Safe Harbour Inverclyde – Evaluation

Final Report – March 2024

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1. Introduction and objectives

This project reviewed the service provided by Safe Harbour in Greenock.

Safe Harbour Inverclyde (SHI) is a third sector organisation that has been operating under the Safe Harbour name since 2017, previously known as the Phoenix Community Project which operated from 2007, so have extensive experience of offering support to the local community. They support clients with a range of mental health and wellbeing issues including psycho-sexual issues to depression, child abuse, phobias, anxiety, stress, domestic abuse, PTSD, bereavement, separation anxiety. This is a non-clinical service that offers a unique form of supportive therapy with an aim to improve emotional resilience and wellbeing. The service describes the support they offer as a psycho-social, asset-based model, developed primarily through experiential learning and supplemented by an academic framework.

The service aims to help those most in need in Inverclyde, parts of which experience high levels of deprivation, described in one article as among some of the most deprived in the UK (1). The service recognises the impact deprivation can have on clients and the inequity this can lead to in terms of mental health and wellbeing. They aim to help clients to participate fully in their local community through 1:1 talking therapies, group walk and talk sessions or via telephone support. The intended course for 1:1 therapeutic input is 12 sessions, in keeping with NICE guidance for CBT in trauma experienced or participants with multiple issues (2). The telephone support is an important feature of Safe Harbour as it allows them to offer support to clients and to build attachment and relationship with the service team as part of the process even while they are waiting for their therapeutic sessions to begin.

As a charity, the service has benefited from long term funding from the Big Lottery Fund and continues to be funded via donations and access to funding streams including, more recently, the Community Mental Health & Wellbeing fund (3). Additional funding has allowed the team to consider expanding the services Safe Harbour is able to offer and to consider piloting support service directed at families/loved ones of core service users. This service, Softer Safe Harbour (Harbour Light), is planned to offer themed group sessions rather than the one-to-one sessions and alternatives to the talking therapies that are typically offered in the core service. Safe Harbour are also looking to increase staffing levels which is important to meet the local demand which often exceeds what the current staffing levels can support, resulting in the need for a waiting list.

Safe Harbour currently receives referrals from Primary care but as part of the plans for expansion of the service they are in the process of developing links with Community Link Workers (CLWs) as another potential avenue for referrals. This was felt to be an appropriate new pathway as mental health and wellbeing are among the commonest issues referred to CLWs or addressed as part of their work with clients.

Safe Harbour have been collating data on their service using their own in-house wellbeing measure which is assessed via a survey. This is administered at the beginning of the client's face to face journey and is repeated at the point of exit from the service upon completion of the programme, then a 3 monthly follow-up is also performed. This data collection has facilitated the quantitative evaluation of the service.

It must be acknowledged that Safe Harbour's case load involves varying levels of complexity, including at times disclosures of historic abuse. These complexities are rarely fully disclosed or captured in referrals which results in a need for flexibility in the timeline for involvement, with assessment of individual needs being an essential part of Safe Harbour's person-centred and trauma informed approaches.

Safe Harbour report that the clients they support with higher levels of complexity might have several issues to work through including involvement with police/adult protection. These individuals tend to require more appointments, with a suggested input of 12 sessions but in practise no strict limit. This represents a significant advantage of Safe Harbour's flexibility to respond to individual needs, and they believe this results in trust and relationship development with clients who have struggled to engage with other services. However, this can at times lead to capacity issues and drive additional pressure for members of staff.

This evaluation provides evidence on the effectiveness of Safe Harbour to assist the Inverclyde community's mental health and wellbeing. It also makes recommendations for potential improvements or development of the organisation.

The specific objectives of this evaluation were:

- to use data to better understand the range of issues that Safe Harbour can support and the impact this has on client wellbeing.
- to look at demographic patterns to identify which parts of the community are currently being served and consider if any gaps might be identified.
- review efficiency and processes.
- the qualitative component to this work is intended to gather community feedback on what they would like to see from a service to meet their needs and potentially guide development of Softer Safe Harbour (Harbour Light).
- to identify areas of good practise and potential improvements.

2. Evaluation framework/methodology

An evaluation framework was used based on a logic model developed with SHI at the outset of the project. This was used to assess the effectiveness of the core service against each of its intended outcomes and the overarching goal of the service: 'Providing emotional support to those most in need in our Inverclyde community'.

Appendix 1 contains the logic model which includes the inputs, activities, outputs, outcomes and impact that were the basis of the evaluation framework. This evaluation will focus on the measurement of three main outcomes: improved emotional wellbeing of clients, success in offering emotional support for groups most in need and efficiency/processes.

The emotional wellbeing of clients was assessed by comparing the Safe Harbour emotional resilience score at initial assessment to the Emotional resilience score on completion of the programme. Supporting groups most in need was evaluated by looking at the demographic make-up of SHI clients vs the local epidemiological picture of those most in need. Efficiency was measured based on the amount of input required for each client.

Data was shared following development of a Data Processing agreement and Master Agreement between Safe Harbour Inverclyde and NHS GGC(Appendix 2 – Data Processing agreement, Appendix 3 – Master agreement).

To help develop new interventions, feedback was obtained from potential service users within the community, to discuss what they felt would help improve their own and others within Inverclyde's mental wellbeing. Qualitative feedback was obtained from the following sources: a focus group that included 4 community members, identified by Safe Harbour who have family that used the core services, and 2 further members who were unable to attend in person, but were offered an opportunity to answer the focus group questions in a written format.

The focus group was recorded, transcribed and thematic analysis was performed. Recordings were stored securely by Safe Harbour then shared with the author. The recordings have subsequently been deleted by the author in line with standard retention policies as the data is no longer required. Full transcriptions are stored on a secure NHS, password protected computer that is only accessible to the author. These will also be destroyed 6 months after completion of the evaluation.

Participants were given an information sheet prior to attending to explain the purpose of the focus group and all present in person signed consent forms, those attending virtually gave verbal consent. All participants were informed that they could withdraw from the process at any time. All focus group documents are available in Appendix 4 - Focus group documents.

Participants were aware that this was intended to help shape services offered by Safe Harbour but that responses should also reflect what supports would be helpful for this target group more generally, not constrained by what they might feel Safe Harbour were able to offer.

3. Results

Core Safe Harbour quantitative data trends mapped to objectives:

Before considering the following please note, referrals received from the end of 2019 were impacted by the COVID 19 pandemic as the timings for face-to-face sessions for such clients would have been early 2020. During that time only one member of the therapeutic team was working which led to a reduction in available appointments. Data from this time are also only partially complete as these cases were entered as filed paper notes which have subsequently been input to the relevant data fields by a member of the administrative/management team to align with more recent records which are held digitally.

The main body of the report will highlight key findings from the data, to review more detailed data analysis please see Appendix 5 – Data tables. To interpret the data discussed below 'Completed' refers to clients who were deemed by Safe Harbour to have completed the programme and subsequently had an emotional wellbeing score on exit. 'Partial engagement' refers to clients who engaged with telephone input and for some face-to-face sessions but disengaged before Safe Harbour considered the programme to be complete and therefore no exit evaluation/emotional score were recorded. The final group 'Did not engage' refers to those who may have engaged with some telephone support but did not engage with face-to-face sessions, so there is no recorded emotional wellbeing score for either entry to nor exit from the programme. At times in this report the latter two groups are combined as 'Incomplete'.

To summarise the demographics of Safe Harbour's clients they ranged in age from 16-87 years old with a mean age of 43. There was a ratio of 34:66% Male to Female ratio, although the ratio in the group who completed the programme was higher at 26:74%. 57% of all clients were in SIMD 1 or 2. 100% of participants were White Scottish and 80% identified as heterosexual.

Data were categorised as 'missing' when the demographic in question was not recorded, it is possible this is because the category was not something being collected in client records and due to the use of paper notes as noted above. In relation to relationship status (39% missing), but where data was available the largest group was those identifying as 'Single'. For employment status data was missing for 40% of participants. Where data was available

those who were 'Employed' made up the largest group in those who completed the programme, for those who didn't complete the programme the largest group was 'Unemployed'. For disability status 13% had missing data, 13/77 (18%) of participants identified as having a disability 12 of whom (92%) did not complete the programme. Data for carer status were missing for 14% of the cohort, 8/77 (10%) identified as a carer, 6 (75%) of whom did not complete the programme.

Table 1 Descriptive statistics of all service users, separated into those who completed the programme, partially engaged but did not complete and those who did not engage in face-to-face appointments.

	Completed programme 12/05/2017-29/07/23 n=31	**Partial engagement (06/08/18-06/03/2020) n=26**	**Did not engage (no F2F) 20/09/2018-05/02/2020 n=20**
Age			
Mean (as an integer)	39	47	45
Median	34.5	43	43
Range	16-76	23-87	24-70
Missing data	1 (3%)	1 (4%)	1 (5%)
Sex			
Female	23	17	11
Male	8	9	9
Gender ratio M:F	26:74%	35:65%	45:55%
SIMD			
SIMD 1	15 (48%)	10 (38%)	14 (70%)
SIMD 2	6 (19%)	6 (23%)	3(15%)
SIMD 3	3 (10%)	4 (15%)	2 (10%)
SIMD 4	4 (13%)	4 (15%)	1 (5%)
SIMD 5	2 (6%)	1 (4%)	0
Missing data	1 (3%)	1 (4%)	-
Relationship status			
Married	3 (9%)	3 (11.5%)	4 (20%)
In a relationship	3 (9%)	3 (11.5%)	1 (5%)
Single	16 (52%)	6 (23%)	3 (15%)
Cohabiting	3 (9%)	-	-
Unknown	6 (20%)	14 (54%)	12 (60%)
Employment status			
Employed	10 (32%)	4 (15%)	3 (15%)
Education	2 (6%)	1 (4%)	-
Unknown	8 (26%)	11 (42%)	12 (60%)
Unemployed	8 (26%)	6 (23%)	4 (20%)
Self-employed	3 (10%)	-	0
Retired	0	4 (15%)	1 (5%)
Ethnicity			
White Scottish	100%	100%	100%

Disability status			
Disability declared	1 (3%)	9 (35%)	4 (20%)
No disability declared	22 (71%)	16 (61.5%)	13 (75%)
Unknown	8 (26%)	1 (4%)	1 (5%)
Carer status			
Carer	2 (6%)	5 (19%)	1 (5%)
Not a carer	17 (55%)	20 (77%)	19 (95%)
Unknown	12 (39%)	1 (4%)	-
Sexuality			
Heterosexual	20 (65%)	24 (92%)	18 (90%)
Identifies LGBTQ+	1 (3%)	-	-
Unknown	10 (32%)	2 (8%)	2 (10%)

Whose needs are being met

Age

The general age demographics suggested by the data from all clients is that the majority of Safe Harbour participants are younger to middle aged, with the largest group being those aged 25-44 years old.

Figure 1 Bar chart showing proportional distribution of Age groups for all participants, (age groups mirroring Burden of Disease data)

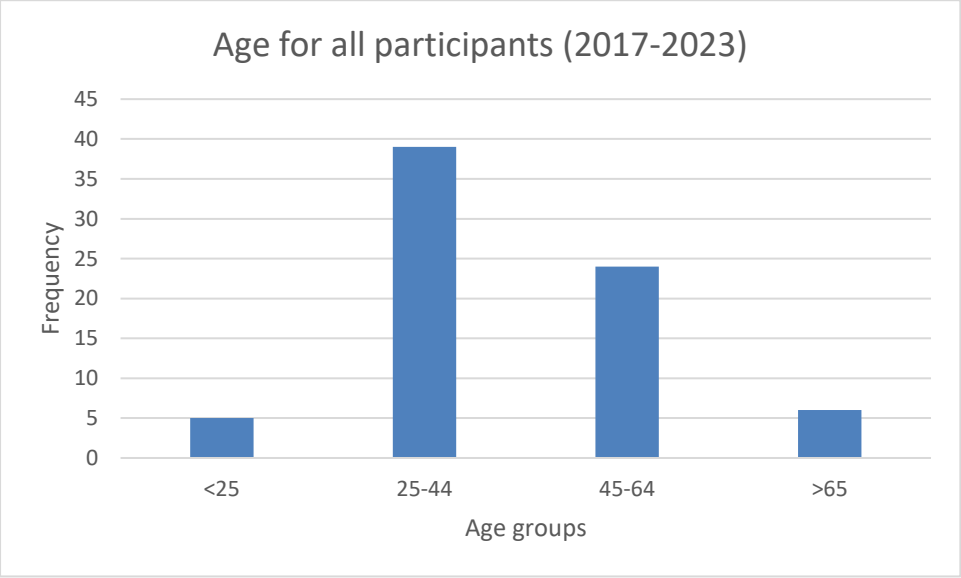


Figure 2 Line graph showing proportional distribution of Age groups for participants who Completed the programme

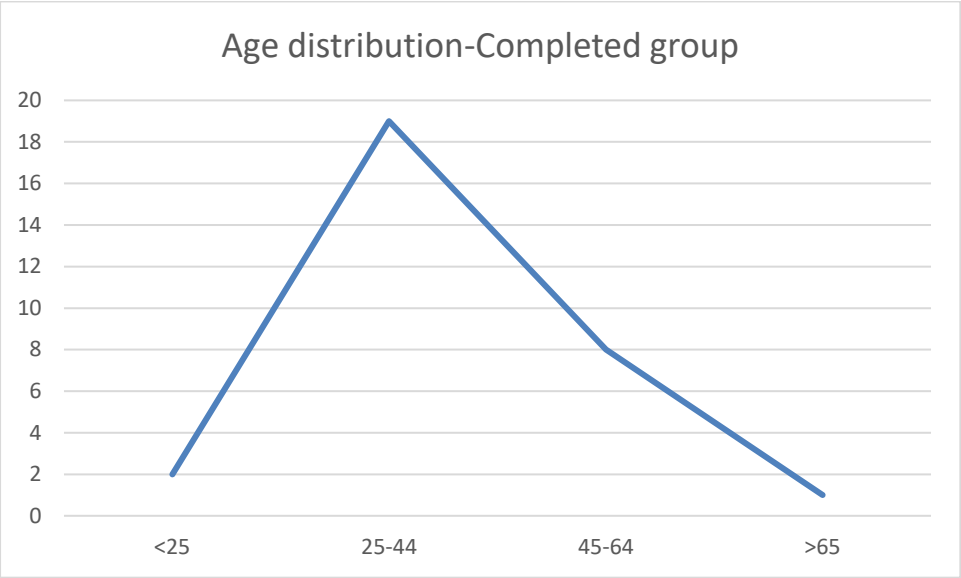
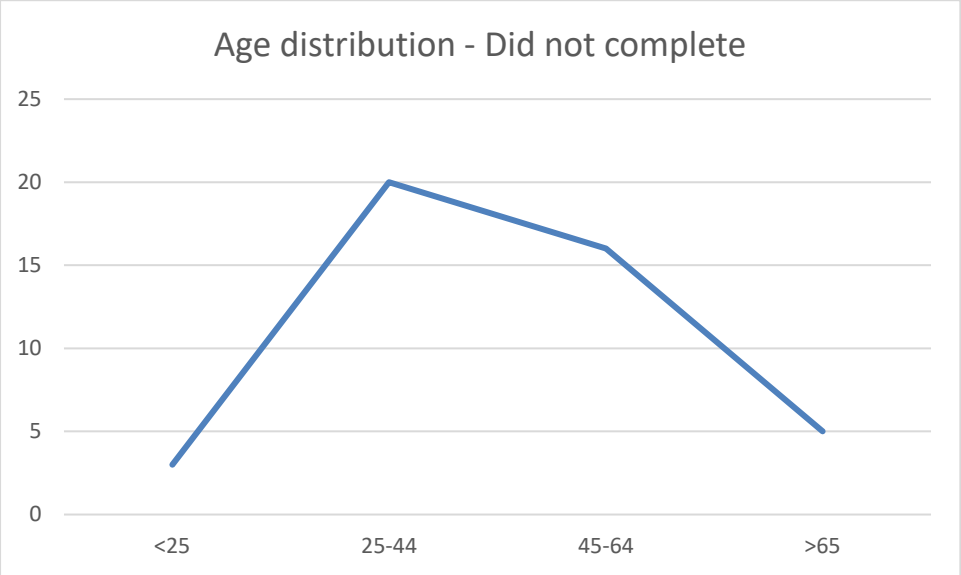


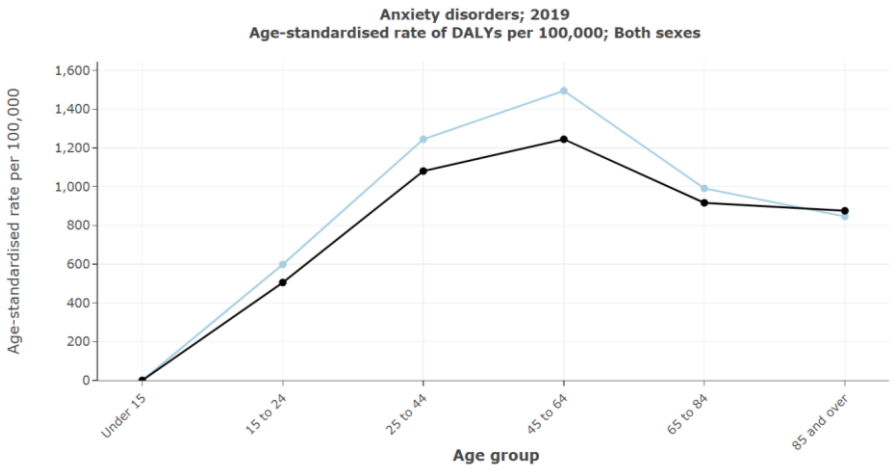
Figure 3 Line graph showing proportional distribution of Age groups for participants who did not complete the programme (Partial & Did not engage groups)



The age distribution for all participants largely mirrors the population demographics seen in Inverclyde and Scotland more generally for age groups experiencing the highest burden of mental health related disorders. The below chart shows the Global Burden of Disease data for anxiety disorders for Inverclyde (pale blue line) vs Scotland (black line). This pattern of a peak in middle age is replicated for depression and schizophrenia. However, the age data for those who completed the Safe Harbour programme has a greater proportion of participants aged 25-44, rather than 45-64 as seen in the local and national data. Safe Harbour clients may tend to be slightly younger than the local and national data indicate is the group with the highest burden, and particularly those who successfully complete the programme

however, as the numbers are so small in the Safe Harbour data it is difficult to draw any firm conclusions about a true difference.

Figure 4 taken from PHS Scottish Burden of Disease data[1].

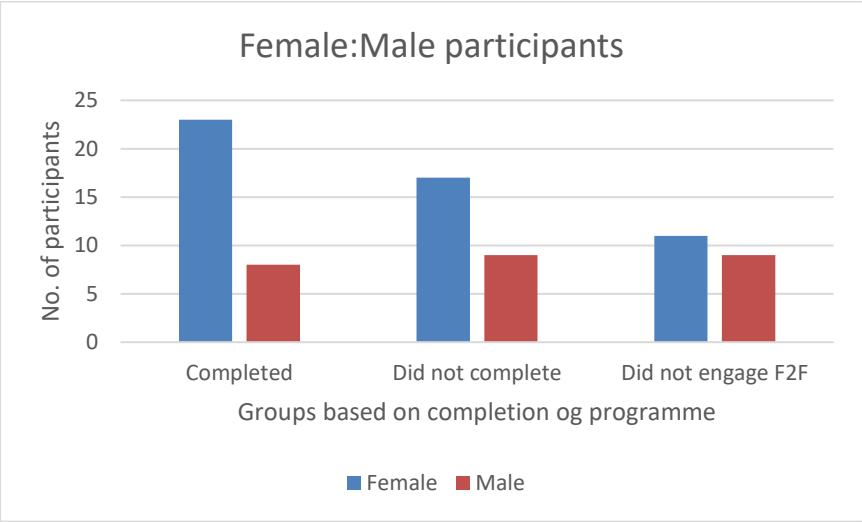


Sex

There was an overall female predominance with 51/77 (66%) of all clients being female with the years 2021-2023 consisting of only female participants. The ratio difference between females:males is most notable in the completed group at 74:26%. Whereas the non-engagement group had a nearly equal division of males to females. When sex is considered as a trend over time the data shows an absence of male clients after 2020. There is a drop off from males being referred to those actually engaging with the service, the reason for this is unclear, but it should be noted that as clients come via GP referrals this represents a potential change in who GPs are referring rather than anything Safe Harbour have directly contributed to.

[1] https://scotland.shinyapps.io/phs-local-trends-scottish-burden-diseases/

Figure 5 Chart to show count of female to male participants between groups



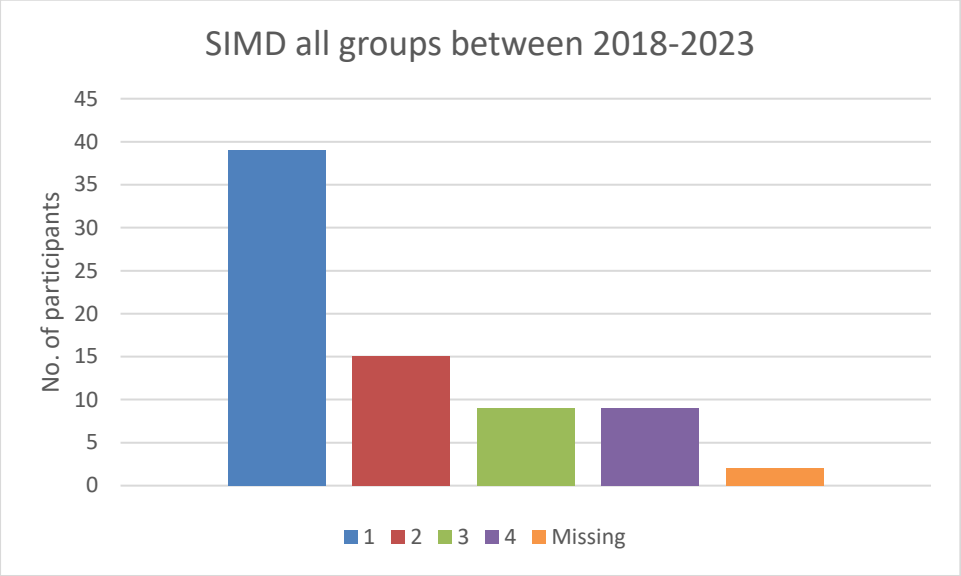
Disability

The disability category had missing data resulting in a large "Unknown", although as 14/77 (18%) participants identified as having a disability it suggests that Safe Harbour was being accessed by a reasonable number of clients from this population. However, it should be noted that there is an evident pattern that a higher proportion of those who did not complete/engage with the programme declared a disability. Test for significance supports evidence for there being a true difference between the groups with a p value <0.05. This relationship was tested with the 'Unknown' group included and excluded and was significant in both scenarios. This test cannot suggest causation but does indicate correlation between identifying as having a disability and not completing the programme. This is something Safe Harbour may wish to explore further to identify potential reasons and mitigations which may support continued engagement.

Deprivation or socioeconomic disadvantage

The majority of participants in the programme were from SIMD 1 or 2. When broken down by group 66% of those in the completed group, 62% of the 'partially engaged' group and 85% in the did not engage group were from SIMD 1 or 2.

Figure 6 Bar chart showing SIMD for all participants (completed, did not complete & did not engage) attending the service.



*data points for SIMD 5 have been suppressed in external reports as n=<5 so could be disclosive.

The chart indicates that overall SIMD1 is the largest group for all participants, the trend over time appears to suggest there may be a shift towards a more affluent client base however this was not statistically significant and the numbers in later years are small, so it is not possible to draw a conclusion about this trend. It remains reassuring that those from SIMDs 1&2 are accessing the service in the greatest frequencies.

In terms of employment status, 18/77 (23%) of all participants were identified as unemployed. When broken down by group 26% of the completed group, 23% of the partially complete and 20% of the did not engage group identified as unemployed. These figures may be higher as this information was unknown for 40% of the group. As unemployment may be considered another source of potential disadvantage, it is encouraging that this group appears to be well represented in the service.

Similarly, 8/77 (10%) of participants identified as carers with 13/77 (17%) participants data unknown. When broken down by groups 6% of the completed group, 19% of the partially completed group and 5% of the did not engage group identified as carers. Although carers appear to be overrepresented in the groups that did not complete the programme there was no evidence of a statistically significant difference between the likelihood of completing the programme if you identified as a carer or not. As carer status may be considered a further source of potential disadvantage, it is good to see reasonable levels of engagement with this group.

Potential gaps

Ethnicity

Safe Harbour clients identified as White Scottish in 100% of cases. This is relatively in keeping with the predominantly White Scottish local demographics, however a recent

Council paper put the estimate for White Scottish at 93.8%, with a further 4% White Other, and the remaining 1.3% made up of Asian or other ethnicities[2]. Although the Inverclyde Mental Health Update report 2019 (4) suggests that Inverclyde is likely to have seen a big change in ethnicity reflecting the Syrian and Afghan refugees who have settled in Inverclyde. It is therefore likely that the proportion of the population who identify as White Scottish will have decreased and that 100% of clients identifying as White Scottish may no longer be as representative of the wider Inverclyde community.

LGBTQ+

The data suggests that only 1% of all participants identified as LGBTQ+. Data suggests that the figure is higher in the Scottish population with 3.1% of Scottish participants identified as gay, lesbian, or bisexual in the Annual Population Survey 2021[3]. It is possible that numbers are lower in smaller cities rather than large urban areas, particularly as there are fewer LGBTQ+ specific services in small towns and cities according to a recent Health Needs assessment (5). It is also difficult to assess the size of the LGBTQ+ population as the national census and other large scale population surveys do not include categories that allow for LGBTQ+ people to identify accurately. A recent HIA by Inverclyde HSCP reported that 0.5% of Inverclyde residents identified as gay or lesbian, it was unable to estimate the population size of the other identities that would make up this group (6).

However, as noted above clients come via GP referrals and so is not something Safe Harbour are able to directly control.

Efficiency

The data suggests that significant telephone support is offered to everyone referred into the service. The mean number of successful phone calls for those who completed the programme was 19.06 (95% CI14.75 to 23.37) and for those who partially engaged was 22.58 (17.79 to 27.36), the overlapping confidence intervals suggest no statistically significant difference between the input for these groups. For unsuccessful phone calls the means appear slightly lower than in the ‘completed’ group, however the confidence intervals overlap once again. The average number of completed appointments was 20 for both mean and median in the ‘completed’ group. Understandably the incomplete group had a lower average and the group that didn’t engage had lower numbers for both measures but still represented a significant amount of effort with an average of 3.3 (0.9 to 5.67) successful and 5.25 (2.01 to 8.49) unsuccessful phone calls per client.

[2] Inverclyde Council. Strategic Needs Assessment 2022 [Internet]. https://www.inverclyde.gov.uk/. 2022 Jul [cited 2024 Jan 19]. Available from: https://www.inverclyde.gov.uk/assets/attach/15284/Inverclyde-SNA2022-FINAL-07-07-22.pdf

3 https://www.scotpho.org.uk/population-groups/sexual-minorities/data/number-in-scotland/

Table 2 data summarising the level of input from Safe Harbour per client for those who Completed the programme

	No. successful telephone calls	Unsuccessful calls	No. completed appointments in programme	No. cancelled appointments in programme	Top ups
Mean	19.06	5.71	20.39	4.43	1.06
Median	18.53	4	20.19	4	1
Range	10 to 35	0-21	10 to 28	0-11	0-6

No data is given for the time commitment this represents for the service, so this cannot be factored in, but based on the increase in emotional resilience score an approximate input cost per 1 point increase in emotional resilience score can be estimated for the 'completed' group. This would equate to 20.39/5.8=3.52 successful face to face appointments for each 1-point increase in emotional resilience. Unfortunately, the impact of the telephone input cannot be measured as the pre-course emotional resilience score is done at the first face to face which is after the completion of the telephone input.

Regression analysis identified no statistical evidence that an increased number of telephone appointments resulted in a bigger increase in resilience scores, although no assessment was performed prior to initiation of calls so it is not possible to gauge if there was an improvement prior to the first face to face engagement.

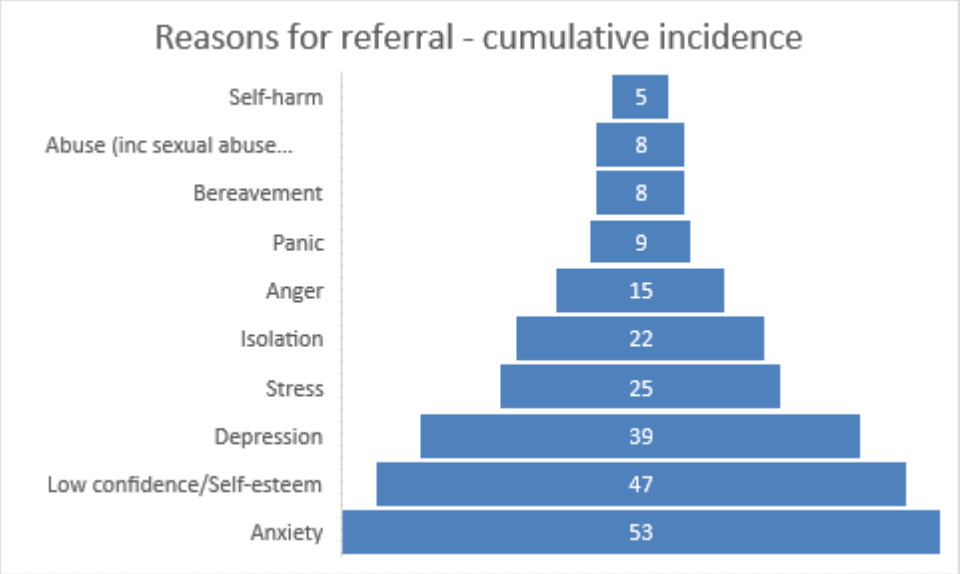
There was evidence to suggest that an increased number of face-to-face appointments did correlate with an increase in emotional resilience scores. However, the sample size is small resulting in quite a lot of uncertainty about how much of an improvement could be expected with increasing amounts of input. Statistical testing indicates that only 15% of the change in the emotional wellbeing scores is explained by the number of face-to-face appointments.

As the average score at the start of the programme is 2.5 and it is only possible to increase the score to a maximum of ten this would support the Safe Harbour suggested service limit of 12 sessions and is likely to achieve an approximately 5-point increase, increasing the number of sessions beyond 18 is unlikely to result in greater improvements in score based on the current evidence.

Common Issues that Safe Harbour supports

The commonest issue for all groups was anxiety, with low self-confidence/self-esteem and depression being in either 2nd or 3rd place in each of the groups, which is broadly reflective of the pattern of how common these issues are in Inverclyde (4) and Scotland more generally (5). Issues that had fewer than 5 referrals included: suicidal ideation, personality disorder, blame, childhood issues, fear, trauma, victim of a crime, relationship issues and guilt. The commonest issues for the entire cohort are shown below, (this graph only shows data where the number of people referred for that issues was >5.

Figure 7 Frequency chart showing commonest reasons for referrals.



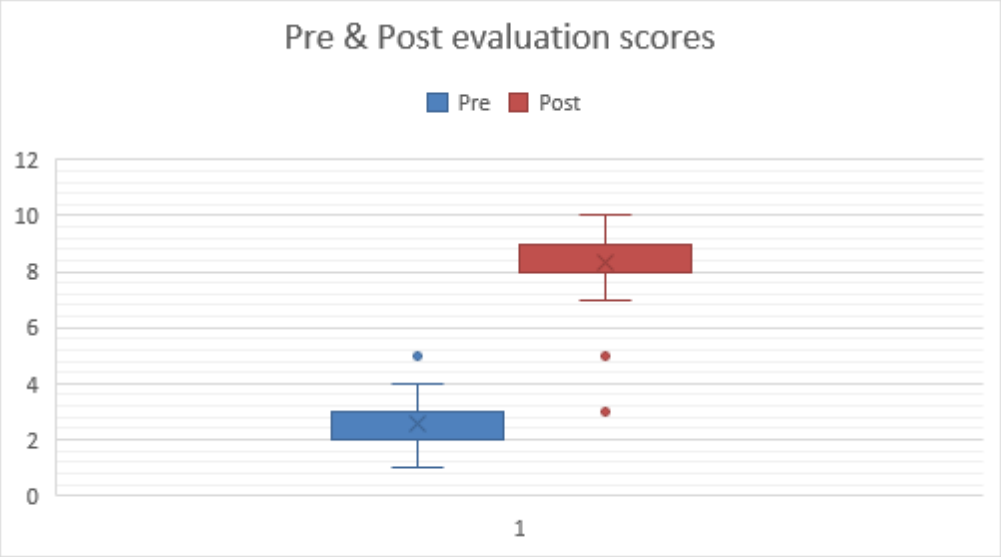
The mean number of issues identified by each client was consistent between those who completed the programme and those who did not with a mean and median of 3 issues for all groups (range 1-7) which represents a significant degree of complexity.

The volume of 'other service use', may also be considered a marker of need/complexity. Although there was a large proportion of clients for whom data was unavailable when these were excluded clients used an average of 2.54 (range 1-7) other services alongside Safe Harbour, which indicates a high level of need and service use.

Impact on client 'Emotional resilience' scores

The impact the service has on wellbeing was measured in the 'Completed group' by comparing the Safe Harbour Emotional resilience scores at the beginning of service use versus on completion of the programme. The average emotional resilience scores improved by 5.8 points upon completion of the programme. This difference was statistically significant at $p<0.0001$, which is strong evidence that participants who completed the programme saw a marked positive increase in their scores and therefore positive benefit in their resilience.

Figure 8 a box and whisker plot showing the mean scores as X, 25th and 75th percentiles are marked by the upper and lower borders of the box and the "whiskers" represent the maximum values calculated as 1.5x Inter Quartile Range.



Focus group/written feedback results:

The thematic analysis focused on three key areas that came up in the discussions around what services would be beneficial for family/friends supporting someone who is struggling with mental health issues. These areas were the types of support they would like, what makes a service user-friendly and concerns they have.

Types of support

Groups:

Most of the discussion in the focus group centred around the need for group sessions, although one member who responded in writing felt they would prefer a 1:1 support to group sessions, although they acknowledged others may prefer group work and they themselves would be open to such things. All participants in the focus group reflected that they would be keen for peer support groups as opposed to needing specific therapeutic offerings. Most agreed the groups should be arranged by Safe Harbour but they did not feel it would necessarily need to be led by a staff member.

They were clear that the role of Safe Harbour would in a moderator role to support the safe management of peer led groups. They would want rules to be set by Safe Harbour not developed by the groups as they felt this would help address concerns such as issues with confidentiality, the need to maintain a safe space, and ensuring respect for others were all embedded.

Tools:

Having 'tools' to manage mental health and wellbeing was an important topic. This included for the participants themselves and their relatives who had been through the core service. Comments around personal development of members in the core group focussed on them being given the tools to help their friend/relative, and that these were to support self-care in the core Safe Harbour client. Participants reflected a lot on building self-efficacy in their relatives and themselves.

A specific ask from a potential service in this regard was around support to ask the right questions. Participants felt Safe Harbour could support them to know what the safe ways to ask questions about mental health are, and how to be supportive of their loved ones. Some reflected on their fears that asking their loved-ones questions might make things worse. The group felt it would be helpful to get advice from both peers and Safe Harbour staff about how to manage these issues and that this would be key part of the service.

Alternative therapies:

One participant mentioned that although they enjoy painting, drawing, dance, exercise and walking in general they would prefer a talking therapeutic service "*talking is more my thing"*.

Out Of Hours support:

The group agreed that ideally there would be an out of hours element to the service. They agreed that this might be a phone or text system to let them know that they weren't alone. They all agreed that mental health concerns in either themselves or the loved ones they were supporting felt worse at nighttime. With one participant reflecting that "*It's always darkest before the dawn"*.

Signposting

During the conversation, it became clear that one member of the group in particular had a wealth of knowledge about council led services while most others were unaware of this. Agreement that it would be beneficial for Safe Harbour to promote other services that may complement theirs e.g. food banks, community cafes, walking groups etc. "*What I'm saying is there's so much support about, but it might also be that people might not feel confident enough to like go to these places and you know, whereas if you get somewhere like Safe Harbour and then you know there's something said within that group…. you would feel safe and secure.."*

What would help make a service more user friendly

When considering timings of groups it was generally agreed that after work was likely to be most convenient for those who work, but the group also reflected that day time may be better for parents of young children and so a choice between different timings on different days would be most helpful.

The group agreed that the key features of a good service were that it should be friendly, welcoming, treat clients with respect, listen and give continuity of care i.e. seeing the same member of staff so that you don't have to "*start again at the beginning and so that each member of staff doesn't only have a little bit of the puzzle*". They all felt these features were present in Safe Harbour.

Spotlighting the unique features of SH that should be maintained.

The most frequently mentioned features were the friendly warm premises and the welcoming staff as well as continuity of input. The group reflected on the feeling of being passed from pillar to post before reaching SH with numerous mentions of their family members or themselves trying GP/other services without success *"I had been through mental health services and I've had counselling therapy, you name it, but nothing worked, but this, it just helped."*

Key issues with other services were having a limit on number of sessions to be offered. This led to a sense of having to either rush through issues within the allotted sessions, or in other cases to be given a diagnosis without any follow up on how to manage this new label. The group felt strongly that this wasn't how their family members were treated at Safe Harbour

and that was reassuring to the group when considering engaging with the service themselves.

Concerns

The group reflected that although Safe Harbour is generous with seeing clients for as long as they need rather than sticking to a strict timeframe there is a balance between waiting lists and number of sessions. The participants generally agreed about this, their suggestion for how these issues could be balanced was to have an increase in staffing.

The group felt that the services/premises would need to grow to accommodate the peer support groups but voiced concerns about Safe Harbour becoming too big or losing the personal touch. They felt strongly that any changes would need to remain friendly, warm & non-clinical.

The group had a strong sense of Duncan Shaw (Chief Executive Officer) being the key member of staff and the main source of therapeutic input. They raised concerns about how sustainable this was if the service was to grow.

4. Ideas for development

Responding to existing demographic data trends

Overall, the service appears to be meeting its objectives of serving those with most need, in terms of deprivation the majority of clients are from SIMD1&2. It may be worth reviewing whether there are opportunities to target other underserved communities identified in the narrative above. As mentioned previously the referrals coming via GPs means that Safe Harbour do not have direct control over the client demographics, however Safe Harbour may consider reaching out to GP practices to discuss the reason behind the shift in referrals to females and how it may be possible to redress the balance in terms of other demographics.

Consideration should be given to how to reach asylum seekers/ refugees as a group and how best to ensure Safe Harbour are able to support those from other ethnicities. There is likely to be a need for interpreters and the use of translated materials as well as a need for increased cultural awareness or understanding. This group is likely to be at a higher risk of having experienced trauma but also represent a group that is less likely to engage with services. The New Scot refugee integration strategy 2018-2022 suggests that offering support in the language spoken by the person seeking help is important. This may require the use of an interpreter which would have associated time requirements and costs. The report also suggests that this groups' needs should be prioritised through shortened waiting times where possible (6). If this is something Safe Harbour are willing to consider we would advise reaching out to organisations with experience of working with these groups, such as the members of the New Scots Core Group[4] which includes the Scottish Refugee Council and British Red Cross among others. However, it must be acknowledged that such support would carry both a financial cost and workload cost and so may not be feasible at this time.

It is encouraging that the service has good levels of engagement with clients who identify as having a disability, however there is an indication from the data that this group is less likely to complete the programme. It would be worth considering undertaking some feedback on what barriers may currently exist to these groups accessing the service from previous service users who fall into this category, or if this is not possible to engage community groups to identify any potential barriers.

In terms of LGBTQ+ engagement, a recent HNA has evidenced that LGBTQ+ people face health inequalities on every measure of wellbeing including mental and emotional health and experience stigma when accessing services (7). Safe Harbour may want to consider ways of increasing inclusion including engagement with the local Inverclyde community to increase visibility and build connections. Although it is also pertinent to note that within the referenced HNA some people spoke about accessing mental health services, but not being out to their mental health practitioners or that it took several sessions before they felt

[4] https://www.gov.scot/groups/refugee-integration-new-scots-core-group/

comfortable to make practitioners aware of this. This may suggest that formal recording of LGBTQ+ status may be inaccurate as it is likely to reflect their demographic information entered at the initial meeting so the accuracy of these data should be considered with caution. It would be advisable to ensure it is widely known that Safe Harbour are a LGBTQ+ friendly service. This may be achieved by attending events and potentially supporting local LGBTQ+ peer support groups which are currently being developed[5] as part of Softer Safe Harbour (Harbour Light).

All of these combined efforts would align with priorities 1 & 3 of Scotland's Mental Health and Wellbeing – Delivery Plan 2023-2025 by identifying ways to reduce stigma and by removing barriers faced by marginalised groups (8).

Softer Safe Harbour (Harbour Light)

At the outset of this project there was an intention to evaluate not only the core Safe Harbour service but also a planned pilot of Softer Safe Harbour (Harbour Light). A number of "taster sessions" were offered to test the potential for alternative therapeutic offerings such as art and music therapy however decisions about who the service would be offered to and risk assessments relating to who would be appropriate for a group session were still in progress. These outstanding decisions combined with service pressures as well as unforeseen events such as flooding made it necessary to shelve the roll out and therefore evaluation of the new service at this time.

However, a logic model and participant surveys were developed in preparation for the pilot of Softer Safe Harbour (Harbour Light) specifically. These materials should help support the team to perform their own evaluation of Softer Safe Harbour (Harbour Light) once data from the first cohort is available.

The advantage of the roll out being delayed is that it will give the service an opportunity to use the feedback obtained from the client focus groups to consider what services should be offered and in which format. In particular it would be good to consider whether peer-support based groups could be facilitated as part of the Safe Harbour offer, this could be supplemented by optional alternative therapy groups as well as expanding the health promoting activities such as the walk and talk groups. Alternatively, they could consider signposting to pre-existing health promoting services that already exist in Inverclyde, as it's important to acknowledge that they don't need to do it all themselves. Instead, they can be the connection to other services. This would align better with the expressed needs of the target group and with the communities and wellbeing fund priority to provide "peer support with and for parents and families" of those with mental health struggles as well as early intervention/health promoting activities (9).

[5] https://www.greenocktelegraph.co.uk/news/23772454.inverclyde-council-helping-establish-lgbtq-support-group/

Ideally the new surveys will be utilised in the planned pilot and results should be reviewed to assess impact before the formal launch of a new service, as this should help shape the service to ensure it's meeting the expressed needs of the community.

Telephone support

This is a unique feature of the service and should be evaluated to show its potential, at present none of the data is able to capture the impact this has on client's wellbeing although anecdotal feedback from the focus group was that this was an invaluable part of the service. A brief survey has been developed with SH to measure pre-intervention emotional resilience scores. These can be compared to scores at the first intervention to identify the impact of the phone support. This may help to guide service decisions about whether service users get significant benefit from phone support in which case resources and appropriate staff mix can be allocated to this part of the service. Although unlikely, if the data does not suggest significant benefit this could help to direct resource use away from phone calls and towards other parts of the service where clear benefit can be shown.

Data collection

As mentioned above, the surveys which were originally developed for the Softer Safe Harbour (Harbour Light) pilot could be used for core Safe Harbour members going forward. The advantages of using the new survey, The Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS)[6] as well as or instead of emotional resilience scores, is it is evidence based and would offer an outcome metric that could be used for comparison with other services. In addition, WEMWBS is used in the Scottish Health Survey and the Greater Glasgow & Clyde health and wellbeing survey and therefore would enable comparisons between SH service user's scores and the general and local population. The telephone, pre and post assessment would identify the impact of telephone appointments. The post assessment survey would align outcome measures with the framework goals, particularly reduction in service use, improved family relations and evidence of excelling/achieving, though these may also be given in qualitative feedback.

Ongoing evaluation

Aligned with the need for data collection is the requirement to plan and perform ongoing evaluation. Throughout the process the evaluator has attempted to be transparent about the method of evaluation and the purpose of measuring certain demographics and outcomes. The need to ensure data is robust and to reduce risk of bias have been emphasised including how best to approach these issues. Upon completion of the evaluation there will be an opportunity to arrange a session on evaluation to ensure Safe Harbour have the tools to perform future reviews. It would be good to consider using the RE-AIM framework and tools to assist with evaluating this[7][8]. It would also be beneficial to

[6] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/
[7] https://re-aim.org/assessing-adoption/
[8] https://transitionnetwork.org/wp-content/uploads/2016/09/Monitoring-and-evaluation-guide.pdf

consider utilising the Scottish Co-production network resources[9] when undertaking any future service developments. These resources could also be used when gathering community feedback about increasing access that was discussed in 'Responding to existing demographic data trends'.

Building communities

The focus group feedback suggested there was a community desire for services to have better connections with other local services. Although Safe Harbour has already been taking positive steps by being part of local mental health networks, and part of the suicide prevention subgroup, it would be good to establish formal connections with other services. This should include signposting to other services or even direct referrals where appropriate. This would align with the priorities of the Communities Mental Health and Wellbeing Fund (9).

Regarding signposting the focus group agreed there might be issues with keeping information about local services up to date. They suggested having a notice board which Safe Harbour would update on a regular basis. Consideration would need to be given to how this would be managed and what the administrative resource would be to maintain this. It should be noted that there is an existing web-based resource in Inverclyde for signposting which Safe Harbour are currently present on[10]. It may be necessary to check how often this resource is updated to reflect up to date information and should be acknowledged that online resources may represent a barrier to those experiencing internet poverty.

Staffing

Increasing numbers of and visibility of other staff members is something the service have identified as part of their plan. Staffing has been identified as a potential risk insofar as there is greater need in the local area than the service can currently meet. Furthermore, although Duncan has become the face of Safe Harbour and represents a trusted community figure it is important to ensure other staff members' roles are promoted to avoid excess reliance on one staff member. It is also important to retain the individual focussed, compassionate approach that he has been delivering that is so widely recognised in the qualitative feedback. Such an approach is in keeping with priority 4 of the Scottish Mental Health & Wellbeing plan whereby the focus is on giving Time, Space and Compassion (8).

Improving processes

Safe Harbour exhibit some good working practices and show a shared ethos of helping the local Inverclyde community and this is evident when meeting all core staff members. There is good recognition of potential risks to the business and ambitious plans to develop the service further. In order to achieve these ambitious plans, it is essential that any documentation or plans includes specific measurable details e.g. number of staff to be

[9] https://www.coproductionscotland.org.uk/resources
[10] https://inverclydelife.com/

recruited and timelines of when things will be implemented. These details are likely to give clarity and accountability that will help to deliver the next steps in these plans.

At present the service relies heavily on story boards, case studies and anecdotal feedback to evidence a number of key features of the service and examples of which are included in Appendix 10 – Safe Harbour Jigsaw model of client experience& Appendix 11 – Case study written up by Safe Harbour. Whilst the voice of lived/ living experience is important in the development, delivery and evaluation of services and these visuals are very compelling, it would be beneficial to have robust processes in place to ensure regular analysis of quantitative data as well.

The SHI team already have excellent support and advice but when reviewing processes around governance, safe-guarding and training requirements in the third sector, they could also consider consulting the Scottish Council for Voluntary Organisations for guidance[11].

[11] https://scvo.scot/

5. Limitations of this evaluation

The main limitation of the evaluation was the inability to evaluate the Softer Safe Harbour (Harbour Light) pilot, as has been outlined in detail above. It was unfortunate as the service is intended to support those with less acute needs or those supporting others who are going through the core service and to alleviate some of the demand on the core service.

In terms of interpreting the impact the service has, the use of Safe Harbour's emotional resilience scores limits this as it is not a validated tool and so it is difficult to know the therapeutic relevance of a 5.8-point improvement in this score. Although the results are highly suggestive of significant improvement, it would be helpful to use a validated measure such as WEMWBs or similar going forward to allow the results to be more fully interpreted and compared to other populations and services.

Demographically the data is relatively representative of the Inverclyde community in terms of age, ethnicity, socio-economic factors and good representation of those with disabilities. The main limitation is in the predominantly female client base which means the results are not likely to be generalisable to the wider population of Inverclyde due to the relative paucity of data from male participants. There were also limitations in the reporting on the data as a number of the variables looked at had very small numbers (<5), which means they would not be reportable due to possibly allowing identification of individuals.

The data for those who had appointments prior to the pandemic were from written copies which were manually entered onto the digital database by a member of the Safe Harbour team. For some categories this may have required some interpretation of the written material to fit with the data fields. This may have introduced reporting bias.

The sample size of the focus group was small, this was in part due to timing and the need to risk assess who would be appropriate to attend, what support would be available if participants were to become upset and who would be available to facilitate introductions. This resulted in a relatively short notice period in which to find appropriate participants.

The participants were also selected by Safe Harbour as it was necessary for them to identify people currently being considered for participation in the Softer Safe Harbour (Harbour Light) programme. This could be considered a source of selection bias. Similarly, the contribution of those who couldn't attend the group but did complete a written form of feedback are likely to be at risk of both selection bias and reporting bias as they may have been concerned about the service seeing their responses and so answered in line with what might be considered socially acceptable.

6. Conclusions

Safe Harbour pride themselves on offering a unique high impact service that puts the individual at the centre. This practise is evidenced by their intensive and flexible approach to client support. The cases they support have experienced a variety of complex issues and

feedback from the focus groups suggest this service is potentially meeting an unmet need that other services have been unable to meet. Due to the intensive nature of this work the service currently has limited data to evaluate their effectiveness, and they acknowledge that the core programme aims for quality of input over quantity. However, Softer Safe Harbour (Harbour Light) may offer the opportunity to better evidence efficiency once implemented.

What is evident is that the service is predominantly supporting those from areas of deprivation to improve their mental health and wellbeing. They can evidence an improvement in emotional wellbeing as measured by the Safe Harbour emotional resilience score. This supports the idea that Safe Harbour work with intention to help improve the lives of those within Inverclyde.

It is unfortunate that it has not been possible to evaluate the Softer Safe Harbour (Harbour Light) programme due to its delay in initiation, however, this could allow for amendments to the service in-line with the community feedback which would be highly beneficial. It would be helpful going forward to use the survey tools provided to streamline the evaluation process as these allow clear mapping to the objectives of the service. Using a validated mental health and well-being measure such as WEMWBs would also offer greater validity to the results of future evaluations.

We have been grateful to the staff at Safe Harbour for their support of this evaluation and are confident that they will use the findings of this report to further improve their service. This is an ambitious charity who have responded well to feedback throughout this process and will hopefully benefit from the insights gained from their data.

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Appendices

The following items are available on request. Please email karen.conduit-turner@nhs.scot to request any of the documents listed below.

Appendix 1 – Logic Model

Logic model core Safe Harbour - final.docx

Appendix 2 – Data Processing agreement

SHI NHSGGC DPA 20231006.docx

Appendix 3 – Master agreement

SHI NHSGGC MA 20231006.docx

Appendix 4 - Focus group documents

Focus Group Consent Form.docx

Focus Group Participant Information sheet.docx

SH focus group script.docx

Appendix 5 – Data tables (Only available for Safe Harbour due to small numbers making clients potentially identifiable)

Data tables.docx

Appendix 6 – Recommended Pre-assessment telephone survey

SSHI Pilot Survey phone-assessment final version.docx

Appendix 7 – Recommended Initial appointment survey

SSHI Pilot Survey pre-assessment - final version.docx

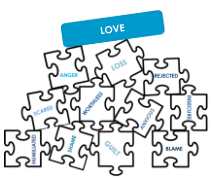
Appendix 8 – Recommended Post-completion survey

SSHI Pilot Survey postcourse-assessment - final version.docx

Appendix 9 – Softer Safe Harbour (Harbour Light) Logic Model

SSH Logic model - final.docx

Appendix 10 – Safe Harbour Jigsaw model of client experience



Appendix 11 – Case study written up by Safe Harbour

Case study written up by Safe Harbour.docx