Residential Programs for Chronically Homeless Adults: Exploring How One Nonprofit Agency Transitioned from a Treatment First to a Housing First Model

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Abstract
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Document Type
Dissertation

Degree Name
Doctor of Education (EdD)

Department
Executive Leadership

First Supervisor
Richard Maurer

Second Supervisor
Steven Block

Subject Categories
Education

This dissertation is available at Fisher Digital Publications: https://fisherpub.sjfc.edu/education_etd/233
Residential Programs for Chronically Homeless Adults: Exploring How One Nonprofit Agency Transitioned from a Treatment First to a Housing First Model

By

Camilla Peters

Submitted in partial fulfillment
of the requirements for the degree
Ed.D. in Executive Leadership

Supervised by
Richard Maurer, Ph.D.

Committee Member
Steven Block, Ed.D.

Ralph C. Wilson, Jr. School of Education
St. John Fisher College

December 2015
Dedication

This dissertation would not have been completed without the support of my dissertation chair, Richard Maurer, Ph.D., and committee member, Steven Block, Ed.D. I sincerely appreciate your guidance, critique, and encouragement.

Thank you to my parents: Claudia Peters and Robert and Debbie Peters. You always knew the right times to contact me, ask how I was doing, and push me forward. You also knew when not to say a word, and for that, I am appreciative.

This doctoral journey started off being grouped with three strangers, also in pursuit of an Ed.D. We sat side by side in each class. Through the scholarly struggles and personal struggles came a bond that I will forever cherish. Team Make It Happen, I love you all!

To my coworkers: Marguerite Brown, Sakinah Townsend, and Ashley Reynoso, I could not have completed this journey without your support, technical skills, and expertise.

Finally, thank you to my mentor, Sherry Fraser, Ed.D. I started this journey due to your recommendation and at the end of the journey, you were there supporting me again. Thank you for all the wisdom, time, education, and support you have provided.
Biographical Sketch

Camilla Peters is a social worker with over 15 years in the field. Currently, she oversees a residential program in the Bronx, New York, for chronically homeless adults. Ms. Peters attended Concordia College from 1994-1998 and graduated with a Bachelor of Social Work degree in 1998. Ms. Peters attended Fordham University from 2002-2003 and received a Master of Social Work in 2003. She began her studies in the Ralph C. Wilson Jr. School of Education at St. John Fisher College in 2013. Under the direction of Richard Maurer, Ph.D. and Steven Block, Ed.D., Ms. Peters’ research focused on the strategic planning nonprofit agencies assume when transitioning to a housing first model.
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This qualitative, single-case study explored the strategic planning one nonprofit agency assumed when transitioning from a treatment first to a housing first model. Data collected included both archival data and individual interviews. Archival data consisted of the strategic plan, policy and procedures, and newspaper articles. A purposeful sample of agency administrators participated in individual interviews.

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Chapter 1: Introduction

Introduction

Homelessness is a major issue worthy of attention in the world today (Goldberg, 2015). While many factors contribute to homelessness, the federal government lists three core factors: “loss of affordable housing and foreclosures; wages and public assistance that have not kept pace with the cost of living, rising housing costs, job loss and underemployment; and closing of state psychiatric institutes without the concomitant creation of community based housing and services” (U.S. Interagency Council on Homelessness [USICH], 2010, p. 10). Additional contributing factors include high incidences of domestic violence and substance abuse (Coalition for the Homeless, 2014a). For the purposes of this study, homelessness is defined as staying in an uninhabitable location, often a shelter or in public spaces such as parks or subways (USICH, 2010).

The homeless population, along with the U.S. government’s response to homelessness, has changed over the last 30 years. The contemporary period of homelessness began in the 1980s when the homeless issues became more visible (Leginski, 2007). During this contemporary period, alcohol abuse and mental illness became common within the homeless community and more families with children became homeless. The federal government, initially, looked to local governments to address homelessness and many local governments opened additional emergency shelters (National Coalition for the Homeless, 2006). As homelessness continued to increase, the
federal government passed a key piece of legislation in an attempt to answer the growing problem.

The McKinney Act, later renamed the McKinney-Vento Act, was signed into law in 1987 and “was the first major federal legislative response to homelessness” (National Coalition for the Homeless, 2006, para 1). As a result, funding had been authorized for food, emergency shelter, and transitional housing. Emergency shelter provides short-term shelter whereas transitional housing provides housing and support services for up to 2 years (U.S. Department of Housing and Urban Development [HUD], 2013a). Additionally, HUD awarded federal grants to provide permanent housing for homeless individuals and families (National Coalition for the Homeless, 2006). Previous federal grants providing permanent housing such as the Section 8 Single Room Occupancy Moderate Rehabilitation and Supportive Housing Demonstration Program were included in the McKinney-Vento Act. The grants are distributed to local agencies that offer affordable, subsidized housing. The subsidized rent, typically 30% of a person’s income, allows individuals and families to remain stably housed. HUD (n.d.) recognized that, without federal support, many more individuals and families would face homelessness.

One significant amendment of the McKinney-Vento Act occurred in 1990 when the Shelter Plus Care program was introduced (HUD, 2002). The Shelter Plus Care program awards funds to residential programs providing both supportive services, such as case management, and permanent housing to vulnerable populations who include individuals with mental illness (HUD, 2002).

As an additional measure to combat the plight of homelessness, the federal government instituted the Continuum of Care Program in 1994, as a federal program
under HUD, with local offices and staff (USICH, 2010). The McKinney-Vento Act also funds this program. The purpose of the Continuum of Care Program is to
promote communitywide commitment to the goal of ending homelessness;
provide funding for efforts by nonprofit providers, and State and local
governments to quickly rehouse homeless individuals and families while
minimizing the trauma and dislocation caused to homeless individuals, families
and communities by homelessness. (HUD, 2014a, para 1)
The Continuum of Care Program monitors the Shelter Plus Care funds (HUD, 2002). Each Continuum of Care Program oversees a specific geographic region where all homeless services are coordinated with the understanding that “people experiencing homelessness would progress through a set of interventions, from outreach to shelter, into programs to help address underlying problems and ultimately be ready for housing” (USICH, 2010, p. 10). Additionally, each Continuum of Care Program evaluates programs and determines the level of funding awarded to each (USICH, 2014a).

In 2009, President Barack Obama signed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. Through this action, the federal government “amends and reauthorizes the McKinney-Vento Homelessness Assistance Act with substantial changes” (HUD, 2014b, para 1). For example, rapid re-housing initiatives, focusing on housing families, are awarded priority status and permanent supportive housing secured and guaranteed for chronically homeless individuals (National Alliance to End Homelessness, 2009a). It was during this time that the federal government began to look at what housing models were effective for chronically homeless adults.
The federal government classified the homeless population into subgroups. These subgroups included veterans, families with children, young adults, and chronically homeless adults. Chronically homeless adults are described as “individuals with disabilities who have either been continuously homeless for a year or more or have experienced at least four episodes of homelessness in the last three years” (HUD, 2014c, p. 2). This subgroup is difficult to house due to its high incidence of failed or negative prior social interactions and other factors, in addition to homelessness. These issues can include mental illness and/or substance abuse disorder, past or current criminal history, chronic and severe medical diagnoses, and trauma history (Parker & Albrecht, 2012; USICH, 2010; Weinstein, Henwood, Matejkowski, & Santana, 2011). Additionally, chronically homeless adults frequently utilize shelters, emergency rooms, psychiatric hospitals, jails, and other treatment programs, translating to a costly burden on society (Moulton, 2013).

In 2010, President Barack Obama, along with Congress, tasked the USICH to develop and implement a strategic plan to end homelessness in America. This plan was a response to the HEARTH Act of 2009 legislative mandate that a collective approach be instituted (USICH, 2010). This was the first national strategic plan dedicated to eliminating and preventing homelessness. The purpose of the plan was to “provide a reference framework for the allocation of resources and the alignment of programs to achieve our goal to prevent and end homelessness in America” (USICH, 2010, p. 4). Federal agencies including HUD, the U.S. Department of Veterans Affairs, and the U.S. Department of Health and Human Services are to collaborate, providing needed resources to eliminate homelessness. One specific goal of this plan was to prevent and eliminate
chronic homelessness within a span of 5 years by increasing available permanent supportive housing.

The two forms of permanent supportive housing models available to individuals who classify as chronically homeless are known as treatment first and housing first. However, the housing first model is currently identified as the preferred model to house the chronically homeless population (USICH, 2010). The Continuum of Care Program oversees nonprofit agencies that provide permanent supportive housing. The treatment first model is viewed as a linear approach, often requiring multiple stages before securing permanent housing (USICH, 2010). The treatment first model assumes “homeless people with severe impairments require a period of structured stabilization prior to entering permanent housing, often involving stays in a series of housing settings along a continuum of increasingly independent living” (Pearson, Montgomery, & Locke, 2009, p. 405). The treatment first model supports abstinence from substance use and psychiatric compliance as prerequisites for access to permanent housing (Henwood, Stanhope, & Padgett, 2011). One concern with this model’s approach is that many individuals fail to take all the steps needed to secure permanent housing (Pearson et al., 2009). For some, simply maintaining sobriety or actively engaging in service plans is too difficult (Pearson et al., 2009).

The housing first model approaches homelessness by getting the individuals housed without delay. In the early 1980s, Dr. Sam Tsemberis created the housing first model (Stefancic, & Tsemberis, 2013). The model was conceived when Tsemberis observed many homeless individuals on the streets of New York City. These individuals evinced a repetitive pattern of being hospitalized and then returning to the streets
(Tsemberis, n.d.). He acknowledged the stigma attached with the chronically homeless as being difficult to engage and concluded that housing systems currently available to the homeless needed to change. Additionally, Tsemberis concluded that the clinical focus must be adjusted in order to understand that homeless individuals had different perceptions of their needs. Tsemberis (2013) further went on to say that “without the safety and security of a place of their own—without housing first, little else seemed possible” (p. 236). In 1992, Tsemberis implemented the first housing first program. He chose to place it in New York City and he called it Pathways to Housing.

Followers of the housing first model, speaking openly of their “dissatisfaction with the status quo of traditional service delivery, and recognition that current approaches to housing and treatment do not work well for certain subgroups of the homeless population, have stimulated searches for more effective models of service delivery across the globe” (Greenwood et al., 2013, p. 646). Once individuals are housed, other services, including primary health, substance treatment, and psychiatric care, are offered (Greenberg, Korb, Cronon, & Anderson, 2013). Additionally, the model requires only limited client engagement (Watson, Wagner, & Rivers, 2013). Self-determination and independence are key factors of the model and, therefore, clients determine levels of assistance needed from staff (Greenberg et al., 2013). The housing first model does not mandate sobriety or psychiatric compliance (Henwood et al., 2011). More specifically, experts in housing first explained that “The theory behind housing first is that a low-barrier approach that removes requirements for treatment and abstinence will more readily engage and retain individuals who are challenging to serve” (Srebnik, Connor, & Sylla, 2013, p. 316).
The USICH (2010) declared that the housing first model was the most effective response for chronically homeless individuals, positing that “Permanent supportive housing using housing first is a proven solution that leads to improvements in health and well-being” (p. 38). Additionally, housing first is credited for being the most cost-effective housing model (USICH, 2010).

Two key factors influenced the government’s favor of the housing first model. The first was its status as an evidence-based model. Tsemberis and colleagues conducted many studies to prove the model’s efficacy, showing that the model had high retention rates, reduced substance use, and reduced costs. Further, Tsemberis championed other research programs that implemented the housing first model. Thus, external validity increased (Greenwood et al., 2013). Those who have studied him stated that “Tsemberis led the charge in making research a normative component of homeless intervention programs” (Greenwood et al., 2013, p. 653). Currently, there is a wide array of research supporting the housing first model (Davidson et al., 2014; Pearson et al., 2009; Stefancic et al., 2013; Tsai, Mares, & Rosenheck, 2010; Tsemberis & Eisenberg, 2000).

The second factor that influenced the government’s support for the housing first model was the influential advocates that endorsed it. Tsemberis credited Philip Mangaro, former Executive Director for the USICH, researcher Dennis Culhane, and The National Alliance to End Homelessness for advocating the need for all governments to develop 10-year plans to end homelessness. The 10-year plans provide opportunities to explore best practices (Greenwood et al., 2013). Although not mandated by the federal government, by 2002, “over 250 cities developed local 10-year plans to end chronic homelessness and
almost every single one contains a housing first component” (Greenwood et al., 2013, p. 656).

Despite studies demonstrating results that housing first is an evidenced-based model, concerns have been raised. One such concern is that substance abuse may increase because individuals are not required to receive substance abuse treatment or maintain sobriety (Kertesz & Weiner, 2009). In one study comparing the housing first model to a treatment first model, several participants dropped out of the study. These individuals stated they were not ready to live in a congregate setting where other individuals were still using substances (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005). This concern was also identified by Kertesz and Weiner (2009), who believed that a congregate setting might not be effective for the housing first model as tenants are at different stages in their recovery.

Property damage was another potential worry specific to the housing first model (Kertesz & Weiner, 2009). Substantiating this concern, Milby et al. (2005) reported that the funders of the study incurred property damage expenses due to the housing first participants. Lastly, critics of the model stated that individuals who are not in treatment and are experiencing psychiatric symptoms cannot live independently and make wise choices (Greenwood et al., 2013). However, the USICH and HUD supported the model due to its success with reducing costs, reducing time individuals remain homeless, and increased housing stability (USICH, 2010).

A 2013 update on the federal strategic plan showed decreases in national homelessness (USICH, 2014a). The council found that “Between 2010 and 2013, the number of people experiencing homelessness declined by 15.7 percent, including a seven
percent decline between 2012 and 2013” (p. 10). The number of chronically homeless individuals also decreased 16% since 2010 (USICH, 2014b). One reason for the decrease was the availability of new housing. In fiscal year 2013, all Continuum of Care Programs collectively renewed 7,374 residential programs and awarded 622 new programs (USICH, 2014b). Additionally, two-thirds of Continuum of Care Programs responded to requests by the USICH and HUD to re-allocate funds to add more permanent supported housing, specifically using the housing first approach. The USICH (2014b) also reported that 30% of new housing went to the chronically homeless population. Further data on current trends in homelessness can be found in Chapter 2.

Despite the decrease in homelessness on a national level, New York experienced an increase in homelessness during the same time period. In 2013; New York, California, Florida, Texas, and Massachusetts made up half of the national homeless population (HUD, 2013a). Of the national count, “California accounted for more than 22 percent of the nation’s homeless population” (HUD, 2013a, p. 8). New York followed with 13% of the national average (HUD, 2013a). Additionally, from 2007 to 2013, New York had the highest increase of homelessness rates at 24%. One method of counting homelessness is a point-in-time count, which is a nationwide initiative to count both sheltered and unsheltered individuals on one night of the year (National Coalition for the Homeless, 2009). The 2014 point-in-time count for New York State counted 80,590 homeless people (HUD, 2014c). Of that, 7,212 were chronically homeless single adults. While the state of New York showed high numbers of homelessness, the majority of homeless individuals and families were reported to reside in New York City (HUD, 2013a). The 2014 point-in-time count determined 67,810 people were homeless in New
York City, and of that count, 5,873 were classified as chronically homeless adults (HUD, 2014c).

The USICH and HUD have encouraged all Continuum of Care Programs to award and reallocate funds for permanent housing programs using a housing first approach (USICH, 2014b). In a notice to all Continuum of Care Programs, HUD (2014d) “encourages all recipients of Continuum of Care Program-funded permanent supportive housing to follow a Housing First approach to the maximum extent practicable” (p. 3).

As a result, New York City’s Continuum of Care has begun making changes and requiring all nonprofit residential programs in the five boroughs to use a housing first approach (New York City Coalition on the Continuum of Care, 2015a). If residential programs do not use a housing first approach, they may not be awarded funds in the future because current efforts are to award and reallocate funds for housing first models. Documentation on the New York City Coalition on the Continuum of Care’s requirement of housing first can be found in Appendix A.

The treatment first and housing first models contain fundamental differences in philosophy. As a result, many treatment first providers in New York City will have to develop strategies to transition to a housing first model. This qualitative, case study explored the strategies taken by New York City residential providers who have recently transitioned from a treatment first model to a housing first model

Problem Statement

Because few studies have provided insight into the strategic planning that treatment first administrators assume when adopting the housing first model, this study addressed and investigated this gap. Senge and Sterman (1990) warned that agencies that
attempt strategic planning often fail because “new strategies and structures threaten traditional habits, norms, and assumptions” (p. 1007). The housing first model is an evidenced-based practice (Greenwood et al., 2013; USICH, 2010). As a result, HUD has encouraged all Continuum of Care Programs to allocate and reallocate funds to agencies that use a housing first model (USICH, 2014b) and the New York City Coalition on the Continuum of Care (2015) is requiring all residential programs to use the model. The philosophy of the treatment first model significantly differs from the housing first philosophy. Therefore, treatment first providers must be prepared to plan, develop, and implement a housing first model.

This study used a case study methodology and utilized one agency that provides permanent supportive housing to chronically homeless individuals in the Bronx, New York, and recently transitioned to the housing first model. The agency currently has 25 permanent supportive housing units spread throughout the Bronx. Agency administrators that were involved in the strategic planning were interviewed. Further, archival data including strategic plan, policy and procedures, and newspaper articles were analyzed.

**Theoretical Rationale**

Systems thinking, as defined by Peter Senge (1990) in his book *The Fifth Discipline*, guided this study. According to Senge, learning organizations are those that “can truly ‘learn,’ that can continually enhance their capacity to realize their highest aspirations” (p. 10). Senge provided five disciplines that organizations must achieve in order to become a learning organization: team learning, building a shared vision, mental models, personal mastery, and systems thinking.
Team learning allows free conversation among employees (Senge, 1990). Conversation is used to share ideas. Senge stressed the important fact that team learning also requires the need to assess and determine “patterns of interaction in teams that undermine learning” (p. 13).

Building a shared vision provides an understanding and acceptance of an agency’s goals, mission, and vision (Senge, 1990). Employees who understand and embrace the goals, mission, and vision will “excel and learn, not because they are told to, but because they want to” (p. 11). Additionally, the shared vision must be seen as long-term and not because of a leader’s short-term plan or any emergencies.

Mental models are “deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action” (p. 11). These mental models are typically unconscious but affect an individual’s behavior. A learning organization is only effective once employees seek to understand their behavior and engage in dialogue with others (Senge, 1990).

Personal mastery permits employees to learn and grow continuously (Senge, 1990). Organizations that do not allow employees to seek knowledge will not benefit from receiving the full potential of their employees. Equally important is the allowance of personal growth. Individuals need to learn what personal and professional opportunities drive them to learn continually (Senge, 1990).

The fifth discipline is systems thinking, which is the level that “integrates the disciplines, fusing them into a coherent body of theory and practice” (Senge, 1990, p. 13). Further, Senge proclaimed that without systemic thinking, the organization and its employees will have no opportunity to understand that the world is interconnected. Flood
(1999) confirmed that systemic thinking makes it possible to understand that one’s actions and behaviors can affect others.

Residential programs that have recently transitioned to a housing first model need to ensure that all five disciplines are being met. Transitioning to the housing first model could cause negative attitudes due to lack of dialogue, shared vision, and individual perceptions. Further, employees need to determine if they can successfully embrace working under the requirements and philosophy of a housing first model.

**Statement of Purpose**

The purpose of this study was to identify and examine strategies on how one agency transitioned from a treatment first to a housing first model. Results of the study may offer information and insights that may be useful as other agencies contemplate or have yet to transition to housing first. A case study approach was appropriate for this study as it was researching a contemporary issue (Yin, 2014). The USICH and HUD have determined the housing first model as an evidence-based practice and encourage its implementation (USICH, 2010). New York City is requiring residential programs to become housing first (New York City Coalition on the Continuum of Care, 2015).

**Research Questions**

The following research questions guided this qualitative study:

- What were the factors that determined the agency’s transition to a housing first model?
- What was the agency’s strategic approach and how did the agency deploy it?
- How did the agency adjust its strategic plan as the model was transitioned?
Potential Significance of the Study

New York City seeks to increase housing first programs (New York City Coalition on the Continuum of Care, 2015). By increasing the number of residential programs using a housing first model, the USICH (2010) and the New York City Coalition on the Continuum of Care (2015) hope to end chronic homelessness. As such, current treatment first providers in the five boroughs of New York must be prepared to transition to a housing first model.

This study addressed the gap in the literature regarding strategies that treatment first providers have when transitioning to a housing first model. Expounding on the current literature, this study can add insight to other treatment first providers who are negotiating the change to the housing first model.

Chapter Summary

Chronic homelessness is at an all-time high in New York’s five boroughs (Coalition for the Homeless, 2014b). Shelter numbers were the highest ever recorded in July 2014 (Coalition for the Homeless, 2014b). The federal government and the New York City government look to the housing first model as the best practice to end chronic homelessness (USICH, 2010). The housing first model, created by Sam Tsemberis, PhD, places individuals in permanent housing first and then addresses other important issues such as psychiatric care, substance use treatment, and medical care (Tsemberis & Eisenberg, 2000). Once placed, all other services are optional. Housing first tenants do not have to attend substance abuse treatment, medical care or psychiatric care (Tsemberis & Eisenberg, 2000).
While several studies have determined housing first to be a successful model, concerns still remain with the model. Some concerns include the idea that important issues are largely neglected, namely substance abuse, property damage, and protecting other tenants who may be struggling with remaining abstinent from substance use. However, New York City is requiring the use of this model. As a result, many treatment first providers will have to transition to the housing first model. There is a lack of research that has examined the strategies involved when planning, developing, and implementing this model.

Senge’s (1990) systems thinking theory guided this study. His five disciplines—team learning, building a shared vision, mental models, personal master, and systems thinking—enable organizations to become learning organizations. The fifth discipline, systems thinking, is “a framework for seeing interrelationships rather than things, for seeing patterns of change rather than static ‘snapshots’” (p. 53). It is important for employees at housing first programs to recognize their role when treating chronically homeless adults.

Chapter 2 next presents a more thorough review on the existing literature.
Chapter 2: Review of the Literature

Introduction and Purpose

This chapter presents a literature review on research into homelessness in the United States. The first section provides an overview of the purpose of the research and includes a definition of homelessness, governmental responses to homelessness, descriptions of those groups who dominate the homeless population, the development of a federal strategic plan and programs intended to address homelessness including data on available housing and funding, and the case of New York. The second section contains a review of the research literature on those evidence-based programs designed to help individuals move out of their homeless state.

Individuals and families who do not have a permanent residence, are at risk of losing their residence, or are leaving a domestic violence relationship often sleep in shelters or places not intended for living. HUD (2013a) considers these people homeless. Homelessness has been a problem since before the days of the Great Depression (Leginski, 2007), but it became a nationally recognized problem in the 1980s, which is considered the start of the contemporary period of homelessness (Congressional Research Service, 2014). One reason why homelessness rose to national attention was the demolition of what was known as skid row areas. Skid row areas were neighborhoods consisting of “a stigmatized resident population that is predominantly poor, street-entrenched, addicted, alcoholic and/or mentally ill” (Huey & Kemple, 2007, p. 2306). Although demolishing skid rows created more urban development
opportunities, individuals who were staying in these areas were forced elsewhere, making homeless individuals more visible to the general public.

**Governmental response.** Since the beginning of the contemporary period, federal, state, and local governments as well as advocacy groups and scholars have strategized and researched solutions to eliminate homelessness (National Coalition for the Homeless, 2006). The response to homelessness shifted considerably during the contemporary period, beginning with short-term solutions to current goals of preventing and ending homelessness. Short-term responses by the federal government in the 1980s included multiple grant programs such as the Emergency Food and Shelter Program, Emergency Shelter Grants Program, and the Transitional Housing Demonstration Program. Distributed to local agencies, these grants provided food, emergency shelter, and transitional housing (Congressional Research Service, 2014). Emergency shelters provide brief refuge for homeless individuals to sleep, and transitional housing provides shelter for up to 24 months while homeless individuals address the need to obtain permanent housing (HUD, 2014c). However, despite such short-term responses, the problem of chronic homelessness and the absence of sufficient permanent supportive housing for individuals and families has continued, prompting further action.

**McKinney-Vento Act.** In response to the continued problem of homelessness, President Ronald Reagan signed the 1987 McKinney Homeless Assistance Act. Later renamed the McKinney-Vento Act, this Act created the U. S. Interagency Council on Homelessness, an “independent agency within the Federal executive branch” (USICH, 2013a, para 2). The purpose of the USICH was to “review the effectiveness of Federal activities and programs to assist people experiencing homelessness, promote better
coordination among agency programs, and inform state and local governments and public
and private sector organizations about the availability of Federal homeless assistance”
(USICH, 2013a, para 4). The McKinney-Vento Act also included 15 new or continued
programs providing vocational training, medical care, emergency shelter, and permanent
housing (National Coalition for the Homeless, 2006), and the housing to homeless
individuals may or may not include support services. Additionally, permanent housing
does not require homeless individuals to have a disability (USICH, 2013b).

Several federal agencies administer McKinney-Vento funds. The Federal
Emergency Management Agency (FEMA), directed by the Department of Homeland
Security, oversees the Emergency Food and Shelter Program. Community mental health
services, substance use treatment, and medical care programs that provide services to the
homeless are administered by the Department of Health and Human Services. Vocational
training programs are supervised by the Department of Labor. The Department of
Education oversees educational programming for both homeless children and adults. The
Department of Housing and Urban Development (HUD) administers emergency shelter,
transitional housing, and permanent housing (National Coalition for the Homeless, 2006).
HUD is “the federal agency that is responsible for national policy and programs that
address America’s housing needs, improve and develop the Nation’s communities and
enforce fair housing laws” (HUD, 2015, para 2.).

Amendments to the McKinney-Vento Act occurred in 1988, 1990, 1992, and
1994 (National Coalition for the Homeless, 2006). Significant development occurred in
the 1990 amendment. As part of this amendment, the Shelter Plus Care program was
introduced and placed under the direction of the HUD program named Continuum of
Care (HUD, 2002). The Shelter Plus Care funds were provided to agencies that offer permanent supportive housing to vulnerable populations, including individuals with mental illness, chronic substance abusers, and individuals with long-term medical issues such as HIV/AIDS (HUD, 2002). The program “was built on the premise that housing and services need to be connected in order to ensure the stability of housing for this population” (p. 2).

The Continuum of Care Program is made up of many local planning continuums that are “responsible for coordinating the full range of homelessness services in a geographic area, which may cover a city, county, metropolitan area, or an entire state” (HUD, 2014c, p. 2). Each Continuum of Care Program oversees funding to agencies that service individuals and families experiencing homelessness (HUD, 2014a). Specifically, the program provides grants to agencies that provide homeless prevention, rapid re-housing, supportive services, transitional housing, safe havens, and permanent supportive housing to the homeless and chronically homeless populations in which the head of household has a diagnosed mental illness (HUD, 2014a).

**Housing Management Information System.** In the late 1990s, data and research on the homeless population became influential as the federal government continued its efforts to assist the homeless population. In 1998, Congress tasked HUD with establishing a system to collect national data about homeless individuals (Hombs, 2011). Specifically, Congress requested data that included unduplicated counts of homeless individuals, demographic information, types of services received, lengths of stay, and employment status (Hombs, 2011). Because of this mandate, the Housing Management
Information System (HIMIS) was implemented in 2001 (Hombs, 2011). Local communities now collect and report the data directly to HUD.

Research drawing on data has contributed to the federal government’s response to homelessness (Hombs, 2011; HUD, 2007). An example of data collected is found in Culhane and Kuhn’s (1998) research on public shelter stay among homeless individuals in Philadelphia and New York City. The purpose of the study was to examine homeless adults as they enter and exit public shelters. Specifically, the authors sought to determine whether individual characteristics could determine the frequency of individuals exiting and returning (Culhane & Kuhn 1998). A computerized system tracked homeless individuals as they entered and exited shelters, and the data were analyzed using survivor analysis, regression analysis, and descriptive statistics. New York City data were collected over a 7-year period, from 1987 to 1994, and information was obtained on 110,604 homeless men and 26,053 homeless women. Philadelphia data were collected over a 3-year period, from 1991 to 1994, and shelter stay history was collected on 12,843 homeless men and 3,592 homeless women. Results from both New York City and Philadelphia indicated that a majority of shelter users, 55% of men and 65% of women, exited quickly and never returned. However, a group of homeless individuals remained for long durations. The frequency of long-term stays was 180 days in New York City and 120 days in Philadelphia (Culhane & Kuhn, 1998). Further, the majority of those individuals who stayed long-term had mental illness, substance abuse, and medical issues and utilized more costly resources such as hospitals. The researchers recommended that “the more timely provision of either transitional housing or permanent housing with
support services would likely reduce their risk of continued utilization of emergency shelter and associated costs” (p. 40).

**Responses to chronic homelessness.** The George W. Bush administration used the available research and data to create the 2002 federal budget to address homelessness (Hombs, 2011). One goal in this federal budget was to eliminate chronic homelessness in 10 years. However, arguments were raised that the goal excluded other homeless populations such as families and veterans. Nonetheless, the Bush administration reasoned that the chronically homeless use more resources such as emergency rooms, jails, and police that were costly to taxpayers and, as such, were given priority. The chronically homeless are “individuals with a disability who has either been continuously homeless for one year or more or has experienced at least four episodes of homelessness in the last three years” (HUD, 2013a, p. 2). Mental illness, substance use, severe medical conditions, trauma, and criminal history are often associated with the chronically homeless (Parker & Albrecht, 2012; Weinstein et al., 2011).

Several projects under President Bush’s term were implemented to achieve the goal of ending chronic homelessness (Congressional Research Service, 2014). One project was the 2003 Collaborative Initiative to Help End Chronic Homelessness. This initiative awarded funding to 11 communities that implemented permanent supportive housing and other social service programs to reduce chronic homelessness (Rickards et al., 2010). The funding was a collaboration among the USICH, HUD, U.S. Department of Health and Human Services, and U.S. Veterans Affairs (Rickards et al., 2010). By 2007, “Collaborative Initiative to Help End Chronic Homelessness created over 600 permanent supportive housing tenancies with only 4% of homeless clients returning to
the streets” (Hombs, 2011, p. 126). Additionally, health care treatment decreased 50% (USICH, 2010). Overall, the number of permanent supportive housing beds increased 6.7% from 2006 to 2007 and homelessness decreased by nearly 6% (HUD, 2008).

**Changing definitions and responses toward homelessness.** One of the challenges in creating programs has been the changing face of homelessness. More women with children became homeless, many individuals had a mental illness, and the homeless population as a whole was younger (Congressional Research Service, 2014). Reasons for the changing demographics of homelessness include reduced public benefits, lack of affordable housing, limited familial support, and a struggling economy (Congressional Research Service, 2014; Leginski, 2007).

The federal government took further action against homelessness when President Obama signed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act in 2009 (Congressional Research Service, 2014). The HEARTH Act reauthorized the McKinney-Vento Act with some modifications. One modification included expanding the homelessness definition to make services available to more people. The expansion of the homelessness definition included individuals who were in transitional housing, staying in a hotel that was paid for by social service agencies, defining youth as those aged 25 years or younger, and including individuals and families who are at risk of losing their homes (Congressional Research Service, 2014). The second modification of the McKinney-Vento Act was designating the USICH to “create the first federal strategic plan to prevent and end homelessness, setting forth the vision that no one in this country should be without a safe and stable place to call home” (USICH, 2013c, para 1). This plan was finalized in 2010 and was called *Opening Doors*. 
Basing goals on research, permanent supportive housing and rapid re-housing were strongly asserted as solutions to homelessness. Additionally, four subpopulations of the homeless were defined and each subpopulation had a timeline to eliminate homelessness. The four subpopulations included veterans, families with children, young adults, and chronically homeless adults (USICH, 2010).

The federal strategic plan aimed to end homelessness among families with children and young adults in 10 years and end homelessness among veterans and the chronic homeless in 5 years (USICH, 2010). However, citing the need for additional support, the goal to end chronic homelessness by 2015 was extended to 2017 (USICH, 2015). President Obama’s fiscal year 2015 budget was approved for $5,486 billion. Additionally, the Obama administration recognized more permanent supportive housing was essential to eliminate homelessness and identified the need for an additional 25,000 units (USICH, n.d.). To do this, the Obama administration proposed a budget of $5,486 billion for fiscal year 2016 (USICH, n.d.). The proposed budget increase “would bring the nation’s inventory of permanent supportive housing to a scale needed to achieve an end to chronic homelessness in 2017” (USICH, n.d., p. 2). The federal government recognized that “while everyone needs safe, stable housing, health care, income, and community support, there are specific approaches and programs that are designed to help each of the sub-populations” (USICH, 2010, p. 10).

**Homeless veterans.** Veterans returning home often have post-traumatic stress disorder, traumatic brain injury, or both (USICH, 2010). Other issues that veterans struggle with include substance use and sexual trauma. Many have had extended deployments which strain family relationships and make it more difficult to find
employment upon returning home (USICH, 2010). Lack of employment opportunities can occur because “military occupations and training are not always transferable to the civilian workforce” (National Coalition for Homeless Veterans, n.d.). Veterans who deal with one or several of these issues may not trust service providers who attempt to offer resources. Affordable housing, employment, mental health services, and medical care are the needs of this subgroup (USICH, 2010).

_Families with children._ The families with children subgroup typically consist of a single, young mother with children (USICH, 2010) and these families have low income. Domestic violence also can be a determinant of this subgroup. For these women, the “experience of becoming homeless is another major stressor amidst already complicated, traumatic experiences” (The National Center on Family Homelessness, 2011, p. 3). Concerns for this subgroup consist of emotional problems and separation of family members (USICH, 2010). Older children may be separated from the family and placed in foster care. This may occur if family shelters do not permit children to stay past a certain age (USICH, 2010). Children may exhibit anxiety, aggressive behavior, and depression. The needs of this subgroup, as identified in the strategic plan, include rapid re-housing which provides supportive services that can assist with stabilizing families. Further resources that are needed for this subgroup include increased domestic violence support, behavioral health, and medical services (USICH, 2010).

_Young adults._ Young adults become homeless when choosing to leave their homes or if their parents or guardians force them out (Thompson, Bender, Windsor, Cook, & Williams, 2010; USICH, 2010). Young adults may leave home for many reasons, including physical or sexual abuse, aging out or running away from the foster
care system, or the family not accepting the young adult’s sexual orientation (USICH, 2010). This subgroup has high rates of depression and substance use (Thompson et al., 2010; USICH, 2010). Furthermore, young adults “have limited ability to cope with stressors experienced in their lives” (Thompson et al., 2010, p. 196). Homeless young adults may engage in criminal activity such as prostitution, stealing, and selling drugs as a means of survival (Thompson et al., 2010; USICH, 2010). Many service providers are not prepared to serve young adults (USICH, 2010). Thus, the federal strategic plan calls for increased collaboration among service providers and more data on this population. More information is needed to “inform the scale of investments and the types of service delivery and coordination that are needed to end youth homelessness” (USICH, 2013d, p. 8). Other goals include increased youth shelters.

**Federal strategic plan.**

**Chronic homeless and the housing first model.** Several objectives are included in *Opening Doors* to prevent and end chronic homelessness by 2017, including increased medical and psychiatric access, employment opportunities, and affordable, permanent housing (USICH, 2015). There are two types of permanent supportive housing models for chronically homeless adults: a) treatment first and b) housing first. Under the treatment first model, permanent supportive housing is awarded once a chronically homeless individual has maintained a period of sobriety, as defined by the housing provider, and is engaged in psychiatric care (Tsemberis & Eisenberg, 2000). As a result of these requirements, many chronically homeless individuals fail to qualify for housing or refuse the service and remain homeless (HUD, 2007; Pearson et al., 2009). The second model, housing first, was founded by Tsemberis in 1992 in New York City.
This model was designed to meet the needs of individuals who were unable to qualify for treatment first housing (Tsemberis & Eisenberg, 2000). The housing first model “entails the provision of low-barrier, immediate and permanent supportive housing to chronically homeless individuals many of whom also have co-occurring substance use and/or psychiatric disorders” (Collins et al., 2012, p. 1679). Individuals do not need to be abstinent from substances or engage in psychiatric care before being housed (Pearson et al., 2009). The philosophy of the model is that everyone deserves a home (Tsemberis & Eisenberg, 2000).

Researchers have identified the critical components and advantages of the housing first model (Davidson et al., 2014; Montgomery, Hill, Kane, & Culhane, 2013; Pearson et al., 2009; Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000; Watson et al., 2013). These components and advantages include: a) tenant choice in housing, b) the importance of separating housing and support services, c) service philosophy, and d) offering a variety of services and program structures (Stefancic et al., 2013). Tenant choice in housing offers tenant preference on housing location, furnishings, and the choice to live independently or with others (Tsemberis & Eisenberg, 2000). Separating housing from services such as case management is important due to the differences between property management and case management roles (Watson et al., 2013, p. 175). Case management staff required to deal with property management issues may have difficulty establishing trust with tenants (Watson et al., 2013). The housing first service philosophy believes all individuals deserve housing, regardless of impairments or disabilities (Tsemberis & Eisenberg, 2000). Lastly, the housing first model does not mandate tenants to comply with services such as psychiatric care or substance use
treatment. Tenants are made aware of the various services and “determine the priority and order of services they receive” (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005, p. 225).

The USICH (2010) endorsed the housing first model as being a solution to ending chronic homelessness. This endorsement of housing first was due to the many research studies that Tsemberis and colleagues conducted to demonstrate that the model was an evidence-based practice (Greenwood et al., 2013). The USICH (2010) has approved of the model because the “practices seek to ‘screen in’ rather than ‘screen out’ and end homelessness for people with the greatest barriers to housing success” (p. 18).

The housing first model has helped to reduce or nearly eliminate chronic homelessness in different cities and states. Phoenix, Arizona, eliminated chronic veteran homelessness using the housing first model (Keyes, 2013). In 2011, 222 chronically homeless veterans in Phoenix were homeless, and by December 2013, all these individuals were placed in housing (Santos, 2014). The city was able to provide housing vouchers to this population due to the federal collaboration between HUD and the U.S. Department of Veterans Affairs (Santos, 2014). This collaboration has “awarded nearly $300 million to more than 300 community agencies to help homeless or at-risk veterans and their families” (Chokshi, 2013, para 7). Santos (2014) interviewed one veteran from Phoenix who admitted having a home has helped him remain 9 months sober.

Utah began utilizing the housing first model after Lloyd Pendleton, Director of the Utah Housing Task Force, heard Tsemberis speak of the housing first model at a conference in 2003 (McCoy, 2015). Since 2005, Utah reduced chronic homelessness by 91% (Glionna, 2015). At that time, the number of chronically homeless adults totaled
1,932. Of that, 1,764 have been placed in permanent housing, using the housing first approach (Glionna, 2015). Utah officials recognized the benefit of “prioritizing housing as an immediate need before connecting individuals with necessary services like addiction programs and mental health treatment” (Couch, 2015, para 7).

**Critiques of housing first.** Concerns with the housing first model have also been identified. These concerns include increased substance use, especially when living in a single building with other actively using individuals, and property damage (Kertesz & Weiner, 2009; Milby et al., 2005; Pearson et al., 2009). Because housing first does not mandate tenant sobriety (Tsemberis & Eisenberg, 2000), a possible issue is that tenant substance use could increase (Kertesz & Weiner, 2009). Residential programs that offer apartments to the chronically homeless in the same building could be a concern if some tenants are actively using while others are either attempting or struggling with sobriety (Kertesz & Weiner, 2009; Milby et al., 2005). To better understand this risk, Milby et al. (2005) compared the substance use of tenants in housing first and treatment first programs and individuals who remained homeless. The study, conducted in Alabama, included 196 individuals with cocaine dependence and nonpsychotic mental disorders. The study occurred over a 1-year period and each participant was provided the same services such as day treatment, vocational training, and group therapy. Random drug screening occurred throughout the study. The researchers used an intention-to-treat analysis and generalized estimating equation to determine differences in abstinence. Overall, the treatment first tenants had higher rate of abstinence but it was not statistically significant. The researchers did report, however, that some treatment first participants reported struggling to maintain sobriety when sharing a building with housing first
participants. Nevertheless, the study did reveal that tenants with housing, regardless of living in a treatment first or housing first program, had a significantly higher abstinence rate than those who were homeless (Milby et al., 2005).

**National data and evidence of program effectiveness.** Data on number of homeless individuals and families and available housing units have been published since 2005 (HUD, 2008). The Annual Homeless Assessment Report (AHAR) uses data from HMIS and point-in-time counts to report national estimates to Congress (HUD, 2014c). Point-in-time counts occur one night a year in January, and provide an estimated number of sheltered and unsheltered individuals (HUD, 2014c). However, the 2005 and 2006 reports only provided a representative sample over a three-month period, as many communities were still implementing HMIS. The 2007 AHAR report was the first to represent all communities and provide a year’s worth of data (HUD, 2008). It is considered the benchmark for future AHAR reports (HUD, 2008).

Figure 2.1 shows the estimated number of homeless people each year from 2007-2014. In 2007, the total number of homeless individuals totaled 651,142 (HUD, 2014c). Annual homeless estimates since 2007 have decreased, with the exception of 2010 when the estimated number of homeless increased by over 7,000 individuals from the previous year. However, since the implementation of the federal strategic plan in 2010, annual updates have shown a national decline in homelessness among all the subpopulations (HUD, 2014c). The most current estimate in 2014 totals 578,424 homeless individuals. The table further demonstrates that more individuals are utilizing emergency shelters and the number of unsheltered individuals is decreasing, demonstrating local and federal efforts to combat this plight.
Increasing the number of permanent supportive housing units has been a priority at the national level, as it has contributed to the decline in homelessness (HUD, 2007; USICH, 2010, 2015a). Increased funding is deemed necessary to continue efforts to eliminate homelessness.

![Figure 2.1. Estimates of homeless people, 2007-2014. Adapted from “The 2014 Annual Homeless Assessment Report (AHAR) to Congress” by HUD, 2014c, p. 6.](image)

Further, HUD (2008) has prioritized “more resources to the development of permanent supportive housing beds, compared to emergency or transitional beds” (p. 41). This is demonstrated in Figure 2.2, which details the estimated number of transitional housing, emergency shelter, and permanent supportive housing units available since 2007. The number of permanent supportive housing units increased 59% since 2007, while the number of transitional housing decreased by 18% (HUD, 2014c). The number of overall
homeless individuals has decreased 11% since 2007, showing there is still a need for more permanent supportive housing (HUD, 2014c).

Figure 2.2. Inventory of beds for homeless and formerly homeless people, 2007-2014. Adapted from “The 2014 Annual Homeless Assessment Report (AHAR) to Congress” by HUD, 2014c, p. 58.

The case of New York State. Despite the decline in homelessness, some states continue to see increases. Between 2007 and 2014, the five states that have had the highest increases include New York, Massachusetts, District of Columbia, Minnesota, and Missouri (HUD, 2014c). Of those five states, the District of Columbia had the highest increase by 45.6%. New York saw a 28.7% increase and had more homeless individuals than the other identified states. New York had an increase of 17,989
individuals, followed by Massachusetts with 6,110 (HUD, 2014c). This information can be found in Table 2.1.

Table 2.1

Largest State Increases and Decreases of Homeless Between 2007-2014

<table>
<thead>
<tr>
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<tr>
<td><strong>Largest Increases</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>3,160/ 4.1%</td>
<td>New York 17,989 / 28.7%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>2,208/ 11.6%</td>
<td>Massachusetts 6,110 / 40.4%</td>
</tr>
<tr>
<td>Nevada</td>
<td>2,113/ 25.0%</td>
<td>District of Columbia 2,428 / 45.6%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>883/ 12.9%</td>
<td>Minnesota 1,054 / 14.4%</td>
</tr>
<tr>
<td>Michigan</td>
<td>700/ 6.1%</td>
<td>Missouri 1,035 / 16.6%</td>
</tr>
<tr>
<td><strong>Largest Decreases</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>-6,320/ -13.2%</td>
<td>California -25,034 / -18.0%</td>
</tr>
<tr>
<td>California</td>
<td>-4,600/ -3.9%</td>
<td>Texas -11,293 / -28.4%</td>
</tr>
<tr>
<td>Oregon</td>
<td>-1,658/ -12.0%</td>
<td>Florida -6,527 / -13.6%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>-1,487/ -22.7%</td>
<td>New Jersey -5,643 / -32.6%</td>
</tr>
<tr>
<td>Missouri</td>
<td>-1,299/ -15.1%</td>
<td>Oregon -5,426 / -30.9%</td>
</tr>
</tbody>
</table>

Adapted from “The 2014 Annual Homeless Assessment Report (AHAR) to Congress” by HUD, 2014c, p. 9.
The USICH (2014a) reported that 83% of New York’s homeless population is based in New York City. New York City data revealed that in July 2014, the number of homeless individuals sleeping in municipal shelters totaled 56,454. Of these individuals, over 8,600 were single men and nearly 3,000 were single women. In September 2014, the total of individuals sleeping in municipal shelters increased to 58,058. Nearly 8,800 were single men and over 3,000 were single women. These are the highest numbers ever recorded (Coalition for the Homeless, 2014b). In 2014, the New York City Coalition on the Continuum of Care reported 16,995 permanent supportive housing beds for individuals. Of that number, 9,300 were dedicated to chronically homeless adults (HUD, 2014e).

Many factors cause New York City to have one of the highest homelessness rates in the United States. Housing costs in New York City are significantly higher than the national average (Bureau of Fiscal and Budget Studies, 2014; U.S. Department of Labor, 2014). The U.S. Department of Labor (2014) reported that New York City households, on average, spent $24,187.00 on rent or mortgage, almost 7% higher than the national average. Additionally, apartment rentals in New York City “experienced a significant rise in inflation-adjusted rents during the 2000 to 2012 period while real incomes stagnated” (Bureau of Fiscal and Budget Studies, 2014, p. 10).

The Advantage Program, initiated by then Mayor Michael Bloomberg in 2007, has been blamed for causing previously homeless individuals and families to return to homelessness (Bureau of Fiscal and Budget Studies, 2014; Coalition for the Homeless, n.d.; Markee, 2011; Secret, 2011). The Advantage Program’s purpose was to assist individuals to become self-sufficient (Secret, 2011). The program was funded by both
the city and state of New York (Bureau of Fiscal and Budget Studies, 2014). Specifically, the Advantage Program “provided rental subsidies to families that had been in the shelter for 90 days and to single adults who had been in the shelter for at least 180 days out of the previous year” (Bureau of Fiscal and Budget Studies, 2014, p. 13). Subsidies were available to families and individuals for a 2-year period (Bureau of Fiscal and Budget Studies, 2014; Secret, 2011). The Coalition for the Homeless opposed the time-limited subsidy and argued it created a “revolving door” for homelessness (Markee, 2011). The program was abruptly stopped when New York State eliminated its funding. Data revealed that out of 17,248 families who lost the subsidy, 8,518 families, or 49%, returned to the shelter (Markee, 2013). These families were comprised of 18,481 children and 12,242 adults (Markee, 2013).

**Proposed changes.** Both HUD and the USICH have encouraged all Continuum of Care Programs to change to a housing first model (HUD, 2014d). As a result, the New York City Coalition on the Continuum of Care (2015) is requiring housing programs to adopt the housing first model. Each Continuum of Care program evaluates and then funds existing and newly developed nonprofit residential programs. Under this model, the Continuum of Care evaluation tool either adds or deducts points on an agency’s evaluation, depending on whether the agency identifies as housing first (New York City Coalition on the Continuum of Care, 2015). This tool is found in Appendix B. It is possible that agencies not following a housing first model could lose funding if other residential programs are more in alignment with the goals set forth by the USICH, HUD, and Continuum of Care.
Current New York City Mayor Bill de Blasio has been responding to advocates and critics about the increase of homeless people both in shelters and on the streets (Flegenheimer, 2015; Grynbam & Stewart, 2015). In May 2015, Mayor de Blasio announced “the city would commit $100 million in annual spending, including funding for rental assistance to more than 7,000 new households, anti-eviction efforts and other measures” (Flegenheimer, 2015, para 3). In August 2015, he announced further plans to increase caseworkers in emergency shelters in order to assist homeless people in obtaining resources, including housing, and offer additional street outreach to mentally ill individuals (Grynbam & Stewart, 2015). Mayor de Blasio is expected to announce additional housing efforts in the fall of 2015 (Grynbam & Stewart, 2015).

As part of the goal set forth by the USICH (2010), the housing first model was deemed the most evidence-based and cost-effective permanent supportive housing model to eliminate chronic homelessness. Given the recommendations to switch to the housing first model and the dominance of the treatment first model, current New York City first providers and administrators may need support with the transition. However, little research has demonstrated how treatment first programs transition to a housing first model and which strategies they use to do so.

**Topic Analysis**

There are a number of key studies on retention rates within programs, the components of the housing first program, and the relationship of retention rates to fidelity to the program components. Specifically, Tsemberis and Eisenberg (2000) and Stefancic and Tsemberis (2007) examined retention rates within programs, and Tsai et al. (2010) compared the experiences and retention rates of participants in treatment first versus
housing first programs. Pearson et al. (2009) identified program commonalities, and Stefancic et al. (2013) identified core components and created fidelity scores for assessing housing first programs. Montgomery et al. (2013) compared housing access and retention rates between housing first and treatment first programs. Davidson et al. (2014) built on this work to examine the relationship between fidelity and retention rates.

Qualitative research has been done to understand better the experiences of individuals involved in housing programs in order to identify challenges within programs. For example, Henwood et al. (2011) and Henwood, Shinn, Tsemberis, and Padgett (2013) compared the perspectives of housing first and treatment first direct care staff, and Collins et al. (2012) examined residents’ transitions into housing and the experiences of residents and staff in a housing first project. These qualitative studies provide insight into the challenges program administrators may face when transitioning from a treatment first to a housing first program model.

This section contains a comprehensive review of this research literature to demonstrate why the housing first model is considered an evidence-based practice and supports the USICH and HUD endorsement that treatment first residential programs should transition to housing first.

Retention rates. Tsemberis and Eisenberg (2000) compared the retention rate of the New York City Pathways to Housing program with the retention rates of treatment first programs also located in New York City over a 5-year period. Two research questions guided the study. The first question sought to determine whether homeless, mentally ill adults, without any previous intervention, could successfully remain in their own apartment. The second question inquired which housing model had higher retention
rates. The New York City Human Resources Administration (HRA) provided the treatment first program data. The HRA monitors and collects data from the programs that receive grants to house the chronically homeless. The researchers intended to only use treatment first tenants referred by drop-in centers, shelters, or street outreach teams. These referral sources are typical for housing first referrals and the researchers aimed to keep the sample as similar as possible. The treatment first sample included 1,600 individuals; the Pathways to Housing sample included 241 individuals. Several differences were identified in demographics. Pathways to Housing had more women enrolled than the treatment first programs, 33% compared to 27%, respectively. Additionally, 52% of Pathways to Housing tenants had more tenants diagnosed with schizophrenia (52%) and fewer with mood disorders (26%) than the treatment first programs, who had 38% diagnosed with schizophrenia and 47% with mood disorders. Lastly, 58% of Pathways to Housing tenants had a substance abuse diagnosis compared to 49% of treatment first tenants. Survival analyses determined retention rates. At the end of the 5-year study, Pathways to Housing had an 88% retention rate, while the treatment first programs had a 47% retention rate. Tsemberis and Eisenberg (2000) concluded that the results “challenge the widely held assumption that a strong relationship exists between psychopathology and the ability to maintain housing” (p. 492).

Stefancic and Tsemberis (2007) also investigated the retention rates and housing access of two housing first programs in a suburban county and compared the two programs with a treatment first program. The study occurred over a 47-month period. One housing first program was Pathways to Housing and was new to the county. The
second program was new to housing first but consisted of many diverse providers from the county. A control group of participants who were waiting for treatment first housing was used for comparison to determine the length of time to access an apartment. Housing first programs had data available for 47 consecutive months. The treatment first data was only available at the 20th month. Data consisted of monthly reports submitted to the Department of Social Services that indicated current housing retention rates, number of tenants no longer housed, and how many outreach and engagement attempts were made. At the 20th month, Pathways to Housing had 57 tenants housed. The other housing first program had 46 tenants housed. In comparison, at the 20th month, 13 tenants were housed in treatment first. The treatment first comparison group had longer wait periods for available housing and “most participants in the control group still had not reached the endpoint of permanent, independent housing” (Stefancic & Tsemberis, 2007, p. 274).

After 2 years, the Pathways to Housing retention rate was 88.5% and the other program had a 79% retention rate. At the end of the study, Pathways to Housing had a 78.3% retention rate and the other program had a 57% retention rate. Obtaining permanent housing provides not only a safe and secure place to live, but also an opportunity for tenants to choose resources that may aid in their recovery (Stefancic & Tsemberis, 2007).

Additionally, Pearson et al. (2009) conducted a study commissioned by HUD to compare three housing first models in an effort to identify program commonalities. The three groups, collectively, recruited 80 participants for the study. The programs included Pathways to Housing in New York City, New York; Downtown Emergency Service Center (DESC) in Seattle, Washington; and Reaching Out and Engaging to Achieve Consumer Health (REACH) in San Diego, California. Quantitative data consisted of
monthly housing status, drug use impairment, service contacts, and temporary leave from the program. Focus groups with participants determined how they were admitted to the program, if they had a choice in service utilization and housing, and their overall satisfaction. All programs committed to servicing chronically homeless, mentally ill adults, offered but did not require a variety of supportive services, and placed individuals directly into housing. An 84% retention rate was achieved among the three programs at the end of 12 months. Pathways to Housing had a 92% retention rate; the other two programs had an 80% retention rate. Pearson et al. concluded that “differences in participants’ living situations immediately prior to program entry appear to have some impact on the differences in the level of housing stability among the housing first programs” (p. 411).

Further insight into the needs of chronically homeless individuals was provided by Tsai et al. (2010) who hypothesized that chronically homeless individuals in treatment first programs would have “better psychosocial and substance abuse outcomes than clients who were placed immediately into independent housing” (p. 220). This observational study included 709 participants from 11 different programs throughout the United States. The participants were followed their first two years upon being housed and were interviewed every three months. Items measured included housing retention, community engagement, substance abuse, employment and income, mental and physical health, and service costs. Frequency analyses, regression analyses, and linear regression were used to measure the data. Results showed that the hypothesis was not accepted. The treatment first participants spent fewer days in their own home, had higher rates of incarceration, and incurred more substance abuse service costs. The housing first
program had an 81% retention rate and the treatment first program had a 72% retention rate.

Further data comparing treatment first to housing first programs were provided by Montgomery et al. (2013) who compared housing access and retention rates between a housing first program and a treatment first program in a metropolitan area. The housing first program was modeled after Pathways to Housing and had 107 participants. The treatment first program had 70 participants. Chi-square and t-tests compared the data. Results indicated that the treatment first program prioritized veterans with families more than the housing first program. There were different recruiting measures, resulting in the differences of families in each program. The housing first participants were generally recruited via street outreach. In contrast, the treatment first participants were often screened at the veteran medical center. The housing first participants were recruited from the streets whereas the treatment first participants were recruited at the veteran medical center. The housing first participants were more likely to be unemployed. Additionally, the average length to wait for available housing for veterans in the housing first program was 35 days and 6 months for the treatment first program (Montgomery et al. 2013). At the end of 12 months, the housing first program had a 98% retention rate and the treatment first program had an 86% retention rate, resulting in continued endorsement of the housing first model.

Components of the housing first program and assessing program fidelity.
Stefancic et al. (2013) found that many housing first programs internationally and in the United States varied from the original housing first model implemented by Pathways to Housing in aspects such as consumer choice, frequency of case management services,
and tenant independence. Housing first principles include consumer choice, easy housing access, and service array. Therefore, Stefancic et al. (2013) sought to identify key elements that made the Pathways to Housing model effective. Once those components were identified, Stefancic et al. developed a fidelity scale to ensure that “programs implement housing, support, and treatment services, and practice philosophy that is consistent with the housing first model” (Tsemberis, 2013, p. 236).

In order to identify key elements, Stefancic et al. (2013) conducted a literature review, researched similar fidelity scales, and conducted interviews with five housing first experts. Two members of the research team synthesized the data and identified five essential domains with 38 key elements. The domains included: a) housing choice and structure, b) separation of housing and case management services, c) service philosophy, d) array of services, and f) program structure. Once key elements were identified, the research team developed a survey for the validation of the identified key elements. Five housing first programs and 99 staff completed the survey.

Stefancic et al. (2013) conducted two separate research projects and multiple residential programs were utilized to field test the fidelity scale. The first research project, based in Canada, followed the Pathways to Housing model. Fidelity was determined by baseline and follow-up assessment. The second research project, located in California, had 20 residential programs that used components of housing first but did not follow the Pathways to Housing model. The fidelity assessment included site visits with staff interviews, client focus groups, and documentation review. Cronbach’s alpha determined the internal consistency of the California programs. Results indicated that the Canadian housing first programs had higher rates of validity. However, the researchers
also acknowledged that some programs may not be able to fully implement the Pathways to Housing model because “programs operate in contexts in which organizational structures and local environments vary in culture, values, and resource availability, contributing beyond fidelity to a diversity of program and client outcomes” (Stefancic et al., 2013, p. 259).

**Fidelity and retention.** Similar to Stefancic et al. (2013), Davidson et al. (2014) acknowledged that not all housing first programs utilize the core principles of the housing first model. Additionally, Davidson et al. were concerned with substance use and retention rates of clients who lived in programs that varied in housing first principles. The researchers hypothesized that “clients housed in programs with high fidelity to housing first principles related to consumer participation would experience longer housing retention and less substance use at follow-up compared with clients housed in low-fidelity programs” (p. 2).

In the Davidson et al. (2014) study, 287 participants from nine different programs in New York City completed a baseline interview and a follow-up interview one year later. The Addiction Severity Index measured substance use 30 days before being interviewed. All nine housing first programs involved in the study provided housing retention data. All statistical analyses were completed with Santa 11. At the completion of the study, retention rate for all nine programs was 75%. Based on the fidelity scale used, five of the nine programs had high housing first fidelity. Results indicated that high fidelity programs that utilized the core principles had higher retention rates and less self-reported substance use.
Qualitative insights. Whereas the quantitative studies have shown trends within the two models for addressing homelessness, several qualitative studies have been conducted to gain deeper insights into the experience of individuals involved in the programs. Two studies compared the perspectives of housing first and treatment first direct care staff (Henwood et al., 2011; Henwood et al., 2013). Henwood et al. (2011) interviewed direct care staff of both housing models to determine if the staff work in a manner and engage with clients that is indicative of each model’s values. The research questions guiding the study inquired about provider perceptions on services provided, how the acquisition of housing affects relationships with clients, and how direct care staff communicate and demonstrate the values of the housing models. The recruitment period took one year and data collection took six months to complete. A total of 41 direct care staff, 21 from three treatment first programs and the remaining 20 from one housing first program, were interviewed. Newly enrolled clients of the housing programs provided consent for staff to be interviewed. Staff was first interviewed within 30 days of a client enrollment and 6 months later, or once a client left the program. Staff turnover during the course of the study was equal in both housing models, with the housing first program having a 65% staff turnover and the treatment first programs having a 66% turnover. A total of 129 interviews were conducted. Thematic analysis of the interviews unveiled three themes which were: the importance of housing, client engagement, and tenant rights to housing.

The philosophical differences between the two housing models defined how direct staff engaged with clients. Housing first providers focused on consumer needs and consumer choice. Housing first providers found that since there was no mandate for
tenants to participate in any treatment, tenants were able to trust and engage easily. Treatment first providers often felt pressure to maintain a tenant’s housing. If a tenant did not participate in treatment or used drugs and alcohol, it was possible that the tenant would lose housing. Therefore, treatment first providers focused on behavioral expectations. The study demonstrated that the “program structure can translate in unexpected ways in front-line practice as providers attempt to be effective within the constraints of the system” (Henwood et al., 2011, pp. 84-85). This study demonstrated the need for research on how treatment first programs transition to housing first, as the models differ in philosophy and practice.

Henwood et al. (2013) collected data from two previous studies to “investigate whether and how differences in approaches are reflected in the views of frontline providers” (p. 266). Research questions centered on the viewpoints and attitudes of direct care staff when working in the two different housing models. Similar to the Henwood et al. (2011) study, the different housing model’s philosophy influenced how providers engaged with tenants. Housing first staff provided more person-centered planning. Treatment first providers worked with tenants to maintain treatment first expectations of psychiatric compliance and abstinence (Henwood et al., 2013).

Whereas Henwood and colleagues examined the experiences of staff, Collins et al. (2012) used a case study approach to “examine residents’ transitions into housing and the day-to-day experiences of residents and staff who live and work in a project-based housing first program” (p. 1681). The study was conducted in Seattle, Washington. Data collection occurred in five phases which included: observing staff and resident interactions; observing daily routines of staff; reviewing agency documentation such as
policy and procedures; conducting semi-structured, one-on-one interviews with residents; and facilitating a focus group with eight program staff. Questions asked of residents pertained to relationships with staff, other tenants, and what they would like to see added to the program. The staff focus group explored relationships with other staff and residents, what the staff identified as strengths and weaknesses of the program, and what was expected of their role in the agency. The researchers look for themes in their data analysis and coded all observations, notes, and interviews. Results indicated four themes which include tenants moving into housing first, sense of community, crisis management, and ongoing transitions. Overall, tenants reported moving in with ease. Observations included several arguments and physical exchanges among residents but also peer support. Staff reported high stress levels and “being on perpetual watch for the ‘next fire to put out’” (p. 1686). Tenants also feared the possibility of having to move out and frequent staff turnover. Researchers recommended more training for staff and support groups for residents to cope with multiple transitions (Collins et al., 2012).

**Single-site and scattered-site housing first programs.** The original housing first program, Pathways to Housing, provided apartments in scattered-site housing. Scattered-site housing offers apartments in different buildings in different locations (USICH, 2013b). As more housing first programs developed, some programs operated in a single-site location, where all available apartments are in one building. Many studies that have focused on whether there are differences between single-site and scattered-site housing have studied tenant perception.

Brown, Malone, and Jordan (2015) explored tenant satisfaction with a single-site housing first program located in an urban city in Washington. The building has 75
individual apartments designated for chronically homeless adults. Staff is present at all times. Of the 75 tenants, 33 participated in the study. The Housing Environment Survey was administered to the tenants to evaluate their perceptions of their housing environment. Open-ended questions asked tenants to identify both advantages and disadvantages with their apartment as well as advantages and disadvantages with the neighborhood, and to identify what they liked the most. The answers were coded to look for both positive and negative themes. Results indicated eight positive themes, including living in a good location that offered many convenient services nearby, accessibility to public transportation, feeling safe in their apartments and in the neighborhood, having on-site staff available, living in a quiet atmosphere, and autonomy. In contrast, the five identified negative themes reported included having drugs in the building and in the neighborhood, noise levels, bug and vermin infestation, crime, and lack of privacy. These results indicated that on-site staff can be viewed as a benefit or hindrance. However, “tenants described the ability to be autonomous as a positive aspect of the program, suggesting that single-site housing first programs can successfully foster autonomy and independence as scattered-site programs do” (Brown et al., 2015, p. 505).

Pearson et al. (2009) compared three different housing first programs by conducting tenant focus groups at each location. Additionally, staff provided quantitative data pertaining to housing stability and substance use. The first program, Pathways to Housing, provides scattered-site housing that offers tenants a choice on where they would like to live. Pathways to Housing owns each apartment and the tenants sublease from the agency. The second program, Downtown Emergency Service Center (DESC) in Seattle, Washington, is comprised of four single-site buildings that have a 24-hour staff presence.
The last program, Reaching Out and Engaging to Achieve Consumer Health (REACH) in San Diego, California, is a scattered-site program. However, REACH does not own the apartments and many landlords have restrictions such as substance use or curfew. There was no statistical difference in housing stability among the three programs. However, Pathways to Housing and DESC had more housing stability than REACH. The researchers attributed this to “REACH not being the best fit with the housing first model because some of the housing providers that leased to REACH participants had strict lease requirements prohibiting drug or alcohol use” (Pearson et al., 2009, p. 415). Similar to Brown et al. (2015) study, tenants identified autonomy, safety, and comfort as benefits to living in the apartments.

Tsai, Bond, Salyers, Godfrey, and Davis (2010) also explored tenant satisfaction with housing. The researchers recruited 20 participants who lived in two different single-site buildings and 20 participants who lived in scattered-site housing. Using semi-structured interviews, the researchers asked questions pertaining to tenant likes and dislikes, current housing preference, opinions on neighbors, and future housing preference. Each interview was coded to look for themes. Results indicated that tenants enjoyed their independence. However, there were some differences, as 64% of scattered-site tenants reported satisfaction with having privacy and only 25% in the single-site locations reported satisfaction with having privacy. Additionally, 15% of the single-site tenants expressed dissatisfaction with staff making ongoing apartment inspections. Tenants in the single-site buildings expressed having a feeling of community with peers. Tenants in scattered-site reported keeping to themselves and had little interaction with other building tenants. As for dislikes, tenants in the scattered-site buildings primary
complained about building upkeep and maintenance. Tenants in single-site building complained about drug use, theft, and noise. A significant number of tenants in both apartment structures reported being satisfied with their housing, were given a choice of housing when they first moved in, and had no plans of moving or exploring other housing options (Tsai, Bond et al., 2010).

**Systems thinking.** Transitioning to a housing first model can be a huge undertaking. Administration needs to strategize how the transition will occur. Additionally, all staff needs to understand and accept the housing first model and the agency’s new vision and mission. Therefore, it is essential that all transitioned housing first programs strive to be a learning organization.

Senge’s (1990) systems thinking theory was introduced in his book *The Fifth Discipline*. According to Senge, five disciplines must be met for an organization to become a learning organization. Learning organizations allow “a shift of mind from seeing ourselves as separate from the world to connected to the world, from seeing problems as caused by someone or something ‘out there’ to seeing how our own actions create the problems we experience” (p. 13). Learning organizations understand that the world is not fragmented; everything is connected. Without the capacity to learn, routines remain set in place and there is no opportunity to advance an organization (Leon, 2008). Additionally, learning advances an organization’s success (Caldwell, 2012). Learning organizations permit the organization to reach its full potential. This is achieved when all staff are involved participants in the learning and growth of the organization. The five disciplines needed to become a learning organization include: team learning, building a shared vision, mental models, personal mastery, and systems thinking. System thinking
is the fifth discipline which is needed to bring the other four disciplines together. Once all five disciplines are mastered, an organization has reached its highest aspirations (Senge, 1990).

Team learning involves the exchange of dialogue. This opportunity allows for sharing ideas. Equally important is the need to “recognize patterns of interaction in teams that undermine learning” (Senge, 1990, p. 13). Senge cautioned about the use of defensive dialogue that can be damaging to the learning organization. Defensiveness is unproductive and inhibits the ability to learn. However, Senge stated that if a group truly has a desired outcome and can communicate the reality of situations, defensiveness can turn into learning experiences.

Building a shared vision is achieved when all staff understands and embrace the organization’s mission, vision, and values. Staff that truly comprehends what the organization strives for will commit and excel in the organization. According to Senge (1990), “the practice of shared vision involved the skills of unearthing shared ‘pictures of the future’ that foster genuine commitment and enrollment rather than compliance” (p. 12).

Mental models are assumptions or beliefs that individuals have. As a result, mental models “affect the way the organization is perceived, what one sees and observes, and what the person in the system truly desires” (Leon, 2008, p. 17). Most mental models are unconscious (Senge, 1990). Staff members must remain in the habit of managing mental models to enhance their worldview (Senge, 1992). Inquiry and reflection are two practices to alter mental models. Inquiry assists with dealing with
conflict with others. Reflection provides the ability to become more aware of what the current mental models are that may require changes or judgments (Senge, 1992).

Personal mastery addresses the need for continuous learning (Senge, 1990). Organizations should provide ongoing training and education. This ongoing learning allows the staff to be experts in their field. As a result, staff will reach their full potential. Personal growth is also imperative. Individuals should reflect on what inspires them both professionally and personally. This discipline “is an essential cornerstone of the learning organization—the learning organization’s spiritual foundation” (p. 10). Senge further stated that many organizations do not permit continuous learning and, therefore, employees lose motivation and commitment to the organization.

The fifth discipline is systems thinking. Systems thinking “is the discipline which makes visible that our actions are interrelated to other people’s actions in patterns of behavior and are not merely isolated events” (Flood, 1999, p. 2). Systems thinking bring all the disciplines together, “fusing them into a coherent body of theory and practice” (Senge, 1990, p. 13). Additionally, systems thinking provides the opportunity to see events as a whole, rather than linearly (Spruill, Kenney, & Kaplan, 2001).

Systems thinking originated in the science fields including physics, psychology, cybernetics, and biology (Laszlo & Krippner, 1998; Mirvis, 1996). Ludwig Von Bertalanffy is considered the founder of general systems theory (Spruill et al., 2001; Von Bertalanffy, 1972). Von Bertalanffy, a biologist, stressed the importance that all factors of an organism be learned before understanding that organism as a whole. Other scientists who have utilized systems thinking include Paul A. Weiss and Alfred North Whitehead, who both studied integrations of organisms (Laszlo & Krippner, 1998).
In 1946, W. Edward Deming began consulting with the Japanese who were concerned with their manufacturing products (Petersen, 1987). Having studied physics, mathematics and engineering, Deming believed that “a system only exists when its components are interrelated in the pursuit of a common aim” (Leon, 2008, p. 15). At the time, the Japanese industry and technology were affected by World War II, causing an economic decline (Petersen, 1987). Deming’s work with the Japanese provided a new perspective that focuses on management rather than production (Petersen, 1987). The managers needed to understand the products before production excelled. His contribution to their industry resulted in an improved economy (Petersen, 1987).

Senge’s (1990) work was inspired by Jay Forrester’s work in system dynamics. In the 1950s, Forrester was a co-creator of computer Random Access Memory (Leon, 2008). Forrester posited that “the causes of many pressing public issues, from urban decay to global ecological threat, lay in the very well intentioned policies designed to alleviate them” (Senge, 1990, p. 14). Policies, he claimed, focused on the symptoms of a problem and did not address the actual cause (Senge, 1990).

In the 1960s, systems thinking became influential in fields other than science (Laszlo & Krippner, 1998). Fields such as social work, behavioral sciences (Laszlo & Krippner, 1998), and public administration (Midgley, 2006) began using systems thinking. Additionally, systems thinking became recognized due to “societal pressures on calling for the development of theories capable of interdisciplinary application” (Laszlo & Krippner, 1998, p. 6).

A Canadian community became concerned many individuals and families were becoming too reliant on a local food pantry (Abdussamad, 2014). The community came
together, using a case study approach and systems thinking perspective to determine how
to lessen the dependence of the food pantry. The community sought to determine why
many relied on the foodbank, societal factors that caused the dependency, and strategies
to reduce the need (Abdussamad, 2014). Economic, social, environmental, and policy
factors were discussed among various stakeholders including foodbank administration,
volunteers, clients, donors, and suppliers. Foodbank administration and volunteers
completed interviews and surveys that focused on the current job skills of the clients.
Volunteers provided input on reducing the foodbanks need in the community. Clients
shared their struggles obtaining employment. Identified solutions consisted of making
additional community resources more visible to the clients, providing vocational skills,
and offering English as a second language courses (Abdussamad, 2014).

A housing coalition in Calhoun County, Michigan, applied systems thinking
theory when developing a 10-year plan to end homelessness (Stroh & Goodman, 2007).
While developing the 10-year plan, a shared vision and goals were discussed and agreed
upon. Previous and current homeless individuals in Calhoun County were interviewed to
determine factors inhibiting housing. Identified issues included: difficulty locating
ethical landlords willing to accept homeless tenants; veterans who received services at the
veteran’s psychiatric hospital in the county often remained in the county; limited case
management services; lack of exposure of the homeless issue; and lack of permanent
housing. The information gathered and analyzed resulted in a seven-step strategic plan.
The initial step was to increase awareness of homelessness in the county. The second
step was to enhance community collaboration to identify solutions to end homelessness.
Addressing funding needs was the third step of the strategic plan. The fourth step
addressed the need for additional permanent housing. Seeking availability of substance abuse and mental health treatment resources was the fifth step. The sixth step concentrated on the county’s need to offer additional employment opportunities. The last step “was to develop a permanent solutions mindset that permeated all of the other interventions” (Stroh & Goodman, 2007, p. 6). A follow-up interview with the Coalition Chair six months later indicated positive results. Funding was reallocated which offered additional permanent supported housing. Additionally, several social service agencies and organizations in the community increased efforts by offering additional services or resources (Stroh & Goodman, 2007).

Maon, Lindgreen, and Swaen (2008) researched a pharmaceutical company’s process to develop a corporate social responsibility (CSR) plan. Systems thinking guided the study. Corporate social responsibility is an organization’s contribution of time and resources addressing societal needs and concerns. However, interpreting societal needs and concerns could vary within an organization. Therefore, using a systems thinking approach is relevant. The study was completed in 4 months. The objectives of the study were to “(1) assess the status of CSR within the company, (2) raise CSR awareness among upper managers and (3) propose guidelines for developing an integrated and structured CSR orientation” (p. 419). Thirteen managers from different departments completed a survey to assess their understanding of CSR. Individual interviews with the 13 managers were conducted to obtain further insight into what they determined was needed to start the CSR plan. Additionally, best practices were explored, including looking at organizations with reputable CSR. Once the data were analyzed, the researchers posed five recommendations for organizational CGR implementation. These
recommendations consisted of assigning a supervisor to oversee CSR activity, continuing to work on understanding different perspectives, conducting research in best practice, holding continuous meetings, and having a CSR committee (Maon et al., 2008).

Mella (2009) identified five obstacles that prohibit systems thinking. The first obstacle is the inability to see slow-moving change from external environments. In contrast, the second obstacle is change that occurs immediately. Immediate changes, therefore, become visible once they have “already produced their effects on the system” (p. 326). Mella continued that the only offense to immediate change is the ability to recognize and prepare for changes that are coming. The third obstacle is what Mella and Senge (1990) referred to as seeing the forest and trees. This concept refers to understanding that different variables exist and can make an impact on its environment. Therefore, within any system, it is important to see the big picture and understand that smaller components make up the larger system. The next obstacle is the lack of perception due to a “mono-directional view” (Mella, 2009, p. 328). The inability to look at an issue from multiple lenses could result in missing crucial information. The last obstacle is having a complex system with many different components. Mella’s operational rule is to break down the many variables to keep the system as simple as possible.

Senge’s system thinking theory also has its critics. Garvin (1993) stated that Senge’s theory does not offer concrete, measurable tools to become a learning organization. Garvin emphasized the need for “clearer guidelines for practice, filled with operational advice rather than high aspirations” (p. 79). Grieves (2008) did not promote
the concept of “learning organizations” and further stated that Senge’s theory is full of “clichéd aphorisms” (p. 467).

Despite the critics of systems thinking, others have recognized its contributions. Heckroodt (2013) stressed that leaders who have the skill set to see interconnections are able to make wiser decisions and create sustainability within the organization. Cabrera, Colosi, and Lobdell (2008) advocated that systems thinking “is a unique perspective that transforms the approach taken to evaluate any program, policy, or initiative” (p. 300). Additionally, systems thinking is considered beneficial in community settings with multiple stakeholders (Spruill et al., 2001).

Chapter Summary

Studies have determined what specific elements make housing first effective (Pearson et al., 2009; Stefancic et al., 2013). One key element is letting tenants choose their housing and any support services they feel they need to have. Additionally, a wide array of supportive services should be made available. Examples include psychiatric care, medical care, harm reduction techniques, and vocational counseling. Other key elements include separating housing from support services and having a low staff-to-tenant ratio.

Comparisons between housing first and treatment first providers have been researched. Studies have sought to determine how each housing model’s philosophy affects the relationship between direct care staff and tenants (Henwood et al., 2011; Henwood et al., 2013). Results indicated that housing first staff offer more tenant choice and person-centered planning. Treatment first providers address issues that could impact a tenant’s housing.
Housing first is an evidence-based practice that has proved easy housing access and high retention rates (Davidson et al., 2014; Montgomery et al., 2013; Pearson et al., 2009; Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000). Due to the large body of evidence determining the model’s success, HUD and the USICH favors this model. As a result, the New York City Coalition on the Continuum of Care is requiring all residential providers to use a housing first model. Therefore, treatment first residential programs must make this transition. One gap in the literature is exploring how treatment first programs transition to the housing first model. Therefore, this study examined and identified strategies of one agency’s recent transition through the lens of systems thinking theory.
Chapter 3: Research Design Methodology

Introduction

There is a gap in the literature that explores the strategic planning involved when treatment first residential programs serving chronically homeless adults transition to a housing first model. This study explored strategies implemented to make this change.

One goal in the 2010 federal strategic plan to end homelessness was ending chronic homelessness in 5 years (USICH, 2010). Chronically homeless adults are those “with disabilities who [have] either been continuously homeless for one year or more or [have] experienced at least four episodes of homelessness in the last three years” (HUD, 2014d, p. 2). The goal to end chronic homelessness has been extended to 2017. The federal government acknowledged that further resources are needed to achieve this goal (USICH, 2015). The objective in meeting this goal is increasing the supply of permanent supportive housing.

The USICH and HUD endorse the housing first model as the most effective solution to end chronic homelessness. The housing first model accepts chronically homeless individuals into housing regardless of substance use or psychiatric compliance. Further, the philosophy of housing first states that all individuals deserve housing (Tsemberis & Eisenberg, 2000). In contrast, agencies that use a treatment first model define levels of sobriety individuals must achieve before being housed as well as are engaged in psychiatric care (Tsemberis & Eisenberg, 2000).
Due to the USICH and HUD endorsement, local Continuum of Care Programs that evaluate nonprofit agencies and distribute HUD funds have been allocating and reallocating funds to agencies that use a housing first model. One Continuum of Care Program that responded to the USICH and HUD is the New York City Coalition on the Continuum of Care, which is now requiring agencies within its Continuum to use the housing first model. This requirement can be seen in Appendix A. Therefore, understanding how agencies that provide permanent housing in New York City strategize to transition to housing first is essential.

This qualitative study used a case study approach to explore one agency’s strategic planning process. Specifically, the study used a single-case design. Case studies are useful when researching a present-day issue (Yin, 2014). Another benefit of using a case study approach is that it “allows investigators to focus on a ‘case’ and retain a holistic and real-world perspective” (p. 4).

Creswell (2013) stated that “qualitative research questions are open-ended, evolving, and nondirectional” (p. 138). Case study questions ask “why” or “how” since the problem being researched is a current issue over which the researcher has no influence (Creswell, 2013; Yin, 2014).

**Research Questions**

- What were the factors that determined the agency’s transition to a housing first model?
- What was the agency’s strategic approach and how did the agency deploy it?
- How did the agency adjust its strategic plan as the model was transitioned?
Research Context

The case being researched should connect to the theory guiding the study (Yin, 2014). Senge’s systems thinking theory addresses the need for an agency to use systems thinking to become a learning organization. Learning organizations are established when all staff become active participants and understand how their mission and vision make an impact that is both internal and external to the organization. Additionally, learning organizations consistently grow and learn (Senge, 1990). This is important to the study since the New York City Coalition on the Continuum of Care is requiring agencies that provide permanent supportive housing to use a housing first model. Senge (1990) reported that agencies must understand its role in society, make adjustments in order to grow, and engage all staff in the process. Therefore, agencies that will be required to transition must understand why this requirement is needed, make strategies to become housing first, and engage all staff in the process.

The setting of the study occurred at a nonprofit agency providing permanent supportive housing in both Westchester County, New York and in the Bronx, New York. The agency transitioned all of its permanent supportive housing units from a treatment first model to a housing first model in 2011. This nonprofit agency was founded in 1981 to provide emergency shelter, transitional housing, and permanent housing to families, veterans, victims of domestic violence, and chronically homeless adults throughout Westchester County, New York. The agency provides both scattered-site and single-site permanent supportive housing. Scattered-site permanent supportive housing is spread throughout neighborhoods and not based in one building (USICH, 2013b). Single-site permanent supportive housing provides apartments in the same building and are often
studio apartments. The agency manages 1,350 permanent supportive housing units that house up to 3,000 individuals and families and reaches up to 10,000 people a year through permanent housing, youth programs, and employment programs. Other services provided by the agency are youth and vocational programs. The agency has 275 employees working in these various programs.

Expanding its services beyond Westchester County, New York, the agency now offers 25 scattered-site permanent supportive housing apartments to chronically homeless adults in the Bronx, New York. Overall, research has indicated that tenants living in this type of structure are satisfied with their housing. Additionally, studies have demonstrated that tenants identify privacy and autonomy as the advantages of scattered-site housing and there is a high rate of housing stability (Pearson et al., 2009; Tsai, Bond et al., 2010).

The agency is a housing developer that has built single-site buildings to help eliminate homelessness. In 2016, the agency will be opening a single-site location in the Bronx with 68 studio apartments, 50 of which will be designated for chronically homeless adults. The remaining 18 apartments will be rented by low-income New York residents. Studies have shown that tenants in a single-site building complain of drug use, theft, and lack of privacy, but enjoy peer interaction and feel safe in their apartments and neighborhood (Brown et al., 2015; Pearson et al., 2009; Tsai, Bond et al., 2010).

**Research Participants**

Information-oriented sampling assisted with identifying participants for the study (Fenno, 1986). Information-oriented sampling occurs when a researcher has local knowledge on an issue and seeks to observe and explain why and how the issue transpired and became resolved. As Fenno (1986) stated, researchers understand the need
to study an issue that is current and occurs at different times and places by collecting various forms of data. In the present study, the researcher explored one agency’s transition to a housing first model. Since New York City is currently requiring nonprofit residential programs to become housing first, this sampling was appropriate for the research. The agency chosen for this research provides permanent supportive housing in New York City and recently transitioned to a housing first model. As a result, the researcher utilized purposeful sampling as the participants can offer experience on the subject being studied and are convenient to use (Creswell, 2013).

The researcher was familiar with the agency because it was used to complete her internship hours when pursuing a Master’s degree over 10 years ago. At the time the researcher was an intern, the current president had recently been hired in a direct care position. In 2014, the Board of Directors selected the current president to fulfill the role when the previous president retired. The researcher made multiple phone inquiries and sent emails to several agencies in an effort to locate an agency for the research. Coworkers of the researcher also attempted to reach out to various agencies throughout the five boroughs of New York City. When these attempts produced no results, the researcher emailed the president in an effort to seek assistance locating a study location. The researcher was not aware that the agency had expanded to provide services in the Bronx. As such, the president offered the agency to be used in the study. The researcher chose the agency as the location for the study because it met all criteria (serving chronically homeless, mentally ill adults in one of the five boroughs of New York; recent transition to housing first in 2011).
A purposeful sample of four administrative staff involved in the strategic planning were interviewed. This study defined an administrator as an employee who oversees programs and/or supervises staff and was employed with the agency when the agency began the strategic planning to transition to housing first. The rationale to interview administrators was due to the purpose of the study, which was to understand how administrators began the strategic planning process. Administrators hired or promoted after the transition would not be able to provide this information. A fifth interview was conducted but was eliminated from the findings since the participant did not work at the agency during the time of the strategic planning.

Due to the study taking place at one agency and at the request of the agency, the titles of each participant were kept confidential. However, each participant is an administrator of the agency. For the purposes of this study, each participant was identified as follows: Participant one, Participant two, Participant three, and Participant four.

The researcher’s primary contact was with the agency’s president who offered the use of the agency for the study. Once the Institutional Review Board of St. John Fisher College approved the study, the president emailed the researcher archival data including the strategic plan, proposal letters to funders, and policy and procedures. The president identified participants for the study, based on the criteria that the researcher defined, and scheduled times for the researcher to interview each participant. Five interviews were arranged and conducted. Each interview was conducted at the agency’s main headquarters in a private office, identified by each participant. Participants were provided with and signed the informed consent form as well as gave the researcher
permission to be audio recorded. As stated earlier, as one participant was being interviewed, it was revealed that the participant was not employed during the agency’s transition to housing first. Therefore, the interview was eliminated from the data analysis. A total of four interviews were analyzed for results.

**Instruments Used in Data Collection**

A case study protocol is essential when collecting data (Creswell, 2014; Yin, 2014). A protocol provides the structure and guidelines, in addition to the instrument used for the study. A benefit of a protocol is that it “is a major way of increasing the reliability of case study research and is intended to guide the researcher in carrying out the data collection from a single case” (Yin, 2014, p. 84). The case study protocol for this study is found in Appendix C. Further, this study utilized a review of documentation and individual interviews as its evidence. Using multiple forms of data, referred to as triangulation, helps increase the validity since it will “build a coherent justification for themes” (Creswell, 2014, p. 201).

**Review of documentation.** The advantage of reviewing documents in case study research is that it complements other instruments being used (Yin, 2014). Additionally, “documentary evidence reflects communication among other parties attempting to achieve some other objectives” (p. 108). The review of documentation was appropriate for this case as its purpose was to explore the agency’s transition to housing first. Documents that were reviewed included the strategic plan, policy and procedures, and newspaper articles that discuss the agency’s use of housing first. These documents provided both internal and external communication regarding the mission of the agency.
The researcher took notes based on the review of documentation to identify themes that enhanced the understanding of the interviews and the process of the transition.

**Interviews.** Yin (2014) postulated that interviews are an important part of case study research; however, “your conclusions cannot be based entirely on the interviews as a source of information (your case study would have transformed into an open-ended survey, not a case study)” (p. 92). Because the case was an agency, the questions asked focused on the agency and not on the individual participants. Additionally, the questions were influenced by the theory guiding the study. The questions inquired about the agency’s strategic plan for continued growth and viability as well as how staff were involved and motivated in the process.

In addition to using triangulation, another way to increase the study’s validity was having a panel of experts review the research questions to ensure that the questions would elicit the required information. Additionally, the panel of experts determined if the researcher had displayed any bias in the questions (Creswell, 2014). As such, a panel of experts familiar with housing first and strategic planning reviewed the research questions and provided feedback and suggestions. The panel of experts selected have either worked with or mentored the researcher at various stages in her professional career. The panel was comprised of four nonprofit administrators in the housing field, employed at different agencies located in New York and Connecticut. One expert has over 9 years of administrative experience in Connecticut and currently oversees a homeless outreach program that assists homeless individuals in obtaining resources and housing throughout Fairfield County. The second expert has over 20 years of administrative experience assisting the homeless and currently oversees several housing first programs in
Westchester County, New York. The third expert has helped develop permanent supportive housing programs in the Bronx and has over 20 years of administrative experience in the field. The fourth expert has over 14 years of experience in the housing field and currently attends the New York City Coalition on the Continuum of Care Steering Committee. Responsibilities of this committee include prioritizing funding, evaluating programs, and endorsing evaluation criteria (New York City Coalition on the Continuum of Care, 2007). The panel suggested more questions pertaining to staff involvement be included in the interview protocol.

All interviews were conducted at the agency in a private room identified by each staff. Participants were informed of the purpose of the study prior to the interview and signed a consent form that included authorization to be audio recorded. The recorder used was a Sony recorder purchased by the researcher. Interviews took up to one hour to complete. The researcher conducted all interviews and all information will remain confidential.

**Data Analysis**

The researcher hired a professional to transcribe the interviews. Only the researcher, transcriber, and volunteer coder had access to the data. Further, the data were stored on a password-protected computer.

After the transcripts were received, the researcher and a volunteer coder independently completed a first cycle of coding to identify themes. The volunteer coder had experience with coding when completing her own dissertation. Once the coding was done, the researcher and volunteer coder compared results. The researcher conducted a second cycle of coding. She also uploaded all data on the computer software system,
QSR NVivo, to assist with the second cycle of coding. This form of analysis assists researchers with building “detailed descriptions, develop themes or dimensions, and provide an interpretation in light of their own views or views or the perspectives in the literature” (Creswell, 2013, p. 184). The coding and themes connected to the research questions and theoretical rationale guiding the study. The researcher determined the final analysis and used descriptive narrative when reporting the results.

Summary

The purpose of this qualitative case study was to research one agency’s transition to a housing first model. The agency provides both scattered-site and single-site permanent supportive housing in both Westchester County and the Bronx, New York. Data collected consisted of a review of archival data and individual interviews.

Prior to the research, the participants signed a consent form providing consent to be recorded. A transcriber transcribed all interviews. A computer software program, QRS NVivo, assisted with coding. The researcher and a volunteer coder independently coded the data and identified themes. The researcher finalized the analysis after a second cycle of coding and reported the results that answered the research questions.
Chapter 4: Results

Research Questions

The purpose of the study was to explore how one agency, which provides permanent supportive housing to chronically homeless adults, transitioned from a treatment first to a housing first model. The agency operates both scattered-site and single-site buildings. This qualitative study used a single-site case study approach, utilizing both archival data and individual interviews. The purpose of this chapter is to present the findings of the research.

The research questions that guided this study were:

- What were the factors that determined the agency’s transition to a housing first model?
- What was the agency’s strategic approach and how did the agency deploy it?
- How did the agency adjust its strategic plan as the model was transitioned?

Data Analysis and Findings

Data analysis was conducted using the recommended steps identified by Creswell (2013) and Saldaña (2013). The steps included: a) organizing the data, b) first cycle coding, and c) second cycle coding.

**Step 1: Organizing the data.** The researcher used both archival data and individual interviews. The agency provided the researcher with the strategic plan, proposal letters to funders, and policy and procedures. Additionally, the researcher reviewed agency newsletters and newspaper articles written about the agency.
Five individual interviews were conducted. However, as previously mentioned, one interview was eliminated from the findings because the participant did not meet the requirements of being employed when the agency began the strategic planning. Once all the interviews were completed, the researcher forwarded the audio recordings to a transcription service. Once the transcripts were received, the researcher compared the transcripts to the audio to confirm accuracy.

**Step 2: First cycle coding.** Creswell (2013) stated that “the process of coding involves aggregating the text or visual data into small categories of information, seeking evidence for the code from different databases being used in a study, and then assigning a label to the code” (p. 184). The researcher began this process with both the archival data and interviews. She used the study’s research questions and theoretical rationale as guides to begin the coding process. This process is recommended by Auerbach and Silverstein (2003):

> As you begin to read the text, everything seems important, and it seems impossible to omit anything a participant has said. On the other hand, if you include everything, the amount of data will become unwieldy. With your statement of research concerns in front of you, you can check a portion of text against your statement. (p. 44)

While reviewing the data, the researcher took notes and began coding for themes, looking at key words, phrases, and commonalities among the interviews. A volunteer who had experience with coding when completing her own dissertation also reviewed the data and shared her initial findings with the researcher. The researcher compared the volunteer’s findings with the findings she herself had identified. Five themes were
identified by both the researcher and volunteer coder: external influences, internal initiative, preparation, internal adaptation, and external barriers.

**Step 3: Second cycle coding.** The researcher used second cycle coding as a way “to develop a sense of categorical, thematic, conceptual, and/or theoretical organization from your array of first cycle codes” (Saldaña, 2013, p. 207). The researcher reviewed all data a second time, coding for themes. As an additional resource, the researcher used QSR NVivo once the first cycle coding and written notes and reflections were completed. The second cycle coding identified six themes and 12 subthemes. The themes and subthemes are identified in Table 4.1

Table 4.1

*Identified Themes and Subthemes*

<table>
<thead>
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<th>Themes</th>
<th>Subthemes</th>
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| External Influences  | 1. Local and national awareness  
|                      | 2. Local government                        |
| Internal Initiative  | 1. Agency administration                     |
|                      | 2. Proactive versus reactive                 |
| Preparation          | 1. Internal resources and operations         |
|                      | 2. External resources                        |
| Internal Adaptation  | 1. Educating staff                           |
|                      | 2. Staff buy-in                              |
| External Barriers    | 1. Affordability and accessibility           |
|                      | 2. Funding                                   |
| Overcoming Obstacles | 1. Expanding and adjusting funding           |
|                      | 2. Housing development                       |
The following section reports the themes and subthemes as they answer each research question.

**Research question [1][C6]:** What were the factors that determined the agency’s transition to a housing first model?

Data analysis revealed two themes and four subthemes that answered the first research question. Participants and archival data identified external influences that provided the agency knowledge about the effectiveness of the housing first model. As a result, the agency took a proactive response to external influences.

**Theme 1: external influences.** Each participant reported external influences that prompted the agency’s transition to housing first. All participants acknowledged the same two external influences. The external influences are identified as subthemes:

**Subtheme: local and national awareness.** The participants identified that agency staff attended conferences and training programs that discussed the benefits of housing first. The conferences and training programs provided an overview of the housing first model that helped the agency understand the model’s principles and core values, as well as demonstrated the model’s success with reduced length of stays in shelters and increased retention rates once permanently housed.

One piece of archival data that was reviewed was a proposal the agency sent to a government funder, requesting funds to become housing first. Analysis of the introduction letter revealed the agency’s acknowledgement that a recent training, provided by the government entity on housing first, sparked the agency’s interest in the model.
Participant three also provided insight into the agency’s local and national awareness of the housing first model: “We attended some conferences, the National Alliance to End Homelessness, they also have a lot of literature and resources on their website.”

Participant one added that in addition to conferences hosted by the National Alliance to End Homelessness, the agency also attended many conferences facilitated by The Supportive Housing Network of New York. Additionally, Participant one estimated various administrators and direct care staff attended 20 training programs and conferences.

*Subtheme: local government.* All participants acknowledged that HUD and local government funding were beginning to look at the housing first model as the solution to end homelessness. For example, Participant three stated: “Well, we were involved with the HUD Continuum of Care, so I think that was an external factor. One of our (government) funders was also moving in that direction.” Participant two elaborated on this and explained the reasons that local government, also the agency’s primary funder, were looking at the housing first model:

> You know, our funders were basically constantly looking at lengths of stay for families and singles in our homeless and transitional programs. . . . Our funders began to look at it [housing first] and say, well, okay, we’re paying for all of these services, in-house lengths of stay are very long, this is very expensive, we need to move people quicker.

*Theme 2: internal initiative.* Analysis of archival data, individual interviews, and researcher observations revealed the agency’s enthusiasm about being a housing first
agency. The strategic planning began with an external awareness, but the agency took a proactive approach and initiated opportunities. The two subthemes detail the agency’s decision to transition to the housing first model.

**Subtheme: agency administration.** Agency administrators drove the process of transitioning to a housing first model. Several participants acknowledged this fact. For example, Participant three stated: “The leadership at the time wanted us to go in that direction, felt it was an effective model based on what they knew about it.” Participant two expanded on this viewpoint by highlighting the strengths of the housing first model:

> It was very organic for us. It just made a lot of sense to do it. . . . When we really looked at it our eyes got this big and we said, “Well, wait a minute.” Now, the pressure we were getting from our funders wasn’t, you need to do this or we’re going to stop funding you or you need to do this starting tomorrow. It was, we want you to start looking at how do you reduce lengths of stay in the shelters. And, like I said, it was—it just made perfect sense.

**Subtheme: proactive versus reactive.** Each participant reported that the agency was proactive in its transition to housing first. The agency was aware that local government was expressing interest in the housing first model, but did not wait for the government to require the model change. Archival data revealed the agency took initiative and submitted a housing first proposal to its primary funder to fund an additional 12 permanent supportive housing units for families. All participants expressed pride that the agency took a proactive lead to becoming a housing first agency. Participant one stated it this way:
So we were actually bringing that conversation to them [government]. So like as Pathways to Housing in New York City was really branding this, we were excited about it. We’ve run shelters for 20-plus years. We saw the need to change so as we were kind of like learning the tenets of housing first, we were bringing that to our funders and saying we got to move in this direction. I think we then threw a lot of fuel on that fire.

Additionally, Participant two commented on the agency’s proactive response toward becoming a housing first agency:

So we’re sort of at the—well, not sort of, we were at the forefront of, okay, we’re not only a homeless service provider, we’re also a community development organization. We have all these other services in the community that we’re already providing in the shelter, so let’s lead the charge to move people out quicker.

**Research question 2:** What was the agency’s strategic approach and how did the agency deploy it?

Two themes and four subthemes were identified, answering the second research question. The participants provided insight, demonstrating the agency’s commitment to have its staff be part of the strategic planning process. The findings also revealed that the agency’s ongoing education and communication with staff provided them with understanding and acceptance of the model.

**Theme 1: preparation.** When the agency transitioned to the housing first model, each program the agency operated became housing first. Therefore, all scattered-site and single-site programs were transitioned. Participants did not acknowledge any differences
when considering the two different types of programs. Each program provides the same level of case management services and 24/7 staff contact. The data revealed that the agency’s strategic plan used a multiphase approach to transition to housing first. These phases included: a) information gathering, b) hiring new staff, c) developing new protocols, and d) communicating and educating staff on the transition. Although the data revealed that the agency primarily used internal resources for its strategic approach, external resources were also used. Further, the emphasis on communicating and educating staff about the transition and the principles of housing first resulted in staff buy-in.

Subtheme: internal resources and operations. A common subtheme identified was that agency staff, at all levels, participated in the strategic planning. All participants recognized that staff at different levels of the agency were involved and contributed to the strategic planning. Interviews revealed between 30-40 staff were directly involved with the strategic planning process. Involving front-line staff was deliberate and recognized by each participant. The following statement confirms this view:

For strategic planning, just to be honest, I think we rely completely on like internal talent for the most part. . . . I mean internal time is the biggest resource. We threw a ton of man hours at the process. . . . We pick our all-stars for strategic planning, we pick folks that we think are going to be free thinkers and willing to put in time and do the research and learn new tricks. (Participant one)

Conducting research was the second step in the strategic planning process. The agency recognized the need to become informed and utilized its staff to gather information on such topics as: a) how other housing first programs operated, b) retention
rates, c) funding sources, and d) supportive services needed for individuals once housing was obtained. The following quotation discusses the agency’s process:

We broke up into groups, so we’d have like a kickoff retreat and then we broke up into groups where, for example, I led a group where I had a handful of caseworkers, I think a director, like a senior caseworker. Each group was assigned different tasks and we had to go out and do research on a certain area and then we had to come back and present to the larger group that we felt was—basically just come back and present what we found, our homework. (Participant two)

The next phase of the agency’s strategic approach was looking at current staffing patterns and needs. A review of archival data showed the agency’s plan to hire new staff. The strategic plan outlined an organizational chart that added four new positions: an assessment coordinator and three housing case managers. A flowchart demonstrated how the model would operate and the roles and responsibilities of each position. For example, a housing specialist’s primary role would be to find affordable housing, outreach to landlords, conduct apartment inspections, and attend lease signings with clients. The strategic plan did not reveal any changes or adjustments affecting clients who were already permanently housed or to the staff that work in those programs.

Subtheme[C7]: external resources. Although the data revealed that the agency primarily used internal resources to develop its strategic approach, evidence demonstrated that the agency relied on external resources as well. The primary external resource was experts in the field.
We looked at other agencies within Westchester County who were providing services to the homeless and brought them in and talked to them about what their thoughts and what their ideas around housing first was. (Participant two)

Participant one also confirmed using an expert in the field who had assisted the agency previously with grant writing: “There was one major homeless expert in Westchester that we lean on a bunch that writes grant for us, et cetera, who we tapped.”

**Theme 2: internal adaptation.** Another theme was how staff adapted to the model. As discussed, 30-40 staff at different levels within the agency contributed to the strategic plan. Additionally, the agency also spent a lot of time providing training and having meetings with all agency staff to discuss the model.

**Subtheme: educating staff.** All participants reflected on the importance of communicating the strategic plan with staff and providing education on differences between the treatment first model and housing first model. As Participant four stated:

We discussed, you know, what would be the best thing. We break it down to all staff. You know, we talk about housing first, how we wanted to approach it, you know, in terms of the benefits to the clients. You know, being stably housed first versus, you know, trying to stabilize them then housing.

Participant three provided more detail on how the agency educated all staff on the transition to housing first:

We had specific meetings for the direct service staff, so for the housing specialists, case managers, supervisors. The other staff, it was just conveyed in supervision or general staff meetings with them just as a reminder that this is what’s happening, there are going to be some changes. . . . We compared and
contrasted the housing readiness model versus the housing first model. We explained the different components of the housing first model . . .

Participant two discussed agency meetings and follow-up meetings, assuring staff understood the changes and the model’s philosophy:

It [the transition to housing first] was communicated in a meeting and we had one meeting and we slowly implemented it and then we did follow ups. I think we did—it was after I think maybe a month, then three months and it slowly just became what we did.

Data analysis revealed the agency spent time communicating and educating staff about programmatic changes and adjustments to staff expectations. The following quote reveals how transitioning to housing first impacted different staff roles:

A maintenance worker, because we are moving families out of the shelter more quickly, the nature of their job has changed. Right now they have to turn over units a lot faster and when we made the shift to this model, we had to prepare them for that. Things are going to be different, you’re going to—your work load is going to change. You’re going to have to turn over a lot more units faster. So, I think we had to prepare everyone for that. The clerks, I mean that’s the—the paperwork they have to do or file might be different, the frequency of filing may be different. (Participant three)

Subtheme: staff buy-in. Interviews indicated that because of ongoing training programs and meetings, staff gave little resistance once the agency made the transition. All interviews revealed a strong subtheme that staff fully understood the model and believed in the philosophy of housing first that everyone deserves a place to live
(Tsemberis & Eisenberg, 2000). As Participant one stated: “We have caseworkers that came and took like the agency driving test. So on Saturday they could move a client to permanent housing and not wait until Monday. I mean, it’s that aggressive.”

Participant two also reflected on how staff responded to the model change and confirmed that the transition was an easy process:

It seemed when we started to talk about it, everybody—from what I recall, everybody was on board. Like it made the most sense and there wasn’t a lot of people questioning is this going to work, how do we make it work? It was everybody was one hundred percent on board. Let’s make it work.

Only one participant provided an example that revealed one particular direct care staff had a specific struggle with the model change. The direct care staff did not believe the individual was housing ready and was reluctant to see that individual move into permanent supported housing. When asked how the agency responded to that particular staff’s struggle, the participant reported utilizing supervision and education in an effort to have the direct care staff see the situation from a different perspective. The participant further stated the direct care staff was able to move forward and is still employed with the agency, fully invested in the housing first model.

**Research question 3:** How did the agency adjust its strategic plan as the model transitioned?

Data analysis identified two themes and four subthemes that answered the third research question. Upon analysis, the participants recognized that, despite the agency’s intentions and planning, the agency is not a true housing first model. All participants stated that becoming a traditional housing first model is still an ongoing process. All
archival data, however, reported that the agency considers itself housing first. Additionally, the agency did not revise its strategic plan once recognizing that it is not a traditional housing first model. Participant one made the following statement regarding the realities that a traditional housing first model is difficult to achieve because of external barriers of locating affordable housing and funding:

There isn’t like—listen, I don’t think there’s a community in the country that is one hundred percent housing first. They meet someone and an hour later they’re in the place with all these kind of follow up supports. If there are, I’m impressed.

A common term that participants used to describe the agency was “housing first light.” Three of the four participants used this term throughout the interview. Again, archival data did not identify this term. Additionally, this term was not observed in the review of the literature, suggesting that the agency created its own culture. The following quote from Participant two reflects why the participants refer to the agency as “housing first light”:

When we did plan it there was this “we’re going to be truly a housing first agency,” like what Pathways to Housing does. We’re not that. A true housing first model we wouldn’t put people in shelters. We would—somebody shows up at the shelter, we would immediately that day or soon thereafter move them into a permanent unit. So, I think in some ways we were naïve to think that we’d be able to move to like a Pathways model.

The data identified several obstacles that prevent the agency from becoming a true housing first model.
Theme 1: external barriers. All participants had consistent answers for what prevents the agency from becoming a true housing first model. All identified barriers were external to the agency and were identified as subthemes.

Subtheme: affordability and accessibility. As previously indicated, the agency recognized, after the strategic planning, that they were not a true housing first model. One of the reasons for this that all participants identified was the lack of affordable housing available. Additionally, participants indicated that finding landlords willing to lease apartments to clients and/or finding landlords willing to take a lower rent was difficult:

I think there are a couple of obstacles. One is finding the housing, that’s just huge. I mean that’s just—it’s a big challenge for us and finding housing, finding affordable housing, number one, then if we do find it just getting them past the screening. A lot of landlords will do credit checks and they find out . . . they have been previously evicted they will not take them. Getting landlords to lower their rent, we have to do a lot of negotiating with landlords. (Participant three)

Participant one also reported affordability as a major obstacle:

We need to [move funding] away from shelters and move it to post-shelter and then, look this is a bear, but within metropolitan New York there is such a lack of affordable housing that there are people that are just going to be have to be on subsidies forever because you could not work 24 hours a day at minimum wage and make it in New York.
Because the agency provides permanent supportive housing in both Westchester County, New York, and the Bronx, New York, Participant two recognized the struggles related to the Bronx:

Well, one difference is we find that the landlords and the property management companies that we work with are not as receptive, not receptive, not as on top of the buildings and repairs and whatever else in terms of building issues as they are here in Westchester. It’s the landlords just—it’s more of a moneymaking opportunity for them.

Subtheme: funding. Another external barrier preventing the agency from becoming a true housing first model is funding. Participants defined three obstacles regarding funding. The first obstacle is that government funding, the agency’s primary funding source, does not provide funding to provide retention services including staff that follow up with clients once they are permanently housed and workshops such as budgeting and cleaning. As a result, the agency becomes concerned that clients will return to the shelter because they do not have the support and skills they require to live independently. As Participant two elaborated:

The biggest thing is the wraparound services and there just isn’t the thinking on the government side or the funders’ side that that is crucial to this happening. I can’t think of—when I describe wraparound services it—a lot of our clients are dealing with whether it be substance abuse, mental health issues. . . . And I wish with wraparound that we had more of an ability to work with them with life skills and just basic budgeting and how to shop and how to eat healthy. . . . So we’re more of like, and this sounds harsh, but we’re more of like babysitters in some
ways advocating more for our clients and I wish we can move more towards really providing an intensive service. We just need the funders to understand that.

A second obstacle is that the agency’s primary funding is for shelter programs and not permanent housing. The following quote from Participant one demonstrated the agency’s external barrier with current funding sources:

I still think that funding hasn’t truly moved to the place that they claim it has. So everyone loves housing first because they know it’s the system they should love, but the agency’s biggest contracts are still homeless contracts and not post-homeless contracts.

The third obstacle defined by participants is the rental subsidy provided to the clients. Participants reported that government-issued subsidies are not enough to afford an apartment. A low subsidy can delay clients from entering permanent supported housing because they cannot locate an affordable apartment. Participant four stated,

Even now we’re still finding, like, yes, we want them to be permanently housed, but the supplement is really like lower than the market rent. So that’s definitely a big obstacle for us.

**Theme 2: overcoming obstacles.** The agency continues to work toward becoming a more traditional housing first model. All participants shared similar opinions of the agency’s needs to further the agency’s goal of becoming a more traditional housing first model.

Three agency needs were defined. The first need is the ability to offer further resources to clients once they are housed. Under the housing first model, clients are housed first and all other supportive services come after (Tsemberis & Eisenberg, 2000).
Participants acknowledged the agency needs to provide more supportive services, such as budgeting skills and cooking skills, to increase the clients’ chances of remaining independently housed. The second need is more affordable housing. Landlords charging high rents, a low government subsidy, and the overall cost of living in New York were recognized as obstacles. The last need was post-homeless funding. The agency has more contracts for providing emergency and transitional shelter than permanent housing which can limit what the agency can and cannot provide. Figure 4.1 displays the agency’s needs, as identified by the participants, to become a more traditional housing first model:

![Figure 4.1. Participants’ identification of agency needs to become a more traditional housing first model.](image)

Once the needs were discussed, participants shared how the agency has already begun overcoming the obstacles.

*Subtheme: expanding and adjusting funding.* Participants recognized the need to seek additional funding sources to continue achieving its strategic plan goals. Participant three discussed how additional government funding was awarded rapidly to house clients: “[We received] rapid re-housing rental subsidies and that was a big game changer for us.
That was a major tool to help us move people out quickly.” Participant four also acknowledged the rapid re-housing funding:

We did get some funding . . . so that kind of helped in terms of helping them [clients] because the supplements are so low, so we were able to offer them like extra income on their supplement to promote them moving to permanent housing. Additionally, Participant one spoke of adjusting current funding to assist with expanding services:

We did bring in new funding from non-county sources to fund retention work. . . . The other side of the answer is we just used some of the old funds to do our new stuff, whether we publicize that every day or not. I mean, if every caseworker is doing home finding, they’re still doing case—I mean you can call that case management. It’s like we tweak the job description of who was currently funded to start achieving the new goals and then supplemented it with new funding and new folks.

An analysis of archival data, specifically agency newsletters and newspaper articles, demonstrated that the agency communicates these needs and future goals. The agency has announced its intentions to provide more wraparound services.

Subtheme: housing development. As previously mentioned, not only does the agency work with landlords and property management companies, but the agency is also a housing developer. Archival data revealed a history of the agency building single-site buildings in an effort to house more homeless individuals and families. The agency is currently building a single-site building in the Bronx, New York, where 50 chronically homeless adults will be permanently housed.
Participants three and four did not offer much insight into the agency’s history with scattered-site versus single-site permanent supportive housing buildings. Participants one and two acknowledged the strengths and weaknesses of both scattered-site and single-site buildings. These strengths and weaknesses support previous studies that identified tenant perceptions of scattered-site and single-site permanent supportive housing (Brown et al., 2015; Pearson et al., 2009; Tsai, Bond et al., 2010).

We actually did some quasi-research three or four years ago where we looked at our scattered-site in all of our singles programs. All of our scattered-site singles programs versus our [single-site] programs. We found that we have more issues with the [single-site] building, with clients having substance abuse issues, with fighting amongst clients, more evictions and people being removed from programs in those settings. And the clients who were in scattered-site apartments were doing great. (Participant two)

As previously discussed, participants identified struggles finding scattered-site apartments and negotiating with landlords. As part of the solution, the agency builds single-site buildings in an effort to continue its goal of ending homelessness, despite preferring scattered-site permanent supportive housing units.

So we have both [scattered-site and single-site buildings]. As we look to build new housing, we want to build studios as much as possible. Now we want to build very small studios with lots of community space so that you will get out of your apartment and interact with people. We want to like promote socialization. . . . I think integrated housing is a good thing anywhere. If there’s—in a perfect world, if every building was mixed use and every building was mixed income you
would not have to have standalone affordable towers, we wouldn’t have to have standalone supportive housing if everyone did their share. The world doesn’t work that way. We have to fight for every unit we can and we end up the way we build often building all in one location. We’re proud to be a developer, actually part of the solution. The solution is producing housing that’s truly affordable. . . . We’re one of the few folks that is trying to build a deeply affordable housing as possible because that’s the biggest unmet need in our opinion and that’s our mission. That’s what we’re suited to do. (Participant one)

Summary of Results

The purpose of the chapter was to report the findings of the qualitative, single-site case study. The agency chosen for this study provides both emergency shelter and permanent supportive housing to homeless individuals and families. The agency utilizes both scattered-site and single-site permanent supportive housing units. The study demonstrated one agency’s strategic planning process of transitioning from a treatment first to a housing first model. Archival data and individual interviews of four participants were analyzed and coded for themes. Six themes and 12 subthemes emerged.

The first research question asked what factors determined the agency’s decision to transition to the housing first model. Two themes emerged to answer this question: external influences and internal initiative. Findings revealed that the agency was well informed of external changes toward permanent supportive housing. The agency attended conferences and training programs on housing first and realized that local government was becoming interested in the housing first model. The agency recognized
the positive aspects of the model and proactively wrote proposals to its funders to become a housing first agency.

The second research question asked what was the agency’s strategic approach and how did the agency deploy it. Two themes emerged to answer this question: preparation and internal adaptation. Data analysis revealed a strategic planning process with multiple phases and participation from staff at different levels. The agency conducted research on several topics including looking at other housing first agencies, funding, and retention rates. Participants provided detailed responses that indicated staff accepted and adjusted their responsibilities to fit the housing first philosophy.

The third research question asked how the agency adjusted its strategic plan once the model was transitioned. The two themes identified to answer this question were external barriers and overcoming obstacles. External obstacles have prevented the agency from becoming a traditional housing first model. These obstacles included finding affordable apartments and lack of funding for retention services and staff. Each participant admitted that the agency continues its efforts to be a housing first agency. However, the agency did not adjust its strategic plan. As housing developers, the agency balances building single-site locations and continued efforts to establish relationships with landlords and other property management companies. Additional funding to add retention services has been obtained and the agency has updated job descriptions to have more staff provide these services. However, the agency did not adjust its strategic plan to reflect that it is not a traditional housing first model.
The following chapter provides a discussion and interpretation of the study’s findings. The chapter identifies the study’s limitations and provides recommendations for further research, based on the findings.
Chapter 5: Discussion

Introduction

This qualitative, single-site case study explored one agency’s transition from a treatment first to a housing first model. The agency provides both emergency shelter and permanent supportive housing to individuals and families. The agency operates many different scattered-site and single-site permanent supportive housing buildings.

HUD is encouraging all Continuum of Care Programs to allocate permanent supportive housing funding to housing first programs. The New York City Coalition of the Continuum of Care is now requiring agencies to provide permanent supportive housing to chronically homeless adults to use the housing first model. There is a gap in the literature that explores the strategic planning that treatment first agencies conduct when transitioning to the housing first model. Therefore, the purpose of this study was to add to the existing literature on housing first. The study was guided by Senge’s systems thinking theory, which states that five disciplines must be achieved before an agency is considered a learning organization.

This chapter discusses the implications for professional practice, specifically the need for continued assessment and strategic planning. This chapter also discusses the implications for organizations striving to become learning organizations. Additionally, the chapter identifies the study’s limitations and provides recommendations for future research.
Implications of Findings

Professional practice. As previously discussed in Chapter 2, Stefancic et al. (2013) researched and determined that the core elements of the housing first model include: a) housing choice and structure, b) separation of housing and case management, c) service philosophy, d) array of services, and e) program structure. The findings of the study revealed that, despite the strategic planning, the participants concurred that the agency is not operating as a traditional housing first model. The core elements that the agency identified as not meeting were housing choice and structure and array of services. External barriers such as lack of affordable housing, low subsidies, and funding have affected the agency’s strategic planning goals. Participants referred to the agency as being a “housing first light” model. This term, appearing to have been created by the agency, is due to the agency’s recognition that they are unable to provide all the services of the traditional housing first model.

The findings also revealed that the agency continues its efforts to overcome external barriers. First, since the agency is a housing developer, it invests and builds single-site locations for both individuals and families. In the Bronx, New York, the agency is building a single-site 68-studio apartment building. Fifty of the apartments will be dedicated to chronically homeless adults. The remaining 18 apartments will be rented to individuals in the community who are defined as low income. While the agency continues to locate affordable apartments in scattered-site locations and work with other landlords and property management companies, the agency does have the advantage of building its own sites. Second, the agency continues to seek income sources to assist in providing retention services such as budgeting skills and other daily living skills.
Despite its recognition that the agency is not a traditional housing first model, the participants identified reduced lengths of stay in shelters and higher retention rates as positive outcomes of the strategic planning. A key component of the housing first model is to reduce the length of time spent in shelters or on the streets (Tsemberis & Eisenberg, 2000). Previous studies have demonstrated that housing first programs have higher retention rates than treatment first programs (Montgomery et al., 2013; Pearson et al., 2009; Stefancic & Tsemberis, 2007; Tsai et al., 2010; Tsemberis & Eisenberg, 2000). This demonstrated that even though the agency is not a traditional housing first model, the agency’s strategic planning provided successful outcomes, similar to a traditional housing first model.

Regarding length of stay at emergency shelters, Participant one stated the following:

We judge our success on length of stay in the shelter. On number of moves to permanent housing, percentage of folks exiting that move to permanent housing and the best we can recidivism. On all of those indicators and I just can’t produce the numbers off the top of my head, but we’ve moved over three hundred folks to permanent housing—over three hundred households to permanent housing each of the last few years even though our total population served is dwindling. So it’s the highest percentage clip we’ve ever hit and the average length of stay in our shelters which was a year ten years ago had just been dropping and dropping and dropping to a low of about sixty-five days or something like that.

Participant four also articulated the success the agency has seen in reducing lengths of stay in the shelters:
We had more people moved to permanent housing since then [changing to housing first]. So less . . . the length of stay is actually lower than it used to be so we don’t have people lingering for like two or three years. . . . So we have people coming in, getting permanently housed, staying housed. So that’s definitely changed in the past couple of years.

Participant three also acknowledged improved retention rates:

There’s some [clients] who I thought I would see again and I just haven’t seen them and I’ve—we do hear back from other people that they’re doing fine in the community and so that is a good thing. There are some names that you just never forget and occasionally they come up and they say we hear, oh yeah, so-and-so we heard from her friend she’s doing fine or they may even come back and just stop by to say hello and we know they’re doing well.

Previous studies have affirmed that not all housing first agencies are able to operate as the traditional housing first model (Davidson et al., 2014; Stefancic et al., 2013). Stefancic et al. (2013) stated that the reason agencies are unable to operate as the traditional model is because “programs operate in contexts in which organizational structures and local environments vary in culture, values, and resource availability” (p. 259). In certain geographic areas, eliminating chronic homelessness has been an easier goal to conquer than in other areas. Two geographic areas that greatly reduced or eliminated chronic homelessness by using the housing first model were Utah and Phoenix, Arizona. Utah reduced chronic homelessness by 91% (Glionna, 2015). However, the number of chronic homeless individuals in Utah totaled less than 2,000 individuals and has been a 10-year process to achieve (Glionna, 2015). Phoenix,
Arizona, reported that by December 2013, all chronically homeless veterans were permanently housed (Keyes, 2013). Once again, the number of chronically homeless veterans in Phoenix was a small number, totaling 222 individuals (Keyes, 2013).

New York City has a considerably higher number of homeless individuals and the numbers continue to increase (HUD, 2014c). A 2014 point-in-time count reported 5,873 chronically homeless adults were located in New York City. Literature has also confirmed that New York City’s housing costs and rents continue to be higher than the national average (Bureau of Fiscal and Budget Studies, 2014; U.S. Department of Labor, 2014). As treatment first agencies in New York City transition to housing first, geographical limitations should be identified and discussed during the strategic planning process.

The study also demonstrated the need to revise strategic plans when barriers or opportunities are revealed. The agency did not have a revised strategic plan since recognizing it was not a traditional housing first model. Despite acknowledgement from participants that the agency continues its efforts to become a more traditional housing first model, strategic plans are important so that agencies do not forget its goals and revert back to similar routines (Senge & Sterman, 1990).

**Systems thinking theory.** A learning organization is one that continues to learn and grow in order to remain relevant (Senge, 1990). Senge posited five disciplines an agency must achieve before becoming a learning organization: team learning, building a shared vision, mental models, personal mastery, and systems thinking. The fifth discipline, systems thinking, brings all the other disciplines together. The findings of this
study revealed that the agency is a learning organization. The following section discusses how the agency met each discipline:

**Team learning.** As discussed in the first two chapters, team learning allows for free and open discussions. The strategic planning created the avenue for free and open conversation. The agency recruited staff at all levels of the agency to do research and report back to the larger group. Opinions and ideas were shared openly.

**Building a shared vision.** This discipline stresses that an organization must effectively communicate its mission, vision, and values to each employee (Senge, 1990). If an organization has done so effectively, employees will be motivated and work in a manner that will accomplish the agency’s mission, values, and goals.

Perhaps one of the more important disciplines, the findings of this study revealed that staff understood and accepted the housing first model and the agency’s desire to transition. The agency made a strong commitment to communicate the important components of the housing first model and how the model fit with the mission, vision, and values of the agency. One specific example revealed in a participant interview was the motivation staff had to move clients into permanent housing as quickly as possible. Staff took the initiative to take the agency driver’s test so that clients could move in over the weekend rather than wait until the start of a new week. This example demonstrates staff acceptance and motivation.

**Mental models.** This discipline addresses individual biases that may affect productivity and contribution toward the agency’s mission. Mental models require inquiry and reflection in order to change or expand one’s worldview (Senge, 1990). As reported in Chapter 4, one participant provided an example of how one direct care staff
was hesitant to move an individual into permanent housing. The direct care staff did not believe the client was ready to live independently. The philosophy of the housing first model believes that individuals should be housed first (Tsemberis & Eisenberg, 2000). Any other support services are offered to individuals once they are stably housed. The direct care staff was provided an opportunity to discuss concerns related to the client. As a result, the supervisor and other staff helped this particular direct care staff understand why it was important to move the individual into permanent housing first. The participant also confirmed the employee remains a valuable asset to the agency and its commitment to being a housing first agency.

**Personal mastery.** An organization that provides and encourages ongoing education to its staff will successfully achieve the personal mastery discipline. The participants identified that ongoing education was provided to staff. Agency administrators conducted PowerPoint presentations to explain the philosophical differences between the treatment first and housing first models. Additionally, the agency encouraged staff to contribute toward the agency’s strategic planning process.

**Systems thinking.** The last discipline, systems thinking, brings all the other disciplines together. As a result, an organization is able to recognize its connection to the external world (Senge, 1990).

Data analysis revealed that the agency was successful in achieving status as a learning organization. The agency utilized staff at all levels of the agency, providing opportunities to engage in open communication. Staff participated in conferences and training programs that detailed the differences between the treatment first and housing first models, articulating why the transition was necessary. As a result, staff were
motivated to see the agency achieve its mission and vision. The agency effectively addressed any staff biases.

Most importantly, the agency continues to learn and grow. Recognizing that the agency has not fully transitioned as a traditional housing first agency, participants acknowledged continued efforts to improve services by locating and building new housing and providing additional supportive services important for clients to remain stable and independently housed.

This study revealed the importance of involving staff at all levels with decision making. The philosophical differences between the treatment first and housing first models are significant. The treatment first model requires tenants to be engaged in services, whereas the housing first model has no mandates. When a treatment first agency transitions to housing first, it is crucial to educate staff on the differences and have them be a part of the process. Staff involvement allows for staff buy-in.

Limitations

This study had four limitations. The first is that the study focused on one agency in one particular geographic location. The findings of this study may not be relevant to or indicative of other housing first agencies in different locations. The second limitation is that the agency provides services in two different geographic areas: Westchester County, New York, and the Bronx, New York. While the participants did discuss programmatic issues specific to the Bronx, New York, the answers might not fully address all the specifics of an agency providing permanent supportive housing in New York’s five boroughs. The third limitation is the small number of participants interviewed. When discussing differences between scattered-site and single-site housing
first programs within the agency, two participants were unable to identify any differences. The fifth participant was eliminated from the study because that participant was not employed during the time of the agency’s strategic planning process. However, participant five provided further insight into the scattered-site versus single-site programs that will be discussed in the recommendations section. The fourth limitation was the availability of the researcher. The president of the agency selected participants based on the time constraints of the researcher. If the researcher had more flexibility, additional participants may have been selected.

**Recommendations**

Based on the study’s findings and limitations, five recommendations for further research were identified.

First, based on the agency’s recognition that they do not operate as the traditional housing first model but have seen improved retention rates and reduced lengths of stay in the shelters, more studies should focus on agencies providing a similar model. The purpose of these studies should compare and contrast positive outcomes and barriers, and determine if a “housing first light” model can produce the same outcomes as the traditional housing first model.

Second, the agency used in this study provides both scattered-site and single-site permanent supportive housing units. Further research on any programmatic differences among the types of housing structures should be explored in relation to successfully transitioning to a housing first model.

Data analysis revealed the agency, as a housing developer, builds single-site buildings to continue its efforts to eliminate homelessness. When the agency began the
strategic planning process, no differences were identified between the two types of permanent supportive housing programs. Both types of programs provided the same level of staff coverage and services. Participants three and four were unable to identify any differences between the two types of permanent supportive housing structures within the agency. Participant two reported more problems occurring in the single-site buildings, which supports the results from previous studies (Brown et al., 2015; Pearson et al., 2009; Tsai, Bond et al., 2010). However, Participant five identified some strengths and weaknesses of both scattered-site and single-site permanent supportive housing program:

When it’s in a [single-site] building, you tend to see more what’s going on. You tend to have the ability to, hey, I saw this person today and something is off. Because you get used to—the case manager in that building gets used to having much more contact on a daily basis that we’re able to pick up something is off. You know, maybe this person is using or something is bothering this person. So it’s easier to have someone in a [single-site] building with other people because you have more access and they have more access to you as well. Also in our [single-site] buildings we tend to have community meetings. So it is easier, like it has its pros and cons, but one of the pros is that when we want to have like an informational and we do the community meetings people come together. One of my [single-site] buildings we had gotten some money to do an art program. I couldn’t have done that with scattered-site.
When asked if there are differences between the two types of permanent supportive housing units in regard to conflicts or substance use, Participant five stated the following:

Conflict definitely has shown more in those that live in the same building more so than scattered. But with scattered obviously there’s also the challenge of monitoring because we’re not seeing people all the time. You know, it’s not like an everyday or every other day I see so-and-so. It’s different. Their access to the case manager is different. I mean clearly those in scattered-site can call their case manager all the time, but sometimes it’s very different calling somebody and actually seeing somebody walking into the office and say I really need to talk to you today. So there are stark differences.

Third, because this study was limited to one geographical area, other case studies should be conducted, either as a single-site or multiple-site, in order to add to the research on strategies taken to transition to housing first.

Fourth, since the agency’s strategic plan did not identify any changes or adjustments to the clients already in permanent supportive housing while the agency was transitioning to a housing first model, a follow-up study should explore what, if any, changes occurred.

Fifth, as reported in Chapter 4, one interview was eliminated from the findings because the participant was not an employee of the agency during the strategic planning process. However, the fifth participant was well informed on the housing first model and reported that the agency needs to have more clinical staff when working with chronically homeless, mentally ill adults:
Housing first focuses on housing the person first and dealing with other needs later and connecting them to services to, you know, work through those needs. . . . So you may have some individuals where once they were in the unit, they didn’t feel the need to be connected to services because they had housing. It’s more of a challenge for the case manager, like am I going to have the ability to engage this person where they will recognize their other needs besides housing? We have a large number of people in our programs that aside from the, you know, substance abuse, they have serious mental illness and I think at—what the agency has been really good at doing is looking as we hire staff and you know people come and go—so as we’re looking to hire staff I think we recognize that we may need to bring in staff with more clinical skills to be able to understand what it is like to work with someone who’s bipolar, what it is like to work with someone who’s schizophrenic. We need to recognize that there’s a level of skill that we need the staff to have.

While no other participant acknowledged this need, it would be beneficial for further studies to determine if there is an advantage of having staff with more clinical experience engage with clients than those who do not carry a higher degree.

**Conclusion**

In 2010, the first federal strategic plan to end homelessness was implemented. One goal in the strategic plan was to eliminate chronic homelessness in five years. Individuals who have been consistently homeless for one year or who have experienced four episodes of homelessness in the last three years are defined as chronically homeless
Recognizing a need for more permanent supportive housing and funding to end chronic homelessness, the federal government extended the goal to 2017.

HUD has encouraged all Continuum of Care Programs to allocate funding to nonprofit agencies that provide permanent supportive housing using the housing first model. As a result, the New York City Coalition of the Continuum of Care is requiring nonprofit agencies to use this model.

The housing first model provides permanent supportive housing to chronically homeless individuals first. Once housed, other support services such as psychiatric care, medical care, and substance abuse treatment is offered but not required. This model is in contrast to the other permanent supportive housing model, treatment first, which declares that individuals need to be psychiatrically stable and have a period of abstinence, determined by the housing provider, before obtaining permanent housing.

Because of the differences between the two models and because the New York City Coalition of the Continuum of Care is requiring all agencies use the housing first model, this study explored how one agency made the transition. There is a gap in the literature that explores strategies involved when a treatment first program transitions to housing first.

Guided by Senge’s systems thinking theory, this qualitative study used a single-site, case study approach. The benefit of this approach is that it provides a holistic view of a current issue (Yin, 2014). The agency selected for this study provides permanent supportive housing in both Westchester County, New York, and the Bronx, New York. Administrators of the agency who were involved in the strategic planning process were purposefully selected for individual interviews. Archival data consisting of the strategic
plan, policy and procedures, and newspaper articles were also analyzed and coded to identify themes.

The data revealed six themes that were instrumental in the agency’s strategic planning process. These themes are: a) external influences, b) internal initiative, c) preparation, d) internal adaptation, e) external barriers, and f) overcoming obstacles. While the agency was not successful with implementing a traditional housing first model, the agency did see positive outcomes consisting of reduced lengths of stay in shelters and higher retention rates in permanent supportive housing units. External barriers need to be identified and realistic goals identified based on resources and funding.

When developing the strategic plan, the agency relied heavily on staff at different levels in the agency to contribute ideas and conduct research. Additionally, the agency provided ongoing education on the housing first model and the changes the agency would face. The involvement of staff at various levels of the agency contributing to the strategic plan and the ongoing training for all agency staff helped the agency move its mission and vision forward. All staff had clear expectations of their job responsibilities and demonstrated motivation to achieve the agency’s mission and vision.

Based on these findings, there are several recommendations. First, ongoing assessment should be conducted to determine if the existing strategic plan is meeting its goals. If there are identified obstacles, strategic plans should be updated to reflect new goals or timelines. Any changes in the strategic plan should be communicated to staff. It is also the recommendation that all agencies transitioning to a housing first model should involve staff at different levels in the strategic planning process. Staff involvement
contributes to staff motivation and, as a result, the mission and vision of the agency will move forward.
References


Appendix A

New York City Coalition on the Continuum of Care Notice on Housing First

Announcement

Housing First Exemptions

The NYC CCoC recently adopted written standards requiring permanent supportive housing (PSH) projects to use a Housing First model unless prohibited by another project funding source.

We anticipate that HUD will release the CoC NOFA shortly. PSH projects will be required to indicate on their project applications that they use a Housing First approach, unless they provide documentation (e.g. copy of a contract, award letter, maybe a recent site visit report and/or other relevant information) to the NYC CoC demonstrating that they are prohibited from doing so by another project funding source.

If you believe your program is exempt from this requirement because of the aforementioned reason, please submit the requested documentation for the applicable project to either Aleida Valentin or Merih Anil by 8/25/15. PSH projects that do not submit documentation by that date will be required to indicate on their project applications that they use a Housing First approach.

If you have any questions, please contact Merih Anil at (212) 232-0830 or MANIL@DHS.NYC.GOV for agencies beginning with (A-K) or Aleida Valentin at (212) 232-0529 or AVALENTI@dhs.nyc.gov for agencies (L-Y). For more information about this and other NYC CCoC news and updates please visit www.nychomeless.com.
## Appendix B

New York City Coalition of the Continuum of Care 2014 Evaluation Tool

<table>
<thead>
<tr>
<th>Programmatic Indicator</th>
<th>Measure &amp; Data Source</th>
<th>Benchmark</th>
<th>Achieved</th>
<th>Exceeded</th>
<th>Score</th>
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<tbody>
<tr>
<td><strong>Utilization Rate</strong></td>
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<tr>
<td><strong>Unit Utilization Rate (PSH, TH, SH)</strong></td>
<td>Average daily unit utilization rate during most recently completed HUD contract (Projects for singles should use bed and projects for families will use units). Source APR: Q10 or 11</td>
<td>85%</td>
<td>2 points for project achieving 85%</td>
<td>(+) 2 points for project achieving ≥90%</td>
<td>6</td>
</tr>
<tr>
<td><strong>Chronically Homeless (Note: Please reference list of exempt programs to check for eligibility of Q2. Exempt programs can self select to participate for points.)</strong></td>
<td>Programs must have a minimum of two new clients to be eligible for questions 2</td>
<td>50%</td>
<td>5 points for meeting NYC CCoC motion of 50%</td>
<td>(+) 3 point for ≥85%</td>
<td>8 for PSH</td>
</tr>
<tr>
<td><strong>Project Eligibility</strong></td>
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<tr>
<td><strong>Participants entering program are literally homeless (PSH, RRH, TH, SH, SSO)</strong></td>
<td>% of participant entering program during federal fiscal year (2014) are literally homeless. (If project serves families, Head of Household will determine family eligibility) Source: HMIS</td>
<td>90%</td>
<td>1 points for project achieving 90%</td>
<td>(+) 1 point for project achieving ≥95%</td>
<td>2</td>
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<tr>
<td><strong>Length of Stay</strong></td>
<td></td>
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<tr>
<td><strong>Average length of stay (PSH,TH, RRH)</strong></td>
<td>Average length of stay for participants served during recently completed federal fiscal year (2014). Source: HMIS</td>
<td>TH &amp; RRH average length of stay ≤ 24 months; PSH average length of stay ≥12 months.</td>
<td>2 points for TH &amp; RRH average length of stay ≤ 24 months; 2 points for PSH average length of stay ≥12 months</td>
<td>(+)1 point for TH &amp; RRH average length of stay ≤ 12 months (+)1 point for PSH average length if stay ≥ 24 months.</td>
<td>3 for TH &amp; RRH; 3 for PSH</td>
</tr>
<tr>
<td>Programmatic Indicator</td>
<td>Measure &amp; Data Source</td>
<td>Benchmark</td>
<td>Achieved</td>
<td>Exceeded</td>
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<tr>
<td>Income, Employment, and Mainstream Benefits Outcomes</td>
<td>% of adults that increased other income at latest status or exit. Source APR: Q24B3</td>
<td>54%</td>
<td>2 points for project achieving HUD benchmark of 54%</td>
<td>(+) 2 points for project achieving ≥59%</td>
<td>4</td>
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<tr>
<td>Gained or Increase other income - adult stayers and adult exiters</td>
<td>% of adults who have increased earned income at latest status or exit. Source APR: Q24B3</td>
<td>20%</td>
<td>2 points for project achieving HUD benchmark of 20%</td>
<td>(+) 2 point for project achieving ≥25%</td>
<td>4</td>
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<tr>
<td>Non-cash benefits- adult stayer and all exiters</td>
<td>% of persons with 1 or more sources of non cash benefits at latest status or exit. Source APR: Q26A2 &amp; 26B2</td>
<td>75%</td>
<td>2 points for project achieving 75%</td>
<td>(+) 2 points for project achieving ≥80%</td>
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<tr>
<td>Housing Stabilization</td>
<td>% of participants placed into temporary shelter, transitional housing, or permanent housing (including PSH) as a result of the street outreach program. Source: APR Q29a1, Q292</td>
<td>70%</td>
<td>4 points for project achieving 70%</td>
<td>(+) 4 points for project achieving ≥75%</td>
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<tr>
<td>Moving from the street (SSO)</td>
<td>% of leavers exiting to permanent housing. Source: APR 36b</td>
<td>75%</td>
<td>4 points for project achieving 75%</td>
<td>(+) 4 points for project achieving ≥80%</td>
<td>8 for TH only</td>
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<tr>
<td>Exiting to Permanent Housing (TH)</td>
<td>% of participants who remain in SH or exit to permanent housing Source: APR Q36e</td>
<td>80%</td>
<td>4 points for project achieving 80%</td>
<td>(+) 4 points for project achieving ≥90%</td>
<td>8 for SH only</td>
</tr>
<tr>
<td>Maintain SH or exit to Permanent Housing (SH)</td>
<td>% of participants who remain in PSH or exit to permanent housing Source APR: Q36a</td>
<td>90%</td>
<td>4 points for project achieving 90%</td>
<td>(+) 4 points for project achieving ≥95%</td>
<td>8 for PSH only</td>
</tr>
<tr>
<td>Maintain PSH or exit to PH (PSH)</td>
<td>% of participants who remain or exit to permanent housing after being placed into housing Source APR: Q36a</td>
<td>85%</td>
<td>4 points for project achieving 85%</td>
<td>(+) 4 points for project achieving ≥90%</td>
<td>8 for RRH only</td>
</tr>
<tr>
<td>Maintain PH or exit to PH (RRH)</td>
<td>% of participants that achieved other income at latest status or exit. Source APR: Q24B3</td>
<td>54%</td>
<td>2 points for project achieving HUD benchmark of 54%</td>
<td>(+) 2 points for project achieving ≥59%</td>
<td>4</td>
</tr>
<tr>
<td>Programmatic Indicator</td>
<td>Measure &amp; Data Source</td>
<td>Benchmark</td>
<td>Achieved</td>
<td>Exceeded</td>
<td>Score</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
<tr>
<td>Housing First (PSH only)</td>
<td>Project has indicated they are using a housing first model. Source: 2014 NOFA. Project Application or Signed Affirmation from ED of intent to convert to model in 2015 NOFA. &quot;Yes&quot; on project application or signed affirmation.</td>
<td>2 points if 'Yes' to housing first model</td>
<td></td>
<td></td>
<td>Maximum of 2 points</td>
</tr>
<tr>
<td>Project is using Housing First</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 points</td>
</tr>
<tr>
<td>Spend down Budget (S+C programs exempt)</td>
<td>% of HUD funds expended during last completed HUD contract. Source APR: Q30/31 Total funds expended/Q3 Contract amount.</td>
<td>95%</td>
<td>3 points for project</td>
<td></td>
<td>3 points</td>
</tr>
<tr>
<td>Spend-down of HUD funds</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Maximum of 7 points</td>
</tr>
<tr>
<td>Consumer Participation</td>
<td>Signatures required for any of the following points: 1 point for client and PD signature; 1 point for survey; 1 point for grievance policy; 1 minutes from tenant meeting.</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Administrative Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Maximum Deduction of 20</td>
</tr>
<tr>
<td>The supplemental evaluation documents (APR, Q12) are submitted on time to DHS.</td>
<td>Items are emailed to appropriate DHS contact by published deadlines.</td>
<td></td>
<td></td>
<td></td>
<td>-10</td>
</tr>
<tr>
<td>Has the program performed at least 7 HMIS uploads between January 1, 2014 - December 31, 2014</td>
<td>Verification of a minimum of 7 monthly uploads to HMIS</td>
<td></td>
<td></td>
<td></td>
<td>-5</td>
</tr>
<tr>
<td>Has the agency signed the HMIS Participation Agreement</td>
<td>Verification of form submission</td>
<td></td>
<td></td>
<td></td>
<td>-5</td>
</tr>
</tbody>
</table>
Appendix C

Interview Protocol

A. Introduction and Guidelines:

- Thank the participant for participating.
- What is the purpose of the research
- Informed consent (including audio recording) and confidentiality

B. Interview Questions:

Research Questions #1: What were the factors that determined the agency’s transition to a housing first model?

1. What, if any, external factors influenced the agency transitioning to housing first?
2. What, if any, internal factors influenced the agency transitioning to housing first?

Research Question #2: What was the agency’s strategic approach and how did the agency deploy it?

1. What resources did the agency use for the strategic planning and why were the resources selected?
2. How did the staff involved in the strategic planning engage in the process?
3. If there were differences in opinion, how did the team reach a consensus in developing the strategic plan?

4. How was staff at all levels of the agency involved in the process?

5. How was the transition communicated with staff at all levels of the agency?

6. How did the agency prepare staff for the transition?

7. How long did it take to plan the transition and was the execution earlier than expected, on target, or later than expected? If longer, what factors caused the additional time?

Research Question #3: How did the agency adjust its strategic plan as the model transitioned?

1. How did the agency enforce the transition, once implemented?

2. Did the agency encounter any obstacles once implemented? If yes, what were the obstacles and how did the agency move forward?

3. Has the agency seen any positive outcomes since the transition? If yes, what were they? If no, why?

4. Does the agency identify other needs it must achieve to be housing first? If yes, please describe.

C. Conclusions

- Thank participant for their time

Once again, ensure confidentiality.