

crosscurrents

WINTER 2010/11
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The Journal of Addiction and Mental Health



Bringing recovery home

On the welcome mat

How to be at home with trauma-informed care

Shelter from the storm

Barrier-free women's housing provides healing spaces, safe places

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A rural perspective on housing barriers

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Evening on the Farm, Deborah Deforest, watercolour, 15" x 22"

Deborah enjoys the calm of watercolour and finds solace in her work. Her paintings are displayed on the Touched by Fire gallery (www.touchedbyfire.ca).

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#4309



note from the editor



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“The federal government is throwing \$7 billion at bridges and roadways, and \$2 billion at housing. I’m thinking that perhaps the homeless are now going to have new bridges under which they can sleep.” That’s how University of Calgary social work professor Jeannette Waegemakers Schiff, speaking at a housing and homelessness conference in Calgary, described Canada’s lack of stable, affordable, appropriate housing.

It’s a problem felt keenly by people with mental health and substance use issues, who identify housing as one of the most important factors in recovery. For those who do find a place, it’s often a tenuous existence, because they may not receive the supports they need to hold onto their homes.

This issue of *CrossCurrents* examines various models of housing with supports, focusing mainly on supported housing. The terminology can be confusing. We use definitions commonly used in the mental health sector, which can differ from those used in the housing sector. In this issue, “supportive housing” describes either housing with supports in general, or, in the narrower sense, housing that is linked to supports, where residents are seen as program clients. Supported housing, on the other hand, de-links the housing and support functions and emphasizes access to independent housing in the community and to individualized, flexible supports provided from outside the home. We try to make the distinction clear in each article.

I hope you’ll enjoy this issue in the comfort of your own place, wherever that may be. As always, I invite you to send us comments and ideas so that we can continue to cover the issues that interest you.

Check out *CrossCurrents* on the web. You can participate in our discussion boards and comment on blogs. Get involved at www.camhcrosscurrents.net.

a view from CAMH

CAMH’s AGM this year focused on housing and homelessness. Acknowledging the contribution of community organizations over the years and the experience of John Trainor, director of the Community Support and Research Unit, this meeting marked a renewed focus on housing as a determinant of health and recovery.

Compelling testimony from Linda Chamberlain, a member of the consumer organization the Dream Team, underlines the importance of the issue. She says her recovery started when she got a roof over her head. With the Dream Team, she advocates for others to get stable housing.

Unfortunately, the service system has insufficient housing to meet the needs of people with mental health and substance use problems. This partly reflects underfunding of services for this population and lack of recognition of the social determinants of health and recovery. It also reflects the fact that the types of high-support housing that some clients need is in scant supply.

This is what the Schizophrenia Program at CAMH found when it was developing its new model of care. This model shifts the

focus of care from hospital to community. It offers better community care so people can be treated at home. However, finding high-support housing became a sticking point. Although there is some excellent housing in Toronto, what exists does not meet the need.

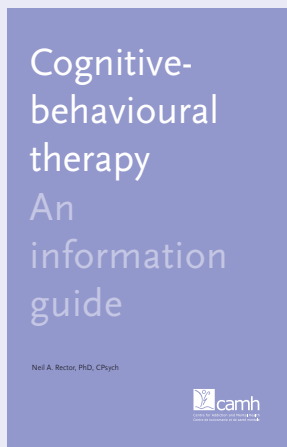
To fill this void, the Schizophrenia Program developed an innovative three-way partnership. CAMH has partnered with the Homes First Society and the Pilot Place Society, a mental health housing support provider, to offer 18 new 24-hour supported units in downtown Toronto. The average hospital stay before clients moved out lasted eight years; these were clients many thought would never leave CAMH. But one year into the program, there have been no readmissions, and some individuals have started to work. Analysis shows that the strategy is working.

Adding to the evidence is the work of the Mental Health Commission of Canada and its At Home/Chez Soi program. Paula Goering, head of the Health Systems Research and Consulting Unit at CAMH, is the program’s research lead. Toronto,

Montreal, Vancouver, Moncton and Winnipeg have been selected as sites that will house more than 2,500 people with mental health problems who are homeless, offer them support and demonstrate that the housing first model works. Some skeptics question whether this research is necessary, but many other high-income countries, such as the United States and the United Kingdom, have expressed interest. It is the largest homelessness housing project ever.

The big question for At Home and other initiatives highlighted in this issue of *CrossCurrents* is whether they can leverage change in health and social policy that currently ignores the fact that a supply of appropriate supported housing could move people out of inpatient wards and onto the road to recovery.

Kwame McKenzie, MD, MRCPSYCH (UK)
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Neil A. Rector, PhD, CPsych
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Neil A. Rector, PhD, CPsych, is a clinical psychologist and director of the mood and anxiety research and treatment program at Sunnybrook Health Sciences Centre in Toronto. He is a founding fellow of the Academy of Cognitive Therapy (USA) and is an active CBT clinician, educator and researcher. Dr. Rector is also the author of two other information guides in this series: *Anxiety Disorders* and *Obsessive-Compulsive Disorder*.



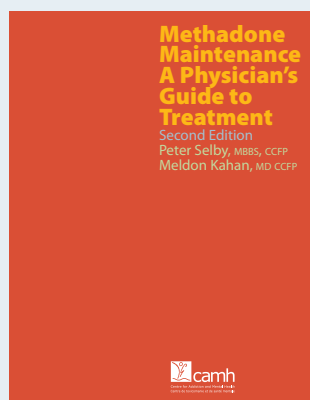
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Homeless people take centre stage with lauded opera company

Linda Hossie

The homeless are those people you step over when you come out of the opera house. That's how a British MP in 1999 dismissed this population. One year later, a group of homeless people proved him wrong by moving from the street onto the stage in the children's opera *The Little Prince*, performed at the world-famous Royal Opera House in London.

The connection between these two events is a man named Matthew Peacock. Peacock was volunteering at a homeless shelter in Westminster when the MP made his now notorious comment. A former singer and the assistant editor of *Opera* magazine, Peacock was the logical person to steer the shelter staff's outrage toward something tangible.

That something became Streetwise Opera, a company of people who are homeless, for which *The Little Prince* was the pilot project.

Confounding the stigma of homelessness is Streetwise's raison d'être. Opera is such an ambitious undertaking that if homeless people can do it, they can do anything, says Peacock. By taking part in performances, they prove themselves and other people wrong about their limitations.

It's a big challenge for a population that is very vulnerable and has extremely low self-esteem, Peacock says. Some Streetwise participants struggle with substance use issues, but more common, affecting about 40 per cent, are mental health issues, from depression to undiagnosed psychosis. "These people have become homeless because of huge turmoil in their lives," says Peacock. "Streetwise proves they can do something so extraordinary that it opens doors for them."

For one performer, the experience was a revelation: "The feelings of elation and accomplishment which I felt standing on the stage to acknowledge the applause were something I will never forget and played a large part in helping me to overcome my difficulties and start putting my life back into order," he says.

Now working on its eighth production, Streetwise Opera has received glowing reviews, not only for tackling stigma, but also for the brilliance of its music. Respected music critic Rodney Milnes of *The Times* gave five stars to the 2002 production of Benjamin Britten's *The Canticles* at Westminster Abbey. "Truly awe-inspiring," he wrote. "Cynics detecting political correctness in overdrive would have felt satisfied if the results were makeshift and amateurish, but the opposite was true. Musically the performances were superb."

From the beginning, Peacock has hired professionals to train the singers, not just because professionals provide the best training, but because paid voice coaches will show up. "It's not just a volunteer gig they might ditch if the pressures of their lives get in the way," says Peacock. "We work with vulnerable people and they can't be let down because they so often do get let down in life."

These paid professionals also take part in Streetwise productions. In the first few years, Peacock had to recruit them, but the company now has such a good reputation that Peacock must constantly turn professionals away.

This support and enthusiasm translate into inspiring success stories: A couple of Streetwise alumni have pursued performing arts degrees. One participant reduced his methadone prescription by 70 per cent. A man who had been ostracized by his family found the confidence to send them tickets to a performance—his daughters came, bringing a granddaughter he had never met.

The company also celebrates more subtle achievements. One man had worn the same jacket for years, refusing to take it off because it contained all his worldly possessions. But he took it off to don a costume for



Performers rehearse a scene from "The Boy Who Cried Wolf," one of the four film-operas from the new production, *Fables—A Film Opera*.

a performance. A support worker who had known the man for years couldn't believe it.

Backing up such inspiring anecdotes is Streetwise's evaluation system, which shows that 50 per cent of participants have had a change for the better in their lives.

Buoyed by its success, Streetwise is taking its opera magic beyond England. The company's last production, *My Secret Heart*, was filmed and has played worldwide, from the Edinburgh International Film Festival to the SuperDeluxe art space in Tokyo. The film has reached more than 175,000 people, and the company has done workshops in Japan and Australia.

But not everyone who is homeless is ready for Streetwise. "People do fall off the radar," Peacock says, "but not as many as you'd think." Those who stay have launched into a new production, *Fables—A Film Opera*, motivated by a new sense of possibility. "We're trying to give people an experience that raises their confidence and self-esteem," says Peacock. "It gives me huge satisfaction that some people have gone on out of homelessness." 

Won't you be my neighbour? Making room for supportive housing

Joy Connelly, a member of the HomeComing Community Choice Coalition, debunks myths about supportive housing. The term “supportive housing” here means housing grouped in a site with attached support.

Myth: Supportive housing hurts property values.

Fact: Not so, according to more than 100 North American studies conducted over the past 30 years. These studies have examined the impact of every type of affordable and supportive housing: large and small, new and renovated, families and singles, for people with mental illness or addiction, youth, ex-offenders and older adults. They have looked at the impacts on property values and saleability, often over many years, and compared them with similar properties with no affordable or supportive housing nearby.

The results provide overwhelming evidence that affordable or supportive housing does not lower surrounding property values. In fact, the astonishing news, from such major studies as New York University's 2008 research on 123 supportive housing developments, is that the values of property close to supportive housing go up faster than others in the neighbourhood.

Supportive housing is also an economic investment in the neighbourhood, often sprucing up old buildings and bringing in residents who buy from local shops.

Myth: Supportive housing causes crime.

Fact: That's not the case in Canada or the United States. In the City of Vancouver's experience over more than 25 years, supportive housing has generated few complaints to the City's inspections or police departments—and these few complaints often come from housing support staff reporting suspicious activity unrelated to their tenants.

Most studies show no increases in crime near supportive housing. The exception was an important 2002 Denver study led by supportive housing researcher George Galster, published in the *Journal of Urban Affairs*. It found increases in minor crime near large supportive housing buildings, primarily for frail older adults. The explanation? Possibly fewer eyes on the street—or tenants were the *victims* of the crimes.

Myth: My neighbourhood already has too much supportive housing.

Fact: Supportive housing in all provinces has long waiting lists. That's because it makes up only a tiny proportion of Canada's housing stock. For example, the Ontario Ministry of Health and Long-Term Care funds about 8,300 supportive housing units for people with mental illness. Compare that to 4.5 million non-supported housing units in Ontario. According to the 2006 census, if *all* these supportive housing units were squeezed into Toronto's four downtown wards, they would make up only about seven per cent of housing units.

Myth: We should have been consulted before supportive housing came to our neighbourhood.

Fact: Planning acts and zoning bylaws set out rules for public consultations for all new developments, including supportive housing. But some people think there should be extra consultations when people with mental illness are involved. However, the Ontario Human Rights Commission ruled in 2009 that people identified by the *Ontario Human Rights Code*, including people with mental illness, should not have to ask permission from prospective neighbours before moving into a neighbourhood. The Commission warns against “requiring additional public meetings, amendments to the planning process, lengthy approval processes or development moratoria” because the future residents are from *Code*-identified groups.

Myth: Supportive housing is too expensive.

Fact: You may have read Malcolm Gladwell's account in *The New Yorker* of “Million-Dollar Murray”—the homeless man who cost taxpayers millions of dollars in emergency and short-term care, yet remained homeless. The story is the same in Canada. For example, a 2008 study from the Centre for Applied Research in Mental Health and Addiction in British Columbia found that it cost an average of \$55,000 per year to keep a person homeless, or \$644.3 million across the province. The full cost of housing plus all supports is \$37,000 per year, a savings of \$211 million to B.C. taxpayers every year.

Here's another way to look at it: According to a 2004 report called *Supportive Housing Strategies for the Mentally Ill in Canada* by University of Guelph political science professor Judith McKenzie, it costs \$155 to \$250 per day to house a person in jail; \$380 in a psychiatric hospital; \$80 to \$185 in a detox centre; and \$60 to \$85 in a shelter. The total cost of a self-contained apartment—anywhere from \$14 to \$88 per day, depending on supports.

Myth: You'll just build it and leave—we're the ones who live here.

Fact: Supportive housing is typically owned and operated by non-profit organizations that are there for the life of the building. Staff are on-site regularly, caring for the building or supporting tenants. If you have a dispute with your supportive housing neighbour, work it out the same way you would with any other neighbour. If the issue involves a municipal bylaw, call the City's bylaw enforcement division. Spot a crime? Call 911. In other words, treat supportive housing tenants as you would expect your neighbours to treat you. ☒

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to read about one front-line worker's experience with NIMBY (not in my backyard).

"My place": Ethical differences between shelter, housing and home

Barbara Russell

Several years ago, I attended a mental health conference in Edmonton as a newly minted bioethicist. The provincial health minister participated in the opening session. He asked the audience, comprised primarily of community-based professionals, what they thought would most benefit people with mental health issues. I thought "more professionals" or "improved medications" would be the popular reply. Instead, people called for more and better housing.

Feminist philosopher Nel Noddings points out that answering the question "Where do you live?" can be accompanied by pride, contentment, ambivalence, apology or embarrassment. Underlying this range of reactions are often-overlooked ethical differences between shelter, housing and home.

To seek or offer shelter typically involves protection from harsh or dangerous forces, whether they are human (e.g., violence within intimate relationships) or climatic or environmental (e.g., the recent aluminum factory spill in Hungary). The goal is to help meet fundamental needs for physical or psychological safety. "Shelter" usually denotes rescue because it relates to urgent, unexpected situations. Since "rescuers" bear all or most of the costs, it has been acceptable if the amount of help is more minimal than maximal.

There isn't a legal duty for you to rescue me, someone you don't know. But do you have a moral duty? Those who shelter strangers think so. Shelter also tends to last only until the immediate danger passes or an alternative is arranged. In recent decades, however, publicly and philanthropically funded shelters have become larger and longer lasting because more and more people face barriers to sustainably meeting their needs for safety, food and warmth.

When a community wants to offer living spaces for long-term or permanent occupancy, "housing" is the commonly used word. Rather than just meeting basic needs, housing allows more activities of daily living to happen under one roof. Housing units make it possible to sleep, eat, bathe, do laundry, store belongings and entertain friends. Being housed also provides a person with an address, which facilitates activities of communal membership, for example, voting. The shelter's traditional moral duty of rescue is replaced by housing's reciprocal moral and legal (usually contractual) responsibilities between landlord and paying resident. Reciprocity means that power is shared more equally, which in turn means that dependence is replaced by interdependence. And interdependence is part of our inescapable human condition.

This excerpt from Robert Frost's poem "The Death of the Hired Man" portrays how home means more than shelter or housing; it includes place as an ethical concept:

"Home," he mocked gently.

"Yes, what else but home?"

It all depends on what you mean by home.

Of course he's nothing to us, any more

Than was the hound that came a stranger to us

Out of the woods, worn out upon the trail."

"Home is the place where, when you have to go there,
They have to take you in."

"I should have called it

Something you somehow haven't to deserve.

In their 1999 book *The Ethics of Homelessness*, Patricia Ann Murphy and David Schrader use this ethical concept of place. Although people and objects take up space, this is not the same as having a particularized space. Murphy describes place as "a space ... invested with human significance and understanding." If a person or object isn't in its place, they are missed or considered lost. When we create a place at our dinner table, we are expecting a particular person to join us. Designating a place for something or someone acknowledges having value.

Using one of Murphy's examples, recall the last time you walked up to a crowded elevator and the occupants reconfigured the space by standing more closely together. They created a place for you *with* them and to help serve your purpose. Feeling "out of place" is uncomfortable and we try to leave as soon as possible to go where we do belong.

Belonging isn't emphasized enough in our discussions about assisting people with mental health and addiction issues. Murphy worries that not having a place diminishes personhood because so much of our shared lives and conversations involve particular spaces, that is, places. Noddings is similarly concerned because home is "a place in which and from which one claims an identity."

Schrader emphasizes autonomy and privacy vis-a-vis home. In terms of autonomy, not having a home undermines development and exercise of our moral personality and civic personality. Homes and deep relationships typically go hand in hand, and home is a place where one influences who is permitted to enter, when, and what happens there. Having a place within a community carries mutual responsibilities: neighbourliness and participation in community-centred decisions. Yet membership also includes opportunities to withdraw from the communal sphere into the (relative) solitude and particularity of one's home. Privacy laws help guard this special space from others' unwanted, unilateral or excessive intervention.

Sheltering will always be needed because emergencies occur. Housing will always be needed because people need unified, more-than-minimal, long-term spaces for living. Having a place, rather than just a space, is not a solitary or independent activity. Instead, having a home is a shared activity. It involves the person, as well as other people who implicitly or explicitly acknowledge, honour and help preserve the meaning, value and possession of "my place." ☒

Do you have a **comment** or **question**
for ethicist Barbara Russell?

Visit the Ethics Matters blog at
www.camhcrosscurrents.net/blogs/ethicist
and have your say.



Depressed medical students more likely to self-stigmatize

Medical students are known to have higher rates of depression, suicidal thoughts and suicide than the general population; yet they are less likely to receive treatment despite presumably having better access to it. New research from the University of Michigan points to a possible explanation for this paradox, indicating that depressed medical students are more likely than their non-depressed peers to agree with statements stigmatizing depression. Researchers surveyed 769 medical students enrolled in the university's medical school. Participants were assessed for depression and were asked whether they agreed or disagreed with 27 statements about stigma and depression. The rate of moderate to severe depression among female participants was 18 per cent, compared with nine per cent among males. Suicidal thoughts were more frequently reported by third- and fourth-year students than by those in their first and second years (8% versus 1%). Students with moderate to severe depression were more likely than those with no to minimal depression to agree that, if they were depressed, other students and faculty would consider them unable to handle their responsibilities (83% versus 55%). They were also more likely to believe that fellow medical students would respect their opinions less (56% versus 24%). Male students were more likely than females to believe that depressed students represented a danger to their patients (36% versus 20%). Students with high depression scores were less inclined than those with low scores to say they would seek treatment for depression (47% versus 87%). In fact, between 70 and 80 per cent of them reported that they had never been diagnosed or treated for depression. According to the authors, these findings point to the need for new approaches "to reduce the stigma of depression and to enhance its prevention, detection, and treatment."

Journal of the American Medical Association, September 15, 2010, v. 304 (11): 1181–1190.
Thomas L. Schwenk et al., Department of Family Medicine, University of Michigan, Ann Arbor, Michigan.

Emphasizing neurobiology may not reduce stigma

The emphasis placed on the neurobiological basis of mental illness over the last two decades may be doing little to reduce stigma, according to researchers at Indiana University. The researchers interviewed almost 2,000 members of the public in 1996 and 2006. A neurobiological cause for schizophrenia was endorsed by 86 per cent of participants in 2006, up from 76 per cent in 1996. The comparable figures for depression were 54 per cent in 1996 and 67 per cent in 2006. Endorsement rates of a neurobiological cause for alcohol dependence rose from 38 per

cent in 1996 to 47 per cent in 2006. However, the belief that alcohol dependence was due to bad character also increased, from 49 per cent in 1996 to 65 per cent in 2006. The number of participants who endorsed medical treatment increased for all three conditions; however, it was only for schizophrenia that a majority endorsed hospitalization, increasing from 53 per cent in 1996 to 66 per cent in 2006. Despite these mostly positive trends, there were no significant decreases in stigma. In fact, there were sizeable increases in the number of participants who indicated that they would be reluctant to have a person with schizophrenia as a neighbour or have a person with alcohol

Mobile outreach helps sex workers access addiction treatment

A peer-led mobile outreach program increases the likelihood that sex workers who use drugs will enter addiction treatment, according to research from the University of British Columbia in Vancouver. Researchers interviewed 242 female sex workers at the beginning of the study and bi-annually over 18 months, resulting in a total of 479 reports. Over the course of the study, 42 per cent of the reports indicated that the respondent had used Vancouver's Mobile Access Project van (the "MAP van"), which operates overnight and is staffed by a driver, a support worker and a peer support worker. Women who used the MAP van were more likely to be at high risk: they were more likely to have had 10 or more clients in the previous week and to solicit clients in isolated settings such as alleys, side streets or industrial areas. A total of 45 reports indicated use of inpatient addiction treatment services (detoxification or residential drug treatment), while 161 reports indicated use of outpatient services (methadone or substance use counselling). Women who used the MAP van were more than four times as likely to access inpatient addiction treatment as women who did not use the MAP van. They were also six times more likely to use a substance use counsellor. The authors conclude that mobile outreach programs play a critical role in reaching sex workers "where and when they work," thus facilitating access to addiction treatment.

Drug and Alcohol Dependence, 2010, doi:10.1016/j.drugalcdep.2010.07.007. Kathleen N. Deering et al., School of Population and Public Health, University of British Columbia, Vancouver, British Columbia.

dependence marry into their family. There was a general increase in all stigmatizing attitudes related to schizophrenia. The authors suggest that efforts to reduce stigma may have to shift their focus to an emphasis on the abilities, competences and community integration of people with mental illness.

American Journal of Psychiatry, September 15, 2010 online, doi: 10.1176/appi.ajp.2010.09121743. Bernice A. Pescosolido et al., Schuessler Institute for Social Research, Indiana University, Bloomington, Indiana.

Conduct disorder linked to ADHD and adult substance use disorders

Research from the New York University School of Medicine indicates that adolescent attention-deficit/hyperactivity disorder (ADHD) increases the likelihood of substance use disorders in adulthood, with the relationship being mediated by conduct disorder. Researchers followed 485 individuals for almost 25 years, with two initial assessments at ages 14 and 16 and three outcome assessments between age 27 and 37. At the first two assessments, 12 per cent of adolescents were diagnosed with ADHD and an additional 12 per cent with conduct disorder. The three adult assessments determined that 11 per cent of participants had substance use disorders (SUDS). Participants who had adolescent ADHD were almost twice as likely as those who did not have ADHD to develop SUDs as adults, but this result was not statistically significant when conduct disorder was controlled for. Those who had adolescent conduct disorder were 3.5 times more likely than those without conduct disorder to develop adult SUDs, and this result remained significant when adolescent ADHD was controlled for. Given that adolescents with ADHD were almost 6.5 times more likely than those without to have a conduct disorder, the findings point to conduct disorder mediating the relationship between adolescent ADHD and adult SUDs.

Archives of Pediatrics and Adolescent Medicine, October 2010, v. 164(10): 930–934. David W. Brook et al., Department of Psychiatry, New York University School of Medicine, New York, New York.

Alcohol problems increase risk of early death

Researchers at the University of Munich have found more evidence that people with alcohol problems have an increased risk of early death. The researchers recruited 1,465 individuals in rural Bavaria over age 15 and tracked them for 20 years. Participants were initially assessed for alcohol problems using the Munich Alcoholism Test. Almost two per cent of participants were classified as having severe alcohol problems, while four per cent were deemed to have moderate alcohol problems. By the end of the study, 448 participants had died, including 11 of the 24 participants with severe alcohol problems, 21 of the 59 with moderate problems and 416 of the 1,382 with no alcohol problems. Participants with severe alcohol problems turned out to be 2.4 times more likely than those with no alcohol problems to die over the course of the study. Those with moderate problems were 1.5 times more likely to die, although this result was not statistically significant. The authors conclude that discussions of mortality risk for people with alcohol problems should consider the degree of the severity of alcohol problems, rather than focusing exclusively on severe alcoholism or severe alcohol consumption. They recommend further research to determine whether comparable results can be found in urban settings.

European Archives of Psychiatry and Clinical Neuroscience, September 13, 2010 online, doi:10.1007/s00406-010-0141-y. Manfred M. Fichter et al., Department of Psychiatry, University of Munich, Germany

Supervised injection facilities help drug users quit

Supervised injection facilities appear to promote increased use of addiction treatment, increasing the likelihood that individuals will stop injection drug use, according to research from St. Paul's Hospital in Vancouver, British Columbia. The study followed 902 people who visited a supervised injection facility in Vancouver between December 2003 and June 2006. After two years of enrolment in the study, 57 per cent of participants had entered injection treatment, and 23 per cent had stopped injection drug use for at least six months. Those who were regular facility users and those who had regular contact with addiction counsellors at the facility were more likely to have entered addiction treatment. Study participants who were engaged in sex work or who were Aboriginal were less likely to enter treatment. The authors note that the provision of a safe space for injection drug use is believed to draw a hidden population of injection drug users into health care settings, and that this may lead users to stop injection drug use. Commenting on the finding that Aboriginal participants were less likely to enter treatment, the authors conclude that there is a "need for innovative and culturally appropriate addiction treatment services developed with full consultation with Aboriginal people who use drugs."

Drug and Alcohol Dependence, August 30, 2010 online, doi:10.1016/j.drugalcdep.2010.07.023. Kora DeBeck et al., B.C. Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Vancouver, British Columbia.

research update

Cultural differences in hallucinations that accompany schizophrenia

The hallucinations experienced by people with schizophrenia vary considerably from culture to culture, according to research from the Medical University of Vienna. The study assessed the one-year prevalence of hallucinations in 1,080 individuals with schizophrenia from Austria, Poland, Lithuania, Georgia, Pakistan, Ghana and Nigeria. Auditory hallucinations were the most prevalent type in all countries, with the highest rates in Ghana and Nigeria (91% and 85%) and the lowest rate in Austria (67%). Visual hallucinations were most frequent in Ghana and Nigeria (54% and 51%) and least frequent in Pakistan (4%). Rates for the European countries ranged between 45 per cent for Poland and 10 per cent for Georgia (classified as European in this study). Cenesthetic hallucinations (relating to the overall sense a person has of their body, resulting from the functioning of their organs) were most frequent in Ghana, followed by the European countries. Hallucinations relating to the senses of smell and taste were most common in European countries. There were no significant country differences for tactile hallucinations. The authors hypothesize that the wide variation in rates of visual hallucinations results from "cultural differences in perceptual and attentional processing" between Westerners and East Asians and that the high rates in West Africa may have to do with a non-Western orientation toward the perceptual (concrete) rather than the conceptual (abstract) aspect of the environment.

Comprehensive Psychiatry, September 6, 2010 online, doi:10.1016/j.comppsy.2010.06.008. Susanne M. Bauer et al., Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria.

Giving hope a home

Supportive housing workers offer new lease on life

By Carolyn Morris

When I peek into Math Radfar's office, he's busy on the phone. As a supportive housing worker with Mainstay Housing, a non-profit agency that provides homes for people with mental health issues in Toronto, Radfar is often fielding calls. Every morning 10 to 20 messages await him at his east-end office. At the moment, he's talking with one tenant about a recent visit to the doctor.

After he gets off the phone, Radfar prepares me for our day together. He tells me about challenges tenants face—from keeping their apartments clean to having confidence about their place in the world and struggling with the impact of poverty. Radfar's days are often filled with simple but important tasks like helping a tenant complete a maintenance request. Other days are taken up by more urgent matters, such as conflicts between tenants and problems arising from substance use.

It's not an easy job. But it's an extremely important one. Supported housing allows people who have struggled to live on their own or who have only lived in institutional settings to gain independence and increase their quality of life. Residents of supported housing are less likely to be hospitalized because of a mental health issue and more likely to maintain permanent housing, a social determinant of health and key factor in recovery, Radfar explains.

Radfar's employer, Mainstay Housing, is Ontario's largest non-profit supported housing provider, with 867 units in 41 buildings and 15 supportive housing workers. These dedicated buildings for people with mental health and addiction issues are owned and managed by Mainstay, and are subsidized, with rent geared to income. The supportive housing workers are Mainstay employees, but tenant referrals and clinical support come from external agencies. Tenants who choose not to receive services from the referring agency are not evicted.

It's not long before Radfar and I set out to visit some of the 65 tenants he assists, spread across four buildings in East Toronto.

We've got a coffee group this afternoon at one of the buildings—in the trunk are bagels, cream cheese and milk that Radfar bought earlier today. But first, we're stopping by another building for a quick visit.

On the way, Radfar tells me about a feud between neighbours that preoccupies him. One tenant, Samuel*, has long accused his upstairs neighbour Mirko of intentionally making noise by throwing balls against his floor. Mirko denies it and denounces Samuel for buzzing up to his apartment constantly. They recently had an altercation when Mirko was passing by the building entrance and claims he found Samuel buzzing him. It got heated and one of them called the police. Radfar intervened, telling the men this has to end. Samuel sent a three-page response, accusing Radfar of bias.

When we arrive at our first destination, a low-rise apartment complex, Radfar grabs a poster to put up for an upcoming theatre performance at one of Mainstay's buildings called "Now Who's Crazy Now?" and an events calendar that announces community kitchens and movie nights. When we walk through the common room, we see remnants of this morning's Daily Bread Food Bank delivery—boxes of vegetables, ramen noodles and cans of beans. A committee of residents dispenses the shipment, but it seems there are leftovers today. The food program is a tenant-led initiative that Radfar, in his role as a community developer, facilitated and supported, as tenants figure out how to address hunger.

Radfar knocks at a door and Rita* a plump, middle-aged woman answers, carrying a mop. Her fridge broke over the weekend, and she's getting it fixed today. She had to clean up after it leaked.

"You've done a good job," Radfar tells Rita, inspecting the kitchen from the front door. "Where do you keep your food now?"

"I had to throw everything out," she answers.

"I'm sorry about that."

After we leave Rita, Radfar puts up his



Mainstay Housing provides various housing types, including high-rises, walk-ups and houses.

Home is where the health is

The Dream Team is a group of psychiatric consumers who advocate for more supportive housing in Ontario for people with mental health issues (www.thedreamteam.ca). They highlight various benefits of supportive housing:

- At least 30% of people living on the street experience mental illness.
- Research has demonstrated that satisfactory housing promotes community involvement for individuals with serious mental health issues.
- Supportive housing reduces hospital stays, emergency service use, landlord abuse and discrimination.
- More than 20 people can be maintained in supportive housing for the cost of one psychiatric hospital stay.
- The existence of supportive housing and community mental health services has been shown to reduce hospitalization by up to 80%.
- Hostels are 40%–50% more expensive per night than supportive housing.

posters, talks to the caretaker about heater repairs in one unit, and inquires about fridge repairs for Rita. Then we get back in the car and head east for our coffee group. When we arrive, we're greeted by a gregarious tenant, Balan, who speaks excitedly in a mix of English and Tamil, making him difficult to understand. But Radfar seems to, and he responds warmly, as he carries the shopping bag of goods to the common room.

While the coffee brews, we tour the building, knocking on the doors of people who usually come to the social gathering. "Some tenants don't come unless I knock," Radfar explains. Because many have little social connection—they often don't have jobs, aren't in school and don't see much of friends or family—an important job for supportive housing workers is to break the isolation and get tenants talking to one another.

Radfar knocks on a door and a stout woman opens it, dropping her toothbrush in the process. The woman, Ursula, laughs and says hi before picking it up. Behind her are stacks of boxes—two in the living room and one in the hallway in front of her bedroom. Radfar chats with Ursula for a few minutes, then says he's concerned about the tower of boxes in front of her room.

"I'm going to move them," she replies, "I just have to get to it." She's been busy cleaning up and still has to unpack after they sprayed the place for bed bugs—another major challenge in housing.

"I'm not worried about the boxes in the living room, but these ones are blocking the access to your room," says Radfar.

They spend a few minutes debating whether the pile impedes access, but Radfar is

adamant it be moved and says he'll come back later in the week to make sure it's been done.

"Come to the coffee group now, and do that later," he says.

The visit, which was intended as a simple invitation to coffee but became an informal inspection, shows the delicate balance that supportive housing workers must strike between supporting tenants and being agents of the landlord. They enforce building rules, sometimes proceeding to the Ontario Landlord and Tenant Board when all efforts to resolve the problem have failed. Sometimes the outcome is an eviction.

To create some distance, these workers are not supposed to be a tenant's primary support or case worker; their role is to help tenants access community resources and supports, provide education about tenancy rights and responsibilities and support tenants in developing community activities for their buildings. But Radfar admits it's a difficult balance.

Ferreshteh Bahmani, another Mainstay supportive housing worker I spend time with, sees tenants in only one building. But it doesn't mean her day is static.

When we meet, Bahmani tells me about Lorena, a woman in her 70s whose hoarding is a major problem. Bahmani explains that for the most part, tenants can do what they want in their apartments, but when it becomes a danger to others, in this case a fire hazard, she must step in. A few months ago, Lorena's apartment became so cluttered that she wasn't able to use her bathroom. Bahmani and a colleague discovered that Lorena was using washrooms of local businesses because she



couldn't access her own. Eventually, Lorena had to be admitted as an inpatient to the Centre for Addiction and Mental Health.

During the month that Lorena was gone, Bahmani had her unit cleared of clutter. Lorena's story is a prime example of that delicate balance between helping and enforcing rules. "Lorena was happy when she came back," says Bahmani, "but she has started [hoarding] again."

While Bahmani and I talk in her office, a man in his early 30s arrives. Sanjay is here to check out an apartment. He had been a tenant, but left when his apartment became infested with bed bugs. Bahmani tells Sanjay that bed bugs are still a problem in the building. Mainstay offers free spraying, but it involves a lot of preparation on the tenant's part. Sanjay nods. He's been staying at a shelter and wants a place to call his own again.

When Sanjay's caseworker arrives, we go with them to view the room. It's a small bachelor with white walls and a large window, renting for \$139 per month. "Your own privacy, your own keys in your pocket," says his caseworker. "If you're not taking it, I am!"

"I want it," says Sanjay.

As we walk back down the hall, Bahmani notices a large piece of plywood propped up outside an apartment, with sketches of a female figure across the front. Hanging over the top is a picture ripped out of a newspaper that depicts a woman's face writhing in pain. It's about depression.

Bahmani knocks on the door. "Emma?" she says, and repeats the name until the door opens and a petite woman appears, smoking a cigarette, her hair messy, feet bare, her gaze distant.

"You left something outside," says Bahmani. Tenants aren't supposed to leave anything in the hallway.

The woman stumbles out to look at her artwork. "That's me," she announces in a loud, slurred voice. "That's me!"

Bahmani quietly asks Emma to go back in her unit with the cigarette (not allowed in the hallway either) and starts helping her through her apartment, which is strewn with litter and broken glass.

"You're going to cut your feet," she warns Emma.

Bahmani gets Emma to sit down and says she will fetch her supportive housing worker. Emma is part of Streets to Homes, a City of Toronto initiative based on a housing first

model that secures permanent housing for people who have been homeless. Emma was likely living on the streets for more than a decade. Twenty Streets to Homes tenants live in the building and receive on-site, intense support from two Mainstay supportive housing workers.

Some of these tenants, like Emma, struggle with substance use issues, Bahmani says. Being drug-free is not a requirement for living in Mainstay housing. The agency takes a harm-reduction approach and believes that substance use problems are best addressed once stable housing has been secured, what is known as the housing first approach.

Emma's worker ends up calling for an ambulance when she notices that Emma is short of breath. The paramedics escort Emma, who is screaming, on a stretcher.

As we settle back into Bahmani's office, several tenants stop by to remind her of the movie night in a few hours. One young woman, Nadja, comes in to chat, and tells me how much she is looking forward to Mainstay's annual seasonal party.

After Nadja leaves for her volunteer work, Bahmani tells me that she has benefited from the independence that supported housing cultivates and has forged ties with the community. Since Nadja has lived in Mainstay housing, she has felt more stable and has reconnected with her parents, from whom she had long been estranged. She is also an active member of the building's gardening committee and wants to form a group for tenants who want to stop smoking—initiatives that Mainstay encourages as tenants strive to create a better quality of life.

Back at Radfar's coffee group, Samuel, Balan, Ursula and a few others are enjoying bagels and coffee. The conversations range from what family members are doing to one tenant's college studies and another's memories of playing music in a band.

After a hectic day, it's nice to enjoy this conviviality. Radfar and Bahmani spend much of their time helping tenants resolve various issues, but they see recovery at the core of everything they do: "When you see many of our tenants now, you know that housing is stability," says Radfar. "Having a stable place matters." ☞

*All tenant names have been changed

Resources for navigating the housing maze

Beyond the Key to the Front Door: A Guide to Helping Tenants Keep Their Homes is a workshop offered by Mainstay Housing, Toronto's oldest and largest supported housing provider. It teaches service providers how to help clients overcome the challenges of independent living and prevent homelessness. The free participant guide can be downloaded from www.mainstayhousing.ca. Search by title under "Publications & Resources."

The **Homeless Hub** is a Canadian clearinghouse for homelessness research that provides resources about housing and people with mental health and substance use issues. www.homelesshub.ca

Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia, developed in 2007 by the Centre for Applied Research in Mental Health and Addiction, describes the scope of the problem and recommends solutions. Do a title search at www.health.gov.bc.ca

Resources Exist for Networking and Training, a network of housing workers funded through the federal Supporting Communities Partnership Initiative, provides training workshops that focus on specific client populations, income supports, landlord/tenant issues, mental health and addictions and immigration and refugee issues. RENT also offers networking sessions, practical resources and an online discussion forum. www.housingworkers.ca

Shelter from the storm

Barrier-free women's housing offers healing spaces, safe places

By Amanda Dale

Before she ran one of Canada's most innovative housing projects, Sarah Warren used to walk through her neighbourhood in Vancouver's Downtown Eastside and wonder, "Why are all these women on the streets? They are so obviously mentally ill. Surely it can't be that hard to get them a home!" Now, as manager of one of the country's few low-barrier housing programs for women, she can say with authority, it really isn't that difficult.

Four years into her job at The Vivian, a transitional housing program for women run by RainCity Housing, Warren remains confident. Stemming the tide of intergenerational violence, homelessness and addiction that especially haunts Aboriginal women, The Vivian is an innovative solution to the problems that are so persistent in Canada's most famous down-and-out neighbourhood.

The Vivian doesn't impose standards or unrealistic expectations for women struggling to stay off the street. Warren and her staff take a refreshing approach in an increasingly professionalized sector: "On my first day, I just walked in and introduced myself," says Warren. "It is still my neighbourhood. These are still my neighbours! I assumed that my openness would help women begin to trust. It's pretty simple, really."

It's a simple approach to a profound need: "Most housing for low-income women comes with moral guidelines that the most marginalized can't meet in order to sustain housing," says Warren. "As a society, we're taking a basic need [housing]—a right, actually—and imposing all kinds of conditions on it."

The Vivian is a modest but tidy street-front three-storey building that stands out in a sea of rundown rooming houses. A specialist in creating accessible housing for multi-barriered tenants, RainCity operates the building, which features 24 rooms, single occupancy and communal washrooms, laundry and kitchen facilities. The average stay is two years.

Where many service providers see the women as difficult, Warren points out that the women see their *lives* as difficult. In this neighbourhood, a largely Aboriginal population constitutes the forgotten casualties of poverty, violence, residential school abuses and bleak futures, famously preyed on by serial killer Robert Picton. Basic safety and daily survival preoccupy the women who live here. Survival sex trade work and severe mental health issues are common, and many women use drugs to cope with unbearable memories and desperate present-day realities.

The Vivian goes out of its way to work with women "where they are at," says Warren. "Expecting women who are surviving through these means to suddenly give all that up for a bed is unrealistic, and it means they stay homeless."

The only rule at The Vivian is no drug use in common spaces, so women who are trying to stop can have a clean environment. "We are adamant about harm reduction and increased safety," says Warren. Harm reduction means that clean needles, safe kits and condoms are always available. "Women tell us later that they were nervous to be seen taking the supplies when they first came," says Warren. "They are so used to being judged." But at The Vivian, non-judgment does not mean neglect, as new resident Amber* explains: "The staff check on me and I feel safe."

Against this backdrop of safety, women's strengths emerge: "Carla, one of the first women I met had walked around for three years on a severely broken foot," Warren recalls. "She refused to access medical services because of the way she was treated. She preferred extreme pain to the indignity of how she was treated. Naturally, because of the pain, her drug use skyrocketed." With the support of Vivian staff, Carla was able to address her addiction and get proper medical attention. Her foot had to be amputated, but it didn't stop Carla, who went on to get her own apartment and reconnect with family.



The Vivian is the first minimal barrier housing program in Vancouver for women with complex needs.

For women like Carla, reconnecting with family and community is healing. But for others, reconnecting would plunge them back into abuse and devastation. This makes The Vivian a true home, where compassion and opportunity replace judgment and abuse. "We have a movie night and it reminds me of being at home and being warm," says long-time resident Donna. "I can walk around in my pyjamas and just be myself and relax."

It's a simple pleasure that Warren doesn't take for granted: "We offer hope and community; we don't demand the impossible." ☐☐

*all resident names have been changed

Waiting on the welcome mat

How to be at home with trauma-informed care

By Richard Bebout

Nearly 10 years ago I articulated an argument for why service providers working in the supportive housing arena need to become “trauma informed.” The vast majority of men and women in mental health and substance abuse services have been exposed to traumatic violence. Whether violent victimization began in the childhood home, institutional settings like jail and hospital, or in shelter, on the streets, or in other precarious living arrangements, housing situations have the potential to evoke familiar trauma dynamics or, even worse, to set the stage for literal reenactments.

Power and control in supervised living arrangements, for example, may reactivate feelings of vulnerability and powerlessness, and of having no choice and no voice. When staff control access to housing resources, or even literally control the front door because a resident does not have keys or the legal protections of a lease, real or perceived threats of housing loss can recall childhood or later interpersonal violence situations and the very real sense of having “no escape.”

Beyond minimizing the risk that supportive housing situations might replicate old dynamics associated with traumatic violence, delivering support services in people’s homes also presents unique opportunities to observe behaviour patterns that are linked to past experiences of violence. Rather than construing these behaviours as “symptoms” or purely “problems,” staff should understand them as the best coping strategies available to the survivor. Self-injury, obsessive-compulsive behaviours, the use of drugs and alcohol for managing common trauma sequelae such as hyper-vigilance, sleep difficulties, intrusive memories or numbing and dissociation—all of these may announce themselves more readily during in-home contacts than at structured, office-based appointments.

This does not mean that all housing specialists need to be experts in treating acute PTSD-related symptoms. It does mean, however, that front-line staff can and should be educated about common trauma impacts through trauma training, for instance.

Even landlords, housing quality inspectors, property managers and repair staff or vendors should be sensitized to the importance of scheduling visits, calling ahead and knocking to gain entry, rather than simply letting themselves into someone’s apartment. The person may be heavily medicated or in a dissociative state, or may have an exaggerated startle reaction or aggressive, self-protective response triggered by an intrusion. Well-trained front-line staff are more likely to respond helpfully by emphasizing what’s healthy and adaptive and by relabeling problem behaviours like substance use, self-harm or recurrent relationship problems as possible examples of trauma-related coping strategies that were once the only things that worked for a survivor, despite the obvious fact that they now have increasingly costly adverse effects.

Likewise, trauma-informed housing support staff understand and reframe key skill deficits as expectable occurrences in the wake of life-long traumatic violence. A shift then becomes possible, so that the housing specialist is not merely cautioning someone about violations of the “guest policy” in their program or lease agreement or about drug and alcohol infractions, but instead seeks to engage a tenant in an ongoing dialogue that frames his or her struggles with managing boundaries, setting limits or appropriate self-protection as a common part of trauma recovery.

Trauma-informed housing specialists might use in-home contacts to develop and monitor a housing-focused Wellness Recovery Action Plan, which encourages individuals to identify, practice, evaluate and refine their use of coping tools and resources available to them in their homes. Such a toolkit should include strategies for self-soothing, emotional modulation and health promotion that can be easily and safely accessed at home. It should include things one can do alone as well as things that might require the help of others, such as a trusted neighbour who is included in and aware of key plan elements. Home should be designed to support and facilitate use of such a plan. For one person, this might mean having his favourite comfort foods on hand. For another, it might mean rediscovering the restorative joy of a hot shower or bath enjoyed in privacy and safety not available to her for years.

My earlier writing about trauma-informed housing support focused on specialized residential treatment settings. However, today’s prevailing models for linking housing and supports emphasize reliance on ordinary housing with flexible, voluntary supports with the rise of the housing first approach. This strategy removes prerequisites such as documented “clean time” and contingent demands for adherence to a standard set of requirements such as anti-psychotic medication or a fixed schedule of individual and group therapies. In the United States, permanent supported housing is now recognized as an evidence-based practice and has been codified in the form of a toolkit published recently by the Substance Abuse and Mental Health Services Administration. The *Permanent Supportive Housing: Knowledge Informing Transformation* guide includes a tool that programs can use to assess their adherence to core principles and practices, as well as training modules for consumer-tenants and front-line staff. (Search for the title at <http://homeless.samhsa.gov>.)

In order to avoid doing harm and inadvertently retraumatizing individuals, workers providing supports in housing settings and seeking to adopt universal trauma precautions would do well to borrow from the toolkit. “House Call Do’s & Don’ts,” for example, implores workers to call ahead, to be transparent about the purpose

of the home visit, to offer and honour meaningful choices wherever possible. Indeed, there is considerable concordance between the core values manifested by trauma-informed systems of care and the guiding principles that frame the permanent supported housing (PSH) approach. (See sidebar for practice recommendations linked to principles drawn from the trauma-informed and PSH literature).

Most importantly, housing staff who are trauma-informed are committed to safe and trustworthy avenues that create opportunities for meaningful choice, active collaboration and recovery-oriented skill building. Effective housing support staff work with tenants to develop an accurate housing history and shared understanding of the issues that have led to housing loss or that have threatened housing tenure in the past. Someone who has lived with chaos and violence throughout life may know only too well that “bad things happen to me” and has a fragmented narrative explanation of why things have happened in the past. Treating the person as “the expert” and a full partner in the development of both an accurate housing history and a customized housing support plan—these are the ordinary, life-size activities that promote recovery, resuscitate hope and help individuals find their voice. ☒

Richard Bebout is associate director for housing at Community Connections in Washington, D.C.



Tips for trauma-informed housing support

Trauma-informed care principles and values	Guiding principles of permanent supportive housing	Trauma-informed supportive housing practices
Safety	Access to safe, decent and affordable housing and privacy	- Encourage tenants to look at neighbourhoods and buildings where rental housing is available with an eye to safety, including lighting, and access to transportation, grocery stores and other essential community resources. - Expect behaviours ranging from a lack of awareness of basic safety practices like locking doors and windows to heightened concern about safety threats such as others leaving outside doors unlatched, loud noise within the building or from the street.
Trustworthiness	Functional separation of housing and services	- Differentiate roles of property managers, landlords (rent collection, housing quality inspections) from roles of service providers (advocate, educate). - Develop written, transparent guidelines (e.g., tenant selection procedures, program requirements, if any, beyond basic responsibilities of tenancy) and stick to them. - Educate front-line providers on “house call do’s and don’ts,” e.g., calling ahead, acting like a guest in someone’s home, respecting privacy.
Choice	Choice in housing, living arrangements	- Help prospective tenants to articulate preferences regarding where and with whom they want to live. - Encourage tenants to personalize their space. - Provide tenants with furniture vouchers where possible and opportunities to shop for furnishings or even to select their own upholstery rather than letting program managers make all the decisions.
Collaboration	Flexible, voluntary and recovery-focused services	- Eliminate arbitrary or universal participation requirements. - Mandate only home visits and ordinary obligations of tenancy (timely payment of rent, no dangerous or illegal activity). - Enlist tenants in identifying wanted, needed services, and recognize that making services attractive and relevant is a provider responsibility.
Empowerment	Community integration and rights of tenancy	- Educate consumers on roles, responsibilities of tenancy. - Develop a brief crisis plan or full Wellness Recovery Action Plan (WRAP) tailored to new housing realities. Identify and recruit support from neighbours and networks; optimizing personal space to develop and practice self-care, self-soothing, wellness. - Support the formation of peer leadership in the form of tenant councils in clustered housing. - Promote participation in tenant and neighbourhood association meetings.

Out of place

A rural perspective on housing barriers

By Ned Morgan

Pierre Cormier was stuck. The 27-year-old, who has experienced mental health issues since he was 14, found himself jobless, homeless and trapped in a rural area outside Moncton, NB. “I didn’t own a vehicle; I had no money. It was almost impossible to get into town,” says Cormier. That meant he was increasingly isolated and cut him off from job hunting and the mental health centre where he could see his counsellor. When he could, he slept on friends’ or acquaintances’ couches or floors. “I would have a spot to stay, but then there would be conflicts and I’d be stuck looking around for weeks,” says Cormier.

Cormier struggled to find stability. Sometimes he found himself outside all night, walking on lonely, unlit roads. “My buddies wouldn’t answer the door, so I would try to find a 24-hour restaurant and buy a toast and coffee. But that four dollars was supposed to last until the end of the week.” As with most rural and remote communities, there was no emergency shelter he could turn to.

Cormier’s story highlights the unique challenges of rural homelessness. Although homelessness is widely viewed as an urban problem, people in rural and remote communities also experience both literal homelessness and precarious housing situations. Rural areas have a profound lack of services and supported housing options for people with mental health and addiction issues and the transportation infrastructure required to access needed supports. Small communities don’t provide the anonymity of big cities, so homeless people are “known,” and many have burned their bridges with landlords.

Despite these unique barriers and needs, research on supported housing overwhelmingly focuses on urban settings. One study that may draw more attention to small communities is led by Phyllis Montgomery of the School of Nursing at Laurentian University in Sudbury, Ont. The study findings about supported housing for people with serious mental illness in rural and northern communities will be published in 2011. The technical advance to the two-year study identified challenges to implementing supported housing in northern and rural communities, including small or non-existent housing

markets, aging demographic trends, rural poverty, poor-quality housing, lack of mental health care services, lack of a continuum of housing services and economic and labour force changes. It also identified the recovery possibilities associated with adequate material and financial resources, especially in a local context of access, choice and co-ordinated services.

It is these challenges and possibilities that Brent Baker sees daily as manager of the supported housing program for the Muskoka–Parry Sound Community Mental Health Service. Baker sees a lot of homelessness in a region better known for its multimillion-dollar cottages.

In addition to co-ordinating support and rent subsidies for

individuals with mental illness, Baker advocates for attainable housing. “We need to create bricks-and-mortar with services to help maintain safe and healthy living environments,” he says. “Rents are going up. The cost of living is going up. Many of our clients may never recover to the point where they can work full time. If you’re a landlord, are you going to

rent to somebody with mental health or addiction problems?”

It is difficult to gauge the extent of the problem in rural Ontario. “There is no transitional housing, no shelters, here at all,” says Baker. “The problem is not visible like it is in Toronto. People aren’t sleeping on the streets. They’re sleeping in the bush or couch surfing or sleeping in abandoned hunt camps, so ‘homeless’ as a visual is much different than in an urban centre.”

While looking for ways to jumpstart attainable housing projects, Baker and his colleagues find themselves hamstrung because his employer, considered a government agency, cannot hold a mortgage. “If we want to create attainable housing and end homelessness, the responsibility falls on the provincial government to change policies and structures that impede the process,” says Baker.

At present, the agency can afford to subsidize just 42 people. “If we don’t get more money to provide subsidies, we may have to back off on how many people we service,” says Baker. He stresses that even though he sees the situation in Muskoka–Parry Sound as a crisis, he

Rural areas have a profound lack of services and supported housing options for people with mental health and addiction issues and the transportation infrastructure required to access needed supports.

doesn't want to sound negative. "I wouldn't be doing this job if I thought it was all doom and gloom, but the focus needs to be on the reality. This is a political issue, not a social service front-line issue. This is a policy development, funding issue at the provincial and federal levels. I know governments are putting money out there, but it's not enough."

Elsewhere in Canada, agencies are partnering with government to find long-term solutions. The region of west-central Manitoba known as Parkland is famed for its lakes and forest reserves. It is also the site of an integrated housing project undertaken by the provincial and federal governments and the local branch of the Canadian Mental Health Association (CMHA). Dubbed ECHO (Emergency Community Housing Opportunity), the recently completed project provides emergency, transitional and long-term affordable housing in the small towns of Swan River and Dauphin.

Regional director of CMHA Parkland Marvin Fried says that ECHO has more applicants than available units. The new units are mostly studios or one-bedrooms because, as Fried points out, "a lot of our clients are single. If they have mental health issues, quite often they are alone and to live with someone else is a challenge."

ECHO employs a housing manager on-site to offer one-on-one support. "We try to connect our clients into the community as well," Fried explains. "If they have addiction issues, we try to connect them with an addiction worker or we'll have a breakfast meeting and bring in a speaker to talk about life skills."

"ECHO is sustainable," Fried adds. "We have a mortgage on our properties and the rents go towards maintaining them. We are a non-profit organization, but we are still trying to run it as viable business so we don't have to rely too much on government funding."

Williams Lake is a town of about 10,700 in the rugged interior of British Columbia. In summer 2010, the province and the local CMHA branch opened Jubilee Place, a renovated former motel with integrated support services. Jubilee Place is similar to the ECHO project in that most of the 33 units are single occupancy. BC Housing outreach worker Wayne Lucier works with the CMHA in and around Williams Lake, offering his clients counselling and help with landlords and budgeting and trying to work closely with their mental health workers.

Despite the new units, the homeless population still overflows the available accommodation. "In the winter, what usually happens is that the Cariboo Friendship Centre puts mats down on the floor," says Lucier. "Our homeless population has gotten bigger in the five years I started doing this, but our town is still small enough that people have a heart and will take somebody in if they have to."

Back on the East Coast, Pierre Cormier has made progress in his quest for a stable home. Early in 2010, he got an apartment in Moncton through the At Home/Chez Soi project of the Mental Health Commission of Canada, which takes a housing first approach—provide stable housing, then help clients address underlying issues.

Cormier reflects on the end of his homelessness. "Having my own home is a breakthrough for me; having someone to keep an eye on me and ask, 'How are you?' and 'How can we help you?' I had lived in an awful, awful setting for the past year and was totally depleted of any positive energy. Getting this one-bedroom apartment was enough for me to start building again." ☐

Resources about rural housing and homelessness

The Homeless Hub

www.homelesshub.ca

This Canadian clearinghouse of homelessness research includes studies from around the world about rural housing and homelessness, including ones that focus on aboriginal people, women, families and children. Do a keyword search on "rural homelessness" or "rural housing."

Pathways Into and Out of Homelessness in Small B.C. Communities

www.cmha.bc.ca

This 2007 study by the Canadian Mental Health Association—BC Division involved interviews with clients and landlords involved in its Homeless/Income Outreach Project about their perspectives on best practices in outreach. Do a keyword search on the title.

You Just Blink and It Can Happen: A Study of Women's Homelessness North of 60

<http://ywcacanada.ca>

Published in 2007, this first report on women's homelessness in Canada's North was prepared for a coalition of women's groups in Nunavut, the Northwest Territories and the Yukon. Do a keyword search on the title.



Far from home

Opening the door to ethnic diversity

By Avril Roberts

Shahla has been trying to find a home for her daughter for four years. The 27-year-old needs round-the-clock mental health support, but Toronto-area group homes have been unable to accommodate her. “They all say they’re not a good match, and they’re right,” says Shahla. “We need a place that respects her culture and her needs.”

Shahla’s daughter was born in Iran. Her first language is Farsi, but “when she is depressed, it is hard for her to express herself in a second language,” says Shahla. “How can she live in a group home when she cannot speak to her roommates or where the caregiver doesn’t know what she wants?”

Housing that respects cultural expression through food, music and events and that reflects cultural norms such as gender segregation is rare. “These things add to the enjoyment of life and, like everyone else, people with mental illness need some motivation to enjoy their lives,” says Shahla.

Shahla and seven or eight other Iranian families are eager to create a group home for their children, but their struggles have led some families to take their children back to Iran, rather than see them languishing in their adopted home.

Shahla’s story illustrates the unique housing challenges that people from ethnic minority and racialized groups face. Strikingly, in an era of multiculturalism and ethnic diversity, there is little attention to whether ethnic or cultural affiliation is related to housing preferences in location or configuration of housing and support services.

One small but determined group is trying to change that. The Supportive Housing and Diversity Group (SHAD) is a partnership of seven Toronto agencies established in 2002 to improve housing stability and reduce homelessness for

ethnoracial clients with mental health and addiction issues. Funded by the Canada Mortgage and Housing Corporation, the group in 2008 released *Home for All*, a toolkit that presents a model of anti-oppressive, culturally competent supportive housing and offers best practice recommendations.

Community agencies attest to the need. “Families with children who develop mental health issues encounter incredible problems because they don’t know how to navigate the system,” says Carolina Gajardo, manager of the North York Housing Help Centre at COSTI Immigrant Services in Toronto. “Some families don’t have a clue that supportive housing exists as an option.”

Another barrier to appropriate housing was expressed by one participant in a SHAD focus group that was part of the study: “Very few people from my community are living in supportive housing—not because they don’t need it, but because of the stigma. It’s degrading for them and they don’t want to reach out. People prefer to live with family, relatives.”

Immigration status poses another challenge. Sponsored immigrants are ineligible for social services during their first 10 years in Canada and have to rely on family. “People stay trapped in situations that are abusive and causing mental health issues and stress,” says Sajedeh Zahraei, community support research and development specialist at the Centre for Addiction and Mental Health in Toronto and chair of SHAD.

The co-ordinated access intake form for supportive housing in Toronto is in English, which is not the primary language of many people on the waiting list, notes Deqa Farah, a mental health promoter with Community Resource Connections Toronto, which is part of the SHAD group.

When supportive housing is available, it is often not culturally appropriate. “Our case managers struggle to accommodate clients’ cultural practices,” says Farah. “Because there is such a lack of housing units, people are encouraged to take whatever they can get. They don’t have many options.”

Lack of family units can be a deterrent. “In some cultures, healing happens through family involvement, but most supportive housing programs don’t accommodate families,” says Gajardo.

Racism, discrimination and stereotyping prevail. One focus group participant, a South Asian man, recalled his experience: “When I asked to be transferred [to another home], they told me, ‘We can’t offer you the Taj Mahal.’” He was upset that the supportive housing worker didn’t realize that the Taj Mahal is a burial place, not a palace.

“Supportive housing is supposed to help people get well,” says Farah, “so when somebody chooses homelessness rather than a roof over their head, it tells you that their needs are not being addressed, and if people’s issues aren’t addressed, they’re not going to recover.”

SHAD hopes to tackle these issues system-wide, armed with its toolkit, which identifies four key principles for creating housing that is culturally competent and anti-oppressive: voice and choice; integrating family and community; community development, partnership, co-ordination, education and advocacy; and holistic support. It organizes the best practice

recommendations into four categories: housing, support, agency and system. These examples illustrate how the best practice principles intersect with the recommendations relating to housing and support:

Location and neighbourhood. Choice in whether or not to live in neighbourhoods close to other members of their ethnic community and institutions and resources such as religious institutions and community organizations.

Housing models. Flexibility in housing options: regular housing dispersed throughout communities, fewer segregated buildings dedicated to supportive housing, market-rent housing with subsidies, family-only buildings, housing supports that enable people to live with relatives in the family home.

Housing quality, structure and design. Variety: smaller group homes to help avoid institutional feel and stigma, multi-roomed units to accommodate larger families, space allocated for spiritual practices and for family and community socializing.

Support services. Support and therapy offered in mother-tongue languages. Tenants linked to culturally relevant community events, activities, programs and services. If a service user wants to move, give them information about alternatives.

Holistic support. Diverse religious and spiritual care services provided in the building or made accessible through partnerships with religious and spiritual care providers in the community. Alternative and traditional medical remedies offered on site.

The next steps for SHAD include disseminating the toolkit, partnering with supportive housing providers to use the toolkit as a training manual for front-line workers and management, and working with organizations that serve ethnoracial communities to improve awareness of and access to supportive housing. Zahraei says the group is seeking funding to pilot a culturally competent and anti-oppressive supportive housing model that can serve as a best practice model.

Gajardo sees a need for champions from within the supportive housing provider community. “We need people in that sector to understand that in our changing society, many people who develop mental health problems are going to come from ethnically diverse communities. These are the people we will serve, so we need to embrace them.”

The SHAD toolkit, *Home for All: What Supportive Housing Agencies Can Do to Be Anti-Oppressive and Culturally Competent*, as well as the literature review and background document, are available from the CAMH Knowledge Exchange at www.knowledgex.camh.net. 

An anti-oppression approach to ending homelessness

The Toronto site of At Home/Chez Soi, a four-year national project about mental health and homelessness, includes a focus on the housing needs of people from racialized communities.

About 30 per cent of homeless individuals in Toronto are immigrants and 10 per cent have lived in Canada for less than 10 years. Racism, discrimination and stigma are barriers that can make their health and economic problems worse. The project, run by the Mental Health Commission of Canada, is evaluating an anti-oppression service model that recognizes the impacts of racism and inequality on mental health and is designed to empower people on their journey to healing.

As part of At Home, Across Boundaries, a community-based ethnoracial mental health centre, is providing housing and support to 100 homeless people with mental health issues. Program manager Sulekha Jama says, “Housing is a basic right.

We’re not saying you must be in treatment, must take your medication, or behave in a certain way to get housing and support. We offer people choices: Where do you want to live? What issues do you want to work on?” The housing is in private buildings and comes with intensive case management.

Of the people Across Boundaries has enrolled so far, some have gone back to school and some are volunteering. Many who have been estranged from their families are working on reconnecting with them. Others have been hospitalized for mental health crises but have returned to their housing.

Jama’s hope is that “at the end of the study, we can prove that people do better when they’re given options and have more freedom to work on other issues when they have a safe place to live.”

Room to grow: Meeting the housing needs of homeless youth

By Ned Morgan

Calgary was the first city in Canada to develop a 10-year plan to end homelessness, so it's no surprise that it is leading the way in addressing youth homelessness. One core goal of Calgary's 10-year plan is to improve housing opportunities and services for youth and to address the mental health, addiction treatment and physical health needs of homeless and at-risk youth. *CrossCurrents* interviewed Tim Richter, president and CEO of the Calgary Homeless Foundation, which is leading the action.

What motivated Calgary to act on youth homelessness?

In the early 2000s, Calgary homelessness statistics began to shoot upward. Between 2002 and 2006, the number of homeless youth aged 13 to 17 jumped by a shocking 80 per cent, and 56 per cent among youth aged 18 to 24. After hearing about the effectiveness of 10-year plans in the United States, a group of corporate, government and community leaders formed the Calgary Committee to End Homelessness in 2007. One year later, the group released the 10-year plan and brought the Calgary Homeless Foundation on board to implement it.

Why are youth considered part of the "hidden homeless" population?

"Some young people I've spoken with don't see themselves as homeless," says Richter. "Rather, they're 'street kids,' or they see their lives on their own or with peers without a permanent home as 'normal,' especially those who grew up in foster homes and have never really had the housing stability to know what's 'normal.'" Many others actively avoid agencies or mainstream systems like police and child welfare, making it harder to find them. Some youth use adult shelters, remain "hidden" inside a homeless family, or run away from an abusive or unsafe family home and thus lie beyond the reach of government statistics. "These young people aren't considered homeless by government, since they technically have a home to go back to," says Richter.

What unique barriers to housing do homeless youth face?

Government can be a barrier, says Richter. "This is a sort of double-edged sword," he explains. "On one hand, the government does a pretty good job of caring for many vulnerable youth, and if their resources and responses were properly utilized, government could be a lifesaver for homeless kids."

But some youth get lost in what Richter calls the "Byzantine and complex networks of large systems." "We in the community need to respond to the needs of youth who fall through the gaps; we can't stand by and accept that these gaps exist and let government off the hook," says Richter. "If charities continue to step in where government steps out of or ignores its responsibilities, we only perpetuate the problems that create youth homelessness. Communities have an important role in making it clear to the public and to government where youth are falling through the cracks."

Why is youth homelessness poorly understood?

The main problem is a lack of data and understanding of the issues youth face, says Richter. "A few years ago, we set out with agencies in the community to create a pilot housing program for youth. We quickly found out that the young people coming into the program had mental health and addiction issues much more severe and complex than anyone had imagined. The program we created ended up failing because it was not set up to support young people with such deep needs." This program's failure led to a renewed focus on housing first programs, with supports designed to address the complex mental health and addiction treatment needs of homeless youth.

How does a housing first approach help homeless youth?

The Calgary Homeless Foundation is running two youth-focused housing first programs, one with the Boys and Girls Club of Calgary and one with Wood's Homes, a mental health treatment centre. "Both of these projects have successfully housed and supported young people with complex needs and have achieved a minimum 85 per cent housing retention rate," says Richter. He has

seen the success of the approach first hand: The Calgary Homeless Foundation has recently hired a graduate of the Boys and Girls Club Infinity Project, an initiative to reduce homelessness through skills and knowledge, to work as a youth homelessness advisor.

Calgary's 10-year plan pledges to work with government and youth agencies to create youth housing opportunities, including the development of 250 family and youth emergency shelter beds, 100 transitional housing beds for youth and 100 foster care discharge housing opportunities.

How has Calgary's 10-Year Plan to End Homelessness fared so far?

As of the end of September 2010, more than 1,900 men, women and children in Calgary have been housed, and more than 2,000 units of affordable housing have been funded. "That's more than in the entire preceding decade combined," says Richter. He adds: "Emergency shelter use has been going down now for more than a year, a reversal of a trend that saw shelter use growing between 10 and 20 per cent every year since the mid-1990s—quite a significant turnaround."

How do you see the situation in Calgary compared to the rest of the country?

"I don't think Calgary is very different from the rest of the country," says Richter. "Everything we need to know to end homelessness is being done somewhere. The trick is for all of us to share what we are learning and not be afraid to shamelessly steal what's working!"

Setting the Course: A Blueprint to End Youth Homelessness in Calgary, as well as other reports about the supported housing needs of youth, are available from the Calgary Homeless Foundation at www.calgaryhomeless.com.

Homeless souls

Addiction as adaptation to psychosocial dislocation

It's been two years since Bruce Alexander's *The Globalization of Addiction* first appeared. The release of the paperback version is a good time to reflect on the book and its impact. It has been praised in diverse quarters, including making it onto the British Medical Association's Books of the Year list for 2009.

The book is not a new foray in this territory, but the summary of a lifetime of scholarly work that has been at odds with conventional addiction theory and science. Over the past two decades, advances in neuroscience have encouraged the belief that addiction can be fully understood and addressed as a disease that occurs in the brains of particular vulnerable people, making the biological sciences the primary domain for understanding and addressing addictive behaviours.

It is against that growing orthodoxy that Alexander has been working for some time. In this book, he pulls it all together in an account that is at once compelling and rigorously scholarly. Without endnotes and references, the text drops from more than 450 pages to under 300. (I say this to encourage anyone who might feel intimidated by the size of the tome to pick it up.) From the revealing excavation of the word "addiction" to his theory of dislocation, Alexander shows that some of the most telling insights into addiction come from the ancient world. Augustine and Socrates show the reader that our current social concerns are, if worse, still similar.

At its nub, Alexander's argument can be presented in a few blunt brush strokes, which he does well. He defines addiction as "overwhelming involvement in any pursuit whatsoever ... that is harmful to the addicted person and his or her society." These pursuits, drugs or gambling or whatever, are not themselves the causes of addiction. For Alexander, addiction is an adaptive response to dislocation—the loss of (or failure to achieve) psychosocial integration. Dislocation includes but is more than the displacement that immigrants, refugees or the colonized experience, which he vividly illustrates using the history of his hometown of Vancouver.

Alexander views psychosocial integration as the goal of human development, both personal and societal. The more people, individually and collectively, are unable to establish an existential sense of wholeness and community, the greater the likelihood that they will recourse to addictive behaviour. Addiction is a way of adapting to the homelessness of the human spirit that dislocation produces.

Alexander shows that our age is particularly vulnerable to addiction and other pathologies because the prevailing economic order undermines psychosocial integration more than any other social structure to date. Because globalizing free-market forces produce mass dislocation as part of normal functioning, Alexander sees this as an age of "unprecedented, worldwide collapse of psychosocial integration." Addiction is not just the problem of the disadvantaged and the destitute; it affects even more perversely those who have wealth and resources; dislocation is "the general condition."

Addictions become the tiny baskets into which more and more people put all their eggs in search of compensation for lives without psychosocial integration. For Alexander, addiction occurs along a continuum, and is not the only manifestation of dislocation. He mentions other pathologies of modern life—depression, apathy, anxiety, self-harm and violence, for example. In building his case, Alexander acknowledges that while dislocation is a necessary condition, it alone is insufficient to "cause" addiction. This turns us back to the need to have a fully integrated bio-psycho-social-spiritual view of these problems. In contributing to that comprehensive model, Alexander points out what we're up against and where we need to look for solutions. Not a bad testament to a lifetime of work.

The Globalization of Addiction: A Study in Poverty of the Spirit.
Bruce Alexander. Oxford University Press, Oxford, UK, 2010,
488 pp., \$42.95.

Wayne Skinner is deputy clinical director of the Addictions Program at the Centre for Addiction and Mental Health in Toronto.

books in brief

Mad and Divine: Spirit and Psyche in the Modern World

Sudhir Kakar. University of Chicago Press, Chicago, Illinois, 2009

Drawing on his Eastern and Western backgrounds, psychoanalyst Sudhi Kakar shows how the gulf that divides native healer from Western psychiatrist can be spanned.

The Therapeutic Relationship: Transference, Countertransference and the Making of Meaning

Jan Wiener. Texas A & M University Press, College Station, Texas, 2010

Informed by philosophy, infant development, neuroscience and the arts, therapist and Jungian scholar Jan Wiener lays the groundwork for the development of a more contemporary Jungian approach to working with transference and countertransference dynamics.

Understanding Suicide: Why We Don't and How We Might

James R. Rogers and David Lester. Hogrefe, Cambridge, Massachusetts, 2010

This book highlights theoretical and methodological challenges that plague the field of suicidology. It recommends what researchers and theorists can do to advance our understanding of suicide and suicide prevention.

Can housing first work if there isn't enough affordable housing?

Stephen Gaetz

In recent years, “housing first” has emerged as a key response to homelessness in North America. With its growing popularity in Canada comes increasing interest in how the approach works, different program models and its effectiveness for specific populations. One key factor that undoubtedly shapes the success of any housing first program is the nature and supply of affordable housing.

The basic underlying principle of housing first, pioneered by Sam Tsembaris at the Pathways to Housing project in New York in the 1990s, is that people do better moving forward with their lives if they are first housed. This is as true for homeless people and those with mental health and addiction issues as it is for anyone. According to Pathways to Housing, “The Housing First model is simple: provide housing first, and then combine that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment.” This approach differs from what has been (and arguably still is) the orthodoxy of our Canadian response to homelessness; in that “treatment first” approach, people who are homeless should be placed in emergency services until they are “ready” for housing (having received access to health care or treatment) or until housing is available.

Research quite convincingly demonstrates the general effectiveness of housing first over treatment first. In a 2000 study, Tsembaris and Eisenberg demonstrated that 90 per cent of people in the Pathways program remained housed five years later. A growing body of research shows that people with mental health and addiction issues do very well with a housing first approach, spend fewer days in hospital and are cheaper to support. (To see the research, visit www.homelesshub.ca/housingfirst.)

Housing first is most effective when, first, people are rehoused rapidly, minimizing time spent on emergency services. Because resources are scarce, priority should

be given to high-needs clients, including families and those with mental health and addiction challenges. Second, ongoing and appropriate support must be provided for those who need them (and many don't). Those with addiction issues should have access to harm reduction-based housing, if that is what they prefer. Finally, where possible, clients should have input into the kind and location of their housing. While providing shelter and supports is central to housing first, the approach works best when it helps people nurture supportive relationships and become meaningfully engaged in their communities.

As housing first grows in popularity, it is applied in new ways and in different contexts. One challenge of implementing the approach is the ability to deliver appropriate housing support in the context of a housing shortage. I have often wondered what would have happened if the City of Toronto had attempted to implement its Streets to Homes program in the late 1990s, when rental vacancy rates were routinely below one per cent, compared to the last five years, when vacancy rates have hovered between three and four per cent.

In a tight rental market, one of the first things to go is the notion of consumer choice. One criticism of housing first is that people are often given housing in remote areas of town, far removed from services, poorly served by transit, and where people struggle to connect. Women fleeing violence may be placed in neighbourhoods that are not safe. The outcome is often isolation, continued marginalization and a compromised ability to access necessary services and supports. In the long run, this can undermine stability and security of tenure.

Different approaches to housing first take on the challenge of affordable housing supply in distinct ways. In Montreal, all levels of government working with the non-profit sector have sought to address the supply problem with an ongoing investment in

social housing, with pathways to that housing for people who are homeless. The Streets to Homes program in Toronto relies almost exclusively on the private market, and rather than use rent subsidies, it has developed a system to fast track people so they can access other government benefits and supports. With a waiting list of more than 75,000 for social housing and with modest targets for expanding its affordable housing supply (up to 1,000 new units annually—though these targets are not being met), Toronto relies on the private rental market, making its housing first program vulnerable if the affordable housing supply shrinks.

In Calgary, the affordable housing supply has shrunk drastically over the past 10 years, while rents have skyrocketed. In rolling out its housing first model, the Calgary Homeless Foundation takes a systems approach, coupling its adaption of housing first with an investment in affordable housing (3,000 units built over the past three years) and with rent supports for people living—or choosing to live—in the private rental market.

The best approach to housing first, then, is to treat it not as a program or service tied to an agency, but rather, as part of a broader and more strategic response to homelessness; one that focuses on prevention by ensuring an investment in an affordable housing supply, and by requiring other sectors (mental health and corrections come to mind) to play their part in diverting people from homelessness through more effective discharge planning strategies. It is only by ensuring a sufficient supply of affordable housing that one of the central tenets of housing first—consumer choice—is protected.

Stephen Gaetz is the associate dean of research and professional development in the Faculty of Education at York University in Toronto, and founder of the Homeless Hub, a Canadian clearinghouse for homelessness research (www.homelesshub.ca).

Would you like to have your say in this debate?

Share your thoughts on our Last Word blog at www.camhcrosscurrents.net



CANADA

Lost in Translation: Addiction Research Conference

February 15–17, Vancouver, British Columbia
tel 604 806-8306
fax 604 806-8210
e-mail ichan@mail.cheos.ubc.ca
www.cheos.ubc.ca

Society for Research on Nicotine and Tobacco Conference Annual Meeting

February 16–19, Toronto, Ontario
Contact: SRNT, 2424 American Lane,
Madison, WI 53704 USA
tel 608 443-2462, ext. 145
fax 608 443-2474
e-mail info@srnt.org
www.srnt.org/conferences/index.cfm

Harm Reduction Canada 2011

February 23–25, Ottawa, Ontario
tel 705 749-6145
e-mail gt@cast-canada.ca
http://cast-canada.ca/HR2011-Main.html

5th Annual 5th Annual Quality Worklife-Quality Healthcare Collaborative Summit

March 2–3, Mississauga, Ontario
Contact: QWQHC Secretariat, 1150 Cyrville Rd.,
Ottawa, ON K1J 7S9
toll-free 1 800 814-7769, ext. 362
tel 613 738-3800, ext. 362
fax 613 738-7755
e-mail information@qwqhc.ca
www.qwqhc.ca

4th International Conference on Fetal Alcohol Spectrum Disorder

March 2–5, Vancouver, British Columbia
Contact: UBC Interprofessional Continuing
Education, 2194 Health Sciences Mall, Rm. 105,
Vancouver, BC V6T 1Z3
tel 604 822-0054
toll-free 1 877 328-7744
e-mail ipad@interchange.ubc.ca
www.interprofessional.ubc.ca/FASD.htm

International Conference on Men and Masculinities

March 9–11, Quebec City, Quebec
Contact: Centre de recherche interdisciplinaire
sur la violence familiale et la violence faite aux
femmes, Pavillon Charles-De Koninck, 1030,
avenue des Sciences-Humaines, Local 0453-A,
Université Laval, Laval, QC G1V 0A6
tel 418 656-2131, ext. 6516
fax 418 656-3309
e-mail francois-olivier.bernard@criviff.ulaval.ca
www.criviff.qc.ca/masculinites_societe

26th International Conference of Alzheimer's Disease International

March 26–29, Toronto, Ontario
Contact: ADI 2011, c/o MCI UK Ltd.,
Durford Mill, Petersfield, Hampshire GU31 5AZ
United Kingdom
tel 44 0 870 458 4171
e-mail adi2011@mci-group.com
www adi2011.org

Society for Research in Child Development Biennial Meeting

March 31–April 2, Montreal, Quebec
Contact: SRCD, 2950 S. State St., Ste. 401,
Ann Arbor, MI 48104 USA
tel 734 926-0612
e-mail biennialmeeting@srcd.org
www.srcd.org

All Our Sisters 1st National Conference on Women and Homelessness

May 9–11, London, Ontario
tel 519 652-0364
fax 519 652-5015
e-mail hreid@innovcc.ca
www.alloursisters.ca

Violence Against Women International Conference

May 29–June 1, Montreal, Quebec
e-mail conferenceviolence@esersoc.umontreal.ca
www.conferenceviolence.com

Canadian Psychological Association 72nd Annual Convention

June 2–4, Toronto, Ontario
Contact: CPA, 141 Laurier Ave. W., Ste. 702,
Ottawa, Ontario K1P 5J3
tel 613 237-2144, ext. 323
toll-free 1 888 472-0657
fax 613 237-1674
e-mail convention@cpa.ca
www.cpa.ca/convention

National Healthcare Leadership Conference

June 6–7, Whistler, British Columbia
Contact: Canadian College of Health
Service Executives,
tel 613 235-7218
toll-free 1 800 363-9056, ext. 37
e-mail loman@cchse.org
www.healthcareleadershipconference.ca

Canadian Association for Suicide Prevention National Conference

October 3–5, Toronto, Ontario
Contact: UBC Interprofessional Continuing
Education, 2194 Health Sciences Mall, Rm. 105,
Vancouver, BC V6T 1Z3
tel 604 822-7524
e-mail ipad@interchange.ubc.ca
www.caspp2011.ca

Canadian Psychiatric Association 61st Annual Conference

October 13–16, Vancouver, British Columbia
Contact: CPA, 141 Laurier Ave. W., Ste. 701,
Ottawa, ON K1P 5J3
tel 613 234-2815
fax 613 234-9857
e-mail conference@cpa-apc.org
www.cpa-apc.org

American Academy of Child and Adolescent Psychiatry 58th Annual Meeting

October 18–23, Toronto, Ontario
Contact: AACAP, 3615 Wisconsin Ave. N.W.,
Washington, DC 20016-3007 USA
tel 202 966-7300
fax 202 966-2891
e-mail meetings@aacap.org
www.aacap.org

UNITED STATES

American Psychological Association Rehabilitation Psychology Conference

February 25–27, Jacksonville, Florida
Contact: Tricia Kirkhart, Department of
Physical Medicine and Rehabilitation,
Johns Hopkins University, Phipps Room 174,
600 N. Wolfe St. Baltimore, MD 21287
tel 410 502-4453
fax 410 502-2419
e-mail pkirkha1@jhmi.edu
www.div22.org

American Group Psychotherapy Association Annual Meeting

February 28–March 5, New York, New York
Contact: AGPA, 25 East 21st St., 6th fl.,
New York, NY 10010
tel 212 477-2677
e-mail info@agpa.org
www.agpa.org/mtgs

36th Annual Association for Women in Psychology Conference

March 3–6, Philadelphia, Pennsylvania
tel 610 436-2925
e-mail lhyers@wvcupa.edu
www.awpsych.org

American Society for Clinical Pharmacology and Therapeutics 112th Annual Meeting

March 3–6, Dallas, Texas
Contact: ASCPT, 528 N. Washington St.,
Alexandria, VA 22314
tel 703 836-6981
e-mail info@ascpt.org
www.ascpt.org

American Association for Geriatric Psychiatry 24th Annual Meeting

March 18–21, San Antonio, Texas
Contact: AAGP, 7910 Woodmont Ave.,
Ste. 1050, Bethesda, MD 20814-3004
tel 301 654-7850
e-mail meetinginfo@AAGPonline.org
www.aagpmeeting.org

24th Annual Children's Mental Health Research and Policy Conference

March 20–23, Tampa, Florida
tel 919 219-2342
fax 240 387-6141
e-mail scott@bcinnovations.com
http://cmhtampaconference.usf.edu/

American Counseling Association Annual Convention

March 25–27, New Orleans, Louisiana
Contact: ACA, 5999 Stevenson Ave.,
Alexandria, VA 22304
tel 607-662-4451, ext. 296
e-mail rhayes@counseling.org
www.counseling.org/Convention/

International Society of Psychiatric-Mental Health Nurses 13th Annual Conference

March 29–April 2, Tucson, Arizona
Contact: ISPN, 2424 American Lane,
Madison, WI 53704-3102
tel 608 443-2463
fax 608 443-2474 or 2478
e-mail conferences@ispn-psych.org
www.ispn-psych.org

International Conference on Eating Disorders

April 28–30, Miami, Florida
Contact: Academy for Eating Disorders, 111
Deer Lake Rd., Ste. 100, Deerfield, IL 60015
tel 847 498-4274
fax 847 480-9282
e-mail info@aedweb.org
www.aedweb.org

Society of Biological Psychiatry 66th Annual Meeting

May 12–14, San Francisco, California
tel 904 953-2842
fax 904 953-7117
e-mail maggie@mayo.edu
www.sobp.org

American Psychiatric Association 164th Annual Meeting

May 14–18, Honolulu, Hawaii
Contact: APA, 1000 Wilson Blvd., Ste. 1825,
Arlington, VA 22209-3901
tel 703 907-7300
e-mail apa@psych.org
www.psych.org/annualmeeting

American Psychological Association 119th Annual Convention

August 7–10, San Diego, California
tel 202 336-6020
e-mail convention@apa.org
www.apa.org/convention/index.aspx

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4th World Congress on Women's Mental Health

March 16–19, 2011, Madrid, Spain
Contact: TILES A OPC, Londres 17,
28028 Madrid, Spain
tel 34 91 361 2600
e-mail info@iawmh2011.com
www.iawmh2011.com

6th International Drugs and Young People Conference

May 2–4, Melbourne, Australia
Contact: Waldron Smith Management
tel 61 3 9645 6311
e-mail alison@wsrm.com.au
www.adf.org.au

World Federation of Societies of Biological Psychiatry 10th World Congress

May 29–June 2, Prague, Czech Republic
Contact: WFSBP, Zum Ehrenhain 34,
22885 Barsbüttel, Germany
tel 49 40 670 882 90
fax 49 40 670 882 91
e-mail info@wfsbp.org
www.wfsbp-congress.org/home.html

World Council for Psychotherapy 6th World Congress

August 24–28, Sydney, Australia
Contact: WCP 2011 Congress Managers,
c/o Arinex Pty Ltd., GPO Box 128,
2001 Sydney, NSW, Australia
tel 61 2 9265 0700
fax 61 2 9267 5443
e-mail wcp2011@arinex.com.au
www.wcp2011.org

World Psychiatric Association 15th World Congress

September 18–22, Buenos Aires, Argentina
Contact: MCI Buenos Aires,
Avenida Santa Fe 1970, 1º Piso, Oficina 1,
C1123AAO Buenos Aires, Argentina
tel 54 11 5252 9801
wpa-argentina2011@mci-group.com

International Association for Suicide Prevention 26th World Congress

September 13–17, Beijing, China
e-mail office@iasp.info
www.iasp.info/congresses.php

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