM) of around seven months' progress; this learning gap grew by an extra month in 2020, totalling eight months of lagged progress, implying that the pandemic had a negative impact on more impoverished students' education. The Education Policy Institute (EPI) found similar results, especially in secondary schools with high rates of FSM eligibility, who they estimated lost 2.2 months of progress compared to 1.5 months in schools with low rates of FSM eligibility. They also compiled reports from outside the UK that corroborated the evidence of pandemic "learning loss" found here.

The Educational Endowment Foundation (EEF) reviewed the literature on the potential impact of the 2020 school closures on the education attainment gap between disadvantaged children and their peers. They concluded that:

- Closures are likely to reverse the progress made to narrow the attainment gap in the last decade.
- Supporting effective remote learning could mitigate the extent to which the gap widens.
- Sustained support is needed to help disadvantaged pupils catch up.

As well as learning loss, the pandemic affected children's mental health and social development. Viner et al (2021) conducted a systematic review of 72 studies (21 from the UK) on the effect of school closures, which found negative impacts on children's attention, alongside emotional and behavioural responses. The results were "substantial and significant," though the strength of the evidence was mixed. A main finding was that between 18% and 60% of children and young people had above-risk thresholds for distress, particularly anxiety and depressive symptoms. For most of these studies, these proportions

were substantially higher than prior to the pandemic. One of the studies in England (Levita, 2021) found 30% of the 2,002 young people surveyed (during April 2020) showed clinical levels of depression and anxiety (i.e., levels high enough to be diagnosed as a health issue). The Levita study did not collect data pre-pandemic.

A recently published longitudinal study of 255 students in the UK found that over a nine-month period during the pandemic, mental wellbeing and physical activity decreased whereas perceived stress and time spent sedentary increased. (Savage et al, 2021).

Another longitudinal study compared the mental health and wellbeing of 3,570 children and young people interviewed face-to-face in 2017 and online in July 2020. (Vizard, 2020). It found rates of probable mental disorder had increased from 1 in 9 children in 2017 to 1 in 6 in 2020. While the pandemic might not have been the only cause, those with a probable mental disorder were more likely to say that lockdown had made their life worse (54% of 11 to 16-year-olds, and 59% of 17 to 22-year-olds). Another concern is the long-term effects on children's development. Animal research has shown that social deprivation and isolation have unique effects on brain and behaviour in adolescence compared with other stages of life. (Orben, 2020).

More positively, limits on face-to-face interactions were mitigated by social media and other technologies. Some studies acknowledged that children who found school stressful did benefit from closures, and there may be benefits to children enjoying spending time with their families (Viner, 2020).

8.2 Effectiveness of the social sector organisations at influencing children and young people's education and development

This section focuses on the ability of VCSE organisations in general, and CCSF grantholders in particular, to reduce or mitigate learning loss. The separate section on mental health summarises what is known about the ability of VCSE organisations to improve the wellbeing of children and young people.

What do social sector organisations do?

Social sector organisations work in a variety of ways with children and young people. In general, we have assumed that the majority of grantholders have not been directly involved in supporting effective remote learning provided by schools. Instead, we have looked at social sector organisations supporting learning through out-of-school support—be that through tutoring programmes, youth clubs, etc. Several systematic reviews based on the experience of such programmes in the U.S. show that they can improve educational outcomes, although conclusions are inconsistent.

What is the state of the evidence base?

Compared to some of the other outcomes in the evidence base, there is somewhat clear evidence on the effectiveness of a variety of programmes targeting children and young people, including multiple systematic reviews and meta-analyses on the effectiveness of interventions. It should be noted that this review includes evidence of programmes that may be provided by the public sector, social sector organisations, or a combination of both.

What does the evidence tell us?

Most relevant evidence on the possible effectiveness of programmes comes from evaluations of summer schools and tutoring programmes. One limitation of the literature is that much of the research has been conducted in the U.S.

A 2006 review of 35 studies with control or comparison groups found small but statistically significant positive effects of out-of-school-time (OST) programmes on student achievement in both reading and mathematics. There were larger positive effect sizes for programmes with specific characteristics, such as tutoring in reading (Lauer, 2006).

A similar review in 2013 concluded that out-of-school programmes, particularly programmes focused on maths or reading rather than general academic support, are effective in increasing academic achievement for at-risk students. The overall median Standardised Mean Difference (SMD) was 0.11¹³, indicating a small effect on children and young people, though there were substantial differences in effectiveness between programmes and subjects. For mathematics, the overall median SMD was 0.09; again, the interpretation of this is that the effect was small. The review also concluded that ongoing school and social environments that support learning and development may be essential to ensure the longer-term benefits of the programme (Knopf, 2015).

By contrast, Apsler (2009) found that the most rigorous research studies failed to find evidence of impact, citing two randomised trials showing little or no improvement for participants in after-school programmes. The review noted that the most promising analysis suggested that after-school programmes can be effective if they meet certain conditions, including an evidence-based training method and targeting specific personal or social skills.

More relevant to the CCSF, there have been two studies of out-of-school programmes in the UK.

Strong evidence for the effectiveness of out-of-school support comes from an evaluation of 'The Study Support National Evaluation and Development Program' which followed two cohorts of students from secondary schools in disadvantaged areas for three years. They found that out-of-school programmes related to the curriculum, drop-in sessions, and revision courses had the strongest effects in improving attainment, leading the authors to conclude that *"the effect of study support on academic attainment is statistically highly significant and educationally important"* (MacBeath, 2001). The study also found that students from Black and ethnic minority groups participated and benefited more than white students (MacBeath et al., 2001).

Another evaluation (Pensiero, 2017) tracked approximately 8,500 students who participated in either self-directed or teacher-led support programmes. It found that teacher-led programmes were moderately effective in improving the academic performance at the end of lower secondary education. The improvement was equivalent to half a grade in one subject—less than the results of the MacBeath study, but still significant. Children from parents from a lower socio-economic status benefitted the most.

Beyond attainment, there is strong evidence from the U.S. showing the potential for programmes to improve the personal and social skills of children and young people (for example, see Almlund, 2011 and Durlak, 2007). In the UK, Clarke et al (2015) looked at 55 evaluations of out-of-school youth programmes grouped into arts and sports, family-based, mentoring, education and career, cultural awareness, and problem-reducing interventions. While the review did not reach any broad conclusions about the effectiveness of programmes, it did note that there is emerging, albeit limited, evidence that out-of-school

¹³ Cochrane (2011) notes that the standardised mean difference is used "as a summary statistic in meta-analysis when the studies all assess the same outcome, but measure it in different ways... The SMD expresses the size of the intervention effect in each study relative to the variability observed in that study". A larger positive SMD indicates a greater positive effect of an intervention on a population.

programmes can produce a range of positive outcomes for young people, including those who are at-risk or socially excluded.

How applicable is the research to CCSF grantholders and beneficiaries?

On the basis of all the studies described above, we conclude that there is evidence that out-of-school programmes can both improve learning outcomes and help mitigate the negative effects of lockdown on the personal development of young people. However, the extent of the loss faced by students, and the ability of grantholders to mitigate the loss in learning outcomes for children and young people (comparatively to catch-up activities undertaken by schools themselves), are relatively unknown.

8.3 What is the value of education and development?

Loss of learning is costly to people. The Institute of Fiscal Studies estimate that, on average, a year of schooling increases people's earnings by 8% per year (IFS, 2021). Assuming a simple linear relationship between learning loss and earnings, if the pandemic leads to two months in learning loss, the cost to young people can be estimated at approximately 1% per year in earnings, a substantial amount over a lifetime. Moreover, it is not just the young people who would lose out. The country as a whole benefits from higher tax revenue and a higher level of education. However, it is very difficult to estimate exactly what this value would be.

Improving social and emotional skills also has a value, but the evidence is limited. The Clarke review of out-of-school programmes found cost-benefit information for three family-based and four social action interventions. The cost-benefit ratios ranged from 1:0.65 to 1:4.8 but most were between 1:1 and 1:2. (Clarke, 2015). For example, one of the family-based interventions was a review of the Incredible Years programme, conducted with 149 families across the UK and Northern Ireland, which reported significant improvements in young people's social and emotional skills through addressing conduct problems.

A review by NPC (Kenley & Pritchard, 2019) on the economic impact of programmes supporting young people's non-cognitive skills found very few relevant studies. Most of those that exist from the UK reported cost-benefit ratios of £1 - £2 in economic benefits for £1 in costs, while those from the U.S. report a broader range of (and typically higher) values.

Overall, compared to other outcomes, there has been more scholarship focused on the value beneficiaries receive from education and development, covering improved learning outcomes, mental health effects, and improving social and emotional skills—all of which is believed to impact the future earning potential of the individual.

8.4 Application to the CCSF value for money model

Values

We present a conservative estimate for the potential impact of CCSF grantholders and economic value of reducing the loss in learning. This value is equal to the potential loss in income given a 2-month loss of education, using the Institute of Fiscal Studies estimate that earnings increase by 8% for each year of education (approximately a 1% increase per 2 months).

Using the estimate of median income in 2020 of £25,780, that equates to £260 per year for as many years as that loss is experienced. The value range here is estimate between 1 and 10 years.

Level of change

We estimate the potential improvements in education within the 1-5% range to account for the relatively weak quantitative evidence on the effectiveness of out-of-school programmes in improving education outcomes. This does not include the value of personal development or the potential wider social externalities of education, which is difficult to estimate quantitatively.

Distribution of grantholders

Three tenths (30%) of grantholders stated that their services had contributed to “Children and young people’s education and development” being improved. This equates to an estimated 796,000 beneficiaries receiving the outcome (after extrapolation and adjusting for grantees’ perception of the proportion of beneficiaries receiving the outcome).

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9 People whose mental health and wellbeing was better

9.1 How the pandemic affected people's mental health and wellbeing

A lot of media and public interest during the pandemic has focused on the pandemic's impact on mental health, and the received wisdom is that many people were affected, some severely so.

This is broadly supported by the evidence. Akinin et al (2021) reviewed all the high-quality literature published during 2020 and found a "clear and consistent" body of evidence that people's mental health was negatively affected, particularly in the early part of the pandemic. The most severe effects were found on anxiety, depression and distress, while factors such as overall life satisfaction, loneliness, social connection, and suicidal ideation seem to have been less affected.

There were several UK cross-sectional and longitudinal studies looking at mental health during the pandemic.

- Jia et al (2020) found that during the early stages of the pandemic, mean scores for depression, stress, and anxiety were much higher than regular population norms.
- Niedzwiedz et al (2021) found that psychological distress increased one month into lockdown, with the prevalence rising from 19% before the pandemic to 31% in April 2020.
- UCL's COVID-19 study collected panel data on the psychological and social experiences of the crisis of 70,000 people. Their thirty-first data release (Fancourt, 2021) looked at the whole period covered by CCSF grants for changes. They found that life satisfaction, happiness, depression and anxiety were all at their worst during the early stages of the pandemic, but then recovered as time went by (while broadly tracking variations in intensity of restrictions over time). On the other hand, thoughts of death or acts of self-harm were not affected and remained static throughout.
- The ONS reported in November 2020 that nearly one in five adults (19%) in Great Britain experienced some form of depression, similar to levels reported earlier in the year (June 2020), but almost double that reported before the pandemic (10% from July 2019-March 2020).

Across all the studies above, certain groups were found to be disproportionately affected:

- Women.
- Young people (18 to 29 years old).
- People from socially disadvantaged backgrounds.
- People with pre-existing mental or physical health conditions.
- People at greater risk from COVID-19.
- People from ethnic minority backgrounds.

- People living with children.

Use of services

Nuffield Trust (2020) looked at the impact of the pandemic on use of mental health services. They found that referrals to Improving Access to Psychological Therapies (IAPT) fell by 61% between February and April 2020, and referrals to NHS-funded secondary mental health services (i.e., those requiring a referral from a GP), learning disability services and autism services fell by 39%. Secondary mental health services returned to normal by July 2020, whereas IAPT appointments remained slightly below normal up to August 2020.

The characteristics of people accessing secondary care also seem to have changed. In a survey of psychiatrists conducted by the Royal Society of Psychiatrists, 43% cited an increase in urgent and emergency cases.

Effects on children and young people

In normal times, around 10% of children (aged between 5 and 16 years) have “clinically significant” mental health difficulties (Public Health England, 2016). Moreover, Ford et al (2021) noted that the mental health of children and young people was declining prior to the pandemic, with reported cases of anxiety, depression, and self-harm rising between 2004 and 2017. The pandemic has caused further distress. Between 2017 and July 2020, the incidence of probable mental health conditions among children and young people increased from 11% to 16%. The nature of deterioration was not uniform, with those from families facing financial hardship being more likely to struggle. Reported incidences of self-harm fell initially during the pandemic, but came back to pre-pandemic levels by September 2020, which was a pattern seen across a lot of psychiatric presentations for self-harm among children and adolescents across multiple countries (Ougrin et al, 2020).

9.2 Effectiveness of social sector organisations in influencing mental health

What do social sector organisations do?

NPC’s *Supporting Good Health: The Role of the Charity Sector* (2014) summarised the different ways in which charities work to improve people’s mental health as follows:

1. Representing patient voice and advancing patient involvement.
2. Helping people to understand their condition and navigate the system.
3. Shaping prevention and early intervention.
4. Addressing the social determinants of health.
5. Delivering services.
6. Influencing the design of services.
7. Making scarce state resources go further.

What is the state of the evidence base?

The evidence base for clinical interventions that support mental health is strong and well-established. In contrast, the evidence for many of the kinds of services charitable organisations provide is weak, particularly by robust standards of evidence.

Newbigging et al (2017, 2020) acknowledge the charitable sector's role in "*providing longer-term holistic support in mental health care, and a compassionate and human response*", but found that there is a "*paucity of evidence*" on how effective this support is. In particular, smaller VCSE organisations fly under the radar in terms of their contribution to improving mental health because their size and informality do not lend themselves to established evaluation methods. Where stronger evidence does exist, it tends to relate to specific services that are hard to generalise from.

Buckland and Fiennes (2016) argue that there are four reasons why the evidence for VCSE organisations work in mental health is so weak:

- Historical underinvestment in mental health research and innovation.
- Paltry funding for evaluations as a percentage of programme funding.
- Lack of knowledge and skills about evaluation within non-research VCSE organisations.
- Lack of confidence and negotiating power with funders around evaluation.

They conclude that there is very little research in this area that "*meets a persuasive threshold for mainstream services or policy makers*".

What does the evidence tell us?

Despite the low quantity and quality of evidence on the effectiveness of VCSE mental health services, it is worth summarising the highlights of what is available.

Power to Change (2017) conducted a semi-systematic review of 29 different intervention models for community mental health. Positive effects were found for 16 different intervention types, including exercise; employment-based interventions; green care; advocacy interventions; yoga; general physical health advice; healthy behaviour interventions; and dance therapy. They found reasonable evidence that projects "*drawing on support networks and skills within a community*" have a positive impact on mental health, but less evidence for projects that "*simply deliver services*". However, the review included papers which had a low evidence quality, or relied on non-experimental and qualitative evidence, and no effect sizes were provided.

Newbigging et al (2020) reviewed the literature on voluntary sector mental health crisis services and found particularly strong evidence for "non-clinical crisis houses", where voluntary sector organisations provided alternatives to in-patient care. They also found strong evidence from the US (Bonyngue et al, 2005) to suggest that combinations of voluntary sector crisis services such as crisis lines, on-call services, crisis beds and urgent appointments can work well in partnership with local healthcare providers. This particular study found these combinations could reduce inpatient admissions by as much as 11%.

According to a systematic review by Castillo et al (2019), there is evidence to suggest that community interventions are effective in promoting mental health and social equity. The authors define community

interventions as those that involve multi-sector partnerships, emphasise community members as integral to the intervention, and/or deliver services in community settings—although VCSE organisations are not explicitly mentioned. Overall, they found that most interventions improved mental health at the individual level. But again, no effect sizes are provided.

Meta-analysis conducted by Mead (2010) found that befriending services had a modest but significant impact on depressive symptoms, both over the short and long term, compared with usual care or no treatment—producing a standardised mean difference of -0.27^{14} in the short term, and -0.18 in the long term (an SMD of -0.2 indicating a small effect, and a SMD of -0.8 indicating a large effect in this circumstance). Conversely, the report also looked at three economic analyses which reported no significant clinical benefits from befriending.

An economic evaluation undertaken by McDaid et al (2017) of a peer support programme implemented by MIND found that quality of life scores had improved as part of an intervention over six to twelve months. However, these changes were not considered to be statistically significant, suggesting low levels of effectiveness.

Regarding mental health interventions to **children and young people**:

- Evidence from an economic evaluation of Place2Be suggested that one-to-one counselling is effective at improving perceptions of children’s mental health by teachers and parents.
- Evidence from a systematic review of school-based interventions on mental health by Clarke et al (2021) found evidence that social and emotional learning interventions (promotion of good mental health) have a small but statistically significant effect on reducing depression, anxiety, and aggression.
- There is some evidence that preventative programmes work. For example, anxiety and depression prevention interventions have been found to work on alleviating symptoms of depression and anxiety with small effect sizes; and there is good evidence that cognitive behavioural therapy reduces symptoms of anxiety and depression. A number of the studies reviewed by Clarke et al (ibid) only reported short-term effects. The same review found limited evidence of school-based interventions in preventing death by suicide and self-harm.

There have been several studies which have sought to place **monetary values on the benefits of mental health interventions**.

McDaid et al (2017) built economic models for eight different intervention types focused on mental health. The evidence showed a strong case for investing in preventative activities—with a Return on Investment (ROI) between £1.25 and £39 per £1 spent on different activities. Where it was possible to estimate impacts on quality of life, all the interventions they reviewed appear to have been cost-effective, with a cost per Quality-Adjusted Life Year (QALY) gained consistently below £20,000¹⁵. Those estimates

¹⁴ Cochrane notes that the standardised mean difference is used “as a summary statistic in meta-analysis when the studies all assess the same outcome, but measure it in different ways... The SMD expresses the size of the intervention effect in each study relative to the variability observed in that study”. The range of an SMD is from -1 to 1 . Depending on the variable being viewed, larger SMD’s indicate greater effectiveness. In this case, the variable being viewed is depression, so an SMD which is negative is desirable.

¹⁵ £20,000 is the typical threshold used by the National Institute for Clinical Effectiveness (NICE) to determine whether a treatment or intervention is recommended for NHS use.

looked at the cost from the point of view of the exchequer (i.e., reductions in use of public services), rather than the value provided to the beneficiaries themselves.

Newbigging et al (2020) identify a small number of studies of mental health crisis interventions by VCSE organisations which show them to be cost-effective and leading to potential savings. This includes:

- Croft and Ísvan (2015) modelled estimates of a peer respite programme using propensity score matching and regression models to predict the likelihood of inpatient emergency services. They found that the odds of any inpatient using emergency services following the programme was 70% lower than those who did not receive respite care. This reduction in emergency services was similar to the reduction from inpatient care provision, but at substantially reduced cost. Nine to ten days of respite care reduced the average time in inpatient and emergency services from around 145 hours to around 45 hours.
- Similarly, an evaluation by Fenton et al (2002) suggested that residential crisis programmes delivered by a community-based organisation provided similar outcomes to inpatient care for symptom improvement, while being 44% less expensive.
- A Social Return on Investment (SROI) analysis conducted by Bagley (2012) of Dial House, a Leeds survivor-led crisis service, estimated the benefits as approximately £2,700 per caller/visitor. The major source of value was from death by suicides averted, which accounted for 72% of the estimation. In terms of cost benefit, Bagley estimated a £5.17 benefit per £1 invested in Dial House.

However, the majority of SROIs reviewed in the literature, including Gwynedd (2012) and RM Insight (2014), do not provide beneficiary outcome estimates for improved mental health; instead, they only look at the value to beneficiaries from the government's perspective (i.e., reduced use of statutory mental health services). We also note the general tendency for SROI studies to be unempirical and overgenerous in their assumptions, so have used them cautiously in our analysis.

How applicable is the research to CCSF grantholders and beneficiaries?

As noted by Newbigging et al (2020), overall evidence on the effectiveness of VCSE organisations supporting mental health is inconclusive and mostly poor-quality. Of course, this does not mean that VCSE organisations do not make a difference, and the evidence from our qualitative research demonstrates the various ways that grantholders support people's mental health. Rather, the problem is that this is very hard to prove. Nonetheless, we need to be faithful to the current state of established knowledge and assume a fairly low effect size for CCSF grantholders.

9.3 What is the value of mental health?

In 2015, the HACT social value bank provided an estimated value of the net benefit to people of improved mental health using the Wellbeing Valuation Method¹⁶. The two main outcome estimates were: 1) 'Relief from depression/anxiety (adult)' of c.£35,000 per year; and 2) 'Feeling in control of life' of £15,000 per year. Continuing this work, Fujiwara et al (2020) surveyed 1,982 adults in April 2019 using the Wellbeing Valuation Method to provide an "*indicative monetary value for the total wellbeing cost to*

¹⁶ The Wellbeing Valuation approach was developed by Daniel Fujiwara (2013) and is an approach to valuing non-market goods. The approach draws on national survey data relating to people's wellbeing and uses this data to create a monetary estimate of how much money an individual would need to receive to have the same level of wellbeing for receiving a good or service. The approach has since been refined by HACT, Simetrica, and Social Value Bank.

adults in the UK to be around £2.25bn per day, or around £43 per adult per day". They then estimated that in April 2020 the pandemic caused *"a 15% reduction in life satisfaction, a 15% reduction in daily happiness, a 14% reduction in sense of purpose in life and a 66% increase in daily anxiety."*

Another attempt to value mental health costs was McDaid (2016), who estimated that the average cost per suicide for those of working age only in England was at £1.67 million (at 2009 prices). This included intangible costs—loss of life to the individual and the pain and suffering of relatives, as well as lost output (both waged and unwaged), police time and the costs of coroner inquests.

There are relatively few economic estimates for children's mental health. One is an economic evaluation of Place2Be's one-to-one counselling services in schools by ProBono Economics (2018), which forecasted improvements across later life for children who receive counselling. Rather than place a direct value on improved mental health, PBE looked at the impact of improved mental health (based off 4,548 responses to the Strengths and Difficulties Questionnaire (SDQ)) on incidences of truancy, exclusion from school, crime, smoking, depression, employment, and improved wages between the ages of 4 and 60 years. Benefits per child were estimated at £3,568 per child, with the majority of that benefit coming from increased lifetime earnings and wages.

9.4 Application to the CCSF value for money model

This section illustrates the variety of research that has tried to estimate the value of outcomes for improved mental health and wellbeing and provides a sense of what the possible impact of grantholders might have been. But as with the other summaries, estimating the extent of benefits of these activities and translating this into a monetary value is complicated by:

- Lack of data on the composition of beneficiaries and different levels of need.
- Variations in duration and intensity of support provided by grantholders. The qualitative research showed us that this could range from one phone call or viewing a page on a website through to intense one-to-one support over six months.
- VCSE organisations operate within a wider system of social care and mental health provision, so it is difficult to unpick their specific contribution alongside those of others.
- The grantholder survey data has a degree of collinearity between the variables 'reductions in loneliness', 'improvements in social contact', and 'improved mental health', which leads to a risk of double-counting outcomes.

Values

For our value figure, we have drawn on wellbeing values from the HACT social value bank: For our lower bound estimate we have chosen *"feeling in control of life (adult)"*, and for our higher bound estimates we have chosen *"relief from depression or anxiety (adult)"*, which we feel are the most appropriate estimates in the social value bank. We know that not every beneficiary was clinically diagnosed as anxious or depressed; therefore, the higher bound estimate could overstate the value. But equally, grantholders will have worked with beneficiaries who have more complex (and high value) needs, so there is an equivalent risk of undervaluing. Therefore, we believe that having these two values as our range is sensible and justified when combined with our conservative depth of impact estimate above.

Level of change

Given the uncertainty of the data on effectiveness and the limitations discussed above, we cautiously estimate that CCSF grantholder services create between 0.27% and 1.37% of annual improved mental health and wellbeing. This aligns with our estimate of improved physical health (section C1.3) and is equivalent to 1-5 days of improved mental health over a year attributable to grantholder interventions.

We base this on our judgement of the uncertainty of the evidence—in particular, the lack of quantitative evidence on precisely how much of a difference community-based health interventions make. While positive effects have been noted, we have not found any community intervention-specific effect size. We also note that a lot of the mental health care support provided by grantholders will have been quite broad and light-touch—with very high value occurring occasionally alongside generally more marginal effects.

Moreover, several studies (Catalan et al., 1984; Kendrick et al., 2006; Spijker et al., 2002; Tennant et al., 1981) have looked at recovery in cases of depression and/or anxiety in primary care and have reported recovery rates of 50–70% over a few months in patients who received modest GP “treatment as usual” that excluded formal psychological therapy. This means that people do often tend to get better without help, which highlights the risk of overestimating the effect of particular interventions. This reinforces our cautious approach.

Distribution of Grantholders

Eighty-six percent of grantholders stated that their services had contributed to people’s improved “mental health and wellbeing”. This equates to an estimated 2,685,900 beneficiaries receiving the outcome (after extrapolation and adjusting for grantees’ perception of the proportion of beneficiaries receiving the outcome). It also accounts for the likelihood of double-counting overlapping outcomes between people feeling less lonely and people who had more social contact.

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