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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1. Priebe S, Frottier P, Gaddini A et al. Psychiatr Serv 2008;59:570-3.
2. The Information Centre. Community care statistics 2006. Supported residents (adults), England. London: The Information Centre, 2006.
3. Department of Community and Local Government. Research into the effectiveness of floating support services for the Supporting People programme. London: Communities and Local Government, 2006.
4. Holloway F. The forgotten need for rehabilitation in contemporary mental health services. London: Royal College of Psychiatrists, 2005.
5. Priebe S, Saidi M, Want A et al. Soc Psychiatry Psychiatr Epidemiol 2009; 44:805-14.
6. Chilvers R, Macdonald G, Hayes A. Cochrane Database Syst Rev 2002;4: CD000453.
7. Leff J, Trieman N. Br J Psychiatry 2000;176:217-23.
8. Priebe S, Hoffmann K, Iserman M et al. Soc Psychiatry Psychiatr Epidemiol 2002;37:387-92.
9. Killaspy H, Zis P. Soc Psychiatry Psychiatr Epidemiol 2013;48:1005-12.
10. de Girolamo G, Picardi A, Micciolo R et al. Br J Psychiatry 2002;181:220-5.
11. Piat M, Lesage A, Boyer R et al. Psychiatr Serv 2008;59:1011-7.
12. Ryan T, Pearsall A, Hatfield B et al. J Ment Health 2004;13:425-9.
13. Walker R, Seasons M. Can J Commun Ment Health 2002;21:137-51.
14. Corrigan P, McCracken S. Soc Work 2005;50:31-9.
15. Stergiopoulos V, Hwang S, Gozdzik A et al. JAMA 2015;313:905-15.

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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].

There has been less research on factors that promote mental health or that moderate stressors in this population, despite the acknowledgement of their direct relevance to planning interventions. Although not always theoretically driven, such studies have identified individual (spirituality, coping strategies, internal locus of control), family (financial circumstances, family acceptance and support) and community factors (neighbourhood safety, social support networks, school retention)[4]. These are important findings, but currently we lack a coherent model that connects them in order to inform the development of interventions and services.

In terms of children's multiple needs, services often aspire to a socio-ecological model, but this is not usually supported by research evidence, as most studies are still based on self-reports, and programmes are rarely implemented at individual, family and community levels. Interventions usually draw on a variety of psychological frameworks, which are largely trauma-focused, whether implemented individually or with groups, but without incorporating the family and community level[5]. They largely target re-experiencing and reconstructing trauma-related cognitions and emotions, and findings are not always exclusively based on refugee children, but rather on children exposed to war and political conflict, and living in a range of circumstances. The theoretical clarity and fidelity of interventions varies considerably, as well as their developmental perspective if adapted from adult programmes, or the demarcation between universal and targeted prevention[6].

Overall, the clinical and socio-ecological fields are gradually converging. Therefore, we need to conceptualize intervention programmes and service development for refugee children in an integrated context. We should also take into consideration the vacuum or limitations of public services in most countries, where there is a huge mismatch between refugee numbers and resources, with this gap usually filled in part by non-governmental organizations (NGOs) of varying philosophies, missions, structures and funding streams. The development of a comprehensive model should also be informed by organizational, in particular implementation theory. The framework proposed by Greenhalgh et al[7] is useful, as it defines sequential stages, each with its own domains, i.e. innovation, adoption by individuals, assimilation by the system, diffusion, and dissemination.

A service distinction should be made between displaced refugee children in low-income countries and those resettled in high-income health care systems, as well as between the acute and the resilience building phases.

In low-income countries, the humanitarian crisis is usually tackled by the United Nations, governmental departments and international NGOs, and this period remains fluid in terms of acute needs and mobility. Group-based, particularly school interventions where possible, are the most cost-effective. A number of modalities have been used, and a small number of studies have employed experimental designs such as randomized controlled trials[8]. These have been based on play, creative-expressive, cognitive-behavioural, narrative exposure, interpersonal, and grief-focused therapies, with a tendency to broaden their scope from only focusing on trauma[9]. This is a useful baseline, but it needs to be maximized through existing systems, predominantly communities and schools; non-specialist health community workers or lay counsellors supporting parents as mediators; and local empowerment[10].

The delivery of interventions in the absence of specialist professionals is another key challenge. In reality, the majority of interventions can only be delivered by suitably trained teachers, NGO staff and volunteers, or lay counsellors, who would thus integrate new skills to their "therapeutic key working role" to form the crucial links with the other eco-levels[11]. This raises implications for consultancy, training and sustainability, e.g. through supervision, which will be the main focus of specialists in addition to using their sparse resources for acute and severe cases. Trauma-focused interventions require a varying degree of skills and training, and this is a major practice issue in balancing treatment fidelity with a large-scale impact on children.

Practitioners and volunteers should be clear on the objectives at different stages of trauma exposure. A tiered model can be clinically and economically effective. Psychoeducation on symptom recognition and management (for example, nightmares) can be put in place relatively early through schools or community settings, preferably by involving parents, who may require additional input in their own right. For children who require a more active intervention, groups of relatively brief duration can be implemented by non-specialist facilitators under clinical supervision, aiming at trauma reprocessing, and these should suffice for a substantial proportion of children. Those children who either do not respond or present with comorbid disorders that necessitate pharmacological treatment or more prolonged therapies, such as depression, should be the focus of the available specialist resources.

When children are resettled in low- or middle-income countries with limited specialist resources, similar approaches to those discussed previously can be adopted, particularly if they are placed in a relatively concentrated area. In high-income countries, service models for a range of vulnerable children with complex needs should be applied, namely direct access, outreach work, and links with refugee charities and employment training[12]. The balance of interventions has gradually shifted from predominantly focusing on the pre-flight trauma to more emphasis on resettlement factors, such as acquiring a new language and communication, socio-cultural adjustment and identity, peer relationships (which can lead to bullying and further victimization), and school inclusion.

Schools still provide an effective entry route into mental health services. Multi-faceted case management can be provided in addition to the described therapeutic interventions, and this can include parenting input or liaison with adult mental health services. Unaccompanied minors require policies and systems equivalent to those for children in public care, e.g. appropriately trained residential staff and foster carers. Reliance on interpreters for a variety of languages makes their training and consistent relationship with services essential.

Following recognition and referral to the appropriate service, a number of practice considerations should be made. Refugee children are likely to have different constructs of mental ill health, attributions that associate it with their asylum applications, and fears of stigma and deportation. Engaging them and alleviating such misconceptions is thus a major step towards a successful outcome. Their psychological mindedness will vary, as many refugee children first experience predominantly somatizing symptoms, and may require several attempts before accepting a trauma-focused treatment. Involving their carers and initially setting goals of, for instance, risk management while developing a trusting relationship can lead to a therapeutic phase, while they also become more adjusted in their country of reception.

In conclusion, refugee children and young people pose a significant public health challenge across the world. Their complex needs require closer collaboration between mental health and non-statutory services to maximize their respective skills and resources. A comprehensive multi-modal service should include clear care pathways, case management, evidence-based trauma-focused interventions, consultancy, and training.

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1. Ziaian T, De Anstiss H, Antoniou G et al. Child Adolesc Ment Health 2012; 17:146-52.
2. Reed R, Fazel M, Jones L et al. Lancet 2012;379:250-65.
3. Michelson D, Sclare I. Clin Child Psychol Psychiatry 2009;14:273-96.
4. Tol W, Song S, Jordans M. J Child Psychol Psychiatry 2013;54:445-60.
5. Vostanis P. Br J Psychiatry 2014;204:1-2.
6. Peltonen K, Punamaki RL. Aggress Behav 2010;36:95-116.
7. Greenhalgh T, Robert G, MacFarlane F et al. Millbank Q 2004;82:581-629.
8. Tol W, Komproe I, Susanty D et al. JAMA 2008;300:655-62.
9. Jordans M, Tol W, Komproe I et al. Child Adolesc Ment Health 2009;14:2-14.
10. Patel V, Rahman A. Child Adolesc Ment Health 2015;20:3-4.
11. Murray L, Familiar I, Skavenski S et al. Child Abuse Neglect 2013;37:1175-85.
12. Vostanis P. Helping children and young people who experience trauma: children of despair, children of hope. London: Radcliffe, 2014.

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Why are some individuals more resilient than others: the role of social support

Trauma is an inextricable component of the human condition. Most individuals are exposed to one or more traumas during their lifetime, but there is great psychological and neurobiological variability in how people respond to these events. While the majority of individuals are largely psychologically resistant or resilient to the negative consequences of trauma, a significant minority develop chronic, debilitating psychological symptoms that markedly interfere with their capacity to function; others may initially develop symptoms and recover, or develop late or delayed symptoms over time.

What explains these differences? The answer is complex and only partially understood. Resilience is generally defined as the ability of an individual to bend but not break, to bounce back, and "to adapt well in the face of adversity, trauma, tragedy, threats or even significant sources of stress"[1]. However, this definition primarily focuses on the individual. In so doing, it fails to explicitly acknowledge that individuals are embedded in social systems, and that these systems may be more or less resilient in their own right, as well as more or less able to support the adaptive psychological capacities of the individual. Thus, responses to trauma and significant stressors are determined by multiple dynamic, interacting individual-level systems (e.g., genetic, epigenetic, developmental, neurobiological), which are embedded in larger social systems (e.g., family, cultural, economic, and political systems).

Like resilience, social support is a complex construct with many definitions. One is from Cohen, who defines it as "a social network's provision of psychological and material resources intended to benefit an individual's capacity to cope with stress"[2]; another is from Eisenberger, who defines it as "having or perceiving to have close others who can provide help or care, particularly during times of stress"[3]. There are many facets of social support which, while overlapping to some extent, reflect unique aspects of this construct. These facets include: structural social support (i.e., the size and extent of the individual's social network, frequency of social interactions); functional social support (i.e., the perception that social interactions have been beneficial in terms of meeting emotional or instrumental needs); emotional social support (i.e., behavior that fosters feelings of comfort leading the person to believe that he/she is loved, respected, and/or cared for by others); instrumental/material social support (i.e., goods and services that help solve practical problems); and informational/cognitive social support (i.e., provision of advice or guidance intended to help individuals cope with current difficulties). These facets of social support can be facilitated and maintained by different systems, including family, community, and state, national, and international systems. Notably, while social support is a key correlate of psychological resilience, it is not universally helpful, as its effectiveness may vary by the type of support provided and the extent to which it matches individual's needs, which may change over time. For example, among Iraq/Afghanistan combat veterans, perceptions of family members' understanding of deployment-related concerns (i.e., functional support) was more strongly related to mental health and resilience than structural and instrumental support[4].