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Supportive Housing: An Evidence-Based Intervention for Reducing Relapse among Low Income Adults in Addiction Recovery

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Within the ranks of the homeless are individuals coping with substance addiction and/or chronic physical or mental disability. Their special needs often pose significant barriers to successfully re-integrate into society. For these individuals, simply securing a roof overhead may not be an adequate solution. Supportive housing combines housing with access to on-site social services to assist persons coping with disabling physical and behavioral health conditions. This study examined whether an association could be found between length of residency in supportive housing and subjective well-being. For the purposes of this study, subjective well-being was measured by length of sobriety, self-efficacy, and employment.

Keywords: Homelessness, supportive housing, addiction, relapse prevention, behavior-place association, ecological perspective

Supportive housing has emerged over the last 25 years as a critical housing option for low-income individuals and families who are not only struggling with homelessness, but are also coping with one or more disabling behavioral or physical health concerns such as substance dependence, severe and persistent mental disorders, or physical illness (Corporation for Supportive Housing [CSH], 2012). This type of housing provides support to people categorized as chronically homeless. Unfortunately, like affordable housing, there is an insufficient supply of supportive housing to meet the demand. This programmatic deficit is partly because individuals with such special needs often experience stigma, which complicates efforts to develop more supportive housing resources. Although chronic homelessness does not typically dominate public discourse, the need for such a resource to address problems of homelessness persists and is an important social concern in the United States (Bernstein, 2002; Hoch, 2000; National Law Center on Homelessness and Poverty, 2012; National Low Income Housing Coalition, 2012).

Homeless individuals who are coping with substance dependence and/or chronic mental and physical health challenges experience significant barriers to securing affordable housing, achieving a sense of self-efficacy, and re-integrating back into society (Booth, Sullivan, Koegel, & Burnam, 2002; Kyle, 2005). Paradoxically, the inability to secure safe, affordable housing is an obstacle to remaining sober (Corporation for Supportive Housing, 2012), thus revealing a cyclical problem. First, there is a nationwide shortage of decent affordable housing stock. Second, the disorganized behavior that often accompanies substance dependence affects employability, which in turn affects credit and rental histories, making such prospective renters less attractive to landlords. Such stressors leave these individuals vulnerable to relapse and a prolonged, debilitating cycle of poverty and homelessness.

Literature Review

The debilitating reality of homelessness creates significant costs to society—both in the breakdown of families and communities, as well as a fiscal burden (Miller & Weisner, 2002; Ray & Ksir, 2004). It is estimated that the segment of homeless people in U.S. society represents 18% of the population; yet, these unstably housed individuals and families consume more than half the resources devoted to addressing homelessness (Culhane & Byrne, 2010; NAEH, 2012). Findings from a study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA, 1999) show that 70% to 90% of the cases requiring placement of children in foster homes are linked to birth parents' disruptive substance use and dependence. These challenging caseloads can cost approximately \$10 billion dollars. The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism commissioned a report to study the economic impact of drugs and alcohol abuse (National Institute on Drug Abuse [NIDA], 2012). Findings from that study reported an estimated \$24 billion was spent on drug and drug-related crimes through our criminal justice system. Low-income individuals who are battling addictions and/or coping with chronic physical or mental illness need additional supports to help lift them out of chronic homelessness (Cohen, 2001; Kyle, 2005).

Supportive Housing as a Solution

Simply securing a roof overhead is not an adequate solution for a chronically homeless individual. Low-income adults coping with recovery from substance addiction need additional environmental supports such as housing, employment, and continued social services to promote ongoing sobriety, self-sufficiency, and stable housing (Booth et al., 2002; Pearson, Montgomery, & Locke, 2009; Schumacher, Mennemeyer, Milby, Wallace, & Nolan, 2002; Tosi, 2005). Access to these resources has been shown to prolong sobriety and re-integrate people back into mainstream society, which helps break the cycle of chronic homeless (Culhane, Metraux, & Hadley, 2002; Martinez & Burt, 2006).

Supportive housing combines decent, affordable housing with access to on-site social services and helps individuals learn to employ effective coping skills while dealing with external challenges that impede management of complex addiction and health-related conditions (Rog, 2004). While philosophical approaches to care and program structures/ activities may vary, supportive housing communities collectively seek to maximize self-sufficiency and enhance the quality of life for its residents (Corporation for Supportive Housing, 2012). Two main components of supportive housing programs are the provision of affordable housing and social support (CSH, 2012).

Affordable Housing

Residential facilities of supportive housing can vary from shared room, dormitory-style units to single room occupancy (SRO) units intended for housing a single adult to traditional rental

apartments for accommodating heads-of-households with dependent children (CSH, 2012). Developments that feature these dormitory-style or SRO units provide community kitchens, bathrooms, and living areas that residents share. Standards established by the Department of Housing and Urban Development (HUD) define rent as affordable if it consumes no more than 30% of household income (HUD, 2012). Low- to no-income households can become tenants in supportive housing by using government-funded rental subsidies that allow rents to be determined by household income.

Social Support

Staff and peers are considered important resources in supportive housing because they broaden social support networks for residents (Hannigan & Wagner, 2003). Paid employees and volunteers provide professional assistance, daily case management support, individual/group counseling, crisis management, and political advocacy. Peer support is valuable because such assistance helps strengthen self-help skills.

In addition to these two main components, effective supportive housing establishes expectations for resident behavior, implements interventions that help people change, coordinates continuity between on-site and community-based services, promotes community building and peer support strategies, offers relapse prevention services, and manages dually-diagnosed resident concerns (Hannigan & Wagner, 2003). Previous research has investigated effectiveness of supportive housing programs. For example, in a four-year study conducted by the U.S. Department of Health and Human Services (the 1994 “McKinney Report”), 85% of the formerly homeless mentally ill tenants living in supportive housing continued in residence and became valuable members of the community.

Few studies examine the efficacy of supportive housing for individuals coping with addiction, and even fewer investigate housing as intervention for improving wellbeing. In one outcome study, Proscio (1998) found that graduates participating in substance-abuse interventions and residing in supportive housing programs remained abstinent from substances at a rate of 90%, compared to a 55% rate for graduates residing in other types of housing. A recent study (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005) compared outcomes of residents in two types of affordable housing settings. One dwelling was a supportive housing setting where abstinence was required to remain housed; in the other residential setting, residency was not contingent on sobriety. Residents in the abstinence-contingent housing showed a clinically significant difference in increased rates of abstinence and sobriety than did residents who lived in housing that did not require sobriety. Building from previous literature on the topic, the current study continues this inquiry of the critical interplay between supportive housing and wellbeing, particularly for low-income adults in recovery from substance addiction. Understanding the efficacy of supportive housing for this population makes a contribution toward efforts to reduce chronic homeless and preserve families and communities (Ray & Ksir, 2004).

Theoretical Framework

Ecological systems perspective provides a unifying framework to link key theoretical constructs from environmental and social psychology. Constructs, such as *experience of place* (Canter, 1977; Genereux, Ward, & Russell, 1995; Proshansky, Fabian, & Kaminoff, 1995) and *behavior- place association* (Canter, 1977; Genereux et al., 1995; Groat, 1995), appropriately frame an inquiry about the therapeutic benefits of living in supportive housing since individuals evaluate, adapt, and adjust behavior in response to program-infused residential environments. These constructs also explain transactional relationships between individuals and their residential environments, both the physical and social milieu, to better understand the role that *place* plays in affecting self-efficacy,

a critical aspect of individual well-being (Diener, 1984) and relapse prevention (Gossop, 2002; Marlatt & Gordon, 1985).

An individual's behavior is influenced either by conforming to pressures from the environment (adaptation) or by imposing changes on the environment causing it to conform to their needs (adjustment). Engaging in adaptive behaviors and making environmental adjustments minimizes negative experiences in the person-environment transaction (optimization; Tognoli, 1987). Consequently, a client's ability to cope using this adaptation/adjustment function in the environment determines the degree of the goodness-of-fit between the individual and the residential context. When one struggles to obtain this goodness-of-fit with the environment, an opportunity to intervene at the troubled interface opens. Supportive housing can be such an entry point for providing care and for building coping skills.

Coping requires management of internal (i.e., self-efficacy and perceived control) and external (i.e., social support) resources. Bandura (1977, 1997) describes self-efficacy as a belief that one is capable of producing the behavior required to achieve a desired outcome. The strength of an individual's self-efficacy regulates use of coping skills and resistance to high-risk crisis situations and relapse (Marlatt & Gordon, 1985; Moos & Moos, 2007). A key factor in determining how an individual will react to a given stimulus is an assessment of the degree to which that individual perceives the outcome is the result of his or her own behavior, or if the outcome results from forces outside of his or her control (Rotter, 1966). For adults coping with addiction and recovery, deficits in these internal or external resources may contribute to continued substance abuse and an inability to access interventions that provide vital social support.

Given the environmental context, there is a goodness-of-fit that supportive housing offers chronically homeless individuals. In particular, this type of housing provides essential environmental supports and resources such as affordable housing, job readiness and training, and childcare, which help mitigate the effects of the socioeconomic barriers attendant to poverty. Further, other supports such as counseling, case management, and crisis intervention are provided to reinforce use of newly learned behaviors for relapse prevention. Therefore, as a resource, supportive housing provides access to a therapeutic setting with individual-oriented interventions to help strengthen existing coping skills and reinforce empowering behaviors and abstinence.

Scholars from various disciplines in the social sciences have long studied the relationship between person-and-environment (Bell, Greene, Fisher, & Baum, 2001; Bonnes & Secchiaroli, 1995; Bronfenbrenner, 1979; Germain, 1979; Germain & Bloom, 1999; Meyer, 1983). However, very few academic studies have examined the efficacy of supportive housing with adults in recovery from substance addiction. Therefore, the purpose of this study was to increase the body of knowledge regarding the efficacy of supportive housing in promoting well-being by asking, when compared to individuals who do not live in supportive housing, are individuals who live in supportive housing likely to experience (a) longer periods of sobriety, (b) higher levels of self-efficacy and expectancy for success, and (c) higher rates of employment?

Methods

Approval for this study was obtained through the University of Georgia Institutional Review Board for research with human subjects. A correlational study was conducted to evaluate the outcomes from residency in supportive housing. To answer the research questions, the following hypotheses were tested: Hypothesis 1: Residents in recovery from addiction who live in supportive housing for three months or more will experience longer periods of sobriety than individuals in recovery who reside in housing without such supportive services. Hypothesis 2: Residents in recovery from addiction who live in supportive housing for three months or more will experience higher levels of self-efficacy than individuals in recovery who reside in housing without such supportive services. Hypothesis 3: Residents in recovery from addiction who live in supportive housing for

three months or more will experience higher rates of employment than individuals in recovery who reside in housing without such supportive residential services.

Sampling

Due to the specialized nature of the research topic, participants comprised a non-probability sample that was highly representative of the study population of low-income adults in recovery from addiction within the city of Atlanta based on data obtained from the Georgia Regional Commission on Homelessness. A purposive sampling technique was implemented, rather than a quota sampling technique, to obtain the necessary number of participants for each group (Aneshensel, 2002; Black, 1999). Eligible participants were chosen based on their length of sobriety (minimum three months) and their housing status (minimum three months in same housing situation).

As the researcher had no control over the nature, implementation, and duration of the intervention, an experimental method was not appropriate (Rubin & Babbie, 2001). Further, it was not feasible for the researcher to have access to subjects in order to conduct a pre-test of the participants before the intervention was implemented. Finally, the specific nature of the sample population, more aptly regarded as a non-probability sample, precluded the ability to make random assignments of subjects to a control group, thereby removing a critical criterion in conducting an experimental study (Rubin & Babbie, 2001).

The actual sample size was $N = 103$. Based on a significance level of .05 for two-tailed testing, the numbers of subjects for each comparison group were Group One-Remington House ($n = 35$), Group Two-Darmouth House ($n = 35$), and Group Three-Non-Supportive Housing ($n = 33$).

Data Collection

For participant recruitment, flyers were created describing terms of eligibility, available interview dates, and a contact number to schedule an appointment. To solicit participants for Groups One and Two, flyers were provided to staff at both Remington House and Darmouth House to distribute among participants that met criteria for length of sobriety and residency. Group Three participants were recruited by circulating flyers at various self-help groups in the metropolitan Atlanta area.

All participants signed informed consent forms and were given a \$15 gift card upon completion of the survey. They were advised that personally identifying information would be kept separate from responses. Participants completed three instruments: A confidential questionnaire developed by the researcher to obtain demographic information and housing/addiction histories,¹ the revised generalized expectancy for success scale (GESS-R) scale, and the drug taking confidence scale (DTCQ-8). Although neither the GESS-R nor the DTCQ-8 scales have been normed using comparable populations, both scales revealed high internal consistency and reliability, alpha coefficients ($>.80$) in previous studies (Fischer & Corcoran, 2007; Hale, Fiedler, & Cochran, 1992; Sklar & Turner, 1999). Analysis of the questions used in both the GESS-R and the DTCQ-8 revealed minimal cultural or racial bias concerns.

Instruments

Supportive Housing

Since the study did not analyze specific program components, supportive housing, the independent variable, was operationalized by identifying housing status and duration of residence.

Sobriety

Between-group differences in duration of sobriety were examined. Further analysis was also conducted to identify any association between the duration of residency in supportive housing and the duration of sobriety.

Self-Efficacy

Self-efficacy was measured by observing between-group differences in the mean scores of the GESS-R and DTCQ-8. Originally designed by Bobbi Fibel and W. Daniel Hale, the GESS-R was used to measure the participants' sense of efficacy regarding mastery of their environment. The 25-item GESS-R primarily measures three aspects of generalized expectancy: General efficacy, long-range career-oriented expectancy, and personal problem-solving (Fischer & Corcoran, 2007). Five filler questions were removed from the original 30-item GESS-R scale to make the scale appropriate for a broader population sample. The scale is scored additively. The authors contend that the higher the score, the higher the level of efficacy and sense of personal control (Hale, Fiedler, & Cochran, 1992). The eight-item DTCQ-8 was derived from an original 50-item version. This instrument was used to determine levels of efficacy among the sample population regarding individual resistance to relapse between the groups. Given Bandura's (1977) theoretical assertion that personal expectations of mastery can determine behavioral change and individuals' levels of expectations regarding self-efficacy changes over time in response to personal experiences or environmental factors, the DTCQ-8 scale helped discover if there was a between-group difference in higher levels of efficacy that could be associated with duration of residency in supportive housing.

Employment

The third dependent variable is employment. Data were examined to determine whether participants were employed or not and if there were any discernable between-group difference in the rate of employment between groups.

RESULTS

Sample Descriptions

Of the sample ($N = 103$), 92 were African American (89%) and 11 were Caucasian (11%). Seventy-six were male (74%) and 27 were female (26%). Of the 103 participants, 43 (42%) reported their income source as employment; 79 (77%) reported an income at or below \$12,000 per year; 43 (42%) reported an income at or below \$6,000 per year (see Table 1). Fifty-five (53%) participants report a history of polysubstance addiction, with crack and alcohol being the most frequently used substances. The mean duration of sobriety for all participants was 13 months. Ninety-three (90%) of all participants were residents of their housing between 3–18 months. Data on education levels indicate that 63 (61%) of all participants earned at least a high school diploma or equivalent and 31 (30%) of participants reported having attended college.

Group One

Thirty-five participants were residents of Remington House SRO located in downtown Atlanta. These participants were leaseholders at this apartment complex and paid rent based on their household income each month. Among this group, 25 (71%) of the participants lived at Remington House between 3–18 months. Their mean length of sobriety was 18 months. Among the Group

TABLE 1
Demographic Characteristics of Participants

Variable	Group One		Group Two		Group Three	
	Freq.	%	Freq.	%	Freq.	%
Age						
25–34 years	4	11.4	1	2.9	1	3.0
35–44 years	9	25.7	11	31.4	22	66.7
45–54 years	12	34.3	19	54.3	8	24.2
55–64 years	10	28.6	4	11.4	1	3.0
Total	35	100.0	35	100.0	32*	97.0*
Race						
Black/African American	31	88.6	32	91.0	29	88.0
Caucasian	4	11.4	3	9.0	4	12.0
Total	35	100.0	35	100.0	33	100.0
Employment status						
No	31	88.6	13	37.1	16	48.5
Yes	4	11.4	22	62.9	17	51.5
Total	35	100.0	35	100.0	33	100.0
Current income range						
\$0–\$500	21	60.0	9	25.7	14	42.4
\$501–\$1000	12	34.3	15	42.9	9	27.3
\$1001–\$1500	0	0	8	22.9	7	21.2
\$1501 or more	2	5.7	3	8.6	3	9.1
Total	35	100.0	35	100.0	33	100.0

*1 missing system = 3%.

One participants, 25 respondents stated that they had a disabling condition that prevented them from working. Parenthetically, 18 participants (51%) reported receiving Social Security benefits, such as Social Security Insurance (SSI), Social Security Disability Insurance (SSDI), and general assistance as their source of income. All participants had access to recovery and other supportive services from on-site staff of social workers and addiction counselors. Although there was 24-hour front desk security, residents at Remington House were free to leave and return to the facility without restrictions. Residents shared common spaces such as kitchens, TV lounges, and bath areas. As relapse is a part of recovery, tenants only lost eligibility housing if they refused to seek treatment after a relapse. Relapse was monitored through mandatory random drug screening.

Group Two

Thirty-five participants were residents of Darnmouth House located in downtown Atlanta. These participants lived in a transitional housing community where residency was at-will and member fees were paid weekly. Resident tenancy ranged from 3–18 months. Duration of sobriety in the sample averaged 14 months. Among Group Two participants, five (20%) respondents reported having a disabling condition that prevented them from working. Parenthetically, seven (14%) participants reported receiving Social Security benefits, such as SSI, SSDI, and general assistance as their source of income. Participants accessed recovery and other supportive services from the 13-member on-site staff of case managers and addiction counselors. Members of this housing facility were required to perform daily chores and adhere to a daily curfew, which was monitored by the 24-hour services staff. Members shared common spaces such as kitchens, TV lounges, and bath areas. Members also agreed to submit to random drug testing. Relapsing members were

terminated from the program in order to enter treatment. After treatment compliance, members were permitted to return to Darmouth House.

Group Three

Thirty-three participants in the study were comprised of individuals that did not live in supportive housing. Ninety percent of the participants lived in their housing situation between 3–18 months. Their average duration of sobriety was seven months. Among Group Three participants, 7 (21%) respondents reported having a disabling condition that prevented them from working. Five (15%) reported receiving Social Security benefits, such as SSI, SSDI, and general assistance as their source of income. None of the members of Group Three lived in housing that offered on-site staff or any services to assist with relapse prevention. All participants lived in various rental apartment communities around the metropolitan Atlanta area. The interviewer reported that 11 (33%) of the participants in this group lived in their own apartment; 22 (67%) lived with relatives or friends.

Supportive Housing on Sobriety

One-way ANOVA was employed to determine if there was a statistically significant group difference for duration of sobriety. Differences in duration of sobriety for participants were found to be statistically significant. The difference in means for duration of sobriety for Remington House participants ($n = 35$) was $M = 18.30$ ($SD = 17.04$), Darmouth House ($n = 35$) participants was $M = 14.10$ ($SD = 9.11$), and Group Three participants was $M = 7.39$ ($SD = 3.54$); $F = 7.80$, $p = .001$. Results of the Levene statistic to test homogeneity of variance was statistically significant at $p = .000$. However, since the group sizes were so close ($n = 35$, $n = 35$, and $n = 33$, respectively), the tests were robust to any marked violation of assumptions (Huck, 2004; Leech, Barrett, & Morgan, 2005).

Post hoc analysis was conducted to further explain why the null hypothesis was rejected. The Tukey HSD procedure revealed statistically significant differences for Remington House and Darmouth House when each were contrasted with the Non-Supportive Housing group. Further analysis to identify any association between the duration of residency and months of sobriety was conducted using the Pearson's r correlation. The findings from that analysis showed statistical significance of a positive association between sobriety and Remington House tenure and sobriety and Darmouth House tenure at $p < .05$. Of particular note was the correlational coefficient .620 for Remington House.

Supportive Housing on Self-Efficacy

Mean scores obtained for the GESS-R and two versions of DTCQ-8 (for alcohol use or substance use) were compared utilizing a One-way ANOVA for between-group differences when factoring housing type. Results of the analysis did not reveal statistically significant between-group differences in outcomes. Meaning, there was no statistically significant difference in supportive housing tenure and ratings of self-efficacy.

The GESS-R is scored additively; the highest possible score is 145. Higher scores indicate higher levels of efficacy and personal control. The difference in mean scores obtained through a One-way ANOVA procedure and Eta scores obtained for measure of association were as follows: Remington House (Group One) participants ($n = 35$) was $M = 126.5$, $SD = 26.81$, $F = .515$, $p = .762$, $\eta = .28$; Darmouth House (Group Two) participants ($n = 35$) was $M = 135.3$, $SD = 17.90$, $F = .147$, $p = .863$, $\eta = .09$; and Non-Supportive Housing (Group Three) participants ($n = 33$) was $M = 132.97$, $SD = 18.41$, $F = .943$, $p = .454$, $\eta = .34$. As indicated by the F-ratios,

there appears to be no statistically significant association between the duration of residency and the GESS-R for any group.

Two versions of the DTCQ-8 evaluated confidence in drug-taking resistance for both alcohol and drug of choice. Participants were tasked to fill out either or both versions based on their response to Question 11: “*What was your drug(s) of choice?*” Scores were obtained by summing responses and dividing by eight for the possible score of 100.

Alcohol Version

The difference in mean scores obtained through a One-way ANOVA procedure and Eta scores obtained for measures of association were as follows: Remington House (Group One) participants ($n = 28$) was $M = 67.10$, $SD = 31.89$, $F = 1.704$, $p = .176$; $\eta = .53$; Darmouth House (Group Two) participants ($n = 30$) was $M = 73.42$, $SD = 17.90$, $F = .065$, $p = .938$; $\eta = .07$; and Non-Supportive Housing (Group Three) participants was $M = 75.00$, $SD = 24.42$, $F = .452$, $p = .770$; $\eta = .35$. There was no statistical difference in the means on the alcohol version of the DTCQ-8 scale.

Drug Version

The difference in mean scores obtained through a One-way ANOVA procedure and Eta scores obtained for measure of association were as follows: Remington House (Group One) participants ($n = 29$) was $M = 65.82$, $SD = 31.89$, $F = .50$, $p = .774$; $\eta = .31$; Darmouth House (Group Two) participants ($n = 28$) was $M = 77.74$, $SD = 17.90$, $F = 1.08$, $p = .354$; $\eta = .28$; and Non-Supportive Housing (Group Three) participants ($n = 30$) was $M = 84.67$, $SD = 18.41$, $F = .21$, $p = .932$; $\eta = .17$. Although Group Three participants' scores were higher on this version of the DTCQ-8, findings from this analysis of association were not found to be statistically significant.

Supportive Housing on Employment

Employing the Chi-square statistical test revealed a significant difference ($p = .000$, $p < .05$) in means for housing type (nominal) and employment status (nominal). There were higher rates of employment at Darmouth House. However, further analysis using Eta statistics to measure the association of employment status (nominal) with length of residency (interval) did not reveal statistically significant results, $p < .05$.

Discussion

The purpose of this study was to evaluate supportive housing as an intervention for positively influencing sobriety, self-efficacy, and employment status among low-income adults. Participants identified as residents of supportive housing or non-supportive housing were divided into three groups. Groups One and Two represented two different types of supportive housing developments. Remington House (Group One) provided permanent housing with services. Darmouth House (Group Two) offered a time-limited transitional housing with services. Participants in Group Three lived in various non-supportive housing settings that included having leaseholder status in a rental apartment to living with friends or family.

Using behavior-place association as a framework, self-reports on sobriety, scores on efficacy scales and employment status were compared for these three groups to determine if there was a correlation between more favorable outcomes for those variables for participants living in

supportive housing. The first hypothesis (supportive housing and sobriety) was fully supported, the second hypothesis (supportive housing and self-efficacy) was not supported, and the findings for third hypothesis (supportive housing and employment) were partially supported.

Duration of sobriety among participants in Groups One and Two were found to be associated with duration of residency in supportive housing. This finding is very important because it helps to further validate the merit of using supportive housing to reduce chronic homelessness. The use of supportive housing as an intervention in reducing the rate of relapse among low-income adults in recovery helps reduce the recidivism back to homelessness that promotes chronic homelessness.

Self-efficacy was not statistically significant in the findings of this study. However, since there was limited historical data available regarding participants levels of self-efficacy prior to move-in, there is merit to conducting further study; especially since previous research establishes a relationship between self-efficacy and relapse prevention (Zhao, Li, Hanhui, Xu, Zhang, & Zhang, 2011).

Employment status was found to be significant, as is evident in Darmouth House elevated employment rates. This association likely reflects deliberate efforts typically made by supportive housing staff to improve employment outlook and engagement for residents (CSH, 2012; Hannigan & Wagner, 2003; LSRO, 2005; Proscio, 1998). Comparatively, there are a disproportionate number of individuals at Darmouth House who seek employment services, whereas Remington House residents typically receive Social Security benefits, such as SSI and SSDI.

This study contributes to the knowledge base of social work professionals and provides empirical support for micro and macro social work using evidence-based practice with chronically homeless populations, particularly adults in recovery. Social work professionals have an obligation to continue to evaluate practice, refine intervention strategies, and share best practices, thus acting as change agents seeking to impact the systems that affect the population they serve. Social work professionals that are currently working in supportive housing must be willing to sacrifice the extra time to evaluate their practice and share their knowledge. As professionals, social workers also have an obligation to stay alert to changes in policies and programs, and to advocate on local and national levels in response to policies that impact the client and the profession. Continued vigilance will help counter the systemic forces that compel practitioners to view vulnerable populations as universally bad or undeserving. Every human being deserves a chance to have basic needs met. Therefore, housing and social work are unavoidably linked, since optimum client functioning and well-being cannot be achieved without a roof overhead. Social workers recognize the critical interplay that exists between an individual's abilities and needs and the resources and supports provided by the environment. With this understanding social workers can play a pivotal role in the development of supported housing practices and policies (Cummings, 2002).

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