EVIDENCE BRIEF:

SUPPORTED HOUSING

OUTCOMES TOWARDS PUBLIC HEALTH, WELLBEING & INEQUALITIES

Context

This evidence briefing provides a summary of the key insights from the academic literature on supported housing outcomes as a sector for the Supported Housing Improvement Programme team.

The aim of the work was to: rapidly identify and summarise evidence of public health, wellbeing, and/or inequality outcomes on different types of supported housing schemes (excluding programmes already well known to the team such as Housing First) across groups; to identify factors that underpin the effectiveness in achieving different outcomes; and lesson drawing that could be used to inform the reform of supported housing in Bradford.

What did we do?

Rapid evidence review

A rapid review was conducted with consultation from an advisory group at University of York working in the supported housing sector in September – October 2024. Results totalled **694 articles for consideration**.

Evidence was reviewed in two rounds. The first round discarded articles that were not in scope, based on the reading of the title and abstract, leaving 220 for consideration. These articles were then scored against the aims of the work and for quality. This round resulted in **45 papers which were reviewed in depth**.

Data was extracted against the aims and findings were analysed thematically, with six themes identified.

What did we find out?

6 key themes emerged from the evidence:

1. **Medical and health outcomes in supported housing vary by type of support and population**
2. **Housing outcomes are non-linear journeys with varied understandings of success**
3. **Quality of life outcomes are related to the housing structure and care support in supported housing**
4. **Environment (housing, social and community) is critical to rehabilitation and life progression outcomes**
5. **Autonomy is clearly linked to resident experience and life progression**
6. **Support and care are currently not addressing all needs, and trust and relationships are key aspects to successful care**

UNIVERSITY OF YORK / BRADFORD COUNCIL HEALTH DETERMINANTS RESEARCH COLLABORATION POLICY HUB

Dr Kelli Kennedy kelli.kennedy@york.ac.uk
Dr Amy Barnes amy.barnes@york.ac.uk
Dr Adam Formby adam.formby@york.ac.uk
Fiona Phillips fiona.phillips@bradford.gov.uk
Kevin Brain kevin.brain@bradford.gov.uk

KEY FINDINGS

About the data

The 45 papers analysed reviewed many settings and types of supported housing. 12 populations were specifically reviewed multiple times across various studies:

·People with severe mental illness (SMI) (26 articles)
·People with psychiatric disabilities (8 articles)
·Homeless populations (3 articles)
·People with intellectual disabilities and people who are neurodiverse (3 articles)
·Veterans (2 articles)

Other groups appearing in the literature included abused women, ex-offenders, and Gypsies and Travellers.

Articles studies 14 countries, with England (15 articles) and Sweden (13 articles) being the most prevalent. Other countries included Australia, Brazil, Canada, France, Germany, Hong Kong, Italy, the Netherlands, Northern Ireland, Norway, Switzerland and the USA.

Medical and health outcomes in supported housing vary by type of support and population 1

Medical and health outcomes assessed in the literature included general health rates (1), mental health rates, stability/symptom severity (1-3), clinical status (4), and appropriate health service utilisation and self-management (2, 5).

Outcomes varied in the literature based on what population was studied (e.g. homeless populations, people with learning disabilities, people with severe mental illness, veterans) (1, 2, 4, 7) as well as based on the level of supported housing residents resided in. This indicates a need for bespoke approaches to reaching positive medical and health outcomes based on a residents' history and placement.

Examples

Service use: For those in mental health supported housing previously experiencing homelessness, their residence increased their use of outpatient clinics, reduced hospitalisations, increased their medication visits and increased appropriate use of crisis services (2).

Mental health and different populations: In Haringey, London in supported housing with people with severe mental illness (SMI), general health and mental health rates were highest for those in supported housing forms with high levels of support (e.g. 24hr staffing) compared to medium (staff available all day or regular visits); the worst being for low support (e.g. travelling staff) (1). This compares to the resettlement of people with severe learning difficulties from England's Orchard Hill Hospital into community supported housing, where psychological and physical well-being either held or improved in the transition (8).

KEY FINDINGS

Outside of the UK, in Switzerland individuals with schizophrenia in supported housing had more issues with psychopathological symptoms outside of psychosis than those in acute psychiatric ward care, mirroring the trend in Haringey (9). US veterans with dual diagnoses in supported housing had poorer mental health functioning status and quality of life compared to those with substance and alcohol issues/dependencies (10), lending towards understanding that personal history and diagnoses within placement matters.

Housing outcomes are non-linear journeys with varied understandings of success 2

Housing outcomes varied by type and form, complicated by whether a successful outcome was remaining in residency and having residency stability, or if exit was classified as success (2, 10, 11). Depending on the population in supported housing, timed exit may not be fully appropriate (e.g. potentially with people with profound learning difficulties) whereas for other groups developing resources, networks and skills to exit support systems may be feasible (e.g. potentially with formerly homeless populations).

Multiple studies identified that 'move on' was commonly back into supported housing or another form of it rather than linearly moving to independent accommodation (6, 7); one study finding for supported housing residents, 33% had most immediately moved in from another supported housing facility (7). Durations in supported housing forms also varied, with the literature showing people may not move on in the expected time frame, potentially reflecting service ineffectiveness (6). Work in England found supported housing and floating supported housing estimated to have residents for two years (7).

In one English study, for each additional year of stay over the expected timeframe, the therapeutic environment diminished (12). This said, longer durations were associated with having the time to build life skills, engage in trainings and programmes and build confidence in their next housing, supporting more successful outcomes (13). Tied to move on, there is potential that supported housing may be structured to be too short in duration or under-addressing care needs during the duration of stay to successfully move out of the temporary systems. This lends towards developing a localised understanding of which groups need what format within their specific community in temporary systems.

Examples

Type of accommodation and moving on:
For homeless young adults (17 -25) in London, Leeds, Nottingham and Sheffield, there was a strong association between their previous accommodation - with 82% having never lived alone before - and how long they stayed in their resettled placement. Those remaining in the temporary accommodation more than 12 months were more likely to maintain a tenancy.

KEY FINDINGS

Outcomes linked to the structure of the housing they were resettled to, with those placed in private rented accommodation (including bed sits with a single room and shared kitchen and bathroom facilities) having the worst outcomes. Private renters were more likely to have moved (29%) or be without a tenancy (41%) when followed up with after 15-18 months. This was linked to issues with weekly pricing being double compared to social housing, poor accommodation conditions and issues with landlords, locals and tenants (13).

How accommodation is allocated: In an English study of those being discharged from hospital in the Homeless Hospital Discharge Fund, factors towards housing outcomes bettered when there was an integrated approach between nursing and housing link workers helped discharge homeless patients into suitable onward accommodation (including supported housing). Notably, housing link workers working alone did not show best housing outcomes, indicating joint working with healthcare professionals is needed (14).

Quality of life outcomes are related to the housing structure and care support in supported housing 3

Quality of life (QoL) assessments were prevalent in the literature via survey work including survey assessment toolkits (7) and interviews and observations (15).

While connections were identified in QoL outcomes to different types of supported housing structures when compared (high support, medium support, or floating outreach), evidence was mixed and inconsistent as to which provided the highest QoL (1, 2, 7, 15, 16). Evidence also showed that QoL scores can change during the duration of a residency or programme, as well as after in follow ups – in some literature QoL scores continuing to rise throughout this full sequence for those with intellectual disabilities (8) whereas QoL stagnated or reverted for others from homeless groups (2).

Explanations in the literature for the variation include that QoL is worse in some cases for those in more intensive supported housing due to residents potentially having worse SMI symptoms, affecting their daily living (16). Others identified that self-perception of one's psychopathology and social need in different levels of supported housing were linked to QoL of residents (those in high support having the best QoL, in low, floating support the least QoL). This compares to observer-rated psychiatric scores for residents, as these were not linked to QoL. These differences in what people experience versus what is observable by others demonstrates that a resident's subjective experience of distress needs centring in examining QoL (1).

KEY FINDINGS

Example

Comparing housing type by QoL score: In a survey of 14 regions in England comparing residential care, supported housing (SH) and floating outreach, supported housing scored the highest in six of the seven QoL domains, notably apart from the human rights domain (7).

-**Living environment** *(SH 83%, Floating NA, Residential 78.3%)*;
-**Therapeutic environment** *(SH 65.4%, Floating 59.2%, Residential 58.1%)*;
-**Treatments and intervention** *(SH 58.9%, Floating 48.8%, Residential 54.1%)*;
-**Self-management and autonomy** *(SH 71.7%, Floating 66.2%, Residential 64.6%)*;
-**Social interface** *(SH 68.2%, Floating 51.7%, Residential 54.1%)*; and
-**Recovery-based practice** *(SH 75.5%, Floating 66.2%, Residential 63.4%)*.

The same study identified that supported housing offers the best 'value for money' compared to residential or floating services as the increased spend (SH £261pw, floating £175pw, residential £581pw) was seen as effected spend and associated with better outcomes (7).

Environment (housing, social and community) is critical to rehabilitation and life progression outcomes 4

Numerous studies focused on the importance of environment with three identified environments: physical, community/neighbourhood, and social environments.

For physical environment, the structures of supported housing and its maintenance were linked to residents finding meaning in life and satisfaction with living conditions (16, 17). Better physical quality of buildings were linked to lower mental health service costs, and greater residential stability, whereas deterioration in physical quality of the neighbourhood could heighten mental health problems (18). How buildings were run, e.g. staff locking kitchens, also contributed to the feelings around environment (15).

Structure of residents' environment and being able to create a home environment was important in the literature, linked to identify and safety (13, 19, 20). An international review of evidence identified that for group supported housing structures, tenant spaces need to be structured as a safe room for sleeping, cooking, living and self-care with built in privacy (i.e. private bathrooms), as an important counterbalance to shared spaces (18). One English study noted the refocus on creating a home and nesting for some became an interest away from drug use and was a major accomplishment for residents, translating into self-esteem and pride of home (19). This points to the notion that home building could be viewed as a tool towards life progression and rehabilitation.

For community and neighbourhood, housing stability was linked to the quality of the neighbourhood (2) but often supported housing is located in potentially problematic or unsafe neighbourhoods or in building with issues (18, 21).

KEY FINDINGS

Community integration widened the potentially narrow world residents may have in supported housing (e.g. by meeting new people, learning about community amenities, joining activities) and was linked to rehabilitation (3, 11, 19, 22, 23).

The social environment and relationships were highlighted in the literature as important to life progression by building new valuable social networks, combating loneliness and impacting social functioning (18, 19). Supported housing can support building social connections outside of family bonds with other residents (23-25), but the act of socialisation may be difficult and taxing (20). Many residents from various studies struggling with feeling 'cut off' but desiring finding friends and romantic partners (26), some reporting only having one friend outside of supported housing or their only friends being their support staff (11, 25, 26).

Multiple factors influence the social environment. Physical environments in supported housing influenced the quality of social relationships and social climate (27). Additionally, as familial breakdowns are a common cause of homelessness, particularly for young people (13), relationship rebuilding is a teetering balancing act for both the support workers and the residents themselves, as not all relationship rebuilding may be wanted or appropriate (19, 28, 29).

Example

Physical environment: Impediments to creating a home environment may be due to lack of funds or support to decorate and furnish or continuing maintenance problems deterring residents. In a 2014 English study, 19% of young homeless people were moved into accommodation without electricity or gas and two-thirds moved in without a bed, cooker and basic household equipment initially. To accommodate this, many went into debt to furnish their accommodations, or were in limbo waiting for their items from a Community Care Grant, living several weeks without these basics (13).

Autonomy is clearly linked to resident experience and life progression 5

Various studies strongly connected autonomy (the ability to control and input into their lives) to supported housing, residents' experiences of it and sense of identity (1, 2, 15, 16, 18, 23). Lack of autonomy, choice, and control being associated with reduced QoL scores (2) and lower social functioning scores based on lack of input (1). In one study, lack of autonomy was viewed as one of the worst aspects of living in supported housing (17). Control included aspects of how residencies were run, such as where the few shared accommodation spaces (e.g. living rooms) were controlled, changed (e.g. changing carpets for staff purposes) and/or were under surveillance by staff (18, 29).

KEY FINDINGS

Privacy and control over the residents' space and time fed into an asymmetrical power relationship with staff and tenants, akin to 'mini-institutions' rather than housing (18). This said, while supported housing workers supported and honour a resident's right to self-determination, they found it difficult when they can foresee the consequences when poor or short-termist decisions are made by resident but cannot intervene (30).

Multiple studies linked choice for those with SMI to how they manage daily routines and their environment to higher satisfaction with living conditions and their personal recovery journey (5, 16). This was balanced against the mixed experiences though of while high restrictive formats of supported housing come with reduced autonomy and choice, there was a built-in safety and stability (16). While floating supported housing offered the most autonomy and choice, this was associated with residents feeling less secure and safe at home and linked with loneliness (16). Additional support being something that can combat loneliness and the effects of previous trauma, acting as a security net (24).

Examples

Income as autonomy: Having personal capacity to obtain income was noted as a desire by residents, tied to wanting to be financial independent, autonomous and self-supporting (3, 5), being associated with reducing or preventing debt (13), and achieving financial stability to help rebuild their lives (23). Within supported housing, one study of young adults with neurodevelopmental conditions found finances as a key barrier to participating in social events and where accessing care has associated costs (e.g. bus fare) impacting their life and care options (31).

Self-determination: For Swedish supported housing residents with psychiatric disabilities, their main concern was being deprived of self-determination. This due to lack of privacy, sharing accommodation with people they did not select, and others being able to make unilateral decisions on their behalf regarding their current and future living situations. This lack of self-determination was experienced as feeling powerless, losing meaning in their lives, low self-esteem, low self-worth and limiting what options they see for themselves in the future.

Self-determination was found through 'striving for meaning' in life, through things such as living in the present (e.g. keeping busy), making self-determined choices (e.g. becoming vegetarian), building self-esteem (e.g. seeking affection from keeping pets or confirmation of talents or value from others), processing emotions (e.g. confiding in someone), and resting/escaping from the present (e.g. into fictional entertainment worlds). The greater self-determination achieved, the greater potential for privacy and freedom linking to increased meaning in life. However, failed attempts at self-determination can reduce self-esteem and meaning in life. Actions to increase self-determination can include residents having rights about decisions in their own home, controlling access to their space by locking doors and to not allow in visitors, moving to a new residence, or declining support from people they do not trust (15).

KEY FINDINGS

Support and care are currently not addressing all needs, and trust and relationships are key aspects to successful care

6

Data showed there are unmet care needs in the supported housing system at all levels (1) for multiple populations, including those with SMI, adults with intellectual disabilities and homelessness groups (1, 7, 32). In one study of formerly homeless persons in England, it was shown young people were the least likely to receive tenancy support, with 37% seeking help from their former hostels and local advice centres to fill in the support gap (13). A separate English study found keyworks of supported accommodations indicated higher need scores for the residents than the residents themselves reported, with the authors suggesting residents may be inclined to downplay needs to avoid more restrictive accommodation formats while staff overstate to attempt to ensure enough of the limited resources are allocated (1).

A range of literature identified the pivotal nature of the relationships between support workers and the residents, and the need for mutual trust, positive interactions, lack of judgement and for residents to have autonomy and control rather than feeling coerced (17, 19, 33). Positive views were reported by participants about care staff in many instances where trust was established (22, 28, 33) and where effective care strategies were implemented, such us substance use management diaries for substance users (19). Trust was gained for families of residents by having phone or email access to workers so they could reduce feelings of responsibility for their care (28, 29).

However, limited staff/worker capacity and skill limitations actively worked against care and life progression (14), with participants from one study questioning staff skill levels for supporting people with mental illness, e.g. when there is over-focus on daily routines rather than supporting an active and meaningful life (29). Increased staff time and resources for skill development and training was identified as a need in the data (22, 31).

How care was integrated into residents' lives made a difference in outcome. For example, there was a greater improvement in psychiatric symptoms for homeless groups when mental health services were integrated into their supported housing rather than it being external (2). Care integration between residents, the supported housing provider and care groups (e.g. the health services workers who discharge patients and external practitioners such as dieticians and occupational therapists that treat or advise treatment for residents) impacts the efficacy and experience of support and care (2, 14, 31, 32, 34). The collaborations link to a finding where mothers or family members step in as informal carers and advocates for residents, particularly for those with intellectual disabilities, and act in some instances as the only continuation in care when supported housing staff turnover is high (32).

Examples

Moving care from risk management to rebuilding lives: A Midlands city study identified a risk management model (managing the risk of homelessness) and a restorative model based on rebuilding residents' lives. In their review of this, to go beyond risk management of sustaining tenancy, support workers must be trained and have skills to support residents in rebuilding their lives – i.e. go beyond supporting cleaning and budgeting, to supporting residents build relationships and community with family, neighbours, their support workers and so forth to form crucial relationships needed for ongoing support and progression (19).

Specialised care needs: For Swedish adults with intellectual disabilities in supported housing with diet/meal-oriented supported needs, for the everyday staff, their skills influenced what food the residents in supported housing consumed. This demonstrated that without appropriate knowledge and skills – which is difficult due to high staff turnover, low pay, low job satisfaction and poor workplace organisation – residents are not receiving proper diet and nutritional support. Residents may have highly complex individual food needs and to avoid nutritional deficiencies, staff need proper training, time (especially for newer staff where diet support may take longer than for an experienced staff member) and support to properly offer care. Informants noted there was a lack of resources, education and time to fully offer the care needed, and this was further troubled by the hiring of mainly young, new staff with no previous knowledge of supporting people with intellectual disabilities (32).

Conclusion

This rapid review identified six key findings from the literature. While evidence location and populations varied, there were interconnected issues within the themes around staff timing and resources being a limiting factor, formats of housing and care having impact across various measures, and the importance participants' voice and control.

ADDITIONAL EVIDENCE: TWO INTERNATIONAL CASE STUDIES

Case study 1: Sicily Group Apartments

A 2016 study reviewed the democratic therapeutic communities group apartments (GA) model (a cooperative type of supported housing) in Italy (35). Typically having three to four residents with diagnosis of psychiatric disorders/SMI, GA looks to reduce costs associated with supported housing via community-focused treatment in places in economic crisis. The local municipality enters an agreement with the service firm funding the accommodation, food, bills, personnel and so forth that is needed.

Looking specifically at Sicily GA, which has operated for 14 years, there has been bed turnover around every four years, with 10 lifetime users, compared to the average 15-year stay in Sicily for those in therapeutic communities for psychosis. The purpose-built apartment has a large, bright kitchen, has one bathroom with two beds in each bedroom. Décor is up to the residents and is changed frequently. Community meetings are held every morning involving all residents and duty of care staff, this time being used to discuss initiatives, plan an agenda of things to do together that week (e.g. group outings, food shopping, training courses) and exchange advice. Employment schemes are built into the service and residents' schedules. At Sicily GA, one resident is intending to leave the housing when her job as a domestic cleaner stabilises and two others residents have jobs – one in crafting and one in a hotel cooperative.

Authors found that GAs in Italy, with their democratic principles, allow for empowerment for the residents and pushes back against stigma around mental illness in recovery-oriented treatment. While the main therapeutic activity may vary, democratic elements are built into the fabric of the structure supporting autonomy and participation as a community. Moreover, the GA approach can be a more appropriate structure for people with mental health problems than larger institutions, with better, cheaper and more appropriate treatment (35).

ADDITIONAL EVIDENCE: TWO INTERNATIONAL CASE STUDIES

Case study 2: The Housing and Accommodation Support Initiative (HASI)

A 2010 study evaluated the Australian Housing and Accommodation Support Initiative (HASI), a partnership between non-governmental organisations (NGOs) and the New South Wales Government Department of Health and Housing (11). The coordinated programme for people with psychiatric disabilities offers permanent social housing with a mental health service case manager to handle mental health care, and the NGOs offering longer term accommodation and community support to support independent living – all approximately AUS$58,000pp per year. The 'clients' receive typically 4 to 5 hours of NGO support per day with life and daily living skills, with the NGOs tapping into existing disability groups and organised activities for community engagement.

Results showed HASI had successful outcomes in stabilising housing with 85% of clients remaining in secure affordable housing. Almost all clients engaged in mental health support and time spent in psychiatric hospital and emergency departments decreased by 81% (for those whose records were available). Socially, clients started with limited social networks and community engagement – 23% had no friends – whereas by later follow-ups 94% had established friendships, 73% were involved in social/community activities and 43% were in paid of voluntary work or education training (up from 10%). Authors identified that the housing structure not only provided stability but enabled social and community participation. The addressment of the mental health issues and reduction in symptoms allowed clients the capacity to engage in social and community life.

The engagement of the NGOs was viewed as integral to the improved outcomes due to the intensity of support, the person-centred support approach offered, and that engagement was long term so relationships and efforts could be built upon. Activities such as one-on-one social outings with support staff and organised group activities where the NGO links clients in, creating community integration, were noted positively. Challenges included practical barriers such has NGOs needing to commit personnel and transport resources and financial costs of activities (11).

1. Lambri M, Chakraborty A, Leavey G, King M. Quality of life and unmet need in people with psychosis in the London Borough of Haringey, UK. The Scientific World Journal. 2012.
2. McPherson P, Krotofil J, Killaspy H. Mental health supported accommodation services: A systematic review of mental health and psychosocial outcomes. BMC Psychiatry. 2018;18(1).
3. Piat M, Seida K, Sabetti J. Understanding everyday life and mental health recovery through CHIME. Mental Health and Social Inclusion. 2017;21(5):271-9.
4. O'Connell MJ, Kasprow W, Rosenheck R. Direct Placement Versus Multistage Models of Supported Housing in a Population of Veterans Who Are Homeless. Psychological Services. 2009;6(3):190-201.
5. Piat M, Seida K, Padgett D. Choice and personal recovery for people with serious mental illness living in supported housing. Journal of Mental Health. 2020;29(3):306-13.
6. Killaspy H, Priebe S, McPherson P, Zenasni Z, Greenberg L, McCrone P, et al. Predictors of moving on from mental health supported accommodation in England: national cohort study. The British Journal of Psychiatry. 2020;216(6):331-7.
7. Killaspy H, Priebe S, Bremner S, McCrone P, Dowling S, Harrison I, et al. Quality of life, autonomy, satisfaction, and costs associated with mental health supported accommodation services in England: a national survey. The Lancet Psychiatry. 2016;3(12):1129-37.
8. Sines D, Hogard E, Ellis R. Evaluating quality of life in adults with profound learning difficulties resettled from hospital to supported living in the community. Journal of Intellectual Disabilities. 2012;16(4):247-63.
9. Jaeger M, Briner D, Kawohl W, Seifritz E, Baumgartner-Nietlisbach G. Psychosocial functioning of individuals with schizophrenia in community housing facilities and the psychiatric hospital in Zurich. Psychiatry Research. 2015;230(2):413-8.
10. McGuire J, Rosenheck RA, Kasprow WJ. Patient and program predictors of 12-month outcomes for homeless veterans following discharge from time-limited residential treatment. Administration and policy in mental health. 2011;38(3):142-54.
11. Muir K, Fisher KR, Abello D, Dadich ANN. 'I didn't like just sittin' around all day': Facilitating Social and Community Participation Among People with Mental Illness and High Levels of Psychiatric Disability. Journal of Social Policy. 2010;39(3):375-91.
12. Dalton-Locke C, Attard R, Killaspy H, White S. Predictors of quality of care in mental health supported accommodation services in England: A multiple regression modelling study. BMC Psychiatry. 2018;18(1).
13. Crane M, Warnes AM, Barnes J, Coward S. The Resettlement of Homeless Young People: Their Experiences and Housing Outcomes. Social Policy and Society. 2014;13(2):161-76.
14. Albanese F, Hurcombe R, Mathie H. Towards an integrated approach to homeless hospital discharge: Managing Community Care. Journal of Integrated Care. 2016;24(1):4-14.
15. Brolin R, Brunt D, Rask M, Syrén SP, Sandgren AP. Striving for meaning-Life in supported housing for people with psychiatric disabilities. International Journal of Qualitative Studies on Health and Well-Being. 2016;11(1):1-9.
16. Harrison M, Singh Roy A, Hultqvist J, Pan AW, McCartney D, McGuire N, et al. Quality of life outcomes for people with serious mental illness living in supported accommodation: systematic review and meta-analysis. Social psychiatry and psychiatric epidemiology. 2020;55(8):977-88.
17. Brolin R, Syren S, Rask M, Sandgren A, Brunt D. Residents' perceptions of the most positive and negative aspects of the housing situation for people with psychiatric disabilities. Scandinavian journal of caring sciences. 2018;32(2):603-11.
18. Friesinger JG, Topor A, Boe TD, Larsen IB. Studies regarding supported housing and the built environment for people with mental health problems: A mixed-methods literature review. Health and Place. 2019;57:44-53.
19. Bowpitt G, Harding R. Not Going It Alone: Social Integration and Tenancy Sustainability for Formerly Homeless Substance Users. Social Policy and Society. 2009;8(1):1-11.
20. Lindström M, Lindberg M, Sjöström S. Home Bittersweet Home: the Significance of Home for Occupational Transformations. The International Journal of Social Psychiatry. 2011;57(3):284-99.
21. Harvey C, Killackey E, Groves A, Herrman H. A place to live: Housing needs for people with psychotic disorders identified in the second Australian national survey of psychosis. Australian and New Zealand Journal of Psychiatry. 2012;46(9):840-50.
22. Lindstrom M, Sjostrom S, Lindberg M. Stories of Rediscovering Agency: Home-Based Occupational Therapy for People With Severe Psychiatric Disability. Qualitative Health Research. 2013;23(6):728-40.
23. Piat M, Seida K. Supported housing for persons with serious mental illness and personal recovery: What do families think? The International journal of social psychiatry. 2018;64(8):707-14.
24. Piat M, Sabetti J, Padgett D. Supported housing for adults with psychiatric disabilities: How tenants confront the problem of loneliness. Health & social care in the community. 2018;26(2):191-8.
25. Roos E, Bjerkeset O, Sondenaa E, Antonsen DO, Steinsbekk A. A qualitative study of how people with severe mental illness experience living in sheltered housing with a private fully equipped apartment. BMC Psychiatry. 2016;16(1).
26. Watson J, Fossey E, Harvey C. A home but how to connect with others? A qualitative meta-synthesis of experiences of people with mental illness living in supported housing. Health & Social Care in the Community. 2019;27(3):546-64.
27. Marcheschi E, Brunt P, Hansson L, Johansson M. The Influence of Physical Environmental Qualities on the Social Climate of Supported Housing Facilities for People with Severe Mental Illness. Issues in Mental Health Nursing. 2013;34(2):117-23.
28. Dorozenko KP, Gillieatt S, Martin R, Milbourn B, Jennings K. Transitional supported housing for mental health consumers enabling personal recovery: Allowing me to be me. Advances in Mental Health. 2018;16(2):117-28.
29. Gunnarsson AB, Brunt D, Tjörnstrand C, Argentzell E, Bejerholm U, Eklund M. Navigating in a Misty Landscape – Perceptions of Supporting a Relative Residing in Supported Housing for People with a Psychiatric Disability. Issues in Mental Health Nursing. 2020;41(11):1038-46.
30. Molin J, Lars Isaksson J, Antonsson H. From traditional counselling to health-promoting conversations? Registered nurses' experiences of providing health counselling to people living with severe mental ill-health in supported housing. International Journal of Mental Health Nursing. 2023;32(3):875-83.
31. Löthberg M, Hirvikoski T, Girdler S, Bölte S, Jonsson U. Support in Daily Living for Young Adults with Neurodevelopmental Conditions in Sweden: A Qualitative Description of Current Practice. Journal of Autism and Developmental Disorders. 2024;54(8):3043-58.
32. Adolfsson P, Carlsson ÕU, Ek P. Significant others' perspectives on experiences of meal-oriented support and diet counselling for adults with intellectual disabilities who live in supported housing. International Journal of Developmental Disabilities. 2024;70(3):435.
33. Asmoredjo J, Beijersbergen MD, Wolf JRLM. Client Experiences With Shelter and Community Care Services in the Netherlands: Quality of Services for Homeless People, Homeless Youth, and Abused Women. Research on Social Work Practice. 2017;27(7):779-88.
34. Eklund M, Argentzell E, Bejerholm U, Brunt D, Tjörnstrand C. Outcomes of the Active in My Home (AiMH) intervention for people with psychiatric disabilities in supported housing: A longitudinal pilot and feasibility study. The British Journal of Occupational Therapy. 2020;83(1):6-14.
35. Bruschetta S, Barone R. Group-apartments for recovery of people with psychosis in Italy: Democratic therapeutic communities in post-modern social communities. Therapeutic Communities. 2016;37(4):213-26.

This work was completed as part of the Bradford Council Health Determinants Research Collaboration (HDRC) which is funded by the National Institute for Health and Care Research PHR programme (NIHR151305). Kennedy, Barnes, and Formby are funded by the University of York Research Development Funds. The York Policy Engine is supported by the UKRI Research England Development Fund. Content and views expressed in this briefing are those of the authors and not necessarily those of the National Institute for Health Research, or UKRI.

The York Policy Engine