A Review of Crisis Skylight's Mental Health Services

Nicholas Pleace and Joanne Bretherton
Centre for Housing Policy, University of York

THE UNIVERSITY of York

Crisis

About Crisis UK

Crisis is the national charity for single homeless people. We are dedicated to ending homelessness by delivering life-changing services and campaigning for change.

Our innovative education, employment, housing and well-being services address individual needs and help homeless people to transform their lives.

We are determined campaigners, working to prevent people from becoming homeless and advocating solutions informed by research and our direct experience.

Acknowledgements

The authors are very grateful for the support received from the Crisis Skylights in Birmingham, London, Newcastle and Oxford and to their staff teams in supporting both this specific piece of work and the larger evaluation of the Skylight programme of which this is one part. We would also like to thank the currently and formerly homeless people making use of mental health services within the four Skylights. Within Crisis we would also like to thank Lígia Teixeira and Sheba Qureshi for their help and comments on this report.

The mental health services provided by Crisis Skylights are funded by the Department of Health through a grant from the Third Sector Investment programme.

Nicholas Pleace and Joanne Bretherton
Centre for Housing Policy, University of York.
August 2013.

Disclaimer

This report draws on statistical data which are collected by Crisis. The authors had no input into the collection or validation of these data. The statistical analysis within this report was undertaken by the authors and they are responsible for any errors in that analysis. Views expressed in this report are not necessarily those of Crisis or the University of York.

Crisis head office

66 Commercial Street
London E1 6LT
Tel: 0300 636 1967
Fax: 0300 636 2012
www.crisis.org.uk

ISBN 978-1-899257-88-1

Crisis UK (trading as Crisis). Registered Charity Numbers:
E&W1082947, SC040094. Company Number: 4024938

Contents

Summary ..... **v**
Key findings v
About this report vi
The mental health services in Crisis Skylights vi
The characteristics of service users vi
Service use and outcomes vi
Views on services vii
Conclusions vii
1. Introduction **1**
About this report 1
2. The Mental Health Services in Skylights **3**
Introduction 3
Crisis Skylight 3
The mental health coordinators 4
Objectives of the mental health services 4
Core roles 5
Key findings 7
3. The People Using Skylight Mental Health Services **8**
Introduction 8
Demographics 8
Homelessness 9
Needs and characteristics 11
Personal history 11
Patterns of mental health problems reported by mental health coordinators 12
Employment 13
Key findings 13
4. Patterns of Service Use and Outcomes **14**
Introduction 14
Referral to Skylight 14
Use of mental health services 14
Support plans 14
One-to-one sessions 15
Counselling, drop-ins, workshops and forums 16
Use of other Skylight services by service users with mental health problems 17
Service outcomes 19
Key findings 20
5. Views on Services **21**
Introduction 21
The views expressed in client feedback forms 21
The views of service users who participated in focus groups 22
Overall views of Skylight 22
Support with mental health 24
NHS and social services 24
Support from the mental health coordinators 25

Service limitations 26
The views of mental health coordinators 27
Successes and challenges 27
An innovative service model 27
Ability to engage with homeless people 28
Relationships with other services 29
Issues in service delivery 29
Key findings 30
6. Conclusions 31
Introduction 31
The achievements of mental health services within Skylights 31
The goals of the original proposal to the Department of Health 32
The achievements of Skylight in improving mental health outcomes 33
Challenges 33
Service users with sustained engagement 34
Service users with limited engagement 34
The case for service expansion 35
Key findings 35

List of Figures

Figure 3.1: Age group of service users by gender 9
Figure 3.2: Previous experience of different type of homelessness 9
Figure 3.3: Current housing situation at first contact with a Skylight 10
Figure 3.4: Personal history of service users 11
Figure 4.1: Referrals to Skylight 14
Figure 4.2: Summary of number of one-to-one support sessions received by service users 15
Figure 4.3: The number of times mental health services had been used 16
Figure 4.4: Summary of the other Skylight services used by people who had made at least one use of mental health services 19
Figure 4.5: Positive outcomes achieved by type for people who had made at least one use of mental health services 19
Figure 5.1: Percentage of service users providing feedback who ‘strongly agreed’ with statements about the quality and content of Skylight mental health services 22

Summary

Key findings

Crisis Skylight services are designed to promote the social integration of single homeless people with the goal of transforming their social and economic position. Mental health coordinators, funded by the Department of Health, have been placed in four Crisis Skylight services to enhance service provision for single homeless people with mental health problems.

The mental health coordinators have enhanced access to health and social services, improved access to counselling and also assisted the social integration of single homeless people with mental health problems. The coordinators have also provided significant direct support, in the form of one-to-one support sessions, group based activities and service user forums to provide direct feedback about services.

- Mental health coordinators were improving service provision for single homeless people with mental health problems. The coordinators reported that people who had experienced barriers to mainstream services due to homelessness were using the Skylights and engaging with the services provided and arranged by those coordinators. There was direct evidence from focus groups conducted with service users that access to NHS, social services and other forms of support had been enhanced by the coordinators.

- Service users reported that the coordinators and the wider Skylight services created tolerant, understanding services in which they did not feel stigmatised by their mental health problems or their experiences of homelessness. There was some evidence from the focus groups that service users could get a better understanding of their mental illness through working with coordinators.

- Service users participating in focus groups generally felt listened to, there was also statistical evidence of participation in service user forums.

- There was direct evidence of access to counselling services being provided via the mental health coordinators, combined with the enhancements in access to NHS and social services reported above.

- Partnership working had been extensively developed by the coordinators. These arrangements could work well, although resource issues could sometimes influence the capacity of other agencies to respond.

- There was evidence that the coordinators could directly enhance the well-being of homeless people with mental health problems and also improve their access to counselling and NHS services. The coordinators also facilitated and supported access to the wide range of meaningful activity, education, training and work related programmes offered by the wider Skylight teams of which they were a part.

- There was evidence that working with Skylights had helped people with a history of homelessness and mental health problems into paid work. Ninety people had secured full and part time work as a result of engaging with a Skylight service (14% of service users). Six per cent of service users were in employment at first contact with a Skylight service.

- There is evidence that an innovative and accessible service model has been developed in the provision of mental health coordinators within Skylight teams and a clear case for expansion of the mental health coordinator service model.

About this report

This report has been produced by Centre for Housing Policy at the University of York using a combination of analysis of anonymised administrative and service user feedback data collected by Crisis, and interviews with staff and service users conducted by the University team. The statistics in this report covers the period September 2010 to March 2013, the period covered by the funding received from the Department of Health. The focus groups and staff interviews reported here were conducted in the Summer of 2013. This report has been produced within the framework of a large scale longitudinal evaluation of six Skylight services being conducted by the Centre for Housing Policy.

The mental health services in Crisis Skylights

Crisis Skylight services offer arts-based activity, basic skills education, including accredited courses, combined with opportunities to volunteer, vocational training and support in securing employment and entering further education and training. Research shows that a relatively high proportion of single homeless people have mental health problems or severe mental illness, Crisis wished to provide specific support for those homeless people who wanted to use Skylight services but who might have specific support needs due to poor mental health. Funding was applied for from the Department of Health to support mental health services within the wider Crisis Skylight teams in Birmingham, London, Newcastle and Oxford. Mental health services were then provided in the form of mental health coordinators.

Mental health coordinators within each of the four Skylights have a clear role. Each directly provides low level support through group based activities and one-to-one sessions, facilitates access to NHS and other forms of support and also works as an integral part of the wider Skylight team. In addition, each mental health coordinator runs a forum in the form of a meeting which enables service users to provide direct feedback about the services they are receiving.

The characteristics of service users

The four Skylights were engaging with large numbers of homeless people and potentially homeless people with mental health problems and severe mental illness. Six-hundred and eighty five individuals made at least one use of a Skylight mental health service during the period September 2010 to March 2013. This included people with high needs who were not using the NHS or social services at the point of first contact. There was some evidence of attrition after only low-level contact with Skylight mental health services, but also of sustained and successful engagement with a large number of service users both in terms of mental health services and also the other services, courses and activities provided by the four Skylights. Administrative data collected by Crisis, which were anonymised and shared with the University for the purposes of this report, showed that the majority of people who had made at least one use of mental health services provided within Skylights were male (64%) and White European. Most service users were aged between 24-54. Fifty-three per cent of service users reported a history of mental health problems. Previous research indicates that some under-reporting of mental health problems among service users was a distinct possibility.

Service use and outcomes

Most referrals to the mental health coordinators came from other services (44%) and people self-presenting based on word of mouth from other Skylight service users (37%). Nearly three-quarters of service users had one or more support plans drawn up by mental health coordinators (72%) and also received one or more one-to-one support sessions (73%) from a coordinator. Hundreds of drop-in sessions, mental health forums and workshop/group based activities

had been conducted by the mental health coordinators during the period under review. Coordinators had also arranged access to 1,172 counselling sessions for the people they were working with.

There was evidence of widespread engagement with other Skylight services. Service users were involved in basic skills education, creative and performing arts, employability related activity, activities focused on physical well-being, vocational training and a range of work designed to enhance personal development.

Administrative data collected by Crisis indicated educational attainment, the achievement of goals related to employability and also personal development. There were also reports of improvements in mental health.

There was some evidence of service user attrition, i.e. service users who engaged with Skylight mental health services only very briefly.

Views on services

Most of the service users who completed anonymous feedback forms reported that they would recommend Skylight mental health services to others (77%). There was evidence that word of mouth recommendations from other homeless people was often a source of the referrals to mental health coordinators. There was strong agreement with statements on feedback forms that mental health coordinators helped improve self-confidence, management of emotional and mental health and also enhanced access to NHS services.

Participants in service user focus groups undertaken by the University research team in the Summer of 2013 reported a very similar picture to that found in the feedback forms collected by Crisis. The tolerance, understanding and patience of the mental health coordinators and particularly their understanding of homelessness was widely praised. The quality of support from coordinators was also widely praised. Skylights were often favourably compared by service users with other forms of service provision.

Focus group participants used a range of Skylight services and this could help provide structure, counter isolation and improve self-esteem. There was widespread praise for the quality of the activities and the supportive and understanding attitudes of the staff teams and tutors in the Skylights.

There was evidence from the focus groups that mental health coordinators had sometimes been instrumental in improving access to NHS and Social Services and had also improved treatment of some individuals. Some service users relied very heavily on the coordinators and on the Skylights more generally, for support. Some questions were raised by the focus groups results about the extent and endurance of the support that some service users wanted from the coordinators and from Skylight services more generally.

The coordinators viewed their role as part of an integrated team as creating an innovative and effective service. Issues such as boredom, lack of structure during the day and social isolation could be practically countered using the range of training, education and arts-based activities that the Skylights also provided. The ability to respond with both flexibility and with an understanding of homelessness was also seen as a strength. There were some concerns about resource levels in terms of capacity to meet need and also the availability of some external services.

Conclusions

There is evidence that the integration of the coordinators within a wide range of activities offered by the Skylights was effective. Alongside providing direct support with mental health problems, coordinators also

facilitated access to the NHS and social services.

Service users reported that service provision in the four Skylights was characterised by tolerance, understanding and patience. Skylight services provide meaningful, structured activity which helps tackle isolation, boredom and low self-esteem and can help homeless people with mental health problems progress towards education, training and paid work. There was evidence of tangible gains in well-being and socioeconomic integration for service users.

Some challenges exist for the mental health services provided by Skylights, but there is a clear case for expansion of these services based on the available evidence. It appears important that the balance of the service mix in Skylights, of which mental health services are just one part, is not altered.

1 Introduction

About this report

This report presents an overview of the use of mental health services provided in four Crisis Skylight services in Birmingham, London, Newcastle and Oxford. The specific focus of the report is the role of four mental health coordinators, whose role in Skylight services has been supported by the Department of Health. The report looks at the period 1st September 2010 to 31st March 2013 which was the period of service provision covered by Department of Health funding.

This report draws on the following sources:

1. Crisis administrative data;
2. Interviews with mental health coordinators;
3. Crisis feedback forms;
4. Focus groups with service users.

The administrative data and feedback forms used systems that were designed by Crisis and the data were collected, administered and validated by Crisis. Anonymised data from the administrative systems and the feedback forms was shared with the University for the purposes of this report.

The interviews with the mental health coordinators and the focus groups with service users were designed and undertaken by the University of York research team. Each of the coordinators were interviewed in Birmingham, Newcastle and Oxford and three coordinators were interviewed in London. The interviews were conducted in confidence to enable the coordinators to speak freely and this report does not include information that might be employed to identify the opinions of a specific individual coordinator.

Focus groups with service users who were using Skylight mental health services were conducted by the University of York research team in each of the four Skylights. In total, 22 people took part in these groups which ranged in size from five to seven participants. Participation was voluntary and participants were offered £10 cash as a 'thank-you' and also to help pay for any travel expenses incurred in attending the group. The focus groups ranged in duration from 47 to 75 minutes. The approaches for recruitment, research instruments and techniques for running the focus groups were subject to ethical review before the fieldwork commenced.

The report is divided into five main chapters. Chapter two describes the roles of mental health services in the Skylights and also reports the views of the mental health coordinators on delivering those services. Chapter three describes the characteristics of the people using mental health services in Skylights, including experience of homelessness. The fourth chapter looks at the patterns of use of mental health and the other services within the Skylights and also explores some data on outcomes. Chapter five looks at service users' perspectives on the mental health services and the other support they received from the Skylights, looking first at feedback provided through forms to Crisis and secondly at the results of four focus groups conducted for this report. The final chapter presents the conclusions of this report.

This report is one element within a much larger evaluation of Crisis Skylight which is taking place over the course of 2013-2015. This independent evaluation is being undertaken by the Centre for Housing Policy at the University of York. The evaluation covers six Skylights, the four covered in this

report and also the Skylights in Merseyside and Edinburgh (not covered in this report as they do not have mental health services at the time of writing). More details of the Skylight programme are available online.[1] The evaluation is longitudinal, exploring the experience of using different aspects of Skylight services from the perspective of service users by tracking 135 service users over the course of three years. The evaluation is also undertaking additional focus groups with other service users, talking to staff within the Skylights and also seeking the views of partner agencies on working with the Skylights. Administrative data on service user characteristics and service delivery collected by Crisis are also being examined as part of the evaluation. The first interim report will be available in the Winter of 2013.

1 Please see www.crisis.org.uk/pages/what-we-do-crisis-skylight-centres-61897.html

2 The Mental Health Services in Skylights

Introduction

This chapter looks at the role of mental health services within the Skylights. The chapter starts with a description of the Skylights. The chapter then describes and explores the delivery of mental health services in Skylights from the perspectives of the mental health coordinators.

Crisis Skylight

Crisis Skylight is a national programme of building-based and outreach services that focus on the social and economic integration of single homeless people. The role of the Skylight services is described by Crisis as centring on progression towards socioeconomic integration, a process which is intended to 'transform' the lives of homeless people. Each Skylight service offers a combination of arts-based activity and basic skills education, including accredited courses, combined with opportunities to volunteer, vocational training and support in securing employment and entering further education and training. The Skylights also have a role in promoting health and well-being, financial management and other practical skills, using both courses and the provision of information and advice.

Unmet health needs, sustained worklessness and social marginalisation all create barriers to exiting from existing homelessness and can also heighten the risk that homelessness will occur, be sustained or be recurrent. The interrelationships between mental ill health, drugs, alcohol, worklessness, social isolation and sustained and recurrent homelessness are best described as 'mutually reinforcing'.[2] The Skylight service seeks to prevent homelessness, stop homelessness from recurring and reduce the duration of existing homelessness by working to reduce a range of these risk factors. Skylights focus specifically on issues around economic integration, social integration and social and emotional support and also provide specific support with physical and mental health.[3]

The exact service mix varies between Skylight projects. Three of the Skylights provide cafes that enable people using the Skylights to get work-based training (who will be referred to in this report as 'service users'[4]) and some have 'progression' workers providing one-to-one support, advice and information centred on socioeconomic reintegration. Some Skylights are based in a modified building and others use an outreach model, working extensively with other homelessness services. This report focuses on the Skylights working in Birmingham, London, Newcastle and Oxford, all of which have mental health services. All except Birmingham are building-based services.

The Skylights work according to a model that emphasises respect for homeless people and the adoption of a non-judgemental approach. While Skylight is a service model that seeks transition, to 'transform' the lives of homeless people in terms of their access to social support, economic and social integration and also their health and well-being, it does not follow a model of enforced behavioural modification within a limited timetable. Service users are able to exercise choices, there is no 'penalty' for not attending activities or changing activities, and while there are some rules (for example, service users are expected not to attend activities in an intoxicated state) emphasis is placed on

2 Kemp, P. A., Neale, J et al. (2006) 'Homelessness among problem drug users: prevalence, risk factors and trigger events' *Health and Social Care in the Community* 14, 4, pp. 319-28; see also the Homeless Monitor research being undertaken by Crisis at www.crisis.org.uk/pages/homelessnessmonitor.html

3 www.crisis.org.uk/pages/what-we-do-crisis-skylight-centres-61897.html

4 Crisis uses the term 'members' to describe people using a Skylight service.

tolerance, patience and on allowing service users to work at their own pace.

The Crisis 'theory of change', which sets out the Crisis definition of a series of needs that should, according to the Crisis service model, be met to reduce the risk of sustained or recurrent homelessness, underpins all Skylight service provision. The Crisis service model has four main goals:

1. Promoting and sustaining good health and well-being;
2. Promoting employment and financial security;
3. Promoting and supporting housing stability;
4. Promoting good social supports, social networks and community participation.

The main functions of Skylight centre on the first, second and fourth elements. There is some access to support with securing housing provided within Skylight (the London Skylight has a dedicated worker focused on access to housing and at the time of writing there are plans to add housing workers to the other Skylight teams, starting with Oxford and Birmingham). However, Crisis seeks to address the third objective primarily through a separate service programme, which is not integral to Skylight, that supports access to the private rented sector for homeless and potentially homeless people.[5]

The particular focus of this report is on one aspect of service provision by the Skylight programmes, the mental health coordinators[6] who work in the Birmingham, London, Newcastle and Oxford Skylights. The report explores the roles of the mental health coordinators in the context of the wider operation of each Skylight service in providing assistance to homeless, formerly homeless and potentially homeless people with mental health problems.

The mental health coordinators

Objectives of the mental health services

Crisis applied for funding for the mental health coordinators within the Skylights under the 'Innovation' strand of the Department of Health Third Sector Investment Programme within the theme 'Information, advice, advocacy and support'. The Department of Health Third Sector Investment Programme was specifically designed to support innovation both in how needs around health and well-being were met and also to develop new ways of delivering health and social care services at local and national level.

Crisis sought funding under the Third Sector Investment Programme with a project entitled *Improving Access to mental health service provision for single homeless people.* The aim of the project was to improve mental health outcomes for the single homeless people using the Skylight centres. The specific goals were as follows:[7]

- Raise awareness of mental health issues amongst homeless people in a safe and accessible environment, therefore reducing the stigma of mental illness.

- Create a mental health forum/support network for Crisis members which will provide a platform for real participation (user led) in the decisions affecting their lives.

- Improve access to mental health services for homeless people, specifically around improving access to psychological therapies, therefore increasing their mental health and wellbeing.

5 Crisis PRS Access Development Programme www.crisis.org.uk/pages/crisis-private-renting.html
6 These posts were not always given the same title by each Skylight, but as the roles were extremely similar, one job title is used throughout this report. A common job title is also employed to reduce the risk that any specific individual might be identifiable.
7 Source: Crisis.

- Build and consolidate partnerships with local voluntary and charitable organisations, community mental health teams and other statutory agencies, sharing best practice on homelessness and mental health needs.

- Demonstrate the importance of the provision of specialist mental health services for homeless people.

- Develop an innovative and accessible service model for rollout in new Skylight services as those services were rolled out.

Core roles

Three of the four Skylight services examined in this report had a single mental health coordinator. The fourth, London, had a three-person mental health team headed by a coordinator. The core functions of the mental health coordinators were threefold:

- As a direct provider of low level support, including:

  > drop-in sessions;
  > one-to-one support;
  > the development of support plans;
  > group based support, and;
  > a mental health forum;

- As an enabler of access to health, care and support services, including the organisation of counselling sessions for service users and joint working with external NHS, social services and other external support providers, and;

- As an integrated part of the Skylight team.

Coordinators were direct providers of practical and emotional support and advice and information. A combination of drop-in sessions, one-to-one support and group-based workshops was used by the coordinators. Service users could also provide feedback about the services and support on offer via a mental health forum.

> *Really looking at problem solving and client-centred case work issues in a sort of group dynamic situation, so that people would bring their particular problems and we would see collectively if we could sort them out or discuss the issues that were raised by them. And I found that a very useful way of getting into the nature of the varied membership we have here but also it was possible to get a handle on the sort of problems that people were facing from their varied situations of homelessness.*
> (Mental health coordinator).

> *Their difficulties in functioning in everyday life out there would be helped and also they would recognise that this was a little oasis of support and a place that could help with practical problems as well as with the sort of mental health issues they might have.*
> (Mental health coordinator).

A typical pattern of service user engagement for a mental health coordinator was to provide regular drop-in sessions, for example one or two afternoons a week, which any service user could attend. This would then be followed by one-to-one sessions during which the mental health coordinator would undertake an assessment, including determining which services (if any) the person had contact with, their social supports and other needs. As a next stage, the coordinator would draw up a support plan, which would include agreed goals, with the service user. Group work provided by the mental health coordinator would also be offered to some service users at this point. Groups of varying numbers of service users, not usually more than 10-15 in total, would work on areas such as assertiveness, anger control, sleep and relaxation and anxiety. Additionally, service users could opt to participate in a mental health forum organised by the mental health coordinator. The role of the forum centred on service user feedback to the coordinator,

allowing them to raise issues about the mental health services offered by a Skylight and make suggestions for specific forms of support (for example the areas covered by group work).

Using both the one-to-one sessions and group work, the mental health coordinators also had a role in facilitating access to NHS, social services and other support for homeless and potentially homeless people with mental health problems. The mental health coordinators worked to develop joint working with a wide range of external services.

> *The brief I had here…was to develop a useful liaison network with the various mental health projects and facilities, such as hospitals, CPNs [community psychiatric nurses], we have a regional secure centre here, we have community mental health teams, we have an open access NHS centre and of course we have lots of projects that do support people who are in fragile mental health. I think my brief was in part to ensure there were good working relationships between us, so that we could refer people on, so that people would be referred to us, so we could liaise effectively together to support those people who came to us with identified problems or maybe came to us without identified problems and needed to have those sometimes brought to their attention and resolved in a partnership way…*
> (Mental health coordinator).

Another key role for mental health coordinators was the organisation of counselling sessions. Mental health coordinators did not directly provide counselling, but they did directly organise access to counselling. In one Skylight service, for example, the coordinator had secured the services of five volunteer counsellors who provided sessions for service users at the Skylight building. These five volunteer counsellors were vetted and tested for reliability and also had regular feedback with the mental health coordinator.

Collectively the counsellors provided a mix of Gestalt therapy, cognitive behavioural therapy (CBT), psychodynamic counselling and person-centred therapy (PCT). Counselling sessions were open-ended, with the counsellor and service users determining the number of sessions. Each counsellor had clinical supervision situated outside the Skylight service.

If there were issues around debt, welfare rights or similar support needs, a mental health coordinator would sometimes refer to Skylight progression workers. Progression workers' role centred on advice, information and support to improve the social and economic integration of service users, which included helping with practical issues.

The mental health coordinators were also an integral part of the Skylight service. A key role for coordinators was as a referral point, if another team member or tutor suspected someone had a mental health problem. In addition, coordinators actively supported and enabled homeless and potentially homeless people with mental health problems to use the education, training, arts-based and well-being related activities that each Skylight service had on offer.

> *What they wanted was a mental health worker to support the members that were already using the Skylight service so that they were more likely to be successful in their training, in their other courses they were doing. They'd come across many people with complex backgrounds, lots of trauma.*
> (Mental health coordinator).

> *I think Crisis do offer something quite unique in breaking homelessness cycles.*
> (Mental health coordinator).

Key Findings

- The mental health coordinator role had three main components: the direct provision of low-level support, advice and information, arranging and facilitating access to health and other required services and, finally, working as part of a Skylight team which sought to enable the positive social and economic 'transformation' of the lives of homeless and potentially homeless people.

- Direct service provision by mental health coordinators was designed to centre on providing drop-in sessions, one-to-one support, drawing up support plans with service users and providing group-based support and running a mental health forum which gave service users an opportunity to feedback about mental health services.

- Signposting and facilitating access to other services by mental health coordinators was designed to have two main components. First, they coordinated the provision of counselling and other services, which could be provided within a Skylight building. Second, the coordinators were intended to liaise and work jointly with NHS and other externally provided services.

- As an integral part of the wider Skylight team, mental health coordinators were intended to both take referrals from other staff members and tutors when they were concerned a service user had unmet mental health needs and also enabled service users to engage with the full range of Skylight activities, courses and services.

3. The People Using Skylight Mental Health Services

Introduction

This chapter examines the characteristics of currently, formerly and potentially homeless people making use of mental health services in the Skylights. The chapter is based on data collected by Crisis on people who made use of at least one mental health service on one occasion. This report does not provide any information on any other service users. The chapter begins by looking at demographic information before moving on to look at homelessness and support needs.

Demographics

Crisis administrative data[8] show that a total of 685 people made at least one use of the mental health services provided at the Birmingham, London, Newcastle and Oxford Skylights from 1st September 2010[9] to 31st March 2013. As noted, the data in this report refer *only* to this group and not to any other people making use of Skylight services.

Men significantly outnumbered women among service users (64% of service users). Basic demographic information is shown in Figure 3.1. The majority of both female and male service users were aged between 25 and 54 (85% of women and 81% of men). The largest single groups of service users for both genders were aged 25-34 (30% of women and 32% of men).

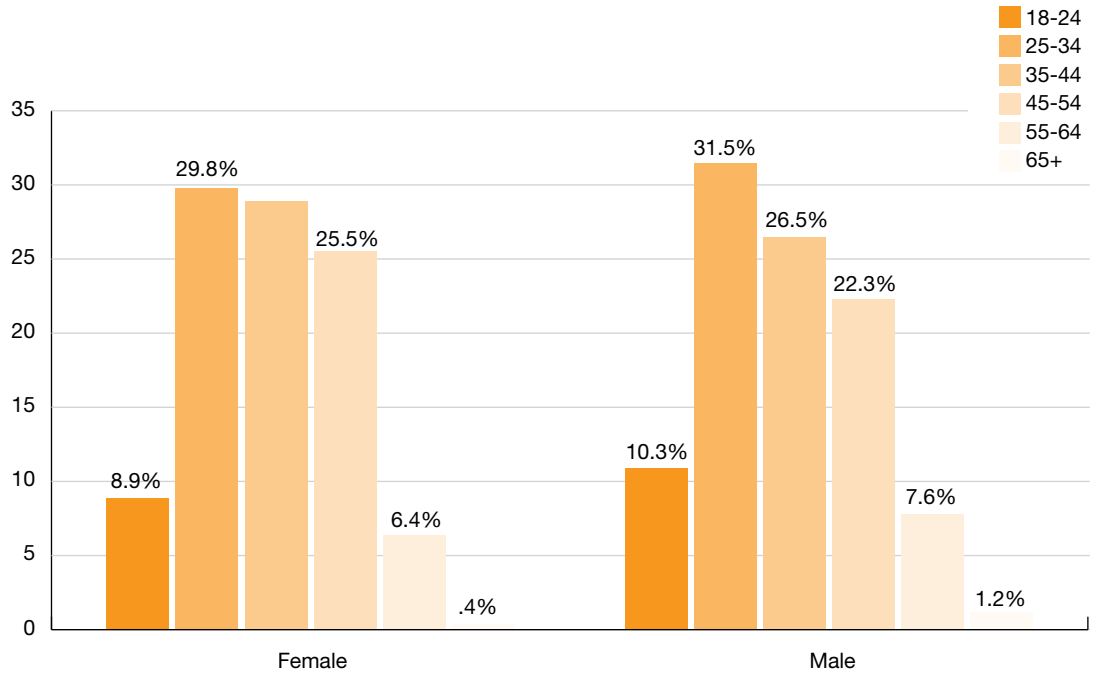
Most service users were White European, though there was some representation of other ethnic minority groups. Seven per cent of service users were Asian/Asian British and 11% were Black/Black British. Service users in London and Birmingham were more likely to be from ethnic minority groups than the people using mental health services elsewhere (38% of service users in London had an ethnic minority background and 26% in Birmingham). This broad pattern is as would be anticipated given the general differences in demography between the four sites, i.e. London and Birmingham have larger populations of people from ethic minorities.

The largest group of service users was in London, reflecting the relatively larger scale of the Skylight service and the mental health services provided there. In total, 361 of the people making use of Skylight mental health services were in London (53%) with Newcastle following with 211 service users (31%). The activity in the other two areas was more restricted, this reflected these services being both newer and also smaller. Forty service users were reported in Oxford (6%) and 73 in Birmingham (11%).

8 Based on data collected at first contact by each Skylight and records of service use, which are entered onto a web-enabled database system that is administered in London. Data used in this report were collected by Crisis and anonymised before they were shared with the University.

9 This is the date that mental health services first came on stream in Skylights. Note that mental health coordinators in the different Skylights did not all take up their posts at this point.

Figure 3.1: Age group of service users by gender (Source: Crisis)[10]

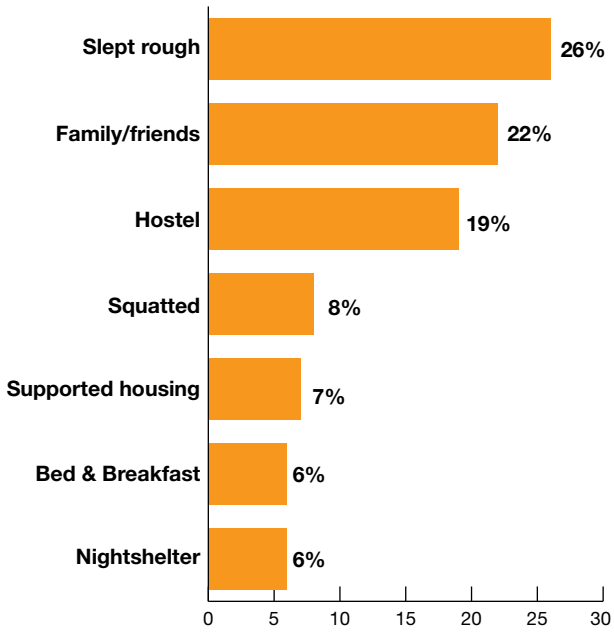


Homelessness

The monitoring systems used by Crisis were designed to determine the extent of homelessness among service users and from 2012 onwards, eligibility based on current homelessness, risk of homelessness or a history of homelessness. Service users had to complete a first contact form, but could skip questions they did not want to answer, meaning data on homelessness experiences were not always complete.

Past experience of homelessness was reported by 54 per cent of service users.[11] Figure 3.2 shows the percentage of service users reporting different types of homelessness.[12] Twenty-six per cent of service users reporting specific experiences of sleeping rough and 22 per cent reporting staying with family and friends because they had no alternative. Previous experience of nightshelters, supported housing and bed and breakfast accommodation were less common.

Figure 3.2: Previous experience of different type of homelessness (Source: Crisis)

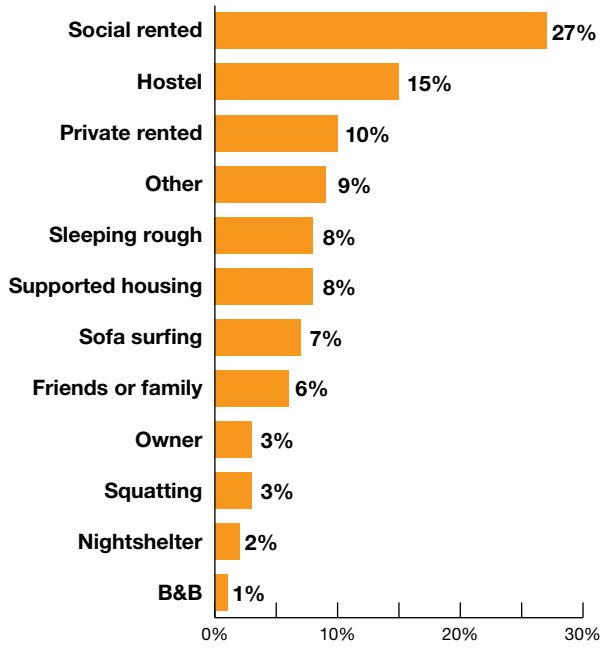


Percentages are rounded up to the nearest 0.5.

10 Age data were not recorded in 14 cases.
11 Service users were asked 'If you are not currently homeless have you been homeless in the past?'
12 Data in this section are based on self-reporting by service users within Crisis first contact forms. Percentages given are for the total user base of 685 people, service users could (and did) opt not to answer questions on past experience of homelessness.

Figure 3.3 shows the current housing status of service users when they first contacted a Skylight. Only a minority (40%) were currently housed when they first used a Skylight, of whom the largest group were people in social rented tenancies (27%), followed by those in private rented tenancies (10%) with only a small number living as owner occupiers (3%), although these housing situations were not necessarily secure or settled. Of those who were homeless when they started using a Skylight service, the largest groups were resident in hostels (15%), living in supported housing (8%) or living rough (8%).

Figure 3.3: Current housing situation at first contact with a Skylight (Source: Crisis)[13]



Percentages are rounded up to the nearest 0.5.

Defining 'homelessness' as being in a B&B hotel because of a lack of alternative accommodation, living in a hostel or supported housing, 'sofa surfing' between friends and relatives homes, living in a nightshelter, sleeping rough, squatting and living semi-permanently with friends or family for lack of alternative accommodation, the housing situation of service users at first contact can be summarised as follows:

- Half of the service users reported current homelessness (50%).
- Fifty-four per cent of service users reported a history of homelessness, i.e. at least one previous episode of homelessness.

A substantial number of service users reported they were at risk of homelessness at first contact with a Skylight. Overall, 30 per cent of service users reported themselves as being at risk of homelessness. Among those reporting themselves at risk of homelessness, the most common reasons reported were risk of eviction (27%), relationship breakdown with either a partner or family (21%) and disputes with landlords (6%). Among those living in social rented housing at first contact 23 per cent reported themselves 'at risk' of homelessness, as did 43 per cent of those living in the private rented sector at first contact.

Women were significantly less likely than men to report current homelessness at first contact (37% of women compared to 57% of men reported current homelessness). This meant women were more likely to be living in social rented housing (35% compared to 22%) or living in the private rented sector (14% compared to 8%). Men were more likely

13 Data were missing for 18 cases. These housing situations were not necessarily secure or settled. Research on women's experience of homelessness tends to be less extensive than the evidence base on single men, but there is UK, US and European evidence that women tend to use informal arrangements with friends and family or squat and try to avoid living rough because of the potential dangers involved. See: Baptista, I. (2010) 'Women and Homelessness' in O'Sullivan, E., Busch-Geertsema, V., Quilgars, D. and Pleace, N. (Eds) *Homelessness Research in Europe.* Brussels: FEANTSA. pp. 163-186.

to be living rough (12% compared to 2% of women) and marginally more likely to be living in hostels (17% compared to 11% of women) or in supported housing (10% compared to 5%).[14] There was very little difference between genders in terms of being at risk of homelessness (32% of women, 29% of men) and while women were marginally less likely to report a history of homelessness than men, the difference was not significant (53% of women compared to 57% of men).

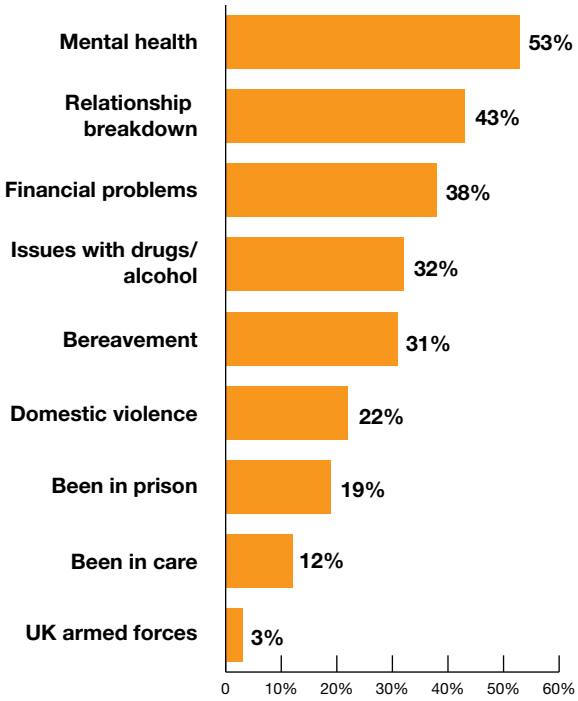
There was no significant difference in terms of past reported experience of homelessness by age group. However, younger people, aged 18-24, were more likely to report current homelessness at first contact (73%) than was the case for other groups. Close to one half of those aged 25-34 (56%) and aged 35-44 (48%) also reported current homelessness. Figures began to fall among older people using the Skylights, with 38 per cent of 45-64 year-olds reporting current homelessness and one third of the small number of service users aged 65 or over (33%).

Needs and characteristics

Personal history

Figure 3.4 summarises some of the personal history data collected by Crisis at first contact.[15] These data should be treated as indicative, because a quite high proportion of service users opted not to answer these questions.[16]

Figure 3.4: Personal history of service users (Source: Crisis)



As can be seen, previous experience of mental health issues (53% of service users) was widespread, and there was also extensive experience of relationship breakdown and financial problems with almost one third of service users reporting a history of issues with drug and alcohol use. Experience of prison and the care system, while not very widespread, were nevertheless many times the rates that would be found in the general population. Service users were unlikely to have been in the armed forces.

Women were more likely to report a history of domestic violence than men (38% compared to 12%) and this reflects the findings of research on women's experiences prior to homelessness.[17] Women were also more likely than men to report a past history of

14 Data in this section are based on self-reporting by service users within Crisis first contact forms. Percentages given are for the total user base of 685 people, service users could (and did) opt not to answer questions on past experiences.
15 For example, over one quarter of service users did not answer the question on previous experience of mental health issues (27%).
16 Jones, A. (1999) *Out of Sight, out of Mind: The experiences of homeless women*. London: Crisis.
17 Rees, S. (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature*. London: Crisis; Centre for Economic & Social Inclusion (2005) *A literature review: Access to mainstream public services for homeless people*. London: Crisis.

mental health issues (57% compared to 51%) although the difference was not statistically significant. Conversely, men were more likely than women to report a history of issues with drug and/or alcohol use (37% compared to 23%) and much more likely to report being in prison (26% compared to 7%).

Data on current health status were incomplete as a large number of service users opted not to answer questions on mental health status and other aspects of health at first contact. Previous research indicates there may be several reasons for this, including lack of awareness or diagnosis of mental health problems (see Chapter 3) and, if an awareness of poor mental health was present, an general anxiety that access to services will be refused if poor mental health is disclosed.[18] There is extensive evidence that mental health problems, including severe mental illness, are much higher among single homeless people than those among the general population.[19] Skylights had a clear policy to allow access to someone with mental health problems, but service users may not have had awareness of this at first contact.

Patterns of mental health problems reported by mental health coordinators

The mental health coordinators reported encountering high levels of need among formerly, potentially and currently homeless people who often faced significant barriers to mainstream services.

> *I assumed that there would be more psychotic illness, schizophrenia, drug induced psychosis and it shocked me how much really is trauma. Trauma and abuse…What I found was that there were lots of people with very worrying risk assessments, very complex needs… but not getting into the NHS, not being referred to the NHS and disengaging straight away. The complexity of needs… is off the scale, but most of them are not treated in the NHS, because they're complicated, because they don't engage very well with their GPs, because they disengage very quickly.*
> (Mental health coordinator).

> *We're getting a lot of people that fall through the cracks of other organisations.*
> Mental health coordinator.

From the perspective of the mental health coordinators, the need for the services that they offered was high. Their views were that a very high proportion of service users using Skylights presented with mental health problems and severe mental illness.

> *I've had to close referrals twice in the last six months and when I reopened it I had twelve new referrals in two days.*
> (Mental health coordinator).

There is strong research evidence that a 'chronically' homeless group experiencing homelessness on a recurrent or sustained basis, can be associated with social and economic marginalisation, social isolation, drug and alcohol use and poor mental health. Alongside high rates of mental health problems, chronically homeless people lack contact with friends and family, are less likely than the general population to have a partner, can feel alienated from (and experience hostility from) mainstream society and are long term workless.[20] There is also extensive evidence that chronically homeless people can face significant barriers to accessing mainstream mental health services.[21]

18 Jones, A. and Pleace, N. (2010) *A Review of Single Homelessness in the UK 2000-2010*. London: Crisis.
19 Jones, A. and Pleace, N. (2010) *A Review of Single Homelessness in the UK 2000-2010*. London: Crisis.
20 Busch-Geertsema, V., Edgar, W., O'Sullivan, E. and Pleace, N. (2010) *Homelessness and Homeless Policies in Europe: Lessons From Research.* Brussels: European Commission.
21 Rees, S. (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature.* London, Crisis; Centre for Economic & Social Inclusion (2005) *A literature review: Access to mainstream public services for homeless people.* London: Crisis.

Employment

Service users were very unlikely to have any form of employment. At first contact, 16 people who made at least one use of Skylight mental health services were in full time employment (2%) and 30 were in part time employment (4%) with 94 per cent of those service users not reporting current employment. Rates of benefit claims were likely to have been high, but the data on this aspect of service users lives was often not complete. Some previous research on homeless populations has suggested that people's awareness of the specific *types* of benefits is often low,[22] reflecting the wider evidence that complexity makes the current benefits system difficult to understand.

Key findings

- Service users had extensive experience of homelessness. 54 per cent reported past experience of homelessness. At first contact, only a minority of service users were in settled housing (40%) and 30 per cent reported themselves as being at risk of homelessness.
- 53 per cent of service users reported histories of mental health problems at first contact. Previous research indicates that underreporting of mental health problems can occur among single homeless people.
- The mental health coordinators reported encountering high rates of severe mental illness and mental health problems among homeless people who sometimes faced barriers to mainstream health and social services.
- Almost all service users were unemployed at first contact with a Crisis Skylight, with 6 per cent in full or part-time work.

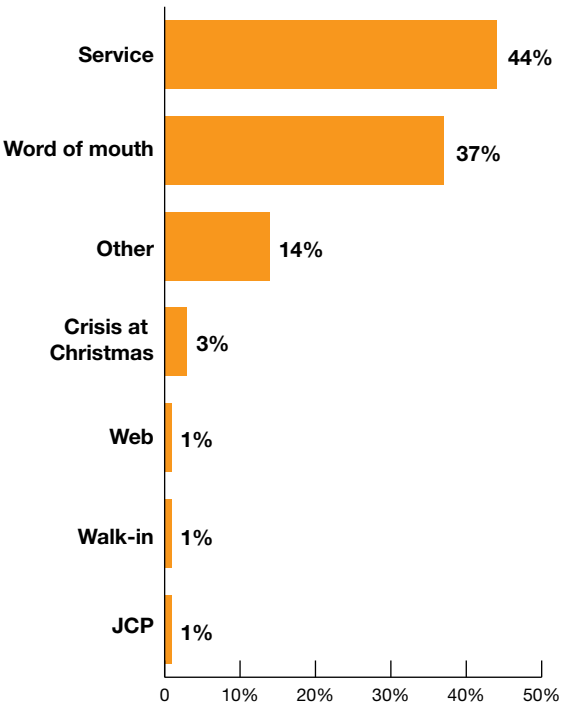
22 Pleace, N. et al. (2008) *Statutory Homelessness in England: The Experience of Families and 16-17 Year Olds.* London: Department for Communities and Local Government.

4 Patterns of Service Use and Outcomes

Introduction

This chapter is again based on the data about people using Skylights who made at least one use of mental health services provided by those Skylights. A total of 685 people made at least one use of the mental health services provided at the Birmingham, London, Newcastle and Oxford Skylights from 1st September 2010[23] to 31st March 2013. As noted earlier, the data in this report refer *only* to this group and not to any other people making use of Skylight services (see Chapter 3). After briefly examining the sources of referral to Skylight services, this chapter provides a statistical overview of engagement with and use of mental health services using Crisis administrative data. The second part of this chapter describes the use of other Skylight services by people receiving mental health services.

Figure 4.1: Referrals to Skylight (Source: Crisis)[24]



Referral to Skylight

Figure 4.1 shows the main sources of referral to the Skylights for people who had made at least one use of mental health services. The largest single sources of referrals were other services (44%), but it was notable that a sizeable number of service users had decided to use a Skylight based on the recommendations of others who had used a Skylight service (37%).

Use of mental health services

Crisis administrative data show that a total of 685 individuals made at least one use of the mental health services provided at the Birmingham, London, Newcastle and Oxford Skylights from 1st September 2010 to 31st March 2013 (see Chapter 3). This section describes the available statistics on use of support plans, one-to-one sessions, group and forum sessions.

Support plans

The number of service users who reached the stage of having a first support plan drawn up for them was lower than the total numbers who made at least one use of mental health services. During the two full years that data are currently available for, 190 people (2011) and 182 people (2012) had an initial support plan drawn up. During the early stages of the mental health project, from September to December 2010, 52 people received their first support plans and in the period January to March 2013, a further 67 people received their first support plans. During the period 1st September 2010 to 31st March 2013, the mental health coordinators had drawn up a first support plan for 491 service users (72% of all service users who had made at least one use of a Skylight mental health service). Each support plan included agreed goals in terms of quality of life, access to required treatment

23 This is the date that mental health services first came on stream in Skylights. Note that mental health coordinators in the different Skylights did not all take up their posts at this point.

24 Data were not available for 34 service users.

and support for health and well-being. Not all service users would have necessarily had a support plan drawn up by a coordinator, for example people participating in some of the mental health forums.

Of the 491 service users who had received a support plan, 75 per cent were reported as having had one plan as at 31st March 2013. In 25 per cent of cases, the support plan had been revised at least once, with 13 per cent of the 491 service users having had two support plans completed and 7 per cent having three plans completed. A smaller group of 5 per cent of service users had seen their support plans revised four or more times as at 31st March 2013. In total, 732 support plans had been drawn up or revised for 491 service users.

Of those service users receiving a first support plan in 2010, 88 per cent did not receive a second or other additional support plans. Similarly, 90 per cent of those receiving a first support plan in 2011 and 96 per cent of those receiving a first support plan in 2012 had not received a second or additional support plans during the following years. These data can only be seen as broadly indicative because a support plan may not have required revision, yet still be in place.

One-to-one sessions

A total of 497 service users (73%) had received at least a single one-to-one support session with a mental health coordinator. In total, during the period from 1st September 2010 to 31st March 2013, the mental health coordinators had provided 2,807 one-to-one support sessions, an average of 5.6 sessions for each service user who had received this form of support (the median was three sessions).

Figure 4.2: Summary of number of one-to-one support sessions received by service users (Source: Crisis)[25]

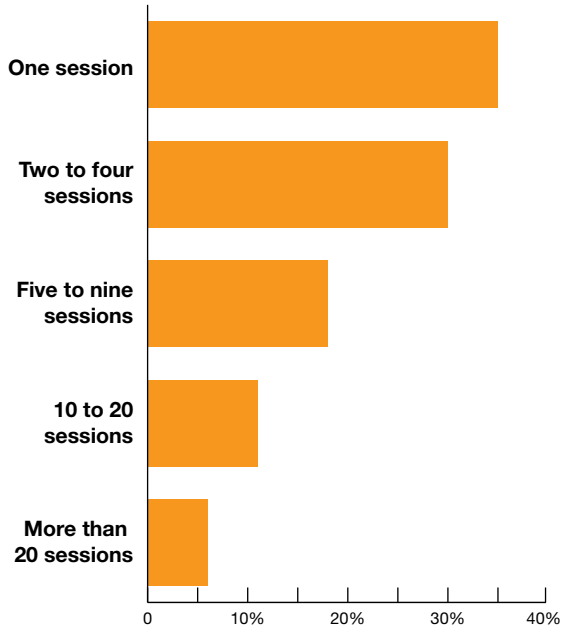


Figure 4.2 summarises the number of one-to-one support sessions that service users had received. The largest single group of services users were those who had received a single one to one session (35%), though the majority of service users had received more sessions. Thirty per cent had received between two and four sessions, another 18 per cent had received between five and nine sessions and 17 per cent had received ten or more sessions.

Of the people who received one-to-one support during 2010, 51 per cent did not receive any in the following years, but 49 per cent did and 16 per cent of the people first receiving a one to one session in 2010 also received one during the period January to March 2013. Similarly, 38 per cent of the people first receiving a one to one session in 2011 and 40 per cent of those who first received a one to one session in 2012 went on to receive additional one to one support

25 Base: 497 service users receiving one to one support.

sessions in subsequent years. Overall, 34 per cent of the service users who had received a one to one session in 2010, 2011 and 2012 had received at least one additional one to one session during subsequent years.[26]

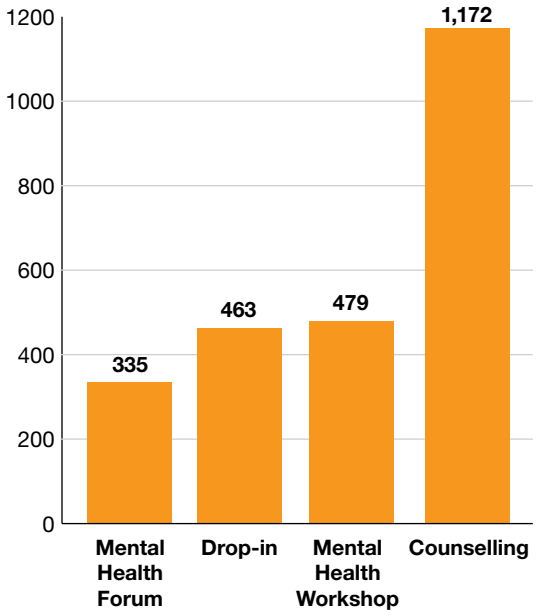
These data suggest that quite high numbers of service users were not engaging with a Skylight service for very long, but also indicate more sustained engagement by a large number of service users. Skylights may have been encountering issues around some service users not engaging for long enough, while others made much more sustained use of the service. This point is revisited in the concluding chapter.

Counselling, drop-ins, workshops and forums

Figure 4.3 summarises the other mental health service activity recorded by Crisis in the four Skylights during the period 1st September 2010 to 31st March 2013. The data show the number of times that a service was used. For example, the graphic shows that 1,172 counselling sessions took place, which includes sessions attended many times by the same individuals (see below).

Counselling was not provided directly by the mental health coordinators, but the coordinators played a central role in arranging access to and organising counselling services (see Chapter 2). During the period 1st September 2010 to 30th March 2013, 1,172 counselling sessions were recorded as having taken place. Counselling constituted 48 per cent of all recorded mental health related service use, compared to 19 per cent for mental health workshops and 14 per cent for forums (group-related activity, covering workshops and forums accounted for 33% of total service use). Drop-in sessions were used 463 times, accounting for 19 per cent of the total number of times services had been used.

Figure 4.3: The number of times mental health services had been used (Source: Crisis)



Complete data were not available on how many individuals had made use of counselling sessions.[27] However, data were available[28] that indicated that at least 112 individuals had used counselling provided by a Skylight, at an average rate of 10 sessions per person. The average was skewed upwards by a smaller group of 46 individuals (41%) who were all recorded as having received 10 or more counselling sessions each, with 59% of service users having used counselling less than 10 times.

There were 814 attendances at group sessions run by mental health coordinators during the period 1st September 2010 to 31st March 2013. These attendances can be divided into participating in mental health forums (335 attendances, 41%) and attendances at mental health workshops, including training and learning sessions and education about mental health (479 attendances, 58%).

26 Forty-nine people received one-to-one support in 2010, the number for 2011 was 167, for 2012, 203 and figures for 2013, as at the end of March 2013, were 78.

27 In 32 cases, the identity of someone using a counselling session was not recorded.

28 Data that could identify a specific individual were not shared with the University for data protection reasons, an anonymous unique code was created for the purposes of this exercise.

Complete data on the numbers of service users involved is not available.[29] However, the unique identities of the bulk of attendees at group sessions was recorded in Crisis administrative data and this showed:

- At least 99 individuals attended one or more mental health forum sessions, with an average of three attendances per person. Twenty-two participants in this group were recorded as attending a forum on four or more occasions (22%).

- At least 117 individuals attended one or more workshops, with an average of four attendances per person. Fifty-one people in this group attended a workshop on four or more occasions (44%).

- Total attendance at group-based activities was at least 167 people, of whom 49 (29%) had attended at least one forum *and* one or more workshops.

Data on the individuals making use of drop-in sessions provided by the mental health coordinators were not complete,[30] but there was data that showed at least 207 people (31% of all service users) had used 463 drop-in sessions, an average of two sessions per person. Analysis shows that the bulk of use of drop-ins was by individuals who had only made use of the service once up to 31st March 2013 (119 people, 57%), with a smaller number making repeated use of this service (45 people, 22% had used drop-ins three or more times).

Use of other Skylight services by service users with mental health problems

The four Skylights are primarily educational and employment related projects that seek to improve and ultimately to 'transform' the lives of homeless people through promoting social integration and economic participation (see Chapter 1). Each service user had opportunities to engage with the range of arts-based work, education, training and work-related activity that was on offer from each Skylight. As noted in Chapter 1, mental health coordinators were both a conduit to this wider range of activity and also acted as a referral point when another staff member or tutor thought that someone may have needed support with their mental health.

Service users who had made at least one use of a mental health service provided by a Skylight had very often used other Skylight services (546 people, 80%). Collectively, those 546 service users who had engaged at least once with Skylight mental health services also used the other activities and courses offered by the four Skylights a total of 26,523 times between 1st September 2010 and 31st March 2013. This figure represents a count of each episode of service use, i.e. each single use someone made of a service, such as a single attendance at a class or a single participation in an arts-based activity.

The rate at which service users engaged with activities varied considerably. The average was 48 activities per person but the median was 20 activities and the mode was just one activity. This indicated the presence of a smaller group of highly participatory individuals and a much less engaged group. People in the upper quartile (top 25%) of the 546 service users had been involved in 65 or more activities during their time with a Skylight service, people in the lower quartile had participated in five or less activities.

29 The identification of the people making 71 attendances at groups were not recorded
30 In 66 cases the identification of someone using a drop-in session was not recorded.

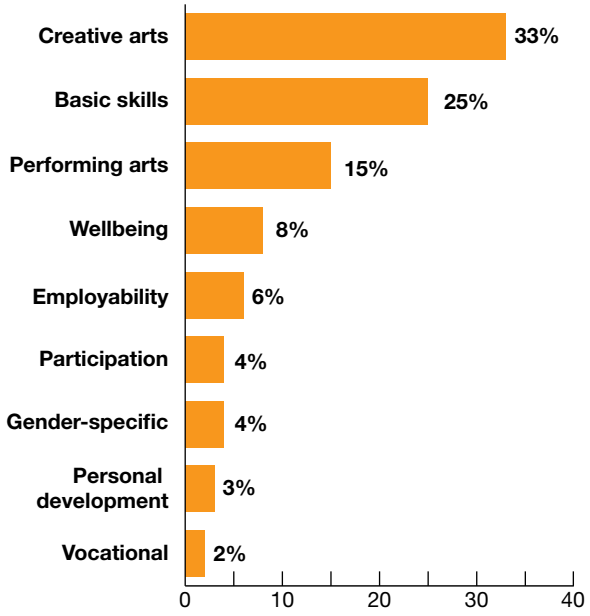
These educational, work-related and arts based activities were many and varied, reflecting the collective extensive curricula of the four Skylight services. The broad range of activities can be classified as follows:

- **Basic skills**, including English, maths and a range of computing related courses, all with an emphasis on improving work-readiness.
- **Creative arts**, an extensive range of activity which is designed to encourage engagement, support socialisation and emotional literacy and working with others. When an individual is found to have a talent that may be commercially exploitable, support is given to access further education and/or develop a business built around that talent. These activities range from drawing and painting, photography, creative writing, through to jewellery and hat making.
- **Performing arts** centring on theatre, film and music, with the same goals and approach as underpins the delivery of creative and visual arts services.
- **Employability** activities centre on CV and application writing, interview presentation and practice, placements and other preparation for paid work.
- **Well-being** encompassing health-related activities can include relaxation and meditation, yoga, Judo, and help with healthy eating.
- **Personal development**, which could include preparation for learning and receiving support with basic skills on a one to one basis from a 'Smartskills' tutor or work with a staff member providing 'progression' support related to well-being, seeking paid work and access to external services, including vocational training and further education.
- **Vocational** activity, centred on training, which in Newcastle, Oxford and London could include working in the café and might also include activities such as learning bicycle or car maintenance.
- **Participation** through mechanisms to involve service users and present them with opportunities to feedback to Crisis. This was mainly achieved by participation in member's (service user's) forums.
- **Gender specific** activities, i.e. groups exclusively for women and men and dealing with informational, practical, emotional and other support needs.

Figure 4.4 summarises the range of activity that service users had been participating in by broad type. As can be seen, creative and performing arts accounted for a large element of use of these other Skylight services (48% of activity), alongside extensive use of basic skills education, vocational, employment-related and personal development services (collectively 36% of service use). Activity focused on health and well-being was also quite widely used, with less use of participation opportunities or gender-specific services.

These findings indicate that engagement with the Skylights could be extensive for some service users. Alongside receiving specific support related to mental health needs, people were often engaging with Skylight as an educational and training resource in a wide variety of ways. Some findings from discussions with service users indicated that various activities, such as arts-based work, also had a therapeutic value (see Chapter 4).

Figure 4.4: Summary of the other Skylight services used by people who had made at least one use of mental health services (Source: Crisis)

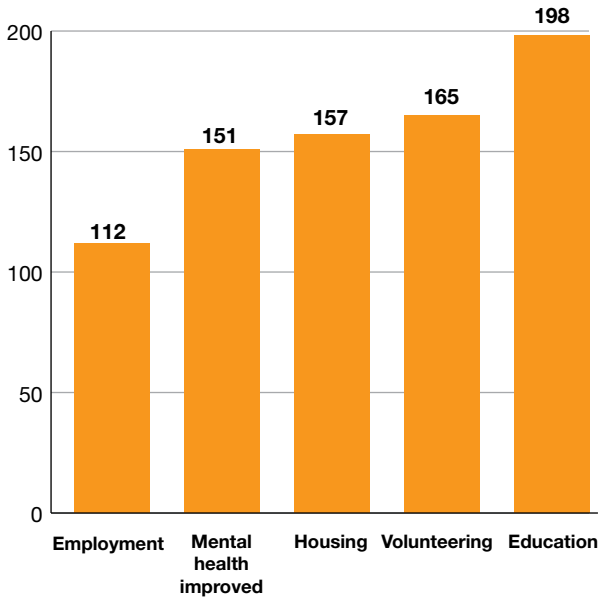


Service outcomes

Crisis administrative data recorded positive 'hard' outcomes in education, employment, housing, volunteering and mental health achieved by people making use of mental health and other Skylight services. These outcomes represented a tangible and measureable achievement as a result of using Skylight services. An outcome in education therefore meant achievement of an accreditation or qualification, in subjects like maths, English or computing. Employment outcomes related to paid work. Outcomes in housing marked an improvement in housing situation, this might mean a move from living rough to a hostel, or from a precarious or temporary living situation to a more settled home. Finally, Crisis also recorded when someone reported that, from their own viewpoint, there had been an improvement in their mental health.

In total, 783 positive outcomes had been recorded between 1st September 2010 and 31st March 2013 for service users who had made at least one use of Skylight mental health services. A single individual could achieve several outcomes, such as two or more educational outcomes or volunteering outcomes. These outcomes are summarised in Figure 4.4. Twenty-five per cent of positive outcomes were in education, another 21 per cent in volunteering, 20 per cent in housing and 14 per cent in securing paid employment. Nineteen per cent of outcomes recorded were improvements in mental health.

Figure 4.5: Positive outcomes achieved by type for people who had made at least one use of mental health services (Source: Crisis)



In total, 314 identifiable individuals achieved one or more of the outcomes shown in Figure 4.5. In the area of education, 198 outcomes were achieved by 124 people, an average of 1.5 attainments or qualifications per person. The largest group (79 people, 64%) achieved one educational outcome, with 45 people (38%) achieving two or more outcomes.

In volunteering, 111 people were involved in the 165 recorded positive outcomes, an average of just under 1.5 volunteering outcomes per person. The largest group had one outcome (80 people, 72%) with a smaller group achieving two or more

volunteering outcomes (31 people, 28%). In housing, outcomes were more likely to be a single positive achievement, which might be explained by only one move in housing situation being necessary to resolve a housing issue. One hundred and twenty-three people were reported as achieving 157 positive outcomes in housing, 80 per cent of which were single outcomes achieved for one individual.

There were some notable gains in employment. Overall, 90 people secured 112 jobs as a direct result of engaging with a Skylight service, the greater number of jobs being explained by securing more than one part time job and by moving between temporary jobs. People in London were the most likely to have secured paid work (61% of all jobs), followed by Newcastle (30% of jobs) and Birmingham (9%). The Birmingham figure reflects the shorter time for which mental health services had been operational. In addition, paid work would also be more likely to be available in the relatively more buoyant London labour market. Overall, 54 per cent of the paid work that was secured was full time, with 46 per cent of work being part-time. There was no significant difference between the balance of full and part-time work that was secured in different areas. Data on the kinds of paid work people had secured were not always complete, but the roles ranged between handyperson through to bicycle mechanic, work in catering, including becoming a chef, factory jobs and becoming a barista in a coffee shop. Only 6 per cent of service users had been in paid work at the point they first made contact with a Skylight service (see Chapter 3).

Finally, reported gains in mental health tended to be a person reporting a gain in their mental health linked to participation in Skylight activities. Ninety-eight of the 122 people (77%) reporting their mental health had improved had made a single report of improvement.

Crisis recorded a broad set of measures, encompassing a range of attainment and activity and not a precise description of exactly what had been achieved with each individual. Nevertheless, these data do indicate that significant gains were being made by a considerable number of service users across a range of areas.

Key findings

- Referrals to Skylights were mainly from other services and by word of mouth.
- The most common examples of service use were having one or more support plans drawn up (72% of service users) and making use of one-to-one sessions (73%). At least 167 service users (25%) had attended one or more mental health forums and/or group based workshops run by a coordinator and 31 per cent had made use of the drop-in services provided by the coordinators. There was quite extensive use of counselling services which were organised by the mental health coordinators.
- There was widespread engagement with other Skylight services such as basic skills education, creative and performing arts, employability, volunteering and vocational training.
- Administrative data collected by Crisis recorded gains in mental health, and the achievement of accreditations and milestones in education volunteering, alongside improvements in housing situations. Ninety people secured full and part time paid work as a direct result of their contact with Skylight.
- There were indications that some service users had only a brief contact with Skylight mental health services and other Skylight services. However, there was also good evidence of sustained and extensive contact with Skylight mental health services and other Skylight services by large groups of currently, formerly and potentially homeless people with mental health problems.

5. Views on Services

Introduction

This chapter briefly reviews the data that Crisis has received from service users via client feedback forms and then moves on to describe the results of four focus groups with service users. The chapter concludes by exploring the perspectives of mental health coordinators on the services they were delivering.

The views expressed in client feedback forms

Feedback on all Skylight services is encouraged through a range of feedback forms which are distributed to all service users. Completion of the feedback forms is voluntary. During the period 1st September 2010 to 31st March 2013, 64 client feedback forms were completed that focused specifically on the mental health services provided by Crisis Skylights. The rate at which feedback was equivalent to just over one in ten of the people making at least one use of Skylight mental health services did provide feedback through this route (64 people, 10%).[31]

Feedback was generally very positive. The proportion of service users who 'strongly agreed' with a range of statements about the mental health services provided through the Skylights is shown in Figure 5.1. One of the most striking findings from this feedback was that almost eight out of the ten people who had made use of mental health services reported they 'strongly agreed' that they would recommend those services to other people (77%). Other areas of strong agreement included the mental health coordinators helping them to feel more confident (66%), help with accessing counselling services (64%) and with managing their own emotional and mental health (62%). A majority of service users also 'strongly agreed' that the mental health coordinators had helped them find additional support, were knowledgeable, and had helped them feel more optimistic.

Other outcomes were somewhat less strongly supported, however most service users who did not opt to 'strongly agree' with a statement opted instead to 'agree' with that statement. For most of the statements shown in Figure 5.1, *all* the service users who made a response either opted to 'agree' or 'strongly agree', except in relation to whether the service was tailored to suit the individual (98% agreed or strongly agreed that it was, 2% did not), access to counselling (same result) and access to health services (94% agreed or strongly agreed they had been helped to access health services, 6% did not).

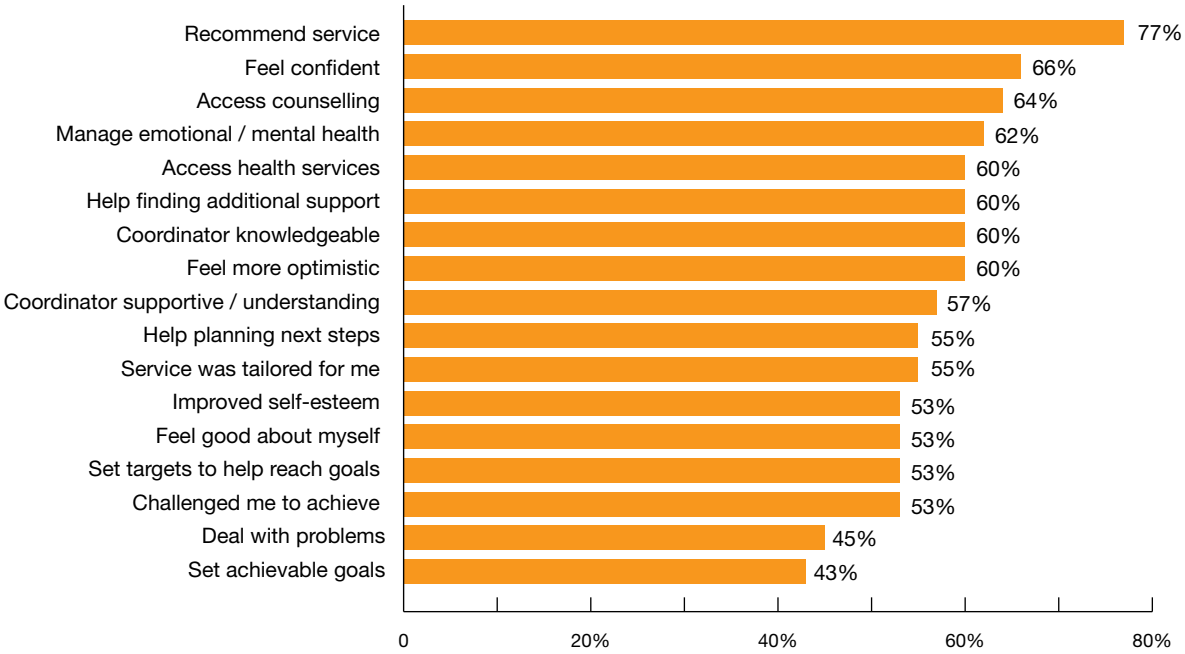
Service users also had the opportunity to provide written comments on the feedback forms which Crisis made available. Fifty-three of the people completing a feedback form opted to make additional written comments on the form (83%). Generally, these comments tended to be positive about the mental health services provided by Skylights:

> *Very understanding, patient and listened well. Also very respectful and really helped me to move forward.*
> (Service user written comment).

> *[Mental health coordinator] was understanding very helpful and listened to me every time…was very helpful and did everything he could to help me.*
> (Service user written comment).

31 Figures for feedback on counselling services were lower at 54 people because 10 individuals reported the question was not applicable to them. The question on whether support was tailored for an individual was not answered by six people. This group were a sub-group of the total of 685 people made at least one use of the mental health services provided at the Birmingham, London, Newcastle and Oxford Skylights from 1st September 2010 to 31st March 2013 (see Chapter 3).

Figure 5.1: Percentage of service users providing feedback who 'strongly agreed' with statements about the quality and content of Skylight mental health services (Source: Crisis)[32]



This is such a valuable service, it has helped me SO [sic] much and [Mental health coordinator] is so kind, compassionate and understanding.
(Service user written comment).

It has helped me get out of a rut being socially active and participating in fun projects and through this has helped my recovery from an eating disorder. I wouldn't know what I'd do without the Crisis Skylight centre.
(Service user written comment).

I am so very grateful for the listening and compassion that Crisis has offered.
(Service user written comment).

Although the process of providing feedback was anonymous, criticism of the mental health services or the Skylight centres was unusual in the feedback forms. A few criticisms were made that centred on the availability of mental health coordinators, but these were phrased in terms of a perceived need to increase resources, including the number of mental health coordinators available, rather than any criticism of the coordinators or the service model. There was evidence that the mental health coordinators were often approached by people who had heard about the service from other formerly, currently and previously homeless people with mental health problems, suggesting recommendation by word of mouth (see Chapter 4).

The views of service users who participated in focus groups

Overall views of Skylight

Service users who participated in the focus groups run by the University research team often talked in terms of how much they valued the *entirety* of the support and

32 Base varies for some indicators, see footnote on preceding page.

services they were receiving from each Skylight, alongside the specific support from mental health coordinators. While the coordinators were in the main very highly rated, the coordination and integration of wider Skylight programmes in Birmingham, London, Newcastle and Oxford was often particularly prized by service users. The mental health services were therefore often seen as one element within a *package* of useful services being offered by the Skylights.

Service users also identified a number of qualities about Skylight services which tended to be viewed very positively. One of these was the sense that a Skylight service was not 'judgemental' or critical in the way that some services were. The three services that were primarily building-based, London, Newcastle and Oxford, were often talked about as 'tolerant' places:

> *Once I am here, I feel relief and respite from problems and I always find that the staff here are really supportive and I don't feel embarrassed, they don't make you feel ashamed of your problems and there's always someone here to listen to you. I find it a really supportive place to be.*
> (Female service user).

> *It's very relaxed, that's what I think, people are happy here, the people who work here, they know what they're doing, they are not condescending, they've obviously been on courses and things, to understand what it's like for some of us basically.*
> (Male service user).

When asked what it was about Skylight services that was different from some other forms of service provision, some service users responded that a key difference was understanding the impacts that homelessness could have on mental health and recovery. Service users reported that specific barriers existed to education, training and to paid work for homeless people, barriers which were thought to be well understood by the mental health coordinators and the wider Skylight staff teams.

Skylights were also generally highly rated as a service and sometimes seen as better organised, more professional and also able to access more resources, than some other homelessness services in the four areas:

> *They understand the stages, that if you don't have permanent housing it can be very difficult, or if your health is not very good.*
> (Male service user).

> *The one thing that is brilliant about this place, having been here two years and done every single course, is the attitude of the staff. I mean compared to other homelessness services, this place is professional, the way they treat you, it's professional.*
> (Male service user).

> *Every single member of staff I have encountered in this building has given me support, whether it be a worker or reception. I found everyone I had contact with has given me support.*
> (Female service user).

Many of the participants in the focus groups stressed the role that Skylights played in giving them structure and meaningful and productive activities to pursue, which had counteracted boredom and isolation. Some of the participants linked their participation in a range of arts-based, educational and other activities as helping to support their well-being, both in the sense of providing structure and also in achieving tangible goals that helped reinforce their self-esteem:

> *The timetable, what was offered, really appealed to me. My biggest problem at that time was isolation, I didn't know anybody at all where I lived, I was really lonely, and I was just in a spiral of having loads of time on my hands, being ill and*

getting worse because all I did was sit inside my head, inside my flat, on my own…so this gave me a structure to my day, somewhere to go, and gradually I made a lot of friends here.
(Female service user).

When I was in supported housing, I had the whole day ahead of me, nothing no structure, very isolated, so it was good to get out, meet people, be active in some way.
(Male service user).

I think I'd be in a worse situation without Skylight. I think it has made a difference. It's given me structure during the week and it's helped with my confidence as well.
(Male service user).

Two other elements relating to the general courses, arts-based activity and other services on offer from the Skylights were important to many of the service users. The first, which was repeatedly emphasised, was the range and choice of activities and learning opportunities that were made available by the Skylights. The second, which was related to the broader points that some service users made about the Skylights being 'understanding' services, centred on the willingness of Skylight staff and tutors providing courses to allow someone to set their own pace and the provision of support if they found themselves struggling to reach goals:

They've got English, maths, IT courses and practical courses as well, like painting and decorating and café training, that's another practical example.
(Male service user).

It is nice to be able to do it in smaller steps, set your own pace.
(Male service user).

One of them is to push boundaries. Coming out of your comfort zone. You're challenging yourself. The support from that is absolutely fantastic…the emotional support. Learning new activities that I'd never have done. The educational programme is absolutely fantastic…allows you to look at other things.
(Male service user).

Support with mental health

NHS and social services

Service users' perceptions of NHS and social services were not always positive. There was a widespread belief that mental health services were under-resourced and worked on a 'fire-fighting' model, only intervening and providing support at the point at which a crisis had already occurred. This attitude also sometimes extended to general practitioners (GPs), who were sometimes seen as lacking expertise, resources and sufficient capacity to refer patients to hospital, psychiatric or community mental health services.

Service users also perceived barriers to services that centred on diagnosis, with the view that if someone were diagnosed as having some conditions, particularly a 'personality disorder', this could be a barrier to mental health services. As the experience of the service users with NHS and social services was not directly examined, it is not possible to comment on the veracity of the opinions that some of the service users expressed. However, very similar issues with access to mental health services have been widely documented in research looking at access to mainstream mental health services for homeless people:[33]

I never even got offered stuff, I mean I went to my GP, and I never got offered any services…unless I'd physically gone

33 Rees, S. (2009) *Mental Ill Health in the Adult Single Homeless Population: A review of the literature.* London, Crisis; Centre for Economic & Social Inclusion (2005) *A literature review: Access to mainstream public services for homeless people.* London: Crisis; Jones, A. and Pleace, N. (2010) *A Review of Single Homelessness in the UK 2000-2010*. London: Crisis.

out and done something to myself, or somebody else, I didn't fit any box.
(Female service user).

A few service users reported that the mental health coordinator had liaised with GPs, psychiatrists and other health professionals in relation to both their treatment and their diagnosis. Some of these individuals reported improvements in well-being following these interventions and discussions and there was also some reports of their treatment having improved:

One thing that it's taught me is to be more open with my own mental health issues… with [mental health coordinator] working with my doctor, we've now got a full diagnosis of my full mental health issues.
(Male service user).

Some service users sometimes talked about Skylight as the main, and occasionally the only, means by which they could access support that they needed. In addition, some service users saw Skylight services as more respectful, less patronising and better attuned to their needs. This linked back to a widespread view that Skylights 'understood' homelessness more clearly than some other service providers:

I've had no outside help. I've been in London for three years. I'd really like to thank Crisis for all that they've give me [sic], and through all different steps I'm now seeing someone about my addictions, a counsellor, progression worker, a housing worker, furthering my education, in the six months I've been here.
(Female service user).

For me it is incredible what I did in Crisis… I'd been in trouble with drugs a long time ago, I don't use drugs for many years now…then a problem with getting a job… now I am working.
(Male service user).

Outside I am not getting the support that I am getting here. Female service user. When I was offered counselling at the doctors it was very clinical, very formal, I did try it, but it's not for me. I just felt more relaxed here [Skylight].
(Female service user).

They treat you like adults here. Quite often you don't get treated like an adult in secondary [NHS] services. Quite often they'll treat you like a kid or an idiot…I've never had the respect from secondary services that I get from here.
(Female service user).

Support from the mental health coordinators

The forums and group sessions and the one-to-one support offered by the mental health coordinators were widely praised by service users. The support that service users described closely reflected the ways in which the mental health coordinators had described their own roles, centring on advice, information, practical support, help with accessing services and also providing some emotional help, as someone who would listen:

Emotional support, comes to meetings with me, and sometimes when I get forms [mental health coordinator] helps me with what they mean, and what I've got to do with them.
(Female service user).

My mental health, I didn't realise I had a problem with it, but it was a manifestation of the caring role I had. But it was identified pretty quickly here. [Name], that's the mental health coordinator, was my first port of call and got me access to a counsellor that I see regularly, and tried lots of organisations and activities that would help prevent my mental health getting worse.
(Female service user).

Helping with forms, bureaucracy, I also attend some of the classes here, two

coordinators, one is for the mental health and one for more practical things, this is the first service that I get here.
(Female service user).

Not all the participants taking part in the focus groups were regular users of the forums and group-based activities arranged and run by the mental health coordinators, although all had had contact with a mental health coordinator via groups or one to one sessions. For those who had been active in forums and groups, both the range of activities that the groups and forums undertook, alongside the peer support that could exist within groups, were viewed very positively. The ways in which group sessions could help further understanding of mental health, reinforce or build up a positive self-image, explore managing stress, anxiety and relaxation and meditation were all viewed positively by focus group participants:

We put ourselves to the back and we never came forward. And now what's happened with Crisis, we come to these groups and are all positive about ourselves, so we can go out there and do things we were not positive about two years back.
(Male service user).

The group's helped me to accept issues, made me more aware of what's going on, but what it's also done for me is give me a drive, and awareness of mental health.
(Male service user).

You feel very isolated in that system, but you don't here. The drop-ins are one to one which is brilliant. The forums are group-related so you can share as much or as little as you want in that, the one to ones will direct you to other services that may be helpful to you.
(Female service user).

One final point was raised by service users that centred on what some of them regarded as the 'positivity' of the mental health services offered through the Skylights. This referred to what was perceived as a focus on capacity, strength and ability, rather than the limitations someone faced because of mental health problems or other support needs. For some service users, both Skylight and the mental health coordinators offered a more constructive attitude than they had found in some other services. Again, this perceived focus on capacity, rather than limitations, was sometimes described as increasing levels of self-confidence by some of these service users:

The focus here isn't on problems. It's on, building up your self-esteem.
(Female service user).

They helped me to go on with my life…I didn't have any hope before I came here, I found the people here so nice, they teach you to overcome your problems and get on with your life.
(Female service user).

They help you work your way back up, to solve the problems.
(Male service user).

It's always positive though as well, it's always like full of encouragement and it's not like someone telling you there is no end to your problem, it's not going to get better, it's always like you feel this place is helping you progress and is going to help you step out of the situation you are currently in.
(Female service user).

Service limitations

As had been noted in a few comments made to Crisis through the feedback forms, the service users participating in the focus groups also sometimes wanted more resources available. Most commonly this was expressed in terms of what they saw as a need for an additional mental health coordinator in the three Skylights that had one coordinator in post. It was unusual,

but a couple of participants reported feeling frustrated that it was not possible to see a mental health coordinator at short notice, though this was seen as being because of the coordinators workloads:

> *If I've got one criticism of Crisis it's they've got a real problem with staffing, because we could sure as hell do with another mental health worker.*
> (Male service user).

While the issue of staff availability was raised, the availability of mental health coordinators was generally seen as relatively good. Some service users talked in terms of being guaranteed a response from a member of staff working for a Skylight, when from their perspective getting a response was less certain when dealing with statutory and NHS services.

> *If I drop a couple of levels, I know I can come into the drop-ins here [Skylight], it's about being able to access those services as and when you need them, not when they're ready to ring you back or offer it, and I think that's a huge difference.*
> (Female service user).

From an external perspective, the high reliance of some of the service users on Skylight and the mental health coordinators was evident from the results of the focus groups. It is not possible to generalise from the results of what was a relatively small qualitative research exercise, yet while some service users talked in terms of being enabled to 'move on', others expressed a wish for continued, open ended support from a Skylight and did not wish that support to end. This was in the context of how positively the services provided by mental health coordinators and the wider Skylight services were viewed by many focus group participants. While a positive finding, this raises some potential questions about maintaining throughput for the mental health services operated by Skylights. This point is revisited in more detail in the next chapter.

The views of mental health coordinators

Successes and challenges

An innovative service model

The mental health coordinators saw their integration within the wider Skylight teams as presenting an innovative and effective way of working. Being part of an integrated service response, which was focused not simply on health and well-being, but also on social and economic integration, was seen as a particular strength of the service model by the coordinators.

When a service user faced issues of boredom, isolation or a need for some sort of meaningful or productive activity, the mental health coordinators, as part of a Skylight, were positioned within a larger service team that was designed to deliver a wide range of services that could directly help. Skylights had the potential to provide structure, purpose and opportunities to socialise that in turn might lead to further education, training and paid work. Alongside offering employment related courses and activities, the Skylights also offered art, music, drama, film and creative writing:

> *It's the creativity here. There's that real kind of core of tapping into people's creativity, which really doesn't get a look in in other places that I've experienced… that's a very unique thing…its very therapeutic.*
> (Mental health coordinator).

> *There is such a variety of opportunity that is being offered here, some people may want to take on five courses all at the same time…but you can ease yourself in, in a therapeutic way, say the art course, which is something people roll in to and out of, it happens two or three or times a week in a different way, with different lengths of time, it provides a quiet and purposeful environment…where people can gently ease themselves in.*
> (Mental health coordinator).

This sense that Skylight could offer a package of services, was, according to some of the coordinators, also viewed as a strength of the Skylight model by external agencies. This was linked to a wider sense that the Skylights had the range of services and the flexibility in approach to be able to produce something approaching a bespoke response to a wide range of service users' needs. For some of those mental health coordinators with experience of working in other areas of mental health service provision, their role within Skylight was sometimes seen as contrasting sharply - and positively - with their previous working environments:

> *Many professionals from the psychiatric sector have referred to what a gap in the market, as it were, that Crisis fills, because of the education, learning, training aspect of it and the fact that people can roll on and roll off a course, if they don't like it, that they don't have to start at the beginning of term, that there are things going on in term break and a huge range on offer…*
> (Mental health coordinator).

> *I think Crisis is far more exciting, dynamic and ethical as an organisation…it's more forward thinking, more creative…individual treatment of people is valued highly whereas in the NHS you can get into the numbers game.*
> (Mental health coordinator).

For some of the mental health coordinators, the use of a building-based model was seen as a strength of three of the Skylights. This was because a building had many services under one roof, something that could be seen as facilitating use of the range of support and activity on offer.

> *The fact that it's all in the one building, that we're here. I used to work independently… here it's not that far to go to engage in something, let's go talk about your employment options, let's go get you into a course or something, with it all being here together…it assists people to make those small steps with our support… People can be anxious about travelling or going to new places, it makes it easier.*
> (Mental health coordinator).

Ability to engage with homeless people

Mental health coordinators talked about the ways in which they were able to engage with service users, emphasizing both their own capacity to be flexible and the emphasis on respect and choice within the broader Crisis and Skylight service delivery models. Skylight was seen by some mental health coordinators as being understanding of homelessness, as being tolerant and also patient in ways that some other services were sometimes not:

> *I think within the environment here, where you've got lots of positivity and people can pace themselves, there is a genuine feeling that people can progress at their own pace…and also they are here on a voluntary basis as well, it's very much more a sort of helpful, supportive environment for people to get in touch with their issues and if they want support, they can take advantage of what I have to offer, if they aren't so ready to identify that's probably what they need then I can get alongside and I'm not in a white coat in a hospital context…*
> (Mental health coordinator).

> *When you speak to the members they often say that because I'm not part of the NHS or the statutory service they don't feel like there's that power imbalance that they do sense when they go to a doctor…Many of the members that I come across have got quite a positive impression of Crisis, they're just pleased that they can get some mental health care support as part of this service.*
> (Mental health coordinator).

> *We can keep in touch a bit better with this client group than the NHS can…They're not going to stick to regular appointments, they're not going to show motivation*

to engage, so that's where it falls down straightaway.
(Mental health coordinator).

Relationships with other services
Joint working could be productive and the mental health coordinators reported having successfully enabled access to treatment or enhancing services responses. However, there could also be two difficulties in working with other services. The first difficulty centred on service availability, in that there could be problems in securing a response or cooperation because other services were dealing with very heavy workloads and were perceived as having insufficient resources by the coordinators. The second difficulty that had been encountered, although joint working had helped mitigate the issue, was a concern among some service providers that Skylight would be 'competing' for local budgets which were the subject of on-going cuts. Crisis Skylight could, at least initially, sometimes be seen as a competitor rather than a potential partner. This made clear communication with other services at an early stage very important. Some issues were also sometimes reported with health services not wishing to engage with what was seen as a 'homelessness' service.

I've been to their team meetings. We are here and this is what we can do…but in return I want people to return my phone calls!
(Mental health coordinator).

We're clearly trying to complement what is provided, we are not a competitor… the more collaborative working we have, the more we can break down those issues that concern other agencies and have an enhanced provision in partnership with other people, with everybody feeling they are not under threat from the presence of Crisis, that we're all working to enhance the life of people with mental health problems.
(Mental health coordinator).

Issues in service delivery
Two challenges in service delivery were reported by the mental health coordinators. The first was that demand for services was high, with the coordinators being conscious that there was scope to run additional forums and groups as well as provide additional one-to-one support. The second was that there was constriction to some health and social services as budgets fell. Reductions in other services were seen as potentially increasing the pressures that both the coordinators and the Skylights in wider sense would face in meeting needs.

There were also thought to be areas of activity into which services might expand. In two areas, mental health coordinators reported what they perceived as a need for more services specifically focused on homeless women with mental health problems.

Key findings

- Optional completion of service feedback forms provided by Crisis indicated a high degree of service user satisfaction with the mental health services provided by Skylights. Nearly eight out of ten service users reported that they would recommend the services to others. There was strong agreement with statements on the feedback forms that mental health services helped improve self-confidence, management of emotional and mental health and also access to health services.

- Participants in focus groups undertaken by the University research team reported a very similar picture to that found in the feedback forms collected by Crisis. The tolerance, understanding and patience of the mental health coordinators and particularly their understanding of homelessness was widely praised. The quality of support from coordinators was also widely praised.

- Focus group participants used a range of Skylight services and this could help provide structure, counter isolation and improve self-esteem. There was widespread praise for the quality of the activities and the supportive and understanding attitudes of the staff teams and tutors in the Skylights.

- There was evidence from the focus groups that mental health coordinators had sometimes been instrumental in improving access to NHS and Social Services and had also improved treatment of some individuals. Some service users relied very heavily on the coordinators and on the Skylights more generally, for support. Some questions were raised by the focus groups results about the extent and endurance of the support that some service users wanted from the coordinators and from Skylight services more generally.

- The coordinators viewed their role as part of an integrated team as creating an innovative and effective service. Issues such as boredom, lack of structure during the day and social isolation could be practically countered using the range of training, education and arts-based activities that the Skylights also provided. The ability to respond with both flexibility and with an understanding of homelessness was also seen as a strength. There were some concerns about resource levels in terms of capacity to meet need and also the availability and engagement of some external services.

6 Conclusions

Introduction

This final chapter considers the key findings of the report. The chapter begins by looking at the evidence of success for mental health services in Crisis Skylight, before moving on to consider some of the limitations and risks that may be faced by these services. The chapter concludes by considering the case for expansion of services.

The achievements of mental health services within Skylights

After reviewing the available evidence on mental health services within the Birmingham, London, Newcastle and Oxford Skylight services, a number of achievements can be noted:

- Mental health coordinators had clear goals and a well-defined role. The coordinators understood what their role was, both in the sense of their individual responsibilities and their wider role as part of the staff team within each Skylight service. While some challenges did exist, the coordinators viewed themselves as delivering an innovative and effective service response. The integration of the mental health services with wider Skylight services was viewed very positively by the mental health coordinators.

- There is extensive evidence that homeless people with mental health problems can be a difficult group of people for services to reach and engage. There was evidence that the target client group of homeless and potentially homeless people with mental health problems was being reached by Skylight mental health services in large numbers. However, there was also some evidence of service user attrition, i.e. loss of contact following only short term engagement with Skylight services.

- Service user feedback was very positive. Both the internal feedback mechanisms provided by Crisis and the separate focus groups undertaken by the University research team generated very positive results. The mental health coordinators were seen as professional, understanding, tolerant and supportive and there was a similarly positive view of the wider Skylight services. In some cases, the coordinators and the wider Skylight service were providing the main or sole source of support for service users.

- Tangible goals were being achieved by the mental health coordinators and the wider Skylight services. There was evidence from administrative data of progression in education, engagement with creative arts, alongside reported improvements in mental health. Individual participants in the focus groups conducted by the University reported gains in health and well-being, improvements in access to treatment and positive changes in self-confidence.

- Engagement with the wider range of support and activities offered by Skylights appeared to be widespread. For some of the participants in the focus groups Skylights offered a comprehensive response to a range of needs, providing specific support with mental health, support in dealing with homelessness, meaningful and structured activity during the day and opportunities to engage with education, training, volunteering and developing a skillset to pursue paid work. The creation of an environment of tolerance, respect and patience was often referred to by service users, allowing them to work at their own pace and progress when they felt themselves ready.

The goals of the original proposal to the Department of Health

As noted in Chapter 2, Crisis sought funding under the Third Sector Investment Programme with a project entitled *Improving Access to mental health service provision for single homeless people.* The aim of the project was to improve mental health outcomes for the single homeless people using the Skylight centres. The specific goals were as follows:[34]

- Raise awareness of mental health issues amongst homeless people in a safe and accessible environment, therefore reducing the stigma of mental illness.
- Create a mental health forum/support network for Crisis members which will provide a platform for real participation (user-led) in the decisions affecting their lives.
- Improve access to mental health services for homeless people, specifically around improving access to psychological therapies, therefore increasing their mental health and wellbeing.
- Build and consolidate partnerships with local voluntary and charitable organisations, community mental health teams and other statutory agencies, sharing best practice on homelessness and mental health needs.
- Demonstrate the importance of the provision of specialist mental health services for homeless people.
- Develop an innovative and accessible service model for rollout in new Skylight services as those services were rolled out.

Reviewing these goals in the light of the available evidence, the following conclusions can be drawn:

- Mental health coordinators were improving service provision for single homeless people with mental health problems. The coordinators reported that people who had experienced barriers to mainstream services due to homelessness were using the Skylights and engaging with the services provided and arranged by those coordinators. There was direct evidence from focus groups conducted with service users that access to NHS, social services and other forms of support had been enhanced by the coordinators.
- Service users reported that the coordinators and the wider Skylight services created tolerant, understanding services in which they did not feel stigmatised by their mental health problems or their experiences of homelessness. There was some evidence from the focus groups that service users could get a better understanding of their mental illness through working with coordinators.
- Service users participating in focus groups generally felt listened to. There was also statistical evidence of participation in service user forums.
- There was direct evidence of access to counselling services being provided via the mental health coordinators, combined with the enhancements in access to NHS and social services reported above.
- Partnership working had been extensively developed by the coordinators. These arrangements could work well, although resource issues could sometimes influence the capacity of other agencies to respond.
- There was evidence that the coordinators could directly enhance the well-being of homeless people with mental health

34 Source: Crisis.

problems and also improve their access to counselling and NHS services. The coordinators also facilitated and supported access to the wide range of meaningful activity, education, training and work related programmes offered by the wider Skylight teams of which they were a part.

- There is evidence that an innovative and accessible service model has been developed in the provision of mental health coordinators within Skylight teams and a clear case for expansion of the mental health coordinator service model (see below).

The achievements of Skylight in improving mental health outcomes

This report relies quite heavily on data which were collected and validated by Crisis for administrative purposes. While almost one in ten service users provided feedback to Crisis using the forms which Crisis had designed for the purpose, they were a self-selecting group and not a representative sample. Finally, while the University research team did control all aspects of the focus groups conducted for the purposes of this report and also the interviews with the mental health coordinators, and provide confidentiality for the respondents, this was a 'light touch' observational study without an experimental or quasi-experimental (control or comparison group) element. However, the results from the Crisis collected service user feedback and the focus groups conducted by the University were very similar, most service users had a positive view of Skylight mental health services.

Bearing these caveats in mind, there is still enough evidence to be confident that the mental health services within the Skylights were successfully engaging with homeless and potentially homeless people with mental health problems and often changing their lives and well-being for the better. Further, the successes of the mental health services was one element in a wider successful engagement between Skylights and service users with mental health problems and severe mental illness. Skylight's work on mental health was a success on two levels, both in terms of the direct support being provided and also in terms of wider engagement with the whole range of activities, learning and services that each Skylight had to offer.

Challenges

The Skylights' achievements in service user engagement can and should be seen as a success. Until recent successes with experiments with 'Housing First' service models in Europe,[35] attempts to reduce sustained and recurrent (chronic) homelessness associated with mental health problems, let alone pursue any attempt at social and economic reintegration, had met with only limited success.[36] Skylight can demonstrate extensive and often *sustained* engagement with homeless people with mental health problems, something which in itself is an achievement.

However, the data collected by Crisis and the focus groups and interviews conducted by the University research team, raise what may be two potentially challenging questions for Skylight. These questions centre on two groups of service users:

- People who become very engaged with Skylight mental health and other services, sometimes on a sustained basis; and,

- People who have only a limited level of contact with Skylight mental health and other services for a short period of time.

35 Busch-Geertsema, V. (2013) *Housing First in Europe: Final Report* www.socialstyrelsen.dk/housingfirsteurope/copy4_of_FinalReportHousingFirst-Europe.pdf.

36 Pleace, N. (2008) *Effective interventions for homeless people with a history of substance abuse: Lessons from a review of the Global evidence base for Scotland.* Edinburgh: Scottish Government.

Service users with sustained engagement

Skylights are a transitional service model, intended to progress homeless people towards greater independence, social integration and economic participation. The mental health services within the Skylights fit within that strategic framework, being designed to be part of a service framework that seeks to 'transform' lives rather than act as a source of long-term support (see Chapter 1).

Sustained engagement is not immediately problematic early on in the life of services, but it can potentially limit capacity to meet new need. One option is expansion of services (see below). However, there are limits to how far it is practical for a Skylight team to extend the size and scope of the mental health services it can provide. Against this, there is strong evidence that setting strict goals for service users or time-limiting services is very likely to be *ineffective.* There is almost overwhelming evidence that showing respect, flexibility, patience and warmth, as Skylight services currently appear to do, is a far more effective route to sustained engagement and positive outcomes for homeless people with mental health problems.[37] This is not an easy question to resolve, since changing Skylight in ways that would reduce longer-term use might have seriously negative implications for engagement with new service users.

Service users with limited engagement

Some service user attrition, i.e. 'loss' of service users after limited amounts of engagement, is inevitable when working with homeless people with mental health problems. Globally, the experience is that while it is now possible to develop relatively effective services, which like Skylight emphasise warmth, respect and choice, there will always be some homeless people with mental health problems with whom it is difficult for any given service model to engage with, not least because their needs can sometimes be extremely high and they can sometimes present with challenging behaviour.[38]

While all the Skylights showed success in engaging with this homeless people with mental health problems, only one project was an outreach service, the Birmingham Skylight. One question that can be explored is the use of outreach services as a means to reach populations who might find the prospect of entering the three building-based services more daunting or challenging than if the services came to them or within easier reach in already familiar environments. Again, this question is not a straightforward one, as some of the service users interviewed for this report, using the three Skylights with buildings, were attracted to the provision of a wide range of services all under one roof and also found the atmosphere and sense of safety within the Skylight buildings appealing. Aspects of the role of the coordinators also required access to private spaces, such as the one to one sessions, which is potentially easier if a dedicated space with suitable meeting rooms is available:

> *Instantly comfortable place. Instantly. People were friendly. Staff and other people. Just not got a bad word to say about this place.*
> (Male service user).

The on-going longitudinal evaluation of the Skylight programme by the University of York research team (running from 2013-2015, see Chapter 1) will explore the questions around sustained engagement and also attrition in much more detail.

37 Busch-Geertsema, V., Edgar, W., O'Sullivan, E. and Pleace, N. (2010) *Homelessness and Homeless Policies in Europe: Lessons From Research.* Brussels: European Commission.

38 Busch-Geertsema, V., Edgar, W., O'Sullivan, E. and Pleace, N. (2010) *Homelessness and Homeless Policies in Europe: Lessons From Research.* Brussels: European Commission.

The case for service expansion

The evidence indicates that the mental health services within the Skylights should be both retained and expanded. Expansion should occur in three senses. First, there appears to be a need to simply provide more of the existing service. There are reasons to explore doubling the capacity available in the three Skylights that are operating with one mental health coordinator at present and considering expansion of the team of coordinators operating at the London Skylight. Second, there is sufficient evidence available to strongly suggest that the case for placing mental health coordinators within the staff teams at the Coventry/Warwickshire, Edinburgh, Merseyside and forthcoming Sheffield/South Yorkshire Skylights should be carefully explored and Crisis has on-going plans in this respect. Third, the coordinators identified a specific gap in mental health services for homeless and potentially homeless women, although further work would need to be done by Crisis to ascertain what form such a service should take.

Expansion is desirable to maintain and increase effectiveness of an approach that is already achieving success. However, services cannot be expanded indefinitely both because of resource issues, but also because the role of the coordinators as one part of an *integrated* service response provided by the Skylights appears to be significant in explaining the successes that have been achieved. The evidence suggests that Skylight should retain its current role and focus as a wide ranging homelessness service that can provide some help with mental health if needed. Skylight should not in a strategic sense become proportionately more focused on mental health, even if there is a good argument for considering expansion of mental health services.

Key findings

- There is evidence of successful engagement with large numbers of homeless and potentially homeless people with mental health problems by Skylight mental health services and also by the wider range of services offered by the Skylights. Previous research has suggested this can be a difficult group of service users for mainstream health and other services to successfully reach and engage.

- There is evidence that service users generally regarded the services provided by mental health coordinators and other aspects of service provision by Skylights very highly. Alongside supporting people with their mental health issues, Skylight was also providing vocational, volunteering and educational opportunities, and meaningful structured activity that helped address isolation and boredom.

- Not all the people initially contacting a Skylight were successfully engaged. In contrast, some service users had a degree of reliance on Skylight and a level of service use that raised some potential questions about how to ensure people moved on to greater independence and social and economic integration. This is a difficult question to address as the aspects of the Skylight service that made service users want to engage also sometimes made them want to keep using Skylight services.

- There is a clear case for expansion of mental health services in the Skylights. However, a key factor in the successes of Skylights is the mix of services that are on offer, so any expansion of mental health services should avoid changing the overall structure and underlying strategy of Skylights.

About Crisis

Crisis is the national charity for single homeless people. We are dedicated to ending homelessness by delivering life-changing services and campaigning for change.

Our innovative education, employment, housing and well-being services address individual needs and help homeless people to transform their lives. We measure our success and can demonstrate tangible results and value for money.

We are determined campaigners, working to prevent people from becoming homeless and advocating solutions informedby research and our direct experience.

We have ambitious plans for the future and are committed to help more people in more places across the UK. We know we won't end homelessness overnight or on our own. But we take a lead, collaborate with others and together makechange happen.

GlaxoSmithKline's committed support for Crisis plays a vital role in ensuring we continue to help improve the Health and Wellbeing of homeless people across the UK. Many homeless people suffer from poor physical and mental health and with GSK's support we are able to help them access the health and wellbeing services they need across the eight regions where we operate. Our partnership with GSK reflects the holistic approach necessary to tackle the many challenges of homelessness in society today.

Get in touch

Crisis head office
66 Commercial Street
London E1 6LT
Tel: 0300 636 1967
Fax: 0300 636 2012
www.crisis.org.uk

ISBN 978-1-899257-88-1

Crisis UK (trading as Crisis).
Registered Charity Numbers:
E&W1082947, SC040094.
Company Number: 4024938

Homelessness ends here