

Dementia and Imagination

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Dementia and Imagination: A social return on investment analysis framework for art activities for people living with dementia

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3 **Dementia and Imagination: A social return on investment analysis framework for art**
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5 **activities for people living with dementia**
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Abstract

Background and objectives

Arts activities may benefit people living with dementia. Social Return on Investment (SROI) analysis, a form of cost-benefit analysis, has the potential to capture the value of arts interventions, but few rigorous SROI analyses exist. This article presents a framework for a SROI analysis. **Research Design and Methods**

One hundred and twenty-five people with mild to severe dementia and 146 caregivers were recruited to the Dementia and Imagination study across residential care homes, a hospital and community venues in England and Wales for a 12-week visual arts program. Quantitative and qualitative data on quality of life, support and program perceptions were obtained through interviews. SROI was undertaken to explore the wider social value of the arts activities.

Results

An input of £189,498 (\$279,320/ €257,338) to deliver the groups created a social value of £980,717 (\$1,445,577/ €1,331,814). This equates to a base case scenario of £/\$/€5.18 of social value generated for every £/\$/€1 invested. Sensitivity analysis produced a range from £/\$/€3.20 to £/\$/€6.62 per £/\$/€1, depending on assumptions about benefit materialisation; financial value of participants' time; and length of sustained benefit.

Discussion

To our knowledge this is the first study applying SROI to an arts intervention for people with dementia. Arts based activities appear to provide a positive SROI under a range of assumptions.

Implications

Decision-makers are increasingly seeking wider forms of economic evidence surrounding costs and benefits of activities. This analysis is useful for service providers at all levels, from local government to care homes.

Keywords: Visual arts, Creativity, arts, and related therapy, economics

For Peer Review

Introduction

There are 47 million people living with dementia worldwide and this is predicted to rise to over 131 million by 2050 (Prince, Comas-Herrera, Knapp, Guerchet, & Karagiannidou, 2016). In the UK, two thirds of the cost of dementia is paid by people with dementia and their families, and unpaid caregivers supporting someone with dementia save the economy £11 billion (\$16.2/ €14.9 billion) a year (Knapp et al., 2014).

There is an emerging body of evidence that arts based activities can be enjoyable and have other benefits for people living with dementia. Research reviews suggest that art interventions have the potential to improve a broad range of outcomes for people living with dementia, including well-being, quality of life, cognitive function and communication (De Medeiros & Basting, 2014; Mental Health Foundation, 2011; Young, Camic, & Tischler, 2016; Young, Tischler, Hulbert, & Camic, 2015; Zeilig, Killick, & Fox, 2014). Such programs could be developed as part of dementia services at a local level if they are proven to yield direct benefits to people with dementia and have wider societal benefits.

The National Institute for Health and Care Excellence (NICE) in the UK has typically supported cost-utility analysis using quality adjusted life years (QALYs) as the metric of benefit for clinical studies. QALYs are a composite measure of health-related quality of life, which combine the length of life gained as the result of an intervention with the quality of life associated with being in a particular health state. As increasing length of life is not always the aim of psychosocial interventions, QALYs may not be the most relevant metric to use. The use of cost-benefit, cost-consequence and return on investment analysis has also been deemed appropriate for capturing outcomes of interventions that include non-health benefits, such as benefits to caregivers (NICE, 2012; NICE, 2011). This approach is particularly relevant for interventions that support people living with dementia, where benefits may appear to be ‘in the moment’ and are hard to capture using a cost-utility framework. Benefits to caregivers are

1
2
3 clearly relevant given the significant contribution of informal care to the provision and total
4
5 cost of dementia (Knapp et al., 2014).
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7 Where benefits fall across sectors, such as the health care sector, social care sector
8
9 and local **government**, cost-benefit analysis, which measures all costs and benefits in
10
11 monetary terms, **has been advocated** (McIntosh, Donaldson, & Ryan, 1999). Social return on
12
13 investment (SROI) analysis is a pragmatic form of cost-benefit analysis which seeks to
14
15 establish the social value generated by an intervention (Inglis, 2012; Nicholls, Lawlor,
16
17 Neitzert, & Goodspeed, 2009; The Centre for Public Scrutiny, 2014). SROI attempts to
18
19 capture a broader picture of the value of an intervention by considering the impact on the
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21 locality of the intervention and incorporating social value where appropriate. A triple bottom
22
23 line approach is taken, meaning the effect on the economy, the environment and its people
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25 are considered.
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28 SROI analysis has been used to assess the social value of creative activities for older
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30 people (MB Associates, 2013; Social Value Lab, 2011). These activities were found to
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32 generate a positive return on investment, meaning that the social value generated was greater
33
34 than the value invested in setting up and delivering the activities. However, the social value
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36 of arts groups for people living with dementia has not been established. **Social return on**
37
38 **investment does not yet have the pedigree of cost benefit analysis (Fujiwara, 2015) and the**
39
40 **method, it may be argued, is still seeking academic credibility in terms of a need to build: 1) a**
41
42 **standardized methodology, and 2) a body of robust published examples of its application.**
43
44 **However, the method has been advocated by the UK cabinet office (Nicholls et al., 2009),**
45
46 **and there is some interesting comparable work in the Netherlands on the social cost benefit**
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48 **analysis of public projects with a potential to improve population health (de Wit et al, 2016).**
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The present study

‘Dementia and Imagination’ was a mixed-methods longitudinal study, exploring the impact of a visual arts program on people living with dementia. The analyses found that across all sites (hospital, community, residential care), scores for the well-being domains of interest, attention, pleasure, self-esteem, negative affect and sadness were significantly better in the art program than the alternative social activity control condition. Proxy-reported quality of life (QoL) significantly improved between baseline and 3-month follow-up, but no improvements in QoL were reported by the participants with dementia. This was contrasted by their qualitative accounts, which described a stimulating experience important for social connectedness, well-being and personal resilience. Communication deteriorated between baseline and follow-up in the hospital setting, but improved in the residential care setting (Windle et al., 2016; Windle, Joling, et al., 2017). We present here the novel social return on investment analysis framework used to explore the economic impact and social value generated by the arts activities.

Design and methods

Dementia and Imagination was a non-randomised mixed methods longitudinal cohort study with all recruited participants offered the intervention. Participants were recruited between May 2014 and May 2015. Assessments were carried out by researchers at baseline, 12 weeks and 6 months using a mixture of qualitative interviews and quantitative measures. The study protocol provides in-depth methodological details (Windle et al., 2016), and findings relating to quality of life, communication and well-being are available elsewhere (Windle, Joling, et al., 2017).

Participants and settings -

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2
3 Research site 1 was comprized of four residential care facilities in the North East of
4 England. Site 2 was two assessment units within a National Health Service (NHS) county
5 hospital in Derbyshire. Here the protocol was modified after the second wave of intervention
6 delivery to also include recruitment from a day care service for people with dementia. Site 3
7 involved three community venues in North Wales (library with a small exhibition area, an
8 arts center with a gallery, an international arts and music venue) with participants recruited to
9 this site through primary and secondary care services. Prior to recruitment, the study
10 calculated that a 95% confidence level with 5% margin of error and a moderate effect size
11 would require n=80. To adjust for attrition, the study sought to over-recruit by at least 25%,
12 resulting in a total required number of 100 participants living with dementia and 100
13 caregivers (Windle et al., 2016; 2017).
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26 Participants living with dementia were included if they had a diagnosis of dementia or
27 evidence of age related memory impairment and were:
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31 • A resident in the chosen care home in Newcastle/Tyne and Wear.
- 32
33 • A resident in the assessment unit/in receipt of services for a minimum of 3 months in
34 Derbyshire.
- 35
36 • Living in the community in rented/private housing or sheltered housing in North
37 Wales.
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42 Participants were excluded if they had a recent or current episode of major mental illness
43 (other than dementia), were at the end of life or terminally ill, had a debilitating illness that
44 would preclude regular attendance, had a severe uncorrected sensory or communication
45 difficulty and were completely unable to communicate verbally through the medium of either
46 English or Welsh.
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3 Professional and family caregivers were recruited between May 2014 and May 2015
4 alongside the recruitment activity for people living with dementia. Participants were included
5 if they were a member of staff in the residential care homes or National Health Service
6 (NHS) facility who had regular contact with the participant living with dementia, or spouse,
7 family member or friend of the participant living with dementia (the primary caregiver).
8
9 Exclusion criteria were recent or current episode of major mental illness, end of life/terminal
10 illness and inability to communicate verbally through the medium of either English or Welsh.
11
12 The caregivers were involved in two ways. The first was to provide proxy data on behalf of
13 the participant with dementia, should they be unable to do so themselves. The second was to
14 provide data on the impact of the program on their own perceptions of the person living with
15 dementia.

16
17 All participant information provided was prepared to be simple, clear and
18 understandable. Bilingual information (Welsh and English) was prepared in Wales.
19
20 Researchers met with potential participants and family or professional caregivers to explain
21 the study. Qualitative and quantitative data were collected concurrently through an interview
22 at baseline prior to starting the 12-week program, and follow up interviews were conducted
23 three months (Time 2) and six months (Time 3) later.

24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 **Ethical approval**

43
44 Ethical approval was granted by the Multi-centre Research Ethics Committee
45 (MREC) for Wales (ref. 13/WA/0365) on February 14, 2014. Each site received approval
46 from their Local Research Ethics Committee (LREC) and for the North Wales and
47 Derbyshire settings, the appropriate NHS Trust Research and Development department.
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The intervention

The intervention program was developed through a theoretical investigation of the contextual factors and mechanisms which shape outcomes (Windle, Gregory, et al., 2017) and builds on identified good practice, such as those offered by national galleries, e.g. Museum of Modern Art, New York; National Gallery of Australia. This work was adapted into the working principles of the intervention and standardized as the guidelines for intervention delivery.

The program comprised two underpinning factors; dynamic and responsive artistic practice, and a provocative and stimulating aesthetic experience. These were implemented through the content of seven key ingredients for excellent practice: 1) artists understanding dementia; 2) developing a safe and supportive physical and psychological environment for an inspirational visual arts viewing and making program; 3) creating a structure for the viewing and making sessions; 4) delivering sessions that enable inspiration, imagination, creativity, enjoyment and celebration; 5) developing social connections; 6) personal development; 7) values, ethics, communication and guiding principles.

The delivery of the program involves participative activities with the emphasis on providing a stimulating, high quality experience for the participants, requiring no prior knowledge or skills. It aims to encourage creativity without overwhelming people with complex instructions, be interesting and challenging and promote learning where possible. It encompasses meaningful engagement to stimulate imagination, play and discussion, not lectures or the generation of factual exchanges reliant on memory for names and dates. It provides some structure, but creates the opportunity for individual expression, fun and celebrations of achievements in a failure free environment.

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3 A lead artist with prior experience and training in art and dementia facilitated each
4 session, supported by a second artist. Generally, the sessions were structured so that the first
5 half was an art viewing activity, focusing on a small number of artworks, followed by art-
6 making, however this was flexible and dependent upon the varying degrees of cognitive
7 impairment presented to the artists. Different materials were provided depending on the art-
8 making task, such as water based paints, pastels, color pencils, collage material, glue, iPad,
9 quick drying modeling clay and print-making supplies.
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18 Up to twelve people attended each intervention group, and eleven groups were
19 delivered in total across the three settings. One group consisted of twelve weekly sessions of
20 two hours. Each care home in site 1 had one visit to a local gallery. No gallery visits were
21 made in site 2 due to restrictions on staff leaving the hospital. Where gallery visits were not
22 possible, the artists brought a small selection of artworks to the participants to facilitate
23 discussions. In site 3, the community libraries had small exhibition areas facilitating art
24 viewing. In the art center, the collection was visited each week. Caregivers and staff were not
25 required to take part in the intervention, although some chose to do so. A post intervention
26 review meeting with the artists indicated the program was delivered according to the core
27 principles, and a practitioners' guide, co-produced with the artists, is freely available
28 (Parkinson *et al.*, 2017).
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41 . **Social Return on Investment**

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44 An evaluative Social Return on Investment Analysis (SROI) was undertaken. SROI
45 analysis involves several steps; establishing scope and involving stakeholders, mapping
46 outcomes, evidencing and valuing outcomes, establishing impact, and calculating the SROI
47 ratio. Each step is explained in detail below.
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52 53 **1) Establishing scope and involving stakeholders**

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3 Stakeholders are the people or **organizations** that are materially affected by an activity.
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5 For the purposes of our analysis people living with dementia, their families and staff
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7 **caregivers** are included as stakeholders (see Table 1). The financial input of state/ partner
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9 **organizations** was included; however, no material outcomes were assumed for this
10
11 stakeholder group. In total, 125 people with dementia and 146 **caregivers** (88 family and 58
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13 staff **caregivers**) were included in the analysis.
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16 For transparency, we describe in Table 1 other groups and **organizations** that were
17
18 considered as stakeholders, but subsequently excluded from the analysis. Boundaries needed
19
20 to be established over what was feasible to measure and include, and exclusion was either on
21
22 the grounds of there being no material impact expected on the group, or their involvement
23
24 was outside of the scope of the evaluation.
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26 27 **2) Mapping outcomes** 28

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30 A theory of change was developed, (see Supplementary Figure 1) which represented how
31
32 the arts activities were expected to bring about change for the key stakeholders. It was
33
34 developed from the findings from the theoretical investigation (Windle, Gregory, et al., 2017)
35
36 and consultation with artists and people with dementia who had previous experience of taking
37
38 part in art groups. Working with stakeholders to identify the impacts of taking part in the
39
40 activities under evaluation is a core component of SROI analysis.
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43 **3) Evidencing outcomes** 44

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46 A mixture of quantitative and qualitative data were collected as part of Dementia and
47
48 Imagination; a full list of measures is available in the study protocol (Windle et al., 2016).
49
50 For the purposes of the SROI analysis, a list of measures were identified that would capture
51
52 changes in the outcomes identified during the mapping outcomes stage. These included
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54 standardized measures and individual items. Table 2 outlines the list of outcomes by
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3 stakeholder group, how changes in the outcomes were measured, and how changes were
4 valued. These included single items (to reflect the topics identified in the initial work with
5 stakeholders) derived from demographic data and the 28-item DEMQOL dementia specific
6 quality of life measure (Smith et al., 2005) with higher values indicating higher quality of
7 life, and questions on their extent of engagement with art.
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14 Family and staff caregivers completed the 31-item DEMQOL-proxy, demographic
15 questions, a self-reported health item, the 19-item Approaches to Dementia questionnaire
16 (Lintern & Woods, 1996), and questions on perception of art activity.
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21 The proxy responses were used when the responses for the person living with dementia
22 were not reported. Specifically, thirty-seven proxy responses were used for the change in the
23 DEMQoL total score between baseline and T3 and the question ‘in the past week have you
24 felt lively’, and forty-four proxy responses were used for the question on increased
25 engagement with art.
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36 **4) Valuing outcomes**

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39 Table 2 presents the associated data for this step of the SROI analysis. Unit prices in UK
40 sterling for the year 2015/16 were applied to the data. Currency conversion rates for 1st
41 January 2016 have been applied to present equivalent \$/€ values
42 (<https://www.xe.com/currencytables/>). Artists were asked to complete diaries to record the
43 materials, time and in-kind contribution (e.g. use of venues for delivering the groups or
44 exhibition space). The associated costs for the artists’ time was not included as this was part
45 of the program costs paid for by the state stakeholder and including it again here would be
46 double counting.
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3 Participants' time input was included in the analysis, with an assumption of 3 hours per
4 session per person with dementia, representing 2 hours of activity, with an extra hour added
5 to account for travelling to and from the sessions and/or getting prepared to attend. Two
6 hours per session per family caregiver were assumed to account for organization and
7 transport tasks, and 0.5 hours per staff caregiver to account for organization tasks (as the
8 sessions were 'on site' no travel time or dead time while people attended sessions was
9 included). These assumptions were derived through initial scoping work by the lead author,
10 who: a) visited a similar arts group elsewhere in the country to discuss organization, and b)
11 met a person living with dementia and their caregiver who had taken part in a similar arts
12 group.

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24 The value of this time input was calculated as £7.20 (\$10.61/ €9.62) per hour for people
25 with dementia, based on the UK National Minimum Wage in 2016, which reflects the
26 assumption that most home care workers are on this minimum wage. Nineteen pounds
27 (\$28/€26) was assumed as the hourly cost of replacing/buying equivalent per hour for family
28 and staff caregivers, the average cost of a home care worker (Curtis & Burns, 2015).

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40 Financial proxies were then applied to the observed outcomes. Choosing proxies is
41 very subjective, and is a challenge of SROI. Financial proxies can be obtained through
42 including additional questions on participants' willingness to pay, however, to minimize
43 participant burden we instead used where possible a databank of social value proxies that
44 have been derived using consistent methodology from sources including national surveys and
45 the UK census. Table 2 presents the sources of the proxies. The primary source of financial
46 proxies was the HACT Social Value Bank (<http://www.hact.org.uk/social-value-bank>). This
47 is a databank of methodologically consistent unit costs for social value indicators. In

1
2
3 economic evaluation it is typical to apply a discount rate to adjust future costs and outcomes
4 to present values. NICE recommends a discount rate of 1.5% for public health interventions
5 (NICE, 2012) as these typically show effects over a long-term time horizon. As dementia is a
6 progressive condition we considered the UK Treasury recommended discount rate of 3.5%
7 for costs and outcomes occurring after one year to be more appropriate for this study.
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16 Results

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18 The average age of the participants living with dementia was 81.4 ($SD=8.5$). Fifty-
19 eight percent ($n=73$) were female, 64% ($n=71$) had a low level of education, 45% ($n=56$)
20 were married and 43% ($n=52$) were widowed. Across sites, the participants attended an
21 average of seven sessions ($SD=3.83$). The family caregivers were older ($M=63.3$, $SD=14.53$)
22 than the professional caregivers ($M=46.5$, $SD=13.93$). Most of the caregivers were female
23 (79%, $n=116$), and 62% ($n=90$) were married.
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33 People living with dementia, their family caregivers and staff caregivers all
34 experienced increased engagement with art, leading to a modest generation of social value
35 (See Supplementary Table 1). Half of staff caregivers reported increased engagement with
36 their local community and 85% reported professional development or improved prestige
37 associated with their work as a result of improved visitor perceptions of the care home. The
38 outcome that led to the most social value was improved well-being for people with dementia,
39 which generated a social value of £373,350 (\$550,318/ €507,009). This was followed by
40 increased feeling of control over their life/ environment, which generated social value of
41 £150,889 (\$222,410/ €204,907); and increased confidence, which generated social value of
42 £109,003 (\$160,670/ €148,026).
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3 The inputs and outcomes for each stakeholder group (Table 2) were transferred on to an
4 impact map adapted from Nicholls et al. (Nicholls, Lawlor, Neitzert, & Goodspeed, 2009),
5 which indicated the scale of material changes for each stakeholder group, and the associated
6 value that was generated (Supplementary Table 1).
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11 **5) Establishing impact**

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14 In SROI analysis the choice of financial proxies, and indeed the stakeholders and
15 outcomes to include, is subjective. To minimize the risk of over claiming benefits,
16 deadweight, displacement, attribution and attrition are included in the analysis. Deadweight is
17 the proportion of change that people would experience over time, regardless of taking part in
18 the study. For people living with dementia this could be a decline in quality of life that would
19 be expected over time. We make this assumption based on observations that health related
20 quality of life in the UK declines for the population as a whole as measured by the EURQoL
21 group (<https://euroqol.org/>).
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34 Displacement is the proportion of change that is being displaced, for example the care
35 homes cancelling or rearranging other activities to make way for the arts groups. Attribution
36 is the proportion of the observed change that is due to taking part in the arts groups, rather
37 than being the outcome from another hobby or activity that the participants were doing. In
38 SROI, attrition refers to the proportion of effects that drop-off after the first year, rather than
39 being the attrition rate of people taking part in the study. Deadweight, displacement,
40 attribution and attrition were measured through questions asked to the participants about their
41 level of activity at baseline, after completing the twelve week art group, and three months
42 later (see Supplementary Table 1).
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53 A series of sensitivity analyses were conducted to address the subjective nature of the
54 financial proxies, which include an assumption of £0 cost for participants' and caregivers'
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3 time, only 50% of observed outcomes materialising, outcomes lasting for 2 years instead of 1
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5 year, and assuming that the financial proxy used for a year of well-being was 75% lower (see
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7 Table 3).
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9 10 **6) Calculating the SROI ratio**

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12 The value of inputs over the 132 art group sessions was £189,498 (\$279,320/ €257,338)
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14 and the value of outputs was £980,717 (\$1,445,577/ €1,331,814), leading to a base case
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16 scenario of £/\$/€5.18 of social value generated for every £/\$/€1 invested in Dementia and
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18 Imagination.
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21 To test the robustness of the results, a range of scenarios are presented in Table 3. When
22
23 we tested a scenario that only 50% of observed outcomes materialized for people with
24
25 dementia the SROI ratio resulted in £/\$/€3.20 of social value for every £/\$/€1 invested.
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27 Assuming that only 50% of outcomes materialized for family and staff caregivers had less of
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29 an impact, with the SROI ratio changing to 4.95:1 and 5.01:1 respectively.
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34 Our base case analysis took a cautious approach and assumed that outcomes lasted for
35
36 one year as the health and well-being of participants with dementia is likely to decrease over
37
38 time. Changing this assumption to outcomes lasting for two years resulted in a higher SROI
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40 ratio of 6.36:1. All tested scenarios resulted in a positive SROI ratio, meaning that for every
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42 £/\$/€1 invested in the arts activities over £/\$/€1 of social value was generated in return.
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46 47 **Discussion**

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49 To our knowledge this is the first study applying Social Return on Investment analysis
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51 to an arts based intervention for people living with dementia. Arts based activities appear to
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53 provide a positive and convincing social return on investment under a range of assumptions.
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3 We found a social value of between £/\$/€3.20 and £/\$/€6.62 for every £/\$/€1 invested
4 in the arts groups, with a base case scenario of 5.18:1. The highest proportion of this social
5 value was generated for the stakeholder group of people living with dementia. The sensitivity
6 analysis scenario of assuming that only 50% of their observed outcomes **materialized** resulted
7 in the lowest SROI ratio (3.20:1). The highest SROI ratio was found in the scenario where the
8 value of time for all stakeholder groups was assumed to be £/\$/€0 (6.62:1); however, we
9 believe this to be a scenario (e.g. a volunteer scenario) where the costs are underestimated
10 due to the economic concept of opportunity cost. Opportunity cost means that when investing
11 time, money or other resources into a particular activity one has to forego investing those
12 resources in another activity. In this evaluation, we assigned a value to participation time
13 because if our stakeholders had not have taken part in the study they could have spent their
14 time on leisure activities, volunteering or on other tasks.
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29 In terms of comparing our findings with previous related studies, two SROI analyses
30 of craft activities for older people found ratios of 3:1 for a **program** of training care home
31 staff in creative activities (MB Associates, 2013), and 8.87:1 for a community craft café in
32 Scotland (Social Value Lab, 2011). Increased independence for people taking part in the arts
33 activities and workforce development for staff **caregivers** were identified as stakeholder
34 outcomes; the Dementia and Imagination study found similar outcomes. The positive findings
35 from our SROI analysis also support findings from the main effectiveness analysis of the
36 study; across all sites, scores for the wellbeing domains of interest, attention, pleasure, self-
37 esteem, negative affect and sadness were significantly better in the arts intervention
38 compared to an alternative activity with no art (Windle, Joling, et al., 2017).
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51 **For people living with advancing dementia who may be unable to provide answers to**
52 **standardised questionnaires, obtaining their thoughts and preferences from a family member**
53 **or professional caregiver through a proxy assessment (as with some of our data collection) is**
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3 a common approach for the evaluation of people with dementia. There is some suggestion
4 that this may at times be prone to some bias, with care-givers under-reporting quality of life
5 compared to the reports from people living with dementia (e.g. Crespo et al., 2012).
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9 However, this was not found in Dementia and Imagination; caregivers reported significant
10 improvements over time in their proxy assessments of quality of life, whereas there was no
11 change over time in quality of life as reported by the people living with dementia (Windle et
12 al., 2017).
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18 The Dementia and Imagination study and the two previous studies we mention above
19 should be viewed in the context of an aging population, of whom 16% have reported
20 experiencing loneliness (O’Luanaigh, et al. (2008). The effects of loneliness and depression
21 are particularly significant. There is a strong association between loneliness and depression
22 with an associated detrimental effect to physical health, affecting blood pressure levels, sleep,
23 the immune system and cognition; the strength of social networks, including arts activities,
24 could be of particular significance in this respect.
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33 Whilst the cost-per-QALY metric is considered the gold standard for economic
34 evaluations of health technologies (Hughes et al., 2016; NICE, 2013), NICE endorses the use
35 of cost-benefit analysis to capture a wider range of health and non-health impacts in public
36 health interventions (NICE, 2012). We feel it useful to think of SROI analysis as a pragmatic
37 form of cost-benefit analysis, appropriate for assessing the social value of initiatives, while
38 taking into account the distinctiveness of specific contexts. However, this is also one of the
39 limitations of both cost-benefit and SROI analyses; being specific to particular contexts
40 restricts the generalizability of results and the ability to make direct comparisons between
41 programs. Consequently, presenting the data used to calculate the ratio in a transparent
42 manner is vital for allowing readers to interpret the rigour and validity of any SROI study.
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3 While the number of studies using SROI analysis is growing, few SROI analyses are
4 currently published in peer-reviewed journals and findings are typically presented as gray
5 literature (reports published on the funders' websites or as commentaries on policy).
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7 Consequently this approach is yet to be fully utilized and established internationally. The
8 quality of available evidence is variable (Banke-Thomas, Madaj, Charles, & van den Broek,
9 2015) and the methodology used has been open to criticism (Fujiwara, 2015), spanning: a) a
10 lack of a normative basis; b) challenges of making interpersonal comparisons about benefit
11 accrual; c) the choice of the number and range of stakeholders may be viewed as subjective;
12 d) the need for transparency to explain how SROI ratios are calculated to avoid concerns over
13 bias; e) statistical methods for inferring causality are problematic in SROI; f) a need for
14 continued work on valuation methods; g) challenges comparing across projects, due to the
15 lack of standardization in SROI methods; and h) the subjective nature of the selection of
16 outcomes and financial proxies.
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31 These criticisms can be summed up as we have argued in our introduction, in the
32 need for: 1) an increasingly standardized SROI methodology and 2) a body of robust
33 published applications of SROI – our paper contributes to this latter goal. Whilst we
34 recognise the limitations of the approach, we have presented the steps outlining how the
35 stakeholders for this analysis were selected, the underlying theory of how the arts activities
36 bring about change (Supplementary Figure 1), comprehensive information on how material
37 changes were identified using quantitative and qualitative measures, and the sources of
38 financial proxies used to value outcomes. In doing so, we hope this paper contributes new
39 insights into this developing area of economic analysis.
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52 **Implications**

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3 Decision-makers are increasingly seeking wider forms of economic evidence
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5 surrounding costs and benefits of activities. This Social Return on Investment analysis of the
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7 Dementia and Imagination art program for people with dementia is useful for service
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9 providers at all levels, from local governments delivering arts programs, to individual care
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11 homes looking at how best to invest their activities budget. The detailed analysis allows
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13 readers to interpret which elements of the activities generated the most social impact, which
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15 has relevance for service providers worldwide.
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20 Given that the annual global economic impact of dementia on society is estimated at
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22 US\$ 604 billion (World Health Organisation, 2017), services worldwide are faced with
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24 incredible challenges regarding the prioritisation of limited budgets to services. This novel
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26 evaluation, underpinned by a theoretical model explaining how arts programs may benefit
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28 people with dementia, demonstrated the positive benefits of arts activities for people with
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30 dementia, their families and staff working with people with dementia, and as such provides
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32 useful information for those planning dementia services.
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3 **List of tables and figures**
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6 Table 1: Stakeholders included and not included in this analysis
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14 Supplementary Figure 1: Conceptual model of how visual arts programs may work
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16 Supplementary Table 1: Impact map calculations for the analysis
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For Peer Review

Table 1: Stakeholders included and not included in this analysis

| Stakeholder | Included/ Excluded? | Reason for including/ excluding | What the stakeholder invested |
|-----------------------------|---|--|--|
| The state | Inputs included, outcomes excluded | The state acted as a funder for the art groups. | The running costs for the groups (excluding research costs) was £103,292 (\$152,252/ €140,271) |
| Partner organizations | Inputs included, outcomes excluded | Partner organizations may have experienced an increase in people seeking information and increased footfall at galleries but this was not measured by the study. | Partner organizations contributed £44,846 (\$66,103/ €60,901) of in-kind contributions e.g. use of venues, promoting and curating exhibitions |
| People living with dementia | Included | People attending the groups were the primary stakeholders of the intervention | Time: 3 hours per session (1 hour travel/ organization, 2 hours group) @ minimum wage of £7.20 (\$10.61/ €9.62) per hour = £19,634 (\$28,941/ €26,663) |
| Family caregivers | Included | It was anticipated that there could be an impact on art engagement, social connectivity and attitudes towards dementia for families following participation of a loved one in the arts groups. | Time: 2 hours of organizational tasks per session attended by a loved one @ £19 (\$28/€26) per hour, the cost of a home care worker = £13,090 (\$19,294/ €17,776) |
| Staff caregivers | Included | It was anticipated that regular contact with participants attending the groups could indirectly lead to increased | Time: 0.5 hours of organizational tasks per person with dementia in their care attending @ £19 (\$28/€26) per hour, |

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|--|-----------------|--|--|
| | | <p>engagement with art and a change in attitude towards people with dementia in the staff working in the hospital and care home settings</p> | <p>the cost of a home care worker = £8,636 (\$12,729/ €11,728)</p> |
| <p>Artists delivering the sessions</p> | <p>Excluded</p> | <p>The artists had experience of working with people with dementia. While their involvement could have led to skill development and greater employment opportunities, it was anticipated that there would be a negligible material impact.</p> | |
| <p>NHS</p> | <p>Excluded</p> | <p>The program was developed with a goal of connecting communities and improving well-being. While it is possible that the benefits could extend to a reduction in participants' health care use, the study did not collect this data. As such, it was not feasible to include the NHS as a stakeholder.</p> | |
| <p>Non-participating residents at care homes/ assessment units</p> | <p>Excluded</p> | <p>It was possible that the program resulted in a more positive environment within participating sites; however, as non-participants did not meet the inclusion criteria of the study or did not consent to take part it was unethical to include</p> | |

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| | | them. | |
| 1 2 3 4 5 6 7 | Participants' wider social networks | Excluded | It was beyond the scope of the project to map participants' wider social networks. |
| 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 | General public residing in the three study settings | Excluded | Public engagement can be a first step in raising awareness but changes in attitudes may require more targeted interventions. A number of engagement/ dissemination activities took place but their impact on the public are not included in this analysis. |

Table 2: Outputs, outcomes and sources of information for indicators and financial proxies

| Stakeholders | Intended/ unintended changes | Outputs | The Outcomes (what changes) | | | | | | |
|-------------------------------------|------------------------------------|--------------------------------------|--|--|---|---|--|--------------------------------|--|
| | | | Indicator- how we measured outcomes | Source | Quantity- how much change was there? | Duration- how long change lasts (years) | Financial Proxy | Value | Financial proxy source for valuing outcomes |
| Who will we have an effect on? | | Summary of activity in numbers | Indicator- how we measured outcomes | Source | Quantity- how much change was there? | Duration- how long change lasts (years) | Financial Proxy | Value | Financial proxy source for valuing outcomes |
| The state/ partner organizations | N/A | 132 D&I sessions delivered | Records of number of sessions delivered | Records of number of sessions delivered | 132 | 1 | Average cost per group (£783/ \$1,154/ €1,063) and average in-kind contribution per group (£340/ \$501/ €462) | £1,123 (\$1,713/ €1,578) | Intervention costs, supplemented by information from weekly diaries completed by the artists describing time and materials used |
| People living with dementia | Increased well-being/ | (36/98) 36.7% experienced an | Change in DEMQoL total score between | Interviews with | 36 | 1 | HEA1603: Good overall | £20,323 (\$29,956/ | HACT Social value bank |

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| | improved mood | increase in wellbeing | baseline and T3 | participants and proxies | | | health age 50+ | €27,599) | |
| | Increased engagement with art | (53/100) 53% reported a maintain or increase in art activities | At baseline, art activities in last 12 months were recorded (visits to museums, galleries). At T3, participants were asked if they had taken part in art activities in the last few weeks | | 53 | 1 | HOB1602: Hobbies age 50+ | £2,424 (\$3,573/ €3,292) | HACT Social value bank |
| | Increased confidence/self-esteem | (17/61) 27.9% reported an increased confidence | Change in DEMQOL Q5 ("In the last week, have you felt confident?" between baseline and T3 | | 17 | 1 | HEA1601: High confidence age 50+ | £12,565 (\$18,521/ €17,063) | HACT Social value bank |
| | Increased feeling of control over | (18/61) 29.5% reported an increased their | Change in DEMQOL Q13 ("In the last week, have you felt that there | | 18 | 1 | HEA1406: Feel in control of life age 50+ | £16,427 (\$24,213/ €22,308) | HACT Social value bank |

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| | their life/ personal environment | feeling of control | have things that you wanted to do but couldn't?") between baseline and T3 | | | | | | |
| | Reduced social isolation/ increased sense of belonging | (6/58) 10.3% reported a decrease in loneliness | Change in responses to the question "Do you feel lonely?" between baseline and T3 | | 6 | 1 | ENV1609: Feel belonging to neighborhood age 50+ | £6,004 (\$8,850/ €8,153) | HACT Social value bank |
| | Increased physical activity | (21/98) 21.4% reported an increase in liveliness | Change in DEMQOL Q10 ("In the last week, have you felt lively?") between baseline and T3 | | 21 | 1 | SPO1607: Frequent mild exercise age 50+ | £5,527 (\$8,147/ €7,506) | HACT Social value bank |
| Families/friend caregivers | Increased engagement with art | (27/54) 50% reported arts activities at T3 | Response to questions about involvement with art outside of work/home at T3 | Interviews with caregivers | 27 | 1 | HOB1602: Hobbies any age | £1,515 (\$2,233/ €2,057) | HACT Social value bank |

| | | | | | | | | | |
|-----------------|---|---|---|----------------------------|----|---|---|--------------------------------|------------------------|
| | Increased social support network | (13/47) 27.7% reported increased social network | Response to T3 question about whether the person has kept in touch with people involved with the art groups | | 13 | 1 | ENV1609: Feel belonging to neighborhood any age | £3,753 (\$5,532/ €5,097) | HACT Social value bank |
| | Change in attitude towards participants | (34/70) 48.6% had an improved attitude towards dementia | Changes in Approaches to Dementia Questionnaire total score between baseline and T3 | | 34 | 1 | EMP1610: General training for the job | £1,567 (\$2,310/ €2,128) | HACT Social value bank |
| Care home staff | Increased engagement with art | (23/29) 79.3% reported arts activities at T3 | Response to questions about involvement with art outside of work/home at T3 | Interviews with caregivers | 23 | 1 | HOB1602: Hobbies any age | £1,515 (\$2,233/ €2,057) | HACT Social value bank |

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| <p>Opportunity for professional development/ increased feeling of prestige</p> | <p>(28/33) 84.8% reported a change in their thinking about working practices OR a positive perception of visitors to the home</p> | <p>Response at T3 to questions about whether they have identified ways of working that they can improve on, and whether there has been a change in the way visitors view their workplace</p> | | <p>28</p> | <p>1</p> | <p>EMP1611: Employment training any age</p> | <p>£807 (\$1,190/ €1,096)</p> | <p>HACT Social value bank</p> |
| <p>Change in attitude towards participants</p> | <p>(18/45) 40% had an improved attitude towards dementia</p> | <p>Changes in ADQ total score between baseline and T3</p> | | <p>18</p> | <p>1</p> | <p>EMP1610: General training for the job</p> | <p>£1,567 (\$2,310/ €2,128)</p> | <p>HACT Social value bank</p> |
| <p>Increased community engagement</p> | <p>(11/20) 55% reported increased social network</p> | <p>Response to T3 question about whether the person has kept in touch with</p> | | <p>11</p> | <p>1</p> | <p>ENV1609: Feel belonging to neighborhood any age</p> | <p>£3,753 (\$5,532/ €5,097)</p> | <p>HACT Social value bank</p> |

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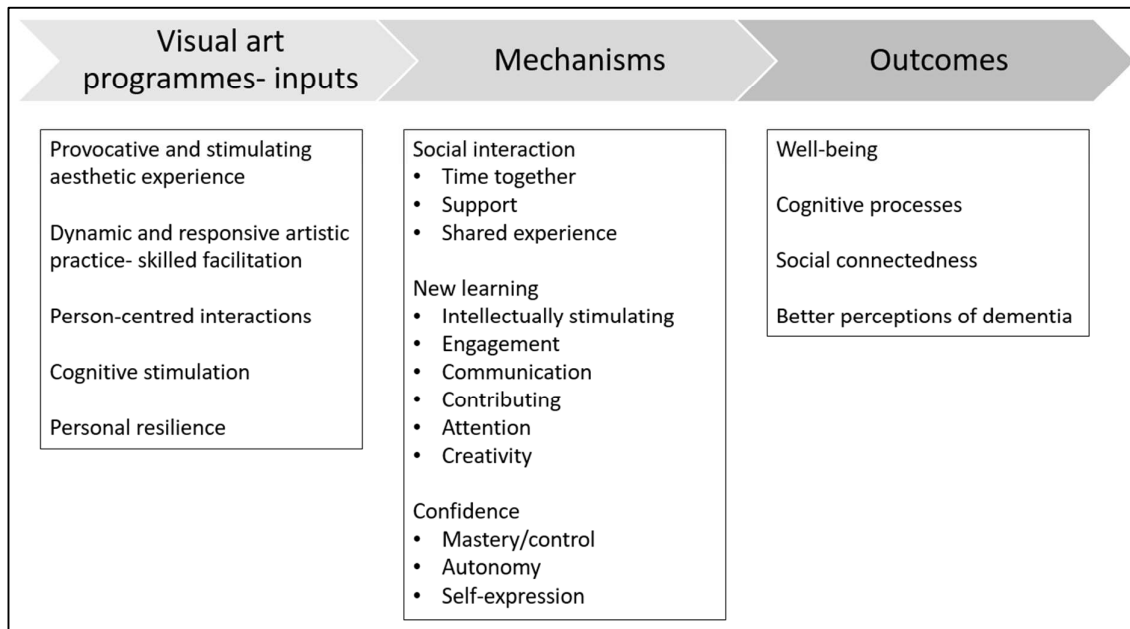
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| | | | people involved with | | | | | | | |
| | | | the art groups | | | | | | | |

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Table 3: SROI analysis results

| Scenario | SROI ratio (£/\$/€) |
|---|--------------------------------------|
| Base case | 5.18: 1 |
| Assuming a £0 value for the time of people with dementia, their families and staff caregivers | 6.62: 1 |
| Assuming only 50% of outcomes materialize for people with dementia | 3.20: 1 |
| Assuming only 50% of outcomes materialize for family caregivers | 4.95: 1 |
| Assuming only 50% of outcomes materialize for staff caregivers | 5.01: 1 |
| Assuming all outcomes last up to 2 years instead of 1 year | 6.36: 1 |
| Assuming the financial proxy for a year of well-being is 75% lower | 3.75: 1 |

Supplementary Figure 1: Conceptual model of how visual arts programs may work, adapted from Windle et al. 2017



Supplementary Table 1: Impact map calculations for the analysis

| Stakeholders | Input | Outcome | Value | Deadweight % | Displacement % | Attribution % | Drop off % | Impact |
|----------------------------------|--------------------------------------|-------------------------------------|-----------------------------------|---|------------------------------|-------------------------------------|---------------------------|---|
| | | | | What would have happened without the program? | What activity was displaced? | Who else contributed to the change? | Drop off in future years? | Quantity times financial proxy, less deadweight, displacement and attribution |
| The state/ partner organizations | £103,292 (\$152,252/ €140,271) | 132 sessions delivered | £783 (\$1,154/ €1,063) | 18% | 20% | 15% | 80% | £57,596 (\$84,897/ €78,215) |
| | £44,846 (\$66,103/ €60,901) | | £340 (\$501/ €462) | 18% | 20% | 15% | 80% | £25,006 (\$36,859/ €33,958) |
| People with dementia | £19,634 (\$28,941/ €26,663) | Increased well-being/ improved mood | £20,323 (\$29,956/ €27,599) | 10% | 30% | 19% | 80% | £373,350 (\$550,318/ €507,009) |
| | | Increased engagement with art | £2,424 | 10% | 30% | 19% | 80% | £65,559 |

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| | | | (\$3,573/ €3,292) | | | | | (\$96,634/ €89,029) |
| | | Increased confidence/ self-esteem | £12,565 (\$18,521/ €17,063) | 10% | 30% | 19% | 80% | £109,003 (\$160,670/ €148,026) |
| | | Increased feeling of control over their life/ personal environment | £16,427 (\$24,213/ €22,308) | 10% | 30% | 19% | 80% | £150,889 (\$222,410/ €204,907) |
| | | Reduced social isolation/ increased sense of belonging | £6,004 (\$8,850/ €8,153) | 10% | 30% | 19% | 80% | £18,383 (\$27,097/ €24,964) |
| | | Increased physical activity | £5,527 (\$8,147/ €7,506) | 10% | 30% | 19% | 80% | £59,229 (\$87,304/ €80,433) |
| Families/friend caregivers | £13,090 (\$19,294/ €17,776) | Increased engagement with art | £1,515 (\$2,233/ €2,057) | 5% | 30% | 5% | 70% | £25,842 (\$38,091/ €35,093) |
| | | Increased social support network | £3,753 (\$5,532/ €5,532) | 5% | 30% | 5% | 70% | £30,822 (\$45,432/ €45,432) |

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|-----------------|--------------------------------------|--|--------------------------------|-----|-----|-----|-----|--|
| | | | €5,097) | | | | | €41,856) |
| | | | £1,567 | | | | | £33,658 |
| | | Change in attitude towards participants | (\$2,310/ €2,128) | 5% | 30% | 5% | 70% | (\$49,612/ €45,708) |
| Care home staff | £8,636 (\$12,729/ €11,728) | Increased engagement with art | £1,515 (\$2,233/ €2,057) | 13% | 30% | 15% | 20% | £18,038 (\$26,558/ €24,496) |
| | | Opportunity for professional development/ increased feeling of prestige | £807 (\$1,190/ €1,096) | 13% | 30% | 15% | 20% | £11,697 (\$17,241/ €15,885) |
| | | Increased community engagement | £3,753 (\$5,532/ €5,097) | 13% | 30% | 15% | 20% | £21,370 (\$31,499/ €29,020) |
| | | Change in attitude towards participants | £1,567 (\$2,310/ €2,128) | 13% | 30% | 15% | 20% | £14,601 (\$21,522/ €19,828) |
| | | | | | | | | |
| Total | £189,498 (\$279,320/ €257,338) | | | | | | | £1,015,042 (\$1,496,172/ €1,378,427) |

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| | £980,717 |
| | (\$1,445,577) |
| Present value of each year (after discounting at 3.5%) | €1,331,814 |
| | £791,220 |
| | (\$1,166,258) |
| Net Present Value (PV minus the investment) | €1,074,477 |
| Social Return on Investment | 5.18:1 |