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HOW COULD LOCAL AUTHORITIES IMPROVE SUPPORTED HOUSING?

LESSONS FROM RESEARCH EVIDENCE ON PUBLIC HEALTH, WELLBEING AND INEQUALITIES OUTCOMES

UNIVERSITY of York

The York Policy Engine

NIHR | Health Determinants Research Collaboration Bradford

EXECUTIVE SUMMARY

Report aims and purpose

This report presents findings from a rapid review of academic literature on supported housing. The review aimed to:

- Identify and summarise evidence of public health, wellbeing and/or inequality outcomes for different types of supported housing schemes (excluding programmes already well known within the sector such as Housing First (1) as was requested by the immediate audience for this rapid review) across different groups supported
- Identify factors that underpin the effectiveness in achieving different outcomes
- Draw lessons that could be used to inform how local authorities review supported housing in their area and develop strategies for the sector

The purpose of this report is to support the development of evidence-informed policy and practice by developing the evidence base local authorities can draw on when developing supported housing strategy, policy and practice with a specific focus on public health, wellbeing and inequalities. This evidence review has particular relevance to the provision of short-term supported housing and the duties relating to exempt accommodation that are provided for in the 2023 Supported Housing (Regulation Oversight) Act.

Defining supported housing

In England, supported housing is **'accommodation packaged with support or care to enable some of the most vulnerable people to live as independently as possible in the community'** (2). Groups served include: people with disabilities, individuals and families facing or who have previously experienced homelessness and people recovering from drug or alcohol abuse; all often with multiple needs (3).

This complex sector covers a range of different types of housing, such as hostels, refuges, supported living complexes and sheltered housing. The accommodation and care components of supported housing may be commissioned, funded and provided by a range of actors including local authorities, Housing Associations and charitable providers; with the groups often interacting in a complex landscape. Provision and practice vary across devolved authorities in the UK and across local authorities in England.

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Policy context

Policy and practice over recent years has focussed on addressing concerns over the quality, cost and effectiveness of supported housing provision, especially of short-term provision in the exempt sector which is exempt from local Housing Benefit caps. These concerns have been highlighted in government reports and enquiries (4, 5). These suggest poor housing quality and exploitation of residents and Housing Benefits for profit (4, 5), including lack of tenant protections and poor conditions, and indicate that supported housing contributes to multiple inequality and wellbeing outcomes.

Key developments include:

- The outlining of national standards for supported housing as part of the National Statement of Expectations (NSE), published in October 2020 (6)
- The Supported Housing Improvement Programme (SHIP), running from 2022 – 2025, to devise approaches to developing better quality and value for money in supported housing provision (7)
- The Exempt Accommodation Third Report of Session 2022-23 from the Levelling Up, Housing and Communities Committee (4)
- The Supported Housing (Regulatory Oversight) Act 2023 (8)

With the recent **2023 Supported Housing (Regulatory Oversight) Act**, local authorities are now being asked to reform their engagement, engage in new ways and have strategic oversight of the exempt sector. Under the Act, English local authorities are required to review exempt accommodation and publish a Supported Housing Strategy, renewable every five years. They are also required to implement licensing regulations, compliant with national standards.

SIX Key Findings

This rapid review identified six key findings from research evidence, informing the core lessons for local authorities when reviewing and developing strategies for oversight of supported housing:

1 Health outcomes (e.g. symptom management, hospitalisation rates) **in supported housing vary by type of support and population**

2 There are varied understandings of 'successful' outcomes for people who access supported housing: success depends on who is being supported and in what types of supported housing (e.g. whether it is short or long-term; i.e. success may be 'moving on' from short-term supported housing or thriving within long-term supported housing)

3 Quality of life outcomes are related to how supported housing is operated and governed, and how support is provided (i.e. low, medium and high levels and types of support)

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4 The quality of the environment (physical housing, social and community) **is critical to rehabilitation, life progression** (e.g. moving forward in resident goals, such as to increased skills) **and health and wellbeing outcomes**

5 Autonomy (i.e. self-determination and control) **is clearly linked to resident experience, life progression and health and wellbeing outcomes**

6 Approaches to support and care are currently not addressing all needs nor promoting 'successful' care. Trust and relationships are key aspects to building successful care

Lessons for local authorities

These recurring findings suggest **three important lessons can be drawn for local authorities** and actions in terms of local reviews of and strategic engagement with the supported housing sector.

Defining supported housing

There are a range of definitions of supported housing, often used interchangeably. **Taken together, they refer to a specific form of accommodation where care, support and supervision are offered to tenants as part of their tenancy; the goal being to support people with specific needs to live as independently as possible** (3, 9). This form of accommodation seeks to provide safe and secure housing with appropriate support to people who may have particular health needs, and/or who have experienced difficult living conditions (e.g. people who have experienced homelessness, substance misuse, domestic abuse, mental health problems and/or who may be disabled) (1, 9, 10).

In England, there are a wide range of models and provider types within the sector, with some groups being expected to transition out of supported housing in the short term (e.g. prison leavers) while others may be supported long term (e.g. people with learning disabilities) (3). Types include managed properties, refuges and local authority hostels (3).

There are two components to supported housing that require funding: 1) the accommodation and 2) care and support. Both can be provided by a range of actors including charitable organisations, Housing Associations, or private organisations (3). For care and support, approximately 38% of all supported housing is funded and commissioned by local authorities or statutory bodies to cover a proportion or total of support, care and supervision as part of the housing service offered (3). Some groups receive more commissioned support services funding than others in their supported housing, such as care leavers and people with disabilities (3).

For non-commissioned supported housing, these costs may be covered by self-funding by the resident, charities, or by the housing provider's income from other activities which they could apply towards the support services (3).

A subset of supported housing is exempt accommodation. This sector takes its name from the fact that the accommodation is exempt from Housing Benefit regulations limiting local housing allowances (locally set caps). Exempt supported housing is a form of private accommodation offered to tenants who have care, support and supervision needs (4, 11). For this, the landlord charges a surcharged rent, attributed to the 'intensive' level of housing management service provided; in practice this means things such as increased security services (4). In exempt accommodation, Housing Benefits are payable at potentially significantly higher rates, above local Housing Benefit rates as they are exempt from local housing allowance caps. Other care needs are then paid for separately in exempt accommodation, often via service charges directly to the resident (4).

Policy context

Policy and practice over recent years has focussed on addressing concerns over the quality, cost and effectiveness of supported housing provision, especially of short-term provision in the exempt sector. These concerns have been highlighted in government reports and enquiries (4, 5, 11). Evidence suggests issues such as poor housing quality and the exploitation of residents and Housing Benefits, including lack of tenant protections and poor conditions (4).

Since 2020, there have been reviews, pilot programmes, policy developments and legislation all aimed at improving the provision of supported housing including:

- The outlining of national standards for supported housing as part of the National Statement of Expectations (NSE), published in October 2020 (6)
- **The Supported Housing Improvement Programme (SHIP)**, running from 2022 – 2025, to devise approaches to developing better quality and value for money in supported housing provision (7)
- **The Exempt Accommodation Third Report of Session 2022-23** from the Levelling Up, Housing and Communities Committee (4)
- **A Supported Housing Review** by the Centre for Regional Economic and Social Research at Sheffield Hallam University, published in 2023 (3)
- **The Supported Housing (Regulatory Oversight) Act 2023** (8)

The Supported Housing (Regulatory Oversight) Act has a specific focus on addressing problems in the exempt sector. Under the Act, English local authorities are required to review exempt accommodation and publish a Supported Housing Strategy for the provision of supported exempt accommodation, renewable every five years. Local authorities must consult with relevant stakeholders when developing the strategy. They are also required to implement licensing regulations, compliant with national standards.

Given the current policy context and legislative duties placed on local authorities, there is scope to review existing evidence to inform supported housing policy and practice at the local authority level.

The research

Policy and practice over the previous recent years has focussed on addressing concerns over the quality, cost and effectiveness of supported housing provision, especially of short-term provision in the exempt sector. These concerns have been highlighted in government reports and enquiries (4, 5, 11). Evidence suggests issues such as poor housing quality and the exploitation of residents and Housing Benefits, including lack of tenant protections and poor conditions (4).

Aims

A rapid review of the literature on supported housing was conducted to:

- **Identify and summarise evidence** of public health, wellbeing and/or inequality outcomes for different types of supported housing schemes (excluding programmes already well known within the sector such as Housing First (1), as was requested by the immediate audience for this rapid review) across groups
- **Identify factors that underpin the effectiveness** in achieving different outcomes
- **Draw lessons** that could be used to inform how local authorities review supported housing in their area and develop strategies for the sector

Method

- A rapid review (12) was conducted in two databases (EMBASE and ASSIA), with consultation from an advisory group at University of York working in the supported housing sector in September – October 2024
- ASSIA was first searched, yielding 451 results; EMBASE returned 326 peer-reviewed articles, 243 which were not identified in ASSIA, **totalling 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

- The second round scored the remaining articles for relevance to the aims and 'richness' out of a total score of 9. At this stage, **220 articles were scanned against the established criteria** (114 from ASSIA, 106 from EMBASE). No papers scored '9', while 11 papers (4 from EMBASE, 7 from ASSIA) scored 8s, and 34 papers (13 from EMBASE, 32 from ASSIA) scored 7s; totalling 45 papers moving forward for review (21 qualitative, 10 quantitative, seven mixed-methods, and seven systematic reviews)
- **45 of the most relevant papers were reviewed in-depth** and data extracted against the aims and analysed thematically, with six findings identified

About the data

The 45 papers analysed reviewed many settings and types of supported housing. Papers included 21 qualitative, 10 quantitative, seven mixed-methods and seven systematic reviews. 12 specifically named populations appeared in the literature.

Evidence on supported housing included papers related to 14 countries. Evidence relating to supported housing in England appeared the most frequently in included papers; being mentioned in 15 papers.

Table 1: Populations

Population	Number of papers
People with severe mental illness	26
People with psychiatric disabilities	8
People experiencing homeless	3
People with intellectual disabilities or are neurotypical	3
Veterans	2
Those leaving hospital	1
Those abusing substances	1
Women facing domestic violence or abuse	1
Gypsies and Traveller communities	1
People with dementia	1
Those engaged in sex work	1
Those classed as ex-offenders	1

Total 12 populations highlighted, with 49 total appearances

Table 2: Countries

Country	Number of papers
Australia	5
Brazil	1
Canada	9
England	15
France	1
Germany	1
Hong Kong	1
Italy	1
Netherlands	1
Northern Ireland	1
Norway	1
Sweden	13
Switzerland	2
USA	8

14 countries, with 65 total appearances

SIX Key Findings

Six key findings emerged from the research evidence:

1. Health outcomes *(e.g. symptom management, hospitalisation rates)* **in supported housing vary by type of support and population**

2. There are varied understandings of 'successful' outcomes for people who access supported housing: success depends on who is being supported and in what types of supported housing *(e.g. whether it is short or long-term; i.e. success may be 'moving on' from short-term supported housing or thriving within long-term supported housing)*

3. Quality of life outcomes are related to how the supported housing is operated and governed, and how support is provided *(i.e. low, medium and high levels and types of support)*

4. The quality of the environment *(physical housing, social and community)* **is critical to rehabilitation, life progression** *(e.g. moving forward in resident goals, such as to increased skills)* **and health and wellbeing outcomes**

5. Autonomy *(i.e. self-determination and control)* **is clearly linked to resident experience, life progression and health and wellbeing outcomes**

6. Approaches to support and care are currently not addressing all needs nor promoting 'successful' care. Trust and relationships are key aspects to building successful care

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

Importantly, **there is no agreement on what constitutes successful outcomes**, including health outcomes, in different types of supported housing. A range of assessment measures for health outcomes were used in the articles reviewed. Health outcomes assessed included:

- general health rates and measures (13-15),
- mental health rates and measures (16, 17),
- stability/symptom severity (13, 18, 19),
- clinical status (20), and
- appropriate health service utilisation (e.g. outpatient clinics, use of crisis services), hospitalisation rates and self-management (18, 21, 22).

Mental health improvements were discussed in included papers as being linked to the support people received within their supported housing (16, 17, 23). There was minimal data indicating improved physical health outcomes (24).

Health outcomes varied based on what population was studied (e.g. homeless populations, people with learning disabilities, people with severe mental illness, veterans) (13, 18, 20, 25) as well as the type of supported housing residents resided in. The reported variations in health outcomes suggest the need for bespoke approaches to reaching positive medical and health outcomes based on a resident's history and placement.

Examples of varied health outcomes by population:

People with mental health problems who have experienced homelessness: A systematic review highlighted for those in mental health supported housing in England previously experiencing homelessness, their residence was associated with increased use of outpatient clinics, reduced hospitalisations, increased medication visits and increased appropriate use of crisis services (18).

People with severe mental health problems: In a supported housing programme for people with severe mental health illness in Haringey, London, 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 for low support (e.g. travelling staff) (13).

People with severe learning difficulties: In the resettlement of people with severe learning difficulties from England's Orchard Hill Hospital into community supported housing, psychological and physical well-being either held or improved in the transition (26).

People diagnosed with schizophrenia: 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 listed above (27).

Veterans: US veterans with dual diagnoses (e.g. depressions and schizophrenia) in supported housing had poorer mental health functioning status and quality of life compared to those with substance and alcohol issues/dependencies (14), lending towards understanding that personal history and diagnoses within placement matters.

There are varied understandings of 'successful' outcomes for people who access supported housing: success depends on who is being supported and in what types of supported housing 2

Length of time in supported housing, past experiences of housing, the conditions of supported housing, how it is provided, and extent of integration within wider systems of health and social care are all factors that can shape 'successful' outcomes (i.e. 'move on' or thriving).

Successful supported housing outcomes vary depending on who is being supported and in what types of housing people reside (e.g. whether it is short or long-term); success may be moving on from short-term supported housing and subsequent residential stability, or thriving within long-term supported housing (14, 16, 18). For example, depending on the population in supported housing, timed exit may not be appropriate (e.g. potentially with people with profound learning difficulties) whereas for other groups developing resources, networks and skills to exit may enable exit to 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 progression to independent accommodation and residential stability (24, 25). One study found 33% of supported housing residents had transferred from another supported housing facility (25). Durations in supported housing forms also varied, with the literature showing people may not move in expected' time frames, with authors reflecting upon service (in)effectiveness (24).

Work in England found supported housing and floating outreach estimated to have residents with them for two years (25).

In one quantitative English study, the length of time people stayed in supported housing was crucial. The longer people stayed over the expected timeframe, the more the therapeutic environment (culture within the supported housing) diminished (28). Alternative work indicated longer durations were associated with having the time to build life skills, engage in trainings and programmes and build confidence in their next housing; these supported more successful outcomes (29). Tied to move on, there is potential that supported housing may be too short in duration or under-addressing care needs for residents during the duration of stay preventing successful move out of the temporary systems. This suggests the importance of developing a nuanced understanding of which groups need what format and durations of supported housing services in relation to outcomes.

Examples of 'success' outcomes:

Type of accommodation and moving on: For homeless young adults (ages 17 -25) in London, Leeds, Nottingham and Sheffield, there was a strong association between their previous accommodation 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. The large-scale qualitative study highlighted that 82% of their young adults had never lived alone before, influencing their duration in their resettled placement (29).

Outcomes were also related to the housing structure of the housing they were resettled in, 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 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 (29).

How accommodation is allocated: In an English study of those being discharged from hospital in the Homeless Hospital Discharge Fund, housing outcomes were improved when there was an integrated approach between nursing and housing link workers. This helped discharge homeless patients into suitable onward accommodation (including supported housing). Notably, housing link workers working alone did not lead to good housing outcomes, indicating that joint working with healthcare professionals is needed (30).

Quality of life outcomes are related to how the supported housing is operated and governed, and how support is provided 3

Quality of life (QoL) assessments were prevalent in the literature via survey work including assessment toolkits (25) and interviews and observations (31) to assess residents' experiences and life quality. Quality of life outcomes varied between high support, medium support and floating outreach. However, the evidence was mixed and inconsistent as to which produced the highest quality of life outcomes and for which groups (13, 18, 25, 31, 32). Evidence also showed that QoL scores can change during the duration of a residency or programme, as well as after in follow ups. Evidence suggests that QoL scores continued rising through residency and afterwards for those with learning disabilities (26). By contrast, for those experiencing homelessness, the evidence suggests that QoL outcomes could plateau or even go into reverse (18). The literature becomes complex because of variations in the definition of supported housing, for example, whether supported housing includes services such as floating outreach. In England, Housing Benefits only apply to specified housing or specified exempt housing meaning floating outreach is not technically viewed as a supported housing scheme (3).

Explanations for the variation in the literature include that QoL is worse in some cases for those in more intensive supported housing, due to residents potentially having worse severe mental illness (SMI) symptoms, affecting their daily living (32). Others identified that self-perception of one's mental illness and social need in different levels of supported housing were linked to QoL of residents (those in high support having the best QoL, those in low, floating support the least QoL). This compares to observer-rated psychiatric scores for residents - 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 (13).

Example of QoL outcomes:

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 QoL in six of the seven QoL domains – notably apart from the human rights domain (25).

- 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%)
- 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 effective spend and associated with better outcomes (25).

The quality of the environment (physical housing, social and community) is critical to rehabilitation, life progression and health and wellbeing outcomes

4

Numerous studies focused on the importance of environment, specifically the physical housing, social environments, and community and neighbourhood of supported housing, for promoting rehabilitation, life progression and health and wellbeing outcomes.

For physical housing environment, the physical structure of supported housing and its maintenance were linked to residents finding meaning in life and satisfaction with living conditions (32, 33). Better building quality was linked to lower mental health service costs and greater residential stability. Deterioration in physical quality of the neighbourhood could heighten mental health problems (34). How buildings were run, e.g. staff locking kitchens, also contributed to the feelings around environment itself (31).

The structure of residents' environment and being able to create a home environment was linked to identify and safety (29, 35, 36). 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 (34).

One English study noted a focus on creating a home and nesting provided an alternative focus for some residents with drug dependency problems (35). Creating a home became a major accomplishment for residents, translating into self-esteem and pride of home (35). This points to the importance of home building as a pathway towards life progression, wellbeing and rehabilitation.

For community and neighbourhood, housing stability was linked to the quality of the neighbourhood (18) but often supported housing is located in potentially problematic or unsafe neighbourhoods or in buildings with issues, e.g. structural issues (17, 34). Community integration offered a way of widening the world of residents (e.g. by meeting new people, learning about community amenities, joining activities) and was linked to rehabilitation (16, 19, 35, 37, 38).

The social environment and relationships were highlighted in the literature as important to life progression by building new, valuable social networks, combating loneliness and influencing social functioning (34, 35).

Supported housing can support building social connections outside of family bonds with other residents (38-40), but the act of socialisation may be difficult and taxing (36). Various studies reported many residents struggling with feeling 'cut off' but desired finding friends and romantic partners (41), some reporting only having one friend outside of supported housing or their only friends being support staff (16, 40, 41).

Multiple factors were reported as influencing the social environment, including the other areas of environment. Physical environments in supported housing influenced the quality of social relationships and social climate (42).

Additionally, as familial breakdown is a common cause of homelessness, particularly for young people (29), relationship rebuilding was a core consideration and balancing act for both the support workers and the residents themselves, as not all relationship rebuilding may be wanted or appropriate (35, 43, 44).

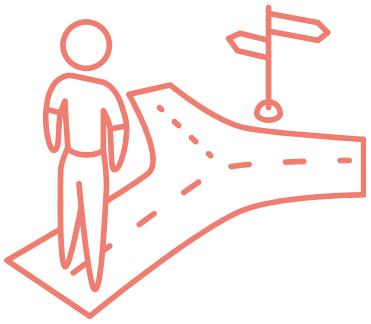
Example of quality of environment impact:

Physical housing 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 went without while waiting for their items from a Community Care Grant, living several weeks without these basic essentials (29).

Autonomy is clearly linked to resident experience, life progression and health and wellbeing outcomes 5

Various studies strongly connected autonomy (the ability to make independent decisions about living arrangements and support and have control over one's life) to residents' experiences of supported housing and sense of identity (13, 18, 31, 32, 34, 38). Lack of autonomy, choice and control were associated with reduced QoL scores (18) and lower social functioning scores based on lack of input (13). In a Swedish study, lack of autonomy was viewed as one of the worst aspects of living in supported housing (33). Control included aspects of how residencies were operated, such as where the shared accommodation spaces (e.g. living rooms) were controlled, changed (e.g. changing carpets for staff purposes) and/or were under surveillance by staff (34, 44).

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 (34). This said, while supported housing workers supported and honoured a resident's right to self-determination, they found it difficult when residents made poor or short-term decisions with what they saw as negative consequences but could not intervene (45).



Multiple studies linked choice for those with SMI over how they managed daily routines and their environment to higher satisfaction with living conditions and their personal recovery journey (21, 32). These studies, however, need to be balanced against other studies which suggest mixed experiences for those with SMI (32, 39). For example, while highly restrictive formats of supported housing come with reduced autonomy and choice, there was a built-in safety and stability (32). By contrast, while floating outreach housing offered the most autonomy and choice, this was associated with residents feeling less secure and safe at home and linked with loneliness (32). Additional support being something that can act as a security net and combat loneliness and the effects of previous trauma (39).

Examples of autonomy's impact:

Income as autonomy: Having personal capacity to obtain income was desired by residents, tied to intentions to gain financial independence and become self-supported (19, 21); this being associated with reducing or preventing debt (29), and achieving financial stability to help rebuild their lives (38).

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, care options (46), impacting choice. This suggests the importance of integrating provision of livelihood-based support for those living in supported housing to broaden their options and independence.

Self-determination: In one study with Swedish supported housing residents with psychiatric disabilities, their main concern was being deprived of self-determination (31). This was 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. 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 (31).

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 (31).

Approaches to support and care are currently not addressing all needs nor promoting 'successful' care. Trust and relationships are key aspects to building successful care 6

A recurring theme in the literature is that there are unmet care needs in the supported housing system at all levels (13) for multiple populations, including those with SMI, adults with intellectual disabilities and homelessness groups (13, 25, 47). 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 (29).

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 (33, 35, 48). Positive views were reported by participants about care staff in many instances where trust was established (37, 43, 48) and where effective care strategies were implemented, such as substance use management diaries for substance users (35). Trust was gained for families of residents by having phone or email access to workers so they could reduce feelings of responsibility for the person's care (43, 44).

However, limited staff/worker capacity and skill limitations actively worked against care and life progression (30), 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 (44). Increased staff time and resources for skill development and training was identified as a need in the data (37, 46).

An English study found keyworkers in supported accommodations indicated higher need scores for the residents than the residents themselves, with the authors suggesting residents may be inclined to downplay needs to avoid more restrictive accommodation formats while staff overstate the needs to attempt to ensure enough of the limited resources are allocated (13).

How care was integrated into residents' lives made a difference to outcomes. 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 delivered as a separate, externally-accessed service (18). 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) impacted the efficacy and experience of support and care (18, 30, 46, 47, 49). The need for collaboration links to research where mothers or family members that step in as informal carers and advocates for residents, particularly for those with intellectual disabilities (47), are acting in some instances as the only continuation in care, as supported housing staff turnover is high (47).

Examples around approaches to support and care:

Moving care from risk management to rebuilding lives: A Midlands UK city study identified a risk management model (managing the risk of homelessness), and a restorative model based on rebuilding residents' lives. In their review, 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 (35).

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 exacerbated by the hiring of mainly young, new staff with no previous knowledge of supporting people with intellectual disabilities (47).

Case studies: reviewing examples featuring multiple key finding areas

The following two international case studies offer insights into two programmes studied in the literature reviewed. These cases were selected as they cover numerous of the findings above and offer examples of what is possible in the supported housing field.

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 (50). 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 users overall, 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 their schedules. At Sicily GA, one resident is intending to leave the housing when her job as a domestic cleaner stabilises, and two other 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 push 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 (50).

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 (16). 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 (estimated £36k, based on January 2010 rate). 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, with time spent in psychiatric hospital and emergency departments decreasing 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 meaning 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 as NGOs needing to commit personnel and transport resources and financial costs of activities (16).

Lessons for Local Authorities

The evidence identified a range of issues in supported housing related to health, wellbeing and inequalities, including around outcomes. This included issues around housing and care quality, the physical and social environments in supported housing, and autonomy amongst others (13, 18, 25, 31, 32, 34, 38). Impacts of supported housing were also identified, e.g. supported housing affects mental health symptoms, hospitalisation rates and housing 'move on' (13, 18, 19, 24, 25).

Based on the research evidence reviewed, **we identified three lessons for local authorities to draw on** in their future engagement in the supported housing sector.

1. Local authorities could usefully approach supported housing as a public health issue and link with relevant parties and leverage partnerships to affect change locally. In order to address the range of health and wellbeing issues and inequalities that are present, created and reproduced within the supported housing sector, interdisciplinary and multi-sector support is required. Partnerships are particularly important given limits to the powers and capacities of local authorities to act alone. As supported housing engages across multiple actors and sectors, in practice and in funding, engagement between them all can help gain clarity on the issues present in their local authority area and identify opportunity gaps. Relevant partners include NHS hospitals discharging patients, primary care, providers of supported housing, and charities participating in the sector, as well as residents themselves. Engaging residents in strategic action, while not straightforward, could be an important means to bringing about change in ways that meets needs, autonomy and life progression, e.g. such as through more democratic approaches (see case study 1). Local authorities could consider reviewing/auditing where within local supported housing systems public health, wellbeing issues and inequalities are present or at risk of (re)production.

2. As supported housing is part of a complicated wider system, complexity-informed evaluation is needed to evaluate appropriate outcomes for populations or individuals accessing supported housing. Having evaluation designs based on a range of evidence can help define what success looks like in supported housing; this includes varied understanding of what assessments and outcomes should be aimed for. Critically, this comes from engaging with and understanding the needs of various housing populations, their needs and their visions of success.

Supported housing engages with various populations and not all may be most appropriately supported through this system, i.e. some may not be well placed in a supported housing structure but arrive there due to gaps or inefficiencies in other areas of service provision within the local authority. Local authorities could consider identifying ways to implement mechanisms, with partners, to ensure tenants are in the most appropriate supported housing structure possible.

3. Because care and support approaches do not currently meet all needs, strategic action is needed in the supported housing sector to address both quality (e.g. undertrained staff) and quantity issues (e.g. insufficient amounts of care provided). Local authorities could ensure that all relevant strategic local boards and committees are aware of the challenges and complexity of issues and devise ways to assess their local supported housing and exempt accommodation landscape. Local guidance and expectations about what 'good support' means could usefully be developed and co-produced with residents. This would also influence experiences of autonomy. While this can be difficult due to constrained financial limitations in the sector (felt by local authorities and providers) (3), without intervention supported housing risks not being fit for purpose and will likely lead to poor outcomes and challenges in other parts of local health and social care systems.

Conclusion

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

Local authorities have a key role in supported housing and lessons from this review are directly applicable. We have identified three lessons for local authorities to apply to their own engagement with supported housing, with a focus on the public health, wellbeing, and inequalities within the system.

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