A home but how to connect with others? A qualitative meta-synthesis of experiences of people with mental illness living in supported housing

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Supported housing principles emphasize the importance of decent, stable and affordable housing, and the provision of individualized support to enable people experiencing mental illness to live in their preferred communities, and to recover. This study sought to synthesize qualitative research addressing the question: how does living in supported housing facilitate social connections and participation from the viewpoints of people living with mental illness? Three databases (CINAHL, PsycInfo, Medline) were systematically searched to identify 19 peer-reviewed reports on 17 studies published during 2001-2016, in which the views and experiences of supported housing residents with mental illness were reported. Most studies were informed by grounded theory and used interview methods. Appraisal indicated the reports were of varying quality, but all met the inclusion criterion of reporting qualitative data relevant to the research question. Constant comparative methods were used to synthesize the reported data, and to identify themes across the studies. There were four overarching themes regarding the

lived experience of supported housing for people with mental illness: (i) living in supported housing gave individuals privacy, a sense of control, stability and security; (ii) stable housing supported residents' confidence to rebuild an identity and meaning in life; (iii) there is a delicate balance between appreciating privacy and dealing with loneliness; and (iv) opportunities and support to reconnect with families, friends and community are valued. The meta-synthesis findings highlight that supported housing residents face challenges of protecting their privacy and being lonely when on their own. Individualized support approaches need to attend to personal preferences for social participation and their varied meanings and significance. Further research is required to better understand how individualized forms of support can enable supported housing residents to connect with family, friends and community in their preferred ways.

Keywords: Housing, qualitative analysis, service user views, community participation, community care, severe mental illness.

What is known about this topic:

- Supported housing leads to reduced rates of homelessness and increased housing stability
- Residents typically prefer choice in housing, privacy, stability and autonomy in their living arrangement
- Supported housing residents may experience loneliness and isolation

What this paper adds:

- Supported housing for people experiencing mental illness facilitates building a new identity and meaning in life

- Balancing desires for privacy and companionship are important in supported housing for people experiencing mental illness

- Opportunities for supported housing residents with mental illness to connect socially and participate in communities may be enhanced through strong alliances with support workers, and access to coaching

Introduction

Living with a mental illness – or recovering from it – is difficult even in the best circumstances. Without a decent place to live it is virtually impossible (Burdekin et al., 1993 p. 337).

A secure, decent and affordable place to live is a basic human right, as is the opportunity to choose housing and those with whom one lives (United Nations, 1948). Yet despite housing being fundamental in supporting recovery and wellbeing (Harvey, Killackey, Groves, & Herrman, 2012; Chilvers et al, 2006), research in Australia and elsewhere demonstrates that the housing needs of people experiencing mental illness often go unmet (Harvey et al., 2012). Poverty and limited availability of affordable housing, compounded by impacts of fluctuating ill-health and limited supports, place people experiencing mental illness at risk for residential instability and homelessness (Forchuck, Nelson & Hall, 2006). Other issues include difficulty in obtaining and sustaining tenancies in a competitive rental market; inadequate and undesirable housing and neighborhoods; and inaccessibility of adequate mental health supports for individuals living in independent housing (Forchuck, Nelson & Hall, 2006). Furthermore, without housing stability, it is

likely to be more difficult to develop social ties or to participate in one's community (Patterson, Moniruzzaman & Somers, 2014).

Supported housing emerged as an approach to addressing the housing and support needs of people experiencing mental illness in the 1990s. It emphasized the provision of "ordinary" housing within the general community; the de-coupling of ongoing residency from the provision of treatment and support; and the provision of flexible and individualized support (Carling, 1996; Rog et al., 2014; Wong & Solomon, 2002). In so doing, it contrasts with residential settings characterized by communal living with other people experiencing mental illness, with limited resident choice about where to live or daily living routines (Parkinson & Nelson, 2003). The supported housing approach also challenged the notion of a residential continuum in which residents were required to achieve certain functional gains to progress to the next "level" of housing, this being viewed as counterproductive to achieving long-term stable housing for people living with mental illness and doing little to enhance their social integration (Wong & Solomon, 2002). Furthermore, communal living is not generally in keeping with consumer preference for choice in type of housing, privacy, stability and autonomy in their living arrangement, albeit that often there are insufficient options to choose from (Richter & Hoffman, 2017).

Varying terminology is used internationally to describe the different housing settings and approaches to the provision of housing and support (Richter & Hoffman, 2017). Here, we use the term supported housing to refer to housing based on principles that include: consumer choice in the type and location of housing, access to long-term sustainable housing, and flexible outreach support services provided separately from the housing itself, so that accepting support services is not a requirement of living in a particular place (Wong & Solomon, 2002). However, consumer choice and control over the focus, frequency and location of the provision of

professional support are reported key characteristics of support services (Sylvestre et al 2007). Elsewhere, this is described as a Housing First or supportive housing approach (Gonzalez & Andvig, 2015a).

A growing body of research on supported housing reports positive housing outcomes, including reduced rates of homelessness and increased housing stability (Rog et al., 2014). The majority of such studies focus on people who are homeless or at risk of becoming homeless, rather than those with persistent mental illness not identified as previously homeless (Kyle & Dunn, 2008). Other less consistent findings include decreased hospitalization and improved quality of life, community functioning and satisfaction with housing (Killaspy et al, 2016; Kyle & Dunn, 2008; Leff et al., 2009; Townley & Kloos, 2011; Tsai et al, 2012;).

Choice in housing, stability of tenure, and neighbourhood conditions, such as safety, appear to be associated with improved resident wellbeing and greater satisfaction with life and housing, but loneliness and isolation can be of concern (Harvey et al., 2012; Kyle & Dunn, 2008; Siegel et al., 2006; Stergiopoulos et al, 2014). Several housing evaluations have addressed similar outcomes for homeless populations but only one trial has reported increased community integration as an outcome of supported housing for homeless adults with mental illness (Stergiopoulos et al, 2014). There is limited research on these social outcomes for people living with persistent mental illness (Tsai et al, 2012; Yanos et al, 2007). Thus, while the larger literature includes supported housing for those dealing with addictions, abuse or family violence and homelessness, this paper focuses on supported housing and social outcomes for people experiencing mental illness.

Internationally, the social outcomes of supported housing are described in terms of community or social integration and participation. Social integration may encompass social, psychological

and neighbourhood dimensions, including opportunities for community activities (Tsai et al, 2012; Yanos et al, 2007). It is also conceptualized as encompassing both connectedness with others through reciprocal relationships and belonging (i.e. social connectedness); and access to citizenship rights and responsibilities (Ware et al., 2007). In comparison, social participation is poorly defined but usually in relation to concepts of social integration, social inclusion or social activity (Piskur et al., 2014). Qualitative research is not only much needed to understand the lived experience of different housing arrangements beyond housing stability (Kyle & Dunn, 2008), but offers a way to better understand how supported housing can contribute to social connectedness.

Qualitative meta-synthesis has recently been used to consolidate the reported findings of qualitative studies of residents' experiences of housing across the spectrum of residential and supported housing programs, and their experiences of the supports received (Gonzalez & Andvig, 2015a; 2015b). It highlighted the importance of stable accommodation and that housing needs to be integral to support strategies for promoting recovery. In keeping with its recommendation that experiences of belonging and participation in communities need further attention, this qualitative meta-synthesis sought to address the question: what can be learned from the lived experience of residents living with mental illness about how supported housing facilitates their social connections and participation?

Method

Qualitative meta-synthesis attempts to integrate the findings from previous studies to gain a deeper understanding of a particular topic than is possible from individual studies (Gewurtz, Stergiou-Kita, Shaw, Kirsh, & Rappolt, 2008). There are varying qualitative meta-synthesis approaches for how to integrate qualitative findings in an interpretive manner (Thorne, Jensen, Kearney, Noblit, &

Sandelowski, 2004). We chose to follow the method outlined by Gewurtz et al since it provides a useful structured approach.

Firstly, three databases were searched (CINAHL, PsycInfo, Medline) using the key terms outlined in Table 1 to identify qualitative studies investigating the experiences of living in supported housing for adults with mental illness. Citations in identified articles were searched manually to identify additional relevant articles. All searches were limited to English-language publications from 2001 to 2016 inclusive. Identified articles were included if they met the following criteria: they reported qualitative research; at least some study participants lived in supported housing; and the primary focus of study was residents' views and experiences of supported housing itself, irrespective of whether they had had prior periods of homelessness. To ensure a focused meta-synthesis, Gewurtz et al. (2008) recommend the exclusion of studies that do not meet the selection criteria on topical grounds. Hence, studies were excluded if: the type of housing did not meet the primary principles of supported housing, that is consumer choice in the type and location of housing, long-term sustainable housing, and flexible outreach support services (Wong & Solomon, 2002); and if the studies primarily focused on experiences of homelessness or transition out of homelessness per se.

Seventeen studies were identified that met these selection criteria. For two of the 17 studies, different elements of the findings are presented in two published reports (Chesters, Fletcher, & Jones, 2005; Jones, Chesters, & Fletcher, 2003; Kirkpatrick & Byrne, 2009, 2011), and therefore 19 articles in total were included in this meta-synthesis.

Table 1 here

The studies were reviewed to consider the appropriateness, adequacy and transparency of their reported qualitative methods, and the interpretive rigor of their reported findings. The purpose was to

identify and report their main methodological features, findings and relative strengths and limitations, rather than to include or exclude studies on the basis of a quality rating. Table 2 describes the quality of the studies using questions based on Kramer, Olsen, Mermelstein, Balcells and Liljenquists' (2012) reported approach. As shown in Table 2, these studies were of varying quality. While all met the inclusion criterion of reporting qualitative data relevant to the research question, overall the housing settings were less clearly described, as were the methods for ensuring the quality of the data analysis.

Table 2 here

A constant comparative method was used to synthesize the reported qualitative findings from across the studies, following steps similar to those typically used in thematic analysis of qualitative data. First, as Campbell et al. (2003) suggested, we listed the reported categories and themes from the 19 articles. We then progressively compared the listed themes and categories to each other so as to group together those that conveyed similar meanings. For each grouping, we then read the reported theme or category descriptions and supporting quotes to further compare and contrast their meanings, and identify common themes across the data from all 17 studies.

Findings

Table 3 summarises the main features of the 19 articles included in this meta-synthesis. They report findings from 17 studies conducted in Canada (8), America (7), Australia (1) and Sweden (1). The majority of studies recruited participants through a mental health service or housing agency, with one study further recruiting through a snowballing technique. The majority were informed by a grounded theory approach (11). Other study designs included narrative (3), ethnography (1), case study (1) and phenomenology (1). All studies used interviewing as their primary data collection method, with two studies using observation to complement the interview data

(Carpenter-Song, Hipolito, & Whitley, 2012; Kirkpatrick & Byrne, 2009, 2011).

Table 3 here

Themes Identified from Included Studies

Four overarching themes were identified across the reviewed studies. These were: living in supported housing gave individuals privacy, a sense of control, stability and security; stable housing supported residents' confidence to rebuild identity and meaning in life; there is a delicate balance between appreciating privacy and dealing with loneliness; opportunities and support to reconnect with families, friends and community are valued. Each theme is discussed in detail below.

Living in supported housing gave individuals privacy, a sense of control, stability and security

Privacy leading to a sense of control, stability and security were valued aspects of supported housing reported by participants, impacting their sense of self and freedom. Increased feelings of control due to having privacy were commonly identified by participants across many of the reviewed studies (Chesters, Fletcher, & Jones, 2005; Dorvil, Murin, Beaulieu & Robert, 2005; Jones, Chesters, & Fletcher, 2003; Kirkpatrick & Byrne, 2009, 2011; Kirsh, Gewurtz, & Bakewell, 2011; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005; Padgett, 2007; Parkinson & Nelson, 2003; Stefancic et al., 2012; Whitley, Harris, & Drake, 2008). Having a personal space facilitated participants' sense of control (Dorvil et al., 2005; Jones et al., 2003; Kirkpatrick & Byrne, 2009, 2011; Padgett, 2007). This was in contrast to previous homelessness and housing-related experiences, such as in rooming houses, which offered little privacy. One participant explained, "Anybody wants to come through that door, it's up to me to decide whether they get in or they don't get in … before … I had to do what he said … and I had no free will, I

had nothing" (Kirkpatrick & Byrne, 2011, p. 37). Another participant explained the meaning of having control, "I got my freedom. I could come and go in my apartment. And I could tell people who could come into my house and who can't and I don't use drugs" (Stefancic et al., 2012, p. 396).

Housing stability and security were seen by people living with mental illness as paramount in reducing stress levels and in providing a base for rebuilding one's life (Carpenter-Song et al., 2012; Forchuck, Ward-Griffin, Csiernik, & Turner, 2006; Jones et al., 2003; Kirsh et al., 2011; Leviten-Reid, Johnson, & Miller, 2014; Nelson et al., 2005; Raphael-Greenfield & Gutman, 2015; Stefancic et al., 2012). Feeling secure seemed even more important when participants' prior experiences of trauma, threat or homelessness may have heightened their vigilance. For instance, "It is great. There's a lock on the door. (You) go to bed at night and know you are safe" (Leviten-Reid, Johnson, & Miller, 2014, p.62). Furthermore, feeling secure helped some participants reconnect with day to day life: "Here I have been able to develop my potential and now I have more control over my everyday life. I like to live here and try to make everyday life meaningful, it is supportive and it helps to prevent problems" (Lindström, Lindberg, & Sjöström, 2010, p.289). And, "I think that having a decent place to live has reduced my stress… I eat better … I exercise more" (Kirsh et al., 2011, p. 21). In comparison, security and stability were undermined by housing in poor physical condition or neighbourhoods perceived as threatening (Carpenter-Song et al., 2012; Kirsh et al., 2011; Kirkpatrick & Byrne, 2011; Lindström et al., 2010; Nelson et al., 2005; Raphael-Greenfield & Gutman, 2015; Whitley et al., 2008).

Stable housing supported residents' confidence to rebuild identity and meaning in life

Permanent housing gave individuals a secure base from which to

begin to rediscover who they are, what they aspire to do and to lead a 'normal' life. Furthermore, supported housing gave participants a sense of being responsible that was grounding and empowering (Chesters, Fletcher, & Jones, 2005; Forchuck, Ward-Griffin et al., 2006; Jones et al., 2003; Kirkpatrick & Byrne, 2011; Leviten-Reid et al., 2014; Nelson et al., 2005; Padgett, 2007; Parkinson & Nelson, 2003; Raphael-Greenfield & Gutman, 2015). As this participant explained, "[It] helped me find some kind of peace. For me, bouncing around from house to house, place to place, now I feel like I have my own. I feel like I'm kinda responsible for my own self … You know, I walk through my door, I feel confident" (Stefancic et al., 2012, p. 400). Another participant explained, "Little things like going to the laundry … I didn't know how to do that. I was freaking out … I didn't do a lot of things that I considered normal because I figured I was automatically out of place … It is a chance to have a new life… I wouldn't give that up for anything else in the world" (Stefancic et al., 2012, p. 401). Through increased independence, participants also described gaining greater self-confidence: "At one time I used to be scared to tackle things. I am, still not perfect at it, but I can manage more. I have more self-esteem to tackle something" (Leviten-Reid et al., 2014, p.64).

Maintaining a sense of pride in one's home through engaging in daily domestic routines provided a sense of purpose and meaning for many individuals (Jones et al., 2003; Padgett, 2007; Raphael-Greenfield & Gutman, 2015). For instance, this participant explained, "Everything in the apartment gives you a sense of pride and builds your self-esteem and makes everyone be more productive. It makes you, you know, want to do things" (Carpenter-Song et al., 2012, p. 438). Furthermore, opportunities to engage in daily routines were satisfying in and of themselves, as this quote indicates: "It is wonderful to feel the satisfaction that comes from something you have just done. I enjoy it when I have done the dishes, and you know

that I can rejoice for the rest of the day" (Lindström et al., 2010, p.294).

Through assuming responsibilities within their homes, some participants described developing or renewing their confidence and motivation for achieving long-term goals beyond the home environment. For instance, they spoke of looking forward to new possibilities previously perceived as unachievable, such as volunteering, employment and renewing friendships (Kirsh et al., 2011; Nelson et al., 2005; Padgett, 2007; Parkinson & Nelson, 2003; Raphael-Greenfield & Gutman, 2015). This was "…One of the big turning points because it simply allowed me to um, reevaluate things, you know, and just get my life together from there…where was I heading what was my purpose" (Padgett, 2007, p.1932). In some instances, work or community involvement were directly obtained through the supported housing program (Dorvil et al., 2005; Forchuck, Ward-Griffin et al., 2006; Kirkpatrick et al., 2009; Nelson et al., 2005; Parkinson & Nelson, 2003).

There is a delicate balance between appreciating privacy and dealing with loneliness

Varied social experiences related to living in supported housing were reported across the studies. Some participants reported positive experiences of reconnecting within their community, whereas others struggled with previous traumatic experiences and felt cautious about reconnecting with others (Raphael-Greenfield & Gutman, 2015).

Many residents in supported housing reported not only a sense of feeling 'cut off', lonely, isolated but also expressed desires for romantic or familial relationships and a sense of belonging (Chesters et al., 2005; Dorvil et al., 2005; Jones et al., 2003; Kirsh et al., 2011; Tsai, Bond, Salyers, Godfrey, & Davis, 2010; Walker & Seasons, 2002; Wong, Metzendorf, & Min, 2006). For instance, as one participant from a study conducted in rural Australia reported, "I have no partner and no one to talk to at home… The most interaction

I have is my thoughts when the TV is on, which is pretty pitiful from someone who was one of the most popular girls in high school… To just living a lonely existence, going out once a fortnight, doing a shop, getting what you need to survive. My only friends are my caseworkers" (Jones et al., 2003).

Supported housing residents in these studies appeared to seek a delicate balance between protecting their privacy and being lonely when on their own (Lindstrom et al., 2010; Walker & Seasons, 2002). As this participant explained, "… that's something that's very important to me. I need to have my privacy. I'm glad I'm living in the unit I'm living in on a fairly quiet floor. Maybe even too much privacy sometimes. Because living alone can be challenging. It can be lonely …" (Walker & Seasons, 2002, p. 141). Furthermore, some participants reported feeling ambivalent about forming connections with others and sought to maintain a safe distance within relationships (Raphael-Greenfield & Gutman, 2015). For example, traumatic experiences meant that participants in this particular study spoke of the need to be "constantly vigilant" about their environments leading to an isolated existence.

Feelings of loneliness also appeared to be reflective of experiencing social exclusion and stigma (Dorvil et al., 2005; Leviten-Reid et al. 2014; Walker & Seasons, 2002). "It's like a jigsaw puzzle and a piece that doesn't fit right. You feel like you just don't fit in with them because you are sick" (Walker & Seasons, 2002, p. 144). To address this, some participants identified the need for a situation "...where the community accepts you and understands that you have a disability or an illness, but that it's being controlled by medication. That way you can try and live a full life, you know, which is not possible right now because of the stigma, social status, and income level" (Walker & Seasons, 2002, p. 145). Limited financial resources were reported as a barrier to greater social connectedness in other studies too (Leviten-Reid et al., 2014; Parkinson & Nelson, 2003).

Opportunities and support to re-connect with family, friends and community are valued

Access to opportunities for social interactions and the provision of practical supports were valuable in enabling people living with serious mental illness to reconnect with family, friends and community (Kirsh et al., 2011; Leviten-Reid et al., 2014; Raphael-Greenfield & Gutman, 2015; Stefancic et al., 2012; Walker & Seasons, 2002).

Many participants felt that having opportunities for activities within the community, to rebuild trust and confidence, were important for engaging in social situations with others (Carpenter-Song et al., 2012; Kirkpatrick & Byrne, 2011; Kirsh et al., 2011; Lindström et al., 2010; Parkinson & Nelson, 2003; Raphael-Greenfield & Gutman, 2015; Whitley et al., 2008). As one participant described, "I feel lonely because I don't have much companionship with other people. I feel a lot of disconnection from the community, you know. I mean if there were more activities, I could go to in town and help with mental health. But I wish I had more company …" (Walker & Seasons, 2002, p. 142). And, as another participant elaborated, "That's my ideal situation to actually be self-sustaining, a regular part of the community, you know. I want to be a part of the community" (Tsai et al., 2010, p. 385).

Social experiences were challenging and demanding for some participants but nevertheless seen as important for developing confidence to re-connect with others. For instance, one participant spoke of "baby steps… [in] learning to conform more to family structure, friend structure as opposed to the institution way" (Wong, Metzendorf, & Min, 2006, p.55). This led to improved relationships with friends or family members (Chesters et al., 2005; Forchuck, Ward-Griffin et al., 2006; Kirkpatrick & Byrne, 2009; Leviten-Reid, et al., 2014; Raphael-Greenfield & Gutman, 2015), as this quote illustrates: "I'm just glad I was able to wake up before it was too late

to meet back with them (family)" (Raphael-Greenfield & Gutman, 2015, p.43).

Engaging in social activities outside their supported housing was a reported challenge for some people living with mental illness. When housing support workers initiated and supported the involvement of residents in social activities, the latter sometimes described feeling less isolated (Kirkpatrick & Byrne, 2011; Leviten-Reid et al., 2014; Lindström et al., 2010; Parkinson & Nelson, 2003; Stefancic et al., 2012; Walker & Seasons, 2002). They also reported wanting individualized types and levels of support, as illustrated here: "There are certain things I'm not going to do on my own. I don't want to say this, but sometimes I think I, personally, need supervision" (Raphael-Greenfield & Gutman, 2015, p. 43); and "It's molded around the person so it fits, instead of the person to the mold … the ball's always in my court" (Kirkpatrick & Byrne, 2011, p. 38). It also meant the support worker believed in the person and was responsive to them: "It's about support to meet people's changing needs, to help them to live independently, to reintegrate back into the community, to keep… I guess the biggest thing was having a support worker that never stopped believing in your ability. I don't think there's anyone else, not even my mum, that really believed that I could do it" (Chesters et al., 2005, p. 7).

Support in the form of coaching allowed housing residents to develop confidence in their ability to cope with social situations. "It's like the work of an enabler; it has been good for me to dare to make contact with others in social contexts, to find a little endurance and energy to enjoy the fun stuff simply to have the strength to try" (Lindstrom et al., 2010, p. 291). Furthermore, the relationships that housing residents formed with their support workers provided an opportunity to learn new ways of relating to others. This helped to overcome their difficulties with trusting others and thereby to build or restore relationships with family and friends. One participant explains: "I was a loner. Little by little with the treatment that I

started getting, I was opening up. I was communicating more with people … Basically I didn't have no friends, cuz in the streets, you know, people just have acquaintances. So when I started getting better they were more like friends, instead of being strictly like program." (Stefanic et al., 2012, p. 400).

Discussion

Using a qualitative meta-synthesis method, we explored the experiences of people with mental illness living in supported housing reported across nineteen articles. The four identified themes suggest benefits and challenges of living in ordinary housing with support for this population. Privacy, leading to a sense of control, stability and security, were consistently reported as valued aspects of supported housing. This is unsurprising given having choice and control of one's living space, rather than communal living, has been a consistent theme of research on housing preferences since deinstitutionalization (Davidson et al., 1996; Richter & Hoffman, 2017). It is also consistent with the premises and reported benefits of supported housing (Gonzalez & Andvig, 2015a). The review findings also indicate that neighborhoods perceived as threatening and stressful, past traumatic experiences and housing in poor physical condition each influence the extent to which safety and security at home is important for individuals, as reported elsewhere (Gonzalez & Andvig, 2015a). These issues highlight the challenges of social and economic disadvantage and have important implications for the choice of location of supported housing, its surrounding neighborhood and community, as well as for weighing up personal autonomy and support needs with individuals (Harvey et al, 2012; Killaspy et al, 2016).

This meta-synthesis highlights that housing provides the foundation for individuals living with persistent mental illness to engage in activities. Once one's basic needs for shelter, safety and security are met, people are more able to focus on rebuilding their

lives and exploring meaningful activities in which to occupy their time (Macnaughton et al, 2016). In the reviewed qualitative studies, having a home of one's own typically created opportunities to assume new roles in the home, to take on new responsibilities and enhance a sense of self-reliance, suggesting the importance of one's material surroundings in recovery (Borg et al., 2005; Gonzalez & Andvig, 2015b). Whether by freeing people from homelessness or uncertain living arrangements, secure housing often becomes a turning point in what they do and their sense of meaning and identity (Gonzalez & Andvig, 2015b).

Links between supported housing and recovery are similarly noted elsewhere (Macnaughton et al, 2016). However, the extent to which supported housing facilitates social connections and participation remains unclear because their inter-relationships are complex (Sylvestre et al, 2007; Tsai et al, 2012; Yanos et al, 2004; Yanos et al, 2007). In particular, these relationships are poorly understood for individuals with mental illness who were not previously homeless. Recent Swedish research also suggests a gap exists between the needs for and opportunities to access meaningful activity and social connections that promote recovery in these settings (Eklund et al., 2017). Therefore, there are needs to further investigate how a greater sense of belonging and participation in communities and citizenship can be facilitated, and to consider these issues in the design of housing support (Eklund et al., 2017; Macnaughton et al, 2016; Sylvestre et al., 2007).

Loneliness and isolation were commonly reported in the studies included in this meta-synthesis, consistent with other supported housing literature (Siegel et al, 2006; Stergiopolous et al, 2014). Moreover, experiences of loneliness and social isolation are widespread among people with persistent health issues, including people with persistent mental illness for whom the prevalence is more than twice that of the general population (Badcock, et al., 2015; Hawthorne, 2008; Linz and Sturm, 2013; Stain et al, 2012).

Loneliness is a complex and dynamic issue impacted by diverse contextual and personal factors, many of which are independent of the home in which one lives (Hawthorne, 2008; Weiner et al., 2010). For instance, the types of local opportunities for social contact might be expected to vary in different geographic, urban and rural contexts, depending on the socio-economic status, amenities, transport and so on of each location. Furthermore, a range of personal factors, including previous traumatic experiences, personal struggles with substance use, persistent symptoms, and the stigma and discrimination faced by individuals merit more attention in developing individualized supports to address issues of loneliness and isolation with people living in supported housing.

Experiences of social connectedness and participation in supported housing were complex across the reviewed studies. For instance, Tsai et al. (2010) found that residents in supported housing reported fewer social connections than those in other residential programs, yet they still reported feeling connected to their community because supported housing allowed them to live as 'regular' community members. This highlights that experiences of housing and community have varied personal meaning and significance. This is because diverse activities performed in varied social contexts may enable either or both social connectedness and social integration, which are related but distinct phenomena (Yanos et al., 2007). Indeed, while individuals' preferences for social involvement may vary from active community participation to activities done in relative solitude or alongside others, any of these activities may be nonetheless meaningful to the individual (Le Boutillier & Croucher, 2010; Yanos et al., 2007).

The findings from this meta-synthesis suggest that social connectedness goes beyond housing, and that opportunities for belonging and acceptance within one's community were central to meeting social needs (Linz and Sturm, 2013; Tsai et al., 2010; Walker & Seasons, 2002). These findings extend current limited

evidence that supported housing is associated with individuals' community integration and social inclusion (e.g. Killaspy et al, 2016; Stergiopolous et al, 2014). The meta-synthesis findings confirm that choice in supports is important in supported housing (Sylvestre et al 2007). More specifically, the findings identify that individualised support was a valued means to pursue personally meaningful goals to re-connect socially, and participate in social situations (Polvere, Macnaughton & Piat, 2013; Tsai et al., 2010). The development of a trusting relationship between the support worker and resident appeared to provide a foundation for building confidence to re-engage with family, friends and the community. Similarly, a stronger working alliance between case managers and Housing First residents was more likely to lead to improved community integration (Stergiopoulos et al., 2014). However, relatively little is known about the support practices that promote social connectedness and recovery (Tideringtон, 2017). Based on this meta-synthesis, support in the form of coaching appeared particularly useful. This is consistent with recovery-oriented approaches (Davidson et al., 2009; Slade, 2009) and merits further research in the context of supported housing.

The reviewed research has several limitations. Firstly, supported housing programs vary and insufficient reported information about the nature of housing and supports made study selection to ensure a coherent and meaningful synthesis more difficult. To mitigate this, all authors independently reviewed included and excluded studies. Secondly, the studies examined were from Australia, Canada, USA and Sweden; no other European studies were identified. This limits the generalizability of our findings to other settings where supported housing exists. Thirdly, supported housing research focusing on the experiences of people with severe mental illness rather than those who were recently homeless is less common. Similarly, few housing studies have focused specifically on social connectedness, including its varied meanings and contributions to quality of life.

Conclusion

This review synthesized seventeen qualitative studies concerning experiences of supported housing, social connections and participation. Location of supported housing, its surrounding neighborhood and community is likely to be important for residents' sense of connection and belonging. Individualized support is essential in providing a foundation for rebuilding lives given that experiences of housing and preferences for social involvement have varied personal meaning and significance. Trust and confidence built through collaboration and coaching can enable residents to re-engage with families, friends and the community. To further elucidate how supported housing can enhance social outcomes for people with severe mental illness, more research exploring the effectiveness of different types of support for improving social participation is needed.

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Table 1. Databases and search terms

Table 2. Quality appraisal of included studies

Table 3. Qualitative Studies on Supported Housing 2001-2016: Lived experiences of supported housing

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Table 1. Databases and search terms

Search concepts	Terms used in each database
Adults	All databases heading: Adult All databases limits: Adult 18-44, Middle Aged 45-64
Mental Illness	CINAHL heading: 'Mental Disorders', 'Mental Health' PsycINFO heading: 'Mental Disorder' Medline heading: 'Mental Disorder' CINAHL key terms: mental illness PsycINFO key terms: mental illness, mental health Medline key terms: mental illness, mental health
Supported Housing	CINAHL headings: 'Housing', 'Independent Living Programs' 'Community Living' PsycINFO and Medline headings: 'Housing', 'Independent Living Programs', 'Mental health Programs' All databases key terms: support*hous*, community hous*, independent living, 'housing and support' All databases heading: 'Life experiences'
Qualitative Design/Experience	All databases key terms: experience*, view*, lived experience*, quality of life. All databases limits: Qualitative (Best balance of specificity and sensitivity).

Table 2. Quality appraisal of included studies

First Author	A	B	C	D	E	F	G	H	I	J
Carpenter-Song	Y	Y	Y	Y	G	Y	G	Y	S	M
Chesters / Jones*	Y	Y	Y	Y	G	Y	M	Y	N	N
Dorvil	Y	Y	Y	Y	M	Y	M	Y	S	M
Forchuck	Y	Y	Y	N	M	Y	G	Y	G	G
Kirkpatrick*	Y	Y	Y	Y	G	Y	S	Y	S	S
Kirsh	Y	Y	Y	Y	G	Y	S	Y	G	G
Leviten-Reid	Y	Y	Y	Y	S	Y	G	Y	S	G
Lindstrom	Y	Y	Y	Y	G	Y	M	Y	S	M
Nelson	Y	Y	Y	Y	S	Y	S	Y	G	S
Padgett	Y	Y	N	Y	S	Y	S	Y	G	G
Parkinson	Y	Y	Y	Y	M	Y	S	Y	M	S
Raphael-Greenfield	Y	Y	Y	Y	S	Y	S	Y	S	G
Stefanic	Y	Y	Y	Y	G	Y	S	Y	S	M
Tsai	Y	Y	Y	Y	M	Y	M	Y	G	M
Walker	Y	Y	Y	Y	M	Y	M	Y	M	S
Whitley	Y	Y	Y	Y	G	Y	G	Y	S	M
Wong	Y	Y	Y	Y	S	Y	S	Y	S	M

* Quality appraisal based on 2 published articles from the same study

Key for quality appraisal questions

A- Are the aims of the study clearly reported N, no. Y, yes.

B- Is there an adequate description of how the sample was identified and recruited? N, no. Y, yes.

C- Is there an adequate description of the sample used in this study? N, no. Y, yes.

D- Is the context of the study adequately described? N, no. Y, yes.

E- Have the authors described the housing setting (and it's relation to the supported housing model) in detail? N, no. M, minimal. S, some. G, good.

F- Is there an adequate description of the methods used to collect date? N, no. Y, yes.

G- Have sufficient attempts been made to establish the reliability and validity of data collection methods and tools? N, no. M, minimal. S, some. G, good.

H- Is there an adequate description of the methods of data analysis? N, no. Y, yes.

I- Have sufficient attempts been made to establish the reliability of data analysis? N, no. M, minimal. S, some. G, good.

J- Have sufficient attempts been made to establish the validity of data analysis? N, no. M, minimal. S, some. G, good

Table 3. Qualitative Studies on Supported Housing 2001-2015: Lived experiences of supported housing.

Citation	Purpose	Design and Location	Participants and Housing Type	Findings-Overall Themes
Carpenter-Song & Hipolito (2012)	To identify features of Recovery Community environments that contribute to recovery from the residents' perspectives.	Qualitative design: focus groups in 8 'Recovery Communities' at 4 month intervals over 2 years (2008-2010); regular participant observation; thematic analysis. Mental health service agency, Washington DC, New York City Greater Chicago Area.	People with severe mental illness living in eight separate Recovery Communities; exact number of participants unspecified. Recovery communities embody the structure and philosophy of "supported independent living." Support staff do not reside in the housing community.	Participants expressed that Recovery Community programs played a key role in their process of recovering. Three features of the contextual environment were important: 1) Service environment: it provided coherence, stability and security for residents; and a forgiving, inclusive and flexible environment that created a sense of autonomy. 2) Physical environment: Recovery Communities provided safety and comfort, stressed as essential for promoting recovery, as well as providing refuge from drugs and alcohol and relief from managing day-to-day without a home. For some, the physical buildings were a source of pride and self-esteem too. 3) Social environment: Feeling known, having others in close proximity, someone to talk to, and others demonstrating care and concern were supportive aspects of Recovery Communities.
Jones, Chesters & Fletcher (2003)	To explore the ways that people with psychiatric disability in an Australian supported public housing program	Qualitative design: open-ended interviews; grounded theory analysis. SNAP Housing and Support Program,	Eighteen people : 15 SNAP housing tenants	Important attributes of home were identified, including: 1) Identity – personalizing their houses with self-chosen objects, décor and furniture helped create a sense of home and identity. 2) Privacy and autonomy – having a home gave residents a sense of safety, valued space to retreat, and control over who entered their

	experience their houses.	Gippsland, Victoria, Australia.		living environment. 3) Stability and security of tenure was vital to residents' experiencing their houses as homes. 4) Physical comfort - the newness and quality of the housing gave residents a sense of pride and worth. 5) Domesticity – responsibilities for doing domestic tasks represented a sense of 'normality', as well as creating purpose and routine in daily life. 6) Support – access to practical support involving working together to manage the struggles of everyday living was viewed as a 'big help' 7) Home ownership – personalizing their homes created a sense of ownership, but owning one's own home was a dream to aspire to. 8) Love - residents reported loneliness and a deep sense of loss in the absence of human affection, others to share their lives with, and loving familial and/or romantic relationships.
Chesters, Fletcher & Jones (2005) [based on same study as Jones, Chesters &	To explore residents' perspectives of a supported housing program for people recovering from low prevalence mental disorders in rural	Qualitative design: individual semi-structured interviews; grounded theory analysis. SNAP Housing and Support Program,	Eighteen people: 15 SNAP residents (11 women, 4 men), aged 26 – mid 50s; and 3 SNAP support workers. All residents lived in self-contained units: 10 on their own; 3 with their children; and	Important attributes of home were identified in this study, as described above (Jones et al., 2003). Two meta-themes were presented in this paper: 1) Importance of place to base recovery – most residents felt more in control of their lives and homes; they also spoke of dreams of having their own place, more space (eg for children, pets, outdoor activity), and someone special to make a home with.

Fletcher, 2003]	Australia.	Gippsland, Victoria, Australia.	2 sharing a unit.	2) Loneliness and lack of supportive meaningful relationships – all residents expressed social isolation in varying degree; their homes provided shelter, privacy and their own space but not companionship or relationships; and they relied on SNAP for community connections.
Dorvil, Morin, Beaulieu & Robert (2005)	To investigate the housing experiences of people using mental health services, and to explore how housing contributes to social integration	Qualitative design: semi-directed interviews; grounded theory. Quebec, Canada.	Twenty-one people, aged 20-74 years, currently using mental health services, 75% of whom received welfare support due to being 'unfit' for work. Participants lived in varied types of housing, including: custodial (eg foster homes), supportive housing (group homes), apartment style supported housing, rented apartments and private rooming houses.	Housing experiences were organized under three thematic headings: 1) Relationship to self - Participants perceived a hierarchy of housing options with differing levels of autonomy / support, meaning housing became a marker of status and progress with 'normal' housing being the ideal that they hoped to attain. Participants also viewed housing as a place for getting a grip on mental health, particularly in settings with other consumers present; those in regular apartments described efforts to conceal mental illness, which bolstered their self-image and supported self-development. 2) Relationship to 'one's home' - Having one's own apartment gave tenants a sense of control over their physical and social space, including the power to retreat and find solitude that is practically impossible in shared residential settings. On the other hand, participants in shared residences spoke of 'us' and more sense of commonality or connection with others. 3) Relationship to dimensions outside one's housing - Social networks were more readily available in shared residential settings, and through links with services. Networks outside their housing

				were harder to create and linked to the housing environment (e.g., neighbours in same building) or longstanding social ties, and infrequently to other occupations or income. In regular apartments, residents also had more autonomy in relationships with services, including psychiatry, than those in shared residences that were more typically integrated with the service system.
Forchuk, Ward-Griffin, Csiernik & Turner (2006)	To explore the housing related experiences of consumers/survivors.	Qualitative design: 9 focus groups with open ended questions; ethnographic analysis. South Western Ontario, Canada.	Ninety people with a history of mental illness recruited through posters/word of mouth. Participants lived in shelters, group homes, supported apartments and independent housing.	The metaphor of a tornado described participants' experiences of upheaval, loss and destruction at three levels: 1) Losing ground: Living in fear and losing control of basic human rights, such as adequate food, shelter, safety and income, is highly destructive. 2) Struggling to survive: Gaining access to social supports and receiving professional services were seen as important to survive, but often a struggle to access in a timely manner. 3) Gaining stability: Securing personal space and attempting to rebuild relationships with others were seen as necessary to restore stability and begin rebuilding their own lives.
Kirkpatrick & Byrne (2009)	To explore the experience of 'moving on' after individuals with severe mental illness obtain permanent housing with	Qualitative, narrative design: 31 open ended interviews and 2 months of participant observation prior to	Twelve people with a major mental illness and prior experience of homelessness. All are tenants of HOMES, a housing-first program. It includes three housing types:	Main reported themes about housing experiences were: 1) Moving on – after being 'on the move' trying to survive without a home, permanent housing with support allowed participants to "move on" from challenging times in a place that provided opportunities to feel in control, and work towards new goals and plans.

	support.	interviews; narrative analysis. Housing with Outreach, Mobile and Engagement Services (HOMES) Program, Ontario, Canada.	(1) single rooms with 24-hour on-site supports; (2) 'clustered' apartments in two large subsidized complexes with on-site and mobile supports; and (3) 'scattered' apartments across the city, with mobile supports only.	2) The door – doors and keys represented the control that having their own places allowed participants, enabling them to protect themselves and choose to keep people out or to let people in.
Kirkpatrick & Byrne (2011). [based on same study as Kirkpatrick & Byrne, 2009]	To describe the program narrative identified in the above study of the HOMES program (Kirkpatrick & Byrne, 2009).	Qualitative, narrative design: 31 open ended interviews with 2 months of participant observation prior to interviews; staff interviews and document analysis of HOMES program; narrative content analysis. HOMES Program, Ontario, Canada.	12 people with a major mental illness and prior experience of homelessness; all HOMES tenants (as described above).	Empowerment was the overarching theme of the HOMES program narrative, within which four sub-themes described how the program helped people move forward with their lives: 1) Having a place of one's own was highly valued; it meant privacy, a sense of control, opportunities to reconnect with family and friends, and to begin a new life. 2) Living the program's mission was a driving force in the lived experience of staff and residents. It meant working with integrity, being creative and going the extra mile to offer individualised timely support and residents having a sense of staff respecting them and 'being there' for them. 3) The program was empowering at a personal level: residents described it as making them believe in themselves and providing support to regain a sense of being in control of their own lives. 4) The importance of social activities: for both staff and residents, social events were valued as opportunities to have fun, reward hard

				work, feel part of something, and become more involved in planning and organizing activities with others.
Kirsh, Gewurtz & Bakewell (2011).	To understand the important characteristics of supported housing from resident and service provider perspectives.	Qualitative design: 35 semi-structured interviews (25 with residents, 10 with service providers); constant comparative analysis. Two community services in Toronto, Canada.	35 participants: 25 mental health service users for 1-38 years (mean = 14 years); and 10 service providers (5 housing workers, 5 case managers/rehabilitation workers). Supported housing residents included: 12 in rent-geared-to-income housing, 10 in homeless housing, 3 in mental health and justice housing). Their supported housing included: independent units within apartment buildings scattered across the city; and clustered housing provided in independent units within designated buildings.	Four core themes were reported: 1) Supported housing as a foundation for recovery - Residents noted relief, reduced stress and greater freedom in having their own place; and improved privacy and control of their living space and lives, so that housing provided a base for moving forward with their lives. 2) Guiding values – residents and service providers spoke of values related to respect, dignity, the importance of flexibility and choice in housing and support as essential to the supported housing program. 3) Key supports in supported housing – five identified key supports were: connecting with social supports (including friends, peer networks and family); moving forward through goal setting and accessing resources; managing crises; learning skills for independent living; building trusting relationships over the long term. 4) Neighborhood and community context: residents spoke of the importance of building upkeep and neighbourhood characteristics (accessible transportation and amenities), while service providers described the importance of a good fit between residents, neighbourhoods, and the housing where they live.
Leviten-	To explore how	Case study design:	Sixteen participants (14 current	Five themes described participants' housing-related experiences

Reid, Johnson & Miller (2014).	supported housing contributes to the quality of life and recovery of consumers in a rural community; and their suggestions for improvement.	16 in-depth interviews; a member checking meeting; thematic analysis. Novia Scotia, Canada.	tenants, 2 former tenants). All had lived in supported housing for at least one year and were clubhouse members or had a connection to community rehabilitation staff.	before and since living in supported housing: 1) Support: prior experiences of being unsupported and lonely, neglected rental property and uncaring landlords contrasted with experiencing stronger support since being in supported housing and improved connections with family, friends and peer networks. Some residents viewed formal supports from housing staff and mental health services as limited. 2) Security: In supported housing, participants described feeling safer than they had previously in poor rental housing and unsafe neighbourhoods, but they continued to struggle with financial security. 3) Normalcy and Integration: prior experiences of not having opportunities to live 'normally' contrast with supported housing in which participants experienced living in regular housing like others and taking part in community activities, albeit that they still faced the stigma and discrimination. 4) Stability and Control: Compared to lack of control over previous living environments, participants described greater stability and security of tenure in supported housing. 5) Recovery: Whereas unstable and poor living conditions were not conducive to their recovery, participants spoke consistently of more positive feelings, self-worth and self-confidence since living in supported housing, which enabled them to take new steps forward in their lives.

Lindström, Lindberg & Sjöström (2010).	To understand individual processes of change for persons living in a supported housing residence.	Qualitative design: semi structured interviews (2-4 per participant); constant comparative analysis. Supported housing residence, Northern Sweden.	Six people (4 men, 2 women aged 24 -37 years) who experienced psychosis. All lived in a supported housing residence (self-contained apartments plus communal areas), with coaching and support available to individuals and groups. Coaching and supports reduced as residents became more independent.	The overarching theme, "Trying interactions generate occupational transformations" describes the need to experiment and the effortful aspects of the process of changing one's life, occupations and understanding of mental illness. Five categories are presented: 1. Home was experienced as a place for living and learning, meeting basic needs and safety, and creating personal space. Structuring their living conditions was seen as supportive and providing a base for further change and development. 2. Being forced to socialize – social interactions were seen as demanding and tiring but also rewarding and opportunities for enjoying company and learning through exposure to conflicts, finding something in common and developing understanding of their peers. 3. Being enabled by coaches – participants described coaches as valuable enablers, supporting them to 'give it a go', respecting them and acknowledging their efforts in processes of change. 4. Facing challenges – finding the balance between expecting too little and too much of a person was described as challenging: sufficient demands to inspire, and not so high as to cause anxiety or too much pressure. 5. Change leads to further change – participants identified events in which they saw change in themselves or other residents, and

				viewed successful doing as motivating to try new activities or explore new ideas.
Nelson, Clarke, Febbraro & Hatzipantelis (2005).	To explore how the life stories and quality of life of residents have changed since entering supportive housing	Qualitative design: 20 semi-structured interviews; narrative analysis. Toronto and Hamilton, Canada.	20 people (11 men and 9 women) with severe mental illness and a history of homelessness. Included 4 residents in independent apartments; 16 in group living with either private or shared rooms. Supports included: on site staff or visiting support staff.	Themes were categorised for two periods of time: participants' lives prior to living in supportive housing and since: 1) Youth and adult life before supportive housing: Participants described lives filled with personal health issues, troubled or unsupportive relationships, abuse and limited social and economic resources. 2) After supportive housing: Participants described their lives more positively, with a greater sense of independence, wellbeing and control, and improvements in the quality of relationships and social lives. Supportive housing also provided practical resources related to the neighbourhood, safety, privacy, access to transportation, and opportunities for work, leisure and community participation.
Padgett (2007).	To examine the subjective meaning of 'home' among formerly homeless persons with severe mental illness	Qualitative design: open ended interviews; grounded theory analysis. New York Housing Study (NYHS), New York City, Washington DC and Greater Chicago Area, USA.	39 people with diagnosed mental disorder (schizophrenia, bipolar disorder, major depression), co-occurring substance abuse was common. All recruited from prior participation in NYHS: 21 from Housing First program; 18 from treatment first program (usual care).	No place like a home – identified themes include: 1) Control and self-determination – freedoms that come with having one's own place. 2) Routines of daily life – 'the simple things' that are possible and gratifying to do in one's own place (eg, having pets, doing one's laundry, taking a walk). 3) Privacy and freedom from supervision – having a haven away from noise, intrusions, surveillance and the stress of communal living environments.

				4) Embarking on identity construction and repair: 'home' as a base for self-reflection, re-evaluation of life directions, and beginning the restoration of social roles. 5) The 'what's next?' of having a home – having the possibility to contemplate the future but also being keenly aware of mortality, losses, and the challenges that lie ahead. 6) Staying in transitional housing – yearning for a 'home' and reluctant acceptance of the need for residential support
Parkinson & Nelson (2003).	To examine the role that supported housing plays in people's journeys of empowerment and recovery.	Qualitative design: 19 semi structured interviews; narrative analysis. Supported housing organisations in Western Canada and Southwestern Ontario, Canada.	5 people with mental illness residing in supported housing programs for at least one year; no further details about mental illness provided. Interviewed residents were also asked to nominate a friend, family member, peer worker and/or staff member for interview.	Consistent themes related to empowerment, community integration and access to valued resources were identified across residents' stories of prior to entering the housing program, living in supported housing, and the impacts that they experienced: 1) Powerlessness, instability, and feelings of dependence; conflict in familial relationships and friendships; and poor access to decent housing characterized participants' lives prior to involvement in supported housing. 2) Developing readiness for change, being in control of supports, and support experiences that build skills and confidence; building more diverse supports and connections with family and friends; and receiving assistance to access resources characterized participants' involvement in supported housing. 3) Changes experienced included: more stable mental health, taking more power and control, developing and fulfilling

				dreams, becoming more involved in community, reduced isolation and improved relationships, and housing beginning to feel comfortable, personalized and like home.
Raphael-Greenfield & Gutman, (2015).	To understand residents' experience in a Housing First program, their occupational needs and goals, and factors that help and hinder maintenance of housing.	Qualitative design: open ended interviews; phenomenological analysis. Housing First, New York City, USA.	4 people with histories of substance abuse and mental illness (eg bipolar disorder, major depression). All living in a Housing First program.	Seven thematic categories described participants' lived experience and factors influencing their daily occupations: 1) Home maintenance and budgeting occupations were viewed as important to live an orderly life and maintain one's apartment. 2) Striving to maintain abstinence by engaging in occupations that provided distraction or incentives to remain abstinent. 3) Housing transformed the occupations and roles available to participants. 4) Fears and feelings about aging, disability, losses and awareness of mortality changing one's perspective of life. 5) Constant vigilance in daily occupations and fears related to prior traumatic events, social relationships, losing housing and the future. 6) Beginning to re-engage with society through daily occupations 7) The desire for occupations through which to offer assistance to others, such as volunteering.
Stefanic, Hul, Gillespie,	To explore how participants experienced a	Qualitative design: semi structured interviews; grounded	20 people with mental illness; diagnoses included schizoaffective disorder (20%),	"Beyond belief" described the overarching experience of Housing First as exceeding participants' expectations. Themes included: Initial disbelief at having their own apartment; taking time to create

Jost, Tsemberis & Jones (2012).	Housing First program, with a particular focus on providing an alternative to incarceration.	theory analysis. Housing First and Alternative to Incarceration program, New York City, USA.	bipolar disorder (20%), major depression (20%), schizophrenia (15%), and anxiety disorders (15%); rates of co-occurring substance use disorder were high (75%). All living in a Housing First and Alternative to Incarceration program (court ordered).	a sense of home and feel comfortable in one's neighbourhood; gaining a sense of security and stability; and experiencing freedom, choice and respect for privacy in housing and daily life. Participants also described feeling listened to and validated in the Housing First program, becoming more trusting, open, confident and productive. Home was seen as transformative: a foundation for having a new life, new expectations and outlook; and beginning to plan for the future (eg career and education goals, family connections, moving).
Tsai, Bond, Salyers, Godfrey & Davis (2010).	To investigate the housing preferences, decision making related to housing choices and perceived housing barriers among residents living in supervised or independent housing arrangements.	Qualitative design: individual semi-structured interviews; content analysis guided by grounded theory. Thresholds psychosocial rehabilitation agency, Washington DC, New York City, and Greater Chicago Area, USA.	40 people with severe mental illness and co-occurring substance use disorders, the majority being African American males. 20 people in supervised housing (residential programs) and 20 living in independent housing (14 in apartments, 5 in single room occupancy, 1 with family). All had comprehensive case management support.	The study compared residents' perspectives of supervised and independent housing. Findings included: 1) Likes and Dislikes: Having their own space, keys, sense of freedom and autonomy were enjoyed by many residents in both settings. Residents in supervised housing reported a sense of community and peer support but also complaints about other residents' behavior, whereas complaints related to independent housing were about the physical condition of properties. 2) Housing Choice and Options: Most participants had choice about their current housing, albeit often few housing options to choose between. Factors influencing their choice reflected diverse pathways, including: moving to leave an undesirable situation, moving based on availability of preferred options or family or service provider suggestions, and as part of their recovery.

				3) Barriers to Housing: Most reported barriers related to seeking independent housing, financial issues being primary, but also waiting lists for supervised and independent housing. 4) Housing Preference Changes: Participants described differing preferences over time in their lives, with preference changes relating to housing experiences, life circumstances, and recovery. Supervised housing was seen as useful at some points to aid recovery, and independent housing at other times. Most desired independent housing in the future.
Walker & Seasons (2002).	To examine supported housing residents' experiences of housing related to its physical environment, social environment, affordability and choice, and housing history.	Qualitative design: individual semi-structured interviews; grounded theory analysis. Waterloo Region, South Western Ontario, Canada.	34 people: 14 men, 14 women and 3 couples. Includes 23 people living in market-rent apartments and 8 people in subsidized housing units.	Four themes described participants' housing experiences: 1) Loneliness is complicated: participants desired privacy and social interaction with neighbours. They noted often not knowing neighbours; that they and neighbours generally kept to themselves; and that disconnection from community or companionship could make living by oneself less likeable. 2) Making do with inadequate housing conditions (eg, poor state of repair, insufficient space, affordability issues) whilst also expressing gratitude for their living situation. 3) A desire for understanding: Participants identified mental illness as causing them to feel apart from others; and expressed the wish for more understanding among landlords, tenants, neighbours and other community members, especially of mental health issues. 4) Fitting-Out: Participants expressed opposition to housing

				specifically for people with mental illness as not supporting integration and creating stressful living environments. They spoke of their desire to live as part of the broader community in apartments and neighbourhoods with more diversity.
Whitley, Harris & Drake (2008).	To identify and understand factors that influence adjustment and stability by exploring residents' lived experiences of a recovery-oriented housing program.	Qualitative design: 4 focus groups (with 5-8 participants) and participant observation with residents, support staff and case managers conducted longitudinally over two years (2005-2007); qualitative content analysis. Community Connections, Washington D.C, New York City, and Greater Chicago Area, USA.	17 people with severe mental illness, the majority being African American in 30s-40s. Most had experienced abuse and had substance use issues. The supported housing comprised self-contained apartments in one building block; support staff did not reside on premises.	The dominant theme was safety and security. Residents described an initial sense of safety and security inside their housing but a range of concerns became more prominent over time: 1) Safety concerns included: fellow residents and their associates' engagement in substance abuse that disrupted equanimity in the apartment block; threats from the potential for loss of self-control; and threats from unknown people coming into the building and being fearful of people on the outside. 2) Feelings of security and community were seen as fostered through residents looking out for others in the building. 3) Ongoing conflicting tensions were present for residents between their wish for meaningful connections with others and a private life.
Wong, Metzendorf	To explore supported housing	Qualitative design: 6 focus groups;	29 people: 18 consumers with a diagnosis of major mental	Three themes relating to lived experiences of interacting with neighbours and social integration were identified by supported

& Min (2006).	residents' neighbourhood experiences; and to identify factors that facilitate social interaction and community membership.	thematic analysis. Community residential settings, Pennsylvania, USA.	illness; and 11 staff. Community residential settings included: a) semi-independent living with 24 hour access to support (4 consumers, 3 on-site staff); b) supported independent living in apartments across the city with flexible supports (7 consumers, 5 off-site support staff); and c) transitional housing program with staff on site daily and some evenings (7 consumers, 3 staff).	housing residents: 1) 'Good' and 'Bad' experiences of interacting with neighbours, and efforts to foster reciprocal relationships with neighbours were described. 'Good' neighbours were portrayed as respectful and looking out for others, whilst complaints of 'bad' neighbours focused on noise and hostility. 2) Experiencing social rejection in situations of high visibility (such as attending community events) were described, along with using strategies for managing difference (such as making efforts to blend in, mind one's own business). 3) Being part of a community meant housing residents noted differences between themselves and other community residents (eg in age, health status, family and economic status); appreciated a diverse neighbourhood as advantageous for reintegration; and viewed integration as involving mutual adjustment for them and neighbours. Support staff viewed community integration as a process of learning skills, adapting to neighbourhoods, overcoming stigma and previous experiences of institutions or homelessness, and developing a 'safety net' of supports.

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