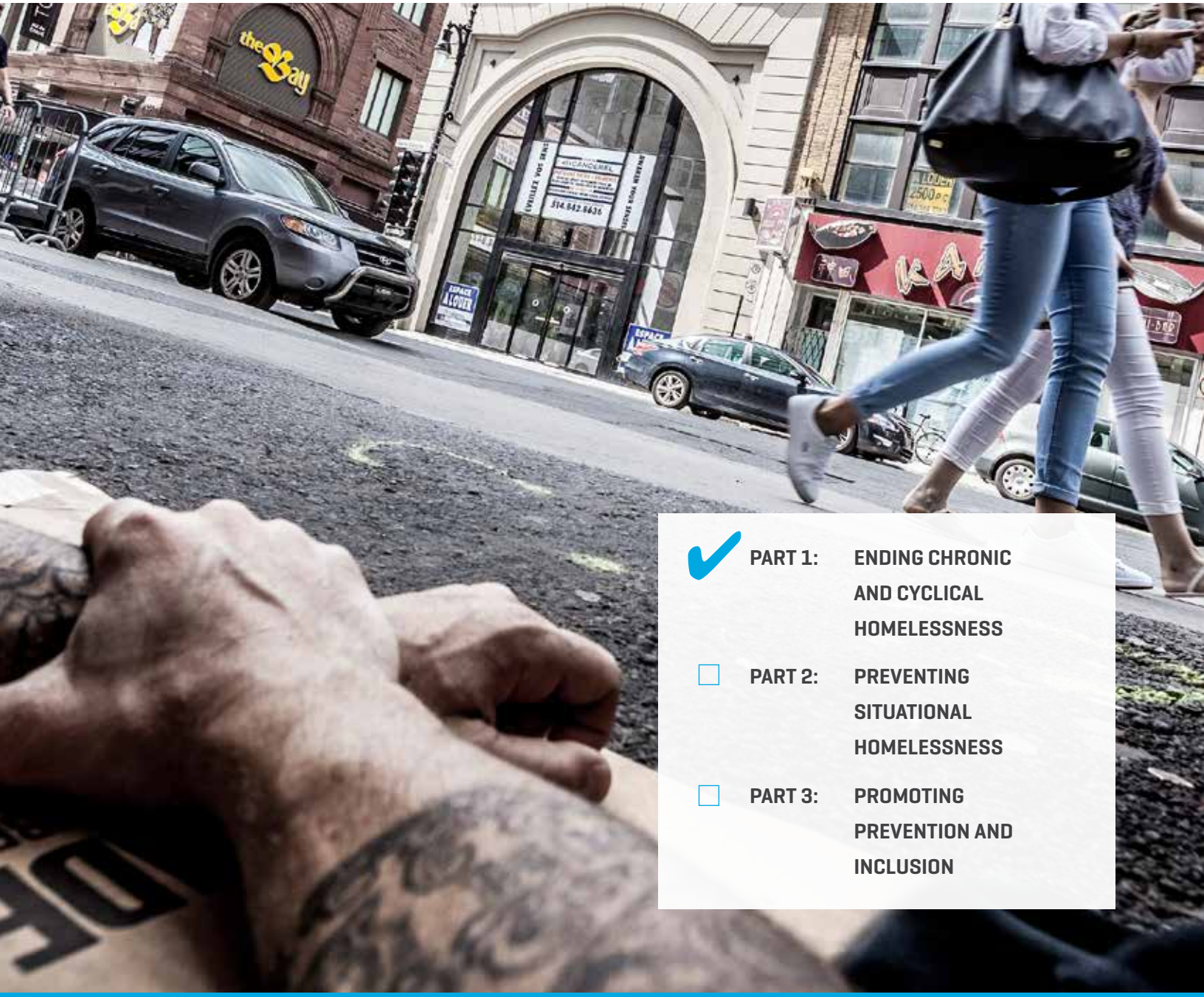
ENDING HOMELESSNESS IN MONTREAL

OBJECTIVE 2020 – ENDING CHRONIC AND CYCLICAL HOMELESSNESS



- ✔ **PART 1: ENDING CHRONIC AND CYCLICAL HOMELESSNESS**
- ☐ **PART 2: PREVENTING SITUATIONAL HOMELESSNESS**
- ☐ **PART 3: PROMOTING PREVENTION AND INCLUSION**

MMFIM
Mouvement pour mettre fin à l'itinérance à Montréal

Montreal, December 2015

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CREDIT ROBERT GAUTHIER, JE COMPTE MTL.

SUMMARY

This plan details an initiative of the Mouvement pour mettre fin à l'itinérance à Montréal (MMFIM) to help 2,000 men and women in Montreal exit chronic and cyclical homelessness over the next five years. Provincial and municipal plans have not specifically targeted this very vulnerable population which has frequent recourse to emergency services (ambulances, hospitals, police, municipal courts, shelters, etc.).

The goal of the MMFIM, a broad network of partners from the Montreal community, is to overcome homelessness as we know it today. The MMFIM proposes better coordination of existing resources, relevant data collection and implementing best practices, including access to permanent affordable housing combined with support services.

The MMFIM departs from the traditional palliative approach to homelessness, proposing instead that services be geared to cure and prevention; its proposal is based on the experiences of cities in Europe, Canada and the United States. The Mouvement is interested in proven models that not only help people exit the street but help them lead satisfactory lives.

To achieve this goal we propose to equip and specialize certain community organizations and establish close links between them and the health network. We estimate that at the end of the first five years 1,500 men and women will still be housed, supported and installed in their community by the specialized community network while 500 will have become autonomous and will live with or without support from the regular system.

VISION 2020

In five years the specialized community network will have welcomed, oriented, supported and housed 2,000 men and women who are currently chronically or cyclically homeless and settled them in the communities of their choice. Some will find work or other worthwhile activities. Some will live in adapted housing.

The network itself will have consolidated its expertise and its organization. It will provide statistical reports on its results and an independent assessment. It will have deployed some 70 community case managers with unique and acknowledged expertise in the field.

The specialized community network will have an ongoing capacity of 1,500 individuals; some will leave (autonomy regained, transferred, dropped out, died or institutionalized) allowing others to arrive, ensuring that they avoid homelessness.

Assisting 2,000 of the least healthy and most at-risk people to leave the street cannot happen without investing. The MMFIM estimates the costs of such an operation over five years (annual inflation at 2%) to be $36.8 million, including $18.8 million in new funds but not including $19.5 million of federal funds ending in 2019 plus an estimated $5 million for 2020.

These costs will be offset by a reduction in the use of emergency services such as hospital and psychiatric services. The investments proposed will lead to savings of some $28 million in value of unused resources, freeing up different kinds of resources such as emergency shelters, temporary housing and psychiatric care units. They should also reduce the pressure on shared public spaces and simplify the operations of public agencies (transit and police) and community organizations.

Table 1: Summary

People off the street	2016	2017	2018	2019	2020	Five years
1. Specialized network (including HSS)	200	600	900	1,200	1,500	
2. Autonomous	—	100	300	400	500	
Support for individuals* (Actions 1, 2, 3)	$1,600 K	$3,262 K	$4,286 K	$5,746 K	$7,238 K	$22,131 K
Rent supplements* (Action 4)	$476 K	$1,435 K	$2,523 K	$4,044 K	$5,625 K	$14,105 K
Implementation (Actions 5, 6)	$140 K	$140 K	$140 K	$140 K	$140 K	$700 K
Total	**$2,216 K**	**$4,837 K**	**$6,949 K**	**$9,930 K**	**$13,003 K**	$36,936 K
Existing appropriations	($1,276 K)	($2,235 K)	($3,323 K)	($4,844 K)	($6,425 K)	($18,105 K)
New funding	**$940 K**	**$2,602 K**	**$3,627 K**	**$5,086 K**	**$6,578 K**	**$18,831 K**

* Costs do not include federal contributions under HPS.

Even when housed, many of these individuals will remain vulnerable and will experience recurring problems, which is why a permanent system providing variable supports according to their needs is necessary. But they will no longer be homeless, and will be better equipped to claim their place in the community.

TABLE DES MATIÈRES

TABLEAUX

ACRONYMS

ACT – Assertive Community Treatment

CHUM – Centre hospitalier de l'Université de Montréal [University of Montreal hospital centre]

CIUSSS – Centre intégré universitaire de santé et de services sociaux [Integrated University Health and Social Services Centre]

DHSS – Department of Health and Social Services

FEANTSA - Fédération Européenne des Associations Nationales Travaillant avec les Sans-Abri

HIFIS - Homeless Individuals and Families Information System

HPS – Homelessness Partnering Strategy

HSS – Housing Stability with Support

ICM – Intensive Case Management

MMFIM – Mouvement pour mettre fin à l'itinérance [Movement to end homelessness]

NHIS – National Homelessness Information System

OBM – Old Brewery Mission

OMHM – Office municipal d'habitation de Montréal [Montreal Public Housing Authority]

PREM - Plans régionaux d'effectifs médicaux [Regional medical staffing plans]

RSP – Rent Supplement Program

SHDM – Société d'habitation et de développement de Montréal [Montreal Housing and Development Authority]

SPVM – Service de police de Montréal [Montreal Police Department]

STM – Société de transport de Montréal [Montreal Transit Authority]

INTRODUCTION

The members of the Mouvement pour mettre fin à l'itinérance à Montréal (MMFIM) come from business, institutions, research centres and community organizations. We want to work together to overcome homelessness as we know it in Montreal.

We share the values of **respect**, **humanism** and **solidarity**, and we seek actions that will result in **sustainable change**. We have three strategic goals:

- prevent homelessness before it begins
- help people break the cycle of homelessness
- help people find their way back into society and communities

Individual wellbeing is central to our action. We focus primarily on housing and helping people remain housed. We will be able to measure our success in terms of concrete results.

Our first objective was to count the homeless in Montreal. This was done on 24 March 2015 and the City of Montreal has published the report of the consortium – which included several MMFIM members – that carried out the count.

This paper proposes an operational vision to the Montreal community, showing how structured approaches could reduce or even eliminate homelessness, using best practices and producing measurable and assessable outcomes.

It draws inspiration from action plans that have been implemented in Canada, the United States, the Netherlands, France, Norway, Denmark and Finland, as well as from the work of the Canadian Alliance to End Homelessness.

This action plan is intended to supplement Quebec's Politique nationale de lutte à l'itinérance [National Policy to Fight Homelessness] and Plan d'action interministériel en itinérance 2015-2020 [2015-2020 Interdepartmental Action Plan on Homelessness] and Montreal's 2014-2017 Action Plan on Homelessness.

Our complete plan will be in three parts, each with specific actions and statistics. Our first Action Plan targets chronic and cyclical homelessness, which affects the most vulnerable people, often found in great distress in public places.

The MMFIM hopes to broaden the discussion and attract support from other organizations, governments and concerned Montrealers for a shared, practical vision aimed at ending homelessness as we know it.

CHAPTER 1: HOMELESSNESS IN MONTREAL

DEFINITIONS

Quebec's National Policy to Fight Homelessness defines "homelessness" as:

> *[...] a process of social disaffiliation and a situation of social rupture evidenced by a person's difficulty in having a stable, safe, adequate and healthy home due to the low availability of housing or that person's inability to remain in one, and at the same time by the difficulty of maintaining functioning, stable and safe relationships in the community. Homelessness can be due to a combination of social and individual factors in the backgrounds of men and women.*

Although rich in meaning, this definition is less useful from an operational perspective. The Canadian definition of homelessness deals more directly with how people are housed:

> *Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioral or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing. (The Canadian Homelessness Research Network).*

The Montreal count on 24 March 2015 used the criteria of the Canadian classification of homelessness.

Table 2. The Canadian classification of homelessness

Unsheltered	Emergency sheltered	Provisionally accommodated	
Visible homeless			Hidden homeless
1.1 In public or private spaces without consent or contract	**2.1** In emergency overnight shelters for the homeless	**3.1** In interim housing for the homeless	**3.2** Living temporarily with others, but without guarantee of continued residence
1.2 In places not intended for permanent human habitation	**2.2** In shelters for individuals/ families impacted by family violence	**3.4** In institutional care, lacking permanent housing **3.5** Accommodation/ reception centres for recently arrived immigrants and refugees	**3.3** In temporary and short-term rental accommodations

In Quebec, as in several other provinces, we generally identify three types of homelessness:

- **situational**, refers to people who are temporarily without housing but who manage to find homes after being unsheltered for some time;
- **cyclical**,[1] refers to people who alternate between a home and the street;
- **chronic**, refers to people who have not had a home for a long time; this is the most visible type of homelessness, which, although less frequent than situational homelessness, generates a large number of interventions and substantial social costs.
  (Gouvernement du Québec, National Policy to Fight Homelessness, 2014, p. 31)

The hidden homeless, i.e. people living temporarily in various unknown locations, are also considered significant. Some agencies say that there is as much hidden homelessness as visible homelessness, if not more so. Raising the Roof estimates that four out of every five homeless people are not actually on the street.[2]

Lastly, there is the category of people "at risk of homelessness" because they face a combination of problems that could lead them to homelessness. With poverty, illness and addiction being the most frequent causes of homelessness, thousands of people are thus at risk.

A BETTER UNDERSTANDING OF THE PEOPLE WHO NEED HELP

There have been only two studies on the number of homeless in Montreal in 20 years (1998 and 2015). Although they do not use comparable methodologies, there are similarities between the numbers of chronically homeless people encountered in one night in 2015 and those determined by Fournier in 1998.

Fournier 1997-1998

In 1998 researcher Louise Fournier and her colleagues estimated that there were 12,666 homeless people in Montreal over the course of a year (Louise Fournier, pp. 9-10). According to several studies (Gaetz SOHC 2014; Aubry et al.), up to 5% of the total number of homeless in any given year is chronically so. Of the 12,666 individuals counted by Louise Fournier over the year, we can estimate that some 633 were chronically homeless.

I Count MTL 2015

The first street count (commissioned by the City of Montreal) took place in March 2015. 3,016 homeless people were encountered in one night, of which 784 were defined as being chronically homeless, using a more stringent definition of chronicity than that of Canada or the United States (1 year or 4 episodes in 3 years). I Count MTL also identified 1,241 people as being cyclically (episodically) homeless on the night of 24 March 2015.

The methodology used to determine the number of homeless people on that night is comparable to that used in other Canadian cities, Toronto in particular, but there are two significant differences in the Montreal count: day centres and soup kitchens were surveyed on March 25 and 26, and data was collected from a wide array of institutions and organizations in the months that followed. Those methodological improvements led to a much more exhaustive count of the homeless. In addition, a total of 1,514 questionnaires were completed rendering quite an accurate portrait of the homeless population.

[1] Also called "episodic" in some documents.

[2] http://www.raisingtheroof.org/our-programs/hidden-homeless-campaign.aspx


CREDIT TEMA STAUFFER

Findings

On 24 March 2015, 3,016 people were identified as being homeless in Montreal. This figure did not include the hidden homeless (staying with others or in hotels or motels with no fixed addresses or in rooming houses). Many people who are homeless one day may not necessarily be homeless some other day, which is the case of the situationally or cyclically homeless.

- Of the 3,016 people counted, 429 had spent the night outside, 1,066 were in shelters, 1,041 in transitional housing and 480 were elsewhere (76 in hospitals, 51 in detention centres, 154 in Montreal therapy centres, 199 in therapy centres outside of Montreal).
- About a quarter (784) of the 3,016 people had been chronically homeless for 4 years or more. Almost half (1,357) were cyclically homeless, having been homeless at least twice in the past three years.
- Nearly a quarter (24%) of the people who had been identified as homeless in those places were women. The proportions vary according to the place where they were found, with 54% in transitional housing and only 7% unsheltered.
- Immigrants represent 16% of the sample, with women counting for 39% of this group. They were much more likely to have children under 18 with them.
- Aboriginals make up 10% of the sample, although they comprise only 0.6% of the total Montreal population. The Inuit represent 40% of this group, although they make up only 10% of Montreal's Aboriginal population.
- Two main reasons were given for the most recent transition into homelessness: financial problems and drug or alcohol dependency. Among women and immigrants, violence and abuse were more likely causes of homelessness than alcohol or drugs.
- The age breakdown is varied, and older people – mainly men – were more likely to be in the street or in shelters.

CHAPTER 2:
PLANS FROM HERE AND ELSEWHERE

According to the Canadian Alliance to End Homelessness (CAEH), some 240 communities throughout North America have coordinated plans to greatly reduce homelessness. Most member countries of the European Union also have such plans.

CANADIAN MUNICIPAL PLANS

In Canada, cities like Toronto, Vancouver, Calgary, Saskatoon, Winnipeg and Halifax are at the forefront of such initiatives.

Their plans have some features in common, despite differences in application and organizational structures:

- they transition from managing homelessness to services designed to eliminate it;
- they coordinate multiple services so that individual solutions can be found for exiting the street;
- they call for greater efforts to provide housing access and stability;
- they provide for monitoring, research and data collection.

Success factors that have been identified include:

- commitments from those involved in combating homelessness;
- a single person or entity charged with implementing the plan;
- consistent organization, planning and coordination;
- monitoring outcomes of the system to help the homeless;
- regular updating in order to adapt to changes, knowledge, best practices and outcomes;
- a vision over 5 to 10 years, adequate income for the poorest, the development of affordable housing and a system of prevention and inclusion.

Municipal plans to end homelessness are relatively recent in Canada. Most of them have not reached their goals of reducing homelessness. Among the difficulties cited are: weak government commitment, insufficient funding and insufficient affordable housing (Adamo, 2014). The Vancouver plan cites a lack of services for existing needs. In other places, a lack of proper coordination among the many different services allows people to slip through the cracks.

IN EUROPE

In 2012 the European Federation of National Organisations working with the Homeless (known by its French acronym FEANTSA[3]) studied the plans to end homelessness of 21 European countries.

Three success factors emerged:

- a firm political commitment to find a solution (including significant funding);
- clearly identifiable goals in terms of residential stability in affordable housing; prevention measures among at-risk populations and critical timely intervention in relation to episodic homelessness;
- a selection of homelessness indicators, collecting and monitoring data.

Plans that only aim at ending visible homelessness are missing the target of reducing this social phenomenon. Although solutions do need to be found for the very vulnerable people who have been on the street for years, truly ending homelessness will require responses in many different areas and among all different kinds of homeless people.

FEANTSA highlighted the efforts made by Finland

[3] Fédération Européenne des Associations Nationales Travaillant avec les Sans-Abri, http://www.feantsa.org/spip.php?page=sommaire&lang=fr.

as a successful example of integrated strategies to end homelessness. That country started counting its homeless in 1980 using an efficient data collection system and made efforts to uncover the different kinds of homelessness, including hidden homelessness. There were 18,000 homeless people in 1980 (out of a total population of 4.9 million). That number had been reduced to 7,877 in 2010 (whereas the population had increased to 5.5 million). Major achievements occurred in 2007, when the central government mandated a working group to create and implement a three-year plan funded by €200 million. Most of this funding (€170 million) came from the central government and the rest from municipalities and foundations. The government signed agreements with the municipalities to implement the plan.

The integrated service approach and the introduction of residential stability with support mechanisms are at the core of the Finnish success story. The country was also able to revise its plan every three years and adapt it to the actual needs of the homeless. Although at the beginning it was important to find solutions for chronic homelessness – the most visible and dramatic form of homelessness – Finland has also worked to solve other forms of homelessness and has set up a quantity of emergency services that lead the way into the assistance system.

IN QUEBEC

Quebec has made many efforts to tackle the problem in recent years: a parliamentary commission in 2008, provincial and municipal action plans in 2010. In 2012 work began on a National Policy to Fight Homelessness, released by the Gouvernement du Québec in February 2014 and followed in December by the Plan interministériel en itinérance [Interdepartmental Plan for Homelessness] 2015-2020 and a First Portrait of Homelessness.

The interdepartmental plan "is based on a preventive approach" and comprises 116 measures grouped into 29 objectives, designed to mobilize all of the Quebec government's departments and agencies. The plan aims at equipping the stakeholders, improving knowledge and working to transform emergency shelters into diversified residential housing with support services. The plan does not include measurable objectives, budgets or timeframes.

The City of Montreal also issued a 2014-2017 Action Plan for Homelessness in 2014. It proposes proactive participation by municipal services (transit authority, police, etc.) to support efforts to combat homelessness. There are four parts to the municipal plan: knowledge (including the count that was done in March 2015), decriminalization, public space sharing and 1,000 social and community housing units.

The federal government has also joined the fight against homelessness through its Homelessness Partnering Strategy (HPS) program. Ottawa has funded Canada-wide research on Housing First (At Home/Chez Soi) and since 2014 has redirected close to two thirds of its funding to that approach.

CHAPTER 3: MONTREAL'S ACTION PLAN – BACKGROUND

Health services to be established

The deinstitutionalization of psychiatric care that started over 50 years ago is recognized as one of the factors increasing the long-term homelessness of mentally ill people who find themselves on the street due to a lack of supports.[4]

During the first decades of deinstitutionalization, the task of supporting people with serious mental illnesses was left primarily to community organizations. These organizations provided all kinds of services to welcome and support thousands of vulnerable people in Montreal and throughout Quebec, often with precarious funding.

That vulnerable population has grown over the past 50 years and the problems related to mental illness have become more complex. There are now people on the street with serious and persistent illnesses who are not receiving the care that they need. The advent of new, stronger drugs that seriously affect mental health has also increased the number of mentally ill people who are not being cared for.

The ministère de la Santé et des Services Sociaux [Department of Health and Social Services] prefers the solution of independent housing with proper supports in the community,[5] Intensive Case Management [ICM] and Active Community Treatment [ACT]. Although such teams will no doubt prevent many people with mental problems from becoming homeless, they do not generally provide the services needed by chronically or cyclically homeless people.

The team associated with CSSS Jeanne-Mance [now the CIUSSS du Centre-Sud-de-l'Île-de-Montréal] has solid expertise, and since May 2015 the CHUM has a new ACT team based at the Old Brewery Mission that *meets the actual needs of the homeless clientele*.[6]

A need for affordable housing

The difficulty of finding safe and affordable housing is another cause of homelessness that arises in all large cities. According to the Office municipal d'habitation de Montréal [OMHM], some 25,000 people are waiting for social housing and have been doing so for several years. In addition, close to 144,000 Montreal households spend more than 50% of their incomes on renting space that is often unsanitary or too small [FRAPRU, 2009].

It is urgent to provide affordable housing and proper support services to house people whose health problems combined with loss of autonomy and social isolation are keeping them on the street. Prevention calls for ongoing efforts to protect the existing housing stock and enlarge the supply.

Montreal has many cards to play: a large stock of private and varied rental housing units, although they are aging and sometimes unsanitary; a diversified stock of public and community housing units and a provincial funding program [AccèsLogis]; two para municipal organizations with a great deal of experience that manage some 30,000 social and affordable housing units [OMHM, SHDM]; many non-profit organizations that manage close to 20,000 social and community housing units; a provincial rent supplement program with many components, including a new one announced during the most recent budget; a modest but useful provincial shelter allowance program.

[4] The Douglas Hospital had 5,000 beds for inpatients during the 1950s, the decade when the number reached its peak. Today there are only about 250!

[5] Plan d'action en santé mentale 2015-2020 MSSS, 2015.

[6] Ibid

CREDIT THOMAS KÖNIGSTHAL

Increasing poverty among people living alone

Quebec has drawn up and implemented ambitious action plans aimed at reducing poverty. Those plans have been largely supported by communities and over time they have succeeded in reducing poverty among families with children (both two-parent and single-parent families), according to the Centre d'étude sur la pauvreté.

However, that success has not included people who live alone. *The proportion of those with low incomes among people living alone rose from 22.8% to 27.1% from 2003 to 2011... During that time period it rose higher among women (from 21.4% to 27.1%) than men (24.3% to 27%). The greatest increase in the segment is among single women with low incomes who are over 65; for this group the rate rose from 3.1% in 2003 to 14.7% in 2011.*[7]

There are several mechanisms to increase incomes without completely forfeiting social assistance. These include rent supplements, shelter allowances and access to employment income for which the present maximum of $200 per month must be increased.

Prevention and inclusion

Every day new people find themselves in at-risk situations, and many will end up on the street. A whole series of homelessness prevention and social inclusion programs will be needed to curb the spread of homelessness. The 2015-2020 Interdepartmental Plan makes many commitments along those lines:

> *This plan is based on a bold preventive approach and proposes measures to be implemented from childhood on among the most vulnerable young people.* (MSSS page 2)

Targeted actions aimed at the most vulnerable people, e.g. those released from institutions (prisons, hospitals, youth detention centres) or fleeing from violence, have produced positive outcomes in European countries.

Who would monitor the implementation of such essential measures in Montreal?

Community networks worth supporting

In Quebec the work of the Réseau solidarité itinérance du Québec (RSIQ) and the Réseau d'aide aux personnes seules et itinérantes de Montréal (RAPSIM) contributed to the drafting and adoption of the National Policy to Fight Homelessness (2014). These community networks also provide a whole range of services to homeless and vulnerable people. Without them life would be even more difficult for thousands of people in Montreal.

In Montreal, this network consists of more than a hundred organizations partly financed by changing government programs and funders. They have developed specialized services in relation to different needs (housing, addiction, shelter, nutrition, etc.).

While most of them work on prevention among vulnerable individuals and households, some have become experts at welcoming the homeless and easing them back into society. These community organizations do a lot with very little, but they cannot meet all the current needs, especially with the growing number of people with serious health needs.

Consolidating and creating approaches

Health institutions and community organizations provide different services with little or no communication among themselves. There is often no consistency between resources, and the responses focus on emergency solutions such as shelters, refuges, ambulances, hospitals or prisons. The challenge is to transition to a curative approach where the homeless are housed and receive the supports they need in order to stay housed. The only way to do this is by adopting a person-centred approach and adapting the support to individual difficulties.

Since the health institutions and community organizations are so diverse, bridges must be built, actions combined and services coordinated within both the health networks and the community networks. Community networks must also be given the human and financial resources they need.

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[7] Report of the Minister of Employment and Social Solidarity, MESS 2014, http://www.mess.gouv.qc.ca/publications/pdf/ADMIN_lutte_pauvrete_R58_rapport_ministre2014.pdf

Montreal already has these kinds of resources and innovations; they must be consolidated and enhanced so that they can meet the challenge.

Responding to the many facets of homelessness

Homelessness has become much more diversified in the past 50 years. The many paths leading to homelessness call for customized countermeasures.

Immigrant women with children, veterans and Aboriginals – particularly Inuit – were overrepresented in the 2015 count. Other sources indicate that young people released from youth detention centres are particularly at risk of becoming homeless.

Violence and trauma are the conduits to homelessness for women, Aboriginals and young people. The resources available to them are different, and adjustments have to be made to easing the way out for them. Plans must be drawn up to address their particular needs with input from them and the organizations that support them.

A 10-YEAR VISION, A 5-YEAR ACTION PLAN

The MMFIM is neither a government organization nor a foundation. It is a coalition of dynamic forces within the Montreal community that seeks original solutions and, in order to achieve its goals, must convince others.

While it may take ten years to make the deeper changes that are required, we propose an initial 5-year action plan to initiate the transition process and achieve concrete results. With clearly defined objectives, delivery deadlines and mechanisms for measuring outcomes, we can create new ways of helping homeless people, aligning the public sector with the community sector and providing more and better assistance.

We are proposing an operational vision to change the way things are done in Montreal. Some measures are to be implemented quickly while other systemic changes will take time to put in motion. MMFIM's vision for a comprehensive plan to end homelessness in Montreal is divided into three parts:

- **Part 1:** Ending chronic and cyclical homelessness (present publication);
- **Part 2:** Preventing situational homelessness (publication at a later date);
- **Part 3:** Promoting prevention and inclusion (publication at a later date).

CHAPTER 4: ENDING CHRONIC AND CYCLICAL HOMELESSNESS

Part 1 covers people (men, women, Aboriginals, young people and older people) who are chronically or cyclically[8] homeless due to mental problems and/or addiction. They are on the street, in shelters or emergency rooms or locked up because there is no adapted care. The specific breakdown is:[9]

- men (76%) and women (24%);
- Aboriginals (overrepresented at 10%, because they are only a fraction (0.56%) of the Montreal population);
- young people 30 and under (19%) and people over 50 (41%) and veterans (6%).

HELPING 2,000 CHRONICALLY OR CYCLICALLY HOMELESS EXIT THE STREETS IN FIVE YEARS

The objective of this Action Plan is to create a supply of services to integrate and house over 2,000 people in five years. ***Based on the March 2015 data, this is a realistic objective.*** Men are the primary targets since they are the majority on the streets and in shelters. Women and young people, who tend to avoid the street and emergency shelters, have known various forms of abuse and violence and need special solutions adapted to their needs. There is an acute shortage of housing for Aboriginals and Inuit in their own communities; they also have addiction problems and other complications. Specific responses to those circumstances will be needed.

THE SPECIFIC SITUATION OF THE INUIT
(comments from the Makivik Corporation)

According to the study by Geneviève Dessureault[10] on the homelessness of Inuit women in Montreal, "the experience of violence and abuse is the trigger toward homelessness, while the lack of housing (in Northern regions) is an element of structural oppression encountered by women who are the victims of violence."

The programs to be created should take into account historical traumas such as residential schools, Inuit cultural specifics such as language, and their specific needs. A residential stability program for the Inuit – run by the Inuit for the Inuit – needs to be set up during the first 5 years of the implementation of Part 1 of the MMFIM plan.

Effective responses to chronically and cyclically homeless men and women will help unclog emergency rooms, reduce hospitalization for both physical and mental health problems, reduce the costs of unnecessary criminal proceedings11 and ease the work of shelters and community organizations.

Under our Plan a specialized part of the community network would be devoted to helping 2,000 very

[8] Also called "episodic" homelessness.

[9] Note: The figures in parentheses come from I *count Montreal 2015: Counting the homeless in Montreal on March 24 2015*, by Eric Latimer, James McGregor, Christian Méthot and Alison Smith, with the Douglas Mental Health University Institute and the City of Montreal, 7 July 2015, 74 p. http://ville.montreal.qc.ca/pls/portal/docs/page/d_social_fr/media/documents/I_Count_MTL_2015_report.pdf

[10] https://papyrus.bib.umontreal.ca/xmlui/handle/1866/12533

[11] "Our jails and prisons have become the last great asylums, with a significant percentage (36% of men and 62% of women) of offenders screened as needing mental health assessment and the majority also experiencing substance-abuse disorders." (Consensus Statement on Improving Mental Health Transitions, Institute of Health Economics, November 2014).

vulnerable chronically and cyclically homeless exit the streets. We propose new tools to make responses more effective for a limited number of organizations that are already involved with that clientele. Services must be delivered where the people are, in their own settings, and must cover health, psycho-social support and housing assistance.

The most established organizations are already working with this target group every day and they can meet the challenge. They need the health network to be present ON SITE and they need proper funding.

The specialized network will have to include several multidisciplinary treatment and referral locations within the community, where the community workers will work together with health network staff (doctors, psychiatrists, nurses) to intake, assess and direct each individual toward the supports and housing he or she needs; all this is set out in the 2015-2020 Interdepartmental Plan (see below) and the MSSS Mental Health Action Plan.

There are two levels of support:

- Active Community Treatment (ACT) by a treatment team (staff/client ratio of 1 : 5)
- Intensive Case Management (ICM) (staff/client ratio of 1 : 15 - 20)

Table 3. Some of the measures in the 2015-2020 Interdepartmental Plan[12]

10.1	Consolidation of the funding of some organizations that provide emergency shelters and transitional housing for the homeless.
10.2	Adaptation and consolidation of practices in those organizations so that homeless people can be helped to exit the streets.
11.1	A total of 500 units under Quebec's AccèsLogis program in 20142015, and at least 10% of the units for each year from 2015 to 2020, to be reserved for people who are already homeless or at risk of being so as well as for people with mental health problems.
11.2	Support for the purchase and renovation of buildings such as rooming houses in order to preserve the purpose for which they were built and ease access to affordable accommodation.
11.3	Greater use of rent supplements to benefit people who are already homeless or at risk of being so, as well as people with mental health problems.
11.4	Increased funding for community support in social housing.
11.5	Support for implementing the "Housing First" approach in an integrated way among people who will benefit the most from it, providing: - financial assistance for housing - support services to help homeless people reintegrate into society and remain housed - support from a housing team that could help private owners who were willing to rent to homeless people

[12] See: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2014/14-846-02W.pdf

15.1. Development of ICM and ACT services for homeless people with serious mental problems.

15.2. Consolidation of the funding for some neighbourhood interdisciplinary teams working with the homeless.

15.3. Financial support for setting up ambulatory health services within the organizations that help the homeless.

15.4. Provision of permanent neighbourhood psychiatric and addiction services for both young and adult clients.

The CHUM has already created two mental health intake and treatment facilities (PRISM[13]) under the auspices of the Old Brewery Mission. Other facilities are to be set up throughout the City and adapted for varied clienteles. People are steered toward support services adapted to their needs, teams and organizations they trust and housing they themselves have chosen.

The CHUM also set up an ACT team in the Old Brewery Mission in 2015 (as one of the initiatives under the 2015-2020 Interdepartmental Plan). As prescribed in the 2015-2020 Mental Health Action Plan, there are ACT and ICM teams in every CIUSSS. The CIUSSS Centre-sud has a particular mandate to create such teams to serve the homeless.

In addition, the eleven organizations (four of which[14] have combined under Projet logement Montréal [Montreal Housing Project]) will implement the federal "Housing Stability with Support" (HSS) program to assist 475 people over four years. They will form several ACT teams working together with real estate agents.

THE FEDERAL GOVERNMENT'S HOMELESSNESS PARTNERING STRATEGY (HPS)[15]

The HPS aims to counter homelessness by working with communities, provinces and territories as well as the private and non-profit sectors. In 2013 the Government of Canada announced it was earmarking close to $600 million over five years (starting in April 2014) to renew and reorient its Homelessness Partnering Strategy toward the Housing First approach.

In April 2015 the Governments of Canada and Quebec signed an agreement for the administration of the HPS on Quebec territory.16 Out of a total of $90 million allocated to Quebec, $61.2 million will go to the Montreal census metropolitan area (CMA).

[13] Programme de réaffiliation itinérance et santé mentale (PRISM) [Homelessness and Mental Health Reaffiliation Program].

[14] Accueil Bonneau, Maison du Père, Welcome Hall Mission, Old Brewery Mission.

[15] http://www.actionplan.gc.ca/en/initiative/homelessness-partnering-strategy

[16] See: https://www.tbs-sct.gc.ca/hidb-bdih/initiative-eng.aspx?Hi=44

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Action 1 PROVIDE PLACES IN THE COMMUNITY TO TAKE IN, TREAT AND REFER.

Equip some organizations to take in, assess and refer men and women to the support services appropriate to the needs of chronically and cyclically homeless people who also have mental health problems, addictions or other pathologies.

Those organizations will take in, assess and refer some 500 chronically and cyclically homeless men and women annually.

Action details	Expected outcomes	Leaders, others involved
1.1 With the help of the Health and Social Services net-work, give neighbourhood community organizations the tools to take in, assess and transfer to mental health, physical health and addiction resources.	Equip intake facilities in the network organizations where medical staff can work alongside the regular staff. — Maintain the 26 PRISM places (18 for men and 8 for women) on the premises of the Old Brewery Mission.	Specialized network community organizations. Street workers. CHUM, CIUSSS...

Action 2 KEEP PEOPLE WHO HAVE EMERGED FROM CHRONIC AND CYCLICAL HOMELESSNESS HOUSED.

Our goal is permanent residential stability for chronically and cyclically homeless men and women, whether in dispersed apartments or grouped living arrangements.

In order to support people who are on the street, in overnight shelters and some organizations, the CHUM's homeless Active Community Treatment (ACT) team must be reinforced to the point where it can support up to 100 vulnerable people a year.[17] That team works with extremely fragile people who need psychiatric help. Its involvement may last from six months to a year.

Based on the experience of the *At Home/Chez Soi* project, a second team will be needed.

The ministère de la Santé et des services sociaux (MSSS) [Department of Health and Social Services] will have to authorize additional PREMs[18] extra-territorial in the same way that the Institut Philippe-Pinel [maximum security hospital] is considered to be extra-territorial.

[17] The CHUM estimates that a team of 12 professionals can support close to 100 chronically or cyclically homeless people on the streets.

[18] Plans régionaux d'effectifs médicaux [Regional medical staffing plans] - MSSS

Action details	Expected outcomes	Leaders, others involved
2.1 Consolidate the CHUM's ACT teams at the Old Brewery Mission premises. Create a second ACT team.	People with extensive needs being supported in housing units and eased back into the community.	CHUM and OBM (1 existing team for men). MSSS for PREMs extra-territorial, CIUSSS.

Intensive Case Management (ICM) may be enough for people with more modest needs who do not have to be followed by a dedicated team.

Each organization in the specialized network will include psycho-social caseworkers designated as case managers; their workloads will depend on the needs of the people they are supporting (ranging from 15 to 20 people per case manager).

> *ICM services are coordinated by a case manager who maintains a direct link with the person (case management model).*[19]

The organizations that create HSS[20] projects using HPS financing[21] will have such teams at their disposal and will be able to increase their intake and support capacities.

Action details	Expected outcomes	Leaders, others involved
2.2 Consolidate the community ICM teams. After additional consideration, create ICM teams for Aboriginals.	People in housing and integrated into the community. People who have become autonomous.	Organizations implementing the HSS program. Organizations that deal with Aboriginals.

The health networks (CIUSSS) already have trained ACT and ICM teams to which people who have become stabilized can be referred.

Action details	Expected outcomes	Leaders, others involved
2.3 Involve the existing CIUSSS teams.	The CIUSSS ACT and ICM teams support some of the people leaving chronic and cyclical homelessness.	CIUSSS ACT and ICM teams. CIUSSS Centre-sud.

[19] Ibid.

[20] Housing Stability with Support.

[21] Homelessness Partnering Strategy.

Action 3 IMPLEMENT ADEQUATE TRAINING AND A COMMUNITY OF PRACTICE.

Case managers are not enough; their success requires adequate and ongoing training. With such training, case managers will be able to update their knowledge and refine their techniques, as do the Toronto caseworkers who benefit from the *Toronto Hostels Training Centre*.[22] The strengths-based recovery approach is recommended.[23]

In order to further support case managers, we propose a community of practice where they can exchange ideas and attain better fidelity to the intervention model.

Action details	Expected outcomes	Leaders, others involved
3.1 Provide adequate and ongoing training for the case managers who support people leaving homelessness. Unite them in a community of practice.	Well trained teams, improving their skills and responses from year to year.	Working group of case managers for a community of practice. National Centre of Excellence in Mental Health (NCEMH). Caseworkers supporting people leaving homelessness.

Action 4 PROVIDE AFFORDABLE HOUSING FOR EVERY CHRONICALLY AND CYCLICALLY HOMELESS MAN AND WOMAN.

Over five years the ACT teams and community ICM case managers will have to find housing for 2,000 people who have been chronically or cyclically homeless. Our Action Plan does not call for construction of new units, other than those that might result from the 2016-2020 *AccèsLogis* program as set out in the Quebec government's 2015-2020 Action Plan[24] and the 2014-2019 Montreal Homelessness Action Plan.[25] Some of those units should be used to create culturally adapted spaces for the Aboriginal community.

However, the teams have several resources to rely on:

The Housing Stability with Support (HSS) program will house 475 people with supports.

The Gouvernement du Québec announced a new program of 5,800 new rent supplement units (RSU) over five years in its 2015-2016 budget. Some of these must be dedicated and adapted for the fight against homelessness, as are apartments developed with the AccèsLogis program.

Subsidized social housing (without community supports) can accommodate chronically or cyclically homeless people if supports are provided.

Private or non-profit affordable rental housing (without rent supplements) can accommodate some people, notably those who cannot work or pensioners, and those who have a little more income.

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[22] http://thtcentre.com/

[23] See: http://www.iusmm.ca/Documents/pdf/Hopital/Publications/docu_pour_vision_cadre.pdf

[24] http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2014/14-846-02W.pdf.

[25] https://ville.montreal.qc.ca/pls/portal/docs/page/d_social_fr/media/documents/plan_action_itinerance_v3.pdf For an English version see: http://www.caeh.ca/wp-content/uploads/2014/11/LP14-2014-2017-Montr%C3%A9al-Activity-Plan-to-Combat-Homelessness-Because-the-street-is-a-dead-end.pdf

Action details	Expected outcomes	Leaders, others involved
4.1 House 2,000 people in 5 years: — private housing under HSS; — individual rent supplement units; — social housing – group or individual; — individual units (private or affordable) without rent supplements.	2,000 men and women housed in the community where they receive supports based on their needs.	Organizations implementing the federal HSS program. City of Montreal and Gouvernement du Québec for rent supplements. Non-profits, cooperatives, OMHM, SHDM.

Our plan recommends that a Housing Assistance Fund be set up as a safeguard against the unpredictability and imperfections of the system; it will speed up the process and meet the teams' most urgent needs.

Action details	Expected outcomes	Leaders, others involved
4.2 Establish a Housing Assistance Fund to respond to urgent needs: — temporary rent supplements; — housing repairs.	200 annually people remain housed.	Private partners.

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Action 5 SET UP A DATABASE AND INFORMATION TRACKING SYSTEM

Men and women who are homeless due to mental illness or addictions have complex needs and require individual follow-up over the medium or long term. Unless there are structured links between the various resources and a common registry where they can share the efforts and setbacks of the people who knock on their doors, support workers will not be able to coordinate their responses to individuals effectively, nor will they be able to measure the outcomes of their responses.

The Montreal Police Service reports that its officers meet homeless people in Montreal every day. This is the everyday reality for the Mobile Reference and Intervention Team for Homeless Individuals whose mandate is to guide homeless people toward the services they need to improve their quality of life and facilitate their reinsertion. *"When we meet a homeless person we would like to help, we don't know whether that person has a family doctor, whether that person consults the doctor regularly and whether that person has had drugs prescribed," said a police officer who has been on the squad since 2009.*

The federal government's Homeless Individuals and Families Information System (HIFIS)[26] is used by many organizations outside Quebec. There are also local initiatives for following individuals who need encouraging. Some of Quebec's major resources have already started using HIFIS without pooling the data; the system allows for pooling and is already operational elsewhere in Canada, but in Quebec it is constrained by legislation protecting personal information. We need to address such constraints and implement a solution. The Welcome Hall Mission has advanced the farthest in that field, and has expertise that would be most helpful to others.

The introduction of such a system is not to be attempted lightly. Front-line employees who will be responsible for entering the data need to be trained. They need to be fully involved and really understand the process, and input will be needed from every level of the organization. Quality control must be ensured and useful and comparable data generated.

A working group will be established to define the data required as well as the people and organizations with access to them, devise security measures to protect the information and obtain the authorization of the individuals whose personal information is stored.

Action details	Expected outcomes	Leaders, others involved
5.1 Set up a system for sharing information so that people can be followed and their progress tracked. **5.2** Produce transparent and verifiable reports of results.	The HIFIS database is implemented in participating organizations. 2,000 people leaving chronic and cyclical homelessness are registered.	Organizations that deal with the chronically and cyclically homeless starting with those implementing the HSS program. Funders.

[26] http://www.esdc.gc.ca/eng/communities/homelessness/nhis/index.shtml

Action 6 PROJECT MANAGEMENT

The success factors that emerge from the Canadian and European plans described in Chapter 2 include:

- a firm political commitment;
- a person or entity responsible for implementing the plan;
- data collection and follow-up so that outcomes can be assessed;
- regular updates.

When the plan is implemented one organization will have to be designated as being in charge and given the authority and independence it requires. It will need a 5-year mandate to implement the plan and should be supported by and accountable to a council or committee.

Action details	Expected outcomes	Leaders, others involved
6.1 Designate a project office responsible for implementing the plan and with sufficient authority to call on all parties.	The different aspects of the plan are implemented and the partners have honoured their commitments.	City of Montreal. MMFIM. Private partners.

The MMFIM endorses the desire of decision makers and funders to measure outcomes as well as activities.

> Our ultimate goal is a matrix that can be used to make decisions, act and transform. **"You simply can't manage anything you can't measure"** or – as Lord Kelvin put it – "to measure is to know." Measurement is linked to the work of representing observed phenomena; it helps identify problems so that good management decisions can be made. If you frame a problem properly, you can solve it.[27]
>
> Although according to Einstein **"Not everything that counts can be counted, and not everything that can be counted counts."**

Reliable information on outcomes will lead to transparency as well as decision making based on evidence and best practices. All qualitative and quantitative information to be collected, reviewed and compared will have to be properly sourced, and regular quality control will be required among all participating organizations.

[27] http://basepub.dauphine.fr/bitstream/handle/123456789/1522/berland_Mesure.pdf?sequence=2

Action details	Expected outcomes	Leaders, others involved
6.2 Mandate an agency to measure the plan's progress using specific indicators and to assess the outcomes.	The nature and data collection methods are defined. Outcomes are compiled and assessed yearly. Qualitative reviews are in place through semi-directed interviews with participants.	Autonomous agency. Possible role for the City of Montreal's Protector of the Homeless.

It is becoming universally acknowledged that the only efficient way to set up new projects is with input from the people affected by them. The "Nothing About Us Without Us" movement started in the handicapped and mental health fields, and was endorsed by the *Lived Experience Advisory Council* that met during the CAEH[28] conference.

Action details	Expected outcomes	Leaders, others involved
6.3 Give a voice to people who are or have been homeless.	A Peer Committee will provide input for the implementation and review of the plan.	Organizations.

Continued documentation, data collection and research on homelessness are necessary, leading to a better understanding of needs and better services. The MSSS is conducting an ambitious research program as part of its 2015-2020 Interdepartmental Plan.

The MMFIM underlines the opportunity, and the necessity, of measuring and assessing implementation of the HSS, a program involving a number of organizations working with a variety of homeless people and applying differing approaches.

Responding to so many different subgroups will require additional research into the most positive actions to be taken. The subgroups include women, Inuit, young people and those who are aging.

Action details	Objectives	Leaders, others involved
6.4 Fund research into improving responses and refining approaches.	Assessment of implementation of the HSS program. Research into the most promising approaches geared to specific subgroups. Assessment of the results.	Universities. Gouvernement du Québec, City of Montreal, research centres.

[28] Canadian Alliance to End Homelessness

IMPLEMENTING THE MEASURES PROPOSED IN OUR ACTION PLAN

Several elements of this plan are already being implemented. What makes this a plan is the goal of housing and supporting 2,000 people emerging from chronic and cyclical homelessness in the next five years and the actions necessary to achieve it. Apart from funding, success depends on implementing a specialized network based in selected existing organizations, training for their case managers, a system for coordinating the organizations and their actions and a means of collecting pertinent data and measuring outcomes.

Year 2016

- Ongoing deployment of the HSS program.
- Designation of a project manager responsible for Plan implementation.
- Allocation of rent supplement for homelessness.
- Discussions with the community network and the Health and Social Services network: CHUM, CIUSSS.
- Creation of a working committee on implementing the HIFIS.
- Designation of an agency to collect and analyze information linked to the implementation and measurement of outcomes.
- Research among organizations that deal with Aboriginal men and women to pinpoint their needs and determine which approaches will work best in particular cases.
- Government financial commitment for community ICM teams over 5 years.
- Creation of a committee to train case managers and a community of practice.
- Creation of an advisory Peer Committee.

Year 2017

- Installation of HIFIS (or equivalent) in the organizations that make up the specialized network, provision of training and quality control.
- Allocation of additional psychiatrists and additional funding for the CHUM ACT.
- Agreements with the Health and Social Services network to create multidisciplinary intake and treatment centres within communities.
- Deployment of additional case managers in community ICM teams.
- Creation of the Housing Assistance Fund, financed by private institutional partners, which will keep 200 people housed.
- Implementation of a training program for caseworkers who support the recently homeless and grouping them in a community of practice.
- Experimentation with approaches geared to Aboriginals.

Year 2018

- Creation of a second ACT team, allocation of additional psychiatrists and additional funding for the CHUM ACT.
- Analysis of results and adjustments to the Action Plan.
- Publication of the results.

Year 2019

- Forecast end of the 2014-2019 HPS-HSS program.

Year 2020

- 2,000 people are housed, 1,500 of them followed by the specialized network.
- Assessment of how the HSS-HPS program worked.
- Assessment of the Action Plan responses and impacts on the target clienteles.
- Publication of the assessment report.
- Roundtable to discuss the results and identify lessons learned.

CHAPTER 5: COSTS

The MMFIM proposes combining several existing initiatives in one Plan with a single goal: to help some 2,000 of the most fragile and at-risk men and women exit the street. To achieve this goal we propose to equip and specialize certain organizations in the community sector and establish close links between them and the health network.

We estimate that at the end of the first five years, 1,500 men and women will still be housed, supported and installed in their communities by the specialized community network, while 500 will be autonomous and living with or without support from the regular system. Annual departures will suffice to maintain the effort to end homelessness beyond the first five years.

The federal Housing Partnering Strategy (HPS) and especially its Housing Stability with Support (HSS) program[29] is already funding the first stage and will help 475 people exit the street by 2019. Half of the estimated average cost of $10,000 per person per year will go toward individual supports and the other half to shelter assistance. For the purposes of the financial forecasts we have assumed that such funding will continue beyond the end of the current agreement.[30]

Over five years, the MMFIM estimates the cost (annual inflation of 2%) at $36.9 million, including $18.8 million in new funds. These amounts do not include $19.5 million of federal funds under the HPS ending in 2019 or future contributions.

Table 4. Summary of costs

People off the street	2016	2017	2018	2019	2020	Five years
1. Specialized network (including HSS)	200	600	900	1,200	1,500	
2. Autonomous	—	100	300	400	500	
Support for individuals* (Actions 1, 2, 3)	$1,600 K	$3,262 K	$4,286 K	$5,746 K	$7,238 K	$22,131 K
Rent supplements* (Action 4)	$476 K	$1,435 K	$2,523 K	$4,044 K	$5,625 K	$14,105 K
Implementation (Actions 5, 6)	$140 K	$140 K	$140 K	$140 K	$140 K	$700 K
Total	**$2,216 K**	**$4,837 K**	**$6,949 K**	**$9,930 K**	**$13,003 K**	**$36,936 K**
Existing appropriations	($1,276 K)	($2,235 K)	($3,323 K)	($4,844 K)	($6,425 K)	($18,105 K)
New funding	**$940 K**	**$2,602 K**	**$3,627 K**	**$5,086 K**	**$6,578 K**	**$18,831 K**

These costs do not include funding under the HPS-HSS program, present and future.

It should be noted that those costs will be offset by a reduction in the use of emergency services (ambulances, hospitals, police, shelters, transitional housing) and a better quality of life for the individuals. The *At Home/ Chez Soi* project estimated that for every dollar invested in measures to help people out of homelessness, about

[29] See: http://www.esdc.gc.ca/eng/communities/homelessness/funding/communities_cfp.shtml

[30] See : http://www.msss.gouv.qc.ca/sujets/prob_sociaux/itinerance/docs/Entente-Canada-Quebec_SPLI_14-19_finale.pdf.

three quarters[31] was saved on other services such as hospital and psychiatric services. The investments we propose will therefore lead to the saving of some $30 million in value of unused resources, which will free up existing resources such as emergency shelters, other types of temporary housing and psychiatric care units. They should also make it easier to share public spaces and simplify the operations of public (transit authority and police) and community organizations.

Support for individuals

Support for individuals starts in the designated community organizations that have physical and mental health resources. People can go there to get their Medicare cards and primary medical care, their needs are assessed and they are sent to specialized ACT teams or ICM teams working within the community organizations. All of them have their choice of permanent housing where they can stay as long as they wish.

We envisage five entry points within select organizations that join forces with those of the health and social services network (doctors, psychiatrists, nurses, social workers). One PRISM is already funded as part of the measures announced on 7 December 2014.[32]

Table 5. Intake facilities

Action 1.1 Create intake facilities (PRISM and others)	2016	2017	2018	2019	2020	Total 5 years
Number of people	300	475	475	475	475	2,200
Number of locations	2	4	5	5	5	
Total investment	$300 K	$612 K	$780 K	$796 K	$812 K	$3,300 K
Budgeted funding	($150 K)	($150 K)	($150 K)	($150 K)	($150 K)	($750 K)
Additional funding	**$150 K**	**$462 K**	**$630 K**	**$646 K**	**$662 K**	**$2,550 K**

An ACT team is made up of twelve professionals including doctors, psychiatrists, nurses, social workers, peer helpers and a lodging adviser. The CHUM already has an operating Intensive Homeless Support (ISH) team, but staff needs to be increased to 12 professionals.

Table 6. Active Community Treatment (ACT)

Action 2.1 Consolidate the CHUM's ACT team	2016	2017	2018	2019	2020	Total 5 years
Estimated number of people being followed	97	187	212	212	212	
Number of teams	1	1	2	2	2	
ACT investment needed	$1,200 K	$2,448 K	$2,497 K	$2,547 K	$2,598 K	$11,290 K
Budgeted funding	($850 K)	($850 K)	($850 K)	($850 K)	($850 K)	$4,250 K
Additional funding	**$350 K**	**$1,598 K**	**$1,647 K**	**$1,697 K**	**$1,748 K**	**$7,040 K**

This amount does not include psychiatrists' fees which are paid by the RAMQ (Quebec Medicare). The ministère de la Santé et des Services sociaux (MSSS) will have to authorize additional extra-territorial "PREMs' in the same way

[31] 83 cents for people with extensive needs and 72 cents for those with more moderate needs. Most of the people served under this Plan will have moderate needs. That is how we arrive at our approximate weighted average of 75 cents.

[32] See: http://www.msss.gouv.qc.ca/documentation/salle-de-presse/ficheCommunique.php?id=846

that the Institut Philippe-Pinel [high security hospital] is considered to be extra-territorial.

Intensive Case Management (ICM) will be sufficient for people with more modest needs who do not need to be followed by a dedicated team.

This plan counts on the community network and proposes to specialize a certain number of organizations. Each organization will have case managers responsible for a certain number of people. They will be supported by housing advisers tasked with finding homes and negotiating agreements with the landlords, (private owners or non-profit corporations), making sure subsidies are paid and any damages repaired.

Additional investments of $6.8 million will be needed over five years, in addition to the amounts awarded under the federal HSS, to provide ICM for homeless people.

The health network (CIUSSS) also has ACT and ICM teams to support people who are mentally ill and living outside of institutions, to which some stabilized previously homeless persons could be transferred. This will not require any additional investment.

Table 7. Intensive Case Management (ICM)

Action 2.2 Community ICM teams	2016	2017	2018	2019	2020	Total 5 years
Yearly total of people in community ICM teams	200	400	700	1,000	1,300	
Federal HSS (people)	(200)	(350)	(475)	(475)	(475)	
Number of additional ICM workers	0	1	11	28	45	
ICM investment needed	$-	$77 K	$858 K	$2,229 K	$3,653 K	$6,817 K
Additional funding	**$-**	**$77 K**	**$858 K**	**$2,229 K**	**$3,653 K**	**$6,817 K**

Ongoing training is a success factor that allows case managers to boost their knowledge and refine their actions. The National Centre of Excellence in Mental Health (NCEMH) which is already providing training, support for caseworkers through a community of practice, and quality surveillance for ACT and ICM mental health teams, could have a role to play. Setting up a community of practice will help community workers exchange ideas, improve their intervention model while adjusting it to the situation in Montreal. These efforts should be coordinated with those of Médecins du monde Montréal.

Table 8. Training and community of practice

Action 3.1 Training and community of practice	2016	2017	2018	2019	2020	Total 5 years
Training and community of practice	$100 K	$125 K	$150 K	$175 K	$175 $	$725 K
Additional funding	**$100 K**	**$125 K**	**$150 K**	**$175 K**	**$175 $**	**$725 K**

Rent supplements

Over the next five years the ACT and ICM teams of the specialized network will house some 2,000 people who have been chronically or cyclically homeless. Our Action Plan does not call for construction of new units, other than those that might result from the 2016-2020 *AccèsLogis* program as set out in the Quebec government's 2015-2020 Action Plan.[33]

We estimate that 70% of the recently homeless will benefit from the rent supplement program (RSP). Quebec announced a new rent supplement program in its most recent budget (2015-2016), providing for 5,800 new places over five years (2015-2020).[34] It is only reasonable to request that a large number of these be devoted to the needs of Montreal and that a significant portion be reserved for the homeless (c.f. Action #11.3 of the 2015-2020 Interdepartmental Plan).

The proposed housing assistance measures will require total investments of $14.5 million, made up of $13.4 million for the rent supplement program and $1.0 million for a new Housing Assistance Fund that will house 200 people and could be financed by private partners.

Table 9. Housing assistance

Actions 4.1 and 4.2 House 2,000 people	2016	2017	2018	2019	2020	Total over 5 years
Rent supplements - number of people not including HSS	67	293	539	875	1,211	
Rent supplements –annual cost excluding HSS	$276 K	$1,235 K	$2,323 K	$3,844 K	$5,425 K	$13,105 K
Housing Assistance Fund	$200 K	$200 K	$200 K	$200 K	$200 K	$1,000 K
Budgeted funding	($276 K)	($1,235 K)	($2,323 K)	($3,844 K)	($5,425 K)	($13,105 K)
Additional funding (annual inflation 2%)	**$200 K**	**$200 K**	**$200 K**	**$200 K**	**$200 K**	**$1,000 K**

Implementation

The MMFIM endorses the desire of decision makers and funders to measure outcomes as well as activities. Reliable information on outcomes will lead to transparency as well as to decision making based on evidence and best practices.

An information system will therefore have to be established within the specialized network to gather, study and publish the data needed for an understanding of how homelessness evolves and how to measure the outcomes, making adjustments based on our observations. The federal HIFIS[35] can be installed at no cost, although a system to control the quality of the data entry will have to be provided.

Implementation of the plan will require additional funds:

- ensuring the reliability of the results and indicators is essential for measuring the success of our initiatives and adjusting the delivery of services;

[33] See: MSSS, Plan d'action interministériel en itinérance 2015-2020 – *Mobilisés et engagés pour prévenir et réduire l'itinérance*, 2014, p.68 http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2014/14-846-02W.pdf.

[34] Source: Plan économique, Budget 2015-2016, ministère des Finances du Québec.

[35] See: National Homelessness Information System http://www.esdc.gc.ca/eng/communities/homelessness/nhis/index.shtml

- mobilizing public and non-profit organizations calls for a dedicated and proactive approach modeled on project management;
- it would be desirable to have an additional research program using university researchers that would be complementary to that of the MSSS, particularly for determining and assessing outcomes.

The costs of implementation break down under four headings:

1. Project management to ensure the Plan's success;
2. Gathering, compiling and publishing the results;
3. Attention to the voice of people with "lived experience' (peers);
4. Funding of complementary and operational research.

Table 10. Costs related to implementation

Actions 6.1, 6.2, 6.3 Implementation	2016	2017	2018	2019	2020	Total over 5 years
Management of the project	$70 K	$60 K	$60 K	$50 K	$50 K	$280 K
Compilation and publication of results	$45 K	$45 K	$45 K	$50 K	$50 K	$235 $
Peers' committee	$5 K	$5 K	$5 K	$5 K	$5 K	$25 K
Research	$20 K	$30 K	$30 K	$35 K	$35 K	$150 K
Additional funding (annual inflation 2%)	**$140 K**	**$140 K**	**$140 K**	**$140 K**	**$140 K**	**$700 K**

WE CAN DO THIS

This plan may be ambitious but it is also feasible. Substantial components of it already exist or have been started. They have to be combined and enhanced as part of a plan and a concerted effort: cooperation between the community and institutional networks, affordable housing with supports, data compilation, results monitoring and regular reviews, adjustments and research as to the best practices.

CHAPTER 6:
ACTION PLANS TARGETED TO SPECIFIC CLIENTELES, PREVENTION AND INCLUSION

The MMFIM will continue its work with Montreal's specialized organizations through 2016, defining needs and testing the promising initiatives with a view to presenting targeted action plans for Part 2 (Consolidating services for specific clienteles) and Part 3 (Creating coordinated prevention and inclusion programs).

Part 1, which is aimed at the chronically and cyclically homeless, will affect only about 5% of the homeless population. Situational homelessness, which is caused by so many different problems, affects thousands of people and dozens of specialized organizations. Prevention and inclusion affect thousands of at-risk people.

It should be noted that if Part I succeeds in helping the chronically and cyclically homeless the existing network will be unclogged and we will be better able to define the future needs of specific clienteles.

Specific needs

People do not find themselves on the street solely because of mental illness or severe addiction. Several other factors can trigger isolation in both men and women: poverty, dysfunctional families, addiction, violence and aging. Specific responses will be needed to meet the needs of those people.

The aid networks have broken down those specific clienteles into categories:

- women
- young people
- people over 50
- families
- Aboriginals
- people who are homeless for the first time
- people with more than one addiction
- the hidden homeless

Hundreds of organizations are working with these people, providing an array of services because there is not just one way of helping them exit the street. Most of these people are situationally homeless. They are on the street one or more times and have to deal with all kinds of ordeals. They find it hard to break the cycle and risk becoming chronically and cyclically homeless unless they get the right help at the right time.

Prevention and inclusion

We will never be able to break the homelessness cycle unless we work to actively prevent it among at-risk people and find a way of bringing the most vulnerable and socially isolated back into society. The 2015-2020 Interdepartmental Plan sets out many measures for doing that:

Different aspects will be studied, including:

- prevention targeted to the people at greatest risk, particularly those released from institutions (youth detention centres, prisons, hospitals);
- creation of indicators and tools for detecting people at risk;
- setting priorities for social inclusion initiatives (particularly in education, access to income and social and socio-professional integration activities);
- socio-professional integration programs and how homeless people really live;
- day centres and other services to prevent social isolation;
- research needs on the topics of prevention and inclusion.

CONCLUSION: CHANGE IN MONTREAL

The Mouvement pour mettre fin à l'itinérance (MMFIM) will continue its work during the coming months so that its Action Plan to end chronic and cyclical homelessness can be implemented with the greatest possible impact.

It will be important to get the essential institutions and organizations on board and supply the services outlined here to support the most vulnerable and sickest homeless people. But above all, we will need a firm commitment at the political level – both municipal and provincial.

The MMFIM will therefore urge the entire Montreal population to support the Plan and will approach public and private funders to help bring it to fruition.

As this paper shows, ending homelessness will take a systematic approach and targeted interventions. But if we go about it methodically and everyone involved has the will to find solutions, we can turn things around in Montreal.

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