The At Home/Chez Soí Project:
Project Implementation at the Vancouver, BC Site

Prepared by:
Diane Schmidt, BA
Michelle Patterson, PhD

Simon Fraser University
Faculty of Health Sciences
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Partners and Collaborators

Researchers:

Providence Healthcare
Simon Fraser University
University of British Columbia

Project Service Providers:

Coast Foundation
Motivation, Power & Achievement (MPA) Society
Portland Hotel Community Services Society (PHS)
RainCity Housing

Community Stakeholders:

BC Housing
BC Ministry of Health Services
BC Ministry of Social Development
City of Vancouver
Providence Health Care/St. Paul's Hospital
Street to Home Foundation
Vancouver Coastal Health
Vancouver Foundation

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Introduction

Over the past 30 years, homelessness has emerged as a significant social problem across Canada, growing in both size and scope in urban, semi-urban and rural communities (Laird, 2007). Homeless adults suffer disproportionately from high rates of serious mental health and substance abuse problems compared to the general population. Further, co-occurring physical health problems are also very common (see Frankish, Hwang & Quantz, 2005). Although individuals with mental health problems constitute a minority of the homeless population, research has shown that they are more likely to experience repeated episodes and longer periods of homelessness as well as require more health and social services than others experiencing homelessness.

Among other structural changes, the growth in the rate of homelessness has coincided with the deinstitutionalization of long-stay psychiatric institutions across North America. This significant downsizing in psychiatric care has been accompanied by inadequate investments in the expansion and integration of community programs that provide services for individuals with mental and substance use disorders as well as welfare, criminal justice, and housing services. As a result, many cities across Canada, including Vancouver, have witnessed a significant increase in the number of homeless individuals with serious mental health problems (including addictions) that have not only diverse housing and mental health-related needs, but needs that are complicated by physical health problems, trauma, and various social and occupational challenges.

While the research literature presents a complex relationship between homelessness and mental health, it is clear that untreated psychiatric and physical health conditions contribute to chronic homelessness. However, the services designed to address various psychiatric, addictions, physical health and social issues are often segregated and inadequate. Mental health and addictions are most often addressed by diverse community-based non-profit organizations while physical health conditions tend to be treated in walk-in clinics and Emergency Departments where continuity of follow-up care is limited. Non-profit agencies are often ill-equipped to address the multiple needs of individuals with complex and concurrent needs, which often leads to incomplete care and further unmet need. Given the high rates of behavioural and physical health problems among homeless individuals and the inadequacy of services, there is a growing need for effective approaches that integrate housing with treatment and support services (Rosenheck et al., 2003).

A growing body of research demonstrates that supported housing has a positive impact on residential stability, regardless of the specific model of housing (Best, 2006; Rog, 2004). Recent research indicates that a Housing First approach, which provides permanent, independent housing that is dispersed throughout the community, is an effective approach for people who are homeless with mental disorders, including substance use (e.g., Tsemberis & Eisenberg,

2000). This model places no treatment demands on clients but offers intensive support services to help individuals integrate into their community. Despite these findings, the impact of supported housing on outcomes other than those related to residential stability and hospitalization have not been thoroughly examined, and existing studies have not yielded consistent results.

Evidence is emerging to suggest the characteristics of effective interventions for homeless individuals with psychiatric symptoms, including the importance of perceived choice (Greenwood et al., 2005; Nelson et al., 2007). *Assertive Community Treatment (ACT)* is a model of care for people with severe mental illness in which a multidisciplinary team provides treatment and rehabilitation in addition to case management functions. An extensive body of research has shown that ACT is effective in reducing hospitalization and improving symptoms of mental illness as well as social functioning (see Ziguras & Stuart, 2000). Focusing on a subset of homeless people with severe mental illness, Coldwell and Bender (2007) used meta-analysis to assess the effectiveness of ACT versus standard case management. Overall, clients who received ACT had a 37 percent reduction in homelessness and a 26 percent improvement in psychiatric symptom severity compared to standard case management. These results suggest that homeless people with highly disabling conditions may best be served by a service model such as ACT.

Intensive Case Management (ICM) is another model of care for people with mental illness in which services are brokered to community agencies by a case manager rather than delivered by a team (as in ACT). The evidence base for ICM is not as strong as that for ACT. However, ICM has been shown to be effective in improving symptoms of mental illness as well as social functioning (see Dixon & Goldman, 2003). Despite the body of evidence in favour of ACT and, to a lesser degree, ICM, little is known about the effectiveness of different intensities of intervention for homeless individuals with differing levels of need.

In addition to the increase in homelessness and diverse service needs, many cities face a substantial shortage in the availability of affordable housing units. In light of limits to housing availability, the implementation of scattered-site housing, as modeled by the Housing First approach, may not offer the most efficient use of available service resources. Alternative strategies, including approaches that provide independent housing of homeless persons with severe mental illness in *congregate* settings where neighbors would include other persons with severe mental illness, have not been adequately explored (see He, O'Flaherty & Rosenheck, 2010; Walker & Seasons, 2002). Further, given the current economic recession, exploring the relative advantages and disadvantages of congregate housing arrangements on persons with severe mental disorders is timely.

Over the past decades, a movement toward evidence-based practice has emerged in medicine and, more recently, in public health (see Des Jerlais et al., 2004). The randomized controlled trial (RCT) is usually seen as the strongest method for assessing the efficacy of interventions. Health Canada and the Mental Health Commission of Canada, the funding bodies for the At

Home Project, predetermined that an RCT would be the underlying design of the study, implicitly supporting the movement toward complex policy trials and multi-site RCTs as primary methods for developing policy-related knowledge. Given these decisions, certain constraints, such as random assignment to intervention and control groups as well as the lack of a clear sustainability plan, were inherent in the basic study design.

Given the growth in both the size and scope of homeless populations and the increasing need for effective approaches that integrate housing with mental health and support services, as well as limitations in the research literature, obtaining a better understanding of how supported housing and services influence the broader context of individuals' lives is critical. An improved knowledge surrounding homelessness and the service needs of individuals is necessary for the development of not only long-term, community-based solutions, but for the formation of well-defined health and social policy.

Purpose

This report examines how the Vancouver site mobilized research, housing, and service provider teams, as well as community partners, in order to recruit, house, and support participants in the At Home/Chez Soi Project. The report describes the strengths and challenges facing various project stakeholders as they implemented all aspects of the project (October 2009 through to January 2011). Given the short time period during which both research and service provider teams were developed, we interviewed selected project stakeholders early on in the implementation of the project (May/June, 2010) and a more complete group in December 2010 and January 2011, including participants from each intervention arm of the study.

More specifically, this report focuses on the following:

- Program models and key components
- Formative evaluation (what works well and what does not?)
- Developmental evaluation (adaptations to the local context)
- Involvement of people with lived experience
- Relationship-building
- Structures and resources

Local Context

In Vancouver, the overlap between mental disorders, substance use, and homelessness has become a civic crisis. When compared to the rest of British Columbia and Canada, Vancouver is unique in terms of the heterogeneity, multi-morbidity and concentration of its homeless population. The extent of chronic medical conditions, including infectious disease, has been well-documented among Vancouver's homeless population (Acorn, 1993; Wood, Kerr et al.,

2003). Furthermore, many homeless individuals in Vancouver are not connected to the formal health care system, and are thus at elevated risk of adverse medical outcomes, including drug overdose (Kerr et al., 2005).

The 2008 Metro Vancouver Homeless Count found 1,372 people who were homeless in the City of Vancouver[1]. This number of homeless individuals represents a 23 percent increase since the previous count in 2005. Notably, between 2005 and 2008, the percentage of people who experienced homelessness for one year or more increased by 65 percent, representing 48 percent of people counted in 2008. In addition to the significant increase in the rate of homelessness, self-reported rates of mental illness and addictions have also increased significantly, by 86 percent and 63 percent, respectively. A 2007 Provincial estimate of the population of adults with severe mental disorders (including substance use disorders) estimated that 1,800 adults in Vancouver are absolutely homeless and an additional 2,280 adults are at-risk for homelessness (Somers, 2008). These reports suggest not only a significant increase in the rates and severity of homelessness in Vancouver, but that a substantial number of people are affected.

The Downtown East Side (DTES) community, home to approximately 16,000 individuals, is unique to the Vancouver context. Many individuals in the DTES are homeless or live in unstable housing conditions, resulting in high rates of health and social service needs. Vancouver Coastal Health (n.d.a) estimated that 3,200 individuals in the DTES have significant health problems and an additional 2,100 have more substantive disturbances that require intensive support and services. Other estimates suggest an even greater level of need. For example, Eby and Misura (2006) estimated that 5,000 injection drug users in the DTES are infected with Hepatitis C or HIV/AIDS. Unfortunately, many individuals do not receive treatment for their conditions other than medical care through Emergency Departments (Kerr et al, 2005).

Although estimates of the clinical, social and housing service needs within the population of people who are homeless with mental disorders vary widely, it is clear that the variability and severity of need within the homeless population requires interventions that respond to individuals with both high and moderate levels of need. In response to the growing levels of homelessness in Vancouver and related issues in health and social problems, several non-profit organizations have established housing and other supportive services, many of which are located in the DTES. However, while Provincial ACT Standards have been developed and a Provincial Advisory Committee has been established to initiate ACT province-wide, there is currently only one ACT team in Vancouver (initiated within the past year), and only three province-wide. Thus, a critical element of context in Vancouver is the lack of basic service components (i.e., Housing First, ACT, ICM). This dearth of services may help explain the magnitude of complexity and tension in planning and implementing the At Home Project (i.e.,

[1] The 2008 Metro Vancouver Homeless Count also identified an additional 1,037 homeless individuals in suburban areas adjacent to the City of Vancouver.

not merely bringing people together around a common framework, but introducing key components of the framework at the same time).

The high concentration of Single Room Occupancy (SRO) hotels is also unique to downtown Vancouver. A high demand for low income housing is evidenced by the 0.5 percent vacancy rate for bachelor suites in Vancouver. As a result, affordable housing is far beyond the shelter allowance of people receiving income assistance. The average rent for a bachelor apartment is $736/month, almost double the $375 monthly shelter allowance. In general, housing in Vancouver for people with multiple barriers due to substance use and other mental disorders has been in *congregate* settings, and this trend is continuing with the purchase and renovation of a number of SROs and the development of congregate housing on 12 city sites.

Growing civic commitment and public concern in Vancouver has been directed toward improving the health, autonomy, and quality of life among those who are homeless and have mental disorders. In November 2008, Vancouver's Mayor struck a Task Force to address the issue of homelessness. Numerous city- and province-led initiatives have recently addressed challenges related to homelessness, including reforms to the justice system (e.g., Community Court), expanded mental health services (e.g., Burnaby Centre for Mental Health & Addiction), access to income assistance (e.g., Homeless Outreach Teams), and investments to stabilize housing stock (e.g., purchase of SROs and development of additional supportive housing). If these activities and commitments fulfill their promise, they will significantly improve the standard of "usual care" for homeless people with mental disorders in Vancouver.

In summary, the *At Home Project* addresses a critical gap in the research evidence surrounding housing and services for a growing population of vulnerable individuals. While service agencies and institutions have struggled to overcome differences of organizational cultures, mandates and styles of work, the *At Home Project* has encouraged diverse stakeholder groups to come together and establish a common framework. The development of a philosophy of shared leadership among high-performance teams that can transcend organizational boundaries is vital for not only the success of the project, but for the country to gain the knowledge needed to provide effective housing, health, and social services to individuals in need.

Methodology

Qualitative methods were utilized in order to examine how the Vancouver project team implemented all aspects of the project. A semi-structured qualitative interview guide was developed in consultation with the National Qualitative Working Group. Consultation with the National Qualitative Working Group assured that the interview guide was generally consistent across all study sites and that it adequately addressed the planning and development issues presented. The interview guide provided the framework for both individual and focus group interviews.

Interviews with stakeholders were conducted in two phases: early phase interviews (n=9) and focus groups (n=2) were conducted in May/June 2010 and later phase interviews (n=4) and focus groups (n=4) were conducted in December 2010 and January 2011. Stakeholders were contacted for inclusion if they were on the Project Team and/or a member of one the intervention teams. Research participants from each of the three intervention arms were also invited to participate in one of three focus groups. See Table 1 for a summary of individual interviews and focus groups by gender of respondents and phase of interview.

Table 1. Number of individual interview and focus group participants by gender and phase of interview

	Total	**Gender**		**Phase of Interview**	
		Males	**Females**	**Early**	**Late**
Individual	**13**	6	7	9	4
Research	4	2	2	2	2
Service Providers	7	4	3	6	1
Other	2	0	2	1	1
Focus Groups	**6**			**2**	**4**
Staff	***3***			2	1
ICM	8	1	7	8	
ACT	9	1	8	9	
CONGREGATE	6	2	4		6
Participants	***3***				3
ICM	6	5	1		
ACT	10	10	0		
CONGREGATE	9	7	2		

The final sample consisted of 61 individuals (13 individual interviews and six focus groups), all of whom were involved in some degree in the early and/or later implementation phases of the project. Four individuals identified as researchers, seven individuals identified as service providers, two individuals were not in either research or service capacities, and 25 individuals were research participants in one of the three intervention arms.

Among the sample of participants, 13 individual interviews and six focus groups were conducted. A few staff members from the ACT and Congregate teams were unable to attend the focus group sessions due to time constraints and prior commitments. An additional two individuals did not respond to several invitations to participate in individual interviews.

A trained research assistant, who was peripheral to the project, conducted, recorded and transcribed the interviews. Two research assistants reviewed and coded the transcripts.

Drawing from the transcripts, each research assistant developed a list of key coding themes. In order to reach consensus surrounding the key themes, the research assistants held several meetings with the purpose of reviewing each other's coding and negotiating interpretations and meanings. Once consensus was reached, a summary document of findings by question was prepared. This summary document served to protect the privacy of stakeholders and to assure that no individual stakeholder could be identified. The summary document was then reviewed individually by the two research assistants along with two co-Investigators.

Findings

Findings are summarized below by key topic areas that formed the interview guide, and are then summarized by overall key themes.

Program Theory

1. Program Model

1.1. Housing First

All respondents, both in individual interviews and within focus groups, identified Housing First as the essential component of the Vancouver At Home Project, without which the majority of participants would be unable to obtain adequate shelter. Respondents described a number of barriers that exclude the majority of participants from housing in the community, the most common being inaffordability of the private rental market and requirements around abstinence from substance use in most supported housing programs. Other respondents described the lack of "real" housing in Vancouver. Even when units are available, they are typically short-term shelter beds or Single Room Occupancy hotel rooms (SROs), which are often of sub-standard quality. In the opinion of many respondents, provision of key health and social services would not be as effective without secure and adequate housing. As one respondent stated: "Housing is integral to the therapy. Without stable housing there is no change. Period."

For many respondents, a critical component of Housing First is a commitment to re-housing, if needed. Regardless of the participants' situation or actions, safe and reliable shelter is provided. In most existing housing programs, if a client is incarcerated or hospitalized for a period of time, or enters long term treatment programs, they lose their accommodation with no place to return to when they reenter the community. Within the At Home Project, if problems arise with a participant's tenancy and the issue cannot be resolved, the participant is re-housed and does not lose their subsidy and home. One respondent described this feature of the project as a unique and critical component:

> "[It's] something that's really positive…that is different from the way a lot of places work. If somebody is evicted or there's some sort of serious incident, we're still able to network with that person and move on. And for me, that's been really challenging sometimes, but it's also…really important because…we're able to follow it through and you can see the difference that makes for the people we're working with. They're not abandoned after a crisis…I think that's a huge strength of this project."

Program staff also noted how the allocation of housing subsidies and the procurement of housing by a designated agency allowed them to focus on service provision rather than spending time and resources securing adequate housing. As a result, some respondents described the transition of clients into housing as a much easier and smoother process than they have experienced in the past. Enabling participants to move into furnished homes within a short timeframe facilitated participant's participation in services and available treatments. Further, some respondents noted that both the timely provision of housing and "doing what you promised to do" assisted in relationship-building between study participants and staff:

> "I haven't had a single person who hasn't thanked me a million times for their apartment. We get [the participant] an apartment [and] we get to be these sort of lovely 'housing angels'. We can say 'Let's go look for an apartment for you. All the furniture's on its way.' … I think starting a relationship with a gift like that is so helpful. I think that that, more than anything, is what I'm recognized for."

Other respondents noted that implementing Housing First in the private rental market supports and ensures the quality of housing provided. In Vancouver, SROs are a common residence for many marginalized individuals. In most SROs, many residents have to share few bathrooms and cleanliness, privacy, and safety are ongoing issues. In contrast, respondents described the quality of the housing offered through the project as "far above standard." The apartments offered are "real homes" that allow individuals to feel valued and respected. Participants from the ACT and ICM focus groups typically stated that they had never lived in such nice apartments or neighborhoods. As one participant stated:

> "I love my apartment and my new neighborhood. I'd rather die than go back there [DTES]. I'm happy just where I am. I feel like somebody now. I don't have to hide in a corner and feel like a piece of scum."

For participants randomized to scattered-site housing (ACT or ICM), several focus group participants suggested that another strength of the Housing First model is that it promotes individual choice. Participants are able to select from a range of apartment styles and neighborhoods throughout the Lower Mainland, including areas previously inaccessible, such as the North Shore, Kitsilano, Yaletown, and the West End. Many respondents as well as participants themselves described the need to move out of the Downtown Eastside (DTES) in order to escape its negative associations and influences. Similarly, respondents

who are involved in congregate housing emphasized how critical having a location outside of the DTES is in supporting the development of community and healing. They described how many residents take pride in where they live, and feel a sense of community and belonging that is reflected in how they interact with the neighborhood. For example:

> "This has given me the opportunity I have now with a part-time job that I work at, and being back in mainstream society, and feeling part of something instead of being stuck in a hospital or in a box in a rooming house and feeling depressed about it and ending up in the hospital all over again."

1.2. Support Services

Following no-barrier housing, respondents identified the provision of high-quality support services as a key component of the project. Many described the importance and success of working from a "one-stop-shop" model of care, where services are tailored to the individual rather than requiring the individual to fit into available services. Under this model, participants do not need to seek out treatment or navigate what is often a complex system of care. Many respondents described Vancouver's current service model as a "silo approach" to care, with agencies targeting their efforts and resources on a narrow segment of the population in need. Many service providers noted the difficulty in obtaining services within Vancouver due to narrow program criteria, long wait-times, and significant service gaps. In all three study arms, participants are linked to community supports that would otherwise be inaccessible.

One respondent described the difficulty staff experience in negotiating and navigating some services that are, for the most part, assumed to be accessible to everyone:

> "I can't imagine what it would be like…to try to access things like welfare or banking or renting an apartment…, never mind taking medication regularly, without a telephone or address or ID or…money. It's hard enough for us and we're not up against those kinds of barriers."

Some respondents noted the differences in service provision between the study arms. For example, within the congregate setting, many services are provided on-site and staff and residents interact several times a day. As one respondent stated, "…housing and services are so strongly integrated that it is difficult to separate them." With an in-house pharmacy service, registered nurses, and case managers working with residents, participants receive on-site services and supports when and where they need them.

While participants assigned to scattered site housing by definition receive services that are separate from their residence, many staff working on the ACT and ICM teams described improved access to services for their clients. "[Services] can meet people literally where they're at, in terms of their homes or in the community and…where they're at in their

lives." Respondents described how participants view such mobility of services as indicative of their own worth and value:

> "We're one of the few [service providers] that actually come to them and that makes people feel special. And it's consistent...not just an expectation. … Coming to a person is definitely a sign of respect and it's a sign [that] you're seeking someone out. It makes people feel like they're worth finding."

And:

> "Without mobile services, [participants] would have either abandoned or been evicted from their apartments by now… Mobile services ensure that participants can take the next steps from where they are."

The majority of respondents also described how the types of services offered through the project differ from the regular care available in Vancouver. The project is very client-focused and is able to offer a range of services, encompassing both clinical and social supports, that extends beyond the typical care participants would otherwise receive in the community. However, staff in all three intervention arms acknowledged that there are some participants who need more support than is available through the project, particularly participants with profound trauma, severe behavioural problems, and cognitive deficits.

1.3. Staff

The majority of respondents emphasized the importance of hiring the "right" people. Many described staffing as the critical piece to a successful team and program. Other respondents described the importance of compassion and approaching people with a non-judgmental attitude, whether they are interacting with participants, other staff members, or with the larger project team, to building relationships and ensuring the participants receive the care they need. Leaders from both service and research teams emphasized the need for staff to be able to work independently in an unstructured, and often unpredictable environment.

One respondent described their experience on the project as "… one of the best teams I've ever worked with. There's been a really good climate, I think, of collegiality [and]…respect among the team. People listen to each other, people consult, we rely on each other … [A]nd there's been a lot of room for learning from each other, and a lot of patience…and a lot of expertise… That's key."

1.4. Leadership

Several respondents spoke to the need for strong leadership, both for the overall project as well as for each of the program teams. Some of the leadership characteristics identified

included the ability to recognize diverse knowledge and expertise, to stimulate an environment of shared learning and respect, and to build trust among members, often through sharing of experiences and expertise. For example, one respondent described their program leader as:

> "Someone who I feel comfortable enough to share my ideas, knowing…that it's a safe place to say what's on my mind. Sometimes that's all someone needs, just to be respectfully listened to."

Many people also described the Site Coordinator's ability to be consistent and decisive in decision-making, and to provide clear direction and strong facilitation. Through her efforts, a more unified team has emerged:

> "I think there's [been] so many times along the way where the walls could've been put up. But rather than see them as walls, [the Site Coordinator]… sees them as opportunities, and…it makes things look a lot different. So we've managed through a lot of bumps and became a strong group because of that facilitation."

2. Outcomes

2.1. Early Outcomes

One of the primary outcomes identified early on was participants' ability to maintain housing. With support, most participants have remained stably housed despite histories of being very marginalized, oftentimes very long durations of homelessness, and complex health and social issues.

Other respondents noted that, while a no-barrier approach ensured individuals with complex needs received housing, it was often the support services that enabled participants to remain housed. One staff member described the positive impact that individual-based services have on a participants' health, quality of life, and on the larger system of care:

> "We have a guy who was going into hospital every couple of days before he entered the project… He was in his apartment for a month and a half before he was hospitalized again. That was huge. That was $600 in rental supplement for someone who goes from shelter to hospital, shelter to hospital, to police to hospital. You know what I mean?... We thought of it as a failure because it was only a month and a half, but when we read his hospital records [we realized]…it was a huge success."

Similarly, one study participant described the impact housing has had on his life:

> "I can say that it's dramatically increased my quality of life and, yeah, my sense of well-being. Not having that consistent thought process, you know, like just feeling like shit and down, you know."

Respondents also identified staff's ability to build trust with participants as an early outcome. Many respondents viewed the development of a trusting relationship as fundamental to each participant's recovery. In a safe relationship, many participants are able to be open about their lives, including their substance use, and identify and ask for what they need.

The engagement of participants was also viewed as a positive and consistent outcome across all intervention teams. Some respondents described how participants who initially were reclusive and withdrawn have become more involved in organized group outings and programs. Such engagement enabled participants to support each other and build a community of peers. This community of peers is most evident in the congregate site, but is also developing in the scattered site arms.

2.2. Anticipated Outcomes

Similar hopes and goals for the project emerged from the individual interviews as well as staff and participant focus groups. All respondents identified the need to keep the housing subsidies and support services in operation beyond the project's termination. In the focus groups with study participants, all participants expressed appreciation for being housed through the project. Many participants stated that the project has changed their lives in profound ways. Most participants in the ICM and ACT arms of the study expressed anxiety around what will happen to their housing at the end of the study, and a few participants were motivated to come to the focus group to voice this concern. As one participant stated:

> "Eventually, I would love to be able to pay my whole rent. The full thing. You know, mine's 1150 bucks a month. I'd love to pay it by myself, but I worry about it. I don't want to go back to where I was before. To bring my hopes up and then yank them out…"

In addition, many respondents hoped that the Housing First model will be adopted and applied across the province, and that participants with mental health and substance use issues be supported in their recovery through a diverse array of support services. Several respondents described the minimum outcome from the study as "having a strategy and the funding to expand on what we've learned to be useful."

Some respondents stated that, in order to create a lasting impact, the project should strive to change public opinion and create a paradigm shift around how society views homelessness:

> "I think the golden egg is more: it is transforming how we think about homelessness and poverty and substance use, and locating that as being very central and powerfully illustrative of a much larger set of dynamics… But it wouldn't be enough to have that. It would have to be on top of providing housing and supportive services."

Other respondents recognized the life-changing effects of providing no-barrier housing and supportive services:

> "I hope to see that people have the chance to...identify alternate stories for themselves, to get a chance to sit back and figure out who they are in a way that's not other people telling them or imposing on them."

And:

> "For some, it's the first time they have options. That can change their life forever, where they don't have to be stuck... One would hope that that's one of the things that can't be clawed back when resources are pulled. There are lots of tangible things that we're doing that, in a couple of years, even if people lose their supports and…go back to where they were before, this change might allow them to move forward. It's something that can't be taken from them."

Several respondents also described their hope of seeing changes to the service delivery framework in Vancouver, including moving from a silo approach to an integrated model that would foster partnerships rather than competition between care providers. Other respondents identified the need to create a more complete continuum of care for individuals with mental illness that supports individuals through each step of their recovery. Overall, the project was described as having the potential to create a fundamental shift in how Vancouver cares for some of its most vulnerable residents.

Implementation Themes

1. Building Relationships & Trust

Effective, trusting relationships were paramount to all aspects of project implementation. Relationships between staff and participants, within and between various project teams, and with community partners were all described as critical to the project's success. Many respondents emphasized the importance of trust, respect, and open communication as key elements in the development and strengthening of relationships. Furthermore, a sincere commitment to achieving highly effective collaboration was often mentioned as an overall project goal.

While strong relationships have been established since the beginning of the project, some respondents recognized the need to strengthen the project's presence in the community through active engagement, partnership development, and open dialogue. Relationships with police, health care providers, including hospital emergency staff, paramedics, and mental health teams, along with local businesses and the public, were thought to be essential to sustainability and the ability to create fundamental, lasting change.

Several respondents spoke to the need to build stronger relationships between different cities participating in the project. Some respondents described sites as "working in isolation" with members "forgetting the larger [national] picture." Many respondents noted the project's potential to inform a national approach to housing and homelessness, and expressed concern that this unique opportunity for change may be lost.

2. Meaningful Involvement of People with Lived Experience

Overall, respondents spoke to the need to increase involvement of people with lived experience (PWLE) and to do so through effective engagement and the building of partnerships and capacity at all levels of the project. Many respondents felt that PWLE should have been involved in the study's overall design, development, and site-specific planning at the national level. For example, several respondents suggested that a PWLE should have been hired along with the local Site Coordinator to ensure that peers were central to proposal development and project implementation.

Respondents also queried the definition of a "peer": does it include experience with only one of street homelessness, mental illness, or addiction, or all three? The population of homeless adults with mental illness is very diverse, therefore, the associated population of "peers" will be also.

While the hiring of a Peer Coordinator in May 2010 has encouraged the involvement of PWLE, meaningful inclusion has been challenging because teams, protocols, and processes were already in place. A Peer Reference Group has been created to advise on various aspects of the project and to promote a more actively engaged community. The on-going development of peer participation remains a focus of the Vancouver site.

The majority of intervention teams were able to hire a Peer Specialist early in their development, which has assisted in ensuring that the concerns of PWLE are addressed. Similarly, the Field Research team has engaged two PWLE who help conduct quantitative and qualitative interviews. However, most respondents described team involvement of PWLE as evolving. One respondent suggested that the value of peer involvement stems from becoming actively engaged:

> "Sometimes it's better to have groups run by [peers] and that's what we've focused on; that, and managing the programs, taking residents feedback, and figuring out how to run

them. It's the participant who knows best what is needed. Our staff promotes and encourages people to say what they want, how they want to be supported, and then we do our best to provide it."

3. Project Structures and Governance

Respondents described how structured meetings, formal training, and all-team events contributed to the breakdown of hierarchies, the creation of a supportive environment, and cross-team cohesion. Within teams, daily morning meetings provide the opportunity for coordination and collaboration and a chance to share experiences. Staff noted the importance of these meetings as opportunities to discuss the challenges of their work within a safe and supportive space. As one respondent said:

> "We needed to talk and we needed to figure out how this setting is different from people's other work settings. And we need to be able to put stuff on the table and, at times, disagree with one another and have those moments of conflict and get through that."

All-Team meetings provide the opportunity for members to get together on a more causal basis, to develop relationships across teams, and provide a forum for sharing experiences and developing greater awareness of each person's contribution to the overall project. As one participant stated, All-Team meetings are a time when:

> "We just reflect where we've come from…, some of the things we've overcome. I think it [is] just being able…to stand in each other's shoes. We know what it's like to stand in our own shoes, but we need to take that time to stand in someone else's shoes."

Regular, structured meetings that bring together team leaders, researchers, and other project staff are critical to cross-team communication as they provide a forum for discussing concerns and solutions. While several respondents felt that inter-team meetings take a substantial amount of time each week, many recognized the benefits of such collaboration in building a strong, unified project. Respondents noted that structures to support communication and collaboration are of particular importance because the project was designed with programs operating in parallel.

Many respondents described the study design as problematic in that it does not support a continuum of care wherein participants would have the opportunity to move between programs as needed. For example, some participants assigned to scattered site housing may do better in the congregate model where services are available in-house, while others may be better served through an ICM or ACT model of care. Respondents worried that the inability to transition participants from one level of support to another has the potential to impede the success of participants and the study overall.

4. Flexible Allocation of Resources

Overall, respondents described project resources as adequate. Some teams were particularly grateful that requests for additional funding to address program gaps were granted. For example, Vancouver was granted an increase to the housing subsidies, rental insurance, and the hiring of an additional case manager on the ICM team. Many respondents noted the responsiveness of the National Team and appreciated that requests for additional resources were handled with respect and fair consideration.

Some teams experienced difficulty in hiring and retaining staff. On-going issues include the difficulty in securing specialists (particularly physicians and psychiatrists) who are willing to work with this population as well as staff workload. Workload and burnout have been a concern during due to the perceived rapid recruitment of participants. Many respondents described the inability of staff to keep up with the demand to assess and house new participants quickly. Unlike traditional settings where programs determine how often new clients are accepted, the intervention teams did not have any control over the rate of intake.

> "People have really struggled with time and what they see as multiple and fairly complex demands being placed on them, by the national project,...by the research team, by their own peers, [and] by the intensity of the needs of the people they're working with."

With such a heavy workload, another respondent questioned staff's ability to extend beyond treating a participant's immediate needs:

> "Right now we're just trying to answer the door while the house is on fire. So how do we make time for the other stuff... like planning groups and recovery and actually doing preventative work, to do counselling? I just want to ask, 'What about all this trauma that's gone on in your life? Hey, let's get at that'… That's really what needs to happen."

With regard to the rapid rate of recruitment, respondents raised concerns around securing enough scattered-site housing units, ensuring participants' needs were met, and staff burnout.

Developmental Evaluation

1. Adaptation of the Programs to the Local Context

Many respondents spoke to the complex needs of the population in Vancouver, particularly around substance use and addiction. Longstanding substance dependence, often involving multiple drugs, resulted in behaviours and other complicating factors that required experienced staff trained in harm reduction approaches. In addition, teams provided specific training around substance use and promoted cross-team learning. An addictions specialist was added to the ACT team.

No other program adaptations were identified.

2. Program Innovations

Respondents shared stories of peer-driven activities that have emerged since initial recruitment. At first, staff developed and organized programs and events for participants. However, many peer-driven initiatives have emerged including social get-togethers for people living in common communities and peer-support programs for individuals with substance use. The importance of such activities in developing relationships among peers and with staff was described by one respondent:

> "It's really important for people to come and participate in a different kind of way. It's not a home visit where they're feeling checked up on... They come to a group and they're just able to *be* in a totally different way, and they talk and share totally different things than they would in a home visit..."

Other program innovations include the development of employment opportunities for participants. For example, the congregate site hires participants to prepare meals twice a day and do in-house laundry for its residents. Eventually, the program hopes to have both services managed by participants with the laundry program contracting to outside businesses. The ICM team has hired peers from within and outside the project to clean rooms after participants have moved out and to help with other aspects of moving.

An on-site pharmacy was added to the congregate site and has improved medication compliance and has provided additional services to participants such as free HIV testing, as well as advice regarding health concerns.

The team that has been working to secure scattered-site apartments has developed strong relationships with many private landlords. Landlord appreciation events have encouraged education around homelessness and mental illness, staff and landlord interactions, and recognizing landlords as key players in the project. One respondent described how important it is for staff to see the landlord as an ally rather than as an outsider from whom they need to protect the participant. Conversely, it is important that landlords view participants as potential tenants rather than potential problems.

> "We have to get out of these mindsets of seeing [homeless] people as hostile enemies ... And we have to think how to work together to get this done. Because it won't happen unless we do… This is all about doing things differently. We've been doing things a certain way all this time and where are we?"

Formative Evaluation

1. Strengths

1.1. Transitioning Participants into Housing

All respondents agreed that housing participants in both scattered-site and congregate settings is working well. Many respondents described how good quality housing in a safe neighbourhood begins to transform the lives of participants. Some respondents noted the responsiveness of the housing placement process; in most cases, participants receive housing within a short time frame if assigned to the ACT or ICM programs, and immediately if assigned to the congregate setting. Such responsiveness has promoted trust between participants and staff; many participants have previously experienced long wait-lists and restrictive program criteria. As one respondent stated:

> "I know people who've been on housing lists for over two years, waiting for a unit… That we can get a referral and have them housed within…three weeks or a month even, it's a dream. I mean, it's the way it *should be* for people. It's the way I'd like it to be for people. So that's amazing."

Other respondents described the relative ease of finding housing placements and the diversity of housing options as being essential to the project's success. Further, the provision of apartments through private landlords serves to create lasting change in the larger community:

> "Private landlords are being viewed differently now. They are no longer seen as self-serving and, conversely, landlords no longer view individuals with addictions and mental illness as unwanted tenants."

1.2. Building Cohesive Teams

Many respondents described the choice of good staff and the resulting cohesiveness of teams as a critical component that is working well. In a strong team, members bring a diverse and wide-range of skills and abilities to each program. This diversity is essential to ensure that participants can engage with the intervention team. For example,

> "A team member might be involved in... a 12-step program which the participant is also interested in, or maybe they have the same recreational interest, or similar personalities, or is someone from a similar generation. A common link can lead to these really innovative interventions with people."

Several respondents suggested that diversity among team members also fostered cross-team learning and sharing. Furthermore, several respondents described how diverse

backgrounds help breakdown hierarchical relationships within teams; when individual experience and knowledge is welcomed and fostered, there is less room for competition.

1.3. Project Communication

The majority of respondents highlighted strong communication processes as a strength that resides within and across teams. Many respondents suggested that communication was critical in order for staff to feel "listened to" and supported. Across teams, staff described their relationship with the research team as being inclusive, and that they felt their voice is heard and concerns are validated. However, a few respondents noted that the issue of recruitment pace was not fully acknowledged or resolved effectively.

Most service provider and research team members acknowledged the importance of meetings to maintain communication, transparency, and to facilitate cohesion both within and between teams. Many service team members described the importance of daily morning meetings as a place for staff to come together to discuss issues and celebrate successes. These meetings were identified as critical to maintaining and promoting positive team dynamics:

> "It's difficult work. It's very solo...there's a lot that people can learn from each other. It's a quality control thing but it's also a learning thing and I think a group cohesion kind of thing as well."

Some respondents described communications with the National Team as a positive experience; these respondents felt that when issues are raised they are generally addressed promptly. Examples include issues with the measurement tools, the need for rental insurance, and additional funds to hire a peer coordinator for the congregate site. In all three cases, changes were made and additional funds approved.

1.4. Developing Key Partnerships

Respondents described several partnerships that have contributed to the success of the project thus far. For example, collaboration with the Ministry of Social Development has increased access to services while reducing wait-times and the need for staff to follow-up on requests.

The congregate team described how the development of a community advisory group consisting of participants, local strata members and business owners, and representatives from the Vancouver Police Department has led to a greater understanding of the project and acceptance of the participants into the community. This advisory group provides an opportunity for issues to be brought forward and addressed before serious problems arise.

Numerous informal partnerships have also been developed, particularly with local service providers such as staff at St. Paul's Hospital and community mental health teams. Many respondents noted how these relationships are beginning to shift the way non-profit organizations are perceived in the community. Other respondents described the project as "a bridge," a way of connecting services that previously worked in isolation.

Respondents also noted how partnerships within the project have the potential to create change in service delivery models in Vancouver. As mentioned previously, there is a need to move from a silo approach to care to one where effective collaboration across sectors is embraced. Instead of non-profit organizations competing for the same funding, the project has created a space for the co-creation of healthy and effective partnerships.

2. Challenges

2.1. Level of Participants' Needs

While respondents described the majority of participants as responding well to their housing and support services, respondents noted that some participants' needs are not being adequately met. For example, some respondents expressed concern around some participants' capacity to live independently and would like to see those participants in a congregate setting. Other participants are able to live independently but need far more intensive support than the intervention teams can offer. Given the design of the project, teams are not able to transfer participants between teams and housing types. Service providers stated that there has not been adequate discussion around how to support participants who are not doing well in their respective programs. For example,

> "What is it like to come inside after being outside for so long? Because we're recognizing that that's a huge issue for people, the change from homelessness to housed. It's an identity change. It's a lifestyle change. It's not just…somebody wants housing and you get them housing and their problems are solved. It's half the battle, but there's also the head stuff that has to happen too."

Many participants in the ICM and ACT arms expressed that, despite enjoying their new apartments and neighborhoods, loneliness and isolation are common. Some participants have connected with other participants in the project who live nearby, and have benefited from group activities such as barbeques, cooking nights, and other group activities. Some participants in scattered-site units have experienced stigma from landlords and neighbours. While participants in the congregate setting did not report feeling lonely and isolated, they did report challenges around accommodating the behaviours of other clients, especially substance use and noise.

Finally, many service providers raised concerns around the high level of trauma and loss among participants. Respondents stated that there are little specialized services in Vancouver, and staff are struggling to ensure the stability of some participants.

2.2. Program Parameters

Several respondents (particularly ACT and ICM team members) described the difficulty in not having established program protocols prior to implementation. Members struggled with having to develop parameters while at the same time attending to the needs of incoming participants. In addition, several respondents noted the problem of establishing processes and guidelines after an incident had occurred. While some respondents noted that a lack of guidelines can facilitate creativity, they also recognized the dangers and drawbacks:

> "There's a line where a certain amount of ambiguity is great and freeing and then there's a line where, once you pass it, it's just aggravating and a waste of time and energy. And I've certainly experienced both sides of that."

The lack of clear guidelines and protocols may also create problems when assessing participant outcomes. For example, it may be difficult to measure precisely what it is that teams do and how their actions translate to participant outcomes. This lack of precision may compromise comparability between and across sites and the ability to draw conclusions around what works well and why.

The majority of respondents also stated the need for a "step-up and step-down" approach to housing and service provision. Many respondents suggested that the project should allow individuals to move between services as needed, with staff assisting in their transition. A few respondents indicated that the study design is not practical from a real-world, on-the-ground perspective.

2.3. Integrating Service and Research

Overall, the majority of respondents noted that communication between the research and service teams was very good. However, some service team members felt the rate of recruitment was too fast. While the research team had some control over the rate of recruitment, there was a need to fill the congregate study arm as quickly as possible, and it was difficult to predict whether participants would be assigned to high need or moderate need arms of the study.

Several respondents noted the additional time needed to complete Biweekly Checklists for the purposes of research. Service providers stated that they have very heavy workloads, and many felt that filling out forms takes them away from client care. Some respondents also questioned the quality of the checklist and its ability to reliably capture good information.

However, many respondents also recognized the need for rigorous data collection to better inform how the service teams are impacting participant outcomes.

> "[Being part of a research study] is more work and more opportunity…So we have to fill out checklists, we have to be really mindful of fidelity, we have to do extra things because it's a research demonstration project. But we also have a lot more luxury at times to be constantly reflecting on the work."

Some service providers mentioned the importance of measuring what it is that they do, and to have their work and skills acknowledged as an essential part of the care continuum. Furthermore, for many service providers, working within a national research project meant there were fewer barriers to services. In particular, securing good quality housing for clients is a task that would otherwise require extensive resources in terms of staff time.

2.4. The National Picture

The lack of a national focus was a prominent theme across interviews and focus groups. All respondents recognized the potential for permanent and significant change in the areas of affordable housing, and mental health and addiction services; however, significant change will be unlikely if sites fail to connect and create a cohesive strategy. Some respondents suggested that the lack of cohesion experienced during the implementation phase may be because different sites are at different points in the process; others noted that geographic distance makes it difficult to coordinate collective efforts. All respondents agreed that a national approach to sustaining the gains of the project needs to be discussed and strategies developed across all sites.

Lessons Learned and Reflections

1. The Need to be Flexible

The majority of respondents spoke to the need for flexibility, particularly during the first six months of recruitment. When recruitment began, intervention teams were still building their teams and developing processes and protocols. In addition, some participants assigned to the moderate needs arms of the study appeared to be very high needs. After further investigation, adjustments were made to the level of need algorithm. Some intervention teams found the rate of recruitment to be too fast and felt they were not able to adequately assess and house new participants. Given the speed at which the project was initiated and implemented, it was very challenging for various teams to cope with the demands of responding to new participants and simultaneously building their teams. Finally, respondents noted the need for program staff to be able to modify and adapt their programs within broad parameters.

Other respondents expressed a need for broad definitions of 'homelessness' and 'mental illness' and, further, how one understands high and moderate needs within the project parameters. With such a diverse group of professionals coming together to achieve the same goal, it became apparent early in the implementation phase that front line workers, health professionals, and researchers sometimes had different opinions on what it means to have a mental illness or be homeless. One respondent suggested that such broad definitions ensured participants are representative of the population under study and that it includes individuals who have been neglected by the larger system because they do not meet certain criteria:

> "… there are lots of people who don't fit nicely into [diagnostic criteria] and present this kind of more complex, co-morbid, blurry picture. They don't fit into any particular box, and yet there's a lot going on for them. And they're not taken by a mental health team and so, even though they're a really tricky group for us to assign to groups …I think we've adjusted to incorporating a more representative sample. [But] then we were getting a lot of feedback from the teams like 'this participant doesn't have mental illness' and then we [thought] maybe we're missing the boat or the criteria provided by the study are too broad or too lose."

2. Program Leads

Most respondents agreed that the awarding of the service leads to non-profit organizations was a progressive decision, and allowed greater flexibility in the way that supports are provided than if services were administered through government agencies.

> **"**Having non-profit service leads, pretty much all of whom have a long, long history of working with people where they're at, has made a huge difference...Working with non-profits…has allowed us to be nimble in a way that is very rare in big systems and big organizations. In most organizations…there's a hierarchy, but [here] it's relatively flat… [they can] do things differently and be supported... I think that, so far, that's been a big difference. There have been challenges and there will be other challenges because of those decisions, but I think on balance...the benefits outweigh the drawbacks."

Respondents also described the experience non-profit staff bring to the project as invaluable and may lead to better outcomes for participants. Several respondents suggested that on-the-ground experience and approaches are critical to working with this population.

Summary and Conclusions

Thirteen individual interviews and six focus groups were conducted with researchers, service providers, and research participants who were involved in the implementation phase of the Vancouver At Home Project. The implementation phase began with the onset of participant

recruitment in October 2009 and included both early-phase (May/June 2010) and later-phase (December 2010, January 2011) interviews.

Overall, respondents expressed a sense of excitement around the work they are doing, and are hopeful that participants feel supported and that such support will translate into strengthening of individual capacity that can be sustained long after the study is over. Other respondents noted the importance of the research component, acknowledging the need to build evidence around what works and what does not work for this population, data that will hopefully influence local and national approaches to housing, mental health and addiction reform.

> "Hopefully, by the end of the research project, we'll be able to change some of the policies around mental health and addiction, and be able to have continued funding. *And* take the stigma out of the way society views mental health and addiction and homelessness."

Respondents identified the integration of Housing First and high-quality support services as the foundation to a participant's recovery. Respondents also suggested that the right staff and building strong internal and external partnerships are essential to the project's success.

Generally, respondents are hopeful that the progress they have witnessed and the changes they have experienced within the project will be reflected in the greater community. Such changes include a restructuring of Vancouver's approach to service delivery, policy decisions based on evidence rather than ideology or speculation, the breakdown of stigma, and a redefining of the way society views this population. Finally, the majority of respondents envision a national consensus on how Canada approaches issues of homelessness, mental health, substance use, and addiction.

Going forward, respondents highlighted a few areas that may require more attention. First of all, the majority of respondents expressed concern around the lack of conversation, both locally and across sites, around building national consensus in order to sustain project gains and to advocate for a national housing strategy. Respondents were clear that in addition to helping the participants who are receiving housing and support through the project, they want to see significant reform to the housing and health care systems that affect homeless people with mental illness across the country.

Second, a number of respondents acknowledged that there are participants across all study arms who are not responding to the interventions. More attention and discussion needs to be focused on these participants, however, it is challenging to find the time and energy given the high demands placed on staff to meet the basic needs of clients on their caseloads. Similarly, respondents described significant gaps in the current system of care which makes it very challenging to address the needs of many participants, including mental health emergencies, inpatient hospitalization, suicidal ideation, and treatment for longstanding and severe trauma.

Finally, respondents called for continued engagement and relationship-building with the

community, particularly key agencies in the existing system of care. This engagement is critical, not only to communicate knowledge gained through the project but to begin to transform the current system of care.

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