



# Understanding Innovation in Homeless Service Provision: A Study of Frontline Providers' Values-Readiness for Change

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## Abstract

Service innovation for adults experiencing mental illness and homelessness typically involves shifting from treatment-led, staircase models toward recovery-oriented, Housing-First models. Aligning frontline service providers' values to those embedded within newer models is an important, but under-investigated, influence on the innovation process. To assess values alignment in this context, we conducted semi-structured qualitative interviews with frontline providers in staircase services in Ireland ( $n = 50$ ). Data showed that, while their values mostly aligned to the treatment-led model, there was meaningful evidence of more recovery-oriented values, too. Strategies to enhance innovation through values-alignment are discussed.

**Keywords** Homelessness · Treatment-led values · Recovery-oriented values

Mental health consumers are a significant subgroup within the larger homeless population and, as a result, there is constant pressure on policy-makers, planners, and managers to respond innovatively to the needs of this group (Nelson et al. 1998; Henwood et al. 2011; Rowe et al. 1996). Innovation in homeless services largely involves moving from treatment-led staircase models to newer, recovery-oriented Housing First models. Despite evidence of Housing First efficacy, the spread of this innovation has not been straightforward (Greenwood et al. 2013). In the present study, we suggest that values-alignment among frontline staircase service providers is an important, but under-investigated, influence on this process.

## The Role of Values in Innovation

Traditional treatment-led models of care rely on professionals to facilitate service users' harm reduction, often by means of control or coercion (White 1998; Slade et al. 2014). Spurred by recovery movements, however, many services now adopt recovery-oriented approaches that focus not only on treatment but also on enabling consumers' roles and

relationships (Miller and Timson 2004), positive interactions (van Boekel et al. 2015), and social connections (Hacking et al. 2008). Recovery is achieved in these settings by means of consumer choice and care tailored to individual needs (Lucock et al. 2011; Anthony et al. 2003). Although the evidence for recovery-oriented care efficacy is strong across contexts (e.g., Davidson et al. 2007; Deegan 1996; Bell et al. 1996; Blackwell et al. 2000), translational gaps still persist in practice (Le Boutillier et al. 2015). While the uptake of even the most evidence-based innovations can be shaped by forces at macro and organizational levels, another key consideration is the individual-level values of frontline providers delivering services (Cunningham et al. 2018; Rogers 1995).

Research suggests alignment of frontline providers' values those of a model influences their sense of satisfaction, development, burn-out, efficacy, effectiveness, and engagement (Robey et al. 1991; Maton 2008). In contrast, values misalignment has been linked to role conflict and ambiguity (Mondros and Wilson 1994). Values alignment may be key to the dissemination of innovations (Aubert and Hamel 2001; Parsons 2007; Chen et al. 2013). Achieving alignment is, however, complicated, not least in part, by variations that exist in settings (Clark 1997). As Vatne and Fagermoen (2007) showed, nurses in the same hospital held values that varied between 'professional expertise' and 'holistic patient experience' which, in turn, predicted whether their care was 'coercive' or 'therapeutic'. Krogh

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(1998) similarly demonstrated that staff members' values vary in disability services settings, reflecting either 'medical' or 'charity' models, which then predicted service users' perceived involvement.

## Innovation in Homeless Service Settings

Services for adults experiencing mental illness and homelessness also traditionally follow a treatment-led, staircase model. Here, consumers graduate through different housing arrangements until they secure an independent home (Kertesz et al. 2009). Transitions from one step to the next are informed by consumers' compliance with rules (e.g., sobriety, curfews). This model is said to be underpinned by values related to treatment adherence, skills acquisition through rule adherence, and, ultimately, access to housing (Henwood et al. 2011). While most homeless services still follow the treatment-led model, its effectiveness is questionable. Rather than moving to independent housing then, this group are left cycling between various institutional facilities (Tsemberis et al. 2004). One recent study suggested that it takes an individual an average of 10 years to exit this system (Feantsa and Fondation Abbé Pierre 2018).

The shortcomings of staircase services have informed the development of recovery-oriented homeless service models, particularly Housing First. Here, consumers are given immediate access to independent, scattered-site, time-unlimited housing with no pre-requisite for treatment. While findings are nuanced, Housing First tends to report more housing stability and better quality of life and community functioning than staircase services (Aubry et al. 2015; Henwood et al. 2015). While research indicates that Housing First is an effective innovation, the model has been adopted in only a minority of settings. Macnaughton et al. (2017) suggest that the spread of Housing First depends on macro- and organizational-level factors, including rigorous evidence, good decision-maker and researcher relationships, and timing.

While macro and organizational factors are important, individual-level factors must also be considered. Several studies point to the influence of frontline providers' values on the spread of this innovation (e.g., Aubry et al. 2018). Henwood et al. (2011) compared Housing First and staircase services in terms of values for housing. They suggest that Housing First providers value housing as a source of recovery, while staircase providers value acquiring housing as a show of moral worthiness. Finally, Tiderington (2017) also reported that providers working in Housing First services exhibit more recovery-related values (e.g., hope, empowerment, choice) than those working in staircase services.

Ultimately, research shows that values have an important role in homeless services delivery and the differences in the values that underpin staircase and Housing First programs.

We hypothesize that the spread of Housing First depends, at least in part, on a shift from treatment-led to recovery-oriented values among frontline staircase providers. To understand the extent of this shift, and ultimately the spread of innovation in this context, it is necessary to identify the extent of frontline providers' current alignment to the staircase current model, as well as any tendency toward alignment with Housing First.

## Capturing Values Alignment

Farkas et al.'s (2005) recovery-oriented mental health framework offers a useful approach to capturing the extent to which service providers' values align with staircase or Housing First models of homeless services delivery. Their framework suggests that recovery-oriented and treatment-led services can be differentiated by four key indicators: person orientation, person involvement, self-determination, and growth potential. In terms of person orientation, recovery-oriented services value individuals' strengths and abilities. Recovery-oriented services also value service users' self-determination and so strive to enhance their choice and control over key aspects of their housing and services. In terms of person involvement, recovery-oriented services value consumers' inputs into care, rather than prescribe treatments options based on professional expertise alone. Finally, recovery-oriented services value consumers' potential for personal growth (Farkas et al. 2005; See Table 1).

## The Present Study

The spread of innovation depends, at least in part, on the receptivity of frontline providers to a new model, which is more likely when values align. Our aim is to describe the extent to which staircase providers' values align to the values of treatment-led models or vary toward the values of the recovery-oriented Housing First model. To do so, we applied Farkas and colleagues' four key indicators of recovery-oriented care (Farkas et al. 2005).

## Method

### Study Setting

This study forms part of a larger project on homelessness in Ireland, where staircase services prevail. Having said that, a pilot Housing First project was implemented in Dublin in 2012. Overall, however, Housing First has been adopted in only a handful of settings in this, like other, countries (Busch-Geertsema et al. 2016).

**Table 1** Codes for themes of interest (drawing on Farkas et al. 2005)

Indicators	Treatment-led services	Recovery-oriented services
Person orientation	Concerned with deficits e.g., mental illness, addiction, family background/social circles	Concerned with strengths, capacities and capabilities, skills, abilities, motivation and resilience
Self-determination	Control guided by expertise/teach housing-readiness e.g., curfew, sobriety, set meal-times/visiting times, exclusions and evictions	Choice-oriented practice guided by service user needs, particularly in housing, schedules, treatment
Person involvement	Provider-led decisions about how services should be run and treatment provided	Service user partnership in designing, planning, implementing and evaluating the service
Growth potential	Alleviation of harm, survival and safety. Perhaps via medication adherence, harm reduction; treatment compliance; abstinence	Promotion of growth, perhaps involving community integration, hobbies, independence

## Participant Recruitment

For the larger study, we sent emails to staircase homeless services across Ireland inviting them to participate in our research on homelessness. Six services agreed to participate. All were staircase services in which consumers were expected to move on after a specified time (usually 6–18 months). They were all also congregate with alcohol use rules that varied from zero tolerance to toleration of use on site. All services prohibited illegal drug use, but some took harm reduction measures. Consumers were encouraged to comply with medication and substance abuse treatment.

One-hundred sixty homeless service consumers were involved in the larger study. We asked each of these individuals to tell us who their frontline provider was. A total of 59 frontline providers were named and invited to a qualitative interview about their work. We explained how we had received their contract details but we kept consumers' identities anonymous. Of the contacted providers, 50 (85%) completed an interview (1 declined; 3 were on leave, and five had changed jobs). They were mostly female ( $n = 41$ , 82%) with a relevant qualification (e.g. social work, psychology). A minority ( $n < 5$ ) had relevant personal experiences (e.g., homelessness, addiction). The amount of time they had worked in homeless services ranged from 6 months to over 40 years are incorporated.

## Interview Procedure

The first author conducted interviews with frontline providers at locations of their choice, usually an office space in the homeless service. After gaining informed consent, participants were asked to: 'describe the people they work with?' (person orientation), 'describe daily practice in the service, including what a typical day involves and what kinds of tasks and activities they undertake?' (person involvement), 'describe what rules or regulations are in place and what these mean for consumers?' (self-determination and choice) and finally, describe what 'what they hope to achieve in their

work?' (growth potential). Interviews lasted about 45 minutes, were audio recorded and transcribed verbatim.

## Data Analysis

Deductive thematic analysis was used to produce rich accounts of participants' values. A codebook was developed to identify the main themes and sub-themes according to Farkas and colleagues' framework (Braun and Clarke 2014). The first author worked with five research assistants (RAs) across five phases of analysis:

1. The team read and re-read all transcripts to immerse themselves in the data. Notes or highlights were made as necessary by each team member.
2. Each transcript was assigned to two RAs. Guided by Farkas and colleagues' indicators, RAs worked line by line through the transcripts to assign semantic or latent codes to meaningful text chunks. This was guided deductively by the literature and also inductively by participant data. Codes were discussed, refined, and streamlined in regular meetings with the lead author.
3. The codes were categorized into sub-categories and then into overarching categories that reflected Farkas and colleagues' four indicators of recovery-oriented care: person orientation, self-determination and choice, person involvement, and growth potential.
4. Themes were recursively reviewed in relation to codes to explore and ensure applicability, refined, and then named.
5. Finally, the team worked to identify relationships between the themes so that an overall story could be told about the data. As will be described in the next sections, an obvious relationship existed between person-orientation and the remaining three indicators (self-determination and choice, person involvement, and growth potential). That is, the more service providers spoke of service users' strengths and abilities, the more they also seemed to recognise the importance of choice,

involvement, and the potential for growth. Conversely, when service providers focused on service users' deficits, they also seemed to emphasize the use of coercion and control, as well as limited recovery potential of the individuals with whom they worked.

## Results

Table 2 lists Farkas and colleagues' values indicators keyed to the key themes we identified in our analysis. From providers' descriptions of 'the people they work with' (person orientation), three sub-themes were identified: strengths versus deficits; causes of homelessness; and championing. As noted, person orientation seemed to infuse the other three indicators. From providers' descriptions of 'rules or regulations' (self-determination and choice), we identified three main sub-themes: coercion, negotiation, and empowerment. From their descriptions of their 'daily practice in the service' (person involvement), two main sub-themes were identified: care planning and complaints and appeals. Finally, from their descriptions of 'what they hope to achieve in their work?' (growth potential), we identified three main sub-themes: hopelessness, harm reduction, and hopefulness.

### Person Orientation

Recovery-oriented services value consumers as individuals with strengths and abilities, rather than as cases with problems to treat (Farkas et al. 2005). As described above, staircase services focus on treating consumers' problems (e.g., mental illness) in order to get them ready for housing. In contrast, recovery-oriented services like Housing First focus on facilitating rehabilitation alongside growth. Providers' person orientation showed in how they characterized consumers, understood homelessness, and championed them in their times of need.

### Characterizations of Consumers: Strengths Versus Deficits

Most frontline providers characterized consumers in terms of their physical illnesses, lack of social connection, family

breakdown, and substance misuse and mental health problems. Focusing on deficits situates consumers as cases with problems that need to be solved, and so reflects treatment-led values. Like many other frontline providers, Laura described consumers as coming in:

...with an awful lot of baggage and... from their own parents, their environment, lack of education... we always have people who drink...we could have more drug users at one point ...we would always have people with mental health issues....

A small number of frontline providers did, however, describe consumers' strengths and abilities, using terms like 'artists', 'carpenters' 'trades people' and as 'real people, with real skills', who were 'mature', 'engaging', 'helpful', 'determined', 'independent', and 'motivated'. Consumers' abilities to overcome trials, handle set-backs, and bend not break were also mentioned. Vincent, for example, commented on how consumers 'come through an awful lot' and if he had faced such trials, he 'probably wouldn't have survived 'til my thirties'. According to Farkas et al. (2005), these types of descriptions are more aligned to the values of recovery-oriented care.

### Causes of Homelessness: Disposition Versus Situation

When providers focused on consumers' deficits, they also often made dispositional attributions for homelessness. In the extract below, David described how a lack of motivation sustains homelessness because some consumers 'do not want' to address their issues. In doing so, he essentially suggests that homeless people are responsible for their own predicament because they:

...have come through the service, and through the service, and through the service...their patterns of behavior haven't really changed...because they, themselves, are not at a point where they want to address their issues...all the services in the world can be around them but if they're not willing....

Victim-blaming explanations were frequent in our data and are typical of treatment-led models in which consumers are often seen as incapable or unable of making good decisions, which in turn, is used to justify the use of controlling and coercive practices.

Among frontline providers who focused on consumers' strengths, however, many offered situational explanations of homelessness. Adam explained how one consumer's alcohol misuse problems resulted from her history of sexual and domestic abuse. Putting himself into her shoes, he said he could 'flipping understand why you want to be [intoxicated]...why would you not drink? Honest to God, why would you not?' These kinds of explanations for

**Table 2** Farkas' indicators and identified themes

Person orientation	Characterizing service users; understanding homelessness: dispositional versus situational; championing
Self-determination	Coercion; negotiation and questioning; empowerment
Person involvement	Care plans; complaints and appeals
Growth potential	Hopelessness; harm reduction; hopefulness

service users' substance dependence align well with Farakas and colleagues' (2005) definition of recovery-oriented values.

Some providers also described how systems and structures exacerbate homelessness, particularly congregate housing. Bridget explained how consumers only stay her program for 6 months, which is difficult because 'it's a very short time to try and...learn to live independent[ly]'. Deirdre described how systems also make consumers 'jump through a million steps' and they often find '...an apartment but they may not get rent allowance... weeks and weeks can go by before they get a housing interview and then they can't get rent allowance". Finally, Karen spoke of institutionalized stigma in healthcare and how consumers are "treated badly" by the hospital staff who "just don't want to deal with [them]" and when they do, "they don't talk to them right... treat them well". She described how one consumer had:

...TB, pneumonia, a 10 year-long heroin addiction and [was] skinny as a wreck... he nearly died. [The doctor] refused to treat him and said instead 'I'll tell you how you can handle that, but I'm not going to be your doctor'....

### Championing Consumers

The strengths-based characterizations that seemed to underpin situational attributions for homelessness also seemed to inform some frontline providers' efforts to champion consumers in their times of need, including, for example tailoring support to individual needs. Ita described how the rules that restricted alcohol use in her service put a particular consumer at increased risk of harm because he would go "street drinking ... 5, 6, 7 days a week" and as a result had:

... multiple arrests... injuries...[got] attacked...robbed ... in and out of hospital... we were... actually putting him into this situation because we don't let people drink [indoors]...forcing him to go out and get beat up... not forcing him, I mean obviously it was his choice to drink, but...if you want to drink we want you to do it safely....

In response, staff decided to give this consumer 'a contract... [so] that he could have eight cans [in] the evening...5 days a week, he has to stay sober for 2 days'. The contract meant that 'at 7 o'clock in the evening', the consumer 'gets two cans... he has to bring back two empties before we give him more'. Since the change, the consumer:

...got [cable television] channels or sports channels put into his room... doesn't end up in hospital anymore, he has [had] no public order offences since it started....

In another service, Zoe spoke of securing mental health treatment for a consumer who had faced discrimination within in an emergency room. She described how she took one of her consumers who was suicidal:

...[to hospital] he was, no doubt, going to kill himself... somebody came in and got in ahead of him...he was down the list to about tenth...I asked 'who is the [psychiatrist] here?' [Staff] said 'You can't see him'. It was so surreal! nurses saying you 'can't talk to him' as if he was some king! I just walked up and said 'I've a guy over there that's going to kill himself'. I gave my name and said 'you might think no one cares about him, but I'll be back if anything happens'. Twenty minutes later they had a bed for him. Twenty minutes after that he was in a lock up ward!

These championing providers can be likened to Rogers's 'early adopters', that is, individuals who are open to changes early in the innovation process. Many scholars suggest that even though early adopters may provide only a portion of care or services, they are crucial to the diffusion of a new practice throughout a network (e.g., Leathers et al. 2016).

Overall, most frontline providers focused on service users' deficits as the source of their homelessness. A few providers emphasized service users' strengths and resilience in the face of structural forces that create and sustain their homelessness. An even smaller number of early adopters described championing consumers. As will be shown, person orientation, especially characterizations of consumers, seemed to underpin providers' perspectives on self-determination and choice. That is, service providers' victim-blaming attributions were often accompanied by emphasis on rules, whereas situational, system-blaming attributions were often accompanied by more understanding, questioning, and negotiating.

### Self-Determination and Choice

In terms of self-determination, frontline providers often used consumers' deficits to justify rules. Having said that, some frontline providers, those who spoke about service users' strengths, questioned program rules. A few even spoke of the importance of choice and empowerment in services. These findings are described in three themes: "Coercion", "Questioning and Negotiation", and "Appreciation for Empowerment".

#### Coercion

Many frontline providers spoke at length about their services' rules. Caroline, for example, explained that if consumers "don't come in by 2 a.m. [they] have to remain out until seven...meal times are incorporated into the rules so that

people aren't grabbing food at every hour...tea at 8 o'clock until half ten...[they're] not allowed to have people in [their] room after midnight". Many providers saw rules as a means to minimize harm and regulate behavior. Gina, for example, concluded that what is best for the consumer 'might not necessarily be what they agree with'. In another interview, Deirdre described program rules as important to preparing consumers for independent living because they provide:

...a structure for people...living chaotic lifestyles... when they graduate back into private rented or living on their own, it will help them....

A number of providers saw rules as a means to coerce consumers into better behavior in relation to substance misuse or mental health. Queeva noted how there were rules about "no drinking or drug taking" and if a consumer "presents under the influence they'll be refused entry [to the service] until half past eight the next morning". George described using rules to punish consumers, in this case by potentially demoting them to lower quality housing:

bags...can be checked by one of the security men or by a member of staff...if they're found with alcohol... they'd get a warning or maybe they'd be put out for a night or two... not put out on the streets. There would be a bed made available in [an emergency hostel]....

Similarly, Anna described a consumer with schizophrenia who is "at times very difficult to manage" and "every so often" decides he no longer wants treatment. She noted that staff will "support him and work around him...but we will say 'well, you have to go [to treatment] if you want to live here". She justified this response because he can be "very chaotic" and "would be bringing people in and having parties and all that kind of stuff".

### Questioning and Negotiation

While many frontline providers talked about the utility of rules for program functioning, some questioned their effectiveness and legitimacy. One provider noted that consumers are 'over 18' which means they shouldn't really be told how to behave. Others acknowledged the Catch-22 of using rule infractions to evict consumers. As Francis notes, a person who:

...isn't working with the service they'd probably be given a discharge date...we sometimes use the date as kind of a kick in the ass to motivate them... sometimes that works...other times the person might do nothing...and just leave and that's it....

Among those who questioned rules, congregate housing was again identified as an undermining feature of homeless services. Helen, for example, spoke of rules about staff

storing consumers' medication, which they 'don't really have the right to' but they do because they 'don't want the dorms to be flooded with tablets...for health and safety'. Some who questioned the rules in this way also described trying find a middle ground. For example, Vera described how consumers may be given permission to break curfew for special occasions:

...the gates are locked down...for everyone else's safety at 11 at night. You can't come in after that unless...so if you've asked for a late night, you're going to a wedding or something, of course you can come in at 12, 1, 2, whatever time...The gates re-open again at 6 in the morning, and if you have to go out for a reason, yes, you can go out....

As in the person orientation theme, recognizing how structures impact on consumers, in this case on self-determination and choice, and trying to overcome barriers, aligns to the recovery-oriented values described in the Farkas and colleagues (2005) framework.

### Empowerment

A minority of providers described the effects of rules on consumers' self-determination. As Tim put it, 'treat a person like a child, they'll act like a child...treat them like an adult, they'll act like an adult'. Bridget highlighted how program rules undermine service users' independence and empowerment:

...services should be more empowering. A lot of the time that's difficult...it might make my life more difficult, but who cares? It's my job...The more empowered people are, I think, the more successful they'll be when they're on their own....

In a similar way, Zac talked about how he fought to promote self-determination, dignity, independence, and privacy in his service:

...I don't want cameras. I fought against cameras...They [consumers] have their own front door keys... They come and go as they please. I don't want institutionalization. I want independent living approaches... I know in this organization we want to go towards that, clients being more independent, having front door keys, having access....

This small group of frontline providers described how they changed their practice to enhance consumers' autonomy and independence. Overall, they show close alignment with Farkas and colleagues' (2005) recovery-oriented values and to the Housing First model.

## Person Involvement

Person involvement, or the extent to which consumers are involved in their program, was identified in two themes: “Care Plans” and “Complaints and Appeals”.

### Care Plans

Care planning refers to the setting of goals and targets for consumers’ support needs, personal goals, or recovery. The extent to which care planning is individualized and client-oriented is an indicator of the extent to which a frontline providers’ values are treatment- or recovery-oriented. Stacey described care plans as a meeting ‘once a week...for about an hour...[to] do a very thorough assessment of someone’s needs. She described how ‘you’d look at all the different areas...try to get the person to set their own goals... guide them a little bit if needs be but it’s really their plan, it’s what they want to do’. In contrast, Frances described a more treatment-led approach, noting care plans as:

...forms that give a brief history of accommodation, what made them homeless...any addiction...mental health issues... a general gist of where the person is at...the person might...not want to talk about it [but I have to be] quite direct sometimes....

She described care plans as less about what consumers want and more about program functioning. In contrast to Stacey, Frances was focused on consumers’ problems. Other providers like Gina saw plans as a bureaucratic exercise forced upon consumers and staff:

... [our funding require[s]...we submit key performance indicators...measure the level of work... that we are meeting...within a week of admission...doing an in-depth assessment...within 2 weeks of admission, and that’s all [the funders] want....

Overall, care planning is an opportunity for person involvement and, in some cases (e.g., Stacey), was used as a means to work with consumers in deciding their futures. In other cases (e.g., Frances), however, care plans were almost entirely treatment-led and so actually undermined consumers’ control and self-determination over their care and goals. In other cases, care plans were seen as a necessary but not valued (e.g., Gina). From these latter cases, we can see how care plans, which are supposed to be a tool for engagement, can actually be treatment-led, deficits-focused, or trivial. Thus, involving consumers in the ways suggested by Farkas et al. (2005) may be a considerable challenge. This has shown to be the case even in Housing First programs (e.g., Manning et al. 2018).

## Complaints and Appeals

Somewhat closer to Farkas and colleagues’ (2005) values framework, person involvement was reflected in frontline provider’ descriptions of complaints and appeals procedures, the mechanisms through which consumers express their opinions to shape service delivery. Many frontline providers described how they encouraged consumers to file complaints and to appeal evictions. Stacey, for example, described how, if:

...someone is annoyed [I] will say ‘if you want to make a complaint please...go to the manager and do...I think it’s important that that person gets the confidence to stand up for themselves and ... learns what it is to be respected and listened to....

Again, on the surface, complaints procedures may seem to foster involvement. Complaints are, however, reactions to perceived negative treatment that occurs in a context of asymmetrical power relations. As such, they may have very few real consequences. Complaints also do not, nor are they intended to, serve as an avenue to consumers’ input into the ways in which the overall program is delivered or managed. Instead, they are mechanisms through which consumers voice complaints about their individual treatment.

There was, however, one organization in which person involvement was valued. Frontline providers from this organization explained how they ensure consumers are aware of procedures and that complaints are welcome. Nora described how complaints are reported in ‘the quarterly statistics [including] how many complaints were made, who were they were against’. Ita, from the same organization, described the structured eviction appeals process:

...when you get excluded...you have the opportunity to appeal it...7 days to appeal that decision... they have a right to a hearing...they can bring someone to represent them, another resident or [frontline provider] The manager or deputy manager would go in as say the prosecution to say what they did and why they were evicted and a second manager from [another service]... would come in and hear the appeal not knowing the case only reading the paperwork and hearing what people have had to say on that day... they make a decision on whether they should be allowed to come back in or not ....

Importantly, Ita referred to efforts to foster person involvement by having meetings:

... where clients add to the agenda...residents’ rep [who] will bring any issues to the management... two residents on our board of management...and ex clients

within our staff team... they give us a lot of insight... continuously challenge for client rights....

Overall, there was little evidence of person involvement beyond the use of care plans, complaints, and appeals. Rarely did any participants' involvement in their care align well with Farkas et al. (2005). In practice, however, there were very few structural opportunities for consumers to have meaningful input into their care.

## Growth Potential

Growth potential, the final indicator of recovery-oriented care values, refers to consumers' abilities to move beyond homelessness. We identified three main themes: "Hopelessness", "Harm Reduction" and "Hopefulness".

### Hopelessness

A small but meaningful number of frontline providers seemed hopeless about consumers' recovery, especially their ability to 'break the cycle' of homelessness. Queeva noted that 'some [consumers] will be in their own place, some... will be in... longer term agencies...some will come back here ...and some will have passed on'. Vera also felt that 'the majority will [go back to the community], a few could but probably won't, and there's a few that just won't'. Ita explained that many consumers are used to this life:

... we have guys in their forties that don't see their lives outside this place...and don't make any effort [they say] 'well this is where I live, this is my home'... they get into their head... they [think] don't deserve any better or that they wouldn't be capable....

While only a few frontline providers spoke this way, this pessimism was quite stark and may have negative consequences for consumers' recovery. Such pessimism may well be a consequence of dispositional explanations of and so it may have negative consequences for the work that frontline providers invest in consumers. Fortunately, most participants' responses reflected more optimistic perspectives on consumers' potential for growth.

### Harm Reduction

Most frontline providers focused on harm reduction. David described the importance of 'get[ting consumers] stable' because 'they come in very chaotic and really unwell...you don't know how they're even still alive'. He described trying to get 'them to eat... make sure they link in with nurses to get clean needles...get them to go the doctor. As illness is a frequent correlate of homelessness, we anticipated this emphasis on harm reduction. As Farkas et al. (2005) note,

however, recovery also involves growth, yet only a small number of frontline providers seemed to be hopeful about this.

### Hopefulness

A small number of frontline providers showed hopefulness about consumers' recovery, particularly potential for community integration and social ties. Gina spoke about her hope for consumers to be 'in a relationship if they want... having met a lovely partner...had a child'. Helen referred to a family who she would like 'to have [a back garden]' and get to 'a place that they're content...able to function... felt confident in themselves'. Interestingly, frontline providers who recognized consumers' strengths also tended to describe these growth-related outcomes. Ita, described earlier, talked about how consumers were 'going to the gym... doing meditation' which she felt was 'a slow process of bringing in lots of different activities... showing that there's more to life... It's about enriching life'. Similarly, Zac, also quoted earlier, described his work not 'just burying young men from overdoses [but] work with them to become people, members of society that can put something back'.

In sum, most frontline providers described recovery as achieving harm reduction such as health or housing. A few appreciated growth potential, which seemed to be underpinned by their focus on consumers' strengths. Supports that focus on growth in at least equal measure to harm reduction and rehabilitation has shown to have tangible positive effects on consumers' outcomes (Manning and Greenwood 2018) and so is an important step for recovery-oriented services.

## Discussion

Farkas et al. (2005) described their framework as a 'first attempt at conceptualizing recovery-oriented programs that can provide direction to those involved in program implementation [and] a stimulus for further discussion' (p. 142). In applying this framework, we build upon what is known about values in homeless services and so help to conceptualize recovery-oriented innovation in this context. By highlighting the importance of values, our findings also offer directions for program implementation. Finally, our work points to avenues of further investigation, thus providing stimulus for further discussion.

### Innovating Toward Recovery-Oriented Programs

We applied Farkas et al. (2005) framework to homelessness. In doing so, we showed the utility of the Farkas et al. (2005) framework in another setting. We now know, for example, that person orientation is reflected in characterizations of

consumers, self-determination can be observed in program rules, and growth potential can be discerned from hopefulness about recovery. Future research might look more closely at these themes, particularly the existence of a potential indicator hierarchy as pointed to in our data. We note that person orientation may be a foundation for self-determination and growth potential values because providers who valued service users' strengths also seemed to value choice and growth. Conversely, when consumers were viewed through a deficits lens, providers seemed more concerned with rules and harm prevention. Future researchers might also consider using these themes to develop quantitative measures for application in more wide scale investigations of values and innovation.

### Directions for Program Implementation

While many frontline providers' values seemed aligned to the staircase model, some did describe consumers' strengths, system causes of homelessness, and championing, all of which are critical recovery-oriented values. In doing so, this minority seem ready for change. Given the growing emphasis on Housing First at policy and planning levels (Busch-Geertsema 2014), these early adopters may be key to implementing new ways of working (Ogunlayi and Britton 2017). In addition to supporting this group, organizations might also wish to focus on person orientation as facilitator of a shifting values. Our data suggest that person orientation may trickle down to facilitate a stronger commitment to self-determination, person involvement, and growth values. This is important for more tricky values related to person involvement, which has shown to be a significant challenge for even recovery-oriented Housing First services (Manning et al. 2018).

### Stimulus for Further Discussion

Our research also offers much stimulus for further discussion. As suggested by Henwood and colleagues (2011), questions remain about whether providers' values reflect organizational context or whether they self-selected a program whose values align with their own. It is widely recognized that individuals bring their own values to their work but that these can be shaped by socialization processes too (Clark 1997; Brown et al. 2010). As such, our findings likely reflect a mix of the two. To disentangle questions of values origins, researchers may wish to look at values over time. In addition to understanding the impact of setting or person, longitudinal studies might help us to also understand how providers' values are constituted and adapted so that they become more recovery-oriented, a process that may be critical to fostering systems change (Gehman et al. 2013).

It is also worth considering the alignment of our data to Farkas and colleagues' framework. Rather than reinventing the wheel, we applied this established framework to identify recovery-oriented values. While we take this alignment as an indicator of generalizability, another approach may have produced a different pattern of findings. As no contradictory themes were produced in our analysis, we believe that while different labels or organization may have resulted from other approaches, key findings would remain the same.

As noted by the American Association of Community Psychiatrists, recovery-oriented care can be identified from a program's mission, vision, strategy, resources, training, and assessment, as well as their service array and planning processes (Sowers 2005). As such, providers are only one small part of a larger system. Moreover, values alignment is not the only route to innovation. Other considerations might relate to 'resources, regulations, and operations' (Foster-Fishman et al. 2007). Even when values align, the resources necessary to implement change must be available, existing regulations must be compatible, and change operations must not be limited to a certain area. This is particularly true for homelessness, where lack of resources (e.g., affordable housing) and competing regulations (e.g., not allowing consumers to manage their medication) have shown to constrain recovery-oriented care (Manning et al. 2018), to constrain the provision of recovery-oriented care. Thus, while values alignment is important, we do not disregard the multiple other forces at work.

### Conclusion

Overall, our findings provide insights into how innovation can be achieved in services for those experiencing homelessness and mental illness. The recovery-oriented values of some frontline providers in our study is a glimmer of readiness for change in this context. Our findings indicate that the potential for systems change from staircase services to Housing First programmes lies systems, structures, and norms that cultivate frontline staff members' person-oriented values.

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### Compliance with Ethical Standards

**Conflict of interest** Authors have no conflicts to declare.

**Informed Consent** Informed consent was obtained from all individual participants included in the study.

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