 **Què funciona**
en cures de llarga
durada?

Report

What works in long-term care?


Housing with support and care

ivàlua ✓
Institut Català d'Avaluació
de Polítiques Públiques

 **Diputació
Barcelona**

 Taula d'entitats
del Tercer Sector Social
de Catalunya

 **laconfederació**



Què funciona en cures de llarga durada?

What works in long-term care?

Housing with support and care

Final report:
February 2026

Thematic area:
Social affairs and inequality

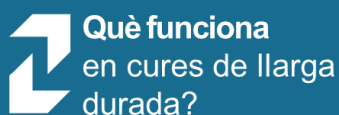
Project funded by:
Diputació de Barcelona (Barcelona Provincial Council)

With the support of:
Taula d'entitats del Tercer Sector Social de Catalunya and La Confederació

Report by:
Daniel López Gómez (Universitat Oberta de Catalunya)

Coordinated by:
Ivàlua

The ideas expressed by the author are not necessarily those of the organizations promoting the project.



A project to compile, analyse, and transfer information in order to
improve public long-term care policies.

A project participated in by:



Index

1. Introduction	4
2. Motivation behind this report	4
3. Description of the services analysed.....	6
3.1. Assisted living facilities for older adults and people with dementia	6
3.2. Supported housing for people with disabilities and people with mental health problems.....	7
3.3. Models of housing with support and care in Catalonia.....	8
4. Questions that guide this review	9
4.1. Block 1: Impact on the lives of the users	9
4.2. Block 2: Systemic impact and efficiency	9
5. Evidence review	10
5.1. Methodology.....	10
5.1.1. Search	11
5.1.2. Selection process.....	11
5.2. Analysis of the evidence.....	12
5.2.1. Effectiveness of housing with support and care in terms of fostering the independence and agency of their users	12
5.2.2. Effectiveness of housing with support and care enhancing social connections, social support, and the participation of users.....	18
5.2.3. Effectiveness of housing with support and care on the quality of life, well-being and health of users	25
5.2.4. Effectiveness of housing with support and care in deinstitutionalizing and preventing institutionalization of people with care needs	30
5.2.5. Effectiveness in optimizing resources	34
6. Summary.....	37
7. Implications for practice	38
8. Reference list and reviewed publications	42
8.1. Reference list.....	42
8.2. Reviewed publications	43
Annex I: Limitations of this study	56

1. Introduction

In the current context of **demographic change** and the crises occurring in both the **care system** and in **housing**, there are new models emerging for people with support needs. These intermediate resources aim to enable people to live **autonomously** and **in the community**, while offering them the adaptations and support that they need.

These models focus on the concept of a **home**, where support and care services are provided, guaranteeing a stable place of residence while fostering socialization. In addition, depending on the group in question, these models **avoid institutionalization or facilitates deinstitutionalization**. Unlike the hospital-like design of traditional care homes, these housing units, which are promoted both by the public sector and the social economy sector, focus on the right of residents to an independent and community-based life in a respectful setting. In this type of housing, support and care are not the end goal: they are instead a means of guaranteeing people's **quality of life** and autonomy.

This type of housing was first developed and implemented in English-speaking and Nordic countries, and focused on community care and deinstitutionalization (Sancho, 2020). The new long-term care framework from the Spanish Ministry of Social Rights, Consumer Affairs and Agenda 2030 has given a **renewed impetus** to developing this form of housing in Spain. However, evidence on the effectiveness of these models is very limited. Despite having operated for years in the countries mentioned above, very few evaluations have been carried out to determine how well these various aspects of these models work and for who. Given the need to make informed decisions, this review seeks to compile the best available evidence to **guide public policy** regarding the development of these models.

This report is part of the "What works in long-term care?" project promoted by IVÀLUA and the Barcelona Provincial Council (Diputació de Barcelona), with the support of the Taula d'entitats del Tercer Sector Social de Catalunya (Third Social Sector Platform of Catalonia) and La Confederació (an employers' association representing non-profit organisations providing social care services). The project aims to improve the design and implementation of long-term care policies and services by collecting, filtering, and presenting the available scientific evidence in an accessible way.

2. Motivation behind this report

In Spain, deinstitutionalization policies have been more based on familism than in countries in northern Europe, and have promoted the idea that people with care needs should remain in their usual environment, aided by services that complement, reinforce, and support families, particularly

women family members, as their primary caregivers. However, this approach has proven unsustainable and unfair to both caregivers and those receiving care. It is understood that people with care needs prefer to live "at home", but that, in many cases, this preference stems from a **lack of alternative types of housing** that adequately meets their needs (Fernández-Carro, 2018).

On the one hand, **nursing homes** present serious limitations in terms of affordability; they are also often overcrowded places whose residents are people who cannot have their care needs met in their usual surroundings (Echevarría, 2024). Furthermore, these environments are often designed as places of work rather than as homes, and prioritize the efficient organization of care over the **quality of life** and autonomy of those who live in them. Reversing this is the goal of the 'cultural change movement' that Nordic and English-speaking countries promoted in their residential care reforms and which Spain now seeks to implement in its new long-term care model (Díaz-Veiga et al., 2022).

Another factor is that the current organization of care **at home**, as already mentioned, is unsustainable and unjust: care is still considered a private responsibility, something that families need to deal with. The care work itself is carried out almost exclusively by women, in precarious conditions and with negative consequences – both health-related and economic – for the caregivers, who are often migrant women (Comas d'Argemir, 2024). Furthermore, home care services, which are intended to reinforce or complement family care, are often insufficient to meet increasingly complex needs (Comas d'Argemir, 2015). The housing policies in place also fail to help. Many people's homes are neither accessible nor equipped for care needs; they lack adequate heating and cooling systems and are structured in a way that they do not meet the needs of people requiring support (Lebrusán, 2017). Moreover, people with care needs, especially women (Ramos, 2017), are also those who suffer most from housing discrimination and evictions, as well as energy poverty and insecurity.

This complex situation makes it urgent for **housing and social care policies** to be harmonized. New residential models are needed that facilitate access to affordable housing for community living, which must also include the necessary support mechanisms for those with dependency needs. Although these policies are relatively new in Spain and they have not been developing in an even manner in all areas, the need for these assisted living facilities will only continue to grow.

The aim of this review is to build a knowledge base on assisted living facilities and to compile the evidence available in the best possible way, to determine what works and what does not. This **review connects several different areas**, since this type of housing is presented as a solution for several groups: older adults, people with dementia, people with disabilities, and people with mental health problems. Although supported housing options have their specific characteristics for each of the groups, the differences between them are not explored in depth. This review will focus on the **aspects they have in common: avoiding institutionalization or promoting deinstitution-**

alization, fostering **autonomy**, **community integration**, and improving **quality of life** for people with care needs.

3. Description of the services analysed

Accurately describing each of these housing models hinges on the contexts and groups they are intended for. Thus, **models aimed at older adults and/or people with dementia seek to prevent their institutionalization in residential care facilities**, while **models for people with disabilities or mental health problems are deinstitutionalization resources**, that is, they facilitate independent living for people who have been institutionalized or live with and are cared for by their families. Furthermore, **it is important to note that these models lack a clear and standardized definition: defining them is conditioned by their geographical context, types of users, and the time in history addressed**. This is reflected in the diversity of terms used when talking about them. All these considerations pose a challenge when studying them, and make it impossible to compare specific models, meaning that generic categories must be used (as will be seen).

In this section, there follows a description of the models that have been most studied internationally, and on which this review is based. The subsequent section briefly outlines the types of housing included in the current **Social Services Portfolio of Catalonia**, as well as models that are being considered for inclusion in it in the future, such as co-housing.

3.1. Assisted living facilities for older adults and people with dementia

In the case of older adults and people with dementia, there are three main types of housing available (Howe et al., 2013): a) lifestyle-centred housing, b) supported housing facilities, and c) housing with care services. This review focuses on the last two types, but especially housing with care services, since it provides support for people with long-term care needs.

For older adults and people with dementia, **supported housing facilities** can be an intermediate resource that lies between living in their own homes and in institutionalized settings (nursing homes, etc.). While nursing homes are geared towards ensuring comprehensive social care and healthcare, supported housing is more focused on social needs. This category includes sheltered housing, shared housing, hostels or guesthouses for older adults (more common in rural areas), retirement communities, and senior co-housing.

An important element of models such as sheltered or shared housing and hostels is to guarantee access to stable housing that meets the needs of older adults. This includes support services for daily needs, which can vary in intensity and/or be customizable: doorman services, telecare, cleaning, meal services, etc. Within this category, there are community-based models where formal support systems are integrated with informal, community-based support systems (mutual

support). For example, **retirement communities** in both the US and Europe are environments where people want to continue living when care needs arise; they thus tend to integrate support services. Co-housing for older adults is also a type of supported retirement community. In this case, these are communities created intentionally to promote a lifestyle for older adults based on mutual support and self-management. In the US, there are also unintentional communities for older adults called NORCs (Naturally Occurring Retirement Communities), which are characterized by their non-segregated nature.

When, in addition to these support services, the housing solutions integrate long-term care services, such as home care (personal hygiene) or even therapeutic services (occupational therapy, physical therapy, etc.), they are referred to as **housing with care services**. Unlike supported housing, this model emerges as a form of "home for life" because it is designed to meet care needs as they arise, thus avoiding institutionalization and allowing residents to continue to live in a community-based environment. In fact, it is considered a potentially beneficial model for physically frail individuals or people with dementia (in its early stages). For this reason, unlike supported housing, housing with care is presented as an alternative to nursing homes (Smith, 2015). Within this category we can find the UK "extra care housing" model and the US "assisted living" model (Howe et al., 2013), both of which are widespread.

This category also includes more community-based models such as retirement communities with ongoing care services. These retirement communities integrate not only support systems (as in the case of NORCs or co-housing) but also long-term care systems (for example, they may include assisted living units for people with dementia). This model is widespread in the US (there are around 2,000 of them) and is slowly becoming more widespread in the UK (Darton & Muncer, 2005). In Spain, some co-living developments that are considered homes for life can be classified as housing with care if their size (over 80 people), service coverage, and architectural design are taken into account (López & Estrada Canal, 2016). Finally, it should be made clear that new residential models for long-term care (Brouwers et al., 2023) have not been included in this category for two reasons: firstly, because they are supported housing facilities that adopt a certain housing model (which is home-like and community-based) rather than being housing in themselves; and secondly, because these facilities fall outside the scope of the provincial council's authority.

3.2. Supported housing for people with disabilities and people with mental health problems

In the case of people with disabilities and mental health problems, the term "supported housing" is used because its purpose is to provide assistance and support during rehabilitation processes and to promote independent living. These housing models are classified according to their coverage and type of support they provide, as well as the housing function and design. McPherson et al. (2018) have developed a taxonomy with five types of housing based on four dimensions (see the

STAX-SA taxonomy): 1) level of support (from high to none), 2) location of care (at home or external), 3) housing design (collective or independent housing), and 4) residential stability (permanent or temporary housing).

Table 1. Taxonomy of supported housing types

	Type 1	Type 2	Type 3	Type 4	Type 5
Staffing location	Staff on-site	Staff on-site	Staff on-site	No staff on-site	Staff on-site
Level of support	High support	High support	Moderate support	Low/moderate support	No support
Move-on	Limited emphasis on move-on	Strong emphasis on move-on	Strong emphasis on move-on	Limited emphasis on move-on	Limited emphasis on move-on
Physical setting	Congregate setting	Congregate setting	Congregate setting	Individual accommodation	Congregate setting

Source: McPherson et al. (2018)

In this field, the terms "supportive housing" and "supported housing" are both used, depending on the role of residential stability in the rehabilitation process. In other words, is obtaining stable housing the goal of the support (as in Housing First programmes) or is housing a means to facilitate rehabilitation or social integration? In the latter case, the facility is not considered the resident's home because they must move on as they progress through their process of rehabilitation and integration: they will move from group housing with extensive on-site support to independent living with occasional external support inputs.

3.3. Models of housing with support and care in Catalonia

This review is based on literature from around the world on housing models for older adults and people with dementia, as well as for people with disabilities and mental health problems.

It is important to note that, in Catalonia, the current **Social Services Portfolio** only includes supported housing options such as:

- **Serviced apartments or sheltered housing**, which are generally collective and offer shared services for daily living and socialization; they are intended for older adults or people with disabilities;
- **Residential homes**, which provide a family environment with ongoing support for people with disabilities;

- **Shelters or emergency accommodation**, which offer temporary housing at the beginning of a reintegration process;
- **Housing First programmes**, which offer quality permanent housing with no conditions as part of the individual's recovery process.

In addition, there are new models, such as **co-housing for older adults**, which are being considered for inclusion in the portfolio. These residences are self-managed communities of older adults, in which the residents work together to manage their housing, support and care services themselves.

As will be seen, **models that integrate long-term care and offer a degree of continuity of care for older adults or people with dementia are quite numerous in the international literature review but have not yet been established in Catalonia**. This review can serve as a framework for policies that aim to develop these types of models here.

4. Questions that guide this review

The review is structured in two blocks and has been guided by the following research questions:

4.1. Block 1: Impact on the lives of the users

This first section focuses on the effectiveness of supported housing in improving the lives of its residents. The research questions are as follows:

- **Independence**: is housing with support and care effective in preserving or improving functional independence and autonomy? For which groups? In what contexts? (see section 5.2.1)
- **Social connection**: does housing with support and care improve social connectivity, support, and participation? For which groups? In what contexts? (see section 5.2.2)
- **Quality of life**: does housing with support and care improve quality of life, well-being, and health, and are they satisfactory? For which groups? In what contexts? (see section 5.2.3)

4.2. Block 2: Systemic impact and efficiency

This second section addresses the effects of housing with support and care on the broader care system. The research questions are:

- **Deinstitutionalization**: does housing with support and care promote the prevention of institutionalization or deinstitutionalization? For which groups? In what contexts? (see section 5.2.4)

- **Cost-effectiveness:** Is housing with support and care cost-effective? For which groups? In what contexts? (see section 5.2.5)

5. Evidence review

This review aims to select and compile available evidence from around the world, particularly from countries where these models are more advanced. Despite notable differences in their target populations (older adults, people with dementia, people with disabilities, or people with mental health problems), all these models share one key element: **they combine providing care needs with promoting the user's autonomy, community integration, and quality of life.** They thus fall within the framework of **deinstitutionalization** policies.

The most important outcomes of these housing options include:

- Maintaining or improving **functional independence and agency.**
- Improving **connections with others, social support, and community participation.**
- Improving **quality of life, well-being, satisfaction, and health** (physical and psychological).
- Preventing or delaying **institutionalization.**
- **Cost-effectiveness** compared to traditional residential settings.

One of the objectives of this review was to study the impact of these models on caregivers. However, the literature on them does not address this aspect; it instead focuses almost exclusively on the impact of the models on users, as well as on systemic considerations such as cost-effectiveness. As will be seen, the results show the importance of how support and care are organized, including aspects such as training and a culture of caring for the caregivers themselves. However, there is little said about what this organization entails, while the impact of these models on caregivers—for example, in terms of their working conditions, stability, quality of life, satisfaction, etc.—is barely considered. This does not mean that such studies do not exist; it simply indicates that they appear elsewhere as separate issues that require another, different review.

5.1. Methodology

Given the nature of this review, which has an **international scope** and covers different target populations (older adults, people with dementia, people with disabilities and people with mental health problems), a methodology that combines several search and analysis strategies has been used.

5.1.1. Search

To compile the literature to be reviewed, we followed these steps:

1. Initial search: the first corpus of references was extracted from the **SCOPUS** database. A combination of English search terms was used for each variable:

- **Population:** older adults, people with dementia, people with disabilities, people with mental illnesses.
- **Housing:** housing with care, housing with support, supported housing, housing with services, assisted living, etc.

To define the terminology, introductory texts and publications that seek to establish common taxonomies were used (e.g., Howe et al., 2013). The search was limited to 2000–2025, which is the period when most scientific output on the topic was produced.

2. Snowball search: based on the initial selection of publications, particularly the systematic and exploratory reviews, studies were identified that met the criteria of thematic relevance and methodological rigor but had not appeared in the initial search. Additionally, the SciSpace AI assistant was used. While the literature synthesis provided by this tool was very flawed, it did prove useful for finding some new references that were relevant based on the research questions that guide this study.

5.1.2. Selection process

To focus on the theme under study, publications on institutional settings or home-based support were generally excluded. However, some of these publications were included when they related to supported housing models, for example, when they made comparisons. Home adaptation programmes were also excluded for the same reason.

A funnel strategy was adopted to select the publications. Firstly, an analysis of reviews was carried out, then the focus was placed on meta-analyses and specific evaluations, considering their methodological design and, therefore, whether it was possible to obtain evidence of causality. This strategy allowed for a progression to be made from the general to the specific and from a search for causal to non-causal evidence.

- **Reviews:** The starting point for this study was systematic reviews that assessed the quality of the evidence. These reviews identified thematically relevant studies that provided causal and non-causal evidence with sufficient methodological rigor. Given that this is an emerging field with few assessments available on effectiveness and impact, **scoping reviews** were also included. These allowed the research field to be mapped and to identify publications that offered results that could be relevant to the study.

- **Meta-analyses and evaluations:** based on the reviews, an analysis was made of studies that were not only thematically relevant but also, due to their methodological design, provided causal evidence (meta-analyses and studies with experimental or quasi-experimental designs). The scarcity of these studies led to including others that provided relevant results, even if they did not establish causality. For this reason, **qualitative or mixed-methods studies** were also reviewed, since, despite not establishing causality, they provide valuable knowledge about the functioning of these types of housing and the user experience.

The final corpus of publications on supported housing that was reviewed consisted of 52 publications on older adults, of which 18 are reviews (one dedicated to the LGBTI community); 15 publications on people with dementia, of which 4 are reviews; 28 on people with disabilities, of which 3 are reviews; and 34 on people with mental health problems, of which 10 are reviews. The references can be consulted in the appendix.

5.2. Analysis of the evidence

5.2.1. Effectiveness of housing with support and care in terms of fostering the independence and agency of their users

The focus here is on two aspects of independent living that studies often highlight as key: **functional independence** (the ability to perform daily activities) and **agency** (the capacity for choice and control over one's own life). The effects of the models on each of these aspects are analysed separately.

Is housing with support and care effective in preserving or improving functional independence? For which groups? In what contexts?

Older Adults

Most studies of US-based retirement communities with continuous care and assisted living solutions and of UK-based housing with care facilities do not provide conclusive results or establish a clear relationship between functional independence and housing. Many are longitudinal and mixed-methods studies in which people with better functional status are often overrepresented, with people whose functional status declines tending to drop out of the studies (Coyle et al., 2020). However, two studies on housing with care facilities in the United Kingdom did control for this bias and showed positive results.

The first is a longitudinal study (Holland et al., 2017; Holland et al., 2019) that showed that people who had moved to housing with care facilities were better able to **mitigate the impact of aging on cognitive decline and mobility than people who continued to live in their own homes**. Furthermore, they were found to engage in more physical exercise, which is a habit associated with a lower risk of falls.

The second study was a cost-effectiveness assessment of housing with care facilities in the UK. This study compared secondary data from older adults in housing with care facilities and in nursing homes, while statistically controlling for their characteristics (demographics, functional capacity, and previous housing type). The study showed that for a homogeneous sample of individuals who could live in either setting, housing with care facilities provided older adults with greater benefits to their functional capacity than care homes (Bäumker et al., 2011).

Thus, **some studies show that housing with care facilities are more effective in preserving older adults' functional capacities than care homes and/or remaining in their own homes, but these results are neither generalizable nor sufficiently conclusive** (Coyle et al., 2020).

People with dementia

In the literature reviewed that is specifically dedicated to this group of people, functional independence **is not an aspect that has been parameterized and evaluated quantitatively**. However, it should be noted that studies on older adults often include people with dementia, and their results could be extrapolated to this group.

Most of the studies are longitudinal, use mixed methods, and focus on housing with care in the United Kingdom. In this way, they do not provide causal evidence regarding the benefits of housing with care. Even so, they do point out aspects of this type of housing that facilitate or hinder the functional independence of people with dementia. The reviews carried out by Atkinson et al. (2023) and Smith et al. (2022) include case studies that highlight the importance of **environmental design**. For example, smaller buildings are considered more suitable than large ones, since long corridors and elevators can disorient people with dementia (Garwood, 2008a). Personalizing and adapting spaces is easier in small structures, and helps to preserve independence (Barrett et al., 2020; S.C. Evans et al., 2020; O'Malley et al., 2018).

On the other hand, it should also be noted that the studies that address people with dementia preserving their independence tend to focus on residential innovations (such as co-living units or "dementia villages"), which have been excluded from this review.¹ However, it is worth mentioning one study on their impact on the quality of life of people with dementia that did assess functional independence (Krier et al., 2023). This review shows that in **these novel home-like care settings, people with dementia preserve their functional abilities better than in traditional nursing homes**. While these settings are not comparable to housing with care facilities, they could offer a better alternative to staying in one's home or in a traditional nursing home, especially for people in the early stages of dementia (Annerstedt, 1994; Boekhorst et al., 2009).

¹ For a review of these models and their impact on people with dementia see Verbeek et al. (2009)

[People with disabilities](#)

Preserving functional independence is one of the most-studied aspects in cases of people with disabilities, and there are generally positive and conclusive results for supported housing (Wright et al., 2020; Roebuck, 2021). The evidence is particularly positive for deinstitutionalized individuals (McConkey et al., 2016; Sines et al., 2012; Stancliffe et al., 2011). **People who move from institutional settings (hospitals and nursing homes) to group or individual housing with care achieve better results in terms of daily living activities than those who remain in the hospital/nursing home.** A three-year longitudinal study compared the situation of people with disabilities who moved to a non-institutional home-like environment with care with the situation of others who remained in a nursing home. The results showed significant changes in functional independence in the first group, while in the second group no changes took place (Sloan et al., 2012).

The results are less conclusive when the comparison is made with people living in their own homes. However, a study on people with brain injuries that analysed their performance in their daily activities in three settings—at home (with or without family members living there), in group housing with care, and in institutional settings—found that their environment influenced performance. People in group housing with care performed the most daily activities with ease (Lamontagne et al., 2013). The study also assessed the type of support needed, with institutional settings offering the most support, and the individual's own home offering the least.

[People with severe mental health problems](#)

In the case of people with mental health problems, it is common to make assessments of functional independence, since studies on housing with care are often framed within a medical-rehabilitative and epidemiological context.

The evidence shows positive results compared to institutionalized individuals, although they are not entirely conclusive.

A meta-analysis on quality of life in three types of settings (nursing homes, housing with care facilities, and at home with home support) showed that people's social functioning was better in housing with care facilities than in more institutionalized settings, especially with regard to social and leisure activities (Harrison et al., 2020), but not better than people living at home who received occasional support. The results of a systematic review on assisted living are consistent with this finding (Ketola et al., 2022). This review synthesizes studies showing that the functional independence of people with mental health problems is maintained or improved in housing with care after being discharged from hospital (Dunt et al., 2017; Hobbs et al., 2002; Meehan et al., 2011), particularly their social functioning.

However, a quasi-experimental study, based on propensity score matching to avoid sampling bias, showed no differences between housing with care and nursing homes. The study compared people with mental health problems (who have their own homes) after two years of living in both

environments. These people showed an improvement in social functioning, with no significant differences between the two environments (Dehn et al., 2022).

Is housing with support and care effective in maintaining or improving autonomy? For which groups? In what contexts?

Older adults

In studies on housing with support and care for older adults, maintaining people's agency is presented as one of the main benefits that distinguish them from nursing homes, which are often characterized as "total institutions" where people have very limited decision-making power and control over their own lives. **There is a plethora of evidence on this topic, although causality cannot be established from it**, as it is largely based on qualitative case studies grounded in the residents' perceptions.

The review of **supported community housing** carried out by Chum et al. (2022) highlights that residents report that **these environments help them become more independent** in their daily activities, thus improving their sense of self-efficacy. The review identifies several factors that promote this autonomy: living in individual housing units, which offer **privacy and security**; an environment that facilitates **access to services** and a **community of neighbours**; and being able to **choose which services and activities to participate in**. The review by Puplampu et al. (2020) on co-housing adds other factors that promote autonomy: **the participation of older adults in planning and designing their future housing**, as well as in the management of the community. In their review of Naturally Occurring Retirement Communities (NORCs) in the United States, Parniak et al. (2022) also include numerous studies that report the residents' **increased self-efficacy, collective efficacy, and enhanced sense of community** (Parniak et al., 2022, p. 8).

In the case of housing with care, a UK study on perceived **control over one's own life** yielded some interesting results. This is a central aspect of autonomy and appears to be particularly debilitated in more institutionalized settings. The study compared older adults' perceived control over their own lives, examining people living in housing with care, in nursing homes, and in their own homes. It did so by analysing four studies that used the same items from the ASCOT quality of life scale. Controlling for factors that influence perceived control (age, level of dependency, and perceived health), the study showed that perceived control over one's own life was higher in nursing homes and in housing with care than in one's own home with home care (Callaghan & Towers, 2014, p. 16). This suggests that moving to housing with care or even a nursing home may be more conducive to maintaining autonomy than remaining in one's own home (Callaghan & Towers, 2014, p. 17). The authors interpret these results as reflecting the limitations of public home care services for older adults, which are exclusively focused on meeting basic physical needs and do not cover key support for leaving the home or for participating in social and leisure activities, etc.; this kind of support is key to maintaining autonomy (Callaghan & Towers, 2014, p. 18).

[People with dementia](#)

In the literature on people with dementia, agency is considered a central pillar of the housing with care model. A review of **longitudinal qualitative studies** details the factors that embody this ethos and promote residents' autonomy (M. Smith et al., 2022). A key aspect is a **culture of care that is not risk-averse**, in which residents have freedom of movement, where the opportunities to do things for themselves are maximized, and when their ownership of the space they inhabit is respected. The importance of **allowing couples to continue to live together** and the possibility of **choosing who to socialize with and what kind of support to receive** is also highlighted. The review by Smith et al. (2022) also emphasizes that **housing rules should be flexible** and the **environment should be open to family members, with 24/7 flexible care services** provided by skilled workers, and **integrated social and medical care** available.

The review by Atkinson et al. (2023) adds that small facilities offer greater security and make it easier for people to maintain their routines. However, their size and potential location in rather remote places could reduce the availability of services and, therefore, opportunities for choice and for social interaction (S.C. Evans et al., 2020; Garwood, 2008b; Twyford, 2016). All these studies reinforce the idea that people living in these environments are more independent when they have the necessary support to take control of their lives. This requires personalized services being offered, as well as consistency, flexibility, and training on the part of caregivers and family members.

[People with disabilities](#)

As well as functional independence, another highly valued aspect for people with disabilities is to be able to exercise their agency. The studies reviewed show that housing with care offers **better conditions for residents to use their agency, especially compared to institutional settings**. Although **no clear causal evidence has been found**, the results detailed below point unequivocally in this direction, unlike in other cases such as studies on older adults, for example.

The systematic review of housing alternatives for people with brain or spinal cord injuries carried out by Wright et al. (2020) includes a study demonstrating that people with disabilities in housing with care have **more choice about their lives than those living in institutional settings** (Winkler et al., 2007, 2015). This improvement is observed in almost all areas of daily life, except for people's relationships with their families, which are similar in both settings. However, this same study also notes that many people in these settings feel socially isolated.

The exploratory reviews consulted confirm these results. One of them, on supported individual housing for people with disabilities, shows that studies evaluating autonomy and agency indicate better outcomes in housing with care (both group and individual), as well as in one's own home, than in more segregated and institutionalized environments (Oliver et al., 2020, p. 12). Similarly, an exploratory review on housing for people with intellectual disabilities (Roebuck, 2021) gathers numerous qualitative studies, including a longitudinal study, which report that people who move from

an institutional setting to community housing not only **improve their functional independence but also their ability to make choices and to gain control over their own lives**. Despite this, there are limitations mentioned, such as residents having limited capacity to choose their support providers or housemates.

People with severe mental health problems

In the case of people with mental health problems, studies on agency are scarce. The few that do exist suggest that there is an **increase in control and decision-making capacity**, but **the evidence is not causal and is difficult to generalize, since most are qualitative assessments** (Nelson et al., 2007; Piat et al., 2020). Furthermore, the concept of agency itself is often sidelined in these studies, and is simply included in the concept of social functioning, which assesses an individual's capacity and that indicates the progress made in the rehabilitation process.

It should be noted, however, that the reviews consulted connect agency to housing preferences. They recognize the need to understand the housing options that people with mental health problems prefer and to address these preferences, and not just those that are considered clinically appropriate. Richter & Hoffmann (2017a) argue that respecting user preferences is central to recovery, since living in an environment that one is not comfortable in can lead to abandoning the housing and, consequently, the treatment process (Richter & Hoffmann, 2017a, p. 276). Preferences are for living independently in one's own apartment (Richter & Hoffmann, 2017b), and supported independent housing increases choice, which results in better quality of life (Nelson et al., 2007).

Table 2. Summary of evidence related to the impact on functional independence and autonomy

Older adults

- There is evidence that suggests that **housing with care is more effective in preserving physical and cognitive functional capacity** than nursing homes or remaining in one's own home.
- Some studies show that **housing with support and care can contribute to increased autonomy** compared to people living in nursing homes or in their own homes, as it offers more opportunities to exercise control over one's own life and to make decisions that go beyond basic activities.
- In any case, the **available evidence is limited and is not causal or conclusive**.

People with dementia

- There is significant evidence that shows that **housing with support and care can improve the autonomy of people with dementia** when they have the necessary support.

Table 2. Summary of evidence related to the impact on functional independence and autonomy

- **There is a lack of evidence on the impact of housing with support and care on the functional independence** of users.
- Several studies identify **aspects of housing with support and care, such as the design of the environment, that improve both the autonomy and independence** of people with dementia.

People with disabilities or severe mental health problems

- Supported housing, **when it is part of a deinstitutionalization and rehabilitation process, improves functional independence** compared to institutionalized environments, both for people with disabilities and for those with mental health problems.
- There is abundant evidence that **supported housing increases people with disabilities' ability to choose and agency, especially in relation to institutional environments.**
- There is a **lack of evidence on the effects of supported housing on the autonomy of people with severe mental health problems.** Existing studies point to the **need to consider people's housing preferences** as a crucial factor in their successful recovery.

5.2.2. Effectiveness of housing with support and care enhancing social connections, social support, and the participation of users

Unlike nursing homes and other care settings, a central objective of housing with support and care is to foster social inclusion, including facilitating the people who require care to participate in and feel connected to the community. Both institutionalization and living with family members can increase social isolation and stigma. Therefore, housing with support and care seeks to offer social and care services while also providing the opportunities for socialization that help prevent isolation and exclusion.

This section focuses on the role of housing with support and care in the development of relationships and social support, as well as in participation in social activities both within the housing facility and outside it. Unlike the previous section, these two dimensions are not presented separately, since studies often combine them and use terms such as "social well-being" or "quality of social life." The concept of "social functioning," which is often more closely related to individual capacity, has been addressed in the section on functional independence.

Do housing with support and care facilities improve social support, connection and participation? For which groups? In what contexts?

Older adults

Housing with care is presented as an environment that can reduce isolation and loneliness among older adults (Kneale, 2013). However, the evidence is unclear as to whether older adults who live in this housing model participate more in the community and are more socially connected. The studies available do not provide causal evidence, and the results are mixed: **on the one hand, they seem to indicate that these facilities promote more social connection and participation, but they also suggest that they can have the opposite effect on older individuals with greater support needs.**

Quantitative studies (Coyle et al., 2020) offer disparate and difficult-to-compare results due to the different measurement instruments and study designs used: many of them are longitudinal qualitative studies or mixed-methods studies with difficulties controlling for sample bias and the impact of factors such as health or age. Some of these studies report high levels of social well-being among residents. For example, a longitudinal study on social well-being in housing with care in the UK (Callaghan et al. 2008) showed that residents perceived an improvement in their social lives after moving in, with 90% making new friends. Furthermore, the study showed that this improvement was related to an increase in participation in social activities. Another longitudinal study showed that five years after moving into housing with care, social connectivity remained high, although social interactions with friends and family members did decrease over time (Holland et al., 2019).

This disparity is also found when assessing loneliness. While some studies indicate that it is a problem, especially in small housing structures (Callaghan et al., 2008), others show that residents do not feel lonely and that this remains consistent over time (Holland et al., 2019). A recent comparative study provides evidence of effectiveness. Through a quasi-experimental study, it was observed that **people living in housing with care facilities report less loneliness than those who remain living in their own homes.** Nevertheless, their **social isolation is greater because they have less contact with friends**, although no significant difference was found regarding contact with family members (Beach et al., 2022).

Qualitative and mixed-methods studies also show inconsistencies. On the one hand, they often indicate benefits. The reviews by Chum et al. (2022) and Hou & Cao (2021a) on supported community housing indicate a decrease in social isolation related to friendships and the community, which is precisely the key aspect of housing with care (Beach et al., 2022). A study on co-housing showed that its residents **gave and received more emotional, instrumental, and informational support** than a comparable sample of older adults from the U.S. General Social Survey (Markle et al., 2015). Qualitative studies also highlight the value of participation in activities for preserving social, cultural, and religious identity, for building a sense of belonging, and for improving health (Chum et al., 2022; Croucher et al., 2006).

On the other hand, some studies report **increased social exclusion, negative groupthink, and greater levels of stigma in different models of supported community housing** (Chum et al., 2022). Other studies point to the negative impact of inequality on social connectivity in housing with care (Atkinson et al., 2014; Croucher et al., 2006). **The more vulnerable individuals, with fewer economic or health resources, tend to have more difficulty socializing and are at greater risk of isolation** (S. Evans, 2009). **People with cognitive or mental health problems, and their caregivers, are at greater risk of exclusion and isolation, and of experiencing hostility** (Streib & Metsch, 2002). The longitudinal study of 15 housing with care units in the United Kingdom had similar findings (Callaghan et al., 2008). The study revealed that social well-being in retirement communities was significantly higher than that of housing with care. The reason for this difference lay both in the better functional condition of the residents of retirement communities and in their policy of excluding people with care needs, implemented precisely to preserve their "active" social life.

Evidence also indicates that older adults tend to experience greater isolation as their social networks shrink due to their friends dying or relocating, and they have more difficulty integrating with newcomers (Stacey-Konnert & Pynoos, 1992). Gender patterns also play a role. Men have more socialization problems than women, and women's marital status affects the formation of new friendships. Married women tend to associate with other couples, while single women integrate more easily into a new living space, as they value friendships more (Mary Ann Erickson et al., 2000). Widows, however, have lower social status and a greater risk of marginalization (Van Den Hoonaard, 1994). Widowed men experience the most difficulties in terms of socialization.

While these aspects are not exclusive to housing with support and care, it is crucial to consider these forms of exclusion and discrimination to avoid idealized views.

One criticism of housing with support and care facilities for older adults is that they can become ghettos and limit residents' contact with the outside world. The review by Coyle et al. (2020) **does not find sufficient evidence to demonstrate that moving to communities of older adults reduces interaction with the outside world, nor the opposite**. However, there is evidence of factors that modulate these relationships. In retirement communities with continuous care in the United States, the younger and more independent residents are the most active outside the community (Sherwood et al., 1997). The residents' place of origin also plays a role: those who have come to the community from farther away establish more social connections within the community than those who had lived nearby, as the latter maintain their external social networks (Waldron et al., 2005). Regarding social support, these studies indicate that it is similar in both cases, since those who move from far away compensate for the loss of social support with new friendships, while those who lived nearby maintain the support networks they had previously.

[People with dementia](#)

As in the previous section, the studies reviewed generally do not use standardized quantitative instruments, making it difficult to determine whether residents' social connections, support, and participation improve over time, and whether they do so more in comparison to other settings

(Atkinson et al., 2023; Smith et al., 2022). Due to the study designs, neither is it possible to establish causal relationships.

However, some longitudinal studies provide valuable information on the contextual factors that, according to participants, facilitate or limit social connections, support, and participation (Barrett et al., 2020; Cameron et al., 2020; Evans et al., 2020). Relationships formed among residents foster social support and a sense of belonging. In some facilities, residents and staff report *good dementia awareness*, meaning that **people without dementia interact with and assist those with dementia**, creating a safe space where the latter can move around freely. Despite this, many studies indicate that **prejudice against people with dementia is very common**, which can lead to them becoming excluded and isolated.

These studies also report that **participation in activities among residents with and without dementia, and without prior limitations, facilitates interaction and prevents isolation** (Evans & Vally, 2007). This largely depends on staff being trained in a flexible and personalized care culture and on adequate living spaces. Smaller living spaces facilitate relationships, but common areas should not be too small, as this limits social interaction and participation in activities (Evans et al., 2020). **Encouraging family involvement is also key** for people with dementia, as it prevents isolation, especially for those with greater cognitive impairment. Staff members note that when these homes have less regulated designs, accessible locations, and outdoor spaces, these factors all contribute to them being more open to family members and to people from the community. However, **the emphasis on independence in these homes can also lead to situations of isolation**, for example, if the apartments are intended only for residents and overnight stays are not permitted.

Due to the design of these studies, it is not possible to determine the extent to which this type of housing is effective in improving relationships and community participation. However, a randomized controlled trial of the Enriched Opportunities Programme (EOP) in five housing with care facilities showed **significant improvements in the perception of social support and inclusion among people with dementia** after 18 months (Brooker et al., 2011). **This programme was based on including a facilitator** who was responsible for maximizing residents' well-being, ensuring that care was tailored to each person's needs, facilitating communication between each individual and social and care services, and helping enable people with dementia to participate in social activities both inside and outside the facility. In addition, the programme included training for caregivers and organizational changes to ensure effective coordination between the facilitator and other staff members.

[People with Disabilities](#)

Most of the studies on people with disabilities that were analysed indicate that those living in supported housing have **more social relationships and greater social participation than those**

residing in more institutionalized settings. However, **housing does not appear to be the most determining factor**, something that, moreover, has just been observed in the evaluation of the Enriched Opportunities Programme for people with dementia. The systematic review by Kozma et al. (2009) provides evidence in this direction: **people living in supported housing, which is smaller and has less turnover, tend to have more friends outside the facility and to receive more visitors** (Emerson & McVilly, 2004; Forrester-Jones et al., 2006; McConkey et al., 2007). Moving from an institutional setting to supported housing improves family contact and maintains it over time (Chou et al., 2008). Roebuck's exploratory review (2021) corroborates this: of the 18 studies reviewed, most longitudinal studies **indicate improvements in community participation and personal relationships after moving to supported housing.** However, both reviews emphasize that **the social participation of people with (intellectual) disabilities is generally very low** (Kozma et al., 2009) and that they commonly report loneliness and limited social interaction (Bigby et al., 2017).

Regarding community integration, studies by Kozma et al. (2009) demonstrate that, while it is low in all types of housing (Baker, 2007), it is better in supported housing and semi-independent housing than in nursing home facilities (Stancliffe & Keane, 2000). The review by Wright et al. (2020), in which community integration is addressed in 6 of its 10 studies, indicates that **people in supported housing report more positive outcomes than those living in nursing home facilities.** A longitudinal study that evaluated the impact of supported community housing (in independent units or for people with disabilities with community occupational therapy included) on people with brain injuries demonstrated benefits in the community integration of residents after three years, with the greatest improvement observed in people living in independent housing (Sloan et al., 2012).

However, it cannot be concluded that this is the case in all situations. Some studies on people with disabilities in highly complex situations indicate that living in more institutionalized environments (group homes) may be associated with greater participation in organized activities and more contact with people outside the institution than if they lived independently with their families (Felce et al., 2011). Another study points out that people living in supported housing outside institutions (whether in their own home, shared housing, or other types of accommodation) had fewer activities with friends, since residential environments dictated the form and content of these activities (Emerson & McVilly, 2004).

These studies indicate, on the one hand, **that more independent forms of housing do not necessarily imply more sociability and community integration**, since some people need more support and more structured environments. Housing type is not such a decisive factor in social connections and participation (Kozma et al., 2009). **Friendships are modulated by the type of support offered**; for example, the implementation of **active support**, which shifts the support style from "caring to" to "working with," is associated with larger social networks (Emerson et al., 2001). In the case of family relationships, **distance from parents or their age** are more decisive factors; and as

for community integration, the services available and the intensity of support seem to carry more weight than housing type (Emerson et al., 2001). Neither does loneliness appear to be related to housing type, but rather to living with incompatible people and residing in unsafe neighbourhoods (Stancliffe et al., 2007).

People with severe mental health problems

It is unclear whether supported housing improves social relationships and community integration for people with mental health problems. A meta-analysis shows greater satisfaction with social relationships in supported housing than in more institutionalized settings (Harrison et al., 2020, p. 6). However, a systematic review indicates that the social benefits of supported housing, such as employability, are limited for deinstitutionalized individuals (McPherson et al., 2018a, p. 10). Nevertheless, **qualitative studies based on the experiences of people with mental health problems indicate potential benefits in this area if they have good support and are offered opportunities for socialization** (Barnes et al., 2022; Watson et al., 2019). These studies also warn of the **risk of loneliness**, as these environments focus on promoting autonomy and privacy, an aspect also noted in the case of people with dementia.

The evidence is somewhat clearer when it comes to people with mental health problems who are experiencing homelessness. In the review by McPherson et al. (2018a), the two causal studies reporting social benefits focused on this group of people. One found **an increase in satisfactory and lasting family relationships** (Tsai et al., 2013), and the other, **an improvement in social participation, use of community resources, and sense of belonging** (Stergiopoulos et al., 2014). In both cases, supported housing was part of a broader support intervention.

Housing First programmes for homeless people with psychiatric problems also proved effective in increasing this group's residential stability (McPherson et al., 2018a, p. 6). While residential stability does not guarantee improvements in social relationships, there is evidence that it does aid them. A systematic review identified three studies which showed substantial improvements and six without significant improvements, but none reported a worsening of conditions (Richter & Hoffmann, 2017a, p. 274). **This suggests that supported housing can have a positive impact on the social integration of people with mental health problems who also experience housing vulnerability.** Although mental illness in Europe does not always imply homelessness, Richter & Hoffmann (2017a) believe that the positive results of interventions in the United States could also be applied to people who are not in this situation.

Table 3. Summary of evidence related to impact on social connection, support and participation

Older adults and people with dementia

- **There is a lack of causal evidence.** In general, the results are disparate and somewhat inconclusive.
- The evidence points to **differences in impact depending on the profile of each user.**
- **Among older adults, those with greater frailty or with unfavourable socio-economic or health conditions may have more difficulty socializing** and are at risk of exclusion, while those who are not in those circumstances report benefits in their social relationships.
- For **people with dementia**, supported housing can be an **opportunity to improve their social connectivity and participation, especially in the early stages of the illness**, as these individuals often face exclusion. Evidence highlights the **need to adapt homes and implement programmes that provide support** to foster socialization.

People with disabilities

- The evidence is consistent and shows that **deinstitutionalized people improve their social connectivity and community integration in supported housing**, although the housing itself is not as determining a factor as the type of support or its location.
- The studies show, however, that this group has low social participation and usually reports loneliness and limited relationships.

People with severe mental health problems

- The **evidence is ambiguous** regarding the impact of supported housing on the social connection and participation of **people that come from institutional environments.**
- The studies show **improvements in the social integration of people with severe mental health problems who come from situations of homelessness.**
- The available evidence suggests that **the type of support offered is a more determining factor than the housing model.**

5.2.3. Effectiveness of housing with support and care on the quality of life, well-being and health of users

Residents' quality of life and health are two key aspects to consider for evaluating housing with support and care. This review first analyses the extent to which living in these environments benefits residents' quality of life, well-being, and satisfaction with their housing. Subsequently, it details the impact on residents' health, particularly their perceived health, psychological health, and physical health.

Does housing with support and care improve quality of life, well-being, and health, and are they satisfactory? For which groups? In what contexts?

Older adults

The evidence on the benefits on the quality of life of older adults is not clear and does not allow a causal relationship to be established. Some studies show improvements when people move from their usual homes (Roberts & Adams, 2018) or from nursing homes (Rossen & Knafl, 2007). The key factors for this improvement are related to the role of the workers and the support they give, as well as the relationships between residents (Mitchell & Kemp, 2000). However, there are also longitudinal studies which use a control group that do not find significant differences with people who continue to live in their own homes (Bernard et al., 2004).

Unlike quality of life, **the evidence on satisfaction is much clearer**, both in housing with care (King, 2003) and in supported community housing, for example, co-housing (Chum et al., 2022; Puplampu et al., 2020). However, again, the design of the evaluations does not allow causality to be established. Two longitudinal studies reported widespread satisfaction (Callaghan et al., 2008; Croucher et al., 2003). However, one of these studies also found that the people who expressed most criticism were those who were the most frail and dependent, as the "home for life" model did not work for them and they had to move to another facility. Qualitative studies also show differences in what produces satisfaction: social aspects are more valued by younger and less fragile people, while services and staff are more important for older and more physically vulnerable people (Bernard et al., 2004; Croucher et al., 2003).

People with dementia

Numerous qualitative and longitudinal studies report good quality of life for people with dementia in housing with care (S. C. Evans et al., 2020; Holland et al., 2017; Means et al., 2006; Vallely et al., 2006). However, this quality of life tends to fall in the middle and advanced stages of the illness, when a move to a more specialized environment becomes necessary (Reimer et al., 2004). The "Enriched Opportunities Program" for people with dementia, which has previously been mentioned, using a control group and randomized sampling in its evaluation, **demonstrated its positive impact on people's quality of life thanks to the introduction of the welfare facilitator figure** (Brooker et al.,

2011). Their function is to serve as a link between the person with dementia and the facility's services and activities, which increases the chances that they will receive the necessary support and have access to activities that could be beneficial.

A recurring factor that the participants highlight to explain the improvement in quality of life is the **security** that these homes provide, both for users and for their families and workers (Evans et al., 2020; Vallelly et al., 2006). The design of the spaces and the type of care provided contribute to this feeling of security, which is also essential to promote independence.

As in the case of older adults, the **evidence on satisfaction is generally positive**. A longitudinal study with people with dementia and their families reported high levels of satisfaction over three years, even when half of the participants had to make a temporary change in where they lived (Vallelly et al., 2006).

People with disabilities

The review carried out by Wright et al. (2020) on people with cerebral and spinal cord injuries points out that the quality of life and the satisfaction of residents are topics that are not addressed in the literature, which focuses principally on independence and community integration. However, existing reviews indicate that **leaving an institution or the family home to live in the community in supported housing improves the quality of life of people with disabilities** (Roebuck, 2021, p. 17). A recent longitudinal study in Spain also reports positive results for deinstitutionalized persons (Navas et al., 2025).

Studies show that, although there is much variability, **improvements in quality of life are associated with the individual's characteristics, as well as variations in worker practices and service procedures** (Kozma et al., 2009, p. 13). The review carried out by Oliver et al. (2020) collects quantitative studies that indicate a positive evaluation of the well-being of people with intellectual disabilities who move to supported housing.

A study based on a natural experiment showed **positive changes in the perceived well-being of people with intellectual disabilities** after moving to supported housing. The natural experiment was possible thanks to a two-year programme that facilitated the transfer of 119 people to less institutionalized environments based on an evaluation of their support needs. The environments they were moved to consisted of the following: individual and collective housing with 24-hour support, housing with personalized support, supported collective housing and housing with family care. This made it possible to compare people who had moved with those who had not yet done so. People with intellectual disabilities who moved to independent housing with support reported **significantly greater well-being than those who stayed in more institutionalized environments**. Well-being also improved, albeit more modestly, for those who moved to collective housing with support (especially if they had more support needs) and for those who remained in family housing

(McConkey et al., 2018). Conversely, perceived well-being worsened in those who stayed in the institution and, in a general way, in the group of people with mental health problems.

The evidence is very clear regarding the levels of **satisfaction** of people with disabilities and their families. Kozma et al. (2009), however, warn that the **results in the case of family members should be interpreted with caution**. Although people with disabilities are satisfied because they are critical of the institutions and do not want to return to them, **the relatives also reported satisfaction with the institutional environments** when there were no other alternatives.

[People with severe mental health problems](#)

According to a meta-analysis, **the well-being of people with mental health problems does not seem to be related to living in supported housing rather than in another type of housing** and does not even seem to be related to the type of support received (integrated, occasional, external) (Harrison et al., 2020). However, **for people that require more support and that have previously been in hospital, there are studies that indicate that they have a better quality of life in assisted living facilities than in hospital environments** (Ketola et al., 2022). There are also studies that indicate that **those who comparatively have worse quality of life are those in independent and permanent housing with temporary support** and conversely, that **people in housing with integrated supports and focused on rehabilitation, that is, with stays that are of a limited length, report better quality of life** (Ketola et al., 2022).

Nevertheless, permanent housing with support is the type of housing that generates the most satisfaction and is preferred by residents, whether it includes services or not (Roebuck, 2021). **The improvement in quality of life is clearest when considering people who also live on the street**, which is a very prevalent situation in the United States. Although Harrison et al. (2020) point out that the most relevant aspect is not so much the housing itself as the support the person receives (McPherson et al., 2018a). In contrast, **the few studies on quality of life in people with mental health problems who do not live on the street or in an institution do not provide clear evidence of an improvement in quality of life**. These studies focus on the processes of re-institutionalization, which show a deterioration in the quality of life when people go back to an institution. The most solid evidence suggests an inverse relationship between the degree of institutionalization and quality of life: people who re-enter psychiatric institutions are those who experience the worst drop in their quality of life (McPherson et al., 20

Studies on people with mental health problems and residential vulnerability show that **residential stability is a key aspect for quality of life**, and where the evidence is most solid and positive (McPherson et al., 2018a; Richter & Hoffmann, 2017a). Employability is another important aspect of quality of life, but there is not enough evidence on the impact of housing on this factor (McPherson et al., 2018a).

Table 4. Summary of evidence related to the impact on quality of life, well-being and satisfaction

Older adults and people with dementia

- **There is not enough consistent and clear evidence** to state that housing with support and care improve the quality of life and well-being of older adults or that of people with dementia.
- **Housing with support and care may house people with very diverse needs, making it difficult to identify clear effects.**
- **The organization and culture of care impact** quality of life, with the best results offered by **flexible and personalized support geared towards independent living.**
- **The level of satisfaction of users and their families is generally good**, although the factors that generate satisfaction vary depending on the frailty of users or the level of support they need.

People with disabilities or severe mental health problems

- It is found that supported housing **provides quality of life to people with intellectual, brain or spinal cord disabilities who have been deinstitutionalized.**
- In the case of people with severe mental health problems, it is not clear that supported housing is an important factor in improving their quality of life, except for those who suffer from **housing vulnerability**, for whom a positive effect can be observed.
- **Satisfaction is high among people with disabilities and their families.** It is worth noting that, in terms of family members, satisfaction is also high in institutional settings when no alternatives exist.

Is housing with support and care effective in improving health? For which groups? In what contexts?

Older adults

The review carried out by Coyle et al. (2020) provides a detailed analysis of the impact of housing with care facilities on older adults' health. Most studies assess **perceived health** and **psychological well-being**. The results are not entirely conclusive, but they do suggest benefits.

Three studies have been conducted to evaluate the effectiveness of housing with health support: two longitudinal studies with a control group (Holland et al., 2019; Kingston et al., 2001) and one matched case-control study (Gaines et al., 2011). All three reported **improved perceived health and psychological well-being among the residents of the housing with health support**. Although the control groups were slightly younger, had fewer comorbidities, and better functional capacity, the

perceived health of residents in housing with health support was higher, and this difference persisted over time (Gaines et al., 2011). Other longitudinal studies did not record significant changes in the perceived health of people in these facilities (Bernard et al., 2004; Rossen & Knafelz, 2007), while other studies did (Pruchno & Rose, 2000).

In terms of psychological health, the results are also positive, although the evidence does not establish causality nor is it conclusive (Coyle et al., 2020). A longitudinal study reported improved psychological health among residents, suggesting that the environment helped them maintain a positive perception of their health (Kingston et al., 2001). Another study with a control group showed an improvement in perceived health and a reduction in depressive and anxiety symptoms after 5 years. Compared to the control group, residents of assisted living facilities also appeared to mitigate the effects of comorbidities and age (Holland et al., 2015; Holland et al., 2019). Other studies show that well-being is maintained when people receive high levels of social support (Cummings, 2002), underscoring the importance of safety and social support.

Regarding physical health, it cannot be stated definitively that living in these environments has a significant impact. However, the studies reviewed by Coyle et al. (2020) indicate an increase in comorbidities, which the authors explain by suggesting that people who move into the facilities already have some health problems, and increased medical supervision leads to better diagnosis and management. One study even suggested that living in a retirement community increased life expectancy by 5 years (Mayhew et al., 2017).

[People with dementia](#)

Evidence on the health of people with dementia is scarce and does not allow for any conclusions to be drawn. This is not an aspect that is specifically evaluated in the studies, as supported housing is not designed as a healthcare environment.

[People with disabilities](#)

According to the review by Kozma et al. (2009), the health outcomes of different living environments have been less studied in this group. **There is no evidence that moving to supported housing causes trauma or worsens mental health problems (Kozma et al., 2009, p. 18). However, evidence does show that living in a less restrictive environment can lead to less healthy habits,** such as inactivity, smoking, or a poor diet that can lead to obesity (Bryan et al., 2000).

Mortality is a factor that has also been analysed, with highly diverse results. In studies that indicate higher mortality rates, the contributing factors are unclear: some studies attribute it to inadequate access to health services, while others associate it with individual health risks.

An important aspect linked to psychological well-being is **disruptive behaviour**. The results are inconclusive: **some studies show no significant changes, others report a worsening or passivity, and still others show no quantitative improvements, but do show some qualitative ones** (Kozma

et al., 2009). The review by Oliver et al. (2020) also identifies studies that appear to suggest that supported housing may be related to a decrease in disruptive or problematic behaviour, although the evidence is scarce and unclear regarding its effectiveness.

People with severe mental health problems

The impact of supported housing varies depending on the person's prior situation. According to the review by McPherson et al. (2018a), **supported housing is an important factor in controlling and improving psychiatric symptoms in people who have been experiencing homelessness**. Few studies report a worsening of health in homeless individuals. In the case of people referred from institutions, the outcome is also positive, although some studies do report a worsening (Kallert et al., 2007). For people who come from other community resources, the results are less conclusive, with evidence of both improvement and worsening.

Table 5. Summary of evidence related to health outcomes

Older adults and people with dementia

- In **older adults, benefits are observed in perceived health, psychological well-being, and better medical supervision** compared to those who live in their own homes.
- **Evidence regarding the health of people with dementia is scarce** and firm conclusions cannot be drawn from it.

People with disabilities

- **There is little evidence** on the impact of supported housing on the health of people with disabilities.
- Existing studies indicate a **higher risk of unhealthy lifestyle habits and less medical supervision**, suggesting that autonomy can come at a cost when support in the housing is insufficient.

People with severe mental health problems

- The **available evidence focuses on the impact on psychiatric symptoms**.
- The **results are positive for people who come from situations of homelessness**: these people experience a significant improvement in their symptoms. The impact is less clear for people who come from institutionalized settings.

5.2.4. Effectiveness of housing with support and care in deinstitutionalizing and preventing institutionalization of people with care needs

The idea that housing with support and care facilities can be "homes for life" is appealing both to residents, as it is better than an institutional setting with negative effects on their autonomy, and

to managers, who see deinstitutionalization as more dignified, respectful of human rights, and potentially more cost-effective.

To address this issue, it is necessary to clarify the meaning of deinstitutionalization for the different groups examined. For the first two groups, older adults and people with dementia, the focus is on **preventing institutionalization**, i.e. avoiding or delaying admission to a nursing home. In the case of people with disabilities and mental health problems, **deinstitutionalization** is understood as a process that moves from institutionalization to recovering their independence and social integration.

Does housing with support and care help prevent institutionalization or aid deinstitutionalization? For which groups? In what contexts?

Older adults

Reviews of supported community housing for older adults in the United States (S.-I. Hou & Cao, 2021a) provide interesting findings. For example, one evaluation of a NORC showed that only 2% of its residents entered a nursing home, a figure lower than the national average of 4.5%. A 6-year longitudinal study of this NORC, with a control group of people living in their own homes, revealed that 7.1% of the control group entered a nursing home, compared to only 3.2% of the NORC residents (Elbert & Neufeld, 2010).

A study assessing whether housing with care arrangements could be lifelong yielded interesting results. Analysing data from 1,189 users, the study estimated that the average length of stay in the housing with care facility was 6.5 years, and the probability of entering an institution after five years was 8%, with a discharge rate due to institutionalization and death of 1 to 3. After ten years, 14% of residents moved to a care home. Compared to a control group of people receiving home care, the probability of entering a nursing home after five years was between 30% and 57% lower in housing with care facilities. This probability was 50% lower for people with the greatest care needs (over 80 years old) (Kneale, 2011). Some studies report better results, although these are usually retirement communities with ongoing care with an attached residential facility (Croucher et al., 2003).

These results demonstrate the potential of housing with support and care to delay and prevent admissions to nursing homes. However, even in cases where the results are most positive –the housing with care model– this may not be sufficient for people with dementia. The most common factors leading to admission to nursing homes are a lack of service coverage (Kneale, 2011) and the individual's functional status: depression, incontinence, increasing cognitive impairment, and dependency are the most frequent triggers (Coyle et al., 2020).

The evidence suggests, therefore, that housing with care can be a lifelong option for those requiring moderate care. When their needs intensify, for example, with the onset of advanced

dementia, it is very likely that individuals will need to move to more specialized settings. The ambiguity of the term “long-term care housing” generates stress for residents, who do not know exactly what services will be provided and may conceal their health problems for fear of having to leave. **Therefore, housing with care facilities are an alternative for some people, but they cannot substitute residential care facilities** (Croucher et al., 2006, p. 81).

[People with dementia](#)

As already mentioned, it is not clear that housing with care prevents the institutionalization of people with dementia. The review conducted by Atkinson et al. (2023) suggests that preventing or delaying institutionalization is one of the potential benefits of housing with care, and underscores the importance of a flexible and personalized support model so that the person can live in this environment for as long as possible (M. Smith et al., 2022, p. 10). However, **there are very few studies that demonstrate its effectiveness in preventing the institutionalization of people with dementia** (Croucher et al., 2006). In fact, one longitudinal study showed that, after 2 years, over half of the 36 people studied had moved into settings with more support (Vallelly et al., 2006).

[People with Disabilities](#)

For people with disabilities, deinstitutionalization is linked to the ability to transition from residential care to independent living. **No conclusive causal evidence of its effectiveness has been found.** However, qualitative studies do point to factors **that influence the process: the scarcity of suitable housing and difficulty in accessing it** (Wiesel, 2015), **and the quality of support, in terms of intensity, flexibility, and adaptation to each individual** (McConkey et al., 2013). This last aspect, as will be seen below, is crucial for the success of the recovery process for people with mental health problems.

[People with severe mental health problems](#)

According to the literature, the transition to independent living is influenced by personal characteristics such as each person's diagnosis, the presence or absence of substance use, and the clinical care received (Lodder, 2024). Furthermore, a lengthy stay in an institutional setting makes progress less likely, with age and gender also playing a role, since older men tend to remain in more institutionalized settings (Harrison et al., 2024).

The QUEST study in the United Kingdom provides relevant evidence on the deinstitutionalization rate, defined as the proportion of people who manage to live in settings which give them greater independence and temporary support (for at least 30 months) (Killaspy et al., 2020). 42% of participants made progress (two-thirds of them moved to independent living and reduced their support time by half). **The study shows that people living independently with temporary support are more likely to progress than those living in homes with ongoing integrated support, and these, in turn, are more likely to progress than those living in residential care facilities. The likelihood of making progress is related to the quality of the service, particularly the promotion of human rights and**

the adoption of recovery-based practices. This involves protecting the privacy, self-respect, and rights of service users, fostering their participation in care planning, encouraging the development of independent living skills, and cultivating a culture of confidence in one's recovery. **Factors that are negatively associated with making progress include family involvement and community resources.** The authors suggest this may be due to resistance from family members and community resources themselves to service users becoming independent and changing their place of residence. The literature also points to other contextual factors such as the availability of affordable housing and opportunities for community integration (Farkas & Coe, 2019).

Another key aspect of the recovery process is the **reduction in hospital admissions.** Numerous studies indicate that supported housing is associated with a reduction in the length of hospital stays (Adamus et al., 2022) or in their frequency and duration (McDermott et al., 2015).

The review conducted by Rog et al. (2014) indicates that supported housing **improves the residential stability of people with mental health problems,** reducing the risk of them becoming homeless (Rog et al., 2014, p. 4). Furthermore, **residential stability** emerges as an important factor in breaking the "revolving door" cycle. This cycle makes access to housing primarily possible after a psychiatric crisis and hospital admission: an approach based more on crisis intervention than on low-intensity, ongoing preventive support (O'Malley & Croucher, 2005, p. 2). Programmes such as Housing First, which provide permanent housing with support without therapeutic conditions, have shown to have very positive results in people with mental health problems who are homeless (Richter & Hoffmann, 2017a).

Table 6. Summary of evidence related to effectiveness in terms of deinstitutionalization and prevention of institutionalization

Older adults and people with dementia

- The goal of supported housing is to **prevent or delay institutionalization.**
- Supported housing is **more effective than home care in preventing the admission of people with moderate care needs into residential care.**
- **People with advanced dementia and high care needs often require environments with more support,** so housing with care is unlikely to prevent their admission to a care home.

People with disabilities or severe mental health problems

- The goal of supported housing is to **promote deinstitutionalization,** and link this to a process of recovery and independence.
- Studies show that **supported independent living is effective in the recovery of people with mental health problems.**

Table 6. Summary of evidence related to effectiveness in terms of deinstitutionalization and prevention of institutionalization

- **Evidence relating to people with disabilities is scarce and inconclusive**, although there are studies that show which factors may influence the process.
- In both cases, **effectiveness depends on the quality of the support provided**, which should be based on users' rights and a culture of fostering recovery.
- **Residential stability** is a key element in aiding the recovery of people with psychiatric problems who are experiencing homelessness.

5.2.5. Effectiveness in optimizing resources

Studies have been conducted on the use of social services and health services and cost-effectiveness in housing for older adults and housing for people with mental health problems. However, no cost-effectiveness studies have been found for housing for people with disabilities, and in the case of people with dementia, only qualitative studies exist that do not allow clear conclusions to be drawn.

Is housing with support and care cost-effective? For which groups? In what contexts?

Older adults

The studies reviewed by Coyle et al. (2020) do not provide clear evidence that housing with care reduces the use of primary health care or social services. A matched case-control study compared residents of retirement communities with continuing care to participants in a health and retirement study; this found no differences in the use of home health services or hospital services.

However, other studies conducted in the UK do suggest a relationship with the use of hospital services, showing a reduction in the length of hospital stays, fewer visits to the doctor, and fewer planned hospitalizations (but not emergency hospitalizations) (Holland et al., 2019). According to Coyle et al. (2020), this could be because hospital services facilitate discharge since they consider the services provided in the housing to be sufficient for recovery. Another study (Yates, 2016) also indicates a reduction in the use of emergency services (police, fire services, etc.).

Despite this data, only a few evaluations exist regarding cost-effectiveness (Croucher et al., 2006, p. 55). The review conducted by Coyle et al. (2020) includes some of them. In the US, two evaluations of a CCRC (Continuous Care Retirement Community) found that **costs were lower than in a residential care home for people with a similar profile and dependency needs** (M. Rantz et al., 2014; M. J. Rantz et al., 2011). In the UK, two cost-effectiveness studies (one from the University of Kent and the other from Aston University) suggest that housing with care is **more cost-effective**

than nursing homes for people with moderate needs. The cost is similar, but the residents' quality of life and care is better (Bäumker et al., 2010; Bäumker et al., 2011; Holland et al., 2015; Holland et al., 2019).

Nevertheless, Darton & Muncer (2005) and Croucher et al. (2006) indicate that these evaluations should be interpreted with caution and that it is very difficult to draw conclusions about cost-effectiveness. When comparing housing with care to nursing homes, it is necessary to include the costs associated with housing in addition to the costs for care. This is not always possible because housing with care may entail separate services that are offered by different providers. When comparing housing with care to home care, it is important to consider that housing with care facilities may have on-site staff 24/7, while this is not usually the case in home care. Furthermore, if unpaid informal care work is not included, the comparison will always be biased: as this type of work is more common in housing with care than in nursing homes and less common than in home care.

[People with dementia](#)

The review conducted by Atkinson et al. (2023) includes several studies suggesting that **housing with care facilities can reduce hospitalizations for people with dementia**. This not only has a positive impact on health and quality of life by avoiding the stress of having to change environments, but also reduces pressure on hospitals. The review conducted by Atkinson et al. (2023) indicates that the degree of savings depends on several factors, such as the housing model, the level of support required, and each individual's specific needs. No cost-effectiveness studies have been identified that are specifically about this population. Nor is there clear evidence available to draw conclusions about its effectiveness.

[People with disabilities](#)

While some models can generate savings, others have similar or higher costs than more traditional nursing home facilities. One study shows that the impact of supported housing facilities on the use of social and health services depends on the user's prior situation. In the case of people who have left institutional care, it is associated with an increase in hospitalizations and use of emergency services and a reduction in visits to primary care. In contrast, there is no difference in use of resources for people who come from community settings (Grove et al., 2023).

[People with severe mental health problems](#)

Ketola et al. (2022) state that there is a **significant reduction in the number of hospitalizations among people living in housing with moderate support** compared to those living independently (Gilmer et al., 2003). The review also notes that **four studies report higher medication use** among people living independently, suggesting that increased medication use is possibly compensating for the lack of support staff.

For people with mental health problems who are experiencing homelessness, the review conducted by McPherson et al. (2018a) indicates that supported housing fosters the effective use of primary care and psychiatric services (Gilmer et al., 2010, 2014) and is associated with a **reduction in number of hospitalizations** and other emergency resources being used (Mares & McGuire, 2000).

Regarding **cost-effectiveness**, O'Malley & Croucher (2005) show that it is difficult to determine whether this type of housing is a cost-effective alternative to hospitals, since costs that are not associated with the housing itself (such as medical visits) may mean that community care is not necessarily cheaper.

According to Ketola et al. (2022), **when considering both the quality and cost of care, Type 2 and 3 assisted living facilities (which have on-site staff, offer moderate to intensive support, and focus on rehabilitation) appear to be the most cost-effective** (Dalton-Locke et al., 2018; Killaspy et al., 2016). Compared to psychiatric hospitals, Type 1 assisted living facilities (those with the most on-site support) are less expensive, but they do not offer the same level of coverage. A study in Sweden showed that deinstitutionalization through the promotion of community care reduced overall costs by 13% (Lindström et al., 2007). However, this could be due to a transfer of costs to family care, which was not included in the analysis.

Therefore, it is key that housing with care is not thought of as a cheaper alternative to nursing homes and other more institutional care settings, as this could compromise the health of residents. For example, it is known that physical health problems in the psychiatric population are on the increase due to this population aging. If supported housing is not adequately prepared to address this situation and continues to treat its residents as though they were all young adults, it may cease to be cost-effective (Chan et al., 2007). In this regard, it might be worthwhile contemplating an extension of the housing with care model to older adults with disabilities or mental health problems.

Table 7. Summary of evidence related to optimizing resources

Use of health services

- **The evidence available does not allow us to affirm that housing with support and care generates clear savings** in the use of health and social services compared to other environments.
- **In people with mental health problems**, the results are more consistent and show a **reduction in hospital admissions and a more effective use of primary care**.
- **In older adults and those with dementia**, some studies indicate a reduction in the length of hospital stays, although the **evidence remains inconclusive**.

Table 7. Summary of evidence related to optimizing resources

- **In people with disabilities**, in some cases deinstitutionalization is associated with **an increase in hospitalizations and a decrease in the use of primary care.**

Cost-effectiveness

- There is evidence that **for people with moderate needs, retirement communities with continuous care are more cost-effective than nursing homes.**
- **For people with mental health problems, housing with continuous support appears to be the most cost-effective in terms of quality of life and care.** However, **if recovery is a key goal, independent housing with temporary support might be more advantageous, although sufficient data is lacking.**
- **Cost-effectiveness studies can be biased:** it is difficult to obtain **reliable data on the real costs and content of services.** In addition, informal unpaid care—key in these models—is not usually included, which can distort comparisons.

6. Summary

Housing with support and housing with care represent alternative care models to traditional institutions. They offer a more person-centred approach, although their effectiveness varies significantly depending on the group served and the context. In general, the evidence suggests that the value of these models lies not so much in the housing itself, but in the **quality, flexibility, and personalization of the services** they provide.

In groups where a rights-based approach prevails, such as some housing for **people with disabilities and mental health conditions**, clearer benefits can be observed. In the case of people with disabilities, these residences have proven effective in promoting **functional independence** and **agency** for deinstitutionalized individuals, although **social connectivity** may be limited. In the field of **mental health**, the evidence is strong regarding deinstitutionalization. Many of the people who access these residences **have experienced homelessness and psychiatric hospitalization. Residential support helps break this cycle**, providing stability and **significantly improving psychiatric symptoms and an effective use of health services.**

For **older adults** and people with **dementia**, the evidence is less conclusive. The "home for life" model works best for those with moderate care needs, helping them delay or avoid admission to nursing homes. Improvements in **perceived health** and in **psychological well-being** are observed, and it has been found that people with moderate needs can better maintain their physical and cognitive abilities in these facilities compared to those who continue to live in their own homes.

However, when care needs become more acute, the limitations of the model become apparent, and the lack of clarity about when a resident should move to an environment that offers more support, such as a nursing home, can be stressful. In terms of how social relationships are benefitted, this is particularly evident in people in good health and with low care needs.

Regarding **cost-effectiveness**, the evidence is ambiguous and biased, as actual costs and informal care are often not accounted for. Despite this, **some studies suggest that housing with care is more cost-effective than nursing home care for people with moderate needs, as it offers a higher quality of life at a similar cost.** However, it cannot be claimed that this is a universal alternative to residential care, as it is not designed to address complex needs and, in some cases, may even increase hospital costs.

In short, **housing with support and care does not offer one-size-fits-all solutions.** Their success depends on the ability of services to adapt to each person's needs and on collaboration among users, professionals, and families to create environments that promote autonomy, self-respect, and well-being.

7. Implications for practice

In Catalonia, housing with support and care is relatively new and has limited resources. No housing with care facilities exist yet that have been designed as "homes for life" that guarantee continuity of care. Reviews like this one can be useful in guiding their development based on the available evidence.

Nevertheless, the available evidence comes primarily from countries like the United Kingdom, which have a longer history of promoting community-based care and whose socioeconomic and cultural characteristics are very different from those of Catalonia. Therefore, the evidence found cannot directly inform decisions in Catalonia unless it considers these differences. What works in those countries may not necessarily work in our context.

For this reason, it would be naive to suggest simply "importing" models, techniques, or designs that have proven effective and efficient in other contexts. While it is acknowledged that they have an undeniable value as inspiration for policies in Catalonia, the practical implications to be drawn from this review need to be contemplated from a vision that is in its infancy. The goal is to highlight the critical issues that policies in these countries have had to address, and how their responses to those issues have helped define their different models.

7.1. Can and should housing with care replace nursing homes?

For individuals who requiring long-term care, models that ensure continuity of care can postpone or even replace admission to a nursing home. However, this review indicates that this approach to housing can generate certain problems, which include:

1. A greater risk that people will not receive the care they need. It is unclear whether people with greater care needs can receive the necessary services in these types of housing.
2. Frustration and anxiety can be generated among residents, since the limits of coverage in these homes are not made clear in advance, creating uncertainty about whether they will be able to avoid institutionalization.
3. The risk that housing with care will be perceived simply as a cheaper version of nursing homes.

Current evidence shows that these models are alternatives that can complement nursing homes, but they cannot hope to replace them when care needs intensify sharply. So, if this is the situation, should policies favour housing with 'end-of-life' care? That is, should it be designed to cover absolutely all care needs until the end of a person's life?

7.2. In the case of elderly people and people with dementia, is the housing with care model very different from the nursing home model?

The differences with large nursing homes are considerable when housing with care facilities have the following values and features:

- When they foster a flexible, personalized care culture and an organization that is focused on quality of life.
- When they have open, home-like spaces that are integrated into the community.
- When they are not located in isolated or peripheral areas.

However, when compared to newer home-like care settings (co-housing units, dementia villages, etc.), the differences become less apparent, as both are based on very similar principles. Nevertheless, unlike housing with care, these new residential models remain a care resource. They are not homes designed to allow people to live independently and in their own environment. In them, care takes precedence over social and community life. Therefore, the development of housing with care cannot be promoted without simultaneously fostering a reform of existing residential settings.

This raises two important questions for public policies:

- Can we promote policies that encourage housing with care without altering the current nursing home model?
- Is it necessary to integrate the housing with care model with the new nursing home model, or should there be a clear commitment to a single model?

7.3. Housing with support and care: stable and "for life"?

For older adults, housing with care facilities provide a stable place to live and varying levels of support to meet their individual needs. This model allows people to live in familiar surroundings and avoids the need for constant relocation as their care requirements change. This housing-centred model caters to individuals with diverse needs, "from fit to frail", i.e. ranging from those who require only occasional support to those who need much higher levels of care.

This approach contrasts with supported housing models that are designed for people with disabilities or mental health problems. In these cases, housing often functions as a tool for therapeutic intervention (for example, rehabilitation and social reintegration). In these models, the housing is not a stable resource; people move from one home to another as their condition worsens or improves, so that they can receive more support or less. However, programmes such as Housing First demonstrate that residential stability is a key aspect in this group's recovery.

This leads us to ask: to what extent is residential stability important, and how key is it for the supported housing facility to be the residents' long-term home?

In a context of growing social inequalities, not only will there be more people with care needs, but more of them will also be facing a greater risk of not having housing. Therefore, it is worth asking questions such as: are we moving towards a scenario of temporary housing that is geared towards increasingly integrated and specialized care, or towards a stable housing model around which we organize services based on people's needs? It appears necessary to consider how to integrate social care with housing policies, and not just with healthcare.

7.4. Housing with support and care for everyone?

The studies that have been reviewed repeatedly indicate that this type of housing, as it stands, does not appear to be accessible to or geared towards all people with support and care needs. People from disadvantaged backgrounds and minority groups tend to rely more heavily on their families, and they also face a greater risk of institutionalization.

Many analyses of these new housing models highlight that those who access them are frequently more highly educated older adults from more affluent backgrounds. Furthermore, very few studies

evaluate their impact on populations such as migrants or the LGBTQ+ community. All of this suggests that the deinstitutionalization process is not reaching certain people.

At the same time, the aging of a significant cohort of people with disabilities and mental health problems poses an additional challenge for supported housing. New care needs emerge in these stages that may not be met by current models. Furthermore, the promotion of independent living that this type of housing encourages may not be aligned with the needs that arise as people age, such as preventing isolation.

This leads us to reflect on two key points:

- Is the promotion of housing with support and care for older adults and people with dementia taking demographic changes sufficiently into account? In particular, it is addressing the growing diversity (resulting from migration and new lifestyles) and the increasing social inequalities among future generations of older adults?
- Are supported housing options for people with disabilities and mental health conditions truly prepared to meet the challenges of this aging population and the long-term care needs that this entails?

8. Reference list and reviewed publications

8.1. Reference list.

Brouwers, M., Broekharst, D. S. E., de Boer, B., Groen, W. G., & Verbeek, H. (2023). An overview of innovative living arrangements within long-term care and their characteristics: A scoping review. *BMC Geriatrics*, 23(1), 442. <https://doi.org/10.1186/s12877-023-04158-9>

Comas D'Argemir, D. (2015). Los cuidados de larga duración y el cuarto pilar del sistema de bienestar. *Revista de Antropología Social*, 24, 375-404. https://doi.org/10.5209/rev_RASO.2015.v24.50663

Comas d'Argemir, D. (2024). Envejecer en el hogar: Ecosistemas de cuidado de orientación local y comunitaria. *Zerbitzuan: Gizarte zerbitzuetarako aldizkaria = Revista de servicios sociales*, 83, 5-18.

Darton, R. A. (2022). Extra Care Housing: The Current State of Research and Prospects for the Future. *Social Policy and Society*, 21(2), 292-303. <https://doi.org/10.1017/S1474746421000683>

de Asís, R. (2023). *Estudio sobre los procesos de desinstitucionalización y transición hacia modelos de apoyo personalizados y comunitarios*. Universidad Carlos III de Madrid.

Díaz-Veiga, P., & Sancho, M. (2022). La reformulación de los cuidados de larga duración en España. Un cambio inaplazable. *Revista Española de Geriátría y Gerontología*, 57(5), 247-249. <https://doi.org/10.1016/j.regg.2022.09.002>

Echevarría, I. V. (2024). *Estudio sobre los procesos de desinstitucionalización y transición hacia modelos de apoyo personalizados y comunitarios: Personas Mayores*. Universidad Carlos III de Madrid. <https://estudiodesinstitucionalizacion.gob.es/wp-content/uploads/2024/01/2.-Resumen-Mayores.-Estudio-EDI.pdf>

Howe, A. L., Jones, A. E., & Tilse, C. (2013). What's in a name? Similarities and differences in international terms and meanings for older peoples' housing with services. *Ageing and Society*, 33(4), 547-578. <https://doi.org/10.1017/S0144686X12000086>

Lebrusan, I. (2017). La vivienda en la vejez: Problemas y estrategias para envejecer en sociedad [Http://purl.org/dc/dcmitype/Text, Universidad Complutense de Madrid]. *A La vivienda en la vejez: Problemas y estrategias para envejecer en sociedad* (pp. 1-502). <https://portalcientifico.uned.es/documentos/5d1df62d29995204f7663994?lang=ca>

Mahmood, A., Seetharaman, K., Jenkins, H.-T., & Chaudhury, H. (2022). Contextualizing Innovative Housing Models and Services Within the Age-Friendly Communities Framework. *The Gerontologist*, 62(1), 66-74. <https://doi.org/10.1093/geront/gnab115>

Rodríguez, P. R. (Ed.). (2020). *Viviendas Para Personas Mayores En Europa. Nuevas Tendencias Para El Siglo Xxi*. Fundación Pilares para la Autonomía Personal.

Sancho Castiello, M. (2020). Viviendas y alojamientos para personas mayores. La experiencia internacional. *Revista internacional de los estudios vascos = Eusko ikaskuntzen nazioarteko aldizkaria = Revue internationale des études basques = International journal on Basque studies, RIEV*, 65(1-2), 180-225.

Wright, F., Tinker, A., Mayagoitia, R., Hanson, J., Wojgani, H., & Holmans, A. (2010). What Is the 'Extra' in Extra Care Housing? *The British Journal of Social Work*, 40(7), 2239-2254.
<https://doi.org/10.1093/bjsw/bcq040>

8.2. Reviewed publications

8.2.1. Assisted living facilities for older adults

8.2.1.1. Reviews

Atkinson, T. J., Evans, S., Darton, R., Cameron, A., Porteus, J., & Smith, R. (2014). Creating the asset base – a review of literature and policy on housing with care. *Housing, Care and Support*, 17(1), 16–25. <https://doi.org/10.1108/HCS-09-2013-0017>

Chum, K., Fitzhenry, G., Robinson, K., Murphy, M., Phan, D., Alvarez, J., Hand, C., Laliberte Rudman, D., & McGrath, C. (2022). Examining Community-Based Housing Models to Support Aging in Place: A Scoping Review. *Gerontologist*, 62(3), E178–E192.
<https://doi.org/10.1093/geront/gnaa142>

Coyle, C., Buggy, S., Cagney, O., Farragher, L., Lee, C., Patje, D., & Long, J. (2020). *Housing with support for older people*. Health Research Board.

Cutler, L. J. (2007). Physical environments of assisted living: Research needs and challenges. *The Gerontologist*, 47 Spec No 3, 68-82. Scopus. https://doi.org/10.1093/geront/47.supplement_1.68

Croucher, K., Hicks, L., & Jackson, K. (2006). *Housing with Care for Later Life: A literature review*. Joseph Rowntree Foundation.

Darton, R., & Muncer, A.-M. (2005). Alternative Housing and Care Arrangements: The Evidence. In *Intermediate and Continuing Care: Policy and Practice* (pp. 183–203). John Wiley & Sons, Ltd.
<https://doi.org/10.1002/9780470774960.ch12>

Hou, S.-I., & Cao, X. (2021a). Promising Aging in Community Models in the U.S.: Village, Naturally Occurring Retirement Community (NORC), Cohousing, and University-Based Retirement

Community (UBRC). *Gerontology and Geriatric Medicine*, 7.
<https://doi.org/10.1177/23337214211015451>

Mpofu, E., Prybutok, G., Meier, N., & Ingman, S. (2023). Social Connectedness Resource Preferences of Older Adults in Assisted Living: A Scoping Review Based on the WHO-ICF Framework. *Journal of Gerontological Nursing*, 49(9), 35-42. ProQuest Central.
<https://doi.org/10.3928/00989134-20230816-03>

Nguyen, T. H. T., & Levasseur, M. (2023). How Does Community-Based Housing Foster Social Participation in Older Adults: Importance of Well-Designed Common Space, Proximity to Resources, Flexible Rules and Policies, and Benevolent Communities. *Journal of Gerontological Social Work*, 66(1), 103-133. Scopus. <https://doi.org/10.1080/01634372.2022.2133199>

Nies, M. A., & Shirley, A. M. (2022). Social Networks in Retirement and Assisted Living Communities: A Literature Review. *Journal of Gerontological Nursing*, 48(1), 42-46. ProQuest Central.
<https://doi.org/10.3928/00989134-20211207-01>

Park, S., Park, S., Ryu, B., Baek, J., Amano, T., & Kim, B. (2024). Subsidized Senior Housing in the US: A Scoping Review. *Journal of Applied Gerontology*, 43(7), 814-828. Scopus.
<https://doi.org/10.1177/07334648231223028>

Parniak, S., DePaul, V. G., Frymire, C., DePaul, S., & Donnelly, C. (2022). Naturally Occurring Retirement Communities: Scoping Review. *JMIR Aging*, 5(2). <https://doi.org/10.2196/34577>

Perone, A. K., Zhou, L., Reed, B., Singh, N., Kopp-Richardson, S., Dubensky, J., Godwin, T., Shin, J., Lee, M., & Glusker, A. (2025). A Community-Engaged Scoping Review of Affordable Housing Models for LGBTQ+ Older Adults. *Gerontologist*, 65(6). Scopus.
<https://doi.org/10.1093/geront/gnaf103>

Puplampu, V., Matthews, E., Puplampu, G., Gross, M., Pathak, S., & Peters, S. (2020). The Impact of Cohousing on Older Adults' Quality of Life. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, 39(3), 406-420. <https://doi.org/10.1017/S0714980819000448>

Smith, R. (2015). Longitudinal studies and housing with care in England: A review. *Housing, Care and Support*, 18(1), 1-11. Scopus. <https://doi.org/10.1108/HCS-08-2014-0020>

Tinelli, M., Knapp, M., & Guy, D. (2019). *Integrated housing with care and support for older people: Economic evidence*. National Institute for Health Research.

Vallely, S. (2002). Extra care housing: A review of the effectiveness of extra care housing for older people. *Housing, Care and Support*, 5(1), 7-11. Scopus.
<https://doi.org/10.1108/14608790200200003>

Westwood, S., & Daly, M. (s. f.). *Social Care and Older People in Home and Community Contexts: A Review of Existing Research and Evidence*. 68.

8.2.1.2. Evaluations

Bäumker, T., Netten, A., & Darton, R. (2010). Costs and Outcomes of an Extra Care Housing Scheme in England. *Journal of Housing For the Elderly*, 24(2), 151–170.

<https://doi.org/10.1080/02763891003757098>

Bäumker, T., Netten, A., Darton, R., & Callaghan, L. (2011). Evaluating Extra Care Housing for Older People in England: A Comparative Cost and Outcome Analysis with Residential Care. *Journal of Service Science and Management*, 4(4), 523–539. <https://doi.org/10.4236/jssm.2011.44060>

Beach, B., Willis, P., Powell, J., Vickery, A., Smith, R., & Cameron, A. (2022). The Impact of Living in Housing With Care and Support on Loneliness and Social Isolation: Findings From a Resident-Based Survey. *Innovation in Aging*, 6(7), igac061. <https://doi.org/10.1093/geroni/igac061>

Bernard, M., Bartlam, B., Biggs, S., & Sim, J. (2004). *New lifestyles in old age: Health, identity and well-being in Berryhill Retirement Village* (1st ed.). Bristol University Press.

<https://doi.org/10.2307/j.ctt1t892nh>

Callaghan, L., Netten, A., Darton, R., Bäumker, T., & Holder, J. (2008). *Social Well-Being in Extra Care Housing: Emerging Theme* [Interim Report]. Joseph Rowntree Foundation.

Callaghan, L., & Towers, A.-M. (2014). Feeling in control: Comparing older people's experiences in different care settings. *Ageing & Society*, 34(8), 1427–1451.

<https://doi.org/10.1017/S0144686X13000184>

Cummings, S. M. (2002). Predictors of psychological well-being among assisted-living residents. *Health & Social Work*, 27(4), 293–302. <https://doi.org/10.1093/hsw/27.4.293>

Elbert, K. B., & Neufeld, P. S. (2010). Indicators of a Successful Naturally Occurring Retirement Community: A Case Study. *Journal of Housing For the Elderly*, 24(3-4), 322–334.

<https://doi.org/10.1080/02763893.2010.522440>

Erickson, Mary Ann; Dempster-McClain, Donna; Whitlow, Carol & Moen, Phyllis (2000). Social Integration and the Move to a Continuing Care Retirement Community. In *Social Integration in the Second Half of Life* (p. 211–227). JHU Press.

Evans, S. (2009). "That lot up there and us down here": Social interaction and a sense of community in a mixed tenure UK retirement village. *Ageing and Society*, 29(2), 199–216.

<https://doi.org/10.1017/S0144686X08007678>

Evans, S., & Vallelly, S. (2007). Never a dull moment? Promoting social well-being in extra care housing. *Housing, Care and Support*, 10(4), 14–19.

<https://doi.org/10.1108/14608790200700024>

Gaines, J. M., Poey, J. L., Marx, K. A., Parrish, J. M., & Resnick, B. (2011). Health and Medical Services Use: A Matched Case Comparison Between CCRC Residents and National Health and Retirement Study Samples. *Journal of Gerontological Social Work*, 54(8), 788–802.

<https://doi.org/10.1080/01634372.2011.595476>

Holland, C., Boukouvalas, A., Wallis, S., Clarkesmith, D., Cooke, R., Liddell, L., & Kay, A. (2017). Transition from community dwelling to retirement village in older adults: Cognitive functioning and psychological health outcomes. *Ageing & Society*, 37(7), 1499–1526.

<https://doi.org/10.1017/S0144686X16000477>

Holland, C., Carter, M., Cooke, R., Graham, L., Shaw, R., & West, K. (2015). *Collaborative Research between Aston Research Centre for Healthy Ageing (ARCHA) and the ExtraCare Charitable Trust*. Aston University.

Holland, C., Garner, I., O'Donnell, J., & Gwyther, H. (2019). *Integrated homes, care and support - Measurable outcomes for healthy ageing*. ExtraCare Charitable Trust.

King, N. (2003). Continuing care retirement communities: Description and an evaluation. *Housing, Care and Support*, 6(4), 29–33. <https://doi.org/10.1108/14608790200300027>

Kneale, D. (2011). *Establishing the extra in Extra Care - Perspectives from three Extra Care Housing Providers*. ILC-UK.

Kneale, D. (2013). *What role for extra care housing in a socially isolated landscape?* Housing LIN.

Markle, E. A., Rodgers, R., Sanchez, W., & Ballou, M. (2015). Social support in the cohousing model of community: A mixed-methods analysis. *Community Development*, 46(5), 616–631.

<https://doi.org/10.1080/15575330.2015.1086400>

Mayhew, L., Rickayzen, B., & Smith, D. (2017). *Does living in a retirement village extend life expectancy? The case of Whiteley Village*. The International Longevity Centre.

Mitchell, J. M., & Kemp, B. J. (2000). Quality of life in assisted living homes: A multidimensional analysis. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, 55(2), P117–127. <https://doi.org/10.1093/geronb/55.2.p117>

O'malley, M., Innes, A., Muir, S., & Wiener, J. M. (2018). "All the corridors are the same": A qualitative study of the orientation experiences and design preferences of UK older adults living in a communal retirement development. *Ageing & Society*, 38(9), 1791–1816.

<https://doi.org/10.1017/S0144686X17000277>

Pruchno, R. A., & Rose, M. S. (2000). The Effect of Long-Term Care Environments on Health Outcomes. *The Gerontologist*, 40(4), 422–428. <https://doi.org/10.1093/geront/40.4.422>

Rantz, M. J., Phillips, L., Aud, M., Popejoy, L., Marek, K. D., Hicks, L. L., Zaniletti, I., & Miller, S. J. (2011). Evaluation of aging in place model with home care services and registered nurse care

coordination in senior housing. *Nursing Outlook*, 59(1), 37–46. <https://doi.org/10.1016/j.outlook.2010.08.004>

Rantz, M., Popejoy, L. L., Galambos, C., Phillips, L. J., Lane, K. R., Marek, K. D., Hicks, L., Musterman, K., Back, J., Miller, S. J., & Ge, B. (2014). The continued success of registered nurse care coordination in a state evaluation of aging in place in senior housing. *Nursing Outlook*, 62(4), 237–246. <https://doi.org/10.1016/j.outlook.2014.02.005>

Roberts, A. R., & Adams, K. B. (2018). Quality of Life Trajectories of Older Adults Living in Senior Housing. *Research on Aging*, 40(6), 511–534. <https://doi.org/10.1177/0164027517713313>

Rossen, E. K., & Knafl, K. A. (2007). Women's Well-Being After Relocation to Independent Living Communities. *Western Journal of Nursing Research*, 29(2), 183–199. <https://doi.org/10.1177/0193945906292539>

Sherwood, P. S. C., Ruchlin, P. H. S., Sherwood, P. C. C., & Morris, P. S. A. (1997). *Continuing Care Retirement Communities*.

Stacey-Konnert, C., & Pynoos, J. (1992). Friendship and Social Networks in a Continuing Care Retirement Community. *Journal of Applied Gerontology*, 11(3), 298–313. <https://doi.org/10.1177/073346489201100304>

Streib, G. F., & Metsch, L. R. (2002). Conflict in Retirement Communities: Applying an Analytical Framework. *Research on Aging*, 24(1), 67–86. <https://doi.org/10.1177/0164027503024001005>

Twyford, K. (2016). *Individuals with dementia living in extra care housing: An initial exploration of the practicalities and possibilities*. Housing LIN.

Van Den Hoonaard, D. K. (1994). Paradise lost: Widowhood in a Florida retirement community. *Journal of Aging Studies*, 8(2), 121–132. [https://doi.org/10.1016/S0890-4065\(05\)80001-5](https://doi.org/10.1016/S0890-4065(05)80001-5)

Waldron, V. R., Gitelson, R., Kelley, D., & Regalado, J. (2005). Losing and Building Supportive Relationships in Later Life: A Four-Year Study of Migrants to a Planned Retirement Community. *Journal of Housing For the Elderly*, 19(2), 5–25. https://doi.org/10.1300/J081v19n02_02

Yates, K. (2016). *A fresh outlook on wellbeing: Delivering person-centred care across the West Midlands*. Housing Learning and Improvement Network and Nehemiah Housing Association.

8.2.2. Assisted living facilities for people with dementia

8.2.2.1. Reviews

Atkinson, T. J., Oatley, R., & Evans, S. (2023). Advantages and challenges of extra care housing in the UK for people living with dementia: A scoping review. *Housing, Care and Support*, 26(3-4), 84–102. <https://doi.org/10.1108/HCS-09-2022-0023>

Krier, D., de Boer, B., Hilgsmann, M., Wittwer, J., & Amieva, H. (2023). Evaluation of Dementia-Friendly Initiatives, Small-Scale Homelike Residential Care, and Dementia Village Models: A Scoping Review. *Journal of the American Medical Directors Association*, 24(7), 1020–1027.e1. <https://doi.org/10.1016/j.jamda.2023.03.024>

Smith, M., Brown, M., Ritchie, L., Papadopoulou, C., & Tolson, D. (2022). Living with dementia in supported housing: A systematic review and thematic synthesis of qualitative research. *Health and Social Care in the Community*, 30(3), e589–e604. <https://doi.org/10.1111/hsc.13618>

Smith, R. (2015). Longitudinal studies and housing with care in England: A review. *Housing, Care and Support*, 18(1), 1–11. <https://doi.org/10.1108/HCS-08-2014-0020>

8.2.2.2. Evaluations

Annerstedt, L. (1994). An attempt to determine the impact of group living care in comparison to traditional long-term care on demented elderly patients. *Aging Clinical and Experimental Research*, 6(5), 372–380. <https://doi.org/10.1007/BF03324268>

Barrett, J., Evans, S., & Pritchard-Wilkes, V. (2020). Understanding and supporting safe walking with purpose among people living with dementia in extra care, retirement and domestic housing. *Housing, Care and Support*, 23(2), 37–48. <https://doi.org/10.1108/HCS-03-2020-0004>

Brooker, D. J., Argyle, E., Scally, A. J., & Clancy, D. (2011). The Enriched Opportunities Programme for people with dementia: A cluster-randomised controlled trial in 10 extra care housing schemes. *Aging & Mental Health*, 15(8), 1008–1017. <https://doi.org/10.1080/13607863.2011.583628>

Darton, R., & Callaghan, L. (2009). The role of extra care housing in supporting people with dementia: Early findings from the PSSRU evaluation of extra care housing. *Journal of Care Services Management*, 3(3), 284–294. <https://doi.org/10.1179/csm.2009.3.3.284>

Evans, S. C., Atkinson, T., Cameron, A., Johnson, E. K., Smith, R., Darton, R., Porteus, J., & Lloyd, L. (2020). Can extra care housing support the changing needs of older people living with dementia? *Dementia*, 19(5), 1492–1508. <https://doi.org/10.1177/1471301218801743>

Garwood, S. (2008a). *Duddon Mews Extra Care Scheme for People with Mental Health Problems and Physical Frailty in Cumbria*. Housing LIN.

Garwood, S. (2008b). *Reeve Court Retirement Village St Helen's - an Evaluation*.

Means, R., Evans, S., Fear, T., & Vallelly, S. (2006). A home for life? Extra care sheltered housing and people with dementia. *Journal of Dementia Care, 14*(4).

Reimer, M. A., Slaughter, S., Donaldson, C., Currie, G., & Eliasziw, M. (2004). Special care facility compared with traditional environments for dementia care: A longitudinal study of quality of life. *Journal of the American Geriatrics Society, 52*(7), 1085–1092. <https://doi.org/10.1111/j.1532-5415.2004.52304.x>

te Boekhorst, S., Depla, M. F. I. A., de Lange, J., Pot, A. M., & Eefsting, J. A. (2009). The effects of group living homes on older people with dementia: A comparison with traditional nursing home care. *International Journal of Geriatric Psychiatry, 24*(9), 970–978. <https://doi.org/10.1002/gps.2205>

Vallelly, S., Evans, S., Fear, T., & Means, R. (2006). *Opening doors to independence – summary*. Housing21.

8.2.3. Supported housing for people with disabilities

8.2.3.1. Reviews

Kozma, A., Mansell, J., & Beadle-Brown, J. (2009). Outcomes in Different Residential Settings for People With Intellectual Disability: A Systematic Review. *American Journal on Intellectual and Developmental Disabilities, 114*(3), 193–222. <https://doi.org/10.1352/1944-7558-114.3.193>

Oliver, S., Gosden-Kaye, E. Z., Winkler, D., & Douglas, J. M. (2020). The outcomes of individualized housing for people with disability and complex needs: A scoping review. *Disability and Rehabilitation, 1–15*. <https://doi.org/10.1080/09638288.2020.1785023>

Roebuck, M. (2021). Housing for People with Intellectual Disabilities: A Scoping Review. *Journal on Developmental Disabilities, 26*(2), On–line first.

8.2.3.2. Evaluations

Baker, P. A. (2007). Individual and Service Factors Affecting Deinstitutionalization and Community Use of People with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities, 20*(2), 105–109. <https://doi.org/10.1111/j.1468-3148.2006.00313.x>

Bigby, C., Bould, E., & Beadle-Brown, J. (2017). Conundrums of supported living: The experiences of people with intellectual disability. *Journal of Intellectual & Developmental Disability, 42*(4), 309–319. <https://doi.org/10.3109/13668250.2016.1253051>

Bryan, F., Allan, T., & Russell, L. (2000). The move from a long-stay learning disabilities hospital to community homes: A comparison of clients' nutritional status. *Journal of Human Nutrition and Dietetics*, 13(4), 265–270. <https://doi.org/10.1046/j.1365-277x.2000.00239.x>

Chou, Y.-C., Lin, L.-C., Pu, C.-Y., Lee, W.-P., & Chang, S.-C. (2008). Outcomes and Costs of Residential Services for Adults with Intellectual Disabilities in Taiwan: A Comparative Evaluation. *Journal of Applied Research in Intellectual Disabilities*, 21(2), 114–125. <https://doi.org/10.1111/j.1468-3148.2007.00373.x>

Emerson, E., & McVilly, K. (2004). Friendship Activities of Adults with Intellectual Disabilities in Supported Accommodation in Northern England. *Journal of Applied Research in Intellectual Disabilities*, 17(3), 191–197. <https://doi.org/10.1111/j.1468-3148.2004.00198.x>

Emerson, E., Robertson, J., Gregory, N., Hatton, C., Kessissoglou, S., Hallam, A., Järbrink, K., Knapp, M., Netten, A., & Walsh, P. N. (2001). Quality and costs of supported living residences and group homes in the United Kingdom. *American Journal of Mental Retardation: AJMR*, 106(5), 401–415. [https://doi.org/10.1352/0895-8017\(2001\)106<0401:QACOSL>2.0.CO;2](https://doi.org/10.1352/0895-8017(2001)106<0401:QACOSL>2.0.CO;2)

Felce, D., Perry, J., & Kerr, M. (2011). A Comparison of Activity Levels Among Adults with Intellectual Disabilities Living in Family Homes and Out-of-Family Placements. *Journal of Applied Research in Intellectual Disabilities*, 24(5), 421–426. <https://doi.org/10.1111/j.1468-3148.2010.00620.x>

Forrester-Jones, R., Carpenter, J., Coolen-Schrijner, P., Cambridge, P., Tate, A., Beecham, J., Hallam, A., Knapp, M., & Wooff, D. (2006). The Social Networks of People with Intellectual Disability Living in the Community 12 Years after Resettlement from Long-Stay Hospitals. *Journal of Applied Research in Intellectual Disabilities*, 19(4), 285–295. <https://doi.org/10.1111/j.1468-3148.2006.00263.x>

Grove, L. R., Berkowitz, S. A., Cuddeback, G., Pink, G. H., Stearns, S. C., Stürmer, T., & Domino, M. E. (2023). Permanent Supportive Housing Receipt and Health Care Use Among Adults With Disabilities. *Medical Care Research and Review*, 80(6), 596–607. <https://doi.org/10.1177/10775587231183192>

Lamontagne, M.-E., Poncet, F., Careau, E., Sirois, M.-J., & Boucher, N. (2013). Life habits performance of individuals with brain injury in different living environments. *Brain Injury*, 27(2), 135–144. <https://doi.org/10.3109/02699052.2012.722253>

Martínez-Leal, R., Salvador-Carulla, L., Linehan, C., Walsh, P., Weber, G., Van Hove, G., Määttä, T., Azema, B., Haveman, M., Buono, S., Germanavicius, A., van Schrojenstein Lantman-de Valk, H., Tossebro, J., Carmen-Câra, A., Moravec Berger, D., Perry, J., & Kerr, M. (2011). The impact of living arrangements and deinstitutionalisation in the health status of persons with intellectual disability in Europe. *Journal of Intellectual Disability Research*, 55(9), 858–872. <https://doi.org/10.1111/j.1365-2788.2011.01439.x>

- McConkey, R., Abbott, S., Walsh, P. N., Linehan, C., & Emerson, E. (2007). Variations in the social inclusion of people with intellectual disabilities in supported living schemes and residential settings. *Journal of Intellectual Disability Research: JIDR*, 51(Pt 3), 207–217. <https://doi.org/10.1111/j.1365-2788.2006.00858.x>
- McConkey, R., Bunting, B., Ferry, F., Garcia-Iriarte, E., & Stevens, R. (2013). *An Evaluation of Personalised Supports to Individuals with Disabilities and Mental Health Difficulties*. Genio.
- McConkey, R., Keogh, F., Bunting, B., Garcia Iriarte, E., & Watson, S. F. (2016). Relocating people with intellectual disability to new accommodation and support settings: Contrasts between personalized arrangements and group home placements. *Journal of Intellectual Disabilities*, 20(2), 109–120. <https://doi.org/10.1177/1744629515624639>
- McConkey, R., Keogh, F., Bunting, B., & Iriarte, E. G. (2018). Changes in the self-rated well-being of people who move from congregated settings to personalized arrangements and group home placements. *Journal of Intellectual Disabilities: JOID*, 22(1), 49–60. <https://doi.org/10.1177/1744629516674086>
- Navas, P., Arias, V. B., Vicente, E., Esteban, L., Guillén, V. M., Alvarado, N., Heras, I., Rumoroso, P., García-Domínguez, L., & Verdugo, M. Á. (2025). Empowering lives: How deinstitutionalization and community living improve the quality of life of individuals with intellectual and developmental disabilities. *Research in Developmental Disabilities*, 157, 104909. <https://doi.org/10.1016/j.ridd.2024.104909>
- Sines, D., Hogard, E., & Ellis, R. (2012). Evaluating quality of life in adults with profound learning difficulties resettled from hospital to supported living in the community. *Journal of Intellectual Disabilities*, 16(4), 247–263. <https://doi.org/10.1177/1744629512463840>
- Sloan, S., Callaway, L., Winkler, D., McKinley, K., & Ziino, C. (2012). Accommodation Outcomes and Transitions Following Community-Based Intervention for Individuals with Acquired Brain Injury. *Brain Impairment*, 13(1), 24–43. <https://doi.org/10.1017/Brlmp.2012.5>
- Stancliffe, R. J., Lakin, K. C., Doljanac, R., Byun, S.-Y., Taub, S., & Chiri, G. (2007). Loneliness and Living Arrangements. *Intellectual and Developmental Disabilities*, 45(6), 380–390. [https://doi.org/10.1352/1934-9556\(2007\)45\[380:LALA\]2.0.CO;2](https://doi.org/10.1352/1934-9556(2007)45[380:LALA]2.0.CO;2)
- Stancliffe, R. J., & Keane, S. (2000). Outcomes and costs of community living: A matched comparison of group homes and semi-independent living. *Journal of Intellectual & Developmental Disability*, 25(4), 281–305. <https://doi.org/10.1080/13668250020019584>
- Stancliffe, R. J., Lakin, K. C., Larson, S., Engler, J., Taub, S., & Fortune, J. (2011). Choice of living arrangements. *Journal of Intellectual Disability Research*, 55(8), 746–762. <https://doi.org/10.1111/j.1365-2788.2010.01336.x>

Wiesel, I. (2015). Housing for People with Intellectual Disabilities and the National Disability Insurance Scheme Reforms. *Research and Practice in Intellectual and Developmental Disabilities*, 2(1), 45–55. <https://doi.org/10.1080/23297018.2014.992037>

Winkler, D., Callaway, L., Sloan, S., & Holgate, N. (2015). Everyday Choice Making: Outcomes of Young People with Acquired Brain Injury After Moving from Residential Aged Care to Community-Based Supported Accommodation. *Brain Impairment*, 16(3), 221–235. <https://doi.org/10.1017/Brlmp.2015.32>

Winkler, D., Sloan, S., & Callaway, L. (2007). *Younger People in Residential Aged Care*: Summer Foundation Ltd.

Wright, C. J., Colley, J., & Kendall, E. (2020). Exploring the efficacy of housing alternatives for adults with an acquired brain or spinal injury: A systematic review. *Brain Impairment*, 21(2), 125–153. <https://doi.org/10.1017/Brlmp.2019.33>

8.2.4. Supported housing for people with severe mental health problems

8.2.4.1. Reviews

Chilvers, R., Macdonald, G. M., & Hayes, A. A. (2006). Supported housing for people with severe mental disorders. *Cochrane Database of Systematic Reviews (Online)*, 4, CD000453.

Harrison, M., Singh Roy, A., Hultqvist, J., Pan, A.-W., McCartney, D., McGuire, N., Irvine Fitzpatrick, L., & Forsyth, K. (2020). Quality of life outcomes for people with serious mental illness living in supported accommodation: Systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, 55(8), 977–988. <https://doi.org/10.1007/s00127-020-01885-x>

Ketola, J., Jahangiri, E., Hakko, H., Riipinen, P., & Räsänen, S. (2022). Assisted living for mentally ill—a systematic literature review and its recommendations. *Nordic Journal of Psychiatry*, 76(6), 403–422. <https://doi.org/10.1080/08039488.2021.2001568>

McPherson, P., Krotofil, J., & Killaspy, H. (2018a). Mental health supported accommodation services: A systematic review of mental health and psychosocial outcomes. *BMC Psychiatry*, 18(1). <https://doi.org/10.1186/s12888-018-1725-8>

McPherson, P., Lloyd-Evans, B., Dalton-Locke, C., & Killaspy, H. (2021). A Systematic Review of the Characteristics and Efficacy of Recovery Training for Mental Health Staff: Implications for Supported Accommodation Services. *Frontiers in Psychiatry*, 12. <https://doi.org/10.3389/fpsy.2021.624081>

o'Malley, L., & Croucher, K. (2005). Supported Housing Services for People with Mental Health Problems: A Scoping Study. *Housing Studies*, 20(5), 831–845. <https://doi.org/10.1080/02673030500214126>

Richter, D., & Hoffmann, H. (2017a). Independent housing and support for people with severe mental illness: Systematic review. *Acta Psychiatrica Scandinavica*, 136(3), 269–279.

<https://doi.org/10.1111/acps.12765>

Richter, D., & Hoffmann, H. (2017b). Preference for Independent Housing of Persons with Mental Disorders: Systematic Review and Meta-analysis. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(6), 817–823. <https://doi.org/10.1007/s10488-017-0791-4>

Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent Supportive Housing: Assessing the Evidence. *Psychiatric Services*, 65(3), 287–294. <https://doi.org/10.1176/appi.ps.201300261>

Watson, J., Fossey, E., & Harvey, C. (2019). A home but how to connect with others? A qualitative meta-synthesis of experiences of people with mental illness living in supported housing. *Health & Social Care in the Community*, 27(3), 546–564. <https://doi.org/10.1111/hsc.12615>

8.2.4.2. Evaluations

Adamus, C., Zürcher, S. J., & Richter, D. (2022). A mirror-image analysis of psychiatric hospitalisations among people with severe mental illness using Independent Supported Housing. *BMC Psychiatry*, 22(1), 492. <https://doi.org/10.1186/s12888-022-04133-5>

Barnes, S., Carson, J., & Gournay, K. (2022). Enhanced supported living for people with severe and persistent mental health problems: A qualitative investigation. *Health & Social Care in the Community*, 30(6), e4293–e4302. <https://doi.org/10.1111/hsc.13822>

Chan, H., Inoue, S., Shimodera, S., Fujita, H., Fukuzawa, K., Kii, M., Kamimura, N., Kato, K., & Mino, Y. (2007). Residential program for long-term hospitalized persons with mental illness in Japan: Randomized controlled trial. *Psychiatry and Clinical Neurosciences*, 61(5), 515–521. <https://doi.org/10.1111/j.1440-1819.2007.01701.x>

Dalton-Locke, C., Attard, R., Killaspy, H., & White, S. (2018). Predictors of quality of care in mental health supported accommodation services in England: A multiple regression modelling study. *BMC Psychiatry*, 18(1), 344. <https://doi.org/10.1186/s12888-018-1912-7>

Dehn, L. B., Beblo, T., Richter, D., Wienberg, G., Kremer, G., Steinhart, I., & Driessen, M. (2022). Effectiveness of supported housing versus residential care in severe mental illness: A multicenter, quasi-experimental study. *Social Psychiatry and Psychiatric Epidemiology*, 57(5), 927–937. <https://doi.org/10.1007/s00127-021-02214-6>

Dunt, D. R., Benoy, A. W., Phillipou, A., Collister, L. L., Crowther, E. M., Freidin, J., & Castle, D. J. (2017). Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: The Doorway program. *Australian Health Review: A Publication of the Australian Hospital Association*, 41(5), 573–581. <https://doi.org/10.1071/AH16055>

Gilmer, T. P., Folsom, D. P., Hawthorne, W., Lindamer, L. A., Hough, R. L., Garcia, P., & Jeste, D. V. (2003). *Assisted living and use of health services among medicaid beneficiaries with schizophrenia. The Journal of Mental Health Policy and Economics*, 6(2), 59–65.

Gilmer, T. P., Stefancic, A., Ettner, S. L., Manning, W. G., & Tsemberis, S. (2010). Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness. *Archives of General Psychiatry*, 67(6), 645–652.
<https://doi.org/10.1001/archgenpsychiatry.2010.56>

Gilmer, T. P., Stefancic, A., Tsemberis, S., & Ettner, S. L. (2014). Full-Service Partnerships Among Adults With Serious Mental Illness in California: Impact on Utilization and Costs. *Psychiatric Services*, 65(9), 1120–1125. <https://doi.org/10.1176/appi.ps.201300380>

Harrison, M., Irvine Fitzpatrick, L., & Maciver, D. (2024). Predictors of Discharge from Hospital to Supported Accommodation and Support Needs Once in Supported Accommodation for People with Serious Mental Illness in Scotland: A Linked National Dataset Study. *Health & Social Care in the Community*, 2024(1), 3905720. <https://doi.org/10.1155/2024/3905720>

Hobbs, C., Newton, L., Tennant, C., Rosen, A., & Tribe, K. (2002). Deinstitutionalization for long-term mental illness: A 6-year evaluation. *The Australian and New Zealand Journal of Psychiatry*, 36(1), 60–66. <https://doi.org/10.1046/j.1440-1614.2002.00984.x>

Kallert, T. W., Leisse, M., & Winiecki, P. (2007). Comparing the effectiveness of different types of supported housing for patients with chronic schizophrenia. *Journal of Public Health*, 15(1), 29–42. <https://doi.org/10.1007/s10389-006-0071-3>

Killaspy, H., Priebe, S., Bremner, S., McCrone, P., Dowling, S., Harrison, I., Krotofil, J., McPherson, P., Sandhu, S., Arbuthnott, M., Curtis, S., Leavey, G., Shepherd, G., Eldridge, S., & King, M. (2016). Quality of life, autonomy, satisfaction, and costs associated with mental health supported accommodation services in England: A national survey. *The Lancet Psychiatry*, 3(12), 1129–1137. [https://doi.org/10.1016/S2215-0366\(16\)30327-3](https://doi.org/10.1016/S2215-0366(16)30327-3)

Killaspy, H., Priebe, S., McPherson, P., Zenasni, Z., Greenberg, L., McCrone, P., Dowling, S., Harrison, I., Krotofil, J., Dalton-Locke, C., McGranahan, R., Arbuthnott, M., Curtis, S., Leavey, G., Shepherd, G., Eldridge, S., & King, M. (2020). Predictors of moving on from mental health supported accommodation in England: National cohort study. *The British Journal of Psychiatry: The Journal of Mental Science*, 216(6), 331–337. <https://doi.org/10.1192/bjp.2019.101>

Killaspy, H., Priebe, S., McPherson, P., Zenasni, Z., McCrone, P., Dowling, S., Harrison, I., Krotofil, J., Dalton-Locke, C., McGranahan, R., Arbuthnott, M., Curtis, S., Leavey, G., MacPherson, R., Eldridge, S., & King, M. (2019). Feasibility Randomised Trial Comparing Two Forms of Mental Health Supported Accommodation (Supported Housing and Floating Outreach); a Component of the QuEST (Quality and Effectiveness of Supported Tenancies) Study. *Frontiers in Psychiatry*, 10, 258. <https://doi.org/10.3389/fpsy.2019.00258>

- Lindström, E., Eberhard, J., Neovius, M., & Levander, S. (2007). Costs of schizophrenia during 5 years. *Acta Psychiatrica Scandinavica*, 116(s435), 33–40. <https://doi.org/10.1111/j.1600-0447.2007.01086.x>
- Lodder, M. (2024). *Fostering independence: Transitioning residents with severe mental illness to independent living* [PhD thesis, Utrecht University]. <https://doi.org/10.33540/2332>
- Mares, A., & McGuire, J. (2000). Reducing psychiatric hospitalization among mentally ill veterans living in board-and-care homes. *Psychiatric Services (Washington, D.C.)*, 51(7), 914–921. <https://doi.org/10.1176/appi.ps.51.7.914>
- McDermott, S., Bruce, J., Muir, K., Ramia, I., Fisher, K. R., & Bullen, J. (2015). Reducing hospitalisation among people living with severe mental illness. *Australian Health Review*, 40(2), 124–128. <https://doi.org/10.1071/AH15073>
- Meehan, T., Stedman, T., Robertson, S., Drake, S., & King, R. (2011). Does supported accommodation improve the clinical and social outcomes for people with severe psychiatric disability? The Project 300 experience. *The Australian and New Zealand Journal of Psychiatry*, 45(7), 586–592. <https://doi.org/10.3109/00048674.2011.559634>
- Nelson, G., Sylvestre, J., Aubry, T., George, L., & Trainor, J. (2007). Housing choice and control, housing quality, and control over professional support as contributors to the subjective quality of life and community adaptation of people with severe mental illness. *Administration and Policy in Mental Health*, 34(2), 89–100. <https://doi.org/10.1007/s10488-006-0083-x>
- Piat, M., Seida, K., & Padgett, D. (2020). Choice and personal recovery for people with serious mental illness living in supported housing. *Journal of Mental Health*, 29(3), 306–313. <https://doi.org/10.1080/09638237.2019.1581338>
- Stergiopoulos, V., Gozdzik, A., O'Campo, P., Holtby, A. R., Jeyaratnam, J., & Tsemberis, S. (2014). Housing First: Exploring participants' early support needs. *BMC Health Services Research*, 14, 167. <https://doi.org/10.1186/1472-6963-14-167>
- Tsai, J., Lapidos, A., Rosenheck, R. A., & Harpaz-Rotem, I. (2013). Longitudinal association of therapeutic alliance and clinical outcomes in supported housing for chronically homeless adults. *Community Mental Health Journal*, 49(4), 438–443. <https://doi.org/10.1007/s10597-012-9518-x>

Annex I: Limitations of this study

The scientific evidence on the effectiveness of supported housing has significant limitations, a fact corroborated by most of the reviews consulted. **Randomized controlled trials (RCTs)** are scarce, and most are **qualitative or mixed-methods studies with longitudinal** designs. This has made it very difficult to draw clear conclusions regarding which type of housing works best for each intervention area and population group.


The literature reviews consulted repeatedly point to the lack of evaluations that would clearly determine the effectiveness of supported housing. Croucher et al. (2006), for example, had difficulty identifying impact evaluations, even though these models have been widely implemented in Europe as part of deinstitutionalization policies. In countries like the USA, where models such as Continuing Care Retirement Communities (CCRCs) have existed for some time, there has also been a lack of sufficient impact evaluations.

The scarcity of studies on the different models of supported housing is notable (Atkinson et al., 2023). Most studies have focused on comparisons with institutionalized settings or with private homes, but little is known about the advantages and disadvantages of the various models when compared to each other. Even in the field of mental health, where there are more evaluations with quasi-experimental designs, the Cochrane review on supported housing for people with mental health problems did not identify any studies that met its methodological criteria (Chilvers et al., 2006).

It should also be noted that the studies reflect different "epistemic cultures" that need to be considered. Studies on housing for people with mental health problems tend to be quantitative and adhere to the standards of the health sciences, while studies on older adults are more rooted in the social sciences and do not always meet these same standards. The former focus on effectiveness, while the latter focus on how the housing functions and the perspectives of the stakeholders. Furthermore, randomized controlled trials are difficult to implement in this area, as participants often refuse to participate in control groups, and professionals consider that it compromises their ethics (Killaspy et al., 2019).

Added to this is a terminological problem. The notion of "supported housing" encompasses a wide variety of models whose characteristics are not well defined (Howe et al., 2013). Although standardized taxonomies have been proposed (McPherson et al., 2021), they are not always applicable, as studies do not always provide the necessary information. The terminology also changes depending on the group: "housing with care" is used for older adults, while "supported housing" is used for people with disabilities or mental health problems, reflecting a different approach in each case.

One recurring limitation is that many studies of older adults have been conducted in the United States, where the residents of these facilities tend to belong to privileged social strata (white, highly educated, and with significant financial resources). Very little is known about the experience and impact of these housing options on disadvantaged individuals or those belonging to minority groups (Croucher et al., 2006). Darton & Callaghan (2009) explain that the lack of studies reflects the limited availability of these models for such groups, unlike nursing homes or day centres. Furthermore, cultural preferences play a significant role. Minorities in the United States (African Americans, Latinos and Asians) often prefer multigenerational housing or family care. For example, older African Americans often prefer to live alone, as they have a broad network of family and friends who provide support (Hou & Cao, 2021a). The only aspects that have been studied in more detail are gender, age, and functional status. Therefore, it would be necessary to evaluate supported housing while considering demographic changes and ask ourselves whether it is effective and adapted to an increasingly diverse population with more unequal socio-economic conditions.



Què funciona
en cures de llarga
durada?

A project to compile, analyse, and transfer information in order to
improve public long-term care policies.

A project participated in by:

