House, Home, Community

Supported housing can provide the community and peer support that many vulnerable groups need to maintain mental well-being

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In August 2006, the CSIP National Social Inclusion Programme published a report on the potential - and under-acknowledged – contribution of mainstream housing services towards the social inclusion of people with a range of mental health problems. The report, "At Home?: a study of mental health issues arising in housing",[1] explored the views of housing staff on what would improve communication and co-working between agencies to help maintain vulnerable individuals in ordinary mainstream housing. Mental Health Today published an abridged account of the study in the November 2006 issue.

Among the "At Home?" report's conclusions was that, if social housing has become the principal vehicle for successive governments' policy commitments to treat and house the most vulnerable in the community, then it should also be seen as one of the essential elements in community care – and this role needs to be better recognised. Considerable progress has been made since then in opening up dialogue between the agencies concerned, and at national government level in prompting greater recognition by mental health services of the importance of housing. (See, for example, the new public service agreement to increase the proportion of socially excluded adults with severe mental health problems in settled accommodation and employment, education or training[2]).

This article is concerned with the role of supported housing in the development of new ways of thinking about mental health in the 21st century. In particular, what is the future for so-called special needs housing – that is, accommodation that individuals choose to move to, in order to live somewhere where their support needs are met, and where the fact of living together adds something extra that visiting support at home just cannot do?

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In his 2004 report The NSF Five Years On,[3] Louis Appleby, national director for mental health, argued that 'we need to broaden our focus from specialist mental health services to the mental health needs of the community as a whole'. At a moment in time when depression has taken over from back pain as the most common disability identified in Invalidity Benefit claims,[4] we, as a society, need to begin to address the 'common mental health problems' of anxiety and depression, and we may need to look again at how best to address issues such as substance abuse, trauma, personality and stress disorders.

Yet this does not need to mean expecting our already over-burdened secondary care services to throw open their doors and become all things to all people. Nor does it mean a huge expansion of mental health services, which would surely create impossible expectations, and would also inevitably provoke accusations about the medicalisation of ordinary human distress.

Instead, if we are serious about developing a social model of disability and a focus on social inclusion, we need to look outside the specialist mental health services to see what the rest of the community has been doing to respond to these issues. This new vista may reveal a different future direction for community mental health care.

Older people

Let us take, for example, older people who experience mental health problems – not those with dementia, and not the people with existing functional mental health problems who are (like the rest of us) ageing - although certainly these are significant issues that need addressing as a new expectation within older persons services. For many older persons, the principal 'common mental health problems' are anxiety and depression.

Worries over loved ones; worries over failing health; fear of increasing dependency, and a wish not to 'be a burden'; dwindling finances, and rising fuel bills; loneliness and isolation, as family members move away, and communities change; and loss – of role, of loved ones, of shared references and common history; all too often, these are the day-to-day experiences of older persons.

If these are seen as mental health issues, then we can see the extent to which warden-aided and even gated "retirement communities" (one of the fastest growing sectors of the housing market) are actually well-tuned and effective responses. While taking care – particularly in 'extra-care housing' – of a person's physical needs, they primarily address their social and emotional needs by providing safety and security, peace of mind, company and companionship, and opportunities for caring about and for each other.

The growth of extra-care housing over the past ten years has demonstrated how popular and effective this kind of integrated care can be in maintaining individuals with all the dignity of independent living, and also the very real benefits of living with congenial company. As the health benefits of 'social capital' are being increasingly recognised, so the healthcare gain from housing options becomes clearer.

In gated and sheltered accommodation we find a community dimension that promotes peer support, befriending, and even mentoring. In the words of Mary Bryce, director of care services at the Housing 21 housing association: 'This is not just "housing-related support". These are housing-based solutions to community care needs. What we are providing here is a real community, not just a building with services in it.'[5]

This is a theme that recurs again and again in the role of housing.

Substance abuse
Another fast-expanding mental health problem is substance abuse. Here, again, the treatment services tend to reside within hospitals or therapeutic communities, and there is a persistent tendency in statutory health and social care to focus solely on such intensive, intentional services for those who need – and recognise the need for – intensive support.

But what of those who have passed through treatment and detox, and now face the challenges of living with sobriety? What are the fundamental anxieties in drug and alcohol recovery, as distinct from the short-term containment of an in-patient detox? Here, the psychosocial issues are somewhat different from those in treatment services. For those who have tried many times to stop their habit, the greatest fear is of being re-absorbed, of slipping back – of finding all the other myriad daily troubles of life just too much without the solace of a drink, a smoke, a fix.

For those all too aware of the powerful lure of oblivion, one of the greatest enemies is denial – the human capacity for self-delusion when faced with temptation. When fragile resolve and lonely ego-strength have proved time and again to be simply not enough, small wonder that many self-help programmes in substance abuse have turned to a power outside of the self.

But this 'outside self' need not be a mystical "higher power"; it can also be other people. We know the power of group membership to help people stick with a difficult decision. Here, the issue is how to rebuild one's life, how to remake a new identity and a new social circle – for street drinkers, the street, and the bus shelter are often the only community they have – and, in particular, how to live in the permanent shadow of the risk of relapse.

Not surprisingly, here too housing has been, for some, a part of the solution. 'Dry' houses for recovering alcoholics and 'clean' houses for ex-users have proved an effective response to the real emotional issues of keeping the faith, and sticking to the decision to live differently. In such existentialist communities where, every day, the individual must retake the decision to stay clean, or stay dry, the fellowship of others is an invaluable resource.

Such houses provide further examples of the benefits of congregating communities in order to provide peer support, with peer-responsibility and peer-confrontation not replacing but complementing solitary struggle. This is, after all, the essential core from which the therapeutic community movement once grew, and it should not be forgotten that the concept of recovery originated in self-help alcoholic treatment.

But still, this is a tiny percentage of the total population of those with problematic substance abuse. The majority either do not need or would not accept such intensive living arrangements. With hazardous alcohol use mounting and amounting to a major public health concern, we need perhaps to think about new ways of creating therapeutic environments for the majority of people with such problems who continue living in their own homes.

Servicemen and women
Another arena where an explicit peer-support, community dimension is proving helpful is in supporting vulnerable ex-service men and women. I recently visited a community for ex-servicemen in Maida Vale, north London, run by the voluntary sector therapeutic community organisation Community Housing and Therapy (CHT). There I talked with half a dozen tough and battle-hardened men who live in their own one-person flats, either in or clustered around a housing complex.

These men were clearly not overly comfortable with the idea that what they received, or needed, was in any way a form of therapy. Nevertheless, what they said to me speaks for itself:

'When you're in the services, you're taken care of, and it's like your little bubble. As soon as that disappears, you feel daunted and isolated. There's just nothing there, and your bubble's gone. But here, it gives you that little sense of belonging that you're missing maybe.'

'I know if I ever had a major problem, I could pop up here and speak to someone, or phone, and we've got each others' phone numbers and that. There is always each other. Even though we have our own lives.'

This may or may not be called therapy,[6] but it is certainly community. We should not forget that the therapeutic community movement has its roots in the resettlement and rehabilitation services devised by the army for traumatised and institutionalised British soldiers during and immediately after the second world war.[7]

Community clusters
The CHT housing solution also demonstrates another valuable point – that 'supported accommodation' does not always need to mean purpose-built, adapted housing. Sometimes, ordinary housing stock can equally well be used in a community project to make it just as much a part of the housing-based solution.

The Foyers Federation, the national federation of Foyer organisations working with young people in the transition to adulthood, has recently reported on the comparative merits of a 'dispersed foyers' model, [8] where support is provided in a cluster of flats and households, rather than in one large hostel. The positive results again seem to suggest that many of the advantages of acceptability, accessibility, a sense of belonging and mutual support are equally available in dispersed housing:

''Cos if you need to talk to people then you know you can. If you don't feel that you can talk to your keyworker, but you can talk to another person that's been through that, then, yeah. I should get a job as a counsellor, me, shouldn't I?'

We also see a similar approach working in the KeyRing networks for people with learning difficulties. The KeyRing approach was explicitly designed to make the best use of its members' own abilities to control their own lives by providing them with the support they need to enable them to do so. Ten ordinary properties are scattered around an ordinary, urban neighbourhood, within easy walking distance from each other. Nine flats or houses are for people with learning disabilities, and the tenth flat is for the KeyRing community living worker, who works part-time on a flexible basis.

KeyRing also builds links with the local community, creating what it calls 'community connections' that, with the mutual support available within the network, reduce dependence on workers and develop members' confidence and self-reliance.

Refuge and resettlement

What is true of the traumas of war and the de-skilling effects of institutional life can be equally true of the traumas that, for some, lead to crime. The proportion of people in the prison population with mental health problems underlying their offending behaviour is estimated to be as high as 70%–80%. A third of all those starting a prison sentence are homeless. A further third will lose their tenancy while in prison.

Yet we also know that, for ex-offenders, the three key things that help prevent a return to offending and re-conviction are a home, a job, and a supportive social network.[9] Of these three keys to averting recidivism, housing has to be the first base: without settled accommodation, how can you get a job, or make a new circle of friends?

For ex-offenders, housing with access to support staff, peer support and, again, mentoring from 'old hands' represents a new approach to re-building lives. The Community Housing and Therapy approach suggests that it would be valuable, and perfectly possible, to develop a peer-and-community support model, even using primarily ordinary housing and individual tenancies.

One area where housing services have gone and mental health services have not is personality disorder. A huge proportion of people with this diagnosis either have not sought help from, or have been turned away by the mental health services. Where did they go? A range of homelessness resettlement services have developed over the past 20 or more years for precisely the populations with a known high prevalence of PD – especially ex-offenders, care leavers, and people with substance abuse problems. Some – not all – of these resettlement services have developed considerable expertise in working with severely chaotic and/or traumatised individuals.[10]

Many refuges for women escaping domestic violence also work therapeutically with residents with problems arising from long-standing and deep-seated trauma and long histories of abuse. The shared recovery paths of individuals in refuges is an important source of emotional support.[11]

Conclusion

All these developments, taken together, begin therefore to suggest a new way of thinking about how we, as a society, support the more vulnerable. It may be that a key role for mental health services in the future may lie not so much – or not solely – in developing new specialist mental health services, but rather in capacity building with other, community agencies, to enable them to help those with both common and also more severe mental health problems in ordinary, non-clinical settings.

Finally, then, what of those with the more severe mental health problems, such as psychoses? Here, too, the need for community, for company, for fellow-travellers in recovery, are the lost dimension within our otherwise more person-centred community care systems – and this is precisely the area where, as we have seen, housing has so much to offer. This topic will be explored in a third article, to be published in Mental Health Today early next year.

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