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Review Essay

Studies regarding supported housing and the built environment for people with mental health problems: A mixed-methods literature review

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ABSTRACT

Places where people live are important for their personal and social lives. This is also the case for people with mental health problems living in supported housing. To summarise the existing knowledge, we conducted a systematic review of 13 studies with different methodologies regarding the built environment in supported housing and examined their findings in a thematic analysis.

The built environment of supported housing involves three important and interrelated themes: well-being, social identity and privacy. If overregulated by professionals or located in problematic neighbourhoods or buildings, the settings could be an obstacle to recovery. If understood as meaningful places with scope for control by the tenants or with amenities nearby, the settings could aid recovery.

1. Background

1.1. Post-asylum geographies

Asylums in the nineteenth and early twentieth century were places for sheltering, disciplining and treating people suffering from mental health problems in segregated and institutionalised environments (Foucault, 2006a; Philo, 2004). These older mental health geographies were replaced by current 'post-asylum geographies' (Wolch and Philo, 2000). Post-asylum geographies are characterised by a complex network of new social spaces such as mental health institutions, facilities and accommodation for housing, caring for and assisting people with mental health problems living in the community within different neighbourhoods and regional contexts. These geographies are the results of several ongoing processes which started in the late twentieth century and are referred to as deinstitutionalisation. Deinstitutionalisation describes the return to the community of people with mental health problems which started when the asylums were downsized in the 1950s in the United States (US) and Great Britain and later in other Western countries. This process of deinstitutionalisation was connected to changes in social policy (Grob, 1991) and critiques of inhuman psychiatric practices by service users movements and scholars (Davidson et al., 2010; Foucault, 2006b; Goffman, 1961; Scull, 2015).

When the walls of the old asylums were metaphorically crumbling (Cornish, 1997), the number of beds in mental hospitals was reduced and former patients returned to lives in the community. The discharged patients with continuous mental health problems transitioned to different types of community-based support. This support could consist of medication, different therapeutic interventions and housing, but some individuals were in the care of their families and others were even left homeless (Kearns and Joseph, 2000; Knowles, 2000; Wolpert and Wolpert, 1976). Deinstitutionalisation in North American cities led to a concentration of people with mental health problems in poor urban districts with affordable housing and resulted in the downward 'drift' of 'service-dependent ghettos' (Dear and Wolch, 1987). Milligan (1996) considered this concept as partly transferrable to the settings in the UK, after allowing for local differences, and highlighted the importance of the voluntary sector. Several other studies indicated that people with mental health problems also face structural barriers such as poverty, disadvantages in the labour market and housing problems (Curtis, 2004; Rogers and Pilgrim, 2006; Sylvestre et al., 2018; Wilton, 2004, 2003).

To address the downsizing problems at the end of the twentieth century, new types of accommodation were established to support and integrate people with mental health problems in the community, often summarised under the term 'supported housing' (Carling, 1990). Some types of supported housing are custodial, while others are more supportive with on-site care professionals (Ridgway and Zipple, 1990) or characterised by off-site support (Nelson, 2010). Supported housing, described as custodial, can be understood as a new kind of institution in

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the community. Even housing comparable with institutions might be homes for integration in society, but at the same time the staff might focus on sheltering, disciplining and providing care, similar to the older institutions; called trans-institutional (Högström, 2018; Moon et al., 2015) or re-institutional movement (Fakhoury and Priebe, 2007).

Concerning post-asylum geographies, there are ongoing debates about the risks of having people with mental health problems living in the community. Moon (2000) and Rose (1998) emphasised a strong focus on confinement and safety issues in mental health policy. In some cases, people with mental health problems also belong to the group of disadvantaged people who are not welcomed as neighbours, a phenomenon described as 'Not In My Back Yard' (NIMBY) (Dear, 1992; Dear and Taylor, 1982). In post-asylum landscapes there is the still-ongoing stigmatisation experienced by people with mental health problems, labelled by their 'unorthodox normalities' as service users in the community (Pinfold, 2000). Even when former asylums were converted for other purposes, such as schools, the 'facility-based stigma' seemed to be embedded in the walls (Moon et al., 2015). Ideas from older days were still present in the buildings by the way they are built and written about (Kearns et al., 2010). Moreover, Parr (2000, 2008) found that participation in a rural neighbourhood could reduce stigmatisation and increase integration; for example, when neighbours invited people with mental health problems to their homes or joined them in church to make them feel included. Nonetheless, service users experienced both inclusive and exclusive rural settings in daily life (Parr et al., 2004). Yanos (2007) recommends further research on all types of supported housing in post-asylum geographies and how these places affect people with mental health problems.

1.2. Supported housing and mental institutions

The post-asylum landscapes consist of a range of small institutions dispersed across the community. Many of them are living places meant to be homes for people with mental health problems. Because of the inconsistent usage internationally of the term supported housing (McPherson et al., 2018; Tabol et al., 2010), in this present article we simply define supported housing as accommodation for people with mental health problems who receive support from either on-site from professionals in congregate settings or off-site in independent settings.

What do we know about the influences of supported housing on the tenants in post-asylum landscapes? Rog (2004) and colleagues (Rog et al., 2014) reviewed quantitative studies and other systematic reviews of housing and concluded a moderate level of evidence regarding reduced homelessness, hospitalisation, increased tenure compared to other housing models or treatment as usual or no housing. Housing with opportunities to accommodate consumer preferences and choices, with few regulations, were rated highly by tenants. These preferences for independent settings were also confirmed in a meta-analysis (Richter and Hoffmann, 2017). A review of qualitative studies (Krotofil et al., 2018) on service user experiences of supported accommodation stressed the interplay of various factors that formed the tenants' lived experiences and affected recovery and identity. Newman (2001) reviewed quantitative studies that measured housing attributes and highlighted that tenants in independent settings were more likely to be satisfied with their accommodation and neighbourhoods. A review of studies on Housing First programmes (Woodhall-Melnik and Dunn, 2016) appraised their outcomes of reduced homelessness and improved residential stability and recommended that these programmes be implemented under local policies and welfare systems. These studies illustrate some positive aspects of living in supported housing, but lack a focus on the surroundings, locations, buildings and interiors in which people with mental health problems are living.

In a comprehensive review of articles on the effects of the architectural design of mental health facilities, such as mental hospitals (Connellan et al., 2013), the authors concluded that the design of security, lighting, the therapeutic milieu, gardens, rooms for patients, and interiors had benefits for the well-being of the patients and staff and the duration of stay. Other authors (Chrysikou, 2014; Shepley et al., 2016; Shepley and Pasha, 2017) similarly pointed out the significance of architectural design for psychiatric environments and therapeutic outcomes.

In our review, we attempt to contribute to post-asylum geographies by summarising the existing literature on supported housing and its built environment.

1.3. Place and architecture

Several scholars emphasise a strong connection between people and places (Casey, 1997, 2003; Donohoe, 2017; Seamon, 2017). They understand architecture as a phenomenology of places where social life is experienced. In this view, architecture is not only referred to as built environment, but as built environment as an element in places.

For Norberg-Schulz (1974, 1979, 2000), phenomenology of places is about the relationship between the natural landscape and the architecture in which human life takes place. Every place has a comprehensive 'atmosphere' called a 'genius loci': a term that is derived from Roman philosophy and means 'spirit of a place.' It expresses a particular identity for a specific place (1979) and an important aspect to consider is the relationship between the surroundings of a building and what is inside that building (2000, p. 191). The meaningful use of a place requires that the built environment is configured in such a way that humans can *orientate*, *identify* and *recognise* themselves in that place (*basic aspects*) (2000, p. 42). The architectural configuration of a place works thereby as a form language: how the built environment is placed horizontally in the environment, how it is vertically constructed and how it is interpreted by humans and 'takes concrete form in the outline' (2000, pp. 51–53). Moreover, Norberg-Schulz understood the genius loci as being relatively stable and influenced by building traditions (styles) and sociocultural contexts. In cases where the form language can no longer convey the basic aspects, the local atmosphere of a place becomes undistinguishable for people. Norberg-Schulz called this loss of meaning 'the loss of place' (2000, p. 225). Therefore architects should create meaningful places and visualise the genius loci, making it possible for people to know where they are, who they are and feel at home (1979, p. 5).

For Relph, phenomenology of places is about exploring 'the geography of lived-world of our everyday experiences' (1976, p. 6). Geography in this context means that a place is always situated in a broader process, despite the particularity of that place. The identity of a place can, thereby, be experienced through either a kind of 'insideness' or 'outsideness' (1976, pp. 49–55). For example, 'insideness' refers to having strong feelings and lived experiences regarding a place, while 'outsideness' refers to the feeling of not belonging to a place or feeling alienated. Relph differentiates between the term *spirit of a place* that 'exists primarily outside us' and *sense of place* that 'lies inside us' (2008, p. 314). Having a sense of place, we are able to experience differences and similarities between places. Missing this sense of place leads to 'placelessness', which occurs through the standardisation that make all places look the same. In these cases it is not possible to distinguish between places and the sense of place falls apart (1976, 2016).

The common features between Relph and Norberg-Schulz can be summarised by Seamon (2017, p. 247): that buildings (as dwelling places) can be understood as 'life worlds', 'atmospheres' or 'environmental wholes'. Both scholars draw on Heidegger's ideas of dwelling as an existential need for all human beings, both to protect them and make it possible for them to grow. They also highlight the inside/outside relationship of places, though with different emphases, Norberg-Schulz focusing more on the inside and Relph on the outside. For example, Relph (2017) criticised Norberg-Schulz's concept of 'genius loci', which stressed the enclosure of places in contrast to his own approach, which emphasises the openness of places. Relph (2017) criticised Heidegger for overemphasising rural settings and understating urban life. Places

are therefore important for both the urban and rural life.

In summary, the built environment can be defined with the help of the phenomenology of places and the important aspects are therefore the surroundings, location, built objects, rooms and interiors in which human life takes place. Because we consider dwellings to be important in people's lives, we wanted to learn more about the built environment in which people with mental health problems lived after the number of beds in the hospitals was reduced (Wolch and Philo, 2000, p. 150). Therefore, we address the following question: what can studies about supported housing tell us about the importance of the built environment for people with mental health problems?

2. Method

We performed a systematic search for both quantitative and qualitative studies on the topic, which is called a mixed methods literature review (Pope et al., 2007). This method can provide a comprehensive understanding of the research phenomena (Booth et al., 2012). Moreover, we selected an integrated design (Sandelowski et al., 2006) that analysed and organised the findings thematically across the included studies (Braun and Clarke, 2006).

2.1. Inclusion and exclusion criteria

We included studies in the review if they were published in English in peer-reviewed journals, without setting limits for the year of publication. Moreover, studies were included if the persons were adults (18 years and older) with mental health problems[1] who were living in supported housing because of salient and persistent difficulties in managing their lives. Thus, people with intellectual disabilities or dementia were excluded.

The participants lived in supported housing, where the housing could be either congregate settings or independent apartments. The support provided by professionals could be on-site or off-site. In particular, we were interested in studies that explored the importance of the built environment for the tenants. The phenomenology of places understands the built environment as part of a context that also includes the surroundings, location, rooms and interiors in which human life takes place.

2.2. Search strategy and databases

We read reviews and articles on the topic to become informed about the research field and research gaps. We then chose search terms[2] relating to the topics of interest (people with mental health problems, supported housing and the built environment) and carried out a systematic search in September 2017 in the databases Medline, PsychINFO, Embase, Cinahl, Scopus, ISI Web of Science, SocINDEX and Social Work Abstracts. We also performed a search in the Royal Institute of British Architects (RIBA) archives to cover architectural articles.

2.3. Screening process

The database search identified 981 articles and the citation search 5 articles. After removing duplicates, we screened the remaining 661 articles for relevant titles and excluded 487. We then read the abstracts of the remaining 174 articles and excluded 122 that did not meet the selection criteria. Finally, we read the full text of the remaining 52 articles and excluded 39 articles that did not consider the relationship between the built environment and tenants or that did not meet the inclusion criteria for the participants, such as transitional housing for persons with substance abuse problems. Thus, the final sample totalled 13 articles for further data extraction, quality appraisal[3] and analysis. The overall screening process and selection are presented in a flow chart (Fig. 1). We met several times during the process and discussed each step for selecting the literature.

2.4. Data extraction and analysis

The study characteristics (aims, study design and method, setting, participants and findings) were extracted from the articles and compiled in a tabular form (Table 1). Additionally, we used Braun and Clarke (2006) thematic analysis to organise and interpret the findings across the included studies. Initially, the first author read all the studies and noted specific points. The author then coded the articles and categorised them according to potential themes. The author discussed these codes and preliminary themes in meetings with the co-authors. Moreover, these themes and codes were constantly related back to the studies and checked for internal consistency. The interpretation steps were carried out by drawing diagrams to clarify the in-depth analysis and refine the themes. The analytical work was supported by the qualitative data analysis software, ATLAS.ti. From the analysis of the studies, we developed three interrelated themes concerning the importance of the built environment for tenants in supported housing: *well-being*, *social identity* and *privacy*.

In brief, the studies highlighted that well-being was connected to neighbourhood quality (e.g. amenities) and community, while privacy was a matter of the architectural style of supported housing and how it was managed by professionals. Social identity was a broad concept referring to the interior and surroundings of the accommodation, such as having meaningful places nearby.

2.5. Limitations

One limitation of the present study is the loss of the statistical power of the quantitative studies due to integrating their findings into a qualitative analysis. Another bias is linked to the different sociocultural contexts and welfare systems described in the studies. A further important limitation is the systematic approach of the literature review, the selectiveness of which in the inclusion/exclusion of studies can be seen as an advantage on the one hand but as an undesirable limitation on the other hand, narrowing the field of past studies and purporting to be comprehensive. As such, we could also have included studies about residential homes for elderly or people with dementia or learning disabilities, because all studies about people and places could be of importance to understand the meaning of the built environment. We acknowledge therefore that our review has limitations and recommend reading more than the included 13 articles to get an overall picture of the field.

3. Report on the systematic review

3.1. Study characteristics

Overall, 13 research articles published in the period 2004–2017 were included in the review (Table 1). Four studies had qualitative designs, one study had a mixed-method design and eight studies had quantitative research designs. The studies were conducted in the US,

[1] We chose to use the term 'mental health problems' rather than the terms 'mental illnesses', 'disorders', or 'psychiatric disabilities' that were used in several included studies (see Table 1). The term 'people with mental health problems' seems artificial, but 'implies that the individuals affected are people first and mentally unwell second' (Wolch and Philo, 2000, p. 1). Thus, we are critical of the medical view of mental states-of-being, highlighting that they are problems which a person is experiencing.

[2] An example can be found in the appendix.

[3] The quality appraisal can be found in the appendix.

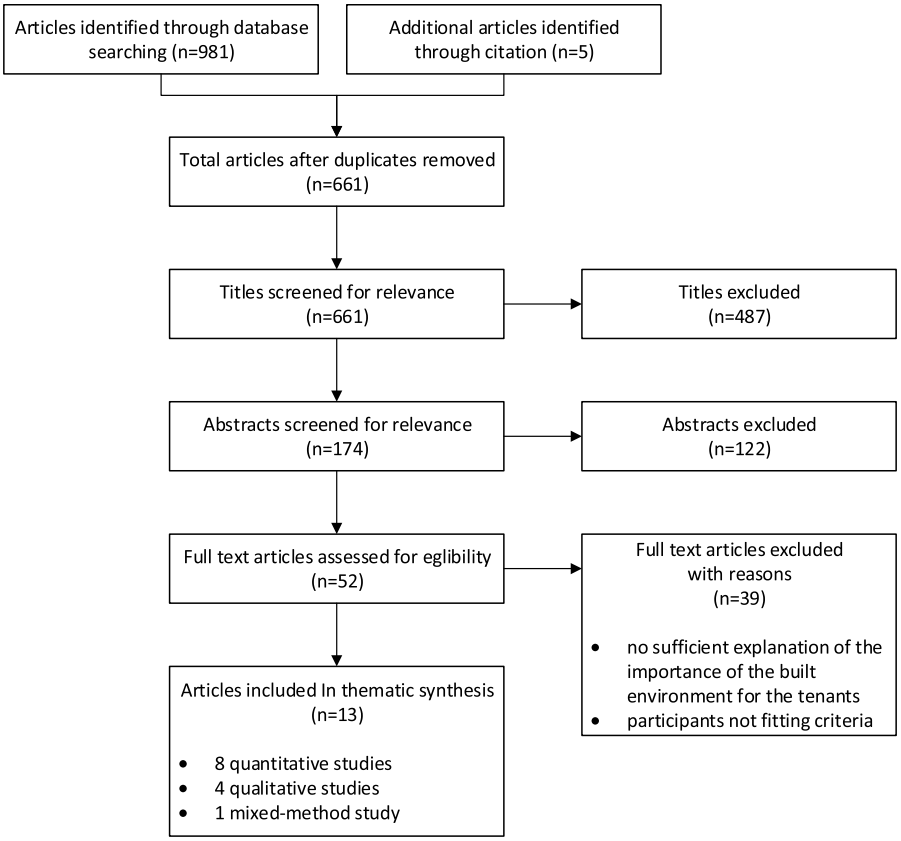

Fig. 1. Flowchart.

Canada, Sweden and Brazil. Half of the studies focused on people with mental health problems living in independent apartments and the other half in congregate settings. One study (Boyd et al., 2016) did not mention the number of participants, and two studies (Marcheschi et al., 2013, 2015) drew on the same empirical data. In summary, the studies included about 2086 people with mental health problems as participants. Some participants also had addiction problems.

3.2. Topography of supported housing

The key themes (and subthemes) emerging of the thematic analysis of the 13 articles: well-being (quality of life, recovery), social identity (regulation, stigma, autonomy) and privacy (surveillance, safety, loneliness, intimacy) can be compared across different supported housing types (independent/congregate) and across two different spatial scales, like the buildings themselves and then of their environing neighbourhoods/communities. We therefore, developed a diagram of what we decided to define as a topography of supported housing (Fig. 2). The diagram shows if a subtheme is more associated with either neighbourhood or built environment of the supported housing types on the top-down axis, and if more associated with congregate or independent settings on the right-left axis. For example, the findings of the included studies pointed out that tenant's well-being are more related to neighbourhood factors, while the tenant's privacy are more related to the built environment of the supported housing type. Moreover, the studies showed that tenants' safety or surveillance are bigger issues in congregate settings, and loneliness or intimacy are more issues in independent settings. Social identity as a theme was a thorough concern.

3.3. Well-being

Most of the quantitative studies examined the relationship between the housing environment and the well-being or quality of life of the tenants. In general, favourable ratings by tenants in independent settings for the housing environment were associated with better ratings of the tenants' well-being outcomes, such as psychiatric distress, recovery, residential satisfaction or adaptive functioning (Wright and Kloos, 2007). In addition, the better physical quality of the building, richer amenities and smaller-scale residential settings were related to low mental health service costs and greater residential stability (Harkness et al., 2004). Harkness et al. (2004) suggested that lower costs and greater stability indicated a mental health benefit for the tenants. By contrast, deterioration in the physical quality of the neighbourhood exacerbated mental health problems. Moreover, the relationship between mental health benefits and social or ethnic segregation was weak. Again, the neighbourhood predictors were most helpful for understanding the variance in the well-being of the tenants in social ecological studies (Townley and Kloos, 2014; Wright and Kloos, 2007). This relied more on the tenants' perception of the social climate in the neighbourhood and less on their closeness to amenities, such as grocery stores or public transportation.

Similarly, in congregate settings the perceived social and physical quality of the environment accounted for variation in the tenants' quality of life (Marcheschi et al., 2015). This variation could also be indirectly understood through the tenants' perception of the built environment or social climate if they felt emotionally attached to the place. Thus, Marcheschi et al. (2015) reflected that congregate settings with areas in the buildings for tenants to rest or to control their environment or to interact socially increased the quality of life as perceived by the tenants. Another study found that these spatial opportunities existed more often in congregate settings with purpose-built architecture than in non-purpose-built ones (Johansson and Brunt, 2012). Moreover, participants in one qualitative study experienced the rooms in congregate settings as healthy if the participants had an available, peaceful and pleasant place to rest (Bengtsson-Tops et al.,

Table 1
Characteristics of the studies.

Authors	Publication year	Country	Aim	Study design and methods	Setting *(housing type)*	Participants	Findings
Harkness et al.	2004	US	To determine the costs/residential stability of housing/neighbourhood sites for individuals with chronic mental illness	Longitudinal cohort study	150 multi-unit apartment buildings *(independent)*	670 individuals with chronic mental illness (342 female)	Fewer units, more residential stability; lower costs in newer buildings with more amenities and no signs of deterioration in the neighbourhood and mixed area with non-residential use
Wong et al.	2006	US	To identify gaps between the principle and practice of supported housing	Cross-sectional	27 supported living programmes *(independent)*	536 people with severe mental illness (SMI)	Suggests variation in housing, tenancy and support (the continuum model)
Wright and Kloos	2007	US	To examine the effects of the perceived housing environment and well-being outcomes	Cross-sectional	10 cities and 34 housing sites *(independent)*	249 people with SMI (129 female)	Neighbourhood level (self-report) is the strongest predictor for understanding variance in well-being, followed by apartment level predictors
Yanos et al.	2007	US	To examine the impact of housing type	Mixed-method	1 city *(independent and congregate)*	44 people with SMI, formerly homeless, stably housed one year	Integration in the community is multidimensional, and the locus of meaningful activity is linked to housing type
Johansson and Brunt	2012	Sweden	To test the environmental psychology model	Cross-sectional	3 non-/3 purpose-built housing *(congregate)*	55 people with psychiatric disabilities (22 women/33 men)	Suggests that experts' assessments measure qualities in the physical environment
Baltazar et al.	2013	Brazil	To investigate housing models	Participant observation, free analysis	3 cities with halfway houses or living alone *(independent and congregate)*	12 people with severe mental disorders	Fewer boundaries and more opportunities for participants living alone than in congregate settings
Marcheschi et al.	2013	Sweden	To investigate the quality of housing by the perceived (physical/social) environment	Cross-sectional	20 supportive housing facilities *(congregate)*	72 people with SMI 117 staff members	Differences in perceptions of the social climate (staff more positive than tenants); resident/staff perceptions of the physical environment account for variations in the social climate perception, while experts did not
Bengtsson-Tops et al.	2014	Sweden	To describe user experiences of living in supported housing	Interviews, content analysis	4 supportive housing units *(congregate)*	29 people with SMI (12 women/17 men)	User experiences are complex and paradoxical
Townley and Kloos	2014	US	To examine the relationship between neighbourhood quality/well-being in the perceptions of participants, researchers or aggregations	Cross-sectional	66 neighbourhoods with supported housing *(independent)*	373 individuals with psychiatric disabilities	Individual perceptions of the neighbourhood were more important indicators for their well-being than objective ratings by researchers
Marcheschi et al.	2015	Sweden	To investigate whether the perceived physical, social and environmental qualities influence variation in people's well-being (quality of life)	Cross-sectional	20 supportive housing facilities *(congregate)*	72 people with SMI	Perceived physical, social and environmental quality predicted quality of life with place attached as a mediator
Boyd et al.	2015	Canada	To examine measures of control and coercion in supported housing	Ethnography	15 supportive housing sites *(congregate)*	People with mental health and addiction problems; lack of information about participants	Three modes of control: physical surveillance technologies, site-specific coercion and police presence
Marcheschi et al.	2016	Sweden	To examine the relationship between physical affordance of supportive housing and observed interactional behaviours between environmental users	Cross-sectional	4 high-low-quality supported housing facilities *(congregate)*	29 people with SMI (14 women/15 men) 27 staff (24 women/3 men)	Dining room and outdoor areas in high-quality housing showed better social interaction support than in low-quality housing
Piat et al.	2017	Canada	To illustrate how places support recovery on a daily basis for people with SMI who moved into supported housing from more structured settings	Photo-elicitation and interviews	5 supported housing sites in 4 cities *(independent)*	17 individuals with SMI, previously lived in custodial housing	Offers the understanding that everyday places indirectly and directly support mental health recovery

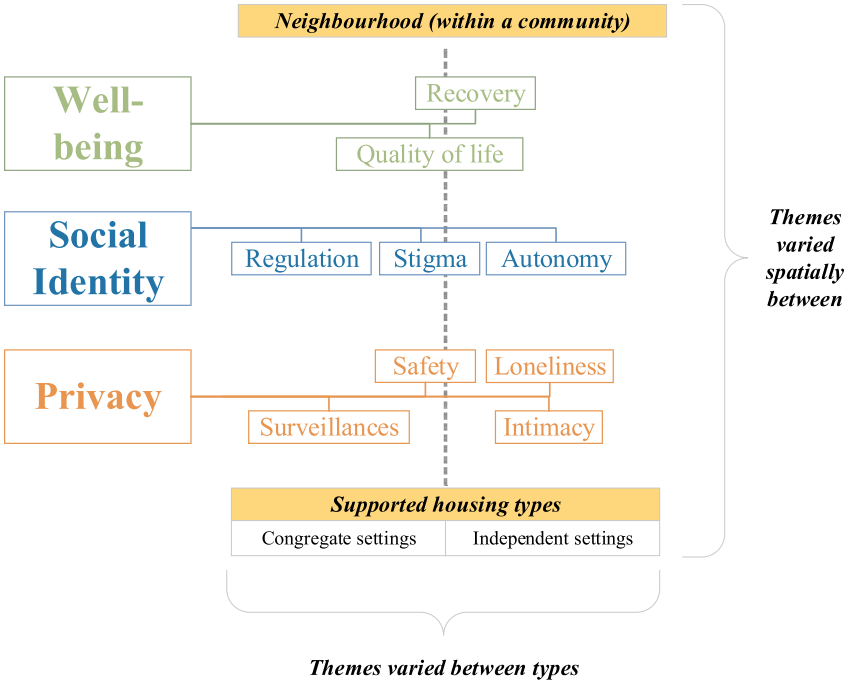

Fig. 2. A topography of supported housing.

2014). This was also associated with privacy issues, which we discuss later.

In congregate settings (Baltazar et al., 2013; Boyd et al., 2016), tenants disliked high regulation by staff of everyday activities, such as day plans or scheduled medication. Piat et al. (2017) studied tenants in supported housing living independently who had recently moved from custodial housing types. The authors suggest that common areas might work for the tenants as therapeutic spaces to support mental health recovery. Examples included apartments with personal interiors that afforded greater comfort; open architectural solutions like balconies or amenities in the neighbourhood; or the tenant having places to visit nearby, such as parks or churches. Yanos et al. (2007) emphasised that people living in independent apartments had higher social functioning than tenants in congregate settings. Tenants in congregate settings had meaningful activities within their building, while tenants in independent settings had meaningful activities related to work situations or their neighbourhood or apartment.

3.4. Social identity

Social identity, of course, concerns the buildings themselves, but it also involves the neighbourhood and community. Inside the buildings, the tenants in congregate settings appreciated that they could decorate their apartments as they wished (Johansson and Brunt, 2012). Thus, the tenants were able to express their identity. However, in the common areas, the tenants had to fit in with others (Bengtsson-Tops et al., 2014). In independent settings, tenants valued their freedom to live without sharing space with other people (Baltazar et al., 2013; Piat et al., 2017). This freedom was linked to their identity as autonomous individuals.

However, the tenants' social identity (as a sense of self) must be maintained, built up and acknowledged in social arenas. Supported housing with congregate settings offers such opportunities with common areas being an integrated and institutionalised part of the environment. Thus, the tenants have a social arena in which to meet staff and fellow tenants outside their own apartments (Bengtsson-Tops et al., 2014; Johansson and Brunt, 2012). Marcheschi et al. (2016) tried to address the issue of how the structure and quality of the built environment support social interactions. The authors found that congregate settings with clear boundaries between outdoor areas and public space encouraged better social interactions, especially if these areas were close to the apartments. These social interactions were also observed in dining rooms designed in such a way that tenants could circulate, interact and communicate with each other in different ways.

However, in congregate settings tenants had to adjust to house rules set up by the professionals for the common areas, and these regulations limited the tenants' personal identities (Baltazar et al., 2013). These regulations were expressed by asymmetric relations between tenants and professionals. The lack of closeness between the two groups emphasised their different social identities (Bengtsson-Tops et al., 2014). The asymmetric relations were illustrated by symbols of power and surveillance, such as 'glass-paned office rooms where staff could easily observe residents and guests' (Boyd et al., 2016, p. 75). Boyd et al. (2016) gave examples of inequality and criminalisation of these living places, such as non-tenants discrediting these places as custodial, tenants' confidential health care information being shared and police often being present inside and outside these places (an 'open-door policy').

Turning to stigma, tenants in both types of housing settings experienced stigmatisation because they had been diagnosed with mental health problems. Some tenants preferred to be with other people with mental health problems, but some found it stigmatising if other tenants in the building (Bengtsson-Tops et al., 2014; Harkness et al., 2004; Wong et al., 2006) or in the neighbourhood (Townley and Kloos, 2014) had mental health problems. Yanos et al. (2007) suggested that a sense of community and integration is associated with the type of housing that offers different opportunities. Thus, tenants' integration into a neighbourhood was related to independent settings and tenants' integration in buildings to congregate settings.

The second finding linked to social stigmatisation was that the poor physical quality of the buildings or visible safety technologies could give the impression of being an outsider living in a problematic neighbourhood (Boyd et al., 2016). The third finding linked to stigmatisation involved tenants living independently. Some were not allowed to include significant others on the leases (Wong et al., 2006), meaning there were fewer chances of living with a partner. Even in neighbourhoods with challenges such as deprivation or crime, places

such as green areas, parks or churches could be found nearby. These places 'possessed symbolic value' for people with mental health problems and 'contributed to positive change' (Piat et al., 2017, pp. 74–75).

3.5. Privacy

The topography of supported housing emphasises privacy. Recovery was aided if the tenants had their own physical place in which to retreat. This particular place was generally their apartment. In congregate settings, a tenant's apartment should provide safe rooms for living, sleeping, cooking and self-care (Johansson and Brunt, 2012) and is an important counterpart to the common area shared with fellow tenants and staff members (Bengtsson-Tops et al., 2014). Congregate settings could be differently designed, for example, as group homes with shared bathrooms and a lack of privacy (Baltazar et al., 2013). Congregate settings could also be equipped with surveillance technologies that recorded the presence of the tenants and their visitors, even if the surveillance was for safety reasons in a problematic neighbourhood associated with crime and drug trafficking (Boyd et al., 2016). In this study, participants in settings managed by public operators reported the constant increase in cameras, while in settings managed by private operators the authors observed a more open substance policy and thus, less surveillance (fewer cameras).

Tenants living in independent settings appreciated their own apartments with entrance doors that the tenants controlled (Piat et al., 2017). Having an independent apartment was associated with a perceived greater sense of choice and independence by the tenants on the personal and household levels versus congregate settings (Yanos et al., 2007). In particular, the tenants valued bedrooms separated from other parts of their apartment, such as the living room or kitchen, and full access to laundry rooms in their housing complexes (Piat et al., 2017). Despite the privacy benefits, one study indicated that tenants who were living independently had to cope with loneliness (Baltazar et al., 2013). However, these personal places might offer possibilities for tenants to practice intimacy and individuality inside their own walls (Piat et al., 2017), which would probably be absent in congregate settings (Bengtsson-Tops et al., 2014).

4. Discussion of the review themes from problems to possibilities

This review analysed studies regarding the importance of the built environment for people with mental health problems living in supported housing in either congregate or independent settings. The methodologies and research questions of the studies differed, but we could identify that the built environment mattered for tenants' well-being, social and private lives. In summary, the studies indicated that well-being was more likely to be linked to community and neighbourhood qualities than to a specific building. Privacy was connected to the architecture of the supported housing type and its management by professionals. Social identity was a broader topic and linked to both the inside and outside of the housing settings, in particular to meaningful places nearby.

In this section, we discuss the reviewed studies in relation to the research on mental health geographies and place phenomenology. We thereby emphasise the shift from a narrowly architectural understanding to a more expansive neighbourhood-community-social perspective with possibilities for the inclusion or exclusion of people with mental health problems. We start the discussion with more critical issues concerning the built environment of supported housing and move then on to more constructive issues. We conclude the section with implications about a meaningful place-making.

4.1. Supported housing as mini-institutions or panoptic sites?

Can supported housing be understood as mini-institutions in post-asylum geographies? The answer tends towards 'yes' with regard to the built environment of congregate settings with integrated common areas that are supervised by on-site professionals offering 24/7 services.

Mini-institutions can, therefore, be understood as minor spatial versions of Goffman (1961) description of mental hospitals as institutions in which the daily lives of the patients are tightly scheduled and strictly ruled by the staff. As a total institution, the site is serving as the one and only place for patients to 'sleep, play and work' (1961, p. 17). Separated from broader society and being under surveillance, the patients became more similar to each other meaning the 'person's self is mortified' (1961, p. 14) and they might all feel like being mentally ill.

This limitation of personal identity and social life was also the case for tenants in congregate settings which were described as custodial (Baltazar et al., 2013; Boyd et al., 2016), while contrasting studies described settings which kept a degree of privacy for the tenants (Bengtsson-Tops et al., 2014; Johansson and Brunt, 2012; Marcheschi et al., 2015). Further aspects of a mini-institution might, firstly, include the fact that congregate settings offer tenants few personal spaces in which to dwell and have common areas, such as dining or living rooms, for socialisation with elements of care and control. Life can be 'experienced as being gloomy and oppressive' (Bengtsson-Tops et al., 2014, p. 415) in such places, with asymmetric power relationships between staff and tenants.

Secondly, the inside of congregate settings had controllable boundaries with the outside, which allowed the staff to monitor all movements between, in and out. Some settings emphasised, therefore, clear architectural boundaries (Marcheschi et al., 2016), while others were equipped with video surveillance technologies, often justified by tenants' safety issues (Boyd et al., 2016). We might wonder: who should actually be protected from whom, and what does a housing setting with many cameras and locked entrances tell us about the people inside? One answer might be that video surveillance in housing settings symbolically conveys the message that the people inside are potentially dangerous. This architectural expression confirms visually the discourse of confinement and risk management of people with mental health problems (Moon, 2000; Rose, 1998).

Thirdly, it seems that supported housing with a congregate setting exacerbates the tenants' lack of interest in their surroundings. For example, tenants in congregate settings stated that their meaningful places lay inside the buildings, while tenants living independently focused on the outside of buildings and on the wider neighbourhood (Yanos et al., 2007). Socialisation might illuminate these statements, meaning that when tenants live permanently in these mini-institutions they gradually lose their 'sense of place' (Relph, 1976) and their identity as citizens. When supported housing with congregate settings are characterised by over-regulation and over-surveillance, they might be understood as total institutions where they are rather patients in need of care than citizens. Finally, supported housing might be seen as part of the de-territorialisation of health care services that emphasises 'the shift from 'institutional to extitutional arrangements' (Milligan, 2009, p. 22); the term 'extitutions' is contrasting the old institutions and referring to networks of health care services meaning 'not to leave any person out of the system' (Vitores, 2002).

When supported housing resembles institutions more than homes and when these places are prisonlike with surveillance equipment and a staff presence (Baltazar et al., 2013; Boyd et al., 2016) they might experience, in terms of Norberg-Schulz's (2000, p. 225) loss of place. This because such custodial settings make it difficult for the tenants to know where they are: is it a real home or an institution? It seems that custodial settings might strengthen the feeling of otherness for the people inside and also by the gaze from people outside these buildings.

It is almost as though the panoptic view is turned upside down. The *panopticon* was designed by Bentham (1791/1995) as a type of institutional building aiming to control inmates with a single watchman without the inmates being able to tell if they were seen or not.

This idea of a system of constant inspection, seeing everything, all

the time, should endorse self-disciplining practices for people within the institution. Foucault (2006a, p. 79) argued in his lectures in 1973–74 that Bentham's idea can be found in most institutional sites such as prisons, hospitals or schools on the one hand and may be transferable to the whole society on the other. *Panopticism* is the term coined by Foucault himself to cover this wider interpretation of Bentham's panopticon (1977). In the case of supported housing, it is no longer the one gaze controlling the many, but it seems that people from outside, for example neighbours, are controlling the few inside the supported housing. Not being aware of this, it will influence the tenants' well-being, social identity and privacy and might be compared with a pillory in which the tenants are placed. This situation has similarities with the concept of the 'rural panopticon' (Philo et al., 2017) and Parr (2008) study of rural sites in Scotland. Her participants described their situation in the local community as: 'You are living under a microscope' or 'It's very much like living in a goldfish bowl' (2008, p. 68).

4.2. Supported housing as safe havens?

An important question, inspired by Pinfold (2000), is whether supported housing might be understood as safe havens for people with mental health problems? Suffering from poverty and being marginalised in the housing and labour markets (Curtis, 2004; Rogers and Pilgrim, 2006; Sylvestre et al., 2018; Wilton, 2003, 2004), people with mental health problems need meaningful places in which to dwell as much as any other citizen.

A personal apartment would help to fulfil this basic human requirement versus living in institutions or having a rough life as a homeless person, but a home is more than just having a shelter. The way the built environment is constructed matters. As such, tenants in Piat et al. (2017) study valued the separation of sleeping quarters from the living room, having their own entrances and full access to laundry rooms. The quality of housing and the materials used are important, but the neighbourhoods are also pivotal to the tenants' safety and well-being. Studies regarding supported housing with off-site support showed that accommodation should be well maintained and not neglected (Harkness et al., 2004). It is also important to have amenities nearby (Townley and Kloos, 2014; Wright and Kloos, 2007). Placing different people suffering from mental health problems in the same building (Wong et al., 2006) or the same urban districts might lead to 'service dependent ghettos' characterised by social problems, crime and poverty (Dear and Wolch, 1987). Wolpert et al. (1975) showed moreover that 'satellite mental health facilities' as an extension of the hospitals are concentrated within low income communities in US cities that are at risk of 'institutional saturation' and least able to arrange NIMBY movements.

We must therefore ask why today's planners locate supported housing in run-down districts or buildings (Baltazar et al., 2013; Harkness et al., 2004; Wong et al., 2006)? You might assume that it is for economy reasons, but planners also tend to avoid locales that do not want people with mental health problems as neighbours. It seems as though the planners take for granted that people with such problems draw less attention in marginalised districts with their 'unorthodox normalities' (Pinfold, 2000, p. 205). Additionally, such people do not have the resources and/or power to struggle with the planners for better locations. This is similar to congregate settings, where fellow tenants have also mental health problems, just in another geographical scale. Despite a NIMBY study that outlined an increased level of neighbourhood acceptance for people with mental health problems (Zippay and Lee, 2008), several studies (Bengtsson-Tops et al., 2014; Harkness et al., 2004; Townley and Kloos, 2014; Wong et al., 2006) indicated that people with mental health problems living nearby each other had little chance of decreasing stigmatisation.

Locating supported housing in run-down areas could reinforce social inequality problems and dependence on others for people with mental health problems. In this case, supported housing does not represent a safe haven and a place to grow and the tenants will, in the words of Norberg Schulz, not be able to dwell. Instead, the places will tend to contribute to general processes of impoverishment (Micheli, 1996) and, instead, represent what Wacquant (2009) calls the 'punishment of the poor' as a consequence of neoliberal policies such as unregulated markets and austerity which led to social insecurity.

4.3. Meaningful places for living?

Place and life are strongly connected for tenants in supported housing. From Norberg-Schulz (1974, 1979, 2000) point of view, it is possible to argue that, if you know where you are, you know who you are. Feeling at home implies meaningful places in which you are able to orientate yourself, express an identity and also recognise the place. This indicates that, when you live in supported housing meant for people having a mental health diagnosis, you must have an identity as someone who is more than a diagnosis to make life meaningful. So, we might ask, what are meaningful places for people with mental health problems?

A meaningful place will, in the words of Norberg-Schulz, gratify the need for a dwelling. This idea has to do with being protected and being inspired to develop oneself. Therefore, supported housing should offer the possibility for an expression of identity as a citizen rather than a person with a diagnosis. As a citizen, you are included in society and an orientation toward recovery might be possible. Recovery is problematic without 'meaningful places' to live in, offering the opportunity to interact with whoever you wish in your apartment, to decorate your rooms or to be close to other places such as parks or holy places (Piat et al., 2017; Yanos et al., 2007). Planners should, therefore, cooperate with the tenants in deciding how their homes should look inside and discussing what possibilities the surroundings might offer (Townley and Kloos, 2014; Wright and Kloos, 2007). Furthermore, planners should be aware of the image that supported housing might express, seen from the outside (Harkness et al., 2004).

4.4. Meaningful place-making

We have discussed that the studies from the review showed that the built environment of supported housing offered tenants a range from problems to possibilities.

We emphasise, in the words of Seamon (2018), a meaningful place-making by taken the wholeness of the place into account: service-users, planners, architects and managers of supported housing should, therefore, create constructive places for tenants that are safe havens and meaningful places. People's identification with a place derives from their experiencing from it, either 'as an insider or as an outsider' (Relph, 1976, p. 45). Thus, tenants living in supported housing should feel at home in terms of getting an 'ontological security' (Giddens, 1991). This implies an environment that the tenants able to control such as, their apartment and a confidence of continuity within their daily lives. Place-makers need to consider 'ontological sense' when planning supported housing (Padgett, 2007), otherwise the tenants might be at risk to what Easthope (2017) called 'losing control at home' or not having a home at all. In regard to the supported housings settings; studies from the review indicated that both congregate and independent settings can offer tenants ontological security (Bengtsson-Tops et al., 2014; Piat et al., 2017), which should be preferably developed beyond a tenancy towards an ownership of a dwelling.

We emphasise that over-surveillance and over-regulation of supported housing sites are the shortcoming ways to achieve that tenants feel protected because they do not contribute to the feeling of ontological security. Place-makers have to include how the tenants might experience the architectural atmospheres of supported housing, both from the inside and the outside of the building. In consequence, the location of the supported housing sites becomes a crucial factor in creating meaningful places to grow for people with mental health

problems. We highlight, lastly, that supported housings types should not be located in areas with institutional saturation (Wolpert et al., 1975) or in rundown districts. Instead, supported housing should be located in meaningful neighbourhoods with possibilities that help tenants to create their self-identity as a citizen (Piat et al., 2017).

5. Conclusions

The findings of the reviewed studies showed that the built environment in supported housing matters to people with mental health problems concerning well-being, which was linked to the housing location and the quality of the neighbourhood; social identity, which was a broader housing topic and linked to places nearby; and privacy, which was related to the housing style and how it was organised by professionals. Each supported housing type had both pros and cons for the tenants. Congregate settings can help tenants to at least have a minimum standard of quality of life and retreat. They can also be highly regulated and professionalised. In such cases, supported housing with congregate settings becomes more like mini institutions. By comparison, tenants in independent settings have more opportunities for personal development, but the opportunities are threatened when tenants are located in problematic neighbourhoods or buildings. Nevertheless, it seems that independent apartments are better choices of dwelling for people with mental health problems, which they also prefer (Richter and Hoffmann, 2017).

Taking a wider view of post-asylum geographies, we can describe a landscape of scattered housing sites intended more for people with mental health problems than for citizens. A step forward would be to introduce mental health policies that create meaningful supported housing in well-chosen neighbourhoods where the tenants are not permanently reminded of their outsider status by their built environment and the people around them. We therefore advocate user involvement in all planning processes for supported housing on the one hand and the explicit taking into account of the inside/outside relationship on the other. People with mental health problems need meaningful places in which to dwell that offer both protection and opportunities to grow.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.healthplace.2019.03.006.

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