5-2021

Transitioning to Housing First: Perceptions of the Role of the Rehabilitation Counselor in Serving Homeless Individuals with Disabilities in Puerto Rico

Ana Vanessa Serrano Garcia
The University of Texas Rio Grande Valley

TRANSITIONING TO HOUSING FIRST: PERCEPTIONS OF THE ROLE OF THE REHABILITATION COUNSELOR IN SERVING HOMELESS INDIVIDUALS WITH DISABILITIES IN PUERTO RICO

A Dissertation

by

ANA VANESSA SERRANO GARCÍA

Submitted to the Graduate College of
The University of Texas Rio Grande Valley
In partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2021

Major Subject: Rehabilitation Counseling

TRANSITIONING TO HOUSING FIRST: PERCEPTIONS OF THE ROLE OF THE REHABILITATION COUNSELOR IN SERVING HOMELESS INDIVIDUALS WITH DISABILITIES IN PUERTO RICO

A Dissertation
by
ANA VANESSA SERRANO GARCÍA

COMMITTEE MEMBERS

Dr. Roy K. Chen
Chair of Committee

Dr. Veronica Umeasiegbu
Committee Member

Dr. Roberto González Valles
Committee Member

Dr. Lynn Fischer
Committee Member

May 2021

ABSTRACT

Serrano Garcia, A.V., Transitioning to housing first: The role of the rehabilitation counselor in Puerto Rico. Doctor of Philosophy (Ph.D.), May 2021, 282 pp., 6 tables, 2 figures, references, 93 titles, 8 appendices.

Since the 1980s, the federal government has developed strategies to eradicate homelessness in the US and its territories. The introduction of evidence-based practices like the Housing First Model helped decrease the number of people living homeless. Still, it continues to be a public health problem, especially among chronically homeless individuals, defined broadly as people with disabilities and substance abuse problems experiencing homelessness. Rehabilitation counselors are professionals specialized in serving individuals with disabilities. However, their role in programs identified as Housing First was unclear.

Thus, the study aimed to identify service providers' views, opinions, knowledge, and experiences about the role of rehabilitation counselors, the chronic homeless population, and the implementation process of the Pathways Housing First model in Puerto Rico. The process included two different data collection strategies: in-depth interviews to explore the experiences of key informants and a review of documents depicting the procedures and job descriptions related to the model. The sample included coordinators, administrators, clinical and case managers from four permanent housing programs at the two Continuum of Care systems on the island. The results were compared with additional information gathered from different

sources to identify similarities. Results showed rehabilitation counselors were unknown to most service providers, who were not aware of their professional skills and capabilities. Furthermore, in many instances, the staff confused rehabilitation counselors with addictions counselors.

In contrast, results showed service providers knew about the Housing First model and agreed with its fundamental principles, values, and notions about the homeless population. Still, some participants expressed reservations about the model's effectiveness on the island due to environmental factors such as lack of sufficient support services, poor accessibility to services, and the local government’s insufficient support to programs working on behalf of the homeless population. The participants' experiences were consistent with those of other professionals transitioning to a housing first approach to service. Still, to effectively implement the model, community-based organizations, service providers, and local government officials need to promote continuity of service, a shared public policy, and an open mind to address homelessness in Puerto Rico.

Keywords: rehabilitation counselors, homelessness, chronically homeless individuals, Housing First model, Puerto Rico

DEDICATION

I dedicate this dissertation to service providers, case managers, social workers, administrators, and coordinators, whose commitment and dedication to service have touch the lives of many in their time of need. I recognize the challenges to meet the needs of the most vulnerable. I am grateful and truly appreciate the daily effort to do your best for the well-being of the homeless population in Puerto Rico. I also dedicate this dissertation to my parents, Annie García Vélez and Pedro M. Serrano Figueroa, who with their love, support, and prayers have carried me throughout the process, to my siblings, Ana Verónica Serrano García (RIP) and Pedro M. Serrano García, and the rest of my extended family and friends who have always believed and supported all my endeavors. I am forever grateful.

ACKNOWLEDGEMENTS

This dissertation would not be possible without the continued support, and patience, of my dissertation Chair, Dr. Roy K. Chen. I want to thank Dr. Chen who has remained with me through all the stages— the good, the bad, and the ugly —a student experiences during a research process. I truly appreciate your support and guidance. I am forever grateful. I would like to also acknowledge the contributions of my esteemed committee members: Dr. Roberto González Valles, Dr. Veronica Umeasiegbu, and Dr. Lynn Fischer. Thank you for your time, patience, and contributions to this dissertation. I also want to take this opportunity to thank Dr. Bruce Reed and Dr. Jerry Fischer for their support at UTRGV throughout the years.

I would like to acknowledge the support and contributions of professionals in Puerto Rico who made this dissertation possible: Mr. Francisco Rodriguez Fraticelli, Executive Director of "Coalición de Coaliciones", Mrs. Liz M. Lamboy López, Assistant Secretary of Planning, and Mrs. Loída Acevedo Ríos at the Puerto Rico Department of Family Affairs. On a special note, I would also like to thank Dr. Miguel M. Marrero Medina and Dr. Himilce Vélez Almodovar, who encouraged me to pursue this dissertation topic. Finally, I would like to thank my colleagues at the Program of Rehabilitation Counseling at the Pontifical Catholic University of Puerto Rico, Dr. Néstor Torres Rentas, Dr. Héctor J. Velázquez González, and Dr. Kanyra Oliveras Martínez for their support and encouragement during the process.

TABLE OF CONTENTS

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER I

INTRODUCTION

Since the 1980s, eradicating homelessness has been the focus of initiatives from the federal government due to its impact as a social, economic, and public health problem. The number of people living without a safe home in the United States (US) fluctuated throughout the years due to personal factors such as medical or mental health issues, and environmental factors like poverty, the lack of affordable housing, and unemployment, among others (Nooe & Paterson, 2010). Statistics from the 1980s and 1990s showed the homeless population in the US increased by 600,000 during the Reagan administration, despite the public and private sectors' efforts to resolve the problem (Dreier, 2004; National Coalition for the Homeless, 2006).

Since then, the government funneled millions of dollars each year to fund programs and initiatives to lower, and ultimately eradicate, homelessness in the US National Coalition for the Homeless (NCH) (2006). Said efforts started to show results. In the 2000s, the number of people living homeless slowly started to decrease, with a few exceptions during periods of economic precariousness. The 2019 Annual Homeless Assessment Report (AHAR) to Congress (Henry et al., 2020) showed the homeless population in the US was 567,715, representing a decrease in numbers for most states, except for California.

In the 1980s, the organizations in charge of providing services to homeless people typically followed one intervention strategy: to identify and refer the homeless person to a string of local services, known as the Continuum of Care (CoC). The purpose of the CoC was, and still is, to reintegrate the homeless person into society as a productive and independent individual (Henry et al., 2013). Within the CoC, one provider would oversee coordinating the complete assortment of services following a Linear Residential Treatment System (LRT) approach.

In the LRT, participants moved through a series of step-by-step services within the continuum ranging from outreach interventions to permanent housing (Tsemberis, 2010a). A person who entered the LRT system voluntarily agreed to comply with its terms and conditions to be eligible for services. That is, participants with substance abuse issues or mental health conditions had to commit to receiving treatment to overcome said conditions (Tsemberis, 2013; Tsemberis & Eisenberg, 2000). This approach successfully decreased the number of individuals living in the streets who experienced homelessness for a short time and had little or no significant medical or dependency issues. However, professionals working with the LRT faced challenges to achieve similar success rates with participants considered hard-to-place or chronically homeless individuals.

The term *chronically homeless* referred to individuals with a disability who have continuously experienced homelessness for at least a year or had four or more episodes of homelessness over the last three years (Henry, 2013; Henry et al., 2020; Martin, 2015; Tsemberis, 2010b). In 2014, an estimated 25% of the US's homeless population fell into the category of chronically homeless; of those, 33% presented a co-occurring diagnosis of mental illness and substance use (Martin, 2015). By 2019, the number of people with chronic

homelessness patterns represented 24% of the US's total homeless population (Henry et al., 2020).

The presence of co-occurring disorders made finding and maintaining permanent housing arrangements more challenging (Martin, 2015; Tsemberis & Eisenberg, 2000). A chronically homeless person could experience frequent relapses from the mental health condition or substance dependency issues, which prevent him or her from continuing receiving services through traditional intervention within the continuum of care. In cases where participants were able to stay in the system, their reluctance to trust service providers and other barriers, such as criminal history, contributed to reducing the opportunities and the possibility to successfully reintegrate the formerly homeless person into society (Tsemberis & Eisenberg, 2000). Critics of the LRT argued that the structure of the approach to service revolved around the professional's perspective rather than being focused on the individual's perspective, resulting in less successful outcomes among the homeless population (Henwood et al., 2013; Tsemberis, 2010b).

In 2010, The Housing and Urban Development Department (HUD) designed and implemented the Opening Doors Program to address homelessness in the US. While the program addressed all homeless, it focused on incorporating and promoting evidence-based practices when providing services to chronically homeless individuals (Henry et al., 2014; United Stated Interagency Council on Homelessness, 2015; Substance Abuse and Mental Health Services Administration, 2016b). To address the needs of this sector of the population, HUD programs and the Substance Abuse and Mental Health Services Administration (SAMHSA) promoted a shift in their philosophies and intervention from a medical to a biopsychosocial approach to service. With the shift, the agency placed the homeless person front and center in the rehabilitation process by providing services despite the personal circumstances of the

participants. This approach is known as the Housing First (HFM) model of intervention (SAMSHA, 2016b).

Since then, several intervention programs that fall under an HFM model have emerged. In a report commissioned by the HUD (2007) about the applicability of the HFM in the agency, the authors identified four common characteristics of these types of programs. First, the program committed to place participants straight into permanent housing or transitional housing, intended to result in permanent housing.

Second, the programs did not require individuals to participate in supported services to qualify for housing placement, although supported services were available throughout the process. Third, the staff engaged and provided housing services to persons with mental illness through an assertive outreach approach. Programs also incorporated a low-demand approach to help clients dealing with alcohol and substance use issues to maintain housing services. Lastly, HFM programs provided ongoing case management services to clients through times when customers had left the program for short periods due to relapses (HUD, 2007).

Perhaps one of the most well-known and successful examples in the field is the *Pathways Housing First* (HFM) model (SAMSHA, 2016b). Professionals involved in the HFM approach to service believed its success directly related to the notion that housing was a fundamental human right. Said notion was essential for the recovery process of any individual (Pearson et al., 2007; Tsemberis, 2015). Professionals considered the core values and philosophies of the approach as both: the theoretical framework to understand the homelessness phenomenon and guide the intervention process, and as a best practice intervention for the delivery of services (Waegemakers et al., 2014).

Even though SAMHSA considered the Housing First model as an evidence-based practice, the effectiveness of each program depended on several factors, such as how closely any particular program adopted the core values and practices of the model. It also depended on the views and opinions held by the professionals involved in the implementation process and the applicability of the HFM in each new environment. For example, in the US, states such as Vermont or California presented different economic challenges implementing Pathways Housing First (HFM) than countries like Canada or Ireland (Stefancic et al., 2013; Tsemberis, 2010b). These factors were unique to each new city or country, requiring attention from agencies involved in the implementation process. The ability and capacity of each agency to assess and recalibrate the efforts as needed increased the probability of attaining successful outcomes and securing the longevity of the program (Stefancic et al., 2013; Tsemberis, 2010b).

Puerto Rico was one such country with a unique set of factors. Described politically as a "commonwealth" form of governance, this island-nation, with close territorial ties to the US and dependent on federal funding to attend to its homeless population, posits challenges regarding the transition to a Housing First Model that need to be explored.

To better comprehend the complexity of homelessness in the US and its territories, it was essential to address the social, political, and economic factors that influence the phenomenon. The following section seeks to provide an overview of the homelessness phenomenon, the characteristics of the population, and the two main intervention models used to address the issue. It also describes the main views, opinions, and attitudes of service providers associated with each approach to services, including the role of rehabilitation counselors with the homeless population and the advantages each model offers to the homeless population.

The Homelessness Phenomenon

Although vagrancy or homelessness was not a new phenomenon in the US, the 20th century registered the highest percentage of people living in the streets. These percentages increased after periods of pronounced economic adversity, such as the Great Depression of the 1930s and later the recessions of the 1970s and 1980s (Padgett et al., 2016). Several factors contributed to the increase in homelessness across the nation. On the one hand, the economic conditions of those years, with high rates of unemployment or underemployment, and the limited availability of affordable housing, provoked the displacement of poor and low-income families and individuals to urban areas. The federal government fashioned several programs to satisfy the demand for affordable housing, including developing public housing initiatives in urban areas. The agency also developed subsidy programs such as Section 8, a voucher program, to provide housing opportunities for low-income families (Padgett et al., 2016).

On the other hand, social factors increased the number of individuals displaced from their homes. For example, the 1940s registered significant demographic changes after the return of soldiers from World War II, as did the Baby Boomer demographic phenomenon in the 1950s (Padgett et al., 2016). Discrimination against minority groups in the 1950s and 1960s, such as that against African Americans in the Southern states and Eastern European immigrants, increased the number of people relocating to inner cities in the Northern states. Consequently, the shift in demographics further limited the availability of affordable housing within urban areas in the north.

From 1960 until the 1980s, the psychiatric wards and hospitals in the main metropolitan areas, such as New York City, began to deinstitutionalize people with psychiatric disabilities due to cuts in programs and a shift in services (Holtzman, 2019). Individuals who lived in controlled

environments most of their lives suddenly had to learn how to seek services and advocate for themselves to satisfy their basic needs (Waegemakers Schiff & Schiff, 2014).

Without support and the necessary skills, many former patients became homeless. Furthermore, society regarded their status as homeless and the living conditions they endured as law infractions, resulting in fines and jail time. By the end of the 1980s, the criminal justice system became a warehouse for homeless people with mental health issues (Padgett et al., 2016).

Adding to problematic social conditions, public policies implemented by the conservative administrations of Presidents Richard Nixon and Ronald Reagan limited funding for social programs like health services and public housing. The lack of funding contributed to the neglect of public housing complexes, deteriorating living conditions, and the proliferation of crime and other social problems related to poverty (Padgett et al., 2016).

The implementation of laws and the increase of funding allowed the proliferation of programs that helped the less-chronically homeless individuals break the homelessness cycle. In 1987, Congress approved the McKinney-Vento Act to develop programs and provide funding to address the homeless population's needs in the US. Still considered the most crucial piece of legislation regarding homelessness, the Act provided funding for housing programs, job training opportunities, and supportive services, such as treatment for mental illnesses and substance use, as well as educational opportunities for the homeless.

The Act also created the United States Interagency Council on the Homeless (USICH), an independent organization to coordinate the efforts of 15 federal agencies to eradicate homelessness (NCH, 2006). However, said programs were not as successful with chronically homeless individuals (Tsemberis, 2010a).

By the 1990s, the proliferation of crime and violence in urban areas and the increase in the homeless population with noticeable symptoms of mental health problems became the focus of local governments, especially those in the most populated cities (Pratt et al., 2014). At the time, housing programs still demanded individuals with mental illness to engage in "treatment and behavioral contingencies" (p.82) that individuals did not consider reasonable (Waegemakers Schiff & Schiff, 2014). As a result, many returned to living on the streets.

In 2009, the Homeless Emergency and Rapid Transition to Housing Act (HEART) expanded the definition of homelessness in the McKinney-Vento Act to include homeless youth and families and the supportive services available for those populations. Later, in 2010, the implementation of evidence-based practices promoted by the Opening Doors Program helped decrease the number of people living in the streets across the country. Between 2010 and 2016, the homeless population declined by 27% within the continental US (US Department of Housing and Urban Development, 2016). In November 2016, the Annual Homeless Assessment Report to Congress showed an overall decrease in the homeless population of 2% from the previous year, reporting 549,928 homeless individuals across the country (14,780 homeless individuals less than in November 2015) (Henry et al., 2015; Henry et al., 2016; Henry et al., 2017).

That same year, numbers showed that 65% of the homeless population lived by themselves, while 35% consisted of homeless individuals in families (US Department of Housing and Urban Development, 2016). Nonetheless, even with the inclusion of evidence-based practices, between 2018 and 2019, numbers showed a 3% increase in homelessness due to economic setbacks, mainly on the west coast (Henry et al., 2020).

The Face of Homelessness in Puerto Rico

In Puerto Rico, like in the US mainland, homelessness has also become a major public health concern. Local agencies and organizations committed to the CoC system focus on eliminating the barriers that prevent vagrant or homeless individuals from accessing the medical and social services they need (Vélez Almodóvar et al., 2013). Each year, the HUD draws estimates on the number of homeless individuals in the US and its territories through Point-in-Time (PIT) counts. The purpose of the PIT is to measure the effectiveness of the efforts made to eradicate homelessness across the country (Henry et al., 2013; Henry et al., 2020).

Since 2007, Puerto Rico has been conducting the PIT counts every two years. The 2017 PIT counts identified 3,501 homeless individuals on a single night (1,017 individuals less than the previous count in 2015) (Puerto Rico Department of Family Affairs, 2017). Of those, 31% of the homeless population identified during the PIT count met the chronic homelessness criteria. At the time of the present study (2021), the lowest numbers registered since the beginning of the PIT counts occurred in 2019, reporting 2,535 homeless people (Puerto Rico Department of Family Affairs, 2020).

During the Puerto Rican PIT count of 2013, the CoC gathered additional information to produce a general health profile of the local homeless population (Vélez Almodóvar et al., 2013). The "Coalición de Coaliciones" (Coalition of Coalitions) in conjunction with the Public Health Program at the Ponce School of Medicine & Health Services (PSMHS), led the PIT counts that same year. "Coalición de Coaliciones" was a not-for-profit organization created to provide support to the homeless population on the island. In 2013, the organization served as the facilitating agency for one of the two Continuum of Care regions in Puerto Rico: the CoC PR 503 in the south/southeastern part of the island. That year, the PIT included two additional

questionnaires: The Vulnerability Index and a Health Questionnaire. The purpose of the questionnaires was to collect socio-demographic information and health-related questions to create a health profile of the homeless population in Puerto Rico. The results suggested a direct association between the homelessness phenomenon and social-environmental problems such as addiction, low levels of education, mental health disorders, few economic resources, and unemployment (Vélez Almodóvar et al., 2013).

Characteristics of the homeless population in Puerto Rico. The February 2013 PIT counted 2,034 homeless individuals on that single night. The face of Puerto Rican homelessness at the time was a 47-year-old male whose primary source of income was food stamps (36.3%) and informal work (24.0 %). More than half of the sample (55.6%) reported relying on public health insurance. Most reported suffering from health conditions such as depression, hypertension, liver problems, respiratory problems, and hepatitis C (Vélez Almodóvar et al., 2013). The average homeless person reported experiencing substance or alcohol dependency problems (49.6%) and having received mental health treatment (23.4%) or services at some point in their lives.

The Vulnerability Index helped determine the probability of any given individual dying while living homeless on any given day. The index showed that 59.8% of the homeless population in Puerto Rico fell into the category of "vulnerable." Of those, 42.1% reported tri-morbidity (psychiatric disorders, substance use, and chronic illness). The average amount of time a person reported living in the streets was 7.19 years, yet 25% of the individuals reported having been homeless for more than nine years (Vélez Almodóvar et al., 2013).

In 2015, the Puerto Rico Continuum of Care was among the HUD regions that obtained grants to provide services and start implementing the HFM Model philosophies to eradicate

homelessness (SAMHSA, 2016a). This change in approach represented a departure in perspective for the agencies and personnel working directly with the island's homeless population (Henwood et al., 2013).

The scope of practice among professionals involved with homeless individuals' rehabilitation process relied on the theoretical approach to service. In terms of services, both the LRT and the HFM model incorporated supportive services for chronically homeless individuals as part of the intervention process. Such services included mental health services, substance abuse management, job placement services, supported employment, counseling, and case management, among others (Tsemberis, 2010b; Tsemberis, 2015). All said tasks were part of the scope of practice of rehabilitation counseling (RC) professionals (Leahy, 2017).

Intervention Models for Homelessness

To understand the homeless population's challenges, it was necessary to provide context to the phenomenon and review the crucial intervention models for the homeless. Since Puerto Rico is a US territory, services available for the local homeless population reflected the federal government's public policies and those of related agencies such as HUD and SAMHSA. Although the way local officials implemented the federal guidelines and public policies may differ slightly due to economic or political differences, both systems share the same protocols, procedures, and standards.

Continuum of Care. The Continuum of Care (CoC) was a community-based service network designed to provide support services to homeless individuals, ensuring continuous treatment and rehabilitation services. The introduction of the network took place during the

1980s as an alternative for addressing the needs of formerly institutionalized patients within the community (Henry et al., 2013; Pratt et al., 2014; Tsemberis, 2010b). Typically, the CoC network included community-based services ranging from health services, food, clothing, welfare and disability services, housing, and vocational services, from different providers scattered across a region. Each agency or community-based service provider within the CoC network was responsible for developing service plans and providing case management services for each participant to ensure continuity, efficacy, and effectiveness of said services. There were several models of intervention within the CoC. However, over time, the Linear Residential Treatment (LRT) model approach to service became synonymous with the CoC when implementing strategies to address homelessness needs (Pratt et al., 2014; Tsemberis, 2010b).

Linear Residential Treatment system model. The LRT System emerged during the 1980s to provide services to the increasing number of people experiencing homelessness (Tsemberis, 2010b). It is based on the traditional medical model of intervention, where the practitioner, as the experts, design interventions and goals to minimize symptoms and reduce risks of the individuals (Pratt et al., 2014). The medical model presumes the patients lack the skills to make sound decisions about their rehabilitation process (Tsemberis, 2010b). The objective of this intervention strategy is to lead participants across a series of step-by-step services within the CoC. The services range from identifying participants in need of services to temporary and transitional housing placement. The last step—and the ultimate goal—of the process is to place participants in permanent supported housing services (Tsemberis, 2013; Tsemberis & Eisenberg, 2000). The foundation of the system's structure is a treatment-first approach. Thus, with each step, clients develop the necessary skills to obtain and maintain their own homes. Achieving an independent living status also implies that participants could manage

any mental health condition or problem with substance use or dependency they may have had in the past.

Structure and sequence of the LRT system. The intervention process of the LRT model consists of three main steps. The first step revolves around the outreach teams in charge of identifying and referring potential participants to transitional housing settings. Such alternative settings include drop-in centers, transitional housing, or shelters, to name a few. When participants enter the CoC system, service providers complete the paperwork required to access supportive public services such as disability benefits or welfare. Once participants move into a facility, they would stay in transitional housing from six to 24 months, at which time they advance to the next step. In the second step, the goal is to assist participants in meeting the terms for Permanent Supported Housing Services (PSH). If the person presents mental health or substance use problems, the service providers would require participants to receive treatment. In other words, each participant attends a mental health or substance use treatment program regularly to keep receiving support services and, eventually, be eligible for permanent housing (Tsemberis, 2010a).

Once the participant has qualified for PSH services, service providers determine the level of support each person needs to achieve independent living status and chose the living facility accordingly. If the participant experiences a relapse in their condition, service providers could relocate the person to a more closely supervised housing facility when service providers determine the participant experiencing the relapse is not ready to live independently. Participants might lose the services altogether until they are ready to commit to the process (Tsemberis, 2010a).

The LRT model has achieved successful outcomes for participants who do not meet the criteria for chronic homelessness or manage mental health or substance dependency issues. However, professionals have faced different challenges when working with chronically homeless individuals with acute mental illness due to the functional limitations resulting from their condition (Tsemberis, 2010a). Said professionals have also had difficulties persuading the hard-to-place participants who refuse to accept services or participate in the CoC.

According to Tsemberis (2000), one of the main obstacles engaging participants has been the difference in perceived priorities between the service providers and the homeless population. For professionals, stabilizing participants' mental illness and substance dependency issues is essential to ensure independent living outcomes. In contrast, the homeless person's priority is to find a safe and secure place to live, which surpasses any other problem the individual may have (Tsemberis & Eisenberg, 2000). Even though the differences in priorities between the service providers and clients could hinder the effectiveness of the intervention, the LRT model stands as an alternative tool to eradicate homelessness in the country (Padgett et al., 2016; Tsemberis, 2010a).

Critics of the LRT model. Although successful, professionals in the field have questioned the ethics of the LRT approach. One criticism is that the approach coerces participants into the program, excluding them from the decision-making process during the rehabilitation phase (Tsemberis, 2010a). The homeless person has very few options: either he or she complies with the requirements (whether they agree with them or not) or remain homeless. Participants who have had difficulty maintaining long-term sobriety could also experience a relapse related to their mental health condition. When a relapse occurs, participants are sanctioned or could lose their slots in the program. In such cases, the person would return to

living on the streets until they are ready to commit to a detox program or mental health treatment program again. This position is in clear contradiction to trends promoted by the professionals within the psychiatric rehabilitation field and SAMHSA. Current intervention approaches consider active participation from the chronically homeless person as *the* key component for increasing their chances of attaining successful outcomes (Pratt et al., 2014).

The perspective of service providers within the LRT model. Service providers working within an LRT program have argued that participants' personal and character flaws would make them "hard-to-house" and unfit to maintain long-term housing (Tsemberis, 2010a). Conversely, the ongoing cycle of homelessness-to-services-and-back-to-homelessness impacts the person's overall health, both physically and mentally. On average, individuals who experience long-term homelessness with co-occurring mental health conditions have a life expectancy of 56.8 years due to poor physical and mental health services (Corrigan, 2016; Pratt et al., 2014). Simply put, the ongoing cycle of homelessness contributes to the deterioration of the persons' mental and physical health.

People outside the continuum of care struggle to obtain health screening for chronic health conditions due to the attitude's healthcare providers have toward the homeless population. Such adverse experiences with professional and medical personnel could prevent homeless individuals from seeking any health services. For example, health care providers may confuse a homeless person's chronic pain symptoms with hallucinations due to a history of psychotic episodes and choose to treat the mental health issues instead of the physical symptoms (Corrigan, 2016; Pratt et al., 2014). Simultaneously, the lack of treatment for physical ailments could trigger frequent relapses for that person's mental health disorder. With each relapse, the person may lose cognitive and perceptual skills, significantly limiting their ability to function and live

independently. Furthermore, if the mental health disorder worsens and its symptoms become more severe over time, the condition itself could prevent the person from applying for the services they need (Tsemberis, 2010a).

Pathways Housing First Model. In 1992, the first program with a housing first philosophy opened its doors in New York City as the Pathways to Housing (HFM) program. Unlike the LRT model, the HFM operated under the assumption that once individuals have a safe and secure place to live, they could manage the rehabilitation process independently and obtain the supportive services needed to achieve their goal (Tsemberis, 2010b).

The guiding principles of the Pathways Housing First (HFM) program placed the client front and center in the intervention process, representing a departure from the LRT approach. The foundation of the HFM rested upon the biopsychosocial model of health, which considers the biological, psychological, and social factors associated with illness and the human experience. This holistic perception of the individual introduced a person-centered approach to services that shaped the psychiatric rehabilitation practice (Borrel-Carrió et al., 2004; WHO, 2001).

Likewise, housing first principles assume that human beings have fundamental rights regardless of their conditions, such as being treated with warmth, respect, and compassion; the rights to self-determination and to be in control of the intervention process; and finally, housing as a fundamental right for people with psychiatric disabilities and substance use problems. These guiding principles shape the rehabilitation process's structure by stressing the importance of providing housing and supported services separately and independently of each other (Tsemberis, 2010b).

Proponents of the HFM model believe in providing independent apartments to participants in scattered-site housing across their geographical area. Equally important is the program's commitment to providing ongoing support to clients without time restraints, allowing them to set the pace in the recovery process. Lastly, the program seeks to implement a recovery orientation for homeless individuals, including a harm reduction approach to services (Tsemberis, 2010b).

Structure and sequence of the HFM model. The HFM model employs two intervention teams, the Assertive Community Treatment (ACT) and the Intensive Case Management (ICM) teams. The assertive community treatment (ACT) team provides clinical support to the HFM participants. Each ACT team consists of professionals responsible for providing psychiatric and addiction services, nursing, condition management, peer support, and supported employment to chronically homeless individuals (Macnaughton et al., 2015; Tsemberis, 2010b). The ACT teams uses an assertive outreach approach to service. In other words, each team manages a small caseload and keeps a place of contact within the community, facilitating the teams' access to clients in times of crisis. The ACT team also sustains ongoing contact with the clients without time restrictions (Tsemberis, 2010b).

Similarly, the Intensive Case Management team (ICM) works through the individual case management model and housing services (Tsemberis, 2010b). The ICM offers support in the same areas as the ACT team, serving as the link between the clients and the community's services providers. Each member of the ICM is responsible for a specific number of clients, although he or she must also be aware of all the case managers' cases on the team. Modeled after the Strength Model of Case Management for people with psychiatric disabilities, the ICM team member coordinates supported services from the community to strengthen skills, promote self-

advocacy, and independence in their clients. The approach is flexible and adapted to the clients' needs, enabling them to take charge of the process (Tsemberis, 2010b). In both instances, the teams are usually mobile and work independently from one another. Still, the teams maintain communication and provide updates to ensure the participants receive support when a crisis or a relapse occurs. Therefore, clients who experience relapses would continue to receive services and resume the recovery process without losing benefits or services (Macnaughton et al., 2015).

Eligibility criteria. Although participants do not have to comply with preset terms to receive housing services, they must meet certain criteria to be eligible for the services. First, the HFM program focused on adults (18 years of age or more) with a history of chronic homelessness and psychiatric disabilities with a co-occurring substance use disorder. The two requirements for participants were: first, willingness to participate in the program (i.e., clients agree to have 30% of their monthly rent deducted from their monthly income or disability benefits). Second, those who enroll must be willing to allow HFM team members to visit their respective apartments on a weekly basis. In later years, the eligibility criteria broadened to include persons with substance use disorders only; however, the terms and conditions for them were less flexible than those with mental disorders (Tsemberis, 2010b).

Critics of the HFM model. The HFM model has proven to be successful in the long-term housing placement of individuals with a history of homelessness (Henwood et al., 2013; Padgett et al., 2016). Supporters of the model attribute its success to these two core elements: a person-centered approach that allows clients to control the process, and the organizations and staffers buying into or believing in the Housing First's values and philosophies (Henwood et al., 2013).

In recent years, and with the backing of the United States Interagency Council of Homelessness (USICH) and SAMHSA, agencies and organizations alike have been transitioning into a HFM model of service. This service transformation could present a challenge for traditional service providers who might still be partial to a system-centered approach to services. Moreover, the staff may need to become aware and recognize their values and personal views about chronically homeless individuals and clientele with substance use disorders to be effective within the new scope of the HFM services (Henwood et al., 2013).

Consequently, implementing a HFM model could be a complicated process that meets resistance from agencies, politicians, and service providers alike (Greenwood et al., 2005). Those reluctant to implement the HFM model argue that the approach could be unfit to address a specific city or country's needs due to the differences between their geographical region and New York State (the birthplace of HFM). Detractors also point out similarities between the HFM and other strategies already in place that have failed to produce the expected results. Furthermore, some detractors perceived their current services as identical to the HFM except for minor differences in the sequence in which each program chose to deliver the services. Equally important, the introduction of the HFM programs could raise concerns among local agencies and organizations having to compete with even more grantees for the already limited funding available (Greenwood et al., 2013).

The Experience of Implementing Pathways Housing First

For Tsemberis (2010b), the key to overcome resistance and effectively transition from an LRT approach into the new HFM framework to service is through the support of key individuals on every level (politics, agency administrators, and field soldiers) who believe in the model and its fundamental values. However, not all the programs that adopt a HFM approach to service incorporate all the model's main elements. Existent literature has identified the main reasons why new programs would not exhibit a high degree of fidelity to the HFM model during its implementation and adaptation phase (Macnaughton et al., 2015). First, the dissemination process about the new program, its values, and intervention procedure may not be as efficient as the program itself. Also, the lack of knowledge about the program could limit their own ability to evaluate expected outcomes and the program's longevity.

Secondly, inadequate assessment during the first stages of the enactment phase could yield results that do not correlate with the original intent or strategies developed for a new program. Finally, some intervention strategies may not be suitable, applicable, or available for all environments due to contextual factors not considered in the original program (Aubry et al., 2018; Durlak & DuPre, 2008).

Rehabilitation Counseling and Homelessness

In 1920, the federal government approved the Smith-Fees Act establishing the state-federate rehabilitation programs and created the rehabilitation counselors (RC) role as the professional in charge of providing effective services to the population with disabilities (Leahy, 2017). For a century, RCs in the field have utilized their unique skillset and knowledge about

disability, and its impact on the people living with it, to help clients achieve their vocational and independent living goals. To attain these goals, RCs assessed individual characteristics, strengths, available resources, and environmental barriers to help individuals with a disability fully engage in all aspects of life (Maki, 2012).

The rehabilitation process, as a concept, proposes to empower individuals with disabilities to achieve meaningful lives in all areas: personal, social, and work environments (Maki, 2012). The rehabilitation concept refers to a series of "holistic and integrated programs of medical, physical, psychosocial and vocational interventions" (Maki, 2012, p. 84). Therefore, interventions within the rehabilitation counseling practice aim to help people with disabilities adapt to the environment. Also, RCs work to adapt the environment to meet the needs of the population with disabilities, increasing their opportunities to be active participants within said environments (Maki, 2012).

In 1994, the Commission on Rehabilitation Counselor Certification (CRCC) developed a scope of practice statement that contributed to setting the standard of practice for most of the professional organizations and educational programs in the field (Tarvidas, 2017). In a nutshell, the statement defined the rehabilitation counseling practice as a systematic and comprehensive series of services agreed upon by the RC and the client. The goal of this collaboration is to make the most of the client's employment capabilities and attain independence at different levels and in diverse social environments (Maki, 2012).

The Type of Services

Although the type of services RCs provide to clients varied across work scenarios, every rehabilitation professional must develop the skills to address the diverse needs of the

population with disabilities. The tools for which rehabilitation professionals have been known include career and vocational counseling; case management and service coordination; job analysis, job development, and placement services. It also includes assisting with employment and job accommodations, providing consultation and interventions to remove barriers, and conducting program evaluations and research. In terms of mental health, rehabilitation counselors also provide individual and group counseling, diagnosis and treatment planning; assessment and appraisal; and access to rehabilitation technology, among others (CRCC, 1994).

However, the RC's scope of practice responds to the range of services available within the organization that employed them (Leahy, 2017). The RC's role has expanded from public rehabilitation settings such as state and federal vocational rehabilitation programs to private and not-for-profit organizations such as independent living centers, hospitals, mental health clinics, and employee assistance programs, among others (Stebnicki, 2012). Hence, a RC has the skills and knowledge to facilitate the rehabilitation process of individuals experiencing psychiatric disabilities and substance abuse disorders, both prevalent within the chronically homeless population (Leahy, 2017).

Still, the role of RCs in service programs targeting chronically homeless individuals remains unclear. Programs following the HFM model would ask the Assertive Community Treatment (ACT) teams to make available the services of a supported employment specialist to participants who express interest in finding a job. Similarly, the Intensive Case Management teams provide vocational and educational counseling services as part of the interventions. No direct references were provided for recruiting rehabilitation counseling professionals to conduct said task, neither for the ACT or ICM teams. Furthermore, the HFM manual only requires the

ICM teams to “hold at least one master’s degree in psychology, social work or another related field” (Tsemberis, 2015, p.134).

The lack of specificity regarding professionals within the rehabilitation field could result from the diversity in job titles. Rehabilitation counseling professionals may perform as such but hold positions as career counselors, mental health counselors, and substance abuse counselors. Such diversity in titles has fueled the general public’s conception that RCs work mostly within state or federal vocational rehabilitation programs (Stebnicki, 2012; Tarvydas et al., 2018; Villafañe Santiago et al., 2013). Consequently, this study focused on the views, opinions, and attitudes of service providers from related fields regarding the RC's role, the experiences, views, knowledge, and attitudes regarding the chronically homeless population, and the process of implementing the HFM model in Puerto Rico.

Statement of the Problem

The US federal government sought to eradicate chronic homelessness by promoting evidence-based intervention practices throughout the United States and its territories. These initiatives aimed to address the homeless population's needs, maximizing available resources by implementing cost-effective programs with the highest success rates (United States Interagency Council on Homelessness, 2015). Furthermore, the government’s goal was to promote and provide funding for programs using a housing first approach to service to address the issues related to chronically homeless persons or homeless individuals with psychiatric disabilities and substance use problems— conditions present among 24% of this population (Henry et al., 2020).

Since the 1980s, government agencies and community-based organizations in the US and Puerto Rico have been implementing different strategies to address homelessness (Nina & Ostolaza, 2013). In Puerto Rico, nonetheless, the HFM approach has not been among the options for services. In 2015, the agencies and organizations that integrate the two CoC systems (CoC 502 and 503) on the island obtained funding to provide services using a housing first approach. In 2016 they prioritized programs that address the needs of chronically homeless individuals presenting 'tri-morbidity' comprised of a mental disability, substance use, and chronic health issues (El Nuevo Día, 2015).

To comply with the new approach, government agencies, community-based organizations, and service providers, such as case managers, clinicians, and administrators, working with the homeless population on the island had to transition themselves from the principles and philosophical beliefs behind the traditional Linear Residential Treatment (LRT) approach to service to a HFM philosophy (Henwood et al., 2011). The LRT's service structure followed a series of progressive steps in which housing was both the outcome and a parallel service for participants. In other words, the individual who chooses to commit to a program would receive case management services, temporary housing, and mental health or substance use treatment services on a single site. As participants learned to manage their conditions and gain control over the mental health or substance use disorders, they would move along the services from transitory housing placement, such as shelters, drop-in centers, and transitional housing, to permanent housing placement. The case managers would monitor each participant's progress, providing support and coordinating services as they see fit. If the person were to relapse, they would be sanctioned with more restrictive living conditions (e.g., curfews) or by losing the benefit altogether (Henwood et al., 2011; Tsemberis, 2010b).

The foundation of the LRT approach was the traditional medical model of intervention. This model requires interventions and treatment plan goals designed to address symptoms and reduce risks from the practitioner's perspective (Pratt et al., 2014). This system-centered intervention assumes that participants need to master basic living skills before qualifying for independent living placement. It assumes the person does not have the necessary skills to make decisions independently during the rehabilitation process (Tsemberis, 2010b). In some ways, the intervention responds to the practitioner's belief that participants need to earn housing services by demonstrating "their moral worthiness" (Henwood et al., 2011, p. 78).

The agencies and organizations usually executed four primary tasks: (1) extend the continuity of care by providing comprehensive services to clients for a limited time, (2) facilitate access and appropriate delivery of services to the person who requires said services, (3) demonstrate accountability as an agency or organization for the services they provide, and (4) offer cost-effective, efficient, and economical services (Pratt et al., 2014). Typically, on-site services would include case management and temporary housing placement (Henwood et al., 2011). On average, the case managers would perform five basic tasks: (1) identify and assess the participant's needs, (2) develop a comprehensive service plan in tune with the person's needs, (3) connect the participant with the services contemplated in the plan, (4) corroborate that clients received the services to which they were entitled, and (5) evaluate the participant's response to the services and follow-up on the service plan (Pratt et al., 2014).

In contrast, the HFM model is a person-center approach based on a biopsychological model that promotes the client's active participation in the rehabilitation process (Tsemberis, 2010b). The model's goal is to provide permanent housing placement to individuals with no restrictions, regardless of their commitment to a mental health or substance use program.

Individuals choose the living arrangement they prefer in a neighborhood of their preference. To support the process, the clients work with two case management teams on two different tasks. Once the participant is ready, the Assertive Community Treatment team (ACT) helps them manage their psychiatric conditions or substance use issues. The Intensive Case Management (ICM) Team oversees coordinating the housing placement process and all additional supportive services. The programs provide both services simultaneously but independently from each other. Therefore, if the client has a relapse, the housing services are not in jeopardy. Although there are no restrictions regarding services, there are two main program requirements: (1) allowing weekly home visits from the staff, and (2) and singing the lease of the home and agreeing to contribute 30% of their income to the monthly rent (Tsemberis, 2010b).

Overall, service providers transitioning from the LRT into the HFM model have reservations about the programs' effectiveness. The staff in traditional programs usually share the views and values of the system they represent. Hence, the LRT program staff would be more likely to believe that people with co-occurring disorders need to be stable in their condition, clean, and sober to engage in the rehabilitation process. They also need to demonstrate having independent living skills before attempting to live independently in the community (Henwood et al., 2013). The LRT staff would also be less likely to tolerate deviant or disruptive behaviors that interfere with the system’s rules and promote conformity to its values among clients. These service providers tend to improve interventions to comply with the numbers required to achieve the agencies’ service goals. All these values run counter to the HFM strategy to support the homeless population (Henwood et al., 2013). Despite the staff’s beliefs, studies have shown that once exposed to the HFM model, most of the LRT service providers involved in the assimilation

process came to support the new paradigm's core philosophies (Tsemberis, 2010b; Tsemberis, 2015; Henwood et al., 2013)

For Tsemberis (2015), a successful transition from an LRT to a HFM approach relies on five main elements. First, the agency's leadership, at all levels, had to support and embrace adopting the model. Second, the staff involved with providing direct services must see the program as a viable alternative to address the needs of the hard-to-place clients that do not respond to the traditional interventions. Third, service providers must embrace the model's core values, including believing that housing is a fundamental right and not a privilege that clients need to earn. Fourth, the process also requires that both the leadership and staff embrace a harm-reduction model when working with individuals with co-occurring disorders. Lastly, the organizations must identify new funding strategies to implement and continue the HFM program (Tsemberis, 2010b).

Still, embracing the core principles and values and the agencies' service providers' willingness to adopt the HFM model alone does not guarantee the program's successful implementation (Macnaughton et al., 2015). As previously stated, not all the strategies within the HFM model are suitable for new environments. Consequently, it is essential for professionals seeking to adopt the model to consider the new city's socioeconomic context or the country in which they are introducing the program. In other words, each new geographical area considering adopting the HFM model needs to adapt the intervention to fit the specific characteristics and situation of their homeless population (Durlak & DuPre, 2008). Thus, it is essential to document, analyze, and review the implementation process at the beginning and during the transition from the LRT to the HFM model (Stergiopoulos et al., 2016; Tsemberis, 2010b).

In 2015, Puerto Rico's Mental Health and Anti-Addiction Services Administration (ASSMCA by its Spanish acronym) applied for and received funding to implement the Cooperative Agreements to Benefit Homeless Individuals (CABHI-PR). The program's purpose was to provide recovery and treatment services to chronically homeless individuals on the island through a housing first approach. Since then, the agency has been working on implementing the program. As a result, a limited amount of information is available regarding the island's transition process and its implications on how service providers should engage participants under the new approach.

Although the HFM model includes services and tasks closely related to rehabilitation counseling professionals, its manual does not mention the RC —by occupational title—among the professionals considered as service providers within the model (Tsemberis, 2010b; Tsemberis, 2015). In Puerto Rico, the RC was an integral part of the homelessness intervention model (H.Y. Serrano, personal communication, February 15, 2016). However, due to the diversity in mission and purpose across the agencies the RC may work for, and inconsistencies in job titles for counselors, it is unclear the range of tasks and the positions these professionals have held when working within organizations serving the chronically homeless population.

Statement of Purpose

This phenomenological study aims to explore views, opinions, and experiences of service providers —continuum of care coordinators—administrators, clinical and case managers, and direct service providers regarding the role of rehabilitation counselors within intervention programs geared toward the chronically homeless population and the process of implementing the Pathways Housing First model in Puerto Rico. The study relies on a transcendental

phenomenology designed (Creswell & Creswell, 2018) to depict the essence of participants' lived experiences with rehabilitation counselors and the chronically homeless individuals as programs transition to a housing first approach to service. The researcher conducted in-depth interviews with key informants (service providers) working in government agencies and community-based organizations to explore said experiences. She also reviewed documents to identify the principles and tasks of the rehabilitation counseling field and the housing first model, and administered a survey to compare the experiences of key informants with other service providers within the same programs.

Research Questions

The research questions for the study are as follows:

1. What is the experience of the service provider (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) with rehabilitation counselors and their role within the intervention models for chronic homelessness population?
2. What is the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the chronically homeless population?
3. What is the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the Pathways Housing First approach to service?

Definition of Terms

Relevant concepts and terms used throughout this research correspond to definitions used in the Annual Homeless Assessment Report (AHAR) (Henry et al., 2016) to Congress Point-in-Time Estimates of Homelessness.

Assertive Community Treatment (ACT) teams. A group in the HFM model of intervention designed to meet the multiple needs of individuals with severe psychiatric disabilities (Tsemberis, 2010b). The ACT team refers to multidisciplinary staff members who provide direct clinical and support services to clients as a single unit. The team offers 24 hours on-call services and maintains "a low participant-to-staff ratio" (p.8) to meet the needs of clients with psychiatric disabilities, health concerns, and or substance abuse issues (Tsemberis, 2010b).

Chronically Homeless Person. An individual with a disability, living alone, who has experienced homelessness continuously for a year or more, or persons who have experienced four or more episodes of homelessness over the past three years (Henry et al., 2013).

Continuums of Care (CoC) System. A network of local organizations in charge of coordinating the complete assortment of services geared toward the homeless population. Each CoC corresponds to a specific geographic area (Henry et al., 2013).

Emergency Shelter. A facility where homeless people receive temporary housing. Usually, the shelters are the first formal contact the client has with the services included within the continuum of care.

Individual. A person who is by himself or herself during their episode of homelessness: single adults, unaccompanied youth, or an unaccompanied person living in multiple-adult or multiple-child households.

Intensive Case Management (ICM) Teams. Clinicians and other caseworkers who provide support services to moderately disabled clients. ICM teams rely on a caseload practice model with a staff-to-client ratio between 10 to 20 participants per staff member. Typically, they serve as a liaison between clients and the community. As part of their responsibilities, at least one staff member is available on call 24 hours a day, seven days a week. Although each case manager handles a pre-determined number of clients, all staff members are familiar with all active clients within the program (Tsemberis, 2010b).

Linear Residential Treatment (LRT) system of care. A combination of different program components to address the needs of the homeless population. Each element corresponds to a level or type of services, ranging from more restrictive to less restrictive environments, as each client learns to manage and regains control of his or her circumstances. The systems include outreach programs, interim housing placement such as drop-in centers, safe havens, shelters, and time-limited transitional housing facilities. Additionally, the system includes different permanent supportive housing programs (PSH) such as community residences, single-room-occupancy buildings, mixed housing, and apartments. Because the LRT continuum was the intervention network of choice in place designed to support homeless individuals, it was also referred to as the traditional approach to services, or the CoC (Tsemberis, 2010b).

Pathways to Housing First (HFM). A not-for-profit organization based in New York City that developed the supported housing program. The program's goal is to provide housing and support services for individuals experiencing homelessness who also have a dual diagnosis of mental illness and substance use. HFM serves as an alternative for the hard-to-place people who could not receive services from the LRT system (Tsemberis & Eisenberg, 2000).

Permanent Supportive Housing. A housing facility (project-and-tenant based) and supportive services on a long-term basis for homeless individuals.

Point-in-Time Counts. One-night estimates of non-duplicated, sheltered, and unsheltered homeless individuals. The counts take place each year over the last week of January across the US. In Puerto Rico, the counts are performed every two years. The agencies that manage the CoC in each state and the territories are responsible for conducting the estimate.

Safe Havens. Long-term housing services for individuals with a diagnosis of severe mental illness. The facility houses a maximum of 25 persons and is administered by private or semi-private agencies.

Service Providers. Continuum of care coordinators, administrators, clinical and case managers, direct service providers working at an agency or community-based organization with chronically homeless individuals at the time of the study.

Sheltered Homeless People. Individuals who stay in emergency shelters, transitional housing programs, or safe havens (Henry et al., 2013).

Transitional Housing Program. A facility that serves as temporary housing for homeless people while they receive supportive services. The length of the stay at the installation is limited to no more than 24 months. It provides a secure place to live that enables participants to move eventually into permanent housing.

Design and Theoretical Framework

This research explored Puerto Rico's service providers' views, opinions, and attitudes for the chronically homeless population through the lens of the Biopsychosocial Model of Health proposed by the World Health Organization (WHO, 2001). This theory conceives the human being not as a detached or an independent unit but as a part of a more complex system that acts and reacts according to its environment (Engel, 1980). Furthermore, the model informs the theoretical basis for the housing-first philosophy and values and serves as the foundation for the psychiatric rehabilitation field and the present research.

Biopsychosocial Model of Health

The Biopsychosocial Model of Health, or the ecological model, was a response to the "traditional" biomedical model that dominated medical and clinical health interventions in the second half of the 20th Century in the US (Borrel-Carrió et al., 2004). The traditional medical model focuses on identifying the problem using an empirical-analytic approach to treatment—a reductionist view of the patient to its biological component. For proponents of the biopsychosocial model, the clinical and medical staff must address the biological aspects of illness and the psychological and social factors associated with the patient. These factors correspond to a complex system in which individuals constantly interact and react to each system and, therefore, create the context of human experience (Suls & Rothman, 2004).

The biopsychosocial model's central premise states that to comprehend and efficiently treat patients, professionals must acknowledge both the individual and his or her context (Engel, 1980). An adequate assessment of all aspects of the human experience allows professionals to

place the patient at the center of the intervention process. It also provides a voice to patients, aiding professionals to better understand said patient's experience. Thus, the biopsychosocial model provides a different framework for understanding illness and disability, where the biological and psychological factors interact with personal characteristics, social context, culture, believes, and spirituality, influencing one another changing the person's perception about disability and illness (McCarthy, 2018; Peterson et al., 2010).

The biopsychosocial or ecological model proposed by the WHO conceptualizes disability and illness as part of a continuum with positive outcomes (function) or negative outcomes (disability or impairment) (McCarthy, 2018). The WHO created the International Classification of Functioning, Disability and Health (ICF) to categorize these outcomes (WHO, 2001). The ICF is a classification system used to describe a person's level of function, disability, and participation and how their characteristics and environmental factors could impact said levels.

As a conceptual framework, the ICF describes the relationship between facilitators and barriers in the environment with health and functioning (Peterson et al., 2010). In other words, it describes the interaction of personal factors such as health condition, body functions, and environmental factors enhancing or limiting the level of participation and social interactions of any given person (Escorpizo, 2015; Peterson et al., 2010). The ICF has defined disability in terms of impairment of the body structures and functions as a limitation in activities due to a condition or disease and restrictions in participation in social environments. It also assumes a person's contextual factors —the environmental and personal factors— influence the outcomes by enhancing or worsening function and participation (Escorpizo, 2015). Consequently, a health condition or a disease does not imply disability; disability occurs when an individual cannot

function and fully participate in one or more areas of life due to structural damage, personal, or environmental factors (WHO, 2001).

Significance of the Study

This study sought to describe the views, opinions, and experiences of service providers about the rehabilitation counselor's role, the chronically homeless population, and the implementation process of the HFM model in Puerto Rico. The research results aimed to provide a baseline to describe the contextual factors during the HFM model's implementation process by identifying related strengths and challenges and by documenting the process from the viewpoint of the people involved. The results also intended to provide a starting point to identify the individual, environmental, and contextual characteristics in the island that may be relevant for effectively implementing the HFM model in Puerto Rico. Although the HFM model worked with the population with disabilities, the RC's role was unclear within said model even though the interventions included tasks directly related to the field. The fact that RC and their scope of practice are not as well-known as other human services professionals may have contributed to the lack of reference of said professional within the HFM manual (Tarvydas et al., 2018; Tsemberis, 2015). Therefore, this study expected to shed some light on what other professionals knew and thought about RCs and to help professionals in the field design strategies to raise awareness about the counselors' scope of practice, technical skills, and capabilities.

To set the context, education programs in the rehabilitation-counseling field have been transforming to reinforce the clinical training for future professionals. In 2017, the Council of Rehabilitation Education (CORE), the accreditation agency that oversaw the rehabilitation services programs, merged with the Council for Accreditation of Counseling and Related

Educational Programs (CACREP). With the merger, programs incorporated the same clinical standards in all the programs accredited by CACREP, such as those for professional counselors (Tarvydas et al., 2018). These changes opened new work scenarios, emphasizing clinical intervention models such as the psychiatric rehabilitation perspective, which was also the foundation for the HFM model. Consequently, this study attempted to provide rehabilitation counselors on the island with expanded alternatives to impact individuals with disabilities experiencing homelessness using the HFM model.

Overview of the Methods

This qualitative study relies on a transcendental phenomenology designed to explore service providers' views, opinions, knowledge, and attitudes. In this type of design, the researcher explores the essence of service providers' experiences working with the chronically homeless population. In a transcendental phenomenology, the analysis of the participant's viewpoint focuses on three main components: the textual experiences (noematic), structural experiences (noetic), and the essence of the experience (Creswell, 2013; Moerer-Urdahl & Creswell, 2004). The researcher performed in-depth interviews to explore the experiences of key informants (service providers) working in government agencies and community-based organizations. The study also focuses on reviewing documents to identify the principles and tasks of the rehabilitation counseling field and the housing first model.

The study incorporated a survey to describe service providers' views, opinions, and knowledge about RCs, the chronically homeless population, and the HFM model. The results from the survey and the review of documents were two of the strategies incorporated to

triangulate the information obtained from the key informants. The triangulation process consisted of gathering information from different sources to identify points of convergence between the experiences of the key informants and the additional documents (Creswell, 2013). The obtained results were analyzed, compared, and contrasted to identify commonalities in themes and to provide a context to participants' experiences about homelessness, the role of rehabilitation counselors during the intervention process, and the housing first model.

CHAPTER II

REVIEW OF THE LITERATURE

In 1980, concerns about the growing number of people living on the streets moved from the state's local arena to the federal government. Since then, the government funneled millions of dollars to fund programs and initiatives to eradicate homelessness from the United States (NCH, 2006). Past statistics showed that throughout the last four decades, the homeless population in the United States (US) had increased despite periods of economic bonanza and the public and private sectors' efforts to resolve the problem (McAllister et al., 2011).

Nonetheless, since the introduction of the Opening Doors program in 2010, the number of individuals experiencing homelessness, in general, has decreased by 10.9% (Henry et al., 2020). Likewise, the number of people experiencing unsheltered homelessness has declined by 8.7% (Henry et al., 2020). The following chapter presents the relevant literature concerning the evolution of initiatives and programs designed to diminish the homeless phenomenon throughout the years and the socio-economic factors influencing the homeless phenomenon in the US and Puerto Rico. Additionally, the discussion explores the unique characteristics and needs of the homeless population in Puerto Rico. The chapter also presents the Biopsychosocial Model of Health by the World Health Organization, which serves as the study's theoretical framework.

The Homelessness Phenomenon

Although homelessness is not a new phenomenon, there are two specific periods in the history of the United States in which the number of people living on the streets increased drastically: The Great Depression in 1929 and the inflation-afflicted 1980s (Padgett et al., 2016). In the 1930s, rapid developments in the social and economic environment drove hundreds of families to move from rural to urban areas. These demographic changes brought an increase in unemployment rates, low wages, underemployment conditions, and fewer affordable housing options. Consequently, the number of homeless individuals and families in urban areas increased throughout the country (Padgett et al., 2016).

History of Homelessness

At the time, the federal government introduced strategies to provide alternatives for low-income working families. Such strategies included creating the New Deal Public Works Administration, the precursor of the Department of Urban and Housing Development (HUD). The New Deal oversaw programs such as Section 8 and other voucher programs to subsidize housing for low-income working families or disadvantaged individuals and families. Additionally, lawmakers introduced legislation in the form of the Wagner-Stegall Housing Act of 1937 to build affordable housing for low-income individuals and working families. Back then, new construction techniques and inventions, such as elevators, allowed the government to build thousands of public housing projects in urban areas. The new public housing projects' design consisted of high-rise buildings allowing for the housing of significant numbers of individuals and families (Padgett et al., 2016).

Despite the construction boom, additional socio-economic conditions contributed to increased homeless populations across the US. After World War II, returning soldiers, the subsequent Baby Boom, and the emergence of a new professional class changed the country's demographic profile. These demographic changes increased the demand for family-size home units. Moreover, at this time, the rising costs of housing in the suburbs displaced single individuals and working families to urban areas (Padgett et al., 2016). In the 1950s, urban public housing demand increased due to changes in social tensions and economic conditions. The displacement of African-Americans fleeing discrimination and persecution in the Southern states led them to relocate to cities like Chicago and Detroit. The growing numbers of migrants from Europe and Eastern Europe prompted city officials to implement urban reform plans. The plans included demolishing run-down public housing buildings and rebuilding said complexes. However, government administrators only replaced a few buildings limiting affordable housing options even more (Padgett et al., 2016).

In 1965, the HUD became a cabinet, and its Secretary, a member of President Johnson's cabinet. The HUD became an essential piece in the President's social initiative: "War on Poverty." Under the Housing Act of 1937, programs such as Section 8 provided housing opportunities to families and low-income individuals which kept the homeless population from increasing. Simultaneously, changes in the Medicare programs prompted hospitals to move patients away from institutions into the community.

The deinstitutionalization movement in the 1960s allowed individuals with mental health problems and developmental disabilities to live and receive services in a normalized environment outside the hospital setting (Shaw & Mascari, 2018). Thus, the federal government became responsible for providing housing and community-based services to formerly institutionalized

patients. Individuals moved from hospital wards to single-room-occupancy hotels or inexpensive housing and engaged in day labor jobs to support themselves in the new neighborhoods. However, in time, socioeconomic factors such as the gentrification of urban areas, limited access and availability to affordable housing, and day labor jobs for people with minimal skills (Burt, 2019; Zlotnick, 2013).

By the 1970s, a new economic recession under President Nixon's administration limited the available funding for social programs such as public housing. Likewise, President Reagan's economic agenda included implementing new tax policies introducing private market-driven federal housing programs. These programs allowed private organizations to build, rebuild, and manage housing complexes with tenants from assorted socioeconomic backgrounds. In other words, the private organization set aside a percentage of the housing complex units to low-income tenants through voucher programs. The voucher programs required families to assume the responsibility for 30% of the rent. However, due to the high cost of living, families could not afford the rent, even with the voucher. Thus, the federal housing program, initially structured to provide essential services for low-income families and individuals, delegated its responsibility as service provider to the private sector. The voucher programs during the Reagan administration further limited the availability of genuinely affordable housing projects for the poor (Khare, 2013; Padgett et al., 2016).

Throughout the 1980s, the ripple effects of the economic recession of the 1970s and significant budget reductions of social programs such as health care and housing during the Reagan years propelled a new period of homelessness. For the second time in history, authorities registered a dramatic increase in the homeless population due to reduced funding, a decreased construction of new projects, and neglected housing facilities in urban areas. In time, housing

projects in inner cities became synonymous with crime and violence, and they were hence perceived as dangerous places to live, especially for families with children (Padgett et al., 2016). Meanwhile, concerns about homelessness at the state level began to resonate at the federal level. In 1987, Congress approved the Steward B. McKinney Homeless Assistance Act to address homelessness. Along with the Act, Congress also adopted a budget to provide emergency shelters, food, and supportive services. The services put in place by the Act received support from both subsequent administrations: President George H. W. Bush and President William Jefferson Clinton (Padgett et al., 2016).

Although emergency shelters, public and private, provided a short-term alternative to living on the streets, the conditions were not ideal (Padgett et al., 2016). Publicly-run shelters could hold up to 1,000 people on a single night providing a place to sleep with no actual services available. Churches and not-for-profit organizations, soup kitchens, and the drop-in center also provided limited support to the population. Individuals with health concerns, such as psychiatric disabilities, received little to no service for their conditions. The consistency in funding provided by the Act made it possible for the organizations working with the homeless population to introduce long-term services, like transitional housing, to address the participants' needs (Padgett et al., 2016).

In New York City, the imminent closing of mental health institutions, along with concerns about public health and safety issues, prompted government officials to act and address the increasing number of homeless individuals in the city (Padgett et al., 2016). People with psychiatric disabilities or substance use issues needed serious attention. Both New York City and New York State signed an agreement to redirect resources previously geared toward mental health institutions into supportive services in the community for homeless individuals. The

funding helped revitalize or build new housing projects and provide voucher programs for homeless individuals.

Although the agreement provided a new alternative, it had little impact on reducing the number of people with mental illness living on the streets due to the new programs' screening process for potential participants. In order to meet the criteria and qualify for services, individuals needed to have a history of homelessness, along with mental health problems, be committed to treatment, have no substance use issues, and be willing to follow the rules. Programs sought to admit individuals who could follow the rules and would not be disruptive to other participants and the staff (Burnes, 2016). Individuals with a long history of mental illness who could not comply with such demands were considered hard-to-place and eventually returned to the streets. Consequently, homeless individuals with mental illness became more visible and harder to ignore by the public. Citizens in major cities started to demand public officials to address the problem, which was considered a public safety issue (Burnes, 2016; Padgett et al., 2016).

For many, crime and violence were the same as homelessness. In the 1990s, the criminal justice system incarcerated many individuals from the homeless population due to felonies committed while living on the streets. Though a direct consequence of the lack of proper living conditions, the delinquent behaviors of homeless individuals became criminalized. For instance, authorities treated minor infractions like riding in trains, indecent exposure due to the lack of bathrooms or showers, and theft of goods such as food as crimes. Odd behaviors related to mental illness were viewed as a safety hazard, resulting in police interventions and arrests. Homeless people charged and fined for the charges were unable to comply with the court’s requests, resulting in their incarceration. Thus, jails became depositories for homeless people,

many of whom showed symptoms of mental illness for which they received no treatment. Moreover, the penal system lacked the services needed to manage the mental health issues and provided little to no security to those vulnerable to abuse from the staff and the general population of inmates (Padgett et al., 2016).

Point-in-Time Counts. Every year, the US Department of Housing and Urban Development (HUD) conducts the Point-in-Time (PIT) counts with a dual purpose: first, to estimate the number of homeless individuals living in the US and its territories, and secondly, as an assessment tool to measure the effectiveness of the programs put in place to eradicate the problem (United States Interagency Council on Homelessness, 2015). In 2005, the official reports from the PITs became available from the agency (HUD, 2020) for public consumption. The PIT collects basic demographic information like age, gender, race, ethnicity, as well as information related to the living conditions (i.e., if the person goes to an emergency shelter or is unsheltered).

In 2010, the data collected from the PITs demonstrated that the US homeless population started to decrease due to the implementation of the Opening Doors Programs. Since then, the estimated number of homeless people in the country decreased by 11%. In January 2015, a report by the Annual Homeless Assessment Report to Congress put the homeless population at 564,708 individuals—13,716 persons fewer than published in 2014, and an overall decrease of two percent (US Department of Housing and Urban Development, 2014). In addition, 64% (or 358,422) of the total homeless population were individuals experiencing homelessness by themselves, while 36% or 206,266 people were homeless individuals in families (Homelessness Research Institute, 2015; HUD, 2015). Those numbers were smaller than reported in 2014 when the number of individuals experiencing homelessness was 362,163 or 63% of the population, and

37% (216,261) of homeless individuals were families (HUD, 2014). By 2019, the number of individuals experiencing homelessness was almost 568,000, most of whom lived in unsheltered locations and experienced severe mental illness (116,179 individuals) and reported having chronic substance abuse (88,873 individuals) (Henry et al., 2020). The states with the most significant concentrations of homeless individuals were California, New York, and Florida.

Legislation Regarding Homelessness

In the 1980s, local governments and community advocates put into place initiatives addressing the homelessness problem without the support of the federal government. At the time, President Reagan's administration did not perceive homelessness as an issue that required the federal government's intervention but as an issue for the local state government to resolve (NCH, 2006). Within that challenging historical, economic, and political context, advocates and lawmakers worked and demanded involvement from the federal government. As a result, Congress introduced several pieces of legislation, but only a few became law. The Homeless Eligibility Clarification Act of 1986 was the first federal law to support the homeless community. The Act removed the permanent address requirement and other barriers to social services programs, including Food Stamps, Aid to Families with Dependent Children, Veterans Benefits, and Medicare for people living in the streets. That same year, Congress approved the Homeless Housing Act to establish transitional housing programs, specifically the Emergency Shelter Grant program and the Transitional Housing Demonstration Program administered by the HUD.

The most relevant piece of legislation advocating for the homeless today is the Mckinney-Vento Act of 1987. Initially, the Act was introduced as the Urgent Relief for the Homeless Act but was later renamed the Stewart B. McKinney Homeless Act after its primary sponsor, Republican Representative McKinney from Connecticut. In 2000, the Act was again renamed as the McKinney-Vento Homeless Assistance Act to also honor Representative Bruce Vento, another champion of the law in 1987 (NCH, 2006).

The McKinney-Vento Act contained nine titles covering a broad range of services, from temporary housing alternatives to job training, education, and health services as needed. Initially, the law provided funding for 15 different programs to aid homeless individuals to get back on their feet (NCH, 2006). The Act established a definition of homelessness and created the US Interagency Council on the Homeless (USICH), an independent organization containing the heads of 15 federal government agencies. It also assigned the Federal Emergency Management Agency (FEMA) to administer the Emergency Food and Shelter Program and authorized and provided funding for emergency and transitional housing programs such as Emergency Shelter Grant programs, Section 8, and Single Room Occupancy Moderate Rehabilitation, among others.

The Act also required federal agencies to identify surplus properties and make them available to agencies and non-profit organizations working to assist the homeless (NCH, 2006). It authorized the Department of Health and Human Services to provide health services to the homeless population, including mental health and drug abuse programs. The legislation provided for the implementation of four programs geared toward educating the homeless population at different stages. Those programs included the Emergency Community Services Homeless Grant Program, the Adult Education for the Homeless Program, the Education of Children and Youth Homeless Demonstration Program, and Job Training. Under Title VIII, the Act presented

amendments to facilitate access to the Food Stamp and Temporary Emergency Food Assistance Programs. Lastly, under Title IX, the Act expanded the Veterans Job Training benefits for veterans experiencing homelessness (NCH, 2006).

In 2009, President Barak Obama signed the Homeless Emergency and Rapid Transition to Housing Act (HEART) to address the high incidence of homelessness in the US and its territories. HEART expands on the definition of a homeless person and includes definitions for homeless youth and families, and describes what constitutes a family and individuals at risk of being homeless (US Department of Housing and Urban Development, 2021). The federal government introduced in 2010 the Opening Doors Program to prevent and eradicate homelessness in the country. Individuals experiencing homelessness became one of the highest priorities of the government and non-profit organizations that provide services to the homeless population (HUD, 2013). The goals of the program were to end chronic homelessness, as well as to prevent and end homelessness among veterans by 2015. Furthermore, the program also pursued to deter and terminate homelessness among families and minors under 18 by 2020 (United States Interagency Council on Homelessness, 2015). Both Acts define these types of homeless groups in similar terms (Nina & Ostolaza, 2013).

The McKinney-Vento Act provided the tools and resources to tackle homelessness problems for those with mental health conditions and substance use problems (HUD, 2007). Although the rate of homelessness has decreased over time in some areas, the number of people living in the streets is still high (HUD, 2013). Since 2007, the number of people experiencing homelessness dropped from 647,258 to 567,715 in 2019 (Henry et al., 2020). By January 2014, the estimated number of the total homeless population in the country was 578,424 individuals (HUD, 2014). Of those, 63% or 362,163 of the total population were homeless people, and 37%

(216,261) were homeless people in families (HUD, 2014). Most of the identified homeless population, or 85% of the people, fell into chronically homeless (HUD, 2013).

Even though the overall economy in the US has improved and the unemployment rates have decreased, the number of individuals living in poverty and struggling to afford rent has increased. Thus, socioeconomic factors such as poverty, unemployment, and lack of affordable housing continue to be significant risk factors for homelessness in the US (Homelessness Research Institute, 2016). In 2017, the PIT counts estimated 553,742 homeless individuals in the US, a 1% increase (549,928 homeless individuals) from the previous year (Henry et al., 2017). By 2019, the number of chronically homeless individuals increased to 96,141, and they were most likely living unsheltered. According to the AHAR report (Henry et al., 2020), the overall number of chronic homelessness decreased in most states, except in California, Oregon, Hawaii, Mississippi, Arkansas, and Florida. Two-thirds of all individuals experiencing chronic homelessness were in California, Florida, and Oregon. The report does not single out any specific reason for said increases in those states.

To eradicate homelessness, the Substance Abuse and Mental Health Service Agency (SAMSHA), in conjunction with the USICH, developed the guidelines and strategies for the prevention of homelessness (SAMHSA, 2016a). The guidelines focus on the importance of housing stability for clients and the collaboration of all sectors involved to maximize available resources. They also establish the role of mainstream systems (e.g., TANF, Medicaid, Housing Choice vouchers, among others) in preventing homelessness and the need to hold them accountable for the outcomes (USICH, 2016). The guidelines promote the integration of evidence-based practices and regular evaluation as part of the strategic planning of the agency or organization. Regarding participants, the guidelines are emphatic. Programs must include the

homeless person in the decision-making process as a strategy to prevent relapses, focus on strengths, and provide support that matches their needs (SAMHSA, 2016a).

Legislation in Puerto Rico. Puerto Rico is a US territory; therefore, every federal legislation approved by Congress applies and is implemented accordingly (Nina & Ostolaza, 2013). The local government submitted and approved Act. No 130 on September 27, 2007 to address homelessness on the island. The law had several objectives, among them to create the Multisector Council to Support Homeless Population, embedded within the Department of Family Services in Puerto Rico. The Council's purpose is to coordinate services to the homeless community, promote the adoption and the implementation of public policy and encourage funding directed at initiatives with the best possible outcomes and consideration of evidence-based practices. Act No. 130 also introduces a legal definition of a homeless person and the public policy for the services the homeless population is entitled to receive on the island. Furthermore, the law includes a Bill of Rights for homeless individuals who live on the island (US Department of Housing and Urban Development, 2021).

Intervention Models to Address Homelessness

Continuum of Care (CoC) System

From the late 1960s to the 1980s, the aftermath of the deinstitutionalization process of people with mental illness in the United States resulted in changes in the way people with psychiatric disabilities received services (Pratt et al., 2014). Back in the 1960s, hospital staff used to cover the basic needs of formerly institutionalized patients. As patients moved from a hospital setting into the community, they suddenly needed to learn how to navigate the

community-based services known as the Continuum of Care (CoC). This network functioned as a delivery system for continuous treatment and rehabilitation services to patients for as long as they were needed. The implementation of the CoC meant that patients had to learn how to navigate a complicated network of practitioners to receive the services they required across all areas of life. However, the continuity of services, especially in the early days of the implementation process, became challenging for service providers and patients (Pratt et al., 2014).

For instance, the community-based network could include partial hospitalization services, food, clothing, medical care, welfare and disability services, medication, housing, and vocational services, all from different providers at different locations. Service providers presumed clients would access supportive services, such as housing from another agency, when none of the agencies involved ensured coordination of housing placements. The lack of or poor communication between providers resulted in fragmented services in which participants went missing.

To address this issue, Congress passed the PL 99-660 of 1973, also known as the Comprehensive Mental Health Services Act. This legislation obliges states to develop plans to provide community-based services for people with psychiatric disabilities, especially case management services. Case management services were included to ensure continuity, efficiency, and effectiveness of the service plan developed for each person. Case management became one of the key elements in the Linear Residential Treatment System of care for homeless individuals with psychiatric disabilities (Pratt et al., 2014).

Linear Residential Treatment System

The Linear Residential Treatment System (LRT) of care emerged during the 1980s to provide services to the increasing number of people experiencing homelessness and other related problems such as the symptomology of mental illness and addiction (Tsemberis, 2010b). The objective of this intervention strategy is to move the participants through a series of progressive levels of services within a continuum of care (CoC), from outreach programs to temporary housing, and eventually, an appropriate permanent housing facility (Tsemberis & Eisenberg, 2000). As previously mentioned, for authors like Tsemberis (2010b), the LRT is almost synonymous with the CoC because it was the standard approach when working with chronically homeless communities within the US.

There are three significant steps or phases in the LRT process integrated into a one-stop structure of services. In the first step, the outreach teams identify potential participants and refer them to transitional housing settings such as drop-in centers, transitional housing, or shelters. The temporary housing accommodations allow the staff members to assist the participants in processing any legal documentation they may need to access the different services available within the CoC. This period of temporary housing services can range from six to 24 months (Tsemberis, 2010a). During that time, service providers also assist participants with access to mental health treatments and substance use programs as needed (Tsemberis & Eisenberg, 2000). In the second step, the goal is to help people meet the requirements to qualify for permanent supported housing (PSH). Consequently, service professionals in charge of coordinating the mental health and substance use programs also monitor each participant's progress to ensure adherence to one or both programs as needed. To remain active within the LRT model, the client

needs to achieve and maintain sobriety and demonstrate adherence to treatment of any mental health condition he or she might have (Tsemberis, 2010a).

The third and final step begins after participants' conditions are stabilized and they demonstrate compliance with the housing program's regulations. During the third stage, staff members refer participants to a permanently supported housing program. The service provider in charge of the process selects the living facility that best suits the participant's needs. The alternatives include various congregated or supervised living arrangements scattered around the city, such as single-room unit studios, group homes, and community residencies (Tsemberis, 2010a). Some facilities incorporate supportive services on-site, while others rely on the services within the community. The service provider chooses the type of living arrangements, depending on his or her assessment of the participant's ability to achieve independent living and the needs he or she may present (Tsemberis, 2010a). The one-stop structure of the services, although convenient, can also be a source of concern for the participant. If they experience a relapse in their condition, they may be relocated to a closely supervised housing facility or lose the services altogether. The participant has the option to request re-admission into an LRT program; however, they must start the process as a new case (Tsemberis, 2010a).

Although the LRT model has been successful among participants who can comply with the program's eligibility criteria, it has also encountered challenges along the way. For instance, because of the functional limitations resulting from their condition, professionals find it very problematic to work with chronically homeless individuals who also struggle with mental illness (Tsemberis, 2010a). In many instances, professionals are unable to persuade the hard-to-place participants who decline to take part in the CoC or to accept services. From the participant's perspective, the mental health system and related supportive services are a source of frustration

and disenchantment due to its inability to satisfy their needs and the multiple restrictions and program requirements. According to Tsemberis (2000), the perceived priorities and needs of the homeless population differ from those of the service providers. For professionals, stabilizing the persons' mental illness and substance use problems are a priority to ensure successful future outcomes for independent living. Conversely, for the participants, finding a safe and secure place to live surpasses any other problem they may have (Tsemberis & Eisenberg, 2000). Despite the differences between clinicians and clients, the LRT is still the most commonly used program to address homelessness in the country (Tsemberis, 2010a).

Pathways Housing First Model

One of the evidence-based practices endorsed by SAMSHA to deal with the homelessness phenomenon is the Pathways Housing First Model (SAMSHA, 2016b). Sam Tsembris first introduced this approach to service in the 1980s in New York City. The HFM presumes that individuals experiencing homelessness can achieve a recovery on their terms. This approach to services offers treatment with humanity and dignity to people experiencing homelessness, translating into the first steps toward recovery (Tsemberis, 2010). The rationale behind the program is straightforward: individuals have better opportunities to overcome health-related or substance use problems if they have a safe and permanent place to live (Stefancic & Tsemberis, 2007). Likewise, having a home opens up new possibilities for supportive services, for which they would not be eligible otherwise.

Studies show that the HFM model is a practical, fruitful, and cost-effective intervention strategy when working with chronically homeless persons (Stefancic & Tsemberis, 2007).

Overall, participants in a housing-first program have been more successful in adherence to treatment for substance use and mental health disorders than individuals who have received treatment first (Stefancic & Tsemberis, 2007). Over time, statistics show that they also have fewer hospitalizations, are more engaged with and integrated into their community, and possess greater capability to manage their conditions (Tsemberis, 2010b).

The population. The Pathway Housing First approach is designed to provide support to the most vulnerable populations: individuals experiencing chronic homelessness, psychiatric disabilities, other types of disabling conditions, and substance use issues (Tsemberis, 2010b). For decades, socioeconomic factors —such as the lack of affordable housing, unemployment, and especially poverty— have perpetuated the homelessness phenomenon across the US (Padgett et al., 2016). The lack of economic resources and the unsteadiness of a home become risk factors for present health concerns among homeless people, not adequately addressed through the system's channels. For example, homeless individuals do not receive adequate treatment for health problems such as heart disease, diabetes, fungal infections, hepatitis c, HIV, and other chronic illnesses (Pratt et al., 2014). The stability of a home facilitates the process of addressing the health concerns the person may have. Chronically homeless persons may also have a history of legal problems that may include those with outstanding warrants, people with court-ordered treatment, or individuals who have been in prison for prolonged periods due to the behavioral problems associated with their conditions. Contrary to traditional programs, the HFM provides the support participants need to handle and resolve these issues without the risk of losing their housing services (Tsemberis, 2010b).

The principles. Above all, the foundation of the HFM model is the belief that housing is a fundamental human right and individuals can define their goals for treatment and life despite their condition (Tsemberis, 2010b). The program's philosophy states that all clients deserve respect, warmth, and compassion regardless of their condition or circumstances. Additionally, the program and staff commit to providing support for as long as the client needs it. In this model, it is fundamental that housing and clinical services are independent of each other. The clinical treatment does not interfere with the housing services and vice-versa. The HFM focuses on a recovery orientation, accepting clients as they are and without judgment and promoting a person-centered approach whereby the client has the right to and responsibility of self-determination.

Furthermore, it includes a harm-reduction approach to treatment as a key component of the model. The HFM defines harm reduction as interventions that diminish the negative consequences of behaviors related to untreated mental health conditions or drug and alcohol abuse that may be harmful to the client (Tsemberis, 2010b). In the broader sense, the program seeks to place individuals in independent apartments using a scattered-site housing model to integrate the participants into the community (Tsemberis, 2010b).

Objectives. The purpose of the HFM model is to aid clients with disabilities who have been living on the streets for extended periods, to seek and retain permanent housing regardless of their current conditions or situations. Once the client is in a safe and secure environment, the program staff focuses on helping to resolve any issues the client may have (Tsemberis, 2010b). The way the client addresses the problems or situations reflects their priorities. The goal of the rehabilitation process is to promote the client’s ability to take charge of their lives to a point when they no longer need support. The services related to housing arrangement could involve

aiding clients to develop independent living skills that will help them retain their respective homes, manage their condition, keep a budget, or achieve sobriety. It could also mean reestablishing family relationships, seeking employment or training, and so forth (Tsemberis, 2010b).

However, this approach does require two basic preconditions to the program, and which are essential to the process. First, the person who joins the program must agree to pay30 % of their rent, usually through Social Security or Disability Benefits. Additionally, the participant must agree to weekly home visits from the program staff (Tsemberis, 2010b).

HFM strategies: ACT and ICM intervention team. The HFM has two intervention or response teams whose main objective is to support the person transitioning from homelessness to permanent housing. In both cases, the intervention teams use a model of their own, but that is compatible with the HFM model of service. One such model is the Assertive Community Treatment (ACT) team, a community-based mental health program for treating persons with severe mental health disorders (Tsemberis, 2010b). The ACT model contains interdisciplinary professionals who provide clinical support to individuals in the community setting. The model originated in the 1970s in Madison, Wisconsin, as the Training in Community Living program, also known as the "hospital without walls." Founded by Leonard Stein, MD, Mary Ann Test, Ph.D., and Arnold Marx, MD, the model accumulated a considerable body of evidence that attests to the effectiveness and success of the approach with clients with similar needs as the ones present in the homeless population. The approach aims to provide clinical services in the client's natural environments.

Currently, the ACT model within the HFM approach includes a specialist in substance use, supported employment, family system treatment, wellness management recovery, and a peer

specialist. As part of the team, the interdisciplinary group has a part-time psychiatrist and a physician or a nurse practitioner. Additional service providers include peer specialists (current or past mental health clients themselves), occupational therapists, or housing specialists. The team's composition may vary across programs, depending on the specific needs of the community they serve (Tsemberis, 2010b). The ACT team relies on a person-centered and recovery-oriented approach that actively engages the client in his or her recovery process (Tsemberis, 2010b).

Although each professional develops the plan in conjunction with the client, the responsibility of the process depends on the team; in other words, it is a shared responsibility. Therefore, the team holds daily and weekly meetings with all the staff members to ensure that the professionals involved are up to date and engaged in the rehabilitation process. Case discussions revolve around adjusting the intervention plans to meet the client's needs or to provide additional support to a specific client.

The ACT team is not involved in the housing process (i.e., issues related to maintenance of the home, communication with the property owner, lease, or rent issues). Although the support provided by the ACT team contributes to a client's ability to maintain his or her permanent home, the housing services are not dependent on adherence to the clinical treatment. As a result, clients will not lose their services due to relapses in their condition, as is the case with the traditional or treatment first type of interventions (Tsemberis, 2010b).

The second model component of service used in the HFM model is the Intensive Case Management Team (ICM). The ICM team rests upon six fundamental principles outlined in the Strengths Model of Service Delivery developed by Dr. Charles Rapp (Tsemberis, 2010b). Those principles, as stated in the ICM, are as follows:

1. Individuals with “psychiatric disabilities can recover, reclaim, and transform their lives” (Tsemberis, 2010b, p.130).
2. The focus of the intervention should be on the strengths of the person.
3. Participants should perceive the surrounding community as “an oasis of resources” (Tsemberis, 2010b, p.130) that aids the process, not an obstacle.
4. The client drives the helping process.
5. The relationship between the case manager and the client is “primary and essential” (Tsemberis, 2010b, p.130) to the process.
6. The community is the core and central work location during the recovery process.

The ICM team utilizes the available resources in the environment to fully support the client during the process. The external resources include family members, neighbors, local businesses, other community members, and available public and private services. The intensive case manager’s task is to identify, contact, coordinate, and refer services within the clients’ community. Offered services may include crisis intervention, treatment programs for mental health or substance use (or both at the same time), and medical care. The ICM team also manages and makes possible the person’s transition process from a homelessness scenario to a home (Tsemberis, 2010b).

As intensive case managers, the ICM team is responsible for all the administrative aspects of the programs. Contrary to the ACT team members, each member of the ICM team is responsible for his or her caseload (Tsemberis, 2010b). The teams’ tasks include helping the client apply for benefits, find a home, deal with lease contracts and property owners, and buy furniture, among other activities. The ICM team continues to provide support through the clinical

interventions until the client's condition is stable and they are discharged from the clinical services.

Intensive case management and clinical services are ongoing for as long as the client needs the support. If the client should experience a relapse, the ICM refers to the ACT team for services. A client "graduates" (is discharged) from the program when they can manage their condition and live independently without the intensive support of the HFM staff. In such cases, the HFM support services are discontinued, or clients continue to receive less-intensive services within the community-based network put in place by the ICM. The goal of the ACT and ICM teams is to help clients graduate from services. Nonetheless, if the person needs support at any given time, the program will provide the necessary services. Although both teams deal with tasks related to the rehabilitation counseling field, the present study will focus on the clinical work performed by the ACT team in the recovery process of the chronically homeless individual (Tsemberis, 2010b).

Outcomes of the HFM Model. Today, the HFM Model is considered by SAMHSA (2016c) as an evidence-based practice to reduce chronic homelessness in individuals with a disability, either mental health or physical, and substance dependency problems (Henry et al., 2013). In essence, its core value and philosophy have become the standard practice for many organizations and agencies in the US and abroad. However, practitioners who are used to the LRT model may not be entirely on board with the transition to a HFM model's client-centered approach such as HFM (Henwood et al., 2013).

The Professional's Views About HFM

Since the 1980s, the US federal and state governments have slowly incorporated evidence-based practices into the public policy-making process as they seek solutions to the nation's social problems (Stanhope & Dunn, 2011). The use of evidence-based practices responded to two main factors. First, there was an increased demand from funders to hold programs accountable for the outcomes of their initiatives and the responsible use of resources. Second, evidence-based practices serve as an assessment tool to identify problems in concrete, measurable terms to enhance or further develop areas in need of improvement. However, one criticism holds that addressing social issues in a business-like manner may minimize or oversimplify social problems reducing human nature and its social context to measurable outcomes of "productivity and efficiency" (Stanhope & Dunn, 2011, p. 277). Furthermore, developing public policy based on measurable outcomes also means making the social and humanistic values of social programs subordinate to the demands of the agencies funding said programs (Stanhope & Dunn, 2011).

Nevertheless, some programs had managed to balance productivity and efficiency by successfully maintaining their core values and philosophy and infusing them into public policy. The Pathways Housing First program is one example of such a program (Stanhope & Dunn, 2011). Since the 1990s, Tsemberis and Eisenberg (2000) demonstrated the effectiveness of the HFM approach to deal with the needs of chronically homeless individuals. To do so, Tsemberis and Eisenberg compared housing between a sample of 242 participants in a HFM supported housing program and a sample of 1,600 people served by traditional programs in New York City from 1993 to 1997. Participants in the traditional sample received services within the CoC

following the LRT approach, where compliance with treatment determined the transitional housing services.

On the other hand, the priority of the HFM programs was to obtain housing for their participants while at the same time providing supportive services such as the intervention of a modified ACT team. Results showed that 88% of the participants from the HFM model remained housed after five years, compared to 47% of the participants in the LRT approach (Tsemberis & Eisenberg, 2000). The findings of this study debunk the general assumption that treatment guided by the clinical experts only is the best strategy to treat and house chronically homeless individuals.

Resistance to the implementation of HFM. Although evidence-based studies facilitated the inclusion of the HFM Model into the public policy-making process, it faced resistance from advocates of the LRT model (Tsemberis et al., 2004). In the early days, detractors of the HFM model expressed concern about the rapid dissemination of the model without having enough evidence to support its effectiveness. For more traditional service providers, the idea of housing a non-stable person represents a departure from their practice and core beliefs. Overall, LRT service providers understand that individuals with mental illness and substance use issues need to be stable in their condition before they are placed in permanent housing.

Tsemberis et al. (2004) examined the effectiveness of the HFM programs in chronically homeless individuals with mental illness. They assessed five core areas: (1) consumer choice over time, (2) homelessness rates and residential stability among participants, (3) substance use rates, (4) participation in substance use treatment, and (5) the presence of psychiatric symptoms. Researchers interviewed 225 participants every six months over two years. The interviews consisted of a modified Consumer Choice Scale, developed by Srebnik, Livingston, Gordon, and

King (1995), to establish a baseline for each participant—reflecting the importance of having choices— and to identify an actual number of alternatives available to clients.

The interviews also included two calendars. One to register the number of times individuals were homeless, and the other to record the number of times people used substances and participated in drug addiction treatment programs. The hypothesis for the study stated that participants in the HFM programs (i.e., the experimental group) would exhibit higher client preference over time, experience fewer episodes of homelessness, and maintain greater tenancy stability. The hypothesis also proposed that levels of substance use and the presence of psychiatric symptoms would be the same or lower than in the control group (LRT), while at the same time expecting the control group would report higher participation in substance use treatment programs. As expected, HFM participants were more involved due in part to having the opportunity to make their own choices during the rehabilitation process.

Regarding housing, the HFM program achieved an approximately 80% retention rate over time. Results also showed no significant differences in drug and alcohol use levels between groups, even though the control group reported higher usage of treatment services. For the authors, the inconsistency between the reported drug and alcohol use and received treatment suggests that clients in the control group were using treatment facilities as temporary housing as an alternative to being homeless (Tsemberis et al., 2004). Subsequent studies in the US and Canada reported similar levels of success when targeting homeless populations from diverse ethnic backgrounds, especially when programs combine the principles of the HFM model within an anti-racism/anti-oppression framework (Stergiopoulos et al., 2012).

In a recent study, Nelson and colleagues (2015) compared the life changes experienced by homeless individuals enrolled in HFM and LRT programs throughout Canada. This

qualitative study consisted of semi-structured interviews conducted in October 2009 and June 2013. The first interview helped establish a baseline, focused on describing life before receiving treatment. Eighteen months later, the research team conducted the second interview, focusing on changes in 13 life domains, ranging from life changes, a typical day, a day at work, and education to finances, medical and mental health, substance use, and services, among others. Participants reported their experiences as positive, mixed, neutral, or as adverse. Researchers interviewed 219 participants at the baseline, assigned at random to HFM and LRT or treatment-as-usual, to programs in five different cities across Canada. In the follow-up interview, 197 participants (119 from HFM and 78 from LRT programs) completed the process (22 of the participants interviewed at baseline were unreachable, declined to participate, or died during the process) (Nelson et al., 2015).

Study results showed that the number of participants enrolled in HFM programs who reported positive life changes was more than double (61%) of that reported for LRT participants (28%). Factors associated with the positive changes in HFM participants included housing quality, ongoing social and service support, and more control of substance use. The negative life changes reported by participants in the LRT programs were associated with social isolation and hopelessness, unfit housing arrangements, and drug or alcohol abuse (Nelson et al., 2015).

Implementing Pathways Housing First

The HFM model is an effective approach to ending homelessness due to its core principles, beliefs, and values, which place participants at the center of the rehabilitation process by giving them a voice. However, not all the programs that adopt an HFM approach to service

incorporate all the model's key elements. Existing literature identifies some reasons service providers may not evidence a high degree of fidelity to the HFM model during implementation and adaptation phases (Macnaughton et al., 2015). First, disseminating accurate and complete information about the HFM program may not be as efficient as the program itself; therefore, its core values and intervention processes may fail to become an integral part of a new program. Second, the lack of information may limit the evaluation of outcomes and the program's longevity. Moreover, the lack of assessment during the first stages of the enactment phase may yield results that do not correspond with the original intent or strategies developed for a particular approach. Finally, the applicability of some of the intervention strategies may not be possible due to socio-political or economic factors not considered in the original program model (Durlak & DuPre, 2008).

Although the HFM model may not adapt to a specific context or the needs of a diverse population, the core values and philosophies should remain the same. To help programs implement, replicate, and change the HFM model, Stefancic et al. (2013) developed the HFM Fidelity Scale to assess the dissimilarities among service providers. The Fidelity Scale allows researchers to determine how closely to the original program the core values, beliefs, philosophies, and delivery of services remain. The purpose of the scale is to provide a tool to complement the Housing First manual (Tsemberis, 2010b) and provide technical support to the new program.

To develop and validate the Fidelity Scale, the authors divided the process into two phases. Phase I consisted of identifying the general key elements of a Housing First approach. In contrast, Phase II aimed to develop an assessment instrument (i.e., the Fidelity Scale) and test it in the field. During Phase I, the authors identified possible key elements by reviewing the

available literature and research related to the HFM model (Stefancic et al., 2013). The research team also reviewed items included in other fidelity scales for HFM and interviews with experts in the field who also produced a list based on their experiences with the model. The researchers identified a total of 38 essential elements or items and divided them into five categories: (1) housing choice and structure, (2) separation of housing and treatment, (3) service philosophy, (4) service array, and (5) program structure. Each category corresponds to the core values of the HFM approach. Different service providers familiar with the HFM rank each item using a five-point Likert-type scale according to the order of importance attributed to each item. In other words, higher ratings mean a greater level of relevance or correspondence with the HFM model.

The second phase consisted of developing and testing the final version of the Fidelity Scale. A panel of experts reviewed the results of the initial evaluation, modified and reworded the items, and added items when necessary, through a consensus based on the principles of the model. The modifications included adapting some of the statements to evaluate the ACT team services (as initially intended) and the ICM services. Two subsequent studies included Fidelity Scales in their design and pilot tested the scale. The first pilot test was in Canada at an agency that follows a HFM program and later in California for programs that did not develop a clear-cut HFM approach (Stefancic et al., 2013).

The results showed that 32 items of the overall scale of the Housing First Fidelity Scale had acceptable to good internal consistency and internal validity. The Cronbach alphas were as follow: housing choice and structure = .80, separation of housing and treatment = .83, service philosophy =.92, and service array = .71. The last domain is not a uniform scale and was excluded from the analysis for internal consistency. Therefore, the Fidelity Scale can be a useful tool to assess the effectiveness of the interventions in a new program over time. The scale can

also be helpful during the implementation phase to evaluate changes needed to adapt to the different cultural contexts and existing resources in the community. It may also be a tool to assess the quality of services for professionals involved in the process (Macnaughton et al., 2015; Stefancic et al., 2013).

Views Held by Service Providers of the HFM Model. The staff involved in the process is as important as the clients themselves to implementing the HFM (Tsemberis, 2010b). Two of the principles of the program correspond to characteristics directly related to the staff: to have "respect, warmth, and compassion" and "commitment to work" (Tsemberis, 2010b, p.18) with the homeless population for as long as necessary. For the author, the "beliefs, values, and principles and how they govern the HFM approach" (p.18) should be thought of as "the program equivalent" of unconditional love or the principle of positive regard found in the Person Center Therapeutic approach of Carl Rogers (Tsemberis, 2010b, p.18). For the staff to be effective, they need to convey to the participant honesty and positive regard, especially through how they behave and deliver services (Meschede, 2011; Tsemberis, 2010b). Therefore, it is important to consider during the hiring process if candidates for staff positions support the HFM model philosophy.

The Face of Homelessness in Puerto Rico

In Puerto Rico, homelessness has become a social phenomenon and a source of concern for government officials and community-based organizations (Nina & Ostolaza, 2013). As a public health issue, different agencies focus on developing strategies to help people overcome obstacles and facilitate their social integration into the community. Overcoming those hurdles includes eliminating barriers preventing homeless individuals' access to physical health and

mental health services, along with substance use and rehabilitation services (Vélez Almodóvar et al., 2013).

Point-in-Time Counts

Each year, the HUD estimates the number of homeless individuals in the US and its territories through a Point-in-time (PIT) count. In the case of Puerto Rico, it conducts the PIT count every two years. The official numbers ranged from 4,309 homeless individuals in 2007 to 4,518 in 2015. The PIT count of 2011 registered 2,900 homeless individuals on a single night, the lowest number registered in Puerto Rico over two years (Puerto Rico Department of Family Affairs, 2015). On July 10th, 2017, the results for the PIT count registered 3,501 homeless individuals on a single night, 1,017 individuals less than in 2015. Although the decrease in the homeless population, specifically among veterans, could be attributed to intervention programs such as housing first, changes in the methodology of the 2017 PIT count, as well as demographic changes due to massive migration to the US mainland, could explain the obtained numbers (Puerto Rico Department of Family Affairs, 2017). By 2019, the number of estimated homeless individuals was 2,535 people where 27% reported chronic patterns of homelessness (Puerto Rico Department of Family Affairs, 2020).

The Puerto Rican PIT count of 2013 gathered additional information related to the general health profile of the local homeless population (Vélez Almodóvar et al., 2013). That year, the "Coalición de Coaliciones," in conjunction with the Public Health Program at the Ponce School of Medicine & Health Services (PSMHS), conducted the count for HUD. "Coalición de Coaliciones" is a non-profit organization created to support the homeless population on the

island. The organization facilitated the CoC (CoC PR 503) in the south/southeastern part of Puerto Rico. The count included two additional questionnaires. The first one, a Vulnerability Index, screens individuals according to the chronicity of their health. The Index helps to prioritize housing services for individuals depending on the fragility of their health. The second instrument is a health questionnaire to collect socio-demographic information and health-related questions to describe health and disability issues, habits, medical problems, and needs for the population's services.

Due to technical difficulties, the Puerto Rican PIT took place on February 25 instead of January. Regardless, the added questionnaires helped draw a more comprehensive picture of the island's homeless population. The subsequent analysis of the information showed a relationship between homelessness and socio-environmental problems such as addiction, low levels of education, mental health disorders, insufficient economic resources, or unemployment (Vélez Almodóvar et al., 2013).

Characteristics of the homeless population in Puerto Rico. The 2013 PIT counted 2,034 homeless individuals on that single night in February. The survey results showed that three-thirds of the homeless interviewed were male, with an average age of 47. The primary source of income for 36.3% of those sampled was food stamps, followed by informal work: 24.0 %. A total of 55.6% of the homeless individuals reported having public health insurance. The most reported health conditions were depression (31.3%), hypertension (24.2%), liver problems (19.6%), respiratory problems (16.2%), and hepatitis c (15.2%) (Vélez Almodóvar et al., 2013). In addition to physical health issues, the average homeless person also reported experiencing substance use or alcohol problems (49.6%) and having received mental health treatment (23.4%) or related services at some point in their lives.

The Vulnerability Index included in the PIT count helped determine vulnerabilities of the homeless population on the island. More specifically, the index may help to indicate the probability of any given individual dying while living homeless on any given day (Vélez Almodóvar et al., 2013). The index showed that 59.8% of the homeless population in Puerto Rico falls into the category of "vulnerable." Of those, 42.1% reported tri-morbidity: having dual-diagnosis of psychiatric disorders with substance use disorder and chronic illness. About 3.5% of individuals reported having had three hospitalizations or more in the previous year, including emergency room visits. Furthermore, 7.5% reported having more than three emergency room visits in the last three months before the interview (Vélez Almodóvar et al., 2013).

According to the index, the average amount of time a person experiences homelessness in Puerto Rico is 7.19 years. However, 25% of the vulnerable population expressed being homeless for more than nine years (Vélez Almodóvar et al., 2013). Simply put, more than half of the homeless population on the island fell into the criteria for chronically homeless individuals. In other words, were individuals with disabilities, who have been continuously homeless for a year, or have experienced four homelessness episodes in the past three years (Henry et al., 2020; United States Interagency Council on Homelessness, 2015).

In 2015, Puerto Rico was among the HUD regions that submitted and was granted a proposal to start implementing a HFM Model to eradicate homelessness on the island (SAMHSA, 2016a). The change in approach represents a radical departure from the LRT in that housing services are not dependent on the person's sobriety or commitment to a mental health treatment (Stefancic & Tsemberis, 2007; Tsemberis, 2013). It also represents a profound change in perspective for the agencies and the personnel involved in the process (Henwood et al., 2013).

Rehabilitation Counseling Field

Rehabilitation counseling is one of the many fields involved in an individual's rehabilitation process (Maki, 2012). Each specialty area (e.g., physicians, psychologists, social workers) work toward preventing the occurrence of disability from different perspectives and at different stages. Hershenson (as cited by Maki, 2012) categorized disability prevention into three types: primary, secondary, and tertiary.

Primary prevention refers to any steps taken to prevent the onset of the disability. The professionals involved in the intervention process typically focus on environmental factors that may impact individuals' health. These professionals usually belong to health-related fields such as public health and occupational health and safety. Secondary prevention focuses on providing individuals the necessary services to prevent or limit the impact of disability through curative interventions (e.g., physicians, psychologists).

Finally, tertiary prevention aims to prevent the worsening of effects that limit the individual's functioning over time. Therefore, interventions focus on the individual characteristics that may limit the person's functionality and the environmental barriers preventing them from thoroughly engaging in different social environments. The rehabilitation counseling professionals are among the professionals who typically provide tertiary services to the population with disabilities (Maki, 2012).

The Evolution of the Rehabilitation Counseling Field

Nearly a century ago, the federal government approved the Smith-Fees Act of 1920, establishing state-federate rehabilitation programs in the US (Leahy, 2017). This legislation also

mandated establishing a specific work role for rehabilitation counselors (RCs) as the professionals responsible for providing services to the population with disabilities throughout the rehabilitation process. Since then, the rehabilitation counseling field has evolved into a discipline area within the counseling field characterized by a unique skill set and knowledge about disability and its impact on the person living with the disability.

In the 1950s, changes in federal legislation set the foundation to further the professionalization of the field. The 1954 Vocational Rehabilitation Act Amendments provided grants, among other things, to promote the development of master' level programs for rehabilitation counseling across the country. Faculty members from counseling and psychology programs and directors of state vocational rehabilitation agencies designed the curriculum for the new academic programs. The programs focused on 24 areas of knowledge and skill development still included in current professional standards, such as medical and psychosocial aspects of disability, legislation, assessment, case management, and counseling skills in vocational and psychosocial adjustment (Sales, 2012). These tools and skills allow RCs to provide comprehensive services to help consumers achieve their vocational and independent living goals (Leahy, 2017).

Although early educators and leaders within the rehabilitation counseling field agreed on areas of knowledge and skill set, they disagreed on the philosophies revolving around the role of the RC during the rehabilitation process. Two main philosophies stood out. On the one hand, professionals perceived the RC's role as coordinators instead of counselors due to the rehabilitation-oriented tasks associated with the role (Sales, 2012). On the other hand, professionals argued that counseling was, in fact, a necessity within the rehabilitation process, as

RCs “facilitate consumers’ self-responsibility so that they can develop their vocational plans” (Sales, 2012, p.47).

Over time, broader and more inclusive definitions of the role of RCs emerged as the functions related to the role expanded to meet the client’s needs. Educators and researchers alike started to identify the everyday tasks associated with the RCs’ role across work scenarios. For example, in the 1960s, a survey identified counseling and guidance tasks and face-to-face consumer contact as the job-related activities the RCs spend most time performing (Sales, 2012). Similarly, surveys conducted during the 1980s identified tasks such as personal adjustment counseling and vocational counseling as additional significant activities related to the RCs’ role. The scales on the debate regarding the role of the RC —coordinators vs. counselors— tilted in favor of the RCs’ role as counselors. Research studies conducted in the 1990s recorded the effectiveness of master’s level RCs as service providers for the population with disabilities. In other words, studies showed that these certified rehabilitation professionals were more effective in assisting consumers in obtaining employment or independence goals (Sales, 2012).

This evidence prompted professional associations and the disability community to advocate for the inclusion of higher standards when hiring rehabilitation professionals across the state-federal vocational rehabilitation system. As a result, the Rehabilitation Act 1992 Amendments (PL 102-569) included language requiring the state-federal rehabilitation programs to recruit master’s level RCs who meet the national certification standards for the field (Sales, 2012).

The Scope of Practice. Today, the concept of rehabilitation refers to a series of “holistic and integrated programs of medical, physical, psychosocial and vocational interventions” (Maki, 2012, p.84) geared toward empowering individuals with disabilities to attain fulfilling and

meaningful lives in all areas: personal, social, and work environments (Maki, 2012). Thus, interventions within the rehabilitation counseling field seek to help individuals with a disability adapt to their environment and to assist the environment in meeting the needs of individuals with a disability, allowing them to function within said environments (Maki, 2012).

The Commission on Rehabilitation Counselor Certification (CRCC) was, and still is, the leading organization for RCs in the US and abroad. In 1994, the CRCC developed a scope of practice statement that contributed to professionalizing the discipline across all practice settings. Adopting the CRCC's scope of practice statement set the standard of practice for most regulatory organisms, professional organizations, and educational programs within the rehabilitation counseling field (Leahy, 2017). The CRCC's statement defines the practice as follows:

> Rehabilitation counseling is a systematic process that assists people with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions. (CRCC, 1994, p. 1)

Although most RCs practice within public, private, or not-for-profit rehabilitation programs, the field has expanded to include additional work scenarios such as independent living services, employee assistance programs, hospitals, clinics, mental health organizations, public school transition programs, and management programs to name a few (Leahy, 2017). Therefore, the type of services available to consumers and the skills and competency areas required for each

program vary across work scenarios. Additional to the general practice, RCs could tailor their practice to a role or task. For example, RCs may have specialized knowledge on disability groups (e.g., blind or substance abuse), focus their practice on one function (e.g., assessment), or take on the role of supervisor or management functions (Leahy, 2017).

However, as RCs, every professional must develop a specific skill set (Leahy, 2017). Thus, the scope of practice statement also lists the tools of the trade as follow:

> The specific techniques and modalities utilized within this rehabilitation counseling process may include, but are not limited to:
>
> assessment and appraisal; diagnosis and treatment planning; career (vocational) counseling; individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability; case management; referral, and service coordination; program evaluation and research; interventions to remove environmental, employment, and attitudinal barriers; consultation services among multiple parties and regulatory systems; job analysis, job development, and placement services, including assistance with employment and job accommodations; and the provision of consultation about, and access to, rehabilitation technology (CRCC , 2017, p. 1).

All master's level RCs from accredited programs comply with said competency areas. As qualified professionals, master's level rehabilitation counselors consistently obtained better outcomes with clients with severe disabilities and perceived themselves as better prepared than professionals in related fields (Leahy, 2017).

Rehabilitation Counseling in Puerto Rico.

The evolution of the rehabilitation counseling field in the island reflects, for the most part, the legislative movement at the federal level. Consequently, the federal legislation that created the vocational rehabilitation programs and established the practice of the RC in the 1920s in the US mainland was extended to include Puerto Rico in the 1930s (Villafañe Santiago et al., 2013). In 1936, the local government created the Division of Vocational Rehabilitation, ascribed to the Department of Instruction (now the Department of Education). The division oversaw the implementation of all federal legislation related to the Rehabilitation Services Administration and the population with disabilities on the island. By default, it also established the rehabilitation counseling practice and the basis for the rehabilitation counseling professional in Puerto Rico (Villafañe Santiago et al., 2013).

In 1959, Puerto Rico did not have any educational degrees to train rehabilitation counseling professionals. To meet the professional needs of the agency, the Division of Vocational Rehabilitation enlisted the University of Puerto Rico in Rio Piedras to create a professional certification in rehabilitation counseling (Villafañe Santiago et al., 2013). Eventually, graduates from the certificate enrolled in rehabilitation counseling programs in the US to finish their master's degree through private and public funding. Eventually, in 1972, the University of Puerto Rico implemented the first master's level program in rehabilitation counseling in the island, consisting of 55 credit units and accredited by the Council on Rehabilitation Education (CORE). The creation of the new program allowed the growth of the rehabilitation counseling field on the island. It prompted, among other things, the establishment of a local Review Board to regulate the practice, the adoption of a local rehabilitation counseling state license and code of ethics, as well as local professional organizations. The field in the island

reflected the core values and principles of the CRCC Code of Ethics and its scope of practice, including the six principles of ethical behavior: autonomy, fidelity, beneficence, justice, nonmaleficence, and veracity (Villafañe Santiago et al., 2013).

Theoretical Framework

Biopsychological Model of Health

Mainstream ideas about disability, its origin, meaning, and implications in terms of the interactions people with disabilities have with the world around them have evolved (McCarthy, 2018). These changes in perception have also led to changes in the way professionals, agencies, organizations, and society address the needs of people with disabilities or disabilities at any given time. Traditional models of disability have ranged from the Moral model, driven by cultural and religious believes in which disability could be either a gift from God or a curse, to modern conceptualizations of disability that embrace differences through a Disability Culture model. Nonetheless, in the 20th century, the biomedical approach to illness was the mainstream approach to illness and disability, and it relied solely on the empirical-analytic approach to treatment (Borrel-Carrió et al., 2004). At the time, the biological or medical information gathered through tests and observations was the main element used to establish the relationship between the cause and its effects (i.e., illness and symptoms). In the medical and clinical fields, the human being was considered subject for study by experts who knew best about treatment options. Furthermore, the patient was a passive participant, having little or no control over the treatment conducted by the medical staff.

In contrast, the Social Model and the Biopsychosocial Model of Health argued that the individual's context was as important as the illness itself. Furthermore, in the biopsychosocial model, the biological, psychological, and social circumstances played a significant role during the treatment process. This conceptualization of disability proposed by researchers like Engel and Bronfenbrenner meant a radical departure from the biomedical model, which dominated medical and clinical health interventions at the time. It implied changing the focus of the intervention from a biological perspective only to one of biology-in-context to expand experts' vision of the individual in the treatment process (Borrel-Carrió et al., 2004).

The biopsychosocial, also known as the ecological model, is a holistic approach for understanding illness and disability. The model assumes that all components are part of a system. Therefore, the personal characteristics, social context, culture, beliefs and spirituality, and biological and psychological factors influence one another, changing the person's experience about disability and illness (McCarthy, 2018).

The World Health Organization. The World Health Organization (WHO) took the model further by conceptualizing disability and illness as part of a continuum with personal and environmental variables within multiple dimensions (McCarthy, 2018). In the 1980s, the WHO (2001) created the International Classification of Functioning, Disability, and Health (ICF) to provide a common framework and language to describe "health and health-related components of well-being" (WHO, p. 3.). Although the ICF is a classification system of function, it also serves as a conceptual framework for health.

As a conceptual framework, the ICF describes the "interrelationships and associations between health conditions" (Escorpizo, p. 12) and their impact on a person's body functions and level of participation in social settings (Escorpizo, 2015; Peterson, et al., 2010). In other words, a

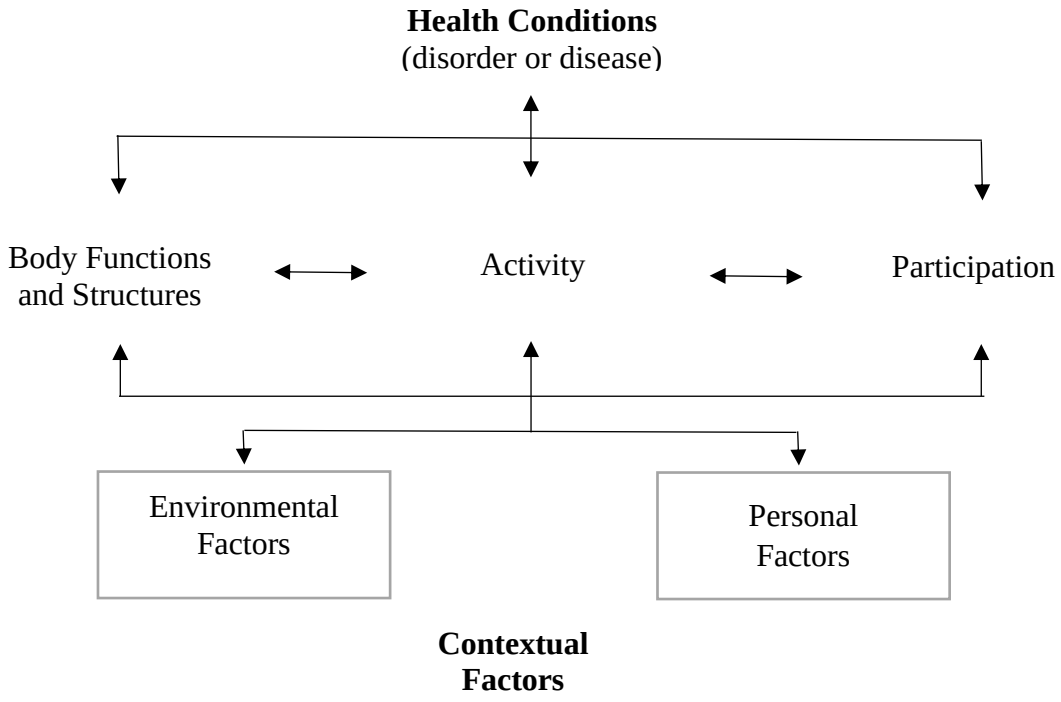
health condition could turn into a disability if one or more of the following conditions are present: (1) an impairment of the body structures and functions; (2) there is a limitation of activities because of the condition, and (3) it restricts the individual's participation in social environments. Contextual factors may influence these three areas: environmental and personal factors that could enhance or worsen the functional aspects of disability. For instance, lower levels of functioning and participation — due to a disease or personal and environmental factors— may result in higher levels of disability for the person who experiences them (Escorpizo, 2015). Figure 1 presents the structure and the interaction of each component of the ICF model (Peterson, 2015; WHO, 2002).

As a classification system, the ICF consists of two parts with two components each. Part 1, *functioning* and *disability* includes the components of (a) body functions and structures and (b) activities and participation (Escorpizo, 2015). In Part 2, the *contextual factors* include the (c) environmental factors and (d) personal factors (WHO, 2001). To describe the level of function and disability, the system relies on an alphanumeric code. The letters identify the components being assessed, and the numbers (or qualifiers) identify the severity or magnitude of impairment, the limitations of activities, and the restrictions in participation that may be present. They also describe the environmental barriers or facilitators to function a person may encounter daily (Escorpizo, 2015).

The ICF refers to each component (body structure or function, activities, and participation) as a chapter (e.g., respiratory system, mental function, applying knowledge, and civic life, respectively) to identify where and what type of limitation or restriction a person has. For this research, only the conceptual framework will be used to analyze the findings.

Figure 1.

The International Classification of Functioning, Disability, and Health (ICF) Model. (WHO, 2001)



CHAPTER III

METHODS

Overview of the Design

The purpose of this phenomenological study was to explore service provider's views, opinions, and experiences about the role of rehabilitation counselors (RCs) in housing programs for chronically homeless individuals and the process of implementing the Pathways Housing First model in Puerto Rico. The study focused on service providers' lived experience while working in housing programs servicing chronically homeless individuals and with rehabilitation counseling professionals.

A phenomenological study focuses on understanding a specific phenomenon or concept from the perspective of the individuals who lived through the experience (Creswell, 2013; Creswell & Creswell, 2018; Hernández-Sampieri & Mendoza Torres, 2018). In this type of methodology, researchers play a significant role in the process, as they become a tool for gathering information. The researcher reviewed documents, conducted interviews, and observed the participants in the natural settings where they experience the problem under study. Qualitative research aims to learn the meaning a situation or phenomenon has for a specific group of individuals without the researcher’s interpretation of the issue (Creswell & Creswell, 2018).

The study followed Moustakas' transcendental phenomenology designed to explore the essence of the experiences and views of service providers in three areas: (1) the role of the rehabilitation counselor in housing programs; (2) the chronically homeless population, and (3) the transition to a housing first model of service in Puerto Rico (Creswell & Creswell, 2018; Creswell, 2013). Moustakas' transcendental phenomenology focuses on exploring individuals' lived experiences about a specific phenomenon or concept. The researcher gathers and analyzes the information to explain the essence of human experience, using meaning or significance as its basic unit of analysis (Moerer-Urdahl & Creswell, 2004). The *transcendence* concept refers to acquiring a new perspective of things, requiring the researcher to "bracket him or herself out" or distance themselves to observe the phenomenon from the participant's perspective. In other words, the researcher describes the phenomenon through the participant's eyes, refraining from using his or her own experiences to provide meaning or interpret the issue at hand (Creswell, 2013).

The transcendental phenomenology design provided structure to analyze the information using three main components: the textual experiences, the structural experiences, and the essence of the experience (Moustakas, 1994; Creswell 2013). The *textual* experiences refer to the participant's description of their lived experiences with the phenomenon as these occur. The *structural* experiences denote the way participants experienced the phenomenon related to the context, condition, or situation in which said phenomenon took place. The results obtained were the phenomenon's universal *essence*: integrating the textual and structural experiences or describing the common elements of the experience as lived by the individuals involved.

This methodology responded to the study's purpose and the nature of the research problem at hand. First, since the transition from a traditional model to a housing first model

started five years later in Puerto Rico (i.e., in 2015), the available information about the process is limited. Furthermore, at the time of this study (2020), no published comprehensive studies depicted the implementation process of the HFM model for the Puerto Rican population. Similarly, there was limited information about how professionals in related fields perceived rehabilitation counselors' role when servicing homeless individuals, especially in Puerto Rico. According to Hernández-Sampieri and Mendoza Torres (2018), a qualitative research approach is a good alternative when the information available on a specific social group or topic is limited. In this context, the transcendental phenomenology design allowed obtaining information to explore the essence of service providers' experience regarding transitioning to a new intervention model, such as the HFM model, the role of RCs, and the homeless population in Puerto Rico.

The study relied on three data collection strategies: a qualitative interview with key informants identified within each selected organization in the two continuum of care systems. The second strategy was a document review process to identify the principles, core values, and philosophies of the HFM model and the rehabilitation counseling scope of practice in the selected organizations. The research also included administering a survey to describe the views and opinions of service providers about the rehabilitation counselors, the homeless population, and the housing first model. The survey served as a tool for triangulation to identify points of convergence between the key informants and other service providers within the same programs.

Analysis. The analysis relied on Harry Wolcott's method (2009) to identify categories or emerging themes from the information gathered through interviews and the document review process. Wolcott's method focuses on describing the information obtained from participants and the research process, analyzing the information to identify emerging themes, and interpreting it.

This dissertation includes an in-depth explanation of each component's purpose and usage in the data analysis section.

Focus of Research

This dissertation focused on exploring the views, opinions, and experiences of service providers regarding RC's role, the chronically homeless population, and the implementation process of the HFM model in Puerto Rico. The researcher explored the service provider's fieldwork experiences, professional perspectives, and personal viewpoints in three main areas: (1) the role of the rehabilitation counseling professional when working with the homeless population, (2) the service provider's experiences with homeless individuals and their needs for services, and (3) the professional's views about the HFM model and its implications for the agencies involved in the process, including those involved in shifting the programmatic philosophies and policies, administrative changes, intervention protocols, economic and human resources, and the role of the rehabilitation professional.

Research Questions

The research questions for the study are as follows:

1. What is the experience of the service provider (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) with rehabilitation counselors and their role within the intervention models for chronic homelessness population?

2. What is the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the chronically homeless population?
3. What is the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the Pathways Housing First approach to service?

Bracketing

In a qualitative study, the researcher becomes an instrument by observing, gathering, and interpreting the information participants contributed to the research process (Creswell, 2013). Thus, the researcher's main task was to explore and later interpret the interviewees' gathered experiences without conveying her ideas and experiences, without expecting to achieve absolute objectivity during the process (Creswell & Creswell, 2018). To increase awareness of the views and experiences and their impact on the research process, the researcher engaged in memo writing and journaling.

Trustworthiness Procedures

Authors such as Creswell and Creswell (2018) and Hernández-Sampieri and Mendoza Torres (2018) stress the importance of validating the findings in qualitative research to establish "trustworthiness, authenticity, and credibility" (Creswell & Creswell, 2018, p. 199). To assess the accuracy and neutrality in qualitative research, researchers focus on five main strategies: credibility, dependability, confirmability, authenticity, and transferability (Elo, et al., 2014; Cope, 2014; Shenton, 2004).

Credibility. In this type of research, credibility refers to the researcher's ability to reflect the "meaning and profound understanding" of the phenomenon from the participant's perspective (Hernández-Sampieri and Mendoza Torres, 2018, p. 504). To achieve trustworthiness, researchers need to show whether the findings are consistent or congruent with reality (Shenton, 2004). In this study, the strategies to establish credibility were reflexivity, triangulation, and a rich and thick description of the findings (Creswell & Creswell, 2018).

Dependability. Shenton (2004) refers to dependability as "addressing the issue of reliability" (p. 71). That is the replicability of the study. If given the same or similar context, participants and methods yield similar results. The strategy used to address dependability was reflexivity.

Confirmability. Authors like Shenton (2004) associate said concept to seeking objectivity or neutrality in the results. Thus, to achieve confirmability, the researcher sought to ensure the results reflected the participants' views, opinions, and experiences in the study and not her own, reducing the investigation bias during the process. The steps followed to obtain confirmability were triangulation and reflexivity.

Transferability. Authors describe transferability as "the extent to which the findings of one study can be applied to other situations" (Shenton, 2004, p. 69). The concepts presume that results from a research study reflecting particular circumstances could be transferred to a similar context or situations and maintain the original implication. In other words, the experiences described in the results would resonate on a personal level with individuals outside the study (Cope, 2014). The researcher used thick descriptions to address transferability.

Sampling Procedures and Rationale

In qualitative designs, the sampling procedures are frequently non-probabilistic and driven by the phenomenon's particularities under study (Hernández-Sampieri & Mendoza Torres, 2018). The purpose of this type of sampling is to provide an in-depth look at the phenomenon at hand and to maximize the information-gathering process by focusing on individuals associated with the phenomenon. This sampling technique employs different strategies, depending on the levels of variation it seeks to explore. In other words, the sampling process aimed to identify individuals who were knowledgeable of the phenomenon and were able and willing to convey their experiences, perspectives, and opinions efficiently. Thus, the researcher reflected upon commonalities and discrepancies among the subjects or cases involved in the process (Palinkas et al., 2013).

In this study, the type of purposeful sampling strategy used was criterion sampling. Criterion sampling focuses on the views and experiences of a specific group of people with the phenomenon under study (Creswell & Creswell, 2018). Sampling criteria consisted of two layers. The first layer entailed identifying housing programs designed for the chronically homeless population within the two-geographical continuum of care (CoC) networks in Puerto Rico. First, the PR CoC 502 consisted of 24 municipalities in the north-central region of the island, and the PR CoC 503 comprised another 54 municipalities in the east, south, west, and central region of the island. The HFM model's insertion was still relatively new on the island; hence, the sample included the agency (in the CoC 502) considered as housing first program automatically. The researcher requested the facilitating agency for one of the CoC’s for the official list of programs serving chronically homeless individuals that fell within the study's

parameters. To select the sample, the researcher placed the programs' names from each CoC in an urn and drew two programs corresponding to each CoC geographical area.

Consequently, the first sample consisted of five housing programs servicing chronically homeless individuals within the two CoC in Puerto Rico. Three of the programs were from the CoC 502 (which included the housing first program) and two from the CoC 503. However, the number of programs dropped to four since the HFM program from the CoC 502 had stopped providing services when the study's fieldwork started. This type of selection procedure minimized the researcher's personal preferences from weigh in the selection process. At the same time, it offered all qualifying organizations an equal opportunity to be part of the study (Hernández-Sampieri & Mendoza Torres, 2018).

The second layer of sampling also relied on a criterion sampling strategy. The researcher focused on identifying potential participants for the interviews. This group of participants or key informants worked at housing programs when the data collection process began. Each informant corresponded to a different service level: the continuum of care coordinators, administrators, clinical and case managers, and direct service providers. All key informants, except for the continuum of care coordinators, were full-time employees at one of the previously selected housing programs. Thus, the total number of potential key informants for qualitative interviews was 14: three service providers from each service level per program (for four programs) and two CoC coordinators. The number of potential key informants varied depending on the selected housing program's size and organizational structure, and available human resources.

The obtained sample for the study consisted of six key informants. In a phenomenological study, authors like Creswell & Creswell (2018) and Hernández-Sampieri & Mendoza Torres (2018) recommend a minimum range, meaning five to 10 individuals and up to a maximum of 25

participants. Although there are studies that have included higher numbers of participants, authors like Wolcott state that larger samples with multiple levels might limit the researcher's ability to gather in-depth information during the fieldwork phase (Wolcott, 1994).

Survey participants. The researcher used a survey to collect additional information about the views and opinions of service providers in the selected programs. The sample consisted of full-time employees who have worked for at least one year at one of the four programs selected for the study. The exclusion criteria for this phase included volunteers or other non-paid workers at the time of the study, employees with less than one year of experience within the program, and administrative employees with little or no contact with the chronically homeless population (e.g., accountants and secretaries). The survey excluded employees identified as key informants in the qualitative phase. The total amount of potential participants for the qualitative phase depended on the size of the organization.

Participants

The participants were service providers from government agencies and community-based organizations working at housing programs for chronically homeless individuals on the island. The researcher identified potential key informants according to their responsibilities or tasks within each program. The key informant for each category was a supervisor or a senior staff member from each service area. The objective was to obtain a homogeneous sample using as common denominators their shared experiences and knowledge as CoC coordinators, administrators, clinical and case managers supervisors, and direct services in housing programs for chronically homeless individuals. Participants completed an interview. The service provider's categories reflect the guidelines established in the *Housing First: The Pathways model to end*

homelessness for people with mental health and substance use disorders (Tsemberis 2010b, 2015).

The first category of service providers consisted of the continuum of care coordinators who oversee the Board of Directors within each CoCs. The key informants in this category are the professionals in charge of coordinating the general operations of each CoC or the professionals appointed by the coordinator to participate as key informants on their behalf. The designated professional has intimate knowledge of the CoC's inner workings, the chronically homeless population, the proposal process, and the housing programs in general, including the HFM model.

The second category of service providers included the program's administrators or professionals in charge of administrative tasks, implementing its mission and objectives, and overseeing everyday operations. Thus, the key informants for this category refers to the program director or general manager of the program, with intimate knowledge of the program's inner workings, the proposal process, and the HFM model. The administrator could also designate a subordinate to complete the interview. However, the appointed individual needed first-hand knowledge of the program, the chronically homeless population, the proposal process, the housing program, and its everyday operations.

The third category corresponded to the clinical or case management staff (Assertive Community Treatment (ACT) teams and Intensive Case Management Treatment (ICM) teams (if available). These professionals work directly with the client to stabilize the symptoms related to their conditions and provide support during the rehabilitation process. Consequently, key informants are the full-time employees in charge of supervising clinical and case management staff (e.g., psychologists, nurses, counselors, social workers). The clinical or case management

supervisor knows the program's inner workings, the chronically homeless population, the proposal process, and the HFM model.

Finally, the fourth category is direct service providers, including supportive service providers (i.e., outreach personnel, peer counselors, and job coaches) and other professionals working directly with participants. The key informants are full-time employees in charge of supervising non-professional employees and volunteers (e.g., peer counselors, job coaches, personal assistants, orderlies) supporting the program and participants. Said participants also had intimate knowledge of the program's inner workings, including basic knowledge about the proposal process, the chronically homeless population and housing programs for the population, and the HFM model. The exclusion criteria for all four categories included service providers who had less than a year in their position, had little or no knowledge and experience working with the chronically homeless population, nor the housing programs' design for said populations.

Survey participants. The researcher distributed an electronic survey among the available personnel within housing programs previously identified for the study. The eligibility criteria to complete the survey included being a full-time employee of the program with experience working with the chronically homeless population in Puerto Rico, a minimum of one year of employment with the organization or agency, and had to be involved in providing direct services to the individuals seeking housing services in said scenarios. The exclusion criteria for the survey included: employees who had been working less than one year in the selected organization, internship or practicum students completing their training in the organizations, volunteers, seasonal workers, and administrative personnel not involved in providing direct services related to the rehabilitation process (e.g., secretaries, accountants). The exclusions also included employees who completed the interviews as key informants.

The individuals who chose to participate did so voluntarily and did not receive any financial compensation for their contribution to the research project. Participants could also abstain from answering specific questions or withdraw from the study without adverse consequences. The information obtained during the research process was confidential. Therefore, the information was not shared with third parties nor used for any other purpose than the study's stated objectives. Upon completing the research process, the information was stored away, locked, and kept confidential in the researcher's private office. The information will be kept for five years and later destroyed as required by the IRB's protocols.

Interviews with Key Informants

The first stage of the study entailed completing qualitative interviews with key informants from the two continuum of care (CoC) networks (PR CoC 502 and PR CoC 503) on the island. The researcher completed the interview process using a semi-structured format with open-ended questions. The questions emerged after reviewing the available literature regarding the RC's role, the needs of the chronically homeless population, the views and opinions of the service providers, and the Pathways Housing First model. The semi-structured interview format aided in focusing the discussion on the experiences of the key informants. Additionally, the guidelines provided the flexibility to go in-depth on different topics related to the study's purpose as they surfaced along the course of the interview (Creswell & Creswell, 2018).

Guidelines for qualitative Interviews Form (Appendix E and F). The first part of the interview focused on gathering necessary sociodemographic information of each participant. The sociodemographic questions had a dual purpose: to ensure the service provider identified as key informant met all the research criteria for the study and to describe the interviewees' main

characteristics. The sociodemographic information focuses on the following: age, gender, highest academic degree obtained, and the occupational title or position within the agency. It also includes questions such as the type of agency they work for (public or private), the number of years working with the chronically homeless population, if their organization had an RC among the staff, and if they knew about the HFM model.

The interview's guidelines focused on exploring the experiences, views, and opinions of key informants about the three main areas of the study: the RCs, their experiences working with the homeless population with disabilities, and the HFM Model. The researcher developed the first set of questions for the qualitative interview in Spanish. A panel of experts reviewed the questions and provided feedback regarding the interview structure, the wording of the questions, and if said questions were consistent with the study's purpose and research questions. The panel consisted of professionals in the rehabilitation counseling field, clinical psychology, clinical social workers, and industrial psychologists (practitioners and academics in their fields). The researcher reviewed the questions incorporating the experts' feedback. The final draft of the interview's guidelines was translated into English, enabling non-Spanish speakers to review the questions. The translation process consisted of a simple back translation from Spanish to English and later from English to Spanish. The two Spanish versions were compared to check for consistency in terms. Since the researcher and the participants were all native Spanish speakers, the data collection process— the interview, the document review, and the forms— were in Spanish (Appendix F). The data collection process did not include the use of the guideline's English version.

Review of Documentation

After completing the interviews, the researcher requested electronic copies of the documents identified before the meeting, such as the CoC's mission and vision and the CoC services. Once received, the documents were reviewed and classified accordingly. First, the researcher recorded the information available on program principles and protocols in Table 1. The form included all the identified statements reflecting one or more of the eight core values and principles of the HFM model as they emerged from the documents. The documents requested for review included the organization's mission, vision, services, list of active organizations within the CoC servicing the chronically homeless population, intervention protocols, request for proposals and granted proposals, service protocols, job descriptions for the personnel working directly for the CoC, among others.

Likewise, the *Duties and Responsibilities of Service Providers Form* recorded the tasks and responsibilities for each position in the program. The form recorded the job title associated with the tasks and the level of service it represented. In other words, the administrators, clinical staff (i.e., ACT and ICM case management teams), or direct service providers available within the program (Tsemberis, 2010b). Also, it identified if said tasks and duties fell into the scope of practice of rehabilitation counselors.

The document reviewing process served two purposes. First, to identify the essential elements of the HFM model, the tasks, and job descriptions associated with the scope of practice of the rehabilitation counselor the programs' literature. Second, it was one of the strategies used to triangulate the information gathered during the qualitative interviews (Creswell, 2013; Hernández-Sampieri & Mendoza Torres, 2018). In other words, the researcher compared the principles and protocols from the housing first approach and the duties and responsibilities from

the scope of the rehabilitation professional with the experiences of key informants. The purpose of the review was to determine whether the information presented in the program's literature related to the experiences of the key informants.

Research Procedures

The researcher completed the preliminary work related to the development of the research proposal. The Institutional Review Board (IRB) of the University of Texas Rio Grande Valley received an application requesting authorization to initiate the data collection process. The application included the proposal itself, the informed consent forms, and the interview protocols. It also included the interview guidelines and protocols developed for the study, the required Collaborative Institutional Training Initiative (CITI) certificate, and commitment letters from the agencies who agreed to collaborate. The researcher submitted all written materials for the study: the consent forms, letters, and qualitative questions in English and Spanish.

In 2020, the COVID19 pandemic forced federal and state governments to implement total or partial lockdowns to reduce the spread of the virus among the general population. As a result, agencies and higher education institutions adopted social distance protocols and telework practices to continue providing service. Hence, to comply with said protocols, the data collection strategies shifted from in-person to remote interviews through a video conferencing platform. Said changes were re-submitted and approved by the IRB Board as an amendment.

Once approved, the researcher contacted the facilitating agency director of one of the continuum of care regions requesting authorization to conduct the study. The facilitating agency's role consisted of assisting the researcher in contacting the CoC coordinators to extend

an invitation to participate in the study. It also made available the list of active programs providing services to the chronically homeless population in Puerto Rico at the time of the study.

Selection of agencies or programs. The researcher selected the four organizations or programs for the sample by placing the programs' names from each CoC separately in an urn and drawing two programs for each CoC geographical area. The fifth program/organization for the sample (CABHI), previously funded to provide services to chronically homeless individuals using the Pathways Housing First model of intervention, was not active at the time of the study and was not substituted.

The facilitating agency director sent an electronic communication to the CoC coordinators (presidents of the board of directors), administrators, and clinical coordinators for the selected agencies/organizations with the study's general information and the researcher's contact information. The first contact with the potential key informants was by email explaining the study's purpose, methodology, participants, and the strategies for the data collection process. The email also requested a meeting with the potential key informants or their representative. The meeting aimed to answer any questions the potential participants may have about the research process and coordinate a date and time for an interview.

Once the potential key informants or their representative agreed to participate in the study, the researcher allocated a date and time in conjunction with the participants to complete the interview process using a videoconferencing platform. Each interview session was, on average, 60 to 90 minutes long. The researcher set up the interview by sending a link for a Zoom meeting conference and a copy of the informed consent form, which also addressed the document review process. The informed consent form listed the documents identified for review such as (1) brochures with the mission and vision of the CoC or programs, (2) copies of any

documentation available describing the purpose and services provided by the program, and when applicable, (3) the job descriptions of the service providers included in the organizations/programs within the CoC. The last part of the interview consisted of requesting electronic copies of the documents previously named and listed in the consent form.

Interviews Protocols

As previously stated, the researcher scheduled an online/distance meeting with the key informant or its representative through the Zoom videoconference platform. At the beginning of the interview, the key informant or participant received another copy of the Informed Consent Form describing the study, an overview of the interview process, and the interviewer's contact information for future communications. The consent form explained the extent of the person's participation in the study, its purpose, and the data collection procedures. The form also stated that the interviewee's involvement was voluntary, anonymous, and confidential. Therefore, the participant could choose to abstain from answering specific questions or withdraw from the research process entirely at any time without any adverse consequences. By agreeing to complete the interview, the key informant acknowledged that he or she would not receive any payment or compensation for participating in the study.

The key informant also acknowledged understanding the study did not represent a risk for the individuals involved and authorizing the researcher to record the interview in a digital format. However, if the participant wished to complete the interview without the video/audio recording, he or she could do so by requesting the interviewer not to turn on the recorder. In said cases, the interviewer would take notes and clarify any information with the participant. If necessary, the researcher could schedule a second meeting to confirm or expand on different

topics not fully covered or addressed during the first session. All the interviewees were native Spanish speakers; hence, the researcher conducted the interviews in said language.

The researcher started the interview by requesting authorization to record the session. The first part of the interview focused on reviewing the informed consent form, answering questions, and reiterating that the interviewee's participation was voluntary. It also covered the participant's sociodemographic information. The second set of interview questions focused on exploring the participant's experiences with rehabilitation counselors, the chronically homeless population, and the HFM model. The semi-structured interview format allowed the researcher to go in-depth on specific areas as they emerged during the conversation (Hernández-Sampieri & Mendoza Torres, 2018). The intervention itself followed a person-center approach to encourage participants to describe their experiences in the field in-depth and allowed the researcher to establish and maintain rapport with the key informant. The researcher concluded each session by asking the key informant for any final remarks they wanted to include regarding the subject discussed in the interview and thanking them for their collaboration.

On average, each intervention was 90 minutes long and was recorded in a digital format. The researcher transcribed each interview *at verbatim* using the Nvivo Transcription (automated transcription assistant). The researcher transcribed the video/audio recording and sent a copy to the participant for review to provide the opportunity to expand or clarify any response they deemed necessary. The researcher followed the confidentiality protocols as required by the Institutional Review Board (IRB). Whenever necessary, the researcher would schedule a follow-up interview to expand on a specific topic or clarify any previously recorded information; however, none of the participants were required to complete a follow-up interview.

Review of Documentation Protocol

The document review process followed a systematic process designed to identify the essential elements of the selected housing programs and the rehabilitation counseling field's duties. To that end, the researcher designed two forms: The Program Principles and Protocols (Appendix A and B) and the Duties and Responsibilities of Service Providers (Appendix C and D).

Program Principles and Protocols Form (Appendix A and B). The form sought to identify the essential elements of the housing programs. The first part of the form focused on the general information of the organization, such as the name of the agency/organization, address, CoC that it belonged to, the mission and vision of the agency, types of services available, and the types of documents reviewed to complete the form. The second part of the form focused on identifying the values and principles portrayed on each program's official records and proposals. The researcher requested each agency the following documents for review: call for proposals for grantees of housing programs, the approved proposals for said programs, the mission and vision, protocol and guidelines for the interventions, and the descriptions of services available at each program. The information was sorted, categorized, and recorded in a table (Program Principles and Protocols, Appendix A and B). The left side of the table recorded the statements identified as housing first programs' values and principles. The table's right side consisted of eight columns with numbers from one to eight corresponding to the core values of the HFM model.

The researcher categorized each statement using a checkmark under the number corresponding to a core value or principle of the model, as depicted in the manual *Housing First. The Pathways Model to End Homelessness for People with Mental Illness and Addiction* (Tsemberis, 2015). The eight-core principles for the HFM model were (1) housing as a

fundamental human right, (2) respect, warmth, and compassion for clients, (3) commitment to work with clients without time restrictions, (4) scatter-site housing or independent apartments, (5) separation of housing and supportive services, (6) consumer choice and self-determination, (7) recovery orientation, and (8) harm reduction.

Duties and Responsibilities of Service Providers Form (Appendix C and D). The purpose of the form was to identify the tasks carried out by service providers and if they fell into the rehabilitation counseling field's scope of practice. The form gathered general information of the organizations such as the name of the agency/organization, the CoC that it belonged to, the types of services offered, and the types of documents reviewed to complete the form. Additionally, the form contained a table to describe and classify each position's tasks and duties included in the grant proposal, program protocols, or any related document available for review.

The table's left side contained the occupational title and the tasks carried out by the professional occupying said position. The middle column in the table recorded the type of service provider (i.e., CoC coordinators, administrators, clinical and case management staff, and direct service providers) conducting said tasks. The table's right side included additional columns to register and classify the task consistent with a rehabilitation counselor's scope of practice by numbers. The competency areas identified from the scope of practice were:

> (1) assessment and appraisal, (2) diagnosis and treatment planning, (3) career (vocational) counseling, (4) individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability, (5) case management, (6) referral, and service coordination, (7) program evaluation and research, (8) interventions to remove environmental, employment, and attitudinal barriers, (9) consultation

> services among multiple parties and regulatory systems, (10) job analysis, job development, and placement services, including assistance with employment and job accommodations, (11) and the provision of consultation about, and access to, rehabilitation technology (Commission on Rehabilitation Counselor Certification, 2017, p. 1).

The information obtained through the Program Principles and Protocols and the Duties and Responsibilities of Service Providers forms described the principles and protocols included within selected agencies and organizations servicing the chronically homeless population in Puerto Rico. In other words, the tables helped identify the principles, protocols, and values of the HFM model and the tasks related to the RC's scope of practice within the organization at the time of the study.

Survey Administration

The study data collection strategy included administering a survey for service providers working at each agency or organization. The researcher administered the electronic survey using the Qualtrix platform while conducting qualitative interviews with the key informants (Appendix G and H). The survey administration process proceeded as follows: the researcher sent an electronic invitation to potential participants through each program's administrator or the clinical coordinator. The administrator or coordinator resent the email to eligible service providers within the program. The email contained information regarding the survey and the eligibility criteria for potential participants, a live link to access the survey, and the researcher's contact information. Participants who chose to complete the survey had to read the informed consent forms and agree to complete the survey before accessing the questionnaire. As previously stated, the consent form

included general information regarding the study and the participant's rights during the process. Participation was voluntary, anonymous, and confidential; therefore, the survey platform nor the survey collected any identifiable information. The researcher sent three reminders to the administrators or clinical coordinators to encourage service providers to complete the survey. Once the data collecting process finished, the responses were exported into an Excel data file and later transferred to SPSS for analysis. The obtained responses described the views and opinions of 21 service providers in three of the four programs. The results were part of the triangulation process for the study.

Securing the information. The information gathered during the research process, in the form of notes, forms, video/audio recordings, and electronic files, was set aside and stored away in a locked filing cabinet, acquired for that purpose, at the researcher's private office. The transcripts and other related documents were stored separately from each participant's identifying information to ensure confidentiality. The researcher will store and preserve the information gathered during the study for five years; at the end of that period, the researcher will dispose of all documents and recorded materials as required by the IRB office.

Triangulation

As stated earlier, the information obtained during the review of documents also served to triangulate the information gathered during the qualitative interviews with key participants. In other words, the researchers compared the principles and protocols from the housing first approach and the duties and responsibilities from the scope of the rehabilitation professional with the experiences of key informants. The purpose was to determine whether the program's

literature or documents related to the experiences of the key informants and to identify points of convergence between the experiences of key informants and the literature.

The researcher developed a survey to describe what service providers knew about the rehabilitation counseling professionals and the Pathways Housing First model. It also described their attitudes toward rehabilitation counseling professionals, the chronically homeless population on the island, and the HFM model. The survey did not have the psychometric properties to enable an in-depth comparison of the participants' responses with the experiences of key informants. However, it described what participants knew about the scope of practice of rehabilitation counselors, service providers' views about homeless individuals, and the principles of the HFM model.

Data Analytical Plan

The next phase of the research process entailed analyzing the information gathered by reviewing available documentation and interviews. The researcher used Harry Wolcott's method (2009) to identify categories and analyze the emerging themes from the investigative process. Wolcott's method presents three main components: description, analysis, and interpretation.

In Wolcott's method (2009), the "description" component refers to the account of the researcher's observations, in this case, during the reviewing of documents from each agency or community-based organization, the interviews, and the occurrences that transpired during the process. Therefore, the researcher prepared a narrative about the process of accessing the information from agencies, organizations, and the participants themselves. The second component, the "analysis," covered determining the interrelation between the functions, facts,

and specific situational attributes of the study's core elements: the RC, the chronically homeless population, and the HFM model.

The first part of the analysis focused on describing the RC's role within the housing programs for chronically homeless individuals and service providers' personal experience with rehabilitation professionals while working with the homeless population. The second part described the service providers' experiences and views about the needs of the chronically homeless population who had mental and substance abuse disorders. The third and final part of the analysis focused on describing their experiences about transitioning from a Linear Residential Treatment approach to service to a Pathways Housing First model of service.

The third component in Wolcott's method, the 'interpretation,' discussed the meaning and significance of those elements within the person's context. Wolcott proposes sorting the information into broad basic categories to answer the research questions. This information categorization system allowed the researcher to classify each emerging category into textual experiences or structural experiences for each stratum. The researcher identified each category's main idea and assigned a code representing the themes as they emerged from the interpretation process. Once organized, the analytic process generated a description of salient topics providing answers to the research questions (Wolcott, 1994).

Interviews. The researcher transcribed the audio-recording from each interview *at verbatim* (in Spanish) using the Nvivo Transcription, automated transcription assistant software. Once the transcription was available, the researcher reviewed the documents for accuracy, labeled each speaker, addressed issues resulting from technical glitches, and proceeded with analyzing the information. The researcher read the transcripts several times throughout the analysis process. The first and second readings focused on becoming familiar with the main

views experienced by participants. The coding process focused on the preset general categories corresponding to the dimensions of the study: the role of the RC, the chronically homeless population, and the views of service providers about housing first. Subsequent readings focused on identifying themes that emerged from the participants' experiences within each category. Finally, the researcher's subsequent reviews of the written material sought to identify specific experiences and recognize the relationships and interactions related to the study's purpose.

Document analysis matrix. The researcher established broad categories for each agency and organization using as reference two guidelines. First, the scope of practice of RCs, as established in the CRCC and the Code of Ethics of Rehabilitation Counselors (CRCC, 2017). Both documents helped identify service providers' duties and responsibilities—on each level of service—as they relate to the rehabilitation counseling professional tasks. The information was recorded and categorized in Table 2: Duties and Responsibilities of Service Providers (Appendix B).

The second set of guidelines referred to the values and principles of the HFM model, as depicted in the manual *Housing First: The Pathways model to end homelessness for people with mental illness and addiction* (Tsemberis 2010b, 2015). This manual helped identify each housing program's values and principles and categorized them as congruent or noncongruent with HFM the model. The information gathered was recorded and categorized in Table 1: Programs Principles and Protocols: Proposal and Protocols (Appendix A).

The analysis for both the document analysis matrix and the qualitative interviews followed the same coding process. All the information from the interviews was reviewed, stored, categorized, and examined using a qualitative data analysis (QDA) program called Nvivo 12 Plus from QSR international (for students) (QSR International, 2018). The Nvivo program helped in

the analysis and management of the qualitative information generated from the interviews (Creswell, 2013). The Nvivo program is beneficial when researchers have identified categories before the analysis process (Sotiriadou et al., 2014).

The final stage focuses on comparing, contrasting, and interpreting the information from different perspectives or providing a new context for understanding the results (Hernández-Sampieri & Mendoza Torres, 2018). Therefore, the final stage of analysis consisted of several steps. The first step was to identify the emerging themes and compare them with the information obtained through the review of documents and the responses obtained through the survey. The second step focused on establishing connections between the experiences, the responses obtained through the survey, and the literature. Finally, the last step was to interpret the information using the theoretical framework of the study.

CHAPTER IV

RESULTS

This chapter presents the information gathered throughout the data collection process. The first sections offer a brief overview of the procedures and relevant findings from the interviews and document review procedures. The second section focuses on analyzing and discussing findings and the relationship between the results gathered during the fieldwork phase. Finally, the chapter includes a report of answers to the research questions and a discussion of the cautions and limitations of said findings.

Review of Procedures

The data collection process consisted of two phases: interviews with key informants and document review. To gain access to potential participants, the researcher contacted the facilitating agency director for one of the continuum of care (CoC) regions requesting authorization and assistance in contacting the CoC coordinators and other potential participants for the study. The first sample required identifying two organizations or programs from each of the two CoC geographical areas. The programs were randomly selected using a simple draw strategy. Once identified, the facilitation agency provided the contact information for directors and relayed the researcher's information along with an overview of the study to the director of

each program. The first contact with the CoC coordinators (presidents of the board of directors), administrators, and clinical coordinators was via email. The message included an overview of the research, its purpose, methodology, and the strategies for the data collection process. All key informants received a copy of the informed consent form, which was reviewed and discussed with each participant before starting the interview. The key informants who agreed to participate in the study completed the interview process through a videoconferencing platform. On average, interviews were 90 minutes long.

The document review process required collecting documents describing the program's services and the tasks conducted by the staff working with the homeless population. The purpose of the document review was to identify the housing first model's principles and the activities related to the scope of practice of RCs. The informed consent form included a description of the document review process and a list of documents sought out for review such as (1) brochures with the mission and vision of the CoC or programs, (2) copies of any documentation available describing the purpose and services provided by the program, and, when applicable, (3) the job descriptions of the service providers included in the organizations or programs within the CoC. At the end of each interview, the researcher requested key informants to provide electronic copies of the documents mentioned in the informed consent form in order to review them.

Each key informant served as a liaison to contact the participants for the survey. The key informants forwarded an email with an invitation to eligible service providers to participate in the research study. The invitation included the study's general information, a copy of the informed consent form, and a link to access the survey. After completing the data collection process, the interviews were transcribed, reviewed, and analyzed with the document review outcomes.

Findings

The following segment showed the key informant's responses by theme and subtheme. The verbatim extracts and examples included in the text are as the participants verbalized them during the interview. However, the researcher omitted fillers and repeated words to facilitate understanding of the text.

Programs and Organizations

The study required two types of samples: (1) the organization or programs with the permanent housing programs and (2) the professionals who provided services to the homeless population of said programs. The first sample consisted of four programs or organizations, two from each PR CoC geographical area. The PR CoC 502 contains 24 municipalities in the north-central part of the island, including the metropolitan area of San Juan, Bayamón, Guaynabo, and Carolina. The PR CoC 503 covered the remaining 54 municipalities on the east, south, west, and central side of the island. Both CoC grouped organizations whose services include permanent and transitional housing, rapid rehousing, and emergency shelters. The organizations provide services to a broad population that includes subgroups such as single individuals, families, youth, the elderly, individuals from the LGBTQ+ community, individuals living with HIV/AIDS, domestic violence victims, and people with disabilities and substance abuse problems across the island.

In addition to the four organizations, the sample included the Puerto Rico Continuum of Care system as a separate organization. Thus, the potential key informants included the CoC coordinators or their representatives from each geographical area. The inclusion of coordinators and the administrative personal responded to their unique perspective about the CoC and the services organizations provided. Each CoC grouped the organizations providing services to the

homeless population and had its board of directors. The board members represented the CoC organization, developed the strategies to address homelessness, gathered data about the needs and characteristics of the population, and assessed the CoC's performance, among other tasks. It also prepared and submitted a consolidated application to HUD requesting funding to carry on with the ongoing programs for the homeless population.

Table 1

Distribution of Municipalities within the Puerto Rico Continuum of Care

Geographical Area	Municipalities
PR CoC 502	Aibonito, Arecibo, Barceloneta, Barranquitas, Bayamón, Camuy, Carolina, Cataño, Ciales, Comerío, Corozal, Dorado, Florida, Guaynabo, Lares, Morovis, Naranjito, Orocovis, San Juan, Toa Alta, Toa Baja, Utuado, Vega Alta y Vega Baja.
PR CoC 503	Adjuntas, Aguada, Aguadilla, Aguas Buenas, Añasco, Arroyo, Cabo Rojo, Caguas, Canóvanas, Cayey, Ceiba, Cidra, Coamo, Culebra, Fajardo, Guánica, Guayama, Guayanilla, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Díaz, Juncos, Lajas, Las Marías, Las Piedras, Loíza, Luquillo, Manatí, Maricao, Maunabo, Mayagüez, Moca, Naguabo, Patillas, Peñuelas, Ponce, Quebradillas, Rincón, Río Grande, Sabana Grande, Salinas, San Germán, San Lorenzo, San Sebastián, Santa Isabel, Trujillo Alto, Vieques, Villalba, Yabucoa y Yauco.

Programs in the continuum of care 502. The programs of the PR CoC 502 included most of the largest metropolitan areas of the island. The location of the municipalities encompassing the CoC included the northern and central sides of the island. It is also the geographical area with the most access to supportive services.

Program #1 is part of a large community-based, not-for-profit organization which has been providing services for over 25 years. The organization's central office is on the northern shore, with locations in several municipalities around Puerto Rico. It manages 13 different programs addressing diverse populations' needs, including individuals and families, survivors of

domestic violence, homeless individuals, and the elderly, among others. Program #1's goal is to provide permanent housing services to homeless individuals, couples, and families with various health and social needs.

Program #2 is also part of a large community-based, not-for-profit organization that has been active for over 35 years on the island's northern side. The organization provides services such as meals, clothing, community outreach, case management, social work, recreational activities, and two different housing services modalities. Program #2 defines itself as a housing first program providing permanent housing to chronically homeless individuals with supportive services. Individuals enrolled in the program receive vouchers for permanent housing and supportive services from professionals in the organizations and the community.

Programs in the continuum of care 503. The PR CoC 503 comprises 54 municipalities across Puerto Rico, including the mountainous region and the island-municipalities of Vieques and Culebra. Although it does include metropolitan areas, they are smaller in size and have fewer resources than the north side's metropolitan areas, closer to San Juan.

Program #3 is part of a community-based, not-for-profit organization which has been working on the island for over 25 years. Program #1 and #3 share the same parent organization; therefore, it is also one of the 13 different programs attending the needs of various people such as individuals and families, survivors of domestic violence, and the elderly, among others. However, the emphasis of Program #3 is to provide permanent housing services to homeless individuals with disabilities in the south side of Puerto Rico.

Program #4 is the only program in the sample that is managed by a municipal government and it has been operating for the past 10 years. It provides permanent housing

without supportive services through a rental assistance program and case management services for various subgroups within the homeless populations. Located on the west shore of Puerto Rico, the project follows the housing first model, but only 50% of the project's participants are chronically homeless individuals.

In Puerto Rico, the Department of Housing and Urban Development (HUD) began implementing the housing first model in 2014. However, the continuum of care did not make it a priority until 2016. The programs that have chosen to implement the housing first approach have at least 4 to 5 years of experience with the model.

Interviews

This section presents the relevant findings gathered through qualitative interviews with key informants. Wolcott's method to identify categories or emerging themes helped group responses during the analysis process. Interviewees described their experiences with rehabilitation counseling professionals, the chronically homeless population, and the housing first model.

Socio-demographic information of key informants. A total of six administrators and service supervisors agreed to complete the interviews as key informants. The key informants represented three of the four categories of service providers: CoC coordinators or representatives, administrators or representatives, and the clinical and case managers coordinators. None of the organizations had a direct service coordinator within the staff. There were three key informants for each PR CoC geographical region. All participants had 10 years of experience or more working in programs geared toward the homeless populations. Likewise, all

reported knowing about the housing first model. None of the key informants reported ever having rehabilitation counselors as part of the staff or with the said occupational title. Table 2 presents a detailed description of each of the key informants.

Table 2

Sociodemographic Information of Key Informants

Characteristics	Key informants					
	#1	#2	#3	#4	#5	#6
CoC	502	503	502	502	503	503
Age	40	36	40	50	51	59
Gender	Female	Female	Female	Female	Male	Male
Level of education	Bachelors	Masters	Masters	Masters	Bachelors	Masters
Position	3	3	1	3	2	2
Type of program	Community-based/ NPO	Community-based/ NPO	Community-based/ NPO	Community-based/ NPO	Community-based/ NPO	Public-government run program
Years of experience	19.5	11	12	26	12	10

Note. Position 1= CoC coordinator/ representative; 2= Administrators or representatives; 3= Clinical and case managers

The interviews' responses were grouped into three broad domains: (I) the rehabilitation counselor, (II) chronically homeless individuals, and (III) the Housing first model. Each domain corresponded to the study's research focus, and additional subthemes emerged within each domain from the participants' experiences.

(I) The rehabilitation counselor. The information in this segment showed key informants' responses regarding their lived experiences with the rehabilitation counseling professional. The domain *rehabilitation counselor* included responses reflecting the views, opinions, and attitudes of service providers toward the rehabilitation counselors. Three subthemes emerged from the analysis: (a) experiences with rehabilitation counselors, (b) characteristics of the rehabilitation counselor, and (c) the practice of the rehabilitation profession.

Subtheme (a) Experiences with rehabilitation counselors. This segment contained the personal and professional experiences of key informants resulting from their interaction with rehabilitation professionals. Three of the six key informants expressed not knowing who the rehabilitation counseling professional was, had doubts about their professional competencies, or described them as addictions counselors. At least one interviewee expressed searching for information about the field after being invited to participate in the research study. The remaining three key informants described personal or professional experiences with an RC. One of them came one credit short of completing a master's in rehabilitation counseling.

All key informant's experiences mentioned the vocational rehabilitation counselors and vocational components of the practice. For example, Participant #2 referred clients and had case discussions with professionals at the Puerto Rico Vocational Rehabilitation Administration (VRA). Nonetheless, the participant did not visualize the rehabilitation counseling professional as part of the staff working at her program; her response to the question was a straightforward "No." Participant #3 received services from the VRA and described her experiences with the RC as a "determinant" in helping her move forward in life. She described her RC as a dedicated professional who went "above and beyond" his duties, guided, and supported her process. The experience of Participant #4 showed a different perspective. She became aware of the

profession's principles and practice as a student enrolled in a master's program in rehabilitation counseling. As a student, she foresaw the opportunities beyond working in a traditional vocational rehabilitation scenario. The rehabilitation counseling field was flexible enough to allow her to work with clients who had mental health and physical conditions through a holistic approach. The participant believed the RC's knowledge about disabilities sets them apart from other types of counselors and acknowledged that if a person knew about who rehabilitation counselors were, they usually saw them as part of the VRA and were unaware of the scope of practice and professional skills.

Participant #4 said:

> No sé, pienso que la gente siempre se quedó pensando que el consejero en rehabilitación, en el que trabaja en rehabilitación vocacional... al Gobierno, allí llenando papeles y marcando 'ceritos'... Y esa visión... y era una de las cosas que yo siempre discutía con los compañeros en la Escuela de Consejería, que decía 'Dios mío, pero es que yo quiero ser consejero en rehabilitación, pero yo no quiero trabajar en Rehabilitación Vocacional'.
>
> [I do not know, I think that people always kept thinking that the rehabilitation counselor, the one that works at vocational rehabilitation ... in Government, there, filling out papers and marking 'zeros'... And that image ... and it was one of the things that I always discussed with my classmates in the Counseling School, I used to say, 'My God, I want to be a rehabilitation counselor, but I don't want to work in Vocational Rehabilitation.']

Subtheme (b) ***The characteristics of the rehabilitation counselor***. The second subtheme gathered the views and opinions of key informants about the rehabilitation counselor's professional and personal characteristics. The responses described the views and opinions about the rehabilitation counselor's role, tasks, and attributed professional characteristics. Four of the key informants described the RC's broadly as the professional capable of working with people with physical and mental disabilities to attain their goals and objectives for the rehabilitation process. Two of the key informants added that the RC helped clients reintegrate into their families and community life in meaningful ways. Most described the professional characteristics of RC's as helping clients to manage substance abuse issues. Two of the key informants described RC's intervention approach as person-centered, where the client had a voice in the rehabilitation process and their decisions supported by the counselor. Table 3 shows a brief sample of key informant's views about the rehabilitation counselor's characteristics.

Table 3

Views About the Characteristics of Rehabilitation Counselors

Characteristics	Original quote	English translation
Professional	"[…] es esa persona que puede ayudar a aquel participante que tenga alguna discapacidad física o mental, y que lo puede llevar de la mano para que pueda alcanzar unas metas, un objetivo o una mejor calidad de vida". (Participante #1)	"is that person who can help that participant who has a physical or mental disability, and who can take him by the hand so that he can achieve goals, an objective or a better quality of life". (Participant #1)
Professional	"Un consejero en rehabilitación bien puede asistir a la persona a poder desarrollarse en un empleo, a poder reintegrarse a su familia, a la comunidad, a la socialización en grupo". (Participante #4)	"A rehabilitation counselor may well assist the person to be able to grow in a job, to be able to reintegrate themselves into their family, the community, and group socialization". (Participant #4)
Personal	"Bueno... el consejero en rehabilitación es el que... Básicamente el que durante el proceso de rehabilitación asiste al participante en ese proceso. A manejar su problema de adicción". (Participante #6).	"Well ... the rehabilitation counselor is the one who ... Basically, during the rehabilitation process assists the participant in that process. To manage their addiction problem". (Participant #6).

Subtheme (c) The practice of the rehabilitation profession. The third subtheme for the domain referred to views, opinions about the professional role, duties, and tasks associated with the scope of practice of rehabilitation counselors (RC) within programs servicing chronically homeless individuals. The responses identified specific tasks, duties, and responsibilities about managing substance abuse disorders among clients enrolled in permanent housing programs as the primary focus of interventions.

Four of the six key informants described the rehabilitation counselor's role as helping clients with physical or mental disabilities achieve their goals, obtain employment, and a better quality of life. Key informants identified the tasks such as case management, needs assessments, establishing goals and objectives, and carrying out intervention plans among activities RCs could perform in their respective housing programs.

The three key informants who had personal experiences with RCs added individual counseling, psychoeducation, reintegration into their families and community, developing interpersonal skills, and eventually seeking employment. Participant #3 believed RCs could be full-time employees in the clinical team. For her, rehabilitation counselors could focus on intervention with concrete goals, spend more time reinforcing treatment adherence, and helping clients manage their condition. On the other hand, Participant #4 viewed the RC as "an orchestra director" capable of coordinating comprehensive intervention and integrating all related disciplines to develop their potential. Table 4 presents the roles associated with the RCs from the key informant's perspectives.

Table 4

Role, Duties, and Tasks Associated with the Scope of Practice of Rehabilitation Counselors

Role	Original examples quote	English translation
Case manager	"Yo lo veo como si fuera un tipo de manejador de casos que va a identificar necesidades, establecer unos objetivos, unas metas y lleva a cabo el plan". (Participante #1)	"I see it as a type of case manager who is going to identify needs, establish objectives, goals, and carry out the plan." (Participant #1)
Counselor/ psychotherapy	"Yo pienso que el... que el consejero iría más con planes concretos... con esa persona mirando las necesidades de manera bien puntual […] va a ser esa persona que va a estar ahí... de la mano, totalmente con el tratamiento... con la adherencia de ese tratamiento con ese participante. Porque va a buscar la forma de cómo adherirlos a ese tratamiento. De cómo le entramos, como lo enganchamos, cómo lo enamoramos, cómo hacemos que el participante responda de manera efectiva y asertiva al tratamiento". (Participante #3).	"I think that the ... counselor would go for more concrete plans ... with that person looking at the needs in a very timely fashion [...] is going to be that person who will be there ... hand in hand, totally with the treatment ... with the adherence to treatment with that participant. Because he is going to find a way to adhere them to that treatment. How do we engage him, how we hook him, how do we make him fall in love, how do we make the participant respond effectively and assertively to treatment". (Participant #3)
Team leader (ACT teams)	"Y yo pensaría, de lo que conozco de consejería en rehabilitación, que un consejero de rehabilitación funcionaría como el director de orquesta. Entre todo esto, entre todas estas disciplinas, el director de orquesta, porque es el que va a tener ese conocimiento integral para el desarrollo de esta persona, dentro de ese nuevo ambiente. Ir manejando los niveles de intervención de todas estas disciplinas con esta persona". (Participante #4)	"And I would think, from what I know about rehabilitation counseling, that a rehabilitation counselor would function as the conductor. Between all of this, among all these disciplines, the conductor, because he is the one who will have this comprehensive knowledge for the development of this person, within that new environment. Managing the intervention levels for all these disciplines with this person". (Participant #4

Although none of the professionals interviewed had first-hand experience working with RCs within the workplace, one of the key informants noted subtle discrimination toward professionals whose titles did not include the term clinical regardless of the specialty. As a result, clinicians devalued the opinions of counselors and social workers (except for clinical social workers), excluding them from case discussions. The counselor's and social worker's

perspectives and input about clients were not always considered as crucial as the clinician's professional opinions. For Participant #3, the reasons for assuming said positions may include (1) lack of knowledge about the professional competencies of counselors and social workers and its impact on the intervention process and (2) a perceived need to preserve professional boundaries.

(II) Chronically homeless individuals. This domain grouped responses corresponding to views, opinions, experiences, and service providers' attitudes toward the chronically homeless population. Three subthemes emerged from the responses: (a) characteristics related to the chronically homeless population, (b) experiences and attitudes toward the homeless population, and (c) supported services.

Subtheme (a) Characteristics of the chronically homeless population. Every year, HUD carries out the Point-in-Time (PIT) counts to identify the number of homeless individuals at one specific point in time (Henry et al., 2020). The description key informants provided of the homeless population had similarities with the official profile derived from the PIT. Nonetheless, at least two key informants believed the report might not reflect the reality of the problem and that the number of homeless people may be significantly higher. In the last four years (from 2017 to 2020), Puerto Rico has experienced two back-to-back hurricanes, earthquakes, and a global pandemic (COVID-19) which may have increased the number of people experiencing homelessness for the first time, and therefore not considered as chronic homelessness. At the same time, not all people living in the streets were considered homeless. Some individuals may have a residence or a place to live but chose to live in the street due to substance abuse, mental health problems, or family problems. Thus, the PITs did not include people who had a choice of where to live.

All key informants described the homeless population in Puerto Rico as predominantly male, between the ages of 35 to 54 years. Most have been living in the streets between 5 to 10 years or longer and presented substance abuse disorders as the main problem, followed closely by mental health issues such as depression, schizophrenia, or bipolar disorders. However, one participant mentioned that mental health issues had increased in the past 10 to 15 years, becoming as prevalent, or even more, than substance abuse disorders (Participant #4). According to Participants #1 and #4, the general misconception was that homeless individuals were illiterate. In their experience, however, many were educated professionals and proficient in using the English language.

Although males continue to be most of the homeless population, key informants reported an increase in other subpopulations such as women, the elderly, young adults, and the LGTBQ+ youth, who may not always meet chronic homelessness criteria. In other words, they may not have been homeless for more than a year or have had several episodes of homelessness in the last three years, and they may not have a disability or a substance abuse disorder.

Regarding the causes behind homelessness, participants agreed that substance abuse was a factor, but not the only one. Participant #4 thought a traumatic event drove most people to homelessness, such as losing a loved one, a divorce or family problems they could not overcome, a mental health disorder, or economic factors. Participant #4 recalled the impact Act 7 of 2009 had on the local economy and the community to exemplify economic factors. Act 7, implemented under the administration of former governor Luis G. Fortuño Burset, was part of the administration’s plan to reduce the local government's size, resulting in the loss of thousands of jobs in the public sector almost overnight.

Participant #4 said:

> Cuando ocurrió lo de la Ley 7..., nosotros enseguida no vimos el efecto. Vinimos a verlo de un año, a año y medio después. Personas que eran profesionales, que eran... que tenían carreras y perdieron sus trabajos, y año y medio después al no poder recuperarse estaban alcohólicos en la calle con una depresión severa.
>
> [When Law 7 happened… we did not see the effects right away. We came to see it a year, a year and a half later. People who were professionals, who… had careers and lost their jobs, and a year and a half later, unable to recover, they were experiencing alcoholism and severe depression in the streets.]

Other factors may come into play in other subgroups of homeless individuals such as women, young adults, and young adults from the LGTBQ+ community. For women, homelessness could be the result of violence. According to Participants #3 and #6, the increase in homelessness among women is related to domestic and gender violence. In young adults, the causes may be economic factors. At least three key informants observed an increase in homelessness among college students with few or no economic resources. According to Participant #6, in 2017, college students who did not receive enough financial aid to cover their living expenses started to show up in the PIT counts. Participant #4 added that students had nowhere to go and began visiting the organization's homeless service centers when other community resources closed.

Participant #4 described it as follows:

> […] otro grupo que ha subido, se ha disparado son los adultos jóvenes de 18 a 24. Estudiantes que les cerraron las residencias... en la iupi (UPR). Las dos residencias cerraron. Están invadiendo. Durmiendo en carro, invadiendo edificios cerrados, y nos llegan a la organización. Y tú los ves con sus libros, y se sientan a desayunar, estudian un ratito, se bañan y se van a sus clases cuando eran presenciales.
>
> [Another group that has increased, has skyrocketed, are young adults from 18 to 24. Students whose dorms closed ... in the UPR in Rio Piedras. The two dorms closed. They are invading. Sleeping in cars, occupying closed buildings, and they show up at the organization. And you see them with their books, and they sit down for breakfast, study for a little while, bathe, and go to their classes, when they were face-to-face.]

Homeless individuals with disabilities. When asked about servicing people with disabilities, all key informants focus first and foremost on homeless individuals' substance abuse disorder. Although not all programs focus on providing services solely to chronically homeless individuals, the programs did provide services to individuals with physical or mental disabilities. Most of the experience with said population revolved around providing accessible housing and supporting services, especially to those with mental health disorders. Programs incorporate housing first guidelines to place people with disabilities and follow the Guidelines for Fair Housing, adjusting to provide adequate living facilities for various residents.

Participant #6 described working with individuals with disabilities as follows:

> No ha sido difícil, pero si, por ejemplo... no hay muchas unidades de vivienda en mercado que estén preparadas para personas... para recibir personas con impedimento. Y hemos —obviamente— he tenido que trabajar con el arrendador, para que el arrendador haga unos ajustes en su vivienda para poder recibirlas. Pero obviamente, lo hemos trabajado y se ha podido lograr, [...] Yo creo que la población con impedimentos mentales ha sido, quizás por decir... un poquito más complicada.
>
> [It has not been difficult, but yes, for example ... there are not many housing units on the market that are prepared... to receive people with disabilities. And we have —obviously— had to work with the landlord, so that the landlord makes some adjustments to the home to be able to receive them. But obviously, we have worked on it, and it has been achieved, [...] I think that the population with mental disabilities has been, perhaps to say ... a little more complicated.]

Participant #1 noted that individuals with a disability had to be independent and maintain the housing unit in good conditions to qualify for placement. That said, a person may have support to complete daily activities, but they had to be capable of taking care of themselves. If the person has a chronic condition diminishing their capacity to take care of themselves, wanders off, or needs constant supervision, they would not qualify for housing at that specific program. People with a disability seeking housing services from programs within the continuum of care (CoC) needed to provide evidence of said disability and undergo an assessment with the

program's personnel. The programs followed the guidelines and definitions of disability established by HUD.

Participant #1 describes the rationale behind the process:

> […] después que el participante traiga ese certificado de discapacidad, de ahí entonces continuamos, no importa si es física, si es mental, […] si tiene ambas, si le falta una pierna. Aquí nosotros... nos mantenemos según lo que HUD nos dice, […] evaluando que sí pueda vivir solo, porque eso es parte también de nuestro trabajo. Ser honestos y no tirar a una persona a que vaya a vivir solo, y que le vaya a pasar algo.
>
> [After the participant brings that certificate of disability, from there on we continue, it does not matter if it is physical, if it is mental, […] if it has both, if it is missing a leg. Here we ... we abide according to what HUD tells us, [...] assessing whether they can live alone, because that is also part of our job. To be honest and not send a person to live alone when something could happen to them.]

Subtheme (b) Experience and attitudes toward the homeless population. The second subtheme of the domain gathered service providers' lived experiences with the chronically homeless individuals and the attitudes toward the population. All key informants recognized the positive and challenging aspects of working with a hard-to-serve population. Although key informants viewed the homeless population as complex and challenging to work with, all key informants also enjoyed working with vulnerable populations. Most of them described the experience as personal and professional growth and learning every day from the individuals they

served. Even though experiences among service providers were similar, some differences emerged between the administrators' experiences and those of the clinical and case managers, depending on the type of interaction they had with the population.

Administrators. Most of the administrators' experiences revolved around the adjustment process of new residents to permanent housing and their ability to maintain the housing unit required by HUD. In both instances, administrators recognized that residents needed time to adjust and re-learn independent living skills. The experiences of Participant #5 taught him that not everyone could transition from a dysfunctional life to being a productive person, be well and in a home, and capable of maintaining it in optimal conditions. The following extract describes the participant's view about the process: "Hay personas que logran el objetivo.... Hay personas que lamentablemente no, por "X" o "Y". […] hay cosas que no se pueden controlar". [There are people who achieve the goal .... There are people who unfortunately will not because of "X" or "Y." […] There are things that cannot be controlled.]

Participant #5 expressed feeling disappointed when inspectors visited the apartment complex, and the units were dirty and unkempt. The staff worked hard to provide a "decent, safe and affordable living," and dirty and unkempt units did not comply with said standards. He described the experience working with the population as "difficult" but felt comfortable and appreciated by the residents who did cooperate and tried to follow the rules, "especially during the COVID-19 pandemic". As an administrator, he relates to the residents and sees them as his "boys and girls," and aims to be fair, finding a balance between being "strict but also a friend." Participant #5 emphasized the importance of being empathic toward the resident, assuming the role of facilitators, and treating them with respect.

A second administrator, Participant #6, mentioned that homeless individuals were "difficult." He described the population as follows:

> […] hemos tenido que trabajar con clientela difícil con actitudes difíciles. Y en esa medida, pues hemos tenido que, hay que... Hay que ser tolerante, hay que ser paciente. Hay que ponerse en sus zapatos y ponerse en su lugar.
>
> [We have had to work with difficult clientele with difficult attitudes. And to that extent, well, we have had to ... You must be tolerant; you must be patient. You have to put yourself in their shoes and put yourself in their place.]

Participant #6 also admitted that the attitudes sometimes bother him, but he tried to understand their perspective. The administrator described the residents as strong for surviving life on the streets but also as "reluctant to get out of the cycle," a situation he described as "painful," because some individuals did not allow service providers to help them despite all efforts.

CoC coordinators, clinical and case managers. As the administrators, key informants directly involved in providing supportive services (the CoC coordinator, the clinical/service coordinators) also described chronically homeless individuals as challenging to serve. Their experiences ranged from the challenges of helping homeless people access services to personal stories about why the residents ended up being homeless.

All service providers interviewed expressed enjoying working with homeless individuals and learning from their experiences every day. At the same time, they admitted the challenges of serving said individuals. The key informants shared similar experiences when working with the population and summarized them as follows. First: the longer a person stayed homeless, their

reluctance to change and accept placement increased. One of the service providers, Participant #4, described the trait as getting used to being homeless and developing a way of life focused on obtaining the essentials to survive. She described the daily routine of an elderly man who refused placement in housing: “he sleeps on the sidewalk, comes in early, showers, has breakfast, and gets his medication.” Others were reluctant to return to programs after frequent relapses, failed attempts to stay sober or clean, and when they (the homeless person) were aware of how much of themselves got lost in the process.

Participant #3 reflected on an experience with a homeless individual she worked with:

> […] a él se le hacía más difícil aún salir de eso, porque él decía ‘Es que yo nunca me visualicé de esta manera. Cuando yo estaba detrás de aquel escritorio, dando órdenes, trabajando, haciendo todo lo que...yo sabía hacer y verme ahora en esta posición tan vulnerable’, ... Él dice... ‘Pues se me hace difícil salir. No... le veo salida porque no es una… No fue algo con lo que yo viví toda la vida. Fue una situación en el peor momento’. Y le resulta más difícil aún, con todos los conocimientos, salir. De hecho, no salió.
>
> [It was even more difficult for him to get out of it because he said ‘It's just that I never visualized myself in this way. When I was behind that desk, giving orders, working, doing everything that ... I knew how to do, and seeing myself now in this vulnerable position’, ... He says ... ‘Well, it is difficult for me to get out. I do not see a way out because it's not ... It was not something I lived with all my life. It was a situation at the worst time’. And it is even more difficult for him, with all the knowledge, to get out. In fact, he never got out.]

Eventually, people living on the streets find themselves alone, without their family's support. Participant #1 described it as follows:

> Muchos se ponen agresivos, otros roban, le roban a su propia familia, así que... Cuando la familia se cansa, se aleja y realmente el deambulante quiere salir, y no tienes apoyo, es bien duro para ellos y ahí entonces entramos nosotros.
>
> [Many get aggressive, others steal, they steal from their own family, so ... the family gets tired, they step aside, and when the homeless person really wants to leave, and doesn't have support, it is very hard for them, and that's when we come in].

Other experiences reflected the opposite: groups of homeless individuals requesting a place to live and rehabilitation services to deal with addiction problems. With support, many did manage to stay housed, even after relapses, and achieved stability. For Participant #4, the action of placing a person into housing diminished the burden felt by those living homeless and made them more receptive to services.

Participant #4 recalled an experience with a person who qualified for housing:

> […] nosotros hemos tenido casos, como que sencillamente los hemos puesto en la casa y les digo 'Mira, no tienen una cama hoy, la cama llega mañana'. 'No importa missis. Déjenme irme hoy para el apartamento. […] Si yo dormía en la acera. Yo duermo en el piso. Deme una frisa y una almohada. Pero no, así no estoy en la calle'.
>
> [We have had cases like, we have simply put them in the house, and I tell them 'Look, you don't have a bed today, the bed comes in tomorrow'. 'It doesn't

> matter miss. Let me go to the apartment today. […] If I slept on the sidewalk. I sleep on the floor. Give me a blanket and a pillow. But no, that way I'm not on the street'.]

Opinions and attitudes about homelessness. Although organizations have successfully placed people in permanent housing, dealing with the public's perceptions about homelessness and the stigma associated has been challenging. For Participant #1, society was uninformed and had a lack of understanding about the homelessness phenomenon. For her, people have become numb to the problem and ignore homeless individuals until they become a problem for them.

Furthermore, Participant #3 described the neighbors and merchants of a community in San Juan as follows:

> Para ellos las personas sin hogar afean las calles […]. Y es como el issue de la gente que vive allí y que tiene que bajar y ver a la persona sin hogar curarse delante de ellos. O tirado frente a la acera de sus apartamentos, cuando van a salir, cuando ahí no hay espacio. Como afecta incluso la economía, el andamiaje turístico…
>
> [For them, homeless people tarnish the streets [...]. And it's like the issue of the people who live there, who have to come down and see the homeless person getting high in front of them. Or lying in front of the sidewalk of their apartments when they are going out, when there is no space there. How it even affects the economy, the tourism structure ...]

All six key informants acknowledge the commitment of most individuals working within the continuum of care as respectful of the homeless person and empathetic towards their needs.

The service providers were also knowledgeable about homelessness, experienced in advocacy, and “knew what they were doing.” At least three key informants described their work with the population as gratifying and noticed the positive impact the access to housing and supportive services had on people's quality of life. Still, for Participant #1, “no todos los programas son iguales” [not all the programs are the same].

Government officials and other service providers from different branches may also have difficulty understanding the homeless population nor have their needs or interests among their priorities. One participant noted differences between the services offered at municipal and state government levels. For Participant #4, service providers at the municipal level had a better understanding and significant experience with the homeless population. They were more sensitive to their needs than officials at the state level. In said cases, Participant #2 focuses on providing information to facilitate the process.

Participant #2 said:

> Muchos proveedores... pues es difícil poder hacerlos entender cuál es nuestra población... y la dificultad que pueda tener... la persona o el participante, pero muchas veces por eso explicamos ‘nuestra población es ésta... tienen estas limitaciones... requieren unos servicios’, pero podría decir que si, que reciben el servicio necesario...
>
> [Many providers ... well, it is difficult to make them understand what our population is ... and the difficulty the person or the participant may have ... but that is why, most times, we explain ‘this is our population... they have these

limitations... they require some services', but I could say that yes, they receive the necessary service ...]

At least two key informants believe politics among government employees at the state level may contribute to the lack of understanding and knowledge about homelessness. When a new administration comes into office, government employees come in and out of positions in programs servicing homeless individuals due to political affiliations. As a result, some government officials lack the knowledge or expertise in the area. Some try to learn about the issues, but it is not always the case. Participant #4 felt the practice was one of the factors behind the lack of sensibility and limited efforts on behalf of the population.

Participant #4 noted:

> […] a veces de gobierno, son personas que están en puestos de carrera. Cambió la política, los pusieron ahí. Tú tienes que ir a esta mesa y participar, y a lo mejor nunca habían trabajado con la población. Hay quien entonces demuestra el interés de aprender, acerca de la población y hay quien dice 'déjame pasar estos cuatro años como pueda, en lo que viene el próximo y me sacan de aquí'.
>
> […] sometimes in government, they are people in career positions. The politics changed, they put them there. You must go to this table and participate, and maybe they had never worked with the population. There are those who then show an interest in learning about the population, and there are those who say 'let me spend these four years however I can, until someone else comes next and takes me out of here'.]

Personal views. The personal views and the stigma associated with homelessness were other factors influencing the ways service providers interact with the homeless population. For example, Participant #1 stated that people reacted to the homeless person's worn-out physical appearance, lack of hygiene, visible health issues, and did not want to provide the services they needed. From the perspective of Participant #3, the fear of serving chronic individuals and wanting to work with less complicated clients points to barriers not associated with the homeless person but from a profound limitation coming from within the service community.

Participant #3 described her views about some service providers as follow:

> De mirar a una persona sin hogar y etiquetarla como una persona adicta. Y como una persona que no tiene... posiblemente... no tenemos forma de cómo rehabilitarla. Porque así la mira a la población en general... y aunque tu no lo creas, dentro de nuestro mismo sistema, tú lo puedes ver. En el personal que a veces labora. O sea... a veces yo siento que estamos trabajando por trabajar, y no necesariamente por lograr un cambio social.
>
> [To look at a homeless person and label them as an addict. And as a person who does not have ... possibly ... we have no way, of how to rehabilitate them. Because that is how the general population looks at it ... and even if you don't believe it, within our own system, you can see it. In the staff who sometimes works. I mean ... sometimes I feel that we are working for the sake of it and not necessarily to achieve social change.]

Subtheme (c) Supported Services. All key informants referred to supported services as a critical factor for the recovery process. The programs and the personnel relied primarily on community-based services to complement the homeless people's needs while transitioning to permanent housing. The geographical location of the programs could facilitate or limit the access to services and availability of resources. For instance, programs operating in larger cities closer to the metropolitan area of San Juan, the capital, had better access to services than programs in the south or west side of the island. Hence, most participants expressed the need for an increase in the number of services available, especially for detox, recovery, shelters (especially for women), and mental health programs.

According to Participant #4, a single organization cannot address a complex issue like homelessness by itself. The organizations needed multisectoral support from other community-based organizations, state and federal government, the private sector, faith-based organizations, and academia. If all sectors worked together, the services available could be enough. The participant described the organization she worked for as well established and "large," functioning as a small CoC. Smaller organizations that did not have the internal resources to develop their supportive services could face more significant challenges to provide for their clientele. Likewise, Participant #1 noted the importance of the resources available throughout the community, including meals or groceries from programs like Bill's Kitchen and other articles such as furniture and clothing to provide the essential items for individuals moving into a housing unit. Also, access to funding to cover expenses like utilities typically comes from local churches, private organizations, and small businesses.

In terms of clinical and psychological services, programs and organizations complemented the available staff by hiring psychologists, psychiatrists, or medical personnel

through professional service contracts or referred the clients to other programs within the community. Programs may also serve as practicum and internship sites for academic programs such as nursing, social work, counseling, psychology, and other clinical and medical programs to support the full-time staff.

Other available resources included programs run by local government agencies. Service providers referred participants to agencies for mental health treatments or addictions and recovery programs. For example, community-based organizations frequently referred individuals to the Mental Health and Anti-Addiction Services Administration (ASSMCA by its acronym in Spanish). Other agencies that addressed homelessness issues included the Department of Family Affairs, programs under the Workforce Innovation and Opportunity Act, the Supplemental Nutritional Assistance Program, and the Temporary Assistance for Needy Families. In some cases, a person may not be eligible for services if they had substance abuse issues or could not comply with other requirements. For example, housing services of the Section 8 program administered by the Puerto Rico Public Housing Department may disqualify a candidate for housing if he or she was previously evicted for drug use or possession of drugs.

Even though there were public programs available, Participant #1 felt the central government needed to pay more attention to homelessness issues. Participant #1 described it as follows “El gobierno no tiene muchos mecanismos para bregar con las personas sin hogar lamentablemente. [The government does not have many mechanisms to deal with the homeless, unfortunately].” For Participants #1 and #6, the local government's limited support was due to not having enough resources or not assigning sufficient funding to support programs for homeless individuals. Except for legislative donations, most of the funding received came from

federal programs and other not-for-profit organizations within the CoC, which also received funding from the federal government.

Challenges and barriers to service. The information included in this segment presented the factors obstructing chronically homeless individuals' rehabilitation process. Responses referred to internal and external factors associated with the individual and the environment. The internal factors included the personal characteristics and behaviors of individuals served within their respective programs. External factors referred to environmental circumstances that could significantly impact the rehabilitation process of the person.

Internal factors. The first factor was active use of substances or lack of adherence to treatment. For Participant #2, guiding individuals through a placement and rehabilitation process while still using substances was challenging. People who actively used drugs could not be entirely focused on the recovery process and may not complete the steps they needed to stay housed. Even if the programs had little to no barriers, the service providers still needed the person to cooperate in the process and gather the required documentation to make them eligible for services. The second factor was the development of independent living skills. After years of living in the streets, many lose the ability to take care of themselves. A person could need support to relearn basic tasks such as basic hygiene, prepping a meal, paying for utilities, and taking care of a house or apartment. Not being able to comply with the requirements due to a lack of basic skills could result in relocating the person to another type of living arrangement.

Participant #5 described it as follows:

> Una de las partes más complicadas […], con el residente es la parte del mantenimiento de la unidad. Donde el residente pueda ser autosuficiente en

> lograr que mantenga su unidad nítida. Por ejemplo, yo tengo que cumplir con Tax Credit, con Puerto Rico Housing y las unidades tienen que estar inmaculadas, porque si no son señalamientos generales y a veces es bien difícil.
>
> [One of the most complicated parts […], with the resident is unit's maintenance component. Where the resident can be self-sufficient in getting them to keep their unit optimal conditions. For example, I must comply with Tax Credit with Puerto Rico Housing, and the units must be immaculate, if not, there are serious reprimands, and sometimes it is very difficult.]

The third internal factor referred to mental health issues. For some individuals, moving from living in the streets into a structure could leave them feeling *boxed in,* and in some cases, less creative than they used to be. As a result, being housed could trigger an underlying mental issue like depression or an episode of any diagnosed (or undiagnosed) condition. All three factors required clinical and case management interventions from service providers and supportive services from the community.

External factors. The key informants identified five environmental factors that could delay the rehabilitation process of the person transitioning out of homelessness. Said factors included (1) little or no family support, (2) a limited number of professionals providing supportive services, (3) limited number of rehabilitation programs, (4) a reduction of the housing market, and (5) limited government support.

Little or no family support. Most individuals living in the streets lose touch with family members for a variety of reasons. The relationships could have deteriorated due to substance abuse issues, mental health issues, or family problems present before the first episode of homelessness. Family members grew tired of trying to help their loved ones.

A limited number of professionals providing supportive services. Participant #6 believed there were many services available, but not enough to satisfy the demand for said services. He agreed on the importance of having mental health and medical personnel such as social workers, psychologists, psychiatrists, and medical services to provide support and follow-ups on residents. Professional services helped individuals focus on the rehabilitation process and comply with paperwork and some housing facilities required.

Participant #5 expressed the following:

> A que logre ser una persona funcional en todos los aspectos de la palabra. […]. Eso se logra con mucho esfuerzo de parte del equipo multidisciplinario. Logra que esa persona, a la larga, pueda tener una unidad como dice la Ley de Vivienda: decente, segura y asequible.
>
> [To succeed in being a functional person in every sense of the word. This is achieved with a lot of effort on the part of the multidisciplinary team. It enables that person, in the long run, to have a unit as the Housing Act says: decent, safe, and affordable.]

Participant #4 described the role of the clinical and case management professional in the rehabilitation process:

> […] trabajamos lo que es equipo multidisciplinario. […] Y si,… con el servicio de apoyo y un seguimiento bien, bien de cerca de parte de los equipos clínicos y de trabajo social. […] de donde sea el profesional que la trabaje, es la parte que más cuidado tenemos que darle. Porque definitivamente estos son personas con trauma y tenemos que poder saber trabajar desde el trauma informado. Poder trabajar la persona desde sus traumas, porque por algo cayó en la calle.
>
> […] We work with a multidisciplinary team. […] And yes ... with support services and very, very close follow-up from the clinical and social work teams [...] Wherever the professional who works with it comes from, it is the part that we must provide the most care. Most definitely, these are people with trauma, and we must be able to work from informed trauma. Being able to work the person from his trauma, because they ended on the streets for a reason.]

The limited number of rehabilitation programs. Three of the key informants reported very few detox and rehabilitation programs available on the island. Most of the programs available were located in the metropolitan area of San Juan. Residents requesting services to address substance abuse issues could also receive treatment from APS Health. The APS clinics are mental health service providers who accept the government's health plan for low-income individuals. Nevertheless, for Participant #3, services did not meet the demands of many individuals who needed a focused intervention to deal with the addiction.

Participant #2 described the situation as follows:

> Si antes teníamos 10 ...Pues, ahora han ido en disminución. Tenemos cinco centros de rehabilitación y dos détox, por ejemplo. Porque a veces no hay fondos para ese servicio particular.
>
> [If we had 10 before ... Well, now they have been decreasing. We have five rehabilitation centers and two detox (programs), for example. Because sometimes there are no funds for that particular service.]

Participant #2 added:

> […] es un reto bien grande porque a veces queremos brindarle un servicio, ya sea détox... sea un programa de rehabilitación externo [...] Pues no lo encontramos. Es como que, nosotros como proyecto tenemos que asumir toda esa responsabilidad, y ver cómo podemos canalizar la situación del participante, para que se pueda mantener sin el uso de sustancias.
>
> [It is a very big challenge because sometimes we want to provide a service, be it detox ... or an external rehabilitation program [...] Well, we cannot find it. It is like, we as a project, must assume all that responsibility and see how we can channel the participant's situation, so that he can stay away from using substances.]

*A reduction in the housing market***.** Another factor impacting the rehabilitation process was the availability of housing. At least one participant, Participant #6, reported a limited number of housing units available to place homeless individuals. Also, he believed that the CoC needed to promote new housing projects and options for housing.

Participant #6 expressed it as follows:

> "Porque obviamente, una de las necesidades mayores que tiene la población es vivienda. Tiene que haber vivienda para poder ubicarlos."
>
> [Because obviously, one of the greatest needs that the population has is housing. There must be housing to be able to place them.]

They have limited government support. Participant #1 believed the ignorance associated with the homeless population and their needs resulted from the lack of governmental emphasis. The local authorities' message about the homeless population did not reflect a coordinated effort to inform the public about the problems they face. Hence, the lack of information contributed to the desensitization of society.

Participant #1 described it as follows:

> Yo creo que, la relación pública... hay que trabajar con esta información. Aquí se habla mucho del cáncer, de la diabetes, pero no se habla de las personas sin hogar en todo el contexto, la definición, y qué programas hay, dónde se puede buscar ayuda […].
>
> [I believe that, public relations ... you must work with this information. Here we talk a lot about cancer, about diabetes, but we do not talk about homeless people in the full context, the definition, and what programs are there, where to seek help.]

Participant #1 said the problem went beyond homelessness:

> Vemos una inactividad de gobierno hacia estos eventos, hacia las personas vulnerables. No solamente a las personas sin hogar, sino que también están los envejecientes.
>
> [We see a government inactivity towards these events, towards vulnerable people. Not only toward the homeless, but also the elderly.]

Participant #4 summarized her views about governmental action as follow:

> No podemos contar con la mayor parte de las estructuras gubernamentales... por la estabilidad de las estructuras gubernamentales o que la estructura le provea lo que la persona necesita por completo.
>
> [We cannot rely on most of the governmental structures ... because of the stability of the governmental structures or that the structure provides all that a person needs.]

The Housing First Model. The information included in this portion focused on the obtained responses regarding the views, opinions, and attitudes of service providers about the housing first model. There were two pre-identified main domains: (I) the Pathways Housing First (HFM) Model and (II) the housing first model in Puerto Rico. Several themes and subthemes emerged from the responses for each broad category.

(I) Pathways Housing Fist (HFM) model. There were three subthemes under the Pathways Housing First model category: (a) knowledge about the principles of HFM, (b) housing first vs. treatment first, and (c) legislation and funding.

Subtheme (a) Knowledge about the principles of HFM. All the key informants in the study expressed some knowledge about the housing first model. They defined the model and the intervention process as placing a homeless person in safe housing and then addressing all the related problems the person could present. All key informants identified housing as the focus of the intervention and acknowledged the role of support services in the recovery process. The supported services enabled a person to function in the new environment.

Every participant identified the staff: social workers and case managers, psychologists, and other clinical personnel, as supported services for homeless individuals and an essential part of the intervention process. However, they spoke of said professional services in general terms and were not always directly connected to the model. At least one participant associated the clinical and case management staff's tasks directly with the principles of the HFM. She also reported keeping two separate files: one for the administrative paperwork related to housing placement and a second file to record each participant's social and clinical services.

Other essential components of the HFM mentioned included recognizing housing as a fundamental human right, using a person center approach where the homeless person had a voice in the decision-making process, respect and value for others, and a risk reduction approach to service. In terms of procedures, all key informants referred to the new definition for the chronic homeless individual as stated by the model and HUD. Furthermore, all key informants included eliminating barriers to housing as pivotal in the approach to service.

Subtheme (b) Housing First (HF) vs. Treatment First (TF). Key informants compared the housing first approach to service with previous interventions focused on providing treatment before placing an individual into permanent housing. Although none of the key informants voiced opposing the HFM approach to service, four expressed reservations about the model's

effectiveness. The HF's adoption implied a paradigm shift focused on placement instead of developing independent living skills or treating any mental, alcohol, or substance abuse issue a person had before permanent placement.

Reservations about HF. Key informants who expressed reservation about the HFM approach felt individuals who received treatment for substance abuse or mental issues first had the opportunity to focus on the rehabilitation process. They were more cooperative, understood the process and requirements better, and had better adherence to treatment. At least three of the key informants believed that the HFM approach was not for everyone. Some individuals who experience chronic homelessness benefited from moving from one step to the next, allowing them to develop the independent living skills needed for permanent housing. Furthermore, the current HFM model did not focus on including transitional housing services for said population.

Participant #2 expressed her views about chronically homeless individuals with addiction issues as follows:

> Estás en un albergue de emergencia, te paso a una vivienda transitoria, en la vivienda transitoria, ahí vamos trabajando eso... esto nos ayudaba mucho. Pero ya las viviendas transitorias para HUD no es algo importante. No es necesario, diría yo. Pero eso nos ayudaba, porque esa persona pasaba por el proceso de calle a albergue de emergencia, a vivienda transitoria... algo interino, dos años... no era por mucho tiempo. Ya habíamos trabajado la situación del participante. Ya está entonces apto para vivienda permanente. Así que, para mí... eso funcionaba, entiendo yo. Pero ahora es, cógelo de la calle, lo cogemos de la calle... dale la vivienda y después trabajamos lo demás.

> [You are in an emergency shelter, I move you to a temporary housing, there, in the temporary housing, we are working on that, ... this helped us a lot. But transitional housing for HUD is no longer important. It is not necessary, I would say. But that helped us, because that person went through the process from the street to an emergency shelter, to transitional housing ... something intermediate, two years, ... it wasn't for long. We had already worked on the participant's situation. He is then fit for permanent housing. So, for me ... that worked, as I understand it. But now it's, take him off the street, we take him off the street ... give him the housing and then we work the rest.]

Key informants with reservations about the model agreed with its fundamental principles and acknowledged not working on programs fulling functioning under HF's premises. In other words, key informants served a mixed clientele of chronic and non-chronic homeless individuals in programs with different regulations at the same time. The programs running the housing projects had to comply with regulations, at times at odds with one or more of HF's basic principles.

Openness to Housing First. Two of the four key informants in the study believed that the HFM approach to service worked. One participant acknowledged that working under the HFM came with the risk of having a resident destroying the housing unit. Participant #4 believed the way HFM programs managed the situation under housing first was more effective than previous approaches because of how closely the professional teams monitor residents. Close monitoring and frequent follow-ups allowed case managers and the clinical staff to address issues during the process and to provide support in a timely fashion. The interventions focused

on risk reduction; therefore, a person could have a relapse, work on the recovery process, and stay off the streets.

Participant #4 described the intervention process as follows:

> Como lo manejamos ahora es más efectivo. […] como hay un seguimiento más de cerca […] Puedo identificar los diferentes asuntos con los cuales trabajar, pero por lo menos no va a estar en la calle. Porque el problema es que lo poníamos en una vivienda transitoria, allí se metía en algún problema, lo votaban y a la calle. Y entonces era volver a empezar, y volver a empezar. Pues entonces en este punto, podemos trabajar con esta persona, que de entrada estamos reduciendo daño.
>
> [How we handle it now is more effective. […] there is closer monitoring […] I can identify the different issues on which to work on, but at least he will not be on the street. Because the problem is that we put him in a temporary home, there he got in trouble, they throw him out, and out into the street. And then it was starting over and starting over. Well, then at this point, we can work with this person, we are reducing harm from the get go.]

According to Participant #4, she was hesitant about the approach and recognized that adopting the housing first model took time and a willingness to change. Nonetheless, in the long run, it has proven to be more efficient than previous strategies. For example, it used to take six months to place someone in permanent housing. Under the current model, the placement process could take two to three weeks.

Opinions and attitudes about housing first. The following information reflected the overall opinions and attitudes of the key informants about the HFM model. Said views range from the challenges of implementing the model to impressions about the gaps in capabilities and resources intrinsic to the programs.

It was complicated to implement the housing first model in Puerto Rico. Most of the programs servicing homeless people adopted in some way the HFM approach to service. Still, for Participant #4, there was some resistance to embrace the approach fully. Four of the six key informants felt HFM was complicated to implement "as is" in Puerto Rico. Two participants stated that the federal government's expectation about the HFM programs in Puerto Rico did not consider the local environment's capacity or resources. Both felt organizations in the US had access to a comprehensive professional team and greater resources than most programs on the island.

Participant #2 explained it as follows:

> [...] entiendo que ellos tienen el equipo profesional completo y tienen mayores servicios. Creo que hasta cuentan con el respaldo del Estado para poder trabajar con esta problemática de las personas sin hogar, y tienen una serie de servicios, ya sea de vivienda... Por lo que he escuchado, hay muchas viviendas para la población de personas sin hogar en Estados Unidos.
>
> [I understand that they have a complete professional team and greater services. I think they even have the support of the State to be able to work with this problem of homeless people, and they have a series of services, either housing

... From what I have heard, there are many houses for the homeless population in the United States.]

Housing first was not for everyone. Three key informants expressed that working with the homeless populations was not easy, and not every homeless person was ready to commit to the housing project's rules. For example, an organization could have more than one program addressing homelessness and servicing different subgroups of the population. As a result, programs that run housing complexes may have to comply with different regulations simultaneously. Some housing projects could require residents to maintain the apartment unit clean and orderly or abstain from using substances. When a resident was unable to comply with the project's requirements and refused to receive supportive services, he or she could be transferred to another housing facility.

Participant #2 stated the following:

He compartido con otros compañeros que sí, [...] tienen sus proyectos Housing First y dicen 'Es que esto es como una locura... porque ponemos al participante tal y como está... Y después vamos a trabajar todo lo demás'. Pero […], tenemos el participante, él no quiere ningún tratamiento. Él no quiere hacer nada... y está constantemente alterando a la otra matrícula, que ya está estable, que está en tratamiento... pero él solamente está pensando en que, 'No. Yo quiero seguir usando sustancias. Yo voy a seguir usando droga'.

[I have shared with other colleagues that yes, [...] they have their Housing first projects, and they say 'This is crazy ... because we place the participant as he is ... And then we will work on everything else'. But […], we have the

> participant, he does not want any treatment. He does not want to do anything... and is constantly altering the other key informants, which are already stable and in treatment ... but he is only thinking about 'No. I want to continue using substances. I'm going to continue doing drugs.]

The key informants recognized that the HFM model enabled people to access housing faster, making the process agile and responsive to the residents' needs. Nevertheless, for Participant #1, the turn-over of residents that some programs working under the model experienced related to residents' inability to commit to some type of intervention.

We are working alone. Key informants named two factors impacting supportive services, (1) lack of interconnectivity among programs within the continuum of care and (2) little support from the local or central governments. The first factor, lack of interconnectivity, refers to the programs and organizations' capacity to work together effectively. Participant #3 felt organizations within the CoC did not know the extent of the services each provided and how to complement each other's needs. Although organizations may have collaborative agreements with each other, not all took full advantage of said resources. In some cases, the agreement ended without executing a single action. Likewise, Participant #2 noted that the lack of support from service providers from different segments, mainly referring to the mental health network and rehabilitation programs, translated into a decrease in accessibility to resources when they needed them the most.

The second factor refers to the amount of support organizations receive from the local or central government. Three of the key informants noted a lack of government-run initiatives toward the homeless population or not prioritizing initiatives related to homelessness. For instance, the COVID-19 pandemic became a public health emergency that resulted in a stay-in-

place order in March 2020. The governor at the time, honorable Wanda Vazquez Garced issued an executive order focused on providing support for the homeless population.

Participant #4 described the status of the order and subsequent actions eight months later as follows:

> Todavía estamos esperando el supuesto plan para poder darle asistencia a las personas sin hogar por lo del COVID. […] La gobernadora hizo una orden ejecutiva […] un mandato a Familia, Vivienda y Salud para que hicieran el plan, para poder lidiar con las personas sin hogar. […]. Eso fue en marzo. Y estamos esperando todavía el bendito plan, que ha corrido de agencia en agencia, pero nunca se hizo nada.
>
> [We are still waiting for the supposed plan to be able to give assistance to the homeless due to COVID. […] The governor signed an executive order […] a mandate to the Family, Housing and Health Departments to make the plan, to be able to deal with the homeless. […]. That was in March. And we are still waiting for the darn plan, which has gone from agency to agency, but nothing was ever done.]

Participant #1 also noted:

> No... no ha sido prioridad. No ha sido prioridad. [...] acaban de recapturar no sé cuántos millones de Salud. ¿De qué estamos hablando? Si el mismo Gobierno central no puede actuar... no nos van a escuchar a nosotros como organizaciones de base comunitaria.

[No… it has not been a priority. It has not been a priority. […] they just recaptured I don't know how many millions from the Health (Department). What are we talking about? If the central government itself cannot act ... they will not listen to us community-based organizations.]

Subtheme (c) Legislation and funding. The Legislation and funding topic sought to explore new initiatives to support the chronically homeless population and the organizations working on their behalf. None of the six key informants were able to identify any new legislation on the subject. Most key informants stated that in the last four years, honorable José A. Vargas Vidot, an independent senator and advocate for the homeless population had submitted a legislative piece that was buried in the legislative process. The purpose of the legislation was to replace the current law, which created the Multisectoral Council in Support of the Homeless Population (Act of 130 of 2007, now Act 194 of 2016). Said initiative was not well received by the organizations.

Participant #4 stated the following:

[…] nosotros hicimos una ponencia en contra. Porqué, lo que están haciendo con el proyecto de ley, habiendo ya una ley, que lo que hay es que ponerla en vigencia y tal vez revisarla. Quieren derogar esa ley, y hacer una que va en contra de muchas cosas que tiene ya la ley federal.

[we made a presentation against it. Because, what they are doing with the bill, having already a law, what you must do is put it in effect, and perhaps review it. They want to repeal that law and make one that goes against many things that the federal law already has].

Funding. At least two key informants expressed that the available funding opportunities for services focused primarily on chronically homeless individuals. Hence, organizations adjusted their goals and objectives to comply with said opportunities. Participants #1 and #3 believed local programs moved to request funding from HUD that did not necessarily reflect the homeless population's needs in Puerto Rico. In other words, other subpopulations may be underserved because they were not a priority at the federal level. At the same time, programs in Puerto Rico have not explained to HUD the differences between the Puerto Rican homeless population and the population in the United States.

Key informants noted the importance of performance among the organizations within the continuum of care (CoC). The federal government assessed the performance of the CoC as a single entity. Organizations or programs that did not achieve the projected outcomes could put the CoC at risk of losing funding. For Participant #1, local programs needed to make sure they could meet all the proposal requirements and provide the services they agreed to offer in the application.

(II) Housing First in Puerto Rico. The second domain, housing first in Puerto Rico, also had three main subthemes (a) the program's structure in Puerto Rico, (b) the advantages and challenges in service of said programs, and (c) improving the implementation of the housing first model in Puerto Rico.

Subtheme (a) Program's structure in Puerto Rico. In this segment, key informants described the general structure of programs and the procedures for providing services to the homeless population. Of the four programs included in the study, three were part of a community-based or not-for-profit organization and one government-run program. Two of the

programs belonged to the same community-based organization. All programs worked with chronic individuals, and three of them also accepted other types of homeless populations.

Two of the programs identified themselves as HFM programs, and one focused only on chronically homeless individuals. The rest of the programs were not fully implementing the HFM approach. However, they did adhere to some of the principles when working with chronically homeless individuals (i.e., following the definition of chronic homeless and removing barriers).

Program's procedures. The programs followed the same basic admission process, established for programs on each continuum of care (CoC) system, for new applicants. First, the person requesting services must go through the Coordinated Entry System (CES) to determine the eligibility for services. Once the CES determined the level of chronicity and characteristics (e.g., a chronic homeless individual with a disability, victims of domestic violence, elderly individuals), it referred applicants to a specific program or organization within the CoC. The organizations continued the assessment process, provided options, and identified additional needs and support the person could require.

Participant #1 described the admission process as follows:

> Esa es la manera de lo que es 'housing first'. Tú identificas a esa persona, al deambulante, o él va directamente. Se envía al Sistema Coordinado, el Sistema Coordinado le hace una entrevista, que es un VI-SPDATA… algo así. Son unas 16 preguntas, le da un número, y ese número dice si es para vivienda transitoria, vivienda permanente... de albergue... se le dan todas las opciones y el cliente escoge. Ellos te lo refieren, y nosotros acá lo entrevistamos […].

> [That is the way housing first is. You identify that person, the homeless person, or he shows up directly. He is sent to the Coordinated System, the Coordinated System does an interview, which is a VI-SPDATA… something like that. There are about 16 questions, it gives him a number, and that number says if it is for transitional housing, permanent housing ... shelter ... they are given all the options, and the client chooses. They refer them to us, and we interview them here […]

Programs could choose to implement, or not, the HFM approach to service. By 2020, a significant number of permanent housing programs in both the Puerto Rico Continuum of Care (PR CoC) systems adopted, in some way, the principles of the HFM model. However, key informants believed not all programs identified as HFM adhered to all the approach's essential characteristics.

Participant #1 explained the situation as follows:

> Y no todos los programas actúan según lo que han propuesto, y eso ha sido una de las quejas principales dentro de nuestro CoC.
>
> [And not all programs act according to what they have proposed, and that has been one of the main complaints within our CoC.]

She went on to add the subsequent statement:

> Y es que tenemos tantos, tanto proyecto, que dicen que son 'Housing First' y no me aceptan los participantes. Y ¿entonces de qué estamos hablando? Si tú no tienes ninguna barrera, no me puede... no lo puede rechazar... Y ahí es que

ha venido un poquito el roce, […] en ocasiones los programas no aceptan al participante, aunque tengan puesto en la propuesta que son 'Housing First'.

[And the thing is that we have so many, so many projects, that say they are Housing first and they do not accept the participants. And then, what are we talking about? If you don't have any barriers, you can't ... you can't reject them ... And that's where we have a little friction, […] sometimes the programs don't accept the participant even if they say in the proposal that they are Housing First.

Participant #4 added the following:

Y entonces me encajona a eso, a unos servicios que posiblemente yo no... me obligaron recibir. Qué pasa con la mayoría de los participantes, que tú los obligas a entrar a un détox para que puedan entrar a un programa de vivienda.

[And then it restricts me to that, to services that possibly I did not ... they force me to receive. That's what happens to most of the participants, that you force them to enter a detox so that they can enter into housing program.]

Services within programs. The inhouse services refer to supportive services available to maintain the residents housed after placement. All the organizations with permanent housing programs included at least one type of supportive service within their structure and used referrals to supplement any additional services residents could need. The geographical location of the program determined the accessibility to specific services.

Human resources. Program's services and professional staff varied according to the size and type of population each one served. All programs had two main areas: the administration or management team and a social services team. The administration or management teams dealt with the regulations and compliance with the program's guidelines, the regulations of HUD, Fair Housing Act, and any other type of regulation linked to funding sources the organizations received. The social services team included the clinicians and case management personnel. Most clinical staffers, such as psychologists, medical doctors, and psychiatrists had professional service contracts and worked part-time in the programs. The case managers included social workers, clinical social workers, and addictions counselors hired as full-time employees and in charge of the day-to-day follow-ups to residents. Some of these professionals also served as service coordinators. Like in traditional HFM programs, the administrative and social services teams maintain two separate files for each resident, working cooperatively together but independently from each other.

Adopting the Housing first model. HUD started implementing the HFM model in Puerto Rico in 2014, and the PR CoC made it a priority in 2016. As previously stated, two of the organizations in the study identified as HFM programs. The change in strategy to address homelessness required organizations to restructure their methods and implement different service strategies. For Program #2, said changes implied a capacity-building strategy for employees, volunteers, and the homeless population applying for services. The program had the basic HFM structure as described by Tsemberis (2015) for the HFM model. In other words, the structure included two intervention teams working cooperatively together but independently. The case management team (or social work team), in charge of the case management services, house visits, and follow-up on residents in the community, and the clinical team that provided support

related to residents' mental health and substance abuse issues. Additional therapy and pharmacological services were available through the government's public health services and health care insurance. The organization also adhered to a harm reduction model and Prochaska and DiClemente's transtheoretical model for change as part of their approach to service.

Services. The organization and programs in the sample provided permanent housing services to chronically homeless individuals, as defined by HUD, with a disability or substance abuse problem. If the person was eligible for services, the case manager could place them in permanent housing in three to four weeks. In terms of supportive services, the program maintained a multidisciplinary approach to services. It had access to psychologists, social workers, addictions and mental health counselors, nurses, and medical doctors. Additional services included a clinic, workshops for residents focused on building independent living skills, financial education, job training, social development, and wellness.

Participant #4 explained that the program has been successful because it was flexible enough to make the necessary adjustments to meet the residents' needs. She also acknowledged that the organization has grown to be a small CoC, providing the services the government cannot provide to their residents. For example, the organizations owned housing projects to place new applicants, had housing vouchers available for the homeless individuals, and sustained good relationships with landlords. Participant #4 stressed that no organization could address an issue as complex as homelessness by themselves. Therefore, the organization also developed collaborative agreements with community-based organizations, faith-based organizations, the private sector, and government programs to complement its services. The holistic approach helped maintain former homeless individuals housed for more extended periods, even when they

experienced a relapse. The program maintained over 97% of the occupation, most of the time, since adopting the model.

Adapting to Housing First. Complying with HUD regulations to serve chronically homeless individuals was difficult, especially for service providers. Participant #4 admitted she was among the skeptics who doubted the effectiveness of the model in Puerto Rico in the early stages.

Participant #4 described her feelings about the model as follows:

> Y en ese momento, yo como muchas personas pensaba '¡pues esto es ideal! porque yo no puedo llevar una persona que está... usando... el ejemplo del uso de droga, que está usando droga brutalmente, y ¿lo voy a meter en una vivienda? La va a desbaratar, la va a vender'. Esa era la forma de pensar en ese momento.
>
> [And at that time, I, like many people thought 'well this is ideal! because I cannot take a person who is... using... the example of drug use, with severe drug use, and I am going to put him in a house? He is going to destroy it; He is going to sell it'. That was the way of thinking at the time.]

Employees had difficulty comprehending how the program could provide housing to homeless individuals without achieving stability before the placement. Participant #4 recalled that social workers had a hard time buying into the philosophy behind the model after years of working with hard-to-place individuals with little to no skills for living independently and in need of mental or substance abuse treatment. Some employees could not handle the model and decided to leave the program. New employees who did not have experience with previous

interventions were more receptive to the HFM approach to service and adapted quickly. In time, the employees accepted and adapted to the model and found ways to address the participants' needs.

Participant #4 admitted having cases where residents destroyed property and knew it most likely will happen again, but the new strategies helped minimized said risks. The personnel closely followed each case and could identify the issues residents may have and address them before they escalated. Addressing potential situations as they arise helped keep individuals off the streets, and that alone is a risk reduction strategy with a direct impact on the individual.

Subtheme (b) Advantages and challenges in service. The following subtheme focused on the advantages and challenges in providing services to chronically homeless individuals under the HFM model. Key informants mention various advantages and challenges in areas such as availability of resources for supportive services, active participation of homeless individuals in the rehabilitation process, and support from stakeholders.

Advantages. The key informants identified various advantages of using the HFM model. First, it reduced the amount of time a homeless person spends waiting for housing. Before the HFM program adopted the model, it could take up to six months to house a homeless person in a permanent home. Second, service providers sought to simplify the process by helping individuals access the documents needed to complete the housing application process. Participant #5 noted that changes brought up by the COVID-19 Pandemic forced government agencies to develop online resources to process official documents, facilitating the placement process. Thus, the staff could help homeless individuals obtain documents and benefits online, minimizing delays in placement. It also reduced the frustration a homeless person experienced moving from

office to office requesting documents without having the resources, minimizing the number of documents lost or not submitted on time.

Lastly, case managers closely monitored residents and worked with them to develop independent living skills and to access economic resources and mental or physical health services as needed. Providers could adjust services to address the issues when they arose and when the resident was able and willing to work on said issues. Also, case managers could request and coordinate supportive services directly from the clinical resources available within and outside the program to address residents' mental or substance abuse issues.

Challenges. Key informants identified several challenges in applying the HFM model in Puerto Rico. First, all key informants stated the importance of providing supportive services throughout the process. However, all agreed that the services available for substance abuse and mental health disorder were insufficient to meet the population's needs. People transitioning from homelessness to a housing program typically qualified for the health care plan provided by Puerto Rico's Department of Health Services, and private providers may not accept said plan. According to Participant #1, there were five to six programs for detox and rehabilitation services on the island for all individuals dealing with addictions. That is, providers who accepted participants dependent on the government's health insurance. Most programs were in the metropolitan areas near San Juan and some focused on specific populations. Second, the model required participants to be willing to take part in the rehabilitation process. However, not all participants were ready or wanted to engage in a rehabilitation process.

Participant #1 said the following:

> Nosotros recibimos un adiestramiento donde decía que HUD te dice tú lo recibes con ese problema, pero el participante tiene que tener un compromiso de... salir de ello... que necesita recibir la ayuda. Debe recibirla. Tiene que estar dispuesto. Si el participante se niega, tú lo puedes sacar. Y ahí vienen esos problemas del 'turn over', de que el participante realmente no está listo para la rehabilitación. Y ese es uno de los problemas.
>
> [We received a training saying that HUD tells you to receive him with that problem, but the participant must have a commitment to ... get out of it ... that he needs to receive help. He must receive it. He must be willing. If the participant refuses, you can remove him. And that's when you have those turn over problems, that the participant is not really ready for rehabilitation. And that's one of the problems.]

In short, service providers were not always able to persuade residents with serious addiction issues to accept services and, in some cases, they may start using substances within the housing projects. In such cases, if a resident cannot comply with the living standards and regulations set by HUD (a safe, secure, and affordable housing), he or she may lose the housing unit.

Challenges within programs. Key informants identified challenges related to issues within the programs themselves. Two of the key informants noted that not all programs fully understood what it meant to be an HFM program. As a result, programs could not perform as expected, which impacted the entire CoC's performance. There were several reasons why

programs could underperform. First, some providers requested funding to provide permanent housing services without understanding what the proposal was about nor the commitment to services the organization assumed. The programs' personnel could rely on faulty interpretations of the model, turning away the chronic homeless individuals they were supposed to serve.

Participant #1 described it as follows:

> Bueno, eso tiene que venir de adentro de los programas... tienen que aprender a manejarlo. Vamos, a ser realistas... Cuando se solicita unos fondos para trabajar con unas poblaciones específicas, usted tiene que estar seguro de cumplir con todas las exigencias... de esos fondos. Para quién va dirigido... Así que primero tenemos que trabajar... que cada programa entienda su propuesta, que, usted se puede sorprender de cuántas personas han trabajado esa propuesta y no saben.
>
> [Well, that must come from within the programs ... they have to learn to handle it. Come on, let's face it ... When applying for funds to work with specific populations, you have to be sure that you meet all the demands ... of those funds. Who it is aimed at... So first we have to work on... that each program understands its proposal, you may be surprised how many people have worked that proposal and do not know it.]

In other instances, programs requested residents to adhere to certain practices or activities to receive housing and the supportive services the person needs. It was not an overt practice. HUD could learn about programs subtlety putting conditions to residents if residents complained directly to the agency. As a result, programs may not reach the occupancy goals specified in the

proposal because they would turn people away. In those cases, programs fail to perform and comply with the model's fundamental principles and procedures as stated in the funding application.

The second reason some programs underperformed was assuming a commitment to provide services they were not equipped to provide. Participant #3 phrased it as follows “Lo que pasa es que no todos los programas […] tienen el andamiaje para entonces poder cubrir esa necesidad”. [What happens is that not all programs […] have the scaffolding to be able to cover that need.] The programs could focus more on housing the homeless person and less on providing the supportive services they could need to stay house. Hence, programs did not always have all the clinical or case management staff needed to follow up with residents, or the services were not available in the community.

The third challenge programs faced related to the continuum of care (CoC). The CoC was a network of organizations working together to provide services to chronically homeless individuals. Still, services within the network were disjointed or not cohesive enough to enable organizations to work together, complement each other’s services, and follow up with the homeless individuals they serviced. Nonetheless, two of the key informants acknowledged that even with limited cohesiveness in services, the communication and collaboration among the organizations had improved over the years. Both key informants expressed the need for programs and organizations to learn about each other's services and act on the collaborative agreements already in place. Another participant added that organizations tended to provide the same services (e.g., permanent housing) instead of seeking funding for complementary services.

The fourth and last challenge organizations faced under the HFM model was funding. According to key informants, funding opportunities available through HUD focused on the

agency's priorities and did not necessarily reflect the priorities of the PR CoC. Participants #1 and #3 noted that the homeless person in Puerto Rico was not the same as the person in the US. Participant #3 stated that individuals in the states fell into homelessness due to economic reasons and lack of resources. In Puerto Rico, the causes of homelessness could revolve primarily around individuals experiencing emotional or physical health issues more frequently than economic reasons alone. Therefore, resources such as transitional housing and shelters were alternatives for accessing supportive services.

Participant #3 stated the following:

> A veces HUD establece, por lo menos dentro de nuestro Cuidado de Continuo, 'no que esto va destinado a cronicidad.' Pero más, sin embargo, cuando vamos a los datos estadísticos, posiblemente esa no es la necesidad real. Porque HUD lo establece basado en un marco de Estados Unidos, de todos los estados. Nosotros somos un territorio que tenemos unas peculiaridades y particularidades. Nuestra población es bien distinta posiblemente a la población que se atiende en Texas o que se atienden en California…
>
> [Sometimes HUD establishes, at least within our Continuum of Care, 'no, this is intended to chronicity.' But still, when we go to the statistical data, possibly that is not the real need. Because HUD established the framework based on the United States, of all the states. We are a territory that has its peculiarities and particularities. Our population is very different, perhaps, from the population served in Texas or served in California…]

Nonetheless, organizations leaned toward adjusting their priorities to mimic the agency's, enabling them to compete for funding. As previously stated by Participant #6, most funding directed toward services for the homeless population came from the federal government. Hence, funding opportunities in Puerto Rico from the private or public agencies were very few. Participant #4 did acknowledge that the legislative branch provided funding to community-based organizations, but it was never included within the budget. The monies were usually assigned and disbursed late in the fiscal year. As a result, these non-for-profits organizations felt they could not rely on local government for support. In the last few years, several shelters and programs had to close their doors due to budget cuts and lack of funding. Participant #3 added that well-established organizations could have fewer difficulties to obtain legislative funding than smaller organizations. At least one participant felt programs adjusted to the Notice of Funding Availability (NOFA) priorities for fear of losing funding.

One last concern about funding had to do with the performance and compliance of organizations. HUD provided a limited amount of funding available to all programs providing permanent housing services under the HFM model. All programs within the CoC could increase, but the funding available may not.

Participant #1 described it as follows:

> [...] si son 294 mil, eso fue lo que pediste y te otorgaron en el 2001, es lo mismo, ellos no... aumentan porque... aumentó el costo de vida. No, eso también a nosotros, pues nos dificulta. Si tú quieres tener un empleado con una maestría o con un doctorado, necesitas mayor presupuesto para poderle pagar, según los estudios.

> [if there are 294 thousand, that's what you asked for and they gave you in 2001, it's the same, they don't ... increase it because ... the cost of living increased. No, that also makes it difficult for us. If you want to have an employee with a master's degree or a doctorate, you need a higher budget to be able to pay them, depending on their education.]

Programs within the CoC competed for funding. An increase in the number of programs requesting funding diminished the opportunities of obtaining a higher budget. Therefore, when programs request funding and do not perform as expected, the available resources for those who do comply with the model are reduced.

Government support. According to four of the six key informants, the local government has not provided enough support to the organizations or the island's homeless populations. As previously stated, many initiatives directed toward the population never materialized in concrete actions. Some issues were not addressed promptly unless it was brought to the public's attention through the media or when it became an issue for the community in general. The examples commonly mentioned by key informants were the government's responses to the natural disasters from the last few years: hurricanes Irma and María in 2017, the earthquakes of January 2020, and the COVID-19 Pandemic also in 2020. Although almost all sectors have criticized the overall government response, the homeless population was largely overlooked.

Participants #1 stated the following:

> Y lo vimos ahora. Cada vez que viene la temporada de huracanes, y lo que pasó de los movimientos telúricos, de los dos terremotos. ¿Dónde vamos a colocar a los deambulantes, a las personas sin hogar?

> [And we saw it now. Every time hurricane season comes, and what happened from the telluric movements, of the two earthquakes. Where are we going to place the homeless, the homeless people?]

Key informants pointed out that there was no plan for addressing the needs of homeless individuals during emergencies. They also felt there was no clear public policy to support the homeless population, especially during emergencies and natural disasters. Furthermore, the government agencies appointed to articulate an action plan never followed through with the plan's development. If they did, it was unknown for most of the key informants at the time of the study. Not-for-profit organizations developed their strategies and action plans to address any issue that may arise. However, the lack of support and continuity to any initiative left service providers frustrated and seeking other options to fill the gap the government did not fulfill.

Subtheme (c) Improving the Housing First model in Puerto Rico. The following subtheme groups the opinions of service providers on factors organizations need to consider for improving the implementation of the HFM model in Puerto Rico. The opinions ranged from openness toward the model, resources such as housing and to organizational changes within the CoC and programs.

Openness toward the model. Service providers needed to be open to the HFM model and willing to change and adapt their internal process to the new intervention approach. Two of the key informants noted that the HFM model was not going away. For Participant #1, HUD was moving toward a zero-barrier approach to service, so programs needed to accept and adapt to said changes. Adopting the HFM model also implied that organizations needed to learn to be flexible and open to designing and redesigning their action plans and training the personnel accordingly.

Capacity building. Employees within the programs need training regarding the housing first model, its philosophy, and implementing it in the Puerto Rican environment. For programs to apply the model effectively, all staff members need to know and understand the model. The training needs to focus on every aspect of the model, from the basic principles to technical assistance, and on when to implement specific strategies. For one participant, capacity-building training should be taught by professionals knowledgeable about the model and with experience working with the homeless population.

At least one participant pointed out the need to establish a program for ongoing technical assistance and workshops about the housing first model. Each CoC system had a facilitating agency, which received funding to develop and provide technical assistance for the CoC. Although key informants acknowledge receiving workshops and training about HF, at least three felt the need for more information. To improve the implementation of the model, the facilitating agencies could develop an action plan for capacity building that met organizations' needs within each CoC. The workshops or training should range from the basic definition of housing first and what it meant in terms of services to practical and technical information about performance and compliance. At least two key informants specified being interested in learning about how to address the issues of a complex population using the model in the local environment from professionals with experience with HFM and the homeless.

Participant #2 noted the following:

> Por lo menos preparación como tal... no hemos tenido. Nos han dicho que debemos cumplir con ese modelo, pero darnos las herramientas como tal, qué debemos hacer ... 'mira si te pasa esto... puedes hacer esto, puedes hacer esto, esto y esto con esta población'... Yo diría que no. No lo tenemos.

> [At least training as such ... we have not had. They have told us that we must comply with that model, but to give us the tools, what we must do ... 'look if this happens to you ... you can do this, you can do this, this, and this with this population' ... I would say no. We don't have it.]

Key informants also identified the need to educate the local government official at the municipal and state level and the community. Government officials ought to understand the problem so they could develop public policies supporting the homeless population. Also, the government should address the concerns of the communities through a public relations campaign educating the public about homelessness, the organizations, and the strategies in place to address the issue.

Organizations could also educate both local and federal governments about the needs of the local population through information. Every year, organizations within the CoC collect information about the Puerto Rican homeless population and its services. For one participant, the CoC needed to carry out a deeper analysis of the data collected and use it to understand and explain the population's needs. Furthermore, the information could also help explain to the local and federal government how chronicity manifested and to identify the gaps in services on the island. Also, the data should be used to help HUD and the federal government understand the differences between the local homeless population and the states' homeless. Participant #1 expressed not expecting HUD to have a separate Notice of Funding Availability (NOFA) for Puerto Rico but at least hoping it could gain a deeper understanding of the challenges the local organizations faced.

Human resources. Programs and organizations need a complete staff, including clinical personnel, who know the residents and are available when a crisis arises. The inclusion of professionals such as psychologists and addiction counselors, as regular employees, could also make the follow-up interventions more effective. Furthermore, the additional personnel should improve their strategies to ascertain the progress and challenges residents may have after being placed in permanent housing to prevent relapses and provide additional support when needed. At the time of the study, clinical staff in most programs was hired a few hours a week through professional services. On a side note, one participant suggested the clinical staff could include the RC because she believed most programs in the US include said professionals among the clinical staff. Four of the six key informants thought programs in the US working under the HFM model premises had the professional and community services and housing opportunities within reach, making it possible to implement the model as proposed by HUD.

Supportive services. All key informants felt supportive services went hand in hand with housing options for homeless people. Key informants focused on three main areas for services: developing internal resources, establishing connections with other programs in the community, and identifying housing opportunities. In terms of developing resources, at least one participant hoped for programs and organizations to develop their detox or rehabilitation program, enabling the staff to access and refer residents when needed. For other key informants, collaborative agreements were crucial factors for improving services. Key informants believed in the importance of finding and connecting with community resources to complement their services, creating collaborative agreements, and using them accordingly. Because half of the key informants believed the housing first approach was not for everyone, maintaining current resources not contemplated under the model was essential. Nevertheless, for those programs to

be effective, they needed to be accessible to the clients and within the same geographical area as the homeless person. At least one participant deemed necessary services such as detox programs, emergency shelters, and transitional housing.

The third factor, housing opportunities, refers to the role programs and organizations play in increasing housing opportunities for homeless individuals. For Participant #6, programs and organizations needed to seek housing options and promote housing projects with and without supportive services for permanent housing. Without housing options, moving homeless individuals to permanent housing units would not be possible.

Support from governments and government agencies. At least two of the key informants thought the local government needed to support the programs and organizations working with the homeless population. The government could show support by establishing a clear public policy regarding homelessness, allocating funding, and maintaining supportive services. Additionally, key informants stated the importance of developing plans to address vulnerable populations' needs during natural disasters and other emergencies. Key informants described the governments' and government agencies' response to emergencies in the past for years as an example of lack of preparation. For half of the key informants, the lack of preparation prompted organizations to assume the state's responsibility by providing the services the government did not provide.

Consequently, organizations needed to divert financial and other organizational resources to address emergencies. Participants #2 and #3 felt they worked alone and that the responsibility of the outcomes fell on the organizations. Nonetheless, the government expected positive outcomes and promoted itself using said results while providing limited support.

Participant #4 described it as follows:

> Ahora mismo, la semana pasada [en octubre] fue que nos llamaron a buscar el cheque de donativo legislativo y empezó en julio, el año fiscal... ¿Y por qué? Porque la directora ejecutiva de la organización la entrevistaron en las noticias y había un legislador allí, y ella […] Lo puso nuevo frente a las cámaras. Al otro día nos estaban llamando para que fuéramos a buscar el cheque. Entonces hay que recurrir a eso, para conseguir algo que tiene el Gobierno, los fondos, y que son específicamente para las organizaciones que te dan los servicios, que tu gobierno, no puedes dar.
>
> [Right now, they called us last week [October] to get the legislative donation check, and it started in July, the fiscal year ... And why? Because the executive director of the organization was interviewed on the news and there was a legislator there, and she […] put him in his place in front of the cameras. The next day, they were calling us to go get the check. You must resort to that, to get something that the Government has, the funds, which are specifically for the organizations that provide the services that you, the government, cannot provide.]

Review of Documentation

This segment presented the information obtained through various documents from the PR CoC 502 and 503 and their programs. The document review process focused on identifying the Housing first model's features and the rehabilitation counseling professional's scope of practice

as depicted by the CoC and programs' literature. The identified information was recorded on two forms: Program Principles and Protocols (Appendix A and B) and the Duties and Responsibilities of Service Providers (Appendix C and D). The purpose of the review of documents was to triangulate the information obtained through the interview process.

Program Principles and Protocols. Most information available for the document review was from the 2019 Consolidated Application for both CoC (502 & 503), the webpages, and program brochures. HUD required all CoC systems to apply for funding as a single unit. Thus, the application included objectives and strategies reflecting the procedures of all the organizations under said CoC.

The Notification of Funding Availability (NOFA) for HUD aimed to promote the housing first approach to service to end homelessness, focusing on funding services in tune with the approach. Therefore, all the activities included in the application related to chronic homelessness were housing first based. The analysis centered on classifying the planned activities and strategies described in the application to identify specific principles. Most of the activities and strategies depicted in the application related to four of the model's eight principles. The principles were the scatter-site housing or independent apartments, consumer choice and self-determination, recovery orientation, and harm reduction.

On the other hand, the documents from programs and organizations reflected three of the models' principles: (1) respect, warmth, and compassion for clients, (2) scatter-site housing or independent apartments, and (3) recovery orientation. Although all activities described in the program's brochures and web pages could result in harm reduction, they were included in the recovery orientation principle. Table 5 presented an example of the activities described in the organization's literature related to the housing first principles.

Table 5

Example of Housing First Principles Depicted in Organizations

Source	Statement	HF principle	Organization
Consolidated application			
	"The CES and the CoC organizations are also collaborating with several stakeholders including landlords willing to wait for deposits to facilitate placements, CBOs"	4	CoC 502
	"All these organizations work with the SSO CES to identify, refer and serve DV clients, and maximize client choice for housing and services, while ensuring safety and confidentiality."	6	CoC 502
	"To increase employment income, CoC projects' CM's work with the PR-DOL and Federal WIOA-funded Regional Job Centers to identify and access job training and placement opportunities for participants, and to assist homeless participants to move from part-time to full-time jobs and improve skills to upgrade employment and increase income."	7	CoC 503
	"Integrating a peer component to promote CH willingness to receive services and their understand the Housing first Model, changing their mind-set about becoming housing-ready"	8	CoC 503
Brochure			
	"Values: commitment, credibility and reliability, respect, loyalty, sensitivity, ethics or integrity, spirituality."	2	Programs 1 & 3
	"Services: Social work and case management, medical services, counseling, individualized psychology, transportation to medical appointments and socio-economic management, health education, referrals to external agencies, recreation activities for the community."	7	Programs 1 & 3
Webpage			
	"Permanent housing program that provides rental subsidy with support services to its participants with funds provided by HUD."	4	Program 2
	"The main purpose is to strengthen the life skills of each individual that allow them to obtain and maintain a home and income opportunities."	7	Program 2

Note: The Housing First principles are (1) housing as a basic human right; (2) respect, warmth, and compassion for clients; (3) commitment to work with clients without time restrictions; (4) scatter-site housing or independent apartments; (5) separation of housing and supportive services; (6) consumer choice and self-determination; (7) recovery orientation and, (8) harm reduction.

Duties and Responsibilities of Service Providers

The document review process for service providers' duties was limited to documents provided by two programs from the same organizations, which had identical paperwork. The organization provided de job description of four positions: senior service coordinator, service coordinator, case manager, and social worker, all corresponding to the category of clinical and case management staff. The two positions with the most duties and tasks in common with an RC were the case managers and social worker. The job description task corresponded to the scope of practice related to assessment and appraisal, diagnosis and treatment planning, counseling, service coordination, and program evaluation. Table 6 portrays the duties and tasks associated with the scope of practice of rehabilitation counselors.

Table 6

Duties and Responsibilities within the Scope of Practice of Rehabilitation Counselors

Position	Scope of practice
Senior service coordinator	Program evaluation and research
Service coordinator	Referral and service coordination
Case manager	Assessment and appraisal; diagnosis and treatment planning; individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability; case management; and referral, and service coordination.
Social worker	Assessment and appraisal; diagnosis and treatment planning; individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability; referral, and service coordination; Program evaluation and research

The 2019 Consolidated Application for CoC 502 and 503 included activities geared toward developing job skills and employment opportunities for the homeless individuals enrolled in the CoC programs. However, the employment and training services were coordinated through community-based organizations and government agencies in charge of programs such as those included within WIOA and managed by the Department of Labor (DOL). The application did not mention the PR Vocational Rehabilitation Administration directly, which was part of the DOL. The application described at least one organization that included specific activities and programs to develop the residents' pre-employment skills as part of their services.

Analysis and Interpretation

There were limitations in the analysis and interpretation of the findings. The responses obtained from the six key informants did not allow to draw a conclusion for all service providers in the two CoC on the island. The experiences and responses described the views and opinions of said six participants only.

The basis for the analysis's structure and subsequent interpretations of the findings was the transcendental phenomenology design. Its three main components are: the textual experiences, the structural experiences, and the essence of the experience. Thus, the analysis focuses on describing the lived experiences (*textual)* and how participants experienced the phenomenon (*structural)*. The analysis results would be the phenomenon's universal *essence* or the combination of the common elements of the experience as lived by the participants (Creswell 2013). The results provide a broad understanding of the RC's role, the Housing First model, and the homeless population from the participant's perspective.

Qualitative Interviews and Document Review

Using the transcendental phenomenology design, the researcher explored participants' lived experiences through the meaning or significance attached to said experiences (Moerer-Urdahl & Creswell, 2004). Once identified, the experiences were classified as (1) textual, the description of the experience as it occurred, and (2) structural, or the way participants experience the phenomenon. The integration of both types of experiences resulted in the essence of the outcome of the analysis process.

The information gathered was categorized into the three main domains of the study. The information was further analyzed and grouped into themes and subthemes. The following presents the outcome of the analysis for the interviews and the document review.

The rehabilitation counseling professional. Of the three main domains of the study, the rehabilitation counseling section was the least commented on by the participants and the most difficult to explore. Although half of the participants had experiences with RCs, only one had experiences directly related to their work with the homeless population. Three of the six participants did not know who the RC was or confused the rehabilitation professional with addictions counselors. As a result, none had any direct experiences to report during the interview process on the subject. The remaining participants reported having personal or professional experiences with RCs. Three subthemes emerged from the responses: (1) the experiences of service providers with rehabilitation counselors, (2) the characteristics of the rehabilitation counselor, and (3) the duties or tasks related to the practice of the rehabilitation profession.

Subtheme (1) experiences of service providers with rehabilitation counselors. One key informant reported having professional experiences with the RC. The experiences were limited to referrals and case discussions with professionals from the Puerto Rico Vocational Rehabilitation Administration (VRA). The participant's understanding of the VRA included self-employment opportunities for the housing program residents (e.g., like hot dog stands, among others). However, VRA counselors did not always consider the residents eligible for services, even though the program's staff screened them beforehand. The same participant did not envision an RC working within her organization and stated so with a forthright "No." Thus, the response suggested the experience was not as productive or as positive as she expected.

The two participants recounted personal experiences related to the RC at the VRA and the activities associated with academic and extracurricular experiences in a rehabilitation counseling program. Both participants described the experience as positive. For one participant, being a consumer at the agency was a "determinant" factor in obtaining her goals. She described her RC as a guide, a supporter during the process, empathic, respectful of her views, and focused on her strengths. The second participant reflected on the capacity of RCs for working on different scenarios and populations, not just the VRA. Still, she recalled that many professionals from related fields and the public were unaware of the rehabilitation counseling field.

Subtheme (2) characteristics of the rehabilitation counselors. The views of the two services providers with personal experiences overlapped with the counselor's professional characteristics and duties. On the one hand, the participants stressed the professional's abilities to help people with disabilities attain their goals and achieve a better quality of life. Simultaneously, people familiar with the field saw the RC more as a government employee "filling out papers and marking 'zeros'." In other words, people did not associate the

rehabilitation process at the VRA with tasks directly linked to the counseling side of the field unless their personal experience focused on included said component.

Both key informants recognized that the RC would be a good fit in the housing programs for homeless individuals. None thought about including RCs until the interview or knew about any rehabilitation counselors working as such in a program at the time.

Subtheme (3) duties related to the practice of rehabilitation professionals. In terms of the duties or tasks related to the rehabilitation profession's practice, key informants identified several activities that directly fell into the RC's scope of practice. The activities included case management, needs assessments, employment, and establishing plans with goals and objectives from the client's perspective. Key informants noted RCs' tasks could provide services to people with physical and mental disabilities as depicted by the HUD and the Housing First model.

One participant felt the RC could link the professionals from different fields, coordinating the staff's interventions and services. In the housing first manual developed by Tsemberis (2015), coordinating the clinical and case management staff corresponded to the Assertive Community Treatment team leader (ACT). However, the RC was not listed among the professional contemplated within the primary staff for a housing first based program. The manual vaguely mentioned the services of the VRA as supported services for homeless individuals transitioning into housing.

The model did call for a supported employment specialist who "teaches, guides and coaches" participants in the process of obtaining a job (Tsemberis, 2010b, p. 114). The supported employment specialist did not conduct formal assessments or training periods but followed a hands-on approach, guiding participants through the job placement process, focusing on their

strengths. At least one program in the sample included activities to develop employment opportunities and skills. Nonetheless, programs within the CoC sought to establish collaborative agreements with agencies managing funds for the WIOA at the Department of Labor in PR: the agency the VRA was part of at the time of the study.

The document review process confirmed key informants' observations regarding the RC's tasks within the housing programs. The job description of case managers and social workers had the most tasks associated with the RC. These professionals shared duties and tasks such as assessment and appraisals, diagnosis and treatment planning, individual and group counseling, interventions focused on adjustments to the medical and psychosocial impact of disability, referrals, and service coordination (see Table 6 for additional information). None of the skills related to job placement development and increasing employment opportunities for residents were addressed in any of the job descriptions available. Activities related to the workplace or employment are included in the 2019 Consolidated Application; the target is to develop said skills, either in-house with other professionals or through other programs or agencies like Job Centers.

Chronically Homeless Population. Contrary to the previous domain, all key informants had between 10 to 26 years of experience working with the homeless population in Puerto Rico. It was the second domain with the most references within the study. The responses revealed three subthemes: (1) characteristics and factors related to the chronically homeless population, (2) experiences and attitudes toward the population, and (3) supported services. On each subtheme, key informants' statements described the direct experience with homeless individuals and the context in which the services were delivered.

Subtheme (1) Characteristics of the chronically homeless population. All key informants agreed with the Puerto Rican homeless population's basic profile depicted in the 2019 PIT. The homeless population on the island continues to be primarily male, with ages ranging from 35 to 54 years, experiencing substance abuse and mental health issues. At least one participant noted the mental health issues had been increasing for the past 10 to 15 years. However, four of the six key informants acknowledged an increase in other subpopulations such as women, youth 18 to 25, youth from the LGTBQ+ community, and the elderly.

The overall profile of the homeless population did not convey the complexity of the problem. From a recovery perspective, homelessness resulted from adjustment issues or problems within the environment (Tsemberis & Henwood, 2019). As professionals, service providers recognized the difficulties individuals faced and expressed empathy, acceptance, and understanding toward homeless individuals in their programs. Based on key informants' experiences, the primary causes behind homelessness were the person’s inability to cope and respond to situations such as a traumatic event (e.g., loss of a loved one, violence), family problems, mental health issues, and domestic and gender-based violence. In other cases, the person did not have the necessary support to deal with said issues. Although substance abuse could be a cause for homelessness, at least three of the key informants noted that addiction, in many cases, was the result of living in the streets. Other reasons, such as economic problems due to losing a job or a business, although important, were not always the primary reason a person was homeless.

One participant stated that not every person who lived in the streets was thought of as homeless (i.e., a person may be out on the streets and have a house or a space accessible if they chose to do so). Therefore, the estimates obtained through the PIT may not reflect the complexity

of the whole picture. The statement suggested that the number of people roaming on the streets and seeking out services from government agencies and organizations may be higher than the PITs suggest. Nonetheless, higher demand for services, such as soup kitchens or community kitchens, implied that organizations might not meet the demands of services.

Homelessness and disability. In terms of disability, most key informants reported including individuals with mental or physical disabilities in their programs and housing projects. There may be limited options for an accessible unit for a person with physical disabilities. However, it could be handled more efficiently than issues related to individuals with mental health issues. Nonetheless, the main concerns of most key informants were the substance abuse issues and dealing with the residents' rehabilitation process.

Subtheme (2) Experiences and attitudes toward the homeless population. The experiences described by the key informants were positive in terms of learning and growing as professionals and human beings. The somewhat negative experiences and attitudes revolved around other service providers' attitudes observed while working with the homeless population. The key informants described discrimination against homeless individuals due to their appearance, lack of hygiene, and overt mental health issues. For the administrators, transitioning from homelessness to housing was difficult for the new residents who could not comply with the regulations.

On the other hand, for coordinators and clinical staff, homelessness was not something a person could overcome overnight. The transition required support from the social services staff and the availability of services within the community. Their experiences ranged from working with individuals who refused any type of placement and made homelessness a way of life; to people who would take any type of placement. The way key informants described their

experiences with the population reflected acceptance, empathy, and commitment. These attitudes reflected the Housing First model's basic principles, and the values and the principles of the psychiatric rehabilitation perspective, infused in current rehabilitation counseling curriculum. The service providers' experiences also revealed frustration with the lack of supportive services and support from other agencies, specifically the central government.

Opinions and attitudes about homelessness. At least four of the key informants described dealing with society's opinions and attitudes about homelessness as challenging. Three of the key informants referred to the community at large (including government officials) as numb, desensitized, and indifferent to the issues of homeless people and their needs. Homeless individuals were viewed as an eye-sore or an inconvenience, and not as people. For one key informant, the lack of information added to said views and lack of understanding about the population. Likewise, government officials also had biases that impacted the way organizations worked and influenced public policies about homelessness, especially when government officials were political appointees with no knowledge or experience on the subject. Thus, there was a need for educational and public relations campaigns geared toward the public and elected officials about the homeless population and the work community and private organizations do to address the population's needs.

Subtheme (3) Supported services. All six key informants agreed on the importance of providing supportive services to homeless individuals transitioning to housing. Key informants focus on three types of services: mental health, substance abuse and rehabilitation treatments, and developing independent living skills. For administrators, mental health and independent living skills were crucial in keeping the person housed in an independent unit. These services

helped residents manage their condition and helped them comply with the rules and requirements of the housing project.

Similarly, coordinators, clinical, and case management staff felt the need to increase the island's availability of supportive services. For them, an increase in services implied accessing services when the person needed them, aiding the staff to retain residents and away from drug consumption. Although the government agencies provided some support, the services were not always available when needed. Also, key informants felt the local government lacked the resources to support programs for homeless individuals.

Challenges and barriers to service. The key informants mentioned experiences depicting several challenges to services interfering with the rehabilitation process of homeless people. The first group of challenges referred to a person’s willingness or motivation for change. Challenges included a lack of adherence to substance abuse or mental health treatments, lack of independent living skills, and mental health issues that could arise during the placement process. For key informants, residents unwilling to adhere to or accept treatment, especially after years of drug use or untreated mental health issues, could be disruptive and eventually lose the housing unit. Simultaneously, working with residents to develop independent living skills could be a time-consuming task that proved challenging for some residents to achieve. Thus, the staff needed to work with landlords and administrators, explain the residents' needs, and help them develop independent living skills at their own pace. In some cases, the stress of the process and the new environment would trigger other underlying mental issues residents might have. Therefore, the staff needed to stay vigilant to new potential symptoms that could arise while placing them in a new setting.

The Housing First model. This segment of the analysis contains the service providers' perspectives about the Housing First (HF) model as structured by Tsemberis (2010b, 2015). The responses clustered around two predetermined domains: The Pathways Housing First model and the Housing First model in Puerto Rico. Each domain included four and three subthemes respectively, related to what key informants knew about the model, their thoughts, and their experiences. This domain was the most referenced by key informants.

Pathways Housing First (HFM) Model. Like the chronic homeless person category, all the key informants reported knowing the Housing First (HF) principles. The basic HFM principles referenced throughout the interview process included: the definition of chronically homeless individuals; the role and importance of supportive services, including close follow-ups with the clinical and case management staff; recognizing housing as a fundamental human right; and using both a person-centered and a harm reduction approach to service. This domain had four subthemes: (1) knowledge about the HFM model, (2) Housing First vs. Treatment First, (3) supportive services, and (4) funding.

Subtheme (1) knowledge about the HFM model. At least two of the key informants summarized the approach as eliminating barriers to housing and this goal as cornerstone of the model. In terms of knowledge, all key informants mentioned at least two of the model's basic concepts. However, based on the key informants' experiences, understanding the concepts was not the same as understanding the model and how to effectively apply it. Hence, three key informants noted the importance of reinforcing training on “how-to” apply the model effectively on the island. Professionals working at Programs #2 and #4 reflected a better understanding of the model and how to implement it in their organizations. Program #2 was running as a 100% HFM program and had incorporated most of the model's structure suggested in the manual

developed by Tsemberis (2010b, 2015). It was also the program that reported higher occupancy and retention rates.

Subtheme (2) Housing First vs. Treatment First. Key informants compared the housing first and previous approaches to services focused on providing treatment before housing. Although all key informants agreed with the principles and philosophy of the HFM model, most of them had reservations about the model. From the participant's perspective, implementing the approach with individuals with a long history of substance and mental health issues and no commitment to the program represented a challenge. The accessibility to supportive services and residents' unwillingness to accept services were common themes among key informants. For at least one participant, the step-by-step approach helped individuals achieve stability in their condition; it helped them understand the process better and comply with the regulations needed to stay housed. In contrast, housing first proponents argued interventions focused on harm reduction and person-centered approaches tapping into the person's internal motivation could be as effective —if not more—than requiring treatment first for substance use or mental illness (Tsemberis & Henwood, 2019). At least one of the housing first programs in the sample, Program #2, reported incorporating all said elements: harm reduction, person-centered, and motivational interventions as part of the current service structure.

The reservations mentioned by the key informants were consistent with concerns shared by other service providers who felt clients needed to work on their independent living skills and be sober before being placed in housing (Henwood et al., 2013). Tsemberis (2010b) noted that skepticism among service providers transitioning to a housing first approach usually subsides after working and being exposed to the model and its results. The statement was consistent with Participants #4 and #6, who admitted having reservations about the model until implementing the

approach. At the time of the study, both key informants were convinced of the effectiveness of the model. Still, Participant #6 admitted thinking the model was not for everyone.

Based on the experiences of Participant #4, the advantages of the housing first approach centered on harm reduction. Placing a person under a roof reduced harm immediately. Other advantages included the close monitoring and follow-up of the client's progress which helped service providers foresee more effectively any potential issue that may arise. Other key informants agreed that the HFM model eliminated barriers to accessing a housing unit and shortened the waiting period to receive services, making the process more agile. For key informants who worked in organizations with multiple programs servicing a variety of homeless populations, implementing the HFM model in Puerto Rico was complicated. At least three key informants believed HUD's expectations might not be in tune with the reality of local resources.

Subtheme (3) supportive services. The limited availability and accessibility to supportive services, especially for smaller programs, diminished the staff's ability to provide services to residents when needed. Furthermore, the lack of government support complicated, and in some instances compromised, the organization's ability to function effectively. Three key informants felt programs in the US had more support from their local government than programs in Puerto Rico. According to Tsemberis (2010b), the HFM model's success depends not only on the correct implementation of the program but also on having champions (e.g., organizations, government officials, funding agencies) willing to support the programs and the approach. For most key informants, the homeless population and the organizations supporting them were not a priority for the local government. Key informants mentioned the government lacked a plan to address the homeless population's needs during a natural disaster or other types of emergencies such as the 2020 COVID-19 Pandemic. Furthermore, none of the key informants reported being

aware of any discussions about new legislation in favor of the homeless population at the time of the study.

Subtheme (4) funding. Funding was another factor impacting the implementation process of the HFM model in Puerto Rico. At least two key informants pointed out that the local homeless population's needs differed from those in the US. The funding opportunities available prioritized areas that may not be as relevant for the local programs. Most of the funding focused on chronically homeless individuals when the priority might be in other groups. At least two key informants thought organizations opted to follow the Notice of Availability of Funding (NOFA) priorities to stay open and provide services to the homeless population.

Programs within each CoC submitted a consolidated application for funding, allowing them to provide services to stakeholders. In other words, the performance or underperformance of one program affected the CoCs' overall performance. Concurrently, the number of organizations at the CoC could increase, but the funding available may not. If the programs were competing for funding committed to providing services they were not always equipped to deliver, the CoCs' overall performance was affected and it jeopardized all organizations' efforts.

Housing First Model in Puerto Rico. This segment's responses incorporated service providers' views and opinions about how the housing first model functioned on the island. Three subthemes emerged from the participant's experiences: (1) the programs' structure, (2) the advantages and challenges in service of said programs, and (3) improving the model's implementation in Puerto Rico.

Subtheme (4) the structure of the Housing First programs in Puerto Rico. All programs included within the sample had the same basic structure and procedures. The basic structure consisted of two teams. The first is the administrative team in charge of compliance, regulations, and any administrative task related to the housing placement process. Second, the social work team oversees what the clinical or case management services clients or residents needed. The admission process to programs was the same for the organizations within the CoC. All homeless individuals, either through a referral by an agency or on their own, went through the Coordinated Entry System (CES), where they were interviewed and the level of chronicity was assessed. Once the personnel identified the person's needs and situation, they referred individuals to an organization within the CoC. Later, service providers at the program determined eligibility for services, completed the program's assessment, and developed an intervention plan. The system referred the chronically homeless individual to permanent supported housing programs. That was the standard procedure for all CoC systems in the US and its territories.

Most programs offered case management services. In larger organizations, the in-house services included at least three of the following: housing, case management, clinical and medical support, opportunities to develop independent living skills, job-seeking skills and opportunities, training, volunteering, referrals, and help requesting benefits for which the person may be eligible. In terms of professional services, programs could have social workers, addictions counselors, and nurses as part of the full-time staff. Most organizations had clinical personnel, such as psychologists and psychiatrists, as part-time employees. Smaller programs coordinated most services outside the organization.

At least one key informant assumed HFM programs in the US typically had all clinical staffers' components as full-time employees. The manual for the Pathways Model to End Homelessness for People with Mental Illness and Addiction (Tsemberis, 2015) described the clinical staff as a psychiatrist and a primary care practitioner (doctor or nurse) who are part-time employees. The two other positions that required clinical skills were the team leader and the mental health specialist. In both cases, Tsemberis suggested a social worker occupied said positions. The rest of the positions in the HFM described the assertive community treatment team in general terms. Various professionals could fill the position, including candidates with a bachelor's degree or certification (e.g., wellness management specialist, supported employment specialist, peer specialist).

Regarding community resources, organizations sought out services from government agencies to address mental health, detox, and substance abuse rehabilitation services or programs related to other areas such as employment like WIOA. The availability of services and programs depended on the resources within each geographical area and the programs themselves. As previously stated, the resources available within the community were not sufficient to satisfy the demand. Like with human resources, at least three key informants believed the supported community services, including housing, were more available and accessible in the US than in Puerto Rico.

The principles of the housing first model. The document review process showed the ways organizations within the CoC included the principles of the model in their literature. Most of the identified information came from the 2019 Consolidated Application for Puerto Rico CoC 502 and 503. Although some of the samples included subpopulations other than chronically homeless individuals, the statements reflected how services aimed toward an HFM approach. The

principles linked to the consolidated application included: respect, warmth, and compassion for clients; scatter-site housing or independent apartments; consumer choice and self-determination; recovery orientation and harm reduction (Table 5). The activities included collaborating with landlords to wait for deposits facilitating placement; facilitating an increase in employment income through programs such as WIOA and Job Centers; referencing the program's values like commitment, respect, sensitivity, and integrity; and promoting the development of life skills.

Adapting to Housing First. The most salient remarks related to adapting the model to the Puerto Rican environment focus on ideas and concepts explicitly depicted in the HFM manual and studies conducted to explore the model's effectiveness. First and foremost, organizations and employees needed to approach the HFM model with an open mind and buy into the model's principles and philosophy. Service providers struggled to let go of previous beliefs and ideas about services. For example, expecting homeless individuals to address mental health and substance abuse issues before they were ready to do so was considered a system-centered approach to services. Thus, the focus was on compliance not on the person (Henwood et al., 2013).

Second, the case management or social work team needed to follow up closely on clients to identify problems the person may be dealing with and address them as soon as possible. The HFM manual explained the reasons behind requiring participants to accept home visits from the program’s staff, including assessing the transition process, monitoring the person's well-being, providing support, and the tools to cope with the new environment (Tsemberis, 2010b). Third, the organization needed to be flexible and willing to adapt to the new program and philosophy. It was also important to acknowledge that there would be issues with clients. The process will present challenges, and moving and relocating people from one housing unit to another will be

part of the process. For Participant #4, some organizations had a hard time embracing the model due to perceived conflicts between philosophies and services approaches. Thus, organizations had to understand the model, the implications in services and procedures, and decide if they wanted to work under the said model.

Subtheme (2) the advantages and challenges in service. The HFM model offered a fast-track type of access to housing for chronic homeless individuals based on their preference and considering their opinions. It allowed them to choose where and how they wanted to live. The model sought to reduce or eliminate barriers to housing, facilitate access to supported services, and allow the clients to assume control of the rehabilitation process. The model also presented service providers with strategies, from a person-centered and harm reduction perspective, to address the needs and issues a client may present during the placement process and beyond.

The identified challenges for implementing the Housing First model in Puerto Rico included environmental factors such as the limited availability of supportive community resources for the homeless community and the local government's lack of support. Other factors revolved around the homeless person; for example, the unwillingness of some participants to engage in recovery activities such as managing their mental health and substance abuse issues.

The responses also reflected challenges that originated within the organizations. For some programs, the internal factors related to committing to services they could not provide or having little to no understanding about the model and its implications for service. Thus, programs identified as housing first could turn away participants if they were actively using substances or rejected supportive services. In other words, the admission was condition to their enrollment in a rehabilitation program. Said practices were done subtly and contradicted the housing first

approach to service. The only way the HUD and the CoC heard about said cases was when individuals filed complaints against a specific program. However, most people avoided complaining about the programs' requirements for fear of losing services or benefits from other programs in the CoC.

Another internal factor representing a challenge for the organizations was the ability to work together cohesively. The CoC programs were not always aware of each other's services, resulting in a somewhat disconnected service network. A least two of the key informants felt programs needed to learn about each other and collaborate and complement each other's services. Still, key informants admitted the CoC had improved over the years and worked better than it did years ago.

Once again, key informants mentioned funding as one of the challenges of implementing the housing first approach to services. The concerns could be summarized as follows: (1) funding priorities may not reflect the realities of the homeless population in the island, (2) there was little to no funding from the local government for programs working to eradicate homelessness, and (3) programs competed for the same type of funding, very few sought out funding to provide supportive or complimentary services for other agencies within the CoC. One participant stated that programs had the same goals and focused on the same things. The sentiment behind the statement suggested the network or CoC needed to recalibrate the way it channels the resources, promoting effective collaboration among programs and diversifying services and funding sources to obtain said complementary services.

Government support was another recurring theme among key informants of the study. Like in previous sections, all agreed that the lack of support from the Puerto Rican government in funding, public policy, and the lack of interest in the homeless population's needs was one of

the challenges of shifting to a housing first approach. Community-based organizations had assumed the government's responsibility but were left alone in the process. At the same time, the government expected positive outcomes from programs not funded with local resources.

Subtheme (3) improving the implementation of the housing first model. In 2016, the two CoC systems in Puerto Rico made implementing the housing first approach a priority. Based on their experiences, key informants identified different areas considered essential to improve implementing the program locally. The responses yielded five areas: openness to the model, capacity building, human resources, supportive services, and support from the government and government agencies.

The first three areas: openness to the model, capacity building, and human resources, are related to the organization's inner workings and context. The service providers in the programs needed to believe and embrace the model and trust the client's capacity to improve and take charge of their process. Therefore, the staff needed adequate training to fully understand the model, put it into action, and address the challenges of working with chronically homeless people. Furthermore, they needed to establish adequate boundaries to help homeless individuals be successful in the process. Although the facilitating agencies from each CoC were tasked with providing training and technical assistance, not all key informants felt they had received enough training to implement the model correctly. In terms of human services, programs needed professionals knowledgeable about the approach, familiar with the residents, and available when a crisis arises.

The last two areas focused on supportive services and support from the government and government agencies. Key informants agreed that the number of supported services, community-based and government-run programs, was not enough to satisfy the homeless population's

demands. At least three key informants reported that many organizations had lost programs, such as shelters, due to the lack of funding. Simultaneously, the government and government agencies in charge of providing for the homeless population needed to develop a clear public policy about homelessness and identify additional funding to promote and maintain supportive services around the island.

The Survey

The survey analysis focused on describing the responses obtained from the survey administered to service providers of three of the study's four programs. The purpose of the survey was to compare how much participants knew about the basic principles of the housing first model and the scope of practice of rehabilitation professionals with the views and experiences of the key informants. It also described service providers' views about the model, the homeless population, and the rehabilitation counselor. Twenty-one participants completed the survey. Due to the limited number of responses, the statistical analysis consisted of frequencies and percentages to describe each section's answers.

General Knowledge. Part A of the survey was scored as a test; therefore, the higher the number of correct responses, the higher the understanding of the Housing First model and the rehabilitation counselor scope of practice. The responses of most participants suggested knowing about the model and the basic principles included within the survey. The only two responses that leaned toward a traditional intervention related to providing treatment services before housing and that case managers assume an active role by choosing the type of service the client could receive. Both responses were consistent with the thought of key informants who had reservations

about implementing the housing first model in their programs. Likewise, most participants considered RCs could perform the tasks (e.g., vocational counseling, individual therapy, developing independent living skills) from the scope of practice while working with chronically homeless individuals.

Attitudes. The purpose of Part B's statements was to describe the views of service providers about the Pathways Housing First (HFM) model, the chronically homeless individuals, and rehabilitation counselors. Like in the previous section, the only statistics used were frequencies and percentages. The responses showed most participants agreed with the model's values, such as housing is a fundamental human right, interventions should focus on risk reduction and providing housing services simultaneously while individuals receive mental health treatment. Said views resemble the key informants' responses when all admitted agreeing with the principles of the model, even those who reported having reservations about the implementation process in Puerto Rico. It is worth noting that most participants belonged to the PR CoC 502, where the housing first program was located, hence, they were exposed to the model and its principles. This pattern would be consistent with the notion that once a service provider was exposed to the program, they become more receptive and eventually embrace the approach (Padgett et al., 2016, Tsemberis, 2010b)).

In the statements related to the rehabilitation counseling professional, most participants agreed or strongly agreed that counselors provided services only when the client was ready for employment. Also, almost half did not believe rehabilitation counselors specialized in working with people with disabilities. Still, all participants agreed or strongly agreed that counselors could help homeless individuals develop and maintain their independent living skills. The results suggested that service providers were not associating the rehabilitation professional with the

tasks from the scope of practice of the field. Like with the key informants, the responses suggested some confusion about the figure of the rehabilitation counselors and their competency areas.

Preliminary Findings

The final stage of the analysis compared the results from the different data collection strategies and the additional sources of information to better understand service providers' perspectives about the programs, RCs, and housing first. This segment of the analysis exemplified the study's essence or outcomes (Moerer-Urdahl & Creswell, 2004). Thus, the analysis centered on the same three main categories: the RC, the chronic homeless individuals, and the housing first model.

The rehabilitation counseling professional. The responses of the key informants showed that the rehabilitation counseling professional was not well known among the participants. Half of the key informants were not familiar with RCs or confused them for addiction counselors. None of the participants who held leadership positions within their organizations reported ever having an RC as part of the staff or working as such. In contrast, five of the 21 respondents in the survey reported having RCs among the staff at the time of the study. It was unclear if the survey respondents had the same confusion between rehabilitation and addictions counselors as the key informants.

Only one informant had past experiences with RCs directly related to her tasks as a service coordinator. The participant referred and held case discussions with counselors about residents requesting services from the PR Vocational Rehabilitation Administration (VRA). The

participant mentioned two points that hinted the experiences with the counselors were not entirely positive. First, she pointed out that not all referred residents were eligible for services, even after being screened to ensure the person could apply for the VRA. Second, when asked if she could see an RC working at the organization with the homeless population, the answer was a straightforward "No."

The survey described the views of participants through three statements in Part B of the document. Most of the participants believed an RC began to provide services only when residents were job-ready. Simultaneously, the tasks of the rehabilitation counselors' scope of practice that the service providers believed could be carried out by RCs included interventions such as developing independent living skills and adherence to the clinical treatment. Although the tasks could be addressed at any stage of the rehabilitation process, they were significant during the transition from homeless to housing.

These results suggested a slight inconsistency in responses within the survey. Most survey participants believed an RC *began to provide services when a resident was job-ready*, suggesting they would not include an RC in the pre-employment phase of the interventions. Still, the tasks from the survey relate to the pre-employment phase. It is unclear if participants thought an RC could carry out the tasks depicted in the survey before residents would be ready for employment. Only one key informant pointed out that clinicians did not always include other professionals whose titles did not contain the word "clinical" in case discussions regarding residents in the programs. The statement could explain why an RC would not be included in the stages before employment, along with the lack of knowledge about the field by other professionals and maintaining professional boundaries.

The key informants with personal experiences with rehabilitation professionals had a broader perspective of the counselors' capabilities, putting them beyond the administrative tasks of case management at the VRA. For them, an RC could also provide services such as individual and group counseling and substance abuse and mental health management. Furthermore, one participant felt they could lead the intervention teams (clinical or case management) due in part to their capacity to work holistically from a rehabilitation's perspective.

Chronic homeless population. Participants agreed with the overall characteristics and factors associated with chronic homelessness: primarily males between 35 to 54 years with mental health or substance abuse problems. They also have had a long history of homelessness which is consistent with the last PIT count in 2019. Although individuals with substance abuse problems continued to be the number one issue, mental health conditions were a close second.

The participants' responses helped categorized the chronic homeless population into two distinct groups: people who wanted to transition to housing and people who refused placement. The first group included individuals who were ready and eager to transition into housing and wanted to overcome their situation. The second group rejected any placement. If they did accept a housing unit, they could not be persuaded to commit to any supportive service or to follow the housing project or landlord's rules. In said cases, if evicted, the person needed to be relocated to another housing unit or project. For one key informant, the particularly hard-to-place individuals who had adopted homelessness as a way of life were people who had lived in the streets for 10 years or more, who also had a severe addiction problem, and were unable or unwilling to change.

At least three participants argued the hard-to-serve individuals needed professionals and supportive services that would address the substance abuse and mental health issues before entering a permanent housing program. They also needed access to supportive services and

effective follow-up and support while transitioning to housing. From their experience, providing interventions centering on the rehabilitation process helped residents focus on the recovery process, stay engaged, and cooperate with professionals.

The experience of key informants was not consistent with responses gathered in Part B of the survey. In question 21, *participants should develop independent living skills before attaining permanent housing*; almost half of the participants disagreed or strongly disagreed with the statement; still, six agreed with key informants. The survey did show that all participants agreed or strongly agreed with the statement: *a homeless individual needed the help of a professional to identify the best treatment options for them*. The response suggested a more active role of the service providers in residents' rehabilitation process. The lack of accessibility and the availability of supportive services was a recurring theme throughout the interview process. The lack of services was named one contributing factor interfering with the rehabilitation process and the residents' ability to stay housed.

The survey did not gather any information regarding supportive services outside the programs or the role the local government and government agencies had in a homeless person's recovery process. Consequently, there was no additional information to compare the views of key informants on said topics.

The Housing First model. The following section compared the views, opinions, and how much key informants and the survey participants knew about the housing first model in Puerto Rico. In both cases, through the in-depth interviews and the survey, the responses demonstrated participants knew basic premises and principles of the housing first approach to service. The key informants who knew less about the model characterized it as a low-barrier approach to service. Even though four of the key informants had their reservations about

implementing the model in Puerto Rico, they all agreed with the model's philosophy and its advantages for chronic homeless people.

Survey participants obtained eight out of 10 possible correct answers related to the model. The two statements participants missed were: […] *is essential to provide supportive services to chronically homeless individuals before housing*, and […] *case managers determine the type of services for each participant and refer them to programs within the service network*. Both statements represent values from a treatment-first approach to service. The results suggest that, as key informants, the survey participants could consider the principles of the HFM model depending on the characteristics and the history of the resident. Key participants stated knowing about the model but not having all the "knowhow" to apply it in the best possible way.

Housing First vs. Treatment First. The key informants in favor of the housing first approach based their support on the agile and straightforward process, its short waiting period, with low to no barriers for homeless individuals, and the hands-on interventions through clinical and case management service teams. One participant recognized organizations with in-house supportive services and access to additional supportive services within the community and government agencies made the approach possible. Participants who completed the survey also agreed or strongly agreed with the principles of the HFM model. The only treatment first-based items that obtained a higher number of responses centered on (1) the need that residents develop independent living skills before permanent housing services and (2) the need for help from professionals who identify the best treatment options.

The document review process centered on identifying the housing first model's principles and values in brochures and web pages of the programs in the sample and the 2019 Consolidated Application for both CoC systems. The program's literature of three of the permanent housing

programs reference the following HFM principles: (1) respect, warmth, and compassion for clients, (2) scatter-site housing or independent apartments, and (3) recovery orientation. The 2019 Consolidated Application included four of the model's principles: (1) the scatter-site housing or independent apartments, (2) consumer choice and self-determination, (3) recovery orientation, and (4) harm reduction. Principles related to the philosophy, values, and specific services associated with the model were identified in brochures and the programs' webpages as part of the general information available to the public. Specific activities associated with the model's procedures, strategies, and goals were depicted in the Consolidated Application. According to one key informant, in 2016, the CoC made the Housing First model a priority; hence, most of the programs within each system incorporate the principles of the approach.

The housing first model in Puerto Rico. The CoC system in the island was consistent with the states' CoC structure. The homeless person requesting the services went through an entry point into the system and referred to programs according to the level of chronicity. From that point on, programs assessed the needs of each person and developed an intervention plan. Since the housing first approach was new on the island, programs that chose to do so were still adapting and transitioning to the model. Larger organizations might manage several programs with different service approaches toward more than one subpopulation of homeless individuals. Thus, not all the programs within an organization followed the housing first model as intended. All programs offered case management services and referred participants to other programs or agencies providing access to clinical care and rehabilitation services. However, there were few places where programs could refer their clients; in some cases, the appointments were few and very spread out.

The program functioning as a 100% housing first program, opted to modify its programmatic structure. In the process, it became a smaller CoC, providing supported services (i.e., social work, counseling, and case management) for the participants in the program. In other words, the program decided to close the gap in services by developing in-house supported services. It also complemented the supportive services with other community-based organizations and agencies within the geographical area. However, not all programs had the resources to do so.

The document review showed that aiding residents who obtained a job and increased their income was part of the programs' goals addressed through the Consolidated Application. The subject of employment was addressed by the two key informants from the housing first programs only. The first key informant described in-house programs to develop skills and eventually employment opportunities. The second key informant identified programs targeting vulnerable communities and helping them obtain meaningful employment or training. In both areas, rehabilitation counselors could be involved; however, none included RCs as part of the intervention by said occupational title. If programs had RCs as part of the staff, they did not work or were known as such.

The opinions and experiences associated with the housing first model varied among participants. On the one hand, the model helped homeless individuals access permanent housing in a fraction of the time, regardless of their conditions, providing support to manage health and substance abuse problems the person had, and the opportunity to recover from their situation. Still, key informants who expressed reservations about the model believed implementing the housing first approach in Puerto Rico was challenging. First, because it did not necessarily reflect the local population's needs, there were limited resources for supportive services, and

because programs and the personnel did not have enough knowledge about how to implement the approach effectively.

Service providers also had some reservations about making permanent housing available to people lacking the skills to live independently, especially if the program could not closely monitor said participants. Besides the lack of adequate resources, key informants repeatedly mention the local government's lack of support to the homeless population and the organizations working on their behalf. For key informants, it was important for the government to design and implement a public policy regarding the homeless population and assume an active role in meeting the population's needs.

Based on the information gathered from key informants, to effectively implement the housing first model in Puerto Rico, organizations, service providers, and other stakeholders need to:

- Embrace the model and its principles. Organizations and service providers need to be open-minded about the model's strategies and the implications to service.
- Adopt a will to change. Implementing the housing first approach implied changing the programmatic structure to something new, flexible, and constantly evolving. Therefore, programs need to create new alternatives to service and to strengthen the relationships with other programs and organizations.
- Educate stakeholders. Knowing the basic concepts of the model is not enough to implement it effectively. The views held by service providers about the model may have responded to their interpretation of the approach. Thus, it is important that all people involved understand the inner workings of the approach and implement the concepts. Furthermore, government officials (including elective officials) also need to

fully understand the model and its implications for services and the resources needed for the approach to work.

- Ensure support from the central government. Organizations need the central government's support with a clear public policy regarding homelessness and increased support to the organization working with the population.

Research Questions

The study sought to answer two research questions based on the information gathered by documenting service providers' experiences and conducting a document review. Six key informants completed in-depth interviews. The following answers reflect the views, opinions, knowledge, and experiences of said participants at the time of the study. The research questions read as follows.

Question 1. What was the experience of the service provider (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) with rehabilitation counselors and their role within the intervention models for chronic homelessness population?

Based on the gathered information, rehabilitation counselors could assume four distinct roles at permanent housing programs serving chronically homeless people. The roles could depend on the size and services each program had available. First, they could act as an employment specialist, in charge of assessing and developing pre-employment skills and guiding residents through a job placement process, using a psychiatric rehabilitation approach. Second, counselors could assume case managers' roles and work with social workers to assess needs, identify goals, service coordination, and provide counseling to people transitioning from

homelessness to permanent housing. In both instances, the knowledge of rehabilitation professionals of disability and chronic conditions, functioning, and strategies to improve said functioning could help and support the work other professionals carry on in permanent housing programs.

The third role an RC could assume would be as part of the clinical team, providing individual and group counseling, providing diagnostic impressions, functional diagnosis, and developing treatment plans. The fourth and last role would be as a team leader or service coordinator. The role would be consistent with some programs that include the rehabilitation counselor among the professionals capable of filling the position. Rehabilitation counselors could perform administrative tasks, such as service coordination, program evaluation, and clients' assessment. Counselors' scope of practice included assessing barriers and finding ways to minimize their impact, helping people function better in their environment. Said critical skills could be transferred to a work scenario focused on building on strengths and meeting people "where they are" in the rehabilitation process. Also, rehabilitation professionals share a common language and professional skills with other human services professionals, facilitating communication among team members, supporting treatment plans developed by other professionals.

Rehabilitation counseling in context. Most rehabilitation counseling professionals in Puerto Rico work for the Vocational Rehabilitation Administration; thus, professionals from related fields not directly involved with the agency have little contact with said professional. Key participants with limited or no experience with the rehabilitation counseling professional would be less likely to include said professional among the staff members. Most participants were unfamiliar with the occupational title and their professional skills. Participants did associate the

RCs' tasks with the profession, but it was unclear if they believed the rehabilitation professional dealt with addictions only. Furthermore, if participants associated RCs' tasks with job placement alone, they would be less likely to include the counselors during the transition process from homelessness to housing.

Question 2. What was the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the chronically homeless population?

The overall experiences of key informants regarding chronic homeless individuals were characterized as positive since working with the population helped them grow personally and professionally throughout the years. The service providers showed a sense of commitment toward their clients and programs and derived satisfaction from their work and the successes of the people they served. At the same time, key informants defined working with chronic individuals as challenging; especially when dealing with those individuals who had a long history of mental health and substance abuse problems and had adopted homelessness as a way of life. Others faced untreated traumatic experiences and chronic conditions, which added another level of complexity. Nonetheless, the biggest challenge was not the population's characteristics but the lack of support to effectively face the situation.

Question 3. What is the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the Pathways Housing First approach to service?

On the other hand, experiences related to the housing first approach to service were mixed. In both CoC systems, most organizations had adopted some component of the housing first model. All key informants admitted they agreed with the model's philosophy and principles

and knew about the approach. Nevertheless, the key informants still had reservations about the model, particularly those whose programs were not fully functioning as Housing First programs. First, the smaller organizations not able to expand services in-house or coordinate supported services as needed found themselves wondering how to best support the residents without having the resources to do so. For them, resources like transitional housing could support residents in ways otherwise not available in the community. Second, not all participants felt they knew the model well enough to implement it effectively. Key informants considered it essential to obtain training from professionals who were knowledgeable about homelessness, the population, and the model.

On the contrary, key informants who worked at Housing First programs believed in the model and described it as effective for working with the local homeless population. However, a program could not do it alone. Programs that fully embraced the model needed to be flexible and willing to adapt to eventualities, grow and provide in-house services, or reinforce working relationships with agencies and other organizations.

The participants' views and opinions were rooted in the social, economic, and political context of Puerto Rico. Service providers agreed with the basic principles of the Housing First model and the potential for rehabilitation for individuals experiencing homelessness. The reservations about the approach revolved around various environmental factors. Key informants assessed the advantages and disadvantages of the model based on the availability of supported services, funding, and government support. Participants whose programs were in areas lacking supported services and working with limited resources (i.e., funding, professional staff) perceived the model as idealistic. Two of the key informants reported feeling alone as they worked on behalf of the homeless population due to the lack of support.

The statements suggested programs were working “in spite of” the situation or the perceived obstacles. The idea was reinforced as key informants compared local resources with resources organizations in the states may have. The overall impression was that services and resources in the States (including funding) were sufficient and more accessible than local resources. Also, key informants felt programs in the states had more support from their local government and government agencies and addressed the homeless community's issues more efficiently than the local central government.

In Puerto Rico, constant changes in politics also meant changes in public policies and priorities. Therefore, there was a level of uncertainty on whether initiatives and programs would continue after a new administration took office. Finally, key informants felt organizations in the US mainland had alternative funding sources at the state level. At the time of the study, Puerto Rico had been in an economic recession for 15 years, and funding for the community-based organization had diminished over time. Thus, obtaining funding to maintain organizations up and running was increasingly challenging. With a service record for over 10 years, the larger and better-known organizations had better access to alternative funding sources than new and smaller organizations.

Limitations in Interpreting Findings

The study's findings provided a glimpse into participants' experiences, knowledge, and views toward the RCs and the implementation process of the Housing First approach. However, the results should not be considered a comprehensive view of implementing the model or the rehabilitation professional. Since completing the study took several years, some of the original

expectations related to the sample, methodology, and the overall social context changed over time, impacting the process's results.

Although the number of completed interviews was within the margin for reasonable sample size for a phenomenological study, the final number of key informants who agreed to participate in the study was small. The key informants' responses provided a context to understand the homeless phenomenon, the Housing First model, and their experiences with the rehabilitation counseling professionals. Thus, the experiences described should not be considered representative of all service providers' views on the island but a starting point to explore the needs of the service providers, organizations, and the homeless populations in-depth.

The purpose of the document review process was to identify elements of the Housing First approach to service and the tasks of the service providers that overlapped with the scope of practice of rehabilitation professionals. It was also meant as a tool to triangulate the information gathered during the data collection process. Even though the documents gathered from organizations provided information about the model and the tasks associated with the scope of practice, they were few and from programs associated with the same parent organization; hence, there was not enough information to support, or deny, the information provided by the participants.

Likewise, the obtained survey responses were too small to analyze. Because the study focused on the service providers employed at a handful of the programs, it limited the number of potential participants to said programs only. The actual number of participants (21 service providers) weakened the statistical analysis reducing the statistical procedures to frequencies and percentages. The issues with the sample and selection bias limited the analysis and interpretation

of data to those individuals who took part in the study and cannot, in any way, be generalized to a larger population of service providers.

Several events took place on the island throughout the research process, which impacted its development, and later, the data collection process. The natural disasters between 2017 and 2020 delayed the pre-data collection process. In 2020, the COVID-19 pandemic required changing the data collection protocols from face-to-face interventions to remote interventions. As a result, the interviews were completed through a video conferencing platform, and the administration of the survey changed from paper and pencil to an electronic-based survey system. Said changed ensured the participants' and researcher's safety. As a result, some field observations were limited to the capabilities of the technology at hand.

CHAPTER V

DISCUSSION

The first section of the chapter features a brief review of the study's purpose, a summary of relevant findings, and the interpretation of said findings from the researcher's perspective. The second part focuses on discussing the limitations of the study, the implications for the rehabilitation counseling field, especially for practice in Puerto Rico, and the conclusion.

Purpose and Focus of the Study

The study aimed to explore service providers' (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) views, opinions, and experiences associated with the role of rehabilitation counselors at permanent housing programs for chronically homeless people and the implementation process of the Pathways Housing First model in Puerto Rico. The researcher used two different strategies to gather the information: in-depth interviews with key informants and a review of the literature for each of the programs in the sample and the CoC systems

Bracketing

The nature of the qualitative study implies that researchers need to become aware of their past experiences, views, and opinions and the influence they may have during the research

process (Creswell, 2013). To reduce the impact of said views and experiences, the researcher engaged in two bracketing techniques: memo writing and journaling to gain awareness of her thoughts and reduce their influence during the process (Tufford & Newman, 2010). The researcher made a conscious exercise of monitoring her thoughts while conducting interviews, reading the transcripts, and analyzing data to acknowledge their influence and reevaluate the selection of ideas and themes during the analysis. She also engaged in informal conversations with a colleague and member of the research team to express her thoughts and views during the process.

As a Puerto Rican rehabilitation counselor involved in volunteer work for various community-based organizations, the researcher explored her feelings of sympathy and identification with service providers. She also acknowledged the points of convergent and divergent ideas and thoughts related to the Puerto Rican social and political context, the intervention models, and the researcher's beliefs about the recovery processes of people with disabilities, especially psychiatric disabilities.

Interpretation of Relevant Findings

The findings related to the experiences of key informants and the review of documents represented the views and opinions of the service providers who took part in the study. Thus, the results were not representative of all service providers on the island. Furthermore, said views could change over time due to environmental factors. However, their responses about the experiences with the rehabilitation counseling profession, the chronically homeless population, and the Housing First model echoed issues related to the professional identity of RCs and the implementation process of the Housing First approach to services.

Research Question (RQ) 1. What was the experience of the service provider (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) with rehabilitation counselors and their role within the intervention models for chronic homelessness population?

The findings associated with the RC's role corresponded to experiences of service providers with said professionals. Although the rehabilitation counseling field in Puerto Rico had been part of the service network for over 50 years, the profession was virtually unknown for most of the study's participants from related fields. Key informants with little to no experience with rehabilitation counseling professionals confused them with addiction counselors, equipped to deal with substance abuse issues. Said confusion is not new among professionals from related fields due, in part, to professional identity issues among rehabilitation counselors themselves (Zankas & Sherman, 2018).

The rehabilitation counseling field has expanded beyond traditional vocational settings to include other scenarios providing services for individuals with disabilities. Rehabilitation professionals focusing on providing services within the scope of practice for a given group of individuals with disabilities (e.g., individuals with psychiatric disabilities) may have a different job title depending on the work environment, tasks, and the specific service they provide (Stebnicki, 2018).

The key informants with personal experiences with rehabilitation counselors could see them as part of the staff, performing tasks ranging from case management and counseling to service coordinators or team leaders. The participant who had professional experiences with vocational rehabilitation counselors did not always see them as relevant team members in programs for homeless individuals; perhaps, because the clients were not always eligible for

services at the Vocational Rehabilitation Administration (VRA). Thus, rehabilitation counselors recruited as case managers, substance abuse counselors, or mental health counselors and who did not perform tasks related to traditional vocational rehabilitation interventions would go unnoticed by other professionals in related fields (Stebnicki, 2012). Adding to the confusion, changes within the field had fueled the debate on who the RC is, a case manager or a counselor. One of the most significant changes was the shift in the accreditation for rehabilitation counseling programs. At the time of the study, programs previously accredited under the Council on Rehabilitation Education (CORE) became accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). Rehabilitation counseling programs chose to stay as a general rehabilitation counseling program or became a clinical rehabilitation counseling program.

The new specialty allowed licensing opportunities as Licensed Professional Counselors for the new generation of rehabilitation professionals to use the clinical skills to further the quality of life of people with disabilities through assessing and developing employment and independent living skills. Although these changes would allow rehabilitation professionals to insert themselves in clinical scenarios where people with disabilities work on developing their pre-employment skills, they also made the professional boundaries among counseling specialties blurry, even within the rehabilitation counseling field.

Participants' views and opinions about the role rehabilitation counselors could assume with the homeless population related to the level of participation counselors had with said population and their lived experiences. Homeless individuals working through the rehabilitation process may not be eligible for services within the VRA, especially if they are not stable in their condition. Hence, professionals working in permanent housing programs may have little to no

interaction with rehabilitation counselors. In most cases, counselors from the VRA would not be involved in the first stages of the rehabilitation process when individuals developed pre-employment and independent living skills.

On the other hand, key informants who knew firsthand the capabilities of RCs could see them helping individuals manage their symptoms and provide support during the rehabilitation process. Therefore, the more key informants knew about the skills of RCs, the more likely they would see them assuming a professional role as part of the program. This statement was consistent with the expressions made by personnel from the Puerto Rico Mental Health and Anti-Addiction Services Administration (ASSMCA by its Spanish acronym). The agency won a grant to start a program under the Cooperative Agreements to Benefit Homeless Individuals (CABHI-PR) in Puerto Rico. Back in 2015, CABHI provided funding for the first Housing First program on the island. The program had RCs among the professionals involved and they were considered an integral part or an asset for the intervention model (H.Y. Serrano, personal communication, February 15, 2016). Moreover, ASSMCA is one of the agencies that hires RCs to fill positions as such, but also in other positions with different job titles, depending on the tasks assigned to said professional.

RQ 2. What was the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the chronically homeless population?

Key informants described their experiences with the chronically homeless population as rewarding but also challenging. Individuals who fell into the chronically homeless category were individuals with a long history of homelessness, mental health, and substance abuse issues,

making interventions very difficult. Current trends in interventions focus resources and efforts in the recovery process of the hard-to-served individuals. Still, the resources available to provide supportive services were not enough to satisfy said demand.

Half of the key informants believed the Puerto Rican homeless population was different from those in the US. Hence, their needs would be different. They also believed programs operating within the US had better access to resources and supported services than local programs. Nonetheless, even with the noticeable cultural and sociopolitical differences, when it came to homelessness, and in paper, the experiences were very similar.

In 2019, the profile of a homeless person in the US was primarily white (48%), male (61%), and 24 years or older (91%) (Henry et al., 2020; US Department of Housing and Urban Development, 2020). Of those, almost a quarter (24%) were chronically homeless individuals who experience severe mental illness and chronic substance abuse (Henry et al., 2020; US Department of Housing and Urban Development, 2020). In Puerto Rico, the profile of a homeless person was Hispanic males (79%), middle-aged individuals with chronic substance abuse followed closely by mental illness. The chronically homeless population on the island was over the national percentage: 27% for PR CoC 502 and 36% for PR CoC 503 (Puerto Rico Department of Family Affairs, 2020). In both instances, chronic substance abuse and mental illness were issues service providers had to deal with when servicing the homeless population. Still, key informants felt environmental factors in Puerto Rico made the issues even more challenging.

Said perception is inconsistent with the literature about homeless in the US. Service providers in Puerto Rico and the US face the same challenges and barriers providing services for chronically homeless individuals, even under the Housing First model of service. In a similar

qualitative study conducted by Quinn et al. (2018) seeking to explore the experiences and challenges of servicing chronically homeless individuals in Chicago, IL, participants reported the same concerns and barriers Puerto Rican key informants experienced. Like in the island, service providers in Chicago faced the same shortage of supportive services, qualified personnel, and funding. Participants in the study also struggled to keep clients housed and encourage clients with severe mental health issues, substance abuse, and chronic health conditions to seek the services they needed (Quinn et al., 2018). At the same time, people refusing to receive supportive services added another layer of complexity to the recovery process in Puerto Rico and the US.

Another perceived difference between homeless populations was the main reasons people became homeless. In Puerto Rico, people reported being homeless due to problematic drug use and abuse, family problems followed by economic problems (Municipio Autónomo de Caguas, 2020; Puerto Rico Department of Family Affairs, 2020). At least three key informants felt the main reason for becoming homeless in the US was economic problems, which led individuals to develop drug dependency or mental health problems. For participants, this slight difference implied most of the Puerto Rican homeless population had a long history of dependency that, together with a lack of rehabilitation services, made the recovery process even more challenging. However, said contrasts made little to no difference in the implications for services between local and US service providers. Even though service providers in both studies admitted getting frustrated with participants, their main concern was not providing appropriate services promptly to those who needed them (Quinn et al., 2018).

Although key informants focused on the difference in needs and characteristics between the local and the US homeless population, results suggest similar experiences. Most of the

experiences did not focus on the homeless individuals themselves but on the barriers in services (i.e., funding, availability of rehabilitation and mental health services and professionals) they faced as service providers. Mainly they spoke of the lack of supportive services. These environmental barriers could keep chronic homeless individuals from developing the necessary skills to effectively manage their conditions, perpetuating the disability and limiting the recovery process.

Still, cultural and environmental differences between the US and PR impacted the way service providers and clients provided and received services. Acknowledging those differences could make services and procedures more effective and responsive to the needs of the local population. For instance, the methodology used to carry out the PIT counts may not be the most effective for the reality of the local environment. In the US, the PIT takes place in January, during the winter when most homeless people in the US go to shelters due to the season's low temperatures. In PR, winter has little to no impact on the number of people seeking shelter. Thus, the estimated number of actual homeless individuals could be a lot lower than the PIT has typically shown.

The PIT excluded individuals who reported having a place to go to or of their own during the counts. In such cases, individuals could not be considered homeless because, technically, they have a home. Thus, the number of people roaming in the streets and seeking services from not-for-profit organizations and agencies may be a lot higher than the estimated number of individuals considered homeless. This scenario presented an additional challenge for organizations with housing programs.

Like many other agencies, HUD provides funding based on the population's needs according to reports and information gathered through the organizations and strategies like the

PIT. Excluding such groups from the PIT and other data collection strategies may limit the ability of the organizations to assess the demand for services effectively. Said update might include changes in the programmatic structures, the development of strategic plans and services, and programs geared toward addressing the issues of all homeless subpopulations, not only the chronically homeless individuals. It also limited the organization's ability to search for and identify new funding sources outside the HUD grants and to meet the service demands.

An overview of the reviewed literature focused on risk factors and strategies to prevent homelessness among vulnerable individuals. The reviewed articles acknowledged several homeless subgroups seeking support from permanent housing programs who may qualify for other programs for non chronically homeless individuals like Rapid Rehousing. However, the articles did not directly refer to individuals who chose a homeless lifestyle when other options were available. Said phenomenon went beyond the scope of this study. Nonetheless, it may impact the overall resources and functioning of programs for homeless individuals in general, not only housing services.

RQ 3. What was the experience of service providers (i.e., continuum of care coordinators, administrators, clinical and case managers, and direct service providers) about the Pathways Housing First approach to service?

The results showed two distinct views and opinions about the Housing First model among participants. One group of participants felt the model worked. The second group had their reservations about the model and was unsure how it could be implemented effectively in Puerto Rico. As with the chronically homeless population, the experiences, views, and perceptions

about the Housing First approach were consistent with the experiences of service providers in the US and Canada.

Participants who believed in the model and its basic principles and values felt it made the process easier and manageable for the chronically homeless individual transitioning into permanent housing. Accepting the model and embracing change took time. Key informants admitted to being skeptical initially, but once exposed, were convinced of the model's effectiveness. This change of heart was consistent with the experience of service providers in the US and Canada described in studies conducted by Henwood et al. (2011), Padgett et al. (2016), Tsemberis and Eisenberg (2000), and Tsemberis (2010b). Adopting the model required all individuals involved to have an open mind about the Housing First strategies, the capability to develop resources, and willingness to adapt and change (Henwood et al., 2013; Nelson et al., 2015; Quinn et al., 2018; SAMSHA, 2016b; Tsemberis, 2010b; Tsemberis, 2015).

On the other hand, key informants who expressed reservations about the model center their concerns on two main issues: (1) lack of resources and the impact it had on the population, and (2) how some programs handled the implementation process. Even though service providers agreed with the model’s philosophy, many felt not all homeless individuals could function in a Housing First approach. The views were founded on their experiences with chronically homeless individuals with a long history of substance and mental health issues. The group focused on the “how-to” address the residents' mental health and substance abuse issues with the limited resources available. Participants were more concerned about the accessibility and availability of services than the severity of the symptoms. The lack of services and support, including financial support from the local central government and the agencies, were barriers to implementing the model proposed by Tsemberis (2010b, 2014). Furthermore, participants also stressed that

available funding opportunities did not always reflect the priorities of the local homeless programs or the local population's needs.

As in the previous section, the literature supports the Puerto Rican service providers' concerns. For service providers in Chicago, IL, most of the available funding went to housing services, and not enough was funneled to the supportive services necessary to maintain housing for a chronically ill population that, by definition, required intensive and consistent services (Quinn et al., 2018).

Results also showed factors within organizations impacting the views and opinions of participants about the model. Key informants expressed concerns about how other service providers interpreted and applied the model. In other words, programs defining themselves as Housing First applied the principles and protocols loosely and did not always comply with the norms as expected. Their concerns were consistent with the results from a longitudinal study focusing on exploring how the staff in Housing First programs evolved over time in the US and Canada (Choy-Brown et al., 2021). Although the results depict challenges after years of implementing the model, limited availability of resources and drifting away from the model resulted in misinterpretation of the approach, raising questions about the model's sustainability in a different context (Choy-Brown et al., 2021).

Even though the housing first model has been on the island since 2016, service providers were already concerned about the resources needed for the program's long-term implementation. At the time of the study, a group of the key informants still felt that homeless individuals benefited more from receiving supportive services before being placed in permanent housing. The resistance to change and adapt their procedures and attitudes were thought of as another barrier for the model. However, said resistance, the skepticism, and barriers for implementing the

model in Puerto Rico were consistent with the experience of service providers transitioning from a traditional intervention into a Housing First approach to service (Henwood et al., 2013; Henwood et al., 2011).

Overview: Responses from the Survey

The responses obtained from the service providers who completed the survey suggested knowledge of the basic principles of the HFM model. In statements referencing competency areas within the practice of rehabilitation counselors, participants considered the tasks as consistent with services counselors could provide to chronically homeless individuals. Likewise, in items related to attitudes toward the Housing First model and the rehabilitation professionals, responses reflected positive attitudes toward the model and the RCs. The results were consistent with the broad experiences of the key informants.

The experiences of key informants with rehabilitation professionals, the homeless population, and the Housing First approach to service provided a starting point for exploring dynamics within the two CoC systems in the island from the participant's perspective. The information obtained from the survey was not sufficient to identify the views and attitudes of service providers in Puerto Rico. The responses suggested that the survey participants could confuse who RCs were and whether the Housing First model was a good alternative for all chronic homeless individuals. Thus, additional research should explore said views and their impact on permanent housing services for the homeless population.

Relationship with the Theoretical Framework.

The homelessness phenomenon could be understood from the perspective of the biopsychosocial model proposed by the World Health Organization (WHO, 2001). The model defined disability and chronic conditions on a continuum, where positive outcomes referred to the capacity to function in any given environment and negative outcomes indicated disability or impairment (McCarthy, 2018).

Based on the biopsychosocial model, the homelessness phenomenon and the chronically homeless individual implied a social condition where the physical structure and associated functions (i.e., a person with mental health, substance abuse issues, chronic illness, and economic problems) could not respond and adapt to the demands of the social environment. In other words, it is a person's inability to function, due to conditions and the associated limitations, carry out daily activities, assume social roles, engage in social structures, and adapt to the demands of the said social environment. As a result, chronic homeless individuals lose their ability to cope with illness and trauma, comply with social expectations, and live marginalized lives without engaging family members and abandoning school and work environments.

At the same time, community-based organizations, government agencies, and other supported resources became part of the contextual factors that promoted, or not, the recovery process. If disability in the biopsychosocial model emerged from the negative interaction with the environment, homelessness would result from the negative interactions of people with disabilities and chronic illness with a social, economic, and political environment that did not meet their needs. In Puerto Rico, the limited access to service providers, supported services, housing, among others, were barriers to the recovery process of individuals experiencing chronic homelessness.

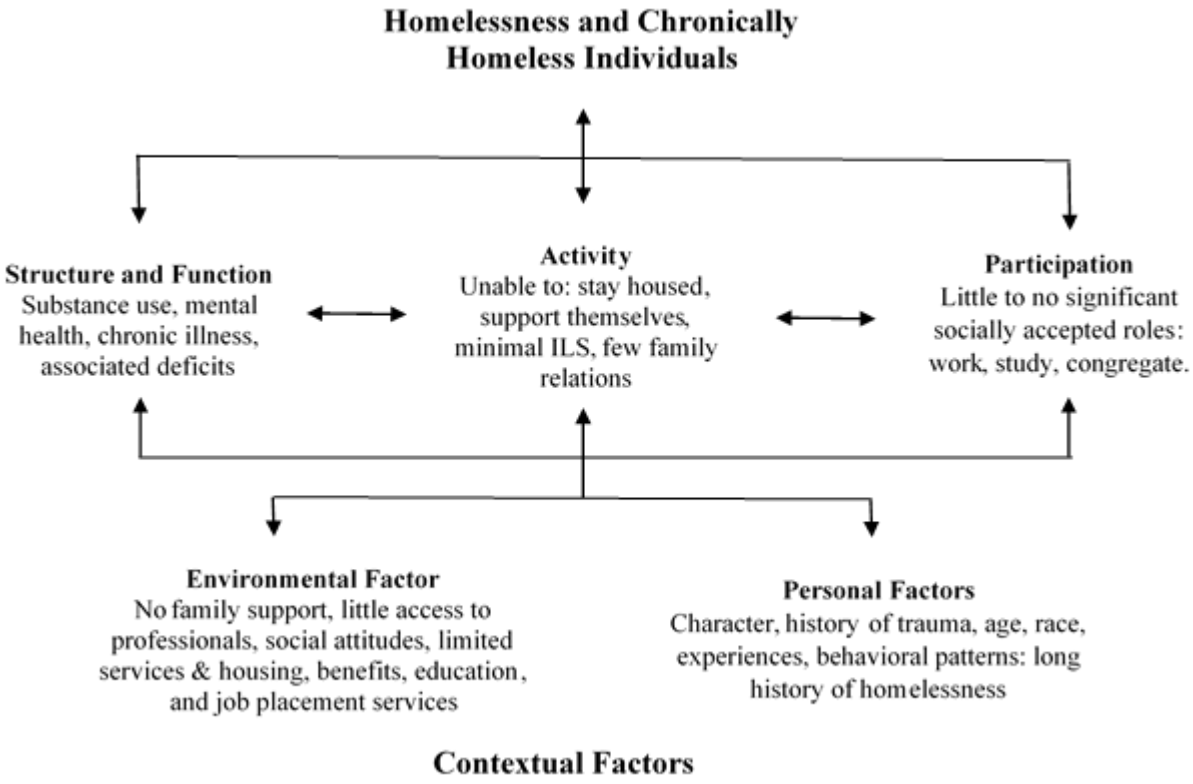
Programs founded in person-centered approaches like the Housing First model would improve homeless individuals' general interactions with the social structures. Furthermore, improving the interactions would provide new opportunities for homeless individuals to rejoin social structures, improving their participation in community life (Figure 2 illustrates homelessness through the factors of the biopsychosocial model).

However, intervention strategies like Housing First are not an easy fix to the problem but a tool that, if used correctly, could improve the quality of life of the hard-to-serve individuals. The interactions between community-based organizations, the central government, and its agencies would need to improve for the approach to be successful. As stated by one key informant, a complex problem such as homelessness could not be confronted alone. For person-centered approaches to work, the environments need to support, facilitate, and promote said approaches. The frequent changes in the local government administrations resulted in a lack of a public policy about homelessness, continuous changes in protocols, and discontinuity of initiatives established by previous administrations. These changes became barriers to service.

Moreover, the disconnect between the central government and its agencies with the community-based organizations prompted organizations to develop work and intervention plans independently, with little or low expectations of official government involvement. The lack of continuity and instability, the skepticism about government support and involvement in the issues of the homeless population, will eventually become an environmental barrier to interventions like housing first, hindering instead of promoting the recovery process.

Figure 2.

Homelessness from a Biopsychosocial Model Perspective



Thus, local agencies need to develop a public policy about homelessness to address the needs of the population and community-based organizations despite administrative changes to ensure consistency within the environment. All stakeholders need to be on the same page, following the same public policy and promoting the continuity of services.

RCs faced environmental factors similar to those of interventions like housing first. The findings of this study suggested that government programs and community-based organizations addressing homelessness knew little about the rehabilitation counseling field or had misconceptions about said professionals. Key informants who had significant interactions with RCs were able to identify the skills and capabilities of the professional as an asset for permanent housing programs. Thus, RC's limited access

and interactions with service providers in non-traditional environments where chronically homeless individuals obtained services could be perceived as a barrier for the insertion of rehabilitation professionals within said scenarios.

From a biopsychosocial perspective, RCs could be understood as the professionals with the knowledge and skills to provide services to chronically homeless individuals (structure and function) by identifying their needs, interests, and strengths, helping them attain a better quality of life (activities). However, the RC level of participation within the homeless community and the organizations that support them were low. There may be at least three theories that could explain the low participation of rehabilitation professionals within the said organizations.

First, the disconnect among government programs, community-based organizations, and other stakeholders hinders the interactions among professionals, limiting the opportunities to collaborate. Second, if service providers only interact with counselors from the VRA, their experiences could be limited to what the agency could do for their clients. Individuals transitioning to permanent housing may not be eligible for services from the agencies' perspective. Turning away potential consumers from the agency may discourage service providers from referring their clients for services. Third, service providers may have positive experiences with RCs working in programs within the community under other occupational titles, making them invisible to other professionals.

Even if any of the three theories could be validated in subsequent studies, there is an additional contextual factor to consider: the personal factors of RCs. Although qualified to work with individuals with mental health issues, professionals within the rehabilitation field may prefer to work in environments not directly addressing said issues or homeless people. Although the rehabilitation field shares the same basic principles as the biopsychosocial model and the Housing First model, professionals would also need to explore their views and think about harm reduction, recovery, and how to address the limitations of the current Puerto Rican socio-economic environment.

In conclusion, most of the barriers, strengths, and interactions related to the role of the RC and the implementation process of the Housing First approach to service related to contextual factors among the government, organizations, service providers, RCs, and individuals. Even though it was challenging, programs and organizations provided services to vulnerable individuals and maximized resources when available. The most significant challenges programs faced related to the availability and accessibility of services and support from the government structures.

Limitations of the Study

The researcher confronted the following limitations during the investigation process. First, the program funded by the SAMHSA grant for working with the chronically homeless population (CABHI) closed at the end of the grant cycle. The program was the fifth organization in the original sample and was not replaced with another program, reducing potential participants. The sampling methodology did not consider an alternative strategy to replace participants who chose not to participate in the study; thus, the final number of participants was lower than initially expected.

Second, organizations in the sample did not include direct services personnel as defined in the Housing First model; thus, a group of potential participants was never available, reducing the sample size for key informants and survey participants further.

The third limitation referred to the agencies or community-based organization's organizational structure. The two different programs shared the same parent organization, and service providers could perform tasks for both programs, reducing potential participants.

Forth, administrative processes such as obtaining authorizations, technical difficulties, changes in procedure, and permits delayed the data collection process.

The fifth limitation revolved around changes in protocols due to the COVID-19 pandemic. The data collection protocol changed from face-to-face interactions to remote interventions through a video conferencing platform to ensure the participants' and the researcher's safety. The additional information obtained from other service providers was gathered using an online survey platform and distributed to participants through a hyperlink. The changes in strategy limited the type of additional observations that could be included during the interview process. Also, technical issues arose during the interview process, although they were managed and resolved accordingly.

A sixth limitation was the researcher's different biases in the study's methodology, specifically in selecting the sample and in the development of the guide for the interviews. As previously noted, the sampling process focused on a limited number of organizations, reducing the number of potential participants in the study. Also, the structure of the guide for the qualitative interview presumed participants knew about the rehabilitation professional. Even though the researcher used a semi-structured interview, the questions related to the rehabilitation counseling section resulted in negative answers due to the key informants' lack of knowledge and experiences with the said professional.

Seventh, the small number of participants reduces the transferability of the findings to other service providers in Puerto Rico. Only six key informants completed the interviews, and only 21 participants from three organizations completed the survey; thus, the information obtained from the additional participants was limited.

The last group of limitations entailed the current social, economic, and political environment on the island. The sample's programs were still dealing with the aftermath of hurricanes Irma and María (September 2017), the earthquakes of January 2020, and the COVID-

19 pandemic (2020-2021). Some programs may have lost staff members due to changes in the migration patterns to the US mainland (Red State Data Center of Puerto Rico, 2018). Also, many of the participants' issues and concerns revolved around the difficulties of servicing homeless individuals in a social and economic environment that may be unique, obscuring other issues while discussing the topics.

Implications for Professional Practice, Policy, and Further Research

Since the 1960's the academic programs in charge of training future rehabilitation counselors sought to establish the standards of practice by pursuing professional accreditations and certifying their programs (Patterson, 2009; Tarvydas et al., 2018). The standards helped ensure that professionals in the area had the skills and knowledge to provide quality rehabilitation services for individuals with disabilities. Although the field was not new, rehabilitation counselors continued to be the "best keep secret" from other behavioral and human services fields, that in some cases, had no idea the profession existed (Patterson, 2009, p. 130).

From the biopsychosocial model's perspective (WHO, 2001), the invisibility of the rehabilitation profession could be explained as the result of the negative interactions between the rehabilitation counseling and the model's environmental factors. For discussion purposes, negative interactions referred to little or no participation within the broader context. The negative interaction could be associated with the rehabilitation professional's level of participation in the broad social, economic, and political context. In terms of the model's components (i.e., the structures and functions and activities), rehabilitation counselors had the knowledge, capacity, and skills to work and adapt to almost any environment servicing individuals with disabilities.

Still, professionals from related areas knew little or nothing about rehabilitation counseling, suggesting their interactions with RCs within their work environment were few. It also suggested that the RCs' functional components surpassed their participation or involvement in non-traditional scenarios where individuals with disabilities received services. Professionals from related fields who had some knowledge about rehabilitation counseling defined and constrained the counselor's competencies and role to finding employment opportunities for people with disabilities. Furthermore, organizations providing services with professional tasks and positions related to the RCs ' scope of practice were enclosed within other occupations titles, making RCs invisible from other fields (Tarvydas et al., 2018).

In Puerto Rico, most of the rehabilitation counselors worked for the VRA. If a person with a disability, for any reason, did not qualify for the agency's services, the probability that they received services from a trained rehabilitation professional would be considerably lower. The study focused on an example of individuals with disabilities in non-traditional scenarios, developing independent living skills, managing their conditions, and learning to cope with the social demands while trying to stay housed. The expertise of RCs could help chronically homeless individuals to achieve their goals and improve their quality of life. Organizations could also benefit from having professionals who could complement and support the work case managers and service coordinators perform.

However, it also implies that RCs need to get involved in initiatives centered in other areas, such as independent living, assessments, and counseling outside the vocational rehabilitation perspective. Furthermore, counselors should also promote including the rehabilitation counseling title to positions where professionals work with people with disabilities

as such—working toward developing the pre-employment skills, social and independent living skills for individuals that may not qualify for services in the VRA.

Recommendations for future research. Based on the study's findings, future research could explore professionals' interactions, views, and experiences from related fields about the rehabilitation counseling professional in Puerto Rico and abroad. Homelessness is a complex phenomenon with ample research. Future research could focus on exploring individuals who live as homeless but do not fall into the definition of homelessness as established by HUD and other agencies. Such a study could help better understand additional factors impacting services organizations provide for the population in Puerto Rico. Other suggested areas for research include using the Fidelity Scale for the Housing First model to assess the implementation process in the island and the challenges organizations face during the process. Although organizations within the CoC comply with internal assessment, formal studies could help organizations establish a baseline, better understand the problem, and get across the differences and unique characteristics of the local homeless population.

Conclusion

Homelessness was considered a complex problem with no simple solutions. The introduction of evidence-based practices such as the Housing First model helped reduce the number of homeless people in the US and Puerto Rico. Still, homelessness continues to be a public health problem. Implementing the Housing First model to address chronic homelessness in Puerto Rico required organizations to adjust and modify their structures to comply with the model. It also implied changes in the local social, economic, and political environment to support the programs' efforts working on behalf of the homeless population. Person-centered approaches,

such as housing first, rely heavily on the commitment of stakeholders in government and private sectors to facilitate funding, technical assistance, and support to eliminate barriers and become allies in the process. Nonetheless, not enough of the necessary changes had been addressed by the local government or the community at large, leaving service providers feeling alone in the process. The participants' proposals to achieve said changes included promoting and supporting services within the community, establishing a clear public policy for homelessness, ensuring continuity of services, and implementing initiatives to protect the vulnerable population.

Even though the professional skills of RCs could help organizations support the homeless population, they were not purposefully included among the staff members of the permanent housing programs. Perhaps, misconceptions and lack of knowledge about the RC could explain why organizations were not actively recruiting RCs for permanent housing programs and other agencies servicing people with disabilities. Still, the tasks performed within the programs were consistent with the scope of practice of the rehabilitation counseling field. Professional organizations and academic programs needed to assume an active stance and implement concrete actions to promote the rehabilitation counseling field. By actively engaging professional and community organizations, the counselors could improve their visibility and the rehabilitation field. Furthermore, professionals could identify new areas of opportunity for professional growth by providing services to the community with disabilities, regardless of the environment or scenario.

REFERENCES

Aubry, T., Bernad, R., & Greenwood, R. (2018, February). "A multi-country study of the fidelity of Housing First Programmes": Introduction. *European Journal of Homelessness, 12*(3), 14-31. https://www.researchgate.net/publication/327646751

Borrel-Carrió, F., Schuman, A. L., & Epstein, R. M. (2004). The Biopsychosocial Model 25 years later: Principles, practices and scientific inquiry. *Annals of Family Medicine, 2*(6), 576-582. https://doi.org/10.1370/afm.245

Burt, M. R. (2019). Three decades of homelessness. In D. W. Burnes, & D. L. DiLeo (Eds.), *Ending homelessnees. Why we haven't, How we can.* (pp. 47-66). Colorado: Lynne Rienner Publishers, Inc.

Choy-Brown, M., Tiderington, E., Tran Smith, B., Padgett,, D. K., & Stefancic, A. (2021). Strategies for Sustaining Fidelity: A Multi-state Qualitative Analysis in Housing First Programs. *Administration and Policy in Mental Health and Mental Health Services Research., 48*(1), 36-45. https://doi.org/10.1007/s10488-020-01041-2

Commission on Rehabilitation Counselor Certification. (2017). *Rehabilitation Counseling*. http://www.crccertification.com/scope-of-practice

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89-91.

Corrigan, P. W. (2016). *Principles and practice of psychiatric rehabilitation* (2nd ed.). The Guilford Press.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Sage Publications.

Creswell, J. W., & Creswell, J. D. (2018). Mixed methods procedures. In *Research design: Qualitative, quantitative and mixed methods approaches.* (5th ed.). Sage Publications.

Dreier, P. (2004, May 1). Reagan's legacy: Homelessness in America. *Shelterforce Online*(135). http://www.nhi.org/online/issues/135/reagan.html

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors that influence implementation. *American Journal of Community Psychology, 41*, 327-350 http://dx.doi.org/10.1007/s10464-008-9165-0

El Nuevo Día. (2015, July 14). ASSMCA extiende servicios a las personas sin hogar. El Nuevo Día. http://www.elnuevodia.com/noticias/locales/nota/assmcaextiendeserviciosapersonassinhogar-2073510/

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open*, *4*(1)1-10. https://doi.org/10.1177%2F2158244014522633

Engel, G. L. (1980). The clinical application of the Biopsychosocial Model. *The American Journal of Psychiatric, 137*(5), 535-544. http://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.137.5.535

Escorpizo, R. (2015). Conceptual framework: Functioning and disability. In R. Escorpizo, S. Brage, D. Homa, & G. Stucki (Eds.), *Handbook of vocational rehabilitation and disability* (pp. 11-41). Springer International Publishing. https://doi.org/10.1007/978-3-319-08825-9_2

Greenwood, R. M., Schaefer-McDaniel, N. J., Winkel, G., & Tsemberis, S. (2005). Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness. *American Journal of Community Psychology*, *36*(3-4), 223-238. https://doi.org/10.1007/s10464-005-8617-z

Greenwood, R. M., Stefancic, A., & Tsemberis, S. (2013). Pathways housing first for homeless persons with psychiatric disabilities: Program innovation, research, and advocacy. *Journal of Social Issues, 69*(4), 645-663. https://doi.org/10.1111/josi.12034

Henry, M., Cortes, A., Morris, S., Khadduri, J., & Culhane, D. (2013). *The 2013 Annual Homeless Assessment Report to Congress. Part 1 Point-in-time Estimates of homelessness.* US Department of Housing and Urban Development, Office of Community Planning and Development. https://www.onecpd.info/resource/3300/2013-ahar-part-1-pit-estimates-of-homelessness/

Henry, M., Cortes, A., Morris, S., Khadduri, J., & Culhane, D. (2014). *The 2014 annual homeless assessment report to Congress. Part 1: Point-in-time estimates of homelessness.* Washington DC: US Department of Housing and Urban Development, Office of Community Planning and Development. https://www.hudexchange.info/resource/4074/2014-ahar-part-1-pit-estimates-of-homelessness/

Henry, M., Shivji, A., de Sousa, T., Cohen, R., Khadduri, J., & Culhane, D. (2015). *HUD 2015 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations.* Washington, DC. https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/

Henry, M., Watt, R., Rosenthal, L., Shivji, A., & Abt Associates. (2017). *The 2017 Annual Homeless Assessment Report to Congress. Part 1: Point-in-time Estimates of Homelessness.* US Department of Housing and Urban Development, Office of Community Planning and Development, Washington, DC. https://www.hudexchange.info/resource/5639/2017-ahar-part-1-pit-estimates-of-homelessness-in-the-us/

Henry, M., Watt, R., Rosenthal, L., Shivji, A., Khadduri, J., & Culhane, D. (2016). *The 2016 annual homeless assessment report (AHAR) to Congres. Part 1: Point-in-time estimates of homelessness.* Washington, DC: US Department of Housing and Urban Development, Office of Community Planning and Development. https://www.usf.edu/cbcs/mhlp/tac/documents/supportive-housing/hud-annual-homelessness-assesment-report-2016.pdf

Henry, M., Watt, R., Mahathey, A., Ouellette, J., Sitler, A., & Abt Associates. (2020). *The 2019 Annual Homeless Assessment Report to Congress.* Abt Associates. U.S. Department of Housing and Urban Development. https://www.huduser.gov/portal/datasets/ahar/2019-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html

Henwood, B. F., Shinn, M., Tsemberis, S., & Padgett, D. K. (2013). Examining provider perspectives within Housing First and traditional programs. *American Journal of Psychiatric Rehabilitation, 16*(4), 262-274. https://doi.org/10.1080/15487768.2013.847745

Henwood, B. F., Stanhope, V., & Padgett, D. K. (2011). The role of housing: A comparison of front-line provider views in Housing First and traditional programs. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(2), 77-85. https://doi.org/10.1007/s10488-010-0303-2

Hernández-Sampieri, R., & Mendoza Torres, C. P. (2018). *Metodología de la investigación: Las rutas cuantitativa, cualitativa y mixta* (6 ed.). McGraw Hill/ Interamericana Editores, S.A. De C.V.

Holtzman, B. (2019). "Shelter is only a first step": Housing the homeless in 1980s New York City. *Journal of Social History, 52*(3), 886-910. https://doi.org/10.1093/jsh/shx042

Homelessness Research Institute. (2015, April 1). *State of Homelessness in America 2015.* National Alliance to End Homelessness. http://www.endhomelessness.org/library/entry/the-state-of-homelessness-in-america-2015

Homelessness Research Institute. (2016). *The state of homelessness in America.* Annual Report, National Alliance to End Homelessness, Washington, DC. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-2020/

Khare, A. T. (2013). Market-driven public housing reforms: Inadequacy for poverty alleviation. *Cityscape: A Journal of Policy Development and Research, 15*(2), 183-203. https://www.huduser.gov/portal/periodicals/cityscpe/vol15num2/ch13.pdf

Leahy, M. J. (2017). Rehabilitation counseling professional competencies. In V. Tarvydas, & Hartley (Eds.), *The Professional Practice of Rehabilitation Counseling* (2nd ed. pp. 14-29). New York: Springer Publishing Company. https://bookshelf.vitalsource.com/books/9780826138934

Macnaughton, E., Stefancic, A., Nelson, G., Caplan, R., Townley, G., Aubry, T., Goering, P. (2015). Implementing Housing First across sites and over time: Later fidelity and implementation evaluation of a pan-Canadian multi-site Housing First program for homeless people with mental illness. *American Journal of Community Psychology*, *55*(3-4), 279-291. https://doi.org/10.1007/s10464-015-9709-z

Maki, D. R. (2012). Concepts and paradigms in rehabilitation counseling. In D. R. Maki, & V. M. Tarvydas (Eds.), *The professional practice of rehabilitation counseling* (1st ed., pp. 83-107). Springer Publishing Company.

Martin, E. J. (2015). Affordable housing, homelessness, and mental health: What health care policy needs to address. *Journal of Health and Human Services Administration*, 67-89.

McAllister, W., Lennon, M. C., & Kuang, L. (2011). Rethinking research on forming typologies of homelessness. *American Journal of Public Health*, *101*(4), 596-601.

McCarthy, H. (2018). Concepts and models. In V. M. Tarvydas, & M. T. Hartley (Eds.), *The professional practice of rehabilitation Counseling* (2nd ed., pp. 72-94). Springer Publishing Company.

Meschede, T. (2011). From street life to housing: Consumer and provider perspectives on service delivery and access to housing. *Cityscape: A Journal of Policy Development and Research*, *13*(1), 71-93. http://www.jstor.org/stable/20868769

Moerer-Urdahl, T., & Creswell, J. W. (2004). Using transcendental phenomenology to explore the "ripple effect" in a leadership mentoring program. *International Journal of Qualitative Methods*, *3*(2). http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.581.4886&rep=rep1&type=pdf

Moustakas, C. E. (1994). Transcendental phenomenology. Conceptual framework. In C. E. Moustakas, *Phenomenological research methods* (pp. 25-41). SAGE Publications.

Municipio Autónomo de Caguas. (2020). *Informe final.* https://caguas.gov.pr/?s=conteo+personas+sin+hogar

National Coalition for the Homeless. (2006, June). *McKinney-Vento Act NCH fact sheet #18.* http://www.nationalhomeless.org/publications/facts/McKinney.pdf

Nelson, G., Patterson, M., Kirst, M., Macnaughton, E., Isaak, C. A., Nolin, D., Goering, P. N. (2015). Life changes among homeless persons with mental illness: a longitudinal study of Housing First and usual treatment. *Psychiatric Services in Advance, 27*(1), 1-6. https://doi.org/10.1176/appi.ps.201400201

Nina, R., & Ostolaza, C. (2013). Homeless people: What are my rights? A community experience through photography. *Revista de Psicologia Universidad de Chile*, 64-74. https://doi.org/10.5354/0719-0581.2013.30854

Padgett, D. K., Henwood, B. F., & Tsemberis, S. J. (2016). *Housing First is: Ending homelessness, transforming systems, and changing lives.* Oxford University Press.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration Policy and Mental Health*, 1-13. https://doi.org/10.1007/s10488-013-0528-y

Patterson, J. B. (2009). Professional identity and the future of rehabilitation counseling. *Rehabilitation Counseling Bulletin, 52*(2), 129-132. https//doi.org/10.1177/0034355208323949

Pearson, C. L., Locke, G., Montgomery, A. E., & Buron, L. (2007). *The applicability of Housing First models to homeless persons with serious mental illness.* US Department of Housing and Urban Development, Office of Policy Development. https://www.huduser.gov/portal//publications/pdf/hsgfirst.pdf

Peterson, D. B. (2015). Mental health management in vocational rehabilitation and disability evaluation: Applying the International Classification and Functioning, Disability and Health (ICF) Conceptual Framework. In R. Escorpizo, B. Sören, D. Homa, & G. Stucki (Eds.), *Handbook of vocational rehabilitation and disability evaluation.* (pp. 295-316). Springer International Publishing. https://doi.org/10.1007/978-3-319-08825-9_13

Peterson, D. B., Mpofu, E., & Oakland, T. (2010). Concepts and models in disability, functioning and health. In E. Mpofu, & T. Oakland (Eds.), *Rehabilitation and health assessment: Applying ICF guidelines* (pp. 3-26). Springer Publishing Company.

Pratt, C., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2014). *Psychiatric rehabilitation* (3rd ed.). Academic Press.

Puerto Rico Department of Family Affairs. (2015). *Conteo de personas sin hogar 2015.* Departamento de la Familia, Gobierno de Puerto Rico. https://agencias.pr.gov/agencias/secretariado/Documents/Conteo%202015/PRESENTACION%20EN%20ADIESTRAMIENTO%20voluntarios-%20CONTEO%202015%20REV%201-21.pdf

Puerto Rico Department of Family Affairs. (2017). *Conteo de personas sin hogar 2017.* Departamento de la Familia, Gobierno de Puerto Rico. https://agencias.pr.gov/agencias/secretariado/ProgramasServicios/Documents/COC_2017/PRESENTACION_COC_2017.pdf

Puerto Rico Department of Family Affairs. (2020, January). *Conteo de personas sin hogar 2019.* Departamento de la Familia, Gobierno de Puerto Rico. http://www.agencias.pr.gov/agencias/secretariado/ProgramasServicios/Pages/MultiSinHogar.aspx

QSR International. (2018, September 9). *QSR International*. https://www.qsrinternational.com

Quinn, K., Dickson-Gomez, J., Nowicki, K., Johnson, A. K., & Bendixen, A. V. (2018). Supportive housing for chronically homeless individuals: Challenges and opportunities for providers in Chicago, USA. *Health and Social Care in the Community, 26*(1), e31-e38. https://doi.org/10.1111/hsc.12467

Red State Data Center of Puerto Rico. (2018, September 13). *Institute of Statistics of Puerto Rico*. http://estadisticas.pr/en/media/3196

Sales, A. P. (2012). History of rehabilitation counseling. In D. R. Maki, & V. M. Tarvydas (Eds.), *The professional practice of rehabilitation counseling.* (1st ed., pp. 39-60). Springer Publishing Company.

Shaw, L. R., & Mascari, J. B. (2018). History and evolution of the counseling and rehabilitation counseling. In V. M. Tarvydas, & M. T. Hartley (Eds.), *The professional practice of rehabilitation counseling.* (2nd ed., pp. 51-72). Springer Publishing Company.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63-75. https://doi.org/10.3233/EFI-2004-22201

Sotiriadou, P., Brouwers, J., & Tuan-Anh Le. (2014). Choosing a qualitative data analysis tool: A comparison of Nvivo and Leximancer. *Annals of Leisure Research, 17*(2), 218-234.

Stanhope, V., & Dunn, K. (2011). The curious case of Housing First: The limits of evidence based policy. *International Journal of Law and Psychiatry, 34*(2), 275-282. https://doi.org/ 10.1016/j.ijlp.2011.07.006

Stebnicki, M. A. (2012). Counseling. In D. R. Maki, & V. M. Tarvydas (Eds.), *The professional practice of rehabilitation counseling* (pp. 241-268). Springer Publishing Company.

Stebnicki, M. A. (2018). Counseling. In V. M. Tarvydas, & M. T. Hartley (Eds.), *The professional practice of rehabilitation counseling.* (2nd ed., pp. 221-240). Springer Publishing Company.

Stefancic, A., & Tsemberis, S. (2007). Housing First for long-term shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. *The Journal of Primary Prevention, 28*(3-4), 265-279. https://doi.org/10.1007/s10935-007-0093-9

Stefancic, A., Tsemberis, S., Messeri, P., Drake, R., & Goering, P. (2013). The Pathways Housing First Fidelity Scale for individuals with psychiatric disabilities. *American Journal of Psychiatric Rehabilitation, 16*(4), 240-261. https://doi.org/10.1080/15487768.2013.847741

Stergiopoulos, V., O'Campo, P., Gozdzik, A., Jeyaratnam, J., Corneau, S., Sarang, A., & Hwang, S. W. (2012). Moving from rhetoric to reality: Adapting Housing First for homeless individuals with mental illness from ethno-racial groups. *BMC Health Services Research,* (12), 345.

Stergiopoulos, V., Zerger, S., Jeyaratnam, J., Connelly, J., Kruk, K., O'Campo, P., & Hwang, S. (2016). Dynamic sustainability: Practitioners' perspectives on Housing First implementation challenges and model fidelity over time. *Research on Social Work Practice, 26*(1), 61-68. https://doi.org/10.1177/1049731515579280

Substance Abuse and Mental Health Service Agency. (2016a, March 6). *Grant Programs and Services*. Substance Abuse and Mental Health Service Agency. https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services

Substance Abuse and Mental Health Service Agency. (2016b, March 8). *Homelessness Resource Center, Best Practices for Providers*. Substance Abuse and Mental Health Service Agency. http://homeless.samhsa.gov/Channel/Housing-First-447.aspx

Suls, J., & Rothman, A. (2004). Evolution of the biopsychosocial model: Prospects and challenges for health psychology. *Health Psychology, 23*(2), 119-125. https://doi.org/10.1037/0278-6133.23.2.119

Tarvydas, V. M., Maki, D. R., & Hartley, M. T. (2018). Rehabilitation counseling: A specialty practice of the counseling profession. In V. M. Tarvydas, & M. T. Hartley (Eds.), *The professional practice of rehabilitation counseling* (2nd ed., pp. 1-14). Springer Publishing Company.

Tsemberis, S. (2010a). Housing First: Ending homelessness, promoting recovery and reducing cost. In I. Ellen, & B. O'Flaherty, *How to house the homeless* (pp. 37-56). Russell Sage Foundation.

Tsemberis, S. (2010b). *Housing First. The Pathways Model to end homelessness for people with mental illness and addiction.* Hazelden.

Tsemberis, S. (2013). Housing First: Implementation, dissemination, and program fidelity. *American Journal of Psychiatric Rehabilitation, 16*, 235-239. https://doi.org/10.1080/15487768.2013.847732

Tsemberis, S. (2015). *Housing First: The Pathways model to end homelessness for people with mental health and substance use disorders.* Hazelden.

Tsemberis, S., & Eisenberg, R. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Journal of Psychiatric Services, 51*(4), 487-493. https://doi.org/10.1176/appi.ps.51.4.487

Tsemberis, S., & Henwood, B. F. (2019). A housing first approach. In D. W. Burnes, & D. L. DiLeo (Eds.), *Ending homelessness. Why we haven't, how we can.* (pp. 67-81). Lynne Rienner Publishers.

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

Tufford, L., & Newman, P. A. (2010). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80-96. https://doi.org/10.1177/1473325010368316

United States Interagency Council on Homelessness. (2015). *Opening doors: Federal strategic plan to prevent and end homelessness as amended in 2015.* United States Interagency Council on Homelessness. https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf

United States Interagency Council on Homelessness. (2016, July). *Enlisting mainstream resources and programs to end homelessness.* United States Interagency Council on Homelessness. https://www.usich.gov/resources/uploads/asset_library/Enlisting_Mainstream_Resources_2016.pdf

US Department of Housing and Urban Development. (2016). *HUD 2016 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations.* https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2016.pdf

US Department of Housing and Urban Development. (2020). *HUD 2020 Continuum of care homeless assistance programs homeless populations and subpopulations.* https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2020.pdf

US Department of Housing and Urban Development. (2021, May 18). *Homeless Emergency Assistance and Rapid Transition to Housing Act*. https://www.hudexchange.info/homelessness-assistance/hearth-act/

Vélez Almodóvar, H., Marrero Medina, M. E., & Rivera, F. (2013, November 1). *"Conteo Boricua" and Vulnerability of Puerto Rican Homeless.* Ponce School of Medicine & Health Science. Coalición de Coaliciones, Coamo. http://static1.squarespace.com/static/513e08bfe4b0b5df0ec24cda/t/533f15a9e4b0e0ebd521ff89/1396643241939/Vulnerable+Puerto+Rican+Homeless+HVA_Velez.pdf

Villafañe Santiago, A., Velázquez Altagracia, J. L., & Báez Lebrón, M. (2013). Evolution of rehabilitation counseling in Puerto Rico: Organizational and legislative efforts. *Educare, 17*(3), 117-136.

Waegemakers Schiff, J., & Schiff, R. A. (2014). Housing first: paradigm or program? *Journal of Social Distress and the Homeless, 23*(2), 80-104. https://doi.org/10.1179/1573658X14Y.0000000007

Wolcott, H. F. (1994). Description, analysis, and interpretation in qualitative inquiry. In H. F. Wolcott, *Transforming Qualitative Data* (pp. 9-54). SAGE Publications.

Wolcott, H. F. (2009). *Writing up qualitative research* (3rd ed.). SAGE Publications.

World Health Organization. (2001). *International classification of functioning, disability and health. Short version.* Geneva: World Health Organization.

World Health Organization. (2002). *Toward a common language for functioning, disability and health, ICF.* http://www.who.int/classifications/icf/icfbeginnersguide.pdf?ua=1

Zankas, S. A., & Sherman, S. G. (2018). Professional credentialing. In V. M. Tarvydas, & M. T. Hartley (Eds.), *The Professional Practice of Rehabilitation Counseling* (2nd ed., pp. 31-50). Springer Publishing Company.

Zlotnick, C., Zerger, S., & Wolfe, P. B. (2013). Health care for the homeless: What we have learned in the past 30 years and what's next. *American Journal of Public Health, 103*, 199-205. https://doi.org/10.2105/AJPH.2013.301586

APPENDICES

Appendix A

Appendix A Table 1: Programs Principles and Protocols

Document Review Form

Programs Principles and Protocols

The following table presents the statements found through the document review process of selected programs related to the Pathways Housing First (HFM) model core values and principles.

Agency or program information Date:_____

Name of the agency or program:_____ CoC:_____

Address: _____

Mission:

_____

_____

_____

Vision:

_____

_____

_____

Type of services available/ offered:

_____

_____

_____

Type of documents (TD) reviewed: 1) _____, 2) _____,

3)_____, 4) _____, 5) _____

Table Key

HFM core principles:

1) housing as a basic human right;

2) respect, warm and compassion for clients

3) commitment to work with clients without time restrictions;

4) scatter-site housing or independent apartments
5) separation of housing and supportive services;
6) consumer choice and self-determination;
7) recovery orientation;
8) harm reduction.

Statement	**TD**	**HFM Core Values and Principles**								**Comments**
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	

Appendix B

Appendix B Table 1-Program Principles and Protocols-Spanish

Planilla para la Revisión de Documentos

Principios y Protocolos del Programa

La siguiente tabla presenta las aseveraciones relacionadas a los principios y valores fundamentales del modelo de Vivienda Primero de "Pathways", encontradas durante el proceso de revisión de documentos de programas seleccionados.

Información de la agencia o programa Fecha:_____

Nombre de la agencia o programa:_____ CoC:_____

Dirección: _____

Misión:

_____

_____

Visión:

_____

_____

Tipos de servicios disponibles/ofrecidos:

_____

_____

Tipo de documento (TD) revisado: 1) _____, 2) _____,

3)_____, 4) _____, 5) _____

Leyenda para la Tabla

Principios fundamentales de Vivienda Primero (VP):

1) vivienda como un derecho humano fundamental
2) respeto, calidez y compasión hacia los clientes
3) compromiso para trabajar con clientes sin restricciones de tiempo
4) vivienda dispersa o apartamentos independientes
5) vivienda independiente y servicios de apoyo
6) elección del consumidor y autodeterminación
7) orientación de recuperación;
8) reducción de riesgo.

Aseveración	**TD**	**Principios fundamentales de VP**								**Comentarios**
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	

Appendix C

Appendix C Table 2 Duties and Responsibilities of Service Providers

Document Review Forms

Duties and Responsibilities of Service Providers

The following table presents the identified tasks, duties, and responsibilities carried out by service providers within each program that falls into the scope of practice of the rehabilitation counselor.

Agency or program information Date:_____

Name of the agency or program:_____ CoC:_____

Type of services available/ offered:

_____

_____

_____

Type of documents (TD) reviewed: 1) _____, 2) _____,

3)_____, 4) _____, 5) _____

Table Key

Category of service provider

1- CoC coordinators, (CSP)
2- administrators
3- clinical and case management staff
4- direct service providers

Scope of practice of rehabilitation counselors (RCs):

1) assessment and appraisal;
2) diagnosis and treatment planning;
3) career (vocational) counseling;
4) individual and group counseling treatment interventions focused on facilitating adjustments to the medical and psychosocial impact of disability
5) case management;
6) referral and service coordination;
7) program evaluation and research;
8) interventions to remove environmental, employment, and attitudinal barriers;
9) consultation services among multiple parties and regulatory systems;
10) job analysis, job development, and placement services, including assistance with employment and job accommodations
11) the provision of consultation about, and access to, rehabilitation technology

Table 2 Duties and Responsibilities of Service Providers

Occupational title	Description	CSP	Scope of Practice RCs			

Appendix D

Appendix D Table 2 Duties and Responsibilities of Service Providers- Spanish

Planilla para la Revisión de Documentos

Deberes y Responsabilidades de los Proveedores de Servicio

La siguiente tabla presenta las tareas, deberes y responsabilidades que realizan los proveedores de servicio de cada programa identificadas que caen dentro de las competencias profesionales del consejero en rehabilitación.

Información de la agencia o programa Fecha:_____
Nombre de la agencia o programa:_____ CoC:_____

Tipos de servicios disponibles/ofrecidos:
_____

_____
Tipo de documento (TD) revisado: 1) _____, 2) _____,
3)_____, 4) _____, 5) _____

Leyenda para la Tabla

Categorías de proveedores de servicio (CPS)

1- Coordinador/a del Continuo de cuidado
2- Administradores
3- Personal clínico y manejadores de caso
4- Proveedores de servicio directo

Competencias del Consejero en Rehabilitación (CR):

1. Evaluaciones y avalúo
2. Diagnóstico y plan de tratamiento
3. Consejería de carrera (vocacional)
4. Intervenciones terapéuticas en consejería individual y grupal dirigidas a facilitar el proceso de ajuste al impacto médico y psicosocial de la discapacidad
5. Manejo de casos
6. Referidos y servicios de coordinación
7. Evaluación de programas e investigación
8. Intervenciones para remover barreras ambientales, de empleo y actitudinales
9. Servicios de consultoría entre varias partes y sistemas regulatorios
10. Análisis de empleo, desarrollo de empleo y servicios de colocación

incluyendo asistencia en el empleo y acomodos en el trabajo

11. Proveer consultoría sobre tecnología de rehabilitación y acceso a la misma

Tabla Deberes y Responsabilidades de los Proveedores de Servicio

Titulo ocupacional	**Descripción**	**CPS**	**Competencias CR**			

Appendix E

Appendix E Guidelines for Qualitative Interview

CoC ____

GUIDELINES FOR THE INTERVIEW PER DIMENSIONS UNDER STUDY

I. Socio-demographic information

1. Age _____
2. Gender/ Sex ____F ____ M
3. Level of education
    a. ___High school graduate
    b. ___Associate/ technical degree
    c. ___Bachelor's degree
    d. ___Masters
    e. ___Doctoral

4. Job title or position-_____
5. Type of program or agency you are currently working for
    a. ___Public- government run facility
    b. ___Community-based services, Non-for-profit
    c. ___Faith-based service programs
    d. ___Private organization
    e. ___Other _____

6. Years of experience working with the homeless population_____
7. Does your workplace include, or has it ever included, the services of a rehabilitation counselor?
    a. ___No, it has never had a RC
    b. ___Yes, it used to have a RC
    c. ___Yes, it currently has a RC

8. Do you know about the Housing First Model of intervention?
    a. ___ Yes
    b. ___ No

II. THE ROLE OF THE REHABILITATION COUNSELOR.

1. What is rehabilitation counseling (RC) for you?
    a. From your experience, what are the areas of professional competence and tasks performed by rehabilitation counselors (RCs)? (TE)
    b. What do you know about the rehabilitation counseling practice? (TE)
    c. How would you describe the rehabilitation counseling professionals? (TE)
2. Based on your experience, what role do RCs have in the recovery process of homeless individuals?
    a. What role do they have in the recovery process of individuals with conditions such as depression, bipolar disorder, schizophrenia problems with additions or both? (SE)
3. What do you know about the Assertive Community (ACT) teams?
    a. What role does the rehabilitation counselor have within the ACT team when working with chronically homeless individuals? (SE)
4. When included, how relevant are the RCs in their intervention with chronically homeless individuals? (if applicable) (TE)
    a. Do RCs influence the decision-making process during the development of the intervention plan? In what way? (SE)
    b. Are there any specific tasks RCs could or should assume within an HFM approach to services? (SE)
    c. In what other areas of the continuum of care (CoC) might be beneficial to include the RC professionals? (TE)

III. THE EXPERIENCE AS SERVICE PROVIDERS WITH THE CHRONICALLY HOMELESS POPULATION WITH DISABILITY (OR DISABILITIES).

1. How would you describe your experience working with chronically homeless individuals? (TE)

a. Based on your experience, what are the main characteristics of chronically homeless individuals? (SE)
b. What are the challenges you have encountered when working with chronically homeless individuals? (TE)

2. How would you describe your experience as a service provider for homeless individuals with disability (disabilities)? (TE)
    a. How do you define disability (disabilities)? (TE)
    b. What are the main characteristics of chronically homeless individuals with disabilities (disabilities) (TE)
3. How does the program you work for address the needs of people dual-diagnosis and co-morbidity? (TE)
4. What are the challenges you have encountered when working with homeless individuals with disabilities (disabilities)? (TE)
    a. What services are the most needed?
    b. Currently, what services are available in the community to address those needs?
        i. How accessible are those community resources to the homeless clientele? (SE)
        ii. What attitudes have you observed in other professionals within the CoC toward the chronically homeless population? (TE)

VI- THE OPINIONS OR POINTS OF VIEWS HELD BY SERVICE PROVIDERS ABOUT THE HFM MODEL.

1. How would you describe the HFM model for services? (TE)
2. What are the main differences between the treatment first approach and the HFM model when working with people who are homeless? (TE)
    a. What administrative changes were implemented (or would need to be implemented) to transition effectively to an HFM Program? (TE)
        i. How would the procedures, eligibility criteria, and intervention protocols change to work under an HFM approach? (SE)

ii. In your opinion, what would be the barriers that chronically homeless individuals could face to access services if the HFM approach to service is implemented? (or have face- if applicable) (SE)

iii. From the perspective of a homeless person, how different would the services be (or are) under an HFM approach? (SE)

3. Do you know of any new public policies or legislation being approved locally to support the HFM Program? (SE)
    a. Do you know if the local government allocated funding to implement or provide services through an HFM approach to end homelessness? (SE)
4. Has the agency taken the steps to prepare the staff to make interventions following the HFM model? (SE)
    a. Which professionals does the program need to include? (SE)
    b. Your agency, would it be able to use the existing community resources to support an HFM program? (SE)
    c. How does your staff perceive the HFM model to services? (TE)
5. In your opinion, what are the unique cultural or environmental characteristics that would need to be considered to effectively address the needs of the Puerto Rican chronically homeless population? (SE)
    a. What features of the HFM model would need to be modified to respond to the Puerto Rican environment? (SE)
    b. What barriers can you foresee during the transition or implementation process of the HFM model? (SE)

Important terminology:

Textual experiences (TE)- a description of the participants' experience, (what the Participant's experiences).

Structural experiences (SE)- description of the experience: how they experienced it in terms of the conditions, situations, or context.

Essence of the experience (EE)- a combination of the textural and structural descriptions to convey an overall essence of the experience (Creswell, 2013).

Appendix F

Appendix F Guidelines for Qualitative Interviews- Spanish

CoC ____

GUIA PARA ENTREVISTA CUALITATIVA POR DIMENSIONES BAJO ESTUDIO

I- Información sociodemográfica

9. Edad _____
10. Sexo ____F ____ M
11. Escolaridad
    a. ___Diploma de escuela superior
    b. ___Grado asociado/ Curso técnico
    c. ___Bachillerato
    d. ___Maestría
    e. ___Doctorado- Post doctorado
12. Título ocupacional- posición-_____
13. Tipo de programa para el cual trabaja (Centro)
    a. ___Público- facilidad administrada por el gobierno
    b. ___Servicios de base comunitaria, ONG
    c. ___Programas de servicios en organizaciones de base de fe
    d. ___Privada
    e. ___Otra _____
14. Años de experiencia trabajando con la población sin hogar_____
15. Su centro de trabajo ¿cuenta o alguna vez ha contado con los servicios de un consejero en rehabilitación (CR)?
    a. ___No, nunca ha tenido un CR
    b. ___Si, solía tener un CR
    c. ___Si, actualmente tiene un CR

8. ¿Conoce usted sobre el modelo de intervención de Vivienda Primero ("Housing First")?

    a. ___Si
    b. ___No

II. EL ROL DEL CONSEJERO EN REHABILITACIÓN

1. ¿Qué es para usted la consejería en rehabilitación?
    a. Desde su experiencia, ¿cuáles son las áreas de competencias profesionales y tareas que realiza el CR? (TE)
    b. ¿Qué conoce de la práctica de la consejería en rehabilitación? (TE)
    c. ¿Cómo describiría a los profesionales de la consejería en rehabilitación? (TE)
2. Basado en su experiencia, ¿qué rol tienen los CR en el proceso de recuperación de las personas sin hogar?
3. ¿Qué rol tienen en el proceso de recuperación de personas que tienen condiciones como depresión, bipolaridad, esquizofrenia, problemas de adicción o ambas? (SE)
    a. ¿Qué conoce sobre los equipos de Tratamiento Asertivos Comunitario ("Assertive Community Treatment" (ACT)?
        1. ¿Qué rol tiene el CR dentro del equipo ACT cuando trabaja con individuos sin hogar crónicos? (SE)
4. Cuando se incluyen, ¿cuán pertinentes son los CR en su intervención con individuos sin hogar crónicos? (si aplica) (TE)
    a. ¿Influyen los CR en el proceso de toma de decisiones durante el desarrollo del plan de intervención? ¿En qué forma? (SE)
    b. ¿Hay alguna tarea específica que el CR pueda o deba asumir dentro de un acercamiento de servicios de Vivienda Primero Pathways? (SE)
        1. ¿En qué otras áreas del continuo de cuidado (CoC) podría ser beneficioso incluir profesionales de la consejería en rehabilitación? (TE)

III. LA EXPERINCIA DE PROVEDORES DE SERVICIOS CON LA POBLACIÓN SIN HOGAR CRÓNICA CON DISCAPACIDAD (O DIVERSIDAD FUNCIONAL).

1. ¿Cómo describiría su experiencia trabajando con las personas sin hogar crónicas? (TE)

c. Basado en su experiencia, ¿cuáles son las características principales de la población sin hogar crónica en Puerto Rico? (SE)
d. ¿Qué retos ha tenido que enfrentar al momento de trabajar con individuos sin hogar crónicos? (TE)

2. ¿Cómo describiría su experiencia como un proveedor de servicios para personas sin hogar con discapacidad (diversidad funcional)? (TE)
    a. ¿Cómo define usted discapacidad (diversidad funcional)? (TE)
    b. ¿Cuáles son las características principales de las personas sin hogar crónicas con discapacidad (diversidad funcional)? (TE)
3. ¿Cómo el programa para el cual usted trabaja maneja las necesidades de la población con un diagnóstico dual y comorbilidad? (TE)
4. ¿Cuáles son los retos que usted ha encontrado al trabajar con individuos sin hogar con discapacidad (diversidad funcional)? (TE)
    a. ¿Qué servicios son los más necesarios?
    b. Al presente, ¿qué servicios hay disponibles dentro de la comunidad para atender esas necesidades?
        1. ¿Cuán accesibles son dichos recursos comunitarios para la clientela sin hogar? (SE)
        2. ¿Qué actitudes ha observado en otros profesionales dentro del CoC hacia la población sin hogar crónica? (TE)

IV- LAS OPINIONES O PUNTO DE VISTA QUE TIENEN LOS PROVEEDORES DE SERVICIO SOBRE EL MODELO DE VIVIENDA PRIMERO (HFM).

1. ¿Cómo describiría el modelo de servicios de Vivienda Primero (HFM)? (TE)
2. ¿Cuáles son las diferencias principales entre el modelo de servicios de tratamiento primero y el modelo de Vivienda Primero al momento de trabajar con personas sin hogar? (TE)
    a. ¿Qué cambios administrativos se han implementado (o necesitarían implementarse) para hacer una transición efectiva a un modelo de Vivienda Primero? (TE)

1. ¿Cómo los procedimientos, los criterios de elegibilidad y los protocolos de intervención cambiarían (o han cambiado) para trabajar bajo un modelo de Vivienda Primero? (SE)
2. En su opinión, ¿Cuáles serían las barreras que podrían enfrentar las personas sin hogar crónicas para acceder los servicios si se implementa el modelo de Vivienda Primero? (o han enfrentado- si aplica)
3. Partiendo de la perspectiva de la persona sin hogar, ¿Cuan diferente sería el servicio que recibiría (o recibe) bajo el modelo de Vivienda Primero?

3. ¿Conoce usted de alguna nueva política o legislación que se esté aprobando a nivel local para apoyar el programa de Vivienda Primero PFH? (SE)
    a. ¿Conoce usted si el gobierno local ha asignado fondos para implementar o proveer servicios a través del modelo de Vivienda Primero HFM para erradicar la deambulancia (sinhogarismo)? (SE)
4. ¿Ha tomado la agencia u organización los pasos para preparar al personal para hacer intervenciones siguiendo un modelo de Vivienda Primero HFM? (SE)
    a. La agencia u organización, ¿necesita incluir personal nuevo para implementar un modelo de Vivienda Primero HFM? De ser así: (SE)
        1. ¿Qué nuevos profesionales necesitaría incluir su programa?
        2. Su agencia, ¿podría utilizar recursos comunitarios existentes para apoyar un programa de Vivienda Primero HFM?
        3. ¿Cómo percibe su personal el modelo de servicios de Vivienda Primero HFM? (TE)
5. En su opinión, ¿Cuáles son las características culturales o ambientales únicas que tendrían que considerarse para atender de forma efectiva las necesidades de la población sin hogar crónica de Puerto Rico? (SE)
    a. ¿Qué características del modelo VP necesitarían modificarse para responder al medio ambiente puertorriqueño? (SE)
    b. ¿Qué barreras usted prevé durante la transición o en la implementación del modelo de Vivienda Primero HFM? (SE)

Términos importantes:

Experiencias textuales (TE)- descripción de la experiencia del participante: lo que el participante experimenta.

Experiencias estructurales (SE)- descripción de la experiencia (cómo es la experiencia en términos de condiciones, situaciones o contexto)

Esencia de la experiencia (EE)- una combinación de las descripciones de las experiencias textuales y estructurales para transmitir la esencia general de la experiencia (Creswell, 2013).

Appendix G

Appendix G Knowledge and Attitudes Survey-Original format in English

SOCIO-DEMOGRAPHIC INFORMATION

CoC ____

1. Age _____
2. Gender/ Sex ____F ____ M

3. Level of education

    a. ___High school graduate
    b. ___Associate/ technical degree
    c. ___Bachelor's degree
    d. ___Masters
    e. ___Doctoral

4. Job title or position-_____

5. Type of program or agency you are currently working for
    ___Public- government run facility
    ___Community-based services
    ___Faith-based service programs
    ___Private organization
    ___Other

6. Years of experience working with the homeless population_____

7. Does your workplace include, or have it ever included, the services of a counselor in rehabilitation (RCs)?
    ___No, never
    ___Yes, we used to have RCs
    ___Yes, we currently have RCs

Do you know about the Housing First Model of intervention?

a. ___ Yes
b. ___ No

Part A- General Knowledge- The following statements refer to the Pathways Housing First (HFM) model and the professional practice of the rehabilitation counselor (RC). Based on your knowledge about HFM and the rehabilitation counseling field, indicate if you consider the statement to be true or false.

Statement	True	False
In the Pathways Housing First approach to service…		
1. it is essential to provide supportive services to chronically homeless individuals before housing.		
2. participants stop receiving services from the program when they are place in permanent housing.		
3. participants stop receiving services from the program when they can achieve sobriety and manage their mental health condition.		
4. participants may go back to receiving supportive services from the program, even after completing the process.		
In the Pathways Housing First model …		
5. case managers determine the type of services for each participant and refer them to programs within the service network.		
6. service providers establish the service plan based on the preferences, priorities and the expressed needs of each participant.		
7. The client or participant has a say on the type of housing they want to live in.		
8. the clinical staff and the case management staff work together, in a coordinated fashion, but independently from each other.		
When a rehabilitation counselor works with chronically homeless individuals...		
9. is responsible for developing functional capacity evaluations for independent living and employment.		
10. provides vocational counseling services to participants.		
11. refers to other professionals those participants who need individual therapy.		

12. is responsible for identifying the participant's independent living skills that will be developed together with an interdisciplinary team.		
13. provides direct support in the management of mental health problems.		
14. provides direct support in the management of problems related to substance abuse.		
15. can perform crisis interventions.		
16. works directly with participants toward the development of skills that promote their wellness and quality of life.		
17. promotes adherence to the clinical treatment.		
18. provides support services during the transition process into the community.		

Part B- Attitudes toward the Pathways Housing First model, the chronically homeless population, and rehabilitation counselors.

Using the scale below, where: *1= Strongly disagree, 2=Disagree, 3= Neither agree or disagree; 4= Agree, and 5= Strongly agree*; indicate how much do you agree or disagree with the following group of statements.

Statements	**1**	**2**	**3**	**4**	**5**
Based on your experience					
1. participants don't need independent living skills to be eligible for housing.					
2. participants need the professionals' help to identify the best treatment options available for them.					
3. participants should develop independent living skills before attaining permanent housing.					
4. intervention plans for chronic homeless individuals should be focused on symptoms and risk factor reduction related to their conditions.					

Statements	1	2	3	4	5
5. a participant that breaks the rules and policies established by a housing program, should be discharged until he or she is ready to follow them.					
6. a participant who is decompensated can receive housing services while attending his mental health condition.					
7. the participant that is stable in his condition and in permanent housing, does not require additional supportive services.					
8. rehabilitation counselors begin to provide services only when the participant is ready to start looking for employment.					
9. rehabilitation counselors specialize in disabilities (physical, emotional or mental disabilities), which distinguishes them from the rest of the clinical team.					
10. the rehabilitation counselors can help homeless individuals develop and maintain independent living skills.					

Appendix H

Appendix H Knowledge and Attitudes Survey- Qualtrics software. Spanish

Transición al Modelo de Vivienda Primero: El rol del consejero en rehabilitación en Puerto Rico

---

Start of Block: Transitioning to Housing First: The role of Rehabilitation Counselors in Puerto

Transición a Vivienda Primero: El papel de los consejeros de rehabilitación en Puerto Rico

Esta encuesta es realizada por Ana Vanessa Serrano-García, estudiante de doctorado en la Universidad de Texas en Rio Grande Valley

El propósito de este estudio es explorar las opiniones y actitudes de los proveedores de servicios sobre el papel de los consejeros de rehabilitación dentro de los programas de intervención para personas sin hogar crónicas y el proceso de implementación del modelo "Pathways Housing First" (Vivienda Primero) en Puerto Rico.

Esta encuesta debería tardar unos 10 minutos en completarse.

La participación en esta investigación es completamente voluntaria. Si hay alguna pregunta que le incomode responder, no dude en omitir esa pregunta y deje la respuesta en blanco. Además, tenga en cuenta que tiene derecho a retirarse del estudio y finalizar su participación en cualquier momento sin preguntas ni comentarios.

Se solicita su participación en este estudio porque usted es un proveedor de servicios: personal administrativo que brinda servicios directos, personal clínico o de administración (manejo) de casos, o un proveedor de servicios directos que actualmente trabaja en una agencia / organización que brinda servicios a la población sin hogar crónica en Puerto Rico. Sin embargo, debe tener al menos 18 años para participar. Si no tiene 18 años o más, no complete la encuesta.

Todas las respuestas recibidas serán tratadas de forma confidencial y almacenadas en un servidor seguro. Sin embargo, dado que las encuestas se pueden completar desde cualquier computadora (p. Ej., personal, laboral, escolar), no hay garantía de la seguridad de la computadora en la que elige ingresar sus

respuestas. Como participante en este estudio, tenga en cuenta que existen ciertas tecnologías que se pueden utilizar para monitorear o registrar datos y / o sitios web que se visitan.

Cualquier respuesta individualmente identificable se almacenará de forma segura y solo estará disponible para aquellos directamente involucrados en este estudio. Los datos no identificados pueden compartirse con otros investigadores en el futuro, pero no contendrán información sobre ninguna identidad individual específica.

Esta investigación ha sido revisada y aprobada por la Junta de Revisión Institucional de la Universidad de Texas Rio Grande Valley para la Protección de los Sujetos Humanos (IRB). Si tiene alguna pregunta sobre sus derechos como participante, o si considera que el investigador no cumplió adecuadamente con sus derechos como participante, comuníquese con el IRB al (956) 665-3598 o irb@utrgv.edu.

End of Block: Transitioning to Housing First: The role of Rehabilitation Counselors in Puerto

---

Start of Block: DATOS SOCIODEMOGRÁFICOS

CoC Continuo de cuidado al que pertenece su agencia/programa

- ○ CoC 502 (1)
- ○ CoC 503 (2)

Q17 Nombre de la organización para la cual trabaja

_____

*

Edad

_____

Q3 Género

- ○ F (1)
- ○ M (2)

Q4 Nivel de escolariad

- ☐ Cuarto año de escuela superior o GED (1)
- ☐ Grado asociado o grado técnico (2)
- ☐ Bachillerato (3)
- ☐ Maestría (4)
- ☐ Doctorado (5)
- ☐ Otro (6) _____

Q5 Titulo ocupacional o puesto que ocupa.

_____

Q6 Tipo de programa o agencia para la cual trabaja actualmente

- ☐ Agencia o Programa público/ gubernamental (1)
- ☐ Organización de base comunitaria (2)
- ☐ Organización de base de fe (3)
- ☐ Organización privada (4)
- ☐ Otras (5) _____

Q8 Años de experiencia trabajando con la población sin hogar

_____

Q9 En su lugar de trabajo, ¿tienen o alguna vez han tenido los servicios de un consejero en rehabilitación (CR)?

- ☐ No, nunca (1)
- ☐ Si, teníamos CR (2)
- ☐ Si, actualmente tenemos CR (3)

Q10 ¿Usted conoce sobre el modelo de intervención Vivienda Primero (Housing First)?

- ☐ Si (1)
- ☐ No (2)

Start of Block: Parte A- Conocimiento General

Parte A- Conocimiento General- El siguiente grupo de premisas se refieren al modelo de Vivienda Primero (VP) de "Pathways" ("Pathways Housing First") y a la práctica profesional del consejero en rehabilitación (CR). Basado en su conocimiento sobre VP y la consejería en rehabilitación, indique si usted considera si la premisa es cierta o falsa.

Q12 **En el enfoque de servicio del modelo de Vivienda Primero ("Housing First")...**

	Cierto (1)	Falso (2)
es esencial proveer servicios de apoyo a personas sin hogar crónicas antes que la vivienda. (1)		
los participantes dejan de recibir servicios del programa cuando consiguen una vivienda permanente. (2)		
los participantes dejan de recibir servicios del programa cuando son capaces de estar sobrios y manejar su condición de salud mental. (3)		
los participantes pueden volver a recibir servicios de apoyo del programa, aun después de haber completado el proceso. (4)		

Q30 **En el enfoque de servicio del modelo de Vivienda Primero ("Housing First")...**

	Cierto (1)	Falso (2)
el manejador de caso determina el tipo de servicio que requiere cada participante y lo refiere a los programas dentro de la red de servicios. (1)		
los proveedores de servicio establecen los planes de servicio basado en las preferencias, prioridades y necesidades que expresa cada participante. (2)		
el cliente o participante puede opinar sobre el tipo de vivienda en la que quiere vivir. (3)		
el personal clínico y de manejo de caso trabajan juntos de forma coordinada, pero independiente el uno del otro. (4)		

Q31 **Cuando el consejero en rehabilitación trabaja con personas sin hogar crónica…**

	Cierto (1)	Falso (2)
se encarga de desarrollar evaluaciones de capacidad funcional para vida independiente y empleo. (1)		
provee al participante servicios de consejería vocacional. (2)		
refiere a otros profesionales a aquellos participantes que necesitan de terapia individual. (3)		
es el encargado de identificar las destrezas de vida independiente del participante que se estarán desarrollando junto a un equipo interdisciplinario. (4)		
provee apoyo directo en el manejo de problemas de salud mental. (5)		
provee apoyo en el manejo de problemas relacionados al abuso de sustancias. (6)		
está capacitado para realizar intervenciones en crisis. (7)		
trabaja directamente con el participante para desarrollar destrezas que promuevan su bienestar y calidad de vida ("Wellness"). (8)		
promueve la adherencia al tratamiento clínico. (9)		
provee servicios de apoyo en el proceso de transición a la comunidad. (10)		

End of Block: Parte A- Conocimiento General

Start of Block: Parte B- Actitudes hacia el Modelo de Vivienda Primero “Pathways”

Q15 **Parte B- Actitudes hacia el Modelo de Vivienda Primero “Pathways”, la población sin hogar y los consejeros en rehabilitación.** Utilizando la siguiente escala, donde (1) significa completamente en desacuerdo, (2) desacuerdo, (3) ni de acuerdo ni en desacuerdo, (4) de acuerdo y (5) completamente de acuerdo, indique cuan de acuerdo o en desacuerdo está usted con el siguiente grupo de afirmaciones.

Q19 **Según su experiencia,** los participantes necesitan ayuda de los profesionales para identificar las mejores alternativas de tratamiento disponibles para ellos.

- ☐ completamente en desacuerdo (1)
- ☐ desacuerdo (2)
- ☐ ni de acuerdo ni en desacuerdo (3)
- ☐ de acuerdo (4)
- ☐ completamente de acuerdo (5)

Q20 **Según su experiencia,** la vivienda es un derecho fundamental del ser humano.

- ☐ completamente en desacuerdo (1)
- ☐ desacuerdo (2)
- ☐ ni de acuerdo ni en desacuerdo (3)
- ☐ de acuerdo (4)
- ☐ completamente de acuerdo (5)

Q21 **Según su experiencia,** los participantes deberían desarrollar destrezas de vida independiente antes de obtener una vivienda permanente.

- ☐ completamente en desacuerdo (1)
- ☐ desacuerdo (2)
- ☐ ni de acuerdo ni en desacuerdo (3)

- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

Q22 **Según su experiencia,** los planes de intervención para individuos sin hogar crónicos deben estar enfocados en la reducción de síntomas y los factores de riesgos relacionados a su condición.

- [ ] completamente en desacuerdo (1)
- [ ] desacuerdo (2)
- [ ] ni de acuerdo ni en desacuerdo (3)
- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

Q23 El participante que rompa las reglas o no siga las políticas establecidas por un programa de vivienda, debe ser dado de baja hasta que esté preparado para seguirlas.

- [ ] completamente en desacuerdo (1)
- [ ] desacuerdo (2)
- [ ] ni de acuerdo ni en desacuerdo (3)
- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

Q24 Un participante que esté descompensado puede recibir servicios de vivienda al mismo tiempo que atiende su condición de salud mental.

- [ ] completamente en desacuerdo (1)
- [ ] desacuerdo (2)
- [ ] ni de acuerdo ni en desacuerdo (3)

- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

Q25 Los participantes que están estables dentro de su condición, y en una vivienda permanente, no requieren de servicios de apoyo adicionales.

- [ ] completamente en desacuerdo (1)
- [ ] desacuerdo (2)
- [ ] ni de acuerdo ni en desacuerdo (3)
- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

Q26 El consejero en rehabilitación comienza a proveer servicios sólo cuando el participante está listo para comenzar a buscar empleo.

- [ ] completamente en desacuerdo (1)
- [ ] desacuerdo (2)
- [ ] ni de acuerdo ni en desacuerdo (3)
- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

Q27 El consejero en rehabilitación es el especialista en discapacidad (impedimentos físicos, emocionales y mentales), lo cual lo distingue del resto del equipo clínico.

- [ ] completamente en desacuerdo (1)
- [ ] desacuerdo (2)
- [ ] ni de acuerdo ni en desacuerdo (3)

- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

Q28 Los consejeros en rehabilitación pueden ayudar a las personas sin hogar a desarrollar y mantener destrezas de vida independiente.

- [ ] completamente en desacuerdo (1)
- [ ] desacuerdo (2)
- [ ] ni de acuerdo ni en desacuerdo (3)
- [ ] de acuerdo (4)
- [ ] completamente de acuerdo (5)

End of Block: Parte B- Actitudes hacia el Modelo de Vivienda Primero “Pathways”

BIOGRAPHICAL SKETCH

Ana Vanessa Serrano García completed her Bachelor's degree in Psychology and a Master's degree in Rehabilitation Counseling at the University of Puerto Rico, Rio Piedras Campus, and her Doctorate of Philosophy in Rehabilitation Counseling at the University of Texas Rio Grande Valley (UTRGV) in May 2021. Ana Vanessa is a licensed professional rehabilitation counselor in Puerto Rico and a certified rehabilitation counselor (CRC). Her professional experiences include working with community-based organizations and agencies related to individuals with disabilities and their families.

For the last few years, Ana Vanessa has been part of the faculty at the Program of Rehabilitation Counseling at the Pontifical Catholic University of Puerto Rico. She also served as chair and thesis committee member for graduate students. Her involvement with the rehabilitation community in the island includes serving at the Board of Directors of the "Colegio de Profesionales de la Consejería en Rehabilitación de Puerto Rico" (CPCR), (Professional Association of Rehabilitation Counselors of Puerto Rico), and a member of the National Council on Rehabilitation Education. In 2019 Ana Vanessa was granted the Lcda. Alba Palmer de Rodríguez Award as Distinguished Educator from the Professional Association of Rehabilitation Counselors of Puerto Rico. Her permanent address is Park Gardens, H-2 Calle Glacier, San Juan, PR, 00926, and her email is anavserrano04@gmail.com.