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De-Implementation: Lessons to be Learned when Abandoning Inappropriate Homelessness Interventions

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Abstract
Evidence on what works to end homelessness is growing. Evidence also highlights that some forms of help are harmful and should be de-implemented. The ability to abandon low-functioning interventions is considered essential to improve conditions for homeless people. It is common for challenges to be encountered when evidence exists claiming that alternative approaches are more effective and/or cost-effective. This is particularly true in the context of the problematic staircase model and the highly effective Housing First. In this study, the aim was to collect published articles on the process of abandoning established methods with low scientific support. This scoping review explores evidence on de-implementation that may clarify why it can be difficult to introduce interventions like Housing First despite having strong scientific evidence. The call for a shift toward greater provision of Housing First in Sweden underlines the timeliness of this problem. Forty-one articles published between 2014 and 2020 were included.
The review found no articles focusing on the de-implementation of homelessness services. Findings from other fields show that the important first step is to identify what needs to be phased out. Together with organized demands from users and favorable financial effects, scientific evidence can constitute driving mechanisms for de-implementation. We found a lack of practical frameworks and theoretical explanations that could support successful phasing out of unnecessary interventions in the homelessness field. It is suggested that to support the implementation of new ways of working that better benefit homeless people, we must pay attention to established ways of working. This requires a developed theory of de-implementation of homelessness interventions and calls for more robust research.

Keywords
Homelessness, implementation, de-implementation, de-adoption, staircase model, Housing First

Introduction

Internationally, there are a plethora of homelessness interventions in use, such as shelters, staircase models, case management, and Housing First. Some of these interventions have been proven in scientific studies to be successful and are recommended to replace other interventions that may be less successful or even outright harmful (Keenan et al., 2021).

International research has shown that supported housing programs (Housing First) with high-intensity case management, such as Assertive Community Treatment (ACT), are effective even for homeless people with serious mental illness or drug-related problems (Killaspy et al., 2006; Munthe-Kaas et al., 2018; Nelson et al., 2007; Tsemberis et al., 2004). Although this research is widespread and often cited (Denvall, 2017), its encouraging results seem difficult to implement (Benjaminsen, 2014). Scandinavian research problematizes established solutions such as the use of shelters and staircases and claims that they have limited effect and might worsen the problem of establishing a sustainable housing solution (Benjaminsen, 2015; Knutagård & Kristiansen, 2013; Sahlin, 2005). According to Swedish national guidelines, the implementation of Housing First and the phasing out of staircase models are recommended (Socialstyrelsen, 2015). Despite this, it is still difficult to implement Housing First, and other interventions that are recommended to be de-implemented are still used frequently (Pleace et al., 2019).

In this scoping review, we explore evidence on de-implementation in order to explain why it can be difficult to introduce interventions like Housing First to reduce homelessness despite the existence of strong scientific evidence. The review aims to compile knowledge from current research on de-implementation and to investigate whether there are overviews, peer-reviewed studies, or theories of de-implementation that are relevant for interventions aiming to reduce homelessness. The term de-implementation is commonly used to identify and remove detrimental, non-cost-effective, or ineffective methods that lack sufficient scientific basis, some of which are tradition-based (Upvall & Bourgault, 2018). As we will present further on, there is a plethora of similar concepts in the field (Gnjidic & Elshaug, 2015).

This article begins with a method section describing the literature searches, we conducted. The background section then reviews the state of knowledge about interventions to address homelessness with special emphasis on problems with staircase models. It also describes how de-implementation is related to implementation. The findings section is split into three sections: 1) criteria for de-implementation, 2) the complex interplay between barriers and drivers to de-implementation, and finally, 3) theorizing de-implementation. The article concludes with a discussion in which we identify three de-implementation challenges for research and practice when attempting to reduce homelessness.

Methods

We performed a scoping review because of the developing nature of de-implementation in research. It is methodologically closest to a so-called narrative or traditional review compared to more rigorous systematic reviews. This entails carrying out searches to gain greater knowledge about how de-implementation has been empirically and analytically studied. This type of review can generate a greater understanding of the problems that can be associated with the phenomenon in focus rather than presenting all of the current research (see discussions in Dijkers, 2009; Hammersley, 2002). We hoped, during our searches, to find studies about de-implementation and similar concepts in connection with the introduction of evidence-based methods to reduce homelessness.

The searches were carried out in the two extensive databases, Web of Science and Scopus, on three occasions in 2019 and 2020. Both of these databases mainly include peer-reviewed articles, but also books, book chapters, and some conference papers.[1] We used the following search terms in titles and abstracts in the English and Swedish languages to identify current research: de-implementation, disinvestment, de-institutionalization, path-dependency, reassessment, unlearning, and de-adoption, as well as combinations of these search terms. Translations of the Swedish concepts used in the search were overuse, de-implementation, phasing out, and elimination. We limited the procedure by not searching further among other publications of individual researchers, e.g., via

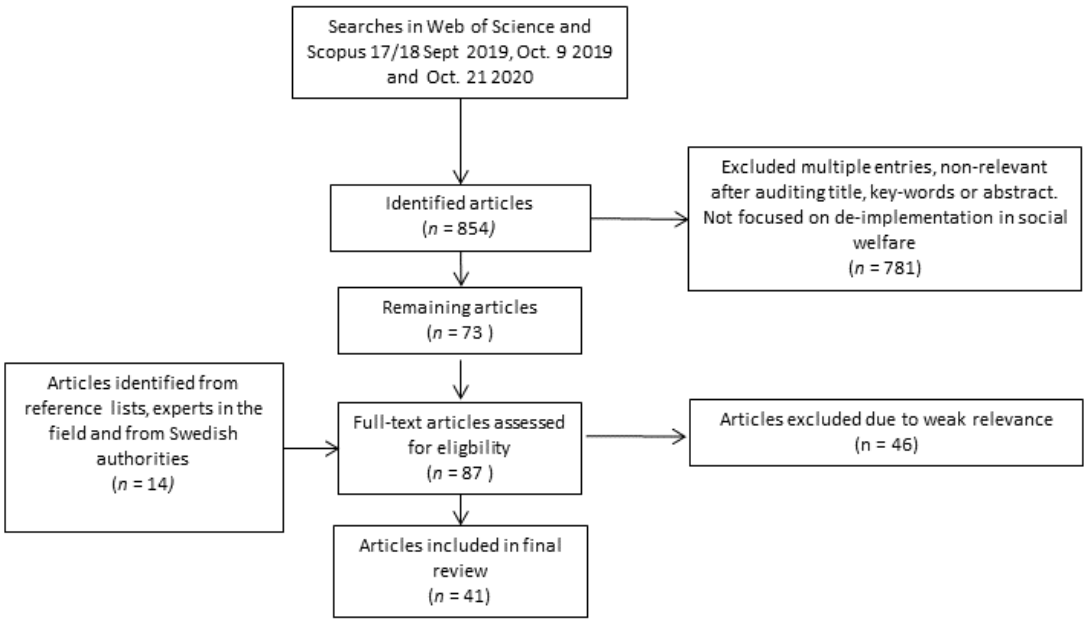
[1] See www.scopus.com and https://clarivate.com/webofsciencegroup/solutions/web-of-science/ for a more detailed presentation of the databases. Because the Web of Science is very extensive, the searches in that database were concentrated on the social sciences.

their homepages. Multiple entries and studies of phasing out of a more technical nature (e.g., climate issues, product development, and IT) were excluded at an early stage. Studies with a marked clinical or technical focus were excluded after a reading of their abstracts, and in some cases, the articles themselves, for example, about welfare technology (e.g., Haines et al., 2014) and clinical practice where the promotion of certain methods was in focus, and the de-implementation issue took second place (a Swedish example is Dahlberg & Lohmander, 2014). We have also excluded study protocols where researchers describe ongoing studies. The first author of this article performed the searches and presented a selection of articles for the other authors to read.

The searches encompassed the period from January 2014 to October 2020. The choice of starting point was based partly on the authors' previous studies and knowledge of the field (Bejerholm et al., 2015; Benjaminsen & Knutagård, 2016; Denvall, 2013) and partly on a call for research on de-implementation in the leading implementation journal *Implementation Science*, where the need for studies on de-implementation was observed (Prasad & Ioannidis, 2014). Two reviews (Alam, 2019; Sypes et al., 2020) reported rapid knowledge growth since 2014, which also justified the time limitation.

It became obvious at an early stage that there were very few reviews of de-implementation, which is why we chose an inclusive approach to single case studies with advanced analyses. This represents a deviation from the stricter recommendations on performing reviews (Arksey & O'Malley, 2005; Levac et al., 2010). The final sample of articles to be read in their entirety was based on three criteria: 1) systematic knowledge compilations and charting literature overviews on de-implementation and corresponding concepts with a focus on social welfare, 2) case studies containing the phasing out of existing methods in connection with the implementation of methods with strong scientific evidence, and 3) articles with the ambition to theoretically explain problems or factors for success concerning de-implementation. In addition to the searches, we used reference lists, mainly in the knowledge compilations (Alam, 2019; Garner et al., 2013; Niven et al., 2015; Powell et al., 2014; Sharma & Lenka, 2019). We also used a few reports and overviews from Swedish authorities. The figure below shows the searches.

Figure 1
Search map



A table appendix that presents both the included and the excluded articles in greater detail is available from the first author of the article.

Background

We begin with a review of the problematic staircase model and of the more promising Housing First, after which we continue with the relationship between implementation and de-implementation.

The Persistence of the Problematic Staircase Model within Homelessness Services

The so-called staircase model is still a prevailing practice in most European countries (Baptista & Marlier, 2019). The logic behind the model is to make individuals progress step-by-step in order to show that they are "housing ready." Research has pointed out that the staircase model tends to keep people within the system because it is difficult to get an ordinary home on the housing market (Knutagård, 2009; Sahlin, 2005). Depending on the individual's situation, some of the housing options within the staircase model are not only ineffective to end homelessness but can also be harmful to the individual. This is particularly a concern regarding shared air housing options, like night shelters, and other types of housing options where people must share the same room as others (Busch-Geertsema & Sahlin, 2007; Knutagård et al., 2007; Sahlin, 2005). The negative impact of shared air options has been even more evident during the ongoing pandemic (Pleace et al., 2021).

The secondary housing market plays a key role in the staircase model in Sweden. In the secondary housing market, the social services rent apartments from housing companies, which they in turn rent out to their clients. Half of those defined as homeless in Sweden live in accommodations in the secondary housing market with fixed-term, conditional contracts (Socialstyrelsen, 2017). Less than 8% of secondary housing market tenants were awarded a more secure contract within a year (Sahlin, 2017). The underlying logic behind this model is that the client must qualify to finally be able to get a home in the regular housing market. Clients experience a high degree of uncertainty about when they can move on to the next step and which conditions must be met to qualify (Knutagård, 2009). This uncertainty is also found in many other countries (Pleace et al., 2019).

Housing First differs radically from the logic of the staircase model, and housing is seen as a means for the individual to be able to deal with other possible problems (Hansen & Juhila, 2021). In Housing First, homeless people are offered a home first, after which support is designed based on the individual's wishes and needs. This new way of working differs from those where homeless people must first undergo treatment and other interventions before they can be considered ready for their own homes. This latter "staircase model" has a clearer focus on control and special rules in addition to those that apply to a regular lease (Culhane et al., 2020).

The scientific support for Housing First as a method of reducing homelessness is extensive (Padgett et al., 2015). Most studies come from the US and Canada, but in recent years the model has also been evaluated in several European cities, including in the Nordic countries (Munthe-Kaas et al., 2018). Housing First has proven to be very effective in supporting homeless people to stay in their homes (80–90% of tenants stay after a five-year follow-up), and the frequency of staying in one's home in the Nordic studies is similar to what is seen in international studies (Benjaminsen & Knutagård, 2016). Housing First has also proven to be cost-effective (Latimer et al., 2020; Pleace & Bretherton, 2019). From an international perspective, there is great variation between different types of Housing First projects, but comparative research has shown that if certain core components are retained, the projects lead to similar results (Pleace et al., 2016). However, current Scandinavian research shows that core components are rarely retained, and a "mind-shift" is recommended (Benjaminsen, 2014). Despite these positive results, Housing First has only been implemented in about 20 Swedish municipalities (7%) over a ten-year period (Knutagård & Kristiansen, 2019; Pleace et al., 2019).

Housing First is often combined with other evidence-based interventions that support individual needs and preferences, such as intensive case management (ACT) and supported employment according to the Individual Placement and Support (IPS) intervention. Housing First is closely related to IPS with its

place-then-train logic, and IPS has also seen limited implementation in a Swedish context despite strong evidence in support of the intervention. IPS has also proven to be more efficient than step-by-step or train-then-place preparation models in Sweden (Bejerholm et al., 2015). The intervention leads to recovery in terms of autonomy, increased quality of life, greater involvement in everyday life, and more active social roles in society when IPS is implemented with a high level of program fidelity (Areberg & Bejerholm, 2013; Markström et al., 2018).

These new initiatives usually set housing and regular work as the initial direct goal, without the individual having to show their worth or capacity in return. They differ radically from the established initiatives in terms of values, logic, and designs, illustrating the tension between control and support. Research has shown that the new methods also have strong support from the target group (Areberg et al., 2013). This has consequences for how professionals handle the introduction of new methods, and there are many indications that it will be particularly challenging.

The Relationship Between Implementation and De-Implementation

The ability to phase out low-functioning interventions is considered essential to improving the results of interventions and to improving the conditions for people in need of services (Norton & Chambers, 2020; Roback et al., 2016). Swedish authorities describe this as a necessary but difficult task: "We stick to what we have because we do not know what we will get" (SBU, 2013, p. 1).[2] In the Swedish National Guidelines, services are evaluated based on the degree of evidence and are recommended according to four options: "do not", "can in exceptional cases", "can", and "should". "Do not" refers to interventions that should be eliminated and which organizations within social welfare should stop applying because they have been shown to work less well or, in some cases, to even be detrimental to patients and clients (Socialstyrelsen, 2015, p. 50). The National Board of Health and Welfare (Socialstyrelsen) emphasizes that "more resources should be allocated to high-ranking interventions than to interventions that are low in the ranking" (Socialstyrelsen, 2015, p. 25). This approach is closely related to the healthcare service's focus on "overuse" (Born et al., 2019), which means overdoing ineffective interventions.

Implementation research has suggested focusing on drivers and barriers, that is, factors that enable or prevent intended change (Damschroder et al., 2009). Fixsen and colleagues place drivers within the spheres of management, co-workers' competence, and how the service is organized (Fixsen et al., 2009). If these drivers are inadequately represented or underdeveloped, the intentions to change are held back. Fidelity is thus created in a complex interplay between these supportive determinants of implementation. A wide variety of diverse barriers that can thwart the introduction of new methods has also been demonstrated in implementation research. There can be fundamental differences between research and practice (Debra, 2007), including lack of time, resources, and organizational capacity (Johnson & Austin, 2008), as well as challenges that arise when the evidence is to be adapted to local conditions (Hasson & von Thiele Schwarz, 2017).

Even if concrete suggestions as to how the implementation of new methods should be performed are on the increase, there is limited knowledge of how well-established but less-efficient methods can be withdrawn (Garner et al., 2013). The focus in implementation research is most often on the introduction of what is new. The problem with phasing out is not mentioned at all in two relatively recent overviews of implementation research and its theories, effects, and conceptual framework (Nilsen, 2015; Powell et al., 2014). New methods will be used partially together with the old ones, and it is well known that they will be modified to fit in the local context. If de-implementation then occurs, already established interventions may be removed, replaced, reduced, or restricted (Norton & Chambers, 2020). However, the retention of work procedures can maintain traditional practices, that accustomed patterns

[2] https://www.sbu.se/en/ (Swedish Agency for Health Technology Assessment and Assessment of Social Services)

are not broken, and that change is hampered despite strong scientific evidence.

International research into de-implementation is in a nascent phase and is only now beginning to be visible. A great deal of the research that focuses on phasing out (disinvestment) and closely related concepts such as "de-implementation", "reassessment", "priority setting", "de-adaption", or "resource allocation" are technically oriented and are focused on technological systems in health care (Garner et al., 2013; Rushmer & Davies, 2004). Concepts such as "un-learning", "re-learning", "de-learning", and "de-institutionalization" are suggested but only discussed to a limited extent, in particular when compared with the literature that is solely focused on management (Becker, 2019; Durst et al., 2020; Mariano et al., 2020a; Mariano et al., 2020b; Sharma & Lenka, 2019). A particular problem is the extensive and ambiguous terminology used to describe phasing out in social welfare services, and researchers have identified 43 closely related concepts (Gnjidic & Elshaug, 2015). Gnjidic and Elshaug, who advocate the term "de-adoption", maintain the importance of a unified language in order to be able to manage the challenge of phasing out flawed procedures. De-implementation and implementation have been proposed as being two sides of the same coin. If this were the case, then there would be similar mechanisms (drivers and barriers) that support or hinder implementation and de-implementation (Sauro et al., 2019). Other researchers maintain instead that implementation differs significantly from de-implementation (Grimshaw et al., 2020; van Bodegom-Vos et al., 2017). The knowledge of which mechanisms support the phasing out of established methods in favor of new evidence-based ones is still in its infancy. We now turn to what our review says about how older, often tradition-driven working methods can be replaced by newer ones with better research support.

Findings

The review found no articles that focused on de-implementation of homelessness services. Therefore, the paper draws upon findings within other fields to identify lessons for the homelessness sector on the de-implementation of services and approaches. The findings are split into three sections: 1) criteria for de-implementation, 2) the complex interplay between barriers and drivers to de-implementation, and 3) theorizing de-implementation.

Criteria for De-Implementation

The review finds some ambiguity in how already established services are to be judged. It proves difficult to agree on whether a particular intervention is of low quality and harmful to its users. Elshaug et al. (2012) reviewed 5,209 articles when searching for recommendations for discontinuing the use of problematic services. More than 150 suggestions could be identified, but only a few of these showed themselves to be common for all patients/service users. Potentially less successful or low-value services can still work for some users and in some contexts (Elshaug et al., 2012). However, the evidence is unequivocal that the important first step is to identify what needs to be phased out, and McKay et al. (2018) contend that a systematic approach is needed. They suggest three criteria for de-implementation: 1) interventions that are not effective or are detrimental, 2) interventions that are not the most effective (better alternatives exist), or 3) interventions that are unnecessary. A challenge where implementation is concerned can be the limited legitimacy of and belief in new methods even if they are based on evidence. The tradition-based practice was compared with evidence-based practice in a study from the US (Bourgault & Upvall, 2019). The nurses interviewed in the study indicated uncertainty concerning the scientific support in their daily practice and found it difficult to distinguish between tradition and evidenced-based practice. This is not a surprising result because it confirms other research showing a fragmented view of what is to be regarded as evidence (Avby et al., 2014).

Verkerk and colleagues (2018), based on a review of 727 articles, presented three overall themes concerning "low-value care" that can initiate de-implementation: 1) ineffective care that needs to be delimited, often due to high costs; 2) ineffective care that needs to be removed due to no longer being of any use; and 3) care that is not desirable from a patient perspective

(Verkerk et al., 2018). Three similar overall conditions for de-implementation have been suggested by other researchers, namely, quality, and patient security, clinical efficiency, and cost-effectiveness (Montini & Graham, 2015; Robert et al., 2014). These types of criteria could then form the guiding principles when considering de-implementation in a homelessness context, albeit identifying low-value care to initiate de-implementation is clearly associated with major challenges – as the next section discusses.

Importantly, several researchers maintain, as the authors of the previously quoted article from the Swedish agency SBU do, that everyday procedures are needed that can systematically consider and adjust to current evidence, and that can play an active role in ensuring that practice can be modified based on implementation research (Stelfox et al., 2019).

The Complex Interplay Between Barriers and Drivers to De-Implementation

Most of the published research on de-implementation comes from attempts to provide evidence for how to make health care services more effective. The campaign "Choosing Wisely" is ongoing in the health care services in at least 20 countries (Grimshaw et al., 2020). The aim of the campaign is first to identify "low-value care" services that are deemed substandard from a medical perspective and second to identify the overuse of unnecessary or ineffective services. One study has shown that approximately 30% of all health care services in Canada and the US are "low-value care" or are "overused" (Born et al., 2019). The difficulty in prioritizing resources where they would provide the greatest benefit is seen as affecting the particularly vulnerable patient groups and as counteracting the aim of creating equality in health care services (Emanuel & Fuchs, 2008; Helfrich et al., 2019; Sipila et al., 2019). One of the key conclusions of this research into healthcare services is that the availability of scientific evidence is insufficient on its own to enable de-implementation.

The available scientific evidence is one enabler of de-implementation, but knowledge from research is not systematically utilized in social welfare (Boaz et al., 2019). A number of barriers that affect the possibilities for de-implementation have been identified in the research literature (Leijen-Zeelenberg et al., 2013), and it has been shown that both the perceptions of individual members of staff and established routines and cognitive processes can be important components in the complex processes that influence the phasing out of less effective procedures (Helfrich et al., 2018; Scheiner et al., 2016). A study from the US showed that extensive surgical procedures for breast cancer were discarded only after patients in an organized action demanded another methodology, but that the phasing out was also influenced by financial considerations as the new treatment methods were more cost-effective (Montini & Graham, 2015).

Another line of research is more focused on presenting the conditions for supporting prioritizations and seeks to "prioritize addressing low-value care; build a culture of trust, innovation, and improvement; establish shared language and purpose, and commit resources to measurements" (Parchman et al., 2017, p. 199). Other researchers are more specific, and Whittington and colleagues propose individual coaching of staff in the form of support and feedback that needs to be informative, critical, and formative (Whittington et al., 2019). The SHARE study from Monash University focused on investigating and supporting de-implementation in health care services in a network of six hospitals in Australia and contained studies of existing practice and attempts to implement new knowledge as well as a literature review (Harris, 2018). The findings show that – despite a high level of ambition – weak management, a lack of time, and financial reprioritization during the progress of the project led to many aims not being attained. That study illustrates the complex nature of creating an understanding for prioritization based on the best scientific evidence and shows that unpredictable local conditions dominate to a great extent (Harris et al., 2018).

McKay and colleagues (2017) have shown in a study from the US that de-implementation (de-adoption) can also concern interventions with strong scientific evidence. They monitored RESPECT, a human immunodeficiency virus (HIV) program that was ended due to a lack of funding, and how this de-implementation had major consequences for the social services that needed to be reorganized and generated

frustration among the staff. Another study examined a few promising programs aimed at people with mental illness in the US that had been phased out (Massatti et al., 2008). Their analysis revealed that five factors had conspired to various extents, namely, lack of funding, external influence on the decision and planning processes, factors related to staff and management, a disbelief in the organization's ability to implement as intended, inadequate harmonization of the intervention in the organization, and insufficient fidelity.

With the increasing volume of research that has demonstrated effective methods to prevent and treat HIV, the need to phase out ineffective interventions in the field has grown (McKay et al., 2020). Pinto and Park (2019), in one of the few published studies focusing on implementation and de-implementation, have investigated methods within the field of HIV prevention. They show how contextual conditions determine implementation/de-implementation, which can make general statements on outcomes more difficult. There is limited knowledge in the field, and these authors point out that the political, institutional, organizational, and cultural factors that drive the phasing out of previous interventions in HIV prevention and other practical fields have been neglected in the existing research (ibid:240).

In summary, the available research indicates that the scientific evidence, together with organized demands from users and favorable financial effects, can constitute driving mechanisms for phasing out programs. Furthermore, individual help and feedback can support the phasing-out process. The perceptions of individual members of staff established routines, and cognitive processes have been suggested to constitute obstacles to de-implementation. An alternative approach that has been discussed is how services can ensure favorable conditions for de-implementation, and within this research field a trusting working atmosphere, a common language, and functioning communication are emphasized as prerequisites for de-implementation. However, as Grimshaw et al. (2020) summarize the level of knowledge, the few empirical overviews that exist are based on specific conditions (user groups, professions), which thus makes generalizing difficult in the myriad of diverse cultures, organizations, and contexts that encompass health care. There is a lack of a distinct framework that can provide support for a successful phasing out of unnecessary interventions. We have not found anything that focuses on homelessness. The limited amount of research that nevertheless exists presents the challenges for both implementing new evidence-based procedures and de-implementing tradition-based procedures.

The Need for Theories of De-Implementation

Most of the studies that have been presented above are empirical and descriptive and are carried out by committed researchers who want to support social welfare services and health care in phasing out ineffective or detrimental procedures in favor of others with stronger scientific evidence. A common feature in a great deal of the research literature is a lack of analytical perspectives; as readers, we seldom receive theoretical explanations as to why de-implementation happens or why it is difficult to carry out. We found no studies about de-implementation with the aim of testing theories. Without more explicit theoretical ambitions, empirically focused studies will hardly be useful in new contexts, be they practical or academic (Corley & Gioia, 2011).

Explanations on an *individual level* have been sought in several studies with analytical ambitions, where an understanding of the staffs' priorities and choices can lead to finding ways to guide them away from unnecessary procedures and towards those that have empirical support. Helfrich et al. (2018) advocate the theory of cognition and emphasize the two concepts of "reflective cognition" (which is needed to identify overuse and incorrect use) and "automatic cognition" (which can explain why this does not occur). Conscious processes are needed for reflective cognition to cope with different types of problems and challenge well-established practices. On the other hand, automatic cognition is driven by previous inherent knowledge. In another study, Patey et al. (2018) have carried out an extensive literature search for theories in the behavioral sciences that could be useful for implementation and de-implementation, and they asked whether there is

empirical support for how behavior can be modified. They found 2,342 articles, of which 66 were used. However, they did not find anything that could clearly be of help other than theories on Operational Learning, i.e., reward and punish, but they argue that these theories would probably not be practically applicable.

Investigations of de-implementation that focus on the *organizational level* are generally unspecific, as in Parchman et al. (2017), which we have presented above. Their suggestion about creating a culture based on trust, innovations, a common language, and a unifying vision sounds basically sensible but can easily become mere buzzwords when more tangible considerations based on research findings are lacking. Rycroft-Malone and colleagues have carried out literature studies and followed three partnerships between academia and the healthcare services that aimed at management training (Rycroft-Malone et al., 2016). By using a realistic design and a theoretical foundation, they were able to develop a "middle-range theory for collective action for implementation" (ibid., p. 15). This theoretical model is very similar to the suggestion made by Parchman et al. (2017), but the former concludes by stating that there are no "quick fixes" and that interventions in complex contexts always tend to lead to unpredictable consequences.

The implementation researchers Hjern and Porter (1981) suggested the use of an analytical approach to understanding implementation 40 years ago, and their suggestion can also be used where de-implementation is concerned. The authors state that a correct analysis unit is decisive, and they suggest a multi-organizational perspective on what they term "implementation structures". An implementation structure can be understood as an overriding organizational unit, the extent of which is constituted by what is to be implemented. For example, actors from the employment agency, social welfare office, and healthcare services could constitute an implementation structure if the implementation of new methods was concerned. The interplay between the actors constitutes the actual analysis unit and is the core of a strategy for administrating a complex implementation with several organizations/companies/parties involved.

We might expect that some staff will uphold earlier types of services (and routines), while other staff will focus on adapting the new programs, perhaps by dismantling parts of previous methods according to the new program's logic. Such an approach emphasizes the importance of investigating administrative procedures when de-implementation is studied because there may be parallel mechanisms maintaining older methods/approaches in the organization's administration. Hjern and Porter's (1981) field theory places the actors in structures at the same time as perceptions and actions can be investigated empirically.

Perceptions of the nature of one's own work and how it is to be defined appear in particular to be difficult to change in comparison with activities in the form of more elementary routines that can be replaced fairly straightforwardly by new ones (Rushmer & Davies, 2004). We do not find analyses that apply an *inter-organizational level* to such problems. However, that kind of analysis was established in organizational theory back in the sixties and has been developed since then (Mahonet & Thelen, 2010; Thompson, 1967). They emphasize the great environmental dependence of organizations and how they act in political, professional, and economic domains where overriding interests and norms frame their independence. The institutional theory assumes that organizations act within fields of activities where they are firmly linked to each other and are interlocked (Fligstein & McAdam, 2012). The freedom of action for organizations will thus be restrained through the prescriptive models, regulations, legislation, and education that create this order. Dominant logics confirm the organization's technologies, and they are embedded in both the organization's history and its external contacts and are established in the form of habits, traditions, and routines. Duplication and adaptation are needed to preserve institutions and attempts to make changes that appear to be sensible, rational, and logically motivated must be based on adaptation to the norms and demands outside and within the organization. Knowledge is perceived as being of importance in certain institutional systems if it confirms a well-trodden path. It can, however, be interpreted as being incorrect or to be ignored if it is deemed to be digressive. Identities, basic assumptions, and values are active components in institutional logics and have been defined as "the socially constructed,

historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton & Ocasio, 2008, p. 804). An organization's technologies (its essential methods and work procedures) can be linked to the core activities that need to be protected from external influence. The existence of these protective barriers may explain why staircase interventions continue despite promising new alternatives.

To sum up: de-implementation is an issue with complex resolutions. Norton and Chambers have suggested that research is needed that can "explore how to identify multi-level barriers, match them with appropriate strategies, and calibrate the barrier-strategy pairing as it changes over time" (2020, p. 4). To carry out such wishes, a theory is required that can explain the mechanisms that make or prevent things to happen. Several mechanisms can be part of the complex dynamics that create drivers and barriers to implementation and that affect de-implementation. This requires analytical abstraction work and concepts and theories to make visible the factors that influence such processes. Our review has shown that there is considerable potential for future theoretical work.

Conclusions

Evidence of what works to end homelessness, and indeed what does not, is growing. This is particularly true in the context of the often problematic staircase model and the highly effective Housing First. Yet the homelessness evidence base is still patchy, and many interventions and approaches are under-evaluated (Teixeira & Cartwright, 2020). There is a need for more evidence concerning services that are less effective, more expensive, or detrimental and that need to be abandoned in favor of new approaches.

In the Swedish context, Housing First is included in the Swedish National Guidelines and is recommended as a replacement for other methods that have shown to be less effective. It questions the current stepwise activities where clients/patients are gradually rehabilitated to their accommodation, often under tight control. Implementing Housing First on a large scale in Sweden would entail an adaptation by the services that are to implement the new approach, and groups of staff may need to be made redundant or retrained. Even if there is knowledge about both the benefits of the new methods and the deficiencies of the previous ones, there is limited knowledge about how they can be adapted to each other and perhaps co-exist, and whether and how the previous methods are to be phased out or retained. We will conclude this article by describing three overall challenges connected to de-implementation.

First, the difficulties in clarifying *what* should be de-implemented have been shown in the literature. However, our review shows agreement that a first step must be to identify poorly functioning working methods, and several concrete proposals are presented, especially the importance of a conscious and strategic way of working. A major challenge seems to be linked to the issue of the views on evidence and its merits. Knowledge is no longer seen as clear-cut and neutral but as something that is associated with interests, interpretations, and positioning. Even if scientific knowledge is usually highlighted as the most secure due to its transparency and validity (Boaz et al., 2019), there are several organizations with comprehensive domains of knowledge. Even if we think we are certain that we know (through strong evidence and national guidelines), there can be influential actors in the field with legitimate interests who assert other interpretations. Thus, even if there are strong recommendations to remove staircase model services, these can have authoritative advocates among both staff and service users who protect the services from being identified as unnecessary. There is also a large variation in the interventions that are used internationally, with changing policies, extensive heterogeneity among people experiencing homelessness, and a range of practitioners. Our perception is that this contributes to weak evidence for the de-implementation of services in the homelessness field.

Second, *how* will this new knowledge assist in the process of de-implementation? Implementation research is developing but needs to be designed to generate concrete and practical

support for services in the field of homelessness. This knowledge needs to be established locally and developed together with the services that introduce new methodologies and which then also need to challenge the current procedures. The phasing out of previously established services has been proposed in national guidelines, the impact of which has been somewhat ambiguous. This literature review shows that de-implementation is challenging both for individual professionals and for their organizations. De-implementation can take place completely or only partly, and substantial investments can be needed to change cultures and to further educate the staff. This is naturally something that can be demanding for services that are seeking both to satisfy the staff's needs of stability and to promote change. The conditions needed for de-implementation appear to be based on individual cognitive factors, processes on a management level in organizations, and not least on regulations (e.g.. law changes) and positions (e.g.. crises) in the field that the organization operates within.

Third, we need to know *why* some implementations/de-implementations are successful while others fail, and analyses based on social science theories need to be carried out. Studies are needed that link the design of de-implementation with concrete strategies and frameworks that are shaped for specific user categories and organizational contexts in the field of homelessness. There is a need for studies that link empirical research to explanations and that create knowledge about what makes things work. This requires insight into the mechanisms that support change. Extensive RCT studies with never-so-well-conducted experiments do not provide us with sufficient knowledge for implementation. In our opinion, it also requires a developed theory of de-implementation of homelessness interventions and more robust and analytical research to get a strong evidence-base.

The overarching message in this article is the connection between already established working methods and the possibility of implementing promising new ones. The old methods may need to be replaced by the new ones. To support the implementation of new ways of working that better benefit vulnerable people and in the long run also eradicate homelessness, we must pay attention to established ways of working. International research has shown that Housing First has undergone rapid expansion. It is based on trust in the user and deviates from stepwise methods based on control and qualification. De-implementation of staircase models would be a significant step in the humanization and effectivization of homelessness work.

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