Supported accommodation for people with mental health problems

The process of "deinstitutionalization" over recent decades has led to many countries developing supported accommodation services to enable people with mental health problems to live in the community. In the early days, most of these facilities were communal group homes or residences, but over time it became clear not only that people were often able to gain skills for more independent living, but also that many preferred not to live with other service users. In many countries, a range of provision has therefore evolved, including facilities that are highly staffed, 24 hours a day (such as residential care homes), as well as shared group homes and hostels that are less intensively staffed, apartment blocks where residents have their own private tenancy but there are staff on-site at least part of the day, and "floating" or "outreach" models, where staff who are based off-site visit service users in their own individual or shared homes, providing support of flexible intensity.

In some countries, services are now organized into a local "care pathway", where people move from hospital to highly supported accommodation, graduating to more independent settings every few years as they gain skills and confidence. This has the advantage of providing clear goals for people to work towards and tailored support, but it also means that individuals have to keep moving home as they recover from their mental health problems. However, in other countries, buildings within the asylum campus were re-designated as "supported accommodation", with no or few further options for people to move on to. Concerns about a lack of rehabilitative ethos in the more traditional communal residences have led some to assert that mental health services have undergone a process of "trans-institutionalization" rather than deinstitutionalization[1].

Gaining accurate estimates of the number of people living in specialist mental health supported accommodation services is difficult as, in many countries, multiple providers (including statutory social services and voluntary sector organizations) are involved and there are no centralized registration requirements from which data can be extracted. In 2006, it was estimated that around 12,500 people with mental health problems were living in residential care homes in England[2], and around 24,000 people were receiving specialist mental health floating outreach services[3].

The people who need supported accommodation services often have severe, complex mental health problems, such as schizophrenia, with associated cognitive difficulties that impair their organizational skills, motivation and ability to manage activities of daily living[4]. The support they need to live successfully in the community is mainly of a practical nature, including assistance to manage medication, personal care, laundry, paying bills, shopping, cooking and cleaning[5]. Most are unemployed, socially isolated, and many do not participate in civil and political processes[4]. They may therefore also require encouragement and support to access community resources and to remain in touch with family and friends.

In England, the estimated average cost of providing floating outreach to one tenant is around £150 per week, and a place in residential care is estimated as being around £500 per week. Clearly the costs of providing supported accommodation run into billions when multiplied across the thousands of people using these services internationally. In addition, statutory community mental health services will often provide additional input to the residents and staff of supported accommodation services, and therefore both health and social care costs should be taken into account when considering the cost-effectiveness of this approach.

Despite the major investment in supported accommodation services for people with mental health problems, there is a paucity of high quality research investigating the effectiveness of different models. The only rigorous systematic literature review in this area reported the simple finding that no trials of adequate quality had been carried out[6]. This is understandable given the logistic difficulties of randomizing individuals to different types of supported accommodation when clinicians and service users may have strong preferences about the kind of support they feel is required. Nevertheless, there is evidence to suggest definite benefits compared to long-term hospitalization. A study of around 700 long-stay patients discharged to the community following the closure of the two large mental hospitals in north London in the 1990s found that the majority were not only able to sustain community tenure but most were able to move on successfully to less supported settings over the subsequent five years[7]. Similarly, the Berlin Deinstitutionalization Study found that patients' quality of life improved after moving to the community[8]. One small study carried out in an area of London with a well-established mental health supported accommodation care pathway found that, over a five year period, 40% of people moved on to less supported (more independent) accommodation and 26% remained in the same accommodation, without requiring readmission to hospital and without any breakdown in their community placement; overall, 10% progressed to completely independent living in a permanent tenancy[9].

A large survey of mental health supported accommodation across England found few differences in characteristics of users of the three main types: residential care, building based support, and floating outreach[5]. The majority were male, with a diagnosis of psychosis, and almost half also had a history of substance misuse. Most were prescribed psychotropic medication and all services provided support with personal care and activities of daily living. The types of service provided appeared to have little to do with the socio-demographic context of the local area and were mostly driven by different regional approaches to health planning and the availability of statutory mental health services. A national survey of mental health residential care in Italy also reported a lack of association between provision and the mental health needs of the local population[10]. This survey also found

low discharge rates and considered that many residential care services were operating as "homes for life", providing little in the way of rehabilitation.

A number of studies have identified discrepancies between different "stakeholder" views about the level of support required, with service users tending to prefer more independent accommodation, while staff and family members tend to prefer their relatives live in staffed environments[11]. Whilst communal, staffed settings can reproduce institutional regimes[12], some service users have found more independent accommodation, such as supported apartments, to make them feel lonely[13].

In the U.S., the "Train and Place" approach (which provides a constant level of staffing on-site to a number of service users living in apartments, with the expectation of service users moving on to more independent accommodation as they gain living skills) was compared in a quasi-experimental study to the "Place and Train" approach (which provides off-site outreach support of flexible intensity to service users living in time-unlimited, independent tenancies). The latter approach was found to facilitate greater community integration and service user satisfaction[14].

In Canada, the efficacy of a similar model, "Housing First", which provides immediate access to a permanent tenancy for homeless people with mental health problems along with intensive, outreach support from a specialist multidisciplinary community mental health team, was assessed in a recent randomized controlled trial. Although participants receiving the model achieved greater housing stability than those receiving standard care at two year follow-up, there was no statistically significant difference between the two groups in quality of life[15].

A five year programme of research, funded by the National Institute for Health Research in England, is now attempting to address some of the evidence gaps in this field. This project, named QuEST (Quality and Effectiveness of Supported Tenancies for people with mental health problems), includes detailed investigation of the provision, quality, clinical and cost-effectiveness of different forms of mental health supported accommodation services across England, and a feasibility trial comparing supported housing and floating outreach services (www.ucl.ac.uk/quest).

In conclusion, many people with severe mental health problems reside in supported accommodation. There is great heterogeneity in the types of service provided and the content of care delivered within and between countries, and little evidence to guide clinicians and service planners. More research in this field is urgently required to establish the most effective models in which to invest.

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New approaches to interventions for refugee children

The alarming global increase of persons forcibly displaced because of persecution, conflict, violence or human rights violation poses a number of challenges to health and other public sector services. Approximately 51.2 million individuals fall into this broad group, largely consisting of 33 million internally displaced, 17 million refugees and 1.2 million asylum seekers. Conflicts are no longer confined to regions, with the Syrian refugee crisis, for instance, spreading especially to Southern Europe, where Syrian refugees have already exceeded 1.5 million in Turkey alone, of whom 250,000 live in camps. Children under 18 years constitute around 50% of the refugee population, with a total of 25,000 unaccompanied minors applying for asylum annually across 80 countries.

In recent years, there has been increasing evidence on the prevalence of mental disorders in refugee children and the underpinning risk factors, but knowledge remains relatively limited about resilience building, treatment and service efficacy. Studies arise from post-conflict areas or from Western countries with newly arrived (asylum seeking) or resettled (refugee) children and young people. The characteristics of these groups, societal contexts and service systems obviously differ, requiring a range of approaches.

Most epidemiological studies have focused on post-traumatic stress disorder, but when they have been extended to other conditions such as depression, the impact of both past trauma and current life adversities on child psychopathology has clearly emerged[1]. The mediating effect of parental mental illness and parenting capacity is prominent[2], although surprisingly there has been less attention so far to the role of the quality of attachment relationships, including those with extended family members. Unaccompanied children have an elevated risk of psychopathology and lower service engagement compared to refugee children living with their parents[3].