




ORIGINAL ARTICLE

Enhanced supported living for people with severe and persistent mental health problems: A qualitative investigation

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Abstract

Supported living has been shown to improve functioning and social inclusion in people with severe and persistent mental health problems, reduce hospitalisation and provide secure accommodation in a population where housing needs are often unmet. Conversely, living in supported accommodation has been depicted by some as de-personalising, marginalising and an ordeal to survive. Discussions regarding housing and support often lack a thorough consideration of individual experiences, with a reliance on quantitative surveys. The question remains how to assure that supported accommodations actually are supportive of the residents' ongoing recovery process. The present study sought to shed light on the experiences of residents in an enhanced supported living service in the United Kingdom. Semi-structured interviews were conducted with nine residents of the service between July 2020 and February 2021. Transcripts were analysed using thematic analysis and indicated three superordinate themes of experiences considered valuable to residents: (1) support from care staff which was readily available; (2), a sense of community and daily activity offered by the residence and on-site activities; and (3) the experience of supported living as a stepping-stone in an ongoing recovery process. Findings indicate the power of comprehensive care with supportive staff, peer-relations, autonomy and fostering hope in empowering individuals in their ongoing recovery.

KEYWORDS

housing, lived experience, qualitative research, recovery, schizophrenia, severe and persistent mental health problems, supported living

1 | INTRODUCTION

1.1 | Overview

The provision of care for individuals with severe and persistent mental health problems (SPMHP) has emphasised the importance of the active participation of the individual in their own recovery (Anderson & Funnell, 2005). The recent trend towards

self-management reflects a wider context regarding the role of patient identity in the recovery process (Armstrong, 2014; Pulvirenti et al., 2014). While the notion of self-management may imply the individual assuming total autonomy and control over the management of their condition (Thirsk & Clark, 2014), adequate support appears crucial in both maintaining engagement and ensuring positive outcomes (Coleman & Newton, 2005; Wagner et al., 2001).

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Supported Living services for those with SPMHP designed to assist with developing the skills required for independent living account for approximately 60,000 people in England (Department of Communities and Local Government, 2006), at a substantial cost to taxpayers (Mental Health Strategies, 2010). Recent investigations have suggested that that a process of supported recovery might improve functioning and reduce individual needs over time (Slade et al., 2015), and that individuals in supported housing demonstrate better living condition outcomes and social functioning outcomes in comparison to more high-support accommodation (Harrison et al., 2020). A body of literature has developed linking supported living arrangements with a number of beneficial outcomes including improved social inclusion (Killaspy et al., 2016), reductions in hospitalisation (Kyle & Dunn Barts, 2007) and improvements in housing stability (Watson et al., 2018) in a population where housing needs can often go unmet (Harvey et al., 2012). One of the most notable series of studies in the area centres around the Housing First model, which aims to provide accommodation for homeless individuals with multiple and complex needs, without conditions attached to sobriety or abstinence (Tsemberis, 2010). The programme has been associated with eliciting rapid improvements in community functioning and quality of life when compared to treatment as usual groups (Aubry et al., 2015) and suggests that, with appropriate support in place, supported living is capable of significantly advancing recovery.

However, studies have also suggested that supported living has been conceptualised by service-users as an ordeal to 'survive', as contributing to feelings of dislocation, or as preventing adequate expression of the self. Previous interviews with individuals living in supported accommodation Humberstone (2002), reported feelings of marginalisation and loss of agency (or assumptions of incapacity). Additionally residents reported isolation and social and economic exclusion, lack of opportunity for self-development or engagement in meaningful life-activities and loss of privacy, contributing to a sense of estrangement. Restrictions on living arrangements, daily activity and possessions appear to have inhibited the development of self-identity. Loss of 'self' emerges frequently in qualitative investigations of experiences with schizophrenia (Fernandes, 2009; Humberstone, 2002; Jarosinski, 2006; Yennari, 2011), with the development of a positive self-identity associated with helping facilitate the recovery process (Davidson & Strauss, 1992). Some have characterised some varieties of supported living as a form of transinstitutionalisation (Drake, 2014). Consequently, this would suggest that supported living arrangements may benefit from a better understanding of the experiences of individuals within their remit, in order to better understand the factors which help foster an environment in which tenants feel supported in their recovery.

Somewhat problematically, there is a wide range of terms currently in use to describe supported living systems (including 'Supported Housing', 'Supported Accommodation' 'Support in Everyday Living', 'Housing Support' and 'Supported Living'). In turn, the lack of clear definition has presented a significant challenge to

What is currently known about this topic

- Supported Living services may improve functioning, social inclusion, reduce hospitalisation and provide secure accommodation for individuals whose needs often go unmet.
- It has also however been reported as producing feelings of estrangement, marginalisation and being an 'ordeal to survive'.
- There is a need for qualitative enquiries to better understand the experiences of individuals in supported living.

What this paper adds to the field

- A comprehensive programme of individual care delivered by supportive care staff may make a meaningful contribution to empowering individuals in their ongoing recovery.
- Policy makers and practitioners should consider the value of peer-relationships, autonomy and functional independence in fostering social inclusion and reducing marginalisation.
- A better understanding of the lived experience of individuals in supported living aids in understanding what makes the care-environment 'supportive' to those who depend upon it.

establishing an evaluation of effectiveness (McPherson et al., 2018). Harrison et al. (2020) reported discrepancies in satisfaction with living conditions across supported accommodation types, and a need for further focus on improving social functioning and well-being outcomes across the range of provision.

While the use of quantitative and structured measures may be effective in describing broader patterns present in supported living, qualitative methods not only provide greater opportunity for individuals to construct the narrative of the research, but are also less likely to be skewed by low expectations or prior assumptions (Khatri et al., 2001). In addition, persistent psychotic experiences such as delusions, hallucinations and disordered thought, may create a number of barriers to effective communication. In addition, negative symptoms and cognitive problems may serve to compromise an individual's motivation or ability to identify appropriate needs and solutions. The use of qualitative methods can provide an environment in which individuals are afforded greater opportunity and flexibility to respond and may therefore be better suited to encouraging the lived reality of supported living to emerge. Indeed, a recent publication highlighted the need for and value of, further qualitative inquiry in this area (Killaspy & Priebe, 2021). Consequently, there is a need for a greater understanding of the lived experience of supported living in people with SPMHP, particularly if its supportive feature is to be better realised.

1.2 | Northern healthcare and the enhanced supported living model

Northern Healthcare was founded in 2013 to provide bespoke accommodation in the form of Transitional Residential Rehabilitation for people with SPMHP who previously had formed part of the 'revolving door' population (Gournay et al., 2019). The population served by Northern Healthcare comprises individuals with long histories of involvement with a range of mental healthcare services, ranging from acute admission wards to medium secure services; many will have experienced homelessness and others will have had contact with the criminal justice system. The great majority of this population will demonstrate significant challenges with daily functioning.

First and foremost, the model considers residents to be 'tenants,' rather than 'patients' or 'service-users', with each person provided with their own private accommodation with private kitchen and bathroom facilities and their own front-door key. Indeed, the accommodation has all the legal safeguards that are attached to more general social housing. The primary focus of the model is to view the individual as a person, to foster their developing independence, and to encourage their recovery. The process may begin with supporting the tenant to gain access to basic facilities and to address long-standing unmet social, financial and health needs, such as applying for relevant benefits, a GP, and dental care. Along with the relevant care-coordinator in the NHS and staff employed by Northern Healthcare (occupational therapists, mental health nurses and support workers), tenants are actively involved the development of an individualised support plan, which contains clearly defined objectives, bespoke to them. These plans are updated in consultation with the above individuals every month depending on need and are also informed by range of transparent outcome measures (clinical, social, economic and qualitative).

As noted above, professional and social support is provided on-site and on a 24-hour basis. The addition of registered mental health professionals in the model is in keeping with the evidence that shows that access to trained staff has been shown to improve quality of life and increase autonomy (Welch & Cleak, 2018). In addition, specialist CBT advice and simple cognitive behavioural interventions are also provided for the reduction and management of symptom-experience and social anxieties, and to improve social skills. The presence of Registered Occupational Therapists in the Northern Healthcare team is aimed at enhancing the experience of supported living by assisting residents with meaningful day-to-day activity and functional recovery.

Furthermore the model utilises features shown to help prevent decompensation such as personal choice (e.g. around food, laundry and self-care) and social inclusion opportunities (e.g. volunteering, engagement with social clubs and employment; Killaspy et al., 2016; Lamb, 1995). A variety of daily activities are provided to support residents with enjoying leisure time, shown to contribute to enhance empowerment (Iwasaki et al., 2015), and develop supportive peer networks which may challenge stigma and provide hope (Naslund et al., 2016).

As positive relationships are associated with better treatment outcomes (Hewitt & Coffey, 2005), staff are encouraged to foster working

relationships with tenants with a focus on recognising individual need and development. These features are of particular importance for individuals who may need assistance in developing their coping skills or who have difficulty with social skills or social anxieties. The model therefore aims to provide a positive opportunity for the reduction of estrangement, often identified as a fundamental and negative attribute of the supported living experience (Corin & Lauzon, 1992).

In these regards therefore, while the term 'Enhanced Supported Living' adds yet another term to an already saturated arena, the model is distinct in both its clarity of definition and transparency of measurement. The primary aim of the present study was therefore to attempt to capture tenant experiences of the model, particularly in regard to aspects relating to feelings of support, or where this could be improved upon.

1.3 | The present study

While the importance of the views of service-users in enhancing the quality of provision has been established in the literature (Kai & Crosland, 2001), discussions regarding housing often lack a thorough consideration of individual experiences and the extent to which supported living is in fact supportive of individual recovery. Linear models of housing have been criticised for failing to appreciate the principles of rehabilitation or of being discriminatory against individuals with SPMHP (Ridgeway & Zippel, 1990). Furthermore, existing literature has tended to focus on the evaluation of quantitative measures or structured surveys when considering satisfaction with services (Trappenburg et al., 2013). The present study therefore aimed to investigate the experience of tenants of one enhanced supported living programme and the aspects of supported living perceived to be most beneficial to supporting and empowering their personal recovery. While not strictly a service evaluation, the study aimed to assess the extent to which the enhancements on offer in ESL may be experienced by residents as supporting recovery. The study aimed to establish the aspects of resident experience at Northern Healthcare which were felt to be effective in supporting recovery and reducing feelings of stigmatisation, marginalisation and depersonalisation. The findings, while focused on this particular model of care, may nonetheless contribute to a wider understanding and discussion of the experience of supported living from the perspective of the individuals in its remit.

2 | METHOD

2.1 | Design

The present study utilised a qualitative design with semi-structured interviews. A qualitative approach was selected to address the deficit of this line of enquiry in the field (Killaspy & Priebe, 2021) and to afford an opportunity for the service-user narrative to be explored (Khatri et al., 2001).

2.2 | Participants

All residents admitted to Northern Healthcare for a minimum of 1 year were eligible to participate in the study. Purposive sampling was employed and participants were identified either by the Clinical Director, staff at one of the residencies, or if a resident requested to participate, upon hearing of the study. Mental health records and pre-admission documents were reviewed in order to confirm the diagnostic status of all participating residents and the current duration of their tenancy.

Ten participants were recruited across four residential units, of whom seven were male, two were female and one was non-binary. Nine of the participants resided in one of Northern Healthcare's residential facilities, and one resident had transferred to a floating outreach service operated by the company. Of these 10 interviews, nine transcripts were analysed, with one male participant withdrawn due to insufficient data. Of the remaining nine participants, the duration of residency ranged between 20 and 79 months ($M = 40.67$ $SD = 22.64$). All residents who took part in the present study had extensive histories of mental health difficulties resulting in multiple hospitalisations and had experienced a range of provisions prior to their admission to Northern Healthcare, including hospitalisation as an in-patient, periods in other supported living arrangements, and independent living (such as own home or with a family member) both with and without 'floating outreach support.' In most cases, the precise number of prior hospitalisations was unknown, with records indicating for an example an 'extensive history' or a 'long history of contact with services'.

Initially, excepting for the requirements of current tenancy and time elapsed since admission, no further specific demographics, features or stipulations were made when recruiting participants. As the interviews progressed, residents were recruited if a particular demographic (e.g. gender) was insufficiently represented, when

TABLE 1 Participants' demographic information

Variable	Item	N
Gender	Male	6
	Female	2
	Non-binary	1
Age (years)	26–35	2
	36–45	3
	46–55	2
	>55	2
Duration of residency (months)	19–24	3
	25–36	2
	>36	4
Diagnostic distribution	Paranoid schizophrenia	4
	Schizoaffective disorder	3
	Personality disorder (incl. Emotionally unstable personality disorder)	1
	Unspecified psychotic disorder	1

considering the proportions of the wider Northern Healthcare population. Further demographic details regarding the final sample can be found in Table 1 below:

2.3 | Materials

A semi-structured interview schedule was devised (a copy of the interview schedule can be found in the Appendices), which aimed to address a number of areas of interest including quality of life, personal history and experiences of the mental healthcare system both present and previous. Where scientifically validated measures existed, such as for quality of life (Manchester Short Assessment of Quality of Life (MANSA; Priebe et al., 1999) and the Recovering Quality of Life Scale (ReQoL; Keetharuth et al., 2018), these were used to inform the question design.

As with recruitment, these questions were also modified based on the responses received during the early stages of the study. Questions were designed to be relatively short and direct in nature, in an attempt to reduce thought disordered responses, which may arise with more abstract questioning (Humberstone, 2002). Participants were also offered the opportunity to submit further information after the interview should they wish, with residency staff forwarding this information to the research team.

2.4 | Procedure

The research interviews were conducted, recorded, transcribed and analysed by a male research assistant (SB). After providing consent, as the researcher was unknown to the participants, a brief period of non-recorded and non-interview-based discussion took place to allow participants to establish some degree of rapport. Participants were reminded that the interviews aimed to uncover information relating to their own personal experiences and that as such, there were no right or wrong answers. Due to restrictions caused by the COVID-19 pandemic, interviews took place on either Zoom or Microsoft Teams, depending on which software was more convenient for the staff at the residence.

Additionally, while the majority of interviews lasted approximately 30–40 minutes, the interview length had to be kept flexible, in order either to allow for participants to have sufficient time to process the questions at their own pace, or to respond if participants became increasingly thought disordered as the interview progressed. Furthermore, while participants were offered sufficient time to consider their responses, guiding prompts back to questions were employed as needed. Listening without interruption has previously been shown to produce increasingly unstructured responses, which can lose focus on the question and topic (Humberstone, 2002). However, such interruptions were only used when necessary in an effort to ensure participants did not feel unheard.

Thematic analysis was selected as the means for analysis (Braun & Clarke, 2006), with an inductive approach taken to best

allow for the outcomes of the analysis to be determined by the content of the data, rather than existing concepts or theoretical assumptions. Preliminary codes were used to generate preliminary categories. This involved reading transcripts multiple times and highlighting recurring or salient patterns in the data, which were titled either using a word or phrase that appropriately summarised the material or a quote taken from one of the transcripts directly. Preliminary categories were then reviewed and analysed in terms of their relation to each other and the improbability that material contained within one category may be accounted for by other categories, to assure that while material between themes may share some relation, that final themes themselves were distinct. Where appropriate, preliminary categories were merged. The analysis and outcomes were subsequently shared and discussed with the other authors. From this analysis, three final themes emerged, all of which despite having some commonality, had distinct features.

Ethical approval for the study was obtained from the Psychology Department at the University of Bolton, in line with British Psychological Society Guidance (British Psychological Society, 2018).

3 | FINDINGS

Analysis resulted in three superordinate themes of experiences considered valuable to residents. These were: the provision of readily available support from care staff; the sense of community and daily activity offered by the residency and choice; and third, the experience of supported living as a stepping-stone in an ongoing recovery process. A summary of the themes can be found in the table below: (Table 2).

TABLE 2 Super- and subordinate themes

Superordinate theme	Subordinate theme
Support	...from care staff/therapeutic provision ...from the security and stability of tenancy
Community and choice	...making connections within the residency/the social value of supported living ...benefits of choice in daily activity
Ongoing recovery	...supported living as a 'stepping-stone' ...functional gains in supported living to foster future independence

In addition, the analysis yielded the following subordinate themes:

1. Support (both from care staff and therapeutic provision, as well as feelings of being supported through the security of their tenancy;
2. Community and choice and their importance in recovery (connections with others and the 'social value' of enhanced supported living); and.

3. Recovery as an ongoing process (supported living as providing the means to develop functional independence and therefore as a 'stepping stone' to further recovery).

Of note, while one participant was recruited from floating outreach rather than a live-in residency, their views and experiences did not differ to those of other participants. Note, names of residencies and staff members have been changed to protect anonymity.

3.1 | Support

One theme which emerged continuously throughout the interview process was the feeling of being comprehensively supported in their recovery process. Participants alluded to several provisions which manifested this feeling. These ranged from the delivery of both formal therapeutic services to informal support from residence staff with basic everyday tasks to the security offered by stability of their tenancy and support in recovery, which promoted a state of feeling 'at home'. Residents frequently cited the availability and consistency of support as being important to their recovery and ongoing stability in terms of not only their diagnosis, but also wider associated health problems:

...I haven't drunk for three years now and without the staff or anyone it's erm, if I was living on my own or something, I know myself I would still be drinking for sure (Participant 4).

About half my life's been spent in hospitals. But since I moved here it's a lot because I really am getting support in everything you know... and apart from anything else it's my home (Participant 3).

For me it's er, stability, staying well, and er, trying to, there's been so much in my life that's been negative and this is er a shot in the arm really, it really is. It makes me feel better than I have been for a long long long time. Like I say I've been here seven years and not one hospital admission. So... that's the er, measuring stick if you like? (Participant 3).

They listen. Yeah, and listen in a way that you feel is understanding. Yeah, regardless of who's on shift at any given moment. There's always somebody there (Participant 5)

Analysis revealed that residents responded positively to the comprehensive support offered by Enhanced Supported Living. Residents frequently commented that readily available staff support had been of importance in their recovery process, both in terms of advancing their

recovery and preventing relapse and decompensation during periods of difficulty or symptom presentation.

3.2 | Community and choice

Residents also frequently commented on the feeling of community offered by their tenancy. Every resident partaking in the interviews noted that they felt that they had made connections within the residence, either with staff members or fellow residents, frequently citing that these connections had developed into, or felt like, friendships.

We connect to each other. In a feeling of community. We are together, and, and, and, we are a community in these terms (Participant 2).

I've got two close friends here which has made a real big difference (Participant 5).

Additionally, the choice and trust placed in residents to assist in managing their own recovery was perceived to be important in finding a suitable balance between the provision of care, without inducing feelings of being controlled by their environment:

...there's an appropriate balance between... between any care that you might want or need, and also the freedom to make your own decisions and manage your own life effectively (Participant 7).

[I have] Never been anywhere like this before. The responsibility for stuff like administering your medication being trusted (Participant 6).

One resident did however report that while they felt comfortable and settled with staff in their residency, that the extent to which these interactions represented a true relationship (particularly those with staff members) was compromised by the enduring power imbalance of the staff: service-user relationship:

Kindness expresses a great deal to do with the functioning of healthcare. And er, er, I think kindness is not a value, it's an apology. It's an apology because... there is not and cannot be an actual relationship, but we behave as if there was a relationship, and that is kindness, and kindness is the characteristic particularly of the staff of The Grove (Participant 2).

3.3 | Ongoing recovery

Finally, supported living was often discussed as a means of developing functional independence. Again, residents associated the

support offered by their residency and care staff in supporting their rehabilitation and fostering their autonomy:

And when I came here I also asked for cleaning for PIP* and to have a clue how well where to start and the staff member that no longer works here and Wendy and we sat down and we wrote our draft. I thought I couldn't have done that. But financially I manage my money. I do my money very well. I'll always pay my utilities and never leave myself skint like (Participant 6).

(* PIP refers to 'Personal Independence Payment and is designed to assist with additional living costs for individuals with a long-term physical or mental health condition or disability, or who encounter difficulties undertaking certain everyday tasks or getting around because of their condition).

While residents remarked on their previous hospitalisations, comments were directed to the need for supported living to provide more than just clinical care, more comprehensively supporting ongoing recovery and directed towards their wider rehabilitation.

Well, I think some of the more restricted environments are necessary... I think it should be a bit more proactive about more rehabilitation rather than control. Supporting you too. Progress because it can just go round and round around in circles. Rather than just being purely reactive to their current condition (Participant 6).

The value of wider rehabilitation in the support provided by supported living was echoed in residents' conceptualisations of their time at Northern Healthcare as being a 'stepping-stone' in their ongoing recovery:

Northern Healthcare is there for people who are vulnerable in the community. Er, in order that they can have assisted living to return to the community. I think that that, that is the position which Northern Healthcare has (Participant 2).

Now I was inspired by things. And it just helps you do a bit more like the cooking how to improve when you want to move out of here to get your own house (Participant 7).

4 | DISCUSSION

The present study aimed to examine the experiences of a number of individuals in an enhanced supported living programme. Three superordinate themes emerged from the interviews. The emergence of these themes may have implications for how supported living

services may better support the needs and expectations of their residents.

The first theme to emerge from the study was that of feeling comprehensively supported in their recovery process. Previous literature has pointed to the value of environmental structure with regards to its positive effects on reducing decompensation (Lamb, 1995), and the availability and value of positive interactions with care staff for outcomes (Hewitt & Coffey, 2005; Welch & Cleak, 2018). A safe, secure and suitable housing context with appropriate amenities may also be a determinant of health outcomes (Aubry et al., 2015; Bower et al., 2021). However, surprisingly little has been written on the experiences of individuals living in supported living, the extent to which they feel settled and supported, and their feelings regarding what constitutes effective 'support'.

Psychiatric and nursing staff play central roles in the everyday lives of patients with SPMHP, particularly in long-stay rehabilitation settings (Berry et al., 2007). The quality of the interactions and relationships between staff and patients is therefore an important determinant of health outcomes (Berry et al., 2011).

However, as noted by one of our participants, staff: resident relationships may be somewhat inextricably determined and limited by inherent power imbalances and may not represent the same quality of connection that peer-relationships may provide. In a longitudinal study of 399 patients in receipt of treatment from a community crisis service, loneliness was found to be a strong predictor of overall symptom severity, affective symptom and self-rated recovery (Wang et al., 2020). Despite recovery often being conceptualised as an individualised process (Price-Robertson et al., 2017), a number of our participants alluded to the positive value of the friendships they had made in their residence. Service users often report feeling more listened to and better understood by other service users (Gilbert et al., 2008), with the shared experience even described as being in itself beneficial to recovery (Gray, 2019; Naslund et al., 2016). Our findings add to those of previous studies, in that people with SPMHP are often concerned with stigma, loneliness and loss of self, and that recovery as a multidimensional construct represents not only an outcome, but a wider process (Leonhardt et al., 2017). Consequently, how to deliver appropriate clinical interventions within a wider framework of personal recovery remains a challenge which supported living arrangements need to reconcile.

Of note, none of the participants mentioned during the interviews that they had experienced any form of stigmatisation or marginalisation; this in notable contradiction to the wide body of literature which has previously found feelings of estrangement to be commonplace in this population (Fernandes, 2009; Humberstone, 2002; Jarosinski, 2006; Yennari, 2011). The discussion around social cohesion is particularly salient in the context of the COVID-19 pandemic, which has been described for individuals in psychiatric services as an isolating and disorienting experience (Fixsen, 2021; Kozloff et al., 2020). In this regard, while the quality of staff: resident relationships is important in enriching and directing recovery, our findings indicate that supportive living arrangements may be enhanced by further considering the peer-relationships which develop within

them and the extent to which these might be a valuable resource in 'supporting' individuals in supported living.

Our participants also frequently commented on the feeling of community and choice offered by their tenancy, both in terms of the connection they had made and the freedom to actively participate in their own recovery. Psychologically informed interventions demonstrate potential in improving relationships and reducing depersonalisation (Berry et al., 2015). The literature has emphasised the importance of the active participation of individuals in their own recovery (Anderson & Funnell, 2005). The recent trend towards self-management reflects a wider context regarding the role of patient identity in the recovery process (Armstrong, 2014; Pulvirenti et al., 2014). While the notion of self-management may imply the individual assuming total autonomy and control over the management of their condition (Thirsk & Clark, 2014), adequate support appears crucial in maintaining engagement and supporting positive outcomes (Coleman & Newton, 2005; Wagner et al., 2001). In addition, the availability of social support and daily activity can enhance empowerment and provide a platform for the development of meaningful social connections (Iwasaki et al., 2015), with individualised provision of particular benefit to those with poor social support (Hendryx et al., 2009).

Previous literature points to feelings of depersonalisation as being a limiting factor in the recovery process (Fernandes, 2009; Humberstone, 2002; Jarosinski, 2006; Yennari, 2011), with the development of positive self-identity associated with helping facilitate recovery (Davidson & Strauss, 1992). In this sense, balancing the need for (at times extensive) readily available care to ameliorate symptom experience with the need to allow for independence and freedom of choice in a personable environment, may be critical in creating an environment in which residents feel able to both recover and thrive.

Finally, participants made frequent reference to see supported living as an interim step in their ongoing recovery, but one which was of value in enhancing their functional independence. These statements often were presented in the context of a discussion about future plans and hope for ongoing recovery. Hope and positive expectations for recovery both from individuals in supported living and from various stakeholders have long been known to be of significant importance in the recovery process (Coşkun & Altun, 2017; Strauss et al., 1981). Furthermore, hope for recovery has been associated with negative affect, psychological distress and the extent of symptom presentation (Andresen et al., 2010; Hayes et al., 2017; White et al., 2007). While recovery can occur independently of symptom manifestation (Anthony, 1993), symptom presentation can challenge the hope for recovery (Resnick et al., 2004). Positive environments which not only foster functional recovery, but also support and encourage hope are therefore likely to nurture ongoing recovery and reduce future dependency on services. In contrast to other forms of supported living which may place their emphasis solely on maintenance of clinical recovery such as symptom management, the Enhanced Supported Living model places greater emphasis on occupational therapy and progression towards wider functional recovery, the development of peer-support groups, and autonomy. The present findings suggest

that this distinctive feature may be beneficial in preventing supported living from becoming a form of transinstitutionalisation.

4.1 | Limitations

While the present study offers valuable insights into the benefits of supported living in a population whose perspective is highly under-researched, it is not without its limitations. First, the most significant challenge posed by the study related to obtaining the required data when participants were experiencing symptoms or difficulties with disordered thinking. While efforts were made to encourage participants back to the topic of the questions, and while participants generally engaged well with the online format of the interviews, some participants became increasingly 'thought disordered' as the time elapsed. Interview duration therefore had to be kept flexible, as did the level of detail in the questioning (including probing questions), indicative of the challenges of using qualitative approaches within this population.

An additional challenge concerned ensuring participant voices were heard amidst thought disordered or delusional responses. While it is important to consider the effect of background symptoms (e.g. delusional ideas or disordered thinking) on responses, delineation of 'normal' and 'abnormal' thinking would be, to say the least, unhelpful. As previously stated, the presence of psychotic symptoms in responses is reflective of the participants' difficulties in communicating (Humberstone, 2002). Future research may wish to explore means of overcoming these issues, such as extending the flexibility of the interview process, using peer-interviews, or staggering interviews over multiple sessions.

Additionally, all participants in the present study were interviewed within the context of a specific supported living setting. Consequently, due to the wide-ranging nature of what constitutes a supported living arrangement, the extent to which the present findings and their associated applications apply more broadly to housing and support may be limited. Future research may wish to consider the experiences and perceived value of supported living retrospectively in individuals who have since moved on from supported living.

Finally, the relatively small sample size may suggest that saturation may not have been reached and that additional interviews may have been desirable to more fully explore the issues raised. Nonetheless, the present study offers a detailed insight into the lived realities of individuals with schizophrenia in an enhanced supported living environment, in contrast to considering the value of such provision on the basis of symptom presentation alone.

5 | CONCLUSIONS

The analysis of the transcripts yielded three superordinate themes: (1) Support both from care staff and therapeutic provision, as well as feelings of being supported through the security of their tenancy;

(2) A sense of community and activity available and choice in how to engage, and its importance in recovery, connections with others and the 'social value' of enhanced supported living; and (3) Recovery as an ongoing process, supported living as providing the means to develop functional independence and therefore as a 'stepping stone' to further recovery.

Personal and clinical recovery require individuals to develop the capacity to determine the meaning of their own recovery and the challenges this represents (van Weeghel et al., 2019) and to make sense of the experience of SPMHP and recovery. Supported living arrangements have proven valuable in providing secure accommodation and engaging individuals in the recovery process but have historically faced challenges associated with depersonalisation and marginalisation. As personal recovery has features distinctive to the individual, a broad network of clinical, social and occupational support is required to ensure individuals are appropriately supported in this journey. Dialogue which involves service-users at the heart of understanding how to enhance the support offered by supported living will be useful and necessary in its betterment.

The present study sheds light on the experiences of individuals living in an enhanced supported living model for people with SPMHP. Findings indicate the power of comprehensive care with supportive staff, peer-relations and autonomy in empowering individuals in their ongoing recovery. Policy makers and practitioners may wish to consider the value of peer-relationships, autonomy and functional independence in fostering social inclusion and reducing marginalisation. A better appreciation of the intricate interactions between interpersonal, systemic and social challenges would more effectively enable supported living arrangements in aiding recovery and reducing their potential to become a form of transinstitutionalisation which residents are challenged to 'survive'.

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CONFLICT OF INTEREST

Steven Barnes is employed by Northern Healthcare as a paid part-time Research Assistant. Professor Jerome Carson is not directly affiliated with Northern Healthcare but the University of Bolton received a £1000 sponsorship from the company for his interview series 'In the Psychologist's Chair'. Professor Kevin Gournay has acted, in a paid capacity, as a clinical adviser to Northern Healthcare since 2013.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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