Behavioral Health Network of Greater St. Louis

Regional Housing Needs Assessment and Resource Inventory

Defining the housing needs of persons with mental illness and addictions and the resources available in the Eastern Region to meet these needs.

March, 2012

Behavioral Health Network of Greater St. Louis

Creating a better system of care for those impacted by mental health and substance abuse issues.

Forward & Acknowledgements

The Behavioral Health Network of Greater St. Louis (BHN) Board of Directors identified the expansion of safe, affordable housing options as one of its top strategic priorities for 2011-2012. As a result, a Regional Housing Collaborative was envisioned to address this issue and an initial planning workgroup was established by the Board to guide the development of a Needs Assessment and Inventory of Resources. This assessment would not have been possible without the hard work and dedication of the workgroup members. For a full listing of the workgroup members see Appendix B.

This assessment benefitted from the support of a number of people and organizations. Special thanks to Jackie Lukitsch who chaired the workgroup, and to Stephen Acree, Don Linhorst and Jim Topolski who volunteered additional time to share their expertise and provide guidance throughout the process of putting this assessment together. This report also benefited from the assistance of Missouri Housing Development Commission (MHDC) and the Missouri Department of Mental Health who provided valuable information and data. Special thanks to the organizations that assisted in the distribution and collection of the BHN consumer survey and to the organizations that hosted consumer focus groups.

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Executive Summary

Introduction and Overview

A home of one's own, whether rented or owned, is a cornerstone of independence and wellness for people with mental illness and addiction disorders, many who can also benefit from in-home or community-based services and supports. Locating appropriate and affordable housing and services has often been a major barrier for these people.

> "My housing needs have not really been addressed during my treatment. Yet I know that when I leave here, I'll be heading right back into the situation that caused me to seek help in the first place. I just really don't have many options."
>
> **~Focus Group Participant**

The Behavioral Health Network of Greater St. Louis (BHN) Board of Directors identified the expansion of safe, affordable housing and supportive service options for persons with behavioral health needs as one of its top strategic priorities for 2011-2012. An initial planning workgroup was established by the Board to guide the development of a Needs Assessment and Inventory of Resources to identify and quantify the critical housing needs of persons who are impacted by mental illness and substance abuse in the Eastern Region of Missouri, along with the housing and supportive service resources that are required to meet these needs.

For the purposes of this report the **Eastern Region of Missouri** is comprised of the counties of **Franklin, Jefferson, Lincoln, St. Charles, St. Louis, Warren and the City of St. Louis**. These counties range from urban cities to a range of suburban counties and more rural, agricultural counties with varying demographic characteristics. The population density of the counties varies greatly; ranging from 75 persons per square mile of land in Warren County to 5157 persons per square mile in St. Louis City. The overall population of the Eastern region is 2,084,037. This represents 35% of Missouri's total population of 5,988,927.

The report is not intended to be an exhaustive review of all the needs and resources that exist, but rather a focused and quantifiable overview of the needs and resources most critical to developing an initial plan of action for the region. In order to contrast and compare the needs and resources across the varying counties that comprise the region, comparable sources of data were required. This was not always easy and some data collected could not be broken out for each individual county.

Overview of Consumer Housing Needs

In 2010, there were 28,497 individuals that received publicly funded treatment for mental health and addiction problems in the Eastern Region.[1] A large proportion of these individuals are low-income- many with income at or below federal poverty thresholds. Based upon a review of available data and responses to surveys, interviews and focus groups, a critical need for safe and affordable housing exists for this population as demonstrated by the following information:

[1] http://dmh.mo.gov/ada/mobhew/index.htm; reported by DMH Behavioral Health Epidemiology Workgroup; does not include all sources of public funding.

- There is a significant **over-representation of persons** with mental illness and substance abuse disorders **who are homeless**;
- **52%** of the consumers surveyed by the BHN are **currently looking for housing** and **60%** have **searched for housing in the past 24 months;**
- **85%** of the survey respondents **reported that they wanted to own and/or rent a house/apartment.** However, **60%** identified **housing as being too expensive;**
- Four housing characteristics represented **79%** of all responses that resulted in client satisfaction with their housing. These were **privacy, independence, safety, and affordability**.

An array of affordable housing and supportive service options is required to meet the individual needs of consumers and allow them to choose the type of housing they want. Additionally, opportunities for employment and improved access to information on housing and services could mitigate some of the current issues people face in finding and keeping a place to call home.

Critical Resource Gaps/Key Issues

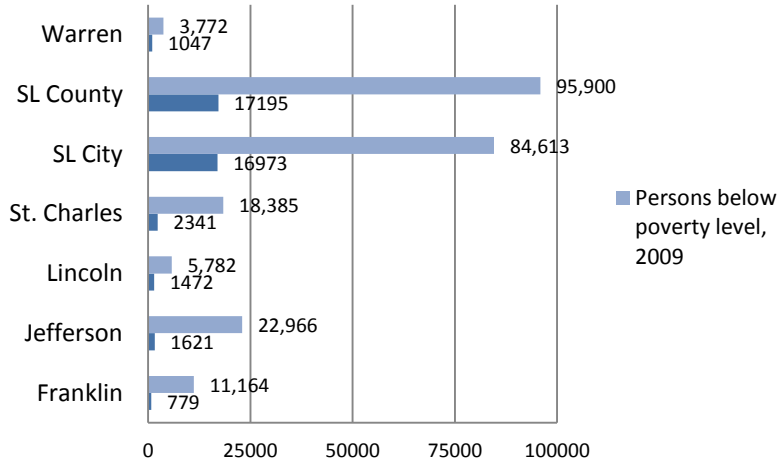
An extensive review of the available resources in the Eastern Region was performed. These included the **available housing stock, supportive services and the financial resources** necessary to support the development and operation of affordable housing and needed services. Many challenges exist as resources are limited, scattered and vary widely across the region. Five critical gaps/ issues were identified as follows:

1. **There is an overall lack of affordable housing available in the region especially in areas that are safe, accessible, and supportive to a person's wellbeing. Persons with mental illnesses and addiction disorders must compete with the general population for very scarce resources.**

   The gaps in the region's affordable housing stock compared to the need that exists go beyond those faced solely by persons with mental illness and/or addictions problems. The Eastern Region faces a much larger dilemma in that there is not sufficient affordable housing for the overall population of low-income people. Thus those whom may have more specialized needs must compete with the general population whose income is limited.

   The 2009 Census showed 242, 582 people below poverty in the Eastern

Figure A: Public Housing units/Section 8 vouchers available as compared to Persons below Poverty Threshold

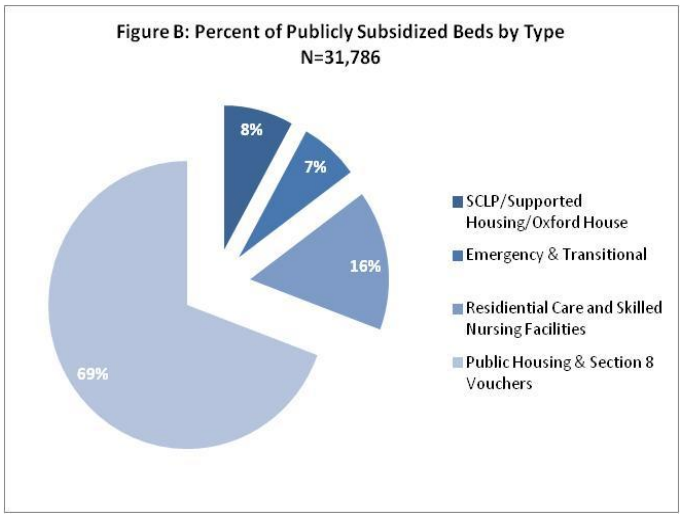


Region. Public housing and Section 8 Vouchers form the bulk of subsidized housing in the region, however there exists a huge gap in such subsidies when compared to the persons in the most need as depicted in **Figure A**. Long waiting lists are the norm.

With existing subsidized housing resources limited, the overall availability of affordable rental property is a critical issue. The median rental rates in the eastern region average between $500-$749 and almost 50% of the renter-occupied units are paying 30%, or more, of their monthly household income on their rent. An individual needs to make at least $13.25 per hour full-time to spend 30% of their monthly income on rent. This means that people making less than $13.25 per hour are going to struggle to afford fair-market rent. Missouri's state minimum wage is $7.25. People living on fixed incomes, such as SSI and/or SSDI, cannot even afford the upfront cost of paying a deposit much less monthly rent.

2. **Few options are available for permanent supportive housing in the region that offers an array of housing choices with flexible support services. This is especially true in the more rural and outlying counties.**

There is strong evidence for the use of a permanent supportive housing[2] [3]model for many persons with mental illnesses and addictions. This can range from small dedicated units to individual apartments with rental subsidies and supportive services available. However, few options exist in the region. Of the primarily publicly subsidized beds[4] available to those with behavioral health needs, only 8% are dedicated to a supported housing approach as reflected in **Figure B**.[5] This includes reported Continuum of Care permanent supportive housing beds and supported housing options funded directly by the Missouri Department of Mental Health (DMH) Supported Community Living Program (SCLP) and local community mental health providers. Although not deemed as typical supportive housing arrangements, Oxford Houses that are occupied and managed by persons recovering from addictions are included in this mix. Additional units/beds are funded (public housing, Section 8 rental assistance, DMH licensed residential care and skilled nursing facilities, emergency shelter and transitional housing) but often do not maintain a permanent supportive housing approach.



[2] Substance Abuse and Mental Health Services Administration (SAMHSA) describes permanent supportive housing as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences."
[3] http://www.csh.org/supportive-housing-facts/evidence
[4] The number of "beds" vs." units" are used here for comparative purposes as a residential care or skilled nursing facility may count as a single unit but have a large number of beds. . Public housing figures were derived based upon the average household size per available unit.
[5] In 2008, the HUD showed 14,200 Units receiving funding through the Low Income Housing Tax Credit. The number of beds is unavailable. Some of these units are likely included in above counts and the total number of additional units/beds is unknown.

Although supportive services may be provided to people in a variety of housing arrangements by local providers, the lack of affordable housing options and existing service capacity constraints pose major challenges to meeting the need that exists. The need for more permanent supportive housing options across the region is significant. There is an even larger gap in more rural counties that have relied more heavily on residential facilities. Also, few people with behavioral health needs should require a skilled nursing facility for their room, board and care. Yet, far too many young and middle aged adults reside in these facilities due to housing and service capacity constraints.

3. **There is confusion among consumers and providers about what resources are available and how to coordinate them. There are no "one-stop shops" for housing assistance. Instead people must access services from multiple agencies based on what they need.**

Consumers and providers indicated the need for increased communication and coordination between agencies that provide housing and support services. Overall, people seemed generally confused on where they should seek housing assistance. Consumers stated that they do not know where to find housing information to meet their needs. Providers expressed concern that there was no organized way for providers to communicate between each other about what housing is available, and for whom, across the region. Resources are constantly changing and there is little coordination, on a regional level, between providers.

4. **Public funds for both the development and provision of housing and services are limited and the distribution of these resources varies across the region. Also financing is very complex -funding sources have different criteria for who can be served, which makes it difficult to navigate the system and plan regionally.**

Public funding for both housing and supportive services is limited and inadequate to support the needs that exist. However, financing is also very complex. There are a variety of financing resources at the federal, state and local level that exist for the capital development of affordable housing, rental subsidies and supportive services throughout the region. Different funding resources are administered by a vast array of entities and have different rules on how the funding can, and cannot, be used. Some funding sources are designed for a specific geographic area and many have strict guidelines on who is eligible to receive the funding. These differences cause confusion among providers and make it challenging to develop a cohesive plan. Housing resources, both affordable housing stock and public financial assistance, vary across the region and are more available in the St. Louis area when compared to the outlying counties for a variety of reasons. Also, financing options for permanent supportive housing varies; for example not all geographic areas have received Shelter+Care funding (a supportive housing program for people who are homeless).

5. **Planning and development among key stakeholders and across geographic areas in the Eastern Region occurs in silos. Also, the level of participation by organizations providing behavioral health services in existing community planning collaboratives varies.**

The scarcity and complexity of the financial resources available for affordable housing and supportive services noted above makes planning difficult in the best of circumstances. Although several community planning mechanisms are currently in place across the region, including the Consolidated Plan and local Continuum of Care planning processes, the participation from behavioral health providers, advocacy

groups and consumers varies. A strong and consistent voice from the behavioral health community can ensure that the needs of people with mental illnesses and addictions are addressed as part of the planning process. Also, much of the planning that does occur happens within organizational and geographic silos. The existing planning processes need to be tied together so that there is a more cohesive, regional plan that bridges different communities and facilitates conversations between communities that are seeking to address related problems.

Service providers, developers, housing managers, funders and other stakeholders all have varying expertise in the development and operation of housing and the provision of supportive services. Behavioral health providers acknowledge that consumer access to affordable housing is critical to their mission but do not feel they have the core competencies to meet this need on their own. Funders, developers and housing managers have different expertise related to the planning, financing, development and/or operation of affordable housing but lack knowledge about the specific needs of people with mental illnesses and addictions and the supportive services available. To adequately address the housing needs faced by persons with behavioral health illnesses, key stakeholders need to convene around the same table. Some of these stakeholders include: housing developers, housing financers, housing managers, behavioral health providers, local community leaders and consumers.

Promising Public Policy and Practice Trends

Despite the myriad of issues that exist, there are many promising public policy and practice trends that can contribute to needed systemic changes. For example, the reauthorization of the HEARTH (Homeless Emergency Assistance and Rapid Transition to Housing) Act has created two major changes in the direction of federal policies to address homelessness. The first is the move to promote greater interagency cooperation and collaboration. The second is to standardize the planning components of the sections of Consolidated Plans that relate to homelessness and the Continuum of Cares annual plans. Another promising federal example is the Affordable Care Act which will improve the availability of health benefits for mental health and addictions services. In addition the Frank Mehlville Supported Housing Act outlines provisions for long-term rental assistance options for persons with disabilities.

At the state level, the Missouri Housing Development Commission (MHDC) recently approved a set-aside of low-income housing tax credits to be used to develop affordable housing for persons with special needs. Also, DMH has recently published a housing toolkit designed specifically for providers to address the development of affordable supported housing options.

An excellent example of a local initiative is the partnership between St. Louis City and County to create the 10-Year Plan to End Chronic Homelessness. This has led to a marked increase in permanent supportive housing and numerous local policy changes.

Practice trends include a broader adoption of a Housing First philosophy along with greater emphasis on trauma-informed housing practices and harm reduction models used for supported housing. There are many examples of best practices both locally and nationally that can be drawn upon as the planning process moves forward.

Summary and Next Steps

An array of affordable housing and supportive service options is needed to meet the individual needs of people with mental illnesses and addictions in the Eastern Region and allow them to choose the type of housing they want. There are significant and obvious gaps in the resources available as compared to the needs that exist across the region. Also, the complexity of the system as it exists today makes it extremely difficult for consumers and providers of services to navigate the system and access the limited resources that do exist.

In addition to the issues identified above, public policies (local ordinances, categorical funding requirements, etc.) as well as the stigma that is often associated with having a mental health or addiction problem, can significantly impact a person's choice in living arrangements. Also, differing housing philosophies exist amongst and within the various stakeholder groups which impact consumer choice. Each of these issues must be considered and addressed to garner effective solutions.

Despite the myriad of issues that exist, there are many promising public policy and practice trends that can contribute to needed systemic changes. Given the complexities of the system and the scarcity of resources, collective action between all sectors involved in the development and provision of affordable housing and support services must be taken to develop effective and sustainable solutions that will increase the availability of decent, safe and affordable housing for persons with mental illness and addiction problems. The next steps planned by the BHN include meeting with key stakeholders to share and discuss the information contained in this report and expanding the current workgroup to develop a regional action plan. Although the issues are daunting, it is hoped that the development of a regional approach will result in a shared vision and common purpose that will produce the best outcomes for the people and communities we serve.

Introduction and Overview

Home is the heart of life. Home is where we feel at ease, where we belong, where we can create surroundings that reflect our tastes and pleasures... Making a home is a form of creativity open to everyone.

Terence Conran □

Introduction

Decent, safe, affordable housing is one of the most important factors that affect our mental health. Poor housing, such as housing that's too expensive, run-down or over-crowded, can lead to poor overall health. It can also make recovery from mental health or substance abuse problems much more difficult. Housing is about more than a place to sleep. It's linked to our physical well-being, mental well-being and social well-being. Housing is an affordable, safe and private space of our own that protects us. And it's a place to gather with members of our communities. Good housing can help build and maintain independence, day-to-day routines, confidence and social networks.

A home of one's own, whether rented or owned, is a cornerstone of independence for people with behavioral health needs including mental illness and addiction disorders, many who can also benefit from in-home or community-based services and supports. Many people live in and wish to continue living independently in their homes and communities. Others are living in more institutional type settings but would like to return to the community. However, locating appropriate and affordable housing has often been a major barrier to independent community.

Affordability is a major barrier for people with significant behavioral health needs when looking for decent housing. A large number of people with a serious and persistent mental illness are dependent on SSI and there is virtually no housing available that would not consume their entire income. Persons with serious addictions also face affordability challenges. Many have lost employment as a result of their addiction and often do not have access to any sort of disability income. Also, people need a diverse array of services and supports to live successfully in the community, and such services and supports may not be available.

The absence of sufficient affordable housing along with supportive services for people with mental illnesses and addiction disorders has been shown to result in a proportionally higher rate of homelessness than the general population. Data from research conducted in the past five years indicates that about 30% of people who are chronically homeless have mental health conditions and about 50% have co-occurring substance abuse problems.[6] Adequate housing is the cornerstone of care for homeless persons, particularly for those with multiple issues such as co-occurring mental health and substance use problems. Homeless people are more likely to return to the street, emergency rooms, and inpatient wards if they are not provided with adequate housing and support services. For those with alcohol and drug problems, including those dually diagnosed, maintaining sobriety may be impossible without adequate housing and support. Additionally, research shows that people with mental illness who live where they want to are more likely to have a job, social supports and a higher quality of life than those whose housing doesn't meet their needs.

[6] SAMHSA HRC FACT SHEET-Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States (Last Updated July 2011)

Stigma is another barrier. "Not In My Back Yard, or NIMBY", is the attitude that something doesn't belong in your neighborhood. People living with mental disorders or substance abuse problems are among the least likely to be accepted into a neighborhood. This is often based on the myth that people living with a mental disorder or substance abuse problem will negatively impact community safety and property values. These arguments are based on myths, but NIMBY affects housing projects across the nation. People living with mental health and substance abuse problems live in all neighborhoods in all communities. But NIMBY is particularly noticeable when a group of people live together in a neighborhood.

Affordable housing is a vital element of healthy communities. When it is developed to meet resident and community needs and is well managed, it can change the lives of individuals and transform communities. While rental housing is the home of choice for a diverse cross-section of Americans, it is also the home of necessity for millions of low-income households. However, the share of US households unable to find affordable rentals has been on the rise for a half-century, with an especially large jump in the last decade as renter income fell even further behind housing and utility cost increases. Even as the need for affordable housing grows, long-run pressures continue to threaten both housing assisted by the government and supplied in the private market.

The affordable stock of rental properties has decreased significantly over the past decade for various reasons. In combination, the shrinking affordable stock, falling incomes, and increased competition from higher-income renters have widened the gap between the number of very low-income renters and the number of affordable, adequate, and available units. In 2003, 16.3 million very low-income renters in the United States competed for 12 million affordable and adequate rentals that were not occupied by higher-income households. By 2009, the number of these renters hit 18.0 million while the number of affordable, adequate, and available units dipped. 16.3 million very low-income renters competed for 12.0 million affordable and adequate rentals that were not occupied by higher-income households.[7]

On March 24, 2011, HUD published a new report that begins to more accurately reflect the extreme housing problems faced by people with disabilities struggling to pay for housing. HUD's 2009 Worst Case Housing Needs of People with Disabilities[8] states that:

- In 2009, approximately 1 million renter households that included non-elderly people with disabilities had worst case housing needs;
- Renter households that include nonelderly people with disabilities are more likely than those that don't include people with disabilities to have very low incomes, experience worst case housing needs, pay more than half of their income for rent, and have other housing problems such as living in inadequate or overcrowded housing;
- Between 2007 and 2009, there was a 13 percent increase in worst case needs households that included non-elderly people with disabilities. Renter households with disabilities were almost one and one-half

[7] http://www.jchs.harvard.edu/publications/rental/rh11_americas_rental_housing/AmericasRentalHousing-2011.pdf
[8] Souza, M., Collinson, R., Martin, M., Steffen, B., Vandenbroucke, D., and Yao, Y. 2009 Worst Case Housing Needs of People with Disabilities: Supplemental Findings of the Worst Case Housing Needs 2009: Report to Congress. U.S. Department of Housing and Urban Development, Office of Policy Development and Research. March, 2011.

times more likely to pay more than one-half of their income for rent than renter households without disabilities.

The challenges mentioned are currently coupled with federal and state budget challenges that could potentially exacerbate the affordable housing crisis in general and the crisis for persons with low incomes and behavioral health needs in particular. Collective action amongst and between all sectors involved in the development and provision of affordable housing and support services must be taken to address these challenges if we are to make any progress in increasing the availability of decent, safe and affordable housing for persons with significant behavioral health problems.

Purpose and Overview of this Report

The purpose of this Needs Assessment and Inventory of Resources is to identify and quantify the critical housing needs of persons who are impacted by mental illness and substance abuse, along with the housing and supportive service resources that are required to meet these needs in the Eastern Region of Missouri.

Two important notes:

- The report is not intended to be an exhaustive review of all the needs and resources that exist, but rather a focused and quantifiable overview of the needs and resources most critical to developing an initial plan of action for the region. In order to contrast and compare the needs and resources across the varying counties that comprise the region, there was a need to identify sources of data that were comparable. This was not always easy and some data collected could not be broken out for each individual county. When feasible, standardized surveys and interviews were administered to supplement existing data.
- The report almost exclusively addresses the housing needs and resources for adults. Although some information is included related to children and youth, the complexity of the services systems and housing needs necessitated a more narrow focus given the resources available for preparing this report.

The report is broken out into 7 major sections as follows:

1. **Eastern Region at a Glance-** this provides a broad overview of the population demographics and other information for each county represented in the region.
2. **Consumer Need Assessment**- This section attempts to identify the housing needs and preferences of persons with behavioral health needs across the Eastern Region based primarily on surveys, focus groups and interviews conducted in the region.
3. **Resources-Current Housing Stock**- This section provides information specific to the current housing stock and affordable housing resources that include publicly supported housing in the region. Included are the different types of housing units and beds available within a variety of settings across the region.
4. **Resources-Behavioral Health and Other Support Services-** There is a wide array of behavioral health services and other supportive services available throughout the Eastern Region. This section primarily

identifies the public behavioral health services available to support people in their home whether the person is living in completely independent housing or living in housing with on-site supports.

5. **Resource-Financing & Development**-There is a vast array of financing resources that are administered through a variety of governmental and other agencies at the federal, state and local level. This section attempts to identify and quantify the major sources of financing for the purposes of developing and operating affordable housing particularly as it relates to serving those with mental health needs. It also includes a summary of the financing sources that is available for supportive services.
6. **Policy, Financing and Practice Trends-**This provides a summary of the major trends that may have a significant impact in the development and provision of affordable housing and supportive services in the future.
7. **Gap Analysis and Recommendations-**This section summarizes the key findings of the report especially as they relate to the gaps that exist between the identified need and available resources. Preliminary recommendations for action are included to guide the next steps which includes the development of a regional action plan.

Eastern Region at A Glance

Description & Population Demographics

For the purposes of this report the Eastern Region of Missouri is comprised of the counties of **Franklin, Jefferson, Lincoln, St. Charles, St. Louis, Warren and the City of St. Louis**. These counties range from urban cities to a range of suburban counties and more rural, agricultural counties. The population density of the counties varies greatly; ranging from 75 persons per square mile of land in Warren County to 5157 persons per square mile in St. Louis City.

The overall population of the Eastern Region is 2,084,037. This represents 35% of Missouri's total population of 5,988,927. The region's population has increased by close to 4% overall with significant increases in the outlying counties of Lincoln, St. Charles and Warren Counties. **Table 1** provides an overview of the age, sex race, education level, employment and income status by county and region overall, as reported by the American Community Survey.[9] A brief description of each of the counties is provided below.

Franklin County -Union is the county seat of Franklin County, which has an estimated population of 101,492. Manufacturing is the dominant industry, primarily in the city of Washington. Small farms and wineries also contribute to the economy.

Jefferson County-Jefferson County, bordered on the east by the Mississippi River, has experienced rapid growth recently to 218,733 due to migration from St. Louis City and County. Manufacturing is the major industry. Interstate 55 connects the county to Memphis, the City of St. Louis, and Chicago.

Lincoln County-Lincoln County, whose county seat is Troy, is north of Warren and St. Charles Counties with the Mississippi River to the east. Manufacturing and service industries are major employers. The county is one of the fastest growing in the country with a population of 52,566, which increased by more than 35% from 2000 to 2010.

St. Charles County-St. Charles County, with a population of 360,485, has been one of the fastest-growing counties in the country for decades. The county features a cross-section of industry, as well as extensive retail and some agriculture. St. Charles County has two small airports and two ferries that cross the Mississippi River.

City of St. Louis-Home to an estimated 319,294 people within 61.9 square miles, the City of St. Louis is the most densely populated and industrial county in the metropolitan area. Manufacturing and corporate headquarters have a strong presence. Interstates 55, 70, 64, and 44 all pass through the city.

St. Louis County-With 998,954 residents, St. Louis County is the most populous of the metropolitan-area counties. There is still some agriculture along the Missouri River in the north, but overall the area is thoroughly suburban with many corporate offices and service businesses. Clayton, the county seat, is often called the St. Louis area's "second downtown".

Warren County-Warren County, population 32,513, is primarily agricultural. The Missouri River forms the southern border; Interstate 70 crosses the county east to west. Warrenton is the county seat.

[9] http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2009_5YR_G00_&_lang=en&_ts=343052211154

Table 1-Eastern Region Population Demographics	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Population, 2010	101,492	218,733	52,566	360,485	319,294	998,954	32,513	2,084,037
Population, percent change, 2000 to 2010	8.20%	10.40%	35.00%	27.00%	-8.30%	-1.70%	32.60%	3.85%
Land area, 2000 (square miles)	922.81	656.8	630.49	560.42	61.92	507.81	431.31	3771.56
Persons per square mile, 2010	110	333	83.4	643	5,157	1,967	75	553
Age/Sex (2009)								
Persons under 5 years	6.70%	6.80%	7.40%	6.80%	7.10%	6.10%	7.50%	6.53%
Persons under 18 years	24.90%	24.70%	27.30%	25.40%	22.30%	23.50%	25.30%	23.96% (499335)
Persons 65 years +	13.50%	10.90%	10.40%	11.00%	11.10%	14.60%	13.70%	12.88%
Female persons, , 2009	50.30%	50.20%	50.30%	50.70%	52.50%	52.30%	50.30%	51.65%
Race (2010)								
White	96.80%	96.50%	95.00%	90.70%	43.90%	70.30%	94.40%	74.82%
Black	0.80%	0.80%	1.90%	4.10%	49.20%	23.30%	1.90%	19.62%
American Indian and Alaska Native	0.30%	0.30%	0.30%	0.20%	0.30%	0.20%	0.40%	0.24%
Asian	0.40%	0.60%	0.40%	2.20%	2.90%	3.50%	0.40%	2.60%
Hispanic or Latino origin	1.40%	1.60%	2.00%	2.80%	3.50%	2.50%	2.90%	2.55%
Language other than English spoken at home	1.80%	3.50%	2.20%	5.70%	8.80%	7.90%	4.10%	6.70%
Education/Military (2005-2009)								
High school graduates,	83.50%	84.60%	82.40%	91.80%	79.50%	90.40%	82.00%	87.69%
Bachelor's degree +	16.60%	16.20%	10.10%	32.60%	25.50%	38.50%	15.50%	31.01%
Veterans	9,064	18,926	4,524	28,090	24,394	80,277	2,576	167,851
Household/Income 2005-2009								
Households	38,104	80,143	15,700	127,228	143,045	403,699	11,559	819,478
Persons per household	2.6	2.67	3.21	2.65	2.4	2.4	2.56	2.50
Per capita money income in past 12 months (2009 dollars)	$23,469	$24,609	$20,989	$30,517	$20,818	$33,236	$23,702	$29,024
Median household income, 2009	$49,034	$53,939	$50,795	$68,669	$34,065	$56,939	$49,201	$54,488
Unemployment Rate (2010)	11.04%	10.35%	11.54%	9.60%	12.27%	9.38%	11.01%	10.12%
Persons below poverty level, 2009	11,164 11.00%	22,966 10.50%	5,782 11.00%	18,385 5.10%	84,613 26.50%	95,900 9.60%	3,772 11.60%	242,582 11.64%
Children below Poverty,2008	3560 14.3%	6555 12.3%	2609 18.4%	5233 5.9%	28, 811 36.2%	29805 12.8%	1317 17.2%	77,890 15.6%

Consumer Need Assessment

Overview and Data Sources

This section attempts to identify the housing needs and preferences of persons with mental illness and/or addiction disorders (behavioral health needs) across the Eastern Region. When determining the housing needs, we have access to the following sources of information that are comparable across the Eastern Region:

- **2011 DMH Behavioral Health Epidemiology Workgroup County Profiles**
- **2010 Point-in-Time Counts conducted by each Continuum of Care**
- **2011 Consumer Survey and Focus Groups conducted by the BHN**
- **2011 Provider Interviews conducted by BHN**

The DMH Behavioral Health Epidemiology Workgroup County Profiles provides an overview of behavioral health key statistics in Missouri.

Continuum of Care Homeless Point-in-Time Counts are conducted to determine the number of sheltered and unsheltered individuals on one night in each Continuum of Care (CoC) region. Information is also gathered on subpopulations, which includes persons with behavioral health needs.

Consumer Survey and Focus Groups provides information on housing needs from the consumer point of view. It also identifies the housing preferences of persons with behavioral health needs.

Provider Interviews present housing needs as perceived by local providers.

Summary of Key Findings

The following is a summary of key findings based upon a review of the data collected:

- The Eastern Region had **28,497 individuals receiving publicly funded treatment** for behavioral health issues in 2010.[10] A majority of the people receiving these services are low-income given that the services are publicly, not privately, funded. Additionally, prior research shows that this population is more likely to be lower-income.
- The Continuum of Care Point-In-Time Counts shows a **significant over-representation of persons with severe mental illness and substance abuse disorders who are homeless.**[11]
- Of the consumers who completed the BHN Consumer Survey:[12]
    - **52% are currently looking for housing and 60% have searched for housing in the past 24 months;**
    - **64% identified housing as being too expensive** as the primary barrier keeping them from living where they want. Housing affordability was a key theme identified during the focus groups conducted by BHN and was also seen as a primary barrier;

[10] http://dmh.mo.gov/ada/mobhew/index.htm; reported by DMH Behavioral Health Epidemiology Workgroup; does not include all sources of public funding.
[11] "State of Homelessness in Missouri: 2011 Report", P 31. http://www.mhdc.com/ci/documents/SHM_2011.pdf
[12] Survey conducted by Behavioral Health Network. See Table 4.

  - **Four housing characteristics represented 79% of all responses** that caused clients to be satisfied with their housing. These were **privacy, independence, safety, and affordability;**
  - **85%** of the BHN Consumer Survey respondents **reported that they wanted to own and/or rent a house/apartment.** This indicates that clients believe the housing characteristics they value (privacy, independence, safety, and affordability) will be more prevalent by owning or renting their own house/apartment.
- The BHN Consumer Focus Groups also identified **privacy, independence, safety, and affordability** as impacting their level of satisfaction with their current housing. Additionally the focus groups identified: **access to transportation, access to housing information, and the need for greater employment opportunities** as impacting their level of satisfaction with their current housing:[13]
  - The lack of independence and privacy were of special concern for people living in residential care facilities;
  - Clients with addictions voiced concerns about returning to the same environment after treatment which was risky to their recovery;
- Providers consistently identified the housing needs for persons with behavioral health issues to include **the affordability of housing, the types of housing available, and the location of housing:**
  - The rental assistance programs available, such as shelter plus care and public housing, are already operating at capacity and there is a greater demand than the available resources. This means that clients must pay a higher percentage of their monthly income for a fair-market rent apartment;
  - Providers identified deposits for fair-market rent apartments to be a key barrier faced by clients;
  - Affordable housing is often located in less safe areas. One ADA provider referred to these neighborhoods as "**trigger areas"** and commented that it makes recovery much more difficult when a person is returning to the same environment that caused their illness;
  - Several interviewees commented that there are no "one-stop shops" for housing assistance. Instead clients must access services from multiple agencies based on what they need. Providers thought that if there was more communication between agencies they would be able to more effectively direct clients to where they needed to go so that their needs would be met.

The remainder of this section provides additional detail on the data collected.

2011 Behavioral Health Profiles

The Missouri Behavioral Health Epidemiology Workgroup represents state agencies and universities that share an interest in data on behavioral health. The workgroup is funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention. The group has recently created and published behavioral health profiles for each county in Missouri. Although population-based data remains limited for behavioral health, the profiles are an excellent starting point based upon data that is available.

Table 2 provides a snapshot of behavioral health indicators for the counties in the Eastern Region as reported in the county profiles. Full profiles by county can be accessed at http://dmh.mo.gov/ada/mobhew/index.htm

[13] Focus groups conducted by Behavioral Health Network. See page 16.

TABLE 2- 2011 Behavioral Health Profile	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Population 2010	101,492	218,733	52566	360,485	319,294	998,954	32513	2,084,037
Prevalence Estimates								
Serious Psychological Distress [14]	14,107	30,404	7,307	50,107	44,382	138,855	4,519	289,681
Illegal Drug Use	8,870	19,117	45,94	31,506	27,906	87,309	2,842	182,145
Alcohol Abuse	8,617	18,570	4,463	30,605	27,108	84,811	2,760	176,935
Total Illegal Drug Use and Alcohol Abuse	17,487	37,687	9,057	62,111	55,014	172,120	5,602	359,080
2009 BH Indicators								
DUI Arrests	444	2,055	209	2,288	644	6,091	207	11,938
Alcohol-related Traffic Accidents	172	295	59	348	181	803	31	1,889
Meth Lab Seizures	96	227	37	64	8	30	26	488
Drug Arrests	396	1,682	477	1,754	2,907	6,314	169	13,699
Suicide-# Committed 2009	23	32	3	47	49	130	3	287
Suicide Rate per 100,000	***22.7***	***14.6***	***5.7***	***13.0***	***15.3***	***13.0***	***9.2***	***13.8***
Received Publicly Funded Treatment[15]								
Serious Mental Illness	835	2,054	412	1,563	7,130	4,725	365	17,084
Substance Abuse	529	1,196	737	1,325	4,039	3,339	248	11,413
Total	**1,364**	**3,250**	**1,149**	**2,888**	**11,169**	**8,064**	**613**	**28,497**
% of Population(prevalence estimates) Receiving Publicly Funded Treatment								
Psychiatric Services	***5.9%***	***6.8%***	***5.6%***	***3.1%***	***16.1%***	***3.4%***	***8.1%***	***5.9%***
Substance Abuse Service	***3%***	***3.2%***	***8.1%***	***2.1%***	***7.3%***	***1.9%***	***4.4%***	***3.2%***

[14] Serious psychological distress (SPD) is a nonspecific indicator of past year mental health problems, such as anxiety or mood disorders. It is often used interchangeably with the "moderate or serious mental illness". Office of Applied Studies. (2008). Results from the 2007 National Survey on Drug Use and Health: National findings (DHHS Publication No. SMA 08-4343, NSDUH Series H-34). Rockville, MD: Substance Abuse and Mental Health Services Administration.

[15] This represents clients served by the DMH Division of Comprehensive Psychiatric Services (Psychiatric Services) and Division of Alcohol and Drug Abuse (Substance Abuse Services.)

Continuum of Care Homeless Point-in Time Counts

A Continuum of Care (CoC) is a collaborative funding and planning organization that applies for Housing and Urban Development (HUD) funding as a group. They are designed to provide emergency, transitional, and permanent housing for a region. The group consists of a variety of people and organizations that address homelessness as a community. The CoC is based on the principle that the underlying causes of homelessness are not only lack of shelter, but also unmet physical, social, and economic needs.

Figure 1 shows the Continuum of Care Regions. There are four CoC regions representing the Eastern Region. These include St. Louis City; St. Louis County; St. Charles, Lincoln, and Warren Counties; and Region 1 of the Balance of State, which includes Franklin and Jefferson Counties.[16]

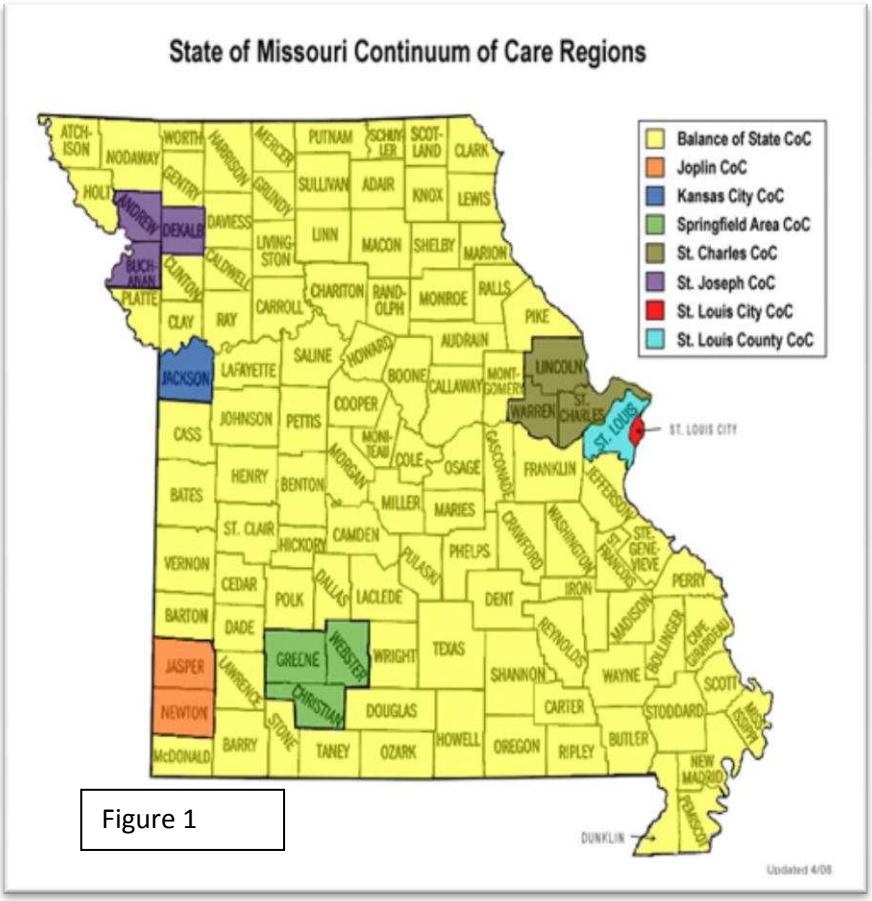


Figure 1

HUD requires CoCs to conduct Point-In-Time Counts (PITC) every odd number year to count sheltered and unsheltered people. Many CoCs conduct PIT counts annually. The PIT counts included in this report count the total number of sheltered and unsheltered homeless persons on a single night in January. Subgroup characteristics are also collected, such as persons with behavioral health illnesses. The data is collected by observation and by speaking with clients at a shelter or a location that provides services to homeless people (such as a soup kitchen). Due to the methodology, the data is seen as not fully representing subpopulations and it is likely that there are more persons with behavioral health needs who are not being counted in the PIT counts.

The data presented in **Table 3** shows that 19% of clients who are homeless are persons with a severe mental illness and 17% are persons with chronic substance abuse problems. Data is also included on the chronically homeless population because the definition of chronically homeless includes individuals with a "diagnosable substance use disorder, serious mental illness." About 30% of people who are chronically homeless have mental health conditions and about 50% have co-occurring substance use problems.[17]

[16] http://www.masw.org/HMIS/map.php#missouri
[17] "State of Homelessness in Missouri: 2011 Report," P. 31. http://www.mhdc.com/ci/documents/SHM_2011.pdf

Table 3 2010 Continuum of Care Point-In-Time Counts	Balance of State Region 1 (Includes Franklin and St. Charles, Lincoln Warren	StL City	StL County	Eastern Region TOTAL
Total Individuals				
• **Sheltered**	147	688	1,134	408	**2,377**
• **Unsheltered**	NA[18]	NA	171	251	**422**
• **Total**	147	688	1,305	659	**2,652**
% of Total Severely Mentally Ill					
• **% Sheltered**	6.8%	30%	16.9%	9.8%	**19%**
• **% Unsheltered**	NA	NA	24.6%	8.8%	**15%**
• **% Total**	6.8%	30%	17.9%	9.4%	**19%**
% of Total Chronic Substance Abuse					
• **Sheltered**	27.9%	6%	22.3%	11.8%	**16%**
• **Unsheltered**	NA	NA	22.2%	8%	**14%**
• **Total**	27.9%	6%	22.3%	10.3%	**17%**
% of Total Chronically Homeless[19]					
• **Sheltered**	25%	5.2%	10%	5.6%	**9%**
• **Unsheltered**	NA	NA	32.7%	6.4%	**34%**
• **Total[20]**	25%	5.2%	13%	6%	**11%**

Note: NA indicates that the CoC reported that it did not have this type of program or data.

[18] NA denotes that the CoC did not have this type of program or data.

[19] The Federal definition which defines a chronically homeless person as "either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years." A disabling condition is defined as "a diagnosable substance abuse disorder, a serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." In addition, "a disabling condition limits an individual's ability to work or perform one or more activities of daily living." Note this definition is changing as part of new legislation.

[20] According to the Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States (Last Updated July 2011) about 30% of people who are chronically homeless have mental health conditions and about 50% have co-occurring substance use problems (homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf).

Consumer Survey Results

The BHN conducted a consumer survey during the months of September and October. The survey was designed to be a "convenience survey", which would provide a simple, snapshot of the region. The target was 15 completed surveys from each of the counties in the Eastern Region. Surveys were sent directly to providers who offered services to behavioral health clients. In total, 132 surveys were completed.

Of the respondents who completed the survey:

- 56% were male and 74% were Caucasian. The largest age group responding was between 40 and 59 years old at 51%;
- 21% owned their own home, 39% rented a home or apartment and 21% lived with family and friends. 7% were currently homeless and the remainder lived in some type of residential care setting;
- 32% ranked their level of satisfaction 1-4 (dissatisfied), 36% ranked their level of satisfaction 5-7 (neutral), and 32% ranked their level of satisfaction as 8-10 (satisfied). 18% reported being totally satisfied with their current housing;
- 52% are currently looking for housing and 60% have searched for housing in the past 24 months;
- 64% identified housing as being too expensive as the primary barrier keeping them from living where they want. Housing affordability was a key theme identified during the focus groups conducted by BHN and was also seen as a primary barrier;
- Four housing characteristics represented 79% of all responses that caused clients to be satisfied with their housing. These were privacy, independence, safety, and affordability. The same four housing characteristics represented 72% of responses as to what caused clients to feel dissatisfied with their current housing;
- 85% of the BHN Consumer Survey respondents reported that they wanted to own and/or rent a house/apartment. This indicates that clients believe the housing characteristics they value (privacy, independence, safety, and affordability) will be more prevalent by owning or renting their own house/apartment.

Although the above provides a snapshot for the region, there were some significant differences in survey responses across counties that need to be taken into consideration. **Table 4** provides the detail of survey responses by county and for the region overall. The survey was organized to gather respondent demographics, current housing situation, and housing need.

Table 4- BHN Consumer Survey Response by County[21]	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Respondent Demographics								
Total Respondents	13	17	8	20	33	27	14	132
Gender								
• Male	77%	13%	63%	56%	61%	44%	79%	56%
• Female	23%	87%	37%	44%	39%	56%	21%	44%
Age Range								
• 18-25	15%	0%	25%	15%	6%	7%	29%	12%
• 26-39	8%	56%	38%	35%	21%	19%	36%	30%
• 40-59	69%	64%	25%	45%	64%	67%	36%	51%
• 60-75	8%	0%	12%	5%	9%	7%	0%	6%
Race								
• Caucasian	92%	94%	100%	95%	24%	37%	79%	74%
• African-American	8%	0%	0%	5%	76%	59%	14%	24%
• Hispanic	0%	6%	0%	0%	0%	4%	7%	2%
Current Housing								
Current Living Arrangements								
• I own a house/apartment	70%	50%	0%	7%	0%	15%	7%	21%
• I rent a house/apartment	15%	44%	25%	50%	42%	35%	64%	39%
• I live with family or friends	0%	6%	25%	33%	12%	39%	29%	21%
• I live in a group home that provides support services	0%	0%	25%	0%	6%	0%	0%	4%
• I live in an apartment that provides support services	0%	0%	0%	0%	3%	0%	0%	1%
• I live in an emergency shelter	0%	0%	0%	0%	15%	0%	0%	2%
• I live in a residential care facility	0%	0%	25%	0%	9%	0%	0%	5%
• I am homeless	15%	0%	0%	10%	12%	12%	0%	7%
Level of Satisfaction								
• 1-4	46%	19%	25%	35%	27%	30%	43%	32%
• 5-7	31%	50%	50%	48%	42%	22%	29%	36%
• 8-10	23%	31%	25%	17%	30%	48%	28%	32%
Reasons For Satisfaction								
• I have enough privacy	21%	19%	23%	13%	14%	15%	17%	17%
• I have enough independence	28%	21%	31%	22%	20%	20%	20%	23%
• It is affordable	21%	26%	31%	23%	19%	17%	29%	21%
• I feel safe	17%	17%	23%	24%	17%	20%	17%	19%
• I have access to support services	7%	10%	8%	4%	14%	11%	11%	9%
• I receive the level of care that I need	3%	7%	15%	4%	11%	12%	6%	9%
• I am completely unsatisfied with my current housing	3%	0%	0%	10%	6%	5%	0%	3%

[21] Not all questions total 100% due to rounding

Table 4- BHN Consumer Survey Response by County (continued)	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Reasons for Dissatisfaction								
• I do not have enough privacy	27%	25%	40%	33%	25%	15%	28%	28%
• I do not have enough independence	14%	0%	20%	14%	11%	12%	11%	12%
• It is too expensive	14%	19%	20%	19%	11%	10%	6%	14%
• I feel unsafe	32%	13%	10%	19%	15%	17%	22%	18%
• I do not have access to the support services I need	9%	0%	0%	5%	10%	12%	6%	6%
• I do not receive the level of care that I need	0%	6%	0%	5%	11%	12%	0%	5%
• I am completely satisfied with current housing	5%	38%	10%	5%	17%	22%	28%	18%
Current Financial Assistance								
• Section 8 voucher subsidy	8%	13%	0%	6%	18%	15%	20%	11%
• DMH voucher subsidy	17%	0%	25%	6%	9%	0%	7%	9%
• Shelter Plus Care	0%	0%	0%	0%	21%	0%	0%	3%
• Subsidy from a local provider	8%	0%	13%	35%	9%	0%	0%	9%
• Friends and family	25%	13%	38%	23%	12%	29%	33%	25%
• None	42%	73%	25%	30%	32%	56%	40%	43%
Housing Need								
Currently Searching for Housing								
• Yes	69%	25%	38%	45%	52%	25%	57%	52%
• No	31%	75%	62%	55%	48%	75%	63%	48%
Searched for Housing in Past 24 Months								
• Yes	69%	38%	38%	65%	64%	38%	57%	60%
• No	31%	63%	62%	35%	36%	62%	63%	40%
Housing Preferences								
• Own a house/apartment	43%	88%	40%	45%	29%	41%	50%	48%
• Rent a house/apartment	50%	12%	40%	23%	49%	33%	50%	37%
• With family or friends	7%	0%	0%	23%	9%	19%	0%	8%
• Group home that provides support services	0%	0%	10%	0%	0%	11%	0%	3%
• Apartment that provides support services	0%	0%	10%	5%	3%	15%	0%	5%
• Emergency shelter	0%	0%	0%	0%	3%	4%	0%	1%
• Residential care facility	0%	0%	10%	0%	9%	0%	0%	3%
Barriers to Accessing Housing								
• Too expensive	80%	60%	50%	58%	61%	59%	57%	64%
• Landlords have not been willing to rent to me	6%	7%	13%	15%	7%	14%	29%	13%
• The subsidies I am eligible for do not apply to the housing I want	7%	7%	13%	15%	4%	0%	7%	8%
• I have not chosen my own housing	7%	7%	13%	16%	7%	18%	7%	9%
• The housing I wanted was unavailable	0%	7%	13%	0%	21%	9%	0%	7%
Sources of Housing Information								
• I have never gotten information on housing	15%	24%	15%	29%	13%	24%	19%	20%
• Friends and family	25%	21%	31%	23%	20%	21%	19%	23%
• Social Workers/Case Managers	20%	21%	15%	19%	44%	21%	19%	24%
• Public Housing Agency	5%	10%	0%	9%	7%	10%	13%	7%
• I have done my own research	35%	24%	39%	20%	17%	24%	31%	26%

Consumer Focus Group Results

Background

The availability of physical housing and housing resources for behavioral health clients vary from community to community. Each client has their own unique housing needs. Data was gathered to capture multiple points of view on the needs consumers think have not been addressed within the existing resources to which they have access.

During the month of September 2011, four focus groups were convened in the Eastern Region of Missouri. A total of 43 individuals participated in the focus groups. The focus groups targeted specific geographic areas to ensure that consumer input was gathered from as large a catchment area as possible within the entire region. Consumers with a variety of mental illnesses and alcohol and drug abuse disorders participated. The focus groups explored what consumers liked about their current housing, what they disliked, what consumers would want to change, and what assistance the clients need to make these changes.

There were multiple themes that came up in all of the focus groups. The Summary of Key Themes presents the topics that were most prevalent across all focus groups.

Procedure

The BHN contacted four agencies across the Eastern Region who serve behavioral health clients and asked them to host and recruit consumers to participate in the focus groups. Focus group members received $10 gift cards to Walgreens for participating in the focus group. At the beginning of each focus group, participants were asked to complete an anonymous demographic questionnaire. This allowed the researchers to learn demographic information, usual source of income, clients' current zip code, and their current living arrangement.

Two facilitators attended three of the focus groups and only one was available for the fourth focus group. There was one primary facilitator and one primary note-taker; in the fourth case the facilitator performed both tasks. The conversations with all of the focus groups were recorded to ensure accuracy of consumer comments. In the focus group with one facilitator, the recorder provided support in note taking.

Table 5 outlines the location and the demographics of participating consumers.

Table 5 – BHN Focus Group Location	Agency	# of Participants	Average Age Range	% Female	% Male	% Caucasian	% African-American
Jefferson County	COMTREA	8	40-59	38%	62%	88%	22%
St. Louis City	Independence Center	12	40-59	50%	50%	58%	42%
St. Louis City	Adapt of Missouri	11	40-59	55%	45%	64%	36%
St. Charles County	Bridgeway Behavioral Health	12	26-39	33%	67%	67%	33%

35 clients listed SSDI and/or SSI as their usual source of income. Six clients listed none, or did not know their usual source of income. Two clients had part-time employment listed as their usual source of income.

Summary of Key Themes

The focus groups represent a subsection of behavioral health consumers in the eastern region. When the results of all the focus groups were analyzed there were many recurring themes. The following list represents the topics that came out during two, or more, focus groups.

- **Mentioned by 4 of 4 Groups**
  - Affordability
  - Independence
  - Access to transportation
- **Mentioned by 3 of 4 groups**
  - Employment opportunities
  - Access to housing resource information
- **Mentioned by 2 of 4 Groups**
  - Privacy
  - Safe neighborhoods
  - Concern of losing support systems
  - Access to Support services
  - Assistance with home maintenance
  - Relationships with landlords

What follows is a more detailed description of each of the themes.

Affordability

Mentioned by four out of four groups

The affordability of housing was a recurring theme across all focus groups. Affordability directly impacted clients' ability to access the housing they wanted. A combination of having a low income and rents being too high stopped clients from accessing the housing they wanted. One client stated that rents should be determined by level of income, explaining that someone with a higher income should pay more for rent than someone with a lower income for the same housing. High rent required clients in RCFs and group homes to share rooms and bathrooms with other clients because they could not afford single rooms, which was their preference. Clients living in RCFs felt that the "spending money" they received on a monthly basis was so small that they would never be able to save enough money to put down a security deposit for their own home. Consumers suggested that lower income housing needs be developed so that rents would be cheaper. Consumers also stated that they needed some kind of rental assistance in order to access the housing they wanted. Clients who already had some form of rental assistance, such as Shelter Plus Care, reported that the voucher succeeded in giving them access to the housing they wanted. Consumers recommended that more vouchers be made available through HUD and DMH. Other clients suggested that by helping them with other costs, like utilities and home maintenance, their rent would be more affordable. Affordability had other indirect impacts on clients' lives that are apparent in themes presented below.

Greater Independence

Mentioned by four out of four groups

Consumers living in independent housing commented that they valued their independence. Several clients had lived in RCFs and group homes previously and said that they preferred their current living situation as opposed to living in a congregate living setting where they had less independence. Consumers living in RCFs and group homes commented that the structured nature of their living environments impacted the amount of independence they have. Some facilities limit the number of showers consumers take per week, distribute cigarettes to clients throughout the course of a day, and have curfews. Consumers also stated that there is little variation in the food provided and that they are not allowed to cook for themselves or request that other foods be provided. There was concern that the staff at RCFs are not trained to teach clients how to care for themselves; instead they do everything for the client which increases their dependence on the RCF services. There were others who valued these services and thought that they needed these types of services and benefitted from them.

Access to transportation

Mentioned by four out of four groups

Consumers commented that they disliked that there was limited access to transportation where they lived. Either there was no public transportation, or the available transportation was too expensive for clients to use on a regular basis due to their limited income. The clients felt that transportation was crucial to access support services that that they needed on a daily basis. These included peer-support groups like Alcoholics Anonymous and services provided by local agencies. Access to transportation also affected consumers' quality of life in general by preventing them from going where they wanted when they wanted. Consumers felt they needed to live closer to services that they needed to access and suggested that low income housing be built near areas where services already exist. Another recommendation was for an agency to contract with call-a-ride to pick up consumers for specific meetings or provide taxi vouchers.

More employment opportunities

Mentioned by three out of four groups

Some clients stated that if they were employed, then their level of income would be greater and they would not have to rely on low income housing or housing vouchers. Consumers commented that additional job training and job placements programs were needed. Several clients emphasized that more jobs need to be made available for people with criminal records and for people recovering from addictive disorders.

Access to housing resource information

Mentioned by three out of four groups

A barrier identified by consumers was a lack of knowledge of where to get assistance with accessing different housing and who they should talk to. Consumers expressed confusion on where they should go to get

information on housing. Some said they needed help searching for affordable housing. Others said they needed assistance in applying for financial support. Overall, clients seemed generally confused on what their rights were as tenants and where they should get help if they feel that they have been discriminated against or if their landlord has broken their rental agreement.

Need for Privacy

Mentioned by two out of four groups

Consumers valued having their own rooms. It was important for people to have their own space and privacy, especially in congregate living setting like RCFs and group homes. Clients who had their own rooms in these congregate living facilities commented that they were much happier with their current housing than living situations in the past when they had to share rooms. Consumers also preferred having their own bathroom. While some clients emphasized the need for privacy and their own room, many still liked living in a congregate setting because they were not alone and were able to make friends. Clients who currently lived in their own apartment commented that they valued their privacy and a primary reason they were satisfied with their current housing was because of the level of privacy they had.

Safe neighborhoods

Mentioned by two out of four groups

Living in a safe neighborhood was important for clients. Clients who felt they lived in a safe neighborhood commented that this was a benefit to their current housing situation. There were also clients who felt they lived in less safe areas, which caused them to not be satisfied with their current housing situation. Clients explained that the housing they could afford was located in areas that were less safe, which ties back into the larger issue of affordability in accessing housing. Additionally, ADA clients expressed concern with having to return to the same environment after treatment which was risky to their recovery.

Concern of losing support systems

Mentioned by two out of four groups

There was concern that if clients moved out of their current housing they would lose access to support systems that they had developed. These supports included relationships with staff, other clients living in a congregate setting, and support from their family and friends. These relationships and support systems made clients feel comfortable with their current housing, even if they also expressed a level dissatisfaction with their housing. There was a sense that “things could be much worse,” which made clients not want to risk losing the existing support they had.

Access to Support Services

Mentioned by two out of four groups

An advantage to living in less-independent housing was that clients had direct access to some support services. Clients expressed satisfaction with several of these support services. Medicine management was mentioned as being especially valuable for clients and so was having access to a therapist. There was a concern that if clients moved to a more independent living setting, they would no longer have access to these support services. A number of clients had payees and power of attorneys who helped them manage their money. Clients living in independent apartments commented that having assistance in managing their bills was especially helpful and made living independently less difficult for them.

Assistance with home maintenance

Mentioned by two out of four groups

Consumers who owned their own homes, or who lived with family or friends that owned their own homes, said that they were dissatisfied with their current housing because of the amount of maintenance they required. The cost associated for the needed maintenance was too much given the individual consumer's level of income. As a result of not having enough income, they were not maintaining their homes as much as they would like. Additionally, some consumers did not know how to take care of their homes on their own.

Relationships with landlords

Mentioned by two out of four groups

Some consumers who lived in rented homes said that they had had negative experiences with landlords. Most of the concerns were that landlords were taking too long, or not responding, to maintenance requests. Several clients felt they had been discriminated against by landlords because of their behavioral health illness as they searched for housing or had been manipulated into paying more rent than other tenants.

Provider Interview Results

Ten phone interviews were conducted during the week of November 28th with housing and behavioral health providers across the Eastern Region. The purpose of the interviews was to get the provider point-of-view on the housing needs for persons with behavioral health issues and to learn what resources providers felt they needed. The core questions of the interviews were:

1. What do you think the housing needs are for the clients you/your organization serve?
2. What resources do you/your organization need to more effectively serve the housing needs of your clients?

Table 6 shows the name and agency of who was interviewed:

Table 6-Housing Provider Interview Name	Organization
Amy Ring	Bridgeway Behavioral Health
Nancy Pope	Disability Resource Board
Gloria Lee	Our Lady's Inn
Mary Lauenger	Our Lady's Inn
Rosie Buchanan	Economic Development Corporation of Jefferson County
Scott Bayliff	Places for People
Jennifer Perera	COMTREA
Carla Potts	North East Community Action Center
Linda Huntspon	Queen of Peace
Miriam Mahan	Sts. Joachim and Ann Care Service

Summary of Interviews

The people interviewed consistently identified the housing needs for persons with behavioral health issues to include: **the affordability of housing, the types of housing available, and the location of housing.**

The consensus was that the available housing across the region is too expensive, especially for persons living on a fixed income. Providers also stated that housing affordability is the primary concern for clients and that accessing support services is a secondary concern. The rental assistance programs available, such as shelter plus care and public housing, are already operating at capacity and there is a greater demand than the available resources. This means that clients must pay a higher percentage of their monthly income for a fair-market rent apartment. Providers identified **deposits for fair-market rent apartments to be an initial barrier** faced by clients. People living on a fixed income cannot afford an upfront cost in addition to their first month's rent. Housing affordability is a huge issue for behavioral health clients and is also a problem for the larger community of low-income people. Housing providers commented that they have experienced an increase in the number of calls received from people with minimum wage jobs who also need assistance paying for housing. Areas with a higher percentage of home ownership have seen an increase in the need for home ownership counseling because of bad credit and increase in home foreclosures.

Providers identified that **additional housing with support services**, both transitional and permanent housing, are needed. Getting a client housed is not enough. It is crucial for clients to remain housed. This requires support services and includes helping clients pay their bills, general keep-up of their housing unit, and medicine management. Providers also said that these support services need to be flexible so that they can meet individual clients' needs as they arise. This is challenging for providers serving clients with substance abuse problems because the case management available is less than for persons with mental illness. Additionally, several providers mentioned that there is a **lack of housing units available for large families** that have more than four children.

The location of housing is important because clients need to live in a safe and decent neighborhood where they either have direct access to support services or access to public transportation so that they can get to service providers. Affordable housing is often located in less safe areas. One ADA provider referred to these neighborhoods as "**trigger areas"** and commented that it makes recovery much more difficult when a person is returning to the same environment that caused their illness. Access to public transportation is needed, especially in rural areas, so that a person may access support services and employment opportunities.

The obvious resource that providers felt they needed was additional financial resources for their organization and for the region so that more housing would be developed. Providers also commented that better communication was needed between organizations serving similar populations.

Providers felt that additional financial resources need to be allocated for housing development and to fund support services. Additional funding could be used for rental assistance and the expansion of existing programs such as SCLP and shelter plus care. Several providers also thought funding could be used to assist clients with the one-time payment of a deposit. Funding for support services would allow providers to increase their staff capacity and serve more clients.

Several interviewees commented that there are no "one-stop shops" for housing assistance. Instead clients must access services from multiple agencies based on what they need. Providers thought that if there was more communication between agencies they would be able to more effectively direct clients to where they needed to go so that their needs would be met. One example is that an agency was receiving calls requesting assistance with home ownership, but this agency did not have any home ownership programs. This organization developed an informal relationship with another agency that specialized in home ownership counseling and was able to direct clients to this group for assistance. This type of simple communication and coordination allowed for clients to get what they needed more effectively.

Resources- Current Housing Stock

Overview and Data Sources

This section provides information specific to the current housing stock and affordable housing resources that include publicly supported housing in the region. We have access to the following sources of information that are comparable across the Eastern Region to determine what the housing resources are:

- **2010 US Census Data**
- **2010 Homeless Management Information System (HMIS) Data**
- **2008 Public Housing Units and Section 8 Vouchers**
- **2010 DMH Supported Community Living Program Data**

Regional Housing Market data was gathered from the US Census Bureau and provides comparable housing data across counties in the Eastern Region. This includes information on renter versus owner occupied units, mortgagees, rental costs, and the gross rent as a percentage of monthly income.

Homeless Management Information System (HMIS) Data provides information on the number of individuals who are receiving housing services through the Continuum of Cares and he total beds/units funded in the region as reported by the continuums in 2010. Data is also provided on subpopulations, including persons with behavioral health needs.

Housing and Urban Development (HUD) Public Housing and Reported Number of Section 8 Vouchers shows the total number of units and vouchers available by county. It also shows the percentage of people who have a disability, which includes behavioral health illnesses.

DMH Supported Community Living Program Data was collected for both service and residential/housing support resources. It provides information on the services and types of residential settings funded along with the total bed capacity of the residential facilities that DMH contracts with. It also shows the type of housing clients are living in through DMH's Supported Community Living Program (SCLP).

Summary of Key Findings

The following is a summary of key findings identified from the data collected.

- Data from the US Census Bureau shows that there are vacant homes across the Eastern Region, suggesting that there is available housing for people to live in. However, the same data also shows that the median rental rates in the Eastern Region averages between $500-$749.[22]
- Almost 50% of the renter-occupied units in the Eastern Region are paying 30%, or more, of their monthly household income on their rent.[23]

[22] http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2009_5YR_G00_&_lang=en&_ts=343053788130
[23] Ibid.

- 40,623 individuals in the Eastern Region are receiving Supplemental Security Income.[24] This is an average payment of $674 per month.[25] For a client whose primary source of income is SSI, paying fair market rent consumes most if not all of their monthly income and they are priced out of the market.
- The Continuum of Cares (CoCs) in the region provides a total of 3,750 beds in the Eastern Region.[26] These beds include emergency shelter, transitional housing and permanent supportive housing. During the 2010 Point-in-Time Counts, the regional CoCs identified 44% of the available beds being occupied by persons with behavioral health needs (these people were identified as being severely mentally ill, having chronic substance abuse, or being chronically homeless).[27] This means that an estimated 1,650 beds of the total beds available through the continuum of care are being utilized by behavioral health clients. Additional beds are available through organizations that are not members of a continuum of care. The exact number of these beds is unknown because they are funded by private donations and grants and not public funds.
- There are a total of 954 emergency shelter beds available funded through the continuum of cares across the region.[28] There is a higher concentration of emergency shelters in St. Louis City and St. Louis County. The outlying counties have some emergency shelters specifically for women. Those who cannot access emergency shelters, rely on emergency motel vouchers. Overall there is a shortage of emergency shelter in more rural communities, especially for single men.
- There are a total of 1,278 transitional housing beds in the Eastern Region funded through continuum of cares.[29] The transitional housing in the region is either specialized for behavioral health clients, or is scattered site/vouchers. Again there is a higher concentration in St. Louis City and St. Louis County. This shows the trend of moving away from congregate living settings to transitional housing that is integrated with the larger community through the use of voucher programs. Again, there is an obvious shortage of beds available given the need identified in the previous section.
- There are a total of 1,518 total permanent supportive beds in the Eastern Region funded through the continuum of cares permanent supportive housing programs are almost all scattered site and voucher programs.[30] St. Louis City has the highest number of beds funded and has made a conscious effort to allocate more resources for permanent supportive housing.[31] There is a gap in the permanent supportive housing in more rural areas, especially in Jefferson and Franklin Counties.
- Other housing resources are available that are not funded through the CoCs. One example is Oxford Houses for persons recovering from addictions. There are a total of 172 beds in the Eastern Region.[32] 101 beds (59%) are located in St. Louis City, which illustrates again that lack of availability of specialized housing in Jefferson, Franklin, Warren, and Lincoln Counties for recovering alcohol and drug abusers.[33]

[24] http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2010/mo.pdf
[25] http://www.tacinc.org/resources/data/pricedout/results.php?yr=2010&state=MO&areaid
[26] State of Homelessness in Missouri: 2011 Report," P 71-103. http://www.mhdc.com/ci/documents/SHM_2011.pdf
[27] State of Homelessness in Missouri: 2011 Report," P 41. http://www.mhdc.com/ci/documents/SHM_2011.pdf
[28] State of Homelessness in Missouri: 2011 Report," P 71-103. http://www.mhdc.com/ci/documents/SHM_2011.pdf
[29] Ibid.
[30] Ibid.
[31] http://stlouis-mo.gov/government/departments/human-services/homeless-
[32] "An Evaluation of the Network of Oxford Houses: Missouri," P 23. http://www.oxfordhouse.org/userfiles/file/doc/eval_mo2009.pdf
[33] "An Evaluation of the Network of Oxford Houses: Missouri," P 23. http://www.oxfordhouse.org/userfiles/file/doc/eval_mo2009.pdf

- DMH contracts with different residential facilities in the region. These facilities offer a total of 5,243 beds in the Eastern Region.[34] 1,184 beds (23%) are located in a Residential Care Facility I or II and 3,941 beds (75%) are located in a Specialized Nursing Facility.[35] The remaining 2% of the beds are spread across more specialized residential facilities, such as psychiatric group homes.
- DMH provides subsidies for 1,423 behavioral health clients who meet their funding requirements. Of these, 846 (60%) clients live in apartments.[36] The remaining 40% live in some type of residential facility mentioned above. It is unknown how many of the remaining beds located in residential facilities are occupied by behavioral health clients. There are more total residential beds in St. Louis City and St. Louis County, but the total number is more equally distributed across the region. This suggests that the absence of permanent supportive beds has caused people to take advantage of the available beds at residential facilities, especially in Jefferson and Franklin Counties.
- HUD also provides housing support for low-income people through Public Housing and Section 8 Certificates and Vouchers. There are a total of 3,898 Public Housing units in the Eastern Region, however, there are no Public Housing units in Franklin, Lincoln, and Warren Counties.[37] 1,389 (36%) occupying these units are persons with disabilities.[38] There are a total of 14,933 Section 8 Certificates and Vouchers in the Eastern Region.[39] 3,864 (26%) using these vouchers are persons with disabilities. We know that these two programs are providing 5,253 units to persons with disabilities, however we cannot determine the number of disabilities attributed to serious mental illness and addictions.
- Most of the rental assistance resources are already operating at full capacity. In some cases, there is a five to ten year waitlist for vouchers, such as Section 8. Such a long waitlist shows the high demand for these vouchers and also demonstrates the high need for rental assistance.
- There is a clear absence of affordable housing across the region for low-income people, especially for persons with behavioral health needs. This absence has caused additional stress on the resources that do exist. This is especially apparent in more rural counties that have very little, and in some cases no permanent supported housing and very few housing options for behavioral health clients.

Regional Housing Market

Tables 7 and 8 provide information from the US Census Bureau on the housing stock in each county. The data suggests that the region lacks sufficient affordable housing units. The median monthly rent is $500-$749, which is too expensive for a consumer whose primary income is SSI or SSDI. More alarming is that almost 50% of the renter-occupied units are paying 30%, or more, of their monthly household income on their rent. Ideally, a person should not pay more than 30% of their household income on rent. This information demonstrates that the existing housing stock does not include enough affordable housing units.

[34] Data provided by Department of Mental Health Supported Community Living Program
[35] Ibid.
[36] Ibid.
[37] http://www.huduser.org/portal/picture2008/form_1S4.odb
[38] http://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/disabilities/inhousing
[39] http://www.huduser.org/portal/picture2008/form_1S4.odb

Table 7 - Housing Stock Data from Census[40]	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Population, 2010	101,492	218,733	52,566	360,485	319,294	998,954	32,513	**2,084,037**
Housing units, 2009	43,680	88,396	17,841	138,268	181,497	435,939	14,329	**919,950**
Homeownership rate, 2005-2009	76.40%	84.50%	80.70%	82.70%	49.50%	73.40%	77.40%	**72.90%**
Housing units in multi-unit structures, percent, 2005-2009	10.50%	9.00%	6.00%	14.70%	52.20%	23.20%	8.50%	**23.40%**
Median value of owner-occupied housing units, 2005-2009	$143,100	$150,900	$150,400	$193,500	$119,900	$175,000	$156,500	**$164,766**
Living in same house 1 year ago, pct 1 yr old & over, 2005-2009	86.80%	87.60%	85.90%	87.30%	79.20%	86.10%	84.90%	**85.42%**
Occupied housing units	38,456	81,122	16,114	131,569	146,463	402,346	12,012	**828,082**
Vacant housing units	5,222	7,249	1,603	6,704	35,044	33,615	2,137	**91,574**
1-unit, detached	33,105	66,908	13,361	103,031	76,784	314,570	10,468	**618,227**
1-unit, attached	683	1,231	129	8,685	8,513	18,493	287	**38,021**
2 units	881	880	341	2,195	28,713	6,511	131	**39,652**
3 or 4 units	1,114	3,015	383	4,601	25,796	23,067	378	**58,354**
5 to 9 units	839	1,307	255	4,504	11,145	24,908	537	**43,495**
10 to 19 units	1,368	1,893	38	4,885	5,858	23,895	73	**38,010**
20 or more units	186	1,222	23	5,931	24,517	22,901	89	**54,869**
Mobile home	5,502	11,915	3,183	4,441	181	1,550	2,186	**28,958**
Boat, RV, van, etc.	0	0	4	0	0	66	0	**70**
Lacking complete plumbing facilities	42	189	13	227	208	1,611	24	**2,314**
Lacking complete kitchen facilities	161	254	112	584	1,189	2,628	23	**4,951**
No telephone service available	274	1,392	520	1,134	3,947	9,257	207	**16,731**
Owner-occupied	29,401	68,327	13,318	106,730	68,242	288,016	9,329	**583,363**
Renter-occupied	9,055	12,795	2,796	24,839	78,221	114,330	2,683	**244,719**
Housing units with a mortgage	19,474	48,088	9,513	86,207	49,324	207,600	6,161	**426,367**
Housing units without a mortgage	9,927	20,239	3,805	20,523	18,918	80,416	3,168	**156,996**

[40] http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2009_5YR_G00_&_lang=en&_ts=343053788130

Table 8- Rental Data from 2009 Census[41]	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Occupied units paying rent (some units-no rental charge)	**8,214**	**11,607**	**2,486**	**23,950**	**75,722**	**109,719**	**2,436**	**234,134**
Less than $200	0	33	74	448	2,570	1,386	87	**4,598**
$200 to $299	329	545	92	644	3,358	2,580	93	**7,641**
$300 to $499	1,244	1,714	511	1,814	11,316	6,982	462	**24,043**
$500 to $749	4,108	4,844	831	7,106	30,440	35,080	693	**83,102**
$750 to $999	1,687	2,855	737	7,322	17,474	37,318	732	**68,125**
$1,000 to $1,499	811	1,390	224	4,889	9,426	21,057	345	**38,142**
$1,500 or more	35	226	17	1,727	1,138	5,316	24	**8,483**
Gross Rent as % of Household Income								
Total Occupied Units*	**8,202**	**11,316**	**2,479**	**23,889**	**73,655**	**108,055**	**2,347**	**229,943**
Less than 15.0 percent	**1,683**	**1,153**	**356**	**3,895**	**10,682**	**15,467**	**325**	**33,561**
15.0 to 19.9 percent	**777**	**2,010**	**140**	**3,756**	**7,451**	**12,727**	**136**	**26,997**
20.0 to 24.9 percent	**770**	**1,279**	**419**	**4,031**	**7,979**	**13,616**	**262**	**28,356**
25.0 to 29.9 percent	**716**	**1,521**	**338**	**2,801**	**8,504**	**12,048**	**303**	**26,231**
30.0 to 34.9 percent	**739**	**828**	**219**	**2,045**	**5,264**	**9,849**	**183**	**19,127**
35.0 percent or more	**3,517**	**4,525**	**1,007**	**7,361**	**33,775**	**44,348**	**1,138**	**95,671**
% of total paying > 35% Income	***43%***	***39%***	***41%***	***31%***	***46%***	***41%***	***49%***	***42%***

some units not computed

Publicly Supported Affordable Housing Resources

Continuum of Care Housing (CoC) Resources

The CoC, (referenced earlier in this document) is developed through collaboration with a broad cross section of the community and is based on a thorough assessment of homeless needs and resources. The U.S. Department of Housing and Urban Development (HUD) recommends the CoC model as a comprehensive and strategic approach to addressing homelessness. If an agency wants to apply for HUD funding to develop affordable housing with supportive services for homeless persons with disabilities, the agency must typically participate in its local Continuum of Care. Each CoC coordinates its own application process to HUD for all agencies within the CoC that are seeking HUD Homeless Assistance funds. Each CoC is also charged by HUD to develop a plan to end homelessness within the area covered by the CoC . The following sections provide data from HUD

[41] http://factfinder.census.gov/servlet/ADPGeoSearchByListServlet?ds_name=ACS_2009_5YR_G00_&_lang=en&_ts=343053788130

Homeless Resource Exchange on the three main types of housing provided in the Eastern Region: Emergency Shelters, Transitional Housing and Permanent Supportive Housing. (**See Appendix A-Glossary of Terms for definitions of each**)

Emergency Shelters

The number of Emergency Shelter Units and Beds reported by each Continuum of Care is outlined in **Table 9**. There is a higher concentration of emergency shelters in St. Louis City and St. Louis County. The outlying counties have some emergency shelters for women impacted by domestic abuse. Men, and women who cannot access emergency shelters specifically for domestic violence victims, rely on emergency motel vouchers. Overall there is a shortage of emergency shelter in more rural communities, especially for single men.

Table 9 -Emergency Shelter Bed and Unit Capacity by CoC[42]	Franklin (Region 1 BoS)	Jefferson (Region 1 BoS)	St. Charles, Lincoln Warren	StL City	StL County	TOTAL
Emergency Shelter for Families						
○ **Units**	0	0	5	0	0	**5**
○ **Beds**	0	0	45[43]	0	0	**45**
Emergency Shelter for Mixed Populations						
• **Family**						
○ **Units**	12	6	9	76	63	**166**
○ **Beds**	42	22	39	196	200	**499**
• **Individuals**						
○ **Beds**	12	3	16	45	49	**125**
Emergency Shelter for Single Individuals						
• **Family**						
○ **Units**	0	0	2	0	0	**2**
○ **Beds**	0	0	6	0	0	**6**
• **Individuals**						
○ **Beds**	0	0	6	239	26	**271**
Safe Haven Single Individuals						
○ **Beds**	0	0	0	8	0	**8**

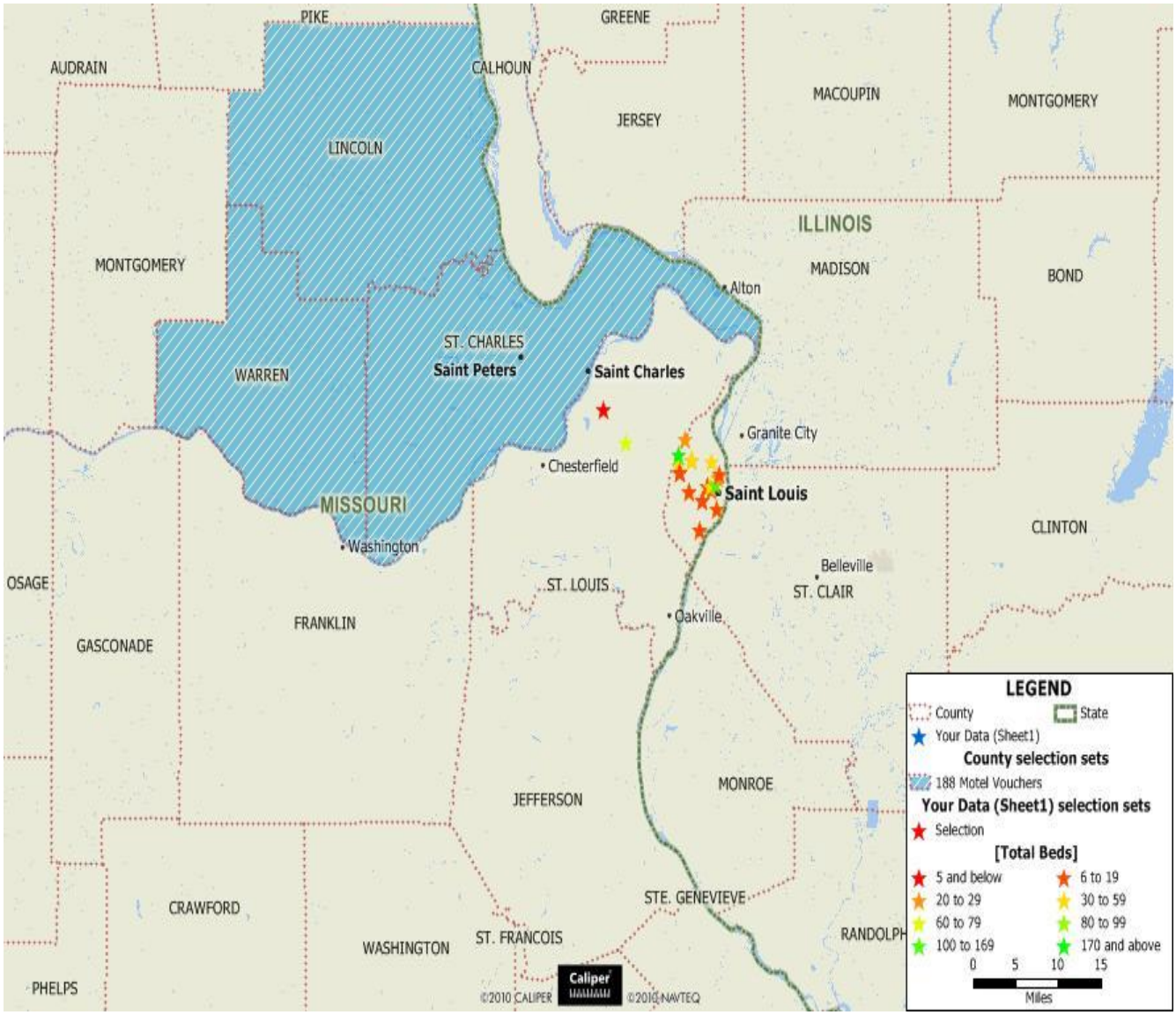
Figure 2 highlights the physical location of the emergency shelter beds available in the region. The stars on the map represent the physical locations of emergency shelters. The colors of the stars reflect the number of beds at the specific facility. The shaded region represents emergency motel vouchers available in the region (it also includes overflow vouchers). The Map Legend provides data for specific numbers of beds and vouchers.

[42] http://www.hudhre.info/index.cfm?do=viewHomelessRpts
[43] 30 Beds listed as "Overflow/Voucher"

Emergency shelters exclusively serving women do not disclose their physical address for security reasons and are not represented on the map.

There is a high concentration of emergency shelter facilities in St. Louis City. Jefferson and Franklin Counties both have emergency shelters for women, but are not marked. These counties do not have emergency shelters for single men.

Figure 2-Emergency Shelter Location Map[44]



[44] Map made by Behavioral Health Network. Addresses were gathered by calling providers directly.

Transitional Housing

The number of Transitional Housing Units and Beds reported by each Continuum of Care is outlined in **Table 10**.The transitional housing in the region is either specialized for behavioral health clients, or is scattered site/vouchers. This shows the trend of moving away from congregate living settings to transitional housing that is integrated with the larger community. Again, there is a higher concentration in St. Louis City and St. Louis County.

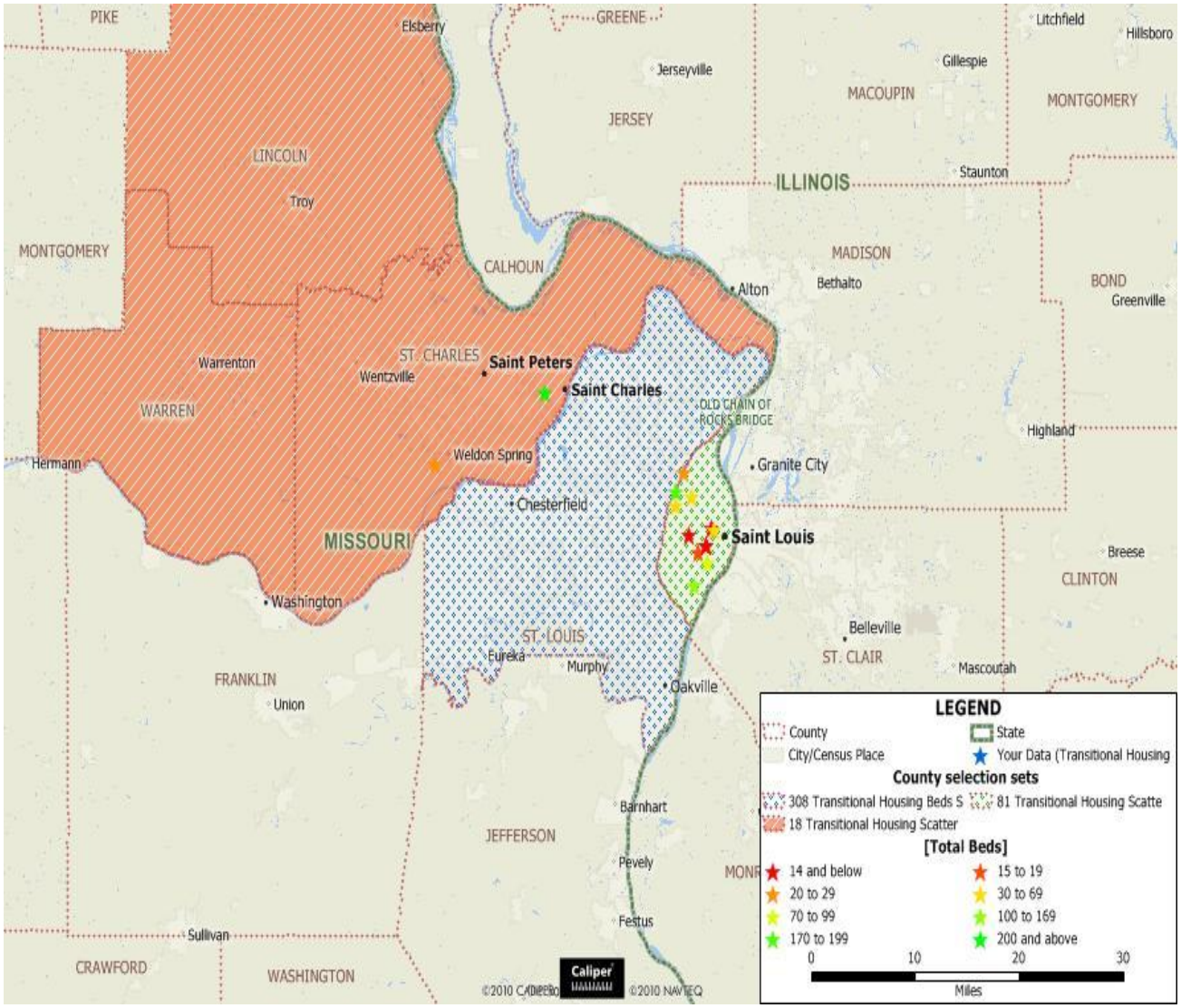
Table 10-Transitional Housing Bed and Unit Capacity by CoC[45]	Franklin (Region 1 BoS)	Jefferson (Region 1 BoS)	St. Charles, Lincoln Warren	StL City	StL County	TOTAL
Transitional Housing for Families						
○ **Units**	0	0	4	61	25	**90**
○ **Beds**	0	0	16	309	85	**410**
Transitional Housing for Mixed Populations						
• **Family**						
○ **Units**	3	0	64	100	9	**176**
○ **Beds**	18	0	160	256	30	**464**
• **Individuals**						
○ **Beds**	8	0	136	14	2	**160**
Transitional Housing for Single Individuals						
• **Individuals**						
○ **Beds**	0	0	0	232	12	**244**

Figure 3 highlights the physical location of the transitional housing beds available in the region. The stars on the map represent the physical locations of transitional housing facilities. The colors of the stars reflect the number of beds at the specific facility. The shaded regions represent vouchers and/or scattered site facilities available in the region. The Map Legend provides information for specific numbers of beds and vouchers.

Several transitional housing facilities have the same physical address as emergency facilities and are run by the same provider, but they are different programs. Again, transitional housing exclusively serving women do not disclose their physical address for security reasons and are not represented on the map. Jefferson and Franklin Counties both have transitional housing programs for women and are not marked on the map.

[45] http://www.hudhre.info/index.cfm?do=viewHomelessRpts

Figure 3-Transitional Housing Location Map[46]



[46] Map made by Behavioral Health Network. Addresses were gathered by calling providers directly.

Permanent Supportive Housing

The number of Permanent Supported Housing Units and Beds reported by each Continuum of Care is outlined in **Table 11.** Permanent supportive housing programs are almost all scattered site and voucher programs. They include rental assistance under the Shelter Plus Care program. St. Louis City has the highest number of beds available and has made a conscious effort to allocate more resources for permanent supportive housing rather than emergency and transitional housing. There is an obvious gap in the available permanent supportive housing units available.

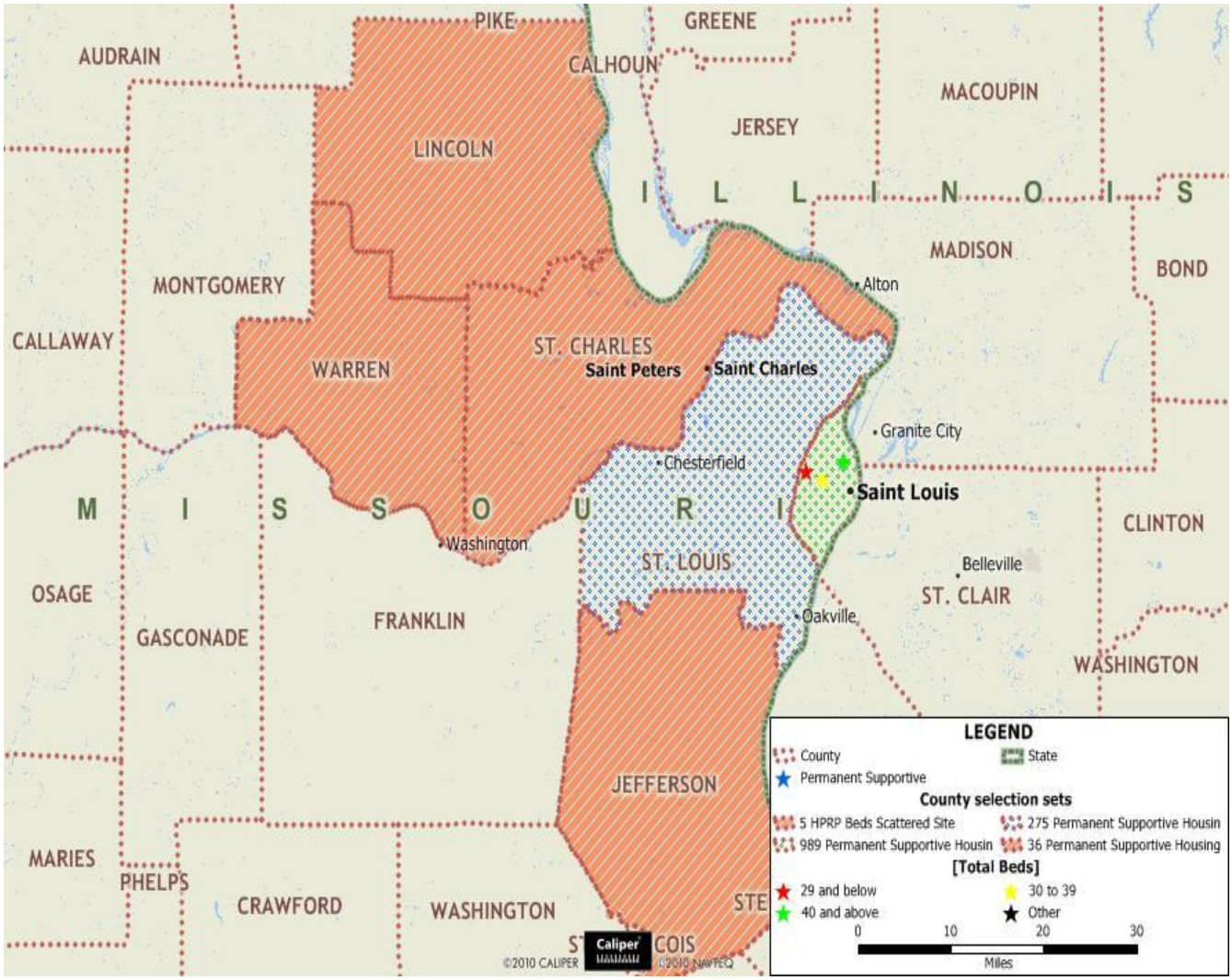
Table 11-Permanent Supportive Housing Bed and Unit Capacity by CoC[47]	Franklin (Region 1 BoS)	Jefferson (Region 1 BoS)	St. Charles, Lincoln Warren	StL City	StL County	TOTAL
HPRP- Rapid Re-housing for Mixed Populations						
• **Family**						
○ **Units**	0	1	0	0	0	**1**
○ **Beds**	0	4	0	0	0	**4**
• **Individuals**						
○ **Beds**	0	1	0	2	0	**3**
Permanent Supportive Housing for Families						
• **Family**						
○ **Units**	0	0	0	191	0	**191**
○ **Beds**	0	0	0	438	0	**438**
• **Individuals**						
○ **Beds**	0	0	0	35	0	**35**
Permanent Supportive Housing for Mixed Populations						
• **Family**						
○ **Units**	0	0	9	196	65	**270**
○ **Beds**	0	0	26	391	228	**645**
• **Individuals**						
○ **Beds**	0	0	10	141	33	**184**
Permanent Supportive Housing for Single Individuals						
• **Family**						
○ **Units**	0	0	0	1	0	**1**
○ **Beds**	0	0	0	1	0	**1**
• **Individuals**						
○ **Beds**	0	0	0	194	14	**208**

Figure 4 highlights the physical location of the permanent supportive housing units and beds available in the region. The stars on the map represent the physical locations of permanent supportive housing facilities. The colors of the stars reflect the number of beds at the specific facility. The shaded regions represent vouchers

[47] http://www.hudhre.info/index.cfm?do=viewHomelessRpts

and/or scattered site facilities available in the region. The Map Legend provides information on the specific numbers of beds and vouchers. It is apparent that permanent supportive housing is more likely to be in the form of scattered site, rather than a congregate setting. Jefferson County has one permanent supportive housing program that is scattered site, but only serves women. Franklin County does not have any permanent supportive housing programs

Figure 4-Permanent Supportive Housing Location Map[48]



[48] Map made by Behavioral Health Network. Addresses were gathered by calling providers directly.

DMH Supported Community Living Program

The Missouri Department of Mental Health (DMH) provides a variety of residential services for clients receiving department funded mental health services through its Supportive Community Living Program (SCLP). The program assists Missourians challenged by mental illness in obtaining and maintaining safe, decent and affordable housing options that best meet their individual and family needs. The vision of the Department is that all Missourians challenged by mental illnesses have housing options that are affordable and accessible, integrated into communities, and provide real choice.

DMH contracts with a number of residential service providers of varying types. Dollars are allocated to seven (7) local DMH community mental health service providers to use for placement. The Supported Community Living Program provides oversight of the contracts and directly administers the funds.

Table 12 depicts the type of program by DMH Service Area (SA) and the overall capacity of the facilities that DMH contracts with. This table does not include information on residential services for children and youth. Facilities are assigned to DMH designated Service Area's where they are physically located except for Hopewell RCF, which is listed in Hopewell's SA even though technically in BJC's SA 25. Counts are unduplicated except for apartment providers, some of which operate in multiple service areas. There is no ceiling on the number of apartment clients for each program; limits are dictated by available funds.

SCLP beds are more equally distributed across the region. However the data suggests that the absence of permanent supportive housing options beds has caused people to take advantage of the available beds at residential facilities, especially in outlying counties.

Also, **it is important to note that of the 31 skilled nursing facilities under contract, 5 have designated units for persons with mental health needs.** This type of living arrangement has come under sharp criticism in recent years. Numbers obtained through the Freedom of Information Act and prepared exclusively for the Associated Press[49] by the Centers for Medicare and Medicaid Services show nearly 125,000 young and middle-aged adults with serious mental illness lived in U.S. nursing homes in 2008. That was a 41 percent increase from 2002, when nursing homes housed nearly 89,000 mentally ill people ages 22 to 64. Most states saw increases, with Utah, Nevada, **Missouri,** Alabama and Texas showing the steepest climbs. Younger mentally ill people now make up more than 9 percent of the nation's nearly 1.4 million nursing home residents, up from 6 percent in 2002. This is significant in that it indicates that the number of clients residing in skilled nursing facilities in the region exceed those receiving funding support by SCLP.

[49] Associated Press. March 22, 2009

Table 12-Residential Programs with DMH Contracts-Total Number of Units and Beds (ADULTS)[50]	Franklin	Jefferson	St. Charles Lincoln Warren	SL City	SL County	TOTAL
Residential Care Facility I						
• **Units**	0	3	3	5	3	**14**
• **Beds**	0	111	105	93	90	**399**
Residential Care facility II						
• **Units**	1	6	5	8	4	**24**
• **Beds**	20	143	136	371	115	**785**
MH Residential Care Facility						
• **Units**	0	1	1	1	0	**3**
• **Beds**	0	24	8	12	0	**44**
Intensive Residential Treatment Setting –Psychiatric Ind. Supported Living (IRT)						
• **Units**	0	0	2	0	0	**2**
• **Beds**	0	0	7	0	0	**7**
IRTs-Clustered						
• **Units**	0	0	0	0	1	**1**
• **Beds**	0	0	0	0	15	**15**
Apartment*						
• **Units (Programs)**	0[51]	1	1	0[52]	5	**7**
• **Beds**	NA	NA	NA	NA	NA	**846**[53]
Psychiatric Group Home I						
• **Units**	0	0	0	2	0	**2**
• **Beds**	0	0	0	27	0	**27**
Psychiatric Group Home II						
• **Units**	0	0	0	0	1	**1**
• **Beds**	0	0	0	0	10	**10**
Skilled Nursing Facility (SNF)						
• **Units**	2	5	3	7	14	**31**
• **Beds**	180	464	432	1143	1722	**3941**
Intermediate Care Facility						
• **Units**	0	0	0	0	1	**1**
• **Beds**	0	0	0	0	15	**15**

[50] Data provided by Department of Mental Health Supported Community Living Program. Full definitions of the types of residential facilities are available in Appendix A- Glossary of Terms.

[51] Franklin County is served by the apartment program in St. Charles/Lincoln/Warren.

[52] St. Louis City and County are served by the same apartment programs.

[53] Count is point-in-time number of persons in apartment program. Data not available by county at time of data run, however later data shows that 80% of apartments are located in St. Louis City..

Oxford House

Oxford House is a network of self-run, self-supported recovery houses. Each house is chartered by Oxford House, Inc. In order to be considered for a charter, each house abides by three basic rules. The house evicts anyone who relapses, the house is financially self-sufficient, and the house is democratically run by the members themselves. Oxford House provides a safe, supportive, and secure place to call home. It is a place where individuals can make the changes necessary to ensure continued sobriety. **Table 13** shows the distribution of available Oxford Houses in the region and illustrates again the concentration of resources in St. Louis City.

Table 13 - Oxford House Locations and Number of Beds[54]	Franklin	Jefferson	Lincoln	St. Charles	Warren	SL City	SL County
TOTAL BEDS	**0**	**0**	**10**	**28**	**0**	**101**	**33**

HUD Public Housing Units and Reported Number of Section 8 Vouchers

Public Housing units are owned by a local public housing authority, which is contracted by HUD. The available units are rented to eligible residents who meet certain income and other qualifications. The average annual income for households participating in this program is $10,265. The local public housing authority tracks certain subpopulation characterizes, such as how many household heads and spouses have a disability. Section 8 Certificates and Vouchers is a rental subsidy, also funded by HUD, for households that are required to pay 30% of their adjusted income towards rent. To qualify, a household's annual income must not exceed the applicable income limit for the area as adjusted by family size. The average annual income for households participating in this program is $10,265.

Table 14 shows the breakdown of the number of units. The number of Public Housing and Section 8 Certificates and Vouchers represent total units. The average household size is 2.2 people, which means an estimated 41,428 individuals are served through these programs in the Eastern Region.

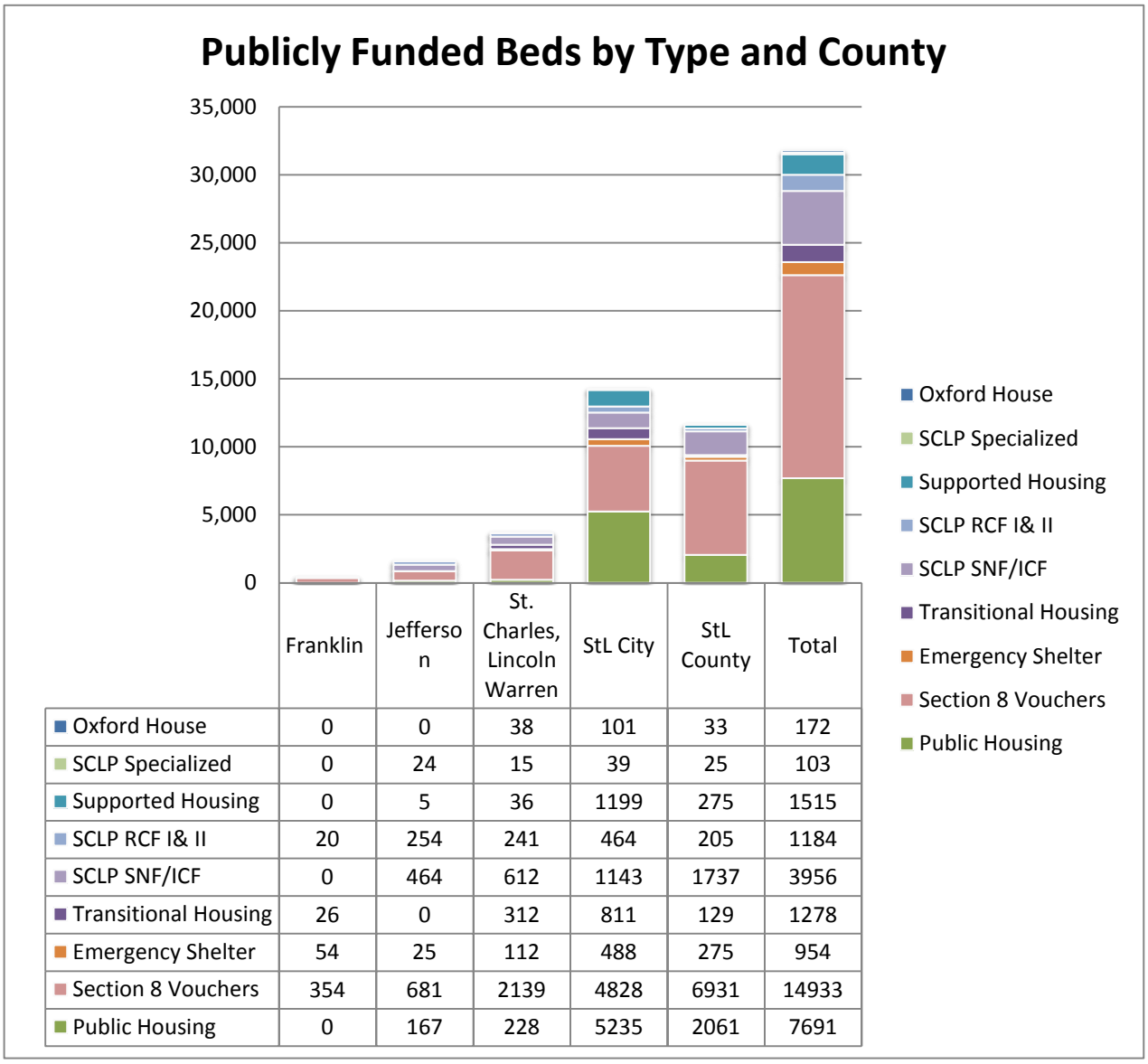
TABLE 14- Public Housing Authority Total Units and Reported # of Section 8 Vouchers by County in 2008[55]	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Public Housing Units	0	56	0	70	2,887	885	0	**3,898**
Section 8 Certificates and Vouchers	354	681	669	994	4,828	6,931	476	**14,933**
Total	354	737	669	1064	7,715	7,816	476	**18,831**

[54] "An Evaluation of the Network of Oxford Houses: Missouri," P 23 http://www.oxfordhouse.org/userfiles/file/doc/eval_mo2009.pdf
[55] http://www.huduser.org/portal/picture2008/form_1S4.odb

Summary of Publicly Supported Affordable Housing Stock

Figure 5 provides an overview of the combined types of publicly assisted housing in the region. The different types of publicly subsidized housing available is vast and varies across counties. Although the data does not necessarily capture all units/beds of affordable housing such as those developed with tax credit (it was not possible to get an unduplicated count of additional units not included in the chart below), the existing stock does not match the demand for low-income housing. Additionally, housing dedicated to serving persons with behavioral health needs represents only a small percent of the overall stock that exists.

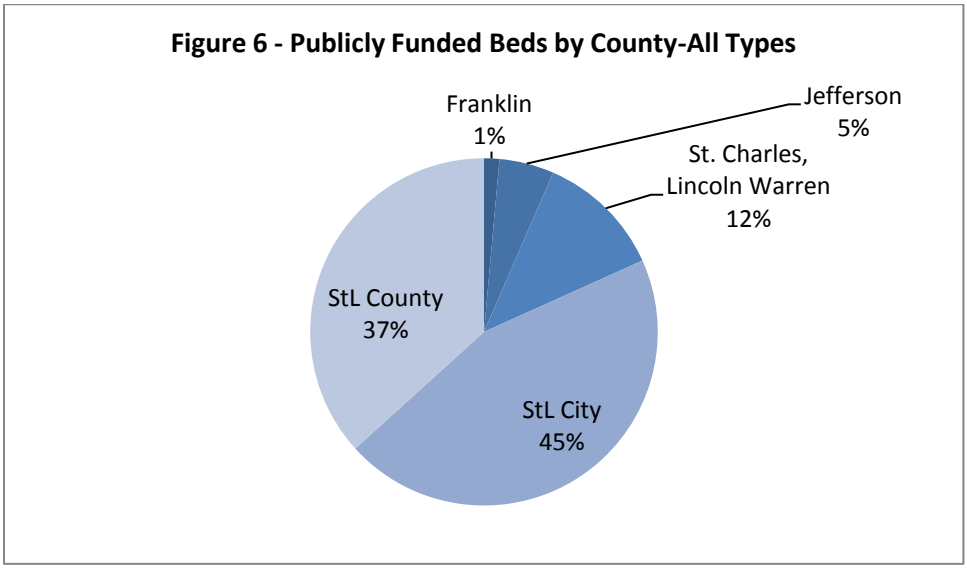
Figure 5- Publicly Funded Beds by Type and County[56,57,58]



	Franklin	Jefferson	St. Charles, Lincoln Warren	StL City	StL County	Total
Oxford House	0	0	38	101	33	172
SCLP Specialized	0	24	15	39	25	103
Supported Housing	0	5	36	1199	275	1515
SCLP RCF I& II	20	254	241	464	205	1184
SCLP SNF/ICF	0	464	612	1143	1737	3956
Transitional Housing	26	0	312	811	129	1278
Emergency Shelter	54	25	112	488	275	954
Section 8 Vouchers	354	681	2139	4828	6931	14933
Public Housing	0	167	228	5235	2061	7691

[56] Chart does not include the DMH Supported Community Living Program (SCLP) Apartment Subsidies which total 843 for the region. "SCLP Specialized" includes all categories other than Apartment, RCF's, and SNF/ICFs.

Figure 6 shows the percentage breakout of beds by county of all types.



Data on Consumers Receiving Publicly Funded Housing

We have access to two sources of data that provide information on how many persons with behavioral health needs are receiving publicly funded supported housing. They are: Homeless Management Information System (HMIS) data and data from the DMH Supported Community Living Program. The HMIS data provides information on the number of individuals who are receiving housing services through the Continuum of Cares and provides information on subpopulations, including persons with behavioral health needs. DMH Supported Housing Program data shows the type of housing where clients are living in who are housed through DMH's Supported Community Living Program.

We also have access to HUD public housing data related to persons housed with disabilities. However this information does not specifically break out those with behavioral health needs.

HUD Continuum of Care Counts

The Homeless Management Information System (HMIS), coordinated by HUD, stores client-level information on the characteristics, services, and needs of homeless individuals and families. These systems collect additional information and have multiple uses. Counts of the number people who used emergency shelters, transitional housing, and/or permanent supportive housing programs at some time during the course of a year are captured in the HMIS system. See **Appendix 1-Glossary of Terms** for definitions of each type of housing. The data collected by HUD has some problems because not every individual has a unique identifier across HUD data sources. This leads to the possibility of duplicated counts- "The amount of duplication is not known or estimated".[59] **Table 15** shows the number of persons with behavioral health needs as reported in the HMIS

[57] Chart compiled from variety of data sources contained in this full report. Public housing data counts number of people in units vs. beds This chart does not reflect other affordable housing units developed with public financing (e.g. LIHTC)
[58] In 2008, the HUD showed 14,200 Units receiving funding through the Low Income Housing Tax Credit. The number of beds is unavailable. Some of these units are likely included in above counts and the total number of additional units/beds is unknown.
[59] "State of Homelessness in Missouri: 2011 Report," P 8. http://www.mhdc.com/ci/documents/SHM_2011.pdf

database by each Continuum of Care (CoC). It is likely that the counts listed below do not fully represent the number of persons with behavioral health needs. However the data provides an idea of the number of persons with behavioral health needs who are accessing publicly funded housing through CoCs.

Table 15 2010 HMIS Data on Number of Participants Housed with a Disabling Condition[60]	Region 1 BoS (Includes Franklin and Jefferson	St. Charles, Lincoln Warren	StL City	StL County	TOTAL
Supportive Housing					
• **Transitional**					
○ **Mental Illness**	2	NA[61]	26	3	**31**
○ **Substance Abuse**	4	NA	69	14	**87**
• **Permanent Supportive**					
○ **Mental Illness**	2	NA	121	36	**159**
○ **Substance Abuse**	1	NA	96	33	**130**
• **Shelter Plus Care**					
○ **Mental Illness**	13	NA	325	53	**391**
○ **Substance Abuse**	5	NA	306	50	**361**
Emergency Shelters					
○ **Mental Illness**	1	NA	373	29	**403**
○ **Substance Abuse**	0	NA	292	96	**388**
Beds Used by Behavioral Health Clients					
○ **Mental Illness**	18	NA	845	121	**984**
○ **Substance Abuse**	10	NA	763	193	**966**
Combined Total	**28**	**NA**	**1608**	**314**	**1950**

Consumers Served by DMH Supported Community Living Program

The data in **Table 16** shows the number of clients receiving specialized housing services offered by DMH through the Supported Community Living Program (SCLP). DMH provides a variety of residential services for clients receiving department funded mental health services through SCLP. The department contracts with a variety of residential facilities to provide an array of options for clients. Over 60% of the total clients are living in scattered site apartments across the Eastern Region. The table also shows the service areas where the clients are located. The majority are located in St. Louis City and St. Louis County. See **Appendix 1-Glossary of Terms** for definitions of each type of housing. As noted previously, there are likely a significant number of people with serious mental illnesses currently living in skilled nursing facilities (as well as residential care facilities) that do not receive subsidies from the DMH SCLP.

[60] Region 1 HMIS data is from 2007.
[61] NA denotes that the CoC did not have this type of program or data.

Table 16 –DMH SCL Current type of Residential Setting and Location by Service Provider	Skilled Nursing Facility	Residential Care Facility II	Residential Care Facility I	Psychiatric Group Home	Apartment	Child and Youth Facility	Semi-Independent	Treatment Family Home-Youth	Other*	Total
Comtrea, Inc. (Jefferson County)	8	22	21	0	16	3	0	2	1	73
Crider Health Center (Franklin, Lincoln, St. Charles and Warren)	13	56	18	0	95	5	0	1	2	190
BJCBH - SA 23 (SL County)	37	39	51	1	261	3	1	5	13	411
Hopewell Center (SL City)	22	26	32	0	54	1	0	0	4	139
Adapt, Inc. (SL City and County)	0	19	13	0	82	0	2	0	6	122
Independence Center (SL City and County)	1	22	19	0	56	0	3	0	0	101
Places for People (SL City and County)	2	3	12	0	151	0	2	0	8	178
BJC - SA 25 (S. Louis City)	1	38	21	1	131	0	5	4	8	209
Address unknown or out of region	0	0	0	0	0	0	0	0	0	0
Total	**84**	**225**	**187**	**2**	**846**	**12**	**13**	**12**	**42**	**1423**

**Other - Clients who are open to SCLP but not currently receiving services of a residential provider*

HUD Reported Occupants with a Disability

In addition to the data source above, HUD collects data on the number of disabled households. Although the HUD definition of disability includes persons with disabling mental illnesses and addiction disorders, it also includes other disabilities. Therefore it is not possible to get an actual estimate of persons with significant behavioral health issues receiving this housing assistance. **Table 17** shows the breakdown of the number of units and the percentage that are occupied by a person with a disability. The number of Public Housing and Section 8 Certificates and Vouchers represent total units. The average household size is 2.2 people, which means an estimated 41,428 individuals are served through these programs in the Eastern Region. The disability figures listed above only represent the household head and/or spouse living in the unit.

TABLE 17- Public Housing Authority Total Units and Reported # of Section 8 Vouchers by County in 2008[62]	Franklin	Jefferson	Lincoln	St. Charles	SL City	SL County	Warren	Eastern Region
Public Housing Units	0	56	0	70	2887	885	0	**3898**
• % of household below age 62 where either household head or spouse has a Disability	0%	20%	0%	16%	40%	24%	0%	**36%**
Section 8 Certificates and Vouchers	354	681	669	994	4828	6931	476	**14933**
• % of household below age 62 where either household head or spouse has a Disability	65%	47%	32%	32%	25%	21%	25%	**26%**

[62] HUD defines disability as: "Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment. http://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/disabilities/inhousing

Resources-Behavioral Health and Other Support Services

Overview and Data Sources

There is a wide array of behavioral health and other supportive services available throughout the Eastern Region. This section provides information on the available publicly funded behavioral health services primarily provided by the State of Missouri. We have access to the following sources for information on the available support services:

- **Department of Mental Health (DMH)Services :**
    - **Division of Alcohol and Drug Abuse (ADA)**
    - **Division of Comprehensive Mental Health Services (CPS)**
- **Local County Boards**
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
- **MO-Healthnet**

Department of Mental Health (DMH) serves as the state authority for mental health for persons with mental illness, developmental disabilities and addiction disorders. DMH makes services available through state-operated facilities and contracts with private organizations and individuals. DMH is also responsible for establishing standards for licensure and certification of community-based programs and residential facilities who receive public funding. ADA and CPS are both divisions within DMH.

- **Division of Alcohol and Drug Abuse (ADA)** provides a variety of treatment programs and offers multiple levels of care. Two primary ADA treatment programs are Primary Recovery Plus and Comprehensive Substance Treatment and Rehabilitation (CSTAR). Information in this section includes where these programs are physically located in the Eastern Region.
- **Division of Comprehensive Mental Health Services (CPS)** presents the variety of services available for persons in need of CPS services. These include: Comprehensive Outpatient Services, Community Psychiatric Rehabilitation Program (CPRP), Assertive Community Treatment (ACT), Consumer Operated Service Programs (COSP), and 24 Hour Access-Crisis-System (ACI). Information in this section explains each of these programs and where these programs are physically located in the Eastern Region.

Local County Boards are dedicated boards that administer county property or sales taxes designated for mental health and addiction services locally. There are two types of mental health tax funds: one is specifically dedicated for children and their families while the other is targeted to the broader population. They publish data specific to mental health needs and services funded in their specific county.

Substance Abuse and Mental Health Services Administration (SAMHSA) is a federal agency under the Department of Health and Human Services (DHSS) that administers a combination of competitive, formula, and block grant programs and data collection activities.

MO-Healthnet directly administers several programs for Medicaid-eligible individuals, including an MC+ managed care plan that that has a behavioral health service benefits.

Summary of Key Findings

The following is a summary of the key findings identified in the data sources outlined above.

- The array of services needed to support people in their home are typically the same whether the person is living in completely independent housing or living in housing with on-site supports.
- The vast majority of publicly funded behavioral health services are available through local agencies certified by the **Missouri Department of Mental Health** divisions of **Alcohol and Drug Abuse (ADA)** and **Comprehensive Mental Health Services (CPS)** through a combination of state general revenue funds, MO Healthnet Medicaid Funds and Federal Block grant/ other funds from the Substance Abuse and Mental Health Services Administration.
- MO-Healthnet directly administers several programs, including MC+ that has a behavioral health service benefits. Unlike federal funds for housing which often go directly to local communities, the majority of federal funds for behavioral health, with the exception of Medicare, flows through and is administered by the designated state mental health authority (DMH) and Medicaid Agency (MOHealthnet).
- Several counties also have local taxes dedicated to the provision of behavioral health services. However, the availability of this funding varies by county. Jefferson County and the City of St. Louis have a dedicated local county tax to fund behavioral health services for the general population that is primarily targeted to adults. All of the counties in the region, with the exception of Warren County have passed a tax dedicated to children's mental health services.
- Service resources are constrained and availability is often limited. Estimates of unmet need indicate that only about 23% of adults with serious mental illness and 14% of children with serious emotional disturbance in need of publicly funded mental health services are actually receiving them.
- Additionally, many Missourians lack adequate private or public insurance coverage particularly for substance abuse problems.

Overview of Services

The array of services needed to support people in their home are typically the same whether the person is living in completely independent housing or living in housing with on-site supports. Those services, typically, include the following:[63]

  - Coordinating behavioral health and primary health care services and assistance with understanding and implementing a health and wellness plan, including medication management;
  - Case management services, which includes linking persons to other services and supports such as entitlements, legal assistance, etc.;
  - Crisis intervention services;
  - Supportive counseling;

[63] From the "Missouri Department of Mental Health Housing Toolkit: Blazing New Trails in Services and Funding," September 2011

- Self-help services and support groups;
- Illness management (understanding the illness and developing coping techniques);
- Recovery support services that includes working on things like school, employment, community involvement, regaining custody of children and parenting skills;
- Assistance with "Activities of daily living"—cooking, cleaning, shopping, money management, arranging and using public transportation.

There is a wide array of behavioral health and other supportive services available throughout the Eastern Region. However, It is important to note that public service resources are constrained and availability is often limited. Estimates of unmet need (measured by prevalence based on federal methodology contained in the latest DMH Community Mental Health Services Plan) indicate that only about 23% of adults with serious mental illness and 14% of children with serious emotional disturbance in need of publicly funded mental health services are actually receiving them. Additionally, many Missourians lack adequate insurance coverage particularly for substance abuse problems (addiction disorders do not qualify for SSI disability which prevents many families from receiving Medicaid for needed treatment and support services if they do not have private resources.

The remainder of this section will focus on the key services available through the DMH divisions of ADA and CPS. A brief summary of other publically funded service resources is also included.

DMH-ADA Regional Service Resources

The Division of ADA has developed treatment programs that focus on providing a complete continuum of recovery services, including extended outpatient services in the community and, where possible, close to home. Multiple levels of care and comprehensive service packages are offered to provide people with ready access to treatment and to assist them in achieving and maintaining recovery from alcohol and drugs. Services are individualized and have three basic levels of intensity. Treatment routinely includes assessment, individual and group counseling, family counseling, education, participation in self-help groups, and other structured, therapeutic measures. In addition, families can also participate in individual and group codependency counseling. Detoxification and residential support services are offered for those who need a safe drug free environment early in the treatment process.

Primary Recovery Plus

These treatment programs provide a full continuum of care including detoxification, outpatient services, and residential support if clinically appropriate. Recovery Support Programs, funded through the ATR grant, supplement Primary Recovery Plus programs and expand access to an array of treatment and support options, to include faith-based and non-traditional programs. Services are designed to enhance participation in treatment and help improve individuals' functioning, promote community integration, and foster recovery from substance use disorders. Primary Recovery Plus services are available to assist those individuals without Medicaid coverage. Table 18 shows the Recovery Plus Programs available in the region by location.

Comprehensive Substance Treatment and Rehabilitation (CSTAR)

Developed by the Division of ADA and funded by Missouri's Medicaid program and ADA's purchase-of-service system, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program also provides a full

continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. To better address the specific needs of those seeking treatment, four specialized CSTAR programs were developed:

- **CSTAR Women and Children**- Substance abuse affects women in unique ways, both physically and psychologically. These programs are designed for women and their children. Priority is offered to women who are pregnant, postpartum, or have children in their physical care and custody. Depending on assessed needs, additional services may include daycare, housing support and community support for children that accompany their mother into treatment.
- **CSTAR General Population**-These programs offer intensive outpatient treatment services to both men and women with substance abuse problems. The full menu of treatment services is available.
- **CSTAR Opioid** -These medication-assisted treatment programs are designed for medically supervised withdrawal from heroin and other opiate drugs, followed by ongoing treatment and rehabilitation for addiction and related life problems. Priority admission is given to women who are pregnant and persons who are HIV positive. Missouri's opioid treatment programs meet required federal guidelines.

Table 18 provides an overview of the treatment programs by county. Although the table lists programs by location, services are available to residents from other counties.

Table 18 – ADA Program Locations by Type and County *	Franklin	Jefferson	Lincoln	St. Charles	Warren	SL City	SL County
Primary Recovery Plus Programs	**2**	**5**	**0**	**2**	**1**	**7**	**3**
General Population Programs	**0**	**5**	**0**	**0**	**0**	**2**	**1**
Opioid Programs	**0**	**0**	**0**	**0**	**0**	**1**	**1**
Women & Children Programs	**0**	**0**	**2**	**1**	**0**	**3**	**1**

*Although table depicts actual physical location of programs, residents from other counties are served by these programs.

DMH CPS Regional Service Resources

The Division of Comprehensive Psychiatric Services (CPS) is responsible for assuring the availability of prevention, evaluation, treatment, and rehabilitation services for individuals and families requiring public mental health services throughout the State of Missouri. The Division exercises this responsibility by providing services directly through its state operated facilities and programs and by contracting through 25 administrative agents to provide an array of community programs. Services for the Division of Comprehensive Psychiatric Services are accessed through 25 service areas, with each service area serving particular counties of the state.[64] Community Mental Health Centers and/or Affiliates are responsible for providing these services.

[64] http://dmh.mo.gov/mentalillness/org/adminagents.htm

In Missouri, community mental health centers, designated as Administrative Agents by the Department of Mental Health (DMH), are the primary treatment providers for both adults and children in DMH's Comprehensive Psychiatric Services Division. These designated centers serve as entry/exit points in each geographic area, into and from the state mental health delivery system, offering a continuum of comprehensive mental health services. These agencies determine a person's eligibility for services and provide those services.

Additionally the division contracts with private entities for 24-hour residential services for individuals needing that level of care. It is the Division's goal to give priority to people with serious mental illness (SMI), individuals in acute crisis, individuals who are homeless and mentally ill, those committed for treatment by the court system, and children with severe emotional disturbances (SED). In FY 2009, the Division served approximately 77,363 individuals statewide.[65]

CPS provides an array of services, including evaluation, day treatment, outpatient care, psychiatric rehabilitation, housing, crisis services, and hospitalization as well as evaluation and treatment of persons committed by court order. The core services are described below.

Comprehensive Outpatient Services

Outpatient services provided in an individual's community offer the least-restrictive environment for treatment. An evaluation and treatment team provides services utilizing the resources of the individual, his/her family, and the community. Outpatient programs offer individual, group, and family therapy, medication management, etc.

Community Psychiatric Rehabilitation Program (CPRP)

This program uses a consumer-centered approach that emphasizes individual choices and needs; features flexible community-based services and supports; uses existing community resources and natural support systems; and promotes independence and the pursuit of meaningful living, working, learning, and leisure-time activities in normal community settings. The program provides an array of key services to persons with severe, disabling mental illnesses. Services include evaluations, crisis intervention, community support, medication management, and psychosocial rehabilitation. Because CPRP is a Medicaid supported program, the federal government pays approximately 60 percent of the costs for eligible clients. ***An important note:*** The Division of CPS has recently added new service definitions to offer **Intensive Community Psychiatric Rehabilitation in Specific Residential Settings (I-CPR RES)** for those adult consumers whose severity and chronicity of mental illness is such that they have either failed in multiple community settings and/or present an ongoing risk of harm to self or others, resulting in long-term psychiatric hospitalization. I-CPR RES involves on-site staff in the residential setting on either a full or part-time basis to ensure that consumers in the complex do not engage in behaviors that are harmful to themselves or others, or in activities that involve a high risk of relapse of psychiatric symptoms or other behaviors requiring long-term hospitalization. There are three tiers of residential settings in which I-CPR RES can be provided, each geared to population groups with differing levels of need for immediacy of supervision and oversight, with differing levels of tolerance for interactions with other consumers, and with differing levels of ability to participate in and benefit from other community based

[65] http://dmh.mo.gov/mentalillness/about.htm

interventions. In all cases providers must submit a proposal to CPS and have it approved before they begin providing Intensive CPR to adults in any settings.

Assertive Community Treatment (ACT)

The goal of Assertive Community Treatment (ACT) is to help people stay out of the hospital and to develop skills for living in the community, so that their mental illness is not the driving force in their lives. Assertive Community Treatment offers intensive services that are customized to the individual needs of the consumer, delivered by a team of practitioners, and available 24 hours a day. The program addresses needs related to symptom management, housing, finances, employment and medical care.

Consumer Operated Service Programs (COSP)

COSP programs are consumer owned and operated programs designed to provide an array of site and community-based peer support services. There are two types of programs: A site-based drop-in center and a phone-based warm line.

24 Hour Access-Crisis System (ACI)

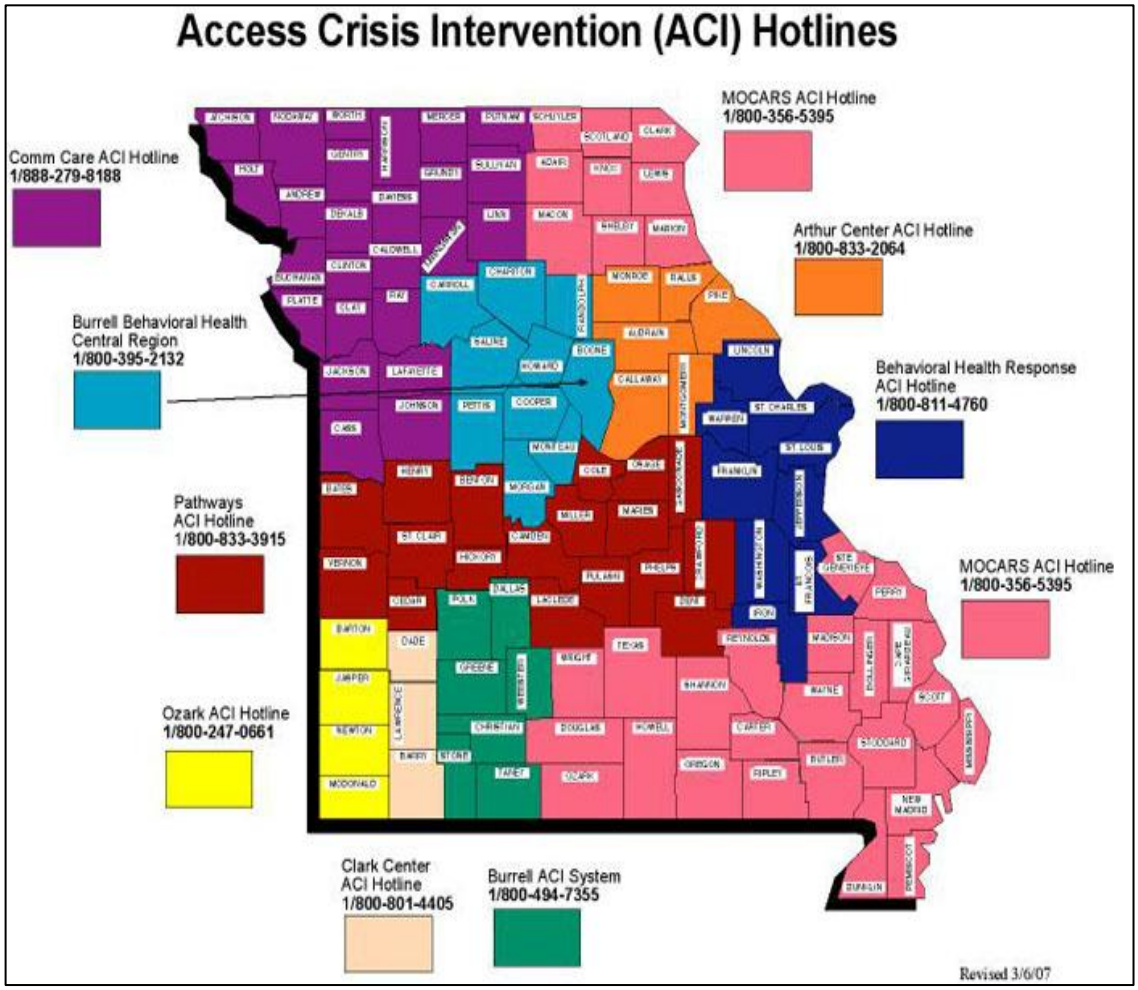
The principal goal of the ACI system is to provide immediate response, intervention, and referral for persons experiencing mental health crisis on a 24 hour, seven day a week basis whether in a rural, urban or metropolitan area. Services include 24 hour "live" phone response, mobile community-based face-to-face crisis stabilization, next day urgent appointments with local community mental health centers and alternative crisis intervention services such as observation and stabilization beds.

In addition to the above services, DMH directly provides long-term psychiatric rehabilitation and forensic inpatient services for the region at the St. Louis Psychiatric Rehabilitation Center (SLPRC) and the Metropolitan St. Louis Psychiatric Center. It also provides region-wide inpatient services for children and youth at Hawthorne Psychiatric Children's Hospital located in St. Louis County.

Table 19 provides a listing of the key community based service programs by county. **Figure 7** shows the state wide map of ACI services including the ACI serving the entire Eastern Region.

Table 19 – CPS Program Locations by Type and County *	Franklin	Jefferson	Lincoln	St. Charles	Warren	SL City	SL County
Comprehensive Outpatient Services	**1**	**1**	**1**	**1**	**1**	**2**	**1**
CPRP	**1**	**1**	**1**	**1**	**1**	**5**	**1**
Assertive Community Treatment	**0**	**0**	**0**	**0**	**0**	**3**	**0**
Consumer Operated Drop-in Programs	**0**	**0**	**0**	**0**	**0**	**1**	**1**

Figure 7- Map of ACI Hotlines[66]



Other Service Resources

In addition to the DMH services provided in the region, there are a variety of other publicly funded behavioral health services provided. These are briefly described below.

Services Provided through Local County Boards

All of the counties in the region, with the exception of Warren County have passed a sales tax dedicated to create a county-wide children's services fund for a variety of children's mental health services. These funds are used to support a wide range of programs that address the mental health needs of children related to emotional and behavioral health, trauma and establishing healthy, supportive family environments. Counties typically conduct a local needs assessment, prioritize funding to meet the needs identified and then contract with local providers to deliver the services. Jefferson County and the City of St. Louis are the only two counties in the Eastern Region that have also passed a local property tax to fund behavioral health services primarily for adults. This includes a broad array of both mental health and addiction services. Some funding has also been

[66] http://dmh.mo.gov/mentalillness/progs/acimap.htm

dedicated recently by the St. Louis City Mental Health Board to support the development of supported housing. Similar to the Children's Boards, local Mental Health Boards typically conduct a county/citywide needs assessment and then contract for services with local community-based agencies or directly administer services through the local community mental health center (as is the case in Jefferson County). All service providers who receive funds are required to seek and receive certification from the Department of Mental Health for services covered as part of the Departments' certification standards.

Other Federal and State Service Resources

Unlike federal funds for housing which often go directly to local communities, the majority of federal funds for behavioral health, with the exception and Medicare, flows through and is administered by the designated state mental health authority (DMH) and Medicaid Agency (MO Healthnet). However some funding can be billed directly by independent providers and many funds are awarded locally through competitive grants.

- **Substance Abuse and Mental Health Services Administration (SAMHSA)**
  SAMHSA was established in 1992 and directed by Congress to effectively target substance abuse and mental health services to the people most in need and to translate research in these areas more effectively and more rapidly into the general health care system. To accomplish its work SAMHSA administers a combination of competitive, formula, and block grant programs and data collection activities. Block grant funds are provided to DMH as the State Mental Health and Substance Abuse Services Authority. Other funds are typically provided in the form of targeted competitive grants for which other governmental and non-profit entities are eligible.

- **MO-Healthnet (Medicaid)**
  In addition to the CSTAR and CPRC Medicaid rehabilitation services administered under DMH, MO-Healthnet directly administers several programs for Medicaid-eligible individuals, including an MC+ managed care plan that that has a behavioral health service benefits. A variety of service providers including local health centers and independent practitioners offer Medicaid covered outpatient services the region. Hospital psychiatric acute inpatient services are also covered by Medicaid and provided by several area private community hospitals throughout the region.

- **Other Service Resources**
  In addition to the above, other public resources for behavioral health and related healthcare services include outpatient and hospital services covered by Medicare (for qualifying seniors and persons with disabilities who receive social security benefits), and special purpose grants and funds through federal and state governmental units (e.g. prisoner reentry programs, supported employment services, etc.)

There are also a variety of private resources available to fund behavioral health and related services. Most insurance plans have a behavioral health benefit and a variety of providers across the region provide services through these benefits. Additionally, many services are funded through area United Way organizations as well as local charitable foundations and trusts. These additional funding sources are critical to filling in the gaps for services that exist within the public realm. However, a further description goes beyond the scope of this report.

Resources-Financing & Development

Overview and Data Sources

This section provides information on types of public sources of financing for housing and is divided into three parts: **a description of the different types of financial resources, the budgets for different programs , and an overview of the network of developers.** We have access to the following sources of information that are comparable across the Eastern Region to determine what the housing resources are:

- **The Missouri Department of Mental Health Housing Toolkit: Blazing New Trails in Services and Funding, September 2011**
- **US Department of Housing and Urban Development (HUD)**
- **Missouri Housing Development Commission (MHDC)**
- **State of Missouri Consolidated Plan**
- **Additional Funding Sources**
- **Missouri Workforce Housing Association**
- **"Creating Whole Communities: Enhancing the Capacity of Community Development Nonprofits in the St. Louis Region"**

The Missouri Department of Mental Health Housing Toolkit: Blazing New Trails in Services and Funding, September 2011, provides information on how to develop housing and why supportive housing is important to the wellness of persons with behavioral health needs. It also provides examples of housing developments and services that have been successful in Missouri.

US Department of Housing and Urban Development (HUD) funds a variety of housing programs in the Eastern Region. These funding streams have been categorized as Continuum of Care Grant Programs, HUD Programs Requiring the Submission of a Consolidated Plan, and Additional HUD Programs. Each subsection identifies specific programs, identifies the type of financing, and provides a description of what the funding source can be used for.

Missouri Housing Development Commission (MHDC) is another primary funding source for housing development. The various MHDC section identifies specific programs, identifies the type of financing, and provides a description of what the funding source can be used for. The programs MHDC administers include: Missouri Housing Trust Fund, Federal and Missouri Low Income Housing Tax Credit, Missouri Affordable Housing Assistance Program, and the Rental Production and Preservation Program. MHDC NOFA Requests and Award Announcements shows what housing projects have been awarded funding through MHDC. This also tells us where the housing project will be located and how many housing projects are being proposed across the state. The NOFA Awards also show which developers have successfully received funding.

State of Missouri Consolidated Plan shows the financial resources that have been allocated for projects, which includes housing development. It also shows what areas of the state receive funding. This plan directs the activities of the Community Development Block Grant, HOME funds, Emergency Shelter Grants, and Housing for Persons with AIDS.

Additional Funding Sources are sources of funding that do not fit into the categories outlined above. They include the St. Louis Mental Health Board and the City of St. Louis Affordable Housing Trust Fund.

Missouri Workforce Housing Association is a local organization that advocates for non-profit and for-profit developers that develop and sustain affordable housing the St. Louis area. This provides information on specific groups, such as developers and housing financers, who are committed to developing affordable housing.

"Creating Whole Communities: Enhancing the Capacity of Community Development Nonprofits in the St. Louis Region" is a report that outlines the role Community Development Corporations play in developing affordable housing and shares where they are active in Eastern Missouri.

Summary of Key Findings

- There is a wide array of sources available for financing affordable housing. Four types of financing resources are important to consider as they relate to housing for persons with behavioral health needs:
    - **Pre-Development Financing** is required for the money that will be spent on activities for capital projects during the planning stages.
    - **Capital Financing-** Capital (or development) financing resources are those sources that may be used to fund the costs associated with acquiring, creating, and/or rehabilitating housing units, costs sometimes referred to as "bricks and mortar".
    - **Operational Financing-** Operating financing resources are defined as those sources that may be used to pay for the costs of operating and/or maintaining housing including but not limited to rent assistance and home ownership loans.
    - **Services Financing**- Services financing refers to sources that can be used to support voluntary, flexible services designed primarily to help tenants maintain housing. A wide array of services may fit this category.
- Financing is complex-there are multiple sources and specific requirements linked to each source.
    - Multiple sources of financing are often required to complete capital projects and assure that adequate operating and service costs are available.
    - Different sources of financing are available through multiple federal, state and local agencies. Each of these funding sources have different requirements for eligibility, project scope, etc. making it difficult to put together all of the different pieces of financing that may be required for a project.
    - Some financing, particularly funds from HUD, require a consolidated plan and/or local participation in a Continuum of Care. Although these local planning processes are excellent in determining area needs and resource allocations, participation by behavioral health providers varies and planning occurs in geographic silos.
- The Eastern Region has received significant financing from a variety of sources for the development and operation of affordable housing. However, the resources vary significantly across counties. For example:
    - The Eastern Region received **$39,903,610 from statewide grants, loans, and tax credits** to help finance affordable housing development and fund affordable housing programs in 2011. However

the distribution of these funds ranged **from a low of $0.00 in Franklin County to** a high of **$29,587,566 in St. Louis City.**

- St. Charles, Lincoln and Warren counties have received no Shelter+Care funding that provides rental assistance with matching supportive services from local providers for persons with mental illness and addictions who are homeless.
- Area income and other criteria specific to a geographic area often drive the allocation of funding. Although this typically results in funding for counties with the most need, it can also lead toward those in need to relocate to areas with the greatest resources.

- Both for-profit and non-profit developers work to develop affordable housing in the Eastern Region. Some of these developers have specifically partnered with behavioral health providers, however such partnerships are not necessarily the norm.

Overview of Financing Resources

There is a wide array of sources available for financing affordable housing. Four types of financing resources are important to consider as they relate to housing for persons with behavioral health needs: [67]

- **Pre-Development Financing** is required for the money that will be spent on activities for capital projects during the planning stages. Such costs may include those related to site control that include market and environmental studies, architectural and engineering fees and application fees. Some capital financing sources provide for a portion of pre-development, however there may be other sources that can be used as well.
- **Capital Financing-** Capital (or development) financing resources are those sources that may be used to fund the costs associated with acquiring, creating, and/or rehabilitating housing units, costs sometimes referred to as "bricks and mortar" Multiple sources of capital financing are often combined to provide the complete funding for one project.
- **Operational Financing-** Operating financing resources are defined as those sources that may be used to pay for the costs of operating and/or maintaining housing including but not limited to rent assistance and home ownership loans. Operating costs in a project owned by a housing sponsor include all costs of maintaining the project once it is ready for occupancy, such as property management, utilities, maintenance, insurance, security, debt service or other loan payments, and operating and replacement reserves. In projects leased by the sponsor (either single site or scattered site), operating costs generally include the cost of leasing the units and any maintenance that is not covered by the owner/landlord. For more detail please see "Missouri's Guide to Housing Assistance Programs".[68]
- **Services Financing**- Services financing refers to sources that can be used to support voluntary, flexible services designed primarily to help tenants maintain housing. A wide array of services may fit this category.

The remainder of this section provides information on sources and types of public finance sources for housing (HUD and other sources), budgets of financial programs, and developers.

[67] From Missouri Department of Mental Health toolkit
[68] http://dmh.mo.gov/docs/ada/housingbook.pdf

U.S. Department of Housing and Urban Development (HUD)

Continuum of Care Grant Programs

Three federal sources collectively known as Continuum of Care funding (**Shelter Plus Care, the Supportive Housing Program and the Section 8 Moderate Rehabilitation SRO Programs)**. These programs also have been referred to as HUD McKinney funding. As of fiscal year 2012 these three programs will be governed by new authorizing legislation call Homeless Emergency and Rapid Transition to Housing (HEARTH) Act. Grants are administered through an identification of entitlement areas (those, mostly urban, areas with enough population to apply for their own funding) and BOS (balance of state)—those areas that together are administered through a state program. HUD requires CoCs to conduct a community-based planning process to determine goals and strategies for addressing homelessness and priorities for funding for the coming year. The CoC also is required to conduct a broadly publicized application process whereby individual project sponsors submit proposals to the CoC body, which rates and ranks all applications received. The applicant can be a state, local government, other government agencies (such as a public housing agency), private nonprofit organizations, and community mental health associations that are nonprofit organizations. The CoC then submits its CoC Plan along with a ranked set of funding applications to HUD. HUD awards funding to projects in the order they have been ranked by the CoC, up to the community's adjusted pro rata need amount.

Continuum of Care Grant Programs	
Shelter Plus Care (S+C) **Type of Financing: OPERATIONS**	The Shelter Plus Care (S+C) Program offers rental assistance to individuals and families receiving supportive services. HUD restricts this program to serving only homeless individuals (see Appendix A-Glossary of terms for latest definition) with serious disabilities and requires grantees to provide supportive services. The definition of a disability for this program is broader than the one used by the Social Security Administration in determining eligibility, i.e., ***it includes alcohol and drug addiction in its definition of disability***. S+C rental assistance is modeled on the Section 8 program, with tenants paying 30% of their adjusted income for rent and the program paying the difference between that share and the HUD-established Fair Market Rent (FMR) for the unit. The program is somewhat more flexible than Section 8, making it a highly desirable operating source for supportive housing sponsors. The rental assistance is offered in several forms (tenant-based, project-based, or sponsor-based) and can be provided in a variety of housing settings, including both single site and scattered site units: HUD"s stated goals for this program are to increase housing stability, raise skill level and/or income of participants and improve self-sufficiency. S+C is widely used for permanent supportive housing projects, particularly when Housing Choice Vouchers are in short supply. The Department of Mental Health Housing Team administers S+C for persons with mental illness and substance abuse disabilities and has done an excellent job of expanding this program across Missouri.
Supportive Housing Program (SHP) **Type of**	The Supportive Housing Program (SHP) helps develop housing and related supportive services for people moving from homelessness to independent living. Program funds help homeless people live in a stable place, increase their skills and their income, and gain more control over the decisions that affect their lives. Eligible applicants include States, local governments, other government agencies (such as public housing agencies), private nonprofit organizations, and

Financing: CAPITAL OPERATIONS SERVICES	community mental health associations that are public nonprofit organizations. As with the other programs in this section, SHP is specifically designed for people who are homeless. The range of eligible activities, however, is very broad and allows for creativity in service design. Program components include six main features or services: **Transitional housing**—Housing for people who are homeless for up to 24 months with associated supportive services that help them live independently and prepare for moving into permanent housing. **Permanent housing for people with disabilities—**Long-term housing with supportive services for people who were homeless and with disabilities. **Supportive services only**—This category assists providers who do not provide the housing but do provide the associated services. These services may be delivered in a structured or operated independently, such as street outreach or in a mobile van. **Safe Havens**—This is a form of supportive housing for people with disabilities who have not been well served by traditional programs and who are classified as "hard to reach." This service should be low demand, focused on engagement and working towards involving people in appropriate treatment and services as they learn to trust providers. **Homeless Management Information System (HMIS)**—Data collection program designed to identify characteristics of people experiencing homeless. **Innovative Supportive Housing**—An applicant may design a program outside the scope of the other components above. The project must show a compelling need, be able to be replicated, and prove that it is distinctly different from other approaches in the region. In order to implement the programs identified above, the funds may be used in the following ways: **Acquisition and rehabilitation for a building where homeless people will reside**—This is an eligible use of funds but there are generally limits between $200,000 and $400,000 per structure and any funds used for this purpose must be matched or leveraged with other funds on the project. **New Construction**—Similarly, these funds are capped up to $400,000 per structure and must be matched. **Leasing**—Grantees may lease structures to provide supportive housing or services or individual units. **Supportive Services**—Those services which directly advance the movement of homeless participants to independent living are eligible. Examples include outreach, case management, child care, job training, health care and transportation. Grantees must share in the cost of services including at least a 20% cash match of total services budget. **Operating Costs**—Basic costs of operating a supportive housing facility such as maintenance, repair, operations staff, utilities, equipment, insurance, supplies, food. Grantees must provide a cash contribution equal to 25% of the total operating costs. The term of a new SHP grant is three years. Renewals may be for one-, two-, or three-year terms.
Moderate Rehabilitation Single Room Occupancy	The Section 8 Moderate Rehabilitation SRO Program provides rental subsidies for homeless persons in SRO projects that have undergone moderate rehabilitation (at least $3,000 per unit). An SRO unit is a one-room unit intended for occupancy by a single individual. It is distinct from a studio or efficiency unit, in that a studio is a one-room unit that must contain a kitchen and

(SRO) Program **Type of Financing: OPERATIONS**	bathroom. An SRO unit is not required to have either one, although many may have one or the other. Unlike Shelter Plus Care (S+C), the tenant does not have to have a chronic disability, and the subsidies are tied to the project, not the tenant. Public housing agencies (PHAs) and private nonprofit organizations are eligible for the SRO Program. Nonprofit organizations, however, must subcontract with a PHA to administer the rental assistance. The Single Room Occupancy (SRO) program is authorized by Section 441 of the McKinney-Vento Homeless Assistance Act. Under the program, HUD enters into Annual Contributions Contracts with public housing agencies (PHAs) in connection with the moderate rehabilitation of residential properties that, when rehabilitation is completed, will contain multiple single room dwelling units. These PHAs make Section 8 rental assistance payments to participating owners (i.e., landlords) on behalf of homeless individuals who rent the rehabilitated dwellings. The rental assistance payments cover the difference between a portion of the tenant's income (normally 30%) and the unit's rent, which must be within the fair market rent (FMR) established by HUD. This rental assistance program has a term of 10 years, so it is attractive for supportive housing, and combines well with tax credits (given the longer term of contract). The fair market rent (FMR) is based on 75% of the FMR for a studio apartment. Administrative responsibility lies with the local public housing agency operating the Section 8 Program, usually the public housing authority (PHA). This program is an excellent source of rental subsidies for permanent supportive housing, given its relatively long term, stability (since it's project-based) and its flexibility. However, it is less attractive than other Section 8 programs or S+C for studio (self-contained) apartments, since is uses the lower FMR for SROs. This is a competitive grant program that functions within a formula allocation. HUD awards funding to Local Housing Authorities (LHAs), who enter into contract with the owners of SRO properties. The owner rehabilitates the units, and Housing Authority makes Section 8 rental assistance payments on behalf of homeless individuals who rent the rehabilitated dwellings. The rental assistance payments cover the difference between the tenant's share of the rent (30% of their income) and the Fair Market Rent for the unit as established by HUD. The rental assistance also pays for any debt service for any funds borrowed by the owner to rehabilitate the units.

HUD Programs Requiring Submission of a Consolidated Plan

In order to be eligible for this funding states (and local entitlement communities) must submit a three- or five-year Consolidated Plan that includes an assessment of the need for affordable housing and annual One-Year Action Plans identifying the activities that will be carried out to address the needs. In Missouri, the state Department of Economic Development (DED) is the designated lead agency for the Missouri Consolidated Plan and Action Plan which helps direct the activities of State CDBG, HOME, Emergency Shelter Grant and HOPWA (Housing for Persons with AIDS) entitlement funds. Local entitlement communities each have agencies that are responsible for the development and submission of local Consolidated Plans and Action Plans. To ensure that the Consolidated Plan and the use of HUD entitlement funds adequately reflect the needs in the community, supportive housing project sponsors can get involved in the Consolidated Plan process in several ways, including attending public hearings, reviewing and commenting on Consolidated Plan drafts, gathering and submitting data documenting the need for supportive housing, and developing clear strategies to ensure

funding controlled by the Consolidated Plan helps to address such needs. The following is a description of each program.

Programs requiring Submission of a Consolidated Plan	
Home Investment Partnerships Program (HOME) **Type of Financing: CAPITAL OPERATIONS**	The Home Investment Partnership or HOME Program is the largest federal block grant program to states and local governments designed exclusively to create affordable housing for low-income people. The money is allocated annually (based on a formula) and can be used to: construct, acquire, and/or rehabilitate affordable housing for rent or homeownership; or to provide direct rental assistance to low-income people. MHDC is the HOME fund administrator in Missouri. The website (MHDC.com) explains the program. Both nonprofit and for-profit developers are eligible to apply and will be expected to demonstrate a history of successful housing experience as well as the financial ability to complete and operate the proposed development. The development must: • Meet a low-income housing need; • Provide housing for low-income and very low-income families or individuals; • Show local support; • Leverage HOME funds with tax credits and other equity or rental assistance; • Provide rents below the HUD Fair Market Rate; • Be economically feasible. These funds are generally allocated along with tax credit and tax-exempt bond financing through MHDC and DED. The NOFA is usually published during the month of August with deadline for submission in late October. Recommendations are made to the commission in January or February. This is another process that could be modified as a result of the new 811 legislation, specifically allowing it to be mixed with application for 811 PRAC funds.
Housing Opportunities for Persons with AIDS (HOPWA) **Type of Financing: CAPITAL OPERATIONS SERVICES**	The purpose of the Housing Opportunities for Persons with AIDS (HOPWA) Program is to provide states and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with HIV/AIDS or related diseases and their families. HOPWA is the leading federal source of capital, operating, and services financing for the development and operation of housing programs that serves persons with HIV/AIDS, and is principally allocated to cities and states based on the incidence of AIDS diagnoses in their communities. HOPWA grant funds for capital financing are typically combined with other sources of capital funds, but in some markets, HOPWA may be the sole source of capital financing for a project. Participation in the local HOPWA planning process is encouraged, which is usually part of the Consolidated Plan and Ryan White local planning processes. The program includes both a Formula Grant and a Competitive Grant component. Approximately 90% of the funding is distributed to states and cities in formula grants, while the remaining 10% is competitively available on an annual basis for model projects or programs. HUD decides which states and municipalities receive a Formula Grant based upon the rate of incidence of HIV/AIDS diagnoses as recorded by the Center for Disease Control. The states or municipalities that have the highest incidences of HIV/AIDS receive formula grants which can establish their own processes for awarding HOPWA funds to sub-grantees. States, municipalities and individual not-for-profit organizations can also apply directly to HUD for HOPWA funding under the Competitive Program. Technical assistance is also available for sponsors of HOPWA-funded programs through

	HUD-funded Technical Assistance Providers. Both permanent and transitional housing projects are eligible for HOPWA funding. HUD's HOPWA program information explains: "HOPWA funds may be used for a wide range of housing, social services, program planning, and development costs. These include, but are not limited to, the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services."
Community Development Block Grant (CDBG) **Type of Financing: CAPITAL OPERATIONS SERVICES**	Begun in 1974, the Community Development Block Grant (CDBG) program provides funding to "entitlement communities" (cities and urban counties) and states. States and entitlement communities receive their allocation of funds on an annual basis which then expend these funds either on their own projects or sub-allocate funds to local non-profits for eligible activities. The amount of funding HUD allocates to entitlement communities (cities and urban counties over $50,000) and states is based upon a formula comprised of several measures of community need, including population, the extent of poverty, housing overcrowding, age of housing, and population growth in relationship to other metropolitan areas. Each state and entitlement community establishes its own competitive process for awarding of CDBG funds to sub-grantees. The CDBG can be used in development or operation of supported housing. Appropriations are divided to provide 70% of funding for entitlement cities and counties and 30% for non-entitlement communities. The Missouri Department of Economic Development administers the grant funds for the non-entitlement communities through its own competitive process. Depending on the funding category, applications are accepted year round or may have a specific deadline. HUD requires that over an identified period of years, not less than 70% of the CDBG funds must be used for activities that benefit low- and moderate-income persons. These funds can be used for a wide variety of activities, however, and many governmental entities use these funds for their own infrastructure and economic development projects. So while supported housing projects are not a mandate or focus of the funding, they are an eligible category. The funding would generally not be sufficient to cover a whole project but could well be used (and has been by other providers) as a part of your gap funding. For providers, it is worth noting that these Block Grant funds can be used for a wide variety of projects serving low income people, not just housing. Your facilities may have other needs that would qualify for funding. For a complete list of eligible activities, see http://www.missouridevelopment.org/topnavpages/Research%20Toolbox/BCS%20Programs/Community%20Development%20Block%20Grant/Eligible%20Activities.html
Emergency Solutions Grant (ESG) **Type of Financing: CAPITAL OPERATIONS SERVICES**	The HEARTH Act, which reauthorized the McKinney-Vento program in 2009, makes significant modifications to the ESG program, including renaming it from "Emergency Shelter Grants" to "Emergency Solutions Grants". The Emergency Solutions Grants (ESG) program builds upon the existing Emergency Shelter Grants program, but places greater emphasis on helping people quickly regain stability in permanent housing after experiencing a housing crisis and/or homelessness. The key changes that reflect this new emphasis are the expansion of the homelessness prevention component of the program and the addition of a new rapid re-housing assistance component. The homelessness prevention component includes various housing relocation and stabilization services and short- and medium-term rental assistance to help people

	avoid becoming homeless. The rapid re-housing assistance component includes similar services and assistance to help people who are homeless move quickly into permanent housing and achieve stability in that housing. Interim rules have now been issued by HUD and can be found at the HUD Homeless Resource Exchange http://www.hudhre.info/index.cfm?do=viewResource&ResourceID=4517 . These rules include requirements for coordination with the local CoC and entering of data into the HMIS. Communities receive ESG funds based upon the same formula as for the distribution of Community Block Grants (CDBG). Local jurisdictions receive ESG funds and then either contract with local services providers or self-perform services. The Consolidated Plan for each community outlines priorities for ESG funding.

Additional HUD Programs

Additional HUD Programs	
Section 8111 Supportive Housing for Persons with Disabilities **Type of Financing: CAPITAL OPERATIONS**	The Section 811 Housing for Persons with Disabilities program provides low-income disabled persons with options that allow them to live independently but in an environment that may provide a range of support services. These supports may consist of coordination of services, staffing and training in independent living. In addition, Section 811 provides capital advances to not-for-profit entities to build and/or rehabilitate community housing for persons with disabilities. This includes financing property acquisition, site improvement, conversion, demolition, relocation, and other expenses associated with supportive housing for persons with disabilities. To be eligible for funding under Section 811, the applicant must be a private, non-profit organization with prior experience in housing or related social service activities. Government entities are not eligible for funding under this program. Key aspects of the program include: • Eligible grantees are 501(c)(3) organizations who commit to providing a minimum capital investment equal to .5% of the capital advance up to a maximum of $10,000; • Purpose of funding is to allow people with disabilities to live as independently as possible in the community by increasing availability of affordable housing with services; • Funding provides interest-free capital advance to finance development of rental housing, including independent-living projects, condominium units, and group homes. The capital advance can finance construction, rehabilitation, or acquisition with or without rehabilitation. The advance does not have to be repaid as long as the housing remains available for very low income persons with disabilities for at least 40 years; • Provides rental subsidies—attached to the project (project rental assistance contracts [PRAC]). Rent is generally approved at a level similar to regional fair market rates. The subsidy pays the difference between the approved rent and 30% of tenant income; • Each project sponsor must have a supportive services plan accompanying the application. Services can be on-site or provided by off-site staff. The HUD budget allows some funds for a service coordination position. The supportive services plan must be approved by the relevant state authority; in the case of people with psychiatric disabilities, that is DMH; • In order to live in 811 housing, a household may consist of a single qualified person who is 18 years old or older who has a disability or a family where there is at least one person

	18 years or older with a disability. The household must be very low income (within 50% of median income for the area). The exact household configuration or housing design is not dictated by HUD. Historically, the Notice of Funding Availability (NOFA) for 811 has gone out in May and decisions are usually finalized in September or October.
Section 202 Supportive Housing for the Elderly **Type of Financing: CAPITAL OPERATIONS**	The Section 202 Supportive Housing for the Elderly program provides low-income elderly within 80% of median income with options that allow them to live independently but in an environment that provides support activities such as cleaning, cooking, or transportation. The program may benefit any low-income resident age 62 years or older.
Section 8 - Housing Choice Voucher Program **Type of Financing: OPERATIONS**	Established in 1974, the Section 8 Program is the single largest source of rental assistance in the country. The program is designed to bridge the gap between the cost of operating and maintaining housing units and what low-income individuals and families can afford to pay in rent. In 1998, a Federal law combined the Section 8 certificates and several other voucher programs into one program, which is now called the "Section 8 Housing Choice Voucher Program." The voucher is a rental subsidy, for households that are required to pay 30% of their adjusted income towards rent. To qualify, a household's annual income must not exceed the applicable income limit for the area as adjusted by family size. The average annual income for households participating in this program is $10,265. The Section 8 Program is administered at the local level by Public Housing Authorities (PHAs). Subsidies are available as Tenant-Based Vouchers (TBV) (attached to a person) or Project-Based Vouchers (PBV) (attached to a specific building). The PHA directly pays the landlord on behalf of the participant, who then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. Disability-specific preferences are not allowed under HUD regulations (meaning preferences for a tenant with one specific type of disability over a tenant with a different disability). PHAs, however, may establish additional "service-related" preferences, which are critical in order for PHAs to be able to refer people from the waiting list that fit the service focus of a sponsor's project-based project. HUD requires PHAs to stipulate all "service-related" preferences in their annual Section 8 Administrative Plan and PHA plan. HUD imposes strict regulations on PHAs regarding waiting list management, but PHAs have some flexibility to prioritize households on the list to reflect locally-determined priorities by establishing "preferences" for certain groups. HUD allows for the following three preferences: Homeless individuals or families; People paying more than 50% of their income toward rent; and Involuntarily displaced families or individuals.
Section 8- Mainstream Housing Opportunities	The Mainstream Program provides special-purpose vouchers within the Section 8 program. The goal of the program is to enable ***persons with disabilities*** to access affordable housing of their choice in the private rental market. Eligible participants include income-eligible families that include a disabled person. Vouchers must be provided to eligible households selected from the

Type of Financing: OPERATIONS	local Housing Authority's Section 8 waiting list. No preference system may be established favoring any specific type of disability over another, but Housing Authorities may be able to establish local preferences based on other criteria to prioritize those households eligible for assistance. The program provides tenant-based rental assistance and seeks to ensure that support services are provided to help participants secure and maintain housing. Eligible persons must be 18 years of age or older, low-income and have a disability per Social Security definition. This program is operated similar to the Housing Choice Voucher Program with the following exceptions: Must have a disability per Social Security definition; May pay no more than 30% of gross income; and Is not statewide Currently, only the following Public Housing Authorities in the Eastern Region have Mainstream Vouchers: Lincoln, Franklin and St. Louis Counties. ***No new Mainstream vouchers have been made available since 2003.*** **Eligible Applicants/Sponsors**: Housing Authorities: Those that have leased 97% of their Section 8 vouchers or that are expending at least 97% of their Section 8 funding allocation receive a competitive advantage. Non-profit organizations providing services to disabled persons. Non-profits must meet fairly stringent capacity requirements and must also comply with the requirement that vouchers be issued to eligible individuals with any type of disability, not to just a sub-population of disabled persons (such as persons with severe mental illness).
Section 232-Lean Program **Type of Financing: CAPITAL**	The Office of Residential Care Facilities (ORCF) manages the Section 232 program, which provides mortgage insurance for residential care facilities such as assisted living facilities, nursing homes, intermediate care facilities, and board and care homes. Section 232 is an FHA-Insured loan product that covers housing for the frail elderly - those in need of supportive services. Nursing homes, assisted living facilities, and board and care are all examples of this type of housing (a project may include more than one type). Section 232 may be used to finance the purchase, refinance, new construction, or substantial rehabilitation of a project. A combination of these uses is acceptable - e.g. refinance of a nursing home coupled with new construction of an assisted living facility. Many persons with behavioral health needs reside in these types of settings and operating and supportive services are typically funded through a combination of the person's disability income, Medicare and Medicaid.

Other Sources of Financing

Missouri Housing Development Commission Administered Programs

The Missouri Housing Development Commission, created by the 75th General Assembly, is an instrumentality of the state of Missouri, which constitutes a body corporate and politic. MHDC has invested almost $4 billion to construct, renovate and preserve affordable housing. MHDC functions as a bank, providing financing directly to developers of affordable rental properties. The commission also provides funding for home loans to

qualified, first-time buyers through a network of certified, private mortgage lenders. Mortgage financing is provided through the sale of tax-exempt notes and bonds that the commission is authorized to issue.

The commission provides advisory, consultative, training and educational services to non-profit housing organizations. In addition to administering the HUD Project-Based Section 8 Rental Assistance Contracts described previously, the commission also administers the: federal and Missouri Low Income Housing Tax Credit (LIHTC) programs, federal HOME funds, the direct MHDC funding of several housing assistance programs and the Affordable Housing Assistance Program Tax Credit. Further, the commission administers the Missouri Housing Trust Fund to help prevent homelessness and to provide emergency housing assistance for very low-income Missourians. The commission participates with the Department of Economic Development in preparing the state's Consolidated Plan for HUD. The commission includes the governor, lieutenant governor, attorney general, state treasurer and six persons appointed by the governor with the advice and consent of the Senate.

Missouri Housing Development Commission Administered Programs	
Missouri Housing Trust Fund **Type of Financing: CAPITAL OPERATIONS**	The Missouri Housing Trust Fund was created by the State Legislature in 1994 to help meet the housing needs of very low income families and individuals. The Missouri Housing Development Commission administers the Trust Fund, which provides funding for a variety of housing needs, such as homeless prevention, rehab or new construction of rental housing, rental assistance and home repair. Developers or non-profit organizations that provide housing and/or related services may apply. Applicants must demonstrate prior, successful housing experience and have the financial capacity to successfully complete and operate the housing and/or service proposed. Provider of services must have qualified and trained staff, and a successful record of providing the proposed services. The Fund provides grants to organizations that provide housing assistance to individuals with income below 50% of median income. Of particular note, the Fund must use 50% or half of its funds for people who are below 25% of median income (a category that would easily include many people living on disability). 30% of the grants must go to nonprofit organizations. It is funded through a $3 recording fee for each real estate document filed in the state of Missouri so the level of funding available is dependent on the amount of real estate activity in the state. Typically, the range has been from $3,000,000 to $6,000,000. Providers know the risk of building a program around an annual reallocation. At the same time, many programs have successfully been refunded for years with Trust Fund dollars. The Trust Fund, like most other public funding streams, administers its grants in accordance with an Allocation Plan that establishes funding priorities. The Plan identifies the following eligible uses: • Emergency Assistance—For people at immediate risk of homelessness; funds can be used for rental assistance, deposits, utility assistance, deposits, hotel/motel vouchers; • Operating Funds—Basic support for salaries and overhead costs for organizations that provide housing or housing services;

	• Construction or Rehabilitation—For organizations that provide emergency, transitional or permanent housing, funds can be used to help cover costs of new construction or modification of existing facilities. Note: This should be considered a potential source for gap funding; • Home Repair or Modification—Available to organizations that provide housing services for payment of certain repairs of homeowner occupied homes; • Transitional Housing—Available for organizations that provide transitional housing for rent assistance and utility assistance; • Rental Assistance—Available to organizations that provide rent assistance to individuals in a permanent low-income housing community. The program is competitive, however, and the amount of need generally far exceeds the amount of grants available. The schedule is set annually by the Commission. Generally, a NOFA is issued in June. The deadline for proposals is September and staff recommendations are sent to the Commission in December for approval. The NOFA and application packet are posted on MHDC.com. The allocation is allotted by percentage geographically with the two large urban centers (St Louis and Kansas City) receiving over half of the total. These allotments are based on a formula including population, poverty rating and unemployment rates.
Federal and Missouri Low Income Housing Tax Credit (LIHTC) **Type of Financing: CAPITAL**	This is a program created by Congress in 1986 to spur the development of affordable housing (Section 42 of the IRS Code). The federal government allocates LIHTC to states (based on a per capita formula). The State Housing Finance Agency (in Missouri that is MHDC) creates a Qualified Allocation Plan (QAP) which establishes the state's criteria and preferences for allocating the credits. The state of Missouri also provides a state LIHTC and may allocate an amount equal to 100% of the federal credit. MHDC also administers these credits. Developers (for-profit and nonprofit) are eligible to apply for tax credits. They must demonstrate history and experience in housing administration as well as show that they have the financial capacity to successfully complete and operate the housing in compliance with regulations for an initial 15 years compliance period and an additional 15 years extended use period. The developer then sells the housing tax credits to investors to generate equity for the project. There are two types of credits: 9% and 4%. These percentages refer to a percentage of the eligible development costs (the 9% credits cover more of your costs and are awarded competitively). Investors pay their equity for the ten-year stream of tax credits into the development partnership during the development of the project and receive the tax credits over the ten years following the initial lease-up of the project. MHDC requirements allow both for-profit and nonprofits to apply. The proposal must: • Meet a demonstrated affordable housing need; • Provide housing for low-income persons and families; • Demonstrate local support; • Leverage tax credit funding with other financing and/or rental assistance. MHDC sets the schedule for application rounds annually. Generally, the NOFA is published in August and an application is available on the website. Deadline for proposals is generally in late October with recommendations and vote in December or January.

	Reviewers look for applicants that can demonstrate the ability to both use (sell) the credits and leverage the credits with additional fund sources. HOME, CDBG and other grant funds can also be used in your total budget. Another source of tax credits that can be used are historic preservation tax credits (HTCs). These federal and state tax credits can be used with federal and state LIHTCs to fund the rehabilitation of buildings on the National Register of Historic Places or that contribute to National Register Historic Districts. Some key aspects of the program are: • Renovation costs must be at least 50% of the acquisition cost; • Plans must be approved by the Missouri State Historic Preservation Office; • The federal historic preservation tax credit is equal to 20% of the eligible expenses of renovation and the state tax credit is equal to 25% of the eligible expenses of the renovation. Some significant redevelopments have been made possible by the combination of HTCs and LIHTCs. The cost of historic renovation, however, is often higher than new construction and the higher per-unit cost is making these developments less competitive when seeking the very competitive 9% LIHTCs.
Missouri Affordable Housing Assistance Program (AHAP) Tax Credit **Type of Financing: CAPITAL OPERATIONS**	In contrast to the LIHTC, which is an "investment" credit, the AHAP tax credit is a "donation" credit. The tax credit is earned by an eligible donor for the donation of cash, equity, services, or real or personal property to a non-profit community-based organization for the purpose of providing affordable housing assistance activities or market rate housing in distressed communities. Under the AHAP program, affordable housing is housing that is affordable to households at or below 50% of area median income. The AHAP tax credit is administered by MHDC. The AHAP tax credit is a one-time credit that may be allocated to an eligible donor for up to 55% of the total value of an eligible donation (for each $1 contributed by the donor, the donor receives 55 cents in tax credits). There are two types of AHAP tax credits: housing production credits for donations related to construction, rehabilitation, and rental assistance activities; and operating assistance credits for donations that help fund the operating costs of the non-profit organization. The program offers $10 million in housing production tax credits and $1 million in operating assistance tax credits annually.
Rental Production and Preservation Program **Type of Financing: CAPITAL**	The MHDC Rental Housing Production and Preservation Program provides funding to developers for the acquisition and rehabilitation or new construction of rental housing for low and moderate income families. The MHDC funds are typically combined with Low Income Housing Tax Credits to fund affordable Multifamily housing developments. Developers (for-profit and not-for-profit) are eligible to apply for financing. Applicants must demonstrate prior successful housing experience and engage the services of housing professionals such as architects, appraisers, attorneys, accountants, contractors and property managers with demonstrable multifamily housing experience. Developers must have the financial capacity to successfully complete and operate the proposed housing development. Proposed housing developments must: • Meet a demonstrated affordable housing need; • Provide housing for low and moderate income persons and families; • Demonstrate local support; • Leverage MHDC funds with tax credits, other equity and/or rental assistance, and;

	• Be economically feasible Fund Availability is determined annually by MHDC. Typically, a Notice of Funding Availability (NOFA) is published during the month of August. The deadline for proposal submission is typically in late October, and recommendations are made to the Commission in December.

Other Programs

A variety of other local, state and federal resources exist in addition to the HUD and MHDC resources listed above. The listing below is not inclusive but provides an overview of the key resources available.

Other Programs	
Tax Exempt Bonds **Type of Financing: CAPITAL**	The Missouri Department of Economic Development allocates tax-exempt multi-family housing revenue bonds for of eligible projects. These "private activity bonds" are authorized by the Internal Revenue Code at 26 U.S.C. §§ 141 to 150 and are issued to finance construction or rehabilitation of multi-family housing projects where either a minimum of 20% of the units will be made affordable to people at 50% of area median income or a minimum of 40% of the units will be made affordable to people at 60% of area median income. Because the interest earned by the bond purchasers is tax-exempt, the interest rate paid by the borrower is low.
Federal Home Loan Bank (FHLB) Affordable Housing Program (AHP) **Type of Financing: CAPITAL OPERATIONS**	The Federal Home Loan Bank of Des Moines is part of a larger system of 12 district banks and is the one which relates to projects in Missouri. Each of the banks contributes 10% of its net earnings to Affordable Housing Program funding. This fund is used to subsidize housing for very low income and low- to moderate-income owner-occupied or rental-housing projects. To qualify, a rental project must have at least 20% of units designated for families earning 50% or below of area median income. Additional points can be awarded for projects serving people who are homeless or with "special needs." Applications are made through a member bank sponsor. In other words, if a nonprofit wishes to apply for this funding, they must find a local bank that is part of this particular FHLB region or district to submit the application. The FHLB of Des Moines website has a list of Member banks in Missouri, http://www.fhlbdm.com/ms_directory.htm. It is a good idea to double check on the status of your partner bank. Bank mergers and changes of ownership are happening regularly and where the home office of the bank is located determines whether the bank is part of a particular region or not. Applications and information are available on the website http://www.fhlbdm.com/ci_ahp.htm. Applications are generally accepted from May through June with technical assistance from the Community Investment Department being available in April.
Department of Veterans Affairs (VA) **Type of Financing: CAPITAL OPERATIONS**	If, there is enough of a population of people who are homeless and veterans, there is funding available through the United States Department of Veterans' Affairs (VA) program called Health Care for Homeless Veterans (HCHV). The goal of the program is to promote the development and provision of supportive housing and services with the goal of helping homeless veterans achieve residential stability and greater self-determination. This VA program will fund programs with transitional supportive housing (up to 24 months). The Programs has two levels of funding—the grant funding and the per diem. For capital projects, the grant can fund up to 65% of the costs of construction, renovation, or acquisition of a building. The project sponsor must obtain at least the 35% matching funds from other sources.

USDA Rural Development Programs **Type of Financing: CAPITAL OPERATIONS**	The United States Department of Agriculture (USDA) Rural Development (RD) program has a range of loan, loan guarantee, and grant programs whose purpose is to enhance economic opportunity and improve the quality of life in rural America. These programs encompass housing, community facilities, and businesses. While there are not programs targeted specifically for people with disabilities or behavioral health disorders, these programs and services are not excluded from the scope of RD. The Missouri USDA RD website is http:www.rurdev.usda.gov/mo and it has links to the whole range of programs, services, and technical assistance available. It also provides a list of areas eligible for RD support and the local contact information. Edwin Cooper of the DMH housing team is also familiar with Rural Development programs and can offer assistance and referral. http://dmh.mo.gov/housing/members.htm Examples of programs that may be useful include: • Community Facility Grants http://www.rurdev.usda.gov/HAD-CF_Grants.html to assist help construct, enlarge, extend or improve essential community facilities including those providing health care or community and social services. This can include the purchase of major equipment and nonprofit organizations are eligible applicants. (One provider used this resource to make improvements in a PSRC building); • The Multi Family Housing program helps subsidize apartment rental units in rural areas. It is worth knowing about this program if you live in an area that is covered and looking to make partnerships for set asides. The map on this link can lead you to lists of housing corporations in different areas: http://rdmfhrentals.sc.egov.usda.gov/RDMFHRentals/select_county.jsp?st=MO&state_name=Missouri&st_cd=29 • The Rural Development Office is also available to work with organizations to see how to package a combination of low interest loans, grants, and technical assistance to create affordable housing. http://www.rurdev.usda.gov/LP_Subject_HousingAndCommunityAssistance.html
Missouri Department of Mental Health **Type of Financing: OPERTIONS SERVICES**	Division of CPS Services and SCLP Division of ADA Services Rental Assistance Program -DMH received funds from the Missouri Housing Trust Fund (MHTF) in 1996 to provide long-term rental assistance to persons with mental illness, substance abuse disorders and developmental disabilities. That funding ended in 2002 and DMH has since used its own funds to operate what is now called the Rental Assistance Program (RAP). RAP is a transitional rental subsidy program limited to two years of assistance and designed to assist people with disabilities experiencing a housing crisis to transition to housing self-sufficiency or to a form of assisted permanent housing.

The financial resources identified above are far from exhaustive. Medicaid, Medicare and Disability Supplemental Income Payments are often used to subsidize residential costs and fund a variety of behavioral and other related services especially in residential care and nursing home facilities that also serve other populations, primarily the elderly. There are, of course other public and private resources that can be used to finance housing and services supports as well. For example a number of foundations that have supported projects in Missouri. Additionally, certain local public agencies may dedicate funding sources including but not limited to local county mental health boards. Also St. Louis City has its own Affordable Housing Trust Fund.

Financial Resource Budgets

This section provides information on the budgets of certain funding and tax credit programs. Many operating funding awards are made for program renewals vs. funding of new programs. Table 20 shows total funds and tax credits allocated to the production of affordable housing projects and the operation of affordable housing programs by Missouri in 2011. **Please note, in some cases, the amount of funds and tax credits awarded exceeds the amount of funds and tax credits budgeted because budgets may have underestimated the amount of the applicable resource that would be available for that year.**

Table 20 2011 Statewide Funds & Tax Credits	Funds & Tax Credits Budgets in 2011[69]	Funds and Tax Credits Awarded in 2011[70]
State CDBG Funds	$24,120,069[71]	$23,954,082[72]
State Emergency Shelter Grants	$1,424,770[73]	$1,428,349[74]
Missouri Housing Trust Fund (MTF)	$3,000,000	$3,724,278[75]
State HOME Funds	$16,865,427[76]	$11,061,656
MHDC Fund Balance	$6,860,000	$5,065,000
Tax Exempt Bonds	No Cap[77]	$33,850,000
Federal 4% LIHTC	No Cap[78]	$1,726,429[79]
State 4% LIHTC	$6,000,000	$286,000
Federal 9% LIHTC	$12,900,000[80]	$13,254,000
State 9% LIHTC	$12,900,000[81]	$7,541,000
AHAP Tax Credit- Production	$10,000,000	$7,340,448
AHAP Tax Credit- Operating Assistance	$1,000,000	$1,000,000[82]
TOTAL	**$95,070,266**	**$112,006,242**

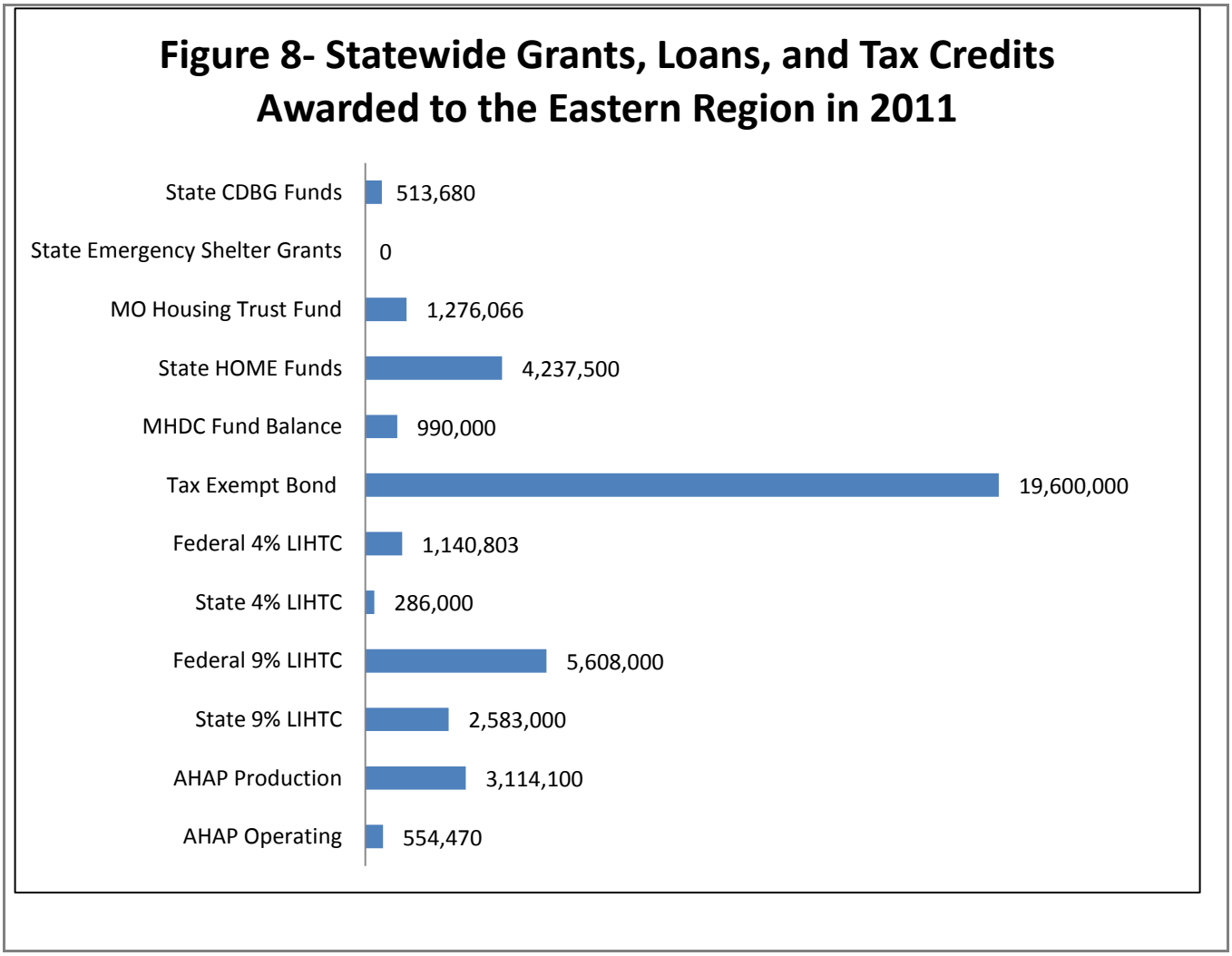
[69] Information from: http://www.mhdc.com/ci/documents/CP_AP_11.pdf unless otherwise noted.
[70] Information from: http://www.mhdc.com/nofa/FY2011_Funding_Approvals/default.htm unless otherwise noted.
[71] This funding is the total amount allocated to the State for award to non-entitlement communities in Missouri, which is managed by the MO Department of Economic Development (MODED). This includes Warren, Franklin, and Lincoln Counties.
[72] Awards as of 11/4/11. Provided by *Andy Papen*, State of *Missouri* Department of Economic Development.
[73] This funding is the total amount allocated to the State for award to non-entitlement communities in Missouri, which was more than what was projected in the State's Consolidated Plan.
[74] http://www.hudhre.info/index.cfm?do=actionGrantAwardsSearch&yr=2011&rptType=ESG&pickScope=byState&optTwo=MO&optThree=
[75] http://www.mhdc.com/nofa/FY2011_Funding_Approvals/2011_MHTF_Approved_List.pdf
[76] Includes program income.
[77] There is a cap of $538,882,200, however these funds are not exclusively used to support housing development or rehab. There is no set amount that can be used exclusively to finance affordable housing development.
[78] There is no set amount of federal 4% LIHTC allocated to MO. All tax exempt bonds for multifamily development are automatically eligible for however much federal 4% LIHTC is supported by the eligible costs of the project.
[79] http://www.mhdc.com/nofa/FY2011_Funding_Approvals/2011_RP_R2_Approved.pdf and http://www.mhdc.com/nofa/FY2011_Funding_Approvals/default.htm
[80] The amount of federal 9% LIHTC allocated to MO in 2011 was more than what was projected in the State's Consolidated Plan.
[81] The LIHTC amounts shown are for one year. These tax credits are issued over a 10-year period, so the total amount of tax credits available to the investors in these developments is 10 times the amount shown. So, for example, $129 million each in State and Federal 9% LIHTCs were available to be awarded to eligible projects in 2011 and those tax credits will be delivered to the investors over a 10-year period. The amount of the tax credits is not the amount of money that is invested in the affordable housing development. Investors pay a "discounted" value for the tax credits. If investors pay an average of 85 cents on the dollar for federal LIHTCs allocated in 2011 (about what they are getting in the market at the time of this report), then $109,650,000 would be invested in these affordable housing developments by the federal LIHTC purchasers.
[82] http://www.mhdc.com/rental_production/ahap/application_history/AHAP_Funded_Operating_Applications_2011.pdf

Of the total amount of funds allocated to Missouri, the Eastern Region received **$39,903,610 from statewide grants, loans, and tax credits** to help finance affordable housing development and fund affordable housing programs in 2011. **Table 21** shows the distribution of these funds for affordable housing development projects and programs in our region and the counties where these projects and programs were located in 2011.

Table 21 2011 Allocations for Statewide Grants, Loans & Tax Credits[83]	Jefferson	Franklin	St. Charles	Warren	Lincoln	SL City	SL County	Eastern Region
State CDBG Funds[84]	-	-	-	$91,680	$422,000[85]	-	-	**$513,680**
State Emergency Shelter Grants	-	-	-	-	-	-	-	**$0**
MO Housing Trust Fund[86]	$79,750	-	$7,666[87]	$7,666	$7,666	$929,606	$243,712	**$1,276,066**
State HOME Funds[88]	350,000	-	$600,000	$750,000	-	$2,150,000	$387,500	**$4,237,500**
MHDC Fund Balance	-	-	$990,000	-	-	-	-	**$990,000**
Tax-Exempt Bonds	-	-	-	-	-	$19,600,000	-	**$19,600,000**
Federal 4% LIHTC	-	-	-	-	-	$1,140,803	-	**$1,140,803**
State 4% LIHTC	-	-	-	-	-	$286,000	-	**$286,000**
Federal 9% LIHTC	$775,000	-	$1,503,000	$880,000	-	$1,565,000	$885,000	**$ 5,608,000**
State 9% LIHTC	$446,000	-	$565,000	$582,000	-	$420,000	$570,000	**$ 2,583,000**
AHAP Production[89]	-	-	$89,100	-	-	$3,025,000	-	**$3,114,100**
AHAP Operating[90]	-	-	-	-	-	$471,157	$83,313	**$554,470**
TOTAL	**$1,650,750**	**$0**	**$3,754,766**	**$2,311,346**	**$429,666**	**$29,587,566**	**$2,169,525**	**$39,903,610**

[83] Information from: http://www.mhdc.com/nofa/FY2011_Funding_Approvals/default.htm unless otherwise noted.
[84] Awards as of 11/4/11. Data provided by *Andy Papen Missouri* Department of Economic Development.
[85] Amount awarded to city of Silex.
[86] http://www.mhdc.com/nofa/FY2011_Funding_Approvals/2011_MHTF_Approved_List.pdf
[87] This project was awarded $23,000 and has a service area that includes St. Charles, Warren, and Lincoln Counties.
[88] Funds can be awarded to jurisdictions within entitlement areas.
[89] http://www.mhdc.com/rental_production/ahap/application_history/AHAP_Funded_Production_Applications_2011.pdf and http://www.mhdc.com/nofa/FY2011_Funding_Approvals/default.htm
[90] http://www.mhdc.com/rental_production/ahap/application_history/AHAP_Funded_Operating_Applications_2011.pdf

Figure 8 provides a visual breakdown of Table 21 and shows the total amounts by source that were allocated to the Eastern Region in 2011.



In addition to statewide grants, loans, and tax credits, funds to develop affordable housing enter the Eastern Region through "entitlement" communities. These funds include Community Development Block Grant (CDBG), HOME funds, and Emergency Shelter Grants. Entitlement communities are cities and counties that have a large enough population (in the case of CDBG funds, greater than 50,000 for cities and greater than 200,000 for counties) to receive funds directly from the federal government. St. Charles County will become an entitlement community in 2012.

Table 22 shows the 2011 CDBG budgets, including program income, for the entitlement communities in the Eastern Region.

Table 22- 2011 CDBG Budgets for Entitlement Communities	Jefferson County[91]	St. Charles City[92]	O'Fallon City[93]	Florissant City[94]	SL City[95]	SL County[96]	TOTAL
Community Development Block Grants	$1,034,211	$390,249	$238,976	$240,000	$21,800,299	$6,117,000	**$29,820,735**

HOME Funds and Emergency Shelter Grants also enter the Eastern Region through entitlement communities. **Table 23** below shows the 2011 budgets for the HOME and Emergency Shelter Grant entitlement communities that are in the Eastern Region. The counties of St. Louis, St. Charles and Jefferson, and the cities of St. Charles, O'Fallon, Wentzville, and Florissant have joined to create the St. Louis HOME Consortium. St. Louis County is the lead agency and administers the funds on behalf of the members of the Consortium.[97] St. Louis City is also a HOME and Emergency Shelter Grant entitlement community. Affordable housing development projects located in HOME entitlement jurisdictions are also eligible to receive state HOME funds.

Table 23- 2011 HOME and Emergency Shelter Budgets for Entitlement Communities	SL City[98]	SL HOME Consortium[99]	TOTAL
HOME Funds	$4,649,417	$4,183,700	$8,833,117
Emergency Shelter Grants	$820,000	$235,000	$1,055,000
TOTAL	$5,469,417	$4,418,700	**$9,898,117**

In addition to the above sources, budget data available for other publicly supported housing programs include the Supported Housing Program, the Shelter Plus Care program **(Table 24)** and the Public Housing Authorities **(Table 25)**.

[91] Data provided by Rosie Buchanan, Assistant Executive Director Economic, Development Corporation of Jefferson County.
[92] http://www.stcharlescitymo.gov/Portals/0/CDBG/2011%20Action%20Plan%20Narrative.pdf
[93] Includes program income. http://www.ofallon.mo.us/pubs/cdbg/cp.pdf
[94] Includes program income. http://www.florissantmo.com/cd/_6_%20DRAFT%20Florissant%20-%20AP1FY%202011.pdf
[95] Includes program income. http://stlouis-mo.gov/government/departments/community-development/documents/upload//2010-14ConsolidatedPlan.pdf
[96] Includes program income. http://ww5.stlouisco.com/plan/conplan06/ConsolidatedPlan_2011-2015_DRAFT.pdf
[97] http://ww5.stlouisco.com/plan/conplan06/ConsolidatedPlan_2011-2015_DRAFT.pdf
[98] Includes program income. http://stlouis-mo.gov/government/departments/community-development/documents/upload//2010-14ConsolidatedPlan.pdf
[99] Includes program income. http://ww5.stlouisco.com/plan/conplan06/ConsolidatedPlan_2011-2015_DRAFT.pdf

TABLE 24- 2010 allocation of Supported Housing Funds[100] and Shelter Plus Care Funds	Region 1 BoS (Includes Jefferson and Franklin)	St. Charles Lincoln Warren	SL City	SL County	Eastern Region
SHP[101]	$105,663	$220,832	$6,080,056	$1,395,166	**$7,801,717**
S+CARE[102]	$402,660	$0	$6,223,356	$1,620,632	**$8,246,648**
Total	$508,323	$220,832	$12,303,412	$3,015,798	**$16,048,365**

TABLE 25- Public Housing Authority Budgets	Franklin/ Jefferson[103]	Lincoln/ Warren[104]	St. Charles	SL City[105]	SL County	Eastern Region
Total Budgets	$4,008,736	$8,400,000	$4,200,200	$60,000,000	$44,000,000	**$120,608,936**

Additionally the region-wide budget for the DMH Supported Community Living Program for the current Fiscal Year for the 7-county Eastern Region is **$4,063,598.** A breakdown by county is unavailable.

Additional Funding Sources

There are some funding sources that are only available in the City of St. Louis or serve specific populations. Two additional funding sources in St. Louis City are: the St. Louis Mental Health Board and the City of St. Louis Affordable Housing Trust Fund.

St. Louis Mental Health Board

Beginning in 2011, the St. Louis Mental Health Board has allocated $1 million per year for development of supportive housing. The funds can be used for rehabilitation of housing, start- up costs, and other project related costs approved on a case by case basis.[106]

[100] Includes both new awards and renewed funding of existing projects.
[101] http://www.hudhre.info/index.cfm?do=actionGrantAwardsSearch&yr=2010&rptType=CoC&pickScope=byState&optTwo=MO&optThree=
[102] MO DMH Housing Manual January 2011
[103] Franklin and Jefferson are served the same public housing authority and share the $4,008,736.
[104] Lincoln and Warren are served by a public housing authority that includes nine other counties. The eleven counties share the $8,400,000.
[105] http://www.slha.org/wp-content/uploads/2011/09/SLHA-Fact-Sheet-101410-revised-090811.pdf
[106] Information provided by St. Louis Mental Health Board staff on 12/16/2011.

City of St. Louis Affordable Housing Trust Fund

The City of St. Louis Affordable Housing Commission provides grants and loans to non-profit agencies that provide affordable housing related services and to developers for the construction or rehabilitation of affordable housing for city residents. By ordinance, all funds awarded by the Commission must benefit families and individuals with incomes at or below 80% of the area median, with 40% benefitting families and individuals with incomes at or below 20% of the area median. The Commission's fall 2010 funding awards were:[107]

Accessibility Modifications:	$94,400
Affordable Housing Construction and Major Rehabilitation:	$655,000
Education and Counseling:	$198,000
Education/Training and Rent/Mortgage Subsidies:	$168,000
Rent/Mortgage/Utility Subsidies:	$284,200
Foreclosure Prevention:	$176,000
Neighborhood Stabilization:	$364,000
Home Repair Programs:	$421,400
Homeless Prevention & Shelters:	$1,045,000
Transitional Housing:	$666,000
Total:	**$4,072,000**

Local Developers

Both for-profit and non-profit developers work to develop affordable housing in the Eastern Region. Many of these developers have specifically partnered with behavioral health providers. The following list shows some of the developers who have worked to develop affordable housing in the eastern region. Over the past three years, they have all been awarded 4% tax credits, 9% tax credits, or HOME funding for their development projects.[108] These developers include:

- McCormack Baron Salazar
- Spinnaker Properties
- North Newstead Association
- Northside Community Housing, Inc./Greater Ville Historic Preservation Commission
- Better Living Communities
- Bear Land
- GHL Development
- Delphi Community Housing
- North Tower Group
- Landmark Capital
- Patrick Development

[107] http://stlouis-mo.gov/government/departments/affordable-housing/documents/upload//Fall-2010-award-list.pdf
[108] http://www.mhdc.com/nofa/

- St. Luke's Inc.
- Banner Property Mgmt.
- Sherman Associates
- Dalmark Development
- ND Consulting
- JES Development
- Watercolor Developer LLC
- Beyond Housing Inc.
- Golden Management Inc
- Falcons Way GP, LLC
- Loftworks
- National Church Residences
- Gardner Development LLC
- Regional Housing and Community Development Alliance (RHCDA)
- Evergreen Partners II LLC
- Missouri Housing Partners LLC

An additional resource to learn more about developers who are committed to affordable housing is the Missouri Workforce Housing Association (http://www.moworkforcehousing.com/). This is an organization that advocates for both the for-profit and nonprofit affordable housing industry. The membership of this organization includes developers and other organizations that all work towards developing and sustaining affordable housing in the St. Louis region.

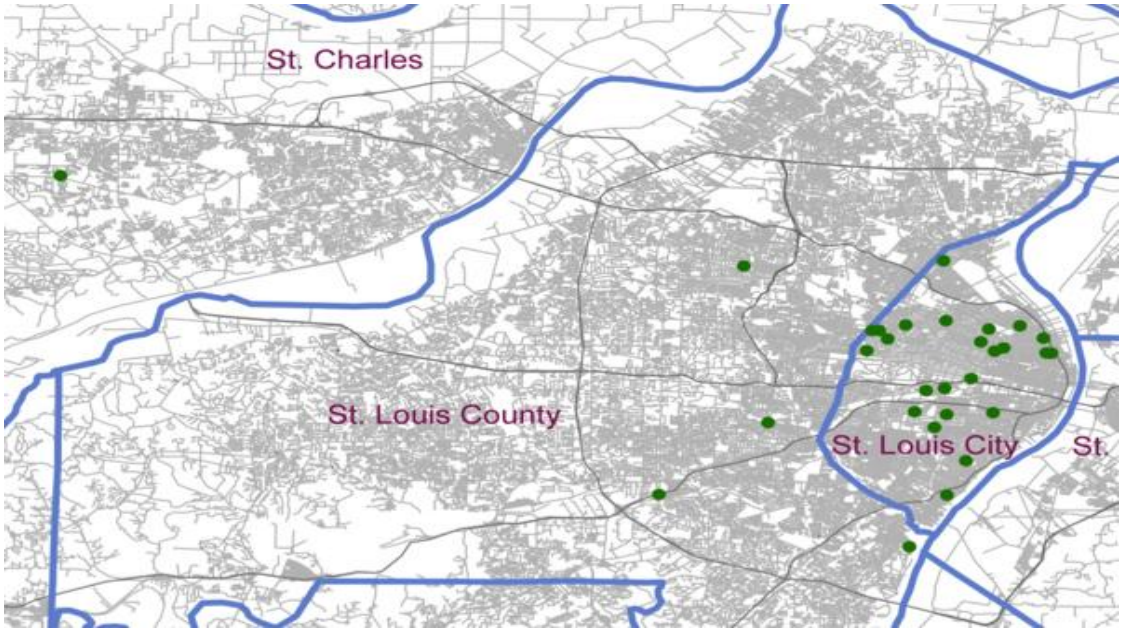
Many nonprofit developers are community development corporations (CDCs). CDCs apply a "place-based" strategy to their housing development. This means that they provide development assistance to one, particular geographic area. The logic is that a grassroots approach will be more successful at mobilizing the key stakeholders in the area which will allow for more successful developments and community revival.[109]

CDCs provide a variety of services. They include: housing development, housing rehabilitation and repair, home weatherization, financial literacy, credit counseling, foreclosure intervention/prevention, and predatory lending education.

The St. Louis area has 42 CDCs (in Missouri) that are active in the community. **Figure 9** shows the distribution of CDCs in the region and it is clear that the majority of the CDCs are concentrated within St. Louis City with three in St. Louis County and one in St. Charles County.

[109] http://pprc.umsl.edu/data/EnhancingCapacity2011.pdf P. 4

Figure 9-Active CDC locations



Almost 90% of these CDCs identify themselves as housing developers and have played an important role in developing housing in the region. In the past three years, 532 new housing units have been reported as being developed by these CDCs.[110] 72% of these new units were designed to be rental housing.[111]

On average, 50% of the CDCs' budgets come from rental collection and private grants. The remaining 50% of their budgets come from government funding. "The most common sources of federal funding are Community Development Block Grant and HOME."[112] Additional sources of operating revenue include developer fees from Low-Income Housing Tax Credit, Historic Tax Credit, and New Market Tax Credit developments. These are the same funding sources that behavioral health providers need to utilize if they are going to develop supportive housing.

In addition, there are nonprofit "intermediary" organizations active in affordable housing development. Intermediaries assist other nonprofits, providing resources and technical expertise. Some are national, such as Enterprise Community Partners and Local Initiative Support Corporation (LISC), and others are local. Regional Housing and Community Development Alliance (RHCDA) is the only local affordable housing development intermediary in the St. Louis Region. RHCDA provides the resources and expertise that make it possible for many of our local CDC's to develop affordable housing.

RHCDA and the network of CDCs in the St. Louis area have experience and expertise that most behavioral health providers do not, especially when it comes to accessing federal funds for developing housing. They are committed to strengthening neighborhoods and are not solely profit-driven, which makes them a possible partner for behavioral health providers who want to develop housing.

[110] http://pprc.umsl.edu/data/EnhancingCapacity2011.pdf P. 6
[111] http://pprc.umsl.edu/data/EnhancingCapacity2011.pdf P. 8
[112] http://pprc.umsl.edu/data/EnhancingCapacity2011.pdf P. 17

Key Policy, Financing and Practice Trends

Policy and Financing Trends

The following outlines some of the more significant trends primarily in governmental policy at the federal, state and local levels that need to be considered in any planning activities. These trends need to be considered in light of the current federal budget crisis which has the potential to impact the financing available for affordable housing.

The HEARTH Act of 2009

The reauthorization of the HEARTH **(Homeless Emergency Assistance and Rapid Transition to Housing)** Act has caused for two major changes in the direction of federal policies to address homelessness. The first is the move to promote greater interagency cooperation and collaboration. The second is to standardize the planning components of the sections of Consolidated Plans that relate to homelessness and the Continuum of Cares annual plans.

The HEARTH Act requires the United States Interagency Council on Homelessness (USICH) to update its "Plan to Prevent and End Homelessness" annually. The most recent update, from 2010, identifies the need to "Increase leadership, collaboration, and civic engagement" in order to effectively address homelessness.[113] The USICH Plan seeks to accomplish this through greater intergovernmental collaboration on all levels. The USICH Plan also states that it hopes to reward communities that engage in more collaboration.[114] To reflect this Federal trend, the State of Missouri has recently renamed the "Governor's Committee to End Homelessness" to "Missouri Interagency Council on Homelessness".[115] The hope, from the federal level, is that greater coordination among government agencies on all levels will result in more effective efforts to address homelessness.

The HEARTH Act has also revised the rules governing the Emergency Solutions Grants (formerly Emergency Shelter Grants) so that the Consolidated Plans and Continuum of Cares planning process become more integrated and the planning processes more standardized. The ESG no longer focuses on emergency and transitional housing. Now the focus is on getting homeless individuals directly into permanent housing.[116] HUD has released the Interim Regulations, which outline the immediate changes being made.[117] One of the major changes is that the elements of Consolidated Plans relating to homelessness have been standardized to fit more with the Continuum of Cares' planning process. "The interim rule strengthens and standardizes the homelessness elements affecting all jurisdictions required to submit a Consolidated Plan."[118] Now, the Continuum of Cares must participate in the Consolidated Plan that serves their same geographic area. The CoCs are required evaluate the outcome of the ESG funds. ESG recipients are required to consult with CoCs

[113] "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness-2010," http://www.usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf (P. 30)
[114] "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness-2010," http://www.usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf (P. 31)
[115] http://mo-ich.org/index.html
[116] http://www.hudhre.info/index.cfm?do=viewResource&ResourceID=4517
[117] Full report http://www.hudhre.info/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf
[118] http://www.hudhre.info/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf (P. 9)

and submit data/information to the HMIS system. The ultimate goal is that the "changes to the Consolidated Plan will foster closer coordination between not only Emergency Solutions Grant (ESG) and Continuum of Care (CoC) programs, but other mainstream housing and services programs that can provide greater resources to homeless persons and people at imminent risk of homelessness."[119]

Both of these changes at the federal level show the allocation of HUD funding is being changed so that it coordinates between existing agencies and begins to standardize the multiple planning processes that occur in a single community. The HEARTH Act also has potential to enhance the development of permanent supportive housing as it incentivizes Continuums of Care to increase permanent supportive housing for the chronic homeless with an expanded definition of homeless. The Act is to be implemented in 2011. Local Continuums of Care are collaboratives that include: provider agencies, local governments, and other stakeholders that prepare a housing strategy for a specific area or region utilizing HUD funding. Therefore it would benefit nonprofit agencies interested in developing supportive housing for its clients to participate in their local Continuum of Care. In the Eastern Region of Missouri, there are 4 Continuums of Care—St. Louis City; St. Louis County; St. Charles, Lincoln, and Warren Counties; and the Balance of State Continuum of Care.

The Frank Mehlville Supportive Housing Act of 2010

On January 4, 2011, President Barack Obama signed into law the Frank Melville Supportive Housing Investment Act of 2010 – groundbreaking legislation to revitalize and reform the U.S. Department of Housing and Urban Development (HUD) Section 811 Supportive Housing for Persons with Disabilities Program. The new and reformed Section 811 program has important features, with the potential to create thousands more units of integrated permanent supportive housing every year by: (1) providing stronger incentives to leverage other sources of capital for 811 units, including federal Low Income Housing Tax Credits, HUD HOME funds, and bond financing; (2) authorizing a 'stand alone' Project Based Rental Assistance approach to help state and local governments systematically create integrated supportive housing units in affordable rental housing developments.

The legislation also permanently transfers Section 811 funded vouchers to the Housing Choice Voucher program and ensures that other Housing Choice Vouchers appropriated by Congress for non-elderly people with disabilities continue to be used for that purpose. Funding through this Act would provide up to 30 years of rental assistance funds for housing units dedicated to people with disabilities. There is one caveat: the housing project needs to be multi-family and only 25% of the total units of the project can be dedicated to people with disabilities. There is also the question of how much the federal government will fund this act.

The National Housing Trust

After years of hard work, challenges, and setbacks, advocates across the country celebrated the creation of a National Housing Trust Fund in July of 2008. The National Housing Trust Fund was established as a provision of the Housing and Economic Recovery Act of 2008, which was signed into law by President George W. Bush. The passage of National Housing Trust Fund legislation is a major victory for low income housing advocates and the lowest income people in our country with the most serious needs. The housing trust fund will, once

[119] http://www.hudhre.info/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf (P. 9)

capitalized, provide communities with funds to build, preserve, and rehabilitate rental homes that are affordable for extremely and very low income households. The Housing Trust Fund's most important features are:

- It is a permanent program, and will have dedicated source of funding not subject to the annual appropriations process;
- At least 90% of the funds must be used for the production, preservation, rehabilitation, or operation of rental housing. Up to 10% can be used for the following homeownership activities for first-time homebuyers: production, preservation, and rehabilitation; down payment assistance, closing cost assistance, and assistance for interest rate buy-downs;
- At least 75% of the funds for rental housing must benefit extremely low income households and all funds must benefit very low income households.

Unfortunately, the financial crisis that followed shortly after authorization required the suspension of funds to that program. The challenge for advocates now is to see that funding for the program makes its way into the budget.

The Affordable Care Act

This act was recently signed into law in March 2010 and makes health insurance coverage more affordable for individuals, families, and the owners of small businesses. The Affordable Care Act is one aspect of a broader movement toward a reformed behavioral health system. Mental health parity laws, including rules issued by the Obama administration earlier this year, have taken important steps forward to stop the insurance company practice of arbitrarily limiting care for mental health or substance use disorders. Unfortunately, it can be difficult for people with mental health and substance use disorders to find affordable, quality coverage in the health insurance marketplace. Right now, estimates show that one-fifth to one-third of the uninsured are people with mental and substance use disorders. The Affordable Care Act takes steps to change that. Starting in 2014, substance abuse or mental illness can no longer be used by insurers to deny coverage as a "pre-existing condition" – and insurers also won't be able to use those conditions to raise premiums. Also in 2014, mental health and substance use disorder services will be part of the essential benefits package, a set of health care service categories that must be covered by certain plans, including all insurance policies that will be offered through the Exchanges, and Medicaid.

Low Income Housing Tax Credits (LIHTC):

The **Low Income Housing Tax Credit—LIHTC** (often pronounced "lie-tech")—was created under the Tax Reform Act of 1986 and is a dollar-for-dollar tax credit for affordable housing investments in the United States. This Act gives incentives for the utilization of private equity in the development of affordable housing in America aimed at those with low incomes such as the elderly, persons with disabilities, and the homeless. It has been widely successful – accounting for a majority of all affordable housing created in the United States since its inception. Almost all investors in LIHTC are corporations because the Tax Reform Act made changes that greatly reduced the value of tax credits and deductions to individuals. Each state is given a certain amount of tax credits based on the population of that state.

In August, 2011, the Missouri Housing Development Commission (MHDC), the largest funder of affordable housing in the state, approved its 2012 Qualified Allocation Plan for low income housing tax credits which included a 33% set aside for projects serving those with special needs. This brings great potential for increasing development of supportive housing units in Missouri. The actual language states MHDC will endeavor to set aside 33% depending upon the strength of applications; but, nonetheless, the opportunity is available if the special needs community takes advantage of it. The State Treasurer's Office estimates that this set aside could develop as many as 400 new supportive housing units with $120 million in tax credits. If this set aside continues in future years, it creates the potential of producing over 1,000 new housing units for people with special needs just within a 3-year period.

10-Year Plan to End Chronic Homelessness (St. Louis City and County)

In 2004 the City of St. Louis and St. Louis County partnered to create an ambitious plan to end chronic homelessness in 10 years (by 2015). The core goals of the plan in the City of St. Louis are:

- The addition of 500 permanent supportive housing beds for the homeless;
- The establishment of 8 Assertive Community Treatment Teams (ACT); and
- The creation of 4 Safe Havens.

In 2010 the City of St. Louis distributed a progress report which included the following:

- The number of permanent supportive housing beds for the chronically homeless have increased from 70 in 2005 to 217 in 2010;
- The number of permanent supportive housing beds for the homeless have increased from 750 in 2005 to 1,231 in 2010;
- One of the four safe havens is fully operational. Two more safe havens are in the planning and development stages;
- Six ACT teams are fully operational and one modified ACT team is under development;
- A 20% reduction in chronic homelessness;
- A decrease in the overall number of persons who are homeless from 1,485 in 2005 to 1,305 in 2010.

While significant progress has been made by the City of St. Louis to reduce homelessness, there is still a lot to do and several other challenges to take into consideration (listed below).

- The City is looking for regional collaboration to serve the homeless. Currently, a large portion of people presenting for shelter in the City are from other counties in the metropolitan area or from out of state;
- The City is looking for a way to help those with severe mental illness who are homeless find access to mental health care. The reduction in public funds over the last several years has reduced the amount of services that are available for the uninsured;
- Lack of jobs and income continue to be a barrier to people trying to achieve long-term housing stability in the City;
- The City will likely see an increase in the count of its overall homeless population. HUD is expanding its definition of homelessness and chronic homelessness.

The fact that the City of St. Louis is focused on reducing homelessness and wants regional collaboration to help people who are homeless creates possible opportunities for the region to increase the amount of supportive housing available to those with mental illness and addictions.

Other Policy Trends

Housing designed to serve persons with behavioral health needs is not a new topic in Missouri. The following summary presents recommendations from two state-wide groups: "Housing Implementation: Report and Recommendations Workgroup" and the "Governor's Committee to End Homelessness."

Missouri Mental Health Transformation Housing Workgroup- Housing Implementation Plan

The plan identified four problems facing persons with mental illness who are seeking housing. They are: Housing Availability, Housing Services and Support Availability, Legal and Administrative Issues, and Access to Information. The group developed recommendations to address each issue.

- **Housing Availability:** Provide ongoing technical assistance and expertise to developers and community partners to plan projects and identify/obtain funding sources, maximizing all federal dollars available. Provide strong support for the creation of truly affordable housing for individuals with disabilities. Ensure that the tools are available to keep people in their homes- rental assistance, utility assistance, and appropriate eligibility requirements.
- **Housing Services and Support Availability:** Increase the level of knowledge regarding the ability of people living with disabilities to live on their own by those who assist or advise them. Move to a system where funding follows the person so that services and supports also follow the individual regardless of where they live.
- **Legal and Administrative Issues:** Ensure that all citizens with disabilities have the freedom and the opportunity to make informed and enforceable decisions about how and where they will live.
- **Access to Information:** To create an integrated multi-media clearinghouse for information for clients and service providers.

Governor's Committee to End Homelessness

The Governor's Committee to End Homelessness has three primary responsibilities. First is facilitating the Balance of State Continuum of Care process. The second function of the Governor's Committee to End Homelessness is to raise awareness of homeless issues in Missouri. Third, the Committee maintains a list of resources and shares resources throughout the state. In the coming years the Governor's Committee seeks to:

- Gather and maintain information about homelessness and resources within the state;
- Provide affordable housing and supportive services for people who are homeless;
- Encourage commitment from state leadership to use mainstream resources to end homelessness;
- Facilitate local planning collaboratives to address community housing and homeless service delivery strategies;
- Take the necessary actions to fully utilize federal, state, and other funds available to address the needs of those experiencing chronic homelessness;
- Take the necessary actions to fully utilize federal, state, and other funds available to end generational homelessness among families;

- Take the necessary actions to fully utilize federal, state, and other funds available to end homelessness among veterans and their families;
- Take the necessary actions to fully utilize federal, state, and other funds available to develop housing for ex-offenders;
- Assure that various state discharge policies do not increase the number of formerly institutionalized individuals that become homeless.

Practice Trends

The general trend in housing for persons with behavioral health needs includes an array of housing options designed to incorporate safe and affordable community-based housing with access to needed services and supports. Historically the philosophy for housing used a traditional continuum model whereby individuals progress in a step-wise fashion from emergency and transitional programs with more intensive support and monitoring to more permanent, independent living situations. A continuum implies linearity in housing/support needs that often does not exist in reality. Some individuals do not progress to independent housing while others can skip levels along the continuum.

As an alternative to the continuum model, many housing advocates and researchers have argued for a housing first model, that by-passes transitional housing. Proponents of this model argue that independent housing should be offered immediately in order to prevent homeless people from becoming caught in the shelter system and the cycle of chronic homelessness.

Housing First

This is an approach that centers on providing homeless people with housing quickly and then providing services as needed. What differentiates a Housing First approach from other strategies is that there is an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing. This approach has the benefit of being consistent with what most people experiencing homelessness want and seek help to achieve. Housing First programs share the following critical elements:

- There is a focus on helping individuals and families access and sustain rental housing as quickly as possible and the housing is not time-limited;
- A variety of services are delivered primarily following a housing placement to promote housing stability and individual well-being;
- Such services are time-limited or long-term depending upon individual need; and
- Housing is not contingent on compliance with services – instead, participants must comply with a standard lease agreement and are provided with the services and supports that are necessary to help them do so successfully.

Permanent Supportive Housing

There is also a strong movement toward the use of a permanent supportive housing model. SAMHSA describes permanent supportive housing as “decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants’ needs and preferences.” It makes housing affordable

for people on SSI through rental assistance or housing development and provides sufficient wraparound services to allow people with significant support needs to remain in the housing they have chosen.

Core value: People with mental health disorders have the right to live in the most integrative setting possible with accessible, individualized supports.

There are six core principles of permanent supportive housing (PSH):

- **Choice in housing:** Consumers are not likely to be successful in housing that does not meet their needs and preferences;
- **Functional separation of housing and services:** There is NO requirement for participating in support services offered to get or keep housing. PSH is most successful when rent collection and maintenance of property is functionally separated from case management and other support services;
- **Decent, safe, and affordable housing:** PSH should meet HUD's housing quality standards. Tenants should pay a reasonable amount of their income towards rent and utilities. HUD's standard is paying no more than 30% of one's income for housing expenses;
- **Community integration and rights of tenancy:** PSH is in regular residential areas and mixed populations in buildings and neighborhoods are encouraged. Tenant rights are distinct from program rules and residents enjoy full legal rights in the tenant-landlord relationship. Tenants must abide by standards of behavior and conduct outlined in lease;
- **Access to housing and privacy:** PSH eliminates barriers and redefines "readiness". People with mental illness are not more successful in housing when they pass a "readiness screen". Determining access to housing should be the same as it would be for any tenant—such as ability to pay rent;
- **Flexible, voluntary, and recovery-focused services:** Supportive services are voluntary—tenants have the right to refuse them. However, staff must continue to offer support and use flexible engagement strategies. Tenants must have a flexible array of support services available to them. A "whatever-it-takes" attitude toward helping people stay in the housing of their choice is important. Recovery-oriented, consumer-driven, and evidence-based services work best. Fundamental elements of recovery include: self-direction; individualized and person-centered; empowerment; holistic; non-linear; peer support; respect; responsibility; and hope.

Models of Permanent Supportive Housing include:

- **Scattered-site:** Individual units dispersed throughout an area. This includes leased or owned apartments, condos, or single-family homes;
- **Single-site, mixed population:** This includes a large building or complex with multiple units of housing that serves more than one type of tenant (e.g. people with mental disorders, low-income families, seniors, etc.). This type often includes "set asides" targeted at a specific group and can be either owned or master-leased by a housing agency;
- **Housing First Strategy:** People move directly into affordable rental units directly from shelters, streets, or institutions. Home-based services are provided as long as needed.

Trauma Informed Housing

When it comes to housing, most consumers prefer an individual apartment or at the least their own room. While it may be cost effective to have people share rooms or restrooms, this does not always work well for people who are very symptomatic or for people who have experienced trauma. For some people with a history of trauma related to sexual abuse, single-sex housing may even be indicated. Ultimately the goal of trauma-informed housing should be to help people feel safe in their environment and in control of their own lives and situations. Privacy and boundary issues need to be carefully respected.

Harm Reduction Model

A central tenet of low barrier housing is that abstinence from substance use is not required or enforced; tenants are encouraged to pursue treatment if they wish. Thus principles of harm reduction and motivational enhancement are often guiding philosophies. Harm reduction is a set of practical strategies designed to reduce the negative consequences of drug use by promoting safer use, then managed use, and finally abstinence, if possible. Motivational enhancement interventions are incorporated into the overall treatment approach.

Although the harm reduction approach is controversial in some circles, it has been embraced by many professional bodies (e.g., American Association of Community Psychiatrists), and reviews of best practices in addictions housing. For people with long-term histories of substance abuse, harm reduction models are among the most effective treatment approaches. The success of this model may be partly due to its acceptability by individuals with addictions, many of whom are reluctant to stop using substances.

There are many best practice models locally and nationally. **Appendix B** provides a list of state and national best practice models as identified in the Missouri Transformation Housing Implementation Plan and by Corporation for Supportive Housing respectively.

Gap Analysis and Next Steps

Key Gaps/Critical Issues

The Needs Assessment and Resources Inventory identified many challenges faced by the behavioral health community. Five key gaps/critical issues identified in the assessment were:

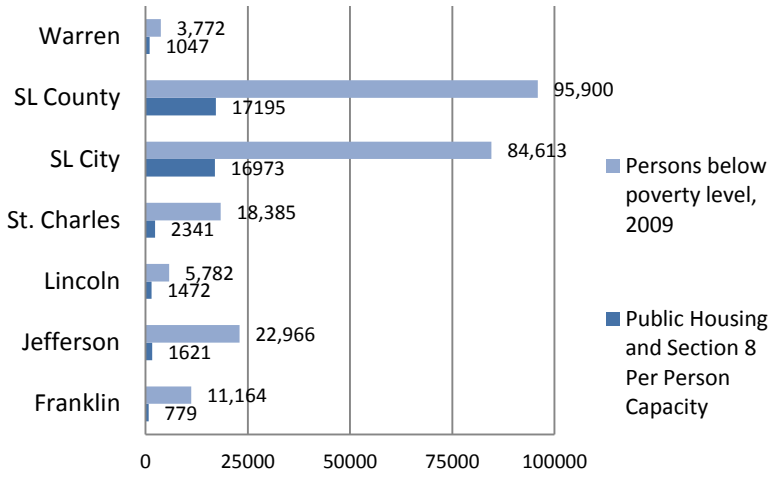
1. There is an overall lack of affordable housing available in the region especially in areas that are safe, accessible, and supportive to a person's wellbeing. Persons with mental illnesses and addiction disorders must compete with the general population for very scarce resources.
2. Few options are available for permanent supportive housing in the region that offer an array of housing choices with flexible support services. This is especially true in the more rural and outlying counties.
3. There is confusion among consumers and providers about what resources are available and how to coordinate them. There are no "one-stop shops" for housing assistance. Instead people must access services from multiple agencies based on what they need.
4. Public funds for both the development and provision of housing and services are limited and the distribution of these resources varies across the region. Also financing is very complex -funding sources have different criteria for who can be served, which makes it difficult to navigate the system and plan regionally.
5. Planning and development among key stakeholders and across geographic areas in the Eastern Region occurs in silos. The level of participation by organizations providing behavioral health services in existing community planning collaboratives varies.

Each of these is described in more detail below.

1. **There is an overall lack of affordable housing available in the region especially in areas that are safe, accessible, and supportive to a person's wellbeing. Persons with mental illnesses and addiction disorders must compete with the general population for very scarce resources.**
   - **a.** 85% of the BHN Consumer Survey respondents reported that they wanted to own and/or rent a house/apartment**.** However, 64% identified housing as being too expensive as the primary barrier keeping them from living where they want. Housing affordability was a key theme identified during the focus groups conducted by BHN and was also seen as a primary barrier by providers who were interviewed.
   - **b.** The existing gaps in the availability of affordable housing goes beyond challenges faced solely by persons with mental illness and/or substance abuse. The Eastern Region faces a much larger dilemma in that there is not sufficient affordable housing for the broader population of low-income people. Thus those with more specialized needs must compete with the broader population whose income is limited. We know there is a lack of affordable housing options because:

- The 2009 Census showed 242, 582 people below poverty in the Eastern Region. Public housing and Section 8 Vouchers form the bulk of subsidized housing in the region, however there exists a huge gap in such subsidies when compared to the persons in the most need as depicted in **Figure10**. Long waiting lists are the norm.

Figure 10: Public Housing units/Section 8 vouchers available as compared to Persons below Poverty Threshold



- With existing subsidized housing resources limited, the overall availability of affordable rental property is a critical issue. The median rental rates in the Eastern Region averages between $500-$749 and almost 50% of the renter-occupied units in the eastern region are paying 30%, or more, of their monthly household income on their rent.
- An individual needs to make at least $13.25 per hour to spend 30% of their monthly income on rent. Missouri's state minimum wage is $7.25. This means that people making less than $13.25 per hour are going to struggle to afford fair-market rent housing.
- People living on fixed incomes, such as SSI and/or SSDI, cannot even afford the upfront cost of paying a deposit, much less monthly rent. There are 40,623 individuals in the eastern region receiving Supplemental Security Income[120], which is an average payment of only $674 per month. Many persons with significant disabilities, including those with serious mental illnesses, are dependent upon SSI as their primary source of income.

c. The available affordable housing in the region is often undesirable because of where it is located. Some of the factors making the housing more affordable and also less desirable is that the housing is located in:

- Less safe neighborhoods (e.g. high crime rates);
- Isolated areas with minimal or no available public transportation making it difficult for people to access support services and employment opportunities;
- "Trigger areas" that are the same environments that caused someone to develop substance abuse problems, which makes relapses more likely.

[120] Social Security Administration, http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2010/mo.pdf

2. **Few options are available for permanent supportive housing in the region that offer an array of housing choices with flexible support services. This is especially true in the more rural and outlying counties.**
   a. There is a strong movement toward the use of a permanent supportive housing model for persons with significant behavioral health needs. SAMHSA describes permanent supportive housing as "decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences."

   b. There is **significant over-representation of persons with severe mental illness and substance abuse disorders who are homeless.** This indicates a need to develop more specialized supportive housing options in the region and shows that by serving persons with behavioral health illnesses we will also be addressing the needs of the homeless population.

   c. There is **limited availability of permanent supportive housing** to meet the needs of persons with behavioral health illnesses in the region. Continuum of cares reported only 1515 permanent supportive housing beds in the eastern region.

   d. An array of supportive housing options is needed to meet the individual needs of clients and allow clients to choose the type of housing they want. A variety of housing qualities need to be included with the development of new permanent supportive housing including varying degrees of privacy and independence to fit the needs of individual clients. The same issues with the location of affordable housing apply to the location of permanent supportive housing. The housing must be located in:
      - Safe neighborhoods;
      - Areas with public transportation so clients can access support services and employment opportunities;
      - Areas that are supportive to a person's recovery and are not the same environment that caused a person to develop substance abuse problems.

   e. There is a need for more permanent supportive housing across the region, however there is a larger gap in more rural counties for permanent supportive housing. Of the 1515 permanent supportive beds reported by continuum of care members, 79% are located in St. Louis City. Currently, there are few housing alternatives for someone other than living in a residential facility that offers room and board. This type of housing works for some people, but is not appropriate for all persons with behavioral health illnesses. The concentration of housing options in St. Louis City causes people to gravitate towards the city. To address this, more permanent supportive housing is needed in Jefferson, Lincoln, Warren, Franklin, and St. Charles Counties.

   f. Once a client is housed, it can be difficult for them to remain housed due to the symptoms of their illness. Persons with mental illness and substance abuse problems do not follow a linear path of recovery. Their symptoms often change and vary. This means that support services need to be flexible and change when a client's symptoms, and needs, change. It has been proven that the success of people staying housed is based on the support services that they are receiving.

3. **There is confusion among consumers and providers about what resources are available and how to coordinate them. There are no "one-stop shops" for housing assistance. Instead people must access services from multiple agencies based on what they need.**

   a. The BHN Consumer Survey and Focus Group results both indicated that clients do not readily know where to find housing information to meet their needs. Clients commented that even the case managers and social workers they had worked with did not always know where, or who, the clients should be directed towards. Overall, clients seemed generally confused on where they should seek housing assistance.

   b. Providers indicated the need for increased communication and coordination between agencies that provide housing and support services. Several providers who were interviewed acknowledged that providers need to have a better understanding of what resources are available and who provides them. Agencies often develop specialties and niches within the support services they provide. Greater communication between agencies would allow the agencies to know where to direct clients to so that their needs would be met.

   c. There is no organized way for providers to communicate between each other about what housing is available, and for whom, across the region. Resources are constantly changing and there is little coordination, especially on a regional level, between providers. Consumers and providers indicated the need for increased communication and coordination between agencies that provide housing and support services.

4. **Public funds for both the development and provision of housing and services are limited and the distribution of these resources varies across the region. Also financing is very complex -funding sources have different criteria for who can be served, which makes it difficult to navigate the system and plan regionally.**

   a. Public funding for both housing and supportive services is limited and inadequate to support the needs that exist.

   b. Financing is very complex. There are a variety of financing resources at the federal, state and local level that exist for the capital development of affordable housing, rental subsidies and supportive services throughout the region. Different funding resources are administered by a vast array of entities and have different rules on how the funding can, and cannot, be used. Some funding sources are designed for a specific geographic area and many have strict guidelines on who is eligible to receive the funding. These differences cause confusion among providers and make it challenging to develop a cohesive plan.

   c. Housing resources, both affordable housing stock and public financial assistance, vary across the region and are more available in St. Louis City when compared to the outlying counties for a variety of reasons.

   d. Financing options for permanent supportive housing varies; for example not all geographic areas have received Shelter+Care funding (a supportive housing program for people who are homeless).

5. **Planning and development among key stakeholders and across geographic areas in the Eastern Region occurs in silos. The level of participation by organizations providing behavioral health services in existing community planning collaboratives varies.**

a. Although several community planning mechanisms are currently in place across the region, including the Consolidated Plan and local Continuum of Care planning processes, the participation from behavioral health providers, advocacy groups and consumers varies. A strong and consistent voice from the behavioral health community can ensure that the needs of people with mental illnesses and addictions are addressed as part of the planning process.

b. Also, much of the planning that does occur happens within organizational and geographic silos. The existing planning processes need to be tied together so that there is a more cohesive, regional plan that bridges different communities and facilitates conversations between communities that are seeking to address related problems.

c. Service providers, developers, housing managers, funders and other stakeholders all have varying expertise in the development and operation of housing and the provision of supportive services. Behavioral health providers acknowledge that consumer access to affordable housing is critical to their mission but do not feel they have the core competencies to meet this need on their own. Funders, developers and housing managers have different expertise related to the planning, financing, development and/or operation of affordable housing but lack knowledge about the specific needs of people with mental illnesses and addictions and the supportive services available. To adequately address the housing needs faced by persons with behavioral health illnesses, key stakeholders need to convene around the same table. Some of these stakeholders include: housing developers, housing financers, housing managers, behavioral health providers, local community leaders and consumers. This level of participation has recently been promoted and emphasized at a state level. The Eastern Region needs this kind of facilitation to bring the key stakeholders together to discuss how to effectively collaborate.

Summary & Next Steps

An array of affordable housing and supportive service options is needed to meet the individual needs of people with mental illnesses and addictions in the Eastern Region and allow them to choose the type of housing they want. There are significant and obvious gaps in the resources available as compared to the needs that exist across the region. Also, the complexity of the system as it exists today makes it extremely difficult for consumers and providers of services to navigate the system and access the limited resources that do exist.

In addition to the issues identified above, public policies (local ordinances, categorical funding requirements, etc.) as well as the stigma that is often associated with having a mental health or addiction problem, can significantly impact a person's choice in living arrangements. Also, differing housing philosophies exist amongst and within the various stakeholder groups which impact consumer choice. Each of these issues must be considered and addressed to garner effective solutions.

Despite the myriad of issues that exist, there are many promising public policy and practice trends, as described in this report, that can contribute to needed systemic changes. Also there are many examples of best practices both locally and nationally that can be drawn upon as the planning process moves forward.

Given the complexities of the system and the scarcity of resources, collective action between all sectors involved in the development and provision of affordable housing and support services must be taken to develop effective and sustainable solutions that will increase the availability of decent, safe and affordable housing for persons with mental illness and addiction problems.

The next steps planned by the BHN include meeting with key stakeholders to share and discuss the information contained in this report and expanding the current workgroup to develop a regional action plan. Although the issues are daunting, it is hoped that the development of a regional approach will result in a shared vision and common purpose that will produce the best outcomes for the people and communities we serve.

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Appendix A-Best Practice Models

The following are examples of permanent supported housing projects that can be found at the Corporation for Supportive Housing website at www.csh.org). Below is a list of projects by topics:

Employment: Deborah's Place

Family Supportive Housing: Canon Barcus

Rural Housing: Kentucky Housing Corporation

Scattered-site project: Community Engagement Program

Single-site project: Outreach Center Apartments

System-wide strategies: Chicago

The Missouri Mental Health Transformation Housing Workgroup report identified several best practice models both nationally and within Missouri as follows:

"Best Practices" in Housing: Missouri Examples

Beyond Housing www.beyondhousing.org

Community Housing Network www.communityhousingnet.org

Burrell Behavioral Health www.burrellcenter.com

Family Counseling Center www.familycounselingcenter.org

Places for People www.PlacesforPeople.org

Doorways www.doorwayshousing.org

"Best Practices" in Housing: National Examples

State of Washington 1811 Eastlake Supportive Housing Project www.desc.org/1811.html

Tennessee Creating Homes Initiative (CHI) www.housingwithinreach.org

Denver: Renaissance Housing www.coloradocoalition.org

Minnesota: The Mental Health Housing Mission www.dhs.state.mn.gov and

www.mnhousing.gov

Collaborative Support Programs of New Jersey, Inc. www.cspnj.org

Appendix B- BHN Planning Workgroup Membership List

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Appendix C-Glossary of Terms

The following glossary is based in the Glossary of Terms used in "State of Homelessness in Missouri: 2011 Report", published by the Missouri Housing Development Corporation. http://www.mhdc.com/ci/documents/SHM_2011.pdf.

Additional definitions were added from the Department of Mental Health, Department of Health and Senior Services, and Corporation for Supportive Housing.

Affordable Housing

A general term applied to public and private-sector efforts to help low- and moderate-income people purchase or lease housing. As defined by the United States Department of Housing and Urban Development, any housing accommodation for which a tenant household pays 30% or less of its income.

Area Median Income (AMI)

A figure calculated by HUD based on census data, for specific size households in a specific area. The median income divides the income distribution into two equal groups, one having incomes above the median, and other having incomes below the median.

Assertive Community Treatment (ACT)

ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year.

Assisted Living Facility (ALF)

Facility provides 24-hour care, services and protective oversight to residents who are provided with shelter and board, and who may need assistance with activities of daily living which include eating, dressing, bathing, toileting, transferring and walking. Facility also provides oversight for storage, distribution, or administration of medications; and health care supervision under the direction of a licensed physician, and consistent with a

social model of care. A social model of care includes long-term care services based on the abilities, desires, and functional needs of individuals delivered in a setting that is more home-like than institutional and which promotes the dignity, privacy, independence, and autonomy of the individual. A licensed Nursing Home Administrator is required. This type of facility may accept or retain residents who require minimal assistance in their safe evacuation from the facility.

At Risk of Homelessness

The term "at risk of homelessness" with respect to an individual or family, means that the individual or family:

- has income below 30 percent of median income for the geographic area;
- has insufficient resources immediately available to attain housing stability; (C) (i) has moved frequently because of economic reasons;
    - is living in the home of another because of economic hardship;
    - has been notified that their right to occupy their current housing or living situation will be terminated;
    - lives in a hotel or motel;
    - lives in severely overcrowded housing;
    - is exiting an institution;
    - otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness.

Balance of State (BoS)

Many states have large areas (often rural in nature) which are not covered by regional, county or city continuums. These were generally formed in the late 90s to take advantage of the formula funding of the HUD McKinney-Vento grants. Balance of state continuums operate in 31 states and make up 7 percent of all continuums. These continuums often include both highly functional local continuums and weak local organizations which have joined together to submit a single McKinney-Vento application for their combined geographical area.

The Balance of State Continuum of Care encompasses 101 counties throughout the state of Missouri. The Continuum of Care is a community plan to end homelessness. Agencies in the Balance of State regions can apply for funds through the Balance of State Continuum of Care on an annual basis. These funds are released by the Department of Housing and Urban Development. Funding categories include permanent housing, transitional housing, supportive services only and safe havens. The Community Initiatives Department has divided the state into two areas consisting of ten regions, with an individual coordinator for each area.

Behavioral Health Services

This is an umbrella term that includes services for mental illnesses and addictive disorders.

Case management

The overall coordination of an individual's use of services, which may include medical and mental health services, substance use services, and vocational training and employment. Although the definition of case management varies with local requirements and staff roles, a case manager often assumes responsibilities for outreach, advocacy, and referral on behalf of individual clients.

Chronically Homeless[121]

The term chronically homeless means, with respect to an individual or family, that the individual or family

- Is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter;
- has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least 4 separate occasions in the last 3 years;
- has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions;
- person who currently lives or resides in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital or other similar facility, and has resided there for fewer than 90 days shall be considered chronically homeless if such person met all of the requirements above prior to entering that facility.

Community Development Block Grants (CDBG)

Community Development Block Grants are provided to communities from the U.S. Dept. of Housing and Urban Development (HUD) for a range of eligible activities, setting their own priorities as long as they meet basic program requirements. Larger cities and counties receive formula funding; small communities compete for funding which is administered by states.

[121] This definition will likely change in 2012 as a result of federal legislation.

Community Development Corporation (CDC)

Non-profit groups accountable to local residents that engage in a wide range of physical, economic and human development activities. CDCs rebuild their communities through housing, commercial, job development and other activities. A CDC's mission is normally focused on serving the local needs of low- or moderate-income households.

Consumers

Recipients of mental health and substance abuse services. This term is used interchangeably with "client", "patient" or "persons with behavioral health needs".

Continuum of Care (CoC)

A collaborative funding and planning approach that helps communities plan for and provide, as necessary, a full range of emergency, transitional, and permanent housing and other service resources to address the various needs of homeless persons. HUD also refers to the group of service providers involved in the decision making processes as the Continuum of Care. The Continuum of Care is a comprehensive system assembled to address homelessness by providing communities with a framework for organizing and delivering housing and services. The overall approach is predicted on the understanding that homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs physical, economic, and social.

Disabling Condition

Federal laws define a person with a disability as "Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment. In general, a physical or mental impairment includes hearing, mobility and visual impairments, chronic alcoholism, chronic mental illness, AIDS, AIDS Related Complex, and mental retardation that substantially limits one or more major life activities. Major life activities include walking, talking, hearing, seeing, breathing, learning, performing manual tasks, and caring for oneself. Not all disability definitions include the above referenced conditions, for example, an addictions disorder is not considered a disability for the purposes of eligibility for Supplemental Security Income (SSI).

Division of Alcohol and Drug Abuse

A division of the Missouri Department of Mental Health that is the single state agency responsible for overseeing a statewide network of publically-funded substance abuse prevention, treatment, and recovery support services throughout the State of Missouri.

Division of Comprehensive Psychiatric Services (CPS)

A division of the Missouri Department of Mental Health that is the single state agency responsible for assuring the availability of prevention, evaluation, treatment, and rehabilitation services for individuals and families requiring public mental health services and overseeing a state-wide network of publically funded mental health services throughout the State of Missouri.

Domestic Violence

Domestic violence can be defined as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.

Dually-diagnosed

Term used to describe individuals who are diagnosed with two different disorders, typically a combination of mental health and substance abuse diagnoses.

Eastern Region of Missouri

This region consists of St. Louis City and County, St. Charles County, Franklin County, Warren County, Lincoln County, and Jefferson County.

Emergency Shelter

Emergency shelters are intended to provide a safe, secure, temporary place for individuals and households to reside while they seek more permanent housing or supportive services that will facilitate access to permanent housing options. Emergency shelters often times are the point of entry into the homeless system, assisting those confronted with an immediate loss of housing or those who are already homeless. Emergency shelters generally have a length of stay ranging from 1 to 90 days, depending on the individual program.

Fair Housing Act

Legislation first enacted in 1968 and expanded by amendments in 1974 and 1988, which created within HUD investigation and enforcement responsibilities for fair housing practices. The Act prohibits discrimination in housing and mortgage lending based on race, color, religion, sex, national origin, disability, or familial status.

Federal Housing Administration (FHA)

A federal agency that provides mortgage insurance on loans made by FHA-approved lenders. FHA insures mortgages on single family and multifamily homes including manufactured homes and hospitals. It is the largest insurer of mortgages in the world, insuring over 34 million properties since its inception in 1934.

Fair Market Rent (FMR)

Rent schedules published in the Federal Register that establish maximum eligible rent levels allowed under the Section 8 program by geographic area. FMRs are also used by other federal rent subsidy programs such as Shelter Plus Care.

Housing Assistance Payment (HAP)

Funds paid to a Landlord as rental assistance for a tenant enrolled in a rent subsidy program; the amount is the difference between the contract rent and the tenant's share of the rent, which is based on the household's income.

Harm reduction

Harm reduction is a set of strategies that reduce the negative consequences associated with drug use, including safer use, managed use, and non-punitive abstinence. These strategies meet drug users "where they're at," addressing conditions and motivations of drug use along with the use itself. Harm reduction acknowledges an individual's ability to take responsibility for his or her own behavior. This approach fosters an environment where individuals can openly discuss substance use without fear of judgment or reprisal, and does not condone or condemn drug use. Staff working in a harm reduction setting work in partnership with tenants, and are expected to respond directly to unacceptable behaviors, whether or not the behaviors are related to substance use. The harm reduction model has also been successfully broadened to reducing harms related to health and wellness as well as many other issues.

HIV/AIDS

The human immunodeficiency virus (HIV) is the virus that causes AIDS. HIV attacks the immune system by destroying CD4 positive (CD4+) T cells, a type of white blood cell that is vital to fighting off infection. The destruction of these cells leaves people infected with HIV vulnerable to other infections, diseases and other complications. The acquired immunodeficiency syndrome (AIDS) is the final stage of HIV infection. A person infected with HIV is diagnosed with AIDS when he or she has one or more opportunistic infections, such as pneumonia or tuberculosis, and has a dangerously low number of CD4+ T cells (less than 200 cells per cubic millimeter of blood).

Homeless Emergency and Rapid Transition to Housing Act (HEARTH Act)

The 2009 reauthorization of the McKinney-Vento Homeless Assistance Act. The HEARTH Act altered several parts of the McKinney-Vento homeless assistance programs, including consolidating HUD's competitive grant programs; creating a Rural Housing Stability Program; changing HUD's definition of homelessness and chronic homelessness; simplifying grant match requirements; increasing homelessness prevention resources; and increasing emphasis on performance.

Homeless Individual,* (*Homeless, Homeless Person)

In general the term "homeless" or "homeless individual or homeless person" includes:

- an individual who lacks a fixed, regular, and adequate nighttime residence; and
- an individual who has a primary nighttime residence that is:
    - a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
    - an institution that provides a temporary residence for individuals intended to be institutionalized;
    - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.
- Income eligibility: In general, a homeless individual shall be eligible for assistance under any program provided by this chapter, only if the individual complies with the income eligibility requirements otherwise applicable to such program.

The term —homeless, —homeless individual, and —homeless person, as defined in the 2009 Hearth Act means:

- an individual or family who lacks a fixed, regular, and adequate nighttime residence;

- an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
- an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
- an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
- an individual or family who:
    - will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations;
    - has no subsequent residence identified;
    - lacks the resources or support networks needed to obtain other permanent housing.
- unaccompanied youth and homeless families with children and youth defined as homeless under other federal statutes:
    - the Secretary shall [HUD] consider to be homeless any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

Homeless Management Information Systems (HMIS)

HMIS provides communities with a tool to collect and analyze data on people using homeless service programs. By allowing communities to calculate accurately the size and needs of the homeless population, the demand for and use of housing and services, as well as the outcome of various interventions, an HMIS allows a community to determine where things are working well, what is not working, and how to use resources in the most strategic manner.

Housing First

The goal of "housing first" is to immediately house people who are homeless. Housing comes first no matter what is going on in one's life, and the housing is flexible and independent so that people get housed easily and stay housed. Housing first can be contrasted with a continuum of housing "readiness," which typically subordinates access to permanent housing to other requirements. While not every community has what it

needs to deliver housing first, such as an adequate housing stock, every community has what it takes to move toward this approach

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Housing and Urban Development (HUD)

The U.S. Department of Housing and Redevelopment, created in 1965 to administer programs of the federal government which provide assistance for housing for the development of the nation's communities. HUD administers housing and home finance programs, the Public Housing Administration and FHA.

Individuals (Sheltered homeless individuals)

The HMIS-based estimates of sheltered homeless individuals include single adults, unaccompanied youth, persons in multi-adult households, and persons in multi-child households. A multi-adult household is a household composed of adults only—no children are present. A multi-child household is composed of children only (e.g., parenting youth)—no adults are present.

Intake

The process for determining or assessing eligibility of applicants for services

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Intensive Community Psychiatric Rehabilitation in Specific Residential Settings (I-CPR RES)

The DMH program is for those adult consumers whose severity and chronicity of mental illness is such that they have either failed in multiple community settings and/or present an ongoing risk of harm to self or others, resulting in long-term psychiatric hospitalization. I-CPR RES involves on-site staff in the residential setting on either a full or part-time basis to ensure that consumers in the complex do not engage in behaviors that are harmful to themselves or others, or in activities that involve a high risk of relapse of psychiatric symptoms or other behaviors requiring long-term hospitalization. Rehabilitation Services are available both on site and in the community to promote symptom amelioration and psychiatric recovery, and to assist the consumer in progressing toward lower levels of care. There are three tiers:

- ***Clustered Apartments***: This setting involves individual apartments clustered together in one or more apartment complexes, with on-site staff available on either a full or part-time basis, who are able to monitor points of ingress/egress, provide periodic room checks, assist with medications, and offer intensive clinical interventions and supports to reduce symptoms of mental illness, and to intervene and redirect consumer who are in psychiatric crisis and are exhibiting behavior that are potentially dangerous to themselves or others. Unlike other I-CPR RES settings, the provision of services in a Clustered Apartment setting (I-CPR RES/CA) is of particular value for those consumers who are unable

to tolerate congregate living arrangements in which the presence of other consumers in their immediate living area tends to precipitate psychiatric relapse, aggression or other behaviors associated with a risk of re-hospitalization. However, such consumers may possess sufficient competence in activities of daily living that round the clock observation and oversight on site are unnecessary, enabling limited independence while in the apartment setting. Although many rehabilitation activities will be provided on-site, it is expected that the majority of psychiatric rehabilitation services received will be obtained in the community.

- ***Intensive Residential Treatment Setting (IRTS):*** This setting involves a congregate living environment with 5 to 16 beds, with on-site staff available on a full -time basis, who are able to monitor points of ingress/egress, provide periodic room checks, assist with medications, and offer intensive clinical interventions and supports to reduce symptoms of mental illness, and to intervene and redirect consumer who are in psychiatric crisis and are exhibiting behavior that are potentially dangerous to themselves or others. Unlike Clustered Apartment settings, the provision of services in an Intensive Residential Treatment setting (I-CPR RES/IRTS) is of particular value for those consumers who tolerate regular interaction with their peers, but who have significant difficulties with activities of daily living, and may require round the clock observation and oversight on site. In addition, they will require periodic redirection from on-site staff to avoid behaviors potentially harmful to themselves or others. It is expected that rehabilitation services received will be evenly distributed between those provided on-site and those obtained in the community.
- ***Psychiatric Individualized Supported Living Environment (PISL)****:*This setting involves a private home with 2 to 4 bedrooms, with on-site staff available on a full-time basis, who are able to monitor points of ingress/egress, provide periodic room checks, assist with medications, and offer intensive clinical interventions and supports to reduce symptoms of mental illness, and to intervene and redirect consumer who are in psychiatric crisis and are exhibiting behavior that are potentially dangerous to themselves or others. The provision of services in a Psychiatric Individualized Supported Living Environment (I-CPR RES/PISL) is of particular value for those consumers who have intermittent difficulty tolerating other consumers in their immediate living area, requiring access to an individual bedroom to avoid psychiatric relapse, aggression or other behaviors associated with a risk of re-hospitalization. However, unlike consumers in Clustered Apartment settings, they will have substantial difficulties with activities of daily living, and will require round the clock observation and oversight on site. In addition, unlike consumers in all other I-CPR RES settings, they will require daily redirection from on-site staff to avoid behaviors potentially harmful to themselves or others. It is expected that rehabilitation services received will be predominantly provided on-site, although some services will be obtained in the community.

Intermediate Care Facility (ICF)

Facility provides 24-hour accommodation, board, personal care, and basic health and nursing care services under the daily supervision of a licensed nurse and direction of a licensed physician to three or more residents dependent for care and supervision. Licensed Nursing Home Administrator is required.

Low Income Housing Tax Credit (LIHTC)

A congressionally created tax credit (Internal Revenue Code Section 42) available to investors in low income housing designed to encourage investment that helps finance construction and rehabilitation of housing for low income renters.

Master leasing

A legal contract in which a third party (other than the actual tenant) enters into a lease agreement with the property owner and is responsible for tenant selection and collection of rental payments from sub-lessees.

McKinney-Vento Homeless Assistance Act (a.k.a. McKinney Vento)

The McKinney-Vento Act is the original 1987 authorizing legislation for all HUD homeless assistance programs. It originally consisted of fifteen programs providing a range of services to homeless people, including the Continuum of Care homeless assistance programs: Supportive Housing Program, Shelter Plus Care, and Single Room Occupancy Program, as well as the Emergency Shelter Grant Program. The Act was reauthorized and extensively amended by the HEARTH Act effective May 2009.

Median Income

The income level at which half of the population earn more income and half earn less. Each year HUD establishes the Median Income for states and metropolitan areas based on household size. HUD revised these figures periodically.

Medicaid

State and federally funded health care insurance for low income and needy populations. Medicaid is the means by which many participants in Shelter Plus Care pay for their case management and other needed mental health services. In Missouri, the Medicaid program is called MO HealthNet.

Medicare

The national health insurance program for those age 65 and older and for some persons under age 65 with disabilities.

MHDC (Missouri Housing Development Commission)

Missouri's state housing finance agency established by the 75th General Assembly in 1969. MHDC functions as a bank, providing financing directly to borrowers or through a network of private lending institutions. Most of MHDC's programs operate as a public-private partnership. MHDC operates the Missouri Housing Trust Fund and facilitates the Missouri Balance of State Continuum of Care process.

MHTF (Missouri Housing Trust Fund)

The Missouri Housing Trust Fund was created by the State Legislature in 1994 to help meet the housing needs of very low-income families and individuals. It provides funding for a variety of eligible activities, including rental housing production, housing and related services for the homeless, homeless prevention and rental subsidies, among other activities.

Mental Health Residential Care Facility (MHRCF)

The Mental Health Residential Care Facility is a long term residential setting licensed for 12 to 15 residents by the Division of Health and Senior Services as a Residential Care Facility I and may also be licensed by the Department of Mental Health. The Administrator shall have an administrator's license issued by the Division of Health and Senior Services. These facilities are designed to serve an adult population of mentally ill individuals who require increased structure, oversight and support to be maintained in placement. The program is directed toward a population which has been characterized as a "problem" or "difficult" to place.

Mental Illness

A medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. Mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.

MO Healthnet Division

MO Healthnet is a division of the Missouri Department of Social Services responsible for purchasing and monitoring health care services for low income and vulnerable citizens of the State of Missouri. The agency is the state Medicaid authority. It assures quality health care through the development of service delivery systems, standards setting and enforcement, and education of providers and participants.

One-Year Sheltered Counts

12-month counts of homeless persons who use an emergency shelter or transitional housing program at any time from October through September of the following year. The one-year counts are derived from communities' administrative databases, or Homeless Management Information Systems (HMIS).

Permanent Supportive Housing (As defined by the Corporation for Supportive Housing)

Supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. Supportive housing works well for people who face the most complex challenges—individuals and families who are not only homeless, but who also have very low incomes and serious, persistent issues that may include substance use, mental illness, and HIV/AIDS. Features of a Permanent Supportive Housing unit includes:

- The unit is available to, and intended for, a person or family whose head of household is homeless, or at-risk of homelessness, and has multiple barriers to employment and housing stability, which might include mental illness, chemical dependency, and/or other disabling or chronic health conditions;
- The tenant household ideally pays no more than 30% household income towards rent and utilities, and never pays more than 50% of income toward such housing expenses;
- The tenant household has a lease (or similar form of occupancy agreement) with no limits on length of tenancy, as long as the terms and conditions of the lease or agreement are met;
- The unit's operations are managed through an effective partnership among representatives of the project owner and/or sponsor, the property management agent, the supportive services providers, the relevant public agencies, and the tenants;
- All members of the tenant household have easy, facilitated access to a flexible and comprehensive array of supportive services designed to assist the tenants to achieve and sustain housing stability;
- Service providers proactively seek to engage tenants in on-site and community-based supportive services, but participation in such supportive services is not a condition of ongoing tenancy;
- Service and property management strategies include effective, coordinated approaches for addressing issues resulting from substance use, relapse, and mental health crises, with a focus on fostering housing stability.

Permanent Affordable Housing

Permanent affordable housing is long-term, safe, decent, and affordable housing for individuals and households. The principle challenge facing communities in preventing and eradicating homelessness continues to be centered on the lack of permanent affordable housing. As such, it is critical that continuums work with the broader housing and community development community and coordinate long-term planning efforts.

Permanent Housing

In the world of supportive housing, the term "permanent" typically refers to affordable rental housing in which the tenants have the legal right to remain in the unit as long as they wish, as defined by the terms of a renewable lease agreement. Tenants enjoy all of the rights and responsibilities of typical rental housing, so long as they abide by the (reasonable) conditions of their lease.

Persons in Families

The HMIS-based estimates of homeless persons in families include persons in households with at least one adult and one child.

Point-In-Time (PIT) Counts

One-night counts of both sheltered and unsheltered homeless populations. The one-night counts are reported on CoC applications and reflect a single-night during the last week in January.

Psychiatric Group Home I (PGH I)

A transitional residential treatment setting licensed by the Division of Aging as a Residential Care Facility I and by the Department of Mental Health for 15 clients or less. The facilities are designed to provide a living arrangement and treatment services for “young chronic” adult clients, ages 17 - 45, with severe or persistent mental or emotional disorders that severely limit their functional capabilities related to primary aspects of daily living and social role functioning, but who have a high probability for response to this form of treatment intervention. While there is a great clinical diversity in this population, most clients can be profiled as active, aggressive, non-compliant persons who have a low tolerance for frustration. Because this population grew up with de-institutionalization, they are not expected to have long histories of inpatient hospitalizations in state facilities. The length of stay in psychiatric group home is limited to 18 months

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Psychiatric Group Home II (PGH II)

A transitional residential treatment setting licensed by the Department of Mental Health for eight to ten residents. These group homes are designed to provide a therapeutically nurturing environment with an extensive program of care services based around adult learning skills and prevocational and vocational exposure. The target population to be served is severely disturbed young adults, ages 17 - 21 years. Exceptions must meet the guidelines established in 9 CSR 40-4.116 (7) (A). The target population whose profile might include aggressive with combative behaviors, mixed with immaturity, dependency, impulsiveness, low self-esteem, an inability to establish positive relationships and/or a dysfunctional use of services. This population does not fit into residential treatment programs for mentally ill children and youth or adult

placement facilities. Although these adolescents and young adults frequently have long histories of state facility hospitalizations and are severely disturbed, the length of stay is limited to 24 months

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Residential Care Facility I (RCF I)

Facility which provides 24-hour care to three or more residents who need or are provided with shelter, board, and protective oversight, which may include storage, distribution or administration of medications and care during short-term illness or recuperation. Residents who live in a RCF are required to make a path to safety unassisted. A licensed Nursing Home Administrator is not required.

Residential Care Facility II (RCF II)

Facility which provides 24-hour accommodation, board, and care to three or more residents who need or are provided with supervision of diets, assistance in personal care, storage, distribution or administration of medications, supervision of health care under the direction of a licensed physician, and protective oversight, including care during short-term illness or recuperation. Residents who live in a RCF are required to make a path to safety unassisted. A licensed Nursing Home Administrator is required.

Residential Facilities

This is a general term used to describe congregate living settings that provide room and board for clients such as specialized nursing facilities and residential care facilities.

Scattered-site

Housing units that are not located at one single location.

Serious Mental Illness

Includes: major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder.

Sheltered

A homeless person who is in an emergency shelter or transitional housing program for homeless persons.

Shelter Plus Care (S+C)

This program is designed to ensure the availability of supportive housing opportunities for homeless people with disabilities and their families. S+C also has a primary focus on persons who have mental illness; who have chronic problems with alcohol, drugs, or both; or have HIV/AIDS. Through this program four types of rental assistance are available: tenant-based, project-based, sponsor-based, and single room occupancy.

Skilled Nursing Facility (SNF)

Facility provides 24-hour accommodation, board and skilled nursing care and treatment services to at least three residents. Skilled nursing care and treatment services are commonly performed by or under the supervision of a registered professional nurse for individuals requiring twenty-four hour care by licensed nursing personnel including acts of observation, care and counsel of the aged, ill, injured or infirm, the administration of medications and treatments as prescribed by a licensed physician or dentist, and other nursing functions requiring substantial specialized judgment and skill. Licensed Nursing Home Administrator is required.

Single room occupancy (SRO) Building

A type of building that offers residents a single, furnished room, usually with shared bathroom and kitchen facilities.

Supplemental Security Income (SSI)

United States government program that provides stipends to low-income people who are either aged (65 or older), blind, or disabled. Although administered by the Social Security Administration, SSI is funded from the U.S. Treasury general funds, not the Social Security trust fund. SSI was created in 1974 to replace federal-state adult assistance programs that served the same purpose. The restructuring of these programs was intended to standardize the eligibility requirements and level of benefits

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Social Security Disability Insurance (SSDI)

SSDI is a payroll tax-funded, federal insurance program of the United States government. It is managed by the Social Security Administration and is designed to provide income supplements to people who are physically restricted in their ability to be employed because of a notable disability, usually a physical disability. SSDI can be supplied on either a temporary or permanent basis, usually directly correlated to whether the person's disability is temporary or permanent

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Supportive Housing

The term "supportive" in supportive housing refers to housing with voluntary, flexible services designed primarily to help tenants maintain housing. These *voluntary services* are those that are available to but not demanded of tenants, such as service coordination/case management, physical and mental health, substance use management and recovery support, job training, literacy and education, youth and children's programs, and money management.

Transitional Housing

Transitional housing provides interim placement for persons or households who are not ready for or do not have access to permanent housing. Transitional housing is limited to a length of stay of up to 24 months and provides an opportunity for clients to gain the personal and financial stability needed to transition to and maintain permanent housing.

The term transitional housing means housing the purpose of which is to facilitate the movement of individuals and families experiencing homelessness to permanent housing within 24 months or such longer period as the Secretary determines necessary.

Underserved populations

The term underserved populations includes populations underserved because of geographic location, underserved racial and ethnic populations, populations underserved because of special needs (such as language barriers, disabilities, alienage status, or age), and any other population determined to be underserved, as appropriate.

Unsheltered

A homeless person who is living in a place not meant for human habitation, such as the streets, abandoned buildings, vehicles, parks, and train stations.
