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ORIGINAL ARTICLE

Distal supports, capabilities, and growth-focused recovery: A comparison of Housing First and the staircase continuum of care

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Abstract

Adults who have substantial histories of homelessness and complex support needs may feel ambivalent about integrating into their communities and find it difficult to do so. Being familiar to and recognized by others as a resident in a neighborhood or community are sources of "distal support" that provide individuals with feelings of belonging to their community and are important to recovery from homelessness. We hypothesized that individuals engaged with Housing First (HF) programs would report more distal support than individuals engaged with traditional homeless services (treatment as usual, TAU), and that distal support would predict more community integration, growth-related recovery, and achieved capabilities. We analyzed data collected from homeless services users ($n = 445$) engaged with either HF or TAU in eight European countries. Measures included achieved capabilities, growth-focused recovery, distal supports, and community integration. Serial mediation analyses confirmed our hypothesis that the effects of HF on growth-related recovery and achieved capabilities are indirect, mediated by distal supports and community integration. Findings are discussed in relation to the importance of modeling the effects of HF on social and psychological outcomes as indirect and identifying important mediators that translate the effects of HF components on social and psychological outcomes. We also note the importance of case management activities that encourage clients to develop and sustain distal supports with others who live and work in their neighborhoods.

KEYWORDS

achieved capabilities, community integration, distal supports, Housing First, recovery

Highlights

- Participants in Housing First (HF) reported more distal supports (DS) than those in staircase services.
- More distal supports predicted stronger sense of community integration (CI).
- The link from Housiing First to well-being indicators is indirect, through DS and CI.
- More research on the indirect effects of HF on important well-being outcomes is needed.
- Future research should identify the specific mechanisms through whch HF programs promote DS.

INTRODUCTION

Housing First (HF) is an internationally recognized, evidence-based practice that effectively ends long-term homelessness for adults who have complex support needs resulting from mental health or substance use problems (Padgett et al., 2016; Tsemberis et al., 2004). The HF model is underpinned by both a human rights perspective on housing and a harm reduction orientation to mental health and substance use treatment (Tsemberis, 2020). HF programs provide independent scatter-site housing along with intensive wraparound support services that are client-led and recovery-oriented. Community integration is a key principle of HF, and case managers support their clients to develop connections with the people who work and live in their neighborhoods (Tsemberis et al., 2004). These "weak ties," referred to as "distal supports" (DS), may help new residents feel accepted and recognized, and so foster a sense of belonging, which is important to recovery and well-being (Townley et al., 2013; Wieland et al., 2007). In this study, we examined the relationship of distal supports to community integration (McColl et al., 2001), achieved capabilities (Greenwood et al., 2023), and growth-related recovery (Corrigan et al., 2004) for adults with histories of homelessness and complex needs who were engaged with either HF services or traditional services aligned with the staircase continuum of care, which we refer to as treatment as usual (TAU).

Using community resources, meeting others, and being recognized by others are important to well-being for everyone (e.g., Seligman, 2018), but they are particularly important to individuals living in or exiting from homeless situations because community integration is associated with better recovery outcomes (e.g., La Motte-Kerr et al., 2020; Pahwa et al., 2021; Townley et al., 2013). Small regular interactions with others to whom one has weak ties have the potential to grow into positive and supportive relationships (Moreton et al., 2023; Sandstrom & Dunn, 2014). However, stigma and discrimination are social factors that undermine integration into a community and sense of belonging to it (Belcher & DeForge, 2012; Mejia-Lancheros et al., 2020; Schreiter et al., 2021). HF programs strive to overcome stigma by providing housing integrated into the community and by supporting clients to use neighborhood resources like shops, cafes, pharmacies, and recreational facilities (Tsemberis et al., 2004), which creates opportunities for clients to become familiar to others who work and live around them. We hypothesized that participants engaged in HF programs would experience greater distal support than participants engaged in traditional mainstream homeless services.

Throughout this article, we use the term "treatment as usual" (TAU) to refer to services on the staircase continuum of care. TAU services are often referred to as the "staircase continuum of care" because they require individuals to move through a series of steps, from outreach through emergency, temporary, and long-term homeless accommodation, that are highly regulated, often abstinence-based, and contingent on compliance with mental health treatment (Padgett et al., 2016; Sahlin, 2005). Although community integration may be an aspiration of traditional services providers for their clients, they tend to emphasize rehabilitation-focused goals such as abstinence, treatment compliance, and behavioral change (Manning & Greenwood, 2019). Moreover, the typical configuration of these services as congregate accommodation with onsite supports means they are readily identifiable within a neighborhood, making residents visible and easily stigmatized targets of discrimination (e.g., Armstrong et al., 2021; Bhui et al., 2006; Bourlessas, 2022). For these reasons, we hypothesized that participants in TAU will report lower levels of distal support than participants in HF programs.

DISTAL SUPPORTS, COMMUNITY INTEGRATION, AND RECOVERY

DS arise from regular informal interactions with others who work or live in one's community, for example, in pharmacies, shops, and cafes (Townley et al., 2013; Wieland et al., 2007). DS can be tangible (e.g., financial, material, or service needs), informational (e.g., helpful information, advice, and directions), or emotional (e.g., concern, trust, and empathy) (Townley et al., 2013). Previous research demonstrated that DS correlates with community integration and improved mental health (Wieland et al., 2007).

Linking clients to resources and activities in the community that match their preferences and needs is a core activity of HF teams (Tsemberis, 2020). Examples include services like pharmacies, shops, paid employment, volunteer work, attending church, going to restaurants, and using parks and gyms. HF case managers encourage positive interactions between their clients and the individuals who provide services to them and those who participate alongside them in community activities. In these ways, HF clients are actively encouraged to create the kinds of weak ties that Wieland et al. (2007) hypothesized channel distal support and foster feelings of belonging within a community.

However, evidence that HF programs successfully enable their clients to integrate into their communities and feel they belong in them is mixed. In a recent systematic review, Marshall et al. (2020) identified five studies that examined the effectiveness of HF for community integration measured as either physical, social, or psychological, and reported that none were associated with more physical integration, while two reported mixed results for social integration. Of three studies that assessed psychological integration, only one reported improvements in psychological integration. In this study, HF clients with moderate support needs living in scatter-site accommodation reported higher psychological integration at two time points than participants in the TAU group (Patterson et al., 2014).

Evidence from qualitative, quasi-experimental, and correlational investigations of the integration experiences of HF clients are somewhat more encouraging, but still mixed. For example, Ornelas et al. (2014) reported that clients in HF described positive changes in the extent to which they met up with friends and visited places in their communities like cultural centers, coffee shops and churches once they received housing through HF. Other findings suggest that any relationship between HF and community integration may be indirect rather than direct. For example, participant and neighborhood characteristics may be important moderators or mediators of the relationship between HF and community integration outcomes (Terry & Townley, 2019; Yanos et al., 2007). Individuals with problematic substance use or psychiatric symptoms may find it more difficult to establish a sense of belonging or ties with others in their new communities than those with mild or moderate needs (Bassi et al., 2020; Patterson et al., 2014). In the present study, we hypothesized that the effect of program type (HF vs. TAU) is indirect, mediated by distal supports, so that individuals engaged with HF programs will experience more distal support, and that distal support will mediate the relationship between program type and community integration.

For individuals learning to manage serious mental health problems, DS may be important not only for community integration, but also for recovery. Among individuals living in the community with psychiatric disabilities, DS predicted both community integration and recovery (Townley et al., 2013; Wieland et al., 2007). In another study, positive appraisals of neighbors were related to a stronger sense of community and less loneliness for participants with and without psychiatric disabilities (Kriegel et al., 2020). Together, these studies demonstrate that community integration may be enhanced in neighborhoods where individuals living with serious mental illness have opportunities to experience DS. Through the experience of DS, an individual may feel recognized and included in their community in ways that allow them to feel safe and secure (Wieland et al., 2007). DS may also stave off the loneliness one might experience upon moving to a new home in a new community (Rhoades et al., 2021).

Recovery is complex and multidimensional. Corrigan and Phelan (2004) defined recovery from serious mental illness as a growth-related process through which individuals develop and strengthen positive appraisals of themselves and their futures, particularly in the domains of hope and goals and as an outcome, in which individuals have learned to effectively manage their symptoms. These aspects of psychological well-being, principally in terms of a meaningful life and satisfaction with life, are important domains of recovery for individuals with histories of homelessness, psychiatric disabilities, and problematic substance use (Henwood et al., 2015; Kirst et al., 2014; Mathis et al., 2009; Schrank et al., 2012).

"Achieved capabilities" refers to opportunities: an individual's freedom to do what they want to do and to be who they want to be, given their social, cultural and economic contexts (Sen, 1979), and researchers in homeless studies have begun to apply the capabilities approach (CA) in their conceptualizations of homelessness, homeless services interventions, and recovery (Batterham, 2019; Greenwood et al., 2022; Kerman & Sylvestre, 2020; Mcnaughton-Nicholls, 2010; O'Shaughnessy & Greenwood, 2020; Shinn, 2015). Recent research demonstrated that achieved capabilities are important indicators of the extent to which an individual has recovered functioning in important life domains (Greenwood et al., 2020, 2022; O'Shaughnessy & Greenwood, 2020).

In the present research, we tested the hypotheses that individuals engaged with HF programs would report greater recovery as measured on the Recovery Assessment Scale (Corrigan & Phelan, 2004) and more achieved capabilities (Greenwood et al., 2023) than individuals engaged with traditional staircase services. Further, we hypothesized an indirect relationship of program type to our recovery outcomes in which the effect of program type is mediated by distal support and community integration (see Figure 1).

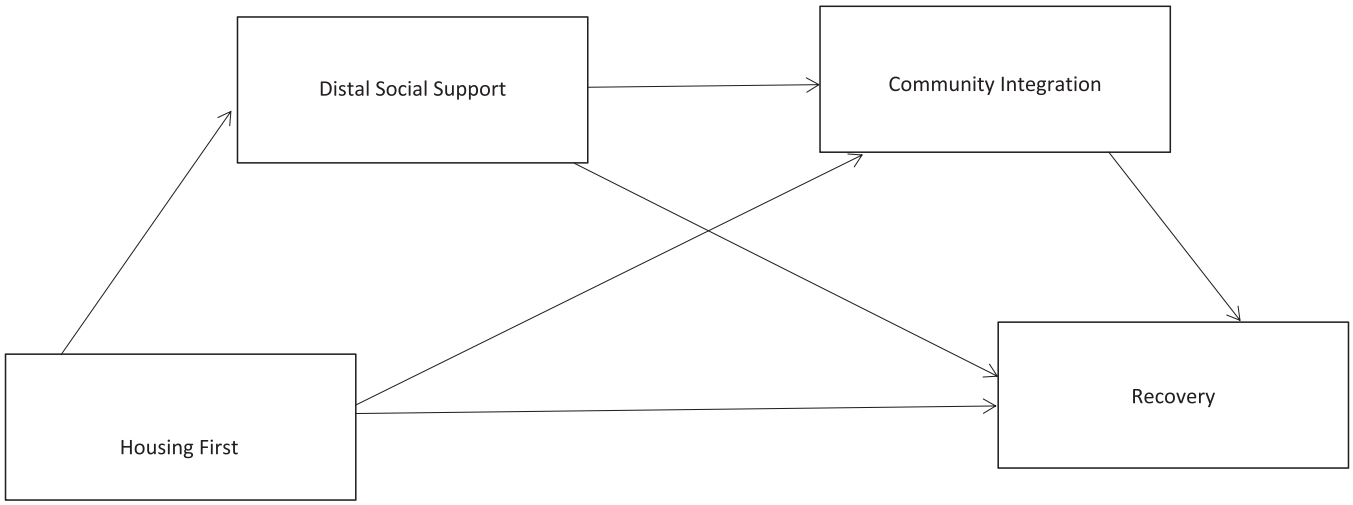


FIGURE 1 Hypothetical serial mediation model.

We used an existing data set obtained from homeless adults engaged with either HF or TAU in eight European countries to test this hypothesis.

METHODS

Study context

A European Consortium of researchers, practitioners, and NGOs worked collaboratively to investigate the ecological aspects of homelessness in eight European countries (European Commission, 2023). Aspects of homelessness investigated by the Consortium include public attitudes, policies, service providers' experiences and service users' experiences. Consortium members' areas of expertise include population-based attitude surveys; homeless services; Housing First; rehabilitation-related recovery from homelessness, substance use, addictions, and mental health problems; and growth-related recovery and well-being. The present study was one subcomponent of the Consortium's larger investigation of adults' experiences of homelessness and homeless services in eight European countries: France, Ireland, Italy, the Netherlands, Poland, Portugal, Spain, and Sweden. All consortium partners have robust connections to homeless services and other community health and social services through which they recruited participants to the study. Consortium members worked together to develop and administer a protocol for selection, recruitment, and data collection from participants who were engaged with either HF or TAU in their home countries. There are no conflict of interest disclosures related to this project.

Procedures: Recruitment, eligibility, and data collection

Ethics approval for the entire project was first obtained by the Lead Partner's University through their institutional review board and from the European Commission. Data collection commenced at each study site once ethical approval was granted. Consortium partners worked with gatekeepers to purposively recruit participants from HF programs and from organizations that provide TAU services aligned with the staircase continuum of care to adults living in homeless situations or who recently exited from homeless situations. Because this was an opt-in design in which gatekeepers identified potential participants and referred them to us, we do not have data on the number of participants who declined to participate.

Potential participants were eligible if they were currently engaged with a HF program or an organization that provides housing or services to individuals in homeless situations, were 18-year-old or over, and sufficiently fluent in their language of residence to understand the questionnaire and provide consent.

Researchers met participants individually in a confidential location such as their residence, a quiet public space, or a private office within their homeless services organization. They explained the study to participants and obtained written informed consent and then orally administered the questionnaire using standardized procedures. Participants received a €20 shopping voucher in exchange for their time and information.

Sample characteristics

The sample includes 445 participants from 8 European countries, 244 (54.8%) from TAU and 201 (45.2%) from HF programs. All HF participants were engaged with HF programs that provided independent accommodation and wraparound supports consistent with the HF model, but at the time they completed the questionnaire, not all were living in independent accommodation. Of the HF group, 176 (89.3%) were living in independent accommodation, 6 (3.0%) were living in homeless accommodation, and no one was rough sleeping. All TAU participants were engaged with services that support individuals in homeless situations, and some had obtained independent accommodation from non-HF sources. Of the TAU group, 142 (58.4%) were living in homeless accommodation, 22 (9.1%) were rough sleeping, and 17 (7.0%) were living in independent accommodation with supports. Average reported lifetime rough sleeping was greater for HF participants ($M = 3.94$ years) than TAU participants ($M = 2.31$ years, SD = 4.67), $t_{313} = 2.21$, $p = .028$, adjusted for unequal variances. No significant difference was found between the HF group ($M = 2.64$, SD = 4.95) and TAU group ($M = 3.48$, SD = 4.50) on lifetime residence in hostels or other accommodation for the homeless ($t_{295} = 0.887$ $p = .376$).

Participants' ages ranged from 19 to 84 ($M = 46.58$, SD = 12.19). Most were male ($n = 337$, 75.7%) and single ($n = 368$, 82.7%). Health concerns were common: 58% ($n = 258$) had at least one physical health problem; 40.9% ($n = 182$) reported a mental health problem, and 39.6% ($n = 176$) reported problems with alcohol or illicit substance use. Over half had completed at least secondary school education or equivalent ($n = 299$, 67.2%). Most were currently unemployed ($n = 380$, 85.4%). Nearly all participants were citizens of the country in which they resided ($n = 374$, 86.4%) and born in their country of residence ($n = 348$, 78.9%). See Table 1 for additional information about participants' demographic characteristics.

Measures

To ensure consistency across the different languages spoken by participants, the study materials were translated using best practices for translation and back-translation (Beaton et al., 2000). Means, standard deviations, and bivariate correlations are presented in Table 2.

TABLE 1 Participant characteristics.

Characteristic	TAU	HF	Total
Nationality			
France	23	38	61 (13.7%)
Ireland	44	34	78 (17.5%)
Italy	33	31	64 (14.4%)
Netherlands	26	22	48 (10.8%)
Poland	44	0	44 (9.9%)
Portugal	19	33	52 (11.7%)
Spain	19	26	45 (10.1%)
Sweden	36	17	53 (11.9%)
Total	244 (54.8%)	201 (45.2%)	445
Gender			
Male	189 (77%)	149 (74.1%)	227 (75.7%)
Relationship status			
Single	198 (81.1%)	170 (85%)	368 (82.9%)
Children under 18			
No	141 (68.4%)	114 (73.1%)	255 (70.4%)
Education			
Secondary (high school) or less	179 (75.3%)	164 (82%)	343 (78.3%)
Employment status			
Unemployed	219 (92.4%)	161 (84.3%)	380 (88.8%)
Age			
M (SD)	46.6 (12.91)	46.45 (11.33)	46.48 (12.19)

Distal supports

Following Townley et al.'s (2013) lead, we used Wieland et al.'s (2007) approach to measure distal supports. For each of five domains: grocery store, pharmacy, restaurant or café, other public space, and "other," participants responded "yes" or "no" to items that assessed the extent to which (a) people recognize or acknowledge them, (b) they feel welcome there, (c) they know someone's name, (d) someone knows their own name, and (e) if someone there would help them in a time of need. Responses in each domain were summed, so that each domain received a summary score. Then, an average score across the five domains was calculated. Internal consistency reliability was moderate (Cronbach's $\alpha = .76$).

Community integration

Participants rated the ten items in the Community Integration Measure (CIM; McColl et al., 2001) on a scale from 1 = *always disagree* to 5 = *always agree*. An example item is "There are people I feel close to in this community." Internal consistency reliability for this sample was high (Cronbach's $\alpha = .84$).

Achieved capabilities

The Measure of Achieved Capabilities in Homeless Services (MACHS; Greenwood et al., 2023) is a 21-item scale that assesses the extent to which individuals in homeless situations perceive their service provider as supporting them to achieve capabilities to be who they want to be and do what they want to do (Nussbaum & Sen, 2011; Sen, 1979). For example, participants are asked to indicate their agreement with statements such as, "Through this programme one is able to feel safe where one lives" on a scale from 1 = *strongly disagree* to 5 = *strongly disagree*. Internal consistency reliability for this sample was high (Cronbach's $\alpha = .95$).

TABLE 2 Means, standard deviations, and bivariate correlations for all study variables.

Variable	HF***	TAU	1	2	3
Distal social support	2.41 (1.27)	2.02 (1.19)			
Community integration	3.93 (0.77)	3.64 (0.86)	.36***		
Achieved capabilities	4.00 (0.67)	3.36 (0.91)	.30***	.56***	
Recovery	4.11 (0.61)	3.89 (0.61)	.15*	.32***	.40***

*$p < .05$; ***$p < .001$.

Recovery

The Recovery Assessment Scale (RAS; Corrigan & Salzer, Ralph, et al., 2004) is a 24-item measure of individuals' self-perceptions of growth-related recovery, especially hope, empowerment, quality of life, and self-determination (Fukui & Salyers, 2021). Participants respond to items such as "I continue to have new interests" on a scale from 1 = *strongly disagree* to 5 = *strongly agree*. Internal consistency reliability for the present sample was high (Cronbach's $\alpha = 91$).

Plan for analysis

The first step in our analysis plan is to assess the bivariate correlations among the study variables. The next step is to run two serial mediation models using Hayes's Model 6 to test our hypothesized model of the indirect effects of progamme type on recovery and achieved capabilities through distal supports and community integration (See Figure 1). Two serial mediation analyses were performed with Hayes's (2013) PROCESS macro (Model 6) with 95% bias-corrected confidence intervals and 10,000 bootstrap samples. These analyses tested the indirect effect of service type (HF vs. TAU) on (a) recovery and (b) achieved capabilities through distal support and community integration. Indirect effects are considered significant if the confidence interval does not include 0. We tested the hypothesis that, compared to traditional staircase services, HF is associated with more experiences of distal support, which fosters a sense of psychological community integration, which, in turn, predicts higher levels of well-being measured as recovery and achieved capabilities.

RESULTS

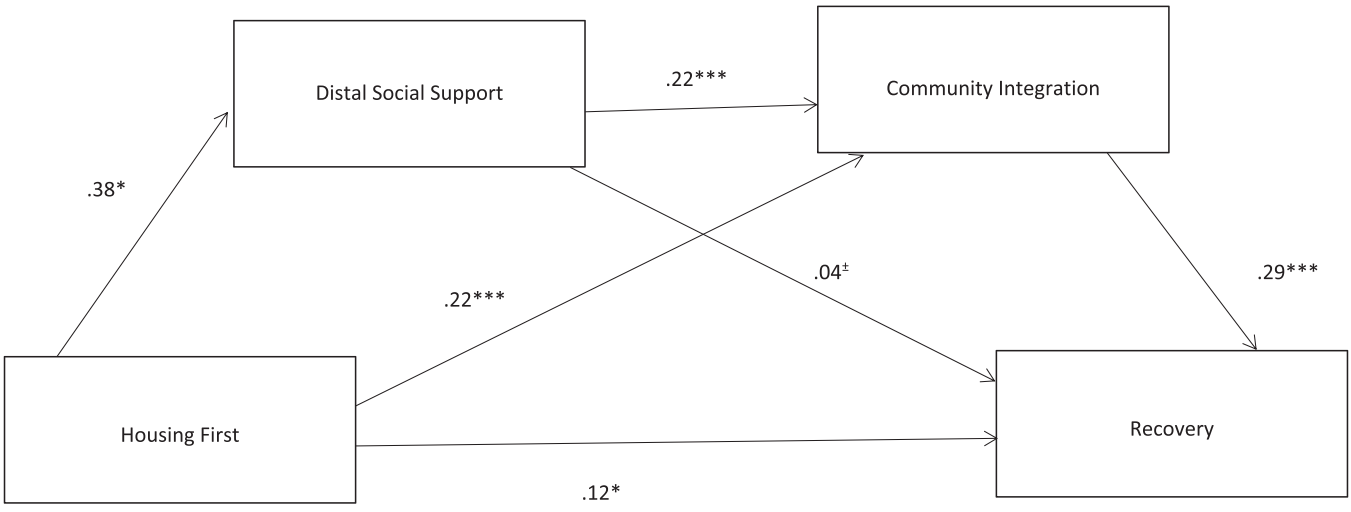
Preliminary analysis

As can be seen in Table 2, participants engaged with HF reported more distal support, more community integration, more achieved capabilities, and more recovery than did participants engaged with TAU. All predicted patterns of correlations were significant (all $p < .05$): More distal support predicted more community integration, achieved capabilities, and recovery. More community integration predicted more capabilities and recovery. Next, we describe the results of the tests of our serial mediation hypothesis that because engagement in HF programs is associated with more DS than engagement with TAU, HF participants experience more achieved capabilities and more growth-focused recovery, and this relationship is mediated by community integration.

Serial mediation analysis

Recovery

Figure 2 illustrates the findings from our test of the serial mediation hypothesis for the recovery outcome. Housing First predicted distal support ($B = 0.38$, SE = 0.12, $t = 3.21$, $p = .001$, 95% CI = [0.15, 0.61]) and community integration ($B = 0.22$, SE = 0.08, $t = 2.92$, $p = .004$, 95% CI = [0.07, 0.37]). Distal support also predicted community integration ($B = 0.21$, SE = 0.03, $t = 6.81$, $p < .0001$, 95% CI = [0.15, 0.27]). Both Housing First ($B = 0.12$, SE = 0.06, $t = 2.08$, $p = .04$, 95% CI = [0.006, 0.23]) and community integration ($B = 0.19$, SE = 0.04, $t = 8.21$, $p < .0001$, 95% CI = [0.22, 0.36]) predicted recovery.



±p < .10, *p < .05, **p < .01, ***p < .001

FIGURE 2 Serial mediation of service type, distal social support, and community integration on recovery ($n = 422$).

The direct effect of Housing First on recovery was significant ($B = 12$, SE = 0.06, $t = 2.08$, $p = .038$, 95% CI = [0.006, 0.23]). The total effect of Housing First on recovery was also significant ($B = 0.10$, SE = 0.03, 95% CI = [0.05, 0.16]). The indirect effect from HF through community integration to recovery was significant ($B = 0.10$, SE = 0.04, 95% CI = [0.04, 0.18]). Finally, as predicted, the hypothesized serial indirect effect of HF on recovery through distal support and community integration was significant ($B = 0.04$, SE = 0.01, 95% CI = [0.01, 0.07]).

Achieved capabilities

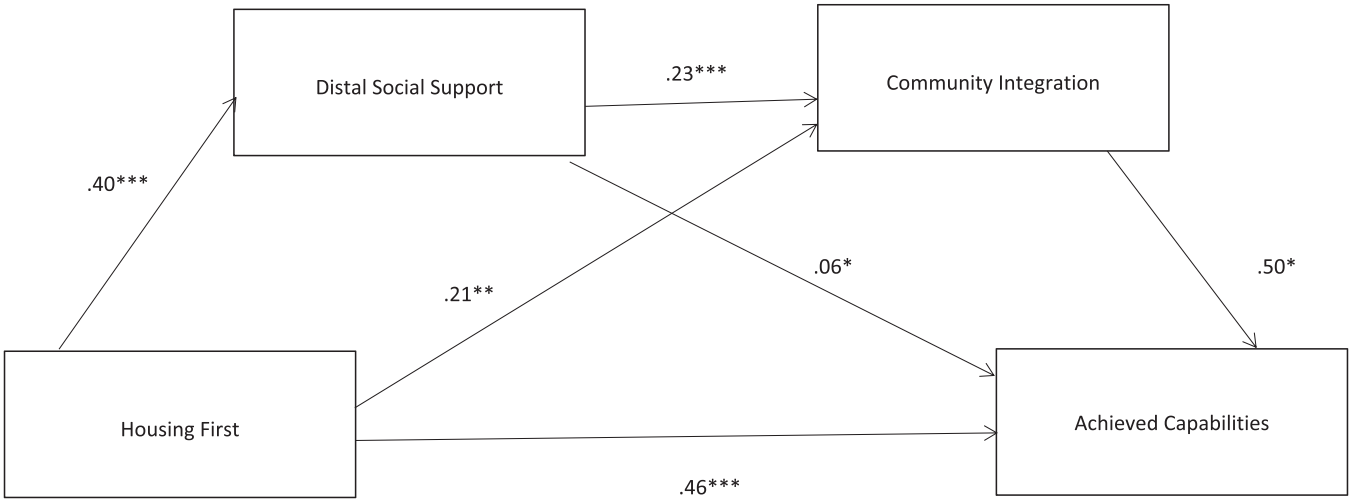
Figure 3 illustrates the results of our test of the serial mediation hypothesis for the achieved capabilities outcome. Again, HF predicted distal support ($B = 0.40$, SE = 0.12, $t = 3.40$, $p = .0007$, 95% CI = [0.17, 0.63]) and community integration ($B = 0.21$, SE = 0.08, $t = 2.77$, $p = .006$; 95% CI = [0.06, 0.36]). Distal support also predicted community integration ($B = 0.23$, SE = 0.03, $t = 7.40$, $p < .001$, 95% CI = [0.17, 0.28]). Housing First ($B = 0.46$, SE = 0.07, $t = 6.83$, $p < .0001$, 95% CI = [0.33, 0.60]), distal support ($B = 0.06$, SE = 0.03, $t = 1.97$, $p = .049$, 95% CI = [0.0002, 0.11]), and community integration ($B = 0.50$, SE = 0.04, $t = 11.70$, $p < .0001$, 95% CI = 0.42, 0.59]) each directly predicted achieved capabilities.

The direct effect of HF on achieved capabilities was significant ($B = 0.46$, SE = 0.07, $t = 6.83$, $p < .001$, 95% CI = [0.33, 0.60]). The total indirect effect on HF on achieved capabilities was also significant ($B = 0.17$, SE = 0.05, 95% CI = [0.09, 0.27]). The indirect effect from HF to achieved capabilities through community integration [$B = 0.12$, SE = 0.04, 95% CI [0.04, 0.21]) was significant. Finally, as predicted, the hypothesized serial mediation effect of Housing First through distal support and psychological community integration on achieved capabilities was significant ($B = 0.05$, SE = 0.02, 95% CI = [0.02, 0.09]).

DISCUSSION

The aim of HF is to end long-term homelessness by offering individuals independent accommodation integrated into the community combined with wraparound supports that are client-led and recovery-oriented. Robust evidence affirms HF's effectiveness for ending homelessness and sustaining tenancies (Woodhall-Melnik & Dunn, 2016). Investigations of HF have yielded evidence that it effectively supports clients to reduce harm from psychiatric symptoms, problematic substance use and alcohol use (e.g., Cherner et al., 2017; Collins et al., 2012; Greenwood et al., 2005, 2020; Kirst et al., 2015). However, evidence for HF's direct effects on aspects of social functioning, such as community integration and on recovery indicators is weaker and mixed (Woodhall-Melnik & Dunn, 2016). We propose that one reason for weak, null, or mixed findings is that the effects of HF on these sorts of outcomes are indirect, mediated by other important factors. Findings from the present study support this explanation by demonstrating that the effect of HF on community integration is mediated by distal social supports.

Our analyses also support our hypothesis that HF clients would report more distal supports than participants engaged with TAU, and that distal supports would mediate the relationship between service type and community integration. This finding lends support to



$^{\pm}$p < .10, *p < .05, **p < .01, ***p < .001

FIGURE 3 Serial mediation of service type, distal social support, and community integration on achieved capabilities ($n = 429$).

our hunch that links between HF and social outcomes like community integration are, at least in part, indirectly explained by distal social support. To the extent that case managers support their clients to interact informally with others who live and work around them, and be positively recognized by them, they lay the groundwork for clients to feel accepted within their community, and therefore like they belong to the community (Wieland et al., 2007).

Our findings also confirm and extend previous research that demonstrated the importance of distal supports and community integration to recovery and well-being (e.g., Terry et al., 2019). In the present study, participants engaged with HF programs reported more growth-related recovery in areas such as hope and goals (Corrigan et al., 2004) and in achieved capabilities (Greenwood et al., 2023) than did participants engaged with TAU. The effect of service type on these outcomes was carried through distal supports and community integration, a finding that offers an explanation for the processes through which the structure and philosophy of HF gets translated into positive outcomes for clients. These findings also suggest that, and future research is needed to examine whether, TAU's potential to promote growth-related recovery relevant to a life well-lived is constrained by aspects of their structure, such as congregate housing, and values orientation, such as provider-led focus on rehabilitation and treatment compliance (Manning & Greenwood, 2018).

Growth-related recovery and achieved capabilities are both aligned and distinct aspects of individual well-being. Where recovery draws from concepts of positive self-regard and hope (Corrigan & Phelan, 2004), the CA highlights the social inequalities that infringe on the rights of disadvantaged groups (Nussbaum & Capabilities, 2011). When applied to homelessness research, each offers complementary ways of understanding how the community context can buttress service delivery practices to reduce inequality and promote person-centered development. Findings affirm HF is a model of homeless services delivery that not only fosters person-centered growth at the individual level, but one that is sensitized to social injustices that constrain the choices available to individuals who are recovering from homelessness and poor mental health. For formerly homeless adults, HF effectively promotes nurturing bonds within the community, and has the potential to go beyond this to sustainably address the social inequalities that pervade our communities.

LIMITATIONS AND FUTURE DIRECTIONS

The measure of community integration that we included in our study is often used in research with adults who have substantial histories of homelessness and complex needs (McColl et al., 2001). Our experiences of measuring community integration with conventional scales and of reviewing literature on this topic has led us to conclude that there is scope for further refining the conceptualization and measurement of the different facets of community integration. We also suggest that conventional interpretations of low levels of community integration could be critically reappraised and improved. For example, measures of physical integration could be expanded and refined to flexibly map onto both the actual amenities that are present in an individual's community and the actual locations of the amenities that are used. Similarly, measures of social and psychological integration should be broadened to capture the range of settings and locations where clients feel socially and psychologically integrated. A greater focus on neighborhood characteristics and individual-neighborhood fit is needed to provide important context to reports of low levels of community integration. With a few exceptions (e.g., Bassi et al., 2020; Stefancic et al., 2012), most research has not accounted for the importance of neighborhood quality in assessments of community integration. Measures of community integration should be reviewed and refined to better match neighborhood amenities, assess preferences for connections in neighborhoods other than one's own, and differentiate integration with other homeless community members from integration with nonhomeless individuals who live and work in the neighborhoods.

Even though our analysis returned an overall positive indirect effect of HF on community integration and recovery, we suggest that a more critical appraisal of negative effects is needed. When researchers do observe low levels of community integration for HF clients living in unsafe neighborhoods with few amenities, researchers should focus on understanding the meaning of low sense of community in such contexts and consider reinterpreting such associations as adaptive responses to difficult circumstances. For example, when HF clients live in poor quality neighborhoods, the conditions are optimal for developing a negative sense of community (NSoC), which is an adaptive response to a negative environment (Brodsky, 1996). High NSoC would predict lower community integration, and when they co-occur, it is important for researchers to consider whether they should be interpreted as savvy and self-protective responses to unsafe living conditions and assessed as indicators of clients' good judgment rather than evidence that HF fails to support clients to integrate into their communities.

It is important to recognize that that aloneness and loneliness are experiences associated with moving into a new neighborhood for anyone regardless of their housing history. When an individual has a personal history of housing loss, eviction, stigma, and discrimination, it only makes sense that they may be reluctant to interact with others. The social aspects of recovery may not happen within one's neighborhood, but this is not necessarily evidence that HF clients do not recover functioning in social and interpersonal domains. Many individuals

without a history of homelessness do not know their neighbors. They may work and shop at distances from their home. If measures of physical, social, and community integration only focus on the neighborhood in which one lives, then for HF clients, measures of these outcomes may be artificially low because they are insensitive to the actual locations of their social interactions and the communities to which they belong.

We propose that low levels of community integration are not always indicative of poor recovery in social domains but may instead indicate good decision-making for individuals struggling with alcohol or other drug use, who are working to extricate themselves from dysfunctional relationships, who simply need quiet and alone time after substantial periods of time living in crowded congregate conditions with little or no privacy (e.g., Padgett et al., 2008). Future research that situates community integration in a person's full ecology, their own life story, and stage of recovery, will produce a richer and more trustworthy interpretation of their experiences, appraisals, and desires for connection and belonging.

In this study we used cross-sectional quantitative methods to assess homeless service users' perceptions of DS, community integration and recovery at a point in time. A longitudinal examination of DS and community integration could assess positive and or negative changes in DS and their relationship with community integration and recovery over time. Additionally and importantly, because our data are cross-sectional, we cannot rule out that greater recovery facilitates the development of distal supports. Longitudinal data would allow researchers to assess the temporal relationships among distal supports, recovery, and community integration.

Applying qualitative methods could expand these findings to explain the variety of DS exchanges perceived by service users and the relative impact these have on their well-being. Additionally, negative DS experiences such as microaggressions, social exclusion or discrimination were not measured, and future research could examine the relationship these may have on community integration and the development of positive wellbeing for homeless service users in the community.

Most participants reported health issues, and it is possible that some had limited mobility. In this study we did not measure physical mobility issues but they may constrain individuals' abilities to engage effectively with their communities. It is possible that homeless service users with mobility issues are particularly vulnerable to experiencing isolation and their experiences in the community warrant further examination.

IMPLICATIONS FOR PRACTICE

An individual with a history of homelessness may need and want to spend some period of time in solitude after the dangers and undpredictabilty of streets and homeless accommodation are behind them. Case managers have the dual responsibilities of supporting their clients to create a home of their own in which they can feel safe and secure and to support them to develop positive relationships with others who live and work near them. The HF principles of choice and control are key here, and case managers should maximize clients' choice and control over when, how, and with whom they engage in their communities. For anyone who has spent significant periods of their life on the streets and in homeless accommodation, interacting with individuals with no histories of homelessness can understandably feel intimidating and uncomfortable. For clients who belong to different ethnic or cultural groups than the majority of residents in their neighborhood, this may be even more difficult or objectively more risky. Related to this point, individuals who have obtained homes of their own often reside in poor quality neighborhoods with higher crime rates and fewer amenities. A creative, individualized, and strengths-based case management approach to active engagement and encouragement will support clients to venture out—not necessarily or only in their local neighborhoods—but also beyond, into places with people where they will become known and recognized in positive ways that can foster important distal supports.

CONCLUSION

Taken together, our findings contribute to the growing literature on the importance of distal supports to local ties that promote well-being. They expand our current understanding of the relationship of HF to community integration and distal supports, and the importance of community integration and distal supports to growth-related recovery and achieved capabilities. Our findings illuminate the ways in which the structural components of Housing First may translate into community integration, recovery, and achieved capabilities. When case managers encourage clients to engage with others in their communities in ways that maximize positive interactions, they may foster the kinds of distal connections that facilitate recognition, familiarity, and mutual trust. These nurturing bonds within the community in turn promote the advancement of clients' recovery journeys and the actualization of opportunities across a wide range of life domains.

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