Report, October 2020

The social value of vocational rehabilitation and employment for people with mental illness

Social Return on Investment analysis for WISE Ways to Work

thinkimpact
TOWARDS A NEW PROSPERITY



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Executive summary

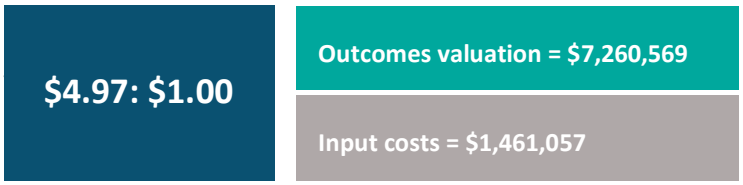
WISE Ways to Work (WWtW) is a vocational rehabilitation and employment support program within WISE Employment that has been developed to help people living with mental illness prepare for the world of work and be supported on a graded pathway to employment.

To gain a deeper understanding of the social and economic value created by the program, WISE Employment commissioned this Forecast Social Return on Investment (SROI) analysis. SROI is an internationally recognised approach for understanding and measuring the impact of a program or organisation. It looks at what changes for key stakeholders from the perspective of the stakeholders themselves. Once outcomes have been identified, a monetary value is used to represent these outcomes experienced by stakeholders. This value can then be compared to the investment required to deliver the initiative, providing an indication of cost-effectiveness in relation to the social value that has been created.

This report provides the results of the Forecast SROI that analysed the social value created by the WWtW program in its 24-month pilot phase, between February 2018 and February 2020.

The analysis found that for every dollar invested, **$4.97** of social value is created.

There is a positive return for the investment that is being made. For a total investment of $1.46m a total value of $7.2m was created over the 24-month period.



This value is experienced by six stakeholder groups – the participants, carers, referrers, employer partners, funders and government. Each of these stakeholder groups is experiencing change. Participants experience the most value, followed by government. This is illustrated in Figure ES.1 below.

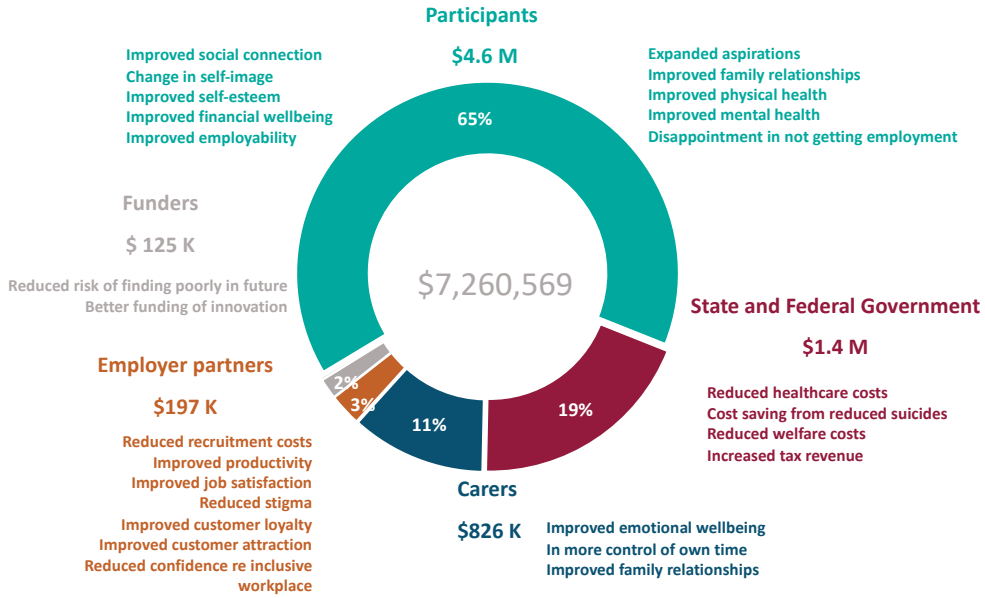


Figure ES.1 Total social value by stakeholder

Evaluation findings

The key findings from the Forecast SROI analysis are summarised below:

- **WWtW is achieving positive outcomes.** It is clear from the SROI ratio presented above that the program is creating value.
  - **Participants** experience **value through changes in their circumstance, capacity and attitude**. The majority of the participants live with severe mental illness, were long-term unemployed, and had experienced long-term isolation. Having access to a program that focuses on vocational rehabilitation as well as employment support offers participants the opportunity to improve their **mental health** and **financial wellbeing**. It also improves their **self-esteem**, and **aspirations** to pursue their vocational goals and increases their **social connections**.
  - **Carers experience value through the improved mental health of their family member.** This in turn leads to reduced caring responsibility, improved value through emotional wellbeing and improved family relationships.
  - **Referrers experience value through improved job satisfaction of staff.** Referrers are a key stakeholder and the outcomes that are experienced by their clients enable them to more positively deliver on their purpose. This is achieved through the ability to transition their clients into a program that supports people to achieve their vocational goals. This also allows referrers to provide a more targeted service to clients, improving mental health outcomes through earlier intervention. By doing so referrers are able to make a valuable contribution in their client's employment journey.
  - **Employer partners experience value through improved business performance such as reduced stigma and improved customer loyalty.** WWtW provides employer partners with improved understanding of strategies to support participants at the workplace, which contributes to reducing stigma around mental illness. This helps to change attitudes towards people with mental illness and to create an inclusive workplace, which creates customer loyalty due to this improved profile of being an inclusive employer.
  - **Funders experience value through learning lessons from funding an innovative demonstration project that will help reduce risk of funding poorly in the future and better funding of innovation.**
  - **State and federal government experience value through a reduction in provision of services such as healthcare and welfare, and cost savings from reduced suicides.** As participants improve their mental health and get into employment, they are using less healthcare services and are less dependent on welfare, which reduces costs for government.

- **WWtW is underpinned by an evidence-based model.** It has been developed from a strong evidence base of the approaches that are most effective in creating sustainable job opportunities for people experiencing serious mental illness. A key component of the WWtW approach is the focus on improving cognitive skills, which is a critical early change in the value flow experienced by participants.

- **WWtW is building a bridge between systems.** WWtW primarily provides a clear bridge from unemployment to employment. The demonstration project is also developing other bridges that, given time, could span across the various eco-systems that people with serious mental illness have to navigate, such as:
  - The Disability Employment Service (DES), enabling it to more fully understand how to support people with serious mental illness to move back into work
  - The mental health system to more fully understand how to support people to get clarity on their vocational goals and start the journey towards meaningful employment

- The National Disability Insurance Agency (NDIA) to more fully understand how and what to fund re employment planning within the National Disability Insurance Scheme (NDIS).

- **WWtW has been designed to achieve enduring impact.** The basis of the Enduring Impact Model is that for long-term change to occur, programs or services have to be improving outcomes in each of the three dimensions, Intrinsic (internally focused outcomes), Extrinsic (externally focused outcomes), and Functional (knowledge and capability outcomes). It was evident from the outcomes being achieved by participants that the foundations are in place for enduring impact to take place. Central to achieving enduring impact was the modality utilised by the WWtW team (Figure ES.2) Stakeholders repeatedly focused on the "how" of the service delivery as being of key importance.



Figure ES.2 WWtW modality

- **WWtW has developed a strong inclusive employment approach for employers.** This has been achieved by providing clarity around what inclusive employment for people with a mental illness entails and practical support to employers around how to develop an inclusive employment approach.

Recommendations

Based on the findings from the SROI evaluation there are a series of recommendations. These cover technical improvement to evaluation approaches in order to be able to better manage impact alongside some recommendations for the next phase of development of WWtW.

- **Prepare for summative evaluation.** This Forecast SROI analysis was a formative evaluation. It is recommended that at the end of the next phase of development a summative SROI evaluation is carried out. A series of key steps are outlined for this.

- **Develop a viable, long-term business model**. WWtW operates at a critical nexus in the service eco-system. It achieves multiple outcomes across different service systems. Policy makers should be engaged in understanding the value of WWtW in order to secure funding for the next phase of development.

- **Revisit the program approach.** The evaluation was carried out during lockdown period of COVID-19 with a significant pivot in approach underway. The WWtW team should consider the learning from this in terms of future delivery.

Glossary

The following acronyms are used in this report:

Term	Definition
Activity	An action or effort undertaken which is intended to create change for beneficiaries.
Attribution	An assessment of how much of the outcome was caused by the contribution of other organisations or people.
Beneficiary	People, organisations or entities that are intended to experience change as a result of the activity. Note – beneficiaries are key stakeholders.
Benefit period	The period beyond the intervention that benefits last.
Deadweight	An assessment of what would have occurred anyway, in terms of achievement of outcomes, in the absence of the intervention/activity.
Distance travelled	The extent, degree or intensity to which a beneficiary or stakeholder experiences progress towards an outcome or group of outcomes.
Displacement	An assessment of how much of the change is a net benefit (i.e. a new change) or simply the movement of change from one place to another or the offsetting of one change for another.
Drop off	The rate at which outcomes deteriorate over time.
Financial proxy	Social value is calculated by placing a financial value on the quantified change commensurate with the degree of change experienced by stakeholders. These financial values are known as financial proxies.
Impact	The total sum or effect of change caused by an organisation, program or activity. Note – this factors in critical aspects such as deadweight, drop off, attribution, contribution, displacement, etc.
Intended impact	A statement of the future impact that the program or activity intends to create.
Indicators	The ways of knowing an outcome is occurring or has occurred, and to what extent.
Materiality	Information is material if its omission has the potential to affect the readers' or stakeholders' decisions. Materiality requires a determination of what information and evidence must be included in the accounts to give a true and

	fair picture, such that stakeholders can draw reasonable conclusions about impact.
Measure	The qualitative or quantitative data that is sought to test whether the outcome is occurring and to what extent it is occurring.
Outcome	The change that occurs for stakeholders from an activity. An outcome can be positive or negative, intended or unintended, direct or indirect, long-term or short-term, social, environmental or economic.
Outcome incidence	The proportion or number of people in the stakeholder cohort group experiencing the outcome.
Output	The quantities or scale associated with an activity (e.g. number of people who took part in a program).
Program logic	A logic model that illustrates the causal flow of activities through to impact. Note – program logics are presented in table or linear form. A more in-depth program logic that explores the value flow in more detail is called a 'benefit pathway', a 'value chain' or a 'results chain'.
Results	Results are the outputs, outcomes or impact of activities.
Social Return on Investment (SROI)	SROI is a framework for measuring and accounting for the broader concept of social value. It tells the story of how change is being created for the people and organisations that experience or contribute to it, by identifying and measuring social outcomes. Monetary values are then used to represent those outcomes.
Stakeholder	People, organisations or entities that either experience change as a result of the activity that is being analysed or contribute to the change taking place.
Theory of change	A theory of change tells the story of how stakeholders are impacted by an activity, program or initiative. There are three parts to a theory of change: the development **process** which essentially helps to answer the questions 'what is the change we are working for, and what needs to happen for the change to come about?'; the **product** which enables you to share your ideas and create a shared vision of the long-term change you want to see; and the **plan** which outlines the key strategic imperatives to be pursued to achieve your intended change.

1. Introduction

WISE Ways to Work (WWtW) is a vocational rehabilitation and employment support program within WISE Employment that has been developed to help people living with mental illness prepare for the world of work and be supported on a graded pathway to employment.

WISE Employment is a not-for-profit organisation founded in 1992. Focused on providing employment services, it operates in New South Wales, Victoria, Queensland, Tasmania, South Australia and the Northern Territory. WISE Employment provides employment services under the Australian Government's Disability Employment Services (DES) and jobactive programs. These services are free to eligible job seekers and employers. Each year the organisation helps more than 12,000 people on the path to self-sufficiency through meaningful work. They also assist employers to find the right person for roles or to complete their team.

Since 2001, WISE Employment has invested $3.5 million into innovation or demonstration projects to better support the most disadvantaged people in communities. It also operates three social enterprises: Clean Force, ELS and Incito Maintenance, employing more than 150 people.

WWtW is one of the demonstration projects that was developed by the Innovation in Mental Health and Employment (IMHE) Division of WISE Employment. The initial pilot program commenced in 2016, in collaboration with international partner Fife Employment Access Trust (in Scotland), St Vincent's Mental Health, Melbourne Business School, and five founding employer partners. The program aims to integrate best-practice vocational rehabilitation with employer training, tailored job-matching and ongoing employment support for WWtW participants. Following a successful pilot, the demonstration project that is the subject of this evaluation was established.

1.1 Evaluation scope

To gain a deeper understanding of the social and economic value created by the program, WISE Employment commissioned this Forecast Social Return on Investment (SROI) analysis.

The scope was to use the baseline data gathered through the demonstration project and carry out a formative evaluation – in SROI parlance this is a Forecast SROI. An SROI is a framework for measuring and accounting for the social, environmental and economic value created through the delivery of activities. It is a principles-based approach that draws on well-established methodologies in economics, accounting and social research. Section 5.1 provides a more detailed explanation of SROI.

The evaluation examined the value created by the program in its 24-month pilot phase.

As indicated, it is a formative evaluation (see Figure 1.1) as it is focusing on the initial stages of WWtW. Formative evaluations usually take place within the first few years of a program with the focus being on learning lessons to improve future outcomes and effectiveness. As a Forecast SROI, one aspect of the scope was to understand the value created over the first few years of operation and provide recommendations on future development.

WWtW commissioned this formative evaluation predominantly as an internal management process to enable them to better manage impact, although it will also be shared with funders and other interested stakeholders. In addition, WISE Employment asked for the evaluation to consider how WWtW was supporting the organisation to contribute to the Sustainable Development Goals. This is outlined in section 2.6.

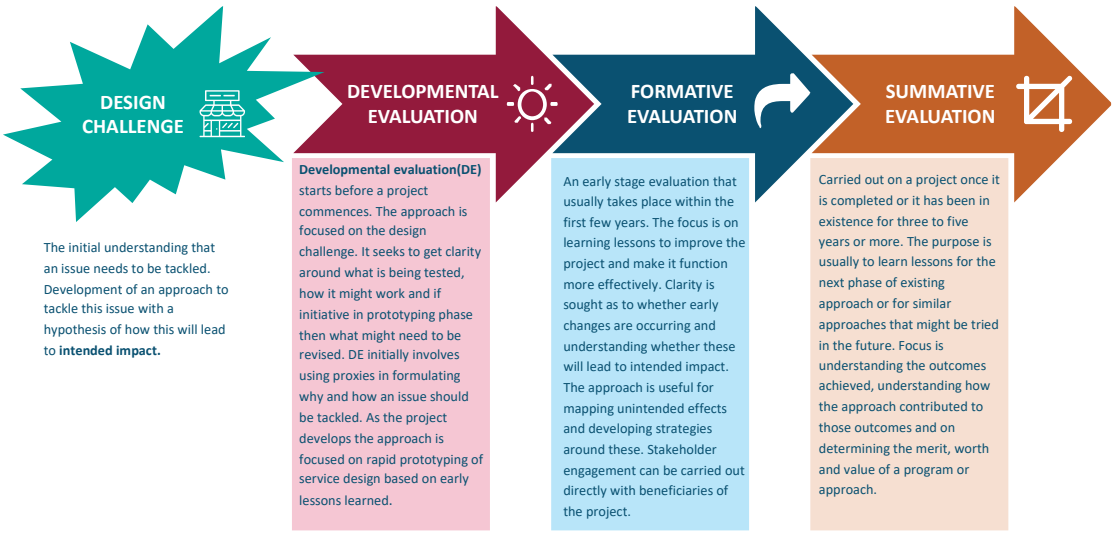


Figure 1.1 Evaluation spectrum

This report presents the finding of the Forecast SROI, which was conducted between February and June 2020 to analyse the baseline value created by the WWtW activities delivered between February 2018 and February 2020. The findings and recommendations are focused on improving the WWtW project as it moves into the next stage of delivery.

About the report authors

This SROI analysis was conducted by Think Impact. Yussra Medani was the author of the report and was mentored through the SROI process by Kevin Robbie.

Think Impact is a social impact consultancy working to create positive change for business, government, the for-purpose sector and the community. We help organisations understand, communicate, and transform the impact of their work. Think Impact has one of the most experienced SROI teams in Australia. The Think Impact team includes five accredited SROI practitioners alongside one of only three people in Australia qualified to deliver accredited SROI training.

2. Context

2.1 Mental health in Australia

Mental illnesses are clinically diagnosable disorder(s) that significantly interfere with an individual's cognitive, emotional or social functioning (COAG Health Council, 2017). Mental health conditions exist on a spectrum, with disorders varying in severity and duration, and may also be episodic. Around 45 per cent of Australians aged between 16 and 85 will experience a mental illness at some point in their life, while one in five Australian adults will experience a mental illness in any given year. The typical age of onset for many mental illnesses, but especially schizophrenia, is in the late teens and early adulthood. Young Australians (16–24 years old) have the highest prevalence of mental illness while individuals over 65 years old have the lowest prevalence of mental illness (DHHS,2016).

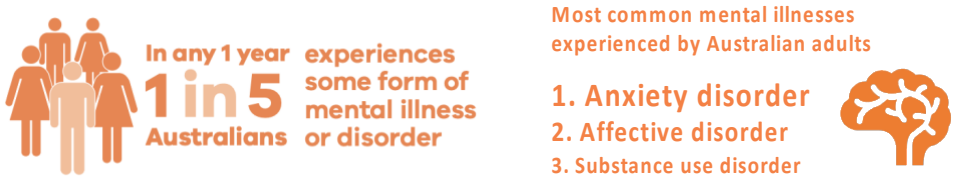


Figure 2.1 Mental health in Australia

Anxiety disorders are the most common form of mental health problems reported in the Australian National Survey of Mental Health and Wellbeing (NSMHWB), with 14 per cent of Australian adults experiencing an anxiety disorder in the previous 12 months. This was followed by affective disorders and substance-use disorders. (ABS, 2008). Around 2–3 per cent of Australians are affected by a severe mental disorder, according to diagnosis, intensity of symptoms, duration of symptoms and degree of disability. Between 4 per cent and 6 per cent of the Australian population have a moderate mental disorder, and a further 9–12 per cent have a mild disorder (AIHW, 2019a).

People severely affected by mental illness often have a diagnosis of a psychotic illness (such as schizophrenia), bipolar disorder, or other serious condition, to an extent that they are recognised as having a psychiatric disability. Because of the severity of symptoms and the early age of onset – leading to a lifelong impact – illnesses such as schizophrenia are a major contributor to disability overall. Thirty-two per cent of all disability service users in Australia have a psychiatric disability, making them one of the largest groups (AIHW, 2020). Psychotic illnesses such as schizophrenia are rated as one of the most burdensome and costly causes of disability, with active psychosis ranked as the third most disabling condition, ahead of paraplegia and blindness (AIHW, 2019b; Ustun et al., 1999).

WWtW is primarily focused on helping people whose mental health has been severely affected, reducing the impact of their disability by improving cognitive and other functioning so that they are better prepared for employment. By targeting this poorly served group, WWtW offers a critical and unique service in both the mental health and employment sectors.

2.2 Mental health and other vulnerabilities

Mental illness can have damaging effects on both individuals and their families, and its influence is far-reaching for society as a whole. The impact of a mental illness varies and can affect a person's ability to function in everyday situations as well as result in other vulnerabilities such as social isolation, discrimination and stigma, economic disadvantage, unemployment and homelessness. It is often associated with co-occurrence of other physical and mental health conditions (comorbidities).

2.2.1 Isolation, discrimination and stigma

Stigma against people living with mental illness is prevalent in Australia, with almost three out of four people with mental illness reporting stigma. Discriminatory behaviours may include avoidance, withholding opportunities or withholding support (National Mental Health Commission (NMHC), 2019).

Stigma and discrimination may discourage people from disclosing information regarding their mental health, decreasing the likelihood of them seeking support and creating additional distress. According to Black Dog Institute (2006) social and cultural stigma (including self-stigma) around mental illness is one of the biggest reasons people experiencing mental illness do not seek help or access services.

Experience of stigma can result in fears about accessing support, misconceptions about mental illnesses, lack of awareness of support services and fears of experiencing social isolation and discrimination for having an illness. This can result in exclusion and isolation, adversely affect personal relationships and affect opportunities for social interaction and community involvement (NMHC, 2019).

Positive and hopeful attitudes of family, friends, service providers, employers and other members of the community towards people with mental illness are critical to ensuring quality of life for people with mental illness and supporting their recovery.

2.2.2 Comorbidity

People being treated for mental illnesses often have poor physical health outcomes and co-occurrence of more than one disorder at a time (Morgan et al., 2011). A quarter of the one in five Australians experiencing a mental illness will have more than one class of mental disorder. Affective and anxiety disorders were the most common comorbidity, followed by anxiety disorders and substance-use disorders (ABS, 2008). People being treated for mental illness were also more likely to experience a number of physical health conditions compared with the general population (Morgan et al., 2011).

2.2.3 Homelessness

For many people with a mental illness, achieving and maintaining a stable home can prove difficult (Mental Health Council of Australia (MHCA), 2009).

In 2017–18, about one third of people who accessed specialist homelessness services were experiencing mental ill-health (AIHW 2018). About half of these people were homeless upon their first presentation to these services. The causes of accommodation instability and homelessness can be complex, arising from factors such as domestic violence, drug or alcohol use or mental illness (AIHW 2018).

Mental health issues combined with homelessness can have a large impact on individuals, families and communities, and can influence a person's health, economic security, level of social support and level of access to and use of health services (ABS, 2014).

2.2.4 Suicide

Suicidality is a major health issue, creating a significant burden for individuals and their families, services and society. There were 3,046 deaths from suicide in Australia in 2018, an average of eight deaths per day, and a suicide rate for Indigenous Australians that is much higher than for other Australians. Approximately 75 per cent of people who die by suicide are male. Suicide is the leading cause of death for people aged 15 to 44 years and the third leading cause of death for people aged 45 to 55 years. It accounts for one in three deaths among people aged 15 to 24 years and over one in four deaths among people aged 25 to 34 years. The number of people who are hospitalised due to self-harm is more than twenty times the number who lose their life to suicide, with females much more likely than males to plan or attempt suicide. (ABS, 2019a)

Despite ongoing efforts to improve suicide prevention in Australia, there has been no significant reduction in the suicide rate over the last decade (ABS, 2019a). In light of this, in 2017, suicide prevention was made a focus for cross-jurisdiction coordination under the Fifth National Mental Health and Suicide Prevention Plan. This includes a commitment to develop a national implementation strategy, which will set the direction for future planning and investment (NMHC, 2018).

2.3 Mental health and employment

Employment is a key component of social engagement and economic inclusion. It can be important in providing a sense of self-identity, purpose and daily structure, and is associated with better mental wellbeing, including lower rates of depression and anxiety (Harvey et al., 2012). According to Morgan (2011) the three top goals of Australians living with a severe mental illness are **having a job, financial security and social connections.** Assisting someone to gain and maintain employment addresses all three of these goals, but the proportion of this population not in work is persistently high, around 25 per cent. Only 8.1 per cent of people with profound or severe disability have a full-time job and 16.5 per cent in part-time work (ABS, 2017).

People with mental illness are more likely to be unemployed or to have poor-quality jobs with fewer opportunities for advancement (Frijters, Johnston, and Shields, 2014). In 2014 the Reserve Bank of Australia (RBA) released a report looking at economic disadvantage and unemployment. The report notes that the impacts of long-term unemployment are "a depreciation of skills, reduction of social networks and adverse consequences in terms of health outcomes and life satisfaction, all of which impede the task of finding employment" (Cunningham, Orsmond and Price, 2014, p.29).

There are many reasons for the high unemployment rates among people with a mental illness. These include the disabling symptoms of mental illness, the side-effects of treatment, disrupted education or training, stigma, gaps in support services or the lack of suitable workplace adjustments.

2.3.1 Nature of mental illness

Mental illnesses are complex conditions. The levels of impairment and disability can fluctuate as a result of the episodic nature of the illness, changes to medication and treatment, the varying levels of support available, environmental stressors, individual coping strategies and varying levels of need. A significant challenge for many people with conditions such as schizophrenia is the impact of the associated cognitive impairments, which affect memory, concentration, planning and problem-solving (WISE Employment, 2017).

The lack of coordination between treatment and vocational rehabilitation interventions can act as a barrier to employment goals (Waghorn and Lloyd, 2005). While medication addresses some of the more overt symptoms of mental illness (such as hallucinations and delusions) it is not so effective at addressing the cognitive impairments that affect the person's thinking and communication skills, which are key requirements for many roles in today's workplaces. The side-effects of the medication can add further challenges in terms of work-readiness skills. The above, combined with associated isolation and disconnection and the limited range of effective support options available, result in many people losing confidence and hope of achieving employment, contributing to poor outcomes for this group (WISE Employment, 2017).

2.3.2 Lack of education or training

The majority of people with mental illness experience the onset of the illness in mid-to-late adolescence, a period in which most young people are completing their education, first entering the workforce and establishing new social networks (DHHS, 2019). This early age of onset often has negative impacts on educational attainment and the transition to the workforce.

In 2018, only a third of people with a disability completed Year 12 or equivalent (ABS, 2019b). In the general population, as well as the population of people with mental illness, it is well-established that more education can enable increased workforce participation and is associated with higher earnings.

2.3.3 System wide issues and discrimination

System wide issues such as a lack of understanding about mental illness and discrimination, the changing nature and demands of the workplace and lack of appropriate workplace supports all contribute to high unemployment for people with a mental illness. Stigma associated with mental illness contributes to some employers being reluctant to hire people. Low expectations of people with mental illness may also occur among the mental health workforce and other health professionals as well as with employers. This can prevent many people from receiving vocational rehabilitation and employment support, having support needs incorrectly assessed, and receiving ongoing assistance (MHCA, 2007). Those employers who do want to offer opportunities to people with mental illness often lack the information and tools they need to facilitate greater workplace participation and support for people with a mental illness.

Many people with mental illness will require ongoing pre-, current and post-vocational support to keep a job once they have found employment. The current system, particularly in relation to people on income support, does not allow for the long-term assistance often needed. The ability to provide flexible support is often constrained by strict guidelines, and the time limits placed on assistance do not promote employment support that is responsive to the person's needs (MHCA, 2007).

Thus, the participation and productivity of people with mental illness depends on the opportunities for them to acquire skills, the necessary support to find and maintain a job and a mentally healthy workplace that supports and maintains the good mental health and wellbeing of all its employees (Productivity Commission, 2019).

2.4 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is the national approach for providing support to Australians with a disability, their carers and families. This includes people with a severe mental illness or psychosocial disability. It is jointly governed and funded by the Australian Government and participating state and territory governments. The NDIS was introduced in 2013 and rolled out nationally in 2016.

The NDIS is administered by an independent statutory agency, the National Disability Insurance Agency (NDIA). Once fully operational, the NDIS will provide more than $22 billion in annual funding to an estimated 500,000 Australians who have permanent and significant disability.

The main component of the NDIS is individualised packages of support to eligible people with disability to:

- access mainstream services, such as health, housing, education and employment
- access community services, such as sports clubs and libraries
- maintain informal supports, such as family and friends.

One of the NDIS strategies is the Participant Employment Strategy that sets out the NDIA's vision, commitment and action plan for supporting NDIS participants to find and maintain meaningful employment. In this strategy the goal is having 30 per cent of participants of a working age in meaningful employment by 30 June 2023. This goal is to be achieved by delivering a comprehensive program of work across the following five key focus areas:

1. Increasing participant aspiration and employment goals in NDIS plans
2. Increasing participant choice and control over pathways to employment

3. Increasing market innovations that improve the path to paid work
4. Improving confidence of employers to employ NDIS participants
5. Leading by example as an employer.

2.5 Sustainable Development Goals

Part of this formative evaluation is to consider how WWtW was supports WISE Employment to contribute to the Sustainable Development Goals.

In September 2015, the General Assembly adopted the 2030 Agenda for Sustainable Development that includes 17 Sustainable Development Goals (SDGs) (Figure 2.2). The SDGs provide a powerful framework to guide local communities, countries and the international community toward the achievement of disability-inclusive development. Building on the principle of "leaving no one behind" including persons with disabilities and other disadvantaged groups, the new Agenda emphasises a holistic approach to achieving sustainable development for all and recognises disability as a cross-cutting issue, to be considered in the implementation of all of its goals.

The SDGs also explicitly include seven targets and 11 indicators explicitly making reference to people with disabilities. Disability is referenced in multiple parts of the SDGs, specifically in the sections related to education, growth and employment, inequality, accessibility of human settlements, as well as data collection and the monitoring of the SDGs.



Figure 2.2 SDGs

2.6 The mental health service and employment support gap

Poor mental health has become a pressing yet ignored health crisis. Many mental health services struggle to provide adequate treatment, care and support to people living with mental illness, their families and carers when and where it would offer the greatest benefit. At present the system is not able to respond to the increasing demand, changing needs and community expectations. At one level,

this means many people cannot get the services they seek; at the extreme, it places some at risk of a variety of harmful, even fatal, consequences. (State of Victoria, 2019).

The ongoing challenges for the state mental health services, the current absence of a coherent community mental health sector, particularly in terms of vocational rehabilitation, and the limited scope of the disability employment sector to assist with work preparation skills development results in a service gap for Victorians with a mental illness who have employment goals.

WWtW bridges a critical gap in service delivery by assisting people with mental illness throughout the process, from the rehabilitation stage through to employment, customising support to the individual throughout their journey to work (WISE Employment, 2017).

3. About WISE Employment and WISE Ways to Work

3.1 WISE Employment

WISE Employment started in West Melbourne in 1992 as a not-for-profit employment agency for people with a disability. WISE Employment operates in:

- Job seeker employment services: offering cost-free services to eligible individuals, provided under the federal government's jobactive and Disability Employment Services employment programs
- Employer recruitment services: supporting employers with recruiting workers from diverse backgrounds and teaching them about wage incentives to help with the cost of employing job seekers
- Community projects: since 2001, WISE have invested $3.5 million into innovative projects and demonstration projects for youth, refugees and Indigenous communities. They also operate three socially inclusive social enterprises.

Through these services, WISE Employment aim to achieve its vision of:

> "Inspire, transform and enable people to realise their potential."

Relating to this vision, WISE Employment created "The WISE Impact Promise" as a decision-making compass, to create an impact for those they serve.

> "The WISE Impact Promise is a framework and suite of impact measures designed to guide decision making at WISE for our customers, employees, community and planet.
>
> WISE always aspires to do the 'right thing', to facilitate the best outcome, to cause no harm, and to act in a sustainable manner.
>
> The Promise Framework acts as a compass for doing the right thing for all WISE people and the wider community and will help measure our impact beyond job outcomes for stakeholders.
>
> Everything we do is interconnected."

3.2 The development of WISE Ways to Work

The Innovation in Mental Health and Employment division is based in North Melbourne, Victoria and was initiated by WISE Employment in 2016 in response to the challenges and support gaps many jobseekers with mental illness face when seeking employment alongside building the capacity of support services to meet the needs of this group.

In 2016 WISE Employment and St Vincent's Mental Health developed a partnership with Fife Employment Access Trust (FEAT) in Scotland, to adapt and deliver FEAT's innovative 'Employ Your Mind' (EYM), program that integrates cognitive remediation with vocational rehabilitation. WISE delivered EYM to four community mental health services in 2016-2017. St Vincent's Mental Health and Melbourne University coordinated an initial evaluation.

Results showed statistically significant improvement in participants' cognitive functioning skills as well as their belief in their ability to work.

3.3 WISE Ways to Work

As a result of the success of the EYM pilot, a broader program of support, 'WISE Ways to Work' (WWtW) was developed around EYM with the goal of assisting jobseekers with mental illness to achieve their vocational goals. WWtW aims to provide a pathway of support that includes key skills development, health management, peer support and a graded pathway to employment. Funding was secured to trial this approach with a pilot program running from 2018 to 2020.

WWtW aims to integrate best-practice vocational rehabilitation with tailored job-matching, employer training, and ongoing employment support for participants in the program. This critical aspect is done by Occupational Therapists and Vocational Coaches at WWtW.

All participants start with WWtW's six-month vocational rehabilitation EYM program to build self-awareness, skills and confidence.

WWtW consists of three stages:

- **Stage 1: Employ Your Mind** (skills development)
  This program is designed to help people living with mental illness build social and cognitive functioning skills to better achieve employment and community engagement goals.
- **Stage 2: Transition to work** (exposure to work)
  This module includes 'work tasters' and opportunities for work experience as well as the Optimal Health Program to build a personal health and wellbeing management plan, particularly in the context of getting and keeping a job.
- **Stage 3: Support at work** (jobs and support)
  This module aims to assist participants to achieve their employment and other vocational goals.

Regular social events, such as monthly lunches, information sessions and occasional outdoor adventure activities are offered to promote peer support and social interactions, and to reinforce the skills learned. Another key component, **WISE Champions**, assists people who want to explore peer work or improve their leadership and advocacy skills.

Critical to the success of the WWtW is a network of employer partners who, with support from WWtW staff, commit to helping achieve employment for people with mental health illness. The Employment Generation Group (EGG) was developed in 2019 to help identify and support 'Good Egg' employers to join the network. The pilot of WWtW started in February 2018, and by February 2020:

- 73 individuals had participated in the program
- 25 employer partners had been engaged.

3.4 Key activities

WWtW key activities and features fall under three main categories: skills development, employment and peer support/ social connection.

3.4.1 Skills development

Employ Your Mind: EYM is a key component of WWtW. Every participant has a vocational coach who guides them through the four six-week phases. The activities involved include:

- Cognitive remediation therapy (CRT) in the 'Thinking Gym' to help participants build key thinking skills such as concentration, planning and problem solving
- Bridging sessions to transfer skills developed in the online program to everyday and work settings
- One-on -one as well as group reflection sessions
- A focus on self-discovery, social cognition, and goal setting to help participants prepare for work
- Individual project work to reinforce skills learnt in CRT
- A work-orientation phase in an area of interest, to gain exposure to the workplace.

A range of objective and subjective assessments are conducted at commencement and completion of EYM to track progress.

A key feature of EYM is the embedding of Occupational Therapists in the program, who work alongside the Vocational Coaches and oversee the subjective and objective assessments which are completed in the first and last phases to measure progress.

WWtW is the only organisation in Australia that offers EYM program.

Optimal Health Program: The health management Optimal Health Program (OHP) is a holistic eight-week program, that helps participants to increase their self-awareness and equips them with the skills to manage their mental, physical, emotional, spiritual and occupational health.

The OPH was originally developed by the Collaborative Therapy Unit at the Mental Health Research Institute of Victoria. Optimal Wellbeing Australia Pty Ltd, trading as Optimal Health, has been responsible for coordinating and reviewing OHP since 2019 and is dedicated to improving the quality and impact of the program through research, program development and training. Optimal Wellbeing Australia has been working in partnership with WWtW since 2019.

The program has been designed to be highly responsive to the individual, allowing participants to engage at their own pace and to reconnect as and when required. It is delivered in four six-week phases over seven months, and helps to build a sense of direction, confidence, routine, and improved communication and cognitive functioning skills. Completion of each phase is celebrated, and the final phase includes a work-orientation component of four hours per week for four weeks.

3.4.2 Employment

The key components of employment support are:

- **Information sessions for participants:** on resume writing, what jobs are available, skills required, training opportunities, disclosure of a mental illness at work, roles, rights and responsibilities, nutrition, sleep and other health related topics
- **Partnering:** working with employer partners, committed in their support of participants and offering work-tasters, volunteer work, work experience, paid transitional employment, and open employment
- **Training for employers:** information sessions on best practice mental health workplace support
- **Support to employer partners**: Occupational Therapists and Vocational Coaches work with employers to identify and adapt positions to be more accessible for people with mental health conditions.

3.4.3 Social connection

WWtW supports enhanced social connection via:

- **Social events, outdoor adventure activities and monthly dinners**: to build a sense of community, inspiration and hope for otherwise isolated individuals. These activities are focused around developing teamwork, resilience, initiative and confidence, alongside improving capacity and skills for the workplace.

3.5 About WWtW participants

At February 2020 WWtW had a total of 73 individuals with mental illness participating in the program. The characteristics of the participants are:

- the average age of participants is 40 years old
- 36 females, 36 male and 1 non-binary
- 21 participants have secured employment
- 20 participants are studying or volunteering
- 32 participants are engaged in non-vocational activities (that is, not employed, studying or volunteering)
- the average participant's mental illness has significantly affected their ability to work
- the average participant experiences long-term unemployment.

WWtW has an 82 per cent retention rate of those who have started the program. The drop-out rate of 18 per cent is anecdotally considered low with participants ceasing to attend primarily as a result of recurrence of illness.

In addition to the majority of the participants being long-term unemployed, most had been hospitalised due to their mental illness at some point in their lives and the majority had been in the care of community mental health services or other clinical services for lengthy periods. There was also evidence of people experiencing a range of associated issues such as dual diagnosis of other disabilities, homelessness, drug or alcohol problems. What could not be clarified from the existing data was the depth, length, nature and severity of these compounding factors. This is discussed in chapter 10 Recommendations.

3.6 WWtW theory of change

3.6.1 Theory of change

One foundation of an SROI is the theory of change.

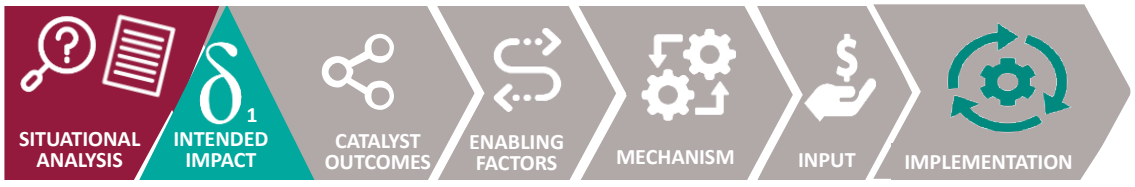


Figure 3.1 Think Impact theory of change approach

A theory of change tells the story of how stakeholders are involved in the WWtW program and their understanding of how their lives or circumstances have changed as a result. The theory of change depicts the story for those stakeholders who are experiencing what are referred to as 'material' outcomes.

By developing a theory of change, an organisation has a roadmap that outlines the strategies necessary for change to occur for stakeholders. A theory of change can refer to the process, the product of that process and the plan produced from the process.

- The **process** of developing a theory of change is iterative. It involves stakeholder engagement, research, team discussions and workshops. A good theory of change process provides an opportunity to engage stakeholders, deepen thinking, improve collaboration, improve decision making and strengthen teams.
- The **product** of a theory of change process is often presented as a conceptual model that is a visual representation to tell your story of change or in impact narrative form.
- The **plan** outlines the key strategies that require implementation for the intended impact to occur.

A theory of change helps answer the questions:

- What is the change we are working for?
- What needs to happen for the change to come about?

A good theory of change will be a **living document** that provides clarity around how what is done leads to impact, that incorporates any learning along the way.

3.6.2 WWtW theory of change

The WWtW team went through a theory of change process. The theory of change for the WWtW program is summarised below. It is then presented as a conceptual model (see Figure 3.2).

Through the development process, multiple benefit pathways have been developed to account for the diversity of activities, outputs, chains of events and final outcomes for each material stakeholder. They are presented in more detail in diagrammatic and narrative format in chapter 6 Stakeholder outcomes.

The intended impact of WWtW is articulated in their vision:

> ''People living with mental illness have the skills and support to achieve their vocational goals, whether employment, study, or volunteering. Workplaces are responsive to the mental health needs of employees, suitable adjustments are provided as required, the stigma associated with mental illness is reduced, and inclusive employment is the norm.''

The context for people living with mental illness is that they often experience problems such as isolation, unemployment, stigma and discrimination. They have few support options, particularly in vocational rehabilitation. People are not receiving the support needed to improve their life and achieve their goals. The current support systems are limited, siloed, fragmentated and complex. The lack of appropriate support to build skills and confidence, the increasing complexity of many workplaces and the stigma associated with mental illness traps many into unemployment and isolation, increasing the burden on carers and clinical services.

WWtW provides a service in a niche area: it provides vocational rehabilitation to people with mental illness and supports them to obtain and sustain a job. WWtW also supports employer partners with tools to facilitate greater workplace participation for people with mental illness, which helps to tackle issues of discrimination and stigma. WWtW operates as bridge between long-term unemployment and the achievement of vocational goals.

WWtW does this by employing highly skilled staff to deliver the program, creating a conducive and adaptable environment for participants that is designed for peer support and optimal learning:

- They work with referrers to recruit participants who want to improve their skills to achieve their vocational goals.
- They work with employer partners who want to be more inclusive and adaptive, and able to offer meaningful placements or employment to people with mental illness.

The WWtW service has embedded characteristics within its activities to ensure outcomes are achieved. WWtW staff build rapport with participants, employer partners and referrers to create relationships of trust that will enable all parties to share information and not feel judged. WWtW takes an individualised, person-centred approach and establishes positive relationships by providing participants with one central contact person to support them on their journey. They also ensure that participants are in control of their own vocational journey. The benefits of this approach were continuously highlighted in the stakeholder engagement.

> *"They treat us as adults not as children." – Participant*

> *"This program was different and the support I received from [staff member] was very individualised and I would not have achieved what I have without it." – Participant*

> *"Through developing a strong working relationship with [staff member]. She was willing to meet me where I was and support me to get where I wanted to go." – Participant*

> *"[WWtW] believe he was worth working with … complete acceptance of his level of disability. … [the] amount of rejection he gets from people in mental health services is huge and hard to take, WWtW were the opposite. He doesn't feel judged. [They] maintain stability for him." – Carer*

Another important aspect of the WWtW service is the flexibility it offers to participants, despite having a structured program.

> *"We flex around the participant, and not have the participant flex around the program." – WWtW staff*

By offering a flexible and effective program, WWtW creates impact in four spaces. The initial impact is for participants and employers, leading to a ripple effect that contributes to longer-term change:

- **People living with mental illness** have improved quality of life due to achieving their vocational goals and building strong social connections.
- **Employers** have improved understanding of how to develop inclusive employment.
- The **sectors** have a beacon of best practice in skills development and employment creation for people living with mental illness
- **T**he **system** provides a cohesive and effective continuum of support.



People with mental illness have few support options, particularly in vocational rehabilitation. Disjointed systems lead to a lack of appropriate support to build skills and confidence, the increasing complexity of many workplaces and the stigma associated with mental illness **traps** many into unemployment and isolation, increasing the burden on carers and clinical services



Wise Ways to Work is a bridge between the disadvantage associated with long-term unemployment and the inclusion of having a job. We equip people living with mental illness with the skills, tools and confidence to pursue their vocational goals whether volunteering, study or employment. Wise Ways to Work also helps employers to provide responsive workplaces; building their understanding of how to support people with mental health issues back into employment.



- **Employers** have improved understanding of how to develop inclusive employment
- The **system** provides a cohesive and effective continuum of support

People living with mental illness have improved quality-of-life due achieving their vocational goals and improving social connection

- The **mental health and employment services sectors** have a beacon of best practice in skills development and employment creation for people living with mental illness

Our Impact

Figure 3.2 WWtW overarching theory of change

4. SROI evaluation scope

4.1 Scope

This Forecast SROI utilises baseline data to analyse the social value created by WWtW over a 24-month period (February 2018 to February 2020). In addition to assessing the social value created, the formative evaluation was commissioned to review key lessons from the demonstration project that would inform future delivery and to look at whether WWtW was supporting WISE Employment in making a contribution to the SDGs.

The period covered during the formative evaluation includes the initial four months of pre-implementation, which comprised the development of resources, staff recruitment, extensive outreach to mental health services and other community organisations, and fundraising. During this period there were no participants in the program.

The activities examined and outputs achieved include:

- Provision of Employ your Mind and the Optimal Health Program to 73 individuals
- Provision of transition to work for 20 individuals in volunteer positions or studying
- Provision of support at work for 21 individuals in paid work as a result of WWtW.

The program continued to be delivered after February 2020, including pivoting to adapt to the COVID-19 crisis. Additional outcomes were observed or reported as achieved, particularly in terms of transition to employment during this period but were not within the scope of the evaluation.

5. Methodology

5.1 What is Social Return on Investment?

Social Return on Investment (SROI) is a framework for measuring and accounting for the broader concept of social value. It tells the story of how change is being created for the people and organisations that experience or contribute to that change. It does this by identifying and measuring social outcomes. Financial proxies are used to place a value on the outcomes that occur for stakeholders.

SROI is an approach that draws on well-established methodologies in economics, accounting and social research. It is underpinned by seven principles which ensure that the analysis understands the changes that take place and the additional value that has occurred through the activities being delivered. The principles are:

1. Involve stakeholders
2. Understand what changes
3. Value the things that matter
4. Only include what is material
5. Do not over claim
6. Be transparent
7. Verify the result.

An SROI calculation provides an indication of cost effectiveness, by comparing the investment required to deliver the activities with the value of the outcomes experienced by all beneficiary stakeholders. Social value is calculated by placing a financial value on the quantified change using what are known as financial proxies. SROI seeks to understand all types of value – social, economic and environmental – and represent this in a language which is widely understood by funders, investors, policy makers and decision makers.

The value of the outcomes represents 'additional value' that would not have occurred in the absence of the activities being analysed. Value that would have happened anyway (deadweight), that is attributable to other actors (attribution) or that has displaced other outcomes (displacement) has been deducted.

The values calculated, although expressed in monetary terms, do not equate to a financial return. The values represent the size of the value and the relative scale of different outcomes, so that economic, environmental and social outcomes can be understood using a common unit of measurement.

A breakdown of the SROI calculation is depicted in Figure 5.1. The definitions of these terms are provided in the Glossary at the start of the report.



Total present value of an outcome = Number of stakeholder x outcomes incidence x financial proxy x benefit period – [deadweight, attribution, displacement]

Outcome incidence = the change reported by stakeholders, generally measured on a scale of -3 to +3, where -3 is ''A lot less'' and +3 is "A lot more'' and 0 is ''No change''. The outcome incidence is the weighted average of all responses, including positive and negative change.

Figure 5.1 SROI equation

5.2 Research undertaken

Our methodology is outlined in four key stages. As illustrated, these stages are aligned with the six stages of the Social Value International (SVI) SROI guide stages and assurance policy, see Figure 5.2.

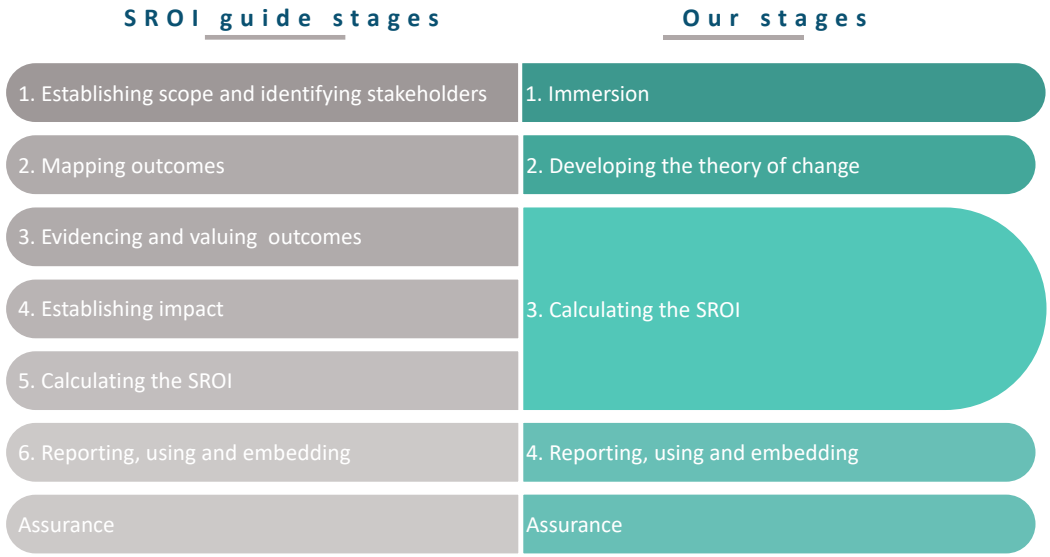


Figure 5.2 Methodology stages

The methodology used is summarised in diagrammatic (Table 5.1) and narrative format below and outlined in more detail in Appendix A. The four stages were implemented between February and June 2020.

Table 5.1 Summary of research stages

Stage	Timing	Activities
1. Immersion	February 2020	• Inception meeting with WWtW to establish scope and identify stakeholders. In-depth review of all program documentation and key research documents.
2. Developing the theory of change	February–May 2020	• Theory of change workshop with WWtW team to identify stakeholders, mechanisms and anticipated outcomes. • Phone/video interviews with 33 stakeholders to inform the theory of change, relative importance of outcomes and to avoid over claiming. • Desktop research: for example, similar SROI reports, review of mental health and employment programs and reports.
3. Calculating the SROI	May–June 2020	• Survey of stakeholders experiencing material outcomes. • Stakeholder benefit pathways reviewed by participants, employers, funders, sector representatives (peak bodies) and WWtW staff team. • Desktop research: for example, financial proxies presented in the model, government or other stakeholders' outcomes.

4. Reporting, using and embedding	June 2020	• Reviewed and verified by stakeholders including participants, funders and employer partners. • Verification workshop with WWtW team who have knowledge of the stakeholders. • Verification with peak bodies. • Peer reviewed by people experienced in SROI within the Think Impact team.

5.2.1 Immersion

In this stage the focus was on establishing scope and identifying stakeholders to include in the research.

An in-depth review of all project documentation was carried out, including previous evaluation, project plans, marketing materials, funding submissions and accessible data that had been collected.

Additional desktop research was carried out into best practice in employing people with serious mental illness.

5.2.2 Developing the theory of change (outcome mapping)

In this stage, stakeholders were further identified to understand 'what changes' and develop the theory of change.

In accordance with the SROI Principle 1: Involve stakeholders, the perspective of the stakeholders who have experienced change has driven this analysis. Specifically, stakeholders have been involved for the purposes of:

- Identifying stakeholders experiencing or influencing change
- Defining and identifying outcomes
- Quantifying the amount of change
- Valuing outcomes
- Identifying levels of attribution, deadweight and drop off
- As proxy stakeholders to explore changes experiences by others
- Verifying results.

Which stakeholders to involve in the analysis were identified through an initial consultation in the immersion stage and followed up in theory of change workshop with WWtW staff. The workshop identified a hypothesis re key outcomes that were being achieved, this was tested with the key stakeholders during quantitative and qualitative research and refined through the process of developing the benefit pathways.

Through the process, 35 stakeholders have been interviewed to understand what changes as a result of WWtW. The addition of peak bodies as proxy representatives of stakeholders was confirmed through conversations with program participants and WWtW staff to accommodate issues arising because of the COVID-19 lockdowns.

The workshop and qualitative stakeholder engagement confirmed the materiality of the stakeholder groups identified; no new stakeholders were added.

Table 5.2 provides summarised information about the qualitative stakeholder engagement undertaken in this stage.

Table 5.2 Qualitative stakeholder engagement

Stakeholder group	Engagement approach	Total number	Number engaged
Participants	Phone interviews	73	6[1]
	Email interviews		2
Carers/family members	Phone interview	70 households and 111 family members[2]	4
WWtW staff	Phone interviews	8	6
Referrers	Phone interviews	98 individuals working in 34 referral organisations	6
Employer partners	Video interviews	25	3
Funders	Video interviews	7	5
Sector peak bodies	Video interviews	3	3

The individuals involved were selected to ensure breadth across the range of characteristics within the stakeholder groups, including:

- Participants with different demographics, mental illness, employment and vocational status and stage of completion of the program
- Family members and/or carers of participants
- Employer partners with different size, sector and people with mental illness supported
- Support service workers and case managers (hereafter referred to as "Referrers") in different types of organisations and intensity of working with participants of WWtW
- Funders of the program
- Representatives working for peak bodies in the disability employment, mental health and carers sectors.

The value of involving stakeholders was balanced with the need to minimise the demands on their time, especially since most of the stakeholder engagement was planned in March when the COVID-19 lockdown measures were introduced, and many stakeholders were overwhelmed and not in a position to speak to us.

Priority was given to involving as many stakeholders as possible in stage 2 (theory of change development, identifying stakeholders, understanding what changes) and stage 3 (calculating the SROI, measuring and valuing what changes). However, during verification in stage 4, all stakeholders who had agreed to review and verify the results were contacted. The results were verified by participants,

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[1] Seven participants agreed to be interviewed, but only six interviews were completed. The seventh interview had to be stopped after approximately ten minutes as the participant felt unwell. After two failed attempts to contact the participant and notifying WWtW, the decision was made not to proceed with trying to finish the interview.

[2] 4.8 per cent of respondents stated that the statement "My family relationships have improved" is not applicable to them. Assuming that this response is representative means that remaining 95.2 per cent is in contact with their family. 95.2 per cent out of total 73 participants is 69.5 participants. Family members are assumed to be an average of 1.6, which is the national household average (2.6) minus the beneficiary (1). Source: Australian Bureau of Statistics, 2016. https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/036
69.5 participants * the national household average of 1.6= 111.2 family members in total.

funders, employer partners, peak bodies and WWtW team members to minimise demands on other stakeholders.

COVID-19 considerations

The stakeholder research was carried out during "stage three" lockdown period as a result of COVID-19 in Australia. Stage three lockdown involved people only being able to leave their homes for a limited number of reasons such as essential work, food shopping, essential supplies and medical care. Whilst this was eased for a few weeks, Melbourne re-entered stage three lockdown the stage four lockdown during the verification phase of the SROI analysis.

WWtW suspended face-to-face interaction and group work with participants during this period, all communication moving to online, by phone or via text.

The initial scope of the SROI research had involved formation of a participant focus group to work through theory of change, mapping of outcomes, verification etc. With the onset of COVID-19 lockdown restrictions this was revised to telephone engagement working with participants on a one-to-one basis rather than in a group format. Stakeholder engagement was enhanced by involvement of additional funders, employers and representative bodies as proxies for participants. This was repeated for verification of results.

The principle of data saturation was adopted to guide the number of stakeholders involved. Saturation refers to the point when no new information or themes are identified through the research. When this point was reached, it was decided that no further qualitative research was necessary in order to develop the theory of change.

Desktop research was used throughout the first three stages to:

- Complement and verify the findings of the stakeholder engagement. The desktop research focused primarily on the findings relating to the outcomes for government which are less able to be determined through stakeholder engagement
- Explore unintended or negative outcomes that may not have been identified through stakeholder engagement
- Inform the measurement and valuation of outcomes and other aspects of the SROI model such as financial value (proxies) and deadweight.

5.2.3 Calculating the SROI

Following the qualitative stakeholder engagement and theory of change development, evaluation tools and processes were developed to collect, measure and value what changes for material stakeholders. In this stage a survey for participants and referrers was developed and distributed to collect and quantify the changes. Further information about the data collection is provided in Table 5.3.

Table 5.3 Quantitative research - surveys undertaken

Who was surveyed	Population size	Target number (Surveys sent)	Number of survey respondents	Percentage response of target
Participants	73	49[3]	21	43%
Referrers	98 individuals working in 34 referral organisations	98[4]	6	6%

Following the qualitative research, quantitative data collection and desktop research all the data was analysed quantify and value outcomes, from this an SROI model was developed.

This stage included:

- Analysing results (outputs and outcomes) and assigning values to the outcomes evidenced
- Determining impact: This step used the principles of deadweight, displacement and attribution to crystallise the impact that is genuinely due to the initiative and determining drop off
- Calculating the investment: This involved calculating the financial value of the investment and financial value of the social costs and benefits.
- Calculating the SROI ratio: The SROI model was fleshed out to quantify the impact of each outcome, for the specific stakeholders who achieved those outcomes. SROI shows who benefits, for how long, and what the value of that benefit to society is. It also shows the difference between what would have happened anyway and what has actually happened
- Sensitivity analysis: This explored various scenarios in relation to variables on the above calculation
- Verifying results with stakeholders.

5.2.4 Reporting, using and embedding

This stage involved developing sharing the evaluation insights with key stakeholders.

The evaluation findings were verified with six stakeholder groups, namely participants, the carers peak body, the disability employment peak body, referrers, employer partners and funders. The verification processes involved telephone conversations, video conferences or emailing data for consideration and feedback. The methods were chosen to minimise disruption during COVID lockdown in response to stakeholder request.

In addition, the findings were verified with the WWtW staff team. The report was also peer reviewed by an accredited practitioner within the Think Impact team to add an additional layer of verification.

More details on the verification process can be found in Appendix A.

The recommendations were shared with key staff in the WWtW staff team with a focus on practical steps required to embed processes for the next stage of WWtW development.

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[3] The survey went sent out to 49 participants, as WWtW staff were no longer in contact with some participants who completed the program in early 2018.
[4] The survey was sent to all individual referrers who are part of the 34 organisations that refer participants to WWtW.

5.2.5 Assurance

The report was submitted to Social Value International (SVI) for assurance in July 2020.

This assurance process ensures adherence to the seven principles that underpin SROI.

5.3 Analysis of the research

5.3.1 Materiality

Throughout the research process there was a focus on SROI Principle 4: materiality. Change is seen as material if it is both **relevant** to stakeholders or activities and **significant** enough in the context of the total social value created. Figure 5.3 illustrates material and not material stakeholders. The process for determining which stakeholders experience material outcomes is provided in Appendix B.

Material stakeholders with variety of characteristics were engaged to uncover correlations between stakeholder characteristics and the outcome experienced. Survey analysis has identified material changes for participants with different characteristics, this has led to the segmenting participants into three subgroups. No other subgroups for other stakeholders experiencing different outcomes have been identified through the stakeholder engagement.

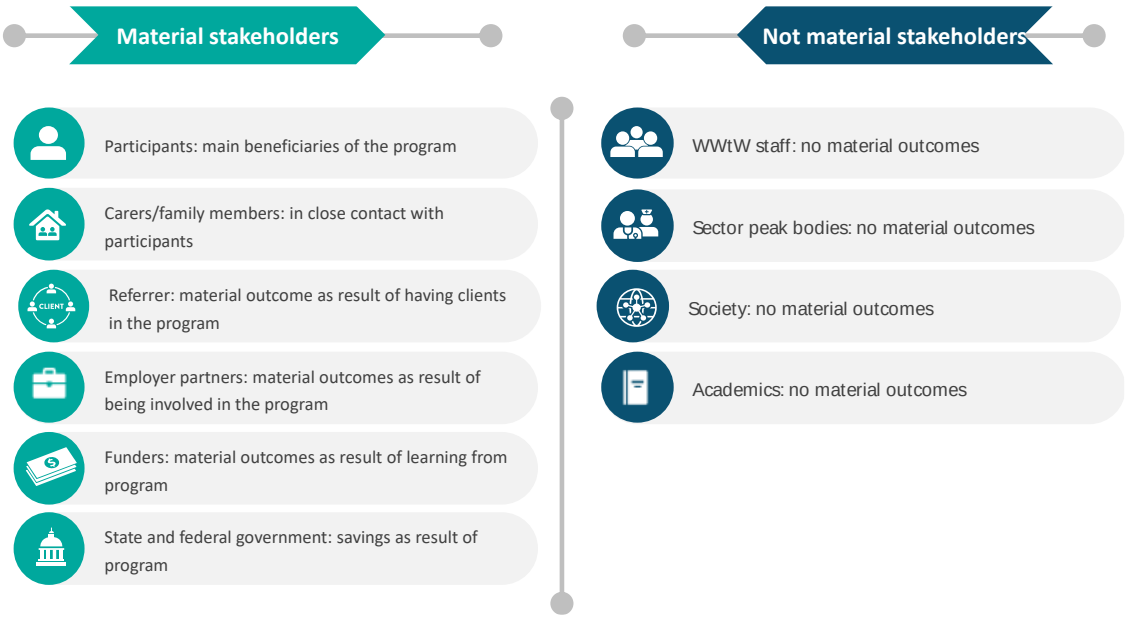


Figure 5.3 Summary of materiality of stakeholders

5.3.2 Stakeholder sub-groups

The background and life experience of each WWtW participant varies significantly, yet stakeholder sub-groups can be identified where the members of a cohort group experience similar outcomes and degrees of change.

To account for these similarities, three sub-groups have been identified based on the characteristics against which change could be valued and defined. These subgroups have been developed during the analysis phase, and they have then been verified in consultation with the WWtW staff, participants and other stakeholders. Table 5.4 describes the three subgroups identified.

Table 5.4 Participant sub-groups descriptions

Sub-group	Sub-group description	Highly valued outcomes
Participants: achieved full-time, part-time or casual employment	This group includes participants who are full-time, part-time or casually employed. This group represent **21** participants.	• Improved mental health • Improved self-esteem • Change in self-identity • Improved physical health
Participants: achieved volunteering, and/or studying	This group includes participants who are volunteering and/or further studying. This group represent **20** participants	• Change in self-identity • Improved mental health • Improved self-esteem • Improved physical health
Participants: all other	This group includes all other participants who are unemployed, linked with an employment agency but unemployed at the moment and whose employment or vocational status is unknown. This group represent **32** participants	• Improved mental health • Improved social connection • Improved self-esteem • Improved family relationships

5.3.3 Approach for measuring change

A consistent approach was adopted to measure outcomes. An initial hypothesis of outcomes was developed through the theory of change workshop. This was tested and refined with stakeholders through development of the benefit pathways. After well-defined outcomes were identified through stakeholder engagement and supplementary desktop research, indicators were developed to measure these outcomes through surveys with stakeholders. The surveys asked stakeholders to self-report the changes that they (or in some instances, the changes they believe others) had experienced against the corresponding indicators. Stakeholders were asked to assess how much change had taken place as a result of their involvement in the WWtW program.

Outcomes were measured using a 7-point Likert scale that ranged from negative change (1) to no change (4) to positive change (7). There were 3 units of positive change that respondents could report, 1 unit of no change, and 3 units of negative change. Refer to survey in Appendix F.

A more detailed example and description of the calculation is provided in Appendix A.

5.4 Considerations and limitations

In accordance with the principle five 'Do not over claim', a conservative approach has been adopted for decisions on data and assumptions used in the SROI calculation.

The following information relating to aspects of the research and analysis is provided as context for the findings. Where these circumstances or limitations could have a material impact on the ratio, the relevant aspect of the model has been tested through a sensitivity analysis results presented in section 8.3 and Appendix C.

5.4.1 Limitations and considerations of stakeholder engagement

Some limitations to data collection were identified. These are described below alongside a description of how each limitation was addressed (if relevant).

- WWtW was provided with guidance about the breadth of characteristics and perspectives that it was desirable to include in the stakeholder engagement phase. They sought to satisfy these criteria in order to ensure that the information gathered was representative of all experiences within each stakeholder group. While it was possible to secure involvement from a wide range of stakeholders, after several attempts, some limitations may still exist. It is possible that those representatives who are willing to get involved in research have had a more positive experience than others.
- The initial stakeholder engagement plan consisted of focus group of a diverse group of 8–10 participants who would be involved in the three phases of the evaluation in identifying stakeholders and understand what changes, measuring and valuing changes and verifying the results. However, due to the COVID-19 pandemic and the nature of the mental illnesses experienced by some of the participants, a focus group was not possible.
  - *How this limitation was addressed:* The engagement approach was changed from focus group sessions to individual phone interviews. This also applied for other stakeholder groups who initially were going to be engaged either via focus group sessions or face-to-face interviews.
- Number of referrers (predominantly staff working in community mental health services) engaged in the first phase was lower than anticipated. The primary reason for this was COVID-19. The COVID-19 pandemic meant that the workload for people working in the mental health space increased significantly as people with pre-existing anxiety disorders and mental health problems are at increased risk of experiencing significant anxiety and distress during a disease outbreak (Black Dog Institute, 2020).
  - *How this limitation was addressed:* Desktop research was used to complement the findings from the interviews with the various stakeholder groups. Representative voices (peak bodies) were engaged as proxies for referrers and participants.
- Limited engagement with carers and family members who experience material outcomes. During the stakeholder engagement phase another research project was being conducted on the impact of the program on family members, this will be published in August 2020. To not overburden carers/family members, particularly during the COVID-19 crisis, it was decided not to engage the significant numbers of carers/family members with whom WWtW are in contact. One of the offshoots of this limitation was that there is a lack of in-depth understanding of the nature and extent of 'caring' responsibilities carried out by family members.
  - *How this has been addressed*: A total of four carers have been interviewed, and then participants and WWTW staff were used as proxies for carers. In addition, the carer representative body was interviewed as a stakeholder for gaining an understanding of the outcomes for carers and family members.

5.4.2 Limitations and consideration of data collection

Some limitations to data collection were identified. These are described below alongside a description of how each limitation was addressed (if relevant). It is possible that despite the efforts of the research team to mitigate the risks presented by these limitations, any resulting skewing or errors in the data may have affected the findings of the analysis. The sensitivity analysis in section 8.3 and Appendix C presents additional calculations to account for the most likely possible errors in the data or findings.

- Both the surveys that were distributed had low response rates. The survey sample size was 21 for participants and six for referrers. Multiple requests and reminders were made by the WWtW team and the research team to maximise the response rates – this included phone calls, text reminders and emails. Low response rate of referrers was ascribed to the excessively high workload due to COVID-19. It was also identified that there was a high turnover of case managers in mental health, with many referrers not in the roles they had been at the point of initial engagement with WWtW. The low response rate of participants was also ascribed to COVID-19 and the lack of digital equipment, for example a laptop or computer to complete the survey. These small sample sizes may mean that the survey results are skewed and not representative of the entire population.

  - *How this limitation was addressed:* WWtW sent the link of survey over text to participants, so they could complete the survey using their smartphone. This increased the sample size by four. Survey results were complemented with participants output data from WWtW. No action was taken for the referrers' survey.
- Employer partners who were identified as a stakeholder group experiencing material outcomes were not involved in the data collection phase. Interviews with employer partners were planned during March 2020, but due to COVID-19 these interviews were postponed a number of times and the majority of them happened in May 2020. This was because businesses had to close for lockdown and the focus of managers was on business survival. During this time, multiple requests and reminders were made by WWtW and the research team to increase the numbers of interviews. Given the difficulties in engaging employer partners during the pandemic, it was decided that no survey would be developed as it would most likely result in low response rate (as the survey for referrers)
  - *How this limitation was addressed:* Desktop research was used to complement the findings from the interviews. However, a recommendation will be made to develop either a focus group or a survey in future research in order to understand and quantify the amount of change and identify levels of attribution, deadweight and drop off.
- Carers/family members who were identified as a stakeholder group experiencing material outcomes were not involved in the data collection phase.
  - *How this limitation was addressed:* Surveys distributed to participants asked questions about the outcomes experienced by family members. Participants were considered to have knowledge of their families and minimal motivation to misreport change. It is still possible that some nuance of the experience of family members was not captured through this method. Carers/family member outcomes and values were verified with the Victorian peak body for carers.
- During early stakeholder engagement phase the participant outcome 'greater sense of belonging' was identified and indicators were developed to measure this outcome in the survey. However, during the verification phase with participants, following the survey analysis this outcome was understood to be different and changed to become 'change in self-image'.
  - *How this limitation was addressed:* Other indicators in the survey that related to the outcome 'change in self-image' were used to quantify this outcome.
- In the surveys, outcomes were measured using a 7-point Likert scale that ranged from negative change (1) to no change (4) to positive change (7). Respondents were asked to report whether they had experienced any change in relation to statements (indicators) that measure the extent to which the outcomes were achieved. The indicator statements were constructed based on the knowledge gained through the face-to-face stakeholder engagement. In some instances, the indicator statements adopt the language that stakeholders themselves used to describe the change. The use of Likert scales provides an efficient means for collecting, analysing and communicating data. The 7-point scale was designed as a way of capturing more granularity than binary or 5-point scales in measuring change. In the context of this SROI, their use was deemed appropriate to efficiently collect data from stakeholders. There are some risks with the use of Likert scales:
  - Respondents may feel limited by the pre-determined options or understand the points on the scale differently to they were intended.
  - There can be a tendency for people who are unsure or confused to default selecting the mid-point on the scale, misrepresenting their actual experience.
  - Responses may also be biased to what respondents believe is desirable or polite, a common challenge with many research approaches. This may lead to over-stating the positive changes
  - *How this limitation has been addressed*: These risks were managed by providing descriptions of the scale points and open questions alongside the Likert scales to enable scope for respondents to clarify their responses and provide more detailed information. These risks were also

managed by piloting the surveys with representatives from WWtW to enhance clarity and eliminate bias.

- To establish whether outcomes have been experienced and the amount of change experience the survey included a measurement scale of -3 to +3, where -3 is “A lot less” and +3 is “A lot more” and 0 is “No change”. The outcome incidence is the weighted average of all the responses, including positive and negative change. A potential risk with using this approach is negative outcomes within stakeholder groups is part of the weighted average
  - *How this limitation has been addressed*: Negative outcomes that were material were included in the benefit pathway and reported as standalone outcomes in section 6. Negative changes for individual participants have been briefly explored in narrative of the outcome in section 6.

5.4.3 Limitations and consideration of verification of findings

- Not all material stakeholders have been involved in the verification of the SROI findings. The verification of the SROI findings was undertaken with participants, funders, carers representative body, referrers, employer partners and the WWtW staff team. There is a risk that the SROI findings do not represent the experience of the stakeholders, in which case the ratio could be over- or under-stated.
  - *How this limitation was addressed:* These risks have been managed by involving stakeholders such as WWtW and sector peak organisations who have detailed knowledge of the experience of the stakeholders and visibility on both intended and unintended stakeholders. The findings were also peer reviewed by an accredited SROI practitioner during the verification process.

6. Stakeholder outcomes

Six material stakeholder groups have been identified (refer summarised description 5.3.1 or Appendix B for more details) and a 'benefit pathway' for each has been developed. The overarching theory of change is explained in section 3.6. The six stakeholders are participants, carers/family members of participants, referrers, employer partners, funders and government.

The benefit pathway or chain of events depicted for each stakeholder stems from the activities, that lead to early change outcomes and intermediate outcomes to key well-defined outcomes that have been valued for this SROI. Early and intermediate changes are vital changes that need to occur for well-defined outcomes to occur. Early change outcomes need to be monitored to ensure the foundations are in place for longer-term change to take place.

The benefit pathways presented in this chapter illustrate positive and negative outcomes experienced by the six material stakeholder groups.[5] In order to avoid double counting some of the outcomes presented in the benefit pathways have not been valued, as explained in the narrative. The benefit pathways have been drafted following stakeholder interviews and shared with participants, referrers, employer partners, funders and WWtW staff that agreed to be involved in the process at multiple stages. This was done to understand and verify causality of outcomes as well as to identify whether outcomes presented in the benefit pathway are complete.

6.1 Outcomes for participants

This stakeholder group refers to the beneficiaries of WWtW, during the analysis this group has been divided into three subgroups:

- Subgroup 1: Participants who have achieved full-time, part-time or casual employment
- Subgroup 2: Participants who have achieved volunteering and/or further study
- Subgroup 3: Participants who have achieved neither of the above.

Stakeholder interviews/surveys identified that the three groups participated in the same activities and all broadly experience the same outcomes, however participants from subgroup 1 experience financial wellbeing through being in employment, whereas participants from subgroup 2 and 3 have not achieved that yet. In addition, some people from subgroups 2 & 3 experience the negative outcome of disappointment from not yet getting a job, however, they also experience improved employability.

Studies have shown that unemployment is associated with worsening psychological illness and increasing social exclusion (McKee-Ryan et al., 2005). In line with these studies, participants who are employed achieve higher outcomes, compared to participants who are engaged in other vocational outcomes such as volunteering or studying. Participants in the second group are more likely to achieve their goal of obtaining employment and therefore were expected to experience higher outcomes compared to participants who are not volunteering or studying.

Figure 6.1 illustrates the change that occurs for all participant groups. [6]

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[5] Whilst the majority of stakeholders groups experienced positive outcomes, some individuals within stakeholder groups have experienced negative outcomes. These negative changes have been briefly explored in the relevant subsections below. The development of the benefit pathways also allowed for exploration of whether a negative outcomes experienced by on stakeholder (or group) flowed into the benefit pathways of other stakeholder groups.
[6] Key outcomes have been verified with participants to make sure outcomes are not double counted. For example, improved self-esteem is an outcome that could potentially lead to improve mental health, however participants described these two outcomes as being separate.

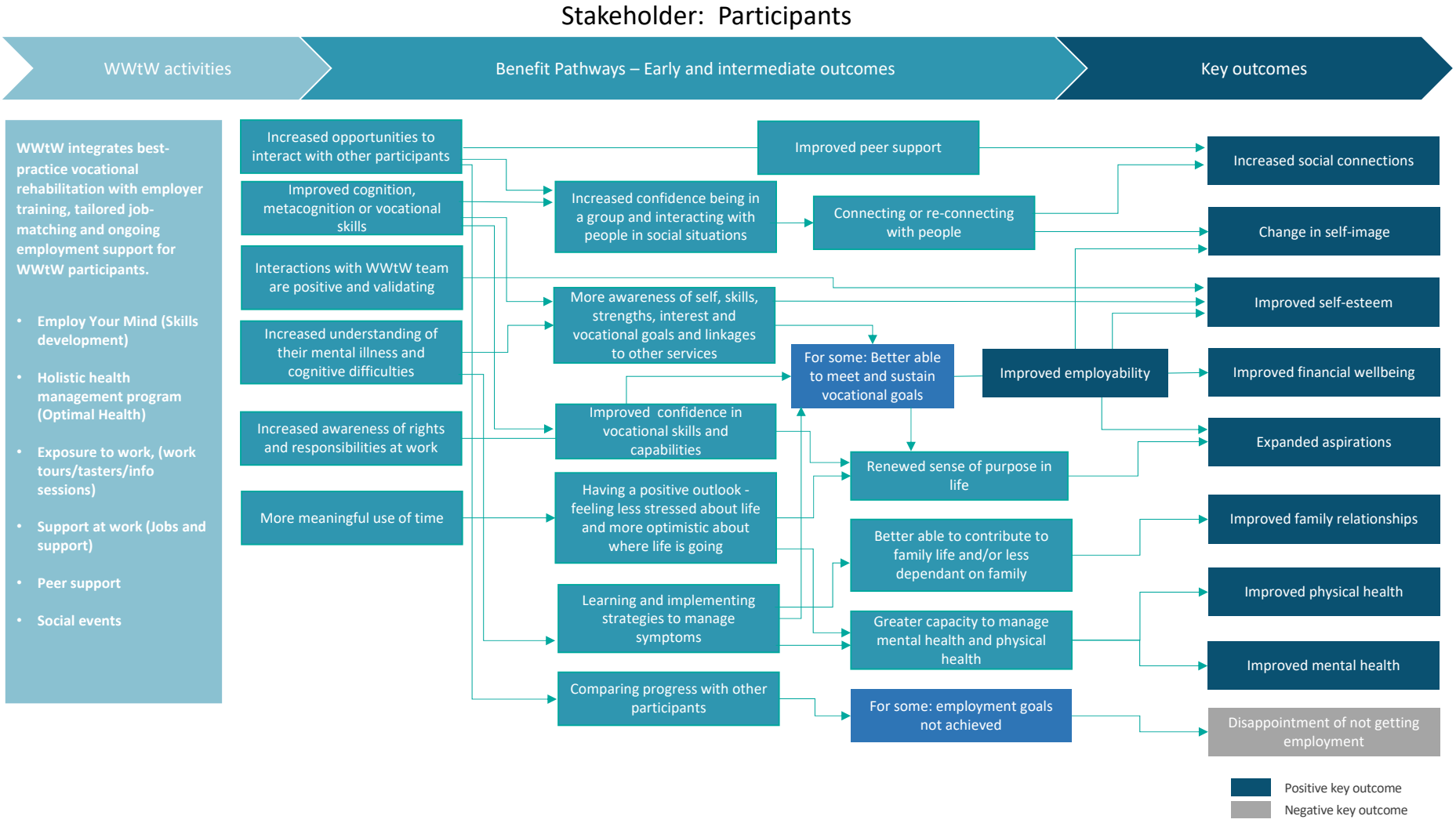


Figure 6.1 Participant benefit pathway diagram

6.1.1 Improved social connection

People with mental illness often experience social isolation, and WWtW participants were no exception to that. **62 per cent** of all program participants stated they experienced isolation and loneliness at the time they started participating in WWtW. After engaging in the program, **67 per cent** of participants stated that they feel less socially isolated and **71 per cent** stated that they feel comfortable with their community or social life.

> *"I'm more connected with participants from the program, and I feel less isolated. I have also reached out to my own friendship circle more, and I am doing community volunteer work. I'm even encouraged to talk to people I work with." – Participant*

> *"I have been able to leave the house several times a week to engage with others in a meaningful way." – Participant*

WWtW provides participants the opportunity to engage with people who are experiencing similar issues and to provide peer support to each other. Another important part of WWtW is focused on improving vocational skills, including community skills, which help build confidence to interact with people in social situations.

> *"I got the ability to go back into community. I was very withdrawn and still can be that way, but now I can openly speak to 100 people, where normally I wouldn't say anything." – Participant*

Despite the majority of participants reporting feeling less socially isolated, a small minority (3 individuals) reported feeling more socially isolated. The majority of the research was conducted during stage three lockdown of COVID-19 restrictions, which has exacerbated feelings of isolation.

Together with improved self-esteem, this outcome was valued as one of the most important changes in participants' lives as a result of WWtW. Participants not only stated feeling more socially connected with other participants, but also with friends with whom they have reconnected, other people, colleagues and WWtW staff members.

> *"The most important thing to me is that I can better socialise with others, and that I have lasting connections with the WISE staff." – Participant*

6.1.2 Change in self-image

This outcome had been described as "greater sense of belonging" in an earlier iteration of the benefit pathway and indicators were developed as such in the survey. However, during the second verification process, it was further developed and understood, which led it to be updated to "change in self-image". This update emerged from interviews with participants employers and WWtW staff during verification.

People with mental illness experience many obstacles to employment. Through involvement in WWtW, participants are given the opportunity to become "a normal part of society", someone who is working. This changes their perception of their identity and they start seeing themselves as someone who is more than just "mental health patient" or a consumer/user of mental health services. How the participants talked about themselves once they had a job or saw themselves as employable was the key factor – it was a new narrative about themselves from the change in self-image.

> *"Being able to say they have a job is the biggest difference. It alters how people are viewed by society." – Employer partner*

"Monthly lunch & learn [organised by WWtW] made me feel I was normal. My friends have lunch and learn meetings, and professional development and to know that I was doing that as well helped a lot.'' – Participant

"Identity of being a working person, or a person who belongs in the paid employment space, this change is enormous" – WWtW staff member

"It is about the value of self-respect and having a self-image as a potential worker not just a client or a patient." – WWtW staff member

"Whenever you meet someone for the first time, the question: 'What do you do?', is always focused around work. My son didn't have a job and couldn't really be part of these conversations and now he does." – WWtW staff member (proxy for carer)

6.1.3 Improved self-esteem

Improved self-esteem was cited as one of the most valuable changes experienced by participants. People with mental illness often experience stigma, which reinforces a belief that others will devalue and reject them for having a mental illness. Stigma and the resulting self-stigma can therefore lead to significant loss in self-esteem.

"It's demoralising being excluded from society, but WISE really helps them to start believing in themselves again." – Referrer

WWtW helps participants understand how their mental illness affects their cognition and provides them with the tools to improve their skills.

"…I was monitoring a Zoom meeting. I have never been in charge of doing that before... I would have never done that a year ago." – Participant

"My daughter noticed the confidence I have gained. I'm able to speak up and with enthusiasm, share my opinion and not being afraid people won't agree with it." – Participant

Besides the skills gained, the positive and validating interactions with WWtW staff, and having someone that believes in them is often described as an important reason for improving self-esteem. Improved self-esteem can also have the effect of leading to improved mental health. This was explored with participants who clearly identified improved self-esteem as a separate outcome obtained via WWtW.

"I started to believe in myself a bit more, through seeing the positive results in the program. They have shown me an internal strength that I didn't know I had, and they have helped me unravel that. I know I'm still getting there but I would say that's been the biggest so far." – Participant

6.1.4 Improved financial wellbeing / Improved employability

Participants in subgroups 2 and 3 experience the outcome "improved employability" while participants from subgroup 1 who are employed also experienced this then once they had a job, they experienced "improved financial wellbeing".

People who have mental illness are more likely to fall into economic disadvantage, due to low education attainment and other system wide factors such as stigma and discrimination (Waghorn and Lloyd, 2005). WWtW has been specifically developed to help people living with mental illness prepare for the world of work and be supported on a graded pathway to achieve their vocational goals. Participants who have not yet obtained employment identified that they have improved employability due to improved cognition and skills as well as more experience due to work placements, volunteering or studying. Nine

out of 14 participants in subgroups 2 and 3 expressed gaining more skills and experience to help find a suitable job, however five out 14 reported negatively when it comes to gaining experience that will help them get a job.

> *"I have been able to develop my soft skills and engage in cognitive remediation therapy which has helped my cognition greatly in all areas tested." – Participant*

> *"One of my clients just finished the program and did work experience. He wants to work in... but doesn't have experience working with children and parents, so explained how he could get this by doing the school-crossing… Clients are now open for more roles and understand that sometimes you need a stepping stone to get to where you want to be." – Referrer*

Improved mental health is an important part of improving employability and financial wellbeing. For participants who have been long-term unemployed this meant focusing on their mental illness as well as getting work experience. For participants who had had negative experience of being in a workplace, this meant learning strategies to deal with triggers before they spiral and cause a relapse.

> *"It's a slow trajectory of getting well, but the program helped the process. I didn't know how to go from being at home to go back to work. Going into the workplace and even the workplace kitchen was a trigger for me, I had to remind myself that no one was going to attack me. As the program continued, I got more comfortable being in an office environment which reduced my anxiety. I would not have got that without this program… I have found a part-time employment in August last year." – Participant*

Improved financial wellbeing is an outcome that follows improved employability for those in subgroup 1. The main source of income for 85 per cent of people surveyed in the 2010 Australian national survey on people living with psychotic illness was a government payment (Morgan et al., 2011). The main form of government support was the Disability Support Pension, which is $860.60 per fortnight for a single person. For participants who have obtained employment, this meant that they are either less reliant on government support or they can complement that support with other sources to increase their income. 51 per cent of participants who have achieved employment stated that their financial position has improved as a result of WWtW.

> *"Without the program I would probably still be anxious about returning to work and struggling to find part-time work and be broke because Newstart doesn't pay the bills." – Participant*

> *"I went back to work at the same place as I worked at before. So, I didn't really get that job to due to the program, but it definitely helped me get to place where I can cope with the work expectations. I'm working more hours now." – Participant*

6.1.5 Expanded aspirations

As participants understand their own capabilities, gain skills, and better understand different pathways to achieve their goals and the support that is available to them, they feel better equipped and hopeful for the future. This leads to expanded aspirations to pursue their goals, including vocational goals. For example, one participant stated even though she did not get a job at the end, she learned a lot about social engagement and work experience that she can put into her daily life and use when she starts looking for job again (after COVID-19). Other participants expressed that WWtW helped them to think about other vocational goals such as studying or volunteering.

> *"I went back to study. Last year I wouldn't be able to do that, I had no confidence and a problem with my memory." – Participant*

"I wanted to do something meaningful, study, volunteer or do part-time work. But I didn't know how to build resilience and confidence to go and do it. I have found part-time volunteering job and I am still doing that currently, but just online." – Participant

"[The program is great at helping you to] find the positives in the negatives." – Participant

From the total number of participants engaged, four participants expressed not feeling confident in being able to achieve their career goals. They acknowledged that WWtW has supported them on their journey to achieve their vocational goals but saw the lack of achievement as being due to stigma and other challenges experienced by people with severe mental illness participants seeking to re-enter the workplace.

6.1.6 Improved family relationships

Another change identified in a participant's life is improved family relationships. This was mainly due the fact that they were provided with strategies to manage their symptoms as well as getting a more positive outlook on life and being more able to participate in and contribute to family life.

"… really encouraged me to strengthen my social connections and interact with family members that I have been avoiding." – Participant

"I'm able to contribute more to the family and my relationship." – Participant

"My partner moved in because I was doing better." – Participant

6.1.7 Improved physical health

The stakeholder engagement identified that for many participants, physical health was heavily intertwined with mental health. Prior to joining WWtW, some participants expressed having low energy levels and not being able to do complete basic chores such as grocery shopping. As their mental health improved, their physical health improved. Physical health is an important component of the Optimal Health Program that helps maintain wellbeing and other parts of WWtW that enable greater capacity to manage physical and mental health.

"I now have stamina to go to places, before I would only be able to go for 1 or 1.5 hour appointments and be done for the day. I'm slowly increasing my activity levels now." – Participant

[most valuable difference] "Getting back to life and the ability to do things. Cooking went from impossible to doable now." – Participant

"I have better stamina at work." – Participant

For participants living with a physical disability or physical health problems that have led to mental health problems, improving their mental health also helped improve their physical health. One participant expressed how her physical health has improved partly to due to an improvement in mental health:

"Physical wellbeing and mental are meshed for me... I still have pain flare-ups, but how I respond to them has changed. My low moods are balancing a bit better" – Participant

6.1.8 Improved mental health

Improved mental health was one of the highest valued outcomes for participants. WWtW integrates best-practice vocational rehabilitation developed for people with severe and persistent mental illness. Throughout the different modules, participants are supported in understanding how their mental illness

affects their cognitive skills and are then provided with tools and strategies to manage their mental health.

> *"I didn't know what my options were with my depression. I worked most of my life and now have mental health problems. I went on a pretty horrible downward slide and needed something to stop it. WISE helped me to stop it and turned my life around to now having a positive outlook." – Participant*

> *"I learned to laugh again." – Participant*

> *"My daughter has noticed a change. She says it's almost like I'm looking up a bit more. The way I talk is a bit more excited and bubblier. I still have ups and downs and maybe that's never going to change. I feel like I'm getting a bit stronger and am more able to draw myself back out so I'm not getting stuck so severely…. I got something positive to focus on." – Participant*

Given the severity of their mental illnesses, it is no surprise that most of the WWtW participants make use of health services from GPs, psychologists, psychiatrists and other community mental health services, however the majority expressed the importance of the methods and modality of WWtW in improving their mental health.

> *"The teaching and work experience have been very helpful for my self-esteem, which also helps with my depression." – Participant*

> *"I find periods of feeling down less severe. [why] It's the support from staff and skills we learn in program." – Participant*

> *"I'm 90 per cent able to get on top of depression and carry on with life." – Participant*

> *"I'm still learning my limits and manage my wellbeing in my part-time volunteering role. It brings stress and anxiety at times, but I use the tools taught and benefit from checking back in with the Vocational Coach." – Participant*

6.1.9 Disappointment in not getting a job

Some of the participants who did not achieve their employment goal (subgroups 2 and 3) stated feeling disappointment in not getting a job after they finished WWtW. From conversations with the WWtW team it became clear that some participants were comparing their situation and achievements with other participants, and when they don't achieve similar goals their confidence gets affected. However, WWtW has clear mechanisms in place to support participants and help them to understand their individual journey to manage negative feelings. Wherever possible WWtW continues to provide support to those participants and refers to DES services where appropriate. Some have since been assisted into work. Given the low participation rate in the workforce and stigma for people with severe mental illness, the challenges faced, and disappointment is understandable.

Some participants experience no change or negative results

There a few outcomes where four or more respondents reported experiencing no change. These outcomes were improved social connection (four respondents), change in self-image (five respondents), improved family relationships (eight respondents) and improved psychical health (six respondents) as illustrated in Table 6.1. These responses are not surprising given the main focus of WWtW is to improve skills and confidence and assisting participants in remaining in or obtaining meaningful employment. In order to increase the value created by WWtW these outcomes should be monitored to understand how participants can be assisted to experience positive change.

Table 6.1 Participants within each subgroup report experiencing no change

Outcome	Subgroup 1	Subgroup 2	Subgroup 3	Total # respondents experiencing no change
Improved social connection	0	2	2	4
Change in self-image	1	1	3	5
Improved family relationships	1	4	3	8
Improved physical health	0	3	3	6

Furthermore, a very small minority of respondents (two respondents in subgroup 2) reported experiencing negative change for different outcomes, and two respondents (one in subgroup 2 and one in subgroup 3) that have reported negative change in feeling confidence they can achieve their career goals which is part of the expanded aspirations outcome. These negative changes especially for the two respondents in subgroup 2 that reported experiencing negative change for more than one outcome, should be further investigated to understand the possible reasons and look at options to increase the value. Possible reasons might include:

- COVID-19 restrictions implications on mental health and social connections (for example, the limited physical contact allowed contributing to or increasing feelings of social isolation).
- By engaging in program becoming more aware of their situation (for example, being comfortable with community and social life before the program, but due to improved social skills obtained at the program wanting to have a more engaging community and social life).

Both no changes and negative changes should be monitored and further explored with participants in order to mitigate negative outcomes.

6.2 Carers

This stakeholder group refers to the carers of participants. These carers are frequently family members and provide a wide range of support to the participants in the WWtW program. The carers experience change due to participants' improved mental health and situation (Figure 6.2).

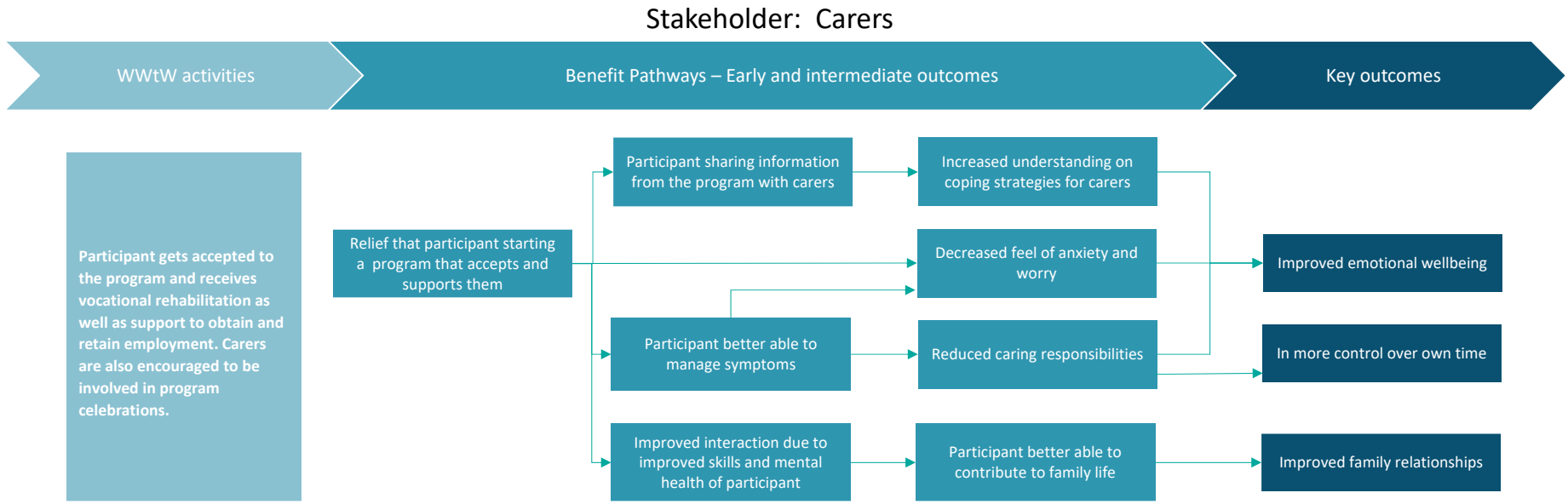


Figure 6.2 Carers benefit pathway diagram

6.2.1 Improved emotional wellbeing

WWtW provides a relief for many carers who have tried to get support for their family members but kept on hearing that their loved one is "too difficult to work with" or "doesn't meet the criteria". The WWtW pilot was a free program available for people with severe mental illness with or without an NDIS plan. This is seen as a lifeline for some carers. Having a program that accepts and supports their family members, helps decrease feelings of anxiety and worry which leads to improved emotional wellbeing.

"At times we have been doing the treatment as no one else accepted him. A while back he did an assessment for a program that is helping autistic people get work. A week after the assessment they decided he was not well enough to work with them." – Carer

"I think both my kids are feeling a bit more relaxed to see that I have got help and I am getting better. They were both really scared and worried about me and didn't like seeing me the way I was." – Participant

"I thought I was becoming unwell myself by being so consumed by my daughter's situation… I got a cloud of worry around me. I can't help her the way they can, but with WISE [providing assistance to her] I'm getting a break." – Carer

Improved emotional wellbeing was also characterised by participants being able to share information from the program with carers or other family members, who then increased their understanding on appropriate coping strategies.

"I worry about my son a lot. If he's not careful he will end up going down the same path as me. I wouldn't have been able to have discussions with him on mental health if WISE Ways to Work hadn't given me tools to use and impart that wisdom on to my son." – Participant

6.2.2 In more control of own time

Carers spent a lot of time providing informal assistance to their family members. As the participants' ability to manage their symptoms better and improving their mental health, carers experience reduced caring responsibilities and more control over their own time.

"He went from having nothing positive in his life and relying on us… When he goes to WISE, we get some time to do something from ourselves." – Carer

"Prior we would spend hours looking for things for him to do. Now he is working three days and we are not having those conversations about what he can do as much. Now we can do our own thing and not having to worry about it as much." – Carer

"She gained independence from me. It's a huge relief for me that I don't have to do it all and that she is being taking cared of… She's under their wing." – Carer

6.2.3 Improved family relationships

Just as participants experience improved family relationships, carers experience the same improvement. From the carer's perspective, this was related to better interactions with family and more contributions in family life due to the improve mental health of participants.

"He is challenging to live with, but this program… helped. He is more relaxed and can focus more on things. It's good having someone in the house who is not agitated all time." – Carer

"I got to a point where I was trying to fix it all, but I couldn't. I'm part of the support team, but I'm glad that they [WWTW] are taking the psychological side. I'm just as her mum now and I don't have to fix it all. There is a team who can do that now." – Carer

6.3 Referrers

This stakeholder group includes community mental health staff, Occupational Therapists, support service workers and case managers working in the health and disability employment sectors.

Referrers experience value from WWtW (Figure 6.3).

Whilst referrers were able to identify outcomes that were achieved through WWtW, the majority of value for referrers flows to clients/participant outcomes which have been identified and valued in the participant benefit pathway (Figure 6.1). These outcomes will only be valued for participants to avoid double counting.

In addition, referrers were also able to identify outcomes that were achieved for government funders, particularly in terms of more effective use of health resources leading to reduced health care costs (Figure 6.6). As above these outcomes will only be valued for government to avoid double counting.

The other value for referrers which comes from improved job satisfaction. The value flow to referrers for this outcome is low.

Whilst referrers were clearly identified by other stakeholders as a material stakeholder, without whom the program could not function, and outcomes were being achieved this did raise concerns about materiality. The issue was addressed with the referrer representative during verification and the decision was to retain referrers as a material stakeholder. The implications if they were excluded from the value calculation are discussed in the sensitivity analysis.

6.3.1 Improved job satisfaction

It was frequently stated by referrers that WWtW was the only program in this space, and that they are not only focusing on vocational rehabilitation but also on supporting people with severe mental illness to find and sustain employment. As result of interacting with WWtW staff members, referrers improve their understanding of mental illness and employment and have a program they can refer their clients to.

> *"Having a good option for employment support has meant we feel able to discuss employment options with our clients." – Referrer*

> *"Increased opportunities to be able to confidently provide patients with an excellent service we know will support their needs." – Referrer*

Referrers also highlighted the importance of WWtW being a program that accepts non-NDIS recipients as many of their non-NDIS clients are excluded from many support services.

> *"That's a space no one was helping with… Now we regularly refer clients who want to do that… NDIS supports clients, but the majority of our clients are not eligible for NDIS. So, WISE being open to non NDIS clients has been good." – Referrer*

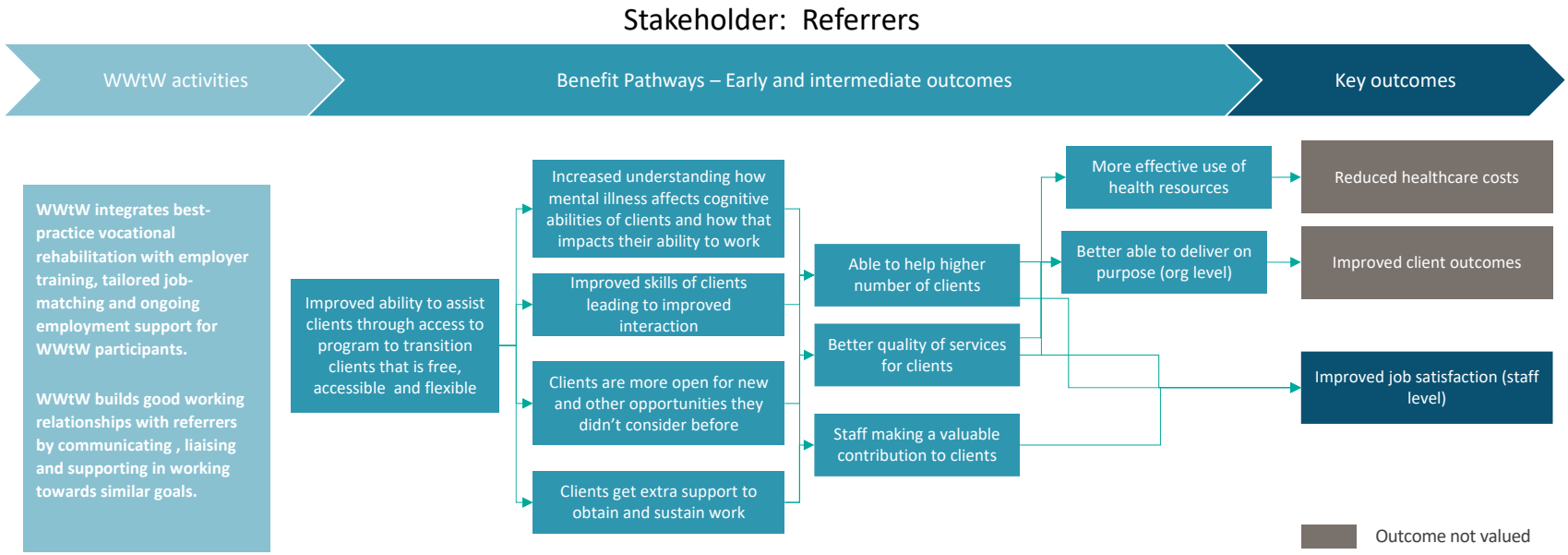


Figure 6.3 Referrers benefit pathway diagram

6.4 Employer partners

This stakeholder group includes employer partners that have committed to offering work experience, placements, volunteer positions and/or paid positions to WWtW participants. Employer partners experience change by engaging with WWtW program and staff as well as engaging with its participants (Figure 6.4).

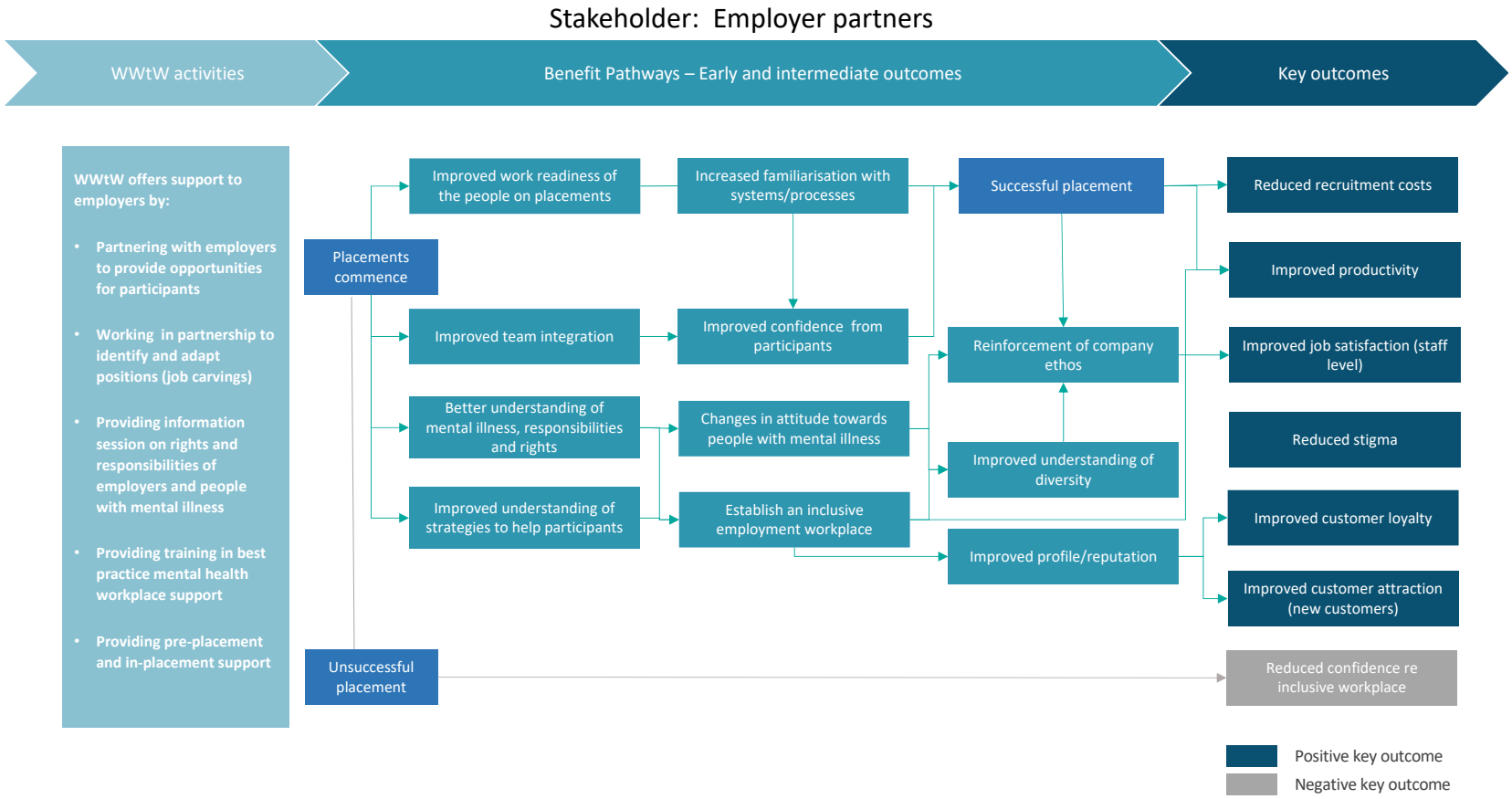


Figure 6.4 Employer partners benefit pathway diagram

6.4.1 Reduced recruitment costs

Employer partners can have reduced recruitment costs when participants are offered a position after the work experience or placement. During the work experience or placement, employer partners get to know a participant and their capabilities and establish whether they are a good fit for the company. By offering participants a position, employer partners don't have to use recruitment method such as advertising or using a recruitment agency that charges a fee.

> *"WWtW and other employment agencies provide referrals for our workforce. WWTW is great as we do not have to go out there and market ourselves to people with mental health issues." – Employer partner*

> *"It is a beneficial relationship. We get people who clearly fit out social mission. With others it is hard to assess." – Employer partner*

6.4.2 Improved productivity

Research shows that the mentally healthy workplaces are positive and productive. By establishing an inclusive workplace and changing attitudes towards mental health, employers create a healthy and safe workplace that benefits all workers, including participants and other staff with mental illness. Furthermore, research suggests that the productivity of employees with a disability, including employees with mental illness, is equal or superior to other employees without disability and that their loyalty often surpasses their counterparts without a disability (Graffam, 2002).

> *"We have found that when you give people a chance, they often give back through working harder and being more productive." – Employer partner*

6.4.3 Improved job satisfaction

Employer partners and their staff reported improved job satisfaction from contributing to the employment journey of people with mental illness and witnessing/contributing to the transformation that participant's experience.

> *"You see improvements in people." – Employer partner*

> *"It takes time to support people, but it is very rewarding." – Employer partner*

> *"I'm proud to be part of something that is successful and becomes part of their story and enables them to change their story and future." – Employer partner*

6.4.4 Reduced stigma

People with mental illness are subjected to stigma and discrimination in and outside the workplace. WWtW works with employer partners to create a better understanding of mental illness and helps improve understanding of strategies to support participants at the workplace, this contributes to reducing stigma around mental illness, often through looking at diversity in the workforce. This is turn helps to change attitudes towards people with mental illness and to create an inclusive workplace.

> *"It added an additional string to the bow. It has allowed us to look at different style of working with people." – Employer partner*

> *"We have a supportive model that we developed with WWtW. It challenged us around how people fit into the workplace and has been great from a diversity point of view." – Employer partner*

6.4.5 Improved customer loyalty

Employer partners also reported improved customer loyalty due to the improved profile and reputation of being an inclusive employer.

> *"We keep business because of the social impact of the work we do, growth of social procurement has helped with this." – Employer partner*

> *"Customers say they love seeing participants working. The profile from WWtW has enhanced our reputation for doing good and doing it well. It reinforces our ethos on creating positive change." – Employer partner*

6.4.6 Improved customer attraction

Improved customer attraction (alongside improved customer loyalty) was also attributed to an improved reputation of being employer that wants to improve business and create a positive social change.

> *"Customers comment on the nature of our company. We win business now because we are a social enterprise and are known as a good employer." – Employer partner*

> *"Things only changed in last five years when social procurement became flavour of the month… Today social procurement has become acceptable and part of business requirement… Social procurement is now part of the law, which is awesome, but we still had to prove ourselves and deliver high quality services." – Employer partner*

6.4.7 Reduced confidence regarding inclusive workplace

Due to one of the placements not being successful, one employer partner expressed temporary, reduced confidence in whether their workplace could be an inclusive workplace. This feeling only lasted for a short time for the employer partner and the WWtW team supported them to get structures in place for other successful placements. It should be noted that the participant did not experience the placement as negative.

> *"The key changes are increased understanding of diversity, reduced stigma and improved profile in terms of giving people a chance. We had one placement that was hard and unsettled staff's confidence, but that recovered quickly." – Employer partner*

WWtW has good processes in place to support both employer partners as participants in managing ''unsuccessful placements''. This issue should be tracked over time to see how many employer partners experience this and whether it leads to other outcomes.

6.5 Funders

This stakeholder group includes both philanthropic funders, governmental funders and WISE Employment. Funders experience outcomes by learning from the results of WWtW as well as flow back outcomes for participants (Figure 6.5). Value flows to participants as funded projects deliver successful results. Similar to referrers, the participant outcomes have not been valued for funders to avoid double counting.

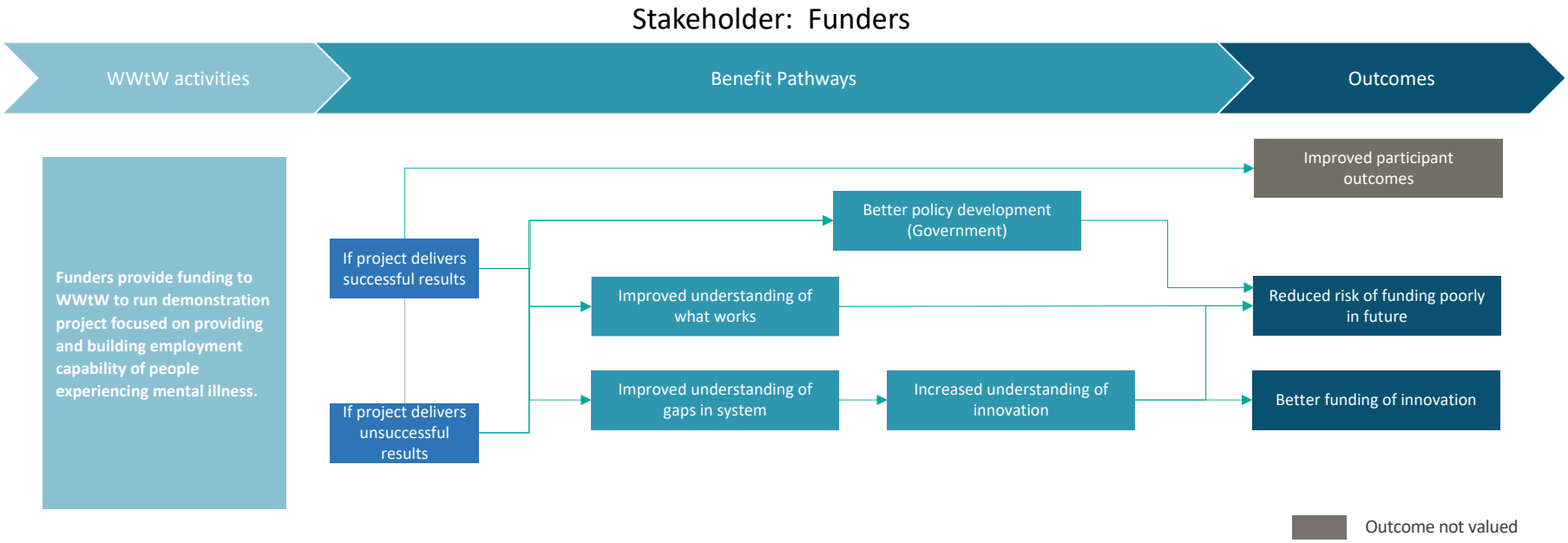


Figure 6.5 Funders benefit pathway diagram

6.5.1 Reduced risk of funding poorly in the future

Many of the funders stated that currently there is a lack of understanding of what makes an effective program for people with mental illness. One of the drivers for funders to fund WWtW was that they would get a better understanding of 'what works' and this would lead to a decrease in the risk of funding poorly in the future. The aim of funding WWtW was to learn from a program that works in this critical space.

Alongside the focus on tackling an issue for people with severe mental illness: a flexible modality, strong partnerships and track record of delivery from the prototype/pre-pilot phase were important aspects of funding decisions. The program was said to have a unique balance in terms of evidence base, innovation and prior success in that a key component of the model has been brought to Australia from Scotland where it worked, then adjusted to the specific local context and piloted. This helped increase funder's confidence.

> *"Employment is where social policy rubber hits the road. Funding it made sense." – Funder*

> *"It will make us a better funder in the future." – Funder*

Funders also stated wanting to support better policy development, especially in the area of NDIS.

> *"As a funder we are well aware of the challenges that people with mental health problems have in terms of accessing the NDIS. This program seemed to be tackling that challenge head on." – Funder*

> *"It was the innovation element that was attractive. We know that there is lower uptake of NDIS by people with mental illness, so we are keen to know what works and how we might change this." – Funder*

> *"The value comes for being able to direct NDIS intervention more successfully to people who need it." – Funder*

6.5.2 Better funding of innovation

Better funding of innovation was related to a better understanding of what works, knowing the gaps in the landscape and having a better understanding of innovation. Funders were keen to learn what was needed to bridge the gap in service provision for a group that consistently has poor outcomes, this would enable improved understanding of gaps in the system. Funders were also keen to see how the innovative approach was applied and how this program can be replicated.

> *"We are always seeing to build our awareness of what works across the landscape and seek to then identify what innovation might be needed. We looked at this as a demonstration project that could navigate a new path in a difficult space." – Funder*

> *"Knowing what works allows us to fund the best interventions. Understanding where gaps exist helps us to respond more effectively to complicated issues, particularly in the area of innovation." – Funder*

A critical part of WWtW is having vocational rehabilitation combined with support into work. This was said to be innovative and helps funders understand how to better fund for innovation.

> *"The role of the program in terms of working across the divide between health and employment. It crosses silos." – Funder*

6.6 Government (state and federal)

This stakeholder group includes the state and federal governments. Both experience outcomes due to participants improving their mental health and participating in the workforce (Figure 6.6). The federal government, and to a lesser extent the state Government, provide social services and welfare to people with severe mental illness. When people's mental health improves and they get a job, the income they obtain often have flow on benefit for governments. When participants' mental and physical health is improved, it can result in a reduction of other social services usage. The reduction is related to support services that help people with disabilities utilise to obtain employment. Being in a better headspace, provides people with mental illness to opportunity to improve their wellbeing which could involve a reduction in other social services usage. Similar to other stakeholders, the outcome of "improved wellbeing" has not been valued for the Government to avoid double counting.

6.6.1 Reduced healthcare costs (state government)

The Bettering the Evaluation and Care of Health (BEACH) survey estimated that 12.4 per cent of all GP encounters in 2015–16 were mental health-related encounters. Thus, an improvement in mental health will decrease the amount of visit to GP, as participants are better able to cope with symptoms. This was evidenced in the survey in which participants reported making less use of GP and community mental health services alongside spending less time in hospitals. As state government is primarily responsible for healthcare costs, this is mainly experienced by the state government.

6.6.2 Cost saving from reduced suicides (state and federal governments)

Research indicates that mental illnesses such as depression, psychosis and substance use are associated with an increased risk of suicide. Interventions to improve mental health can prevent people from committing suicide. Furthermore, being unemployed is reported to be associated with a twofold to threefold increased relative risk of death by suicide, compared with being employed (Blakely, Collings, Atkinson, 2003). Improving mental health and assisting people with mental illness into employment, therefore, notionally saves the state Government direct costs associated with suicides such as policy, ambulance and coronial and federal government in terms of future earning potential of individuals.

> *"[Without WWtW] My ability to work would cease completely. Now I don't know whether I can work again. But without it [WWtW] I might have suicidal thoughts." – Participant*

> *"Unemployment and suicides go together. Our patients have very little hope in finding work, so having something that we can refer people to and that actually works makes a difference…Getting people into WISE assists with managing suicides." – Referrer*

6.6.3 Reduced welfare costs (federal government)

There are 21 participants who are now working. As people who would otherwise not have been employed get a job, the income support they receive from government is reduced.

6.6.4 Increased tax revenue (federal government)

Based on the assumption made in the reduced welfare costs, newly employed participants are now paying taxes which would have not been paid otherwise. This results in increased annual tax revenue

the federal government. The survey results indicated that 71 per cent of participants who are employed, did not think they would be working if they had not engaged in WWtW.

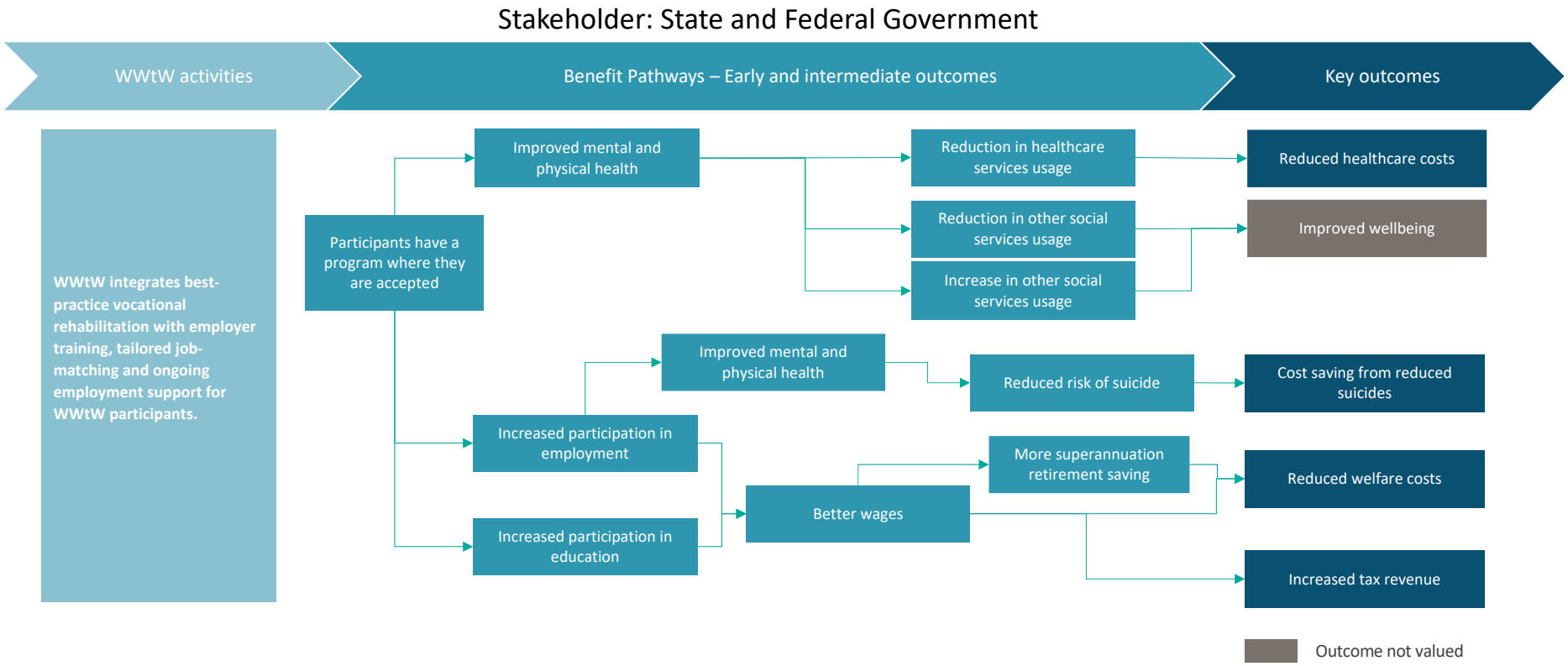


Figure 6.6 State and federal government benefit pathway diagram

7. Measuring

7.1 Measuring the value

The outcomes were measured using indicators that were identified and defined as part of the SROI analysis. Indicators provide the evidence for whether and to what extent outcomes are occurring. The evidence was collected through the stakeholder surveys and supplemented with other data from WWtW and desktop research.

Both objective and subjective outcome indicators were identified during stakeholder consultation to allow the creation of a more robust measurement. Objective indicators can form a core of a robust measurement framework. However, subjective indicators are also critical in measuring whether an outcome has happened. The current analysis relied mostly on subjective measures, as this is the first time WWtW has undertaken an SROI analysis and has not been systematically collecting data on all outcomes experienced by the stakeholders over time.

The indicators that were evidenced with data collected through the stakeholder surveys were devised based on the understanding provided by the stakeholder engagement phase. A full list of the indicators used to measure the outcomes in the theory of change is provided in Table 7.1.

7.2 Summary of investment

WWtW receives funding from philanthropic trusts, state and federal governments and WISE's Community Investment Fund to enable the project to be delivered. WISE Employment provided detailed information in a spreadsheet on the funding secured to deliver WWtW and the cost of delivery during the two-year period. In addition, it was clarified that no in-kind or pro bono support was secured in terms of delivering the project.

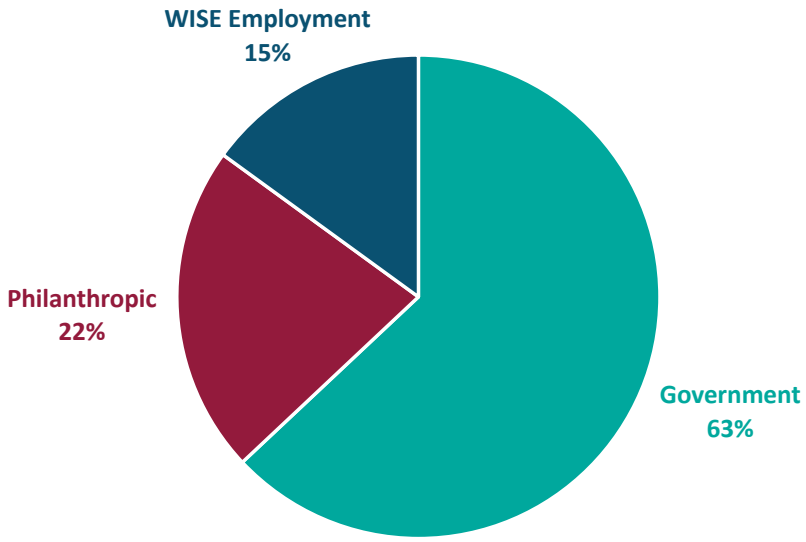


Figure 7.1 Funding sources

The total investment required is outlined in below. The investment was **$1,461,057** over the two-year period. This figure is used for calculating the SROI ratio.

Table 7.2 Summary of investment (2018–2020)

	Inputs			
	Description	Value invested AUD/year (Feb 18 - 19	Value invested AUD/year (Feb 19 - 20)	TOTAL
Expenses	Total Salary Expenses	$ 464,453	$ 623,947	$ 1,088,400
	Total Other Costs	$ 162,352	$ 210,305	$ 372,657
	TOTAL	**$ 626,805**	**$ 834,252**	**$ 1,461,057**

WWtW has also estimated that the establishment cost of the program was just over $250,000. This is shown in Figure 7.2 below.

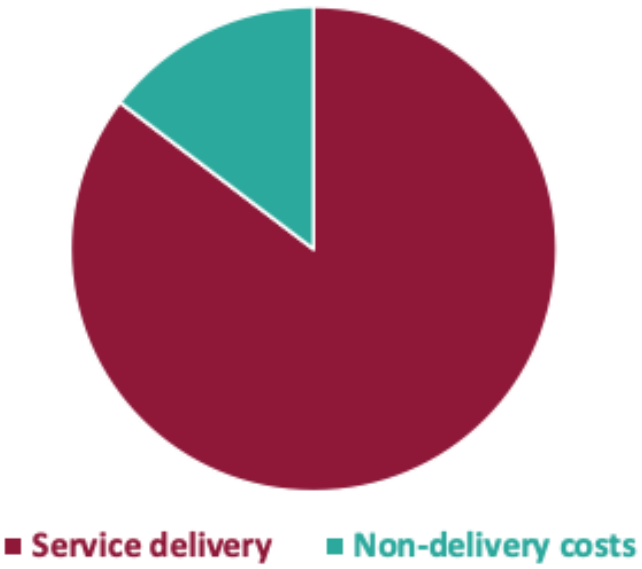


Figure 7.2 Total delivery costs

The implications of this reduced cost of delivery is discussed in the sensitivity analysis in Appendix C.

7.3 Calculating the value

Stakeholder engagement and involvement was at the heart of this research. Stakeholder engagement and surveys determined the value creation of WWtW. The financial proxies sourced through desktop research have been used to value outcomes. These were verified with key stakeholders.

The stakeholder engagement was an opportunity to explore in depth the understanding of value with people who know WWtW and the stakeholders well. This input provided an understanding of the relative value by stakeholder and by outcome.

During stakeholder engagement, individuals were also asked questions to identify the relative importance of the outcomes they identified. An example of these questions is “You’ve mentioned a few changes. From your perspective, what are the most important changes? Can I ask you to rank these things in order of the size of the change, from the most important or biggest change through to the least important to you?”

Survey respondents were also asked to indicate the relative importance of the outcomes experienced by themselves – “What are the three most valuable things you experienced as a result of participating in the Program?”

The information from the stakeholder engagement and the surveys is reflected in the relative value of the outcomes for the participants following the highest ranked changes (improved mental health, improved social connection and improved self-esteem) to the lowest rank changes (improved employability and improved family relationships). Equivalent values have been used for all three participants subgroups as stakeholder engagement and survey responses did not reveal different relative values.

The table below presents the relative value of the outcomes per stakeholder group.

Table 7.1 Indicators used for outcomes and relative value of financial proxies

STAKEHOLDER	OUTCOME	INDICATOR *As a result of the program…*	Value/ Proxy	Proxy description
Participants	Improved social connection	*I feel comfortable with my community/social life*	$35,555	Commensurate with average of the disability adjusted life year (DALY) of mild to moderate social phobia times the value of statistical life year.
		I feel socially isolated		
	Change in-self image	*I am more accepted for who I am*	$4,280	Commensurate with the value of climbing Kilimanjaro. This is a significant experience that becomes part of your life narrative.
		Built my confidence around getting a job		
	Improved self-esteem	*I am more confident*	$25,236	Based on wellbeing technique (HACT research), value of high confidence in adults (individual of unknown age and living in London).
		I feel that my work is valuable to others		
		I feel comfortable expressing myself		
	Improved financial wellbeing	*I have more money to do things that are important to me*	$2,000	Equivalent to being able to raise $2,000 in an emergency. (part of definition of Financial Resilience)
		I have more options when it comes to how I use my money		
		I have more money to spend		
	Improved employability	*Gained skills to help me find a suitable job*	$1,400	Equivalent to participation in a 10 weeks Certificate II in Skills for Work and Vocational Pathways course.
		Gained experience that helped me get a job		
	Expanded aspirations	*I feel more positive about where my life is going*	$2,340	Commensurate with average cost of consultation with motivational life coach at 1 per month. This service is often sought by people who wish to identify and be encouraged to reach for their aspirations.
		I am confident I can achieve my vocational goals		

STAKEHOLDER	OUTCOME	INDICATOR *As a result of the program…*	Value/ Proxy	Proxy description
	Improved family relationships	*My family relationships have improved*	$1,800	Equivalent to 15 counselling sessions valued at $120 per session. Family therapy is averaged between 5-20 sessions.
	Improved physical health	*I am in better physical health* *Compared to before participating in the program, how often do you make use of the following services*	$2,600	Commensurate with the cost of one session per week with a personal trainer, valued at $50 per session for 1 year.
	Improved mental health	*I can manage my mental health* *I am in a good state of mind*	$32,079	Commensurate with monetary equivalent costs associated with depression, anxiety using wellbeing valuation. Using a conservative 40% improvement in mental health.
	Disappointment of not getting employment	*Are there any negative changes as a result of participating in the Program?* *How long did this negative feeling last for?*	-$2,400	Commensurate with the cost of 10 packaged sessions consultation with a career coach. This service is often sought by people who wish to focus on improving their career or expand their employment opportunities.
Carers	Improved emotional wellbeing	*My family worry less about me* *Their mental health has improved* *I have been able to inform or share mental health coping strategies with family members*	$5,926	Commensurate with average of the disability adjusted life year (DALY) of mild anxiety disorder times the value of statistical life year.
	In more control of own time	*They have more free time*	$16,089	Commensurate with personal time gained from reduced caring burden. The largest subset of carers works 0-20 hrs per week, so assuming 10 hours of care average, which is the median point within this range.

STAKEHOLDER	OUTCOME	INDICATOR *As a result of the program…*	Value/ Proxy	Proxy description
	Improved family relationships	*Our relationships have improved*	$1,800	Equivalent to 15 counselling sessions valued at $120 per session. Family therapy is averaged between 5-20 sessions.
Referrers	Improved job satisfaction (staff)	*I feel that I have made a valuable contribution to my clients' journey(s)*	$16,826	Commensurate with the costs of employee turnover. The average costs to replace an employee is 20% of annual salary for an Occupational therapist.
Employer partners	Reduced recruitment costs	*Number of participants in paid employment*	$9,772	Commensurate with saved business costs of recruiting new paid staff. Applicable to employers of program participants who ended up in paid employment.
	Improved productivity	*Number of participants in paid employment*	$5,600	Mental ill-health costs employers an average of $5,600 per employee with severe mental illness per annum in absenteeism and presenteeism.
	Improved job satisfaction (staff)	*I feel that I have made a valuable contribution to my clients' journey(s)*	$16,000	Commensurate with the costs of employee turnover. The average costs to replace an employee is 20% of annual salary for a hospitality manager.
	Reduced stigma	*Managers reporting workplace is more understanding of mental health issues*	$8,800	Equivalent to the reduced stigma that would come from staff training specifically for disability awareness.
	Improved customer loyalty	*Customers reporting that returning is due to social issue being addressed*	$85,880	Equivalent to the increased and retained sales likely from 'conscious buying'.
	Improved customer attraction	*Customers reporting that meeting social goals was reason for purchasing decision*	$75,000	Equivalent to the average Victorian Government social procurement spending on Disability Enterprises or social enterprises led by a mission for people with disability.

STAKEHOLDER	OUTCOME	INDICATOR *As a result of the program…*	Value/ Proxy	Proxy description
	Reduced confidence re inclusive workplace	*Number of participants in short-term ''unsuccessful'' placements (different employer partners)*	-$4,175	Equivalent to a 4-hour program workshop on Equal Employment Opportunity and Anti-Discrimination. Program is aimed at discussing the establishment of an equitable, productive, inclusive and diverse work environment in organisations.
Funders	Reduced risk of funding poorly in future	*Funders reporting that making better funding decisions*	$20,721	Equivalent to funders' ability to manage future funds for greater impact, often achieved through a system or software such as ImpactMapper, that allows funders to measure their impact, learn and make better funding decisions. Includes the staff time going into using and maintaining the software.
	Better funding of innovation	*Number of funders*	$100,000	Commensurate with the average NFP have invested in innovation activities in Australia
State government	Reduced healthcare costs	*Compared to before participating in the Program, how often do you make use of the following services. (Decrease use of GP, hospital, ED and community mental health services) (Score reversed)*	$541,003	Total government expenditure on health services per person in 2016-17 was $7,411. This includes Public hospitals, Private Hospitals, Patient Transport, Dental Services, Public Health and Other.
State and federal governments	Cost saving from reduced suicides	*Desktop review of suicide rates among people with mental illness (over 10%)*	$558,269	The cost of suicide to the Government includes the direct costs of services such as police, ambulance and coronial, combined with future earning potential of individuals and intangible costs.
Federal government	Reduced welfare costs	*If you had not joined the Program, would you be working now? (Most likely no)*	$345,412	Maximum Newstart Allowance before income and asset testing for single adult, no dependents. Plus, cost per person of jobactive employment services.

STAKEHOLDER	OUTCOME	INDICATOR *As a result of the program…*	Value/ Proxy	Proxy description
	Increased tax revenue	*If you had not joined the Program, would you be working now? (Most likely no)*	$77,728	WWTW provides employment opportunities for candidates who are or may be unemployed. This creates tax payable to the government.

7.3.1 Selecting financial proxies

Many of the financial proxies used for participants are defined as “revealed preference” methods. Revealed preference proxies involve looking at market values of things to reveal the value that people place on an outcome. For example, the amount of money that people spend on a security system can be assumed to reveal the value they place on their personal security.

There are different valuation techniques available, all of which have benefits and limitations. The risks can vary but, in this case, include:

- The risk of under claiming. The revealed preference proxies show us the transactional value of something but not necessarily all of the intrinsic value it might create, which for some outcomes/stakeholders may be significantly higher than the market rate
- The risk of inaccuracies (and therefore over- or under-claiming) due to the nature of making assumptions about value on behalf of someone else (the stakeholder). Assumptions have been minimised or informed by the stakeholder engagement and ranking of outcomes using open-ended survey responses, but this does not eliminate the risk fully.

The aim was to conduct a valuation workshop (the value game) with a focus group of participants. This was changed due to the COVID-19 pandemic. Instead, revealed preference approach technique was chosen. However, in future evaluations it is recommended to involve stakeholders in creating the financial proxies, using a mix of valuation techniques such as the stated preference approach in which participants are asked to select the different amounts, they would be willing, and not willing to pay from a range of options. This allows increased amount of context for the values and more choice for the participant to reflect an accurate evaluation.

The outcomes that are exclusively financial in the case of some outcomes for employer partners, funders and government were valued with reference to the actual cost or revenue.

Professional judgement has been used to determine proxies that reflect the relative value of the outcomes for the participants based on the ranking of participants. Think Impact has access to a database of more than 60 SROIs or Social Value Modelling Reports that have been carried out in Australia, some written by Think Impact but many by other organisations. This database includes both assured and non-assured SROIs. This is used to support professional judgements on appropriate proxies by utilising existing proxies from existing reports where practical and/or testing assumptions when thinking through revealed preference judgements. Furthermore, the selected proxies were analysed by the team working on the data and cross referenced with another accredited practitioner at Think Impact.

7.4 Avoiding over claiming

The proxies presented in the Table 7.1 above are the values before discounting to take account of deadweight, attribution and displacement, therefore the overall values will be different to those presented in The SROI value in section 8.

Principle 5 of conducting an SROI is *Do not over claim*. This principle exists to ensure that the analysis is credible and is a genuine attempt at understanding the additional value that the activities are responsible for creating. Satisfaction of this principle requires estimates of:

- **Deadweight**: What would have occurred anyway, in terms of achievement of outcomes, in the absence of the intervention/activity.
- **Attribution**: How much of the outcome was caused by the contribution of other organisations or people.

- **Displacement**: An assessment of how much of the change is a net benefit (that is, a new change) or simply the movement of change from one place to another or the offsetting of one change for another.
- **Benefit period**: how long an outcome lasts into the future beyond the intervention (in years) and **drop off** which is by the proportion of value that diminishes (per year) over time as the benefit period elapses.

Each of these concepts is estimated on an outcome by outcome basis and used in the model to calculate overall value.

The assessment of over claiming inevitably involves estimates as it is simply not possible or feasible to be precise about some of these concepts. The approach for avoiding over claiming is presented below.

7.4.1 Estimating deadweight

Deadweight was estimated based on information gathered by:

- Asking all stakeholders in phone and video interviews what would have happened in the absence of the activities (refer to Appendix E)
- Using survey questions to ask what would have happened in the absence of the program (refer to Appendix F)
- Using desktop research to supplement qualitative and quantitative stakeholder engagement
- Using professional judgment in combination with the results above. For example, the improved financial wellbeing for participants for subgroup 1 would be unlikely to occur for those that said in the survey that they would be unemployed if they had not joined the program (29 per cent), but desktop research suggested this percentage for this stakeholder group is more likely to be 6 per cent.

7.4.2 Estimating attribution

Attribution was estimated based on information gathered by:

- Asking all stakeholders in phone and video interviews what else contributed to the outcomes they reported or observed (refer to Appendix E)
- Using survey questions to ask if anything else contributed to the outcomes they reported or observed (with an open-ended box for recording what that was) (refer to Appendix F)
- Using professional judgment in combination with the results above. For example, the improved financial wellbeing for participants for subgroup 1 would likely be attributable wholly to the program among survey respondents who selected “I have experienced these changes only because of the Program and the support I receive at the Program”, and partially (50 per cent) among respondents who selected “Other things have contributed to the changes I have experienced”.

7.4.3 Estimating displacement

Displacement was estimated based on information gathered by:

- Asking all stakeholders in phone and video interviews whether any positive changes were offset by negative changes for themselves or others (refer to Appendix E)
- Using professional judgment to understand whether outcomes represent a transfer of value rather than additional value. For example, improved customer attraction and loyalty might mean that customers from other organisations would stop going to those organisations and go to the employer partners instead which may therefore result in displacement.

7.4.4 Estimating benefit period and drop off

Benefit period and drop off were estimated based on information gathered by:

- Asking WWtW staff at the verification workshop whether the outcomes are short-lived or long-lasting. WWtW staff acted as proxy for other stakeholder groups specifically participants in estimating benefit period and drop off due to the fact that they conduct a 12-month assessment with participants
- Estimates using Think Impact's framework of Enduring Impact that predicts the endurance of outcomes into the future. More information on how this was used is provided in section 9.5 and Appendix D.
- Using Think Impact's database of over 60 SROI reports written by Think Impact and other organisations to inform and compare benefit period and drop off of similar outcomes.

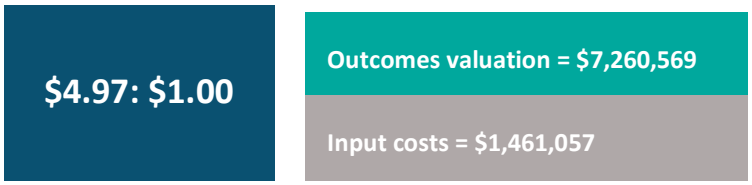
Approach of estimating benefit period and drop off is further explained in Appendix D.

The rates of deadweight, attribution, displacement, benefit period and drop off are detailed for each outcome in the SROI model.

8. The SROI value

8.1 SROI ratio

The baseline data from the demonstration project has indicated that for every dollar invested in WWtW, then **$4.97** of social value is created.



The Forecast SROI analysis carried out suggests that this baseline of $4.97 for every dollar invested will be repeated as the project moves forward. Recommendations are made below in terms of how this value can be increased.

8.2 Value created by stakeholder group

WWtW creates value for six[7] stakeholder groups, a summary of the valuation by stakeholder group is provided in Table 8.1 and illustrated in Figure 8.1.

Table 8.1 Summary of value created for each stakeholder

Stakeholder Value Summary				
Stakeholder	# of stakeholders	Value per Stakeholder	Total valuation after discounts	% of Total
Participants	73	$ 64,297	$ 4,693,653	65%
State and Federal Government	1	$ 1,401,179	$ 1,401,179	19%
Carers / Family members	70	$ 11,894	$ 826,599	11%
Employer partners	25	$ 7,892	$ 197,307	3%
Funders	7	$ 17,906	$ 125,341	2%
Referrers	98	$ 168	$ 16,490	0.23%
			$ 7,260,569	100%

- **Participants** experience **65 per cent** of the total social value; the greatest social value of all stakeholder groups. The majority of this value is created from improved mental health and improved self-esteem.
- **State and federal governments** experience **19 per cent** of the social value mainly from cost saving from reduced welfare costs, reduced use of other health services and suicide prevention.
- **Carers/family members** experience **11 per cent** of the total social value. There are over 70 carers who are in more control of their own time due to reduced caring responsibilities.
- **Employer partners** experience **3 per cent** of the social value. The majority of this value is created through reduced stigma and improved customer loyalty.
- **Funders** experiences **2 per cent** of the social value through reduced risk of funding poorly in the future and better funding of innovation.
- **Referrers** experiences considerably low social **0.23 per cent** value as a result of the program.

[7] State and federal government are counted here as one stakeholder.

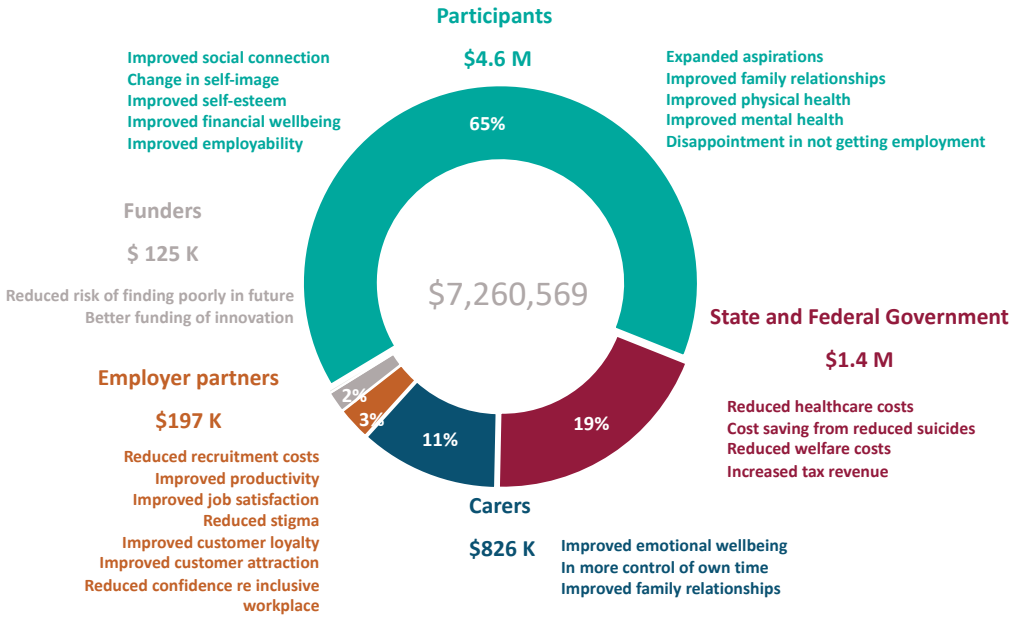


Figure 8.1 Total social value by stakeholder

8.2.1 Value experienced by participants

As outlined in previous sections, to meaningfully reflect the varied experienced of participants three subgroups were developed to segment the participant group:

- Subgroup 1: 21 participants who have achieved full-time, part-time or casual employment
- Subgroup 2: 20 participants who have achieved volunteering and/or further study
- Subgroup 3: 32 participants who have not achieved the above.

Analysis shows that participants in subgroup 1 experience the most social value ($2M), followed by subgroup 3 ($1.7M) and subgroup 2 ($905K) (Figure 8.2).

As explained in section 6.1, employment is one of top three goals for people with mental illness and is also associated with social engagement and better mental wellbeing. This can explain why participants in subgroup 1 experience the highest value. Table 8.2 illustrates the value per individual for each subgroup. It is worth noting that a lower value per individual in subgroup 2 compared to subgroup 3 could be explained by the fact that more individuals (two individuals) in subgroup 2 reported experiencing negative changes for various outcomes. A recommendation is included in section 10 to obtain a bigger sample size of subgroup 2 to understand whether those negative changes are occurring other individuals in this subgroup.

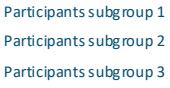


Figure 8.2 Total social value by participant subgroup

Table 8.2 Summary of value per participant subgroup

Stakeholder Value Summary				
Stakeholder	# of stakeholders	Value per Stakeholder	Total valuation after discounts	% of Total
Participants subgroup 1	21	$ 96,396	$ 2,024,314	43%
Participants subgroup 2	20	$ 45,258	$ 905,168	19%
Participants subgroup 3	32	$ 55,130	$ 1,764,171	38%
			$ 4,693,653	100%

When looking at the value per individual for the three subgroups rather than the percentage of the total, individuals of subgroup 1 still experience the most value, but the value difference between subgroup 2 and 3 is heavily reduced. The social value per person range from $45,258 to $96,396.

As illustrated in Figure 8.3 and Table 8.3, all participant subgroups experienced the most social value through improved mental health (41 per cent), improved self-esteem (29 per cent) and improved social connection (19 per cent). With slight difference in percentages for the individual subgroup, these outcomes are followed by change in self-image (5 per cent) and expanded aspirations (2 per cent).

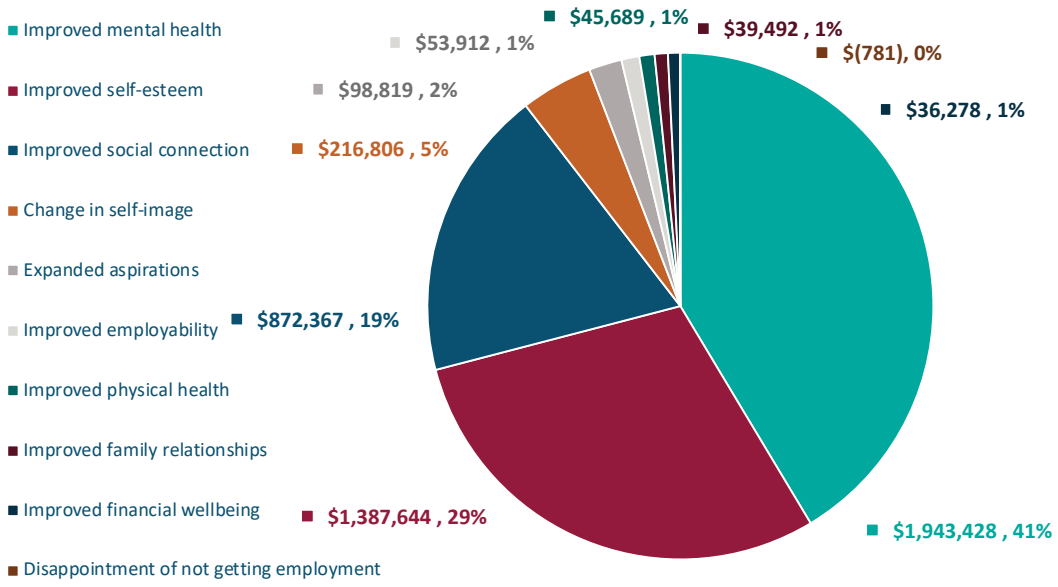


Figure 8.3 Social value experienced by participants by outcome

Table 8.3 Social value experienced by participants by outcome

	Participant Subgroup 1	Participant Subgroup 2	Participant Subgroup 3	Participants ALL	Participants ALL
Outcome	Total value	Total value	Total value	Total value	% of value
Improved mental health	$ 797,393	$ 390,004	$ 756,031	$ 1,943,428	41%
Improved self-esteem	$ 609,460	$ 299,863	$ 478,320	$ 1,387,644	30%
Improved social connection	$ 403,833	$ 109,284	$ 359,250	$ 872,367	19%
Change in self-image	$ 85,374	$ 51,499	$ 79,933	$ 216,806	5%
Expanded aspirations	$ 46,995	$ 18,560	$ 33,264	$ 98,819	2%
Improved employability		$ 23,734	$ 30,177	$ 53,912	1%
Improved physical health	$ 26,323	$ 11,269	$ 8,097	$ 45,689	1%
Improved family relationships	$ 18,659	$ 1,275	$ 19,558	$ 39,492	1%
Improved financial wellbeing	$ 36,278			$ 36,278	1%
Disappointment of not getting employment		$ (320)	$ (461)	$ (781)	0%
Total	$ 2,024,314	$ 905,168	$ 1,764,171	$ 4,693,653	100%

8.2.2 Value experienced by government

Figure 8.4 illustrates the total social value experienced by state and federal governments by outcome. Government primarily accrues values from improvement of mental health of participants and employment, leading to costs saving from reduced suicides (50 per cent), reduced welfare costs (26 per cent) and reduced healthcare costs (18 per cent).

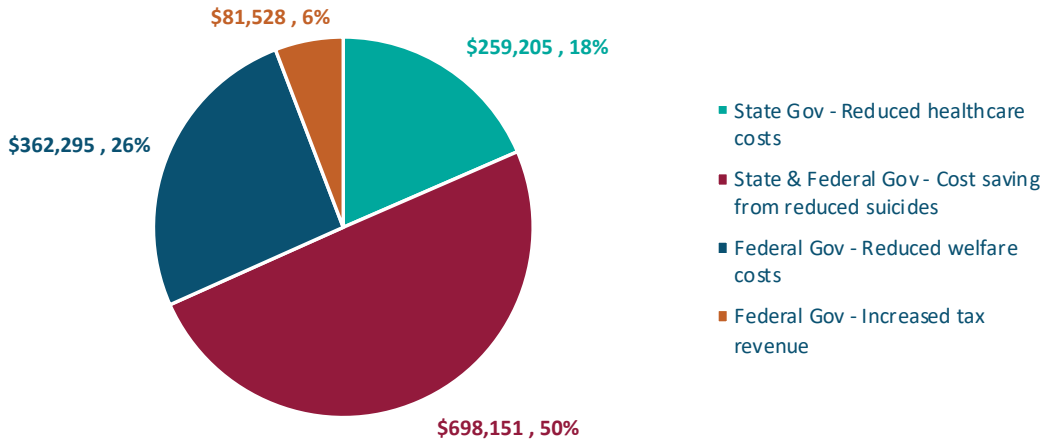


Figure 8.4 Social value experienced by state and federal governments by outcome

8.2.3 Value experienced by carers/family members

Carers experience the most social value mainly through being in more control of their own time (75 per cent), followed by improved emotional wellbeing (21 per cent) and improved family relationships (4 per cent).

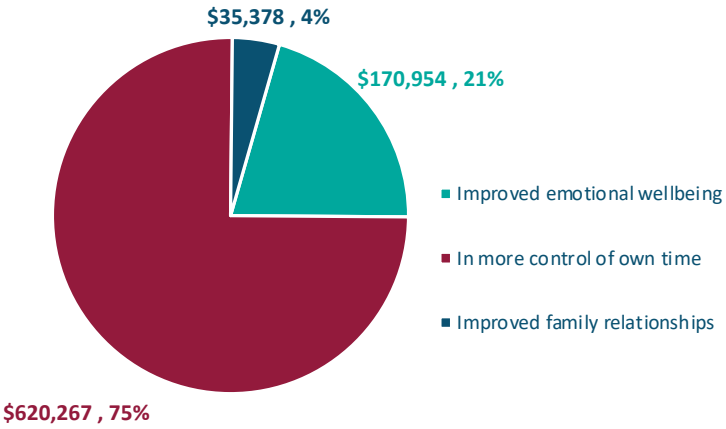


Figure 8.5 Social value experienced by carers by outcome

8.2.4 Value experienced by employer partners

The biggest value for employer partners was created through reduced stigma (39 per cent), improved customer loyalty (32 per cent), and improved customer attraction (13 per cent) (Figure 8.6).

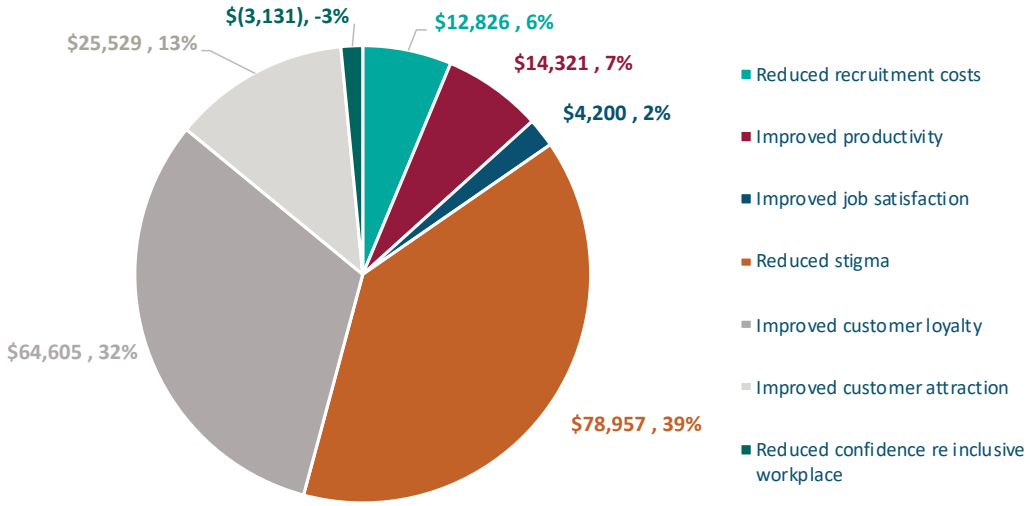


Figure 8.6 Social value experienced by employer partners by outcome

8.2.5 Value experienced by funders

Funders experience social value in terms of better funding of innovation (61 per cent) and reduced risk of funding poorly in the future (39 per cent).

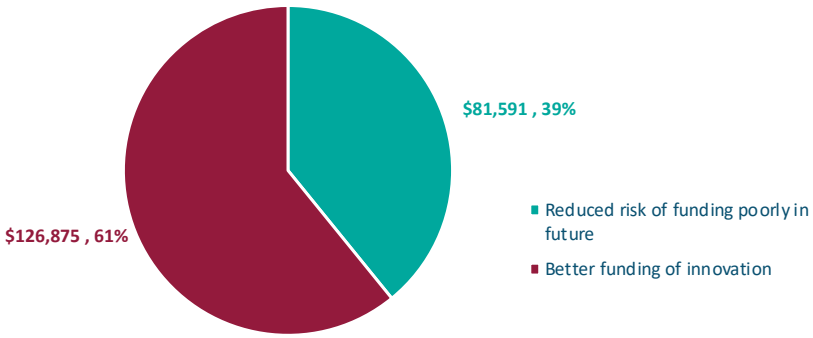


Figure 8.7 Social value experienced by funders by outcome

8.2.6 Value experienced by referrers

Referrers experience exceptionally low social value from increased job satisfaction for staff as a result of the program (0.23 per cent). Whilst referrers were clearly identified by other stakeholders as a material stakeholder, without whom the program could not function, and outcomes that were being achieved did raise concerns about materiality. The issue was addressed with the referrer representative during verification and the decision was to retain referrers as a material stakeholder. The implications if they were excluded from the value calculation are discussed in the sensitivity analysis.

8.3 Sensitivity analysis

The SROI model has been developed applying the seven principles of the SROI methodology. In particular, where professional judgment has been required, a conservative approach has been used. However, any approach requiring judgement and assumptions carries the risk of errors in the data and findings. For this reason, a sensitivity analysis has been conducted to understand the influence that any variation in these inputs would have on the SROI model. The sensitivity analysis is a key mechanism for exploring the risks and impacts of over claiming. The full results of the sensitivity analysis are provided in Appendix C and summarised below.

There is potential that the ratio presented in this report is both over and underestimated. The variations explored would result in the ratio varying from **$4.01** through to **$10.28** for every $1 invested. The variations include:

- **Financial proxies and their allocated values** across different types of stakeholders or subgroups may be over- or under-estimated to some extent. The sensitivity analysis tested what the ratio would look like if a different financial proxy was used. This could see the ratio between $4.51 and $6.01.
- **Value of inputs** decreasing the value of the input by deducting non-delivery costs incurred in the start-up phase and funding specific requirements. This could see the ratio rise to up to $6.00.
- **Quantality of the outcomes** decreasing the number of funders experiencing outcomes would decrease the ratio slightly to $4.89. Assuming different outcome incidence for employer partners would create a ratio between $4.89 and $5.06.
- **Discounting factors (attribution, deadweight, benefit period and drop off)** were predicted based on a combination of survey results, desktop research and professional judgments. Significantly changing the estimates for benefit period and drop off changed the ratio more significantly to between $4.01 and $10.28. Significantly changing the estimates for attribution changed the ratio to $4.07.
- **Outcome incidence for participants** were calculated based on the survey results. Participants stated that their outcomes were impacted by COVID-19 and they may be viewing things more negatively as a result. Thus, increasing the outcome incidence to accommodate this would bring the ratio between $5.07 and $5.60.
- **Excluding low value outcomes** would bring the ratio slightly to $4.89.

9. Evaluation findings

The Forecast SROI analysis was also a formative evaluation of the WWtW program with a view to understanding how it was performing and where improvements in the approach could be made. The key findings are detailed below.

9.1 WWtW is achieving positive outcomes

It is clear from the SROI ratio presented above that WWtW is creating value. This value is predominantly experienced by the participants in the program (65%) with other value flowing to state and federal governments, carers, employer partners, funders and referrers, Figure 9.1.

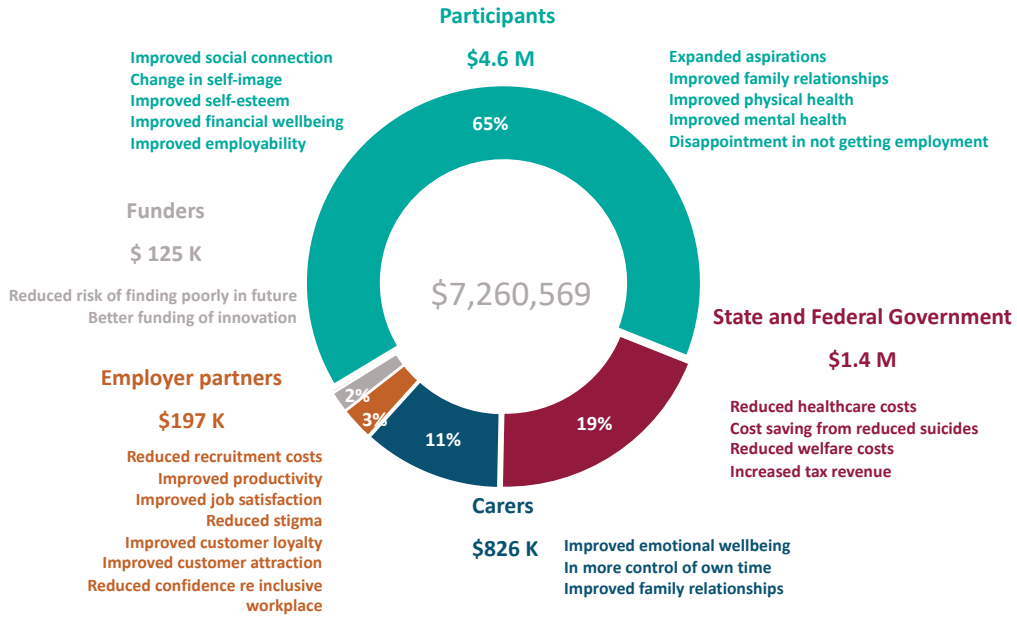


Figure 9.1 Total social value by stakeholder

WWtW is providing support to people who are long-term unemployed because of their serious mental illness and for whom in many cases this unemployment is compounded because of a range of associated factors. Despite this, and with limited resources, WWtW has started to deliver strong results for the people it supports.

Central to the delivery of results is the focus on achieving the key outcomes identified by Morgan (2011) where people with serious mental illness said their three most important areas of impact were:

- Having a job
- Having financial security
- Having social connections

WWtW is delivering outcomes in each of these key areas, alongside enabling people with serious mental illness to improve their health outcomes.

> *''It is funny how the program was about getting employment, but most of the value is on mental health. It worked out to be a mental health program.'' – Participant*

> *''If it wasn't for Wise Ways to Work, I wouldn't have recovered from my acute phase of health issues and regained myself, my life and what I believe in!! '' – Participant*

By achieving these employment outcomes, WWtW is also contributing the NDIA's vision for its participants to have same opportunities to work as other Australians and the confidence, and support and skills to take advantage of these opportunities.

9.2 WWtW is underpinned by an evidence-based model

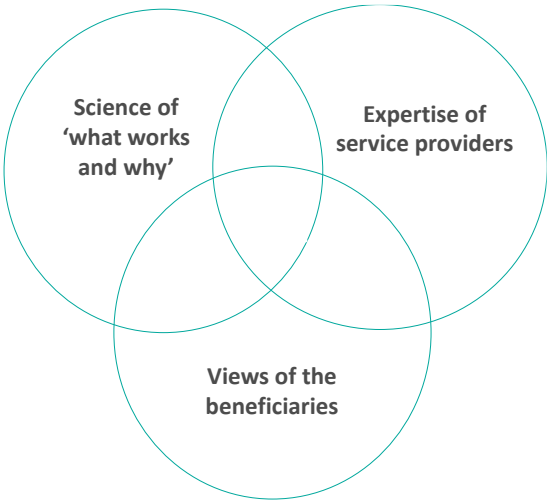
WWtW has been developed from a strong evidence base of the approaches that are most effective creating sustainable employment outcomes for people experiencing serious mental illness. The vocational rehabilitation program uses evidence-based approaches to skills development, health management and relapse prevention that fit within the recovery framework.

Central to the achievement of the outcomes is the early focus on cognitive functioning (Contreras et al., 2016a; Contreras et al., 2016b, Contreras et al., 2014; WISE Employment, 2020). This early change provided a platform for intermediate and key outcomes to be achieved.

WWtW was able to draw on the success of the development work done by Fife Employment Access Trust (FEAT) in Scotland with the Employ Your Mind program. They could then apply this to the development of the model in Australia. In doing this they ensured that the evidence base was not only theoretically understood but the development team had previous experience of applying it in a range of prior settings to solidify learning. The initial pilot of EYM in 2016/17 also allowed for an understanding of the views of people with serious mental illness to be canvassed in terms of what further support was needed to enable the proposed WWtW approach to be successful.

The Optimal Health Program also has a strong evidence base and WWtW continues to partner with St Vincent's Mental Health and Melbourne University to evaluate the WWtW program's outcomes. All evaluation assessments used are internationally recognised tools and the WWtW evaluation advisory panel consists of research experts from Melbourne, Monash and Swinburne Universities.

WWtW is underpinned by an evidence-based model, as outlined in Figure 9.2 below.



An evidence-based model (EBM) requires the fusing of:

- An understanding of the research evidence around 'what works and why' to tackle the issue you are seeking to solve.
- The expertise of service providers around what is needed to solve this issue in this context.
- The views of the people who will benefit from the service on what will solve their issue.

Through fusing these three components one is able to apply any insight gained to the development of new approaches. This approach is used extensively in service re-design by Think Impact.

Figure 9.2 Application of evidence-based model

9.3 The WWtW approach is built on solid foundations

WWtW is an innovation program that has been solidly constructed. Some of the key elements of this solid construction were:

- As indicated above, application of the initial learning and design input from the FEAT model in Scotland regarding the core components of the program that needed to be in place to ensure outcomes were achieved.
- Also as indicated there is a deep understanding of the evidence base surrounding 'what works and why' in order to create sustainable employment opportunities for people with serious mental illness.
- Development of strong partnerships with referrers, academics and support partners to ensure that the WWtW could be tested for people with serious mental illness.
- Initial prototyping of the EYM in 2016 and 2017 on a small scale to learn the lessons, with application of an internal developmental evaluation approach to learn lessons prior to this recent demonstration project.

- Co-funding from engaged philanthropic foundations and other funding partners that allowed for the innovative approach proposed by WWtW to be tested at the larger scale of demonstration project.

While a simple linear path hasn't been followed, WWtW has moved through a set of stages involved in designing a new service, an approach suggested by Think Impact is outlined below in Figure 9.3. The pilot or demonstration project that is the subject of this evaluation is the last step before looking at how the approach can be incorporated into mainstream service provision.

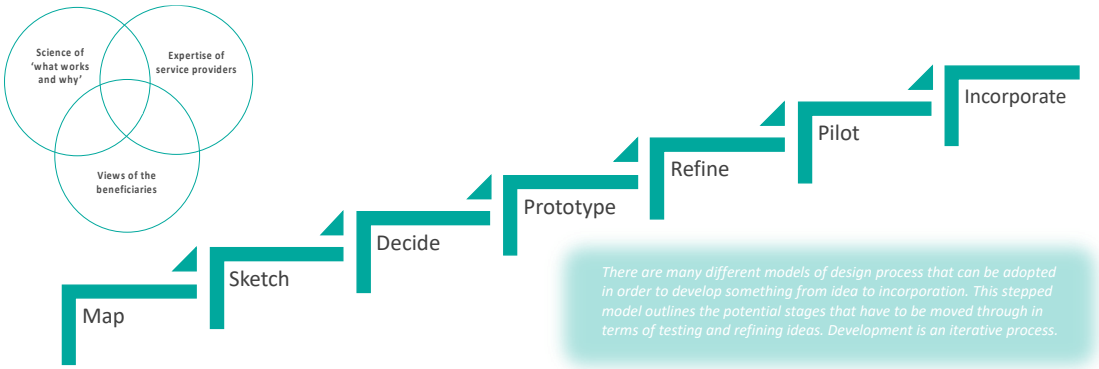


Figure 9.3 Design process for innovative service development

During the evaluation the implicit theory of change that existed for WWtW was brought to life in workshops with the staff team and through involvement of key stakeholders in developing the benefit pathways outlined above.

Think Impact worked through their theory of change development process and this highlighted a series of additional strengths within the WWtW foundations.

SITUATIONAL ANALYSIS	**The WWtW staff team has deep expertise –** this has been acquired through lengthy experience of working in the mental health sector and through the strong understanding of the evidence of what works alongside the context that surrounds people with serious mental illness trying to access employment in the Australian job market.
δ_1 INTENDED IMPACT	**WWtW is able to clearly articulate their intended impact** – the program staff were very clear on the intended impact of the WWtW program. This was focused around creating sustainable employment options for people with serious mental illness. They knew that to do this they needed to develop an approach that acted as a bridge from unemployment into inclusive employment.
CATALYST OUTCOMES	**Outcomes mapping has strengthened program** – an aspect of the WWtW program where there was a lack of clarity was around the outcomes system that existed for participants. The staff team were initially working on the premise that all outcomes were equal. From the theory of change development process, they were able to map the outcomes and gain an understanding of the benefit pathways. These have been tested with stakeholders.
ENABLING FACTORS	**The WWtW team has a strong understanding of the enabling factors required to achieve success** – there are range of enabling factors that are required to ensure the program runs successfully. These vary from having a strong and engaged referral network, through to tackling stigma within employers. The WWtW is utilising the resources they have to address the wide range of issues needed to ensure success.

MECHANISM	**WWtW has exceptionally strong mechanisms in place to ensure outcomes are achieved** – the most impressive aspect of the WWtW program was around the mechanisms that have been developed to deliver the program. This aspect of the program will be discussed more fully below.
INPUT	**WWtW is achieving good results in a cost-effective manner** – the program has been funded by a mixture of WISE investment, philanthropic and government funding during the pilot phase. WISE Employment was able to provide a clear outline of the costs of delivery (the investment) and also clearly understood the additional costs for establishment of the program.
IMPLEMENTATION	**WWtW has been implemented well** – the program has a solid action plan in pace to ensure that implementation of theory of change takes place. In addition, the WWtW staff team regularly review progress against intended impact.

From the development process in the workshop and the stakeholder engagement it was also apparent that WWtW had followed an impact-led design approach to the development of the program.

Impact-led design puts the use of evidence at the core of the co-design process and engages key stakeholders in that design process (see Figure 9.4 below).

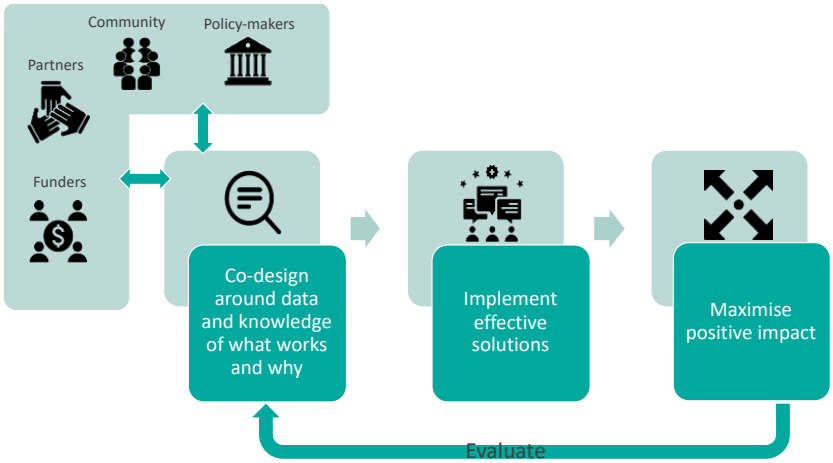


Figure 9.4 Impact-led design

The only aspect of impact-led design that did not seem to be fully utilised was around engagement of policy makers in the design process. This is addressed in the recommendations section below.

9.4 WWtW is building a bridge between systems

It has long been recognised that for people with severe mental illness, the current disjointed nature of the health and employment systems has made moving into jobs difficult (State of Victoria, 2019). This is compounded by the stigma that surrounds mental illness, particularly within the workplace (MHCA, 2007). The introduction of the NDIS has added an additional layer of complexity, as this new support system is still in the process of bedding down how employment support can be utilised by individuals as part of their NDIS plan.

Attempting to navigate this in the realm of emergent practice adds a level of complexity. From stakeholder engagement it was evident that players from different parts of the various systems were keen to understand how WWtW was performing with a view to using the lessons learned to shape this emergent practice.

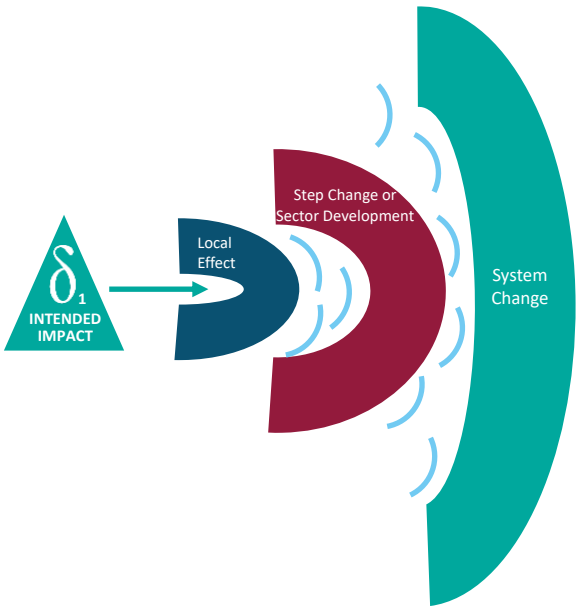
A core aspect of WWtW's theory of change is the concept that by equipping participants and employers with skills, tools and support is providing a bridge from unemployment to employment. From the evaluation it was evident that through WWtW, WISE Employment is developing another bridge that, given time, could span across the various systems. The emergent practice assists:

- The Disability Employment Service (DES) to more fully understand how to support people with serious mental illness to move back into work.
- The mental health system to more fully understand how to support people to get clarity on their vocational goals and start the journey towards meaningful employment.
- The National Disability Insurance Agency (NDIA) to more fully understand how and what to fund re employment planning within the NDIS.

The NDIS Participant Employment outlines five streams of activity designed to increase the employment rate of NDIS participants. WWtW addresses four of the give key areas namely:

1. Increasing participant aspiration and employment goals in NDIS plans
2. Increasing participant choice and control over pathways to employment
3. Increasing market innovations that improve the path to paid work
4. Improving confidence of employers to employ NDIS participants

It is too early to say whether this will be achieved, as these are complex systems to influence and bring about change in. It was clear from the evaluation that WWtW is starting to achieve local effect, but given that WWtW is a small-scale demonstration project, the full ripple effects into sector development and systems change have yet to be realised (see Figure 9.5 below). Recommendations on next steps are made in the following chapter.



Intended impact can occur in three key areas or a combination of each:

Local effect – is where the focus of activity is around bringing about change to a local population or local issue. Examples are provision of early learning support to young children in pre kinder support, drug rehabilitation services, homelessness support for people in crisis or creating jobs for people who are long-term unemployed.

Step change or sector development – is where the activity is focused on providing insight into a significant development in understanding of a problem, an issue or an approach to tackling issues. It is an important change and can be scaled up.

Systems change – is where of activity is focused on addressing the root causes of social problems, which are often intractable and embedded in networks of cause and effect. It is an intentional process designed to fundamentally alter the components and structures that cause the system to behave in a certain way.

Figure 9.5 From local effect to step change[8]

9.5 WWtW has been designed to achieve enduring impact

Through its work in service design, Think Impact has developed the Enduring Impact Model, to identify combinations of outcomes which are likely to support individuals towards long-term change, see Figure 9.6 below.

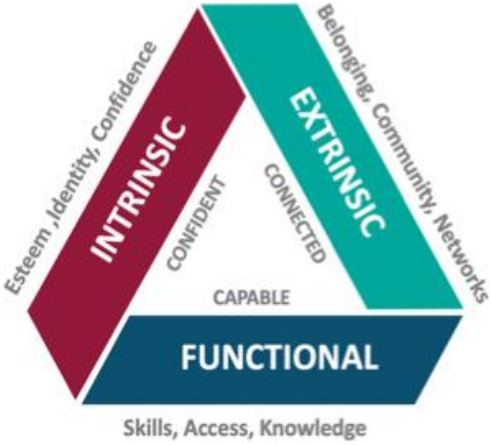


Figure 9.6 Think Impact's Enduring Impact Model

The model consists of the three dimensions:

- **Intrinsic** – these are internally focused outcomes.
- **Extrinsic** – these are externally focused outcomes.
- **Functional** – these are improvements in areas such as knowledge or capability outcomes.

[8] Adapted from Mark and Wong, 2010

The basis of the Enduring Impact Model is that for long-term change to occur, programs or services have to be improving outcomes in each of the dimensions. Change in one or two of the dimensions, while useful, will not lead to intended impact being achieved.

Having assessed the WWtW program, it was evident from the outcomes being achieved by participants that the foundations are in place for enduring impact to take place (see Table 9.1).

Table 9.1 Dimensions of Enduring Impact Model to key outcomes

Outcome	Dimension of Enduring Impact
Improved social connection	Extrinsic
Change in-self image	Intrinsic
Improved self-esteem	Intrinsic and Functional
Improved financial wellbeing	Functional
Improved employability	Functional
Expanded aspirations	Intrinsic and Functional
Improved family relationships	Extrinsic
Improved physical health	Functional
Improved mental health	Intrinsic and Functional
Disappointment of not getting employment	Intrinsic

It was clear that when planning the activities which would achieve the intended impact, strong consideration had been given to four key components, beyond a simple notion of "what activity should we do" – these components are collectively referred to as 'mechanism' within a theory of change. These components were:

- **Modality** – there was clarity within the WWtW around how they were going to deliver the activities, not only to participants but in the support, they provided to employers.
- **Dosage** – the duration of the EYM and OHP services had been refined through the initial prototypes, focused on how many activities were required and when to achieve impact.
- **Quality** – the evidence base around quality of service provision had been drawn on, particularly around the rapport that Vocational Coaches and Occupational Therapists have to build with participants and employers in order to achieve results.
- **Reasoning** – the WWtW team was clear about where on their vocational journey a potential participant has to be for the program to maximise impact, that is, there needs to be motivation to work. This is clearly communicated to referral agents, cementing the notion of mutually reinforcing activities.

> *"If you give people control of the intervention, they will stick with the program for longer and you get better results." – Funder*

Central to the achieving enduring impact was the modality utilised by the WWtW team (Figure 9.7). Stakeholders repeatedly focused on the "how" of the service delivery as being of key importance.



Figure 9.7 WISE Ways to Work modality

9.6 WWtW has developed a strong inclusive employment approach for employers

Key to the success of the WWtW program is having a strong network of employers that are willing to offer placements to participants, and beyond that, to offer employment opportunities.

WWtW has used the demonstration project to build on the initial group of employers that were engaged in the process. Key to engaging these employers has been a focus on providing both clarity of what is involved and support to employers around how to develop an inclusive employment approach.

The feedback from employers on the support provided by the WWtW team illustrates how effective they have been at providing this support.

> *"What they do to prepare the person is crucial for us, they really understand what barriers and issues a person has." – Employer partner*

> *"The work that goes in from the OT (Occupational Therapist) side is impressive... real ability to get people ready for work… support structure and the work they do, you get someone who understands what work is about." – Employer partner*

While the WWtW team did not use the term 'shared value[9]' to describe their inclusive employment approach with employers, there were strong aspects of this within how they engage employers, including:

- **Joint value creation** – illustrating how the placements and jobs create value for both companies and the community and communicating this value to stakeholders.
- **Internal buy-in** – ensuring that there are champions within the companies to drive the process.
- **Integration** – ensuring that there is the budget within the company to support engagement.

[9] For more information see www.sharedvalue.org.au

9.7 Sustainable Development Goals (SGDs)

WWtW contributes to several SDGs, namely:

- **Goal 3 Good health and well-being**: WWtW enables and support participants to improve their physical and mental health.
- **Goal 4 Quality education**: The early onset of mental illness often impacts people living with mental illness's educational attainment and transition to the workforce. The program offers participants tools and confidence to pursue their vocational goals and including returning back studying.
- **Goal 8 Decent work and economic growth**: WWtW not only supports participant to find or sustain employment but it also works with employers to create meaningful employment positions for participants.
- **Goal 10 reduced inequalities**: Closely linked to goal 8, WWtW supported participants to improve their social engagement, economic inclusion and financial wellbeing.

Figure 9.8 illustrates a brief description of the SGDs goal identified above.



Figure 9.8 Contribution to SDGs

This contribution towards the SDGs should be integrated into the reporting that WISE Employment does via the WISE Impact Promise.

10. Recommendations

Based on the findings from the Forecast SROI analysis and formative evaluation there are a series of recommendations. These cover technical improvement to evaluation approaches in order to be able to better manage impact alongside some recommendations for the next phase of development of WISE Ways to Work.

10.1 Prepare for summative evaluation

This Forecast SROI analysis was also a formative evaluation of WWtW, as the program was culminating the pilot phase of development.

- It is recommended that at the end of the next phase a summative SROI evaluation is carried out. This would be best done three years from now.

To prepare for that summative SROI evaluation the following steps should be taken:

10.1.1 Develop Outcomes Framework

The involvement of stakeholders in this SROI analysis has created a series of benefit pathways which has formulated a series of key outcomes for each stakeholder. These outcomes and the subsequent indicators and measures provide the foundation for the development of an outcomes framework for ongoing impact measurement.

This outcomes framework should be produced, socialised with the WWtW team and then used to collect data for ongoing analysis.

The benefit pathways also provide the WWtW team with clarity on the early changes that should be taking place for stakeholders through the program activities. Now that there is increased clarity on these early changes, then the existing monitoring systems within WWtW should be enhanced to incorporate a focus on these early changes.

In addition, the WWtW staff team currently carries out follow-up interviews with participants one year after they are involved in the program which contributes to the evaluation overseen by St Vincent's Mental Health. The outcomes framework could assist to shape the questions in this semi-structured interview and the data could be assimilated into the data collection for the future SROI analysis to provide deeper clarity on issues such as drop off or attribution.

10.1.2 Co-ordinate evaluation activities

Another research study was being conducted at the time our research which focused on the potential impact of the program on the mental health on carers/family members, and the evaluation overseen by St Vincent's Mental Health. In order to avoid over-surveying stakeholders, carers and family members were not fully engaged in this process. The results from this research are not yet accessible for this SROI analysis.

To support the future summative SROI evaluation, there should be co-ordination of the all evaluation activities for the WWtW program and sharing of results across the different evaluations.

10.1.3 Develop focus group of stakeholders to support ongoing co-design

This SROI analysis had substantial stakeholder involvement, particularly around developing the benefit pathways, establishing key outcomes, understanding value flow and verifying results. Through the process, and despite the impact of COVID-19 on the planned activities, it was clear that there is interest from stakeholders in being involved in co-designing the WWtW program.

Best practice in co-design through involving stakeholders is detailed in Figure 10.1 below. To co-design effectively with stakeholders they have to be involved throughout the process.

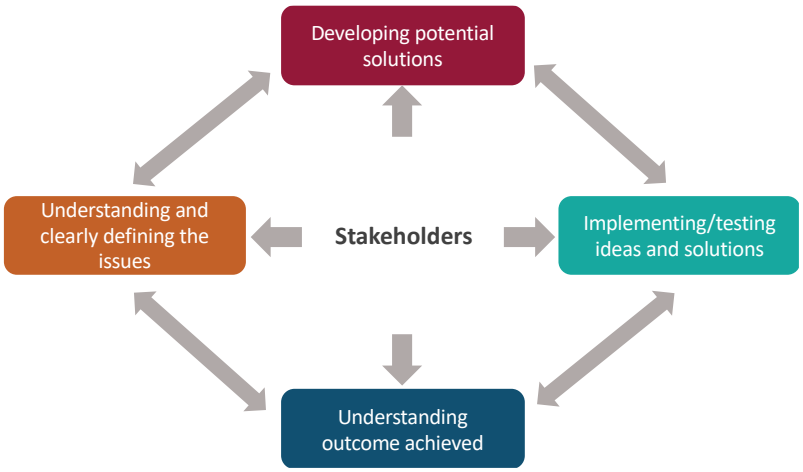


Figure 10.1 Stakeholder involvement in co-design

As WWtW moves into the next phase of development it is recommended that a focus group of key stakeholders is formed to provide input into the ongoing design of the program. While this focus group would predominantly be comprised of participants in the program it should be enhanced with funders, employer partners, carers and referrers to capture broad perspectives on the impact of WWtW.

In particular, given the difficulties of engaging referrers due to turnover of mental health staff and excessive workload during COVID-19 crisis, then additional effort should be made to engage this group of stakeholders to more fully understand what outcomes occur for them and if additional value exists.

10.1.4 Refine benefit pathways

The above ongoing engagement with stakeholders will assist in iterative refining of the benefit pathways. During the development of the initial benefit pathways, several key judgements were made:

- For employers it was suggested by other stakeholders that additional outcomes may be the creation of a “better workplace culture” and the ability to provide “improved mental health retention services” to existing staff. These were not articulated by employers during the stakeholder engagement and so were not included in the benefit pathway. This judgement should be tested through ongoing engagement with employers. If these outcomes exist or emerge then additional value may be generated for employers.
- Family members were judged to be in caring roles for the participants. This should be more fully tested, and the benefit pathway updated if outcomes occur for those family members who are not in a caring role.
- Sector peak bodies were engaged as stakeholders to test the assumption that value existed for the broader disability sector in having “improved understanding of innovation”. On the basis of the interviews, the “sector” was judged to be not a material stakeholder with this outcome not being experienced. But the interviews took place during the COVID-19 crisis and sector peaks were focused on the maintenance of existing services, so this judgement would be worth revisiting once the demonstration phase of WWtW is completed and they can talk about their results.

10.1.5 Introduce impact reporting

Through the SROI analysis and ongoing evaluation activity, WWtW now has the foundations in place to carry out annual impact reporting. Alongside informing key stakeholders of the ongoing impact of the program on the lives of people, annual impact reporting would enable WWtW, and through them WISE

Employment, to articulate their contribution towards outcomes and the Sustainable Development Goals (SDGs), which are reported within the WISE Impact Promise.

10.1.6 Explore preventative value

The Mitchell Institute for Education and Health Policy at Victoria University has identified that the "social cost of lifetime disengagement from work and school per person is $1.1 million" (Lamb and Huo, 2017, p4). The rationale for this is that if young people are not in full-time work or study at the age 24 they are treated as disengaged, then using longitudinal data on the labour market it was estimated how many of them would likely disengaged for the majority of their adult life (25–64 years of age), and the cost of this was calculated.

If the above data is correlated with existing data around the onset of mental illness for the majority of people in mid-to-late adolescence (DHHS, 2019) then it can be assumed that a significant portion of those for whom the social cost of lifetime disengagement could be people with serious mental illness.

It was outside the scope of this Forecast SROI analysis to delve into the background history of participants. It is therefore unclear whether there is actually a greater value flow in place through the prevention of lifetime disengagement for the WWtW participants. To support this type of analysis in the future, it is recommended that changes to participant data collection (see below 10.2) are made to ensure that there is greater understanding of their life employment trajectory.

10.1.7 Develop statistical personas

Linked to the above would be the recommendation to develop clearer statistical personas of the participants in the program.

It was clear from discussions with the WWtW staff that the majority of the participants were long-term unemployed, had been hospitalised due to their mental illness at at least one point in their lives, had been in the care of community mental health services for lengthy periods, and had experienced long-term isolation. In addition to their serious mental illness, many had experienced a range of associated issues such as dual diagnosis of other disabilities, homelessness, drug or alcohol problems. What could not be clarified from the existing data was the depth, length, nature and severity of these compounding factors.



The lack of clarity surrounding this hinders WWtW in terms of communicating their impact narrative.

Through reviewing the data, they collect on the participants and asking different questions they could develop strong statistical personas that would enable WWtW to articulate their work more clearly. An example of how this has previously been communicated in a different piece of SROI analysis is provided here as Figure 10.2.

Figure 10.2 Statistical persona from Shelter Housing Action Cairns (Think Impact, 2015)

10.2 Improve data collection

As recommended in section 10.1.2, co-ordination of the all evaluation activities and sharing of results will allow for better data collection. WWtW should also develop a data collection plan including which, how and when to engage stakeholders to measure and value the change.

10.2.1 Stakeholder engagement

All material stakeholders were involved during the stakeholder engagement stage, however it is recommended that this should continue to enable WWtW compare this baseline data with future evaluations. Furthermore, it is recommended that:

- Family members, employer partners and referrers should be further engaged in focus group sessions understand and unpack the value created for them by WWtW. This engagement should strive to include a broad range of characteristics within employer partners and referrers such as sector, size, type and length of relationship with WWtW to understand outcomes and whether material differences exists within the stakeholder groups that warrant segmentation into subgroups.
- Participants being the primary beneficiary of WWtW should continue to be engaged to understand the different (positive and negative) changes and value created for the three identified subgroups and the value they ascribed to the changes. As well as to further explore the attribution, deadweight, displacement, benefit period and drop off of outcomes. This engagement should be on an ongoing basis to inform data collection and can occur during the regular meetings WWtW staff have with participants and upon completion of the program and at the 12-month evaluation to limit the burden on participants.
  - Analysis showed that participants in subgroup 1 experience the most social value, followed by subgroup 3 and subgroup 2. It was expected that individuals in participant subgroup 2 would experience more value than subgroup 3. It is important to understand the reasoning behind this finding by engaging more participants from this subgroup to understand whether the findings is representative of the whole subgroup or whether the low response rate influenced the negative change experienced by a few participants in this subgroup. By continuously monitoring changes WWtW will be able to early track and minimise the incidence of negative outcomes.

10.2.2 Data collection

Data collection will need to continue to improve sample sizes and to enable comparison between this data with future evaluations. When collecting data special attention should be given to strive for a broad range of stakeholder groups to ensure representativeness.

- Better integrate SROI data requirement with current data collection processes, such as data from other evaluations, output and outcome data collected for participants at different stages of the program and the 12-month evaluation, to reduce burden for participants and ensure higher response rates. Change should continue to be measured using Likert scale questions that are informed by stakeholder engagement and provide respondents with non-binary options to record the change experienced by them over the duration of their program. In developing and distributing the participant survey, “before” and “after” surveys that enable comparison of indicators at two different points in time has been considered but it has been predicted that for the participants involved in this SROI, a single survey upon program completion would yield greater success, in the following ways:
  - Greater feasibility – less burden on stakeholders, less likely to lead to survey fatigue
  - Greater accuracy – less susceptible to fluctuations that may cause stakeholders to adopt different answering styles for the “before” survey and the “after” survey, which could lead to false measures of positive or negative change

  - Greater completeness – less reliant on stakeholders completing multiple surveys that could lead to data gaps.
- Attribution, displacement, benefit period and drop off have been estimated using various methods including stakeholder engagement. These estimations should be further substantiated in future evaluations. Engagement with stakeholders post involvement with WWtW would assist in this process.
- Develop and distribute surveys for carers and employer partners. These surveys should include questions that will enable WWtW to understand and quantify the amount of (positive and negative) change and identity levels of attribution, deadweight, displacement, benefit period and drop off. Carers survey should be distributed following the completion of the program and employer partners survey should be distributed once a year.
- A survey had been developed and distributed to referrers but received a low response rate. It is recommended to finetune the survey after conducting focus group discussions and distribute it on a yearly basis to ensure higher response rates.
- Hard copy entry, or assisted survey entry may be required for participants for whom online surveys are not always accessible. This may increase the response rate overall as well as with individuals where digital literacy levels are low.

10.2.3 Calculating the value

Many of the financial proxies used for participants are defined as “revealed preference” methods. For this Forecast evaluation, outcomes for the three subgroups have been valued the same. This was based on stakeholder engagement and survey results in which participants were asked to identify and rank their most important changes. The value of the different outcomes has been verified with participants as well as WWtW staff. It is recommended that future evaluations gather valuation data from directly from stakeholders and explore other valuation techniques such as cash transaction (money saved or spent by the stakeholder group) or stated preference (asking stakeholders explicitly how much they value an outcome).

10.2.4 Verification

Various stakeholders have been involved in verifying the results, however the number of stakeholders involved could be improved. It was intended to engage a focus group of participants throughout the whole research to verify results, but due to COVID-19 this has not been possible. It is recommended that to further involve all material stakeholders in the verification of:

- the theory of change (causality of outcomes)
- the outcomes (positive and negative, and discount factors)
- the relative value of the outcomes (financial proxies).

The verification can be undertaken throughout the program.

10.3 Develop viable business model

WWtW is coming towards the end of the pilot phase. Having delivered a successful demonstration project that can be incorporated into mainstream service delivery, they now need to build a viable business model (see Figure 10.3 below).

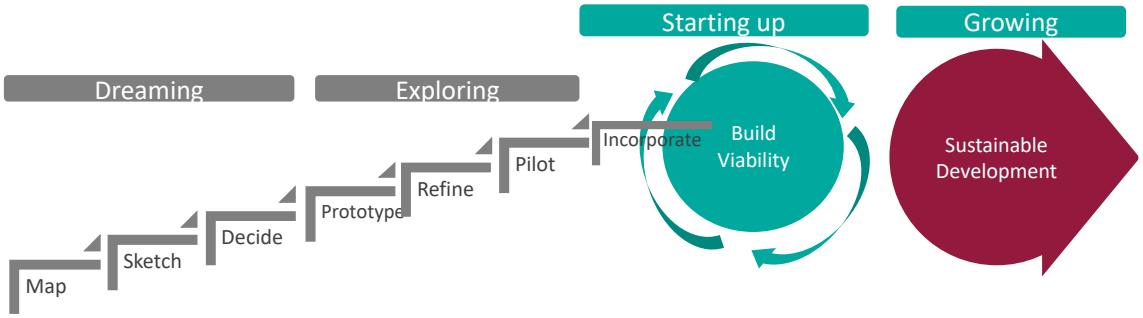


Figure 10.3 Business development cycle[10]

This means that, in effect, WWtW is entering start-up phase similar to a new business start-up.

One of the keys to long-term success is ensuring that there is a market for the service that WWtW has developed. As discussed above this market could exist in three key areas, the three systems to which WWtW provides a bridge: funding via the NDIS within individual plans for participants in the program, funding via the Disability Employment Service (or within developed disability employment strategies by the federal government) and funding via state or federal mental health strategies. Straddling these three systems is complex but also provides a possible advantage for WWtW in that given the value flow and positive social return, then a future funding mix for the service could contain funding from each area.

To develop a viable, long-term business model then three short- to medium-term strategies are recommended:

- Engage policy makers in understanding the value of WWtW
- Secure funding for the next phase of development
- Consider Payment by Results (PbR) as an option for long-term funding.

10.3.1 Engage policy makers

Quite naturally, WWtW has been focused on the 'dreaming' and 'exploring' phases of service or business development. The service has moved through the stages of design outlined above and as discussed has engaged funders, service partners and participants in this co-design process. One gap in the design process has been deep engagement of policy makers.

Now that WWtW has a strong story of social change to tell, it is crucial that they engage policy makers in understanding the value flow to both participants and government of this innovative approach to tackling long-term unemployment for people with serious mental illness.

10.3.2 Secure funding for next phase of development

The next phase of development could last for three years as WWtW moves through start-up to viability. For many innovation projects this is the point at which they fail. Seelos and Mair (2016) identify a plethora of reasons for the failure to scale up social innovation but one of the key reasons is the lack of long-term funding for the innovative process. Funding innovation requires more than a two to three-year window, as the process often takes five years or more to get from initial idea to viability.

WWtW should utilise the results of this SROI analysis and the complementary evaluation work they are carrying out to re-engage with the existing funders to explore the potential opportunities for funding

[10] Adapted from a Social Ventures Australia and Parramatta Council, 2009.

over the next three years as they develop their business model. In addition, WWtW should explore additional options for philanthropic co-funding during that period.

10.3.3 Consider 'Payment by Results' as an option for long-term funding

As indicated an impact-led business model for WWtW might mean that funding for the service is drawn from a variety of funding pools. Hutton and Robbie (2007) referred to this approach as 'partnership purchasing', where different government departments pool funds or jointly commission services to provide services for people with complex social needs.

Over the past decade a new funding mechanism has arisen that could unlock the potential of 'partnership purchasing' by government funders operating in different systems. This is impact investment.

Impact investments are made into organisations, projects or funds with the intention of generating measurable social and environmental outcomes, alongside a financial return. Impact investments are different from grants because a financial return is expected, and different from mainstream finance because measurable social and environmental benefits are expected (Impact Investing Australia, 2020).

Alongside this, Payment by Results (PbR) is relatively new public policy instrument where payments are made contingent on results. PbR has been linked with impact investment as the initial capital to finance the service delivery has frequently come via impact investing, with the investors willing to take the risk and receive a return once the service delivers.

- It is recommended that WWtW reviews the options for impact investing as it explores whether Payment by Results contacts can be established with different government funding partners, to enable effective partnership purchasing.

10.4 Revisit the program approach through learning from COVID-19 crisis

This SROI analysis took place during the COVID-19 crisis. From the initial discussions with the WWtW staff team, one of the key aspects of modality to emerge was the peer to peer support that participants provided to each other within the groupwork sessions. This was seen as key to supporting reduced social isolation. With the onset of COVID-19, the service had to rapidly pivot to online and telephone delivery. Given the ongoing nature of the COVID-19 crisis, it has been impossible to assess whether this has had any effect on outcomes, but the WWtW staff team are aware that it has altered modality.

Alongside this there is anecdotal evidence that COVID-19 is causing an increase in mental health issues within Australia. Service providers have reported skyrocketing referral rates for mental health services (Pro Bono Australia, 2020), which is understandable given the self-isolation measures introduced. No research yet exists in public domain to quantify the impact of COVID-19 on people with serious mental illness but anecdotal discourse is that the impact will compound already complex issues.

The other major factor that the WWtW team will need to grapple with is the rise in unemployment as a result of COVID-19. Within Australia, unemployment has risen from 5 per cent to 7 per cent (ABS, July 2020) and there is significant anecdotal discussion of a crisis in business confidence. As the economy re-emerges from the crisis, the WWtW team will need to work more closely with employers to ascertain the appetite for inclusive employment approaches during the recovery phase. This may require adaptation of the program approach.

- It is recommended that WWtW reviews the program approach through the learning from the COVID-19 crisis

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Appendix A Methodology

More detailed information about methodology and the research undertaken is provided here to support section 5.2.

Stages 1 and 2 – Immersion and developing the theory of change

Both stages focused on identifying stakeholders and understanding what changes. Stakeholders to involve in the analysis were identified through:

- An initial consultation, followed up in a theory of change workshop with WWtW staff. The stakeholders that were identified included the intended beneficiaries, anticipated beneficiaries and people/organisations who can provide a perspective on the change experienced by other stakeholders. The possibility of unintended stakeholders, and unintended and negative outcomes was discussed during the theory of change workshop and consultation with WWtW staff.
- A review of literature relating to people with mental illness and employment, with a particular focus on identifying unintended stakeholder groups or outcomes.

This process provided the basis for the initial stakeholder engagement plan, however the possibility for the existence of other stakeholder groups was considered throughout the analysis. During the interviews, individuals were asked for their perspective on who else experiences change and in what ways.

Within each of the stakeholder groups, it was important to ensure that the individuals selected to be involved represented the breadth of characteristics and experiences. This would ensure that the analysis and the findings provide a fair representation of the whole stakeholder group. The stakeholders identified and the breadth of characteristics is presented in Table A.1. The engagement approach for involving these stakeholder groups is also provided.

With this guidance, WWtW identified individuals to involve. Throughout the stakeholder process, a snowballing approach to identify other stakeholders was used.

Stakeholders were involved through different methods including phone interviews, video interviews, surveys and email interviews. The initial stakeholder engagement plan included face-to-face interviews and focus groups, but due to the social distancing requirements of COVID-19 all interviews have been completed using phone and video conferencing tools. Two participants requested to have the interview questions sent by email and responded by email, due to their mental illness. Stakeholders were involved in phone and video interviews of approximately 45 minutes each to identify what changes. These interviews were guided by a semi-structured interview template that is provided as Appendix E.

Table A.1 Profile of stakeholders involved in the stakeholder engagement

Stakeholder group	Variable characteristics	Input provided on	Engagement approach	Total #	# involved
Participants	- Mental illness - Demographics - Employment history - Stage of completion of program - Support system	Themselves Their families	Phone interviews	73	6
			Email interviews		2
			Survey		21

Stakeholder group	Variable characteristics	Input provided on	Engagement approach	Total #	# involved
Carers/ Family members		Themselves The participants	Phone interview	69.5 households and 111 family members[11]	4
WWtW staff	Program knowledge	Themselves All other stakeholders	Phone interviews	8	6
Referrers	- Sector - Variables of participants working with - Relationship length	Themselves Their organisation The participants	Phone interview	98 individuals working in 34 referral organisations	6
			Survey		6
Employers	- Organisation size - Sector - Relationship length - Mental disabilities supported	Themselves Their organisation The participants	Survey	25	3
Funders	- Type of funder - Funding stream	Their organisation and links to sectors	Video interviews	7	5
Sector organisations	Mental health sector Disability employment sector	The sector and linkages to other sectors	Video interviews		3
			Total		**62**

The engagement provided an opportunity to explore the change that is experienced, the context within which the change occurs, and to develop a preliminary identification of outcomes (both intended and unintended, positive and negative). All aspects of the SROI calculation were explored including deadweight, attribution, displacement, benefit period, drop off and the relative value of outcomes. Specific questions were asked to identify unintended and negative outcomes and other possible stakeholder groups experiencing change.

[11] 4.8 per cent of respondents stated that the statement "My family relationships have improved" is not applicable to them. Assuming that this response is representative means that remaining 95.2 per cent is in contact with their family. 95.2 per cent out of total 73 participants is 69.5 participants. Family members are assumed to be an average of 1.6, which is the national household average (2.6) minus the beneficiary (1). Source: Australian Bureau of Statistics, 2016. https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/036
69.5 participants * the national household average of 1.6= 111.2 family members in total.

This phase also included a desktop review of:

- Program documentation and materials provided by WWtW
- Outcomes experienced for larger scale stakeholders (for example, government)
- Review of the intended outcomes in terms of Enduring Impact model in Figure 9.6.

The research informed the:

- Conclusions about which stakeholders were likely to be experiencing material outcomes and therefore needed to be included in the theory of change (although it was planned to include stakeholders such as employer partners and participants in the theory of change, due to the social distancing measures of COVID-19 only WWtW staff were included) and the third stage of research – the surveys to measure and value what changes
- Development of the theory of change
- Surveys used in stage 3 to measure and value change
- Decisions about SROI model inputs.

Stage 3 – Calculating the SROI

This stage focused on measuring and valuing what changes and included:

- Online surveys including a series of Likert scale and open-ended questions about material stakeholders to establish the changes experienced, changes for other stakeholder groups, relative value of changes, attribution and deadweight. Surveys were sent out to the following stakeholder groups:
  - Participants (also acting as proxy for carers/ family members)
  - Referrers

  The intent was to develop and send out a survey to employer partners as well, but due to the limited response in the qualitative phase reported due to COVID-19 situation it was decided not to overburden this group of stakeholders.
- Desktop research to inform financial proxies to use in the SROI model and understand and value the outcomes experienced by the stakeholders.

A consistent approach was adopted across participants and referrers to measure their outcomes. After outcomes were identified in the qualitative stakeholder engagement and supplementary desktop research, they were measured through surveys (stage 3) which asked stakeholders to self-report the changes that they (and in limited instances, the changes they believe others) had experienced against the corresponding indicators. Stakeholders were asked to assess how much change had taken place as a result of the WWtW program.

Outcomes were measured using a 7-point Likert scale that ranged from 'A lot LESS than' (1) to 'no change' (4) to 'A lot MORE' (7).

The quantity of people experiencing change was determined by their responses to the Likert scale questions.

- If they selected '4 – no change', they were treated as not experiencing the outcome
- If they selected 5, 6, or 7, they were treated as experiencing the outcome positively
- If they selected 1, 2, or 3, they were treated as experiencing the outcome negatively.

Table A.2 shows an example of how questions were used to determine whether respondents had experienced an outcome and the extent to which they experienced it.

Table A.2 Example of survey data used to determine whether outcomes have occurred

Q11. As a result of participating in the Program, how have the following things changed for you?								
I am in better physical health								
	1 - A lot LESS	***2***	***3***	***4 - No change***	***5***	***6***	***7 - A lot MORE***	***Did the outcome occur***
Respondent 1							*x*	*Y*
Respondent 2							*x*	*Y*
Respondent 3						*x*		*Y*
Respondent 4				*x*				*N*
Respondent 5						*x*		*Y*

The outcome was quantified further using an approach to measuring 'outcome incidence' that used respondents' Likert scale scores to discern *to what extent* an outcome had occurred. This was then used to scale the financial proxy to reflect individual responses, as demonstrated in Table A.3.

Table A.3 Example of survey data used to determine to what extent outcomes had occurred

Q11. As a result of participating in the Program, how have the following things changed for you?											
I am in better physical health											
	1 - A lot LESS	***2***	***3***	***4 - No change***	***5***	***6***	***7 - A lot MORE***	***Did the outcome occur***	***What was the outcome incidence***	***Financial proxy (max)***	***Value per stakeholder***
Respondent 1							*x*	*Y*	*100%*	*$ 2,600*	*$ 2,600*
Respondent 2							*x*	*Y*	*100%*	*$ 2,600*	*$ 2,600*
Respondent 3						*x*		*Y*	*67%*	*$ 2,600*	*$ 1,742*
Respondent 4				*x*				*N*	*0%*	*$ 2,600*	
Respondent 5						*x*		*Y*	*100%*	*$ 2,600*	*$ 2,600*

The value was then counted using the value per stakeholder and scaling up to reflect the total population. This approach to measuring change was also used to record negative changes that stakeholders experienced, which were included in the aggregated calculation of change. Negative outcomes that were material were included in the benefit pathway and reported as standalone outcomes in section 6. Negative changes for individual participants have been briefly explored in narrative of the outcome in section 6.

Stage 4 – Reporting, using and embedding

Principle 7 of SROI is to *Verify the result*. Throughout the project, the Think Impact team engaged in frequent reflection with WWtW team to ensure mutual understanding and fill knowledge gaps as they arose. Additional verification took place through:

- Verification with various stakeholder groups who had agreed to be contacted again during the first stakeholder engagement. A handful of stakeholders, including participants, referrers, employer partners, funders and sector representatives reviewed and verified the findings.
- A verification workshop with WWtW to test assumptions, review the theory of change and chain of events, the range of outcomes, and to assess the relative importance of different outcomes. WWtW staff were taken as representative of the stakeholder groups as it was not feasible to verify directly with all stakeholders engaged during the first stakeholder engagement.

- The reports were peer reviewed by staff within Think Impact with a background and expertise in SROI and social impact measurement.

The table below states the stakeholder groups involved in verification. In most cases stakeholder groups were emailed the benefit pathways and/or findings including graphs as displaced in section 8 of this report prior to engaging them over the phone.

Table A.4 Stakeholder groups engaged in verification process

Stakeholder group	What was verified	When	Engagement approach	Number engaged
Participants	• Outcomes experienced (whether all positive and negative outcomes were captured in the benefit pathway) • Causality of outcomes – benefit pathway	Upon completion of stage 2 – Finalising the benefit pathways	15-minute verification over the phone	Emailed 6 participants only 2 responded and were engaged in verification.
	• Division of the three subgroups and outcomes experienced by each group • Relative value of participant outcomes • Deadweight, attribution, benefit period and drop off • Relative value flowing to the other stakeholder groups	Upon completion of initial value map (SROI model)	30-minute verification over the phone	Emailed 6 participants only 2 responded and were engaged in verification.
Referrers	• Outcomes experienced (whether all positive and negative outcomes were captured in the benefit pathway) • Causality of outcomes – benefit pathway • Participant benefit pathway	Upon completion of stage 2 – Finalising the benefit pathways	Verification toke place over email	Emailed 4 referrers only 1 responded and was engaged in verification
Carers peak body	• Outcomes experienced by carers and participants – benefit pathway • Relative value of carers and participants outcomes	Upon completion of initial value map (SROI model)	30-minute interview and verification over the phone	1
Disability employment peak body	• Outcomes experienced by participants – benefit pathway • Relative value of participants outcomes • Deadweight and attribution	Upon completion of initial value map (SROI model)	30-minute interview and verification over the phone	1

Stakeholder group	What was verified	When	Engagement approach	Number engaged
Mental health services peak	• Outcomes experienced by participants and referrers – benefit pathway	Upon completion of initial value map (SROI model)	30-minute interview and verification over the phone	1
Employer partners	• Outcomes experienced by participants and employer partners – benefit pathway • Participant subgroups • Relative value of participants outcomes • Value flowing to all stakeholders	Upon completion of initial value map (SROI model)	15-minute verification over the phone	Emailed 3 only 1 responded and was engaged in verification
Funders	• Outcomes experienced by all stakeholder (focusing on participants and employer partners) – benefit pathway	Upon completion of stage 2 – Finalising the benefit pathways	Verification toke place over email	Emailed all 5 only 3 responded and were engaged in verification
	• Participant subgroups • Value flowing to all stakeholders	Upon completion of initial value map (SROI model)	Verification toke place over email	Emailed all 5 only 2 responded and were engaged in verification
WWtW staff	• Outcomes experienced by all stakeholders – benefit pathways	Upon completion of stage 2 – Finalising the benefit pathways	Video meeting	8 staff members
	• Participant subgroups • Deadweight, attribution, displacement, benefit period and drop off • Value flowing to all stakeholders	Upon completion of initial value map (SROI model)	Verification meeting	8 staff members

The findings of the verification are summarised below:

Table A.5 Verification findings

What we heard	What we changed
The value for family relationships is described too high with 2 counselling session per month for one year.	We did desktop research and found the average sessions of family therapy is between 5–20 sessions and adjusted that in the model.
The outcome 'greater sense of belonging' was further unpacked and described as 'change in self-image'. The outcome is about participants seeing themselves as someone who can be employed rather than just a patient or client.	Only indicator for 'greater sense of belonging' has been developed and tested in the survey. The second verification happened after the survey, thus existing indicators that speak to this outcome have been used for 'change in self-image'.
The outcome 'disappointment in not getting employment' goes beyond the control of the program. The aim is to help participants find or sustain employment however many factors influence this.	Attribution for this outcome has been adjusted to 50%
The value for improved social connection was 5% of the total value for participants. In verifying with participants, referrers and WWtW staff it was mentioned that this value was much lower than experienced.	Our initial financial proxy was based on the value volunteering once a week for a whole year. Based on this the financial proxy for one stakeholder for one year was valued at $8,108. Following verification with participants this value was increased to a value of $35,555 for one stakeholder for one year.
Employers experience a higher value from the program than funders.	We did more desktop research on the proxies of funders and used a more conservative proxy than previously. By doing this the value decreased for funders.

Appendix B Materiality

Stakeholders are defined as people, organisations or entities that either:

- experience change as a result of the activity that is being analysed; or
- contribute to the change taking place.

An SROI seeks to measure the 'material' outcomes experienced by 'material' stakeholders as a result of the activities. An outcome or stakeholder is deemed to be material if it is:

- **Relevant** to at least one of the following: policies, stakeholders, work of peers, societal norms, short term financial impacts; and
- **Significant** enough, in the context of the total social value created, that it influences decisions and actions.

Immateriality is not a reflection of low importance; some of the most important stakeholders are the enablers or creators of value, rather than recipients of value such as key WWtW staff.

The process for determining material stakeholders and outcomes is below.

1. Anticipated stakeholders were identified in consultation with the WWtW team before and during the theory of change workshop. While the intended beneficiaries of the activities are typically easily identified as potential stakeholders, it is imperative to consider the existence of unanticipated stakeholders. Desktop research focused on initiatives of a similar nature was undertaken to identify unanticipated stakeholders or outcomes.
2. We engaged with these stakeholder groups to determine the outcomes they experience, if any, and if these outcomes were material. Open ended questions were posed to allow for the identification of unintended and negative outcomes. These stakeholders were also asked to identify whether they were aware of any other stakeholder groups who contribute to or experience outcomes.
3. Following the engagement, a determination was made about which stakeholders are experiencing material outcomes. This is a subjective decision based on qualitative information; therefore, these decisions were verified with members of the WWtW team who have knowledge of the program.
4. Those stakeholder groups who were deemed to be experiencing material outcomes were invited to contribute to a survey to quantify the amount of value being realised. The results demonstrated that some outcomes were not material, and these were removed from the calculation of value.
5. Materiality results are presented in the following tables.

B.1 Materiality of stakeholders

In total eleven stakeholder groups were identified as contributing or experiencing change as part of WWtW. Out of the eleven groups, six stakeholder groups were identified as experiencing material changes. Table B.1 below summarises the stakeholder groups included or excluded from the SROI model based on the significance and relevance of the outcomes experienced.

Table B.1 Materiality of stakeholders

Stakeholder group	# of stakeholders	# engaged	Materiality conclusion	Rationale
Participants	73	8	Relevant: Yes Significant: Yes **Material**	Participants are the primary beneficiaries of this program and experience material outcomes as a result of the program.
Carers/ Family members	70 households and 111 family members[12]	4	Relevant: Yes Significant: Yes **Material**	Family members who are in close contact with participants experience direct changes as a result of the program.
Referrers	98 individuals working in 34 referral organisations	6 organisations	Relevant: Yes Significant: Yes **Material**	Referrers experience material outcomes as a result of having their clients involved in the program.
Employer partners	25	3	Relevant: Yes Significant: Yes **Material**	Employer partners experience material outcomes as a result of being involved in the program.
Funders	7	5	Relevant: Yes Significant: Yes **Material**	Funders experience material outcomes as a result of learning from this program in terms of future funding

[12] 4.8 per cent of respondents stated that the statement "My family relationships have improved" is not applicable to them. Assuming that this response is representative means that remaining 95.2 per cent is in contact with their family. 95.2 per cent out of total 73 participants is 69.5 participants. Family members are assumed to be an average of 1.6, which is the national household average (2.6) minus the beneficiary (1). Source: Australian Bureau of Statistics, 2016. https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/036
69.5 participants * the national household average of 1.6= 111.2 family members in total.

Stakeholder group	# of stakeholders	# engaged	Materiality conclusion	Rationale
Government (state and federal)	1	0	Relevant: Yes Significant: Yes **Material**	Changes that are happening for individuals contribute to the objectives of the federal and state governments (for example, decreased costs to government services/increased tax revenue).
WWtW Staff	9	6	Relevant: Yes Significant: No **Not material**	WWtW staff are key enablers of change experienced by other stakeholders, however the change experience by the staff members was not considered material to the overall analysis.
Sector peak representatives	N/A	3	Relevant: Yes Significant: No **Not material**	Sector representatives have been interviewed but all value identified flowed back to participants or the Government
Society	N/A	0	Relevant: Yes Significant: No **Not material**	Material outcomes were not identified for society during the research period.
Academics	N/A	0	Relevant: Yes Significant: No **Not material**	Material outcomes were not identified for academics during the research period.
WISE Employment	1	1	Relevant: Yes Significant: No **Not material**	WISE Employment as a funder experiences material outcomes. However, these outcomes as captured in funder stakeholder group.

B.2 Materiality of outcomes

Following the identification of stakeholder groups who were defined as material, the research team identified the outcomes experienced by these stakeholders. The chain of events was constructed to determine how outcomes contribute to others, leading to the identification of the final outcome that was valued. This process was important to avoid any double counting. The final outcomes were then assessed in terms of their relevance and significance in order to determine the materiality of each outcome.

Where the outcomes are deemed to be both relevant and significant, these outcomes were included in the SROI model. In accordance with Principle 6 Be transparent, those items that the project team deemed to be non-material are outlined context to the outcomes that have and have not been included in the theory of change.

Table B.2 below summarises the outcomes included or excluded from the SROI model based on the significance and relevance. Participants are referred to as subgroup 1, 2 and 3 in the table, these subgroups correspond to:

- Participants Subgroup 1: Achieved full-time, part-time and/or casual employment
- Participants Subgroup 2: Achieved volunteering, placement and/or further study
- Participants Subgroup 3: All other vocational outcomes.

Table B.2 Materiality of outcomes

Stakeholder group	Outcome	Materiality conclusion	Rational
All participants: Subgroup 1, Subgroup 2 & Subgroup 3	Improved social connection	Relevant: Yes Significant: Yes **Material**	Improved social connection is a key outcome experience by individuals in all subgroups. Making it relevant and significant. Refer to section 0 for details.
All participants: Subgroup 1, Subgroup 2 & Subgroup 3	Change in-self image	Relevant: Yes Significant: Yes **Material**	Change in-self-image is a key outcome experience by individuals in all subgroups. Making it relevant and significant. Refer to section 0 for details.
All participants: Subgroup 1, Subgroup 2 & Subgroup 3	Improved self-esteem	Relevant: Yes Significant: Yes **Material**	Improved self-esteem is a key outcome experience by individuals in all subgroups. Making it relevant and significant. Refer to section 0 for details.
Participants: Subgroup 1	Improved financial wellbeing	Relevant: Yes Significant: Yes **Material**	Improved financial wellbeing is an outcome that participants in subgroup 1 experiencing making it relevant and significant. Refer to section 0 for details.
Participants: Subgroup 2 & Subgroup 3	Improved financial wellbeing	Relevant: Yes Significant: No **Not material**	Improved financial wellbeing is an outcome that is perceived as important, however due the fact that participants in the subgroup 2 and 3 have not yet achieved employment. This outcome is not yet experienced.

Stakeholder group	Outcome	Materiality conclusion	Rational
Participants: Subgroup 1	Improved employability	Relevant: No Significant: No **Not material**	Improved employability is not a key outcome for this subgroup as improved employability leads to financial wellbeing. Which this subgroup has achieved through employment.
Participants: Subgroup 2 & Subgroup 3	Improved employability	Relevant: Yes Significant: Yes **Material**	Improved employability is one of the key goals of WWtW, experienced by subgroup 2 and 3 and is therefore relevant and significant. Refer to section 0 for details.
All participants: Subgroup 1, Subgroup 2 & Subgroup 3	Expanded aspirations	Relevant: Yes Significant: Yes **Material**	Expanded aspirations is one of the key goals of WWtW, experienced by all subgroups and is therefore relevant and significant. Refer to section 0 for details.
All participants: Subgroup 1, Subgroup 2 & Subgroup 3	Improved family relationships	Relevant: Yes Significant: Yes **Material**	Improved family relationships is relevant for participants in all subgroups. The relative value makes it significant. Refer to section 0 for details.
All participants: Subgroup 1, Subgroup 2 & Subgroup 3	Improved physical health	Relevant: Yes Significant: Yes **Material**	Improved physical health is relevant for participants in all subgroups. The relative value makes it significant. Refer to section 0 for details.
All participants: Subgroup 1, Subgroup 2 & Subgroup 3	Improved mental health	Relevant: Yes Significant: Yes **Material**	Improved mental health is one of the key goals of WWtW, experienced by all subgroups and is therefore relevant and significant. Refer to section 0 for details.
Participants: Subgroup 1	Disappointment from not getting a job	Relevant: No Significant: No **Not material**	This particular subgroup has achieved full-time, part-time and/or casual employment. Thus, the outcome is not relevant or significant.

Stakeholder group	Outcome	Materiality conclusion	Rational
Participants: Subgroup 2 & Subgroup 3	Disappointment of not getting employment	Relevant: Yes Significant: Yes **Material**	This outcome is relevant for participants in subgroup 2 and 3 who have not achieved employment. It is also significant. Refer to section 0 for details.
Carers	Improved emotional wellbeing	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The outcome is caused by participants completing the WWtW program and it's relative value is significant to carers. Refer to section 6.2 for details.
Carers	In more control of own time	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The outcome is caused by participants completing the WWtW program and it's relative value is significant to carers. Refer to section 6.2 for details.
Carers	Improved family relationships	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The outcome is caused by participants completing the WWtW program and it's relative value is significant to carers. Refer to section 6.2 for details.
Referrers	Improved job satisfaction (staff)	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The outcome is caused by engaging with WWtW participants and is therefore significant. Refer to section 6.3 for details.
Employer partners	Reduced recruitment costs	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The relative value of the outcome is significant. Refer to section 6.4 for details.
Employer partners	Improved productivity	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The relative value of the outcome is significant. Refer to section 6.4 for details.

Stakeholder group	Outcome	Materiality conclusion	Rational
Employer partners	Improved job satisfaction (staff)	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The outcome is caused by engaging with WWtW participants and is therefore significant. Refer to section 6.4 for details.
Employer partners	Reduced stigma	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The relative value of the outcome is significant. Refer to section 6.4 for details.
Employer partners	Improved customer loyalty	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The relative value of the outcome is significant. Refer to section 6.4 for details.
Employer partners	Improved customer attraction	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The relative value of the outcome is significant. Refer to section 6.4 for details.
Employer partners	Reduced confidence re inclusive workplace	Relevant: Yes Significant: Yes **Material**	This outcome was identified during the research, making it relevant. The outcome is caused by engaging with WWtW participants and is therefore significant. Refer to section 6.4 for details.
Funders	Reduced risk of funding poorly in future	Relevant: Yes Significant: Yes **Material**	This outcome has financial implication for funders and is therefore relevant. The relative value of the outcome is significant. Refer to section 6.5 for details.
Funders	Better funding of innovation	Relevant: Yes Significant: Yes **Material**	This outcome is relevant for funding strategies and it's relative value is significant. Refer to section 6.5 for details.

Stakeholder group	Outcome	Materiality conclusion	Rational
State government	Reduced healthcare costs	Relevant: Yes Significant: Yes **Material**	This outcome has financial implication for the state government and is therefore relevant. The relative value of the outcome is significant. Refer to section 6.6 for details.
State and federal governments	Cost saving from reduced suicides	Relevant: Yes Significant: Yes **Material**	This outcome has financial and social implication for the both governments and is therefore relevant. The relative value of the outcome is significant. Refer to section 6.6 for details.
Federal government	Reduced welfare costs	Relevant: Yes Significant: Yes **Material**	This outcome has financial implication for the federal government and is therefore relevant. The relative value of the outcome is significant. Refer to section 6.6 for details.
Federal government	Increased tax revenue	Relevant: Yes Significant: Yes **Material**	This outcome has financial implication for the federal government and is therefore relevant. The relative value of the outcome is significant. Refer to section 6.6 for details.

Appendix C Sensitivity analysis

The SROI model has been developed applying the seven principles of the SROI methodology. In particular, where professional judgment has been required, a conservative approach has been used. However, any approach requiring judgement, assumptions and extrapolation carries the risk of errors in the data and findings. For this reason, a sensitivity analysis has been conducted to understand the influence that any variation in these inputs would have on the SROI model.

The results of the sensitivity analysis are presented below.

C.1.1 Changing the financial proxies for participants and Government

The value of proxies varies from sources and methods of calculating. In this SROI conservative financial proxies have been used. Using different proxy for improved social connection (participants), improved mental health (participants), expanded aspiration (participants) and cost saving from reduced suicides (Government).

- **Improved social connection:**

Prior to verification social connection was valued based on volunteering hours this financial proxy has been changed to commensurate with average DALY of mild of moderate social phobia. Using the value of volunteer hours would bring the ratio down to $4.51.

Proxy rationale	Calculation	SROI ratio
Commensurate with average of the disability adjusted life year (DALY) of mild to moderate social phobia	Value of statistical life year is $182,000 in 2014 adjusted for inflation is $197,528 in 2019 * disability weight of mild to moderate social phobia 0.18	4.97 (Base case)
Commensurate with the value of volunteer hours contributed to community projects. Volunteering is a way feel connected and socially interact. Value of volunteering 8 hours per week for 1 year.	Value of volunteering hours based on national minimum wage $19.49 per hour * 8 hours per week *52 weeks for a year	4.51 (New)

- **Improved mental health:**

Using a subjective wellbeing valuation rather than a Quality-adjusted life years (QALYs) approach would increase the ratio to $5.73.

Proxy rationale	Calculation	SROI ratio
Commensurate with monetary equivalent costs associated with depression, anxiety using wellbeing valuation. Using a conservative 40% improvement in mental health.	Monetary equivalent of depression, anxiety GBP 44,237 converted to AUD $80,198 (June 2020) * 40% improvement	4.97 (Base case)
Commensurate with average of the disability adjusted life year (DALY) of severe major depressive disorder. Using a conservative 40% improvement in mental health.	Value of statistical life year is $182,000 in 2014 adjusted for inflation is $197,528 in 2019 * disability weight of severe major depressive disorder 0.658 * 40% improvement	5.73 (New)

- **Expanded aspirations:**

Value in base case represents the feeling of improved aspirations. If expanded to include their actual future earning potential, this number would increase the ratio to $5.21.

Proxy rationale	Calculation	SROI ratio
Commensurate with average cost of consultation with motivational life coach at 1 per month. This service is often sought by people who wish to identify and be encouraged to reach for their aspirations.	Cost of a single session ($195) * 12 sessions (once per month)	4.97 (Base case)
Commensurate with difference between median monthly incomes for people of different qualification levels in Australia. Equivalent to moving from non-school qualifications to Certificate Level	Monthly difference ((1017-836) *4) multiplied by 12	5.21 (New)

- **Cost saving from reduced suicides:**

Cost of suicide to the Government total cost between $1.6bn and $6bn in 2016. Using the higher figure would bring the ratio up to $6.01.

Proxy rationale	Calculation	SROI ratio
The cost of suicide to the Government includes the direct costs of services such as police, ambulance and coronial, combined with future earning potential of individuals and intangible costs.	2,866 people committed suicide in Australia in 2016, at a total cost between $1.6bn and $6bn to the Australian economy. Using $1.6bn figure	4.97 (Base case)
The cost of suicide to the Government includes the direct costs of services such as police, ambulance and coronial, combined with future earning potential of individuals and intangible costs.	2,866 people committed suicide in Australia in 2016, at a total cost between $1.6bn and $6bn to the Australian economy. Using $6bn figure	6.01 (New)

C.1.2 Changing the input costs

The base case input costs captured the whole budget which included the pre-pilot costs and other project expenses related to funding specific requirements.

Input	SROI ratio
$1,461,057	4.97 (Base case)
$1,210,158	6.00 (New)

C.1.3 Changing the quantity of the outcomes

- **Estimating the quantity of the outcomes for employer partners**

The quantity of the assumptions for employer partners' outcome have been made based on interviews, the number of organisations that have customers and direct line of manager of participants who are in paid employment. It is assumed that for the outcomes: reduced recruitment costs, improved productivity, improved job satisfaction and reduced stigma, number of participants in paid employment or line manager of participants in paid employment make up the outcome incidence. For improved customer loyalty and attraction, the outcome incidence is based on the number of organisations that have customers and assuming that one third of those organisations experience those outcomes. Reduced confidence re inclusive workplace outcome is based on interviews and 'unsuccessful placements' in which participants had to temporary stop their work placement.

Rather than using participants to determine outcome incidence, if we assume that all employer partners' outcomes except reduced confidence, as the assumption was higher and WWtW has strategies in place to mitigate this outcome, are 20%, 40%, 60% and 80%, the ratio would be between $4.89 and $5.06.

Outcome incidence (%)	SROI ratio
	4.97 (Base case)
20%	4.89 (New)
40%	4.94 (New)
60%	5.00 (New)
80%	5.06 (New)

- **Estimating the quantity of the outcomes for funders**

The quantity of the assumptions for funders' outcomes have been made following the stakeholder engagement in which five of the seven funders have been interviewed. Assuming that the outcome incidence for funders is not seven but three for both outcomes would decrease the ratio to $4.89.

Outcome incidence (#)	SROI ratio
7	4.97 (Base case)
3	4.89 (New)

C.1.4 Changing the discount factors

- **Estimating benefit period and drop off for participants:**

Estimating benefit periods and drop off have been based on a conservative approach, however assuming that we have overestimated the benefit period and drop off would result in a ratio between $4.49 and $4.01. Assuming that all intrinsic outcomes last one year less than expected but maintaining the same drop off would decrease the ratio to $4.49. If the drop off is 80% then the ratio would decrease even further to $4.01.

Benefit period	Drop off	SROI ratio
2	40%	4.97 (Base case)
3	40%	
1	0%	4.49 (New)
2	40%	
1	0%	4.01 (New)
2	80%	

The benefit period and drop off used in this report might also have been underestimated. Other SROI reports have modelled the costs and benefits over the lifetime (working age) of program participants, with no drop off. Assuming that all participant outcomes would have a benefit period of 5 years and maintaining the same drop off would increase the ratio to $5.77. If there was no drop off then the ratio would increase even further to $10.28.

Benefit period	Drop off	SROI Ratio
Base scenario	Base scenario	4.97 (Base case)
5 years for all participant outcomes	Base scenario	5.77 (New)
5 years for all participant outcomes	0%	10.28 (New)

- **Estimating attribution to all participant outcome:**

The attribution for outcomes for participants are based on the response to the survey question 'Thinking about the changes you have experienced, which of the following best applies?' For individuals who responded 'I have experienced these changes only because of the Program and the support I receive at the Program' it has been assumed that all of the value is attributable to WWtW. For those who responded 'Other things have contributed to the changes I have experienced' it has been assumed that 50 per cent of the value is attributable to WWtW and 50 per cent to other organisations or persons. Attribution level has been established for each subgroup based on the responses.

Assuming that attribution to all participants is same figure indicated in the survey for the three-subgroup combined, and that responses 'Other things have contributed to the changes I have experienced' are all attributable to other organisation or persons, would bring the ratio to $4.07.

Attribution	SROI ratio
Subgroup 1: 17%	4.97 (Base case)
Subgroup 2: 28%	
Subgroup 3: 10%	
Subgroup 1: 40%	4.07 (New)

Subgroup 2: 40%	
Subgroup 3: 40%	

C.1.5 Excluding low value outcomes

Referrers experience exceptionally low value as a result of WWtW. However, they are deemed a material stakeholder and are therefore not excluded from the model. Assuming that all outcomes that have a value less than one per cent are excluded from the model would bring the ratio slightly down to $4.96.

Stakeholder	Outcome excluded	% of value to stakeholder
Referrers	Improved job satisfaction	Only outcome for referrers, but 0.23% of total value
Participants subgroup 2	Improved family relationship	0.2%
Participants subgroup 2	Disappointment in not getting employment	0.04%
Participants subgroup 3	Disappointment in not getting employment	0.03%

C.1.6 COVID-19 lens

The survey was conducted during the COVID-19 crisis, and a question has been added to the survey to understand how the pandemic might have affected participants' responses. Participants stated that COVID-19 has negatively affected the changes they have identified in the survey; for 30 per cent of respondents COVID-19 has negatively affected their responses to a moderate extent and for 20 per cent it has negatively affected their life and responses to a great extent.

Increasing outcome incidence by	SROI ratio
10%	$5.63
20%	$6.27

Appendix D Benefit period and drop off

Drop off and duration for participant outcomes have been estimated drawing on WWtW staff experiences based on the 12-month assessment and the Enduring Impact Model which has been developed by Think Impact. The basis of the Enduring Impact Model is that for long-term change to occur, programs or services have to be improving outcomes in the following three dimensions: intrinsic change, extrinsic change and functional change.

Drawing on the enduring impact principles, the following benefit periods and drop-off rates have been applied to the outcomes in the model.

Dimension of Enduring Impact	Benefit period	Drop off	Description
Intrinsic	2	40%	Intrinsic changes are changes in self in terms of areas such as confidence, identity, self-esteem etc. They tend to be more inward focus and are more volatile to situations. Therefore, the benefit period is generally short-term with a medium drop off.
Extrinsic	2	40%	Extrinsic changes are in networks, sense of belonging, community etc. They tend to be more outward focus and depend on contribution from others. Extrinsic outcomes are generally short-term with a medium drop off.
Functional	3	30%	Functional changes are in skills, knowledge, access to information etc. Functional outcomes are generally medium-term with a low drop off.
Intrinsic and Functional	3	40%	A change in combination of two dimension is more likely to remain for a longer period, but have a medium drop off.

For some participant outcomes this logic of the Enduring Impact Model did not strictly apply, and an alternative approach was utilised and described in the value map. In these examples, rather than using the benefit period associated with Enduring Impact Model, they were given reduced benefit periods of:

- One year for the outcome disappointment of not getting a job rather than the two-year associated with intrinsic outcomes
- One year for the outcomes improve physical health rather than the three- years associated with functional outcomes

Benefit period and drop off for other stakeholders have been estimated based on professional judgement and using Think Impact's database of over 60 SROI reports to sense check. To establish whether the duration and drop off outcomes are short/low, medium or long term/high.

Benefit period		Drop off	
Short	2	**Low**	30 %
Medium	3	**Medium**	40 %
long	5	**High**	60%

Appendix E Interview guides

E.1 Participants

Stakeholder background and involvement

1. Can you tell me about yourself?
2. Engagement in program

Identifying change for the individual

3. Going into the program what did you hope to achieve? Have you been able to do so? Why yes or no?
4. Why did you want to achieve that?
5. What changed for you as a result of your participation (positive and negative)?
6. How and why do you think this happened?
   Prompt for negative change: Was there anything you had to sacrifice to be able to participate?
7. Have other people noticed any change? What do they say/notice?
8. What is the most valuable difference/change that occurred for you?
   Can I ask you to rank these things in order of the size of the change, from the most important or biggest change through to the least important to you? Split into positive/negative if needed

Discount factors

9. Did you experience any challenges in the program? Did you have to give anything up to experience the change you identified?
10. What would have happened if you did not become involved in the program?
11. In terms of the changes you have described, do you think any of them would happen anyway - if you were not involved in the program? If so, which ones and what things other than the program might help improve these aspects of your life?
12. Are you currently doing anything else to improve these aspects of your life?
13. Are there any other things that might have influenced the changes you experience?

Identifying change for others

14. Has anyone else experience changes as a result of the program? If so, what has changed for them?
15. What is life like for them now and how do you think it has changed as a result of this program?
16. What is different for them?
17. Why and how do you think these changes happen? What is it specifically about your/their involvement that led to the changes?

General

18. In one word how would you describe the program?
19. Recommendations – what would make the program better?
20. Is there anything else you would like to add?

E.2 Referrers

Stakeholder background and involvement

1. Tell me about yourself/your role
2. How many people have you referred to WWTW? Do you have much interaction with the participants?
3. How did you get involved with the WWTW program? How did you hear about it? How long have you been involved?

Identifying change for the individual/company

4. What did you hope to achieve by partnering with WWTW?
5. Have you been able to do so? Why yes or no?
6. What changed for you/your company as a result of your involvement? (positive and negative) Are there any other things that might have contributed the changes you experience?
7. How and why do you think this happened?

Identifying change for others and discount factors

8. What changes have you noticed for participants since they engaged with WWTW? (positive and negative)
9. How and why do you think this happened? What do you think would have happened if not for WWtW?
10. Where are/were the barriers and enablers to change?
11. Has anyone else experience changes as a result of the program? If so, what has changed for them?
12. Why and how do you think these changes happen?

General

13. How is this program different from others?
14. Recommendations – what would make the program/your relationship better?
15. Is there anything else you would like to add?

E.3 Family

Stakeholder background and involvement

1. Can you please tell me about your experience as carer?
2. How many people do you provide care for? What is your relationship to them?
3. Why does the person need care? What kind of care do you provide? How long have you been their carer? Where do you care for them?

Identifying change for the participant and discount factors

4. Going into the program what did you/they hope to achieve? Have you/they been able to do so? Why yes or no?
5. Why did you/they want to achieve that?

6. How long have they been engaged in the program?
7. What changed for them as a result of their participation in the WWTW program? Positive/Negative
8. What is life like for them now and how do you think it has changed as a result of this program? How and why do you think this happened?
9. In terms of the changes you have described, do you think any of them would happen anyway - if they were not involved in the program? If so, which ones and what things other than the program
10. Are there any other things that might influence the changes the participants experience?

Identifying change for the individual and others

11. Before they were involved with WWTW, how did their mental ill-health affect your life?
12. Have you noticed any changes since they have been involved in the program?
13. What has changed for you since they participated in the program? (positive and negative)
14. How and why do you think this happened? Who else experiences these changes?
15. Has anyone else experience changes as a result of the program? If so, what has changed for them?
16. What is life like for them now and how do you think it has changed as a result of this program?
17. What is different for them? Why and how do you think these changes happen? What is it specifically about your/their involvement that led to the changes?

General

18. In one word how would you describe the program?
19. Recommendations – what would make the program better?
20. Is there anything else you would like to add?

E.4 Employer partners

Stakeholder background and involvement

1. Tell me about yourself, your role and your company
2. How did you get involved with the WWTW program? How did you hear about it? How long have you been involved? How many participants of WWtW did you work with?

Identifying change for the individual/organisation and others

3. What did you hope to achieve by partnering with WWTW?
4. Have you been able to do so? Why yes or no?
5. What reservations did you have before engaging with WWtW/people with mental illness?
6. What changes have you noticed for participants since they engaged with WWTW? (positive and negative)
7. How and why do you think this happened?
8. What changed for you/your company as a result of your involvement? (positive and negative)
9. How and why do you think this happened?

10. What changes have you noticed in your other employees since your engagement with WWTW? (positive and negative)
11. How and why do you think this happened?
12. Have other people noticed any change at work? What do they say/notice?
13. Has anyone else experience changes as a result of the program? If so, what has changed for them?
14. Why and how do you think these changes happen?
15. What were the barriers and enables to change?

General

16. Recommendations – what would make the program better?
17. What are the key characteristics of a successful placement company? What should they offer?
18. Would you recommend other companies to engage with WWTW? Why yes or no?
    If yes, how might it be used to bring other employers on the same journey?
    What support do you think WWTW should provide to them?

E.5 Funders

Stakeholder background and involvement

1. Tell me about yourself/your role/your organisation
2. What was your motivation for funding WWtW?
3. What other factors influenced the funding decision?

Identifying change

4. What changes were you aiming for from the funding?
5. What aspects of the program attracted you in terms of believing the change would happen?
6. What change will occur for you as a funder?
7. What value is there in that change for you?

General

8. What would make the program more effective?
9. Based on your experience, what negative changes or results might arise from a program like WWtW?
10. Is there anything else you would like to add?

E.6 Sector representatives

1. Tell me about yourself/your role/your organisation
2. How have you heard about WWtW?
3. What challenges exist for your sector in terms assisting people with mental illness with employment?

4. If a program is delivering good results in terms of improving employment outcomes for people with mental illness, what value does that provide to you as a sector representative? And what value does it provide for the sector?
5. What change will occur for you as a sector in terms of having an innovative approach that works?
6. What value is there in that change for you?
7. These types of outcomes are being spoken of by stakeholders [insert appropriate outcomes], from your perspective as a representative of the sector how much do the resonate? What change do you think occurs for people through WWtW? What negative results might arise from WWtW?
8. Is there anything else you would like to add?

Appendix F Survey

F.1 Participant survey

WISE Ways to Work - Participant survey

Thank you for your participation in this survey

Think Impact are doing research to help WISE Ways to Work (hereafter referred to as "the Program") understand what difference the Program makes to you and help grow the positive impacts the Program seeks to create.

Your responses will be kept anonymous and will only be available to the research team at Think Impact. The overall findings will be written up in a published report.

This survey will take about 15-25 minutes to complete.

* 1. In what stage of the Program are you?

- ◯ Currently still engaged in the Program
- ◯ Completed less than 6 months ago
- ◯ Completed 6 months to 1 year ago
- ◯ Completed more than 1 year ago

* 2. What best describes the reason you participate(d) in the Program?
You can select more than one reason, plus you can use the space below to explain if there were reasons other than the ones given below.

- ☐ To find opportunities for paid work
- ☐ To develop my skills
- ☐ To engage socially
- ☐ To work on my self-perceptions and confidence
- ☐ To manage my mental health
- ☐ To further placement/volunteering opportunities
- ☐ To further my studying
- ☐ To spend my time more meaningfully
- ☐ Other (please specify)

* 3. Prior to the Program, how has your mental illness affected your ability to work?

- ◯ Significantly (I have been unable to work for many years)
- ◯ Moderately (I have been in and out of work)
- ◯ Slightly (I have had fairly stable work)
- ◯ Not at all

WISE Ways to Work - Participant survey

Demographics

* 4. What is your age?

- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65+

* 5. How do you identify?

- ◯ Female
- ◯ Male
- ◯ Other (please specify)

* 6. Are you of Aboriginal and/or Torres Strait Islander origin?

- ◯ Yes, Aboriginal
- ◯ Yes, Torres Strait Islander
- ◯ Yes, Aboriginal and Torres Strait Islander
- ◯ No

* 7. Did any of the following apply at the time you started participating in the Program? Please tick all that apply

- ☐ Long-term unemployment (12 months or more)
- ☐ Living with a physical disability or physical health problem
- ☐ Homelessness
- ☐ Refugee or asylum seeker background
- ☐ Culturally or linguistically diverse background
- ☐ Stigma and discrimination
- ☐ Isolation/loneliness
- ☐ Poverty
- ☐ None of the above

WISE Ways to Work - Participant survey

Changes you have experienced - Vocational outcomes

* 8. Has the Program helped you to achieve any of the following? If more than one applies, please select the best outcome that has emerged from your participation.

- ◯ Full-time employment
- ◯ Part-time employment
- ◯ Casual employment
- ◯ Volunteer or placement
- ◯ Undertaking further study
- ◯ None of the above

WISE Ways to Work - Participant survey

Changes you have experienced - Vocational Outcomes

* 9. If you had not joined the Program, would you be working/studying/volunteering now?

- ◯ Most likely yes and participating for same or more hours
- ◯ Most likely yes, but participating less hours
- ◯ Most likely no

* 10. To what extent have you experienced the following.
Due to participating in the Program I have:

	Not at all	Very little	Somewhat	A lot
Gained understanding of my strengths in relation to getting a job	○	○	○	○
Gained understanding of my vocational goals	○	○	○	○
Gained skills to help me find a suitable job	○	○	○	○
Obtained skills that helped me get a job	○	○	○	○
Gained experience that helped me get a job	○	○	○	○
Built my confidence around getting a job	○	○	○	○
Gained skills to help me keep my job	○	○	○	○
More positive social interactions with co-workers at work or outside of work	○	○	○	○
More money to spend	○	○	○	○

What is the most important change from the list above?

WISE Ways to Work - Participant survey

Changes you have experienced - Health and Connections

* 11. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

As a result of participating in the Program, how have the following things changed for you?

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
I am in better physical health	○	○	○	○	○	○	○	○
I can better manage my mental health	○	○	○	○	○	○	○	○
I am in a good state of mind	○	○	○	○	○	○	○	○

* 12. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

As a result of participating in the Program, how have the following things changed for you?

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
My family relationships have improved	○	○	○	○	○	○	○	○
I feel comfortable with my community/social life	○	○	○	○	○	○	○	○
I feel more socially isolated	○	○	○	○	○	○	○	○
I am more accepted for who I am	○	○	○	○	○	○	○	○

WISE Ways to Work - Participant survey

Changes you have experienced - Empowerment

* 13. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

As a result of participating in the Program, how have the following things changed for you?

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
I feel ready to tackle new challenges	○	○	○	○	○	○	○	○
I feel confident in my abilities	○	○	○	○	○	○	○	○
I have improved my thinking skills, such as memory and concentration	○	○	○	○	○	○	○	○
I have improved my communication skills	○	○	○	○	○	○	○	○
I am more confident	○	○	○	○	○	○	○	○
I have a clearer sense of my strengths/skills	○	○	○	○	○	○	○	○
I better understand how I think	○	○	○	○	○	○	○	○

* 14. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

As a result of participating in the Program, how have the following things changed for you?

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
I feel that my work is valuable to others	○	○	○	○	○	○	○	○
I feel comfortable expressing myself	○	○	○	○	○	○	○	○
I have renewed purpose in life	○	○	○	○	○	○	○	○
I have meaningful activities in my life	○	○	○	○	○	○	○	○
I feel more positive about where my life is going	○	○	○	○	○	○	○	○
I am confident I can achieve my career goals	○	○	○	○	○	○	○	○
I have more money to do things that are important to me	○	○	○	○	○	○	○	○
I have more options when it comes to how I use my money	○	○	○	○	○	○	○	○

WISE Ways to Work - Participant survey

Changes you have experienced

15. Since participating in the Program, what **positive** changes have you noticed in yourself?

16. What are the three most valuable things you experienced as a result of participating in the Program?

1

2

3

* 17. Thinking about the changes you have experienced, which of the following best applies?

- ◯ I have experienced these changes only because of the Program and the support I receive at the Program
- ◯ Other things have contributed to the changes I have experienced (please specify below)

Please specify

18. How might your life be different if you did not become involved in the Program?

* 19. Thinking about your survey responses so far, how has COVID-19 affected these changes you have identified in your life? Please elaborate below.

- ◯ Not at all
- ◯ To some extent
- ◯ To a moderate extent
- ◯ To a great extent

Please elaborate

* 20. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

Compared to before participating in the Program, how often do you make use of the following services.

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
GP/Doctor	◯	◯	◯	◯	◯	◯	◯	◯
Medical specialist	◯	◯	◯	◯	◯	◯	◯	◯
Psychologist/psychiatrists/counsellor	◯	◯	◯	◯	◯	◯	◯	◯
Hospital (day only)	◯	◯	◯	◯	◯	◯	◯	◯
Hospital (overnight or longer)	◯	◯	◯	◯	◯	◯	◯	◯
Emergency department	◯	◯	◯	◯	◯	◯	◯	◯
Community mental health services	◯	◯	◯	◯	◯	◯	◯	◯
Other types of social services	◯	◯	◯	◯	◯	◯	◯	◯
Medication	◯	◯	◯	◯	◯	◯	◯	◯
Any other health clinic	◯	◯	◯	◯	◯	◯	◯	◯

* 21. Are there any negative changes as a result of participating in the Program?

- [ ] Reinforced negative thoughts from comparing my progress with other participants
- [ ] Disappointment from not getting employment or a placement
- [ ] Nothing negative
- [ ] Other (please specify)

* 22. How long did this negative feeling last for?

- ◯ It went over quickly
- ◯ For about a week
- ◯ Longer than a week
- ◯ Still experiencing the negative feeling
- ◯ Not applicable

WISE Ways to Work - Participant survey

Changes your family have experienced

For these next questions, please think about your family members (such as partner, children, parents, other family) and any changes they might have experienced as a result of your participation in the Program.

* 23. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

As a result of your participation in the Program, how have the following things changed for members of your family?

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
My family worry less about me	◯	◯	◯	◯	◯	◯	◯	◯
I have been able to inform or share mental health coping strategies with family members	◯	◯	◯	◯	◯	◯	◯	◯
Our relationships have improved	◯	◯	◯	◯	◯	◯	◯	◯
They have more free time	◯	◯	◯	◯	◯	◯	◯	◯
Their mental health has improved	◯	◯	◯	◯	◯	◯	◯	◯

Other (please specify)

WISE Ways to Work - Participant survey

Comments and recommendations

24. Do you have any other comments or recommendations for the Program?

F.2 Referrers survey

WISE Ways to Work - Referrers survey

Thank you for your participation in this survey

Think Impact are doing research to help WISE Ways to Work (hereafter referred to as "the Program") understand what difference the Program makes to its participants and your organisation and help grow the positive impacts the Program seeks to create.

Your responses will be kept anonymous and will only be available to the research team at Think Impact. The overall findings will be written up in a published report.

This survey will take about 5-10 minutes to complete.

* 1. What type of organisation do you work within?

- ◯ Community mental health service
- ◯ Clinical mental health service
- ◯ Forensic mental health service
- ◯ Disability employment services
- ◯ Other (please specify)
- ◯ GP clinic
- ◯ Community Health
- ◯ NDIS LAC

* 2. How long has your organisation been involved with the Program?

- ◯ Between 0 and 6 months
- ◯ Between 6 months and 1 year
- ◯ Between 1 and 1.5 years
- ◯ More than 1.5 years

3. What best describes the reason your organisation became involved with the Program?

WISE Ways to Work - Referrers survey

Changes clients have experienced

4. What type of support do you or have you provide(d) to the WWtW participants?

5. Since referring someone to the Program, what positive and/or negative changes have you noticed in them?

WISE Ways to Work - Referrers survey

Changes for your organisation

6. Since being involved with the Program, what positive and/or negative changes have you noticed for your organisation?

* 7. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

As a result of getting involved with the Program, how have the following things changed for you/your organisation?

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
We have somewhere we can refer our clients to that is accessible for them	○	○	○	○	○	○	○	○
We have a better understanding of how our clients' cognitive abilities can affect their ability to work	○	○	○	○	○	○	○	○
We have a vocational rehabilitation service to refer our clients with employment goals to	○	○	○	○	○	○	○	○
We are able to help people in better ways	○	○	○	○	○	○	○	○
We are able to help more people	○	○	○	○	○	○	○	○

* 8. For the following question please indicate on a scale of 1 to 7 where:
1= A lot LESS 4= No change 7= A lot MORE or N/A

As a result of getting involved with the Program, how have the following things changed for you/your organisation?

	1. A lot LESS	2.	3.	4. No change	5.	6.	7. A lot MORE	N/A
It is easier for us to work with clients	○	○	○	○	○	○	○	○
It is easier for us to help clients find work	○	○	○	○	○	○	○	○
We are not referring our clients to other services/programs	○	○	○	○	○	○	○	○
Our organisation is better able to deliver on its purpose	○	○	○	○	○	○	○	○
We are able to be more effective in our service delivery	○	○	○	○	○	○	○	○
I feel that I have made a valuable contribution to my clients' journey(s)	○	○	○	○	○	○	○	○

9. If referring clients to other programs, please describe how this program differs from those programs, if at all.

10. What might happen for your organisation and for the clients if you were not able to refer clients to WWtW? Is it likely that similar changes would occur for your **clients**?

- ○ Highly likely
- ○ Somewhat likely
- ○ Can't say
- ○ Somewhat unlikely
- ○ Highly unlikely

Please explain your answer

11. What might happen for your organisation and for the clients if you were not able to refer clients to this Program? Is it likely that similar changes would occur for your **organisation**?

- ◯ Highly likely
- ◯ Somewhat likely
- ◯ Can't say
- ◯ Somewhat unlikely
- ◯ Highly unlikely

Please explain your answer

12. Has anything outside of the Program contributed to the changes covered in this survey?

13. Thinking about your survey responses so far, how has COVID-19 affected the above changes you've identified for your organisation?

- ◯ Not at all
- ◯ To some extent
- ◯ To a moderate extent
- ◯ To a great extent

Please explain if affected

WISE Ways to Work - Referrers survey

Comments and recommendations

14. Do you have any other comments or recommendations for the Program?



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