Pro-Active Versus Reactive Responses: The Business Case for a Housing Based Approach to Reduce Homelessness in the Region of Waterloo

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By

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EXECUTIVE SUMMARY

This report was commissioned to help Waterloo Region develop a business case for more purposeful proactive responses to homelessness by identifying social/economic cost/benefit estimates specific to Waterloo Region and the Regional Municipality of Waterloo (the Region). In addition to living on the streets, people experiencing persistent homelessness often cycle through costly public services such as emergency shelters, the emergency and institutional health system, and the judicial system. In short, there is a significant cost related to doing nothing to reduce or eliminate persistent homelessness.

The critical question is whether a more purposeful approach involving supportive and affordable housing can divert use from high cost services such as emergency psychiatric beds and corrections facilities etc., to lower cost and more appropriate services such as affordable and/or supportive housing. In short, is there a business case to invest in the housing stability system and a housing based approach?

Various research studies undertaken in Canada and in the US were reviewed and document reduced frequency and intensity of use of emergency and institutional services among individuals that are provided with appropriate, affordable, supportive housing compared to those that remain homeless. In one US study, placement in supportive housing was associated with a reduction in service two and one half times less expensive than the costs when homeless (from $40,000 per person per year to $16,282 per housing unit per year, adjusting for concurrent changes in the individuals' service use patterns).

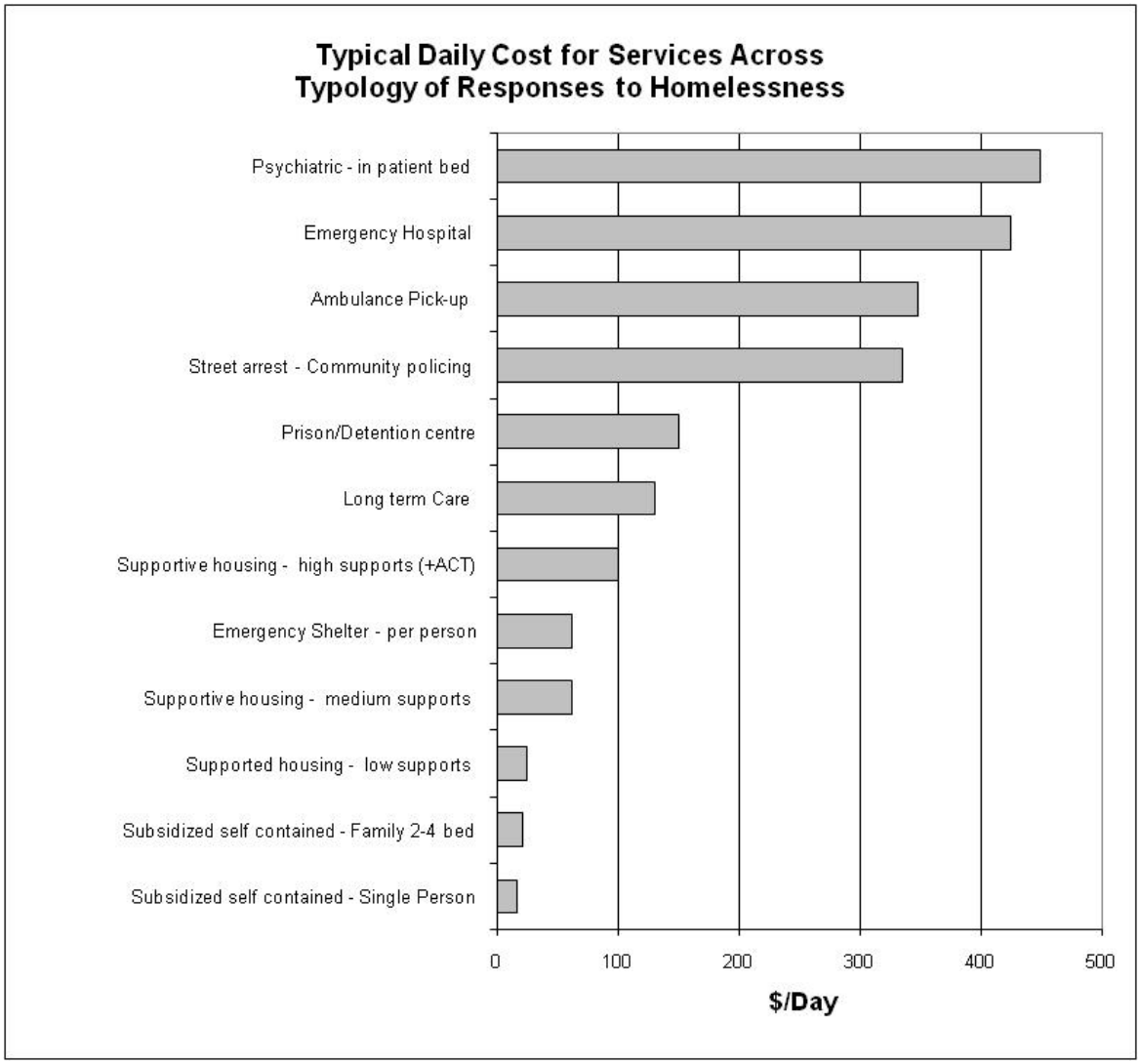
For this research, a typology (range of institutional, emergency and residentially based options) was identified. Information was collected on the range of existing facilities in Waterloo Region within each row of the typology. Operators were then contacted to collect data on both the type and intensity of services provided and annual expenditures (either last year's financial statements, or current year budgets).

The chart clearly illustrates that institutional and emergency responses fall at the high end, while residentially based options are lower cost, even when stacked with supports. Key highlights of the findings are:

- Use of various emergency services (policing, detention, ambulance and emergency admittance to hospitals) are roughly 10 times more expensive on a per diem basis than supportive housing.

- For people with serious mental health and substance use issues that may require more intense levels of service, as provided through Assertive Community Treatment (ACT) teams, the cost of institutional tertiary care is four times that of stabilized supportive housing plus ACT support.

- While residentially based supportive housing is roughly equivalent or slightly lower in cost compared to the expenditures incurred in the emergency shelter system, supportive housing provides a much more stable situation and likely reduces incidence of use of emergency services (as measured in US research and illustrated in the three case studies from the Region profiled in the full report). It also provides a higher quality of life for the formerly homeless victims.



It is important to note also that while the costs of serving someone for one day under different responses varies greatly and might be identified as “savings”, in most cases these are not true savings. Most of the costs are fixed and incurred whether a person/patient is accessing services or not. However, in certain cases there may be reductions in the subsidy expenditure for billed services, such as OHIP. The impact is more one of demand management (which would assist in addressing issues of growth), improved quality of life and preventive outcomes. By reducing service utilization from people who are experiencing or at-risk of homelessness, and particularly from people experiencing persistent homelessness, emergency services such as ambulance and

emergency hospital admissions can be freed up for other users. Potential infrastructure expansion can also be deferred if current use can be reduced through diversion to less costly approaches, for example introducing street outreach and diversion programs while ensuring sufficient supply of supportive housing options.

Stable, affordable housing with support levels appropriate to needs can remove an individual from the debilitating effects of repeated homelessness cycles, improve quality of life and, in some cases, enable the individual to recover the ability to live and function independently. While some people will have the potential to return to or enter the labour market (with associated productivity impacts and reduced use of social assistance), others may continue to need permanent supports to maintain housing stability, but enjoy an improved quality of life and ability to contribute to the community.

There is, however, a critical issue of fiscal imbalance and a matter of who pays and who saves within the overall funding system. Stabilized housing tends to generate the greatest efficiencies in the health care and judicial system; however, these efficiencies and "savings" accrue to Provincial and, to some extent, Federal treasuries. To the extent that housing is a Regional responsibility (and existing social housing is 100% funded by the Region; due to Federal-Provincial capital grants roughly one-third of new affordable housing developments is funded by the Region of Waterloo), but savings as a result of increased housing stability (criminal justice and health related) are generated in provincially funded mandates, there is an economic disincentive to localities like the Region of Waterloo to invest in these lower cost preventive and diversionary approaches (as the savings accrue entirely to provincial ministries). However, further investments in the housing stability system by the Region should translate into savings or deferral of potential infrastructure expansion in areas where costs are borne by municipalities (i.e. ambulance, policing, overnight detention, emergency shelters) if current use can be reduced through diversion to less costly approaches (e.g. enhancing street outreach and transition programs while ensuring a sufficient supply of supportive housing options).

Other than some administrative expenses for the provincially subsidized programs (Community Services, Mental Health and Long Term Care), the Region currently incurs minimal net expenditures to provide supports in the community, because most are funded under Provincial programs. Increased funding for these supports – such as stacking supports onto newly created housing units, funded under the Affordable Housing Strategy (where the Region is able to leverage significant Federal and Provincial funding) is an effective way for the Region to invest in a stronger housing stability system – focusing its investment on the more cost effective parts of the system and the ones that most benefit the beneficiaries through improved quality of life and well-being.

Consequently, greater efficiencies can only be stimulated and realized with strong interagency and inter-jurisdictional cooperation and with ongoing investment by all orders of government including the Region.

1. INTRODUCTION: SETTING THE CONTEXT

Pro-Active Versus Reactive Responses: The Business Case for a Housing Based Approach to Reduce Homelessness in the Region of Waterloo is one of what is now ten[1] background documents commissioned as part of a larger project – the development of a *Homelessness to Housing Stability Strategy* designed to increase the housing stability of all Waterloo Region residents. *All Roads Lead to Home: A Homelessness to Housing Stability Strategy for Waterloo Region* will synthesize all ten background reports and include an action plan for housing stability service providers, the Regional Municipality of Waterloo (the Region) and the Homelessness and Housing Umbrella Group (HHUG) with its member groups.

Figure 1. The development of a Homelessness to Housing Stability Strategy and an action plan for the future.

[1] In the background reports released in May 2007, there were seven background reports identified to be contributing to the strategy/action plan. With the addition of the persistent report and a social/economic analysis report there are now nine background reports, and the inventory of services document brings the total to ten.

This report was commissioned by the Region to help develop a business case for more purposeful proactive responses to homelessness. This report replicates previous research undertaken in other cities that have examined costs across a continuum of responses – from emergency and institutional care to transitional supports, to supportive and independent permanent affordable housing. The purpose of this research is to develop social/economic cost/benefit estimates specific to Waterloo Region.

There is a significant cost, both in terms of direct public cost and broader societal costs associated with persistent homelessness. Typically, someone living without a permanent home over an extended period of time cycles though various living arrangements and consumes a variety of emergency services including: ambulance, policing, over-night detention, use of hospital emergency services, and emergency shelters. In some cases, people experiencing homelessness may be involved in criminal activity resulting in incarceration and the associated public expenditure of the judicial system. In short, there is a significant cost related to doing nothing to address or eliminate persistent homelessness. The critical question is whether a more purposeful approach can divert service use from high cost services such as emergency psychiatric beds, corrections facilities etc., to lower cost and more appropriate services such as affordable and/or supportive housing. In short, is there a business case to invest in the housing stability system and a housing based approach?

This report first reviews the literature on related cost-benefit studies. It then outlines the methodology used to collect cost data, presents the recent cost estimates for facilities and services in Waterloo Region, and concludes with a summary of findings.

2. REVIEW OF PREVIOUS RESEARCH

The use of costing and cost benefit analyses as a way to highlight the impacts of homelessness and more particularly to measure the true cost of an ineffective response system began to emerge from empirical work undertaken in the 1990s.

In an influential piece of exploratory research, Culhane et al (1997) used administrative data collected through the New York and Philadelphia shelter systems to examine the shelter utilization patterns among the diverse homeless population. Culhane discovered that a high proportion of services (bed nights and associated shelter services) were consumed by a small number of individuals labeled as “chronically homeless”.

Culhane’s approach was emulated in work undertaken in Toronto as part of the Mayor’s Homelessness Action Task Force (Golden Report) in 1998-99. The Task Force research documented that a chronic group of 17% of City of Toronto hostel users accounted for almost half (46%) of bed/shelter usage over a one-year period. The report also identified that roughly one-third of persons experiencing homelessness suffered from mental health issues (with a much higher proportion among the “chronically homeless” group, many of whom were also dually diagnosed with substance abuse issues). This Toronto report also suggested that the existing “system” was biased toward emergency and survival measures (e.g. shelters) and did not [then] seek to prevent or facilitate recovery from homelessness (Toronto 1999) or promote prevention of homelessness.

A working paper prepared for the Toronto Task Force (Pomeroy and Dunning, 1998) developed estimates of the costs of a continuum of responses from hospital emergency and acute psychiatric beds, incarceration through shelters and various forms of supportive, transitional and permanent affordable (social) housing. This study found dramatically higher costs for emergency health and shelter responses compared to approaches that emphasized housing stability as a critical first step, with stacked

support services when appropriate for a particular client group, particularly individuals with mental health and substance use issues.

The missing element in this early exploratory research was any measurement of frequency and intensity of use of emergency services by people experiencing homelessness. Eberle et al (2001) undertook an exploratory investigation in British Columbia, with a limited sample of 13 case studies, for whom use and costs were tracked for a 12-month period (1998-99). While this approach illustrated patterns and frequency of use including health services (hospital emergency, walk-in clinics, ambulance/fire dept emergency, and pharmacare prescriptions) criminal justice (police arrests/ lock-up, corrections institutions and community supervision) and social service (income assistance), the sample was not statistically significant. The study also compared service use of a homeless population with that of a formerly homeless and stabilized population and determined that the cost of public services (health, criminal justice and social services) among the stabilized group was one-third lower than that among the homeless cohort.

Working with US data, Culhane et al (2002) reported on a much larger and statistically valid sample although the focus was more specifically on persons with severe mental health issues. This examined the impacts of supportive housing for individuals that had previously been homeless and suffered from severe mental health issues, compared to people that remained unassisted living on the streets and utilizing the emergency shelter system. The study tracked almost 5,000 individuals over a decade 1989-97 on the utilization of public shelters, public hospitals, Medicaid-funded services, veterans' inpatient services, state psychiatric inpatient services, state prisons, and city jails. The research documented significant reductions in shelter use, hospitalizations (regardless of type), length of stay per hospitalization, and time incarcerated. Prior to placement in supportive housing, people experiencing homelessness with severe mental health issues used an average of $40,449 per person per year in such services (in 1999 dollars). Placement in supportive housing was associated with a reduction in service use to $16,282 per housing unit per year, adjusting for concurrent changes in the

individuals' service use patterns – two and one half times less expensive than the costs when homeless.

More recently, Pomeroy (2005) has replicated the costing analysis undertaken for the Toronto Task Force in 1999 for the various emergency, institutional, shelter, supportive and permanent housing services for four cities in Canada - updating costs for Toronto and Vancouver from the earlier studies and adding data for Montreal and Halifax. The analysis did not seek to compare costs between cities, but rather to determine if the same pattern of costs across the continuum is evident within each city. The conclusion is that there is a consistent pattern – in all four cities, acute emergency, tertiary psychiatric care and incarceration involves significantly higher costs than various forms of transitional, supportive and permanent affordable housings, recognizing that differing levels and intensity of supports are required by differing sub-populations.

A group of researchers at Dalhousie University (Palermo et al, 2006) has reviewed and updated the Halifax data (from Pomeroy 2005) and again corroborated the relative cost levels across the continuum. This report emulated the methodology developed by Pomeroy and Dunning (1998) and also applied the usage rates developed by Culhane to generate relative costs of emergency/institutional versus supportive housing. Costs for six major public services typically accessed by people experiencing homelessness (shelter, jail, prison, hospital, psychiatric hospital, and supportive housing) were calculated per person per day. Based on the assumption that frequency of service usage (i.e. days per year) would reasonably mirror those reported by Culhane's study in New York, the Palermo study determined that a cost savings of 41% per person experiencing homelessness could be achieved by investing in supportive housing in Halifax.

A forthcoming study undertaken by the Simon Fraser University Centre for Applied Research in Mental Health & Addiction (CARMHA) in Vancouver, reported on the results of two small studies completed in British Columbia. The first study (2002) investigated the impact of supported housing on a small sample of tenants and found an

overall reduction in the length of hospital stay, stemming from a decrease in mental health related admissions and a small increase in physical health related admission. The second study (2006) focused on individuals who entered mental health supported housing. The study reported a reduction in emergency room visits, a reduction in average length of stay in hospital, and a reduction in hospital bed days, including a reduction in both physical and mental health related admissions.

While not examining the impacts of improved supports, a new study in Canada does highlight the link between mental health and homelessness and use of acute mental health treatment. It found that mental health is related to more than half of hospital stays among the homeless in Canada. The Canadian Institute of Health Information (CIHI) reported that mental disorders accounted for 52% of acute care hospitalizations among the homeless in 2005–06 (outside Quebec). In addition, the report shows that 35% of visits to selected emergency departments (EDs) – mostly in Ontario – by homeless people were related to mental and behavioural disorders, a proportion that is higher than that for other patients (3%). Among ED patients recorded as homeless, the most common type of mental disorder was substance abuse, which accounted for 54% of visits (62% for homeless men and 30% for homeless women), followed by other psychotic disorders (20% of visits), such as schizophrenia.

This CIHI report also sheds some light on the incidence of use of hospital emergency services as well as on inpatient acute care. Homeless persons accounted for 0.3% of total (5.4 million) emergency admissions in a sample of primarily Ontario emergency departments. With a wider national sample, but still excluding Quebec, admissions of homeless persons to acute inpatient care accounted for 0.1% of total admissions (2.3 million). While small in absolute terms, that is compared to admissions of homeless persons, these reflect a disproportionate level of use. With total homeless estimated at 10,000, people experiencing homelessness account for less than 0.03% of the total Canadian population.

In most cases, these studies are seeking to quantify what Burt (2005) labels as cost avoidance – essentially, by purposely placing individuals in lower cost services, expenditures can be reduced. Burt (2005) overviews a number of examples where cities have evaluated cost avoidance by tracking the utilization rates for some period prior to and following placement in permanent supportive housing. The analysis was restricted to health care costs, drawing on administrative data from the federal Medicaid program (augmented in some cases with State health care records) with records for the two years prior and three years following placement. In the Connecticut Supportive Housing Demonstration Program, in which individual's data was tracked from 1992 to 2001, results showed that tenants decreased their use of acute and expensive health services, mostly medical inpatient services, and increased utilization of necessary ongoing health care and support, such as home healthcare and outpatient substance abuse treatment services. These care and support services enabled tenants to remain in the community rather than be hospitalized. More tenants used lower cost appropriate outpatient services and fewer used inpatient services, increasing the efficiency of health care use (Burt 2005).

Similarly, a San Francisco study on the impact of placement in permanent supportive housing, found a significant reduction in acute service use. Emergency room visits fell by half (from approximately two to less than one per person per year) and inpatient days went from 441 in the year before permanent supportive housing to 278 in the year after. In addition, over time, service utilization was further reduced with even less frequent use in the second year and beyond, after placement. For the year that began 24 months before placement (i.e., months 13-24 pre-placement), days of residential mental health treatment outside of hospitals had been 465 for the 177 people for whom informed consent was obtained to search the relevant records, and for whom data were available. These days went to 415 during the year just before placement in supportive housing and to none during their first full year of residence. A number of other US studies have also documented the effects of a housing first approach in contributing to reduced intensity in health care service use (Gulcur, 2003; Gilmer, 2003; Kessell 2006 and Rosenbeck 2003).

Overall, while most empirical research focuses on the sub-population of persons with severe mental health and substance use issues (both quite prevalent in the persistent homeless population), the evidence does confirm significant reduction in frequency and intensity of use in higher cost emergency and institutional facilities. This of course is a largely theoretical saving as most costs are fixed (e.g. jails, hospitals). However, it can assist with growth (and demand) management, freeing up capacity and thereby reducing or deferring new capital and human investment for expansion of the emergency or institutional facilities.[2]

[2] While the facility operating costs are fixed, there may be real savings in other parts of the funding system, especially in the form of reduced billings and thus expenses in the Medicaid program in US context, or in OHIP in Ontario.

3. COST ANALYSIS OF RESPONSES TO HOMELESSNESS

Homelessness is a broad issue and involves a range of conditions and situations. While various definitions have been developed, most literature seeks to embrace the notion that there are degrees of absolute homelessness (Cordray and Pion 1991, Hopper 1991, Toronto 1999, Palermo et al 2006). An individual may not have a permanent address and consequently move between various forms of sheltering – with friends or acquaintances, emergency shelters, or live in parks and on the street (a condition described in the UK as “roofless”). For some, homelessness is a one-time transitional phase. For others, it is recurrent or episodic and, for a small but more visible group, it is persistent (NAEH 2007). The characteristics of the homeless population are also diverse and have evolved from the stereotypical male vagrant (often associated with mental health and/or addictions) to a broader range of individuals, including youth and increasingly families.

Individuals or families that experience homelessness, whether transitional, episodic, or persistent, often turn to, or are captured in, various emergency response systems, as well as in institutional settings. The previous research in this area (Pomeroy and Dunning 1999, Eberle et al 2001, and Pomeroy 2005) have identified a range or typology of such emergency and institutional facilities and services, together with an alternative set of more purposeful stabilizing and preventative options. The typology is presented and described in Exhibit 1 with a gradation from preventive and diversion approaches through various institutional, emergency, transitional and supportive and eventually independent (subsidized) housing. For each type of response the range and intensity of services typically provided is identified. However, it should be noted that there is often a range of service levels even within a similar type of response, depending on the particular client profile. While few people experiencing homelessness flow through the full (or even more than one element of) typology of responses, some, and especially those defined as experiencing persistent homelessness (recurrent and

ongoing use of emergency shelters) recirculate through various emergency and institutional facilities (NAEH 2007).

The typology begins with prevention – activities designed to reduce the flow of individuals into homelessness. This can include medical and supportive interventions to moderate behavior that contributes to a path into homelessness (e.g. anti-social behavior and eviction). It can also include temporary financial aid to cover rental arrears that are likely to lead to eviction as well as assistance in locating housing that better matches capacity to pay. Similarly, diversion activities may seek to place individuals experiencing homelessness immediately into housing based on an initial assessment – either by street outreach workers or intake workers in shelters. This, of course, presumes availability of housing spaces, which are often not available, thereby creating a bottleneck. [4]

The first stage of the homeless response system is often an emergency shelter – intended as a short-term respite and typically providing counseling and referrals.[5] Various types of emergency shelter are typically provided – emergency responses for individuals (primarily in the form of hostels or shelters, with sub variants of night-time only versus 24 hour service); for families; and for victims of family violence (typically with higher levels of security and more intense crisis counseling).

The typology then presents two typical institutional forms of response – psychiatric hospitals or facilities and detention or corrections facilities. There are some service and cost differences between overnight lock-up compared with post sentence facilities. Both are applicable to the offenders in the homeless population. As noted earlier, neither is designed as a homeless response per se, but a variety of research work has identified a significant level of homelessness among both former patients of psychiatric institutions

[4] Neither prevention or diversion cost estimates are presented in the later analysis, as such practices are not yet well developed in Canada, and consequently there is a lack of usable cost data.
[5] Although initially intended as a basic emergency response, many shelters across the country have evolved to become multi-service shelters with a wider range of supportive and transitional activities directed increasingly at diversion and prevention. Thus costs of operating shelters often reflect a broader set of services beyond just “3 hots and a cot”.

and former offenders. Episodes of homelessness are considered a factor in re-offending or in re-institutionalization (Eberle et al 2001, Pomeroy 2005).

Subsequently, a range of emergency responses are examined – these include standard emergency services such as policing, fire, ambulance – as all of these services do incur costs related to serving people experiencing homelessness. Often, emergency (ambulance or police) personnel are called out in relation to a situation involving a person experiencing homelessness, but this does not necessarily result in transportation to hospital or lockup. Often, the emergency paramedic staff simply check on the individual and, in some cases, police officers might assist them in moving somewhere else (such as a shelter).

Supportive housing approaches in the region vary, from group living arrangements to households in self contained, subsidized units. The supports can be provided in a supportive housing format, typically where on-site staff and services are tied to the units, or supported housing, where services are provided to the individual no matter wherever they live. The level of supports can vary and this range of intensity is reflected in Exhibit 2. Transitional housing approaches across the community also vary as they do for supportive housing - from group living arrangements to households in semi or fully self contained units. In terms of the range of costs and supports provided, transitional housing is similar to the low, medium and high supportive housing approaches reflected in Exhibit 2 and are therefore not presented further.

Finally, two independent responses are presented in the typology. These are based on households in Community Housing that only require financial assistance to assist with rent payments (subsidized housing) without any formal supports.

As revealed in the literature review, and also identified in Section 3.2 in reviewing three case profiles in Waterloo Region, reduced frequency of policing and ambulance services have been documented and are a benefit of improved supportive options.

Exhibit 1: Typology of Responses to Homelessness						
	Approach	Support/Management Model	Accommodation	Meals	Supports for Daily Living (SDL)	Medical support
Prevention	Prevention (keeping people housed)	Community worker/tenant aid; Rent Bank; Tenant – Landlord mediation; Referrals. Education -school programs	n/a	n/a	min	n/a
	Diversion (finding housing)	Community workers; street outreach Basic needs services/referrals – to divert from street/shelter to an immediate housing option	n/a	varies	varies	varies
Institutional	Prison/Detention centre	Accommodation/incarceration; some treatment/life skills activities, security	incl.	incl.	incl.	Infirmary
	Psychiatric Hospital	24 hour care, professional staff, intensive level of health care, housekeeping (both acute and long term care)	incl.	incl.	incl.	incl.
Emergency	Ambulance	Response to emergencies calls	n/a	n/a	n/a	varies
	Policing	Community Policing Patrols and response to calls (public disturbance/nuisance)	n/a	n/a	n/a	varies
	Emergency Shelters	Public or Non-profit operated shelters – range of client groups – male. Female and youth. Various in-house community support workers; motels for emergency overflow – families	incl.	incl.	min	min
Transitional*	Treatment Centres	Communal living with bedroom; meals, SDL; 24hr staffing	incl.	incl.	incl.	incl.
	Transitional Housing	Typically communal living with bedroom; meals/shared cooking, SDL; range of staffing intensity and referrals	incl.	varies	incl.	excl
Supportive*	Shared/Congregate Group Home	Private room/ meals provided; community SDL	incl.	incl.	some	excl
	Self contained apartment (incl. SRO/bach/one-bed) single person	Private or non-profit, support services of various intensity	incl	excl	incl	varies
Independent*	Self contained subsidized apartment (incl. SRO/bach/one-bed) single person	Private or non-profit, basic residential services - no support services	incl.	n/a	n/a	n/a
	Self contained subsidized - Family 2-4 bed	Private or non-profit, basic residential services - no support services	incl.	n/a	n/a	n/a

* In addition to on site supports for daily living (SDL), more intense services such as those delivered through Assertive Community Treatment (ACT) teams can be stacked onto transitional, supportive and independent living arrangements, and would significantly impact costs. Supports and services in supportive and transitional housing may be similar but with a different intensity and set of objectives.

3.1. DEVELOPING COST ESTIMATES ACROSS THE TYPOLOGY

Information was collected on the range of existing facilities in Waterloo Region within each approach of the typology. Operators were then contacted to collect data on both the type and intensity of services provided and annual expenditures (either last year's financial statements, or current year budgets).

Separating Residential and Support Costs

Many approaches involve two types of expenditure: accommodations (real estate operations) and support services. One of the largest variables in considering the subsidy cost of alternate responses is the real estate cost. Many existing operators have properties built or acquired some time in the past at a historic cost. Many existing responses involve properties that were funded under earlier programs that fully covered capital costs, or have paid off their mortgages and consequently carry no debt (i.e. they are mortgage free). In previous studies, the real estate related costs have been separately determined based on estimates to build and operate newly constructed housing. Support costs have been extracted from existing properties and added back in to generate a combined estimate.

In the current analysis, it has been possible to access the costs associated with recently constructed housing under the Region's Affordable Housing Strategy (AHS). This involved capital grants and ongoing rent supplements to increase affordability. The grant amounts are converted to annualized expenses by amortizing these over 35 years (the typical duration of mortgages on affordable housing) and then adding this onto any rent supplement expenditure. This provides an annualized (and daily) estimate of real estate related costs for independent subsidized housing.

Separate from this real estate cost, properties providing housing stability support services have a wide range of support service costs, with these costs varying dramatically based on service levels and associated staffing. Typically, facilities providing services to people with severe mental health or substance use issues require

much higher intensity of staffing. These separate support costs can be stacked (added on) to the residential costs.

In existing facilities operated in Waterloo Region, cost data has been obtained across a range of service levels. Looking *only at supports and ignoring property operating costs*, lower levels of support include visiting community workers and on call support workers in cases of an emergency with costs in the $7/day range[6]. The costs for medium levels of support (in house staff during the day, after hours emergency assistance and various types of support and counseling, and support for daily living) fall in the $15-42/day range. At the upper end, more intense support is provided in-house (24/7 staffing) and is augmented by Assertive Community Treatment (ACT) teams which involve costs in the range of $42 per day. This is over and above in-house support costs which were found to be as high as $109/day. ACT cost per case varies on intensity of need and the overall cost is also influenced by overall case load - with target case load of 80 clients (at lower case loads costs will exceed this $42 as costs are fixed). The ACT team includes a number of professionals including nurses, psychiatrist, occupational therapist, nutritionist, social worker and counselors. This is over and above residential related costs of $7-$35 in various congregate and shared home configurations.

For transitional, supportive, and subsidized independent housing, it is possible to identify discrete costs, such as property versus specific services. However, this was not possible for institutional responses, where typically operators were able to provide total costs and total usage rates to generate per capita or per day costs, but without a detailed breakdown. In these cases, the inclusion or exclusion of certain services is noted (e.g. accommodation, food support, medical care), but the associated expense is not identified outside of the total.

[6] Note, the costs shown in Exhibit 2 reflect both these support costs and property operations.

3.2. TYPICAL COSTS TO GOVERNMENT

In most cases, total costs, presented on a per capita or per diem basis, were collected. This reflects the total cost of operating and providing specified services. In some cases, 100% of costs are publicly funded while, in others, the operating agencies undertake fundraising and some charge for rent to cover expenses so the cost to government also varies from total cost (gross cost to operator). The focus of this section is on identifying the cost to government – the publicly funded expenditure.

Exhibit 2 identifies the typical daily cost associated with each type and level of service, based on an average for the range of costs collected in each service type. For the various emergency and institutional uses, costs are average costs based on a fixed capacity (jail cells, beds, etc.) and are not specific to services provided to individuals experiencing homelessness. Appendix A includes a more detailed breakdown that contains the type of services included and the associated range in costs across various similar facilities (where applicable). This data has been collected from facility operators and reflects costs in most current fiscal year (mainly 2006).

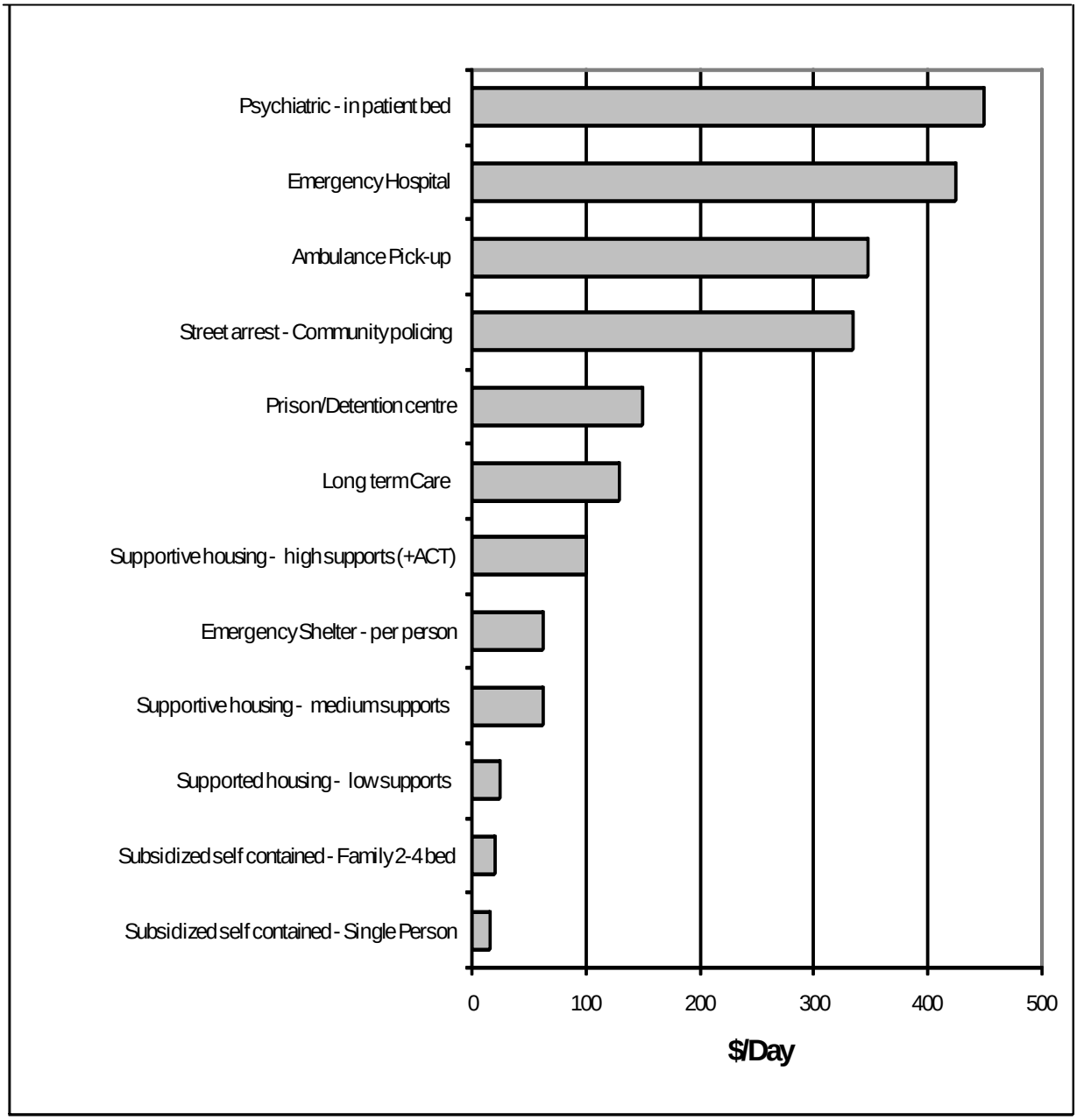
Exhibit 2 presents costs sorted from high to low, and clearly illustrates that institutional and emergency responses fall at the high end, while residentially based options are lower cost, even when stacked with supports.

Institutional psychiatric care tends to be at the higher end. Exhibit 2 displays only the cost for in patient mental health beds ($455). Acute and tertiary care beds (not included in chart) have a somewhat higher cost of $686 (psychiatric tertiary care) and $855 (acute), and these values exclude medical costs billed separately to OHIP.

In the emergency system, costs were collected for ambulance (as above) and police services (community policing). The ambulance costs range from $240- $700. The low end is the fee billed to non OHIP/Non Canadian users; the higher $700 figure is the total cost of operating the ambulance system in Waterloo Region divided by the number of

calls that involve transporting a patient (although often a call-out does not necessarily involve a transport). The overall average cost per call in 2006 is estimated at $348. Street policing is based on the hourly wage benefits and overhead cost of a patrolling police officer, which results in a value of $377 per day.

Exhibit 2: Typical Daily Cost for Services Across Typology



Comprehensive, sustainable, street outreach services do not currently exist in Waterloo Region, so costs from the nearby Region of Peel are used as a representative value. The average daily cost of the service in the Region of Peel is $1,900 with 500 persons assisted in 2006 (a cost of $3.75/person/day).

Emergency health costs for admission to emergency (outpatient services) as well as acute in-patient care and in-patient psychiatric beds were collected from local hospitals. As shown in Exhibit 2 (and detailed in Appendix A), the average cost for outpatient emergency/hospital is $425. In-patient services range from $455 for psychiatric care in-patient services to almost $900 for acute care.

As noted above, service levels vary substantially across emergency shelters. At a minimal level (basic mattress and a meal) the volunteer operated winter Kitchener-Waterloo Out of The Cold program costs approximately $14 per person per night. In the formal shelter system[7], costs per day experienced by operators range from $49 up to $75[8] (average per diem across formal shelters is $62). However, the cost to government is $39.95, which is the standardized per diem funding set by the Province and cost-shared 80/20 by the Province and the Region.

A number of supportive housing operators were contacted to collect data on housing with support, with a range of residential configurations. These include adults in group homes for people with mental health issues and domiciliary care for vulnerable adults, as well as persons with mental health issues in independent self contained apartments receiving supports. Cost presented reflect a range on levels of service – from minimal care with support for daily living to more intense where staffing is provided 24/7. These range from a low of $14 up to $126, again reflecting intensity of supports. These costs generally reflect spaces in existing group homes or self contained properties, built under past programs and while including some property related expenses, likely do not fully

[7] The formal shelter system consists of those shelters that have a purchase of service agreement with the Region and follow the Region's Emergency Shelter Guidelines.
[8] The $75 reflects the cost for a youth shelter which provides greater support and a higher staff to resident ratio.

reflect new real estate/property operating costs (i.e. many of these properties may be mortgage free).

Finally, costs related to permanent independent subsidized housing (no support costs) were derived from recently constructed/renovated Affordable Housing Strategy properties with up front capital costs converted to an annualized and daily number by amortizing grant (and related capital contributions) over 35 years. In addition, the cost of rent supplements were added to this amortized cost. For singles these totals range from $13-$22 per day and for family sized units from $21-$26 per day.

3.3. INCIDENCE AND FREQUENCY OF SERVICE USE

The study did not seek to collect service utilization (frequency and duration) specifically related to the homeless population, since this would involve a much more detailed and extensive scope of work. However, in collecting cost data, it was possible to probe for information on the extent to which people experiencing homelessness can be identified with existing data. Generally this is not collected or recorded, but in some services, administrative data records persons with no fixed address; a useful proxy of homelessness.

For example, for emergency medical services (EMS) or ambulance, over the past three years covering just fewer than 75,000 calls and resulting transportation, the Region's EMS was able to identify just over 1,000 transports of persons with no fixed address. This accounts for roughly 1.5% of all activity. The record also revealed that within these1,000 transports, just fewer than 700 relate to separate individuals, while the remaining 300 involve multiple uses (one individual identified using the service 12 times in this three-year period). These numbers do not account for the number of call-outs in which no transportation was provided (for which data was not available), although Regional staff estimate that in the case of people who are street-involved, less than one-half and perhaps closer to 25% of calls result in the person being transported to hospital.

An additional source of information is case records of individuals now being supported by Assertive Community Treatment (ACT) teams or alternative housing providers.[9] As described earlier, ACT teams involve a range of professional medical, psychiatric and social workers that develop case management supports geared to the particular needs of people with serious mental health issues. Staff in the two ACT teams operating in the community suggest that this intervention has an important impact on use of psychiatric hospital beds – with the rate of hospitalization on average reduced from more than 30 days per year prior to placement in ACT support to less than three days per year. The following cases illustrate the impact of housing and appropriate supports for people experiencing persistent homelessness with severe mental health issues.

Case Profile #1

Jen suffers from bi-polar schizophrenia and previously had an alcohol and drug addiction. Over the past 10 years she became estranged from family and was intermittently homeless. She suffered from episodes of abusive and antisocial behavior and while re-circulating through the shelter system has been banned from the shelter due to unacceptable disruptive behavior. She has experienced half a dozen shelter stays of more than two months each, and has been picked up by the police and taken to hospital on at least 13 occasions with stays in the psychiatric ward of one to six months. During most recent (six month) hospitalization last year she was reunited with her spouse and child and was subsequently discharged back to her family home and provided active support through the ACT team (as well as informal support in her family, who can call ACT personnel as necessary). Jen now engages in a range of public activities (swimming program, visiting the market etc). In the year since placement with ACT she has recorded no arrests, no hospitalization and no time in the emergency shelter.

Case Profile #2

Jacob is similarly diagnosed with bi-polar schizophrenia and has been on and off the streets for over 15 years with frequent stays in emergency shelters. His abusive behavior has resulted in involvement with the police and justice system. He has been placed in lock-up twice and was issued a community treatment

[9] Alternative Housing refers to supportive housing with self-contained units. This supportive housing is non-specific in that it not restricted to serving people with any particular disability but rather provides housing for people that may have non-diagnosed or multiple issues that present challenges in maintaining housing stability.

order after being charged with assault.[10] Like Jen, Jacob has had numerous admissions to the psychiatric hospital – at least eight times in the last decade with a typical stay of one to three months. His most recent stay in 2005 was for more than six months. He was discharged into community care and now lives in subsidized supported housing with ACT team support, and in the year since his discharge and acceptance into the supportive housing/ACT program has no record or shelter use, involvement with the police and justice system and no further hospitalization.

Case Profile #3

Mike suffered from manic depression, and had been estranged from his family for several years. Bouncing from shelter to shelter and jail to jail, he ended up in Cambridge where the outreach worker at Cambridge Shelter connected him with the physician at Lang's Farm Village Neighbourhood Association and Waterloo Regional Homes for Mental Health. Mike was given an apartment with daily support. Mike eventually found a job, got a girlfriend, married, and had a child. Mike and his wife recently moved into their own apartment, but Mike credits the five years he spent with Waterloo Regional Homes for Mental Health for getting him back on track with his life and helping him learn to live independently.

These case profiles suggest a high use of costly institutional and emergency services prior to accessing housing stability supports. While housing with supports and the ACT team also involve significant costs, this investment is much lower than comparable costs in a psychiatric hospital, shelters and jail, and results in a substantially improved quality of life.

Supportive Housing and Older Adults

Although not generally homeless, there is some incidence of homelessness among older adults. The Region's recent report "U*nderstanding Homelessness Experienced by Older Adults in Waterloo Region"* noted the risk of homelessness among low-income older persons. In part, this is attributable to affordability issues and an undersupply of appropriate housing for seniors.

[10] The current study did not investigate court related costs. However in a recent article on costs involved with repeat young offenders, Corrections Canada cites a cost of $1,352 for each court appearance. (Jacks Troubled Career. Restorative Justice Issue 2 Volume B Jan 2007, Corrections Canada).

As is the case with the chronic homeless population, by default, older adults with health issues often consume resources in the emergency health system when they might be better served through supportive housing (either in supported self contained apartments or rooms in supported residential facilities).[11] This approach has been implemented in BC with a partnership of the housing agency (BC Housing) building and operating the housing while the Ministry of Health funds ongoing support services.

Appendix A details costs for acute ($885/day) and long-term care ($130/day) in a health institution. The long-term care cost reflects basic nursing care (i.e. excludes medical treatment, which is reflected in the much higher acute care value). By comparison, supported seniors residentially based care is likely to incur significantly lower costs, comparable to that in supportive housing for mental health.

For example, under the Affordable Housing Strategy a seniors development was built adjoining a residential care facility. The derived daily subsidy cost (amortizing capital subsidy and adding ongoing rent supplements) is approximately $17/day. Care/support costs will vary depending on intensity. The proposed budget for a new seniors supported development being built in Waterloo Region under the Affordable Housing Strategy will cover basic support for daily living and five meals per week. This involves a daily cost per unit of roughly $56, which together with the real estate cost of $17 totals $73, 40% lower than institutionalized long-term care.

[11] A recent report (Waterloo Hospitals Emergency Services Investigators Report, January 2007) notes a far higher utilization of emergency services among older adults. Utilization rates significantly increase among pop over 65 and those over 75 use emergency services more than twice as frequently as those aged 30-55.

4. REGION'S SHARE OF COSTS

Clearly, an investment in housing and appropriate supports is required to achieve the efficiencies and improved quality of life illustrated in the case profiles presented in Section 3.3. One of the key issues in the analysis of various costs incurred across the institutional and emergency services system, in comparison with residentially based (or housing first) models, is the question of which services and jurisdictions achieve reduced costs and which services and jurisdictions incur the impact of new costs.

Exhibit 3: The Region's Share of Subsidy Costs

	Approach	Region's Gross Costs	Region's Net Costs[12]
Prevention and Diversion	All homelessness/housing stability programs currently funded through the Region	100%	0%
Institutional	Overnight lockup/pre-trial detention	100%	100%
	Prison/Detention centre	0%	0%
	Psychiatric - in patient bed	0%	0%
	Regional Operated Long Term Care (Sunnyside)	100%	0%
Emergency	Community policing	100%	100%
	Ambulance Transport	100%	50%
	Emergency Hospital	0%	0%
	Emergency Shelter	100%	20%
Transitional	All homelessness/housing stability programs currently funded through the Region	100%	0%
	Transitional Housing	0%	0%
Supportive and Supported Housing	Homemaking and Nurses Services Act (HSNA)	100%	20%
	Region's Community Relation Workers	100%	100%
	Mental Health	0%	0%
	Physical Disabilities/Acquired Brain Injury	0%	0%
	Developmental Disabilities	0%	0%
	Youth	0%	0%
	Domiciliary Hostels	100%	20%
	Alternative - Non-Specific	100%	0%
Independent Housing[13]	Subsidized self contained apartment - single person	New AHS /Exist SH 32%/100%	New AHS /Exist SH 32%/100%
	Subsidized fully independent self contained - family 2-4 bed	32%/100%	32%/100%

The range of services reflected in the initial typology (Exhibit 1) implicates differing levels of government. While there may be indirect funding support under the Canada Health Transfer (CHT) and Canada Social Transfer (CST), costs in most institutional facilities, including hospitals and provincial corrections facilities, are largely borne by the Province (Exhibit 3).

Emergency services, such as police, ambulance and emergency shelters, as well as domiciliary hostels are either fully funded by the Region or funding is cost shared (50% in case of ambulance and 20% in the case of emergency shelters and domiciliary hostels).

There are currently no direct subsidy costs to the Region for the support services portion in longer-term housing stability programs (e.g. supportive or supported housing) outside of the domiciliary hostel program and community relations workers for Waterloo Region Housing.

However, residentially based options that involve existing Community (social) Housing, excluding some supportive/transitional housing funded by the Ministry of Health and Long-Term case, are generally 100% funded by the Region since the 2000 local services realignment and Social Housing Reform Act.

More recent affordable housing developments, facilitated under the Region's Affordable Housing Strategy (AHS), have benefited from capital grants from both the Federal and Provincial level; however, there are no ongoing subsidies. Operators cover operating and administrative costs from rent revenues, with the exception in some cases of Regionally-funded rent supplements (in 140 units), plus some additional units funded by Provincial rent supplements.[14] Where these involve support services such as supports for daily living, the Ministry of Health and Long-Term Care generally funds this portion of the expense. [15]

To the extent that housing is a Regional responsibility (and existing social housing is 100% funded by the Region), but savings as a result of increased housing stability (criminal justice and health related) are generated in provincially funded mandates there is an economic disincentive to localities like the Region of Waterloo to invest in these lower cost preventive and diversionary approaches (as the savings accrue entirely to provincial ministries).

This raises important issues in terms of fiscal imbalances and funding arrangements. However, as some costs are borne by municipalities, investments in the housing stability system, including prevention, transitional housing and supports, and particularly affordable and supported housing, should translate into savings in emergency services funded by the Region.

As shown in Exhibit 3, the Region is very active in affordable and supportive housing and, in most cases, is able to utilize funding programs from the Province (e.g., Ministry of Health and Long-Term Care, Ministry of Community and Social Services, Ministry of Municipal Affairs and Housing). Other than some administrative expenses for the provincially subsidized programs, the Region currently incurs minimal net expenditures to provide supports in the community. Increased funding for these supports, such as stacking supports onto newly created housing units, funded under the AHS (where the Region is able to leverage significant Federal and Provincial funding) is an effective way for the Region to invest in a stronger housing stability system - focusing its investment on the more cost effective parts of the system, and the ones that most benefit the beneficiaries through improved quality of life and well-being.

5. SUMMARY OF FINDINGS

Highlights of the costing analysis clearly reveal an order of magnitude variation in the relative costs of institutional, emergency and residentially based (housing stabilization) approaches to responding to homelessness:

- Use of various emergency services (policing, detention, ambulance and emergency admittance to hospitals) is roughly 10 times more expensive on a per diem basis than supportive housing.
- For people with serious mental health and substance use issues that may require more intense levels of service, as provided through ACT teams, the cost of institutional tertiary care is four times that of stabilized supportive housing plus ACT support.
- While residentially based supportive housing is roughly equivalent or slightly lower in cost compared to the expenditures incurred in the emergency shelter system, the supportive housing provides a much more stable situation and likely reduces incidence of use of emergency services (as measured in US research and illustrated in the two case studies profiled above). It also provides a higher quality of life for the formerly homeless victims.

These are crude comparisons reflecting the cost of operating/providing a particular service for a single day. The comparisons do not take into consideration frequency or duration of service utilization and such measurement is outside the scope of the current study. However, the review of literature did reveal empirically based longitudinal research that confirms a reduction in both frequency and intensity of use with costs, mainly health and corrections related, almost two and one-half times greater for people experiencing homelessness, compared to formerly homeless but now stabilized individuals.

It is important to note also that, while the costs of serving someone for one day under different responses varies greatly and might be identified as “savings”, in most cases these are not true savings. Most of the costs are fixed and incurred whether a

person/patient is accessing services or not. However, in certain cases there may be reductions in the subsidy expenditure for billed services, such as OHIP. The impact is more one of demand management (which would assist in addressing issues of growth), improved quality of life and preventive outcomes. By reducing service utilization from people who are experiencing or are at-risk of homelessness, emergency services such as ambulance and emergency hospital admissions can be freed up for other users. Potential infrastructure expansion can also be deferred if current use can be reduced through diversion to less costly approaches; for example, introducing street outreach and diversion programs while ensuring sufficient supply of supportive housing options.

Stable affordable housing with support levels appropriate to his or her needs can remove an individual from the debilitating effects of repeated homelessness cycles, improve quality of life and, in some cases, can enable the individual to recover the ability to live and function independently potentially returning to or entering the labour market – with associated productivity impacts and reduced use of social assistance. Others may continue to need permanent supports to maintain housing stability and may not become fully independent, but enjoy an improved quality of life and level of self-confidence.

There is, however, a critical issue of fiscal imbalance and a matter of who pays and who saves within the overall funding system. Stabilized housing can generate efficiencies in the health care and corrections system, but these efficiencies and “savings” accrue to Provincial and, to some extent, Federal treasuries. The Region can use this business case as a way to lobby for sustained investment from the Province and Federal government.

For the most part the costs are incurred at the local level, although recent experience has included capital contributions the Region’s AHS via the Federal-Provincial Affordable Housing Framework funding process. Nonetheless, greater efficiencies can only be stimulated and realized with strong interagency and inter-jurisdictional cooperation.

APPENDIX A: RANGE OF COST ESTIMATES ACROSS THE TYPOLOGY OF RESPONSES TO HOMELESSNESS

Appendix A: Range of Cost estimates Across Typology of Responses to Homelessness								
		Approach	**Support/Management Model**	**Accommod-ation**	**Meals**	**SDL**	**Medical support ***	**Total**
1	Institutional	Prison/Detention centre	Accommodation/incarceration; some treatment/lifeskills activities, security	incl	incl			155.00
2		Psychiatric - Tertiary Care	24 hour care, professional staff, intensive level of health care, housekeeping	incl	incl	incl	extra	686.00
3		Psychiatric - in patient bed	24 hour care, professional staff, intensive level of health care, housekeeping	incl	incl	incl	incl	449.00
4		General in-Patient Treatment	Acute care, professional staff, intensive level of health care, housekeeping	incl	incl	incl	incl	885.00
5		Long term Care (Sunnyside)	Mainly for long term disabled/seniors	incl	incl	incl	some	130.00
6	Emergency	Street arrest - Community policing	Arrests for public disturbance, diisorderly conduct	no	no	no	no	337.00
7		Street Outreach	street counselling, mental health and addiction supports, health care, food and clothing	no	some	no	some	3.75
8		Ambulance Call with Transport	May be some paramedical emergencey treatment	no	no	no	para medical	$240-$700
9		Emergency Hospital	emergency outpatient treatment		no	no		400-450
10		Emergency Shelter or Hostel - Singles	Public or Non-profit operated shelters - various in house and community support workers.	incl	incl	some		$14-$75
11	Supported	Supportive housing - high supports	Communal living or self contained meals, community supports for SDL; Staffing 24/7 (some ACT)	incl	incl	some	emerg only	58-126
12		Supportive housing - medium supports	Communal living or self contained meals, community supports for SDL; Staffing 9-5 (excludes any ACT)	incl	incl	some	no	$49-76
13		Supportive housing - Low supports	Communal living , group or self contained, occassional community supports for SDL; on call emergency	incl	incl	some	no	$14-36
14	Independent	Self contained apartment (incl. SRO/bach/one-bed) single person	Private or non-profit, basic residential services - no support services	incl	no	no	no	$13-22
15		Fully independent self contained - Family 2-4 bed	Private or non-profit, basic residential services - no support services	incl	no	no	no	$17-26

Notes

1	Data from Ministry Public Safety - Provincial detention Centre in Milton for Adult Offenders (approximates provincial average)
2	London data, excludes medical costs billed to OHIP
3	44 bed MH in patient ward at GRH, includes direct and indirect costs
4	Data Finance/Admin Grand River Hospital
5	Per diem rate, excludes medical care, beyond nursing
6	WRPS - based on community patrol officer rate of $45/hr. This includes benefits but not the overhead cost of police facilities and vehicles, so represents a low estimate of the full cost of policing.
7	Based on data from Peel Region
8	From Waterloo EMS - $700 is fixed cost/# trips/yr. Hospital charges $240 to anyone without OHIP; actual cost/trip estimated at $348 in 2006.

9	Base cost in emergency - excludes doctor fee or any testing - data from Grand River Hospital
10	$14 = bare minimum out of cold church mattresses and meal = $14/day; High end = $58 with more intense 24/7 staffing and up to $75 for youth shelter;
11	Reflects high end support (daily or 24/7 for individuals with serious mental health issues) living in group homes or self contained support apt - support costs plus ACT teams for some residents plus property operations
12	Domiciliary care in privately run homes (bed + some basic support and meals); also bed or self contained unit with minimal community supports. Care/support costs are $7-$26 per day; remainder is property operations
13	Independent living, but some community supports and on call emergency
14	Annualized cost of recent AHS (capital plus RS)
15	Annualized cost of recent AHS (capital plus RS)

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