SUPPORTIVE HOUSING: ITS EFFICACY AS INTERVENTION

FOR LOW-INCOME ADULTS

COPING WITH SUBSTANCE ADDICTION RECOVERY

by

CAROL SARGENT COLLARD

(Under the Direction of Rufus E. Larkin)

ABSTRACT

Within the ranks of the homeless are individuals who are also coping with substance addiction recovery and/or chronic physical or mental disability. Their special needs often pose significant barriers to securing affordable housing and achieving the sense of self-efficacy necessary to sustain re-integration into society (Booth, Sullivan, Koegel, & Burnam, 2002; Breakey & Thompson, 1997; Kyle, 2005). For these individuals, simply securing a roof overhead may not be an adequate solution. Supportive housing combines affordable housing with access to on-site social services to assist persons coping with such special needs. Using theoretical constructs from environmental psychology that reinforce the ecological systems perspective, this study investigated whether an association could be found between length of residency in supportive housing and subjective well-being. For the purposes of this study, well-being was measured by length of sobriety, self-efficacy and employment status. The author compared outcomes from participants that were divided into three housing groups. The participants in two of the groups were residents of two distinct supportive housing developments. Their outcomes were compared to those of the third group comprised of residents from various

housing sites that do not offer any on-site services. One of the three hypotheses was fully supported. One hypothesis was partially supported and findings for the third were not found to be statistically significant. The findings are presented and discussed in the final chapters.

INDEX WORDS: Homelessness, Supportive housing, Addiction recovery, Well-being, Self-efficacy, Ecological perspective, Behavior-place association

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DEDICATION

First, I dedicate this effort to the memory of my mother, Ione Ifield, who graced me with a wonderful example of womanhood, integrity and compassion for others that has been the guiding force in my life.

I also dedicate this work to the countless individuals and families who know what it means to be homeless. I pray for the day when our nation realizes that access to decent affordable housing should be a right, not a privilege.

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Finally, to my sons, Brandon and Michael, I love you both very much. I hope my example will inspire you to never cheat yourself of pursuing your dreams.

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CHAPTER ONE

INTRODUCTION

Although it does not dominate current public discourse, the inability to appreciably impact the problem of homelessness persists as an important social concern (Bernstein, 2002; Hoch, 2000; NHLIC, 2007; NLCHP, 2007) in the United States. Within the ranks of the homeless are individuals who are also coping with substance addiction recovery and/or chronic physical or mental disability. Their special needs often pose significant barriers to securing affordable housing and achieving the sense of self-efficacy necessary to sustain re-integration into society (Booth, Sullivan, Koegel, & Burnam, 2002; Breakey & Thompson, 1997; Kyle, 2005). For these individuals, simply securing a roof overhead may not be an adequate solution. Supportive housing combines affordable housing with access to on-site social services to assist persons coping with such special needs. Scholars from various disciplines in the social sciences have long studied the relationship between person-and-environment (Bell, Greene, Fisher, & Baum, 1996; Bonnes & Secchiaroli, 1995; Bronfenbrenner, 1979; Germain, 1979; Germain & Bloom, 1999; Meyer, 1983). However, there are very few academic studies that have examined the efficacy of supportive housing specifically with adults in recovery from substance addiction. Using theoretical constructs from environmental psychology that reinforce the ecological systems perspective, this study investigated whether an association could be found between length of residency in supportive housing and subjective well-being.

Causes of Homelessness

The economic segregation typical of many communities across the country reinforces inequality among rich and poor (Corcoran, 1995; Dreier, Mollenkopf, & Swanstrom, 2004; Epps, 2002; Freedman, 1969; Gans, 1995; Rosenbaum, Reynolds, & Deluca, 2002; Wilson, 1987). For the individuals and families currently living in areas of concentrated poverty, the ability to rise out of their circumstance has become increasingly difficult (Corcoran, 1995; Corcoran & Chaudry, 1997; Rank, 2005; Wilson, 1987). Access to the necessary resources that help lift one out of poverty, specifically, the environmental supports considered normative to a healthy neighborhood, such as decent housing, good schools, employment and social opportunities, adequate medical care, police and fire protection, and other basic services, are severely compromised. For many, living in poverty has even more severe consequences when access to the fundamental need for shelter is compromised. Mark Robert Rank (2005) stated in *One Nation, Underprivileged:*

> The proliferation of low-wage work, the private sector's failure to build an adequate supply of lower-end housing units and the federal government's decreasing expenditures on programs designed to address the housing needs of low-income families have made affordable housing even scarcer over the last two decades (p.215).

Although there are a number of reasons why someone can become homeless, the dramatic rise of homelessness over the last two decades can be linked to the decreasing availability of affordable housing (Kyle, 2005). That shortage not only accelerates the descent into the ranks of homelessness, it also often impedes the ability to rise out of it. A number of housing advocates cite the affordable housing crisis as a violation of human rights ("Is having a home a right?," 2004). Indeed, the challenge of reducing homelessness is becoming a bigger

international problem throughout other industrialized nations (Anderson & Christian, 2003; Busch-Geertsema, 2004; Elsinga, 2004; "Is having a home a right?" 2004).

The judgmental and moralistic regard that our society demonstrates toward its poor is evidenced in our inability to effectively address the lack of affordable housing and homelessness in this country (Ewalt, 1994; Gans, 1995; Okundaye, 1999; Wilson, 1987). According to the National Law Center for Homelessness and Poverty (2007), there are an estimated three million citizens experiencing homelessness in America. Approximately 50% are African American, 35% Caucasian, and 12% Hispanic. An estimated 30% are believed drug or alcohol dependent (NLCHP, 2007); and 23% are believed to be coping with mental illness. Approximately 40% are families with children. Although millions have been spent to provide temporary shelter, there seems to be little evidence that the problem of homelessness will ever be eradicated (Jensen, 2004; Kyle, 2005; "More Homeless, Less Housing," 2005).

According to recent housing data released by the Department of Housing and Urban Development (HUD), the number of low-income renters needing affordable housing exceeds the supply of low-cost units by more than five million (NHLIC, 2007). The waiting lists for households that qualify for Section 8 rental or public housing subsidy programs is upwards of two years in many major metropolitan areas. The options for many of the households who wait are long-term stay hotels, substandard dwellings, overcrowded housing situations with friends or kin, or temporary shelters. The National Low Income Housing Coalition's *Out of Reach* report (2007) gave this assessment:

> While the national two-bedroom housing wage stands at $16.31, in 2005, the most recent year for which data are available, the median hourly wage for all workers was $14 and the estimated average renter wage was $12.64. The problem is particularly stark for the

> lowest wage earners, including those who earn just the minimum wage, even in states that have higher minimum wages than the federal minimum wage, which has been stalled at $5.15 since 1997. Minimum wage earners are unable to afford even a one-bedroom home anywhere in the country, and 88% of renters in cities live in areas where the [Fair Market Rent] for a two-bedroom rental is not affordable even with two minimum wage jobs.

In an attempt to understand and tackle this complex issue, homelessness has been approached by identifying subgroups, such as the mentally ill and substance users, in order to direct services appropriate for their specialized needs (Kyle, 2005; NLCHP, 2007). Cohen (2001) argued that creating subgroups dilutes the effort to solve the overriding cause of homelessness – the lack of decent affordable housing.

While evidence does show that the lack of affordable housing is a critical component of the problem of homelessness, for some individuals, housing alone will not completely address the issues that persistently put them at risk for life on the margins. Those 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 poverty (M. B. Cohen, 2001; CSH, 2005; Proscio, 1998, 2001). This segment of the homeless population, those coping with substance addiction and/or a disabling physical or mental condition, represent what is considered the chronically homeless (Kyle, 2005; NLCHP, 2007). It is estimated that this segment, representing 10% of the population, consumes more than half the resources devoted to resolving homelessness (CSH, 2007; Kuhn & Culhane, 1998).

In the realm of addiction alone, the costs to society are tremendous – both in the breakdown of families and communities, as well as the fiscal burden (Miller & Weisner, 2002; Ray & Ksir, 2004). The 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 the birth parents disruptive substance use and/or dependence. That caseload represents a system operating cost of approximately $10 billion dollars. The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism commissioned a report by the Lewin group in 1992 to study the economic impact of drugs and alcohol abuse (NIDA, 1995). Their findings show that an estimated $24 billion was expended through our criminal justice system for drug and drug-related crime.

Substance dependency and poverty have been linked in various research studies (Blumenthal & Kagen, 2002; Booth et al., 2002; Israel, 1998; Okundaye, 1999). Arguments have been waged and validated that the stress of chronic poverty is a risk factor for substance abuse and dependence. Equally valid is the argument that substance dependency can lead to poverty. In either circumstance, once substance abuse is a factor, it can rarely be addressed in isolation from economic status (Booth et al., 2002). Jobs, housing, and other supportive services must be a part of a comprehensive care strategy.

Statement of the Problem

Low-income adults coping with recovery from substance addiction need additional environmental supports such as housing, employment and continuing social services to help them maintain sobriety, progress toward self-sufficiency, and avoid the cycle of chronic homelessness (Booth et al., 2002; CASA, 1999; Marlatt & Gordon, 1985; McKay et al., 2005; Miller & Weisner, 2002; Schumacher, Mennemeyer, Milby, Wallace, & Nolan, 2002; Tosi, 2005). However as has been established, the availability of such resources is in significantly limited supply. Their ability to gain access to these resources has been shown to help prolong

sobriety and re-integrate them into mainstream society, which will in turn, help reduce the ranks of the chronically homeless (CSH, 2007).

For low-income households coping with recovery from substance addiction, the ability to secure safe, affordable housing can be a serious obstacle to maintaining recovery (Hirsch, 2001). It is often a two-fold problem. First, as previously established, there is a nationwide shortage of decent affordable housing stock. Second, the disorganized behavior that often accompanies substance dependence can affect 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 the prolonged, debilitating cycle of poverty.

In the last two decades, efforts have been made to create specialized housing to serve these individuals that combines a decent, affordable place to live with social services that assist the individual with learning and/or reinforcing coping skills to deal with the external challenges that would impede success. Such housing is called supportive housing. While philosophical approaches to care and program structure and activities may vary, collectively supportive housing communities seek to maximize self-sufficiency and enhance the quality of life for its residents (CSH, 2007). The two components common to all supportive housing programs are the provision of *housing* and *social support* (CSH, 2007).

Housing: Types of housing varies from shared room, dormitory-style units and single room occupancy (SRO) units intended to house a single adult to traditional rental apartments that can accommodate heads-of-households with dependent children (CSH, 2007). Supportive housing developments that feature dormitory-style or SRO units provide common kitchens, bathrooms and living areas that residents share. The standards established by the Department of Housing and Urban Development define rent as affordable if it consumes no higher than 30% of

household income (HUD, 2004). Low- or no-income households can become tenants in supportive housing using rental subsidies that allow rents to be based on household income.

Social Support: Using staff and peers as resources, supportive housing broadens the network of social support for all residents (Hannigan & Wagner, 2003). Staff provides professional assistance and daily supports such as case management, individual or group counseling, benefits advocacy, and assistance during crises. Crisis intervention may range from assisting a resident with a bus token to get to a job interview or medical appointment to securing emergency medical or psychiatric services. Peer support also becomes valuable as the mutual aid helps to strengthen self-help skills (White, 2004).

In addition to these core components, effective supportive housing establishes expectations for behavior, uses interventions that help people to change, ensures coordination and continuity between on-site and community-based services, promotes community building and peer support strategies, offers relapse prevention services, and addresses issues of residents with dual-diagnoses (Hannigan & Wagner, 2003).

According to the Corporation for Supportive Housing (2007), supportive housing has emerged over the last twenty five years as a critical housing option for low-income individuals and families who are homeless or at risk of homelessness and are coping with special needs issues such as substance abuse, or chronic mental or physical illness. However, like all affordable housing, there isn't sufficient supply to meet the demand. Further, individuals with such special needs still experience stigma which further complicates the efforts to create more of such housing.

Purpose of the Study

The purpose of this study was to increase the body of knowledge regarding the efficacy of supportive housing. Specifically, to examine whether time spent living in supportive housing would enhance well-being among individuals in recovery from substance addiction. Anchored in an ecological systems perspective, 'behavior-place association', a theoretical construct introduced in environmental psychology (Genereux, Ward, & Russell, 1995), was used to explain the process in which individuals evaluate, adapt and adjust behavior in response to their environments, specifically, their home and community. Studies have shown that environments can positively or negatively influence the development and/or retention of new cognitive schemata needed to reinforce sobriety (Marlatt & Gordon, 1985; Proscio, 1998). One's ability to achieve a 'goodness-of-fit' with their environment can enhance or inhibit one's sense of efficacy (Germain & Bloom, 1999) in this domain.

The availability of supportive housing for formerly homeless individuals in recovery as well as those with mental health concerns has been shown to reduce the burden on other systems such as hospitals, jails, mental health and other institutions, thus reducing overall societal costs of care (C. Cohen & Phillips, 1997; Proscio, 1998, 2001). In addition, there is evidence that residents of supportive housing are more likely to experience longer periods of sobriety compared to national norms, better cope with mental illness, and become active participants in the workforce (Proscio, 1998). Although limited in number, there are studies that do cite evidence of success with supportive housing. Much of that research as noted above emphasizes cost-benefit analyses. Other research that has focused on the efficacy of supportive housing has largely been targeted to those serving elderly adults or people with developmental or cognitive

disabilities (Casper & Clark, 2004; Cummings, 2002; Dorvil, Morin, Beaulieu, & Robert, 2005; Newcomer, Kang, Kaye, & LaPlante, 2002; Raymond, 2000).

The study sought to answer the following research questions:

1. Does a supportive housing environment positively affect outcomes among low-income individuals in recovery from addiction?

Specifically, when compared to individuals who do not live in supportive housing:

2. Are individuals who live in supportive housing likely to experience longer periods of sobriety?
3. Are individuals who live in supportive housing likely to experience higher levels of self-efficacy and expectancy for success?
4. Are individuals who live in supportive housing more likely to experience higher rates of employment?

This study examined the outcomes of 103 low-income adults in recovery from drug and/or alcohol addiction. The sample (*N*=103) was predominantly African American (89%) and male (74%). Of the 103 participants, 77% reported an income at or below $12,000 per year. The median duration of sobriety for all participants was 13 months. The median range of duration of residency was 6-12 months. The participants were differentiated as residents in three distinct housing groups described as follows.

Group One (n=35) were residents of Welcome House SRO apartments. Welcome House is a 209-unit permanent supportive housing community that serves single, low-income adults. Fifty of the units are rent-subsidized by the Shelter Plus Care program created by HUD and are reserved for formerly homeless adult men and women who are coping with one or a combination of substance addiction recovery, a disabling physical condition such as HIV/AIDS, or a

diagnosable mental illness. Shelter Plus Care residents are expected to access on-site services which includes case management, individual and group counseling and crisis intervention. Services staff is on-site Monday through Friday from 9a.m. until 8 p.m. Residents are leaseholders which affords them a level of autonomy in managing their households. They must, however, comply with random drug screening.

Group Two (n=35) were residents of Hope House. A 70-bed transitional facility, Hope House serves formerly homeless adult males coping with substance addiction recovery. The staff reports that approximately 15% of the residents have a co-occurring disorder. Residents are required to participate in a structured program of services including case management, individual and group counseling, and crisis intervention to assist them with their recovery process. Services staff is available 24 hours a day, year-round. Hope House residents are program members, not tenants so therefore their tenure as residents is solely based on their compliance with program regulations and their abstinence which is monitored through random drug screening.

Welcome House SRO and Hope House are two supportive housing developments in downtown Atlanta, Georgia that were developed and currently owned by Progressive Redevelopment, Inc. (PRI), a nonprofit affordable housing developer. The researcher is employed by CaringWorks, Inc., the social service agency that provides on-site services at both properties.

Group Three (n=33) was comprised of low-income adults in substance addiction recovery living in various housing settings that included living in their own apartment (33%) to living with friends or relatives (67%) in Atlanta, Georgia. None of these housing arrangements are accompanied by any on-site supportive services. Going forward, this group will be referred to as Group Three or the Non-Supportive Housing group.

Significance of the Study

As mentioned previously, research in the area of supportive housing as a means for reducing homelessness is primarily focused on cost-benefit analyses (CSH, 2007). However this research examined the efficacy of supportive housing for impacting individual well-being. This study contributes to the profession of social work in the areas of practice, policy and research. Many social work professionals encounter clients who are either coping with or who have been impacted in some way by addiction and its related problems. It should prove valuable to have an understanding of the environmental supports, such as supportive housing, that can be a vital resource helping to promote relapse prevention for more economically fragile clients.

Supportive housing also gives evidence to the historical link between housing and social work. Harkening back to the days of Hull House, social workers continue to be actively involved in helping vulnerable citizens by integrating housing with social services. As more studies are conducted that demonstrate positive outcomes for residents of supportive housing, social work professionals must then take a more active role in advocating for more of such housing to help meet client needs.

Both policymakers and practitioners will benefit from a better understanding of the efficacy of supportive housing in prolonging sobriety and helping households to stabilize and reduce need for outside subsidy, which ultimately has its own reward in reduced need for services and thus long-term reduced costs. It is also hoped that society will benefit from increased understanding of the role that supportive housing can play in helping to reduce the ranks of the chronically homeless while allowing men and women to live in dignity.

The following chapter offers an extensive review of the literature on housing policy and its intersection with poverty and addiction. It is an important review as it provides context for

understanding how public policy shapes the type and availability of environmental supports or interventions, such as housing, for the poor. The literature review also presents findings in the causes of addiction, recommended treatment options' and how housing interventions contribute or inhibit the successful extension of the benefits of those options for low-income adults.

CHAPTER TWO

A REVIEW OF THE LITERATURE

The purpose of this review is to survey the body of literature that informed the basic questions of the study. This review is divided into three sections. The first section examines the macro level forces or policies that influence both the availability and quality of housing for low-income households, particularly those with special needs such as substance addiction. The second section examines literature on addiction, particularly as it pertains to the role of environmental mastery and self-efficacy in relapse prevention among low-income adults. The third section reviews literature on the relationship between the environment, most notably, supportive housing and well-being.

Poverty, Homelessness and Public Policy

The democratic values of American society are based on equality of opportunity and the achievement of success based on merit. Americans pride themselves on being part of a classless society. However, over the last quarter century, the literature suggests that the disparity between rich and poor has become more pronounced and it has become increasingly difficult for poor people to move up the economic ladder (Corcoran, 1995; Dreier et al., 2004; Ewalt, 1994; Freedman, 1969; Gans, 1995; NLCHP, 2007; O'Connor, 2000; Rank, 2005; Wilson, 1987). Social, political and economic forces have contributed to persistent, intergenerational poverty (M. B. Cohen, 2001; Popple & Leighninger, 1999) from which escape is infrequently achieved. Understanding the context in which these macro forces have evolved is vital to understanding how long-term poverty can be made acceptable to society. Jarmon (1997) wrote:

> In the current electoral climate, we can observe political leaders engaged in a power struggle over the decisions related to welfare reform, and much of the fight revolves around the fundamental definitions and symbolic assertions about the poor (p.127).

Rather than recognizing the principal role that the inequities in our economic structure play in perpetuating poverty, the blame is largely placed on the victim. According to Rank (2005):

> The causes of poverty have been routinely reduced to individual inadequacies, and the impact of such poverty has been localized to individual's household or perhaps the immediate neighborhood. This viewpoint has helped to maintain the status quo of severe economic deprivation in America, and, perhaps worse, to justify rolling back the protections provided by a safety net and other social programs (p.11).

Ideology and religion shape the values that dictate how the poor are perceived and how – and whether – services are provided. These values and the resulting policies have their historical roots in the English Poor Relief Laws (Garr, 1995; Isay & Abramson, 2000; Kyle, 2005; Leonard, 1965) that date back as early as the fourteenth century. Vagrants, as the homeless were then described, were to be punished. The establishment of poor laws reflected an initial acceptance of responsibility on the part of government to give aid to the poor and helpless among us. How the poor were viewed had a distinctly moral tone that did not take into account how social, political or other environmental factors could be contributing to their susceptibility (Kyle, 2005) to poverty. These laws, and subsequently, the laws that the United States created, were imbued with the notion that a distinction should be made between a deserving and undeserving poor (Abbott, 1936; Kyle, 2005; Schneider, 1986).

History of Housing the Vulnerable Poor

The majority of the housing and other assistance the poor received came from religious and charitable institutions (Abbott, 1936; Berson, 2004). Alms-houses were opened and served both the 'deserving' and 'undeserving' (Siegal, 1986). However, as Germain (1979) theorized, the conditions of the housing designated for the indigent were intended to be substandard in order to discourage dependence (Kyle, 2005; Siegal, 1986). The 'deserving' poor, of course, suffered along with the 'undeserving' as there were limited means and apparently little inclination to make the effort to distinguish among them.

Similar examples of how our collective attitudes toward the poor can influence and be reflected in the deplorable physical environments are evidenced in the "skid-row" neighborhoods and tenements of the early twentieth century (Siegal, 1986). The "flops" on skid row were the primary housing option in northern cities such as New York and Chicago for single homeless adults, primarily men at this time. The tenements as described in Edith Abbott's (1936) text, *The Tenements of Chicago: 1908-1935,* gave destitute families a similarly harsh refuge. Through the Hull House which opened in the late 1800s, Jane Addams, Edith Abbott, Ellen Gates Starr and others lived in the community along with their poor neighbors and clients and worked tirelessly to alleviate some of the demoralizing effects of poverty by providing health care, child care, vocational and other social services (Isay & Abramson, 2000; Siegal, 1986). Berson (2004) described the work of Addams, Abbott and their activist colleagues as follows:

> The activists in the settlement movement saw themselves as distinct from earlier traditions of Christian charity, which frequently dispensed largesse even while it held the impoverished individual somehow morally responsible for his failures; it tried to hold the

> poor to strict character and behavioral standards that many of the charitable could not or would not meet (p.67).

Flop houses and single-room occupancy hotels, or SROs as they were more commonly called (Siegal, 1986) provided low-cost housing primarily to indigent single adult men. Frequently segregated to isolated parts of the city and often found in ill repair, they were examples of the continued collective decision to regard the individuals occupying the dwellings as among the undeserving. In fact, SROs did attract the criminal element and addicts, but it was also one of few affordable housing options for the indigent mentally ill, and those down on their luck (Kyle, 2005; Siegal, 1986).

As a precursor to the supportive housing developments of today, case workers and probation officers would use SROs to house their clients as background information such as rental, credit or criminal history was rarely checked (Siegal, 1986), but unlike contemporary supportive housing, services were not consistently available on-site (CSH, 2007). Case managers would come to the property occasionally to check on clients but did not have an office on premises. Siegal's text (1986) cited a description of the SRO population excerpted from a report published jointly in 1969 by the Columbia University Urban Center and St. Luke's Hospital Center's Division of Community Psychiatry:

> We see that nonwhites are strongly overrepresented in this population. A majority of the S.R.O. population in New York is black…In the population, reports of mental hospitalization(s) or extensive psychiatric treatment are so common that little question or stigma is attached to mental illness in the S.R.O. world. Other indicators of mental difficulties seem to abound as well: alcohol abuse is very common. The social workers

> attached to the St. Luke's project projected that some 90 percent of their case loads, that is, people in the hotels, had some sort of problem with alcohol (p.239).

The SROs, located primarily in New York and Chicago were considered blights on the face of humanity. Desperate, far removed places for those society had just as soon forget (Isay & Abramson, 2000). Society once again had failed to recognize and take responsibility for the role its perceptions of and attitudes toward the poor, and particularly poor minorities, played in how they arrived in their desolate condition (Gans, 1995; Harrington, 1981; Wilson, 1987). Originally written in 1962, Michael Harrington's landmark book, *The Other America* (1981), described the self-fulfilling, cyclical pattern of racism and poverty thusly:

> White America keeps the Negro down. It forces him into a slum; it keeps him in the dirtiest and lowest-paying jobs. Having imposed this indignity, the white man theorizes about it. He does not see it as the tragic work of his own hands, and as a social product. Rather, the racial ghetto reflects the 'natural' character of the Negro: lazy, shiftless, irresponsible, and so on. So prejudice becomes self-justifying. It creates miserable conditions and then cites them as a rationale for inaction and complacency (p.82).

In our contemporary poverty discourse, little has changed about the way the poor, and indirectly poor blacks, are viewed. The likes of Charles Murray and James Q. Wilson have persuasively theorized that support such as welfare should be eliminated because it changes the values, attitudes, and behaviors of the poor, thereby trapping them into dependency and prolonged poverty (Corcoran & Chaudry, 1997). Using symbolic language, negative stereotypes have been generated (Corcoran, 1995; Gans, 1995; Jarmon, 1997) to stigmatize and reinforce the perception of an 'undeserving' poor. Poverty is politicized by race – and 'urban' has become the code word for 'black.' Gans (1995) asserts that terms such as 'welfare queens,' 'underclass,' and

'culture of poverty' serve to segregate and imply behavioral and moral deficiencies on the part of the poor. Although the buzzwords have changed, the tactic and end result is the same as it has been for decades.

Supportive Housing as Policy

Although there have always been people who have been homeless, the explosion of homelessness in contemporary American society began in the late 1970s and 1980s. The rise in the number of people displaced was exacerbated by the Reagan Administration's dismantling of funding for federal and state run mental health institutions and changes in tax laws which resulted in disincentives for investors to create or preserve affordable housing (Basolo & Hastings, 2003; Galster, Pettit, Santiago, & Tatian, 2002). Over the next two decades, flophouses and SROs all but disappeared to make way for luxury lofts and condos (Basolo & Hastings, 2003; Galster et al., 2002; Tucker, 1990). The destruction of the flophouses and SROs and the closing of mental hospitals left those struggling with addiction and mental health issues with few housing options.

During the late 1970s and early 1980s, social service agencies, charitable and religious organizations, and concerned individuals used private resources to provide services to the residents of the remaining SROs, while the number of emergency shelters increased to accommodate the growing problem of homelessness (Galster et al., 2002). What few supportive housing developments that did exist were funded by local governments and philanthropic organizations. However, there was no unified response to the crisis of homelessness from the federal government until the late 1980s.

The McKinney-Vento Act

In an attempt to address the plight of homeless citizens, the federal government implemented landmark legislation, The Stewart B. McKinney Act of 1987 (Hoch, 2000). The McKinney Act, included the establishment and/or extension of over 20 different programs and initiatives under the supervision of seven different federal agencies, including HUD, Health and Human Services (HHS), and the Department of Labor. Despite many modifications over the years, the legislation now currently called the McKinney-Vento Act, provides funding for various programs that tackle housing affordability and social services. The White House Interagency Council, which was formed as a result of this legislation, oversees all operations of relevant services and programs for the homelessness that are carried out by the related agencies.

The Interagency Council implemented an overarching Continuum of Care program that links emergency shelters, transitional housing and permanent housing and related social services targeted for citizens who are homeless (Hoch, 2000). Guided by the objectives of the Continuum of Care, and its accompanying funding resources, nonprofit developers, and state and local governments have created scores of supportive housing developments across the country (LSRO, 2005). Some have as few as 20 units, others offering more than 600 (Ground, 2005). Most are located within the city limits in downtown and commercial areas (CGC, 2005; CSH, 2005).

NIMBY: Contemporary Resistance

Although it has been established that there are benefits to society for decentralizing poverty (Ewalt, 1994; Galster & Santiago, 2006; Rosenbaum et al., 2002), there is still resistance to the concept of housing special needs households in suburban areas, a concept known as "Not In My Back Yard" or NIMBY (Proscio, 1998). NIMBYism represents an important and current

example of the continued distrust of and need for distance from the poor. Basolo and Hastings (2003) describe the phenomenon as follows:

> NIMBYism typically is a rejection of a type of land use, such as affordable housing, motivated by individuals' underlying beliefs. For example, residents may believe affordable housing would have negative effects on the community, such as social changes, unwanted increases in density, and reduced property values (p. 454).

Not only are the residents of supportive housing, low-income individuals, as previously indicated, they often are coping with one or more special needs. That combination creates an additional stigma that is often impossible to overcome. Public outcry has manifested itself in zoning restrictions to limit access and ensure that certain residential communities are relieved of their obligation to provide such housing (Basolo & Hastings, 2003; Galster et al., 2002; Tucker, 1990).

In fairness to those who fear the consequences of having members of this community near their home and their families, it is a valid concern. Like the flophouses of old, a housing development targeting the mentally ill or substance-dependent individuals could prove deleterious to a community if the management and services staff are negligent in their duties to adequately maintain the property and to enforce occupancy regulations. In truth, the real injustice in this type of neglect is inflicted on the residents who simply seek decent shelter.

Supportive housing projects that do succeed in overcoming the NIMBY barrier to development are often smaller in size, posing less of a 'threat' to the community (Galster et al., 2002). They also have shown that they are committed to good property management principles and that the services staff is experienced in conducting the proper intake and assessment to

determine the potential resident's ability to live independently. More often than not, the failure to do so can mean the difference between success and failure for the next project.

Early Successful Models of Supportive Housing

Notable among the earlier entries in the supportive housing community are examples of what can happen when such housing is thoughtfully planned by all community stakeholders. They are Lakefront SRO (LSRO) in Chicago and The Times Square in New York.

Lakefront SRO was established in 1985 by a group of homeless advocates and shelter providers in the Chicago Uptown neighborhood. By rehabilitating ten abandoned buildings, the organization created housing for nearly 1,000 single adult men and women. The buildings are well managed and have contributed to the revitalization of their neighborhoods (Hoch, 2000). LSRO established a model for the 'blended management' principles that they created to link management services and social services together. The Lakefront approach differs from most other SRO projects funded by HUD's McKinney Act funds in that it promotes a mix of economic and social differences (Hoch, 2000). By contrast, most HUD funded developments typically offer housing to a special resident population defined by their special needs, i.e., HIV/AIDS, mental illness, or addiction. In 2004 the retention rate of the SRO's by formerly homeless individuals was over 80% (LSRO, 2005). There are two rent structures depending on the building. Tenants either pay 30% of their adjusted gross income in the buildings subsidized by a Section 8 grant, or must pay affordable market rate. Market rate begins in the high $200s.

In New York, The Times Square is the nation's largest example of affordable supportive housing. Converted from an abandoned, 723-room hotel, the historic Times Square now offers 652 rooms for low-income single adults. All tenants who live in the building are leaseholders; 50% are low-income working people and 50% are individuals who have been homeless (Ground,

2005). The Times Square is noteworthy for its extensive efforts in collaboration between government, the private sector and its own residents, to devise a plan for integrating housing and services that was acceptable to all (CSH, 2007; Ground, 2005). Along with providing permanent housing and social services, The Times Square is notable for its extensive involvement in job training and placement. Serving as both partner and employer, Ben & Jerry's operates an ice cream store in the building that is staffed by Times Square residents.

Supportive housing developments such as Lakefront SRO and Times Square are excellent examples of successful housing interventions resulting from good policy and public will. They are also examples of how the right environmental supports can have a positive influence on the individual (Germain & Bloom, 1999).

In Mulroy's chapter on housing published in the Encyclopedia of Social Work (1995), the Cranston-Gonzalez Act of 1990 mandated certain provisions that are important to social work – that "affordable housing projects will be linked with social services, resources will be targeted to neighborhood and community development, and nonprofit community development corporations will be used as producers of affordable housing. Social workers have long recognized the value of blending affordable housing with services and have been advocates of such governmental policies since the Progressive era of nearly a century ago (Mulroy, 1995).

Addiction, Recovery and Well-being

Substance addiction is a consuming dependence on alcohol or drugs (Coombs & Howatt, 2005). The drug of choice can be legal or illegal. Addiction is characterized by (1) tolerance for amounts of the substance consumed, (2) preoccupation with obtaining and using the substance, (3) continued use of the substance despite acknowledgement of potential for harm, (4) repeated

yet unsuccessful attempts to reduce or discontinue use, and (5) physical reactions or withdrawal symptoms when substance use is discontinued (Ray & Ksir, 2004).

Substance abuse and addiction is a social problem that adversely affects the health and well-being of individuals, families and communities (Booth et al., 2002; McLellan et al., 1992). Individuals experiencing addiction pay high costs due to associated health risks, as well as social and economic upheaval (Coombs & Howatt, 2005; Rasmussen, 2000; Ray & Ksir, 2004), and the costs to communities are evidenced by increased health costs, homelessness, and an increased burden on the child welfare and criminal justice systems, (Coombs & Howatt, 2005; Kadden, 1994; Marlatt & Gordon, 1985; Rasmussen, 2000).

Treatment Approaches and Effectiveness

Substance abuse and addiction is considered to be the result of a complex interaction of psychological, social and environmental factors (Davis & Jason, 2005). Therefore, one can speculate that successful treatment of addiction may be found by involving the same factors. The objective of most treatment programs, whether in-patient or out-patient, is to support the client in achieving abstinence. Other, more controversial programs utilize a concept of harm reduction. Initially more commonly used as a treatment approach with alcoholism, harm reduction is viewed as a pragmatic approach to dealing with a public health issue (Marlatt, 1998). According to Marlatt (1998), "this gradual, 'step-down' approach encourages individuals with excessive or high-risk behaviors to 'take it down one step at a time' to reduce the consequences of their harmful behavior"(p.51). The underlying theory is that since prolonged abstinence is often so difficult to achieve, clients should be taught to reduce and then manage their substance use in order to maximize their daily functioning (Coombs & Howatt, 2005; Marlatt, 1998; Rasmussen, 2000). Currently, the cognitive-behavioral approach to treatment

which focuses on changing thoughts and perceptions around using substances while learning new coping skills and behaviors, is the most widely used approach in counseling (Coombs & Howatt, 2005; Ray & Ksir, 2004).

Notable inpatient programs include Hazelden's Minnesota model which was established by the Hazelden Foundation (Rasmussen, 2000). Regarded as one of the foremost leaders in addiction treatment (Coombs & Howatt, 2005) this program provides a therapeutic community model in which the participants reside in congregate within a treatment facility. The 24-hour immersion uses peer influence and intensive counseling to learn new behaviors and coping skills. This model, which provides treatment modules that can range from three weeks to six months, includes various treatment approaches and professionals to address all domains including physicians, psychologists, counselors, clergy, and peer counselors. Additionally, the course of intervention often incorporates a Twelve-Step recovery component for aftercare.

Perhaps most widely known, Twelve-Step recovery programs are a response to the biological theoretical domain that views addiction as a chronic, progressive disease and abstinence as the cure. As indicated by Durant and Thakker (2005):

> The ideology of AA is replete with aphorisms, which are intended to replace the drinking ideas of the alcoholic with new non-drinking ideas that are consistent with recovery. AA meetings adhere to a belief that by "working" the Twelve Steps, one can begin to abstain and then recover from alcoholism. Although the Steps are devoted to moral concerns, members of AA strongly subscribe to the "disease concept" or medical model of alcoholism in their personal recovery programs (p.7).

Alcoholics Anonymous, whose origins date back to 1935, is the prototype for Twelve-Step programs that emphasize mutual and self-help support (Coombs & Howatt, 2005; Miller &

Weisner, 2002; Ray & Ksir, 2004). Participants may get involved with Twelve-Step programs on their own or in tandem with therapeutic care. Since its inception, dozens of similar groups, including Narcotics Anonymous and Overeaters Anonymous have been created all over the world. The program also espouses a spiritual framework as it promotes the concept that an individual's recovery is dependent on a higher power. Further, the individual must rely on others for mutual support. Rasmussen (2000) reported criticism of Twelve-Step programs because of their perceived religious overtones, and adherence to a confrontational, male model of recovery. Reportedly, approximately 30% of all Twelve-Step group participants are women (Rasmussen, 2000).

As the rate of relapse is an indicator of the success of treatment, no singular treatment approach (e.g., Twelve-Step recovery, therapeutic counseling, pharmaceutical) has been found to be fundamentally more effective than any other (McLellan et al., 1992; Miller & Weisner, 2002; Rasmussen, 2000; Ray & Ksir, 2004). McLellan (1998) reported that the rate of relapse regardless of treatment approach is between 40-60%. According to McLellan (1992, 1998), this is consistent with the disease model for understanding addiction as patients coping other chronic diseases such as diabetes and heart disease, usually "relapse" from medical compliance at similar rates. There is consensus, however, that individuals fare far better with some treatment as opposed to no treatment at all (McLellan et al., 1992; Miller & Weisner, 2002; Rasmussen, 2000; Ray & Ksir, 2004; Ridenour, Maldonado-Molina, Compton, Spitznagel, & Cottler, 2005; Walton, Blow, & Booth, 2001); and that inpatient treatment has demonstrated marginally higher success in relapse prevention as compared to outpatient treatment (Miller & Weisner, 2002; Ray & Ksir, 2004). Further, studies do indicate that success rates improve for both methods if

participants adhere to a program of post-treatment after-care services (Marlatt & Gordon, 1985). Fiorentine and Hillhouse (2003) assert:

> There is evidence that longer duration of treatment, frequency of counseling attendance, and empathic client-counselor relationships are associated with favorable treatment outcomes. Individuals who maintain regular attendance of twelve-step meetings during and after treatment have higher levels of long-term abstinence than those who do not attend twelve-step groups (p.359).

One of the leading thinkers on addiction, Alan Marlatt espouses a cognitive-behavioral approach to treatment with an emphasis on teaching new behaviors to facilitate relapse prevention. Marlatt and Gordon (1985) criticize elements of Alcoholic's Anonymous' orientation toward the disease model:

> It is ironic that the major strength of the disease model, absolving the addict of personal responsibility for the problem behavior, may also be one of its major shortcomings. If alcoholics come to view their drinking as the result of a disease or physiological addiction, they may be more likely to assume the passive role of victim whenever they engage in drinking behavior (p.7)…Relapse is the turning point where the disease model is likely to backfire…If an alcoholic has accepted the belief that it is impossible to control his or her drinking, then even a single slip may precipitate a total, uncontrolled relapse (p.8).

Impact of Race and Socio-economic Status on Recovery

While there are many reasons why an individual may fail to successfully complete treatment, there is consensus that the lack of culturally sensitive programs do adversely affect minorities' success rates in completing treatment (Durrant & Thakker, 2003; Loue, 2003; Walton

et al., 2001). Similar challenges have emerged for women, particularly low-income women. Male-centered treatment approaches often use a confrontational style that often conflicts with women's needs (Sun, 2000; Walton et al., 2001). Additionally, more often than men, women need additional supports for child care and attending emotional issues contributing to substance use.

Studies indicate that compared to Caucasians in recovery, minorities are less likely to seek or complete treatment (DATA, 2002; Sanders, 2002). A common theory among those studies is that minorities, namely low-income minorities, are affected by the lack of culturally-sensitive treatment programs. For African Americans, the legacy of racism and (Coombs & Howatt, 2005; DATA, 2002; Sanders, 2002), the culturally-specific expression of spirituality (Durrant & Thakker, 2003; Sanders, 2002), and the failure to recognize the importance of culture and community to African Americans (DATA, 2002; Sanders, 2002; Schiele, 2005) all contribute to a breakdown in treatment efficacy for minority participants.

Sanders (2002) reported on the efforts of some among African American recovery communities to adapt the Twelve-Step recovery concept to encompass an Afrocentric perspective:

> African Americans are capable of a bifurcated mind-set, that is, they learn to get along in the white, "Eurocentric" worldview, while informally subscribing to an "Afrocentric" perspective that recognized a majority culture and a minority culture. Assumption of a bifurcated mind-set affords discussion of the dual perspective in the treatment of alcoholism among African-Americans. The dual perspective is the deliberate and systematic process of understanding and comparing simultaneously the values, attitudes, and behavior of those in the "culture universal" (sustaining system) with those in the

> "culture specific" (nurturing system). The concept of dual perspective stems from the idea that every person is a part of two systems. From this position, the dual perspective can be used as a mechanism to inform practitioners about institutionalized disadvantages, in the larger system of society, erected against individuals who belong to minority groups. And, that often these obstacles can be subtle and not easily recognized unless the dual perspective is assimilated into the clinical reasoning of practitioners who work with African-Americans...Inattention to the dual perspective in AA makes an enormous difference, which results in an unspecified number of African-American alcoholics never completing the affiliation process. The suggestion is that culture specific treatment of alcoholism in African Americans is more effective when the alcoholic's status in life, society's inconsistencies, experiences and feelings of powerlessness are taken into account (p.167).

Indeed, Jerome Schiele (1996) contends that the concepts of an Afrocentric approach should be an alternative social science paradigm for social work practitioners.

According to Weiner (1992) "social learning theorists have demonstrated the importance of environmental, rather than intrapsychic, determinants of action (p.218)." That is consistent with the theory that the environmental stressors such as poverty, racial discrimination, lack of affordable housing, inadequate education, and unemployment, which disproportionately affect minorities, can impact efficacy in recovery (Miller & Weisner, 2002; Rasmussen, 2000; Ray & Ksir, 2004; Ridenour et al., 2005; Walton et al., 2001). According to Walton, Blow & Booth (2001):

> African-Americans may face more difficult social situations following treatment than Caucasians, including high-stress and low-support environments. Thus, our research

> confirms the suggestions of Castellani and colleagues that African-Americans may need relapse prevention approaches that provide more advocacy and teach skills to access community resources effectively (p.237).

Marlatt and Gordon (1985) cited studies that show that community reinforcements along with newly learned behaviors can reduce the risk of relapse. Parenthetically, the importance of community in working with African Americans is expressed in the article, *"Race May Impact Treatment Efficacy, Clients' Sobriety,"* published by the DATA: Brown University Digest of Addiction Theory & Application (2002):

> Additional cultural traits that can be significant for African-Americans include extended family organizations, complex oral expression and the importance of community relationships. All of these elements may be critical for recovery, or may be traditions that are in conflict with standard treatment approaches (p.4).

While Marlatt and Gordon (1985) initially did not acknowledge the influence of racial, cultural or socioeconomic factors on recovery, they did recognize the transactional role that environment plays in influencing recovery. In a later text (Marlatt & Donovan, 2005), race and culture are acknowledged for its importance in shaping treatment and in addressing barriers to recovery.

Abstinence through the Relapse Prevention Model

Marlatt and Gordon (1985) define the Relapse Prevention model as "a self-management program designed to enhance the maintenance stage of the habit-change process" (p.3.). This model combines behavioral skill training, cognitive interventions and lifestyle change procedures to both prolong abstinence and to help individuals recover from an incidental lapse before it leads to total relapse.

Over the years, the effectiveness of RP has been studied by a number of researchers (Irvin, Bowers, Dunn, & Wang, 1999). The meta-analysis conducted by Irvin et al (1999) indicate that relapse prevention demonstrated strong treatment effects with various substances, having the least effective impact on smoking-cessation. Interestingly, Irvin et al reported that relapse prevention demonstrated stronger correlates with improving psychosocial functioning than reducing substance use.

Self-efficacy and Relapse Prevention

While other researchers (Fiorentine & Hillhouse, 2003) have proffered research that suggests a minimal role of self-efficacy in relapse prevention, one of the leading scholars on addiction and relapse prevention, G. Alan Marlatt (1985) posits that self-efficacy is integral to individual success in maintaining sobriety. That theory is supported by many other independent studies that show a strong correlation between higher levels of self-efficacy and drug- or alcohol-taking resistance (Bandura, 1977; Clifford, 1983; Davis & Jason, 2005; El & Bashir, 2004; John, Leonard, & Bradley, 2004; Rainer, Paul, & Tom, 1997; Solomon & Annis, 1990).

It should be noted that these studies do vary in the types of self-efficacy scales (general or situational efficacy) used and the type of behavior responses predicted (abstinence or reduced use). Solomon and Annis (1990) used the Situational Confidence Questionnaire to assess efficacy regarding alcohol consumption. Results using this scale indicated self-efficacy was a high predictor of prolonged sobriety among subjects.

Self-efficacy is not a static state (Bandura, 1977; Marlatt, Baer, & Quigley, 1995), it can be altered "by performance mastery experience, social modeling, verbal persuasion, and from emotional states" (p.309). Bandura (1997) states that any influence on efficacy is communicated through one or more of these sources of "efficacy information"; subject to cognitive

interpretation based on a "host of personal, social and situational factors" (p.79). Higher rates of efficacy do also correlate with stronger coping skills in relapse prevention (Bandura, 1997; Davis & Jason, 2005; El & Bashir, 2004; Maddux, 1995; Marlatt et al., 1995; Sklar & Turner, 1999). Marlett et al (1995) assert that efficacy encompasses "confidence in one's ability to resist relapse" (p.293).

Threats to Self-efficacy

Although varying in specificity, threats to self-efficacy are any situations that challenge individual perceived control. These high-risk situations can be categorized in two ways: (1) intrapersonal-environmental determinants and (2) interpersonal determinants (Marlatt & Gordon, 1985). *Intrapersonal-environmental determinants* are understood as challenges or circumstances that do not involve other people. *Interpersonal determinants* are situational factors where others are involved such as an argument, peer pressure or celebrating at a party. When a high-risk situation occurs, Marlatt and Gordon posit that there is a "conflict of motives" between succumbing to the adverse event or relying on a learned coping response to deal with the high-risk situation. The likelihood of relapse occurs when the individual has a high level of self-efficacy for their ability to cope.

Bandura (1997) provided his assessment of the importance of environment developing perceived efficacy in relapse prevention:

> The severely addicted whose lives were shaped be impoverished environments and who have been deeply enmeshed in a drug user subculture face the formidable task of major lifestyle changes with few personal and social resources to do so…They need to immerse themselves deeply in a wide-reaching enabling environment if they are to restructure their lives. Piecemeal solutions accomplish little (p.165).

Low-income adults are particularly vulnerable to high-risk situations resulting from environmental constraints such as the lack of decent housing.

Housing and Well-being

The fundamental purpose of 'home' is to meet a basic human need. However, the power and meaning of home goes far beyond the need for shelter. For most, it is a place of refuge and security. For others it is an outward symbol of self expression or life's accomplishments (Cooper Marcus, 1995; Gunter, 2000). Studies have shown that the quality and location of our homes and neighborhoods can often impact how we function and how we are regarded by society (Dreier et al., 2004). According to Annison (2000) the "creation and experience of home is an important contributor to a person's humanity and their positive social perception by others" (p.251). Dreier et al (2004) affirmed, "where we live has a powerful effect on the choices we have and our capacity to achieve a high quality of life" (p.27).

Housing has been shown to have unique economic, psychological, and symbolic significance (Easthope, 2004). It has a pervasive impact on the quality of life beyond just the provision of shelter. Safe, affordable, non-transient housing is the key that opens the door to meeting other basic needs. With a nod to Maslow's hierarchy of needs (1970), for low-income adults in recovery, gaining access to affordable housing would rank very high in importance in prolonging treatment benefits.

Assisted living is one of the fastest growing types of supportive housing (Cummings, 2002). It has demonstrated its value in prolonging the ability of frail elderly to remain in independent living before the costly transition to nursing homes (Cummings, 2002; Raymond, 2000). Cummings' study examined the factors associated with psychological well-being for residents of an assisted living facility. Depression, life satisfaction, and demographic, health, and

social support variables were measured through face-to-face interviews. The most significant finding was the strong association between social support to psychological well-being – a critical component of supportive housing:

> Social support is a key variable in bolstering residents' psychological wellbeing. When strong social support was present, the effect of functional impairment and poor health was no longer significant. It is interesting to note that psychological wellbeing was not significantly related to the number of social programs that the residents attended but, rather, to their perception of the level of social support they received (p.294).

Research on housing as intervention for adults coping with psychiatric disabilities (Brunette, Mueser, & Drake, 2004; Casper & Clark, 2004; Dorvil et al., 2005; "The homeless mentally ill," 2005; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005; Nelson, Hall, & Walsh-Bowers, 1999) yields similar findings about the relationship between housing and well-being.

Influence of Housing Environment on Self-efficacy

Rosenbaum, Reynolds and Deluca (2002) conducted a qualitative study on participants of the Gautreaux program which evaluated the relationship between housing and community and individual efficacy. The 'culture of poverty' theory was contrasted with the 'geography of opportunity' theory in determining if low-income residents from one of Chicago's public housing project would continue to demonstrate low efficacy even after moving to a more affluent neighborhood. The results of the study showed that the change in environment did influence efficacy. The "behaviours seen in 'housing project residents' do not indicate inherent capabilities. These behaviours are not seen in former 'housing project residents' after they move if the random assignment placed them in middle-class suburbs" (p.81).

Similarly, a more recent longitudinal study (Boston, 2005) conducted in the metropolitan Atlanta area evaluated the outcomes of public housing residents moving to mixed-income settings in suburban areas surrounding Atlanta's city limits. Residents were followed over a seven-year period. The study reported that residents that relocated experienced higher rates of employment, better health conditions, better schools for their children, and better housing conditions. Boston reported: "focus group and survey results from resident tracking studies in Atlanta indicate that the change in location played a major role in improving households' motivations" (p.401). Boston also cited another study of public housing residents that was conducted by Georgia State School of Social Work. He reported that their findings also indicated that most participants acknowledged experiencing some aspect of personal growth or development that they associated with relocation.

Supportive Housing as Intervention

Supportive housing provides a distinct benefit for those with special needs as it not only provides an affordable housing solution, it also links residents to vital social services and a multi-faceted network of social support (C. Cohen & Phillips, 1997; CSH, 2007; Proscio, 1998). Residents may rely on both instrumental and emotional support for a supportive housing environment. The on-site staff provides instrumental support by advocating on behalf of their client and providing access to community resources (Cummings, 2002). In addition to the staff, the supportive housing resident has access to a network of peers for emotional support. This combination of care is not typically available in other housing settings. This service-enriched environment is a major contributor to the individual's ability to develop and maintain newly learned behaviors.

Positive social interactions have been linked to improved emotional and mental health (Maslow, 1970), and social support has been identified as integral to the well-being of individuals with special needs (Cummings, 2002; Halpern, 1995; Mossbarger, 2005; Raymond, 2000). The physical environment has also been shown to play a role in promoting the formation of social interaction (Halpern, 1995). Halpern (1995) reports on studies that show that for "relatively homogeneous populations" the "built environment can strongly influence friendship and group formation" (p.116). Halpern further stated that this group influence also places a subtle pressure on the individual to conform. In the supportive housing context for adults in recovery, that presents an opportunity for desired behaviors to be mutually reinforced by peers.

Supportive Housing and Relapse Prevention

Geared to serve low-income adults with special needs such as addiction or mental illness, supportive housing integrates affordable housing with on-site social services, i.e., case management, counseling, job training and referral, in an effort to create an environment that assist residents with personal, economic and social functioning. It is theorized that the access to these services reduces their need for emergency or institutional care, thus providing a higher quality of life (Proscio, 1998). A four-year study conducted by the U.S. Department of Health and Human Services (the 1994 "McKinney Report"), pointed out that 85% of the formerly homeless mentally ill tenants living in supportive housing continue in residence and become valuable members of the community.

Outside of those studies that investigate efficacy of assisted living facilities and supportive housing settings for individuals with developmental or psychiatric disabilities, there are comparatively fewer studies about the efficacy of supportive housing for individuals coping with addiction, and fewer still that investigate housing as intervention for improving well-being.

One outcome study (Proscio, 1998) found that graduates of substance-abuse programs who lived in supportive housing stayed clean at a rate of 90%, compared to a 55% rate for graduates who lived in other types of housing. Davis and Jason (2005) cited results from a study of Oxford House (OH), a 'peer-led recovery home':

> It is also likely that by living in an OH recovery environment with peers who have successfully maintained abstinence and who serve as role-models, fellow residents have an opportunity to acquire crucial knowledge and skills related to effectively coping with stressors and high-risk relapse precipitants. Gaining this knowledge and these skills should promote residents' abstinence self-efficacy (i.e., the belief that one can effectively cope and refrain from substance use in stressful situations). Thus, as well as leading to changes in support networks, time spent as a resident in OH should lead to increases in abstinence self-efficacy, such that the longer an individual resides there, the greater his or her abstinence self-efficacy will become (p.261).

A recent study (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005) compared the outcomes of residents of two types of affordable housing settings. One was a supportive housing setting where abstinence was required to remain housed; the other housing setting where residency was not contingent on sobriety. The abstinence-contingent housing did show a clinically, if not statistically, significant difference with residents demonstrating higher rates of abstinence and sobriety than did residents who lived in housing that did not require sobriety.

This study seeks to add to the body of knowledge about the critical interplay between supportive housing and well-being, particularly for low-income adults in substance addiction recovery. A better understanding of the efficacy of supportive housing for this population could

make a significant contribution to efforts to reduce the ranks of the chronically homeless, thus preserving families and communities (Ray & Ksir, 2004).

The next chapter will further explicate the theoretical concepts that link supportive housing environment to enhanced self-efficacy and well-being, and ultimately, to sobriety. In addition, the chapter will outline the research questions that are the basis of the hypotheses later described in Chapter 4 where methodology is explained.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

The ecological systems perspective provided a unifying framework to link key theoretical constructs from environmental and social psychology. The constructs, *experience of place* (Canter, 1977; Genereux et al., 1995; Proshansky, Fabian, & Kaminoff, 1995) and *behavior-place association* (Canter, 1977; Genereux et al., 1995; Groat, 1995), were examined to explain the therapeutic benefits of living in a supportive housing. Historically, scholarly pursuits in both social work (Germain, 1979; Meyer, 1983) and psychology (Bronfenbrenner, 1979; Proshansky et al., 1995) have frequently demonstrated the shared desire to understand human behavior within the context of environment. Although intended as an atheoretical dissertation, by using these constructs the author examined the transactional relationship between the individual and their residential environment, 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).

Ecological Systems Perspective

Although varying in emphasis over the course of its history, the social work profession has long recognized the need to have a simultaneous and dual focus on person-and-environment (Kemp, Whittaker, & Tracy, 1997). Anchored by an ecological systems perspective, social workers strive to understand and help their clients influence the dynamic, multi-transactional relationship between the individual and his/her environment. Although this perspective does not specify what problems can be addressed nor does it prescribe a particular course for intervention

(Meyer, 1983), it does help us to holistically assess the client. Our understanding of this approach has been influenced by the work of many social work scholars, most notably, Carol Meyer and Carel Germain. Also noteworthy for their contributions are leaders in the social sciences, particularly psychology, including Kurt Lewin and Urie Bronfenbrenner. Bronfenbrenner's (1979) definition of human development is a helpful illustration of the utility of the ecological systems perspective in helping us to understand human behavior:

> [Human development is] the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger context in which the settings are embedded (p.21).

The ecological systems perspective as used in social work is derived from general systems theory (Germain, 1979). Its central concept is that all human beings, or individual systems, are in continuous, inseparable, evolutionary transactions with their physical and social environment. The exchange between person and environment yields mutual influence that is referred to as *reciprocal causality* (Bronfenbrenner, 1975; Greene, 1999). Bronfenbrenner (1979) established four primary systems: microsystem, mesosystem, exosystem and macrosystem, to describe the interrelatedness of the individual to his/her environment.

A microsystem is characterized by the reciprocal interaction between the individual and their immediate environment. That physical aspect of the environment is typically the home, the work place or the school. The social aspect would be the family, co-workers, or teachers and peers in the immediate physical setting.

A mesosystem is formed when two or more microsystems interconnect, each involving the same individual. In the case of a child, the interaction between home and school; for an adult, it may be the interaction between work and home.

An exosystem is comprised of one or more settings that do not directly involve the individual but which impacts the microsystem in which the person is contained. One example would be the impact of a parent's job loss on a child.

A macrosystem consists of the larger social patterns, cultures or institutions in which the microsystem participates. A macrosystem sphere of influence would be the socio-economic, religious, political, cultural or ethnic group to which the microsystem belongs. For example, the policies that determine whether housing is available and/or affordable represent macrosystem influences on the individual.

Bronfenbrenner (1979) referred to these systems as "nested structures," one fitting inside the other, and depending on their distance from the microsystem, each of the remaining systems having a successively higher level of influence. Fifteen years later, a fifth level, the chronosystem, was added. Chronosystems incorporate the time dimension of Bronfenbrenner's process-person-context-time model (1995) to address the influence of consistency or change in interactions or 'proximal processes' over the life course. Historical events or life changes, such as the natural disaster Hurricane Katrina or parental divorce, as well as the physical or emotional changes that occur in an individual and delineate a particular time across the life span are part of the chronosystem.

Importance of Adaptation and Goodness-of-fit

In addition to reciprocal causality mentioned earlier, another key concept of the ecological systems perspective is *adaptation*. It is the "continuous, change-oriented, cognitive,

sensory-perceptual, and behavioral process people use to sustain or raise the level of fit between themselves and their environment" (Germain, 1996, p. 817). To further clarify that concept in relation to how an individual responds to his or her environment, Tognoli (1987) referenced the construct of 'adaptation, adjustment and optimization.' An individual's behavior is influenced either by conforming to pressures from the environmental (adaptation) or by imposing changes on the environment causing it to conform to their needs (adjustment). The individual will then engage in a combination of adapting and adjusting to minimize potential negative experience of the environment (optimization).

The client system's ability to adapt to its environment determines the degree of the *goodness-of-fit* (Greene, 1999). Kemp (1997) cited a quote from the 1979 journal article by Holahan, Wilcox, Spearly and Campbell, *"The Ecological Perspective in Community Health,"* that also speaks to the critical importance of achieving goodness-of-fit:

> The environmental emphasis of the ecological view supports environmentally oriented interventions directed toward strengthening or establishing methods of social support…The transactional emphasis of the ecological perspective fosters individually oriented interventions directed toward promoting personal competencies for dealing with environmental blocks to achieving personal objectives (p.131).

A client's inability to achieve a goodness-of-fit with his/her environment can serve as an entry point for care. An individual's ability to cope requires internal (i.e., self-efficacy and perceived control) and external (i.e., social support) resources. For adults coping with addiction and recovery, any deficits in one or more of these resource areas may contribute to an individual's substance abuse and the subsequent inability to abstain. Given this context, there is a goodness-of-fit that supportive housing can offer. It represents an 'environmentally oriented

intervention' that provides vital social support. Within that setting, an individual will have access to 'individually oriented interventions' that will help strengthen existing skills and reinforce newly learned behaviors.

Defining 'Place' in the Context of Home and Community

The concept of place involves the interaction of the physical attributes of a setting, the activities a person carries out there and the cognitive representations individuals make of both of the preceding components (Tognoli, 1987). Easthope (2003) referenced Martin Heidegger's *Being and Time* (1973) assertion about the significance of place – that who we are (our mind, our ego) is influenced by our relationship, through our bodies, to the outside world. This indicates that place can be perceived as an entity as broad in scope as the universe or as specific and present as the space one currently occupies. In studying the construct of place, Canter (1977) theorized that "if we are to understand people's responses to places and their actions within them, it is necessary to understand what and how they think" and to "look within the individual for the *causes* of his actions, at his interpretations of the context within which he finds himself" (p.1). Stokols and Shumaker (1987) advanced Canter's construct of place by pointing out that places are "not only viewed as composite of behavior-shaping forces but also as the material and symbolic product of human action" (p.443).

Home can be understood as a 'place' that holds considerable social, psychological and emotive meaning (Annison, 2000; Rosenbaum et al., 2002; Weidemann, Anderson, Butterfield, & O'Donnell, 1982). Proshansky et al. (1983) asserted that "without exception, the home is considered to be the 'place' of greatest personal significance' (p.60). Home is both a "physical place and a cognitive concept" (Tognoli, 1987). The physical features of a dwelling or house should be designed to meet our basic needs but represent only a part of what defines home

(Galster & Santiago, 2006; Rosenbaum et al., 2002). The long acknowledged link between one's home and one's well-being (and identity) among housing researchers (and architects and public planners) finds theoretical explanation through the concept of 'place'(Easthope, 2004).

In *Motivation and Personality,* Abraham Maslow (1954) theorized that humans have five hierarchical needs: physiological, safety, belongingness and love, esteem and self-actualization, which are progressively attained. Once a lower order need is attained, the next highest level need can then be satisfied. The first, and most vital need, is *physiological*. We must have food and water to survive. The second is *safety*. Safe shelter protects us from the variances of nature and other dangers. Gunter (2000) states safety needs are met when we have "a secure, predictable, habitable, non-threatening environment in which to live" (p.8). Our *social* needs are met when we have the opportunity to develop meaningful relationships with others, to be loved and accepted by others. Although this need may not be necessary for the survival of a particular individual, it is necessary for the species. Fourth, e*steem* needs refer to one's need for self-respect and the need to seek the approval of others. The fifth and highest order need is *self-actualization*. This represents the need for self-fulfillment, to achieve success and discover one's full potential.

In this context, the home enables individuals to achieve psychological well-being through providing for their physiological and safety needs. Maslow (1970) posited that once physiological and safety needs were met, higher needs would emerge. Higher needs require "better environmental conditions (familial, economic, political, educational, etc.)" (p.99) in order for them to be gratified.

In addition to providing shelter, the meaning of home goes beyond defining the physical structure (Galster et al., 2002). Bell et al. (1996) stated that "homes organize much of our

individual and social life and provide bonding" (p.461). Gunter (2000) states that "home is the first place where we learn to exert control over our environment; where we make things happen on our own terms" (p.5); it is a "deeply personal space where we can be ourselves, do largely what we want and feel safe and secure within the bounds of our own private territory" (p.10).

Behavior-place Association

Home is where we first learn to make associations between certain behaviors and place (Genereux et al., 1995; Proshansky et al., 1995). Behaviors are a significant component of establishing the meaning of a place (Canter, 1977; Gallagher, 1993; Proshansky et al., 1995). A behavior-place association begins with the individual processing four components: reason-for-going, suitability for intended behavior, expected behaviors, and activities-while-there (Genereux et al., 1995). The first component, *reason-for-going,* is achieved when the behavior constitutes the reason for going to the place. An obvious example would be going to a restaurant to eat a meal. The extent to which place meets the physical and affective requirements for the behavior determines *suitability for intended behavior.* Going to a bedroom to sleep meets the physical requirements; whether the bed is lumpy or the room is cold addresses the affective requirements. The third component, *expected behavior,* focuses on how that behavior would be received in that setting as well as what other behaviors are expected to occur in that setting. Laughter at a funeral is not an expected behavior. The fourth component, *activities-while-there,* encompasses behaviors that constituted the reason for going as well as other behaviors that may spontaneously occur. Evaluation of whether or not other behaviors inhibit success in achieving reason-for-going, may also ultimately determine suitability of place for intended behavior. Thus the meaning of an environment is integrally linked to its function (Teymur, Markus, & Woolley,

1988) and satisfaction with home seems related less to style or location but more to whether or not the home facilitates desired functions and meets expectations (Michelson, 1977).

Tognoli (1987) defines housing as "a pluralistic concept" acknowledging the inevitability of, due to physical proximity, residents of one house acknowledging and interacting with those in houses nearby; thus linking housing to the concept of neighborhood and community. Supportive housing is an example of place that illustrates the integral link between the concepts of home and community. Using Stokols and Shumaker's (1981) definition, supportive housing can be defined as a place in which "specific individuals share recurring patterns of activity and experience" (p.442). Designed for multi-need populations, it facilitates the development of a community of individuals with common experiences and needs that share recurring patterns of activity related to those needs. Employing the components of behavior-place association, an individual's *reason-for-going* to a supportive housing environment would be to alleviate risk of homelessness and to obtain support to manage a special need, i.e., addiction recovery. The *suitability for intended behavior* is achieved when choosing a supportive housing environment that encourages and reinforces the practice of desired behaviors. The *expected behavior* within a supportive housing setting would be consistent with the individual's reason for going, i.e., abstinence from drug and alcohol. Within a supportive housing setting, the *activities-while-there* would include the desired pursuit of abstinence but may also include access to networks of social support and other behaviors intended to enhance individual expectation for success.

The behavior-place association construct is a useful concept for examining the functional effectiveness of supportive housing. Environmental psychology's behavior-place association complements social work's concept of *goodness-of-fit by* illustrating the process whereby the individual attempts to evaluate and adapt to his/her environment. Manzo (2003) states that

"people choose environments that are congruent with their self-concept, modifying settings to better represent themselves, or moving to find places which are more congruent with their sense of self" (p.54). Parenthetically, our relationship to place, specifically in this instance to housing, is also influenced by the macrosystem, the external factors, i.e., social, economic and/or political forces that determine where and if, we will have adequate housing. Low-income individuals, particularly those who are also coping with addiction recovery, are particularly susceptible to compromised well-being resulting from inadequate or the lack of housing. A closer examination of the role of place in achieving well-being is warranted.

Well-being and Self-efficacy

In *Psychological Well-being,* Ryff and Keyes (1995) outlined six aspects of well-being: self-acceptance, personal growth, purpose in life, positive relations with others, environmental mastery, and autonomy:

> In combination, these dimensions encompass a breadth of wellness that includes positive evaluations of oneself and one's past life (*Self-Acceptance*), a sense of continued growth and development as a person (*Personal Growth*), the belief that one's life is purposeful and meaningful (*Purpose in Life*), the possession of quality relations with others (*Positive Relations With Others*), the capacity to manage effectively one's life and surrounding world (*Environmental Mastery*), and a sense of self-determination (*Autonomy*) (p.720).

Ryff and Keyes (1995) assert that little attention is paid to happiness or positive affect as a defining feature of human wellness. They add that an argument can be made that certain aspects of positive functioning, such as the realization of one's goals and purposes, require effort and discipline that may conflict with short-term happiness. By contrast, the oft-cited Ed Diener (Diener 1984, 1994; Diener and Larson, 1993; Diener and Diener 1995; Diener and Suh, 2000)

does identify happiness as integral to achieving well-being. Happiness, life satisfaction and positive affect are considered the primary components of subjective well-being (Diener, 1984). What noted scholars of well-being do agree on is the importance of environmental mastery and self-efficacy in achieving well-being (Bandura, 1977; Bonnes, Lee, & Bonaiuto, 2003; Diener, 1984; Diener & Suh, 2000; Easthope, 2004; Kahneman, Diener, & Schwarz, 1999; Ryff & Keyes, 1995). Well-being, in the context of adults in recovery from addiction will be defined as having a sense of control over life situations and a positive outlook for the future, which contributes to an individual's ability to resist relapse and maintain sobriety.

The Self-efficacy Construct

Albert Bandura (1977), a leading scholar on self-efficacy, defines it as "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (p.3). He further states (1995) that "a strong sense of efficacy in socially valued pursuits is conducive to human attainment and well-being" (p.1). As there are many factors that contribute to human behavior, Bandura acknowledges that the individuals are "contributors to, rather than the sole determiner of, what happens to them" (p.5). In choosing a course of action, individuals match what they know is humanly possible with their beliefs about their own abilities. However, the outcomes of those actions are not always predictable. Even well-intentioned actions could produce negative consequences for the individual or others.

Bandura (1997) is careful to make the distinction between self-esteem, where self-worth is assessed, and self-efficacy, which is concerned with one's judgment of personal capability. Although individuals tend to develop proficiencies in actions and behaviors that heighten self-worth, Bandura asserts that there is no necessary interdependence between the concepts. An individual could experience high sense of self-worth without the expectation of attaining

personal achievements. Conversely, a successful individual may still not have a high degree of self-worth because their standards for achievement are set to a level that few could achieve. In sum, an individual will set personal goals based on perceived self-efficacy without little or no dependence on their level of self-esteem.

Self-efficacy and Outcome Expectancies

Developed proficiency in performing certain tasks inevitably leads to an expectancy of a causal relationship between behavior and outcome. The relationship between self-efficacy and outcome expectancy is also important to examine. As earlier stated, although one's self-efficacy regarding performance of certain tasks is not the sole determiner of the outcome, the behavior is likely to be positively reinforced and perceived control heightened when the desired outcomes are routinely obtained (Kahneman et al., 1999).

Rotter (1966) theorized that one of the key factors that will help determine how an individual will react to a given stimulus is the degree to which that individual perceives *locus of control*, meaning that the outcome is the result of his or her own behavior or the result of forces outside of his or her control. If the individual perceives that the response is the result of some action of their own, that individual would be considered to have a belief in *internal control*. If the individual perceives that the reward or reinforcement is the result of outside forces, "luck, chance, fate, as under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him" (Rotter, 1966, p.1), that individual is said to have a belief in *external control*. Bandura (1997) cites Seligman's (1975) research on 'learned helplessness' which is similar to Rotter's concept of external control that assesses individual resignation about the expectancy that their actions will not prevent a negative outcome.

Perceived locus of control is thought to influence the individual's specific expectancy in any given situation. If a person is more externally focused, they will attribute any success or failure in a given situation to be the result of chance, or the influence of fate or powerful others. If a person is more internally focused, they will more likely attribute the outcome to their skill or lack thereof. It is expected that individuals with higher self-efficacy are more likely to also have higher internal locus of control. Rotter's social learning theory (1982) on locus of control represents another attempt to integrate reinforcement theories with cognitive theories of behavior.

Role of Self-efficacy in Addiction Recovery

Two critical concepts in understanding relapse prevention are (1) building individual self-efficacy and (2) understanding the individual's perception of his/her locus of control (Marlatt & Gordon, 1985). Both inform an individual's outcome expectancies which contribute to well-being. During treatment and subsequent after-care the primary objectives will be to help participants develop new cognitive structures and learn new behaviors to increase self-efficacy for coping and resisting during high-risk situations (Baer, Marlatt, & McMahon, 1993; Gossop, 2002; Marlatt & Gordon, 1985). The concept of competence is based on the psychological theory that as humans we seek to explore and master our environment. Achieving autonomy, which is considered evidence of mastery of the environment, or success in goal-directed behavior, is critical to prolonging abstinence.

Bandura (1977) defines self-efficacy as the belief that one is capable of producing the behavior required to achieve a desired outcome. Marlatt (1985) asserted that "the strength of the individual's self-efficacy expectations influences the probability of initiating coping behavior as well as the effort expended and the persistence of attempts to exert control in a given situation."

Marlatt and Gordon (1985) define positive expectancies as one's belief in his/her ability to resist the urges of their addiction. Comparatively, negative expectancies are one's beliefs in the inevitability of relapse. An individual in recovery found to have a negative expectancy orientation is likely not going to be successful in prolonged abstinence.

The Role of Supportive Housing in Achieving Well-being

Home and neighborhood can dramatically influence the well-being, and specifically self-efficacy, of its inhabitants (Rosenbaum et al., 2002). Self-efficacy is reinforced by the environments that individuals select. People will typically choose settings or situations in which they expect to perform successfully (Bandura, 1997). That success in turn reinforces the expectancy of future success. Maddux (1995) states "cognitions influence choices of environments and behaviors, which then influence behavioral performance and, ultimately, beliefs concerning those environments and behaviors" (p.15).

Environmental constraints can influence efficacy (Porteous, 1977; Rosenbaum et al., 2002) and negatively affect sense of personal control. Low-income households often find themselves with few options about the quality or safety of the neighborhoods they inhabit (Gans, 1995). Low-income individuals in recovery are often even more compromised in exerting influence over their environmental options. Illustrating the transactional nature of the ecological systems perspective, macrosystems such as societal or cultural attitudes toward the poor can shape the physical environment, or space, as well as the social. For example, the location and design of low-income housing, (i.e., concentrated pockets of poverty featuring isolated high-rises not conveniently located to employment centers) can all reflect and communicate particular perceptions of the poor (Germain, 1979). Reciprocally, these symbols and settings influence the self-image and self-esteem of those who live and work within them (Michelson, 1977).

Germain wrote: "Both the natural and the built aspects of the physical environment also provide opportunities and obstacles to the development of competence, relatedness, and autonomy (p. 14)." Supportive housing facilities are typically found in newly constructed facilities or renovated apartments. They are usually located near public transportation and employment centers and are geographically situated within the downtown areas of the city.

Influence of Ecological Transition on Well-being

In reporting on the findings of the Gautreaux housing study, Rosenbaum et al (2002) cited compelling evidence on how the ecological transition of changing neighborhoods can positively impact efficacy and subsequent behaviors among low-income households:

> Unlike the culture of poverty model espoused by some researchers, it has been seen that the very same individuals who report having very little efficacy over their life experiences in housing projects subsequently show considerable efficacy in middle-class suburbs. Places matter. The attributes of neighbourhoods, and the experiences provided by neighbourhoods have profound effects on people's capabilities and their ideas about what they can accomplish (p.81).

Within the framework of an ecological systems perspective, supportive housing can be considered a tool of intervention conceived by macrosystem forces to help individuals cope with homelessness and special needs such as addiction recovery. For certain populations, providing treatment alone will not solve addiction problems (Loue, 2003; Marlatt & Gordon, 1985; Rasmussen, 2000; Ray & Ksir, 2004; Ridenour et al., 2005; Sanders, 2002; Scott-Lennox, Rose, Bohlig, & Lennox, 2000; Walton et al., 2001). Supportive housing provides the critical environmental supports and resources such as affordable housing, job readiness and training, and child care, that help mitigate the effects of the socioeconomic barriers attendant to poverty.

Further, other supports such as counseling, case management and crisis intervention are also provided, to reinforce use of newly learned behaviors for relapse prevention.

Historically, supportive housing has served single adult men and women coping with multiple needs. But as more and more female-headed families are trapped in the destructive cycle of poverty, supportive (also known as service-enriched) housing developments are emerging as an option to address the needs of the whole family. In a study of Phipps Houses (C. Cohen & Phillips, 1997), a multifamily supportive housing development, many residents reported that living in such an environment was a major contributor to increasing their motivation to better their lives and be more independent.

Theoretical constructs from environmental psychology further complement the ecological systems perspective about the influence of the physical environment on human behavior, notably in regards to treating addiction. Gallagher (1993) wrote:

> One reason traditional addiction treatment programs have had such a poor track record is that they have largely ignored the role of environment…The best treatment of all remains the so-called geographical cure. Studies from all over the world show that after a year, most of those who don't relapse after drug treatment have relocated (p.137-138).

In the context of environmental psychology, because of the known purpose of supportive housing, that environment takes on a certain conceptual meaning particular to the occupant (Canter, 1977; Genereux et al., 1995). Canter wrote: "the links between place and activity, and the expectation of finding certain people in certain places, all indicate how a particular physical location can have its psychological power" (p.123).

Bronfenbrenner (1979) also characterized our ability to adapt to various settings as an ecological transition; the change in setting triggers a change in role and behavior. The adaptation to a

familiar setting also suggests that we know the function and expected behavior for that setting (Canter, 1977; Genereux et al., 1995; Groat, 1995).

Supportive housing also demonstrates the linkage between a cognitive-behavioral approach to treatment and environmental psychology, as its use as intervention represents an opportunity for newly developed cognitive structures to be reinforced by the influence of a positive and nurturing environment (Hinton, 2004). In the context of addiction recovery, the new cognitive structures are critical to creating a new self-identity that does not include engaging in the maladaptive behaviors of abuse substance.

Proshansky et al. describe the important function of place-identity and place-belongingness in establishing self-identity. *Place-identity* allows for the creation of an environmental past. The association with a physical setting that provides a sense of familiarity and stability. Place-identity also serves to give those physical settings a meaning function which reinforces new cognitive clusters that indicate what should happen in that place and how to behave in the setting. Early key influences on self-identity are home, school and neighborhood. These settings are where some of the most significant social roles are learned. It is where an individual experiences the beginning of efficacy and develops a sense of mastery to use, change and derive satisfaction from these settings. This process leads to *place-belongingness*. Place-belongingness occurs when the physical setting is associated with more positive experiences and memories than negative. Supportive housing provides residents with an opportunity to experience place-belongingness where they can learn new roles and environmental skills.

The concepts of environmental psychology offer evidence that supportive housing may have a role in affecting well-being (Hinton, 2004). By providing the setting for individuals to reinforce newly learned behaviors for coping, self-efficacy is increased, the individual

experiences a heightened perception of control, and the individual is also likely to experience a greater expectancy for positive outcomes from one's behaviors. Christopher Peterson writes (Kahneman et al., 1999):

> Personal control is both a cause and a consequence of the way people respond to their environment. Its relationship to well-being is obvious. Whatever else well-being might be, it does not exist apart from the world and from what the world affords. Control makes people more than passive recipients of outcomes. It is the psychological process that guides people as they strive to make the world into a more desirable place, even when this goal proves elusive (p. 290).

The link between physical environment, specifically housing, and well-being has been established for multi-needs populations, particularly the elderly persons and persons with disabilities (Casper & Clark, 2004; Cummings, 2002; Dorvil et al., 2005; Hyman, 1985; Kemeny, 1992; Newcomer et al., 2002; Popple & Leighninger, 1999; Raymond, 2000). A substantial amount of literature is readily available to study the merits of assisted living developments for the elderly. Comparatively, there is a paucity of literature available that examines the efficacy of supportive housing.

Supportive housing may also prove to be valuable as a culturally-sensitive approach to providing post-treatment services for African American clients in recovery. As previously mentioned, African Americans place value on connection to community (DATA, 2002). In fact, in the supportive housing setting, one can extrapolate that "community" is created by the shared experiences between neighbors. In many urban areas it is not uncommon to not know the people living next door to you. By contrast, supportive housing is an extension of the community as

treatment model (Miller & Weisner, 2002); neighboring is actively engaged as residents benefit from peer support, mutual aid and collective coping with their common problem of addiction.

Summary

The focus of this study, *"Supportive Housing: Its Efficacy as Intervention for Low-Income Adults Coping with Substance Addiction Recovery,"* addressed the primary research question of whether time spent living in supportive housing enhances well-being among individuals in recovery from substance addiction. The conceptual framework delineated above demonstrates a link between supportive housing and individual well-being utilizing the theoretical construct, 'behavior-place association', found in environmental psychology, the foundation of which is anchored in an ecological systems perspective. Particular emphasis was given to the influence of place on self-efficacy, a critical component of well-being and relapse prevention. Based on this construct, the dissertation sought to answer the following research questions:

1. Does a supportive housing environment positively affect outcomes among low-income individuals in recovery from addiction?

Specifically, when compared to individuals who do not live in supportive housing:

2. Are individuals who live in supportive housing more likely to experience longer periods of sobriety?
3. Are individuals who live in supportive housing more likely to experience higher levels of self-efficacy and expectancy for success?
4. Are individuals who live in supportive housing more likely to experience higher rates of employment?

The following chapter will outline the hypotheses resulting from these research questions and detail the research design and data collection procedures employed in the study.

CHAPTER FOUR

METHODOLOGY

In the previous chapter, the behavior-place association construct from environmental psychology was used to establish a framework for examining the efficacy of supportive housing as a method of intervention on addiction recovery behavior. In addition, the relationship between housing, specifically supportive housing and well-being was conceptualized. Literature was also presented to demonstrate the integral role of self-efficacy in achieving well-being. Given this context, this author seeks to add to the body of knowledge regarding the influence of housing environments on addiction recovery behavior. Specifically, this research examined whether supportive housing had a greater influence than other housing options on subjective well-being among low-income adults in recovery from substance addiction. For the purposes of this study, well-being will be operationalized by measuring duration of sobriety, self-efficacy, and employment status.

In this chapter, the research design and data collection procedures are explained. Also provided are the description of variables and outcome measures, specifically the General Expectancy for Success Scale (GESS-R) and the eight-item Drug Taking Confidence Scale (DTRQ-8).

Research Design

This researcher conducted a correlational study to evaluate the outcomes from residency in supportive housing. To answer the previously described 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 services.

The purpose was to determine if a statistically significant association exists between the independent variable supportive housing (X) and the three dependent variables duration of sobriety (Y_1), self-efficacy (Y_2), and employment status (Y_3). Data collected on the first hypothesis (H_1) measured the number of months clean and sober; data for (H_2) featured measures of the scores earned on two scales; and data for (H_3) measured the status of employment vs. unemployment.

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 is 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).

Determining Statistical Power

The strength of results of statistical testing was determined by three parameters: (1) reasonable statistical significance criterion was established, (2) power and effect size, or strength of association between variables was credibly measured and (3) the sampling size and methods were deemed reliable (J. Cohen, 1977).

The threshold value for establishing statistical significance was $p < .05$. Having a $p < .05$ is a relatively common value used in social work research and has been shown reliable in reducing the likelihood of committing Type I errors (Black, 1999; Blalock, 1979; Hinton, 2004; Huck, 2004; Keppel, 1991; Rubin & Babbie, 2001). This level of significance was chosen because a more stringent standard ($p < .01$) would reduce the likelihood of identifying any significant association between variables and would increase the likelihood of committing a Type II error (Black, 1999; Boniface, 1995; Bouma & Ling, 2004; Keppel, 1991; Lipsey, 1990; Rubin & Babbie, 2001; Sapsford & Jupp, 1996).

Cohen acknowledges that to balance the risk between committing a Type I or Type II error, power could be established at .90 or higher. However, the sample size required for such a power value would have exceeded this researcher's resources. For the purposes of this research, using the power table from the Babbie text (2001), power was held at approximately .86. Cohen (1977) describes effect size as the degree to which a test result can be attributed to the research hypothesis. Rubin & Babbie (2001) have categorized effect sizes as "strong," "medium" and "weak (p.529)." The Rubin and Babbie text states (2001): "Effect size statistics portray the strength of association found in any study, no matter what outcome measure is used, in terms that are comparable across studies (p.527)." A medium effect size of .30 was chosen (Rubin & Babbie, 2001). Based on those criteria the minimum sample size for this study would be 100.

The actual size $N = 103$. Based on a significance level of .05 for two-tailed testing, the number of subjects for each comparison group are Group One (n=35), Group Two (n=35) and Group Three (n=33).

Sampling Design

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. Although initially considered a suitable option, it was determined that drawing a quota sample would not be appropriate as the subjects identified for participation would not be representative of their proportion of the target population (Black, 1999) – there are fewer low-income adults in recovery living in supportive housing settings than those that are not. Therefore, 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).

Although it is impossible to control for sampling error with a non-probability sample (Blalock, 1979; Rubin & Babbie, 2001; Sapsford & Jupp, 1996), the researcher did take measures to reduce interviewer bias. Both interviewers have previous history working with multi-needs populations and with persons of similar socio-economic and racial status. Additionally, one of the two interviewers also self-disclosed as having a history of recovery.

Data Collection Procedure

Prior to the commencement of data collection, the researcher obtained approval through the Institutional Review Board for research with human subjects. Subsequently, to solicit participants for all groups, flyers were created describing terms of eligibility, available interview dates and a contact number to schedule an appointment. Participants for Group Three were identified by an interviewer who has self-disclosed a history of recovery and who interacts in various self-help groups in the metropolitan Atlanta area. The interviewer distributed the flyers at these meetings. Recovery status and housing status was self-disclosed by participant. To solicit participants for Groups One and Two, flyers were provided to staff at both Welcome House and Hope House to distribute among participants that met criteria for length of sobriety and residency.

All participants of this confidential study completed written informed consent forms. All research participants received a $15 Kroger gift card which was issued upon completion of the survey. Participants were advised that all personal identifying information would be kept separate from their responses. For the members of Groups Two and Three, it was disclosed that the researcher was affiliated with the property owner and service provider, so to minimize any potential for harm it was emphasized that no one would be forced to participate and there would be no affect on their housing status should they decline participation. To reduce any sense of coercion, the researcher hired an interviewer to conduct the interviews with participants at Welcome House and Hope House. To further protect participant confidentiality, interview responses were returned to researcher with the responses separated from consent forms and other identifying information.

Ethical Considerations

Due to the sensitive nature of this research topic, great care was taken to respect the right to privacy and dignity of every participant in this study (Beauchamp, Faden, R. Jay Wallace, & Walters, 1982; Elsinga, 2004; Lee, 1993; Rubin & Babbie, 2001). All efforts were made to reduce any potential risk of harm to the participants. It should be acknowledged that regarding their disclosure about their history with substance addiction, individuals living in supportive housing have already disclosed their recovery status as part of the criteria for qualifying for such housing so there is minimal risk of harm regarding that disclosure to the interviewer. Additionally, as the sample population was disproportionately African American, the researcher endeavored to ensure that the interview process was also racially and culturally-sensitive (Beauchamp et al., 1982; Lee, 1993).

Brown and Topcu (2003) report that rates of participation in health-related studies are generally low but are more so among racial/ethnic minority communities. Once correlated with lower incomes, the authors assert that the numbers drop even lower. There was no expressed concern among participants regarding concern for physical harm as there might be for clinical trials. However, the researcher took measures to mitigate any concern for repercussions to participants resulting from how the information would be used. Although it was not possible to ensure anonymity, measures were taken to ensure confidentiality for all participants as survey responses did not include any identifying data such as the subject's name or social security number on the individual forms. Survey responses were only identifiable by a code "WHouse#", "HHouse#" or "NonSupp#" accompanied by a numerical digit identifying the chronological number of the participant for each group.

Description of Variables

Supportive Housing

Supportive housing combines a decent, affordable place to live with social services that assist the individual with learning and/or reinforcing coping skills to deal with the external challenges that would impede success. The two components common to Welcome House, Hope House and all supportive housing programs are the provision of *housing* and *social support* (CSH, 2007). As the study does not analyze the program components, the independent variable, supportive housing, was operationalized by identifying both housing status and the 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 is the second of three dependent variables featured in this study. Self-efficacy has been identified as integral to both well-being (Bandura, 1997) and relapse prevention (Marlatt et al., 1995). For the purposes of this study, self-efficacy was measured by observing between-group differences in the mean scores of Generalized Expectancy for Success Scale and the Drug Taking Confidence Questionnaire (which are both further detailed later in this chapter). Additional analysis was also prepared on the examination of whether there was an association between said scores and the independent variable.

Employment

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

Further details on how these variables will be measured are detailed in the next section.

Outcome Measures

Participants completed three instruments: a confidential questionnaire developed by the researcher to collect primarily demographic information, the Generalized Expectancy for Success Scale (GESS-R) scale, and the Drug Taking Confidence Scale (DTCQ-8). Data were also obtained from quarterly and annual reports prepared by staff.

The questionnaire was designed by the researcher was used to obtain descriptive demographic data as well as to gather data on participants' addiction and housing history. The instrument also included questions to ascertain relevant data on educational, vocational, social, legal and health background. Such data were collected in an attempt to control for potential confounding variables.

In addition to the survey developed by the researcher, two other instruments were used to assess levels of self-efficacy (GESS-R) and drug-taking resistance (DTCQ-8). Although neither scale has been normed using comparable populations, both scales reveal high alpha coefficients (>.80). Alpha scores above .80 give evidence to high internal consistency reliability. Analysis of the questions used in both the GESS-R and the DTCQ-8 revealed minimal cultural or racial bias concerns.

Generalized Expectancy for Success Scale

The Generalized Expectancy for Success Scale (GESS-R) was published by the American Psychological Association. Originally designed by Bobbi Fibel and W. Daniel Hale, the GESS-R was used to help identify any difference between groups regarding their perception of future success in their endeavors. The researcher used this scale to measure the participant's 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, 2000). In the GESS-R, five filler questions were removed from the original 30-item scale to make the scale more appropriate for certain populations. 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).

According to Fischer & Corcoran (2000), the GESS yielded high internal consistency and scored an alpha of .90 for females and .91 for males. Test-retest reliability was found after a six-week period was .83 for both genders. The original scale was developed using predominantly middle-class, Caucasian college students (207 females and 132 males). The revised scale, tested on a similar population, has a split-half reliability alpha of .92. The scale features 13 items that are reversed scored. The authors, Hale et al. (1992), reported that validity was tested primarily with concurrent validity procedures. Scores correlated significantly with conceptually related measures such as the Rosenberg Self-Esteem Test, the Life Orientation Test (LOT), and the Rotter's Locus of Control Scale.

Drug Taking Confidence Scale

The eight-item Drug Taking Confidence Scale (DTCQ-8) was derived from an original 50-item version. The researcher used this instrument to help determine levels of efficacy among the sample population regarding individual resistance to relapse between the groups. Bandura's (1977) theoretical assertion is that personal expectations of mastery help determine behavioral change. Further, levels of expectations regarding self-efficacy can change over time in response to personal experiences or environmental factors. This researcher was particularly interested in discovering if there was a between-group difference in higher levels of efficacy that could be associated with duration of residency in supportive housing.

The DTCQ-8 was tested by Sklar and Turner (1999) and demonstrated consistent reliability and validity as consistent with the original scale. The 8-item version yielded and alpha score of .89. The correlation between the total scores for the DTCQ-8 and DTCQ-50 was .97. Assessment of construct validity was made by correlating the total DTCQ-8 score with three indicators of expectancies: motivation to quit, difficulty with quitting, and confidence. This scale was normed on 712 adults living in Canada. Subsequent use of the scale was with a population of Saudi Arabian adult males in inpatient treatment. The test has two versions to assess confidence levels in resisting use of either alcohol or drug of choice. Participants were allowed to self-report on one or both depending on their history with substances. Mean scores for each test will be evaluated for each participant.

Timetable and Budget for Research

Data collection was conducted over an eight-month period between August 2006 and March 2007 following IRB approval. Data were analyzed using the SPSS database program. The cost for this project was approximately $2,715, which reflects expenses primarily for interviewer

stipends and participant incentives. This researcher earned a dissertation grant award of $2,000 to cover the majority of the expenses.

Conclusions

This chapter addressed the methodology of the study. The research design, sampling and data collection procedures were examined. The sample population and the instruments used to measure outcomes were also described. The following chapter provides detail on research findings.

CHAPTER FIVE

RESULTS

The previous chapter examined the methodology of the study, describing the research design and data collection procedures. In addition, the variables and instruments of measure were also described. This chapter presents the findings of the study which sought to answer the following research questions:

1. Does a supportive housing environment positively affect outcomes among low-income individuals in recovery from addiction?

Specifically, when compared to individuals who do not live in supportive housing:

2. Are individuals who live in supportive housing more likely to experience longer periods of sobriety?
3. Are individuals who live in supportive housing more likely to experience higher levels of self-efficacy and expectancy for success?
4. Are individuals who live in supportive housing more likely to experience higher rates of employment?

Sample Population

This study examined the outcomes of 103 low-income adults in recovery from drug and alcohol addiction. 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.

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 (n=35) were residents of Welcome House SRO located in downtown Atlanta. These participants are leaseholders at this apartment complex and pay rent based on their household income each month. Among this group, 25 (71%) of the participants have lived at Welcome House between 3-18 months. Their mean length of sobriety was 18 months. Among the Group 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 SSI, SSDI, and general assistance as their source of income. All participants have access to recovery and other supportive services from the on-site staff of social workers and addiction counselors. Although there is 24-hour front desk security, residents at Welcome House are free to come and go without restrictions on their whereabouts. Residents share common spaces such as kitchens, TV lounges, and bath areas. As relapse is a part of recovery, tenants will only lose eligibility housing if they refuse to seek treatment after a relapse. Relapse is monitored through mandatory random drug screening.

Group Two (n=35) were the residents of Hope House located in downtown Atlanta. These participants live in a transitional housing community where residency is at-will and member fees are paid weekly. Resident tenancy ranged from 3-18 months. Their duration of sobriety averaged 14 months. Among Group Two participants, five (20%) respondents reported having a disabling condition that prevented them from working. Parenthetically, seven (14%)

Table 1

Demographic Characteristics for Group One

Variable	Frequency	Percentage
Age		
25-34 years	4	11.4
35-44 years	9	25.7
45-54 years	12	34.3
55-64 years	10	28.6
Total	35	100.0
Race		
African American/Black	31	88.6
Caucasian	4	11.4
Total	35	100.0
Employment status		
No	31	88.6
yes	4	11.4
Total	35	100.0
Current Income Range		
$0-500	21	60.0
$501-1000	12	34.3
$1501 or more	2	5.7
Total	35	100.0

Table 1 continued

Variable	Frequency	Percentage
Duration of Tenancy		
1-6 months	8	22.9
6-12 months	9	25.7
12-18 months	8	22.9
18-24 months	3	8.6
2-3 years	2	5.7
3 years or more	5	14.3
Total	35	100.0

participants reported receiving Social Security benefits, such as SSI, SSDI, and general assistance as their source of income. Participants access recovery and other supportive services from the 13-member on-site staff of case managers and addiction counselors. Members of this housing facility must perform daily chores and adhere to a daily curfew which is monitored by the 24-hour services staff. Members share common spaces such as kitchens, TV lounges, and bath areas. Members must also agree to submit to random drug testing. Relapsing members are terminated from the program in order to enter treatment. After treatment compliance, members are permitted to return to Hope House.

Table 2

Demographic Characteristics for Group Two

Variable	Frequency	Percentage
Age		
25-34 years	1	2.9
35-44 years	11	31.4
45-54 years	19	54.3
55-64 years	4	11.4
Total	35	100.0
Race		
African American/Black	32	91.0
Caucasian	3	9.0
Total	35	100.0
Current Income Range		
$0-500	9	25.7
$501-1000	15	42.9
$1001 - $1500	8	22.9
$1501 or more	3	8.6
Total	35	100.0

Table 2 continued

Variable	Frequency	Percentage
Duration of Tenancy		
1-6 months	18	51.4
6-12 months	11	31.4
12-18 months	6	17.1
Total	35	100.0

Group Three (n=33) was 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 One lived in housing that offered on-site staff or any services to assist with relapse prevention. All participants were residents of Fulton County, Georgia, and 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.

Table 3

Demographic Characteristics for Group Three

Variable	Frequency	Percentage
Age		
25-34 years	1	3.0
35-44 years	22	66.7
45-54 years	8	24.2
55-64 years	1	3.0
Total	32	97.0
Missing System	1	3.0
Total	33	100.0
Race		
Afr. American/Black	29	88.0
Caucasian	4	12.0
Total	33	100.0
Employment status		
No	16	48.5
Yes	17	51.5
Total	33	100.0

Table 3 continued

Variable	Frequency	Percentage
Current Income Range		
0	1	3.0
$0-500	13	39.4
$501-1000	9	27.3
$1001-$1500	7	21.2
$1501 or more	3	9.1
Total	33	100.0
Duration of Tenancy		
1-6 months	23	69.7
6-12 months	5	15.2
12-18 months	2	6.1
2-3 years	2	6.1
3 years or more	1	3.0
Total	33	100.0

Results of Analysis of Sobriety

The hypotheses developed from the above-mentioned research questions and the corresponding findings are presented as follows.

Hypothesis one: 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.

Results: Initial analysis involved using a One-way ANOVA 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 Welcome House participants (n=35) was *M*=18.30 (SD=17.04), Hope 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.

It should be noted that the 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, 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 was chosen as it is among the more conservative procedures that can be employed to control for Type I error. Rather than adjusting the level of significance as with the Bonferroni technique, the Tukey HSD adjusts the size of the critical value used to determine whether the observed difference is significant. The investigation utilizing the Tukey HSD did reveal statistically significant differences for Welcome House and Hope House when each were contrasted with the Non-Supportive Housing group (see Table 4).

Table 4

Tukey HSD Post-hoc Analysis of Between-Group Difference for Sobriety

Housing Type		Mean difference	Std. error	Sig.
Welcome House	Hope House	4.200	2.767	.287
	Non-Supportive Housing	10.909*	2.787	.000
Hope House	Welcome House	-4.200	2.767	.287
	Non-Supportive Housing	6.709	2.767	.045
Non-Supportive Housing	Welcome House	-10.909	2.787	.000
	Hope House	-6.709	2.767	.045

Further analysis to identify any association between the duration of residency (interval) and months of sobriety (ratio) was conducted using the Pearson's *r* correlation. The findings from that analysis also proved statistically significant for a positive association (see Table 5) for Welcome House and Hope House at $p<.05$ (see Table 5). Of particular note was the correlational coefficient .620 for Welcome House.

Results of Analysis on Self-Efficacy

Hypothesis Two: 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.

Table 5

Pearson's r Analysis of Duration of Residency and Duration of Sobriety

Housing Type			Length Of Residency	Months Sobriety
Welcome House	Length Of Residency	Pearson Correlation	1	.620(**)
		Sig. (2-Tailed)		.000
	Months Clean And Sober	Pearson Correlation	.620(**)	1
		Sig. (2-Tailed)	.000	
Hope House	Length Of Residency	Pearson Correlation	1	.422(*)
		Sig. (2-Tailed)		.013
	Months Clean And Sober	Pearson Correlation	.422(*)	1
		Sig. (2-Tailed)	.013	
Non-Supportive Housing	Length Of Residency	Pearson Correlation	1	.224

Table 5 continued

Housing Type			Length Of Residency	Months Sobriety
		Sig. (2-Tailed)		.210
	Months Clean And Sober	Pearson Correlation	.224	1
		Sig. (2-Tailed)	.210	

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
a housing type=Welcome House,:Listwise N=33
b housing type=Hope House,:Listwise N=34
c housing type=Non-supportive housing,:Listwise N=33

Results of Analysis on Self-Efficacy

Hypothesis two: 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.

Results: Mean scores obtained for the GESS-R and both versions of DTCQ-8 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. Reports on data for each scale follows.

Generalized expectancy for success scale-R. As previously stated in Chapter Four, the Generalized Expectancy for Success Scale-R is scored additively and the highest possible score

is 145, with higher scores indicating 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 are as follows: Welcome House (Group One) participants (n=35) was *M*=126.5, SD=26.81, *F*=.515, p=.762, η=.28; Hope House (Group Two) participants (n=35) was *M*=135.3, SD=17.90, *F*=.147, p=.863, η=.09; and Non-Supportive Housing (Group Three) participants (n=33) was *M*=132.97, SD=18.41, *F*=.943, p=.454, η=.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. Table 6 indicates mean scores according to length of residency.

Drug taking confidence questionnaire – 8 (DTCQ-8). As previously stated in Chapter Four, there were two versions of the DTCQ-8 that 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 of the measure were obtained by summing the responses and dividing by 8 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 measure of association are as follows for Welcome House (Group One) participants (n=28) was M=67.10, SD=31.89, *F*=1.704, p=.176; η=.53; Hope House (Group Two) participants (n=30) was M=73.42, SD=17.90, *F*=.065, p=.938; η=.07; and Non-Supportive Housing (Group Three) participants was M=75.00, SD=24.42, *F*=.452, p=.770; η=.35. Table 7 indicates mean scores according to length of residency.

Table 6

Mean Scores for GESS-R by Group and Duration of Residency

Housing Type	Length Of Residency	Mean	N	Std. Deviation
Welcome House	1-6 Months	121.88	8	30.02
	6-12 Months	128.67	9	30.75
	12-18 Months	125.25	8	16.97
	18-24 Months	149.00	3	5.00
	2-3 Years	119.50	2	31.82
	3 Years+	121.00	5	37.05
	Total	126.46	35	26.81
Hope House	1-6 Months	134.50	18	17.72
	6-12 Months	137.73	11	15.50
	12-18 Months	133.33	6	24.74
	Total	135.31	35	17.90
Non-Supportive Housing	1-6 Months	130.57	23	19.89
	6-12 Months	146.40	5	11.35
	12-18 Months	135.00	2	12.73
	2-3 Years	122.50	2	13.44
	3 Years +	138.00	1	.
	Total	132.97	33	18.41

Table 7

Mean Scores for DTCQ-8 (Alcohol version) by Group and Duration of Residency

Housing Type	Length Of Residency	Mean	N	Std. Deviation
Welcome House	1-6 Months	75.00	4	31.89
	6-12 Months	73.33	9	28.31
	12-18 Months	35.63	6	44.30
	18-24 Months	92.50	3	12.99
	2-3 Years	37.50	1	.
	3 Years Or More	78.00	5	38.99
	Total	67.10	28	36.33
Hope House	1-6 Months	73.36	16	34.51
	6-12 Months	71.25	9	27.46
	12-18 Months	77.50	5	24.50
	Total	73.42	30	30.18
Non-Supportive	1-6 Months	72.05	11	26.19
Housing	6-12 Months	75.00	3	30.72
	12-18 Months	57.50	1	.
	2-3 Years	91.25	2	12.37
	3 Years Or More	92.50	1	.
	Total	75.00	18	24.42

Drug version: The difference in mean scores obtained through a One-way ANOVA procedure and Eta scores obtained for measure of association are as follows for Welcome House (Group One) participants (n=29) was M=65.82, SD=31.89, F=.50, p=.774; η=.31; Hope House (Group Two) participants (n=28) was M=77.74, SD=17.90, F=1.08, p=.354; η=.28; and Non-Supportive Housing (Group Three) participants (n=30) was M=84.67, SD=18.41, F=.21, p=.932; η=.17. Findings from this analysis of association were not found to be statistically significant which indicates a failure to reject the null hypothesis. Group Three participants did average higher scores on this version of the DTCQ-8. Table 8 provides mean scores according to length of residency.

Analysis of Rates of Employment

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 services.

Results: Initial analysis employing the Chi-square statistical measure (see Table 9) did reveal a statistically significant difference (p=.000, p<.05) in means for housing type (nominal) and employment status (nominal). As indicated in the cross-tabulation (see Table 10), there were higher rates of employment at Hope 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 (see table 10), p<.05.

Table 8

Mean Scores for DTCQ-8 (Drug version) by Group and Duration of Residency

Housing Type	Length Of Residency	Mean	N	Std. Deviation
Welcome House	1-6 Months	61.25	8	24.09
	6-12 Months	64.29	7	32.97
	12-18 Months	60.89	7	37.48
	18-24 Months	100.00	2	.00
	2-3 Years	66.25	2	30.05
	3 Years Or More	70.00	3	51.96
	Total	65.82	29	31.65
Hope House	1-6 Months	85.98	14	24.45
	6-12 Months	67.54	9	39.93
	12-18 Months	73.00	5	25.34
	Total	77.74	28	30.49
Non-Supportive	1-6 Months	83.00	20	26.97
Housing	6-12 Months	88.50	5	20.36
	12-18 Months	77.50	2	31.82
	2-3 Years	91.25	2	12.37
	3 Years Or More	100.00	1	.
	Total	84.67	30	24.35

Table 9

Chi-Square Analysis of Association between Housing Type and Employment Status

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	20.938(a)	2	.000
Likelihood Ratio	23.196	2	.000
Linear-by-Linear Association	11.469	1	.001
N of Valid Cases	103		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 13.78.

Table 10

Cross-tabulation of Length of Residency and Employment

			Employment Status		Total
Housing Type			No	Yes	No
Welcome House	Length Of Residency	1-6 Months	7	1	8
		6-12 Months	8	1	9
		12-18 Months	7	1	8
		18-24 Months	3	0	3
		2-3 Years	1	1	2
		3 Years Or More	5	0	5
	Total		31	4	35

Table 10 continued

Housing Type			Employment Status		Total
			No	Yes	No
Hope House	Length Of Residency	1-6 Months	5	13	18
		6-12 Months	6	5	11
		12-18 Months	2	4	6
	Total		13	22	35
Non-Supportive Housing	Length Of Residency	1-6 Months	11	12	23
		6-12 Months	2	3	5
		12-18 Months	1	1	2
		2-3 Years	1	1	2
		3 Years Or More	1	0	1
	Total		16	17	33

Table 11

Eta Statistics for Association of Length of Residency and Employment

Housing Type				Value
Welcome House	Nominal By Interval	Eta	Length Of Residency Dependent Employment Status Dependent	.035
				.338
Hope House	Nominal By Interval	Eta	Length Of Residency Dependent Employment Status Dependent	.114
				.247
Non-Supportive Housing	Nominal By Interval	Eta	Length Of Residency Dependent Employment Status Dependent	.109
				.192

Summary of Findings

The research project sought to determine if there was a positive association between the length of residency in supportive housing and longer periods of sobriety, higher levels of self-efficacy and higher rates of employment for low-income adults in recovery. Residents of two supportive housing developments were compared with low-income individuals who were utilizing traditional housing situations. Analysis of data on the correlation between length of residency and length of sobriety was found to be statistically significant. Analysis of data on the association between length of residency in supportive housing the self-efficacy scores proved not to be statistically significant. Analysis of data on the association between housing type and employment status did prove statistically significant. However, when measures were taken of the association between length of residency and employment status, the null hypothesis could not be rejected. The results will be further discussed in the final chapter. Additionally, study limitations, areas of future research and the implications for social work will be explored.

CHAPTER SIX

DISCUSSION

The purpose of this study was to evaluate the efficacy of supportive housing as 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. Welcome House (Group One) provides a permanent housing with services setting. Hope House (Group Two) offers a time-limited transitional housing with services setting. Participants in Group 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 the three groups to determine if there was a correlation between more favorable outcomes for those variables for participants living in supportive housing. One hypothesis was fully supported, one hypothesis was partially supported, and the findings for one hypothesis did not prove statistically significant.

The first hypothesis predicted that there would be a statistically significant difference in the number of months clean and sober for those participants living in supportive housing when compared to participants in non-supportive housing settings. The results of a One-way ANOVA and subsequent post hoc Tukey HSD analysis did produce statistically significant findings. Comparatively, the statistics for mean months of sobriety were higher at both Welcome House and Hope House. Subsequent correlational analysis using Pearson's *r* supported the first

hypothesis and also showed the strength of association. The findings on Welcome House and Hope House do compare favorably with staff reports on sobriety from both supportive housing developments.

The second hypothesis predicted that there would be statistically significant differences in the efficacy scores for those living in supportive housing when compared to the scores of participants who live in non-supportive housing settings. The mean scores of the scales were compared and overall, the differences in means were not found to be statistically significant when supportive housing was compared to non-supportive housing. Although the GESS-R and DTCQ-8 scores for Hope House were significantly higher than Welcome House, the higher scores were not statistically significant when compared to the Non-supportive housing group. Again, further statistical analysis to identify any correlation between length of residency in supportive housing with higher levels of self-efficacy did not reveal any findings of statistical significance. Mean scores for the GESS-R scale progressively increased for participants in all three groups during the first year of residency. After the first 12 months of residency, the mean scores for all three groups also dropped.

Mean scores for the DTCQ-8 were collected based on Alcohol version and/or Drug of choice version. Unexpectedly, the Non-supportive housing group reported higher aggregate scores than the other two groups, with the Drug of choice version demonstrating scores seven points higher than Hope House and 20 points higher than Welcome House. It should be noted that these scores provide interesting contrast to participant self-reports on Question 5a of the Demographic questionnaire, *"How many times have you relapsed?"* which shows Group Three as having 31 reported relapses, the highest number of the three groups, and eight relapse occurrences of 10 times or more, the highest of the three groups, compared to Welcome House

with 11 reported relapses and three relapse occurrences of 10 times or more, and Hope House with 14 reported relapses and one relapse occurrence of 10 times or more.

As established, closer examination of the within group demographics did reveal a higher rate of the number of participants receiving an SSI subsidy (Social Security benefits for individuals who have a diagnosable physical, mental or developmental disability) at Welcome House (51%) when compared to Groups Two (20%) and Three (15%). Further analysis of the relevance of this phenomenon will be discussed in the next section.

The third hypothesis predicted that there would be higher rates of employment for those living in supportive housing when compared to participants residing in non-supportive housing settings. The initial Chi-square analysis did reveal statistically significant findings based on housing type. Specifically, participants at Hope House were more likely to be employed than participants from Welcome House or the Non-supportive housing groups. However, further examination correlating the duration of residency did not yield statistically significant findings.

The significant correlations between duration of residency in supportive housing and duration of sobriety compared favorably to supportive housing staff reports on both participant and program relapse rates for Welcome House and Hope House. Such corroboration serves as an indicator of the reliability of the outcome measures and of the strength of the research design. Furthermore, these results tend to corroborate the findings of Proscio (1998). Although not shown statistically significant, the results of the other two hypotheses do invite an opportunity for further study as the effort to better control for confounding variables, which will be discussed in the next section, may yield more favorable results.

Limitations

This investigation was concerned with obtaining answers to three relevant research questions. *Are individuals who live in supportive housing more likely to experience longer periods of sobriety? Are individuals who live in supportive housing more likely to experience higher levels of self-efficacy and expectancy for success? Are individuals who live in supportive housing more likely to experience higher rates of employment?* To find the answers to these questions the researcher employed a correlational research design that matched the outcomes of two supportive housing groups with a comparison group.

The correlational study design used in this research offered certain advantages, or strengths, compared to other research designs. Compared to doing a qualitative study, this design offered more efficient timeliness in obtaining the data, and its quantitative methods were expected to better measure and therefore express the strength of the relationship between variables (Rubin & Babbie, 2001). Unlike research instruments used in qualitative research design, survey questions typically invite a closed-ended response that can be easily tabulated and measured. However, that efficiency can present a disadvantage in that the researcher cannot capture nuance of participant response, and cannot account for differences in interpretation of questions asked. Importantly, according to the Rubin & Babbie text (2001), "…surveys appear superficial in their coverage of complex topics (p.381)."

By adopting a qualitative approach to the research, the researcher would more likely have attained more depth of understanding of the individual experiences of residents living in supportive housing. However, the qualitative approach would not have provided a feasible opportunity to give weight to a relationship between variables as the number of subjects being studied would have to have been considerably less (Rubin & Babbie, 2001).

This correlational study captured data from subjects who were receiving the intervention of supportive housing and compared it to those who were not. Although correlational studies are not intended to make assertions about a causal relationship between variables (Black, 1999; Rubin & Babbie, 2001), the external validity of this study was strengthened by choosing a moderate effect size (.50) and a high power level (.86) which demanded a credible sample size. Furthermore, based on demographic data obtained from a report (2005) by the Regional Commission on Homelessness, sponsored by the United Way, the sample population represents an accurate reflection of the racial composition and economic status common among occupants of supportive housing in the metropolitan Atlanta area. That said, despite taking considerable precautions, it is rare that a study can be designed and executed that would totally control for the presence of confounding variables or other disruptive factors that may influence outcomes. In this instance, this researcher has identified certain factors that may have imposed limitations for this particular study.

The first limitation was instrumentation, which can pose a threat to internal validity. Although the outcome measures used in this study have reasonably established reliability and validity, there is no evidence that either has been widely used with populations of similar cultural or socio-economic backgrounds, or in the case of the *Generalized Expectancy for Success Scale,* on populations with health concerns that would affect employment status. Given the disproportionately large number of participants at Welcome House reporting permanent disability status, their responses to questions about career expectations would inevitably predict an overall lower score for Group One when compared to the other two groups and thus not provide a genuinely, comparable measure of expectancy for personal success. This is significant as the responses to those four questions could yield a variance in excess of 20 points. Given the

mean score of 126.46 on the GESS-R scale for Welcome House participants, the comparison of outcomes could have yielded markedly different results.

Ancillary to this discussion, the second limitation of this study was the failure to control for the presence of dually-diagnosed participants. Although the researcher did expect individuals with such status to be present in the study, the disproportionate representation within one group was unexpected. Further study is needed to understand what influence the presence of an additional physical or mental health challenge might pose on self-efficacy scores. Again, responses on the DTCQ-8 were found to be markedly lower for Welcome House participants when compared to the other two groups. Indications from the outcomes of this study are that it poses a negative effect on higher levels of efficacy. However since the scores at Hope House were not higher than the non-supportive housing group in most instances despite higher rates of employment at Hope House, it cannot be interpreted as the only determining factor.

The third limitation was the failure to control for a particular kind of housing situation among the Non-supportive housing participants. If Group Three would have been comprised solely of individuals renting their own apartment, the comparison of participants would have been more similar when to those in Groups One and Two. However, given the difficulty already established in securing affordable housing for individuals with low-income status combined with recovery history, such an effort would likely have posed an unreasonable delay on the timely collection of the data.

Significance of the Findings

The participants in Groups One and Two demonstrated significant differences in duration of sobriety that was found to be associated with their duration of residency in supportive housing. This finding is very important because it helps to further validate the merit of the use of

supportive housing in helping to reduce the ranks of the chronically homeless. Its use as intervention in reducing the rate of relapse among low-income adults in recovery helps reduce the recidivism back to homelessness that promotes chronic homelessness.

Regarding self-efficacy, the results of this particular study did not show to be statistically significant. However, given that the persons who are homeless who are also coping with dual diagnoses for substance dependence and other physical or mental health concerns tend to consume the majority of homeless services, and given the established relationship between self-efficacy and relapse prevention, there is merit to conducting further study.

Regarding employment status, the findings demonstrating Hope House as having higher rates of employment is significant as it reflects the deliberate efforts typically made by supportive housing developments (CSH, 2007; Hannigan & Wagner, 2003; LSRO, 2005; Proscio, 1998) to provide such linkages for its residents. Again, the disproportionate numbers of individuals receiving SSI among Welcome House participants did not accurately characterize that effort.

Last, this research effort helps to provide additional empirical data on the effectiveness of supportive housing and brings attention to supportive housing programs in the metropolitan Atlanta area. Importantly, this study also contributes to the knowledge base of policy makers and practitioners seeking to address the issues of both chronic homelessness and relapse prevention.

Implications of Findings

Although not inferring a causal relationship, this study does provide some evidence to support the hypothesis that living in supportive housing may be associated with overall well-being for adults in recovery. Evidence of statistically significant differences in durations of

sobriety coupled with higher rates of employment were found for the supportive housing participants in Group Two.

Further study is merited to better understand if a correlation exists between supportive housing and self-efficacy. Perhaps a better analysis of this phenomenon would include a comparison of self-efficacy levels at move-in with repeated measures in six-month increments for the first 18 months. The research question would then be "what affect does the duration of residency in supportive housing have on the self-efficacy of participant compared to their prior housing arrangement." The outcomes of this analysis would offer a more meaningful understanding of the relationship, should any association be found.

Implications for the Social Work Profession

This study contributes to the knowledge base of social work professionals and provides empirical support for micro and macro social work practice with chronically homeless populations, particularly adults in recovery. The services staff at both Welcome House and Hope House includes social work professionals who coordinate and implement services. This study also highlights the social work profession's unique ongoing history with affordable housing.

Now, just as in the days of Jane Addams and Hull House, social workers are actively involved in helping vulnerable citizens by integrating housing with social services (Berson, 2004). Back then, during the time known as the Progressive Era, community-based programs and services were designed to assist incoming immigrants and the poor to adjust to America's newly industrializing cities. In addition, settlement houses targeting African Americans, such as the Flanner House in Indianapolis and the Neighborhood House here in Atlanta, were also established (Crocker, 1992). Although created to meet a critical housing need, the settlement houses also became environments for social research. Even then, researchers of the time wrote

about the interdependence of housing and neighborhood, stress, and family relationships (Cohen, Mulroy, et al, 2004). Supported by the results of their data, they advocated at policy levels for improvements in deplorable tenement housing conditions. Today, researchers continue to study the correlation between housing and well-being.

Social work professionals have an obligation to continue to evaluate their practice, refine their intervention strategies and share their 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. Kemeney (1992) wrote:

> "There is large literature on the definition of social problems which argues that what is or is not defined as a social problem is the result of the ability of particular interests and social groups to impose their definitions on the ways in which issues are conceived… Governments wishing to reduce housing expenditure, particularly in a time of financial retrenchment, may wish to change definitions of 'housing need' as a means of reducing public expectations of housing standards…(p.31).

Continued vigilance will help counter the systemic forces that compel us to view the weak and vulnerable among us as universally bad or undeserving. Everyone who seeks it should have a chance to change their lives for the better. Every human being 'deserves' a chance to have their basic needs met. Therefore, housing and social work are inexorably linked as 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).

Conclusion

Given the gravity of the costs – both social and economic – connected to homelessness, one might ask why there isn't a more aggressive effort to ameliorate this problem. Part of the answer, as previously addressed, is evidenced in how America has historically regarded its poor. The advent of the creation of the McKinney-Vento Act is an indicator that while positive steps are being taken, more work must be done. This policy represents formal and tangible acknowledgement of government's role in helping its indigent. However, further evidence of the values conflict among our policymakers is the ongoing challenge to ensure that the legislation is adequately funded to meet the unrelenting demand. Also challenging is the constant search for resources to fund the social services provided. Ironically, the Shelter Plus Care program created under the McKinney Act and utilized at Welcome House requires that services be made available to residents but does not authorize any use of the financing awarded to pay for them.

This study demonstrated significant differences in the duration of sobriety for supportive housing residents when compared to sobriety rates for individuals in non-supportive housing settings. This finding is very important because it helps to further validate the merit of the use of supportive housing as macro-level intervention. It is this researcher's hope that this study and others that may follow will contribute more evidence of the social, economic and human benefit of providing more supportive housing opportunities to help reduce the ranks of the homeless.

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APPENDICES

APPENDIX A

Supportive Housing Resident Participant Survey

1. How long have you lived at your current residence? _____

__1 - 6 months __ 6 - 12 months __ 12 -18 months

__18-24 months__ 2+ years __3+ years

1a. Where did you live before moving here?

___ apartment ___ treatment facility ___ with relatives

___correctional facility ___ shelter ___ other _____

1b. How long were you there? _____

__1 - 6 months __ 6 - 12 months __ 12 -18 months

__18-24 months__ 2+ years __3+ years

1c. How many times have you moved since getting clean and sober? _____

2. Are you currently working? ____ Yes____No

If yes, ask 2a only:

2a. How long employed _____

If no, ask 2b, 2c, and 2d:

2b. are there any health issues that prevent you from working? ___Yes ___No

2c. If no, are you currently looking for work? ___Yes ___No

2d. If no, what is your primary source of income? _____

3. What is your monthly income? _____ $0-$500 ____$501-1000

____ $1001-$1500 _____ $1501 or more

4. How long have you been clean and sober? _____

5. Have you ever relapsed? ____ No ____ Yes

If no, skip 5a and 5b:

5a. How many times? _____

5b. Have you relapsed since moving here? ____ Yes ____ No

6. What is the highest level of education that you have obtained?

____ some high school ____ high school diploma/GED

____ vocational training ____ some college ____ college degree

7. What is your trade or profession?_____

8. What was the last job you held before going into treatment?

_____

8a. How long were you employed there? _____

9. Where did you live before going into treatment?

___ was homeless ___ with relatives ___ had own apartment

___ other: _____

10. How old were you when you first started using drugs and/or alcohol? _____

11. What was your drug(s) of choice? _____

12. Have you ever been in trouble with the law? _____Yes _____No

If yes, ask the 12a, 12b and 12c:

12a. Was it related to your drug/alcohol use? _____Yes _____No

12b. Have you ever been incarcerated? _____Yes _____No

12c. How many times?_____

13. How many times have you sought treatment for your addiction? _____

If more than once:

13a. How many times did you complete treatment program?_____

14. Was your last completed treatment program in-patient or out-patient?

___inpatient ___ outpatient

15. What support(s) do you have for aftercare? Choose all that apply:

____ 12-step program ____ sponsor ____ case worker ___ services where I live

____ other: _____

16. What goals have you set for the next six months? _____

_____

17a. for the next year? _____

_____

17. Age: __ 18-24 __ 35-44 __55-64

__ 25-34 __45-54 __65 and older

18. Sex: ____Male _____Female

If you reside in a supportive housing development, please answer the following:

19. Complete the statement by choosing all that apply:

"Because I live in a supportive housing community I have been able to:

___ participate in job training ___ find a job ___ get off welfare

___ remain clean and sober ___ get counseling ___ stay out of trouble

___ be more involved with my family ___ _____

20. Do you agree or disagree with this statement?

"The assistance that I receive by living in supportive housing has helped me to resist the temptation to use again."

_____ Agree _____ Disagree

APPENDIX B

GENERALIZED EXPECTANCY FOR SUCCESS SCALE

Generalized Expectancy for Success Scale – Revised
GESS-R

ITEM	Strongly Disagree 1	2	3	4	5	6	Strongly Agree 7

In the future, I expect that I will…

1. ___ Succeed at most things I try
2. ___ Be listened to when I speak
3. ___ Carry through my responsibilities successfully
4. ___ Get the promotions I deserve
5. ___ Have successful close personal relationships
6. ___ Handle unexpected problems successfully
7. ___ Make a good impression on people I meet for the first time
8. ___ Attain the career goals I set for myself
9. ___ Experience many failures in my life
10. ___ Have a positive influence on most of the people with whom I interact
11. ___ Be able to solve my own problems
12. ___ Acquire most of the things that are important to me
13. ___ Find out that no matter how hard I try, things just don't turn out the way I would like
14. ___ Be a good judge of what it takes to get ahead
15. ___ Handle myself well in whatever situation I'm in
16. ___ Reach my financial goals
17. ___ Have problem working with others
18. ___ Discover that the good in life outweighs the bad
19. ___ Be successful in my endeavors in the long run
20. ___ Be unable to accomplish my goals
21. ___ Be very successful working out my personal life
22. ___ Succeed in the projects I undertake
23. ___ Discover that my plans don't work out too well

24. ___ Achieve recognition in my profession
25. ___ Have rewarding intimate relationships

APPENDIX C

DRUG-TAKING CONFIDENCE QUESTIONNAIRE - 8

(ALCOHOL VERSION)

Drug Taking Confidence Questionnaire
DTCQ-8

For alcohol version: ***"I would be able to resist the urge to drink heavily…***

Response Scale	0, not at all confident	20	40	60	80	100, very confident

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1. ___ If I were angry at the way things had turned out
2. ___ If I had trouble sleeping
3. ___ If I remembered something good that had happened
4. ___ If I wanted to find out whether I could drink occasionally without getting hooked
5. ___ If I unexpectedly found some liquor or happened to see something that reminded me of drinking
6. ___ If other people treated me unfairly or interfered with my plans
7. ___ If I were out with friends and they kept suggesting we go somewhere and drink
8. ___ If I wanted to celebrate with a friend

APPENDIX D

DRUG-TAKING CONFIDENCE QUESTIONNAIRE - 8

(DRUG OF CHOICE VERSION)

Drug Taking Confidence Questionnaire
DTCQ-8

For drug version: *"I would be able to resist the urge to use _____…*

Response Scale	0, not at all confident	20	40	60	80	100, very confident

1. ___ If I were angry at the way things had turned out
2. ___ If I had trouble sleeping
3. ___ If I remembered something good that had happened
4. ___ If I wanted to find out whether I could use _____ occasionally without getting hooked
5. ___ If I unexpectedly found some _____ or happened to see something that reminded me of using
6. ___ If other people treated me unfairly or interfered with my plans
7. ___ If I were out with friends and they kept suggesting we go somewhere and use _____
8. ___ If I wanted to celebrate with a friend