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# Introducing Housing First in a Rural Service System: A Multistakeholder Perspective

Benjamin F. Henwood

University of Southern California

Kelly Melekis

University of Vermont

Ana Stefancic

Pathways to Housing, Inc.

**Author Notes:**
Benjamin F. Henwood, PhD, MSW is an Assistant Professor at the University of Southern California School of Social Work in Los Angeles, CA, USA. Email: bhenwood@usc.edu

Kelly Melekis, MSW, PhD, is an Assistant Professor at the University of Vermont Department of Social Work in Burlington, VT, USA. Email: Kelly.Melekis@uvm.edu

Ana Stefancic, MA, is the Director of Research at Pathways to Housing, Inc. in New York, NY, USA. Email: stafancica@aol.com

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# Introducing Housing First in a Rural Service System: A Multistakeholder Perspective

## Abstract

Housing First (HF) represents a fundamental shift in thinking about how to address chronic homelessness that has taken place during the past two decades. Whether and how the logic of HF fits in rural systems of care has not been previously explored in the research literature. Using a case study approach and thematic analysis of accounts from 20 key stakeholders, this study investigated whether and how the introduction of HF into a small, rural state in the Northeastearn United States affected the dominant institutional logic. The overall account by multiple stakeholders remained largely consistent: The introduction of an outside HF program brought new resources and expertise, which resulted in a previously underserved population being effectively engaged in services. The extent to which the introduction of an outside provider with a specific, well-defined HF philosophy fit within the existing social services system was complicated by existing providers' limited knowledge about or input during the grant submission that provided funding for the HF program. Numerous social forces and concerns regarding limited resources also influenced stakeholder perceptions. The impact of HF on existing institutional logics was not always clearly identified by stakeholders, yet HF's emphasis on providing service options and allowing for client choice, as well as the demonstrated effectiveness of the approach, emerged as influential. Features of local environments (including systems of care but also funding, political, and cultural contexts) and their potential for triggering transformative change may influence the relative merits of implementing HF services by an outside provider with known expertise or supporting an existing provider to develop the infrastructure and foster a service philosophy based on an HF logic.

*Keywords: homelessness, mental illness, Housing First, institutional logics, neoinstitutional theory*

The notion that chronic homelessness can be ended rather than merely managed (Gladwell, 2006) represents a fundamental shift in thinking that has taken place during the past two decades. This shift occurred due to a reimagined approach to homelessness services known as Housing First (HF; Tsemberis, 2010; Tsemberis, Gulcur, & Nakae, 2004). Developed in New York City at an agency called Pathways to Housing, HF is an evidence-based program model (National Registry of Evidence-based Programs and Practices, 2007) that assists individuals with serious mental illness who have experienced homelessness, incarceration, and hospitalization to obtain permanent housing and move forward in recovery. HF refers to the provision of immediate access to permanent housing with ongoing consumer-driven support services, in contrast to a traditional provider-driven staircase approach that requires temporary or transitional housing and treatment placements before accessing permanent housing (Padgett, Gulcur, & Tsemberis, 2006). Although a full and sufficient complement of community housing programs did not materialize that was part of the traditional approach, a combination of factors also hindered consumers' progress towards independent housing, including provider beliefs regarding the necessity for continued supervised and structured living, the paucity of options for more independent living, and individuals' reluctance or inability to comply with program mandates. Developed during a time of mental health systems transformation based on a recovery model (Anthony, 1993; President's New Freedom Commission on Mental Health, 2003), HF represents a new logic to homelessness services designed to be strengths-based, recovery-oriented, and focused on human rights (Byrne & Culhane, 2011; Tsemberis, 2010). This stands in contrast to a logic that has been described as paternalistic, using a housing-readiness criterion that is primarily rooted in providers' beliefs that the ability of individuals with severe mental illness to maintain permanent, independent housing is predicated on achieving clinical stability and adhering to treatment. In some instances, particularly with respect to populations diagnosed with substance abuse, there are underlying questions of moral worthiness, creating systems that rely on practices that require individuals to earn housing by demonstrating abstinence (Dordick, 2002; Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009), a view that is embedded in U.S. social welfare policies (Henwood, Derejko, Couture, & Padgett, 2014).

Institutional logics, or the material practices and symbolic constructions that constitute a field's organizing principles (Greenwood, Díaz, Li, & Lorente, 2010), can be difficult to change. Introducing an HF program with its own logic into the larger landscape of homelessness services represents a change within existing systems but does not necessarily imply systems transformation and the establishment of a new logic. Yet as Nelson (2010) stated, "There is a need to challenge assumptions and build a vision and values that are consistent with the Housing First approach" (pp. 137–138). Neoinstitutional theory, traditionally used to explain systems change at a macro level, has been increasingly applied to systems transformation efforts at the meso level (Macfarlane, Barton-Sweeney, Woodard, & Greenhalgh, 2013) and can be used to help explain how the introduction of an HF approach could result in transformative change. The theory identifies three main social forces that can contribute to changing fundamental institutional logics: regulative forces (mandates about how to address homelessness), normative forces (assumptions and expectations about how to address homelessness), and cultural–cognitive forces (taken-for-granted scripts and mental models about how to address homelessness; Scott, Ruef, Mendel, & Caronna, 2000). Ameliorative change can involve any of these forces alone, yet establishing a new institutional logic that represents transformative change (Nelson & Prilleltensky, 2010)—rather than simply implementing new services—will most likely involve all three.

Rates of homelessness and institutional logics of homelessness service systems are affected by larger political and economic forces. As such, the challenge of ending chronic homelessness nationally requires addressing some of the fundamental conditions that have exacerbated rates of homelessness overall, including decades of government disinvestment in the development and subsidizing of affordable housing (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013). Although larger policy shifts would be required to address the overarching affordable housing crisis, in terms of effective program models or interventions, HF has been recognized as the clear solution to chronic homelessness by the United States federal government (U.S. Interagency Council on Homelessness [USICH], 2010). Supported by more than a decade of research (Collins, Malone, & Clifasefi, 2013; Mares & Rosenheck, 2007; Pearson, Montgomery, & Locke, 2009; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2004), HF has become increasingly disseminated in the United States and internationally (Busch-Geertsema, 2011; Goering et al., 2011; Greenwood, Stefancic, Tsemberis, & Busch-Geertsema, 2013; Keller et al., 2013). Clearly, the dominant institutional logic of homelessness services has been shifting toward HF (see Greenwood, Stefancic, & Tsemberis, 2013; Johnson, Parkinson, & Parsell, 2012; Nelson, 2013; Stanhope & Dunn, 2012; USICH, 2013). Widespread government-supported plans and programs to end homelessness that acknowledge the need for harm reduction and question the legitimacy of housing-readiness assessments represent this new institutional logic.

Nevertheless, at various points and in different locations, local providers and stakeholders have questioned the logic of HF. Resistance to or divergence from HF principles and practices has been driven by a combination of factors: (1) programs adopting the HF label but not significantly changing existing practices, which include continued reliance on housing readiness and prioritizing provider determinations over consumer choice (in many cases clinical stability has remained a prerequisite for independent housing); (2) misinterpretation of many of the key principles that the model seeks to implement; (3) skepticism regarding program effectiveness; and (4) moral judgments regarding the worthiness of various populations for housing (Greenwood, Stefancic, & Tsemberis, 2013). Using an ethnographic approach, Felton (2003) found that when an HF model was first introduced into a suburban setting (Stefancic & Tsemberis, 2007), protests by local service providers were motivated by job protectionism and a clash of institutional logics that most clearly differed in terms of the sequencing of housing and services; existing providers regarded their current practice as consumer driven and disagreed that HF introduced this as a new approach. These findings demonstrated multiple, competing, and even conflicting logics of homelessness services.

To date, whether and how the logic of HF fits within rural systems of care has not been explored in the research literature. Previous research has suggested that HF can be implemented in a rural setting with some program modification (Stefancic et al., 2013). Yet the description of rural homelessness as "different, unrecognised and unresearched" (Kenna, 2002, p. 919) is largely accurate and may account for why HF remains predominantly an urban intervention. Estimates that approximately 9% percent of homeless people live in rural areas (Robertson, Harris, Fritz, Noftsinger, & Fischer, 2007) may be taken to imply that rural homelessness is a minor issue, resulting in limited infrastructure compared to urban settings in terms of both service and housing options to address this complex social problem (Nooe & Patterson, 2010). However, these numbers are underestimations (Edwards, Torgerson, & Sattem, 2009). Limited infrastructure to address homelessness also means limited capacity to assess homelessness, because point-in-time estimates largely rely on existing service

providers to count unsheltered adults. Further, point-in-time estimates conducted at night fail to account for unsheltered people who remain out of sight during those times (Hopper, Shinn, Laska, Meisner, & Wanderling, 2008), an issue that is particularly pertinent in rural areas because many adults sleep in the woods, campgrounds, cars, or other largely hidden places not intended for habitation. Reports that rates of rural homelessness have been increasing in recent years by more than 50% (U.S. Department of Housing and Urban Development [HUD], 2010)—whether due to increased investment in point-in-time estimates or increased numbers of visibly homeless individuals—may result in increased attention to how rural areas address homelessness. Pressure to revise the institutional logic of homelessness services in rural contexts to provide additional resources in a manner consistent with an HF approach may become increasingly powerful.

Rural mental health care systems have certain characteristics that both shape service delivery and create contexts that set the potential for transformative change, particularly when it comes to interventions such as HF that emphasize consumer-driven, mobile, and multidisciplinary services. Barriers in rural areas such as low population density, large geographic distances, lack of public transportation infrastructure, and more limited access to multidisciplinary specialists result in reduced intensity and comprehensiveness of mental health services. In a study of rural mental health systems, Topping and Calloway (2000) concluded that certain characteristics of rural areas result in the development of "a system of care that is provider-driven and crisis-oriented" (p. 394). Mental health treatment options in rural areas are likely to be more limited overall, which can result in "the public mental health center being the only game in town" (Calloway, Fried, Johnsen, & Morrissey, 1999, p. 305). Despite barriers to integrated services, rural mental health agencies may also be more interdependent, given shortages in specialties and the need to coordinate services, resulting in greater communication (Calloway et al., 1999), particularly in close-knit communities with more informal means of information sharing.

Using a case-study approach and thematic analysis of multiple stakeholder perspectives, this study investigated whether and how the introduction of HF into a small, rural state in the Northeastern United States affected the dominant institutional logic. Prior to the introduction of HF, the state was reported to have approximately 1,200 homeless adults with roughly 12% unsheltered. Approximately 300 subsidized supportive housing beds were offered through a patchwork of mental health community providers across the state (HUD, 2010), yet there could only be one provider in a designated geographic area. The introduction of HF into this context was made possible through federal funding from the U.S. Substance Abuse and Mental Health Services Administration and was accomplished, as was the case in Felton's (2003) study, by introducing an outside provider with expertise in HF into the existing system. In this instance, however, an outside agency that is nationally known for its expertise in HF hired new staff members from the rural state that included existing local providers. In addition, during the decade since Felton's (2003) study, HF has gained legitimacy as a competing or potentially dominant institutional logic. In this study, we considered the possibility of transformative change in a rural homelessness service system. Specific research questions included: (1) To what extent did the introduction of HF fit with the existing institutional logic? (2) What influential factors or social forces (i.e., regulative, normative, or cultural–cognitive) facilitated or inhibited an HF institutional logic? (3) How did the introduction of HF affect the existing institutional logic?

## Methods

### Sample and Recruitment

Using a case-study approach to understand whether and how the introduction of HF affected the dominant institutional logic, purposive sampling was used to recruit stakeholders across multiple sectors related to homelessness services for adults with serious mental illnesses. Case studies are a preferred strategy when asking how or why questions about a contemporary set of events over which the investigator has little control (Yin, 2014). This case study employed a constructivist methodology, utilizing stakeholders as observers and interpreters of the implementation and impact of HF (Guba & Lincoln, 1989). In-depth semistructured individual interviews were conducted between 2012–2013 with 20 key stakeholders: policy decision makers ($n$ = 4), social service administrators ($n$ = 12), and front-line service providers throughout the state ($n$ = 4), including individuals from homelessness drop-in centers and shelters, mental health programs, law enforcement and criminal justice systems, housing authorities, youth services, hospitals, and Veterans Affairs.

### Procedures

Respondents were asked to describe their job as it relates to homelessness services for adults with mental health conditions, whether this population has been well served, how and why the system has changed over time, and what can be done to improve the system. These questions were open ended and developed and implemented prior to the application of the neoinstitutional framework used during the analysis

phase. An affiliated institutional review board approved all study protocols. After discussing the introduction of HF, in particular, respondents were asked to nominate any other key stakeholders or informants who could provide an additional perspective. Interviews typically lasted between 35 to 55 minutes. Sixteen of the interviews were recorded and transcribed for analysis. Although four of the interviews were not recorded because they were conducted for purposes of confirming saturation of the data and the validity of emergent themes, detailed notes were taken.

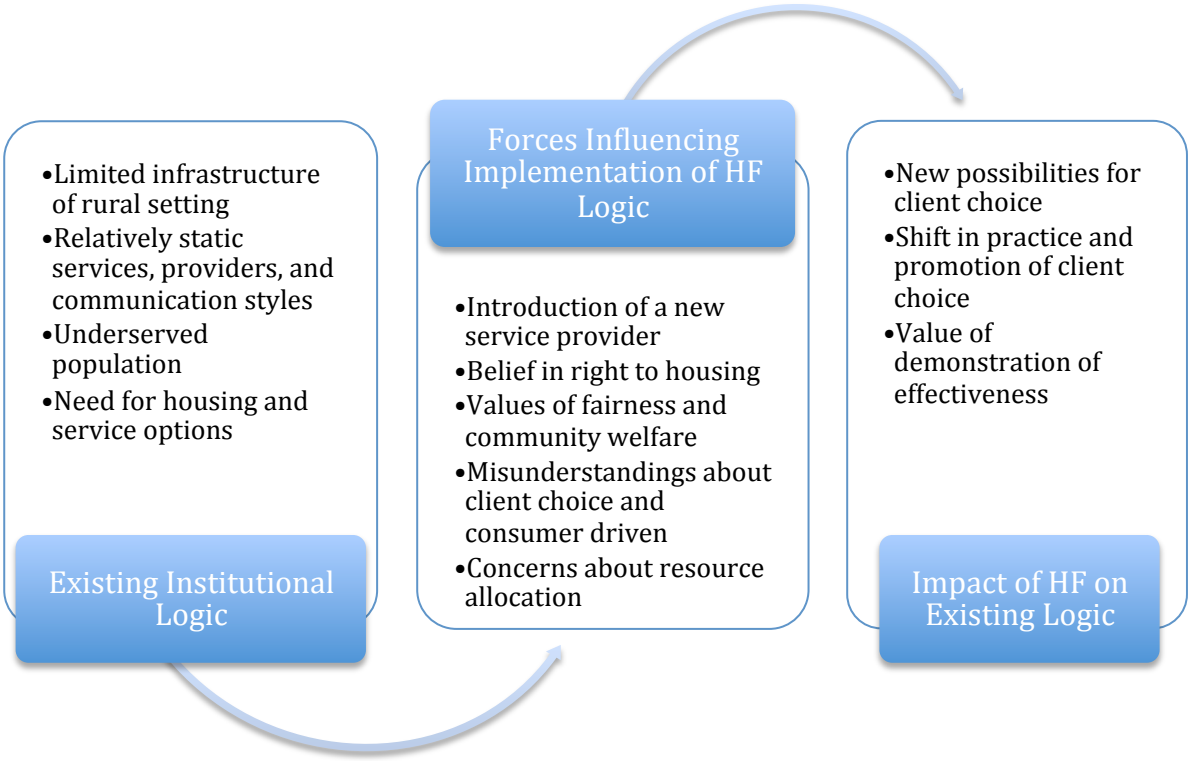
### Analysis Approach

Thematic content analysis was used to systematically categorize and ascertain patterns and themes in the data (Padgett, 2012). During this process, both manifest and latent content was independently coded by three investigators, which allowed for the categorization of the data as well as the development of a deeper understanding of the phenomena (Saldaña, 2013). Initial inductive analysis was employed to establish themes through investigator consensus, followed by a deductive process using sensitizing concepts from neoinstitutional theory to organize the findings (Patton, 2002). The use of this theoretical framework was based on our overarching aim to understand whether and how system change took place. Strategies of rigor related to qualitative methods that were employed during this study included independent thematic development, team debriefing, and consensus-driven findings (Padgett, 2012). In addition, after preliminary analysis was complete, additional interviews were used to establish saturation and completeness of the findings (Charmaz, 2006).

## Results

The 20 individuals who shared their accounts regarding the introduction of HF into a rural state system each had a unique perspective, yet the overall narrative remained largely consistent: The introduction of an outside HF program brought with it new resources and expertise, which resulted in a previously underserved population being effectively engaged in services. The extent to which the introduction of an outside provider with a specific, well-defined HF philosophy fit within the existing social services system was complicated by existing providers reporting that they had limited knowledge about or input into the grant submission that provided funding for the HF program. Numerous social forces as well as concerns regarding limited resources also influenced stakeholder perceptions. Social forces included: norms regarding a right to housing, fairness, and community welfare; a cultural–cognitive understanding of the terms *client choice* and *consumer driven*; and regulatory restrictions on funding. Limited resources meant that HF was regarded as competition for existing programs. The impact of the introduction of HF on existing institutional logics was not always clearly identified by stakeholders, yet HF's emphasis on providing service options and allowing for client choice emerged as influential, especially given a rural context with fewer resources that typically only had one provider option for clients. Demonstrating the effectiveness of the approach also proved to be influential and supported HF's client-choice approach. The larger narrative described later is depicted in Figure 1.

Figure 1. Introduction of HF into a Rural System




**Existing Institutional Logic and the Introduction of Housing First**

With the exception of the state's largest city, which had multiple shelter options, most areas of the rural state where this study took place had only one homeless shelter. Community mental health services were also limited to one designated organization for each area, meaning that there were limited service options available for individuals with mental illness experiencing homelessness. In this system, stakeholders unanimously acknowledged the existence of an underserved population, with one person characterizing the overall attitude as, "'We have no clue what to do with these folks.' You know, they either burn their bridge or decided they don't want to bridge any more with mental health." The vast majority of stakeholders, therefore, expressed support for additional housing and service options. Expressing a common sentiment, one stakeholder stated:

> If you don't have stable housing, nothing else that we want to do for you, whether it's mental health treatment or whether it's a reach out program or anything else, is going to work. Stable housing is foundational. In fact, what I hear from people in the community including people with mental illness is that lack of housing or a threat of losing your housing can actually put you in a crisis and cause you to have a psychiatric crisis. So, housing is absolutely fundamental.

Stakeholders agreed that the provision of housing was an essential resource that would help address a myriad of other social problems.

Despite these attitudes, the introduction of HF by a new, outside provider agency resulted in "suspicion about another nonprofit being created." Lack of transparency regarding the grant development process was a main contributing factor to this sentiment, particularly because several of existing providers had been involved in previous unsuccessful grant applications. Several stakeholders described feeling unsettled regarding the new program's introduction, with one person expressing:

> I think there was a certain amount of cautiousness and concern like, "What? Who are these people? How is this going to work exactly? What do they do that's different then us? What are they serving that's the same or different than us?"

The introduction of an outside player in a system with established providers and interagency relationships was

also acknowledged as difficult because, as one respondent noted, "a lot of people have been in their jobs for 25, 30 years so it's—not an ol' girls'/boys' club … but there's something about it that's just hard to break in [to]." Limited employment opportunities and stagnant wages that are typical of rural areas likely contributed to low staff turnover and longevity of relationships.

Although the program was consistently supported by a few key players that requested the program grant funding, one stakeholder expressed a typical response: "I think [the HF program] needs to be more collaborative. … Whether that's their instinct or not, if they can become part of the system, they've got to be." In fact, stakeholders frequently expressed concerns that the new HF program had violated expectations regarding communication and collaboration. One stakeholder noted, "I'm glad [the HF program] is here. I think it's a really neat thing. I would just love to feel more integrated with them or in touch with them in some way." Some stakeholders, however, identified a deeper resentment. As one person explained:

> What I heard was … "They shouldn't just come in here without talking to us." And I felt like a lot of people were like, "Well, if they just come in here, and think they're going to set something up, they, they really need to be talking to the people who are already the movers and the shakers in that community and say, 'What do you, what do you think's working? Do you, what do you need? Where are your gaps? Could you use a program like us?'"

Concerns that the HF program did not appreciate the difference between working anonymously in a large urban area versus in small rural communities were also mentioned despite the program hiring new staff members from within the rural state that included employees of existing local providers. Such negative reactions to the new HF program seemed to have less to do with the approach and more to do with the way in which an outside program was introduced.

**Forces Influencing the Implementation of an HF Logic**

Stakeholders acknowledged that the HF program had a significant impact and was able to effectively engage adults with mental health conditions who had a long history of homelessness—something acknowledged as missing in the existing system. Respondents frequently described that the HF program "has been good for this community," largely because "they house some people who are pretty hard to house." As one respondent noted, "They're serving a lot of folks in the community that we've been worried [about] or struggling to work with for a long time."

Beliefs about a right to housing represented a normative force that was regarded as important to the success of the HF program.

> I think that housing is a right. And so, yeah. Get people housed. And then deal with these issues if we need to. And so right now we're talking about [the HF program] being for mental health, but I think we should have Housing First for everybody.

Norms regarding fairness, however, were occasionally invoked regarding HF's focus on a specific target population, with some participants questioning what it meant for other vulnerable groups:

> My problem is, you've got slots for that particular population, [but] you haven't done anything for anybody else. You know, there's this whole spectrum of homelessness and where, where is the state stepping up to help all those people that are not so severely in need? They're not.

Concerns about the welfare of the larger community were also sometimes invoked as being at odds with an HF philosophy:

> [An HF] philosophy is fine but you have to think beyond—your philosophy is totally focused on the individual. … You need to pay some attention to how this person's behavior is affecting their neighbors and others in the property and you need to pay attention if they're not paying their rent and trashing their unit because the consequences are not going to be good.

Although there was an overall convergence of support for a HF logic, some identified ways in which it was perceived to be problematic given existing norms.

The perception that the HF logic was sometimes at odds with existing norms appeared connected to the cultural–cognitive understanding of certain key concepts such as client choice and consumer driven. Several existing stakeholders misunderstood this to imply a hands-off approach, and expressed concern that "there needs to be some responsibility on the part of the individual who's moving into the housing to really engage. And I think that's where most of the rub comes from with the community." One stakeholder explained the difference:

> I think there are ways in which our philosophies are similar and ways in which we seem to have rubbed up against … this whole Housing First model and that there really are no strings attached kind of, you don't have to agree to do anything and what the client says is what they go with. We're all for meeting the clients where they are and that kind

> of thing, but we do have, for instance … we have some level of responsibility.

Despite recognizing the success of the approach, some stakeholders misinterpreted the notion of consumer choice to mean that "they [HF providers] sort of let them crash and burn and then help them [clients] along," adding, "We're not comfortable with the idea of that."

Even with misinterpreted ideas of what consumer choice implied, under increasing financial pressure to find community alternatives to social problems such as homelessness, institutionalization, and incarceration, most stakeholders embraced HF. In addition to the state's department of mental health, the department of corrections found collaborating with the HF program to be beneficial because otherwise "we were stuck dealing with landlords and we were housing people kind of without any supervision." Regulatory restrictions on sources of funding, however, raised concerns about how people would remain in housing once their involvement with the criminal justice system ended.

When discussing how to sustain HF services, however, most stakeholders identified concerns about limited resources, not just regulatory restrictions regarding funding streams. In fact, the introduction of HF into the state or community was perceived by some providers as "direct competition" and met with some resistance due to concerns about funding and resource allocation. A few respondents expressed concern that "with [the new HF provider] you're just adding one more layer to the complexity of service delivery" and "now they're going to be fighting for the same mental health dollars or substance abuse dollars that are currently going to the designated agencies." Minimizing the difference between the existing institutional logic and that of HF, a minority of stakeholders expressed the sentiment that "we could have done this" and that there was not a need for an outside agency to provide what some perceived as "duplicative" services. In this case, stakeholders described their philosophy or that of their organization as closely aligned with the HF philosophy, indicating that "some of the differences and philosophies have been subtle." As one person explained:

> I respect they feel really passionate about their philosophy, which is wonderful, but I feel like … well, you have a different philosophy ... and I don't think ours is that far off. As a social worker I definitely don't think we're that far off of client-centered work.

Although there may have been some convergence of perspectives, it was unclear whether these stakeholders did not perceive the previously mentioned differences between their approach and an HF logic as significant or were motivated to obscure these distinctions when discussing resource allocation.

**Impact of Housing First on Existing Institutional Logic**

The vast majority of stakeholders acknowledged that HF represents a different approach to business as usual and that "there are a lot of people who are stably housed, who were not before [the HF provider] got here." These results were viewed as having affected the way in which the overall system responded to issues related to homelessness, with one person explaining, "It's a different model. It's just a very different model. And I do believe that [the HF provider] has pushed the [our] model of service."

Stakeholders referenced a shift in practice toward increasing consumer choice and respecting self-determination, with one person stating, "We try to be less prescriptive now." Referring to a recent shift at a local agency that was influenced by the introduction and logic of HF, one stakeholder reported:

> What we've done, over time I would say, to be as close to Housing First as possible … try to leave it as open as possible for the [consumer] to only engage as much as is somewhat necessary for him to remain system eligible … and self-determination is there as much as can be … while engaging with us. So it's sort of like trying to bring it as close as possible, without it, I think, being truly Housing First. Overall … it also had an impact on how we talk about this issue. … We got in a big debate two years ago about requiring people who got a voucher to take services, and I pushed back and I said, no, that won't work. The very people you're trying to reach are going to refuse to take the voucher if you insist that they accept services. You have to make it voluntary. And this was all part of working with [the HF provider].

Most stakeholders recognized that the introduction of the HF program provided a possibility of client choice that did not previously exist. One person explained the scenario prior to the introduction of HF:

> The challenge … is because we have a system of care that is based on a single door that you can walk through if you have serious persistent mental illness, that it's a community mental health and it's one designated agency. So if you've had trouble with that designated agency or if that designated agency was involved in any way forcibly hospitalizing you or any kind of involuntary treatment, if you've shut the door, you don't have any other options. So … choice of services is not available for people.

With the implementation of HF, there was increasing recognition of the importance of a service system that promotes an HF philosophy of client choice:

> I think it's also nice that there is an option. It might not even be a burned bridge, it would just be like, "I really like the way they work," or "I feel comfortable with them" or "It's nice to know I don't have to go through [the] community mental health center or wherever." Like, here's another game in town and it's nice, it's refreshing.

Yet it was not simply having another choice that was viewed as important, but having a different kind of choice and service model. Referring to community-based care, one stakeholder explained:

> This is a plus for [HF] compared to [the local community mental health center], a very desk-centered operation … where your interaction with your client is by appointment in your office. We feel very strongly that effective service delivery needs, to some degree, happen in the home because when you're in the home, you'll have a much better sense of what's going on.

Although the discourse about whether the current system needed to change preceded the introduction of HF, the logic of HF had become central to the discussion of how to change the existing system, with one stakeholder noting, "It's really interesting to me that that's [HF] finally catching on. … I think there is a general movement."

Several stakeholders attributed HF's impact on the existing system to its demonstrated effectiveness and outcomes as much as to its underlying philosophy. Some noted, however, that "I think people forget there's somebody who's been on the streets for years and then suddenly they're not there and they don't know that they've been housed." Having success stories more so than outcomes appeared to be part of the existing but changing institutional logic. In discussing the effectiveness of the HF approach, one stakeholder admitted, "We have been in operation for [more than 30] years and really haven't done some exploration as to whether our approach is effective or not." To this end, one stakeholder explained, "I think they've been a breath of fresh air, I think they've been creative, I think they've been incredibly person centered, and they've got the results to show it. And I think the rest of the service system can learn a lot from them."

## Discussion

Corrigan and Boyle (2003) contended that transformative change can occur through evolution or revolution. The former refers to a consensus-driven process that often is slow, whereas the latter is more quickly realized through an imposed vision (Sylvestre, in press). The findings from this case study suggest that that these two processes are not mutually exclusive. Although stakeholders noted that institutional actors had remained relatively static for an extended period of time, and that the service community had developed implicit expectations regarding collaboration and community-based services, there was overwhelming consensus that the existing system could not accommodate a vulnerable group that were referred to as "hard to house." This awareness reflects an evolutionary process that primed the system for change. Yet the decision by state officials to bring in an outside provider with expertise in HF to implement a new logic of homelessness services, rather than giving the responsibility to existing providers to implement the new approach, was described as a revolutionary process.

It is not entirely clear whether transformative change at the systems level has taken place in this case study. Changes in an existing service system have been described as either ameliorative or transformative (Watzlawick, Weakland, & Fisch, 1974, as cited in Nelson, 2010). To the extent that HF not only represents a different structure of services but also a different philosophy that cannot be easily reconciled in a traditional service model (Henwood, Shinn, Tsemberis, & Padgett, 2013; Henwood, Stanhope, & Padgett, 2011), its implementation likely represents some degree of transformative change. Yet in this case the introduction of HF did not simply replace the existing system. Even among the vast majority of stakeholders who were supportive of the HF approach, some described a tension between the HF logic and existing norms of community welfare and notions of what it means to provide consumer-driven services. It was not clear whether these tensions were based on real or perceived differences between HF and existing logics, especially given that existing providers reported limited communication or collaboration with the new HF program. Further, concerned about limited resources, some providers who acknowledged the value of bringing in an outside provider with HF expertise nevertheless felt that "we could have done this," yet it is not clear from this case study why these providers had not previously attempted an HF approach. This is consistent with previous findings that job protectionism can motivate objections to change (Felton, 2003) and highlights a fundamental premise of institutional theory—that institutions become self-preservationist, making change more difficult (Scott et al., 2000).

To the extent that transformative change is taking place in this rural system (i.e., the state is now considering how to implement HF statewide), outcomes that included success stories were one of the most powerful

forces influencing agreement with the logic of an HF approach. The salience of these outcomes also reflects regulatory, normative, and cultural–cognitive forces emphasizing data-driven systems. Given widespread momentum toward an HF logic, limited resources and increasing expectations to do more with less will likely result in the increased adoption of HF principles and practices in mental health and homelessness service systems. Yet as seen in this case study, systems barriers including funding structures, as much as individual values and beliefs, can make achieving systems change difficult. Trying to integrate a new approach in an existing system can make transformative change more difficult due to systems barriers and resistance from established social forces; nevertheless, the findings from this study suggest that in traditional service systems there is a variation in attitudes and that transformative change can be facilitated by both internal and external forces.

Consistent with previous literature, we found that in this rural system there were long-standing relationships and a close-knit provider community with expectations of ongoing formal and informal information sharing (Calloway et al., 1999). These characteristics of a rural system, which may be due in part to a scarcity of concentrated resources, can also inhibit competition, innovation, and change. Indeed, the introduction of HF brought with it an alternative for homeless adults who had not been previously well served; this alternative was regarded by some as competition for limited resources. In this case, HF was an alternative approach with a research base that had established effectiveness. Although this study took place in the context of a rural system, some of the aforementioned observations would likely apply to an urban service context. Different expectations of what it means for mental heath services to promote community integration, however, may differ based on a rural versus urban environment. Research has predominantly considered the notion of community integration in the context of an urban environment, which may represent an increasingly important gap in the literature as HF continues to become more widely adopted.

It is important to note that this case study was based on accounts from multiple key stakeholders from a range of organizations and who held different positions, but did not include participants enrolled in the HF program who could have provided an important perspective on systems change. To protect the confidentiality of participants, the analysis did not attempt to differentiate between multiple institutional logics in the existing system and instead presented the findings as a comparison between existing and HF logics. Because a focus on institutional logics assumes that "people in organizations have little choice but to adhere to these institutional scripts, it overlooks those actors' multiple and local meanings, which also shape their practices" (Binder, 2007, p. 550). This study cannot address whether actual practices or service delivery reflected the discourse or underlying logic expressed by stakeholders interviewed for this study.

**Conclusion**

Introducing HF can bring reform to existing homeless and mental health services that more closely aligns with consumer-driven care, but requires strategically considering issues of implementation in the context of an existing service system. The features of local environments (including systems of care but also funding, political, and cultural contexts) and their potential for triggering transformative change may influence the relative merits of implementing HF services by an outside provider with known expertise or supporting an existing provider to develop the infrastructure and foster a service philosophy based on an HF logic. Regardless, given that HF is based on a philosophy consistent with a recovery orientation and basic human rights that is aligned with larger transformation efforts, it will likely become a more prominent institutional logic.

**Epilogue**

Two key events occurred after the study's completion which further inform the potential for Housing First to effect long-term transformative change. The state legislature had considered the formation of a Housing First Study Committee that would explore the potential effectiveness of Housing First statewide. A general consensus emerged quickly, however, that Housing First was a well-established practice with a proven evidence base, obviating the need for such an exploratory committee. Most significantly, after several high-profile public comment and hearing periods, the Department of Mental Health announced that the Housing First agency was being given conditional designation as a specialized agency. Because the federal grant funds were ending, this status allows the agency to sustain Housing First services statewide through direct contracting with the Department of Mental Health. The Department's announcement stated that the Housing First agency, "presents a housing and treatment option that is different from what the Designated Mental Health Agencies provide." This was the first time in approximately 20 years that such a status was granted within the state's adult mental healthcare system.

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