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Capturing the Invisible Wealth in Nonprofits to Overcome Myopic Perceptions

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Abstract: Since nonprofits use third-party funds for their activities, they are often perceived as resource managers or spending units, instead of being considered as social wealth generating entities. The aim of this study is to help to overcome this myopic perception by showing how the invisible wealth generated by these organizations can be made visible. We use the SROI methodology to do so, by identifying stakeholders, outcomes (tangible, intangible) and social impacts in a drug addiction treatment centre. The results show that social impact in monetary terms exceeds that of the inputs used, confirming the idea that addiction-based nonprofits are social wealth generating units. The conclusion drawn is that social impact measurement should be widely used as a management tool and a mechanism for reinforcing the social image of nonprofits.

Keywords: nonprofits; social impact measurement; social value; SROI

1. Introduction

Currently, it seems accepted that sustainability is more related to the quality of acting with the purpose of generating a positive and significant impact in critical and relevant areas for society and the planet, rather than implementing complementary actions to minimize the negative impacts that leave the actions of organizations [1,2]. This way of understanding sustainability is equally associated with the identification, measurement and disclosure of economic, social and environmental impacts (triple bottom line), but it relies even more on social and environmental issues to measure the total cost of doing business and activities. In this new way of acting, there are traditional organizational models, such as nonprofits, social economy entities and charities, along with new hybrid organizations such as social enterprises [1] that are better placed to go that way due to the primacy of their social mission. Nonprofit, social economy or Third Sector entities are different terms used to designate related concepts [3,4]. All of them are entities that seek to alleviate the deficiencies of the two traditional institutional sectors, private and public, carrying out activities for the development and sustainability of society [5,6]. This means that these organizations not only offset the negative impacts, but also create positive and meaningful impacts. Without them, the individual and collective needs of communities would be impossible to meet, so they play a key role in creating more equitable and prosperous communities. However, much of this role, at both the macro and the micro level, remains undercover and undervalued due to the methodological constraints of impact measurement. Largely, this problem has to do with the difficulty of assessing the impacts associated with intangible social costs.

At the meso- and microeconomic level, failure to consider intangible social costs can cause problems of identity and credibility for nonprofits and charities. Often, what cannot be measured remains unseen; it effectively does not exist and is not appreciated. Many of these organizations thus see how a large part of their efforts (e.g., helping drug-dependent people and their family and social

circle regain quality of life and achieve social reintegration) remain hidden. The fact that they are rendered invisible reinforces the widely-held view of nonprofits as merely administrative entities [7] or simple consumers of resources [8], when they should be seen more as social cost-saving units [9], or even generators of social benefits [10,11]. Along with the abovementioned perception, information asymmetry also plays a role, whereby the providers of financial resources are recognized above other stakeholders (volunteers, professionals, beneficiaries, society as a whole [12]).

Consequently, we believe that this represents a clear challenge facing these organizations: publicly promoting an image of themselves as generators of social wealth, in order to boost their credibility and strengthen their identity. In this regard, the aim of this paper is to help affirm this image of said organizations (specifically those specializing in interventions in drug addiction and other addictive behaviours) by quantifying the social impact they generate. In order to do so, we offer an in-depth examination of SROI (Social Return on Investment) methodology and highlight its applicability for measuring the different social impacts (direct, indirect and intangible) typical of organizations in this field.

SROI is based on a cost-benefit approach that involves the active participation of the stakeholders in the process of identifying the relationships between inputs and outcomes. The method also includes a process for monetizing social impacts, whenever possible, which is a positive feature in terms of the interpretation and comparability of information, primarily from the perspective of a social investor/donor seeking to allocate funds. The SROI relates the public value generated to the input invested. Therefore, this method meets the requirements on 'funding type' and 'task programmability and observability' that, according to [13], can be applicable to the performance measurement of a nonprofit as the one we have analyzed, focused on drug rehabilitation.

Several scholars have argued the contribution to the public value as a leading role advocated by nonprofit organizations, e.g., [14–18]. According to [19] whilst the ultimate value of a private sector firm's operations lies in the profit maximization, the ultimate value of a nonprofit organization should be evaluated by the public value it creates for the community. The value generated by a private firm is usually summarised into an only performance measure: the profit/return. This measure blends all the dimensions of the firm's value chain. Therefore, it would be convenient to show the social value generated by a nonprofit through a measure that integrates the relevant dimensions of its value chain. Hills and Sullivan [20] state that the measurement of social value must take into account the quality of life, well-being, and happiness; the social capital, social cohesion, and social inclusion; the safety and security; the equality, tackling deprivation, and social exclusion; and the promotion of democracy and civic engagement. In this study, we argue that SROI blends these items and can be used as a friendly way to show the social value generated by a nonprofit.

The study focused on analysing the project about toxic addiction carried out by a drug rehabilitation centre.

The treatment and prevention of addiction continues to represent a major global challenge in the 21st century, as this issue is the axis around which some of society's main problems currently revolve. According to the United Nation's World Drug Report [21], a quarter of a billion people between the ages of 15 and 64 used at least one drug in 2014, and over 29 million people who use drugs are estimated to suffer from drug-use disorders. These figures paint a devastating picture of what is left in the wake of these addictions. Not only has the individual (damage to physical and mental health) but also by society as a whole felt the negative effects. It is society that has to bear the social costs associated with premature mortality, lower labour productivity, a greater probability of committing crimes, as well as the suffering of both the user and their family or social circle caused by this substance abuse [22]. In short, we are facing a problem that concerns both the health and the social and economic welfare of society. Studies on the social costs of illegal drugs, alcohol and tobacco, both globally and in the European Union, suggest that these costs are high, consuming a significant share of national GDP [23].

Given the magnitude of the problem, the agent that bears the main responsibility for coordinating and implementing policies and tackling the social costs of drug addiction is the State [24], though

it delegates many activities to organizations in the third sector. These organizations are the main providers of drug treatment programmes, after the public sector [25]. In addition, their closeness to the population makes them better able to detect emerging needs and carry out diagnostic analyses that help reformulate strategies, in order to adapt to the changing reality. Such organizations play a key role in the effectiveness of public policies to tackle drug addiction.

The phenomenon of addiction is a problem that needs to be addressed with both public and private resources. For politicians, it is very useful to have economic information about social costs when designing and evaluating prevention and treatment policies. As such, the study of the macroeconomic impact of addiction, primarily drug use, constitutes a well-established line of research, with numerous studies addressing the issue through the cost-of-illness (COI) methodology [23]. The fundamental goal of COI studies is to evaluate the economic burden that disease imposes on society as a whole [23,24,26–29]. When carrying out COI studies, researchers need to recognize, identify, list, measure and value the costs that a particular disease can generate [30].

In such studies, the associated social costs are classified into three categories: direct, indirect, and intangible. Direct costs include all the resources and services directly attributed to the disease, with a distinction being drawn between health-related costs (e.g., hospitalization and medication) and non-health-related costs (e.g., reintegration into the workforce, judicial procedures). The indirect costs are those related to the loss of production or productive time associated with the presence of a disease. Last but not least, intangible costs refer to non-financial welfare losses such as reduced health-related quality of life due to physical or emotional suffering [24,27,29]. These costs are extremely complex to quantify because they rarely leave documentary evidence; they are “invisible” [11,31]. That is why many studies, for the sake of greater objectivity, outline such costs but exclude them from the calculation and monetization [23,29]. For example, [23] analyse the costs arising from drug addiction examined in 11 studies of European Union countries, and none of them estimates the intangible costs. On the other hand, there are studies, albeit fewer, that incorporate these costs into the analysis, with a careful explanation of the methodology used [24,28].

It is our belief that excluding intangible costs at the macro level is damaging to the nonprofit sector [32] because it renders a substantial part of the social impact they generate invisible. This is an impact that, in our case, can be approximated by the social savings associated with the people involved discontinuing their drug use and regaining their quality of life [11]. Furthermore, information on social impact is shown to be fundamental when it comes to ensuring greater social trust in this sector [33].

The main contribution of this paper lies, first of all, in the fact that the results help show organizations dedicated to supporting drug-dependent persons as social cost savers and generators of social wealth, rather than mere resource managers [7] or organizational units for public expenditure [8]. This helps create a vision of these organizations that underlines their utility to society, their credibility and the legitimacy of their actions. By doing so, our paper contributes to one of the three directions for future research proposed by Lee and Nowell [13]: “the role of other less mainstream conceptualizations of performance measurement (input, public value, etc.) in influencing nonprofit functioning and effectiveness.” Second, this paper applies the SROI methodology to a field—support for drug-dependent persons—which has received scant attention both in the theory and in professional practice. While it is true that SROI is fairly widely used these days, it is not equally widespread in all organizations, nor in all fields. It is mostly used in nonprofits and in social enterprises, specifically, in the field of labour market integration and youth groups [34]. Lastly, unlike most of the SROI analyses conducted, which focus primarily on the individual beneficiary, this paper extends the concept of stakeholders to include family members, volunteers and professionals who provide their services in the centre, in an attempt to more fully capture the social impact.

The rest of the paper is structured as follows. The following section examines the role played by support organizations for drug-dependent persons and Section 3 shows the methodology followed to evaluate the impact, detailing the method used (SROI), the context under analysis (a charity dedicated to treatment for drug dependence), and the outcome variables identified. Section 4 presents the main

results whose discussion has been incorporated in Section 5. Finally, Section 6 outlines the conclusions of the analysis.

2. The Role of Drug Addiction-Based Nonprofits and Charities in Providing Social Services and their Contribution to the Economy

Generally speaking, the mission of organizations dealing with drug dependence is to improve the quality of life and promote the autonomy of people at risk of exclusion, and facilitate their social integration. Through a wide range of activities and therapies (psychological, sports-based, socio-educational, vocational training, etc.), they facilitate the acquisition of general skills, abilities and competencies so that drug-dependent persons can handle their lives constructively and autonomously.

When people decide to check themselves in to a treatment centre to start the drug rehabilitation process, the discontinuation of drug use gives rise to a number of different effects, such as an increase in personal wellbeing associated with the development of skills, abilities and competencies (empowerment, self-control, self-esteem, etc.). This triggers a chain of social cost savings and even creates benefits, since the positive effects outweigh those costs and the cost of providing the services. Table 1 provides a summary of these savings.

Table 1. Estimated savings for society stemming from treatment at a drug rehabilitation centre.

	Costs of Drug Dependence Before	Estimated Savings for Society After
Direct Costs	Consequences to health and welfare systems (Direct Costs) Hospitalization Primary Care Emergency Care Number of HIV/AIDS outpatient care	Resulting from drug-use treatment. In the healthcare sphere: Reduction in hospital admissions, primary care Discontinuation of drug use
	Law enforcement and criminal justice costs	In the criminal justice sphere: Fewer trials Fewer prison sentences
	Other costs (e.g., property destruction, fire loss, fire prevention)	In the public administration sphere: Better resource distribution (fewer resources devoted to repairs and preservation)
Indirect Costs	Productivity costs Premature mortality Lost employment or productivity	In the labour market sphere: Less job insecurity Social and labour market reintegration during the final stages of treatment (improvement in labour productivity) Encouraging active job searches
Intangible Costs	Deterioration of quality of life of both the individual and the family due to the associated physical and emotional suffering	In the personal, family and social sphere: Recovery in terms of mental health and quality of life needed to create improvements in the other spheres

Source: Own elaboration based on [11,23,29,31].

The different types of social costs caused by illegal drug use have been appropriately identified and classified (into direct, indirect and intangible costs) in numerous studies [24,29,31]. While it is certainly true that this classification is not entirely free of the problems associated with identifying and measuring the different cost items, the social cost elements that are presented in Table 1 are generally accepted.

Stopping drug use through the monitoring of a drug treatment programme brings with it numerous savings, since it involves a reduction in, if not an end to, many of these costs. Resources are thus freed up for other social purposes. The main savings include:

1. Savings in the healthcare sphere: drug treatment programmes put a stop to the hospital admissions resulting from drug use (primary care visits, medicines, diagnostic tests . . .), while also entailing a reduction in the demand for drugs from people who benefit from the treatment (in Spain, for example, the hospital cost per person stemming from drug addiction is €399, while primary care visits related to drugs cost an average of €24.24 per visit [29]). This means they have more disposable income to devote to the consumption of other goods that contribute to generating general wealth. Said resources can, in part, be subject to social redistribution through the applicable taxes—something that does not happen with the money spent on illegal drugs, which is retained and hidden by mafias.
2. Savings in the employment sphere: abusive and/or habitual drug use is directly associated with greater job insecurity, repeated absences, sick leave, etc. In response to this, the treatment, mostly in the final phases, puts increased emphasis on the processes of social and labour market reintegration for the people undergoing treatment [11]. In addition, treatment programmes for drug dependence, along with other educational and therapeutic activities, encourage training and active job searches.
3. Savings in the criminal justice field: given the relationship between drug addiction and crime, every day spent in treatment translates to a reduction in crimes that would have gone to trial and even, on occasion, would have resulted in another prison sentence—at least relative to the rate and duration occurring before treatment. The savings in this area are threefold: fewer trials, fewer custodial sentences and the savings resulting from people staying out of prison as they do not commit any further crimes.
4. Savings in intangible costs: the therapeutic support received on being admitted to a specialist organization allows the beneficiaries and their families to initiate processes aimed at breaking the dynamics of pain and suffering in which they are immersed. This provides them with the necessary tools at a personal level (i.e., self-control, self-esteem, etc.) to successfully complete the rehabilitation process and achieve social reintegration. Without these personal achievements, the anticipated savings in the other areas are vulnerable and prevention policies are doomed to fail. Fundamental to the process are health monitoring and professional work, as well as the psychological, socio-educational, sports-based and vocational training therapy carried out by these organizations. Each step forward a person makes in their rehabilitation process translates into improvements in their quality of life, as well as in their personal and family wellbeing, which help prepare them to tackle subsequent stages. These achievements are essential and lie at the heart of these organizations. Therefore, this process of recovery from a deteriorated quality of life, both personal and family, must be made visible qualitatively or quantitatively. From a quantitative point of view, specific measurement instruments have been developed to evaluate drug-dependent persons' perceived quality of life, see [35]: QoL-DA (Quality of Life Scale for Drug Addicts); IDUQoL (Injection Drug User Quality of Life Scale); TECVASP—Test for Evaluating the Quality of Life in Psychoactive Substance Addicts; HRQOLDA Test (Health-Related Quality of Life for Drug Abusers Test, GENCAT Scale. Additionally, also applicable are the measures of quality of life associated with medical pathologies, such as the Quality-Adjusted Life-Year (QALY), which is widely used in Health Economics.

Unlike cost analysis, which has traditionally been approached from a macroeconomic perspective in the literature, this paper aims to estimate savings and impacts from a meso- and microeconomic perspective, given that the range of specific activities provided by the organizations varies widely, as do the achievements. The rest of the study focuses on this analysis of the impact generated.

3. Methodology

This study uses the SROI method to measure the social impacts generated by the operations of a centre dedicated to treating people with drug addiction problems: the Los Granados therapeutic community (LGTC hereafter), in Castellón, Spain. SROI is a method used to account for social value, implemented mainly by charities and nonprofits [34]. One of the characteristics of SROI that sets it apart from other methodologies is that it attempts to monetize the social impact [36], which is a positive feature in terms of interpretation and comparability of information; however, it is an aspect that has not been free of controversy [34]. SROI [37–40] is based on a cost-benefit approach but it incorporates a distinctive feature that represents the cornerstone of the process [41]: the participation of stakeholders in the process of identifying the relationships between inputs and outcomes, and in determining positive impacts. This offers a much more comprehensive picture of the social impact (For a comprehensive picture of the path to follow for the application SROI and the monetization procedure, see [42]).

3.1. Scope, Approach and Identification of Stakeholders

The first step to take when performing an SROI analysis is to explicitly narrow down and delimit what is going to be measured. In our case, SROI is to be used on the LGTC, managed by the NGO PATIM, a nonprofit organization dedicated to the prevention of, counselling and treatment for, and research into addictions and other behaviours. The present study measures the social impact generated by the LGTC in 2015; it is therefore a *retrospective* SROI analysis.

A qualitative methodology was used to collect information, consisting of a series of initial interviews, which subsequently led to the identification of stakeholders in the organization and the main changes perceived. Table 2 shows all the stakeholders identified according to their direct or indirect interest in the programme, indicating those that were eventually excluded from the analysis.

Table 2. Identified stakeholders (included and excluded).

Stakeholders	Description	Criteria for Inclusion	Criteria for Exclusion
Users	People admitted to the service to detox.	People directly linked to the service. Main beneficiaries	
Family Members	Relatives of patients.	Indirect beneficiaries.	Partial deadweight ⁽¹⁾
Volunteers	People who voluntarily work in the service, preparing and running some of the workshops.	They run workshops.	
Professionals	People who work in the centre.	They design and carry out activities and workshops.	Deadweight ⁽²⁾
Public administration	Prison facilities.	Cost savings. ⁽³⁾	
Student interns	People doing an internship in the centre.	They do not affect nor are they affected by the programme itself; they are external to it. They could equally do their compulsory internship in another organization.	
Workers completing a community service order	People performing tasks as an alternative to being sent to prison.	No interaction with the programme itself.	

Source: Own elaboration. (1) Family members stated that they spent between 6 and 8 hours a day caring for the individual, but that they did not need to hire anyone specifically to handle this care, nor did they have to request a reduction in their working hours. (2) The workers of the centre, essential for its operation, could equally provide their professional services in another organization. (3) When some drug-dependent persons commit minor offences, such as robberies, the judge may offer to replace their sentence by admission to a detox centre.

3.2. Outcomes, Measures and Monetary Conversion Factors

The stakeholders selected for inclusion in the analysis reported different changes experienced after treatment at the centre (see Table 3). For example, in the case of users, the main change identified is the improvement in their quality of life as a result of acquiring new, healthier habits, the boost to their self-esteem and self-control, and improvements in social relationships and their health, both physical and psychological. In the case of public administration, due to the type of collaboration between the centre and the judicial system, the impacts take the form of savings in prison costs (the information provided by the programme users did not allow a sufficiently reliable estimation of the savings in healthcare costs—hospitals and outpatient clinics), and so they have been excluded from the analysis); specifically, the costs corresponding to those users who would be in prison if they were not in the community programme.

Table 3 shows the outcomes, the measures and the monetary conversion factors used. Based on this information, in order to quantify the intangible outcomes, different specific questionnaires were administered to the same sample of individuals using an “ex-ante/ex-post observation” approach (as suggested by [43], p. 11).

Table 3. Tangible and intangible outcomes, measures and monetary conversion factors.

Stakeholders	Outcomes	Type	Measures	Monetary Conversion Factor
Users	Improvements in quality of life	Intangible	General quality of life indicator (QLI). GENCAT Scale [44]	QALY cost [45]; QALY lost [46]
	Improvements in emotional wellbeing	Intangible	Emotional wellbeing indicator based on ESE. DAU Study [47]	QALY lost [48]; QALY cost [45]
Family members	Improvements in social relationships	Intangible	Social relationships indicator based on ESE. DAU Study [47]	QALY lost; QALY cost [45]
	Increase in disposable income due to not using drugs	Tangible	Surplus due to non-use	Average individual spending per day on drug use [11]
Family unit	Professional experience	Tangible	Internship	Cost of ECTS credit
Volunteers	Cost savings on prison facilities	Tangible	Days spent in prison [11,49]	Average daily cost of one day in prison ([50], p.137).
Public Administration				

Source: Own elaboration.

(a) Improvements in users’ quality of life

The previous literature considers the reduction in the quality of life for users as well as those closest to them, as a social cost that is both intangible [24,27,29] and invisible [23]. To measure the improvement in users’ quality of life after treatment at the centre, the GENCAT Scale has been used, as it is the most appropriate instrument for assessing the individual quality of life of people with drug dependencies [35].

The GENCAT Scale [44] was developed from the multidimensional model of [51] and it enables a comprehensive evaluation of quality of life [52]. The scale provides valid and reliable scores for

the following dimensions: (1) Emotional wellbeing, (2) Physical wellbeing, (3) Material wellbeing, (4) Self-determination, (5) Personal development, (6) Social inclusion, (7) Interpersonal relationships, and (8) Rights, as well as an overall quality of life index. The questionnaire was administered to a sample of 13 individuals, who described their perceptions before and after treatment at the centre. As they were the same individuals, it was not necessary to use a control sample.

Once quality of life has been measured, the key question is whether it can be valued in monetary units. Studies show that there is a direct relationship between income and wellbeing [53,54]. In addition, literature collects a series of methods that can be used to measure the intangible impacts (some examples can be seen at [38,55–57]). This paper uses the synthetic health indicator, QALY (Quality-Adjusted Life-Year), an outcome measure that is widely accepted in cost-effectiveness studies [48,58–61]. The QALY indicator is a health-related measure of quality of life [62] so its value depends on the pathology or condition under analysis.

In the specific field of drug dependence [63] point to losses per year of dependence and use are 0.113 for cannabis, 0.184 for benzodiazepines and 0.27 for heroin or multiple drugs. [64] show a QALY loss of 0.2 for each year that injecting drug users do not participate in methadone maintenance treatment, and a QALY loss of 0.1 for each year they were in treatment. [65] assign a value of 0.125 QALY to the effect of long-term dependence. Taking all these data into consideration, [46] uses values of 0.1 for cannabis dependence and 0.2 for dependence on cocaine, heroin or methamphetamines. The drug-dependent persons undergoing treatment at the LGTC have a diverse drug-use profile. As such, we decided to take the mean value of the two extremes indicated by [46] that is, a QALY loss of 0.15 caused by drug dependence.

In addition, to compute the cost per QALY, we have chosen the range proposed by [45]. They estimate this cost is between €22,000 and €25,000 (in 2012 euros). We have updated them to 2015 values, resulting in a cost per QALY of between [€20,291–€25,364]. The year-on-year variation in per capita GDP has been taken as the updating coefficient. Table 4 shows the main parameters considered in the monetization process.

(b) Improvement in family members' emotional wellbeing

In order to quantify and monetize family members' emotional and social improvements, an adapted version of the questionnaire for family members from the DAU Foundation study was used [47]. Questions others than those related to outcomes identified by relatives were excluded. The questions come from the European Social Survey (ESE), which uses validated questionnaires on different aspects such as social and personal wellbeing or health. Seven responses were obtained. This questionnaire also addressed two points in time: before and after treatment [11,43].

As with users' quality of life, the monetization of the improvement in family members' emotional wellbeing was based on QALY. [48] estimate the impact of severe emotional disorders on quality of life at 0.17 QALYs. However, the information obtained did not justify classifying the family members' disorder as severe, so, following the correction criteria used by [47], the loss of quality of life suffered was estimated at only a quarter of that value (that is, 0.25×0.17 QALYs = 0.0425 QALYs). For the cost per QALY, the range estimated by [45] for the Spanish National Health Service was again used (Table 4).

(c) Improvement in family members' social relationships

The problem of drug addiction has a negative impact on social relationships, both those of the users themselves and those of the family caregivers [67]. The restoration of social relationships was measured with the information obtained from the questionnaire indicated in Table 3.

The improvement in family members' social relationships has also been monetized on the basis of QALY. To that end, it is assumed that the individual's quality of life is a multidimensional concept and it is necessary to approximate the relative weight of social relationships in said quality. The number of dimensions considered varies according to the authors (see for example [67–69]). The World

Health Organization (see [70]) identifies six distinct dimensions, four of which are related to health (Health-Related Quality of Life: Physical health (HRQoL), Psychological health (HRQoL), Level of independence (HRQoL), Social relationships (HRQoL), Environment and Personal values and beliefs). This last study has been taken as a reference; it does not provide information on the relative weight of each component but taking into account the fact that one of the four health-related dimensions corresponds to social relationships, this dimension has been assigned a weight of 0.25.

Table 4. Method for monetizing the impacts for different stakeholders.

Impact	Monetization Method	Quantity(*)	Quality(**)
Improvement in quality of life (users)	0.15 QALY per year of treatment Cost per QALY: [€20,291–€25,364] Vallejo et al. (2017)	40 ⁽¹⁾	QLI increase: from 83.12 to 115.69 (minimum and maximum index values: 52 and 132)
Improvement in emotional wellbeing (family members)	0.0425 QALY per year of treatment Cost per QALY: [€20,291–€25,364] Vallejo et al. (2017)	40	Average increase in the emotional wellbeing indicator from 0.257 to 0.4 (out of a maximum of 1)
Improvement in social relationships (family members)	0.04625 QALY per year of treatment Cost per QALY: [€20,291–€25,364] Vallejo et al. (2017)	40	Average increase in the social relationships indicator from 0.529 to 0.714 (out of a maximum of 1)
Increase in disposable income (family unit)	Average individual daily expenditure on drug use: €22.64 [11] Marginal propensity to consume 2014: 0.64 [66]	40	Increase in disposable income for one year by freeing up amount spent on drug use.
Professional experience (volunteers)	Cost of an internship credit in an official master's degree in the subject area: €46.20 (official rates)	4 ⁽²⁾	Gain professional experience by directly working with patients, equivalent to 6 ECTS credits ⁽³⁾
Cost savings on prison facilities ⁽⁴⁾	Average daily cost of prison facilities: €65.78 [50]	17 ⁽⁵⁾	Estimated number of days spent in prison: 96 ⁽⁶⁾

(*) Quantity: individuals affected by change. (**) Quality: the extent to which things change for them. Source: Own elaboration. (1) The centre treats 40 people a year. (2) Number of volunteers in the centre every year. (3) 6 ECTS: internship credits of an official master's degree in the subject area. (4) The users' hospital and outpatient costs have been excluded as very little related information is collected and it is not very reliable. (5) PATIM carried out a total of 20 expert assessments in 2015, resulting in 17 admissions to the therapeutic community. (6) At a conservative estimate, it has been considered that admission to the centre is equivalent to serving a weekend detention sentence for one year, which means a total of 96 days.

Furthermore, it should be noted that family members' social relationships were not completely deteriorated prior to the user's admission to the centre, so the QALY needs to be adjusted. The value of the indicator before and after the user's treatment at the centre was 0.529 and 0.714, respectively, showing an improvement in these relationships quantified at 0.185. This weighting is used to assign a monetary value to QALY in the context of the deterioration of family-caregivers' social relationships. In short, this approach entails, indirectly, assigning social relationships 0.04625 QALY (0.25×0.185) (Table 3).

(d) Increase in the family unit's disposable income due to not using drugs

Another identified impact affecting the family unit (users and family members together) is the increase in disposable income as a result of the discontinuation of drug use (Table 3). The money previously spent on drugs, retained by drug trafficking networks, is freed up for other purposes and generates an increase in purchasing power within the family unit [11]. This greater disposable income has a net marginal effect on social wealth. The marginal propensity to consume indicates the proportion of each additional euro saved that is spent on consumption; the benefit to society can thus be monetized.

This impact has therefore been monetized on the basis of the estimated average individual daily expenditure on drug use, calculated at €26.86 (see [11]). The 2014 marginal propensity to consume has been applied [66] (Table 4).

(e) Volunteers' professional development and acquisition of professional experience

The work that volunteers do in the project enables them to acquire a set of abilities, skills and competencies that broaden their range of professional opportunities. This work is equivalent to that carried out in professional internships. Therefore, when monetizing this impact, we use the cost of a master's degree internship credit in the relevant subject area as an indicator (see Table 4).

(f) Savings in judicial costs

Under the Spanish legal system, when people with substance addictions commit minor offences, such as robberies, the judge can impose an alternative sentence whereby offenders are sent to a drug treatment centre (as the LGTC) to undergo a certain treatment programme. Consequently, users admitted to the programme for this reason, in line with the literature, represent a saving that is at least equivalent to the cost of a custodial sentence. Without accounting for the rest of the direct social costs established by the literature, such as police costs, judicial costs or property damage [23,27,29], the savings generated have been calculated on the basis of the average daily cost of a prison inmate [11,49].

The monetary conversion factor was taken from the Council of Europe's SPACE I Report ([50] p. 137) with 2011 data (€65 per person per day) and the CPI was used to update it to 2015 values (€65.78 per person per day, Table 4).

4. Results

4.1. Monetized Impacts

The results suggest that undergoing treatment in the therapeutic community has had a positive impact on people with addiction problems. On average, users' quality of life index increased by 32.07 after undergoing treatment (from 83.62 to 115.69). The minimum and maximum values of the quality of life index are, respectively, 52 and 138. The economic valuation of this improvement, for the 40 individuals who were treated at the LGTC (Table 3) is based on a value of 0.15 QALY per year of treatment, with the cost per QALY lying within the range [€20,291–€25,364]. On the basis of these data, the monetary value of the annual contribution that the LGTC makes to improve the quality of life of its users ranges between €120,000 and €152,000 (Table 5).

Family members have also experienced improvements stemming from the activity carried out in the LGTC. On average, family members' emotional wellbeing improves by 0.143 with the user's treatment (from 0.257 to 0.4), that is, by 14.3%. On the other hand, social relationships go from a value of 0.529 to 0.714 (out of a maximum of 1), which also indicates an improvement. To monetize the improvements in family members' emotional wellbeing and social relationships, the values of 0.0425 QALY and 0.04625 QALY per year of treatment were applied, respectively, with the same cost per QALY and number of individuals mentioned above. The resulting amounts are shown in Table 5.

Table 5. Monetized impacts.

Stakeholders	Impact	Tangible		Intangible		Total	
				Minimum	Maximum	Minimum	Maximum
Users	Improvement in quality of life			121,748.46	152,185.56	121,748.46	152,185.56
Family members	Improvement in emotional wellbeing			34,495.40	43,119.24	34,495.40	43,119.24
Family members	Improvement in social relationships			37,539.11	46,923.88	37,539.11	46,923.88
Family unit	Increase in disposable income due to not using drugs	250,979.84				250,979.84	250,979.84
Volunteers	Professional experience			1,108.80	1,108.80	1,108.80	1,108.80
Public Administration	Cost savings on prison facilities	107,352.96				107,352.96	107,352.96
		358,332.80		194,891.77	243,337.48	553,224.57	601,670.28

Source: Own elaboration.

Table 5 also shows the monetary value of the increase in disposable income in the family unit (€250,979.84), the monetized value of abilities, skills and competencies acquired by volunteers (€1,108.80) and the judicial cost savings brought about by the LGTC (€107,352.96); all these amounts were calculated according to the abovementioned criteria (Table 4).

4.2. SROI Calculation

In order to calculate social return, as well as determining the impacts detailed in the previous section, it is necessary to know the total resources the organization has used to fund the activities that have had an impact. In 2015, PATIM allocated a total of €190,838.10 to the LGTC.

As can be seen in Table 5, the total value of the impacts corresponding to tangible elements is €358,332.80 and the SROI ratio is 1.88; that is, every euro invested in the programme run by the centre generates a tangible return of €1.88 (see Table 6). However, SROI not only takes into account these impacts on tangible elements, but also considers the intangibles. Specifically, the analysis yields an SROI of between €2.9 and €3.15 (see Table 6). This means that for every euro invested in the LGTC, the centre generates a minimum impact of €2.9. In other words, taking into account tangible savings, intangible savings and social benefits, the wealth that the organization gives back to society is conservatively valued at €2.9 for each euro it manages. This is an entity that generates social wealth by managing funds received from different sources (public and private).

Table 6. Calculated returns.

	Tangible		Intangible				SROI			
			Minimum	Maximum	Minimum	Maximum	Minimum	Maximum		
Impacts	358,332.80	1.88	194,891.77	1.02	243,337.48	1.28	553,224.57	2.9	601,670.28	3.15
Inputs	190,838.10		190,838.10		190,838.10		190,838.10		190,838.10	

It should be underlined that the results presented here correspond to one year of activity. Given that the LGTC operates continuously, the social return is ongoing.

5. Discussion

There are several articles that present extensive literature reviews on this topic including peer-reviewed articles and gray literature ranging between 2005 and 2016, but none collect any work specifically related to drug dependence or focused on addiction treatment [43,71]. While this is a recognized limitation, attempts were made to detect any academic work on these issues so far, but without success. There are probably unpublished SROI studies but not in the public domain. Anyway, beyond specific comparisons, in general terms, the results of the present paper are aligned with those achieved by other authors. Our study suggests that addiction-based nonprofits and charities are not only managers of third-party resources [7] but (social) wealth-generating entities as well. While the single case aspect of this study can be considered a constraint for generalizability, literature gives us a bridge to do it by presenting a range of SROI studies reporting positive SROI ratios across healthcare settings (see [43]). Even though they vary over a wide range of values, all of them are positive and support the social wealth-generating approach we propose for nonprofits.

Another field that allows a comparison of the achieved results is the monetization method. We have not used any stated preference method, as [72] do. As [73], we use revealed preference techniques for those outcomes where market values can be determined. This allows us to overcome the subjectivity of the stated preference methods where the stakeholders are directly asked about their perception on monetary value of goods and services.

For the monetization of the quality of life, we have used an approach similar to that used by [74]. These authors quantify the individual's subjective wellbeing through an estimation of the level of life satisfaction. We also use the concept of subjective wellbeing, but we support our monetization approach on QALY, as other authors have done.

Our SROI estimates are cautious, since the underlying assumptions when monetizing the impact on quality of life and disposable income have been conservative. Numerous authors have estimated the cost per QALY. According to [75], it is estimated at €40,000 on the context of work accidents and work-related ill-health. [76] establishes a value of \$116,500 in the field of tobacco-related health problems. [47] estimates the cost at €49,500 in relation to traffic accidents. There is a wide range of values as has already been noted in some studies [77,78], because the QALY value depends on the context of the patients who are taken as a reference. In light of the above, we have considered more appropriate to use a range for the QALY value rather than a single monetary value. We have also monetized both the improvement in the user's quality of life and in family members' emotional wellbeing using the cost per QALY cautious approach suggested by [45]. Moreover, for the monetization of disposable income, we have used also a conservative estimate: the average of the daily expenditure on drug use. The studies carried out indicate that cocaine is the most expensive substance in the market [79] and that the region where the centre under analysis is located (the Valencian Community) reports even higher levels of cocaine use than the region where the estimation was made (Balearic Islands) [80,81].

For reasons of homogeneity and consistency with the health sphere, we used QALY to monetize all indicators related with health recovering, including social relationships. The literature has primarily used the shadow pricing method to monetize social relationships. An interesting study in this respect is that of [55], who estimates the annual monetary value of social relationships in the UK at £85,000 (€108,000). This value is higher than most of the monetary values we have detected in the literature. It does not seem to make sense since the latter estimate takes a comprehensive view of quality of life, in all its dimensions (social relationships is one of them). The inconsistency arises from the use of different monetization methods: shadow pricing in the case of social relationships, and QALY for quality of life and emotional wellbeing. This underlines one of the main challenges in the valuation of intangibles: extreme care should be taken when choosing monetary conversion factors and aggregating the results.

The monetization methods for different impacts must be consistent. Otherwise, the simple aggregation of results is not feasible.

6. Conclusions

Nonprofits, for the primacy of their social mission, have to show the global vision about their activities, so they must calculate and show their social and economic results. Describing and measuring the social impacts that these organizations bring to society is a difficult work and it is a real challenge to have criteria and instruments that make easier this task. Thus far, academics have been slow to adopt SROI methodology in health and social care, and there is little evidence, mainly focused on social and labor integration, the healthcare sector, blood donor associations, functional diversity assistance or emergency shelter for minors. To fill the gap, this study contributes to increase the evidence on the development of the SROI methodology: firstly, by applying the methodology to a new unexplored field, a drug addiction treatment center, and, secondly, by providing a range of concrete measurement tools and widely tested monetary conversion factors to assess the specific impact on the community.

It is easy to appreciate the results and impacts of the action of a nonprofit organization on patients and their families, such as those that help overcome drug addiction, especially when we are the direct beneficiaries. However, it is harder to recognize the full impact that these entities produce indirectly in society as a whole. This study tries to shed light on this subject, since it makes visible the invisible wealth created by nonprofit and hybrid organizations (social enterprises, social economy entities), a key element to understand both their organizational sustainability (we show that they are wealth generating units, not expenditure centers), and its contribution to sustainable development (we show the process of generating positive impacts).

The results obtained show the importance of measures to quantify the social impact generated by socially-beneficial organizations. If, as is standard practice, their results are valued from a purely economic and financial perspective, it may seem that they do not generate enough income to cover their expenses, requiring subsidies and grants to survive. These types of restricted and myopic interpretations tend to paint nonprofit organizations more as consumers or managers of third-party resources than (social) wealth-generating entities.

The calculations for the LGTC have demonstrated the social wealth-generating role of the organizations dedicated to caring for drug-dependent persons. Due to the difficulties in measuring this wealth, it tends to be relegated to the background, or even rendered invisible. For this reason, the use of measures aimed at revealing the social wealth generated is recommended. These measures should come from the organizations themselves, and they must be committed to using information on social impacts for their internal management and decision-making (the feedback provided by participatory evaluation instruments such as SROI is a very rich source of data). However, measures should also come from the public administration, which should incorporate variables that reflect the social impact into its decision models for the allocation of public resources. Failure to do so would mean that it is being managed in a myopic, biased and unsustainable way because the social wealth generated, even if only considered in terms of cost savings, remains undervalued.

The quantification and monetization of intangible outcomes is certainly one of the most widely criticized aspects of impact assessment. We believe that the difficulties involved in identifying objective indicators and standardized monetary conversion factors should not be a pretext for dismissing intangible outcomes altogether. Quite the contrary, it provides an opportunity to examine how to obtain generally-accepted indicators and standardized monetization methods that reinforce the comparability of the information. This study shows, for example, that monetary values of intangibles obtained through different monetization methods should not be aggregated. Therefore, when assigning a monetary value to the impact of intangibles, only standardized values should be aggregated; otherwise, the results will be meaningless and will lack transparency. It is necessary to provide information about criteria, methodologies and calculations in order to allow a proper interpretation of the data and enable decision-making.

The single case aspect of this study can be considered a constraint for generalizability. Outputs, outcomes and key variables will be different for those nonprofits whose activity does not focus on the addiction problems. Nevertheless, the paper demonstrates that the task of a nonprofit contributes to the generation of value for the society. Furthermore, this generation can be appreciated through a measure, the SROI, which integrates all the dimensions of the social value chain. In addition, given that the SROI framework actively involves all stakeholders, it is a framework for continuous learning for all of them, especially patients undergoing treatment, who become protagonists of the story of their own experienced changes.

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References

1. Díaz-Correa, J.E.; López-Navarro, M.A. Managing sustainable hybrid organisations: A case study in the agricultural sector. *Sustainability* **2018**, *10*, 3010. [[CrossRef](#)]
2. Dyllick, T.; Muff, K. Clarifying the meaning of sustainable business: Introducing a typology from business-as-usual to true business sustainability. *Organ. Environ.* **2016**, *29*, 156–174. [[CrossRef](#)]
3. Monzón, J.L. Economía social y conceptos afines: Fronteras borrosas y ambigüedades conceptuales del tercer sector. *CIRIEC-España, Revista de Economía Pública, Social y Cooperativa* **2006**, *56*, 9–24.
4. Chaves, R.; Monzón, J.L. The social economy facing emerging economic concepts: Social innovation, social responsibility, collaborative economy, social enterprises and solidarity economy. *CIRIEC-España, Revista de Economía Pública, Social y Cooperativa* **2018**, *93*, 5–50. [[CrossRef](#)]
5. Monzón-Campos, J.L. Herrero-Montagud, M. Identificación y análisis de las características identitarias de la empresa social europea: Aplicación a la realidad de los Centros Especiales de Empleo de la economía española. *CIRIEC-España, Revista de Economía Pública, Social y Cooperativa* **2016**, *87*, 295–326.
6. Sajardo-Moreno, A.; Chaves-Sajardo, R.J. Responsabilidad social en las empresas de economía social: Un análisis comparativo del tejido productivo de la comunidad valenciana. *REVESCO Rev. Estud. Coop.* **2017**, *125*, 213–242. [[CrossRef](#)]
7. Hudson, M. La gestión de las organizaciones no lucrativas. *Revista Española del Tercer Sector* **2007**, *6*, 153–176.
8. Duquette, N.J. Spend or Save? Nonprofits' use of donations and other revenues. *Nonprofit Volunt. Sect. Q.* **2017**, *46*, 1142–1165. [[CrossRef](#)]
9. Cordes, J. Using cost-benefit analysis and social return on investment to evaluate the impact of social enterprise: Promises, implementation, and limitations. *Eval. Program Plan.* **2017**, *64*, 98–104. [[CrossRef](#)]
10. Cartwright, W.S. Cost-benefit analysis of drug treatment services: Review of the literature. *J. Ment. Health Policy Econ.* **2016**, *3*, 11–26. [[CrossRef](#)]
11. Bonet, X. El Coste Económico y Social del Consumo de Drogas en las Islas Baleares: Análisis de los Costes y Beneficios del Tratamiento de las Personas Drogodependientes. Fundació Nous Vents. Projecte Home Balears. 2013. Available online: <https://www.projectehome.com/upload/568e9e9e4ff77.pdf> (accessed on 16 December 2019).
12. Cabedo, D.; Fuertes, I.; Maset, A.; Tirado, J.M. Improving and measuring transparency in NGOs: A disclosure index for activities and projects. *Nonprofit Manag. Leadersh.* **2018**, *28*, 329–348. [[CrossRef](#)]
13. Lee, C.; Nowell, B. A framework for assessing the performance of nonprofit organizations. *Am. J. Eval.* **2015**, *36*, 299–319. [[CrossRef](#)]
14. Anheier, H.K. What kind of nonprofit sector, what kind of society? Comparative policy reflections. *Am. Behav. Sci.* **2009**, *52*, 1082–1094. [[CrossRef](#)]

15. Frumkin, P. *On Being Nonprofit: A Conceptual and Policy Primer*; Harvard University Press: Cambridge, MA, USA, 2002.
16. Gronbjerg, K.A. Forward. In *The Nature of the Nonprofit Sector*; Ott, J.S., Ed.; Westview: Boulder, CO, USA, 2001.
17. Moulton, S.; Eckerd, A. Preserving the publicness of the nonprofit sector resources, roles, and public values. *Nonprofit Volunt. Sect. Q.* **2012**, *41*, 656–685. [[CrossRef](#)]
18. Salamon, L.M. The resilient sector: The state of nonprofit America. In *The State of Nonprofit America*; Salamon, L., Ed.; Brookings Institution Press: Washington, DC, USA, 2002; pp. 3–63.
19. Moore, M.H. *The Public Value Scorecard: A Rejoinder and an Alternative to Strategic Performance Measurement and Management in Non-Profit Organizations by Robert Kaplan (Hauser Center for Nonprofit Organizations Working Paper)*; Hauser Center for Nonprofit Organizations: Cambridge, MA, USA; Harvard University: Cambridge, MA, USA, 2003.
20. Hills, D.; Sullivan, F. *Measuring Public Value 2: Practical Approach*; The Work Foundation: London, UK, 2006.
21. United Nations Office on Drugs and Crime-UNODC. World Drug Report 2016. Available online: <http://www.unodc.org/wdr2016/> (accessed on 5 June 2019).
22. European Monitoring Centre for Drugs and Drug Addiction—EMCDDA. *European Drug Report 2016: Trends and Developments*; Publications Office of the European Union: Luxembourg, 2016.
23. Barrio, P.; Reynolds, J.; García-Altés, A.; Gual, A.; Anderson, P. Social costs of illegal drugs, alcohol and tobacco in the European Union: A systematic review. *Drug Alcohol Rev.* **2017**, *36*, 578–588. [[CrossRef](#)] [[PubMed](#)]
24. Kopp, P.; Ogrodnik, M. The social cost of drugs in France in 2010. *Eur. J. Health Econ.* **2017**, *18*, 883–892. [[CrossRef](#)]
25. European Monitoring Centre for Drugs and Drug Addiction—EMCDDA. *Spain, Country Report, 2017*; Publications Office of the European Union: Luxembourg, 2017. [[CrossRef](#)]
26. Barragán, A.; Martos, Á.; Simón, M.; Pérez-Fuentes, M.; Molero, M.; Gazquéz, J. Consumo de tabaco y alcohol en adolescentes y relación con la familia. *Eur. J. Child Dev. Educ. Psychopathol.* **2016**, *4*, 49–61. [[CrossRef](#)]
27. Verhaeghe, N.; Lievens, D.; Annemans, L.; Vander Laenen, F.; Putman, K. Methodological considerations in social cost studies of addictive substances: A systematic literature review. *Front. Public Health* **2017**, *4*, 1–7. [[CrossRef](#)]
28. Lievens, D.; Vander Laenen, F.; Verhaeghe, N.; Putman, K.; Pauwels, L.; Hardyns, W.; Annemans, L. Economic consequences of legal and illegal drugs: The case of social costs in Belgium. *Int. J. Drug Policy* **2017**, *44*, 50–57. [[CrossRef](#)]
29. Rivera, B.; Casal, B.; Currais, L. The social cost of illicit drugs use in Spain. *Int. J. Drug Policy* **2017**, *44*, 92–104. [[CrossRef](#)]
30. Jefferson, T.; Demicheli, V.; Mugford, M. *Cost-of-illness Studies, Elementary Economic Evaluation in Health Care*, 2nd ed.; BMJ Publishing Group: London, UK, 2000; pp. 17–29.
31. Single, E.; Collins, D.; Easton, B.; Harwood, H.; Lapsley, H.; Kopp, P.; Wilson, E. *International Guidelines for Estimating the Costs of Substance Abuse*, 2nd ed.; World Health Organization: Geneva, Switzerland, 2003.
32. Maccagnan, A.; Wren-Lewis, S.; Brown, H.; Taylor, T. Wellbeing and society: Towards Quantification of the Co-benefits of Wellbeing. *Soc. Indic. Res.* **2018**, *141*, 217–243. [[CrossRef](#)]
33. Populus. Public Trust and Confidence in Charities, Charity Commission. UK Government. Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/532104/Public_trust_and_confidence_in_charities_2016.pdf (accessed on 3 March 2019).
34. Krlev, G.; Münscher, R.; Mülbart, K. *Social Return on Investment (SROI): State-of-the-Art and Perspectives—A Meta-Analysis of Practice in Social Return on Investment (SROI) Studies Published 2002–2012*; Centre for Social Investment (CSI) of Heidelberg University: Heidelberg, Germany, 2013; Available online: https://www.csi.uniheidelberg.de/downloads/CSI_SROI_Meta_Analysis_2013.pdf (accessed on 16 December 2019).
35. Arias, B.; Gómez, L.; Verdugo, M.A.; Navas, P. Evaluación de la calidad de vida en personas drogodependientes mediante el modelo de Rasch. *Revista Española de Drogodependencia* **2010**, *35*, 206–219.
36. Polonsky, M.J.; Grau, S. Evaluating the social impact of non-profit organizations: A conceptual foundation. *J. Macromarketing* **2008**, *28*, 130–140. [[CrossRef](#)]
37. Arvidson, M.; Lyon, F. Social impact measurement and non-profit organisations: Compliance, resistance and promotion. *Voluntas* **2014**, *25*, 869–886. [[CrossRef](#)]

38. Arvidson, M.; Lyon, F.; McKay, S.; Moro, D. Valuing the social? The nature and controversies of measuring social return on investment (SROI). *Volunt. Sect. Rev.* **2013**, *4*, 3–18. [[CrossRef](#)]
39. Gibbon, J.; Dey, C. Developments in social impact measurement in the third sector: Scaling up or dumbing down? *Soc. Environ. Account. J.* **2011**, *31*, 63–72. [[CrossRef](#)]
40. Lingane, A.; Olsen, S. Guidelines for social return on investment. *Calif. Manag. Rev.* **2004**, *46*, 116–135. [[CrossRef](#)]
41. Gardner, C.; Dermody, A.; Quigley, M. *Impact Measurement: An Introductory Guide for Irish Social Enterprises and Charities on Using LM, Theory of Change and Social Return on Investment to Measure Impact*; Quality Matters: Dublin, Ireland, 2013.
42. Narrillos, H. Economía Social: Valoración y Medición de la Inversión Social. Available online: <https://www.ecobook.com/libros/economia-social-valoracion-y-medicion-de-la-inversion-social-metodo-sroi/9788496877559/> (accessed on 19 December 2019).
43. Banke-Thomas, A.O.; Barbara Madaj, A.C.; Van Den Broek, N. Social Return on Investment (SROI) methodology to account for value for money of public health interventions: A Systematic Review. *BMC Public Health* **2015**, *15*, 1–14. [[CrossRef](#)]
44. Verdugo, M.A.; Arias, B.; Gómez, L.E.; Schallock, R.L. Development of an objective instrument to assess quality of life in social services: Reliability and validity in Spain. *Int. J. Clin. Health Psychol.* **2010**, *10*, 105–123.
45. Vallejo-Torres, L.; García-Lorenzo, B.; Serrano-Aguilar, P. Estimating a cost-effectiveness threshold for the Spanish NHS. *Health Econ. (UK)* **2017**, *27*, 746–761. [[CrossRef](#)]
46. Caulkins, J.P. Effects of prohibition, enforcement and interdiction on drug use. In *Ending the drug wars. Report of the LSE Expert Group on the Economics of Drug Policy*; Collins, J., Ed.; The London School of Economics and Political Science: London, UK, 2014; pp. 16–25.
47. Ecodes: Análisis del Impacto Social y Socioeconómico del SPL Para Personas con Transtorno Mental Grave de la Fundación DAU Durante el Periodo 2010–2014 Mediante la Aplicación de la Metodología SROI (Retorno Social de las Inversiones) Ecodes 2015. Available online: http://ecodes.org/component/option,com_phocadownload/Itemid,2/download,283/id,134/view/category/ (accessed on 16 December 2019).
48. Sabes-Figuera, R.; Knapp, M.; Bendeck, M.; Mompert-Penina, A.; Salvador-Carulla, L. The local burden of emotional disorders. An analysis based on a large health survey in Catalonia (Spain). *Gac. Sanit.* **2012**, *26*, 24–29. [[CrossRef](#)] [[PubMed](#)]
49. McCollister, K.; Yang, X.; Sayed, B.; French, M.T.; Leff, J.A.; Schackman, B.R. Monetary conversion factors for economic evaluations of substance use disorders. *J. Subst. Abuse. Treat.* **2017**, *81*, 25–34. [[CrossRef](#)] [[PubMed](#)]
50. Aebi, M.; Delgrande, N. *Annual Penal Statistics SPACE 1. Survey 2012*; European Council: Brussels, Belgium, 2014; Available online: https://www.coe.int/t/DGHL/STANDARDSETTING/PRISONS/PCCP%20documents%202014/Council-of-Europe_SPACE-I-2012-E_Final_140507.pdf (accessed on 4 October 2018).
51. Schallock, R.L.; Verdugo, M.A. *Handbook on Quality of Life for Human Service Practitioners*; American Association on Mental Retardation: Washington, DC, USA, 2012.
52. Gómez, L.E.; Peña, E.; Arias, B.; Verdugo, M.A. Impact of individual and organizational variables on quality of life. *Soc. Indic. Res.* **2016**, *125*, 649–664. [[CrossRef](#)]
53. Boyce, C.J.; Brown, G.D.A.; Moore, S.C. Money and happiness: Rank of income, not income, affects life satisfaction. *Psychol. Sci.* **2010**, *21*, 471–475. [[CrossRef](#)]
54. Boyce, C.J.; Wood, A.M.; Banks, J.; Clark, A.E.; Brown, G.D.A. Money, well-being, and loss aversion: Does an income loss have a greater effect on well-being than an equivalent income gain? *Psychol. Sci.* **2013**, *24*, 2557–2562. [[CrossRef](#)]
55. Powdthavee, N. Putting a price tag on friends, relatives, and neighbours: Using surveys of life satisfaction to value social relationships. *J. Socio Econ.* **2008**, *37*, 1459–1480. [[CrossRef](#)]
56. Fujiwara, D.; Campbell, R. *Valuation Techniques for Social Cost-Benefit Analysis: Stated Preference, Revealed Preference and Subjective Well-Being Approaches—A Discussion of the Current Issues*; HM Treasury: London, UK, 2011.
57. Antón, E.; Corugedo, A.; Hidalgo-Vega, A.; Sanz, J.F. *Variaciones del Bienestar Individual Relacionadas con la Salud: un Nuevo Modelo de Valoración Monetaria, Documento de Trabajo 753*; Fundación de las Cajas de Ahorro (FUNCAS): Madrid, Spain, 2014. [[CrossRef](#)]
58. Moreno-Ternero, J.D.; Østerdal, L.P. A normative foundation for equity-sensitive health evaluation: The role of relative comparisons of health gains. *J. Public Econ. Theory* **2017**, *19*, 1009–1025. [[CrossRef](#)]

59. Taipale, K.; Winfree, K.B.; Boye, M.; Basson, M.; Sleilaty, G.; Eaton, J.; Chouaid, C. A cost-effectiveness analysis of first-line induction and maintenance treatment sequences in patients with advanced nonsquamous non-small-cell lung cancer in France. *Clin. Outcomes Res.* **2017**, *9*, 505–518. [CrossRef]
60. Karnon, J.; Afzali, H.H.A.; Putro, G.V.A.A.; Thant, P.W.; Dompok, A.; Cox, I.; Cameron, I. A Cost-Effectiveness model for frail older persons: Development and application to a physiotherapy-based intervention. *Appl. Health Econ. Health Policy* **2017**, *15*, 635–645. [CrossRef]
61. Pignata, M.; Chouaid, C.; Le Lay, K.; Luciani, L.; McConnachie, C.; Gordon, J.; Roze, S. Evaluating the cost-effectiveness of afatinib after platinum-based therapy for the treatment of squamous non-small-cell lung cancer in France. *Clin. Outcomes Res.* **2017**, *9*, 655–668. [CrossRef]
62. Whitehead, S.J.; Ali, S. Health outcomes in economic evaluation: The QALY and utilities. *Br. Med Bull.* **2010**, *96*, 5–21. [CrossRef] [PubMed]
63. Mathers, C.; Vos, T.; Stevenson, C. *The Burden of Disease and Injury in Australia, AIHW Cat*; Australian Institute of Health and Welfare: Canberra, Australia, 1999; p. 195.
64. Zaric, G.S.; Barnett, P.G.; Brandeau, M.L. HIV transmission and the cost-effectiveness of methadone maintenance. *Am. J. Public Health* **2000**, *90*, 1100–1111. [PubMed]
65. Pyne, J.M.; Patterson, T.L.; Kaplan, R.M.; Gillin, J.C.; Koch, W.L.; Grant, I. Assessment of the quality of life of patients with major depression. *Psychiatr. Serv.* **1997**, *48*, 224–230. [PubMed]
66. Parra, F.J. Propensión Marginal al Consumo en España. 2016. Available online: <https://rpubs.com/PacoParra/164650> (accessed on 2 February 2019).
67. Marcon, S.; Rubira, E.A.; Espinosa, M.; Barbosa, D.A. Quality of life and depressive symptoms among caregivers and drug dependent people. *Rev. Lat. Am. Enferm.* **2012**, *20*, 167–174. [CrossRef]
68. Akranaviciute, D.; Ruzevicius, J. Quality of life and its components measurement. *Eng. Econ.* **2007**, *52*, 43–48.
69. Urzua, A.; Cortes, K.; Maita, C.; Osorio, K.; Caqueo-Urizar, A. La valoración de la importancia en el autoreporte de la calidad de vida en la adultez. *Revista Médica de Chile* **2013**, *141*, 1010–1018. [CrossRef]
70. European Patients' Academy. Measuring Health-Related Quality of Life (HRQoL). 2016. Available online: <https://www.eupati.eu/health-technology-assessment/measuring-health-related-quality-life-hrqol/> (accessed on 20 October 2019).
71. Solorzano-Garcia, M.; Navio-Marco, J.; Ruiz-Gomez, L.M. Ambiguity in the attribution of social impact: A study of the difficulties of calculating filter coefficients in the SROI method. *Sustainability* **2019**, *11*, 386. [CrossRef]
72. Kousky, C.; Ritchie, L.; Tierney, K.; Lingle, B. Return on investment analysis and its applicability to community disaster preparedness activities: Calculating costs and returns. *Int. J. Disaster Risk Reduct.* **2019**, *41*, 101296. [CrossRef]
73. Lombardo, G.; Mazzocchetti, A.; Rapallo, I.; Tayser, N.; Cincotti, S. Assessment of the economic and social impact using SROI: An application to sport companies. *Sustainability* **2019**, *11*, 3612. [CrossRef]
74. Shi, Y.; Joyce, C.; Wall, R.; Orpana, H.; Bancej, C. A life satisfaction approach to valuing the impact of health behaviours on subjective well-being. *BMC Public Health* **2019**, *19*, 1547. [CrossRef]
75. Davies, N.V.; Teasdale, P. *The Cost to the British Economy of Work Accidents and Work-Related Ill Health*; Health and Safety Executive Books: Sheffield, UK, 1994.
76. United States of America. Department of Health and Human Services. Regulations restricting the sale and distribution of cigarettes and smokeless tobacco to protect children and adolescents. *Federal Register* **1996**, *61*, 44576.
77. Department of Health. *Economic Appraisal of the Health Effects of Air Pollution*; The Stationery Office: London, UK, 1999.
78. Pinto-Prades, J.L.; Loomes, G.; Brey, R. Trying to estimate a monetary value for the QALY. *J. Health Econ.* **2009**, *28*, 553–562. [CrossRef] [PubMed]
79. Observatorio Español de la Droga y las Toxicomanías (OEDT). *Informe 2016. Alcohol, Tabaco y Drogas Ilegales en España*; Ministerio de Sanidad, Servicios Sociales e Igualdad; OEDT: Madrid, Spain, 2017; Available online: http://www.pnsd.mssi.gob.es/profesionales/sistemasInformacion/informesEstadisticas/pdf/2016_INFORME_OEDT.pdf (accessed on 11 November 2017).

80. Observatorio PROYECTO HOMBRE. *2015 Report PROYECTO HOMBRE Observatory on the Profile of People with Addiction Problems under Treatment*; Asociación Proyecto Hombre: Madrid, Spain, 2015; Available online: http://proyectohombre.es/wp-content/uploads/2017/04/PROYECTO-HOMBRE-OBSERVATORY_2015_LOW.pdf (accessed on 12 December 2018).
81. Observatorio PROYECTO HOMBRE. *2016 Report PROYECTO HOMBRE Observatory on the Profile of People with Addiction Problems under Treatment*; Asociación Proyecto Hombre: Madrid, Spain, 2016; Available online: http://proyectohombre.es/wp-content/uploads/2017/10/PH-Observatory_2016.pdf (accessed on 14 January 2019).



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